

FEDERATION OF REGULATORY COUNSEL, INC.

FOR WHOSE PROTECTION?

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A pair of recent Montana judicial decisions of first impression dictate that two provisions common in insured employee benefit plans - discretionary review of plan administrators' decisions and exclusion of benefits when recovery is available from a liable third party - will be routinely disapproved by the Montana Commissioner of Insurance. Conferring broad discretion upon the Commissioner to interpret the Montana Insurance Code, Title 33, MCA, they elevate protection of the single consumer over industry uniformity, affordability, and availability.

Standard Insurance Company v. Montana Department of Insurance

It was acceptable past practice in Montana, and other states, for employers or employee organizations establishing ERISA employee benefit plans to confer upon the claim administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan by means of express language commonly referred to as a "discretionary clause." Historically, the Montana State Auditor, *ex-officio* Commissioner of Insurance [Commissioner]¹ approved insurance forms relating to group disability insurance issued by disability insurers² in Montana that contained discretionary clauses.

Federal courts review disputed benefit determinations under an abuse of discretion standard if the employee benefit plan includes a "discretionary clause" giving the ERISA plan administrator discretionary authority to interpret the terms of the plan.³ Absent such a clause, benefit determinations are reviewed *de novo*.⁴ Under abuse of discretion review, a plan administrator's decision will be upheld "if it is based upon a reasonable interpretation of the plan's terms, . . . was made in good faith," and is supported by substantial evidence.⁵ ERISA was enacted to promote availability of employee benefit plans.⁶ Abuse of discretion review furthers a primary goal of ERISA, i.e., to provide an inexpensive and expeditious method for workers and beneficiaries to resolve benefits disputes. Limiting review to the administrative record, as the abuse of discretion standard does, promotes this goal.⁷

Shortly after taking office,⁸ however, Commissioner John Morrison, with strong trial bar support, began a concerted campaign to eliminate their use, claiming discretionary clauses violated Montana law, specifically 33-1-502, MCA, because they are "inherently ambiguous." The Commissioner characterized discretionary clauses as a convention of the insurer, alleging the clauses "negate the operative terms of the insurance contract . . . and leave entitlement to benefits to [the decision of] . . . each . . . insurance company";⁹ "give[] with one hand (policy provisions) and take[] away with the other (discretionary clause)";¹⁰ allow a profit-motivated company to "remove[] the contractual promise to pay and replace[] it with a possibility of payment"¹¹ "saying, 'maybe - and trust us to decide,'"¹² "turn[ing] upside down 80 years of settled Montana law that states ambiguous policy provisions are construed in favor of the insureds."¹³ Relying upon his general authority "to ensure that the interests of insurance consumers are protected,"¹⁴ the Commissioner insisted they must be struck down because "Montana courts consistently and uniformly interpret insurance coverage questions in favor of insureds, not the insurers."¹⁵ They must be struck down because of the "uncertainty they create regarding entitlement to benefits."¹⁶ **17**

After several years of comment, discussion and exchange of correspondence between the Commissioner and the insurance industry, and failed rulemaking,¹⁸ the Commissioner implemented an unannounced practice of blanket disapproval or withdrawal of approval of all forms containing such a clause. The Commissioner's

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public statements, however, revealed that the objective of his practice was to effect a *de novo* standard of review in disputed ERISA benefit determinations.¹⁹

When Standard Insurance Company [SIC] questioned disapproval of discretionary clauses contained in its group disability and disability income policy forms, the Commissioner claimed 33-1-502, MCA, required him to do so. Consequently, SIC sought judicial reversal of the Commissioner's conclusion of law that discretionary clauses were inherently ambiguous and ruling that his practice was not a proper exercise of his statutory duties.²⁰

Relying upon 33-15-304, MCA, which expressly permits provisions in insurance contracts not inconsistent with Title 33 and that are "desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included," SIC advocated continued use of discretionary clauses, pointing out that nowhere in Title 33 are they expressly prohibited nor are employers or employee organizations prohibited from contractually conferring discretionary authority upon their plan administrators. Accordingly, discretionary clauses are presumptively valid in Montana and, therefore, the Commissioner may only disapprove an insurance form that contains such a clause if the clause is "inconsistent, ambiguous, or misleading" or contains "exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract."²¹

