UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	**CV 13-7221 FMO (SHx)**	Date	**March 3, 2015**
Title	**Pamela Jahn-Derian v. Metropolitan Life Insurance Company, et al.**		

Present: The Honorable	Fernando M. Olguin, United States District Judge	
Vanessa Figueroa	None	None
Deputy Clerk	Court Reporter / Recorder	Tape No.

Attorneys Present for Plaintiff(s):	Attorneys Present for Defendant(s):
None	None

Proceedings: (In Chambers) Order Re: Pending Motion

Having reviewed and considered all the briefing filed with respect to Pamela Jahn-Derian's ("plaintiff" or "Jahn-Derian") Motion Requesting De Novo Standard of Review ("Motion"), the court concludes that oral argument is not necessary and orders as follows. See Fed. R. Civ. P. 78; Local Rule 7-15; Willis v. Pac. Mar. Ass'n, 244 F.3d 675, 684 n. 2 (9th Cir. 2001).

BACKGROUND

Plaintiff seeks to recover disability benefits and enforce her rights under an employee welfare benefit plan regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, et seq. ("ERISA"). (See Complaint at ¶¶ 1 & 4). Plaintiff, who is a California resident, was an employee of Kaiser Foundation Healthplan, Inc. ("Kaiser Foundation"), which provided benefits under the Kaiser Permanente Group Long Term Disability Insurance Plan ("Kaiser LTD Plan"). (See id. at ¶¶ 2-3). The parties agree that the Kaiser LTD Plan is an employee welfare benefit plan governed by ERISA. (See id. at ¶ 4; Answer at ¶ 4).

Defendant Metropolitan Life Insurance Company ("MetLife") issued the group insurance policy that funded the long term disability ("LTD") benefits under the Kaiser LTD Plan. (See Answer at ¶ 3). MetLife was also the Kaiser LTD Plan's claims administrator during the relevant time period. (See id.). The parties do not dispute that the Kaiser LTD Plan delegated discretionary authority to MetLife. (See Motion at 2; Defendants' Opposition to Plaintiff's Motion Requesting De Novo Review ("Opp.") at 3-5).

In March 2012, Jahn-Derian submitted a claim for LTD benefits under the Kaiser LTD Plan, which MetLife denied on August 24, 2012. (See Complaint at ¶¶ 9-10; AR-C-3 & 680-84).[1] After

[1] Defendants lodged the Administrative Record, Jahn-Derian-Plan-1-73 and Jahn-Derian-CL-1-1130. (See Notice of Service of Administrative Record). For convenience, the court refers to the Administrative Record documents with the "AR-P" prefix for plan documents, and "AR-C" for claim documents.

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Jahn-Derian appealed the decision, MetLife upheld the denial of benefits. (See Complaint ¶ 11; AR-C-3-9). Jahn-Derian then submitted additional medical records, and MetLife again upheld its denial of disability benefits. (See Complaint at ¶ 12; AR-C-10-12 & 1-2).

The instant dispute centers on the standard of review for the denial of benefits.

LEGAL STANDARD

A motion for summary adjudication must meet the same standards as an ordinary motion for summary judgment under Federal Rule of Civil Procedure 56. See California v. Campbell, 138 F.3d 772, 780 (9th Cir. 1998) (applying summary judgment standards to a motion for summary adjudication); Barsamian v. City of Kingsburg, 597 F.Supp.2d 1054, 1061 (E.D. Cal. 2009) (same). A party may seek summary judgment on all or part of a claim. Fed. R. Civ. P. 56(a). Summary judgment is appropriate if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). In ERISA actions, a motion for summary judgment is largely a "conduit to bring the legal question before the district court." Barnes v. Unum Life Ins. Co., 621 F.Supp. 2d 1097, 1102 (D. Or. 2009) (quoting Bendixen v. Standard Ins. Co., 185 F.3d 939, 942 (9th Cir. 1999), overruled in part on other grounds by Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 966-69 (9th Cir. 2006) (en banc).

