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February 9, 2015

Senate Committee on Business and Transportation
Please Vote YES on Senate Bill 317

Chair Beyer and Members of the Committee,

I am a Portland lawyer. The bulk of my work is in representing consumers in claims against insurers for denied claims under health, disability and life insurance policies.

My first and most critical point, which has been made in other testimony to this Committee, is that **the Insurance Division expressly banned discretionary clauses approximately ten years ago**. However, there has not been adequate compliance with the ban by insurers. In my experience as lawyer who regularly reviews policies issued to Oregon consumers and businesses, these deceptive clauses frequently, if not routinely, appear in policies issued in Oregon despite the Insurance Division's ban. SB317 reinforces the **existing** ban and makes it easier for the Insurance Division, lawyers and consumer advocacy groups to obtain compliance with the existing ban.

My second point is that SB317 should not be controversial. The NAIC (National Association of Insurance Commissioners), unanimously passed a ban on discretionary clauses as model legislation in approximately 2001. See Exhibit 1. At least 21 states took the NAIC's lead and have banned discretionary clauses as a matter of state law or regulation. See Exhibit 2.

I will explain as a practical matter what it means to a consumer when his or her health or disability policy contains a discretionary clause.

Because many of these policies are issued to private employers in the form of group coverage, they are subject to the federal law of ERISA, the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1001.

When a consumer challenges a claim denial under ERISA, the case is not tried before a jury and there is no live tesimony. Instead, the insurer's denial decision is reviewed by a judge, and the "default" rule is that the reviewing judge determines on a *de novo* review whether the claimant met his or her burden of proving by a **preponderance of the evidence** that the claim should be paid. This is the civil standard most of us know from jury trial service.

However, if the policy contains a **discretionary clause** that gives the insurer the "discretionary authority" to make benefit decisions, the court does not apply the *de novo* review standard. Instead, because of the discretionary clause, the judge is **required** to affirm the insurer's decision, unless the judge concludes that the insurer has **abused its**

discretion. This is nothing more than a glorified sniff test. The review is not searching or objective but is highly deferential to the insurer.

There is another gross unfairness in the application of this **abuse of discretion** review standard. A cardinal rule of contract interpretation under Oregon law and under the common law in this country is that any unclear or vague terms in an insurance policy are construed against the insurer and in favor of the consumer. That is a common sense rule that attempts to level the playing field between the sophisticated insurer that that wrote the contract and the consumer that bought it. However, when the policy contains a discretionary clause, this rule goes by the wayside. Instead, the rule that applies is that any **plausible interpretation** by the insurer of the vague term must be affirmed. That is fundamentally unfair.

My third point is that it is critically important to consumers that Oregon ban discretionary clauses as a matter of statute.

The case that is the subject of Exhibits 3 and 4 to my testimony, litigated in 2013, **nine years after** Oregon banned discretionary clauses, highlights why this ban is so important. The case involved a denial of disability benefits by Unum to an Oregon resident who suffered from disabling post-traumatic stress disorder after a sexual assault. Every one of her medical and mental health providers emphatically asserted that she was disabled. Only the insurer's consultants, who never met her, asserted she was not.

The insurer's policy contained a discretionary clause, **even though it was issued years after Oregon banned discretionary clauses.** In response to my argument that the discretionary clause was not enforceable because of Oregon's ban (on pages 4-7 of Exhibit 2), the insurer pointed to the fact the Insurance Division had approved Unum's form despite its inclusion of a discretionary clause as evidence that its clause was allowed (on pages 27-28 of Exhibit 3). Clearly, the current ban is not enough. Despite Oregon's ban, this insurer included the clause and asserted on its forms that it had not.

Until a **statutory** ban is in place in Oregon, insurers will continue to attempt to argue for loopholes in the current ban. I urge you to vote yes on SB317. Thank you for your consideration.

Sincerely,

Megan E. Glor

MEG:cs

Exhibit 1: NAIC Model Discretionary Clause ban.
Exhibit 2: List of states that ban discretionary clauses with authority
Exhibit 3: Plaintiff's brief (excerpts), Case No 3:12-cv-00779-BR (D. Or.)
Exhibit 4: Defendant's brief (excerpts), Case No 3:12-cv-00779-BR (D. Or.)

