Nos. 14-1984 and 14-2302

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MARY C. FONTAINE,
Plaintiff-Appellee,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant-Appellant.

Appeal from the United States District Court
For the Northern District of Illinois, Eastern Division
Case No. 1:12-CV-08738

The Honorable Joan B. Gottschall

BRIEF OF AMICUS CURIAE AARP IN SUPPORT OF APPELLEE URGING AFFIRMANCE

Mary Ellen Signorille
Counsel of Record
AARP FOUNDATION LITIGATION
601 E Street, NW
Washington, DC 20049
Telephone (202) 434-2060
Facsimile (202) 434-6424
msignorille@aarp.org

Attorney for Amicus Curiae AARP

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Appellate Court Nos: 14-1984 and 14-302

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Address: AARP Foundation Litigation
601 E Street, NW Washington, DC 20049

Phone Number: 202 434-2072 Fax Number: 202 434-6424

E-Mail Address: msignorille@aarp.org

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INTEREST OF AMICUS CURIAE[1]

AARP is a nonprofit, nonpartisan organization, with a membership that helps people turn their goals and dreams into real possibilities, seeks to strengthen communities, and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits which countless members and older individuals receive or may be eligible to receive.[2]

Employees and retirees must be able to rely on promised disability and health benefits because the quality of their lives depends heavily on their eligibility for and the amount of such benefits. The level of discretion reserved to an insurer and the judicial standard of review of a benefit denial correlates with the ability of AARP members and other working persons to obtain a full, fair and meaningful review of an insurer's benefits claim denial. AARP advocated for a Model Act to

[1] Counsel states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief.

[2] AARP has participated as amicus curiae to protect the rights of workers and their beneficiaries under ERISA in numerous cases. *See, e.g.*, *Abbott v. Lockheed Martin Corp.*, 725 F.3d 803 (7th Cir. 2013); *Steinman v. Hicks*, 352 F.3d 1101 (7th Cir. 2003).

Prohibit Discretionary Clauses before the National Association of Insurance Commissioners in disability policies, which was passed unanimously. Subsequently, AARP supported the prohibition of discretionary clauses, through insurance regulation, legislation, or both, in Illinois and in the following states: Arkansas, California, Maryland, Michigan, Montana, Rhode Island, Texas, Vermont and Washington. Finally, AARP filed as amicus curiae in the cases of *Standard Insurance Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), and *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), on the same issue upon which AARP writes in this case: whether the Employee Retirement Income Security Act (ERISA) preempts a state law prohibiting discretionary clauses in insurance policies. Accordingly, AARP and its members in Illinois have a substantial interest in the resolution of the issues presented here and respectfully submit this brief amicus curiae to facilitate this Court's decision.

ARGUMENT

I. NOT ONLY DOES ERISA PERMIT STATE DEPARTMENTS OF INSURANCE TO REGULATE UNDERLYING INSURANCE PRODUCTS IN SELF-FUNDED ERISA PLANS, BUT STATE INSURANCE REQUIREMENTS BECOME PLAN TERMS.

Many of Appellant's arguments are premised on a seeming misunderstanding of how the relationship between ERISA plans and insurance products works. For example, Appellant argues that (1) a plan using insurance to pay benefits cannot be subject to insurance regulation; (2) if a plan sponsor offers

an insured plan, the plan cannot be subject to insurance regulation; and (3) insurance regulations should not be applied to an insurer if the plan document calls the insurer something else besides the insurer. Consequently, a review of this relationship and the options for the operation of ERISA plans is in order.

An ERISA plan can choose to completely self-insure, utilize insurers to provide benefits, to act as plan administrators, and/or to decide and/or pay claims, or use a combination of these options. *See generally* Peter Schmidt, *The Basics of ERISA as It Relates to Health Plans*, EBRI Issue Brief, Nov. 1995 at 2, 4-5, *available at* www.ebri.org/pdf/briefspdf/1195ib.pdf. If a plan choses to completely self-insure, state insurance regulations do not apply to them.[3] In contrast, if a self-insured plan uses insurance to provide its benefits, state departments of insurance may regulate the underlying insurance policy. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985) (holding specified minimum health care benefits were not preempted insofar as applied to insured plans). The Supreme Court recognized that its holding created an anomaly between insured and self-funded plans as well as disuniformities in plan administration, but stated that this incongruity was inherent in ERISA. *Id.* at 747 (insured plans are "open to indirect regulation while [uninsured plans] are not").

