No. 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, Judge Presiding

BRIEF FOR PLAINTIFF-APPELLEE
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ORAL ARGUMENT REQUESTED

CERTIFICATE OF INTEREST

Appellate Court No.: 14-1984 & 14-2302

Short Caption: Mary C. Fontaine v. Metropolitan Life Insurance Company

The undersigned counsel of record for Mary C. Fontaine, Plaintiff-Appellee, furnishes the following list in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1:

A. The full name of every party or amicus the attorney represents in this case:

Mary C. Fontaine

B. If such party or amicus is a corporation:

A. Its parent corporation if any and: N/A

B. A list of stockholders which are publicly held companies owning 10% or more of the stock in the party or amicus: N/A

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Other Authorities

JURISDICTIONAL STATEMENT

Defendant-Appellant Metropolitan Life Insurance Company's ("MetLife") jurisdictional statement is complete and correct.

STATEMENT OF THE ISSUES

1. Whether the district court correctly applied the *de novo* standard of judicial review based on 50 Ill. Admin. Code § 2001.3.

2. Whether 50 Ill. Admin. Code. § 2001.3 is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*.

3. Whether Plaintiff-Appellee would have prevailed in her suit seeking long-term disability benefits regardless of which standard of judicial review was utilized.

STATEMENT OF THE CASE

Plaintiff-Appellee Mary C. Fontaine ("Fontaine") enjoyed a successful long-term career as an equity partner in the structured finance group of Mayer Brown LLP ("Mayer Brown"), an international law firm headquartered in Chicago, Illinois. Fontaine practiced law at the Mayer Brown firm for 30 years until May 1, 2011, when she notified her partners of her need to cease working due to significant vision impairments (myopic macular degeneration, extensive vitreous floaters and cataracts) that diminished her ability to perform her job duties on account of visual deficits caused by. (App. 2; Answer ¶¶ 6, 10, Docket No. 28; MET 618, 622, 931-32, 1183; PLA 69, 264).[1]

[1] Citations to "Docket No. ##" refer to the District Court docket (Case No. 1:12-cv-08738). Citations to "Appellate Docket No. ##" refer to the Court of Appeals docket (Case Nos. 14-1984 & 14-2302). Citations to "App. ##" are to the Combined Rule 30(a) and 30(b) Appendix attached to Defendant-Appellee's Opening Brief (Appellate Docket No. 33). Citations to "Fontaine App. ##" are to the Plaintiff-Appellee's Appendix, filed in conjunction with this brief. Citations to "MET ######" and "PLA ######" are to the appendices to the parties' Proposed Findings of Fact and Conclusions of Law, filed under seal with the district court as Docket Nos. 57 and 90 (all citations are to Docket No. 90 unless

As a benefit of her employment, Mayer Brown provided Fontaine with group long term disability insurance issued and underwritten by MetLife (the "LTD Group Policy"), the terms of which were described in a certificate of insurance provided to each insured (the "LTD Certificate of Insurance") (collectively, the "LTD Policy"). (App. 3; Def.'s Proposed Findings of Fact and Conclusions of Law ("PFF") ¶ 1, Docket No. 50; Fontaine's App. 1-75).[2] In addition to group coverage, Fontaine received supplemental coverage under an individual disability income insurance policy (the "IDI Policy"), also issued and underwritten by MetLife.[3] (App. 3-4; Answer ¶ 5, Docket No. 28; Ex. B to Compl., Docket No. 1-2). Fontaine paid the premiums for her coverage under both policies (Fontaine App. 34, 72; MET 1842, 1846, 1904, 1942), which insured her for an aggregate amount of $33,500 per month in the event she suffered an injury or illness that precluded her from performing her work as an attorney in her area of concentration. (App. 3-4, 27; Def.'s Resp. to Pl.'s PFF ¶¶ 9-14, Docket No. 53).

Relevant Policy Provisions

The LTD Policy defines "disability" as follows:

> **Disabled** or **Disability** means that, due to Sickness or as a direct result of accidental injury:
> - You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
> - You are unable to earn:
>   - more than 80% of Your Predisability Earnings at Your Own Occupation from any employer in Your Local Economy; and

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otherwise noted).

[2] The LTD Group Policy (MET 2857-68) was originally filed with the district court in paper format, under seal, as Docket No. 57. The LTD Certificate of Insurance (MET 1883-1945) was also filed in paper format, under seal, as Docket No. 90, although a non-Bates stamped version can be found at Docket No. 61-3. For ease of reference, both the LTD Group Policy and the LTD Certificate of Insurance have been provided in Plaintiff-Appellee's Appendix, filed in conjunction with this brief.

[3] MetLife has not appealed the district court's finding of liability under the IDI Policy, which does not contain a grant of discretionary language; nevertheless, the IDI Policy is discussed here for completeness.

- unable to perform each of the material duties of Your Own Occupation.

(App. 3; Fontaine App. 34; MET 1904). "Own occupation," in turn, is defined as follows:

> **Own Occupation** means the duties that You regularly perform and that provides Your primary source of earned income. For Attorneys, Own Occupation means the specialty in the practice of law in which You were practicing just prior to the date Disability started. Such job is not limited to the specific position You have with the Policyholder or could have with any other employer.

(Fontaine App. 35; MET 1905). The LTD Certificate of Insurance includes a section entitled "ERISA Information" (hereafter the "ERISA Statement") which contains the following language:

> **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**
>
> In carrying out their respective responsibilities under the Plan, MetLife, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(Fontaine App. 74; MET 01944).

The LTD Policy also recites that it was issued to Mayer Brown in Chicago, Illinois on November 15, 2010, and subject to the laws of that jurisdiction. (Fontaine App. 1, 8, 13, 71; MET 1883, 1941, 2857, 2864). Hence, Plaintiff argued, and the district court agreed that the "Discretionary Authority" language is invalidated by Ill. Admin. Code tit. 50, §§ 2001.1 and 2001.3 (effective July 1, 2005), an Illinois insurance regulation applicable both to health and disability insurance policies. 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.

(App. 20). The LTD Policy further recites, "If the terms of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform." (Fontaine App. 8, 64; MET 1934, 2864). The crux of this appeal relates to that provision and its enforceability.

The IDI Policy, like the LTD Policy, defines "disability" as the inability to perform one's own occupation. The IDI Policy states, in relevant part:

> **Total Disability** or **Totally Disabled** means that due solely to impairment caused by Injury or Sickness, You are:
> 1. Before the end of the Regular Occupation Period shown on page 3:
>   a. Prevented from performing the material and substantial duties of Your Regular Occupation;
>   b. Not Gainfully Employed; and
>   c. Receiving appropriate care from a Physician who is appropriate to treat the condition causing the Impairment.
> 2. After the Regular Occupation Period shown on page 3:
>   a. Prevented from performing any occupation for which You are or become reasonably fitted by Your education, training, experience;
>   b. Not Gainfully Employed; and
>   c. Receiving appropriate care from a Physician who is appropriate to treat the condition causing the Impairment.

(App. 3-4; Ex. B to Compl. at 7, Docket No. 1-2). "Regular Occupation," in turn, is defined as:

> **Regular Occupation** means Your usual occupation (or occupations, if more than one) in which You are Gainfully Employed at the time You become Disabled. If You are not Gainfully Employed at the time Your Disability begins, Regular Occupation shall then mean any occupation(s) for which You are reasonably fitted by Your education, training or experience.

(*Id.*). Unlike the LTD Policy, the IDI Policy lacks any language granting discretionary authority to MetLife.

Fontaine's Disability Claim

On May 3, 2011, Fontaine applied for disability benefits under both the LTD and IDI policies. (App. 4; MET 1321). In support of her application, Fontaine submitted a detailed narrative describing her responsibilities as a partner specializing in structured finance. (MET 931-39). Fontaine stated that she designed, documented, negotiated, and closed complex financial transactions that were funded on the global capital markets. (App. 4; MET 931). Hundreds of millions, if not billions, of dollars would change hands in those transactions; and there was no margin for error. (App. 5; MET 931). Fontaine was expected to read and quickly analyze large volumes of dense, often technical documentation with virtually instantaneous turnaround; and to stay abreast of the latest developments in securities law. (MET 931, 936). Fontaine explained that deadlines were very important in her practice, not only due to fluctuations in the market but also because advances in technology had conditioned clients to expect an immediate response and turnaround. (MET 935). Fontaine stated that her work day typically began at 7 a.m. with reading emails while riding on the commuter train to her office; and often did not end until 8 p.m. or later, with additional hours spent working from home during evenings and on the weekends. (App. 5; MET 935-36). Fontaine achieved national recognition as a leader in the field of structured international finance and was one of the highest bonus recipients at Mayer Brown between 2008 and 2010. (MET 543). She was also the highest-paid female partner in Mayer Brown in 2010 (the year before she became disabled). (MET 623).