DISCUSSION

Plaintiff contends that under California Insurance Code § 10110.6 ("§ 10110.6"), the court should apply the de novo standard of review to plaintiff's ERISA claim. (See Motion at 3). Defendants argue that the court should apply the abuse of discretion standard, because the Kaiser LTD Plan documents grant discretionary authority to the plan administrator and fiduciaries. (See Opp. at 10 & 17). Moreover, defendants assert that § 10110.6 does not apply to ERISA plan documents. (See id. at 5-7).

I. THE KAISER LONG TERM DISABILITY PLAN.

In general, "a denial of benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57 (1989) (italics in original); see also Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 963 (9th Cir. 2006) (en banc) ("De novo is the default standard of review."), abrogated on other grounds by Metropolitan Life Insurance Company v. Glenn, 554 U.S. 105, 113-15, 128 S.Ct. 2343, 2348-50 (2008).

The parties do not appear to dispute that the Kaiser LTD Plan delegated discretionary authority to MetLife. (See Motion at 2 & 4; Opp. at 3-5). The court agrees. For instance, the Summary Plan Description ("SPD") in the Kaiser LTD Plan provides that "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," and that "[a]ny 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." (AR-P-71); see also Saffon v. Wells Fargo & Co. Long Term Disability Plan, 522 F.3d 863, 866 (9th Cir. 2008) (interpreting equivalent MetLife SPD provision and construing SPD as part of ERISA plan). The SPD further provides that the employee is to submit claims to MetLife, and that "MetLife will review your claim and notify you of its decision to approve or deny your claim." (AR-P-70). The SPD then provides a right to appeal, which will be conducted by MetLife. (Id. at 71).

Based on the foregoing, the court finds that the Kaiser LTD Plan vests in MetLife the authority to administer the Kaiser LTD Plan, and confers MetLife with discretionary authority to determine eligibility for benefits.

II. CALIFORNIA INSURANCE CODE § 10110.6.

Plaintiff, who is a California resident, (see Complaint at ¶ 2), argues that the de novo standard applies, pursuant to § 10110.6. (See Motion at 3-4 & 6-9). Section 10110.6 provides in relevant part:

> (a) If a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the policy, contract, certificate, or agreement, . . . , that provision is void and unenforceable.
> (b) For purposes of this section, "renewed" means continued in force on or after the policy's anniversary date.
> (c) For purposes of this section, the term "discretionary authority" means a policy provision that has the effect of conferring discretion on an insurer or other claim administrator to determine entitlement to benefits or interpret policy language that, in turn, could lead to a deferential standard of review by any reviewing court.

Cal. Ins. Code § 10110.6(a)-(c).

Section 10110.6 went into effect on January 1, 2012. See Cal. Ins. Code § 10110.6. The parties do not dispute that the Kaiser LTD Plan and MetLife policy were in effect during plaintiff's claims process.[2] (See, e.g., AR-P-1; Declaration of Tracy Baynes in Support of Defendants'

[2] The MetLife policy issued with an effective date of January 1, 2011, so under § 10110.6(b), the MetLife policy renews on the anniversary dates of January 1, 2012, and 2013.

Opposition ("Baynes Decl.") at ¶¶ 1, 4 & 5; Opp. at 3 & 5).

Defendants contend that § 10110.6's limitation on discretionary authority provisions extends only to insurance policies and contracts, and that ERISA plan documents are not insurance contracts. (See Opp. at 1-2 & 5-7). Defendants' argument is based in part on § 10110.6's legislative history. (See id. at 6-7).

When interpreting a California statute, the court should follow California's principles of statutory construction. See In re First T.D. & Inv., Inc., 253 F.3d 520, 527 (9th Cir. 2001). The court should give the statutory language "its usual, ordinary import." Id. Where the statutory text is ambiguous, the "court may consider extrinsic evidence of the legislature's intent, including the statutory scheme of which the provision is a part, the history and background of the statute, the apparent purpose, and any considerations of constitutionality." Id. (quoting Hughes v. Bd. of Architectural Exam'rs, 17 Cal.4th 763, 776 (1998)).