[3] Accordingly, employers establishing completely self-insured ERISA plans always have the option to provide for deferential review.

Both the Supreme Court and this Circuit have recognized that when an ERISA plan includes an insurance policy, the requirements imposed by state insurance law become plan terms for purposes of a claim for benefits under section 1132(a)(1)(B). *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375-76 (1999); *Larson v. United Healthcare Ins. Co*., 723 F.3d 905, 912-913 (7th Cir. 2013). Any other position would leave the states "powerless to alter the terms of the insurance relationship in ERISA plans*,"* *Ward*, 526 U.S. at 376, with insurers displacing "any state regulation simply by inserting a contrary term in plan documents." *Id*. Such a position would read the savings clause out of ERISA. *Id*.

CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1876-77 (2011), confirms this outcome. Although the Court stressed the importance of plan terms, it cited *Ward* with approval, acknowledging that insurance terms of an ERISA-governed plan must be interpreted in light of state insurance rules. *Id.* at 1877 (citing *Ward*, 526 U.S. at 377-79).

Appellant's arguments here are just variations of the arguments previously rejected by both the Supreme Court and this Circuit. Thus, all of Defendant's arguments that that the Insurance Director's actions are "ultra vires" must be completely rejected.[4] Appellant cannot seriously argue that a state cannot regulate

[4] Although the term "ultra vires" is featured prominently in Appellant's district court briefs and is used the district court decision, that term does not appear in its appellate

the content of insurance policies. Under Appellant's theory, Illinois could mandate ovarian cancer screening in insurance policies offered or issued in the state,[5] but a plan sponsor, by dint of plan language not in the insurance policy, could refuse to cover such screening. This argument is just absurd and upends the balance that Congress struck between the states and the federal government concerning regulation of benefit plans.

II. THE LEGAL STANDARD FOR JUDICIAL REVIEW OF BENEFIT CLAIMS DECISIONS IS DE NOVO REVIEW, UNLESS THE PLAN PROVIDES OTHERWISE.

ERISA is silent concerning the appropriate standard of review for a court's review of a benefit claims denial under section 1132(a)(1)(B). *See* ERISA § 503, 29 U.S.C. § 1133 (2012); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108-09 (1989); *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 384-85 (2002). The statute itself neither prohibits nor mandates any specific judicial standard of review of benefit denials. One would think that a provision that was as "foundational" as Appellant claims, Br. 23, 31, 36, would actually appear somewhere in the statute.

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brief. Amicus submits that Appellant has merely changed its terminology; alternatively Appellant has abandoned these arguments.

[5] For a list of state mandated health benefits laws, see Susan S. Laudicina, Joan M. Gardner & Kim Holland, *State Legislative Healthcare and Insurance Issues: 2013 Survey of Plans* 64-69 (Blue Cross Blue Shield Association, Dec. 2013).

As the Seventh Circuit held, "the Supreme Court directs that 'a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan,' in which case a deferential standard of review is appropriate." *Schultz v. Aviall, Inc.*, 670 F.3d 834, 836-37 (7th Cir. 2012) (quoting *Firestone*, 489 U.S. at 115). Accordingly, if there is no such language in the plan, the default standard of review is de novo.

In *Rush*, the Supreme Court confirmed that, "[d]eferential review . . . is not a settled given" nor is there a requirement of a "uniformly lenient regime of reviewing benefit determinations." 536 U.S. at 385-86. "Nothing in ERISA, however, requires that these kinds of decisions be so 'discretionary' in the first place; whether they are is simply a matter of plan design or the drafting of a[] . . . contract." *Id*. at 386.

