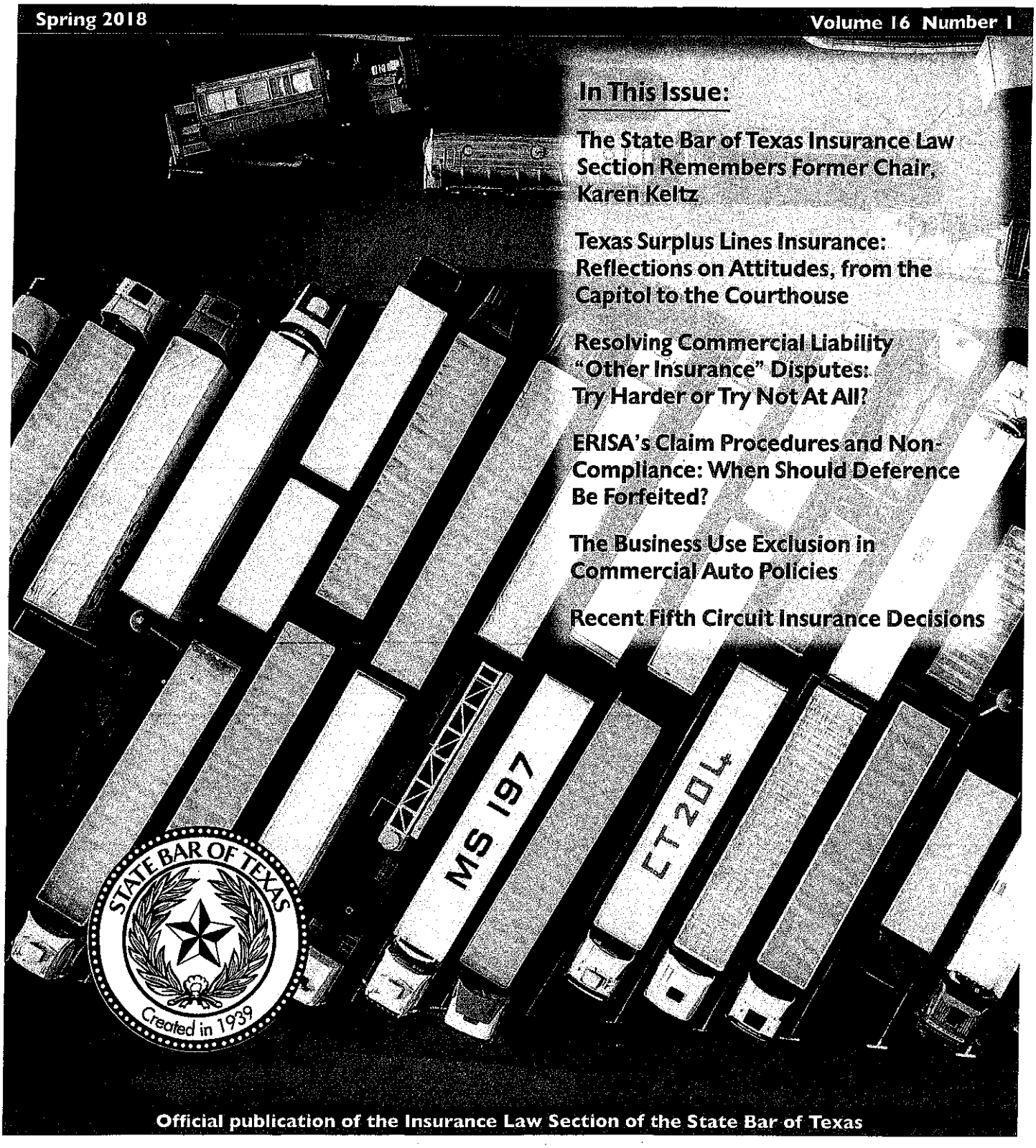
Journal of Texas Insurance Law

Spring 2018 Volume 16 Number 1



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Official publication of the Insurance Law Section of the State Bar of Texas

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By Jeffrey Dahl

ERISA'S CLAIM PROCEDURES AND NON-COMPLIANCE: WHEN SHOULD DEFERENCE BE FORFEITED?