Section 10110.6, under its ordinary language, encompasses any "policy, contract, certificate, or agreement" that "provides or funds . . . disability insurance coverage for any California resident." Cal. Ins. Code § 10110.6(a). By its terms, the statutory language is not limited to insurance policies. Moreover, "[a]n ERISA plan is a contract." Harlick v. Blue Shield of Cal., 686 F.3d 699, 708 (9th Cir. 2012). Therefore, § 10110.6(a) suggests that the legislature intended that the statute apply to ERISA plans and governing plan documents. The statutory language appears ambiguous, however, in the context of other statutory provisions. For instance, subsection (c) provides that "'discretionary authority' means a policy provision that has the effect of conferring discretion on an insurer or other claim administrator[.]" Cal. Ins. Code § 10110.6(c) (emphasis added). Based on this ambiguity, the court will consider extrinsic evidence of the legislature's intent. See In re First T.D. & Inv., Inc., 253 F.3d at 527.

The legislative history confirms that § 10110.6 was not intended to be limited to insurance policies.[3] While the legislative record sometimes refers to "insurance policies," it also refers to

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See Stephan v. Unum Life Ins. Co. of Am., 697 F.3d 917, 927 (9th Cir. 2012) ("The law in effect at the time of renewal of a policy governs the policy even if that law is subsequently changed or repealed."). As for the Kaiser ERISA documents, the Kaiser Welfare Benefit Plan was in effect at least as of June 30, 2012, (see Baynes Decl.at ¶ 5; id., Exh. B), and the Flexible Plan was in effect in 2012 and 2013. (See Baynes Decl. at ¶ 4; id., Exh. A); see Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1159 (9th Cir. 2001) (controlling plan is the one that existed at the time plaintiff's benefits were denied).

[3] Defendants filed a Request for Judicial Notice ("RJN") of documents relating to the enactment of Senate Bill 621 of 2011, including materials relating to Assembly Bill 1868 of 2010. Plaintiff did not oppose defendants' RJN. (See, generally, Reply at 2). The court grants the request. See Palmer v. Stassinos, 348 F.Supp.2d 1070, 1077 (N.D. Cal. 2004) (taking judicial

covering insurance "contracts" and "agreements." For example, the legislative report from a June 22, 2011, hearing states that "[i]f a life insurance or disability insurance policy, contract, certificate, or agreement contains a provision rendered void and unenforceable by this bill, then the parties . . . shall treat the provision as void and unenforceable." (RJN, Exh. B at 129). Likewise, legislative analysis states that the proposed law "[m]akes void and unenforceable a provision in a life insurance or disability insurance policy, contract, certificate, or agreement" if the provision reserves certain discretionary authority to the insurer. (See id. at 96). An additional legislative document cited by defendants states that the bill "[m]akes void and unenforceable a provision in a life insurance or disability insurance policy, contract, certificate or agreement." (See id. at 92). Moreover, the legislative history specifically discusses ERISA plans. An analysis of Senate Bill 621, prepared for the Senate Insurance Committee, refers to an opinion letter by the Insurance Commissioner's general counsel, which explained that in "employer-sponsored disability contracts that are governed by ERISA, the presence of a discretionary clause has the legal effect of limiting judicial review of a denial of benefits to a review for abuse of discretion." (Id. at 43-44). In short, the legislative history corroborates that the statute was intended to cover insurance "contracts," "certificates," and "agreements" – not just insurance policies.

The bill's proponents further stated that § 10110.6 would "give insured people who are denied benefits a fair hearing in court," and rather than "limited judicial review," the "court would engage in a more balanced review of denial of benefits decisions." (RJN, Exh. B at 45). Such language indicates that the legislature sought to preserve the right to de novo review of claims denials. Limiting § 10110.6 to insurance policies could effectively nullify this right, as its scope could be circumvented by inserting discretionary language in plan documents. See UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 376, 119 S.Ct. 1380, 1390 (1999) (States would be "powerless to alter the terms of the insurance relationship in ERISA plans" if "insurers could displace any state regulation . . . by inserting a contrary term in plan documents."). Accordingly, the court adopts plaintiff's interpretation.

Defendants' argument that the ERISA documents are subject only to federal regulation, (see Opp. at 8-11),[4] is unpersuasive. ERISA plans can be indirectly regulated by the State. See

notice of legislative history).

