LINK:

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES – GENERAL

Case No.	**CV 13-07522 BRO (RZx)**	Date	October 28, 2014
Title	**PATRICIA R. SNYDER V. UNUM LIFE INSURANCE COMPANY OF AMERICA**		

Present: The Honorable	**BEVERLY REID O'CONNELL, United States District Judge**	
Renee A. Fisher	Not Present	N/A
Deputy Clerk	Court Reporter	Tape No.
Attorneys Present for Plaintiffs:	Attorneys Present for Defendants:	
Not Present	Not Present	

Proceedings: (IN CHAMBERS)

ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY ADJUDICATION REGARDING THE STANDARD OF REVIEW [22]

I. INTRODUCTION

Plaintiff Patricia R. Snyder ("Plaintiff") seeks declaratory relief and long term disability benefits from Defendant Unum Life Insurance Company of America ("Defendant" or "Unum") pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq. ("ERISA"). Currently pending before the Court is Plaintiff's Motion for Summary Adjudication regarding the standard of review to be applied in this case. (Dkt. No. 22.) Specifically, Plaintiff asserts that California Insurance Code section 10110.6 requires the Court to review Defendant's decision denying her claim for long term disability benefits under the *de novo* standard. Defendant maintains that section 10110.6 does not apply and argues the Court must review the decision for abuse of discretion.[1] For the following reasons, the Court finds section 10110.6 voids the discretionary clauses in the relevant insurance policy and plan document and requires the Court apply the *de novo* standard of review. Accordingly, the Court **GRANTS** Plaintiff's Motion for Summary Adjudication.

[1] Defendant has styled its opposition papers as a cross-motion for summary judgment. (*See* Dkt. No. 26.) Defendant did not notice such a motion, nor file such a motion within forty-nine days before the hearing date as required by this Court's Standing Order. (*See* Standing Order Regarding Newly Assigned Cases ¶ 8(c)). However, in the interests of judicial economy, the Court will nevertheless consider Defendant's Opposition as a cross-motion for summary judgment for an order establishing that the abuse of discretion standard applies.

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II. BACKGROUND

A. Factual Background

Plaintiff worked for Northrup Grumman Corporation ("Northrup") as an executive assistant. (Compl. ¶ 2; *see also* Decl. of Russell G. Petti in Supp. of Pl.'s Mot. for Summ. Adjudication ("Petti MSA Decl.") Ex. B at 2.) Northrup created and administers the Northrup Grumman Health Plan (the "Plan"). (Decl. of Liza Tiglao-Smith in Opp'n to Pl.'s MSA ("Tiglao-Smith Decl.") ¶ 2.) The Plan was established in accordance with ERISA and includes various insurance programs offering coverage to Northrup's employees. (*Id.* ¶ 4.) Northrup also created the Northrup Grumman Health Plan Summary Plan Description (the "SPD") to summarize and govern the Plan and the insurance programs offered under it. (*Id.*; *see also id.* Ex. A.) Northrup considers the SPD a governing Plan document. (*Id.* ¶¶ 4, 6.)

1. The Long Term Disability Plan

Among the Plan's insurance programs is a long term disability plan called the Northrup Grumman Group Long Term Disability Plan (the "LTD Plan"). (*Id.* ¶ 5.) This dispute centers on the LTD Plan. Defendant Unum funds the LTD Plan pursuant to a group insurance policy (the "LTD Policy"). (*Id.*; *see also id.* Ex. B.) The SPD governs the LTD Plan and designates Unum as the claims administrator for all employee long term disability claims. (*Id.* Ex. A at 164.) It also provides that Unum "is the decision-maker for both disability claims and appeals, with full delegated authority for such decisions." (*Id.* Ex. A at 160.)

The instant dispute revolves around a discretionary clause in the SPD. In a section titled "How the LTD Plan Works," the SPD explains that "Unum, not Northrup Grumman, is responsible for the payment of all benefits covered under the LTD insurance contract and has the sole authority, discretion[,] and responsibility to interpret the terms of the LTD contract." (*Id.* Ex. A. at 140.) The parties do not dispute that Unum has the authority to determine whether an employee is entitled to long term disability benefits under the LTD Plan. (*See* Def.'s Statement of Genuine Issues ¶ 10; *see also* Compl. ¶ 4.)

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2. The Group Insurance Policy

The LTD Policy that funds the LTD Plan also contains a discretionary clause. In particular, the "Certificate Section" provides that "Unum has discretionary authority to determine [a client's] eligibility for benefits and to interpret the terms and provisions of the policy" when determining benefits eligibility. (Petti MSA Decl. Ex. A at 12.) The LTD Policy's effective date is July 1, 2006. (Def.'s Statement of Genuine Issues ¶ 2.) The LTD Policy's anniversary date is January 1st. (*Id.*) Unum amended the LTD Policy on June 26, 2012, and the amended version became effective on July 1, 2012. (*Id.* ¶ 3.) The LTD Policy also includes a choice of law provision stating that Virginia is the governing jurisdiction. (*Id.* ¶ 11; *see also* Tiglao-Smith Decl. Ex. B at 3.)

