No. 09-885

In The
Supreme Court of the United States

STANDARD INSURANCE COMPANY,

Petitioner,

v.

MONICA LINDEEN, State Auditor,
ex officio Commissioner of Insurance,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS *AMICUS CURIAE* IN OPPOSITION TO WRIT OF CERTIORARI AND IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether a state insurance commissioner's disapproval of insurance policies with clauses providing discretion to insurers is saved from preemption by § 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974 (ERISA). (29 U.S.C. § 1144(b)(2)(A))

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES:

STATUTES:

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

INTEREST OF AMICUS CURIAE[1]

The National Association of Insurance Commissioners ("NAIC") is a non-profit corporation whose membership consists of the principal insurance regulatory officials of the fifty States, the District of Columbia, the territories and insular possessions of the United States. Founded in 1871, it is the nation's oldest association of state government officials. The NAIC represents the coordinated and considered views of the state government officials that regulate and enforce the insurance laws of the country.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers as well as assist in maintaining the financial stability of the insurance industry.

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[1] No counsel for a party authorized 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 curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least 10 days prior to the due date of the *amicus curiae's* intention to file this brief. Counsels for Petitioner and Respondent have consented to the filing of the NAIC's *amicus* brief in this case.

The NAIC performs numerous crucial services on behalf of state governments, including: developing and publishing model laws, regulations, bulletins, financial and accounting standards, white papers, consumer guides, handbooks, periodicals and the *Proceedings of the NAIC*. Hundreds of state and federal laws assign duties to the NAIC and incorporate NAIC standards, models and other publications. In addition, the NAIC manages and coordinates the accreditation review of insurance departments as well as maintains regulatory and financial databases of insurance company financial data.

The interest of the NAIC in this case arises out of the regulatory responsibility vested in each commissioner over health insurance and disability income protection coverage. The insurance commissioners of the various states are charged by state and federal law with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, *et seq*. (2006). ("McCarran-Ferguson Act"), and state insurance laws. The authority to regulate insurance issued in connection with employee welfare benefits plans is reserved to the states through the savings clause of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq*. (2006) ("ERISA"). 29 U.S.C. § 1144(b)(2)(A) (2006).

The NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act, 1 NAIC *Model Laws, Regulations and Guidelines,* 42-1 to 42-6 (2002,

amended 2004) ("Discretionary Clause Model Act"), that bans discretionary clauses in health insurance and disability income protection coverage partly because of the potential for rendering coverage illusory as a result of self-interested decision making when an insurer responsible for providing benefits has discretionary authority to decide what benefits are payable. The NAIC files this *amicus* brief to emphasize the need for sound regulation and judicial review when the benefit payor that is a health insurer makes its own determinations on benefit claims, and to confirm the power of state insurance commissioners to regulate this area. By having the power to prohibit discretionary clauses in insurance policies, state insurance regulators assure that disputes concerning health insurance benefits and disability income protection coverage are resolved fairly, based on the evidence.

The NAIC endorses the brief of Respondent, Monica Lindeen, Montana State Auditor, Commissioner of Insurance and Securities ("Montana Commissioner of Insurance"), and its legal arguments in opposition to the petition for writ of certiorari. We seek to aid the Court by offering the legal position and public policy perspectives of our national association and NAIC member states.

SUMMARY OF ARGUMENT

The Court of Appeals correctly held that the Montana Commissioner of Insurance had the power to disapprove the use of discretionary clauses in insurance policies issued by Petitioner Standard Life Insurance Company ("Standard") under the authority of MONT. CODE ANN. § 33-1-502(2) (2009). The NAIC appears as *amicus curiae* and joins the Montana Commissioner of Insurance in opposition to this petition for the following reasons:

1. The decision of the Court of Appeals is consistent with the holdings in *Am. Council of Life Insurers v. Ross,* 558 F.3d 600 (6th Cir. 2009) and *Hancock v. Metropolitan Life Ins. Co.,* 590 F.3d 1141 (10th Cir. 2009), the only two other United States courts of appeals decisions which have addressed the issue of discretionary clauses. There is no conflict between federal appellate courts in this matter.