Despite her many accomplishments, Fontaine struggled throughout the latter part of her career due to worsening visual deficits that interfered with her ability to work. Records submitted as part of Fontaine's disability claim documented that in 1997, she was diagnosed with degenerative myopia, a condition caused by extreme elongation of the eyeball, which in turn

causes the retina to stretch and tear, resulting in visual distortions and other complications. (App. 6; MET 1297, 1361). Fontaine's vision progressively worsened over the next decade, resulting in vitreous floaters,[4] difficulty focusing, and migraine headaches, as documented in the notes of her ophthalmologist, Robert Stein, M.D., and retina specialist, Jack Cohen, M.D. (MET 1012, 1294-96, 1309, 1033). In July 2009, Fontaine suffered from choroidal neovascularization (retinal bleeding) in her left eye, causing her corrected vision in that eye to drop to 20/200. (App. 7; MET 1265, 1268-71, 1274, 1305). Although her corrected visual acuity in that eye eventually stabilized, it remained at a diminished level; and Fontaine continued to experience an increase in visual distortions, including haziness and floaters. (MET 1221, 1224, 1228, 1230, 1238, 1242, 1249, 1256). She also developed cataracts. (MET 659, 1228, 1305).

Fontaine's vision deteriorated further in 2011, compromising her depth perception (resulting in falls and other injuries) and causing diplopia (double vision). (MET 659, 1217-18, 1303). Those visual impairments made it increasingly difficult for Fontaine to keep up with the large volume of written materials that crossed her desk each day. (MET 931-39, 1303). In her application for disability benefits, Fontaine reported that she had begun to notice an increase in the number of mistakes she was making at work; and she explained that in her line of work, even a small mistake could have potentially disastrous consequences for herself and her firm. (MET 939).

Fontaine's application for benefits was supported by a certification of disability from her attending ophthalmologist, Robert Stein, M.D., who reported that she was permanently disabled

[4] Vitreous floaters are particles that float in the vitreous (the transparent, gelatinous mass that fills the rear two-thirds of the eyeball) and cast shadows on the retina; seen as spots, cobwebs, spiders, etc. *See* www.eyeglossary.net/ (last visited October 6, 2014).

from working in her occupation due to blurred vision caused by myopic macular degeneration. (App. 8; MET 1359).

MetLife's Initial Denial

After receiving Fontaine's disability application, MetLife forwarded her medical records to Robert Nelson, M.D., an ophthalmologist, to conduct a file review. (App. 8; MET 598-602, 771-76, 904-08). Without examining Fontaine or even speaking with her doctors, Dr. Nelson opined that the "objective evidence" did not support disability from a ophthalmologic standpoint. (MET 776). Instead, he speculated that anxiety, stress, and "burn out" were responsible for Fontaine's claimed diminished capabilities. (App. 9; MET 907). MetLife invited Fontaine's ophthalmologist, Dr. Stein, to comment on Dr. Nelson's report; and he responded by vehemently disagreeing with Dr. Nelson's analysis, pointing out that performing simple tasks such as reading an eye chart could not be equated with the intensive and extensive visual demands of Fontaine's job, which required rapid reading and analysis of a large volume of dense financial material, and continually shifting focus from printed material to computer screens and a Blackberry smart phone. (App. 9; MET 709). Fontaine's optometrist, Alan Karikomi, O.D., concurred, adding that the impaired condition of Fontaine's left eye caused her eyes to be out of sync with one another. (App. 10; MET 711). He analogized Fontaine's vision to attempting to run with a stunted or disabled leg. (*Id.*). Notwithstanding the additional input from Fontaine's treating doctors, MetLife denied Fontaine's claims for disability benefits on November 10, 2011, citing Dr. Nelson's report. (App. 12; MET 575-79, 560-66).

Fontaine's Appeal

On March 1, 2012, Fontaine submitted an appeal of the benefit denial to MetLife pursuant to 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1. (App. 12; MET 420-81). In addition

to challenging MetLife's rationale for denying benefits, Fontaine submitted voluminous additional evidence in support of her appeal, including objective test findings obtained by vision therapy specialist Michael Zost, O.D., and retina specialist Jon Michael, M.D.; a vocational assessment based on evaluative testing performed by James Boyd, M.S., C.R.C.; and a driving evaluation that included a number of visual function tests. (MET 439-78). Fontaine also submitted a report from her psychiatrist, Henry Conroe, M.D., denying "burnout," as well as supportive letters from Mayer Brown's chairman, Herbert Krueger, and from her supervisor, Jon Von Gorp. (MET 479-81).

Drs. Zost and Michael both examined Fontaine and administered objective testing. (App. 12-14; MET 449-51, 461-63). Visual field studies performed by Dr. Zost showed that Fontaine suffers from central and peripheral scotomas (blind spots) in both eyes, worse in her left eye than her right, as well as diplopia (double vision) in her right eye. (App. 13; MET 449-51). Retinal imaging studies obtained by Dr. Michael further showed irregularity in the pigment layer and photoreceptor level of Fontaine's retinas. (MET 461-63, 466-67). Drs. Zost and Michael both analogized the state of Fontaine's vision to peering through a piece of "Swiss cheese," with words or groups of words shifting in and out of focus (App. 12-13; MET 451, 463). They agreed that Fontaine's reading speed and accuracy would be compromised as a result. (*Id.*).

Fontaine's reading difficulties were confirmed by her performance on the Test of Word Reading Efficiency, Second Edition ("TOWRE-2"), administered by Dr. Zost, on which Fontaine scored in the 35th-39th percentile, as compared to a norm group of graduate students. (App. 13; MET 450). Fontaine also performed poorly on the Nelson-Denny Reading Test administered by Mr. Boyd, scoring in the 35th percentile as compared to a normed group of

college/university seniors. (App. 14; MET 441). In addition, Fontaine struggled on several clerical tests administered by Mr. Boyd, which were administered to simulate the numerical data, charts, graphs, and formulas Ms. Fontaine regularly encountered in her work as a Structured Finance Partner. (App. 13; MET 441-42). On the Minnesota Clerical Test, for instance, Ms. Fontaine scored in the bottom 1st-5th percentile, while on the Proofreading subtest of the General Clerical Test, she produced a 50% error rate. (MET 441). Furthermore, Fontaine's driving evaluation confirmed that although she met the legal requirements to drive in Illinois, it was unsafe for her to do so due to her multiple visual limitations. (MET 468-77).

In response to Dr. Nelson's suggestion that Fontaine suffered from anxiety and "burnout," Fontaine's psychiatrist, Dr. Henry Conroe, M.D., stated that he had seen "no indication that [Fontaine] ha[d] ceased working because of burnout, and that "she had expressed pride in her success as an attorney and satisfaction in what she had been doing." (App. 15; MET 480). Mayer Brown chairman Herbert Kreuger similarly remarked that Fontaine was one of Mayer Brown's most highly respected and hardest working partners; and one of the highest recipients of bonuses during 2008 to 2010. (App. 14-15; MET 479). Fontaine's supervisor, Jon Van Gorp, stated that he had reviewed the nine-page narrative Fontaine submitted in support of her disability application and it accurately summarized the responsibilities of a senior partner at Mayer Brown. (MET 481). He added, "For her entire career Mary has met and usually exceeded the difficult demands of her clients" and also remarked, "[a]lthough she is willing and motivated in every way, Mary's impaired eyesight is now a true impediment to performing her job as senior partner at the level that her clients expect, that she expects and that our practice and that our firm expect." (App. 15; MET 481).

MetLife's Appeal Determination

Despite its authority to compel Fontaine to attend an independent medical examination if it disagreed with the treating doctors' findings, upon receipt of Fontaine's appeal, MetLife once again turned to non-examining consultants. (Fontaine App. 48, 64; MET 1918, 1934; Ex. B to Compl. at 14, Docket No. 1-2). Fontaine's medical records were first reviewed by Clayton Hauser, M.D., a family practitioner with no apparent specialization in optometry or ophthalmology. (App. 15; MET 395-97). Dr. Hauser criticized Dr. Zost's administration of the TOWRE-2, arguing that the test is primarily used to assess reading problems among schoolchildren. (App. 15; MET 396). Dr. Hauser further opined, "[T]he best assessment of [Fontaine's] visual ability is her job performance," which he noted had "apparently" been "stellar." (App. 16; MET 397).

MetLife also obtained input from Dean Eliott, M.D., an ophthalmologist who performed a file review. (App. 16; MET 351-52). Dr. Eliott observed that although Fontaine's visual acuity had been relatively stable and was mildly reduced, "she likely has a few small scotomas (blind spots) within her macula which may result in some difficulty with reading such as reduced reading speed." (App. 16; MET 351). Dr. Eliott concluded that although Fontaine presented with no overt restrictions and limitations as a result of her visual problems and can legally drive, "[O]ver time, she likely developed some reduction in reading speed as noted above. *This may impact her job performance due to the high visual need required for her job.*" (App. 16; MET 352). (Emphasis added).

Despite the fact that Dr. Eliott's opinion corroborated the basis for Fontaine's claim, and in spite of assuring Fontaine that it would render a decision immediately upon receipt of Dr. Eliott's report, (MET 299), MetLife ordered yet another file review. MetLife turned to

optometrist Bruce Anderson, O.D., even though MetLife had long since exceeded the deadline for rendering a decision on Fontaine's appeal set forth in the ERISA regulations. *See* 29 C.F.R. § 2560.503-1(i)(3) (requiring that an ERISA plan administrators render a decision on an appeal of the denial of disability benefits within 90 days). (App. 17; MET 203-07). Dr. Anderson maintained that Fontaine's disability was not supported by the clinical evidence. (*Id.*). MetLife also obtained a report from its in-house vocational consultant, Francine Michel, Ph.D., who criticized Mr. Boyd's methodology but proposed no alternative methods for evaluating Fontaine's disability. (App. 16-17; MET 339-49, 370-77). When MetLife still had not rendered a decision on Fontaine's appeal eight months after its submission, Fontaine deemed her appeal obligations exhausted[5] and filed the instant suit on October 31, 2012. (Compl., Docket No. 1).