3. Plaintiff's Long Term Disability Claim

As a Northrup employee, Plaintiff participates in the LTD Plan. (Compl. ¶ 5.) Plaintiff stopped working on July 24, 2012 due to pain and fatigue associated with various medical conditions. (Petti MSA Decl. Ex. B at 2.) Defendant denied Plaintiff's request for long term disability benefits. (*See id.*; *see also* Def.'s Statement of Genuine Issues ¶ 4.) Plaintiff appealed this decision, and Defendant issued a final denial of Plaintiff's claim and appeal on August 13, 2014. (*Id.*)

B. Procedural History

Plaintiff initiated this suit on October 10, 2013. (Dkt. No. 1.) Plaintiff filed the instant Motion for Summary Adjudication on September 29, 2014. (Dkt. No. 22.) Defendant timely opposed on October 6, 2014 (Dkt. No. 26), and Plaintiff timely replied (Dkt. No. 32).[2] The Court heard oral argument from the parties on October 27, 2014.

[2] On October 21, 2014, the Court struck Plaintiff's Reply for failure to comply with the Court's Standing Order, which provides that reply papers shall not exceed twelve pages. (*See* Dkt. No. 36.) Plaintiff's Reply totals twenty-five pages in length. (*See* Dkt. No. 32.) Plaintiff amended the reply papers in accordance with the Court's Standing Order (Dkt. No. 38) and sought *ex parte* relief requesting the Court consider her original, twenty-five page Reply (Dkt. No. 39). Finding good cause, the Court granted Plaintiff's *ex parte* application on October 22, 2014. (Dkt. No. 40.) Accordingly, the Court will consider Plaintiff's first Reply in ruling on the instant Motion for Summary Adjudication.

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III. EVIDENTIARY OBJECTIONS

Plaintiff objects to the SPD's admissibility. (*See* Pl.'s Evidentiary Objections.) Plaintiff's objection is two-fold. First, Plaintiff contends the SPD should be excluded under Federal Rule of Civil Procedure 37 based on Defendant's failure to disclose the document until filing its Opposition. (*See id.* at 4–7.) Second, Plaintiff asserts the SPD should be excluded because it is not part of the administrative record. (*See id.* at 7–9.)

A. Rule 37 Does Not Warrant the SPD's Exclusion

Federal Rule of Civil Procedure 26 requires a party to provide, without request, "a copy—or a description by category and location—of all documents, electronically stored information, and tangible things that the disclosing party has in its possession, custody, or control and may use to support its claims or defenses." Fed. R. Civ. P. 26(a)(1)(A)(ii). Rule 26(e) requires a party to supplement or correct a discovery response if it is incorrect or incomplete and the corrective or additional information has not been disclosed. Fed. R. Civ. P. 26(e). Under Rule 37(c), a party who fails to provide information required by Rule 26(a) or (e) may not use it as evidence supporting a motion unless the failure was substantially justified or harmless. Fed. R. Civ. P. 37(c). Rule 37(c) sanctions are designed to give the parties "strong inducement" to disclose evidentiary materials. *Yeti by Molly, Ltd. v. Deckers Outdoor Corp.*, 259 F.3d 1101, 1106 (9th Cir. 2001). District courts have particularly wide leeway to issue Rule 37(c) sanctions. *Id.*

Defendant made its initial disclosures on April 28, 2014. (*See* Decl. of Russell G. Petti in Supp. of Pl.'s Evidentiary Objections ("Petti Evidentiary Objections Decl.") ¶ 2; *see also id.* Ex. A.) Defendant disclosed the LTD Policy but not the SPD. (*Id.* ¶ 5.) Plaintiff contends her counsel therefore believed the LTD Policy represented the only governing plan document with respect to Plaintiff's long term disability claim. (*See* Reply in Supp. of Pl.'s Evidentiary Objections at 4–5.)

On July 21, 2014, Plaintiff sought further discovery regarding a short term disability claim (not the subject of this dispute) and served Defendant with Requests for Production. (Petti Evidentiary Objections Decl. ¶¶ 6–7.)[3] Defendant did not specifically

[3] Plaintiff filed a short term disability ("STD") claim in addition to the long term disability claim. Plaintiff's July 21, 2014 Requests for Production sought "[a]ny and all Plans, Policies, or Certificates

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produce the SPD, but rather referred Plaintiff to her former employer, Northrup, as well as the company's website. (*Id.* ¶ 9, 11; *see also id.* Ex. B at 4.) Defendant's response included a link to the website from which Plaintiff could access the SPD from a list of various documents. (*Id.* Ex. B at 4). Plaintiff's counsel apparently could not locate the SPD. (*Id.* ¶ 10). According to Plaintiff, her counsel neither saw nor knew about the SPD until Defendant filed it in connection with its Opposition. (*Id.* ¶ 14.)