2. The opinion of the Court of Appeals is consistent with this Court's decision on the use of discretionary clauses in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989), and does not conflict with any other precedent of this Court, including *Rush Prudential HMO, Inc. v. Moran,* 526 U.S. 358 (1999), and *Metropolitan Life Ins. Co. v. Glenn,* 128 S.Ct. 2343 (2008). These cases reveal a strong statement of ERISA's intent to promote the interests of employees and their beneficiaries, and to protect them from arbitrary and capricious claim decisions.

3. In approving the Discretionary Clauses Model Act, the NAIC recognized that the reasonable expectations of insurance consumers must be protected under an objective, contract-based standard for insurance claims adjudication, which falls under the duties and powers of state insurance commissioners. Standard's claim that *de novo* review is likely to lead to far more complex and costly litigation than does abuse of discretion review has not been substantiated by any evidence presented to either the Montana Commissioner of Insurance or this Court. However, both Respondent and the NAIC can present documented examples of what can occur when an insurance company uses discretionary clauses as a shield to protect itself against the nonpayment of legitimate claims. This Court should affirm the authority of state insurance commissioners to protect claimants from discretionary clauses by denying the Petition for Writ of Certiorari in this matter.

ARGUMENT

1. THERE IS NO CONFLICT BETWEEN UNITED STATES COURTS OF APPEALS ON THE AUTHORITY OF STATES TO PROHIBIT THE USE OF DISCRETIONARY CLAUSES IN POLICIES OF INSURANCE.

At the time of filing of this *amicus* brief, two other United States Courts of Appeals had rendered opinions on the authority of state insurance commissioners to prohibit the use of discretionary clauses in

policies of insurance: (1) *Am. Council of Life Insurers v. Ross,* 558 F.3d 600 (6th Cir. 2009); and (2) *Hancock v. Metropolitan Life Ins. Co.,* 590 F.3d 1141 (10th Cir. 2009). Each of these decisions is consistent with the Ninth Circuit Court of Appeals' holding in *Standard Ins. Co. v. Morrison,* 584 F.3d 837 (9th Cir. 2009), and there is no conflict between federal appellate courts in this matter. Therefore, there is no compelling reason to grant a petition for writ of certiorari under SUP. CT. R. 10.

The only real distinction between these cases is factual; i.e., each court was presented with an alternative method used by the respective state insurance commissioner to prohibit discretionary clauses. In *Standard*, the Ninth Circuit addressed disapproval of discretionary clauses under the authority of MONT. CODE ANN. § 33-1-502(2) (2009), which requires the commissioner to disapprove policies that contain inconsistent, ambiguous or misleading clauses or exceptions and conditions which deceptively affect the risk. In *Ross,* the Sixth Circuit reviewed MICH. ADMIN. CODE r. 500.2201-500.2202; 550.111-550.112 (West 2010), which specifically prohibited insurers from issuing, delivering, or advertising insurance contracts or policies that contain discretionary clauses. Finally, in *Hancock* the Tenth Circuit examined UTAH ADMIN. CODE r. 590-218 (West 2010), which prohibits discretion-granting clauses in insurance forms other than those relating to benefit plans governed by ERISA, and permits them in ERISA plans only if their language is

substantially similar to the safe-harbor language set forth in the regulation.

In *Standard,* the Ninth Circuit began its analysis by referencing the position taken by the NAIC that the use of discretionary clauses "may result in insurers engaging in inappropriate claim practices and relying on the discretionary clause as a shield." 584 F.3d at 840. Acknowledging that the prohibition on discretionary clauses related to an employee benefit plan under 29 U.S.C. § 1144(a), the Ninth Circuit turned its attention to whether this was preserved from preemption under the ERISA savings clause and the two-part test laid out in *Kentucky Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329 (2003). "First, the state law must be specifically directed toward entities engaged in insurance" and it "must substantially affect the risk pooling arrangement between the insurer and the insured." *Standard,* 584 F.3d at 842 (quoting *Kentucky Ass'n,* 538 U.S. at 342*)*.