I. Introduction

Although sometimes viewed as mundane by the federal courts, benefit claims by individuals who are covered by employee benefit plans or policies governed by the Employee Retirement Income Security Act of 1974 (ERISA) are vital to claimants and their families. An ERISA claim denial means that the claimant did not receive the medical treatment, disability income, life insurance or retirement benefits that she expected under a retirement plan or an employee group welfare benefit plan or policy. Sometimes a medical benefit denial can mean the difference between life and death.[1]

II. The Power of Deference

Whether or not the parties will play on a level playing field if a denied claim is challenged in federal court is a recurrent issue in ERISA cases. In the unique realm of ERISA benefit claims litigation, the playing field is generally slanted in favor of the insurance carrier or claims administrator who made the final denial. The claim decision will only be overturned if the carrier or claims administrator abused its discretion. Under this common scenario, the claimant bears a heavy burden. She must prove that the fiduciary claims administrator had no reasonable evidence to deny her claim.

The Fifth Circuit Court of Appeals recently described the power of ERISA judicial deference:

> As any sports fan dismayed that instant replay did not overturn a blown call learns, it is difficult to overcome a deferential standard of review. The deferential standard of review our court applies to ERISA decisions often determines the outcome of disputes that are far more important than a sporting event: decisions made by retirement and health plans during some of life's most difficult times, as this case involving a teenager with a serious eating disorder demonstrates.[2]

For Texans and others living within the jurisdiction of the Fifth Circuit, there are two factors that determine whether or not a final denial on an ERISA claim is entitled to judicial deference: 1) when the plan terms grant discretion to the claims fiduciary (the final decision-maker), deference is required when the claim denial hinges upon plan interpretation, and 2) the *Pierre* decision in 1991, providing that factual determinations by ERISA fiduciaries must always be afforded judicial deference.[3]

Since the other federal circuits have not followed the reasoning of *Pierre*, instead holding that factual determinations by fiduciaries should not automatically receive deference, the Fifth Circuit is now questioning whether *Pierre* should be modified or jettisoned. In a rare mood of uncertainty, the Fifth Circuit notes that there is now "robust case law" that indicates that its decision in *Pierre* was wrong.[4]

This article is not meant to speculate over what the Fifth Circuit will do about *Pierre*. Rather, this paper assumes the most common occurrence, namely that the court is required to defer to the decision of the claims fiduciary. The focus of this article is whether or not deference can or should be forfeited if the claims fiduciary does not comply with the claim procedures that were established by the U.S. Department of Labor (DOL) for ERISA claims.

III. Improper Claims Processing Accompanied by a Carrier's Denial: Discovering the Differences Between ERISA and the Texas Insurance Code

Our protagonist needs health insurance. Chances are she will not think much about the origins of her medical coverage. If both an individual health policy and a health policy offered through her work are available, she will probably consider the premium costs, the extent of coverage, the identity of the in-network physicians, and perhaps the reputation of the carrier when deciding which policy to purchase. Naturally, she does not consider the differences in litigating a denied claim. She decides to purchase the group policy offered by her employer. Her premium is deducted from her paycheck each month.

Had she chosen the individual policy, she would have retained her rights under the Texas Insurance Code. Claims

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under the statute's listed "Unfair Settlement Practices" would be available to her.[5] She would have the potential to be awarded consequential damages, even punitive damages for a bad faith or unreasonable denial of her claim. If coverage is decided in her favor, she would be entitled to 18% interest on the amount of covered claim as penalty damages for the carrier's failure to timely pay the claim. She would be entitled to a jury trial and she and her physicians could testify. She could cross-examine the insurance carrier's medical consulting experts. Her case would be decided by a preponderance of the evidence. These factors would give her leverage beginning the day that she submits her claim.