Defendant maintains it adequately discharged its duty to disclose the SPD for three reasons. First, the parties' Rule 26(f) Joint Report required Defendant to lodge the administrative record and plan documents by October 1, 2014. (*See* Decl. of Robert E. Hess in Opp'n to Pl.'s Evidentiary Objections ("Hess Decl.") ¶ 6; *see also id.* Ex. B at 3.) Second, Defendant asserts the SPD was easily accessible from Northrup's website and that Plaintiff's counsel should have been able to locate it from the link. (*See* Hess Decl. ¶¶ 2–4; *see also id.* Ex. A.) Finally, Defendant maintains it satisfied its duty to disclose the SPD because it responded to Plaintiff's Requests for Production on August 25, 2014, four days before Plaintiff notified Defendant of her intent to file the instant Motion for Summary Adjudication.

Defendant's proffered justifications do not dispute the fact that Defendant failed to include the SPD in its initial disclosures. Nor do they dispute that the SPD is relevant to the litigation and the parties' claims and defenses. Indeed, when the parties submitted the Rule 26(f) Joint Report on January 27, 2014, the parties explicitly agreed that "the issue before this Court is whether UNUM's denial of benefits to Ms. Snyder will be upheld or overturned. Ms. Snyder contends that the Court should apply the *de novo* standard in making this decision, while UNUM contends the standard should be whether it abused its discretion." (Hess Decl. Ex. B at 2.) The SPD is relevant to which standard of review applies. Defendant therefore should have known Rule 26(a) required it to disclose the SPD three months before its initial disclosures on April 28, 2014. As a result, the Court concludes Defendant violated Rule 26(a).

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issued and/or administered by UNUM which provides or provided short term disability ("STD") coverage" to Plaintiff. (*See id.* Ex. B at 4.)

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That Plaintiff's counsel could have theoretically accessed the SPD from Northrup's website does not alter this finding. Rule 26(a) required Defendant to include a copy (or description by category and location) of the SPD in its initial disclosures. Defendant failed to do this. Moreover, Defendant directed Plaintiff to the website in response to discovery requests regarding the short term disability claim, which is not the subject of this dispute. Thus, when Plaintiff's counsel searched the website, he was not looking for documents related to Plaintiff's long term disability claim. (Supplemental Decl. of Russell G. Petti in Supp. of Pl.'s Evidentiary Objections ("Supplemental Petti Evidentiary Objections Decl.") ¶ 7.)

That Defendant agreed to lodge the administrative record and plan documents by October 1, 2014 also does not alter the Court's finding that Defendant violated Rule 26(a). The Rule 26(f) Joint Report required Defendant to "produce what it contends is the Administrative Record to [P]laintiff" by February 14, 2014. (*See* Hess Decl. Ex. B at 2.) Moreover, when Defendant lodged the administrative record and plan documents on October 1, 2014, only five days remained before the scheduling order's deadline for hearing motions. (*Id.* Ex. B at 8.)

Accordingly, the Court must consider whether the violation was harmless or substantially justified. *See* Fed. R. Civ. P. 37(c). In opposing Plaintiff's motion, Defendant primarily argues that Insurance Code section 10110.6 applies to discretionary clauses in insurance contracts but not to such clauses in plan documents like the SPD. Defendant therefore asserts the SPD's discretionary clause is valid and requires the Court to review Defendant's denial of Plaintiff's long term disability claim for abuse of discretion. Plaintiff's counsel declares he would have addressed this issue in the motion had he known about the SPD. (Petti Evidentiary Objections Decl. ¶ 15.) Plaintiff therefore contends Defendant's violation was not harmless.

The Court admonishes Defendant's failure to disclose the SPD. Nevertheless, the Court finds this failure was harmless. Plaintiff's Reply discusses the applicability of section 10110.6 to plan documents at length. The Court granted Plaintiff ex parte relief due to the tardy disclosure. The Court has considered Plaintiff's lengthy Reply in ruling on the instant Motion for Summary Adjudication. As a result, the Court finds Defendant's violation has not prejudiced Plaintiff. Plaintiff's request to exclude the SPD under Rule 37 is therefore **DENIED**.