The Ninth Circuit quickly dismissed Standard's argument that the disapproval of discretionary clauses is not specifically directed at insurance companies because it is instead directed at ERISA plans and procedures. Agreeing with the Sixth Circuit's decision in *Ross,* the Ninth Circuit held that "[i]t is well-established that a law which regulates what terms insurance companies can place in their policies regulates insurance companies" and the fact "[t]hat an insurance rule has an effect on third parties does not disqualify it from being a regulation

of insurance." *Standard,* 584 F.3d at 842. Turning next to the second part of the *Kentucky Ass'n* test, the Ninth Circuit addressed Standard's argument that the disapproval of discretionary clauses did not substantially affect risk pooling. Again specifically agreeing with the Sixth Circuit's opinion in *Ross*, the Ninth Circuit held that the prohibition on discretionary clauses "substantially affect[s] the risk-pooling arrangement between insurers and insureds because they alter the scope of permissible bargains between insurers and insureds." *Standard,* 584 F.3d at 845 (quoting *Ross,* 558 F.3d at 606).

Finally, both the Ninth and Sixth Circuits address the argument that the prohibition of discretionary clauses by a state insurance commissioner "is inconsistent with the purpose and policy of the ERISA remedial system, which emphasizes a balance between protecting employees' right to benefits and incentivizing employers to offer benefit plans." *Standard,* 584 F.3d at 847. First, the Ninth Circuit again specifically agrees with the reasoning of the Sixth Circuit that the practice of prohibiting discretionary clauses "neither 'authorize[s] any form of relief in state courts' nor 'serve[s] as an alternate enforcement mechanism[ ]outside of ERISA's civil enforcement provisions." *Standard,* 584 F.3d at 846 (quoting *Ross,* 558 F.3d at 607). In short, the holdings of both *Standard* and *Ross* are completely consistent with one another and are not in conflict.

While the Tenth Circuit in *Hancock* reached a different outcome in the case (ultimately finding for

the insurance company), its reasoning is consistent with both the Sixth and Ninth Circuits. In *Hancock*, Utah imposed a ban on discretionary clauses in insurance policies. UTAH ADMIN. CODE r. 590-218 (West 2010). An exception, however, was provided for ERISA employee benefit plans. *Id.* The regulation authorizes discretionary clauses in such ERISA plans if the clause meets certain safe-harbor language regarding the disclosure of the discretionary clause in the plan documents (e.g., safe-harbor language, font size and bold type). *Id.* Thus, the provision in question did not set general insurance regulatory standards, but rather specifically established detailed requirements relating to ERISA plans. The Tenth Circuit held that this provision was not saved from preemption under ERISA. 590 F.3d at 1149.

Despite this holding in favor of the insurance company, *Hancock* is still plainly consistent with both *Standard* and *Ross*. The Tenth Circuit specifically stated that "[i]f Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case." 590 F.3d at 1149. The Tenth Circuit specifically pointed to the Ninth Circuit holding in *Standard* ("*Miller* prong two is satisfied by Montana's practice of disapproving all insurance forms containing discretion granting clauses") and the Sixth Circuit holding in *Ross* ("Michigan's prohibition on discretion-granting clauses satisfies *Miller* prong two because it limits the contracts that insurers and insureds can enter into, preventing them from granting the insurer

'unfettered discretionary authority'"). *Hancock,* 590 F.3d at 1149.[2]

2. THE COURT OF APPEALS DECISION IS CONSISTENT WITH THIS COURT'S DECISION ON THE USE OF DISCRETIONARY CLAUSES IN *FIRESTONE*, AND DOES NOT CONFLICT WITH THIS COURT'S DECISIONS IN *RUSH PRUDENTIAL* OR *GLENN*.