The Social Security Determination

In addition to applying for benefits from MetLife, Fontaine concurrently applied for Social Security disability insurance benefits as required by the LTD Policy. (App. 18-19; Fontaine App. 51; MET 1921, 1330; PLA 1). Although that claim was initially denied, on February 5, 2013, Fontaine appeared at a hearing before an Administrative Law Judge ("ALJ") for the Social Security Administration, which resulted in an award of benefits. (App. 18; PLA 6-10, 12-17, 20, 301-11). At the hearing, Fontaine testified under oath that her vision problems had caused her to make more and more mistakes at work, prompting her resignation from Mayer Brown on April 30, 2011. (App. 18; PLA 265-68). Fontaine further testified that after she stopped working, she volunteered in a quasi-legal capacity in Mayer Brown's pro bono immigration clinic but found she was making mistakes in reading and filling out even simple, one-page forms. (PLA 273-74). Additionally, Fontaine testified that she enrolled in a remedial

[5] 29 C.F.R. § 2560.503-1(l)(a plan administrator's failure to comply with the ERISA claim regulations allows the claimant to deem appeal obligations exhausted and proceed to court).

driving course as recommended by the driving evaluators, but she had to quit that program prior to completion after nearly running over her neighbor's dog. (PLA 264). The ALJ concluded, with the assistance of testimony from a neutral vocational expert subpoenaed by the judge to be present at the hearing, that Fontaine's visual limitations would cause her to make errors in work product, thus precluding all competitive work at the sedentary exertion level. (App. 19; PLA 288-89). Accordingly, the ALJ issued a bench decision finding Fontaine disabled and awarding her Social Security disability benefits[6] from April 30, 2011 onwards. (App. 19; PLA 289-91).

District Court Proceedings

In her First Amended Complaint, Fontaine filed a claim for benefits due pursuant to 29 U.S.C. § 1132(a)(1)(B). (App. 1; Compl. ¶ 5, Docket No. 1). Fontaine additionally alleged a breach of contract action against MetLife in connection with the denial of her claim for IDI benefits, although she later stipulated that the IDI Policy was also subject to ERISA. (App. 1; Compl. ¶ 5, Docket No. 1; Pl.'s Resp. to D's PFF ¶ 1, Docket No. 63). The parties waived discovery and instead proceeded by agreement to exchange cross-motions for entry of judgment pursuant to Fed. R. Civ. P. 52(a). (App. 3).

On March 27, 2014, the district court entered judgment in Fontaine's favor, finding the facts in Fontaine's favor and concluding that she had established her entitlement to disability benefits under both the LTD and IDI policies by a preponderance of the evidence. (App. 27). The district court rejected MetLife's contention that Fontaine's LTD claim was subject to

[6] The Social Security Act explains in relevant part that:

> An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy.

42 U.S.C. § 423(d)(2)(A).

deferential review, agreeing with Fontaine that the discretionary language contained in the LTD Policy was invalidated by 50 Ill. Admin. Code § 2001.3, and further ruling that § 2001.3 was not preempted by the ERISA statute. (App. 19-22).

Although the district court interpreted the definition of "disability" in the LTD Policy as the inability to perform "*each* of the material duties of your occupation," the district court concluded that the facts as found by the court established that Fontaine met that burden. (App. 22-23). The court was dismissive of MetLife's emphasis on Fontaine's normal visual acuity readings, observing that, in the words of a MetLife field representative, "[Fontaine] is not saying she cannot read and see; she is saying that she cannot read well enough to perform her occupation." (App. 23-24).

The district court was also critical of the reports of MetLife's experts, Drs. Nelson and Hauser. The court remarked that Dr. Nelson's report "reads more like a work of advocacy than a dispassionate analysis." (App. 24). In particular, the court was alarmed by Dr. Nelson's comments about Fontaine's mental health, observing: "Dr. Nelson has no expertise in psychiatry and is wholly unqualified to offer an opinion that Fontaine was suffering from anxiety or burnout. It is troubling that MetLife would rely on such a wildly speculative opinion." (App. 24). The court also dismissed Dr. Hauser's report as "irrelevant," observing that Dr. Hauser is a family practitioner with no qualifications to evaluate job performance, that he never examined Fontaine, and that his statement that "[t]he best assessment of [Fontaine's] visual acuity is her job performance" conflicted with *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 918 (7th Cir. 2003) (ruling that there is no "logical incompatibility between working full time and being disabled from working full time)". (App. 25-26). In contrast, the district court found the reports of Fontaine's treating doctors credible, observing that Drs. Karikomi and

Stein "restricted their conclusions to [Fontaine's] eye conditions and how they might affect her ability to do her job." (App. 26). Furthermore, the district court found Fontaine's allegations credible, citing her testimony before the Social Security Administration, her favorable Social Security determination, her professional accomplishments, and the letters from her colleagues. (App. 26). The court concluded that far from malingering, "the record suggests that Fontaine genuinely loved her work and would have continued to work were it not for her disability." (App. 26). Accordingly, the court entered judgment in Fontaine's favor. (App. 31). Based on the parties' agreements regarding the benefits at issue and prejudgment interest, the court subsequently entered an order inclusive of prejudgment interest, making its decision final and appealable. (App. 32-34).

The only remaining issue was attorneys' fees sought by Fontaine pursuant to 29 U.S.C. § 1132(g). The district court initially denied Fontaine's request for attorney's fees, finding MetLife's position non-frivolous and therefore "substantially justified," thus rendering her ineligible to receive fees. App. 29; *see Herman v. Central States, S.E. and S.W. Areas Pension Fund*, 423 F.3d 684, 696 (7th Cir. 2005) (interpreting the phrase "substantially justified" to mean "something more than non-frivolous, but something less than meritorious"). Fontaine sought reconsideration of that ruling, however; and the district court granted her request, acknowledging that "by equating a substantially justified position with a non-frivolous position, the court misapplied the substantial justification test to this case," thus entitling Fontaine to reconsideration of the fees issue. (App. 38). Applying the standard articulated by the Supreme Court in *Hardt v. Reliance Standard Insurance Co.*, 560 U.S. 242, 254 (2010), the district court satisfied itself that Fontaine had achieved "some success on the merits" and exercised its discretion to award fees. (App. 41). The court analogized MetLife's conduct to its behavior in

Holmstrom v. Metropolitan Life Insurance Co., 615 F.3d 758 (7th Cir. 2010), in which the Seventh Circuit similarly criticized MetLife for disregarding a favorable Social Security determination, ignoring the opinion of one of its own experts, and providing insubstantial and arbitrary explanations for why it discounted credible evidence of disability. (App. 42). Indeed, the district court observed that MetLife's behavior toward Fontaine was arguably worse than its actions in *Holmstrom*, in that "Metlife failed to treat Fontaine's claim with due seriousness, allowing unfounded speculation to substitute for reliable evidence." (App. 42). Acting on Fontaine's motion, which MetLife did not oppose, the district court agreed to stay the proceedings with respect to the amount of attorney's fees and costs to be awarded pending the resolution of MetLife's appeal.[7] (Docket No. 105).

SUMMARY OF THE ARGUMENT

This Court should affirm the findings of fact and conclusions of law entered by the district court, determining that under the correctly applied *de novo* ERISA standard of adjudication, Fontaine established her entitlement to benefits under the LTD Policy by a preponderance of the evidence. MetLife's confusing and sophistic argument that the grant of discretionary authority contained in the ERISA Statement, which MetLife describes as a "non-insurance Plan document," is not subject to 50 Ill. Admin. Code § 2001.3 is absurd. Moreover, that argument begs the question: is the ERISA Statement part of the plan at all, or is it a summary document and therefore incapable of altering the terms of the plan?

[7] Although MetLife appealed that ruling, it has advanced no argument in support of its position that the district court's award of fees was erroneous, other than to protest that it was not invited to respond to Fontaine's request for reconsideration. Accordingly, that issue is waived. *Sanchez v. Henderson*, 188 F.3d 740, 746 n.3 (7th Cir. 1999) (argument that is not meaningfully developed is waived). Moreover, district courts enjoy "broad discretion" in deciding whether to award attorney's fees. *Hardt*, 560 U.S. at 254.

MetLife's argument that § 2001.3 only prohibits discretionary clauses pertaining to contract interpretation, and not benefit determinations, is similarly unavailing, since benefit determinations necessarily involve the interpretation of contract language. Moreover, the title of § 2001.3 ("Discretionary Clauses Prohibited") and administrative guidance issued by the Illinois Department of Insurance confirm that § 2001.3 sets forth an "absolute prohibition" on discretionary clauses in insurance policies issued and delivered in Illinois.

Nor is § 2001.3 preempted by ERISA. Although this is an issue of first impression in this Circuit, the Sixth and Ninth Circuit Courts of Appeals have ruled that nearly identical state law bans on discretionary language in health and disability policies are saved from ERISA preemption as "state laws which regulate insurance." 29 U.S.C. § 1144(b)(2)(A). At least ten district court rulings from within this Circuit have come to the same conclusion with respect to § 2001.3. Additionally, § 2001.3 is not preempted by ERISA's remedial provisions, 29 U.S.C. § 1132(a), since it does not establish a new cause of action or authorize replacement or supplemental remedies.