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B. Plaintiff's Request to Exclude the SPD as Outside the Administrative Record is Premature

Plaintiff also requests the Court exclude the SPD on the ground it is outside the administrative record. (Pl.'s Evidentiary Objections at 7–9.) At this stage of the proceedings, the Court need not decide whether the SPD is part of the administrative record. Plaintiff correctly points out that when a plan participant challenges an administrator's decision to deny benefits, the evidence that a district court may consider depends on the applicable standard of review. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 969 (9th Cir. 2006) (en banc). If the district court reviews the decision for abuse of discretion, the court is generally limited to the administrative record. *Id.* at 970. If the court reviews the decision *de novo*, the court may consider new evidence outside the administrative record. *Id.*

As a result, the case law cited by Plaintiff is inapplicable to the instant Motion for Summary Adjudication. The present inquiry is limited to which standard of review applies to Defendant's decision to deny Plaintiff's long term benefits claim. Because the Court is not yet faced with the task of determining the propriety of Defendant's decision, Plaintiff's objection is premature. Accordingly, the Court **OVERRULES** the objection.

IV. REQUEST FOR JUDICIAL NOTICE

Under Federal Rule of Evidence 201(b), a court may take judicial notice of a fact "that is not subject to a reasonable dispute because it: (1) is generally known within the trial court's territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). In opposing Plaintiff's motion, Defendant requests the Court take judicial notice of two documents regarding California Insurance Code section 10110.6's legislative history. (*See* Def.'s Req. for Judicial Notice ("RJN").) Specifically, Defendant requests the Court judicially notice the declaration of Maria A. Sanders of Legislative Intent Service, Inc., as well as the legislative history of section 10110.6. (*Id.* Exs. A, B.) The Court finds section 10110.6's legislative history is a source whose accuracy cannot reasonably be questioned and a proper subject for judicial notice. *See Chaker v. Crogan*, 428 F.3d 1215, 1223 n.8 (9th Cir. 2005). The Court therefore **GRANTS** Defendant's request for

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judicial notice with respect to this set of documents. Because the Court finds Maria A. Sanders' declaration is not a source generally known or whose accuracy cannot reasonably be questioned, the Court **DENIES** Defendant's request for judicial notice with respect to this document.

V. LEGAL STANDARD

Summary judgment is appropriate when, after adequate discovery, the evidence demonstrates that 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. A disputed fact is material where its resolution might affect the outcome of the suit under the governing law. *Anderson v. Liberty Lobby Inc.*, 477 U.S. 242, 248 (1986). An issue is genuine if the evidence is sufficient for a reasonable jury to return a verdict for the non-moving party. *Id.* The moving party bears the initial burden of establishing the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323–24 (1986). The moving party may satisfy that burden by showing "that there is an absence of evidence to support the non-moving party's case." *Id.* at 325.

Once the moving party has met its burden, the non-moving party must do more than simply show that there is some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). Rather, the non-moving party must go beyond the pleadings and identify specific facts that show a genuine issue for trial. *Id.* at 587. Only genuine disputes over facts that might affect the outcome of the lawsuit will properly preclude the entry of summary judgment. *Anderson*, 477 U.S. at 248; *see also Arpin v. Santa Clara Valley Transp. Agency*, 261 F.3d 912, 919 (9th Cir. 2001) (holding that the non-moving party must present specific evidence from which a reasonable jury could return a verdict in its favor). A genuine issue of material fact must be more than a scintilla of evidence, or evidence that is merely colorable or not significantly probative. *Addisu v. Fred Meyer*, 198 F.3d 1130, 1134 (9th Cir. 2000).

A court may consider the pleadings, discovery, and disclosure materials, as well as any affidavits on file. Fed. R. Civ. P. 56(c)(2). Where the moving party's version of events differs from the non-moving party's version, a court must view the facts and draw reasonable inferences in the light most favorable to the non-moving party. *Scott v. Harris*, 550 U.S. 372, 378 (2007).

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Although a court may rely on materials in the record that neither party cited, it need only consider cited materials. Fed. R. Civ. P. 56(c)(3). Therefore, a court may properly rely on the non-moving party to identify specifically the evidence that precludes summary judgment. *Keenan v. Allan*, 91 F.3d 1275, 1279 (9th Cir. 1996).

Finally, the evidence presented by the parties must be admissible. Fed. R. Civ. P. 56(e). Conclusory or speculative testimony in affidavits and moving papers is insufficient to raise a genuine issue of fact and defeat summary judgment. *Thornhill's Publ'g Co. v. GTE Corp.*, 594 F.2d 730, 738 (9th Cir. 1979). Conversely, a genuine dispute over a material fact exists if there is sufficient evidence supporting the claimed factual dispute, requiring a judge or jury to resolve the differing versions of the truth. *Anderson*, 477 U.S. at 253.

VI. DISCUSSION

ERISA permits plan participants to bring a civil action to recover benefits due, enforce rights, or clarify rights to future benefits under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B). "When Congress enacted ERISA, it did not specify the standard of review that courts should apply when a plan participant challenges a denial of benefits." *Abatie*, 458 F.3d at 962. The Supreme Court first addressed the issue in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Under *Firestone*, district courts reviewing benefits denials must apply one of two standards of review. The default standard of review is *de novo*. *Id.* at 115. But where the benefits plan "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," the court must review for abuse of discretion. *Id.* To alter the standard of review from *de novo* to abuse of discretion, "the plan must unambiguously provide discretion to the administrator." *Abatie*, 458 F.3d at 963 (citing *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999) (en banc)).