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Discretionary Clause Prohibition Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation or bulletin. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation or bulletin.

Section 2. Purpose and Intent

The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this Act shall be construed as imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

Section 3. Definitions

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Disability income protection coverage" is a policy, contract, certificate or agreement that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them.

C. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

D. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service cooperation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statute instead of, or in addition to, the insurance laws and regulations.

E. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or combination of the foregoing.

Section 4. Discretionary Clauses Prohibited

A. No policy, contract, certificate 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 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.

B. No policy, contract, certificate or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

Section 5. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 6. Separability

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 7. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2001 Proc. 4th Quarter 215-216 (model adopted later is printed here).
2002 Proc.1st Quarter 12,176, 180-181 (adopted).
2004 Proc. 3rd Quarter 674-675, 677-678 (amended and reprinted, adopted by parent committee).
2004 Proc. 4th Quarter 57 (adopted by Plenary).

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These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a substantially similar manner. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: States that have citations identified in this column have not adopted the most recent version of the NAIC model in a substantially similar manner. Examples of Related State Activity include but are not limited to: An older version of the NAIC model, legislation or regulation derived from other sources such as Bulletins and Administrative Rulings.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska		ALASKA STAT. §§ 21.36.010 to 21.36.460 (2003/ 2011);
		§ 21.42.130(1996/1997).
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	054.00.101 ARK. ADMIN. CODE §§ 1 to 7 (2013) (disability income protection).	
California		CAL. INS. CODE § 10110.6 (2011); Letter opinion February 26, 2004; Ins. Dep't Notice dated February 27, 2004 (2004).
Colorado		COLO. REV. STAT. § 10-3-1116 (2). (3) (2008).
Connecticut		BULLETIN HC 67 (2008).
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	
Florida	NO CURRENT ACTIVITY	
Georgia	NO CURRENT ACTIVITY	

Glor, Megan: Exhibit 1

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Guam	NO CURRENT ACTIVITY	
Hawaii		Memorandum 2004-13H (2004).
Idaho		IDAHO. ADMIN. CODE r. 18.01.29.000 to 18.01.29.012 (2009); BULLETIN 2010-5 (2010).
Illinois		ILL. ADMIN. CODE tit. 50, § 2001.3 (2005); BULLETIN 2010-5 (2010).
Indiana		BULLETIN 103 (2001).
Iowa	NO CURRENT ACTIVITY	
Kansas	NO CURRENT ACTIVITY	
Kentucky		Advisory Opinion 2010-01 (2010).
Louisiana	NO CURRENT ACTIVITY	
Maine		ME. REV. STAT. ANN. tit. 24-A, § 4303(11) (1995/2014) (managed care).
Maryland		MD. CODE ANN., INS. 12-211 (2011).
Massachusetts	NO CURRENT ACTIVITY	
Michigan		MICH. ADMIN. CODE r. 500.2201 to 500.2202 (2009); 550.112 (2007/2009); 550.302 (2009).
Minnesota		MINN. STAT. § 62Q.107 (1999).
Mississippi	NO CURRENT ACTIVITY	
Missouri	NO CURRENT ACTIVITY	
Montana		MONT. ADMIN. R. 6.6.2101 to 6.6.2104 (2009).
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. 401:03 (2008/2009).
New Jersey		N.J. ADMIN. CODE §§ 11:4-58.1 to 11:4-58.4 (2007).
New Mexico	NO CURRENT ACTIVITY	
New York		CIRCULAR LETTER 2006-8 (2006); CIRCULAR LETTER 2006-14(2006); PROPOSAL TO ADD DISCRETIONARY PROHIBITION TO 11 NYCRR (JAN. 7, 2009).
North Carolina	NO CURRENT ACTIVITY	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma	NO CURRENT ACTIVITY	
Oregon	NO CURRENT ACTIVITY	OR. REV. STAT. § 742.005 (1991/1999).
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS §§ 27-18-79 (2013); 27-20.1-21 (2013); 27-34.2-22 (2013).
South Carolina	NO CURRENT ACTIVITY	
South Dakota		S.D. ADMIN. R. 20:06:52:01 to 20:06:52:03 (2008).
Tennessee	NO CURRENT ACTIVITY	
Texas		TEXAS CODE ANN. §1271.057 (2011); § 1701.062 (2011); 28 TEX. ADMIN. CODE §§ 3.1201 to 3.1203 (2010); BULLETIN B-0003-10 (2010).