Applying the forgoing principles, the district court correctly held that the grant of discretionary language contained in the LTD Policy was subject to § 2001.3 and not preempted by ERISA. But even if this Court were to rule that MetLife is entitled to deferential review, it should nevertheless affirm the decision of the district court due to the numerous examples of arbitrary and capricious behavior identified by the district court below.[8]

[8] The Court of Appeals may "affirm on any ground supported in the record, so long as that ground was adequately addressed in the district court and the nonmoving party had an opportunity to contest the issue. *Thayer v. Chiczewski*, 705 F.3d 237, 247 (7th Cir. 2012) (quoting *Peretz v. Sims*, 662 F.3d 478, 480 (7th Cir. 2011)).

STANDARD OF APPELLATE REVIEW

"Unless a welfare-benefit plan confers interpretive or operational discretion on its administrator or insurer, the judiciary makes an independent decision about benefits." *Krolnik v. Prudential Ins. Co. of Am.*, 570 F.3d 841, 842 (7th Cir. 2009) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). Appellate review of any findings of fact made under Fed. R. Civ. P. 52(a) is for clear error, while questions of law are reviewed *de novo*. *Id.*; *accord Marantz v. Permanente Med. Group, Inc. Long Term Disability Plan*, 687 F.3d 320, 327 (7th Cir. 2012).

ARGUMENT

I. The District Court Correctly Applied the *De Novo* Standard of Adjudication In Awarding Fontaine Disability Benefits

A. The Grant of Discretionary Authority Contained in the LTD Policy Is Invalid

1. MetLife Cannot Evade 50 Ill. Admin. Code § 2001.3 by Characterizing the Document Containing Its Grant of Discretionary Authority as a "Non-Insurance Plan Document"

MetLife confusingly asserts that the discretionary language contained in the ERISA Statement appended to the LTD Certificate of Insurance is a "non-insurance Plan document" not subject to regulation under § 2001.3. (Appellant's Br. at 25, 27). That argument is foreclosed, though, by a well-developed body of ERISA jurisprudence relating to the ERISA savings clause (29 U.S.C. § 1144(b)(1)(A)) establishing that state laws regulating the contents of insurance policies are exempted from ERISA's broad preemptive reach.

ERISA permits welfare plan sponsors to fund their programs either through the purchase of insurance, or through their own assets, or through some combination thereof. 29 U.S.C.

§ 1002(1). The ERISA savings clause provides that if employers choose to fund their programs through the purchase of insurance, despite ERISA's broad preemptive language, state insurance laws are saved from preemption and regulate the content of the policies at issue despite ERISA's regulation of any claims brought under such policies. 29 U.S.C. § 1144(b)(2)(A). If the benefit plan is self-funded, though, the "deemer" clause prevents insurance regulation from applying to non-insured plans. 29 U.S.C. § 1144(b)(2)(B); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990); *see also Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 336 n.1 (2003) (observing that the deemer clause "has effect only on state laws saved from pre-emption by § 1144(b)(2)(A) that would, in the absence of § 1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans."). However, "[i]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *FMC Corp.*, 498 U.S. at 64. Hence, where a state law regulating insurance conflicts with the terms of an insured benefit plan, the conflicting terms must give way to the state law, which the LTD Policy at issue here explicitly incorporates. Fontaine App. 8, 64; MET 1934, 2864; *see, Rush Prudential HMO, Inc. v. Moran*, 526 U.S. 355 (2002) (applying ERISA savings clause to impose an independent review regime from Illinois law upon a health maintenance organization). As will be discussed further below, *Moran* essentially dictates an outcome in Fontaine's favor by overcoming all of MetLife's arguments. *See id.*

Moreover, as to the question of whether an Illinois insurance law can be avoided by placing a provision prohibited by insurance regulation in a non-policy document, the Supreme Court barred that practice as well. In *UNUM Life Insurance Company of America v. Ward*, 526 U.S. 358, 376 (1999), that exact argument was decisively rejected. The Court wisely recognized that an interpretation of the ERISA statute permitting insurers to "displace any state regulation

simply by inserting a contrary term in plan documents . . . would virtually 'read the saving clause out of ERISA.'" *Id.* (quoting *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 747 (1985)).

MetLife's argument that the ERISA Statement appended to the LTD Certificate of Insurance is not an "insurance document, but rather a creation of federal law and congressional intent" and therefore the Illinois Insurance Director is powerless to regulate it (Appellant's Br. at 26) should therefore be summarily rejected. In support of its position, MetLife cites the deemer clause; however, as noted above, the deemer clause applies only to self-funded plans and is, therefore, of no assistance to MetLife here. *See FMC Corp.*, 498 U.S. at 61.

Later in its brief, MetLife suggests that because the "granting of discretionary authority appears in the non-insurance Plan document and not in the group policy, which is the Plan's funding mechanism," it is not subject to § 2001.3. (Appellant's Br. at 27). However, MetLife mistakenly assumes that the savings clause only exempts from ERISA preemption those state insurance laws that regulate the *funding* of ERISA plans. On the contrary, as the Supreme Court recognized in *Ward*, *Moran*, and most recently in *Miller*, beginning with *Metropolitan Life Insurance Company v. Massachusetts*, the savings clause has been held to apply with equal force to state laws that regulate the substantive terms of insurance contracts as well as those laws that directly regulate insurance companies and the sale of insurance.

Multiple district courts within this Circuit have uniformly rejected attempts by insurers to evade § 2001.3 by characterizing documents containing discretionary language as "plan" or "trust" documents exempt from state insurance law. *See, e.g., Novak v. Life Ins. Co. of N. Am.*, 956 F. Supp. 2d 900, 906 (N.D. Ill. 2013) (ruling that § 2001.3 applies not only to insurance policies but also to ERISA plan documents); *Borich v. Life Ins. Co. of N. Am.*, No. 12 C 734, 2013 U.S. Dist. LEXIS 59674, *9-10 (N.D. Ill. Apr. 25, 2013) (same); *Ehas v. Life Ins. Co. of N.*

Am., No. 12 C 3537, 2012 U.S. Dist. LEXIS 169151, *16-21 (N.D. Ill. Nov. 29, 2012) (rejecting attempt by insurer to portray an "appointment of claim fiduciary" agreement as a trust agreement outside the purview of § 2001.3). Those authorities have relied upon the expansive language of § 2001.3, which applies not only to insurance polices but also to any "contract, certificate, endorsement, rider application or agreement" offered or issued in Illinois. *E.g.*, *Borich*, 2013 U.S. Dist. LEXIS 59674, *9; *Ehas*, 2012 U.S. Dist. LEXIS 169151, *19.

Furthermore, *Ehas* cautioned that when applying § 2001.3, courts should employ a "common sense perspective" and be careful not to "elevate form over substance." *Ehas*, 2012 U.S. Dist. LEXIS 169151 (quoting *Curtis v. Hartford Life & Accident Ins. Co.*, No. 11 C 2448, 2012 U.S. Dist. LEXIS 5423, *24-25 (N.D. Ill. Jan. 18, 2012)). Although *Ehas* did not explicitly rely on *Ward*, its point is identical to the point made in *Ward* – that insured benefits are subject to state insurance regulation. *See id.*; *Ward*, 526 U.S. at 376 n.6. *Borich* similarly observed: "The regulation's bar on insurer interpretive discretion would be meaningless, however, if it could be avoided by the expedient of entering into a separate agreement, outside the insurance policy, that provides the same discretion that § 2001.3 takes away." 2013 U.S. Dist. LEXIS 59674, *9. Therefore, MetLife's argument that the ERISA Statement is a "non-insurance Plan document" exempt from regulation under § 2001.3 "elevates form over substance" in a manner that both *Ward* and several lower courts have explicitly rejected and which should be rejected here as well. *See Ehas*, 2012 U.S. Dist. LEXIS 169151.

2. If the Discretionary Clause Is Not Contained in the Plan, It Is Unenforceable

MetLife's position that the ERISA Statement is a "non-insurance Plan document" exempt from regulation under § 2001.3 begs the question of whether the ERISA Statement part of the plan at all. In *Cigna Corp. v. Amara*, 131 S. Ct. 1866, 1878 (2011), the Supreme Court clarified

that "summary documents, important as they are, provide communication with beneficiaries *about* the plan, but [] their statements do not themselves constitute the *terms* of the plan for purposes of *§ 502(a)(1)(B)*." *Amara* arguably abrogated prior Seventh Circuit cases ruling that "[o]ften the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as 'the plan.'" *Raybourne v. Cigna Life Ins. Co. of N.Y.*, 576 F.3d 444, 448 (7th Cir. 2009) (enforcing discretionary language contained in a claim fiduciary appointment between the plan administrator and insurer); *see also Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 811 (7th Cir. 2006) (enforcing discretionary language contained in an administrative services agreement between the plan administrator and insurer).

However, even if *Raybourne* and *Semien* remain valid after *Amara*, those authorities are of little assistance to MetLife, since the ERISA Statement appended to the LTD Certificate of Insurance lacks the same indicia of enforceability as the documents at issue in those other cases. In *Raybourne*, the court cited several factors in support of its determination that the claim fiduciary appointment was a plan document, including the fact that the claim fiduciary appointment: 1) was referenced in other plan documents; 2) provided the name of the plan and plan administrator; 3) was signed by representatives of the employer and insurer; and 4) stated that it "shall be effective" from the date of the underlying insurance policy. 576 F.3d at 449. Similarly, in *Semien*, 436 F.3d at 811, this Court was satisfied that the documentation granting discretion was part of the plan where that document was referenced in another plan document.