Standard, in its Petition for Writ of Certiorari, argues that the prohibition of discretionary clauses is somehow contrary to congressional intent as expressed in this Court's recent opinion in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343 (2008).[3] However, the historical context and basis for the Court's decision in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989), indicate that ERISA was intended to protect the interests of employees and their beneficiaries.

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[2] Metropolitan Life Insurance Company did argue on appeal that Utah's rule was preempted by conflict preemption, but the Tenth Circuit did not address this issue. 590 F.3d at 1147. In addition, *amicus curiae* respectfully disagrees with the conclusion of the Tenth Circuit that Utah's regulation did not substantially affect risk pooling.

[3] *Amicus curiae* understands that the Respondent will address this issue in detail in her response brief; we are in agreement with Respondent's arguments and will not restate them in detail here.

Petitioner Standard and other writers seem intent on portraying *Firestone* as somehow placing limitations on the standard of *de novo* review in ERISA benefit cases, with the Court actually encouraging an arbitrary and capricious standard in order to reduce the costs of administrating these plans by limiting litigation of ERISA claims. However, a careful reading of this Court's decision in *Firestone* reveals that it is instead a strong statement of ERISA's intent to promote the interests of employees and their beneficiaries, and to protect them from arbitrary and capricious claim decisions.

ERISA does not set out the appropriate standard of review for actions challenging benefit eligibility decisions. Prior to *Firestone,* federal courts adopted the arbitrary and capricious standard developed under the Labor Management Relations Act 29 U.S.C. § 186(c) (2006). 489 U.S. at 109. Rejecting this standard of review, this Court held that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefits plans'" (quoting S*haw v. Delta Airlines*, 463 U.S. 85, 90 (1983)), and that adoption of a deferential standard of review "would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 489 U.S. at 113-114. Finally, this Court specifically rejected the assertion "that a *de novo* standard would contravene the spirit of ERISA because it would impose much higher administrative and litigation costs and therefore discourage

employers from creating benefit plans." 489 U.S. at 114.

In *Rush Prudential,* this Court continued to emphasize the intent and consumer protection aspects of ERISA by giving deference to the state regulation of insurance, stating "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. . . . It is therefore hard to imagine a reservation of a state power to regulate insurance that would not be meant to cover restrictions of the insurer's advantage in this kind of way." *Rush Prudential,* 536 U.S. at 387.

Petitioner places great reliance on this Court's decision in *Glenn,* which held that a reviewing court should consider the conflict of interest arising from the dual role of an entity as an ERISA plan administrator and payer of plan benefits as a factor in determining whether there has been an abuse of discretion in denying benefits. *Glenn,* 128 S.Ct. at 2343. However, this Court in *Glenn* again recognized the importance of state regulation of a fair claims process to consumers of insurance. "[T]he marketplace (and regulators) may well punish an insurance company when its products, or ingredients of its products, fall below par. And claims processing, an ingredient of the insurance company's product, falls below par when it seeks a biased result, rather than an accurate one." 128 S.Ct. at 2349.

The decision of the Court of Appeals in *Standard* is consistent with the intent of ERISA and the consumer protection principles evidenced in this Court's decisions in *Firestone, Rush Prudential* and *Glenn,* therefore certiorari should accordingly be denied.

3. STATE INSURANCE COMMISSIONERS MUST BE PERMITTED TO PROHIBIT DISCRETIONARY CLAUSES IN ORDER TO PROTECT THE REASONABLE EXPECTATIONS OF INSURANCE CONSUMERS UNDER AN OBJECTIVE, CONTRACT-BASED STANDARD FOR CLAIMS.