The parties do not dispute that the LTD Policy and SPD include discretionary clauses giving Defendant, the LTD Plan administrator, authority to determine benefits eligibility and construe the terms of the LTD Plan. Rather, the parties dispute whether California Insurance Code section 10110.6 renders the discretionary clauses void and unenforceable. Plaintiff contends the statute invalidates the discretionary clause in both the LTD Policy and SPD such that the *de novo* standard of review must apply. Defendant

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maintains section 10110.6 only applies to the LTD Policy and does not void the SPD's discretionary clause. According to Defendant, because the SPD's discretionary clause remains valid, the Court must review the denial of Plaintiff's long term disability claim under the more deferential abuse of discretion standard.

A. California Insurance Code Section 10110.6

Under California Insurance Code section 10110.6,

> 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, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

Cal. Ins. Code § 10110.6(a). By its own terms, section 10110.6 "is self-executing." *Id.* § 10110.6(g). Thus, if an insurance "policy, contract, certificate, or agreement contains a provision rendered void and unenforceable by this section, the parties to the policy, contract, certificate, or agreement and the courts shall treat that provision as void and unenforceable." *Id.*

As discussed above, the parties dispute the meaning and scope of section 10110.6. Defendant contends the provision does not apply to ERISA plan documents like the SPD, which Defendant maintains is not a "policy, contract, certificate, or agreement." (Def.'s Opp'n to Pl.'s MSA at 11–20.) Plaintiff avers the opposite. Plaintiff asserts that the statute bans the discretionary clause in the SPD because it is a "contract" or "agreement" within the statute's express scope. (Pl.'s Reply in Supp. of MSA at 3–13.)

1. Section 10110.6 Applies to the SPD

When a federal court interprets 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). A federal court should "give the language of the statute

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'its usual, ordinary import.'" *Id.* (citing and quoting *Dyna-Med, Inc. v. Fair Emp't & Hous. Comm'n*, 43 Cal. 3d 1379, 1386–87 (Cal. 1987). If the statute's wording is ambiguous, the court "may consider extrinsic evidence of the legislature's intent," including the statutory scheme and history, background, and apparent purpose. *Id.* (citing and quoting *Hughes v. Bd. of Architectural Exam'rs*, 17 Cal. 4th 763, 776 (Cal. 1998)).

Pursuant to subsection (a), Insurance Code section 10110.6 applies to insurance policies, contracts, certificates, and agreements. Cal. Ins. Code § 10110.6(a). "An ERISA plan is a contract." *See Harlick v. Blue Shield of Ca.*, 686 F.3d 699 (9th Cir. 2012). Thus, subsection (a) suggests the legislature intended that the statute apply to ERISA plans and governing plan documents. Read in conjunction with the other subsections, however, subsection (a) appears ambiguous. For example, subsection (c) provides that "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." *Id.* §10110.6(c) (emphasis added). Defendant contends this language suggests the legislature did not intend that the ban on discretionary clauses apply to ERISA plans. (*See* Def.'s Opp'n to Pl.'s MSA at 11.) Finding the section's plain language ambiguous, the Court will consider extrinsic evidence of the legislature's intent. *In re First T.D. & Inv., Inc.*, 253 F.3d at 527.

a. Legislative History

Defendant cites to California Senate Bill No. 621, which eventually became section 10110.6. (Def.'s Opp'n to Pl.'s MSA at 12.) An analysis of Senate Bill No. 621 prepared for the Senate Insurance Committee provides that the bill's purpose was to "prohibit life and disability insurance policies from containing a discretionary clause, and to prohibit the Insurance Commissioner from approving disability insurance policies that contain a discretionary clause." (*See* Def.'s RJN Ex. B at 42.) The analysis references an opinion letter written by the Insurance Commissioner's general counsel on the issue of whether discretionary clauses are valid under California law. (*Id.* Ex. B at 43.) The opinion letter explains that:

> In the case of group, 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

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> of discretion. . . . This standard of review deprives California insureds of the benefits for which they bargained, access to the protections of the Insurance Code[,] and other protections in California law.

(*Id.* Ex. B at 43–44.)

The analysis also summarizes the arguments in support of the bill. (*Id.* at 45.) The bill's proponents were apparently concerned by

> [The] inherent conflict of interest [that] exists when an insurance company both determines eligibility for benefits and bears the financial burden of paying for them. The abuse of discretion standard of review flies in the face of California's long-standing principle of interpreting a contract against the drafter, rather than against an unsophisticated policyholder, and needs to be corrected. This bill would give insured people who are denied benefits a fair hearing in court. Instead of limited judicial review dictated by an insurance company's inclusion of a discretionary clause in a policy, a court would engage in a more balanced review of denial of benefits decisions.