After all, one of the primary purposes of the Texas Insurance Code is to level the playing field for insureds:

> An insurance policy, however, is a unique type of contract because the insurer generally "has exclusive control over the evaluation, processing[,] and denial of claims," and it can easily use that control to take advantage of its insureds. *Arnold v. Nat'l City Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). Because of this inherent "unequal bargaining power," we concluded in *Arnold* that the "special relationship" between an insurer and insured justifies the imposition of a common law duty on insurers to "deal fairly and in good faith with their insureds." *Id.* Similar to that common-law duty, the Insurance Code supplements the parties' contractual rights and obligations by imposing procedural requirements that govern the manner in which insurers review and resolve an insured's claim for policy benefits. *See, e.g.*, Tex. Ins. Code, §541.060(a) (prohibiting insurers from engaging in a variety of "unfair settlement practices."). The Code grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad faith practices, and it permits insureds to recover "actual damages...caused by" those practices, court costs, and attorney's fees, plus treble damages if the insurer "knowingly" committed the prohibited act.[6]

Since our protagonist chose the group policy offered by her employer instead, all of her potential claims under the Texas Insurance Code are preempted by ERISA.

On the positive side, she is entitled to a fiduciary *de novo* review of a denied claim. The insurer or third-party administrator is required to have a dialogue with her concerning the denial and allow her the opportunity to provide evidence that rebuts the insurer's denial.

On the negative side, if a final denial is issued after a fiduciary review, neither she nor her physicians are permitted to testify at trial. The evidence will be limited to the claim file. She cannot make a claim for consequential damages or punitive damages, even if she incurred additional economic loss as a result of the denial. She is not entitled to a jury. She cannot cross-examine the insurance carrier's experts. The claims fiduciary's medical consultants will stay behind the scenes; they can tender their consulting medical reports to the claims administrator without fear of cross-examination. Her case will probably be decided under the abuse of discretion standard, meaning that if there is some reasonable evidence within the claim file to support the denial, the carrier will prevail. If she is wildly successful at trial, *i.e.* if the denial of the claims administrator is deemed unreasonable after the federal judge's review of the claim file, her maximum recovery is the plan benefits that should have been paid. She may or may not be granted attorney's fees.

She becomes ill. She is told that she needs surgery. Her insurer disagrees and denies her claim. Claim denial in hand, she visits an ERISA lawyer's office. Leaving the office after receiving a primer on ERISA law, she is staggered by the differences between the individual health policy and the employee group health policy that she purchased. She wishes she had this information on the front end, before she chose to purchase the group health policy.

IV. ERISA Claim Regulations

ERISA claims procedures originate from 29 U.S.C. §1133 and 29 U.S.C. §1135. Section 1133(1) requires that a carrier or claims administrator provide adequate notice of the reasons for denial that can be readily understood by the claimant. Section 1133(2) requires ERISA plans to afford claimants a full and fair review (often called an appeal) of a denied claim by a plan fiduciary (hence the term used here, claims fiduciary, for the party who conducts the required full and fair review).[7] The full and fair review is usually conducted by the same entity that issued the denial, typical an insurance carrier or third-party claims administrator, but must be conducted by someone other than the adjustor who denied the claim. Naturally, the adjustor cannot review his or her own decision to deny benefits.

Section 1135 grants the power to the Secretary of the U.S. Department of Labor to establish claims regulations that comply with ERISA, allowing the DOL to specify what is adequate notice to the insured of a denied claim as required by §1133(1), what shall constitute a full and fair review of a denied claim, as required by §1133(2), and to specify the time requirements for a claims decision and a decision on appeal.[8]

The ERISA claim regulations established by the Secretary of Labor are within 29 CFR 2560.503-1. According to the Secretary, adequate notice of a denial must include the following information:[9]

> 1) The specific reason or reasons for the adverse benefit determination;

2) Reference to the specific plan provisions on which the determination is based;

3) A description of any additional material or information necessary for the claimant to perfect the claim and any explanation of why such material or information is important; and

4) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) (§1132) of the Act (ERISA) following an adverse benefit determination on review."[10]

For pension and group life insurance claims, the claims administrator is required to decide the initial claim within 90 days of receipt of the claim, which can be extended for another 90 days by written notice prior to the expiration of the initial 90-day period.[11] The time periods for deciding health care claims are shorter—urgent health care claims must be decided within 72 hours which can be briefly extended if additional information is necessary to decide the claim; pre-service claims must be decided within 15 days with a possible 15-day extension if, due to matters beyond the claims administrator's control, the extension is needed; post-service health claims must be decided within 30 days with a possible 15-day extension if, due to matters beyond the claims administrator's control, the extension is necessary. Disability claims must be decided within 45 days of receipt of the claim, with two potential 30-day extensions if, due to matters beyond the claims administrator's control, the extensions are necessary. For any of the extensions to be valid, the claims administrator is required to notify the claimant in writing during the initial period that the extension will be taken and explain the reason or reasons that the claims administrator needs more time.