Glor, Megan: Exhibit 1

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Utah		UTAH ADMIN. CODE r. 590-218-1 to 590-218-7 (2003); BULLETIN 2002-7 (2002).
Vermont	VT. STAT. ANN. tit. 8 § 4062f (2011).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington		WASH. ADMIN. CODE 284-44-015 (2009); 284-46-015 (2009); 284-50-321 (2009); 284-96-012 (2009).
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	NO CURRENT ACTIVITY	
Wyoming		WYO. STAT. ANN. §§ 26-13-301 to 26-13-305 (2009).

Glor, Megan: Exhibit 1

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This model was developed in conjunction with efforts by the NAIC to clarify to states that they possess the authority to prohibit discretionary clauses in insurance contracts. **2001 Proc. 4th Quarter Vol. I 214.**

One Commissioner asked if there was a possibility that this model would be preempted by ERISA and Commissioner Larsen responded that states are not preempted by ERISA in prohibiting the use of discretionary clauses in insurance contracts because under ERISA states are free to regulate insurance, including the contents of insurance contracts. **2002 Proc. 1st Quarter Vol. I 12.**

One Commissioner said his state would have an external grievance law on the books in a month. He asked how this worked with a discretionary clause. Another Commissioner said that states that have external review provisions have already taken the position that they will not allow carriers to make all decisions. Another Commissioner agreed, opining that the grievance procedure law trumps the discretionary clause. Another Commissioner said this model provides an important consumer protection. There is not one shred of evidence as to how this would increase costs. **2002 Proc. 1st Quarter Vol. I 12.**

A few Commissioners voiced concerns about costs to employers, but did not object to the adoption of the model. **2002 Proc. 1st Quarter Vol. I 14.**

One commenter stated wondered if this model would cause a disadvantage regarding self-funded plans, and whether it would encourage a shift to self-funding. Another commenter responded that in the event of litigation, the discretionary clause caused the policy to be construed against the consumer, the opposite of normal contract interpretation, which is to be construed against the drafter. On the second question, the commenter said that goes to the cost issue, and there was no evidence proffered by industry that any costs were involved. In any event, these cases are the ones most likely to go to external review, which undercuts the cost argument. **2002 Proc. 1st Quarter Vol. I 175.**

A number of associations voiced that they opposed the adoption of the model. A few stated that they believed the model conflicted with ERISA, while others argued that the model would increase costs. On the other hand, a number of commenters supported the model. **2002 Proc. 1st Quarter Vol. I 175-76.**

The advisory committee had requested staff to draft amendments to that model act to prohibit the use of discretionary clauses in disability income insurance as well as health insurance. **2004 Proc. 3rd Quarter Vol. I 673.**

One comment expressed the opinion that an amendment to the model act was perhaps not the best way to solve the problem. He did not think that defining disability was an issue for the courts. He believed that regulators, through market conduct examinations, should be determining that the companies are paying what they should be paying. **2004 Proc. 3rd Quarter Vol. I 674.**

One comment opined that if a dispute arises, the dispute would end up in the courts one way or another. He stated that the use of a discretionary clause limited the courts' options regarding review of the dispute. Another commenter then asked whether mandatory external review could accomplish the same task. Another commenter expressed that when the judge gets a case with an arbitrary and capricious standard the judge is constrained in his analysis. Operationally what occurs is when the

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threshold of proof is reduced; companies will limit the amount of investment they make in their claims department. The inclination then is to have less medical review and resources expended; therefore, the management of claims is reduced. **2004 Proc. 3rd Quarter Vol. I 674.**

One Commissioner questioned whether the end result of a prohibition would be an increase in litigation. Another Commissioner indicated the cases would still be adjudicated under ERISA which has a limited remedial scheme. The litigation process would be the same except for a different standard of review. Another Commissioner stated the prohibition would give a plaintiff a greater ability to prove his or her case, and another commenter stated it gave a judge the opportunity to have a fresh look at the facts. **2004 Proc. 3rd Quarter Vol. I 674.**

One commenter stated that the cost of medical malpractice insurance has been a concern and he was interested in the cost issue; however, he indicated he was supporting the amendments to the model. **2004 Proc. 3rd Quarter Vol. I 674.**