Subsequently, in *Conkright v. Frommert*, 559 U.S. 506, 512-13 (2010), the Supreme Court reaffirmed *Firestone,* requiring deference to a trustees' decision only where the plan provides for such discretion. *Conkright* did not change *Firestone*'s framework for judicial review of benefit claims; de novo review is still the default standard if the plan does not provide for a fiduciary's discretion. And, the Seventh Circuit continues to apply the *Firestone* framework after *Conkright*.

See, e.g., *Aviall*, 670 F.3d at 836-37; *Comrie v. IPSCO, Inc.*, 636 F.3d 839, 842 (7th Cir. 2011). Consequently, Appellant's argument that *Conkright* controls this case is just plain wrong.[6]

MetLife's real complaint is that it does not like the fact that a state insurance department can prohibit "a feature of judicial review highly prized by benefit plans: a deferential standard for reviewing benefit denials." *Rush*, 536 U.S. at 384. Indeed, the Seventh Circuit has long recognized the negative effect discretionary clauses have on employees' ability to secure benefits so that it requires clarity in a plan's provision allegedly granting deferential review in order for the court to review the claim under the arbitrary and capricious standard. *See, e.g.*, *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331-32 (7th Cir. 2000); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1050-51 (7th Cir. 1987) (commenting that the deferential standard of review may virtually eliminate all judicial review of the trustees' exercise of discretion).

Because discretionary clauses are inconsistent with basic insurance consumer rights and such prohibition would eliminate the decision maker's inherent conflict of interest, the National Association of Insurance Commissioners

[6] Not only did *Conkright* not address preemption under ERISA, the issue of the authority of a state to regulate insurance did not arise at all in that case. *E.g.*, *Petrov v. Gonzales*, 464 F.3d 800, 802 (7th Cir. 2006) ("Because [a previous case] did not mention that subject, it does not contain a holding on the issue.").

(NAIC) passed a Model Act prohibiting these clauses in health and disability policies. 1 NAIC Model Laws, Regulations and Guidelines, Prohibition on the Use of Discretionary Clauses Model Act, 42-1 (2004); *see generally* John Morrison & Jonathan McDonald, *Exorcising Discretion: The Death Of Caprice In ERISA Claims Handling*, 56 S.D. L. Rev. 482 (2011) (describing the NAIC process and rationale of passing the Model Act). At around the same time as the NAIC passed the Model Act, UNUM/Provident settled a Multi-State investigation into systematic irregularities found in its claim handling practices for both individual and group disability claims. Joint Press Release, Multi-State Settlement Addresses Concerns Regarding UnumProvident Claims Handling, at 1-2 (Nov. 18, 2004), *available at* http://www.tn.gov/insurance/documents/prsRls111804.pdf; *see generally* John H. Langbein, Essay, *Trust Law as Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1320-21 (2007) (describing the UNUM/Provident scandal).[7]

In 2005, Illinois adopted its own regulation prohibiting discretionary clauses. Ill. Admin. Code tit. 50, § 2001.3 (2005). Illinois joins numerous other states in

[7] Irregularities concerning disability insurance claims handling procedures still occur as shown by CIGNA's recent settlement of a Multi-State investigation into its disability claims handling. CIGNA Regulatory Settlement Agreement (May 13, 2013), http://www.maine.gov/pfr/insurance/Admin_Enforcement_Actions/RSA_2013/CIGNA_RSA.pdf.

prohibiting discretionary clauses in insurance policies. Radha A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. Rev. 500, 504-508 (2011) (listing states which, as of 2011, had prohibited discretionary clauses).

III. THE SUPREME COURT HAS INTERPRETED ERISA'S INSURANCE SAVINGS CLAUSE TO ACHIEVE CONGRESS' INTENT TO PERMIT STATES TO REGULATE INSURANCE.