As mentioned previously, Section 1133(2) of ERISA requires that a fiduciary conduct a full and fair review of the denial if a review is requested by the claimant. The request for review must be made in writing. The minimum time period that a plan must allow a claimant to submit a written request for review of a denied claim, also called an appeal of a denied claim, is 180 days for health and disability plans and 60 days for pension and life insurance claims.[12]

Review of a denied claim has the following requirements:

1) the claimant has a right to obtain the claim file for the purposes of appealing the denied claim, may rebut the reasons given for denial, and may provide additional information in support of her claim;

2) no deference is to be given to the original decision and the same person, or his or her subordinate, cannot decide the appeal of a denied claim;

3) if the denial involved a medical determination, the adjustor must hire a different medical expert than the one involved in the original decision and that expert must have appropriate training to address the medical issue presented; and

4) the medical and vocational experts whose opinions were obtained in the initial review must be identified.[13]

If the claim is denied after a full and fair review, in order to be adequate notice, the denial must contain the following information:

1) specific reasons for the denial after review;

2) reference to the specific plan provisions upon which the denial is based;

3) a continued right to obtain the claim file; and

4) any additional voluntary appeal and the claimant's right to bring a lawsuit under 502(a) of the Act.[14]

The time period for the fiduciary to decide appeals of pension or life insurance claims is 60 days, which can be extended for another 60 days under certain circumstances.[15] For post-service health care claims the appeal is to be decided within 60 days.[16] The time periods for deciding urgent health care claims and pre-service health claims are shorter.[17] For disability claims, the time period is 45 days with a possible extension of another 45 days.[18] Again, if extensions are necessary, the claimant must be given notice that the extension will be taken and the reason for such extension.

Addressing the consequences for the failure to follow these claims procedures, the claim regulations, as revised in 2000, provide as follows:

> [I]n the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.[19]

Along with these revisions, the Secretary of Labor added a preamble, emphasizing that the regulations are minimum standards for benefit plans and a decision that does not comply with the minimum standards "*should not be entitled to any judicial deference.*"[20]

The Fifth Circuit has not followed this admonition by the Secretary of Labor.

V. ERISA's Limited Remedies: There is no Monetary Remedy for Non-Compliance

Generally, the Supreme Court has not allowed any remedy that is not clearly expressed within ERISA's remedial provision 29 U.S. §1132. Section 1132 allows for injunctive relief and the monetary remedies limited to (1) up to $100 per day for a plan administrator's failure to provide certain documents to a plan participant within 30 days of a proper written request, 29 U.S.C. §1132(c), and (2) benefits that should have been paid under the plan. 29 U.S.C. §1132(a)(1)(B).

A narrow opportunity for an additional monetary remedy is created by allowance of "other appropriate equitable relief" under §1132(a)(3). The Supreme Court's decision in *CIGNA Corp. v. Amara* opened the door to a potential monetary remedy under paragraph (a)(3), reviving the term "surcharge" relief from decisions by the equity courts during days of the divided bench (equity courts and courts at law).[21] Surcharge relief is available for certain consequential damages that might result from violations of ERISA.[22] In *CIGNA*, the claimants alleged violations of ERISA due to improper notice of modifications to the Cigna pension plan that resulted in financial harm to some pensioners. The court allowed that monetary relief might be available to some plan participants as a "surcharge" remedy.[23]

Circumstances that invite a legitimate claim for the surcharge remedy are rare. As a general rule, no monetary award is permitted other than benefits due under the plan. No consequential or punitive damages are available for the delay in processing a benefit claim made under an ERISA plan.[24] In *Russell*, the plaintiff was paid the disability benefits due her under the plan, but she sued due to a delay of 132 days in payment. She asserted that during the delay her husband had to cash out retirement savings in order for them to make ends meet and that her disabling impairments were exacerbated by the delay. The Court held that the claimants' request for consequential and punitive damages interfered with the Act's remedial provision, §1132(a):