An ACLI commenter stated she did not believe the absence of the clause would affect the outcome of the cases. She said it would increase litigation costs because cases would take longer. One commenter questioned the claims handling aspect of a prohibition and questioned whether the files would be better documented without a discretionary clause. Another commenter disagreed that claims handling was poor in the first instance. One Commissioner reiterated that when he was in private practice he noticed a pattern that when the clause was in effect, the files were thinner and it took very little to uphold the finding. Another Commissioner noted that another result of having a prohibition is operational uniformity. **2004 Proc. 3rd Quarter Vol. I 674.**

One Commenter stated 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. She also stated 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. Also, with the arbitrary and capricious standard, there are really two lawsuits: The first is process litigation, determining what standard of review you get; then onto a suit on the merits. She stated it is hard to get attorneys to take these cases because due to ERISA's remedial scheme, there are no punitive damages or any damages beyond the cost of the service. She also indicated that the Department of Labor does not have any particular consumer assistance process in this regard. **2004 Proc. 3rd Quarter Vol. I 674.**

One commenter argued that a Supreme Court case, Aetna v. Davila, taken together with other cases, invalidated the ability of the state to prohibit the use of discretionary clauses. He argued that if there is some kind of state option that duplicates an ERISA remedy, it is preempted. In this instance, prohibiting the use of the discretionary clause is taking discretion away from the fiduciary. He suggested that the NAIC should retain counsel for opinion on whether the Davila case preempted the NAIC's efforts. One Commissioner stated that he saw no reason for delay. Another Commissioner noted that the Davila case is about remedies under ERISA, not about a discretionary standard. Nothing in the Davila case overrules prior Supreme Court dicta that discretionary clauses can be prohibited by the state. He believed that in the course of ERISA litigation, the Supreme Court has gotten to the point where it is essentially stating that ERISA is an exclusive scheme of remedies, period. An AARP representative stated that the Davila case is strictly a remedies case.

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The Davila was clear that the states could prohibit the use of discretionary clauses. 2004 Proc. 3rd Quarter Vol. I 675.

Section 1. Short Title

Section 2. Purpose and Intent

The working group discussed including a drafting note in the model act that clarifies the purpose of the model act and the authority of the states, under ERISA's saving clause, to prohibit the use of discretionary clauses in insurance contracts. The drafting note might also clarify why the model act does not conflict with the Supreme Court decision in Firestone. 2001 Proc. 4th Quarter Vol. I 215.

Section 3. Definitions

Section 4. Discretionary Clauses Prohibited

Section 5. Penalties

Section 6. Separability

Section 7. Effective Date

Chronological Summary of Action

2001 Model adopted
2002 Model adopted
2004 Model amended
2004 Model adopted

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States That Have Banned Discretionary Clauses

1. **CALIFORNIA** - Cal. Ins. Code § 10110.6;
2. **CONNECTICUT** – Bulletin HC-67; (March 19, 2008);
3. **HAWAII** – Commissioner's Memorandum 2004-13H (Dec. 8, 2004);
4. **IDAHO** – Idaho Administrative Code § 18.01.29.011;
5. **ILLINOIS** – Ill. Admin. Code 50 § 2001.3 (2005); see also Company Bulletin 2010-05 (June 28, 2010);
6. **INDIANA** – Bulletin 103 (May 8, 2001);
7. **KENTUCKY** – Advisory Opinion 2010-01 (March 9, 2010);
8. **MAINE** – 24-A M.R.S.A. § 4303(11);
9. **MARYLAND**– MD Code, Insurance, § 12-211;
10. **MICHIGAN** – Mi. Admin. Code §500.2201 et seq., Mi. Admin. Code § 550.111 et seq., Mi. Admin. Code § 550.301 et seq.;
11. **MINNESOTA** – M.S.A. § 62Q.107;
12. **NEW JERSEY** – N.J. Admin. Code § 11:4-58.1 et seq.;
13. **NEW YORK** – Circular Letter No. 14 (June 29, 2006);
14. **OREGON** – O.R.S. § 742.005 (see also Form 3172b – Standard Provisions for . . . Policies at p. 5, Form 3631 – Standards for Accidental Death and Dismemberment . . . Policies at p. 7.;
15. **RHODE ISLAND** – RI Gen L § 27-4-28 (2013);
16. **SOUTH DAKOTA** – S.D. Admin. Rules § 20:06:52:01, et seq.;
17. **TEXAS** – 28 Tex. Admin. Code § 3.1202 et seq.;
18. **UTAH** – Utah Admin. Code R590-218; See also Bulletin 2002-7;
19. **VERMONT**: Sec. 31. 8 V.S.A. § 4062f;
20. **WASHINGTON** – WAC 284-44-015, WAC 284-46-015, WAC 284-50-321, and WAC 284-96-012.
21. **WYOMING** – W.S. 1977 § 26-13-301 et seq.