(*Id.*) This language suggests the legislature's overriding concern in adopting section 10110.6 was to ensure insured Californians have a right to *de novo* review of claims denials. Construing section 10110.6 as Defendant suggests would effectively eviscerate this right. If the prohibition does not apply to benefits plans, insurers could readily circumvent section 10110.6 by inserting discretionary language in the plan documents rather than the funding policy. Accordingly, the Court rejects Defendant's interpretation and adopts Plaintiff's.[4]

[4] Defendant cites to *Mixon v. Metro. Life Ins.*, 442 F. Supp. 2d 903 (C.D. Cal. 2006) for the proposition that state law does not apply to ERISA plan documents. In *Mixon*, the court found that California's Department of Insurance has jurisdiction over insurance policies but not summary plan descriptions. *Id.* at 907. The court held that the summary plan description at issue was "governed by federal law, and therefore state law is not applicable." *Id.* at 908. But *Mixon* is inapplicable to the instant dispute. The case was decided in 2006, six years before section 10110.6 came into effect. The *Mixon* court therefore faced a different question than the one before the Court.

Defendant also cites to *Markey-Shanks v. Metropolitan Life Insurance Co.*, 2013 U.S. Dist. LEXIS 102412 (W.D. Mich. 2013). This case is also distinguishable. In *Markey-Shanks*, the court

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b. Relevant Case Law

The Court's conclusion that section 10110.6's prohibition against discretionary clauses reaches such language in ERISA plan documents accords with recent district court decisions. In *Gonda v. The Permanente Medical Group, Inc.*, 11-1363 SC, 2014 WL 186354 (N.D. Cal. Jan. 16, 2014), the court specifically addressed the issue of whether section 10110.6 applies to a summary plan description.[5] In *Gonda*, the insurance policy granted the insurer discretionary authority over claims decisions. *Id.* at *1. Like Defendant, the defendants in *Gonda* argued that even if section 10110.6 voided the discretionary clause in the insurance policy, it did not void a discretionary clause in the summary plan description. *Id.* at *3. The court rejected this argument as "novel but wholly unpersuasive." *Id.* at *4. Finding that the defendants' argument rested "on the untenable assumption" that a benefits plan description "somehow trumps the terms of the [p]lan itself," the court held that section 10110.6 applied to the summary plan description and rendered its discretionary clause void and unenforceable. *Id.* The court found that any other conclusion would render section 10110.6 "practically meaningless: ERISA plans could grant discretionary authority to determine eligibility under an insurance policy, so long as the grants were set forth somewhere other than in the insurance policy. That is clearly not the law." *Id.*

The Court in *Rapolla v. Waste Management Employee Benefits Plan*, 13-CV-02860-JST, 2014 WL 2918863 (N.D. Cal. June 25, 2014) reached a similar conclusion. In *Rapolla*, the benefits plan contained a discretionary clause and incorporated by reference the insurance policy funding it. *Id.* at *1. The defendants in *Rapolla* also argued that section 10110.6 did not void the discretionary clause because it was in the

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applied the abuse of discretion standard of review because of a discretionary clause in the benefits plan. Michigan's Administrative Code Rule 500.2202, which prohibits discretionary clauses in insurance policies and contracts issued as of June 1, 2007, did not void the discretionary clause because the pertinent policywas issued before June 1, 2007. *Id.* at 16–17. Contrary to Defendant's assertion, the *Markey-Shanks* court did not consider whether a state may prohibit insurers from including discretionary clauses in a summary plan description. *Id.* at 21 n.5 ("Whether the State of Michigan may specifically prohibit insurers from including discretionary clauses in ERISA SPDs they furnish to employers in connection with the sale of group insurance policies is a question this Court need not consider.")

[5] During oral argument, Defendant's counsel asserted that the *Gonda* case did not discuss whether section 10110.6 applies to plan documents. For the reasons discussed below, the Court disagrees.

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benefits plan, not the insurance policy. *Id.* at *4, 6. Like the court in *Gonda*, the *Rapolla* court rejected this argument. The court found that the policy and plan were "part of a single integrated contract." *Id.* at *5. Because the plan incorporated the policy by reference, the policy became a part of the plan when the policy became effective. *Id.* Accordingly, section 10110.6 applied to the plan and voided its discretionary clause. *Id.* at *5, 6. [6]

The Court agrees with the reasoning in *Gonda*, *Rapolla*, and *Polnicky*. As in *Gonda*, both the LTD Policy and SPD contain discretionary clauses giving Defendant wide authority to determine long term disability claims eligibility. Section 10110.6 clearly voids this language in the insurance policy. To find the SPD's discretionary language remains valid, despite section 10110.6's clear command, would eviscerate the statute's protections and render it meaningless.