> The six carefully integrated civil enforcement provisions found in §502(a)[25] of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.[26]

As a result, there are no serious negative consequences for a claim fiduciary's non-compliance with the claims procedures established by the Secretary of Labor. The only redress that an ERISA plaintiff can hope to obtain for a fiduciary's abuse of the claims process is (1) gaining a level playing field, *i.e.* a judicial decision vacating the abuse of discretion standard of review in favor of a preponderance of the evidence standard, or (2) obtaining a remand by the district court to the claim fiduciary for another review, a decidedly hollow victory.

VI. The Fifth Circuit's View of Non-Compliance with ERISA's Claims Procedures: Allowing Remand But Protecting Deference

The Fifth Circuit has never found sufficient claims procedure abuse to warrant a change in the standard of review from abuse of discretion to a preponderance of the evidence. In that regard, the court has noted that:

> [t]his circuit has rejected arguments to alter the standard of review based upon procedural irregularities in ERISA benefit determinations, such as delays in making the determination . . . . Absent potential wholesale or flagrant violations that evidence an "utter disregard of the underlying purpose of the plan," this court does not heighten the standard of review from abuse of discretion to de novo. [27]

Oddly, the Fifth Circuit has protected deference to the factual determinations of the claims fiduciary even when the claims fiduciary did not make any factual determinations.[28] This resulted from the Fifth Circuit's overriding concern that allowing *de novo* review of ERISA benefit claims will clot the veins of the federal court system. The court held as follows:

> The courts simply cannot supplant plan administrators, through *de novo* review, as resolvers of mundane and routine fact disputes. Considerations of expediency therefore support reference to factual determinations made in the administration of the plan. Otherwise, federal trials are encouraged in the vast number of claims that are filed in the thousands of ERISA plans throughout this county. . . We therefore conclude that a deferential standard of review for factual determinations is buttressed, if not compelled, by practical considerations.[29]

Although the Fifth Circuit has bristled at the idea that claimants should receive a level playing if claims procedures are violated, the tribunal has found an instance in which substantial abuse of the claims procedures can merit a remand to the claims administrator for further review.[30] Although this may lead to an award of benefits, it may also lead to an extended claims process that results in another

denial that must be challenged again at the courthouse under an abuse of discretion standard.

VII. The Second Circuit Holds that Deference Should be Forfeited Unless the Claims Administrator's Violation was Inadvertent and Harmless

The Second Circuit disagrees. In *Halo v. Yale Health Plan*, Halo, a Yale law student, alleged that the fiduciary claims administrator committed a number of claims procedure violations in denying her claim for health benefits (eye surgery) under the Yale Health Plan.[31] Considering Halo's request for *de novo* review due to procedural violations, the Second Circuit gave substantial weight to the Department of Labor's view. The Court held that unless the claims administrator can show that its other procedures are in compliance with the regulations and the failure to comply was both inadvertent and harmless, the claimant is entitled to *de novo* review.[32] The Court declined to award any civil penalties for the claims administrator's failure to comply with claims procedures.[33] Following *Russell*, it found no justification for such an award within the ERISA statutes and regulations, noting that "because ERISA is a comprehensive reticulated statute, and is enormously complex and detailed, it should not be supplemented by extratextual remedies."[34]

The circuits are split. Whether the U.S. Supreme Court will resolve the split is uncertain, of course, but the Supreme Court has shown its affection for deference. In *Conkright v. Frommert*, the Court held that an abuse of discretion that leads to remand does not cause the fiduciary to lose its discretion and right to deference when it decides the claim a second time (described by the Court as the "one strike and you're out" approach that was taken by the Second Circuit in that case).[35] The Court reasoned as follows:

> *Firestone deference . . . preserves the "careful balancing" on which ERISA is based.* Deference promotes efficiency by encouraging resolution of benefit disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions . . . .[36]

VIII. Conflicting Views on the Impact of Deference: Many States, Including Texas, Outlaw Discretionary Clauses

In protecting deference even in the face of substantial claims procedure violations, the Fifth Circuit's position not only conflicts with the Second Circuit but with the Texas Department of Insurance and other state insurance commissioners regarding what is fair to an insured. In the balance between an individual insured's rights and the efficiency of the federal court system, the Fifth Circuit has found the latter to be more important, perceiving *de novo* review to be a threat to the court system's efficiency.[37] The Texas Department of Insurance and Texas legislators perceive deference to be a greater threat.