Glor, Megan: Exhibit 2

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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

Nancy Petrusich,

Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendant.

Case No. 3:12-CV-00779-BR

Plaintiff's MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Glor, Megan: Exhibit 3

purpose of" "providing benefits to participants and their beneficiaries." 29 U.S.C. § 1104 (a)(1)(A)(i). The Ninth Circuit has described this duty as "**the highest known to the law**." *Howard v. Shay,* 100 F. 3d 1484, 1488 (9th Cir. 1996) (emphasis added, citation omitted). In *Metropolitan Life v. Glenn,* 554 U.S. 105, 115,128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) ("*Glenn*"), the Supreme Court explained:

> ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "**discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries"** of the plan, [29 U.S.C.] §1104(a)(1).

Id. (emphasis added) (citing *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 113, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). In *Gaither v. Aetna Life Ins. Co.,* 394 F.3d 792, 807-808 (10th Cir. 2004), the Court noted that an ERISA insurer "must consider the interests of deserving beneficiaries **as it would its own**." *Id.* at 808 (emphasis added). Even the dissent in *Kearney v. Standard Ins. Co.,* 175 F.3d 1084 (9th Cir. 1999) (*en banc*), acknowledged that an ERISA insurer "cannot simply act as a self-interested party that need only avoid violating the legal floor created by the covenant of good faith and fair dealing," but "must reach much higher, it must act with the very **punctilio of fairness**." *Id.* at 1102 (emphasis added).

C. The Court Should Refuse To Enforce Unum's Deceptive Discretionary Clause Because It Violates The Oregon Insurance Code, And Review *De Novo.*

Where, as here, an ERISA-governed insurance policy grants the insurer discretionary authority to determine a claimant's eligibility for benefits, judicial review is ordinarily for an "abuse of discretion." *Firestone,* 489 U.S. 101 at 111, 115. Under this standard, the administrator's decision must be overturned if it is illogical, implausible, or unsupported by inferences that can be drawn by facts in the record. *Stephan v. Unum Life Ins. Co. of America,* 697 F.3d 917, 929 (9th Cir. 2012). Unum's policy, issued to CresaPartners on August 1, 2007,

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provides: "When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." AR 136.

However, Oregon is one of a number of states (12 by 2008, according to the National Association of Insurance Commissioners[1] and as many as 25 now) that has limited or barred the use of discretionary clauses in health and disability insurance policies. The Oregon Insurance Code, ORS 742.005 ("Grounds for disapproval of policy forms"), states:

> The Director of the Department of Consumer and Business Services shall disapprove any form requiring the director's approval:
>
> (1) If the director finds it does not comply with the law;
> (2) If the director finds it contains any provision,...which is unintelligible, uncertain, ambiguous or abstruse, or **likely to mislead** a person to whom the policy is offered, delivered or issued;
> (3) If, in the director's judgment, its use would be **prejudicial to the interests of the insurer's policyholders**;
> (4) If the director finds it **contains provisions which are unjust, unfair or inequitable**;

Id. The DCBS explained in a letter to plaintiff's counsel, dated December 7, 2009:

> Director Cory Steisinger has asked me to respond on her behalf to your recent letter regarding how [DCBS] views discretionary clauses in insurance policies.
>
> * * * *
>
> **Since approximately 2003, the Department has taken the position that policies cannot include a discretionary clause that gives the insurer full and final discretion in interpreting its insurance contract.** Although our practice has been to disallow these clauses, the Department has not retroactively reviewed forms of existing policies that may have included such discretionary clauses.
>
> For new group policies that have been negotiated, forms do not have to be filed and approved (ORS 742.003(a)(c)), **but the group is subject to market regulation by our compliance unit and must comply with all statutes.**

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[1] *See Standard Ins. Co. v. Morrison,* 584 F.3d 837, 840 (9th Cir. 2009), *certiorari denied, Standard Ins. Co. v. Lindeen,* 130 S. Ct. 3275 (2010)("*Morrison*")(holding that Montana's ban, issued by declaration of its insurance commissioner, was not preempted by ERISA).