When Congress enacted ERISA, it limited a State's power to regulate only to the extent that its laws relate to employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a) (2012).[8] Even if state laws relate to employee benefit plans, ERISA's saving clause "reclaims a substantial amount of ground" for state laws that regulate insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A),[9] so that such laws are not preempted. *Rush*, 536 U.S. at 363-64.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, the Court unanimously adopted a two-prong test to determine whether a state law regulates insurance, resulting in more state laws fitting within the savings clause. 538 U.S. 329, 342 (2003). The first prong is that "the state law must be specifically directed toward entities engaged in insurance." *Id.* Thus, a state statute regulates insurance where it "homes in on the insurance industry." *Ward*, 526 U.S. at 368. The second prong is

[8] ERISA § 514(a) states, in pertinent part, that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

[9] ERISA § 514(b)(2)(A) states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

that "the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Ky. Ass'n*, 538 U.S. at 342. In order to affect the risk pooling arrangement, the state law need not alter or control the actual terms of insurance policies. Instead, the state law must change the scope of permissible bargains between insurers and insureds in a manner similar to mandated benefit laws, *Metropolitan Life*, 471 U.S. at 741-42; notice-prejudice rules, *Ward*, 526 U.S. at 373; independent review provisions effectively denying HMO insurers discretion, *Rush*, 536 U.S. at 386-87; and any willing provider laws, *Ky. Ass'n*, 538 U.S. at 334. Significantly, the state law need not actually spread risk. *Ky. Ass'n*, 538 U.S. at 339 n.3. However, "laws that regulate the substantive terms of insurance contracts" clearly do substantially affect the risk pooling arrangement. *Metropolitan Life*, 471 U.S. at 741-42.

The Supreme Court's jurisprudence has clearly resulted in more state laws being saved as regulating insurance, thus effectuating Congress' intent to permit states to continue regulating insurance as they did prior to the passage of ERISA.

IV. ERISA DOES NOT PREEMPT ILLINOIS' REGULATION BECAUSE IT IS SAVED AS A LAW REGULATING INSURANCE.

It is important to note what Illinois' regulation prohibiting the use of discretionary clauses in insurance policies offered or issued in the state does not do. It does not single out ERISA plans for differing treatment. *See Mackey v. Lanier Collections Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988) (preempting anti-garnishment statute singling out ERISA plans for protective treatment). It is not dependent on ERISA plans for its operation. *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (1992) (preempting workers' compensation law requiring provision of health benefits in proportion to covered benefits of an ERISA plan). It does not provide an alternative enforcement mechanism or remedy to participants. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-53 (1987). Participants in ERISA-covered health and disability plans must still file suit pursuant to ERISA § 502(a)(1)(B) in order to recover their benefits. *See Rush*, 536 U.S. at 375-76. And, it does not deem employee benefit plans to be insurance companies in violation of ERISA § 514(b)(2). *See FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990).

What Illinois' regulation does do is to prohibit discretionary clauses under Illinois law and to prohibit all insurers with discretionary clauses in any insurance

policies including health and disability policies from offering or issuing them in the state of Illinois. Ill. Admin. Code tit. 50, § 2001.3 (2005).

A. Illinois' Regulation Is An Insurance Law That Is Specifically Directed Toward Insurers Issuing Health And Disability Policies In The State.

An analysis of Illinois' regulation prohibiting discretionary clauses in insurance contracts neatly fits within the two prongs of the *Kentucky Ass'n* test.[10] To meet the first prong, *Kentucky Ass'n* made it clear that "ERISA's savings clause does not require that a state law regulate 'insurance companies' or even 'the business of insurance' to be saved from pre-emption; it need only be a 'law which . . . regulates insurance.'" *Ky. Ass'n*, 538 U.S. at 336 n.1 (emphasis omitted). Put another way, "when insurers are regulated with respect to their insurance practices, the state law survives ERISA." *Rush*, 536 U.S. at 366.