Since the Commissioner has only those powers specifically conferred upon his office by the Legislature,²² SIC argued, the Commissioner may not establish law or usurp the Legislature's authority in determining public policy.²³ Where the Legislature has not announced other regulatory goals, the Commissioner may only regulate the business of insurance within the existing statutory framework that permits an insurance contract to contain provisions "desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included" ²⁴ Section 33- 1-502, MCA, requires a Commissioner only to disapprove an *individual* policy form if it is "inconsistent, ambiguous, or misleading."²⁵ Because the Commissioner engaged in no analysis of individual policy forms, but simply disapproved them by way of a check-off list, his practice of blanket disapproval exceeded the scope of his statutory authority. While insurers would not dispute the general rule of law that ambiguities in an insurance policy are construed against the insurer, they did dispute that *all* discretionary clauses, however drafted, are *per se* ambiguous and may be disapproved without individual analysis. Indeed, drafted in plain language, clauses clearly disclosing not only the scope and nature of the discretion being granted, but also potential limitations inherent in judicial review of an adverse decision, are not ambiguous and should be encouraged.

Noting the case was one of first impression, the trial court, with little analysis, reiterated the general principle that in Montana insurance contracts must be construed as a whole and any ambiguity must be construed against the insurer. Because the insurer not only drafted the insurance contract, but also under the authority conferred by the discretionary clause, the insurer was afforded the right to construe its terms and determine participant eligibility, the court held that "on its face" the clause was "ambiguous and inconsistent" and the Commissioner correct in disapproving it under 33-1-502 (2), MCA.²⁶

Blue Cross and Blue Shield of Montana, Inc. v. Montana State Auditor

In 2001, Blue Cross and Blue Shield of Montana, Inc. [BCBS] submitted forms to the Commissioner for approval containing coverage exclusions under which BCBS would not pay for health care costs of its injured members if the members received, or were entitled to receive, benefits from any automobile or premises liability policy. After reaching agreement over specific disputed language, the Commissioner approved the coverage exclusions for use in BCBS policies. In 2007, the Commissioner disapproved new forms submitted with the agreed exclusions on the ground that the exclusions conflicted with statutory subrogation duties and that they "deceptively affect[ed] the risk purported to be assumed in the general coverage of the contract," citing his authority under 33-1-502, MCA. BCBS challenged the Commissioner's decision in state district

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court and on appeal to the Montana Supreme Court. In a 4-1 decision the Montana Supreme Court upheld the Commissioner's conclusion of law and disapproval.²⁷

First, BCBS challenged the trial court's determination that the Commissioner was acting in the scope of his authority under 33-1-502 in withdrawing prior approval of language he had negotiated and approved. The Supreme Court agreed, underscoring the Commissioner's broad powers.

The Commissioner has broad statutory power over the content of insurance documents, and the statutes require that this power be exercised to protect the insured public and to further the goals of Montana's laws on insurance. Section 33-1-311, MCA. The position of BCBS here, and particularly its argument that the Commissioner waived any right to [withdraw prior approval] by agreeing to them in 2002, would immortalize any provision of an insuring document approved in a similar manner . . . however onerous or deceptive the provision proved to be. The provision would survive even if there were statutory changes that caused it to conflict with express law . . . contrary to public policy as expressed in [Title 33]²⁸

The critical holding of *Blue Cross*, however, was that approval of the exclusions was properly withdrawn because they constituted impermissible subrogation by BCBS, violating statutory restrictions in 33-30-1101 and -1102, MCA. Section 33-30-1102 provides that a health service corporation's subrogation right "may not be enforced until the injured insured has been fully compensated for his injuries." Ignoring legal distinctions between exclusions and equitable subrogation, the Court upheld the trial court's agreement with the Commissioner that the BCBS exclusions allowed it to exclude, limit or offset health insurance benefits otherwise due to the insured before the insured was fully compensated for his injuries or "made whole."²⁹ "Only when the insured is made whole as defined in Montana law, and then only after BCBS has paid out benefits to its insured, could BCBS be entitled to claim subrogation."³⁰

The strongly-worded dissent decried the majority's confusion of the distinctly different doctrines.