2. The LTD Policy and SPD's Discretionary Clauses Are Void Under Section 10110.6

Having determined section 10110.6 applies to the LTD Policy and SPD, the Court considers whether the statute voids the discretionary clause in each such that the *de novo* standard of review applies. First, the Court considers whether Plaintiff's long term disability claim accrued after section 10110.6's effective date.[7] Second, the Court considers whether the LTD Policy and SPD were "offered, issued, delivered, or renewed"

[6] *Polnicky v. Liberty Life Assurance Co. of Boston*, 999 F. Supp. 2d 1144 (N.D. Cal. 2013) is also on point. In *Polnicky*, the benefits plan at issue was funded by a group disability income policy. *Id.* at 1146. The policy contained a discretionary clause conferring authority on the defendant insurer to decide claims. *Id.* at 1148. The *Polnicky* court concluded that section 10110.6 "rendered void and unenforceable any provision in the [p]lan attempting to confer discretionary authority" on the defendant and that the *de novo* standard of review applied. *Id.* at 1150. Although the case does not make clear whether plan documents other than the insurance policy contained a discretionary clause, the court's decision does not appear to distinguish between policies and plan documents in finding that section 10110.6 renders discretionary clauses unenforceable.

[7] The default presumption is that a newly enacted statute applies prospectively. *See Chenault v. U.S. Postal Serv.*, 37 F.3d 535, 537 (9th Cir. 1994). The Court need not decide whether section 10110.6 applies prospectively or retroactively because Plaintiff's claim accrued after the statute's effective date.

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after the statute's effective date. *See Gonda*, 11-1363 SC, 2014 WL 186354, at *2; *see also* Cal. Ins. Code § 10110.6(a).

a. Plaintiff's Long Term Disability Claim Accrued After Section 10110.6's Effective Date

An ERISA claim challenging a plan administrator's denial of benefits accrues when the benefits are denied. *See Grosz-Salomon v. Paul Revere Life Ins.*, 237 F.3d 1154, 1160–61 (9th Cir. 2001) (citing *Bolton v. Constr. Laborers' Pension Trust for So. Cal.*, 56 F.3d 1055, 1058 (9th Cir. 1995)). The parties do not dispute that Defendant denied Plaintiff's long term disability claim on February 8, 2013 and denied her appeal on August 13, 2013. (*See* Petti MSA Decl. Ex. B at 1–2.) Section 10110.6 came into effect on January 1, 2012. *See* Cal. Ins. Code § 10110.6. Accordingly, Plaintiff's claim accrued after the statute's effective date.

b. The LTD Policy Renewed and the SPD Issued After Section 10110.6's Effective Date

Section 10110.6 applies to a policy "offered, issued, delivered, or renewed" after its effective date. *Id.* § 10110.6(a). Under subsection (b), a policy "renews" when it "continue[s] in force on or after the policy's anniversary date." *Id.* § 10110.6(b). Here, the LTD Policy has an effective date of July 1, 2006 and an anniversary date every January 1. (Def.'s Statement of Genuine Issues ¶ 2.) Accordingly, when the LTD Policy continued in force after its January 1, 2012 anniversary date, section 10110.6 rendered its discretionary clause void and unenforceable. *See Polnicky*, 999 F. Supp. 2d at 1148; *see also Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 927 (9th Cir. 2012) ("Under California law, 'insurance policies are governed by the statutory and decisional law in force at the time the policy is issued.' . . . This principle governs not only new policies but also renewals: Each renewal incorporates any changes in the law that occurred prior to the renewal.") (internal citation omitted). The SPD's publication date is September 2012. (*See* Tiglao-Smith Decl. Ex. A.) The SPD therefore issued after section 10110.6's effective date. As a result, the statute also voids the SPD's discretionary clause. Because section 10110.6 renders both discretionary clauses unenforceable, the *de novo* standard of

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review applies to Defendant's denial of Plaintiff's long term disability claim.[8]

B. ERISA Does Not Preempt Section 10110.6

Defendant also contends section 10110.6 does not apply to the LTD Policy or SPD because of ERISA preemption. (*See* Def.'s Opp'n to Pl.'s MSA at 21–23.) Under 29 U.S.C. § 1144(a), ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a). Nevertheless, ERISA contains a "savings clause" such that state laws regulating insurance, banking, and securities are not preempted. *Id.* § 1144(b)(2)(A).

Defendant maintains section 10110.6 does not fall within ERISA's savings clause. The Court is not persuaded. To fall within the savings clause, a state law or regulation must satisfy a two-part test. *See Standard Ins. Co. v. Morrison*, 584 F.3d 837, 842 (9th Cir. 2009). The state law must: (1) "be specifically directed toward entities engaged in insurance," and (2) "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* (citing and quoting *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003) (internal quotation marks omitted)).