In 2010, the Texas Commissioner of Insurance wrote as follows regarding discretionary clauses in policies that are meant to bind a court to a deferential standard of review:

> "Discretionary clauses are unjust, encourage misrepresentation, and are deceptive because they mislead the consumers regarding the terms of coverage. For example, a consumer could reasonably believe that if they are disabled they will be entitled to benefits under the policy and will be able to receive a full hearing to enforce such rights in court. Instead, a discretionary clause permits a carrier to deny disability income benefits even if the insured or enrollee is disabled, provided that the process heading to the denial was not arbitrary or capricious."[38]

The State of Texas outlawed discretionary clauses in disability, accident, or health policies effective June 17, 2011.[39] Other states have acted in a similar fashion. Statutes prohibiting discretionary clauses have consistently been found not preempted by ERISA.[40]

ERISA has a broad preemption provision but also a savings clause that protects certain state insurance laws from preemption. The savings clause is invoked when the courts find no preemption, thereby causing the discretionary clause within ERISA policies to be illegal under state law and therefore unenforceable. These cases, finding that discretionary clauses are prohibited by state law and unenforceable, are limited to claims made under insured ERISA plans. A state statute outlawing discretionary clauses in insurance policies does not apply to an employer's self-insured plan, nor does it change the Fifth Circuit precedent established by *Pierre*, that factual determinations by an ERISA claims fiduciary should always be given deference.

IX. Conclusion

Insurance claims made on an individual policy and claims made on an ERISA plan are remarkably different. ERISA requires that the insurer or third-party claims administrator engage in a dialogue with the claimant about the claim and the reasons for denial, allowing the claimant an opportunity to rebut the reasons for denial and compelling a fiduciary review of a denied claim. The downside of that review is that if the claimant asks for judicial review of a denied appeal, the federal court will probably have to defer to the claim fiduciary's decision and the evidence will be limited to the contents of the claim file.

There is no monetary remedy within ERISA for a violation of claims procedures nor does ERISA allow for consequential damages. The remedies for claims violations are potentially (1) a remand to the claims fiduciary for another try, or (2) forfeiture of deference, *i.e.* a change in the standard of review from abuse of discretion to a preponderance of the evidence. The Fifth Circuit has never awarded an ERISA claimant a change in the standard of review as a result of claims handling violations.

The collective philosophy of Texas and other states is that deference is harmful because it impairs the rights of insureds. The Fifth Circuit takes a different view, believing that ERISA deference provides a needed lubricant to a federal court system. According to the Fifth Circuit and many other federal courts, any harm to individual claimants is outweighed by the harm that requiring *de novo* review of each ERISA benefit claim would bring to the court system. The Fifth Circuit is also at odds with the DOL, as the Department considers deference to be forfeited if the claims procedures are not followed.

In the author's view, the Second Circuit has it right. Compliance with the claims procedures, or minimum standards created by the DOL that are to be followed by a claims administrator of an ERISA welfare or pension benefit plan, are important. There should be some negative consequences for non-compliance. Remand offers no deterrent; it merely gives the claims administrator another opportunity to decide the claim. Claimants should receive a level playing field, *i.e. de novo* review, unless the fiduciary claims administrator can prove that the claims procedure violation or violations were both harmless and inadvertent.