The Supreme Court has "repeatedly held that state laws mandating insurance contract terms are saved from preemption" under ERISA § 514(b)(2)(A). *Ward*, 526 U.S. at 375. In *Ward*, the Court held that California's "notice-prejudice" rule, which prohibits an insurer from denying a claim based on an insured's failure to give timely notice under the terms of a policy unless the insurer can demonstrate prejudice from the delay, was saved from preemption. *Id.* at 375-77. That law

[10] ERISA's definition of state law is extremely broad, encompassing "all laws, decisions, rules, regulations, or other State action having the effect of law." ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1).

regulates insurance because it "controls the terms of the insurance relationship" and is "applicable only to insurance contracts." *Id.* at 368 (quoting *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939, 945 (1998)). The Court held that states have the power to alter the terms of the insurance relationship because to hold otherwise would read the saving clause out of ERISA and create an unintended conflict with ERISA's fiduciary requirement of acting in accordance with the plan documents. *Id.* at 375-76. In *Rush*, the Court held that a state law affecting HMO contract terms by granting to the insureds a legally enforceable right to obtain an authoritative determination of the HMO's medical obligation to provide a benefit and effectively denying HMOs discretion is a law that regulates insurance. 536 U.S. at 374. In accord is *Metropolitan Life*, 471 U.S. at 740, which held that a law that regulates the specific terms of an insurance policy is, "[t]o state the obvious," a law that regulates insurance. See also *FMC Corp.*, 498 U.S. at 61, which held that a state anti-subrogation law falls within the insurance saving clause because it "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain." Accordingly, the Supreme Court has consistently held that state laws mandating insurance terms are saved from preemption under ERISA § 514(b)(2)(A).

Like this Supreme Court precedent, Illinois' regulation directly regulates the terms of insurance policies and *only* insurance policies. Ill. Admin. Code tit. 50,

§ 2001.3 (2005); *see Ward*, 526 U.S. at 374; *accord Rush*, 536 U.S. at 373; *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 842 (9th Cir. 2009); *American Council of Life Insurers v. Ross*, 558 F.3d 600, 605 (6th Cir. 2009). Not only does the regulation apply exclusively to insurance companies, it affects the nature of the insurance provided through the insurance policy as well as the insurer's promise by circumscribing the insurer's ability to deny benefits. *See Morrison*, 584 F.3d at 842; *Ross*, 558 F.3d at 605.

"The relationship between insurer and insured, the type of policy that could be issued, its reliability, its interpretation, and enforcement—these were the core of the 'business of insurance.' [T]he focus [of the statutory term] . . . was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'" *SEC v. Nat'l Sec., Inc.*, 393 U.S. 453, 460 (1969). By altering the terms of the insurance policy and effectively creating a mandatory term, the regulations are conditions on the insurer's right to issue a health or disability insurance policy. *Ky. Ass'n*, 538 U.S. at 338. Like the anti-subrogation law in *FMC Corp.*, 498 U.S. at 60, if an insurance term may be invalidated, it certainly may be prohibited.

The regulation is specifically directed at insurance because it affects the nature of the contract between the insurer and the insured by regulating an

insurer's discretion in determining whether a benefit claim will be paid. Ultimately, the regulation is aimed at increasing an insured's chance of actually receiving health or disability benefits by requiring an insurer to fully review the insured's claim and by causing the courts to review the insurer's decision with a fresh eye. Finally, Illinois' Director alone may approve or disapprove insurance policies for sale in the state of Illinois. Ill. Admin. Code tit. 50, §§ 916.20-40 (2005); *Ross*, 558 F.3d at 605.

The Illinois regulation prohibiting discretionary clauses regulates insurance practices – that is how and whether an insurer will pay benefits to a participant. Accordingly, Illinois' regulation is specifically directed toward the insurance industry. *Ky. Ass'n*, 538 U.S. at 334-35.

B. Illinois' Regulation Substantially Affects The Risk Pooling Arrangement Between The Insurer And The Insured Because It Alters The Terms Of The Insurance Policy.