In contrast, in *Schwartz v. Prudential Ins. Co. of Am.*, 450 F.3d 697, 699 (7th Cir. 2006), this Court refused to enforce discretionary language contained in a summary plan description but not in the plan itself, observing that the plan set forth a procedure whereby the employer could apply for a change in the plan, but that no such change had been sought. The court added,

"Without casting aspersions on Prudential, we note that the implication of [29 U.S.C. § 1022] is that the SPD will be an accurate summary, not an unnegotiated enlargement of the administrator's authority. Were we to say the SPD controlled in this situation, we would be--to use an apropos cliche--allowing the tail to wag the dog." *Id.* at 700.

Here, the "plan" consists solely of the LTD Group Policy and LTD Certificate of Insurance. (Fontaine's App. 1-75; MET 1883-1945, 2857-68; Def.'s PFF ¶ 1, Docket No. 50).[9] The LTD Group Policy recites that it is "issued for delivery in and governed by the laws of Illinois." (Fontaine App. 1; MET 2857). The LTD Group Policy contains an "Entire Contract" provision that states: "The entire contract is made up of the following: 1. this policy, including its Exhibits; 2. the Policyholder's application; and 3. the amendments and endorsements to this policy, if any." (Fontaine App. 7; MET 2863). The exhibits to the LTD Group Policy consist of a schedule of premiums and the certificate forms. (Fontaine App. 9; MET 2865). "Certificates" is broadly defined to include "any of MetLife's insurance riders, notices or other attachments to the certificate." (Fontaine App. 8; MET 2864). The LTD Group Policy further provides that all changes or waivers to the group policy must conform to state law, must be "evidenced by an amendment signed by an officer of MetLife and the Policyholder or an endorsement Signed by an officer of MetLife," and must be attached to the policy. (Fontaine App. 7; MET 2863). The LTD Group Policy recites that "If the terms and provisions of this policy do not conform to any applicable law, this policy shall be interpreted to so conform." (Fontaine App. 8; MET 2864).

The ERISA Statement appended to the LTD Certificate of Insurance does not conform to the policy's procedures for amendments or endorsements since the ERISA Statement is not

[9] In *Ruiz v. Continental Cas. Co.*, 400 F.3d 986, 990-91 (7th Cir. 2005), this Court confirmed that an ERISA welfare benefit plan can consist solely of a group policy of insurance and the certificate of insurance issued by the plan administrator to the plan participants.

signed by an officer of MetLife or by a representative of Mayer Brown, and a copy is not attached to the LTD Group Policy. (Fontaine App. 71-75; MET 1941-45). Moreover, the ERISA Statement is preceded by a page that states: "This is the end of the certificate. The following is additional information." (Fontaine App. 65; MET 1935). Thus, the ERISA Statement is analogous to the summary plan description in *Schwartz* which this Court deemed ineffective to alter or amend the terms of the plan. 450 F.3d at 700. Alternatively, the ERISA Statement is one of the "insurance riders, notices or other attachments to the certificate" which the LTD Group Policy expressly incorporates into the LTD Certificate of Insurance, and thereby the LTD Policy. (Fontaine App. 8; MET 2864). Accordingly, if the ERISA Statement is part of the plan at all, it belongs to the LTD Certificate of Insurance. Therefore, it is subject to all of the LTD Policy's terms and conditions, including its conformity of law provision (Fontaine App. 8; MET 2864) which subjects the LTD Policy to § 2001.3's bar on inclusion of discretionary language in both insurance policies and certificates.

3. The LTD Policy Was "Issued" in Illinois and Is Therefore Subject to § 2001.3

Similarly unavailing is MetLife's argument that even if the ERISA Statement is a "covered insurance document" subject to § 2001.3, that regulation is nevertheless inapplicable because the LTD Policy was "offered" not by MetLife but rather by Mayer Brown LLP; and Mayer Brown is not a "health carrier" within the meaning of § 2001.3. (Appellant's Br. at 26). MetLife cites no authority in support of that argument, which was not raised in its briefs to the district court; therefore, it is waived. *Ehrhart v. Secretary of Health & Human Svcs.*, 969 F.2d 534, 537 n.4 (7th Cir. 1992) ("Issues that a claimant fails to raise before the district court are waived on appeal."); *Sanchez*, 188 F.3d at 746 n.3 (argument that is not meaningfully developed is waived). Moreover, § 2001.3 applies to policies "offered or *issued*" in Illinois. (Emphasis

added). The LTD Group Policy recites at page 1, "This policy is issued in return for the payment by the Policyholder of required Premiums," and is signed by officers of MetLife. (Fontaine App. 1; MET 2857). Since Mayer Brown is the "Policyholder," it follows that the policy was "issued" by MetLife. Therefore, the LTD Policy is subject to § 2001.3.

4. § 2001.3 Prohibits All Discretionary Clauses, Not Just Those Pertaining to Contract Interpretation

MetLife further argues that § 2001.3, by its express terms, only applies to grants of discretion to interpret the terms of an insurance policy and does not apply to grants of discretion to make benefit determinations. However, that argument was skillfully dispensed with in *Zaccone v. Std. Life Ins. Co.*, No. 10 CV 00033, 2013 U.S. Dist. LEXIS 62062, *29 (N.D. Ill. May 1, 2013). As *Zaccone* pointed out, "Benefits determinations are not, to borrow Justice Holmes' phrase, 'a brooding omnipresence in the sky.' They necessarily involve an application of one or more clauses of the policy to a given set of facts." *Id.* at *29. *Zaccone* further noted that § 2001.3 prohibits not only provisions "purporting to reserve discretion to the health carrier to interpret the terms of the contract" but also clauses "purporting . . . to provide standards of interpretation or review that are inconsistent with the laws of this State." *Id.* at *22. The court observed: "Plainly, a clause that invests discretion in an administrator to create standards of interpretation and review would be inconsistent with the preceding prohibition, since, as we have shown, benefits decisions and interpretation of contract terms are inextricably linked – at least in most cases."

As additional support for its ruling that § 2001.3 applies not only to contract interpretation but also to benefit determinations, *Zaccone* cited the title of the regulation ("Prohibition on Discretionary Clauses"), as well as administrative guidance published by the

Illinois Department of Insurance referencing "the *absolute* prohibition on discretionary clauses contained in 50 Ill. Admin. Code 2001.3." *Id.* at *18-24 (Emphasis added).

MetLife argues that *Zaccone* is at odds with *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), in which the Sixth Circuit ruled that ERISA did not preempt Michigan's ban on discretionary language in insurance policies. MetLife notes that at the end of the decision, the Sixth Circuit remarked:

> 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.

Id. at 609. However, that passage cannot be reconciled with *Ross's* recognition earlier in the decision that "under [Michigan's] rules, insurers can no longer invest the plan administrator with unfettered discretionary authority *to determine benefit eligibility* or to construe ambiguous terms of a plan." *Id.* at 607 (emphasis added); *see generally* Mich. Admin. Code R. 500.2201(c) (defining "Discretionary clause" to include "a form that purports to bind the claimant to or grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation on terms, coverage, or eligibility for benefits"). However, should there be any question as to whether state regulation applies to benefit eligibility, *Rush Prudential HMO, Inc. v. Moran* erases all doubt by making it clear that state regulation may take away discretion to determine benefit eligibility, finding, "Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly." 536 U.S. at 385. Hence, MetLife's argument fails.

MetLife further argues that Congress intended for the courts, and not state insurance directors, to develop ERISA standards of judicial review, and that "deferential review promotes congressional goals of national uniformity, predictability, and encouraging plan formation." (Appellant's Br. at 31-32) (citing *Conkright v. Frommert*, 559 U.S. 506 (2010); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008)). However, in addition to ignoring *Moran*, MetLife fails to explain what relevance, if any, Congressional intent has on the proper interpretation of § 2001.3, which results in a regime entirely consistent with the default *de novo* judicial standard for adjudicating ERISA cases prescribed in *Bruch*, 489 U.S. at 115. Accordingly, there is no merit to MetLife's argument that § 2001.3 applies only to grants of discretion to interpret the terms of an insurance contract.

B. § 2001.3 Is Not Preempted by ERISA

1. § 2001.3 Is Saved from Express Preemption as a State Law Which Regulates Insurance

Although 29 U.S.C. § 1144 generally preempts state laws that relate to employee benefit plans, Ill. Admin. Code tit. 50, § 2001.3 is decisively not pre-empted by ERISA. That is because, as discussed *supra*, state laws that regulate insurance are "saved" from preemption according to ERISA § 514(b)(2)(A) (29 U.S.C. § 1144(b)(2)(A)). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1985).

"[F]or a state law to be deemed a 'law . . . which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, [] the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 341 (internal citations omitted).

Although this Court has not yet addressed whether ERISA preempts § 2001.3, two other appellate circuits, in reviewing nearly identical state law bans on discretionary clauses in health, accident, and disability insurance policies, have determined, consistent with *Rush Prudential HMO, Inc. v. Moran*, that in satisfaction of the *Miller* test, such laws are saved from pre-emption under 29 U.S.C. § 1144(b)(2)(A). *See Ross*, 558 F.3d at 600 (upholding Michigan's ban on discretionary language); *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (upholding Montana's ban on discretionary language); *cf. Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141 (10th Cir. 2009) (ruling that that a Utah regulation concerning discretionary clauses was preempted by ERISA because it did not meet the second prong of the *Miller* test, but noting that the outcome would have been different if the regulation "imposed a blanket prohibition on the use of discretion-granting clauses").