The intent of the NAIC with respect to the prohibition of discretionary clauses is that the reasonable expectations of the insurance consumer must be protected under an objective, contract-based standard for claims, which falls under the duties and powers of state insurance commissioners. This applies equally to both ERISA and non-ERISA insurance policies. It is important to understand that this is not simply an intellectual exercise in the application of trust law to the ERISA standard of review, but that the prohibition of discretionary clauses by the states in the regulation of insurance plays an important part in the furtherance of the role of state regulators in protecting consumers by promoting the payment of legitimate claims.

A. DISCRETIONARY CLAUSES MODEL ACT.

The NAIC originally passed the Discretionary Clauses Model Act in 2002 prohibiting the use of discretionary clauses in health insurance policies. 1 *Proc. of the Nat'l Ass'n of Ins. Comm'rs* 4, 12-13 (2002). Among the reasons cited were that the NAIC membership believed that discretionary clauses in insurance contracts are considered to be inequitable, deceptive and misleading to consumers. Prohibition on the Use of Discretionary Clauses Model Act, Technical Amendment and Project History. 2 *Proc. of the Nat'l Ass'n of Ins. Comm'rs* 17 (2002).

In 2004 the NAIC extended this prohibition to disability insurance. 4 *Proc. of the Nat'l Ass'n of Ins. Comm'rs* 57 (2004). Currently 16 states (Alaska, California, Colorado, Hawaii, Illinois, Indiana, Maine, Michigan, Montana, New Jersey, New York, Oregon, South Dakota, Utah, Washington and Wyoming) have adopted some type of prohibition against discretionary clauses in either health (sometimes called "disability" or "accident and sickness" coverage in insurance codes) or disability income insurance policies.[4] Some states, including Montana, have adopted a

[4] *See* COLO. REV. STAT. § 10-3-116(2) (2010); ME. REV. STAT. ANN. tit. 24-A, § 4303 (2010); WYO. STAT. ANN. § 26-13-304 (West 2010); ILL. ADMIN. CODE tit. 50, § 2001.3 (West 2010); MICH. ADMIN. CODE r. 500.2201-2202 (West 2010); N.J. ADMIN. CODE § 11:4-58 (2010); S.D. ADMIN. R. 20:06:52:01 (West 2010); UTAH ADMIN. CODE r. 590-218 (West 2010); WASH. ADMIN. CODE 284-44-015 (2010); WASH. ADMIN. CODE 284-46-015 (2010); WASH. ADMIN.

(Continued on following page)

variety of alternative means to prohibit the use of discretionary clauses in insurance policies.

The public policy behind the NAIC's Discretionary Clauses Model Act is clearly stated in *Section 2. Purpose and Intent*:

> The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits

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CODE 284-50-321 (2010); WASH. ADMIN. CODE 284-96-012 (West 2010); *Am. Council of Life Insurers v. Watters*, 536 F.Supp.2d 811 (W.D. Mich. 2008); *Standard Ins. Co. v. Morrison,* 584 F.3d 837 (9th Cir. 2009); Alaska Group Health Policy Form Checklist *available at* http://www.commerce.state.ak.us/insurance/pub/Group_Health_Checklist.pdf (last visited April 5, 2010); Alaska Individual Form Health Policy Checklist *available at* http://www.commerce.state.ak.us/insurance/pub/IndHealthChecklist.pdf (last visited April 5, 2010); Alaska Individual Long-Term Form Checklist *available at* http://www.commerce.state.ak.us/insurance/pub/Long_Term_Care_Checklist.pdf (last visited April 5, 2010); Cal. Dep't of Ins., Notice to Withdraw Approval and Order for Information, Notice 2-27-2004 (Feb. 27, 2004); Hawaii Dep't of Ins., On Discretionary Clauses in HMSA's Agreement for Group Health Plan and Guide to Benefits. Memorandum 2004-13(H) (Dec. 8, 2004); Ind. Dep't of Ins., Full and Final Discretion Clauses in Group Health Contracts, Bulletin No. 103 (June 8, 2001); N.Y. Ins. Dep't, Circular Letter No. 2006-14 (June 29, 2006); Standard Provisions for Long and Short Term Disability Group or Individual (Or. Ins. Div. Apr. 5, 2005), *available at* www.oregoninsurance.org/docs/serff/2447.pdf (last visited April 5, 2010).