The second prong of the *Kentucky Ass'n* test "requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and the insured; it does not require that the state law actually spread risk." *Ky. Ass'n*, 538 U.S. at 339 n.3 (emphasis in the original). Significantly, in *Kentucky Ass'n* the Court held that it was not necessary "that state laws . . . alter or control the actual terms of insurance policies to be deemed 'laws . . .which regulat[e] insurance' under § 1144(b)(2)(A); it suffices that they substantially affect the risk pooling

arrangement between insured and insurer." *Id*. at 338. Those state laws that do indeed alter or control the actual terms of insurance policies, like Illinois' regulation, substantially affect risk pooling. *Morrison*, 584 F.3d at 844-45; *Ross*, 558 F.3d at 606-07.

"[I]nsurance . . . is a mechanism that shifts risk from one party to another . . . in return for a premium payment, . . . [and] [e]very policy of insurance specifies which risk or risks that the insurer agrees to assume in return for the premiums required for by the insurance contract." 7 Couch on Ins. § 101:1 (3d ed. 1997). The Supreme Court agreed that "the primary purpose of the insurance company" is "the payment of claims made against policies." *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 506 (1993). A statute which "serves to ensure that, if possible, policyholders ultimately will receive payment on their claims" is one that has been "enacted 'for the purpose of regulating the business of insurance.'" *Id*. In *Kentucky Ass'n*, the Court explained that even the notice-prejudice rule at issue in *Ward* substantially affected the risk pooling arrangement because it "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." *Ky. Ass'n*, 538 U.S. at 339 n.3.

In *Werdehausen v. Benicorp Insurance Co.*, 487 F. 3d 660, 668 (8th Cir. 2007), the Eighth Circuit held that ERISA did not preempt a Missouri statute

prohibiting an insurer from denying insurance coverage for preauthorized medical treatment. The court reasoned that, like the notice-prejudice rule in *Ward*, the Missouri statute "limits an insurer's contractual ability to deny claims." *Id.* at 669. Both state insurance laws "increase[] the insurer's liability." *Id*. And, both "dictate[] to the insurance company the conditions under which it must pay for the risk that it has assumed." *Id*. (quoting *Ky. Ass'n*, 538 U.S. at 339 n.3.). Thus, the Eighth Circuit held that the Missouri statute satisfied both prongs of the Kentucky test and was saved from preemption. *Id.*

The Fifth Circuit reached a similar conclusion concerning a Louisiana insurance commissioner's directive prohibiting insurers from enforcing subrogation rights until insureds were fully compensated for their injuries. In *Benefit Recovery, Inc. v. Donelon*, 521 F.3d 326, 331 (5th Cir. 2008), the court held that the insurance directive "certainly alters the permissible bargains between insurers and insureds by telling them what bargains are acceptable." *Accord Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 241 (2d Cir. 2014) (holding that the law requires insurers bear the risk of medical expenses thereby substantially affecting how risk is shared when the law is applied).

Illinois' regulation is no different from the notice-prejudice rule in *Ward*, the independent review statute in *Rush*, the any willing provider statute in *Kentucky*, the prohibition against the denial of claims once they have been preauthorized in

Werdehausen, or the prohibition against insurer's subrogation rights until the insureds are completely compensated in *Donelon*. Likewise, Illinois' regulation results in the "imposing [of] conditions on the right to engage in the business of insurance." *See Ky. Ass'n*, 538 U.S. at 338. Like the notice-prejudice rule in *Ward*, by the adoption and enforcement of Illinois' regulation to prohibit discretionary clauses in insurance contracts, the Director has "impos[ed] conditions on the right to engage in the business of insurance" in the state of Illinois. *See Ky. Ass'n*, 538 U.S. at 338. Like the state laws at issue in *Ward*, *Rush*, *Werdehausen* and *Donelon*, Illinois' regulation will cause insurers to more likely pay claims and thus incur more of the risk they have assumed. *See Metropolitan Life*, 471 U.S. at 743; *Morrison*, 584 F.3d at 842.