First, § 2001.3 is "specifically directed toward entities engaged in insurance." *Miller*, 538 U.S. at 334. In *Miller*, the Supreme Court explained that this first prong of its test would be satisfied where the state law regulated "insurance by imposing conditions on the right to engage in the business of insurance." *Id.* at 338; *see also Morrison*, 584 F.3d at 842 ("[i]t is well established that a law which regulates what terms insurance companies can place in their policies regulates insurance"). That is precisely what § 2001.3 does – it provides a condition on health and disability insurers' ability to provide insurance in the state of Illinois by requiring that discretion-granting provisions may not lawfully be included in their insurance policies. Accordingly, both the Sixth and Ninth Circuits determined that the first prong of the *Miller* test was easily satisfied by functionally identical state laws. *See Ross*, 558 F.3d at 605 ("there can be no dispute that the rules meet the first prong of the Miller test because they regulate insurers with respect to their insurance practices"); *Morrison*, 584 F.3d at 843-44 ("the state's bar on

discretionary clauses addresses an insurance-specific problem, because discretionary clauses generally do not exist outside of insurance plans…It is indeed directed at insurance companies").

Second, § 2001.3 also "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. The Court explained that the second part of the test is satisfied where state laws "alter the scope of permissible bargains between insurers and insureds." *Id.* at 338-39. In both *Ross* and *Morrison*, the Sixth and Ninth Circuits found that state laws banning discretionary clauses also meet the second part of the *Miller* test. *See Ross*, 558 F.3d at 606 (the "rules substantially affect the risk-pooling arrangement between insurers and insureds because they 'alter the scope of permissible bargains between insurers and insureds'"); *Morrison*, 584 F.3d at 844-45 ("Montana insureds may no longer agree to a discretionary clause in exchange for a more affordable premium. The scope of permissible bargains between insurers and insureds has thus narrowed. The Supreme Court has repeatedly upheld similar scope-narrowing regulations"). Therefore, since state law bans on discretionary clauses such as § 2001.3 are "specifically directed toward entities engaged in insurance" and "substantially affect the risk pooling arrangement between the insurer and the insured," they are saved from ERISA preemption pursuant to ERISA's savings clause. *Ross*, 558 F.3d at 607; *Morrison*, 584 F.3d at 845.

Relying on the principles annunciated in *Ross*, and *Morrison*, which are firmly rooted in the *Moran* precedent, at least ten district court judges within this Circuit, in addition to the district court below, have ruled that § 2001.3 is saved from ERISA preemption as a state law that regulates insurance. *See Novak*, 956 F. Supp. 2d at 909; *Schlattman v. United of Omaha Life Ins. Co.*, No. 12 C 7847, 2013 U.S. Dist. LEXIS 85906, *14-16 (N.D. Ill. June 19, 2013)(cataloguing cases); *Zaccone*, 2013 U.S. Dist. LEXIS 62062, *7-14; *Borich*, 2013 U.S.

Dist. LEXIS 59674, *7-12; *Ehas*, 2012 U.S. Dist. LEXIS 169151, *30; *Zuckerman v. United of Omaha Life Ins. Co.*, No. 09 C 04819, 2012 U.S. Dist. LEXIS 128204, *19-28 (N.D. Ill. Sept. 6, 2012); *Barrett v. Life Ins. Co. of North America*, No. 11 C 6000, 2012 U.S. Dist. LEXIS 82920, *2-4 (N.D. Ill. June 14, 2012); *Curtis*, 2012 U.S. Dist. LEXIS 5423, *27-30; *Ball v. Standard Ins. Co.*, No. 09 C 3668, 2011 U.S. Dist. LEXIS 19146, *4-18 (N.D. Ill. Feb. 23, 2011); *Haines v. Reliance Standard Life Ins. Co.*, No. 09 cv 7648, 2010 U.S. Dist. LEXIS 104625, *6 (N.D. Ill. Sep. 9, 2010). Tellingly, MetLife is unable to point to a single case reaching a contrary conclusion in this or in any other circuit that has addressed a provision comparable to § 2001.3.

Instead, MetLife argues that § 2001.3 "is not specifically directed to entities engaged in insurance" because it "target[s] all ERISA plan documents, and not just an insurance policy that funds an ERISA plan." (Appellant's Br. at 33). However, in practice, § 2001.3 only regulates insured ERISA plans, since self-funded ERISA plans are exempted from state insurance law under the deemer clause. *See* 29 U.S.C. § 1144(b)(2)(B); *FMC Corp.*, 498 U.S. at 61. Thus, since § 2001.3 is "specifically directed toward entities engaged in insurance" it easily meets the first prong of the *Miller* test. 538 U.S. at 334. The fact that ERISA plan sponsors may also feel the effect of § 2001.3 does not undercut the conclusion that the law is directed towards entities engaged in the business of insurance. *See Miller*, 538 U.S. at 335 ("Regulations 'directed toward' certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of ERISA's savings clause."); *Ross*, 558 F.3d at 606 ("Bound as we are by *Miller*, we conclude that, although others may feel the effect of the rules, they are, in fact, directed toward entities engaged in the business of insurance.").

MetLife further argues that § 2001.3 "does not substantially affect the risk pooling arrangement" because it does not "establish any terms or conditions that determine whether a class of risks is covered" or "require ERISA plans to insure against an additional class of risks." (Appellant's Br. at 34). However, nothing in the Supreme Court's ERISA jurisprudence suggests that state insurance laws must affirmatively establish terms and conditions or insure against additional classes of risk to be saved from ERISA preemption. *Miller* requires only that a state insurance law "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. That can be achieved through affirmative legislation, *e.g., Metro. Life Ins. Co. v. Mass.*, 471 U.S. at 724 (involving a Massachusetts statute that mandated the provision of certain minimum mental health care benefits), or through prohibition, as in the case of § 2001.3.

Moreover, even if the regulation would result in a rise in premiums, that would be sufficient, under *Ward* to result in risk spreading. 526 U.S. at 376 n.6. An actuarial study performed by Milliman, Inc. at the request of an insurance industry trade group, America's Health Insurance Plans, analyzed the effect of a prohibition against discretionary clauses, and found that their prohibition would result in a 3% to 4% rise in group disability income insurance premiums due to an anticipated higher incidence of litigation, a higher cost per litigated claim and lower claim recovery rates. R. Beal and D. Skwire, "Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance," Milliman, Inc., Nov. 14, 2005 at 8 (*available at* http://www.erisa-claims.com/library/Milliman_Report.pdf (last viewed on October 1, 2014)). Both types of law "alter the scope of permissible bargains between insurers and insureds" and, therefore, "substantially affect the risk-pooling arrangement between insurer and insured." *Miller*, 538 U.S. at 338-39. MetLife's arguments to the contrary are therefore

unpersuasive. Hence, this court must uphold the decision of the district court finding § 2001.3 saved from ERISA preemption as a state law which regulates insurance.

2. § 2001.3 Is Not Preempted by the Remedial Provisions of § 1132(a)

MetLife further argues that even if § 2001.3 is saved from ERISA preemption as a state law which regulates insurance, it is nonetheless preempted by ERISA's civil enforcement provisions, set forth in 29 U.S.C. § 1132(a). (Appellant's Br. at 34). The Supreme Court has recognized that ERISA's civil enforcement provisions "are of such extraordinarily preemptive power that they override even the 'well-pleaded complaint' rule for establishing the conditions under which a cause of action may be removed to a federal forum." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. at 376. However, so-called "field" or "complete" preemption is limited to circumstances where a state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy" set forth in 29 U.S.C. § 1132(a). *Aetna Health Inc. v. Davila*, 542 U.S. 200, 2009 (2004) (ruling § 1132(a) preempted Texas law establishing standard of care for insurers making benefit determinations).

Again, the guiding precedent that eviscerates MetLife's argument is *Rush Prudential HMO, Inc. v. Moran*, 526 U.S. at 355. Just as the independent review law at issue there was found non-remedial, the discussion anticipated that states may try to regulate insurers' discretion under ERISA and found such regulation permissible. Just as the law at issue in *Moran* "provide[d] no new cause of action under state law and authorize[d] no new form of ultimate relief" (536 U.S. at 379), the same could be said for §2001.3. Hence, complete preemption would have no bearing on the present case because § 2001.3 does not "duplicate[], supplement[], or supplant[] ERISA's remedial provisions." *See Davila*, 542 U.S. at 209. Section § 2001.3 does not create a cause of action; rather, it regulates the *content* of insurance policies.