> are due. Nothing in this Act shall be construed as imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

The U.S. Congress charged state insurance commissioners with great responsibility in enacting the McCarran-Ferguson Act, which reserves to the states the authority to regulate the business of insurance. 15 U.S.C. § 1012(b) (2006). NAIC members have acted accordingly in adopting the Discretionary Clauses Model Act, which seeks to protect the reasonable expectation of insurance consumers by permitting insurance commissioners to disapprove the use of discretionary clauses in insurance policies. The Court of Appeals decision in *Standard* gives due deference to the collective experience of the members of the NAIC who are statutorily charged and entrusted to regulate insurance coverage, and certiorari should accordingly be denied.

B. IMPACT OF PROHIBITION OF DISCRETIONARY CLAUSES ON ADMINISTRATIVE COSTS.

In its Petition for Writ of Certiorari, Standard claims that *de novo* review is likely to lead to far more complex and costly litigation than does abuse of discretion review. Pet. Cert. p. 4. Citing this Court's decision in *Varity Corp. v. Howe,* 516 U.S. 489 (1996), Standard argues that this would be contrary to the Congressional intent "not to create a system that is so

complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Id.* at 497. However, Standard has not offered any compelling evidence to either the Montana Commissioner of Insurance or this Court that the prohibition of discretionary clauses would cause a significant increase in administration costs for employee benefit plans.

The NAIC specifically considered the cost issue when it reviewed the use of discretionary clauses, and found that it was without merit. In the Project History to the Discretionary Clauses Model Act, the NAIC considered and reported the following: "Insurers also argued that the model act will result [sic] increased litigation and health care costs. However, several states currently prohibit the use of discretionary clauses and industry failed to present evidence of a resulting increase in litigation or rise in the cost of health insurance in those states." 2 *Proc. of the Nat'l Ass'n of Ins. Comm'rs* 17 (2002).

Absent any evidence to the contrary, this Court should disregard Standard's claim that the prohibition of discretionary clauses results in significantly increased administrative costs to ERISA plan sponsors.

C. UNUM MARKET CONDUCT EXAMINATION.

The NAIC can present documented examples of what can occur when an insurance company takes

advantage of ERISA and uses discretionary clauses as a shield to protect itself against the nonpayment of legitimate claims.

The state insurance commissioners who make up the membership of the NAIC are charged with the responsibility to facilitate the fair and equitable treatment of insurance consumers in their states. The NAIC and its members have a rich history and tradition of consumer protection, and as the primary regulators of insurance the commissioners are in the best position to understand and evaluate the risks that are associated with insurance transactions and take appropriate actions to mitigate against these dangers. A brief discussion of a recent action taken by state insurance regulators serves to illustrate why this Court's precedent and the ruling of the Ninth Circuit correctly allows for state regulatory authority in this area. *See* Report of the Targeted Multistate Disability Income Market Conduct Examination (Feb. 29, 2004) ("Unum Multistate Examination Report").[5]

Unum/Provident Corporation ("Unum"), the largest disability insurance company in the United States, had been the target of nearly 3,000 lawsuits, in addition to a 2002 class action suit alleging that Unum was unfairly and deliberately denying disability claims. Many federal courts have commented on Unum's aggressive claims denial practices during

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[5] A*vailable at* http://maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited April 7, 2010).

this time, speaking about Unum's selective review of the administrative record, lack of objectivity, abuse of discretion, misuse of ambiguous test results, and claims evaluation practices that defied common sense and bordered on outright fraud. John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1320 (2007).