A key component to subrogation is consideration -the insured pays a premium in exchange for the insurer's assumption of his risk of loss. . . . On the other hand, exclusions are "insurance-policy provision[s] that except[] certain events or conditions from coverage." We have held that exclusions "will be narrowly and strictly construed because they are contrary to the fundamental protective purpose of an insurance policy." . . . [T]hese provisions do not even include the *concept* of subrogation. [T]he Court . . . has acted with "violent hands . . . to include a risk clearly excluded by the insurance contract" and for which BCBS would receive no payment.³¹

Conclusion

Both decisions disappoint in that in the name of public protection they blur distinct legal and insurance doctrines to advantage only the individual insurance consumer. Until the Montana Legislature announces express public policy or the courts cure the legal confusion, however, insurers are cautioned that policy forms filed with discretionary clauses or exclusions will be disapproved as *per se* ambiguous and in violation of Montana insurance law.

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1. The Commissioner is responsible for the administration, supervision, and control of the Insurance Department which is charged by statute with regulating the business of insurance in the State of Montana. Mont. Code Ann. §§ 2-15-1902, -1903, 33-1-311(1)-(2).
2. The term "disability insurance" is used in the Montana Code Annotated to mean health insurance coverage. "Disability insurance" is defined as "insurance of human beings . . . against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or against disablement or medical expense or indemnity resulting from sickness." Mont. Code Ann. § 33-1-207 (1). Disability income insurance is separately defined as ". . . insurance that primarily provides payment . . . upon lost wages or other earned income or business or financial losses as a result of an inability to work due to sickness, injury, or a combination of sickness and injury." Mont. Code Ann. § 33-1-235.
3. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989).
4. *Id.* at 115.
5. *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005).
6. 29 U.S.C. § 1001(b); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).
7. *Boyd*, 410 F.3d. at 1178; *Taft v. Equitable Life Assur. Society*, 9 F.3d 1469, 1472 (9th Cir. 1994).
8. The Montana State Auditor is elected. The office is subject to term limits, two four-year terms. Morrison took office in 2001.
9. Morrison's Brief in Opposition to Standard's Motion for Summary Judgment [Morr. Opp'n], SIC at 9; Brief in Support of [Morrison's cross] Motion for Summary Judgment [Morr. Main Brf.], SIC at 8.
10. *Id.*
11. Morr. Opp'n at 13; Morr. Main Brf. at 12.
12. Morr. Opp'n at 16; Morr. Main Brf. at 14. The Commissioner also worried that "without plenary court review," the clause would cause coverage in the policy to "vary from company to company." Morr. Main Brf. at 12.
13. Morr. Opp'n at 2, 9-10; Morr. Main Brf. at 2, 9-10 (citing multiple cases). This view also ignores that under a deferential standard of review, courts do overturn benefits decisions when unreasonable or not supported by substantial evidence. See, e.g., *Metropolitan Life Ins. Co. v. Glenn*, _ U.S. _, 128 S. Ct. 2343; *Wirries v. Reliance Standard Life Ins. Co.*, 247 Fed. Appx. 870, 2007 WL 2301250, at *2 (9th Cir. Aug. 10, 2007); *Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1195-98, 1202 (11th Cir. 2007); *Boyd v. Aetna Ins. Co.*, 438 F. Supp. 2d 1134, 1155-56 (C.D. Cal. 2006).
14. Mont. Code Ann. § 33-1-311(3) ("The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.").
15. Morr. Opp'n at 8.
16. Morr. Main Brf. at 11.