1 *See, e.g., Conway v. Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield,* Case No. 14-cv-34 (M.D. La., Dkt No. 26, filed 3/25/2015), in which the ERISA claimant (the plan participant's wife) died as a result of a denial of a claim for surgery to remove a cancerous tumor. *See also Robertson v. Blue Cross Blue Shield,* 99 F. Supp. 3d 1249, 1253 (D. Mont. 2015) (ERISA claimant was denied a hemopoietic stem cell transplant for diffuse systemic sclerosis, a decision which the Court described as akin to the decision of a "death panel"). Notably, because these are claims made under ERISA plans, the heirs cannot make wrongful death or other tort claims against the plan administrator. Due to ERISA preemption, if benefits were wrongfully denied the heirs are limited to the benefits that should have been paid. *Aetna Health Inc. v. Davila,* 542 U.S. 200, 216 (2004).

2 *Ariana M. v. Humana Health Plan of Texas, Inc.*, 854 F.3d 753, 762-63 (5th Cir. 2017), *rehearing en banc granted,* July 10, 2017.

3 *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1558-1559 (5th Cir. 1991).

4 *Ariana*, 854 F.3d at 763.

5 Tex. Ins. Code Ann., §541.060(a) (West 2016).

6 *USAA Tex. Lloyds Co. v. Menchaca*, No. 14–0721, 2017 WL 1311752, *3 (Tex. April 7, 2017), *rehearing granted,* Dec. 15, 2017.

7 The term Plan Administrator is used throughout the ERISA statutes, regulations, and case law as if they are the entity making the final decision. As a practical matter, companies generally either buy group insurance to fund employee benefits or hire third-party administrators and so the Plan Administrator identified in the plan is not the entity deciding the appeals of denied claims.

8 *See* 29 U.S.C. § 1135.

9 This description of the claims procedures does not include the amendments that go into effect for disability claims made on or after January 1, 2018. The amendments contain additional requirements aimed at assuring independence, impartiality, and full disclosure of the evidence relied upon in making the final decision to deny disability benefits, allowing the claimant to respond to any new medical consultants that may be hired by the claims fiduciary on appeal.

10 29 CFR 2560.503-1(g). There are some additional requirements for denial notices of health and disability claims including the disclosure of internal rules or protocols relied upon in denying the claim and additional information to be provided by the claims administrator when a health claim denial is based upon the alleged absence of medical necessity or experimental treatment.

11 29 CFR 2560.503-1(f).

12 29 CFR 2560.503-1(h).

13 *Id.*

14 *See* 29 CFR 2560.503-1(j). The same additional disclosure requirements required when a health or disability claim is denied are also required when an appeal of a health claim or disability claim is denied.

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id.*

19 29 CFR §2560.503-1(l).

20 Pension & Welfare Benefits Admin., 65 Fed. Reg. at 70,255 (Nov. 21, 2000) (emphasis added).

21 563 U.S. 421, 441-42 (2011)

22 *Id.*

23 *Id.* at 444.

24 *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

25 Section 502(a) of ERISA is now codified as Section 1132(a).

26 *Russell*, 473 U.S. at 146.

27 *Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 694 F.3d 557, 567 (5th Cir. 2012) (internal citation omitted).

28 *See Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98 (5th Cir. 1993).

29 *Pierre*, 932 F.3d at 1559 (internal citation omitted).

30 *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 159 (5th Cir. 2009).

31 819 F.3d 42, 46 (2d Cir. 2016).

32 *Id.* at 58.

33 *Id.59*

34 *Id.* (internal citation omitted).

35 559 U.S. 506, 517 (2010).

36 *Id.* at 517 (emphasis added).

37 *Pierre*, 932 F.3d at 1559.

38 Texas Commissioner of Insurance, Order No. 10-1035 (Dec. 3, 2010).

39 *See* Tex. Ins. Code Ann. §1701.062 (West 2016).

40 *See Orzechowski v. The Boeing Co. Non-Union Long-Term Disability Plan*, 856 F.3d 686, 695 (9th Cir. 2017) (finding no preemption for California's anti-discretionary statute); *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 849 (9th Cir. 2009) (finding Montana anti-discretionary statute not preempted); *Am. Council for Life Insurers. v. Ross*, 558 F.3d 600, 609 (6th Cir. 2009) (finding no preemption for Michigan's anti-discretion standard); *Zaccone v. Standard Life Ins. Co.*, No. 10-CV-00033, 2013 WL 1849515, *5, (N.D. Ill. May 1, 2013) (finding Illinois' statute prohibiting discretionary clauses not preempted).