Nor does § 2001.3 impose penalties for non-compliance; instead, non-compliant insurance policies are treated as though they conform. *See* 215 ILCS 5/357.23 ("Conformity with State Statutes"). As such, § 2001.3 is no different than the independent review law at issue in *Moran.*

The Sixth and Ninth Circuit have similarly concluded that § 1132(a) does not preempt state law bans on discretionary language nearly identical to the Illinois law at issue here. *Ross*, 558 F.3d at 607-08; *Morrison*, 584 F.3d at 846-47. Relying principally on *Moran*, 536 U.S. at 379, those courts observed that the state laws in question did not "authorize any form of relief in state courts" or "serve as an alternate enforcement mechanism outside of ERISA's civil enforcement provisions." *Ross*, 558 F.3d at 607; *Morrison*, 584 F.3d at 846. *Ross* and *Morrison* further observed that the *de novo* standard is the default standard of adjudication in ERISA benefit denial cases, "so 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; *Morrison*, 584 F.3d at 846; *see generally Bruch*, 489 U.S. at 115 (establishing the *de novo* standard as the default standard of adjudication in ERISA benefit denial cases). In *Ross*, the Sixth Circuit also relied on the Supreme Court's pronouncement in *Glenn*, 554 U.S. at 112, that a conflict of interest invariably exists when a plan administrator is responsible for both examining and paying a benefits claim. 558 F.3d at 609. *Ross* observed:

> If, as *Glenn* reaffirms, there is a conflict of interest when the same plan administrator decides the merits of a benefits plan and pays that claim, and if, as *Glenn* also holds, it is consistent with ERISA to account for that conflict of interest in reviewing a plan administrator's decision, it is difficult to understand why a State should not be allowed to eliminate the potential for such a conflict of interest by prohibiting discretionary clauses in the first place.

Id. (citing *Glenn*, 554 U.S. at 105). In accordance with *Ross* and *Morrison*, this Court should also rule that § 2001.3 is not preempted by ERISA's remedial provisions, set forth in § 1132(a).

MetLife argues that *Ross* and *Morrison* are superseded by the Supreme Court's decision in *Conkright v. Frommert*, 559 U.S. at 506, which it calls a "monumental ERISA decision." (Appellant's Br. at 37). MetLife cites favorably to *Conkright*'s pronouncement that "permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the 'careful balancing' on which ERISA is based." 559 U.S. at 517 (quoting *Davila*, 542 U.S. at 215 ("The limited remedies available under ERISA are an inherent part of the 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.")). MetLife argues that *Conkright* requires that ERISA plan administrators must at least have the "option" of granting themselves discretionary authority; otherwise, courts in different jurisdictions will arrive at competing interpretations of the same plan language, thus frustrating ERISA's goals of "predictability and uniformity." (Appellant's Br. at 36-37).

However, MetLife overstates the importance of *Conkright*, as well as its applicability to this dispute. *Conkright* did not involve ERISA preemption or standards of judicial review; *Conkright* merely held that a plan administrator cannot be stripped of a *valid* grant of discretionary authority based on a "single honest mistake in plan interpretation." 559 U.S. at 509; s*ee Zaccone*, 2013 U.S. Dist. LEXIS 62062, *10-14 (distinguishing *Conkright*). Moreover, although *Ross* and *Morrison* predate *Conkright*, those authorities relied principally on *Moran* and *Firestone*, neither of which have been overruled by the Supreme Court. *Moran*, in particular, addressed an argument that mandating compliance with an independent review law stripped the health benefit plan of its discretionary authority. The Court found, "Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of

primary conduct, not a uniformly lenient regime of reviewing benefit determinations." 536 U.S. at 384. Both *Moran* ("disuniformity is the inevitable result of the Congressional decision to save local insurance regulation" 536 U.S. at 401) and *Ward* also addressed MetLife's concern about disuniformity. Indeed, *Ward* noted,

> We recognize that applying the States' varying insurance regulations creates disuniformities for "national plans that enter into local markets to purchase insurance." *Metropolitan Life,* 471 U.S. at 747. As we have observed, however, "such disuniformities ... are the inevitable result of the congressional decision to 'save' local insurance regulation.' *Ibid.*

526 U.S. at 376 n. 6. Thus, MetLife's professed concern about disuniformity is not a valid reason for finding preemption. Accordingly, the lower court's finding that § 2001.3 is not preempted by § 1132(a) must be upheld.

II. Even if a Deferential Standard of Review Applies, MetLife's Denial of Benefits Was Arbitrary and Capricious

MetLife is mistaken in its argument that it would have won in the court below if the district court had applied the arbitrary and capricious standard of review to Fontaine's claim for LTD benefits. As a preliminary matter, it should be noted that MetLife does not challenge the district court's finding of liability under the *de novo* standard of adjudication, only the lower court's application of the *de novo* standard in the first place. MetLife also chose not to appeal the district court's finding of liability under the IDI Policy, which the parties agree does not contain a grant of discretionary authority. (Appellant's Br. at 2; Pl.'s Resp. to D's PFF ¶ 5, Docket No. 63). By appealing only the district court's finding of liability under the LTD Policy, and by failing to challenge the district court's finding of liability under the *de novo* standard, MetLife tacitly admits that under the *de novo* standard of adjudication, it lacks any grounds for overturning the judgment entered by the district court.

MetLife also ignores the appellate standard of review. The district court entered judgment pursuant to Fed. R. Civ. P. 52(a). (App. 31). Under that rule, findings of fact are reviewed for clear error, while questions of law are reviewed *de novo*. *Krolnik*, 570 F.3d at 842; *Marantz*, 687 F.3d at 327. MetLife does not address what weight should be given to the district court's findings of fact supporting its determination that the evidence overwhelmingly favored Fontaine's position in contrast to what the district court found were MetLife's weak, irrelevant, or baseless conclusions, although it hints that under the arbitrary and capricious standard, MetLife's determination should be upheld so long as it is supported by "substantial" evidence. (Appellant's Br. at 39). MetLife consented to cross-motions for entry of judgment pursuant to Fed. R. Civ. P. 52(a) knowing full well the consequences for appellate review. MetLife cannot now substitute the "substantial evidence" test, which has no place in ERISA jurisprudence, in place of the clearly erroneous standard. *See Marantz*, 687 F.3d at 327 (refusing to alter appellate standard of adjudication in ERISA cases decided under Fed. R. Civ. P. 52(a)).

In any event, even if this Court were to rule that § 2001.3 does not invalidate the LTD Policy's grant of discretionary authority, and thus disagree with two other courts of appeals as well as *every* district court that has considered the issue, Fontaine would nevertheless have prevailed in her claim for LTD benefits under the arbitrary and capricious standard of review. The district court's ruling on Fontaine's request for reconsideration of the denial of plaintiff's motion for attorney's fees is instructive. In deciding whether to award Fontaine fees, the district court applied the "substantial justification" test utilized by this Court in *Kolbe & Kolbe Health & Welfare Plan v. Med. Coll. Of Wis., Inc.*, 657 F.3d 496, 506 (7th Cir. 2011), which asks, "[W]as the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" (App. 40). The district court then analogized MetLife's conduct to

the same behavior this Court found arbitrary and capricious in *Holmstrom v. Metropolitan Life Insurance Co.*, 615 F.3d at 758 (ruling that MetLife abused its discretion in denying disability benefits to a claimant suffering from complex regional pain syndrome). The court noted that here, as in *Holmstrom*, MetLife failed to adequately explain its reasons for disagreeing with the Social Security Administration's determination that Fontaine was disabled, which was made under a standard of disability eligibility more stringent than the ones contained in the LTD and IDI policies. App. 41; *see Holmstrom*, 615 F.3d at 772-73. Additionally, the district court noted that, as in *Holmstrom*, MetLife had disregarded the opinion of its own expert, Dr. Eliott, that "over time [Fontaine] likely developed some reduction in reading speed [which] may impact her job performance due to the high visual need required for her job." App. 42; *see Holmstrom*, 615 F.3d at 758. Furthermore, the district court noted that, as in *Holmstrom*, MetLife had relied on insubstantial and arbitrary explanations for its actions, "such as its argument that Fontaine was able to do her job because she had good visual acuity, when Fontaine never suggested that she was unable to do her job for this reason." App. 42; *see Holmstrom*, 615 F.3d at 771.

Indeed, the district court went further, opining that Fontaine's claim to an award of attorney's fees was "even stronger" than the claim for fees made in *Holmstrom*, where the district court found that MetLife's degree of culpability was slight. App. 42; *see Holmstrom v. Metro. Life Ins. Co.*, No. 07-CV-6044, 2011 U.S. Dist. LEXIS 58766, *8-9 (N.D. Ill. May 31, 2011). The district court pointed out that it had already faulted MetLife for: (1) relying on the "wildly speculative" opinion of its retained ophthalmologist with no apparent training in psychiatry that Fontaine suffered from "anxiety" or "burnout"; (2) relying on the report of a internist who drew improper inferences about Fontaine's present ability to do her job based on her past work performance when that physician had no special training or expertise to opine on

that subject; and (3) failing to appreciate the unique responsibilities of Fontaine's job as a structured finance partner. (App. 25, 26, 28, 42). The court thus concluded, "In these respects, MetLife failed to treat Fontaine's claim with due seriousness, allowing unfounded speculation to substitute for reliable evidence." (App. 42). Although the "substantial justification" test is not a perfect corollary to the arbitrary and capricious standard of review, the many similarities between Fontaine's case and *Holmstrom*, 615 F.3d 758, not to mention the additional arbitrary behavior noted by the district court above, confirm that even under a deferential standard of review, Fontaine is entitled to judgment.