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Decl. of John Shaw, Ex.A, p. 1 (emphasis added).[2] DCBS included as an enclosure to its letter "an example of our product standards which clearly state our position to provide guidance to organizations filing forms in Oregon." *Id.* The enclosure is a "checklist" entitled "Standard Provisions For Group Short And Long-Term Disability." *Id.*, p. 3. Citing ORS 742.005(2)&(3), one of the items on the checklist ("Credibility") states:

> If a plan includes a discretionary clause, it does not give the company full and final discretion in interpreting its insurance contract. (*Such a clause is considered to be inequitable, deceptive, and misleading to consumers.*)

Id., p. 9.

Unum should not be permitted to circumvent this ban on its discretionary clause. The Ninth Circuit's decision in *Harlick v. Blue Shield of California*, 686 F.3d. 699 (9th Cir. 2012), *certiorari denied*, 2013 U.S. LEXIS 2025 (Mar. 4, 2013), provides authority for the principle that courts should decline to enforce policy provisions that violate state law. In *Harlick*, the plaintiff, who suffered severe anorexia for which residential treatment was medically necessary (*id.* at *3, 53), was covered under an ERISA-governed medical insurance policy issued by Blue Shield that expressly provided that "[r]esidential care is not covered." *Id.* at *3, 6. The Court rejected the plaintiff's contract interpretation argument for coverage (*id.* at *18-23), but agreed with the

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[2] The DCBS took a similar position taken by Montana's Insurance Commissioner, as described in *Morrison*. He "announced that" *Mont. Code Ann. § 33-1-502*, which "requires its commissioner of insurance to "disapprove any [insurance] form . . . if the form . . . contains . . . any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract . . . " "requires him to disapprove any insurance contract containing a so-called "discretionary clause"" as deceptive. He "consistently disapproved such policy forms," even though there is no specific Montana law forbidding discretionary clauses." The Court rejected Standard's challenge to the Commissioner's practice, ruling that ERISA did not preempt the ban. 584 F.3d at 840, 849.

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plaintiff that the California Mental Health Parity Act, Cal. Health & Safety Code § 1374.72, mandated coverage despite the express exclusion. The Court explained:

> ...California's Mental Health Parity Act provides that Blue Shield "shall provide coverage for the diagnosis and medically necessary treatment" of "severe mental illnesses," including anorexia nervosa, for plans coming within the scope of the Act. It is undisputed that Harlick's plan comes within the scope of the Act. **Blue Shield is foreclosed from asserting that Harlick's residential care at Castlewood was not medically necessary. We therefore conclude that Blue Shield is obligated under the Parity Act to pay for Harlick's residential care at Castlewood,** subject to the same financial terms and conditions it imposes on coverage for physical illnesses.

Id. at *53-54 (emphasis added). Unum's discretionary clause (AR 164), which Unum inserted is in violation of the Oregon Insurance Code and in violation of DCBS' express directive to all insurers. The Court should decline to enforce that provision.

On *de novo* review, the court performs "an independent and thorough inspection of [the] administrator's decision," *Silver v. Exec. Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 733 (9th Cir. 2006), "[fully] exercising [its] informed and independent judgment." *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943 (9th Cir. 1995).

D. On Abuse Of Discretion Review, This Court Should Greatly Heighten Its Scrutiny Based On Taint Throughout Unum's Review.

Glenn endorsed the "combination of several circumstances" that the Court of Appeals below had concluded warranted heightened scrutiny of the insurer's claim denial: (1) the structural conflict of interest; (2) MetLife's failure to reconcile its own conclusion that Glenn could work with the Social Security Administration's conclusion that she could not; (3) MetLife's focus upon one treating physician report suggesting that Glenn could work at the expense of other, more detailed treating physician reports indicating that she could not; (4) MetLife's failure to provide all of the treating physician reports to its own hired experts; and (5) MetLife's failure to take account of evidence indicating that stress aggravated Glenn's condition. 554 U.S. at 110.