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17. Morrison relied upon the administrative practice of two other states to support his practice of blanket disapproval. A handful of states have enacted statutes or implemented rulemaking regulating the use of discretionary clauses in some insurance policies. Of those that have, not all have prohibited them. With the exception of New York, where the Superintendent ultimately withdrew the prohibition on discretionary clauses as it had not been properly promulgated through the rulemaking process, no other state insurance regulator has without process simply announced the practice based upon the regulator's personal distaste for such a provision.
18. Morrison twice failed to promulgate rules to prohibit the use of discretionary clauses in all policy forms, in the face of opposition from industry representatives, including the American Council of Life Insurers, America's Health Insurance Plans, Blue Cross and Blue Shield of Montana, Inc. and the American Insurance Association, as well as the Montana Chamber of Commerce and Montana insurance producer organizations. In the matter of the proposed adoption of New Rule I pertaining to prohibition of discretionary clauses in insurance policy forms, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, MAR Notice No. 6-138; In the matter of the proposed adoption of New Rules I and II pertaining to prohibition of discretionary clauses in insurance policy forms, NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED, MAR Notice No. 6-140. The Commissioner met with representatives of the insurance industry to discuss his practice of blanket disapproval of discretionary clauses. In that meeting, the Commissioner informed industry representatives that he would not pursue rulemaking. In the stead of rulemaking, he presented for industry input a draft Advisory bulletin he proposed to circulate to insurers advising of the Commissioner's policy of blanket disapproval of discretionary clauses in ERISA life, health, and disability income policies. Upon consideration of the draft bulletin, insurer representatives reiterated their opposition to the practice and to specific representations of the Commissioner's Advisory. The Advisory was not finalized and distributed. The noticed proposed rules lapsed without adoption.
19. During the same foregoing period of time, the Commissioner announced to practitioners in the State Bar of Montana his intention to disapprove and withdraw approval of all policy forms containing discretionary clauses, including but not limited to seminars conducted by the Montana Trial Lawyers Association, the Montana Defense Trial Lawyers, and the First Judicial District Bar Association. The Commissioner continued to publicly announce the policy he adopted to state practitioners in subsequent meetings of the named associations and others.
20. *Standard Ins. Co. v. Mont. Dept. of Ins.*, Mont. 1st Dist., CDV 2006-706.
21. Mont. Code Ann. § 33-1-502 (emphasis added).
22. Mont. Const. art. VI, § 4 (5); *Polson v. Pub. Serv. Comm'n.* (1970), 155 Mont. 464, 473 P.2d 508, cited with approval in, *Anaconda Co. v. Dep't. of Rev.* (1978), 178 Mont. 254, 257, 583 P.2d 421, 423-34.
23. E.g., *State v. Brown*, 2008 MT 115, ¶ 18, 342 Mont. 476, 182 P.3d 75; *State ex rel. Holt v. Dist. Court* (1936), 103 Mont. 438, [hns 6, 7], 63 P.2d 1026, 1030-31; *State v. Gateway Mortuaries* (1930), 87 Mont. 225, [hns 2, 3], 287 P. 156, 157.
24. Mont. Code Ann. § 33-15-304.
25. Mont. Code Ann. § 33-1-502 (2).
26. Memorandum and Order on [Cross] Motions for Summary Judgment, Standard (Dec. 3, 2008) at 7-9. SIC chose not to appeal.
27. *Blue Cross & Blue Shield of Mont., Inc. v. Mont. St. Auditor*, 2009 MT 318, 352 Mont. 423, _ P.3d _.

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28. *Id.* ¶ 13.

29. *Id.* ¶¶ 17-19, citing *Swanson v. Hartford Ins. Co.*, 2002 MT 81, ¶ 28, 309 Mont. 269, 46 P.3d 584; *Oberson v. Federated Mut. Ins. Co.*, 2005 MT 329, ¶¶ 14-15, 330 Mont. 1, 126 P.3d 459; *Skauge v. Mountain States T. & T.*, 172 Mont. 521, 524 P.2d 628, 630 (1977)

30. *Id.* ¶ 18.

31. *Id.* ¶¶ 27-35 (citations omitted; some alterations in original; emphasis in original).