Heedless of the admonitions of the district court, MetLife advances the same arguments on appeal that the district court rejected below as arbitrary. First, MetLife emphasizes Fontaine's "stable" visual acuity readings. (Appellant's Br. at 41). Yet as the district court noted, Fontaine never suggested that she was unable to do her job because of impaired visual acuity. (App. 23-24, 42). On the contrary, as a MetLife representative noted, "[Fontaine] is not saying she cannot read and see; she is saying that she cannot read well enough to perform her occupation." (App. 24-25; MET 621). Although Fontaine suffers from pathological myopia, she has alleged disability not only due to myopia but also due to visual distortions caused by scotomas (blind spots), vitreous floaters, and cataracts, which are consequences of pathological myopia. (MET 1332). Moreover, it is grossly inaccurate to say that Fontaine's visual acuity readings were "stable" during the time period in question. Although Fontaine's *corrected* visual acuity remained more or less stable at 20/20 to 20/25 in her better-seeing right eye and 20/40 to 20/60 in her left eye, the *uncorrected* visual acuity in Plaintiff's left eye has deteriorated significantly, as indicated by her contact lens prescription, which increased from a correction of -10.25 in 2006

to -22.0 in 2011. (MET 280). Accordingly, Fontaine's ophthalmological condition was not "stable" during the time period in question.

Moreover, even if Fontaine was able to continue working for several years despite worsening vision, that would not be a viable rationale for denying benefits since that precise argument was rejected in *Hawkins*, 326 F.3d at 918, where this Court ruled that there is no "logical incompatibility between working full time and being disabled from working full time." (App. 25). *Hawkins* acknowledged that "[a] desperate person might force himself to work despite an illness that everyone agreed was totally disabling." 326 F.3d at 918. It thus follows that an ERISA plan administrator cannot rely upon a lack of worsening of a claimant's condition as a basis to deny benefits.

MetLife's continued reliance on Dr. Nelson's report is also unavailing. Besides making "wildly speculative" accusations about Fontaine's mental health, Dr. Nelson opined, based solely on Fontaine's corrected visual acuity measurements, that she could "utilize a computer, read, drive an automobile, and perform the employment requirements that she has described competently and capably." (App. 25; MET 775-76). Yet, as Fontaine's treating ophthalmologist, Dr. Stein, pointed out:

> While corrective lenses can provide baseline visual function for brief tasks such as reading an eye chart, they do not provide adequate visual function for the unique demands of Mrs. Fontaine's job, specifically as those demands relate both to the quantity of reading Ms. Fontaine has to perform each work day, as well as the number of hours each day that Ms. Fontaine has to maintain visual function at an exceptionally high level.

(App. 9; MET 709). Indeed, MetLife's own expert, Dr. Eliott, agreed that "certain tasks such as reading . . . require more than visual acuity, and . . . visual acuity is only one measure of visual function." (MET 171). Dr. Nelson's comments, and MetLife's disability determination generally, betray a lack of appreciation for the unique and highly demanding responsibilities of

Fontaine's occupation and disregard the fact that her ability to perform tasks for some of the time does not enable her to perform those tasks for either the time required or at a rate of speed necessary to adequately perform the job.

That is a crucial distinction under both the guiding standards applied in this Circuit for interpreting occupation-specific disability plans, as well as the incorporation of that standard in an ERISA case adjudicated under the arbitrary and capricious standard of review and which also involved MetLife. The district court interpreted the language of the LTD Policy defining "disability" as the inability to perform "*each* of the material duties of your occupation," as requiring that Fontaine establish she was unable to perform "all of the material duties of a structured finance partner." (App. 23). That reading is too narrow, even by arbitrary and capricious standards. In *McFarland v. General American Life Ins. Co.*,149 F.3d 583, 587 (7th Cir. 1998), this Court interpreted the phrase "unable to perform the material and substantial duties of your regular occupation" to encompass both "qualitative" reductions in one's work performance (i.e., the inability of a person to perform "one core and essential aspect" of one's job), and quantitative reductions (i.e., when an injury or sickness does not "physically prevent an employee from performing any given task, but the injury instead renders the person unable to perform enough of the tasks or to perform for a long enough period to continue working at his regular occupation"). *Id.* at 588.

Moreover, in *Seitz v. Metro. Life Ins. Co.*, 433 F.3d 647, 651 (8th Cir. 2006), the Eighth Circuit adopted *McFarland* in the ERISA context, utilizing the quantitative reduction standard to find that the ability to perform an occupation for only some of the time required meant the insured was disabled and entitled to benefits. Likewise, in *Lain v. Unum Life Ins.Co. of Amer.*, 279 F.3d 337 (5th Cir. 2002), the Fifth Circuit rejected an insurer's argument that an attorney

who concentrated in real estate, banking, and finance was not disabled because she failed to prove her inability to perform *every* single one of her job duties under a job-specific disability policy. The court determined that the "legally correct" interpretation of the policy was that "in order to be considered disabled, an insured must be unable to perform only a single material duty of her occupation." 279 F.3d at 345. *See also Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Plan*, 85 F.3d 455, 458 (9th Cir. 1996) (rejecting insurer's position that a claimant "is not totally disabled if she can perform any single duty of her job, no matter how trivial . . . as 'total disability' would only exist if the person were essentially non-conscious.").

Notwithstanding the foregoing authorities, the district court erroneously accepted MetLife's approach that Fontaine needed to show her inability to perform each and every job duty. By interpreting the phrase "each of the material duties of your occupation" to require that Fontaine be unable to perform *all* of the material duties of her former occupation as a structured finance partner, the district court negated the occupation-specific nature of the coverage provided under the LTD Policy. That the district court nevertheless found Fontaine disabled under that rigorous standard is added proof that MetLife's disability determination cannot withstand even deferential review.

MetLife further argues that field of vision testing performed by Dr. Zost confirmed that Fontaine did not suffer from "visually impairing" scotomas. (Appellant's Br. at 43). Yet scotomas are only one of the visual distortions of which Fontaine has complained; she has also alleged visual impairment due to vitreous floaters and cataracts. (MET 1332). The deleterious effects of those visual abnormalities is demonstrated by Fontaine's poor performance on functional tests of reading and clerical ability administered by optometrist Dr. Zost and by vocational expert James Boyd. (App. 13-14; MET 441-42, 450). MetLife dismisses those tests

as "elementary." (Appellant's Br. at 47). But even if that argument were correct, it would nonetheless prove Fontaine's point: the fact that someone as educated and accomplished as Fontaine should fail a test designed for school children offers even more compelling evidence of disability. MetLife disregards that fundamental paradox and instead calls Dr. Zost's test results "preposterous," insinuating either that Fontaine malingered on the tests administered by Dr. Zost, or that Dr. Zost fabricated the results. (Appellant's Br. at 48). MetLife's refusal to credit the results of Fontaine's functional testing, while placing undue emphasis on her visual field tests results, suggests an arbitrary weighting of the evidence of the sort this Court deemed unreasonable in *Holmstrom*, 615 F.3d 758. And the lower court's factual findings on such issues may not be disturbed unless clearly erroneous.

Finally, MetLife argues that Fontaine's favorable Social Security determination is irrelevant under the arbitrary and capricious standard of review. MetLife may be correct that under that standard, the evidence is limited to the evidence before the plan administrator at the time of the final decision, while the Social Security claim was decided after appeals were exhausted. *See Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478 (7th Cir. 2009). However, Fontaine's favorable Social Security determination was only one of several pieces of evidence cited by the district court in ruling for Fontaine.

MetLife further argues that the Social Security award is unreliable because the Social Security Administration did not have access to the reports of MetLife's consultants. (Appellant's Br. at 50). However the Supreme Court ruled in *Richardson v. Perales*, 402 U.S. 389, 402 (1971) that the reports on non-examining physicians not subject to subpoena cannot qualify as "substantial evidence" for the purpose of a Social Security Administration proceeding. Thus, the Social Security Administration would not have assigned any weight to the reports of MetLife's

doctors even if those reports had been submitted. Further, MetLife's argument is completely foreclosed by *Raybourne*, 700 F.3d at 1087-88, in which this Court ruled that Social Security Administration's adjudication without the benefit of the insurance company's consultants reports was no reason to disregard the Social Security award.

Therefore, for all of the foregoing reasons, since this court possesses the power to affirm the lower court's judgment on any ground supported by the record, even if this court were to find error in the district court's utilization of the *de novo* standard of judicial review, it must still affirm the lower court since there is no reasonable basis for reaching a conclusion other than a determination that Mary Fontaine is disabled and qualifies for benefits under the long-term disability insurance policy.

CONCLUSION

As the foregoing demonstrates, MetLife has no basis whatsoever for challenging the district court's application of the *de novo* standard of adjudication. MetLife's effort to evade § 2001.3 of the Illinois Insurance regulations is trumped by policy terms that incorporate the law into the policy. Nor can MetLife convincingly argue that the regulation is preempted by ERISA in the face of the savings clause. Finally, even under a deferential standard of review, the district court's finding of fact dictates the identical outcome favoring Fontaine. Accordingly, for all of the reasons stated herein, the judgment issued by the district court in Plaintiff's favor should be affirmed in all respects.

Dated: October 8, 2014

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I, Mark D. DeBofsky, attorney for the Plaintiff-Appellee, certify, pursuant to Circuit Rule 32(a)(7)(B)(i), that the Appellee's brief contains no more than 14,000 words. According to the Microsoft Word word count, this brief contains 13,429 words, including footnotes.

/s/ Mark D. DeBofsky

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CERTIFICATE OF SERVICE

I, Mark D. DeBofsky, attorney for the Plaintiff-Appellee, hereby certify that on October 8, 2014, I electronically filed the forgoing 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/ Mark D. DeBofsky

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