Clearly, Illinois' regulation affects risk-pooling arrangements in that it "alter[s] the scope of permissible bargains between insurers and insureds" by delineating the terms to which insurers and insureds may agree. *Ky. Ass'n*, 538 U.S. at 338-39; *Morrison*, 584 F.3d at 844; *Ross*, 558 F.3d at 606. Indeed, the purpose of Illinois' regulation is to prohibit discretionary clauses in order to "aid the consumer by ensuring that benefit determinations are made under the reasonableness standard." 29 Ill. Reg. 10172 (July 15, 2005), thereby boosting the probability that benefits will be paid to insureds.

It is difficult to imagine that the prohibition of discretionary clauses by Illinois' regulation is anything other than an insurance regulation as it addresses who pays, in a given set of circumstances, and is therefore directed at spreading risk. Accordingly, Illinois' regulation prohibiting discretionary clauses in health and disability insurance contracts sold in the state substantially affects the risk pooling arrangement between the insurer and insured.

C. The Supreme Court Has Previously Rejected The Argument That ERISA Preempts A State Law Affecting An Insurer's Discretion.

Rush completely controls the issue in this case. The Supreme Court held that a state law restricting the deferential standard of review embodied in the discretionary clause does not conflict with ERISA. *Rush*, 536 U.S. at 384-85. While the statute designed to do this undeniably eliminates whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials, this effect of eliminating an insurer's autonomy to guarantee terms congenial to its own interests is the stuff of garden-variety insurance regulation through the imposition of standard policy terms. *Metropolitan Life*, 471 U.S. at 742 ("[S]tate laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's."). Indeed, inasmuch as de novo review remains the default standard of review, "it is difficult to imagine how a state law requiring that level of review would conflict with the statute." *Ross*, 558 F.3d at 608. Therefore, it is hard to imagine a reservation of state power to regulate insurance that would not be

meant to cover restrictions of the insurer's advantage in this kind of way. *Rush*, 536 U.S. at 387.

In *Kentucky Ass'n*, the Court confirmed that a state law depriving insurers of deferential review "alter[s] the scope of permissible bargains between insurers and insureds" and therefore alters the risk pooling arrangement between the two parties. 538 U.S. at 338-39. *Rush* and *Kentucky Ass'n* compel the conclusion that Illinois' regulation to prohibit discretionary clauses regulates insurance and is saved from preemption.

Finally, AARP notes that Appellant's musings about Congressional objectives and all the wonderful by-products of deferential review ignores the fact that Congress specifically set forth statutory language in ERISA to ensure that states would continue to regulate insurance, ERISA § 514(b)(2), 29 U.S.C. 1144(b)(2), unlike the deafening statutory silence concerning deferential review. Surely if Congress had wanted all ERISA plans – regardless of whether they were insured or self-funded – to review benefit claims under deferential review it could have said so. Permitting states to prohibit discretionary clauses "does nothing to disturb ERISA's goal of national uniformity in employee benefit plan regulation." *Wurtz*, 761 F.3d at 245.

CONCLUSION

Illinois' regulation prohibiting discretionary clauses in health and disability insurance contracts offered and issued in the state is a state law specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and the insured. Because the regulation meets both prongs of the *Kentucky Ass'n* test, it is saved as a law regulating insurance under ERISA's savings clause and ERISA does not preempt Illinois' regulation.

For the reasons stated herein, AARP respectfully requests that this Court affirm the decision and judgment of the district court on these issues.

Dated: October 14, 2014

Respectfully submitted,

/s/ Mary Ellen Signorille
Mary Ellen Signorille
Counsel of Record
AARP FOUNDATION LITIGATION
601 E Street, NW
Washington, DC 20049
Telephone (202) 434-2060
Facsimile (202) 434-6424
msignorille@aarp.org

Attorney for Amicus Curiae AARP

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 4,827 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 for Windows in Times New Roman 14 point font (13 point in the footnotes).

Dated: October 14, 2014

/s/ Mary Ellen Signorille
Attorney for Amicus Curiae AARP

CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2014, I electronically filed the foregoing Brief of Amicus Curiae AARP with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Mary Ellen Signorille
Mary Ellen Signorille
Attorney for Amicus Curiae AARP