[4] Defendants' reliance on Mixon v. Metro Life Ins., 442 F.Supp.2d 903 (C.D. Cal. 2006), and McCutcheon v. Hartford Life and Accid. Ins. Co., 2009 WL 1971427 (C.D. Cal. 2009), is unavailing, as these cases were decided years before § 10110.6 came into effect. Thus, those cases addressed different questions than the ones presented here. Defendants also cite Markey-Shanks v. Metropolitan Life Ins. Co., 2013 WL 3818838 (W.D. Mich. 2013), which is distinguishable, as it interprets Michigan law. Finally, Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, 2014 WL 979191 (C.D. Cal. 2014), is distinguishable, as there was no evidence that the plan at issue had renewed since the effective date of § 10110.6. See 2014 WL 979191 at *8-9.

Ward, 526 U.S. at 376, 119 S.Ct. at 1390; FMC Corp. v. Holliday, 498 U.S. 52, 61, 111 S.Ct. 403, 409 (1990). While defendants have raised Conkright v. Frommert, 559 U.S. 513, 130 S.Ct. 1640 (2010), Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S.Ct. 604, 612 (2013), and US Airways, Inc. v. McCutchen, 133 S.Ct. 1537 (2013), (see Opp. at 11-13),[5] none of those cases addresses a State's ability to regulate insurance under the savings clause. Moreover, other courts have rejected the argument that state prohibitions of discretionary authority provisions cannot indirectly reach ERISA plan documents. See, e.g., Snyder v. Unum Life Ins. Co. of America, 2014 WL 7734715, *8-9 (C.D. Cal. 2014) (collecting § 10110.6 cases); Novak v. Life Ins. Co. of N. Am., 956 F.Supp.2d 900, 906 (N.D. Ill. 2013) ("[P]lacing the discretionary clause in a plan document rather than in the insurance policy would 'elevate form over substance.'") (internal citation omitted).

Finally, defendants argue that the Kaiser LTD Plan documents are ERISA plan documents, not insurance policies, and therefore any state law that purports to regulate them cannot be saved from preemption. (Opp. at 15). Under 29 U.S.C. § 1144(a), ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." However, 29 U.S.C. § 1144(b)(2) saves from preemption "any law of any State which regulates insurance, banking, or securities." To fall under the savings clause, a state law (1) "must be specifically directed toward entities engaged in insurance," and (2) "must substantially affect the risk pooling arrangement between the insurer and the insured." Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342, 123 S.Ct. 1471, 1479 (2003).

Section 10110.6 meets the first requirement, as it is "specifically directed toward" the insurance industry. See Std. Ins. Co. v. Morrison, 584 F.3d 837, 842 (9th Cir. 2009) ("ERISA plans are a form of insurance, and the practice regulates insurance companies by limiting what they can and cannot include in their insurance policies"). Second, the practice "substantially affects" the pooling of risk. See id. at 844-45 (discretionary clause "substantially affects" pooling of risk, for instance, because it impacts "[t]he scope of permissible bargains between insurers and insureds."). Finally, since Morrison, numerous district courts have held that ERISA does not preempt § 10110.6. See Snyder, 2014 WL 7734715, at *10 (collecting § 10110.6 preemption cases).

[5] In Conkright, the Court reversed the Second Circuit's exception to Firestone deference, where the plan administrator had previously construed the same plan terms and "we found such a construction to have violated ERISA." 559 U.S. at 513, 130 S.Ct. at 1646. In Heimeshoff, the Court enforced a three-year contractual limitations provision, as the "controlling statute" did not prevent the provision from taking effect, and the contractual limitations period was not "unusually short." 134 S.Ct. at 612. In US Airways, the Court held that equitable doctrines relating to "double recovery" and reimbursement to pay attorney's fees did not did not override the clear terms of an ERISA plan. However, the Court held that the latter "common-fund doctrine" played a role in interpreting the ERISA plan. See US Airways, 133 S.Ct. at 1543.

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CONCLUSION

Based on the foregoing, IT IS ORDERED THAT plaintiff's Motion Requesting De Novo Standard of Review **(Document No. 21)** is **granted**.

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