NAIC member states conducted a multistate market conduct examination focusing on Unum claims practices starting in 2003. In November 2004, Unum (without admitting, denying or conceding any actual or potential fault) signed an agreement with the insurance commissioners of Massachusetts, Maine, and Tennessee in which Unum settled allegations related to systematic irregularities found in its claim handling practices for both individual and group disability claims. *See* Unum Multistate Examination Report at Paragraph C.12. Forty-seven other states and the District of Columbia joined the three lead states. The U.S. Department of Labor, which conducted a related investigation of Unum's practices involving employee benefit plans covered by ERISA, was also a party to the settlement, and New York's Attorney General also endorsed the settlement. *See* Joint Press Release, Multi-State Settlement Addresses Concerns Regarding Unum-Provident

Claims Handling (Nov. 18, 2004).[6] ("Multistate Settlement Announcement").

The Unum Multistate Examination Report, which was issued after Unum had lost several high-profile disability claim cases, included a $140 million settlement and a $15 million fine against Unum. California, which settled separately with Unum, imposed an additional $8 million civil penalty. California Settlement Agreement, File No. DISP05045984.[7] The Multistate Settlement Announcement identified several claims handling practices of concern to state regulators:

- Excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits;
- Unfair evaluation and interpretation of attending physician or independent medical examiner reports;
- Failure to evaluate the totality of the claimant's medical condition; and
- An inappropriate burden placed on claimants to justify eligibility for benefits.

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[6] A*vailable at* http://www.state.tn.us/commerce/pdf/press/prsRls111804.pdf (last visited April 7, 2010).

[7] *Available at* http://www.secinfo.com/d14D5a.z5UXk.d.htm#1stPage (last visited April 7, 2010).

Joint Press Release, *supra* at 20. As part of the Claim Reassessment Process, the Unum Multistate Examination Report required that Unum form a new Claim Reassessment Unit for the purpose of providing a "de novo" review of claims previously denied or terminated pursuant to a review procedure approved by the Lead Regulators. As part of the California Settlement Agreement, Unum was ordered to discontinue use of a provision that has the effect of conferring unlimited discretion on Unum or other plan administrator to interpret policy language, or requires an "abuse of discretion" standard of review if a lawsuit ensues unless the reviewing court determines otherwise ("discretionary authority provision") in any California contract.

The Unum Multistate Examination Report has been referred to as one of the most significant multistate insurance regulator actions in NAIC history, and it stands as a startling example of what can occur when an insurance company takes advantage of ERISA and uses discretionary clauses as a shield to protect the nonpayment of legitimate claims. *Id.* State regulatory actions to prevent such actions have been appropriately upheld and are supported by this Court's rulings in *Firestone, Rush Prudential* and *Glenn,* and the appellate court decisions in *Standard* and *Ross.*

Please note that the NAIC is not alleging or implying that Standard has been engaged in the same type of inappropriate claim practices as were found against Unum, nor are we making a general

statement that these practices are common in the insurance industry, although another disability insurer, CIGNA, was found to have engaged in similar behavior in a market conduct study conducted by the California Department of Insurance. [8]

However, Unum's conduct demonstrates the type of evidence that will be considered by state insurance commissioners in regulating the use of discretionary clauses in policies of insurance. The actions of the Montana Commissioner of Insurance in prohibiting discretionary policies are consistent with this evidence and the authority of NAIC members to regulate insurance.

[8] Cal. Dep't of Ins., Public Report of the Targeted Market Conduct Examination of the Claims Practices of the Life Insurance Company of North America (June 20, 2006), *available at* http://www20.insurance.ca.gov/epubacc/REPORT/106849.htm (last visited on April 7, 2010). For a discussion concerning other reported CIGNA cases, *see* Mark D. DeBofsky, *How CIGNA Handles or Mishandles Disability Claims*, Chi. Daily L. Bull., March 1, 2010 at 6.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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