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reject Unum's claim denial and enter judgment in her favor for payment of benefits for the 24-month period at issue.

Dated this 20th day of March 2013.

Respectfully submitted,

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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

NANCY PETRUSICH,

Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendant.

Case No. 3:12-cv-00779-BR

MEMORANDUM IN SUPPORT OF DEFENDANT UNUM'S CROSS-MOTION FOR SUMMARY JUDGMENT AND RESPONSE TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

There, however, is an exception to this rule. When the court must consider the impact of the plan administrator's structural conflict of interest, the "traditional rules of summary judgment" do apply. Nolan, 551 F.3d at 1154; see also Stephan, 697 F.3d at 930 ("As to issues regarding the nature and impact of a conflict of interest, summary judgment may only be granted if after 'viewing the evidence in the light most favorable to the non-moving party, there are [no] genuine issues of material fact.'")

Here, the evidence in the record proves that Unum's benefit determination was not tainted by a structural conflict of interest. Thus, "enhanced skepticism" is not warranted when reviewing Unum's decision for an abuse of discretion.

Furthermore, there is ample evidence in the record that Unum's benefits determination was reasonable. Accordingly, the court should grant Unum's motion for summary judgment.

IV. ARGUMENT

A. The Standard of Review Is Abuse of Discretion.

In ERISA cases, when the plan grants the administrator discretionary authority to determine eligibility for benefits under the plan, then the court must review the administrator's decision for an abuse of discretion. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 113, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008); Abatie v. Alta Life & Health Ins. Co., 458 F.3d 955, 963-65 (9th Cir. 2006). In Abatie, the court held that the administrator's decision had to be reviewed for an abuse of discretion because "the plan bestows on the administrator the responsibility to interpret the terms of the plan and to determine eligibility for benefits." Abatie, 458 F.3d at 965.

Here, the Plan provides as follows:

> When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

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AR 136; see also AR 164. This language, standing alone, is sufficient to confer discretionary authority on Unum. Abatie, 458 F.3d at 963-65. Accordingly, abuse of discretion is the applicable standard of review.

Plaintiff, however, contends that the Plan's discretionary clause violates the Oregon Insurance Code and therefore must be disregarded. See Memorandum in Support of Plaintiff's Motion for Summary Judgment ("Pltf.'s Memo.") at 4. Thus, according to plaintiff, Unum's benefit determination must reviewed de novo. For several reasons, this argument fails.

1. The Plan's Discretionary Clause Does Not Violate Oregon Law.

Plaintiff's argument is based on a checklist from the Oregon Insurance Division ("OID") which sets forth standard provisions for LTD and STD policies. Declaration of John Shaw in Supp. of Pltf.'s Mot. for Summ. J. ("Shaw Dec."), Ex. A at 3-21; see also Declaration of Bonita Williams ("Williams Dec.") ¶ 3, Ex. B at 41-59. Specifically, plaintiff relies on this provision in the checklist:

Credibility	ORS 742.005(2) & (3)	If plan includes a discretionary clause, it does not give the company full and final discretion in interpreting its insurance contract. (Such a clause is considered to be inequitable, deceptive, and misleading to consumers.)

Shaw Dec., Ex. A at 9; Williams Dec., Ex. B at 47 (italics in original).

Notably, this provision does not ban all discretionary clauses in LTD or STD policies. Instead, it only purports to ban those discretionary clauses that give the insurer "full and final discretion" to interpret the insurance contract.

The discretionary language at issue here does not give Unum "full and final" discretion to interpret the Plan. AR 136. The Plan's discretionary clause merely provides that when making a benefit determination, "Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." Id. Thus, on its face, the Plan's

discretionary clause does not violate the OID's regulation concerning discretionary clauses. For solely this reason, plaintiff's argument fails.[4]

2. The OID Has Approved Unum's Discretionary Language Multiple Times.

Under Oregon law, the OID must approve all insurance policy forms delivered or issued for delivery in the state of Oregon, except as otherwise required by law. ORS 742.003(1); see also Oreg. Ins. Div. Bulletin 2006-5 (Dec. 6, 2006), available at http://www.cbs.state.or.us/ins/bulletins/bulletin2006-05.pdf. As the Declaration of Bonita Williams (filed herewith) shows, the OID has, on numerous occasions, reviewed and approved the discretionary language that appears in the Plan. Ms. Williams' declaration establishes the following:

