Seventh Circuit Finds that State Insurance Law Applies, Resulting in De Novo Review of Benefit Claim

On September 4, 2015, the U.S. Court of Appeals for the Seventh Circuit in 
Fontaine v. Metropolitan Life Insurance Company 
ruled that the Employee Retirement Income Security Act of 1974, as amended (ERISA), does not preempt an Illinois state insurance regulation that prohibits discretionary authority clauses in health and disability plan insurance policies. The Seventh Circuit upheld the ruling of the U.S. District Court for the Northern District of Illinois, which decided that the Illinois regulation was not subject to preemption under precedent set forth in prior decisions by the Supreme Court of the United States.

In 1989, the U.S. Supreme Court decided 
Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), a case in which the Court concluded that an ERISA plan administrator's decisions will be reviewed under a de novo standard (which allows a court to take a fresh look at the decision without deference), unless the ERISA plan document confers discretion on that administrator to determine eligibility for benefits and construe the terms of the plan. If the plan document grants the administrator such authority, a much less exacting “arbitrary and capricious” standard of review generally applies. Since Firestone, other Supreme Court decisions have addressed issues related to the proper deference to be afforded a plan administrator under ERISA, including 
Conkright v. Frommert, 559 U.S. 506 (2010), where the Court reiterated that when a plan document gives the plan administrator discretion to interpret its terms, the administrator's interpretation should be given deference by the courts. As a result of these cases, most employers and insurance companies began including discretionary language in plan documents.

Fontaine centers on the appropriate standard of review that should apply to a court’s review of a decision under an insurance policy in Illinois and involved a former equity partner in a large law firm. The Illinois regulation at issue, 50 Ill. Admin. Code § 2001.3, provides that:

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. (Emphasis added).

This prohibition against granting discretionary authority to an insurer would, absent preemption by ERISA, most often result in a benefit determination before a court for an insured plan being reviewed de novo. As discussed in Fontaine, the employer had a long-term disability (LTD) insurance policy insured by Metropolitan Life Insurance Company (MetLife). The employer’s benefit plan provided that MetLife’s claim determination would be “given full force and effect” unless it was “arbitrary and capricious.” Thus, the primary issue before the Seventh Circuit in determining which standard of review should apply was whether that plan language violated the Illinois insurance regulation at issue or whether that law was preempted by ERISA.

The plaintiff filed a claim for disability benefits under the LTD policy and MetLife denied her initial claim and administrative claim appeal, leading the plaintiff to sue for wrongful denial of benefits under ERISA. The lower
court applied a *de novo* review standard and found that the plaintiff was disabled as a result of her vision impairment and was entitled to disability benefits under MetLife’s LTD policy. MetLife did not challenge the lower court’s findings on disability, but took the position that the deferential “arbitrary and capricious” standard of review should have applied in the lower court’s review of the benefit denial because the Illinois insurance regulation was preempted by ERISA.

As a general rule, ERISA preempts any state laws that relate to, or have a substantial connection with, an employee benefit plan unless those state laws regulate insurance. The Seventh Circuit, applying a prior decision by the Supreme Court of the United States, found that the Illinois regulation applied to the claim at hand and was saved from ERISA preemption because that law was “specifically directed toward entities engaged in insurance,” and “the state law … substantially affect[ed] the risk pooling arrangement between the insurer and the insured.” Part of the Seventh Circuit’s rationale in denying preemption is that the Illinois law merely restores ERISA’s default standard of *de novo* review in cases challenging benefit denials and that deferential review is not required by ERISA.

**Impact on Plan Sponsors and Administrators**

The *Fontaine* decision is a substantial setback for employers. A primary takeaway is that employers and insurers may be subject to state insurance laws and regulations for insured plans, despite those state laws having otherwise been understood to be preempted by ERISA. Similar to the employer plan at issue in *Fontaine*, most employers and insurers include discretionary language clauses in insurance policies and related plan documents. These clauses are intended to cause a reviewing court to apply the deferential arbitrary and capricious review standard when reviewing a plan administrator’s claim determination. However, the Seventh Circuit held that permitting an insurer to bypass a state regulation by simply placing a contrary term in a plan document is an artificial distinction that would be “too clever,” “is arbitrary and should make no legal difference,” and “could potentially displace any state regulation.” (Emphasis added). To the extent deferential review is not granted to a plan administrator’s decision, the reviewing court will review the claim *de novo*, substituting its judgment for that of the plan administrator.

The *Fontaine* decision should be an important reminder for plan sponsors to review the terms of their benefit plans to ensure that they contain sufficient discretionary language to permit a deferential standard of review for self-insured plan options if a plan administrator’s interpretation of ambiguous or vague plan terms is challenged and reviewed by a court and to evaluate risk exposure for any insured plan options. For insured plans going forward, plan administrators may be subject to differing legal review standards for benefit determinations challenged in court until the U.S. Supreme Court is asked to opine on this new interpretation of ERISA’s preemption rules.

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