In *Morrison*, the Ninth Circuit held that a state commissioner's practice of disapproving discretionary clauses in insurance policies fell within ERISA's savings

[8] Defendant directs the Court to *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan*, 2014 WL 979191 (C.D. Cal. March 12, 2014) and requests the Court follow its reasoning to find section 10110.6 does not apply to plan documents. The Court declines this request because the *Orzechowski* case is distinguishable. In *Orzechowski*, the court found section 10110.6 did not apply to a benefits plan existing before the statute's effective date. *Id.* at *8–9. The benefits plan at issue became effective January 1, 2011, and there was no evidence the plan had renewed since its effective date. *Id.* at 9. Here, however, the SPD issued in September 2012, well after section 10110.6's effective date. *Orzechowski* is therefore distinguishable, as its timing rationale does not apply to the instant dispute. Moreover, the *Orzechowski* court conceded that section 10110.6 could theoretically apply to summary plan descriptions. *Id.* at *9 n.4. The court recognized that section 10110.6 applies not only to insurance "policies," but also to "'contracts' and 'agreements' that 'fund'" such policies. *Id.* Because a benefits plan "is an agreement to fund" insurance coverage and the summary plan description at issue was a governing document (and therefore part of the benefits plan), the court reasoned that section 10110.6 could apply to the plan description. *Id.* Accordingly, *Orzechowski* does not persuade the Court that section 10110.6 is inapplicable to plan documents.

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clause. *Id.* at 845. With respect to the first prong of the test, the Ninth Circuit found that because ERISA plans "are a form of insurance," the commissioner's disapproval of discretionary clauses "regulates insurance companies by limiting what they can and cannot include in their insurance policies." *Id.* at 842. With respect to the second part of the test, the Ninth Circuit found that the commissioner's practice "remov[ed] the benefit of a deferential standard of review from insurers," leading to "a greater number of claims being paid" and "increasing the benefit of risk pooling for consumers." *Id.* at 845.

Since *Morrison*, district courts have concluded that ERISA does not preempt section 10110.6. *See, e.g.*, *Rapolla*, 13-CV-02860-JST, 2014 WL 2918863, at *6; *see also Gonda*, 11-1363 SC, 2014 WL 186354, at *4 ("The Ninth Circuit has already held that state laws regulating discretionary clauses in insurance policies fall under the savings clause. The Court sees no reason why the result should differ when a state law is directed toward a discretionary clause contained in an agreement or other document relating to the administration of an insurance policy.") The Court agrees and finds ERISA does not preempt section 10110.6.

C. The LTD Policy's Choice of Law Provision Does Not Render Section 10110.6 Inapplicable

Finally, Defendant asserts section 10110.6 does not apply because of the LTD Policy's choice of law provision. (*See* Def.'s Opp'n to Pl.'s MSA at 23–24.) By its own terms, section 10110.6 applies to an insurance policy or agreement that provides or funds disability insurance coverage "for any California resident." Cal. Ins. Code § 10110.6(a). The statute applies regardless of where the policy was offered, issued, delivered, or renewed. *Id.* Here, the parties do not dispute that Plaintiff is a California resident. (Compl. ¶ 2.) Accordingly, section 10110.6 applies to the LTD Policy and SPD, regardless of the choice of law provision, because these instruments were either issued or renewed after that statute's effective date. *See supra* Section VI.A.2.b; *see also Rapolla*, 13-CV-02860-JST, 2014 WL 2918863, at *5 (finding section 10110.6 applied to the insurance policy and benefits plan at issue regardless of the policy plan's choice of law provisions designating Texas as the governing jurisdiction).

The Court recognizes that choice of law provisions in ERISA contracts should be followed so long as they are "not unreasonable or fundamentally unfair." *See Wang*

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Labs., Inc. v. Kagan, 990 F.2d 1126, 1129–30 (9th Cir. 1993). But as Plaintiff's counsel argued at the hearing, the instant dispute does not concern the LTD Policy or SPD's proper interpretation. Rather, the dispute concerns the substantive right of insured Californians to a fair review of claims denials. The California legislature granted this right to "any California resident," regardless of whether the insurance policy was "offered, issued, delivered, or renewed" in California. Cal. Ins. Code § 10110.6(a). The statute reflects the legislature's intent that all Californians benefit from the right to a fair review. *See* Section VI.A.1.a, *supra*. Applying the LTD Policy's choice of law provision would subvert this right and undermine the legislature's intent. Accordingly, the Court concludes section 10110.6 applies, regardless of the choice of law provision.

VI. CONCLUSION

For the foregoing reasons, the Court finds Insurance Code section 10110.6 applies to both the LTD Policy and SPD and renders the discretionary clause in each void. Accordingly, the *de novo* standard of review applies to the denial of Plaintiff's long term disability claim. The Court therefore **GRANTS** Plaintiff's Motion for Summary Adjudication.

IT IS SO ORDERED.

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