> The OID's standards and requirements for LTD and STD policies (group or individual) are set forth in checklist no. 440-2447 (rev. 4/05/INS). Williams Dec. ¶ 3, Ex. B at 41-59; Shaw Dec., Ex. A at 3-21.
>
> Any subsequent changes to the base policy form must also be approved by the OID. Pursuant to OID rules, "Previously approved language that is unchanged will not be reviewed, unless such language is clearly contrary to applicable statutes, rules or established Division position and is unjust, unfair or in equitable to consumers or other insurers." Williams Dec., Ex. A at 1.
>
> On May 15, 1995, the OID approved Unum's group modular contract/certificate no. C.FP-1, which is Unum's base group STD/LTD insurance policy form.[5] This base policy contains the following language: "When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." Williams Dec. ¶ 5.

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[4] Furthermore, the Plan's ERISA section provides that, "[o]nce you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions." AR 164. Thus, the Plan makes clear that Unum does not have final authority to interpret Plan terms.

[5] This is the policy form that Unum used for the Cresa Plan. Compare id., Ex. B at 61 and AR 127

> Since 1995, Unum has made over 20 filings with the OID for changes to the base STD/LTD policy. Pursuant to OID rules, these filings include a complete copy of the entire base STD/LTD policy form, not just the proposed changes. Id.¶ 6.
>
> The discretionary language set forth above in paragraph 5 has remained in the base STD/LTD policy since it was initially approved by the OID in 1995. The OID has never objected to that language which is in each policy form that Unum submits with its filings. Id.¶ 7.
>
> On December 21, 2009, Unum filed proposed changes to the base STD/LTD policy form with the OID. Id.¶ 8, Ex. B. The December 21, 2009 filing included the OID's checklist no. 440-2447 (rev. 4/05/INS) referred to above. Id., Ex. B at 41-59.
>
> The base STD/LTD policy form that Unum submitted to the OID with the December 21, 2009 filing contains the same discretionary language that appears in the Plan. Id., Ex. B at 78; AR 136.
>
> On January 28, 2010, the OID approved Unum's December 21, 2009 filing. Williams Dec., Ex. B at 1, 12. The OID did not object to the discretionary language in the STD/LTD policy form.
>
> On April 2, 2010, Unum submitted a proposed group accident only policy form to the OID for approval. This was a new policy form which did not replace or modify any existing forms. Id., Ex. C.
>
> The OID's checklist accident only forms contains the same "Credibility" requirement set forth above. Id., Ex. D at 7.
>
> On April 30, 2010, the OID approved Unum's group accident only policy form. Id., Ex. C at 1. The policy form that OID approved contains the same discretionary language that is in the Plan. Id., Ex. C at 33. The OID did not raise any concerns with Unum in connection the discretionary language in the group accident only policy form. Id. ¶ 14.

See also id. ¶¶ 15-18 (discussing OID's approval of Unum's critical illness policy which has discretionary language identical to the Plan's discretionary language).

Thus, it is undisputed that the OID has approved the Plan's discretionary clause multiple times. For this additional reason, plaintiff's argument that the discretionary language violates the Oregon Insurance Code fails.

sexual assault. But those records do not show that plaintiff is so severely impaired that she cannot work.

Finally, as noted above in the Fact section, plaintiff appears to have issues with her particular workplace. According to Ms. Cleary's May 10, 2011 chart note, plaintiff "openly discussed feeling 'nausea' when she thinks about returning to work." AR 565-66. In her June 7, 2011 chart note, Ms. Cleary states that plaintiff was tearful "as she discussed even the thought of returning to such a high stress career." Plaintiff told Ms. Cleary that returning to work would eventually "kill" her. AR 567.

The Plan clearly provides that a claimant must be disabled from her "Regular occupation" which is defined as "the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location." AR 157.

IV. CONCLUSION

For the reasons set forth herein, the court should grant Unum's motion for summary judgment and deny plaintiff's motion for summary judgment.

DATED: May 7, 2013

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