THE FUTURE OF THE "ABUSE OF DISCRETION" STANDARD OF REVIEW IN LITIGATION OF ERISA DISABILITY CLAIMS

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1. Background

Justice O'Connor explained in *Firestone Tire & Rubber Co. v. Bruch* that "a denial of benefits challenged under § 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." Since then, the battle has raged. On one side are ERISA claims review fiduciaries, bent on limiting judicial review to a determination of whether the fiduciary abused the grant of discretion in the handling of the claim and/or the decision making process. On the other side are ERISA participants and beneficiaries whose claims have been denied, seeking both the opportunity to argue their claim anew to a jurist, and to introduce supporting evidence that the claim reviewing entity did not possess. Set squarely in the middle of this fray, neither Congress nor the Department of Labor have seen fit to take a position on the appropriateness of a plan administrator granting discretionary authority to an insurer that acts as claims review fiduciary (and, in many instances, as the funding source for the benefit plan as well).

From the perspective of plan sponsors, plan administrators, and claims review fiduciaries, the issue revolves around the resolution of the handful of claims that fall within the murky area between the clearly compensable and the clearly non-compensable. Particularly in the disability context (unlike life insurance coverage), many questionable claims turn on the interpretation of medical, occupational, and/or vocational issues. Plan sponsors that have arranged for claim review and handling by individuals with extensive experience in these areas believe that such expertise is entitled to deference. Moreover, plan sponsors and administrators believe that outsiders such as district court judges, attending physicians and claimant's counsel, while no doubt acting in the perceived "best

interests" of the claimant, lack the knowledge and experience necessary to place the needs of a particular claimant within the appropriate scope of the best interests of the plan as a whole.

Over the last five years, however, state courts and state insurance commissioners have interjected themselves into this issue, coming down squarely in most cases on the side of the individual claimant (who is viewed by these agencies as the "consumer" without regard to whether the individual had any involvement in the creation of the plan or the coverage at issue). States that have previously passed legislation disapproving the use of discretionary clauses in disability insurance policies that act as funding vehicles for ERISA benefit plans include Florida, Illinois, Montana, Oregon, and South Dakota. Utah created an interesting compromise by banning discretionary clauses in benefit arrangements that are not ERISA governed, but specifically allowing them (including approval of certain discretionary language) in ERISA plans. Additionally, the National Association of Insurance Commissioners passed Model Act 42 in 2002 prohibiting the use of discretionary language in health insurance plans, which it later extended to group disability contracts in 2004. More recently, in December 2004 the Hawaii Insurance Commissioner issued Memorandum 2004-13H, opining that discretionary authority constitutes an "unfair or deceptive act[] or practice[] in the business of insurance in violation of HRS § 431:13-102."

2. California

Prior to 2005, several California state court opinions recognized the "abuse of discretion" standard of review without finding any violation of California law. In 2003, State Assembly Member Fran Pavely introduced Assembly Bill No. 1552, which was designed to prohibit the use of discretionary clauses in health insurance contracts. California Insurance Commissioner John Garamendi wrote a letter in support of this bill. However, the bill died in committee.

In February 2004, in response to a letter of inquiry from a noted ERISA claimants' counsel, the California Insurance Commissioner issued an opinion letter stating that discretionary clauses violate the California Insurance Code because they render insurance contracts "unintelligible, uncertain, ambiguous, abstruse, and likely to mislead the insured." Concurrent with the issuance of this opinion, the California Department of Insurance ("DOI") issued a Notice of its Intention to Withdraw Approval of all policy forms containing discretionary clauses, and specifically disapproving group disability insurance policy forms issued by Hartford Life Insurance Company, Metropolitan Life Insurance Company, Provident Life & Accident Insurance Company, and Unum Life Insurance Company of America.Metropolitan Life Insurance Company opted not to challenge the DOI's determination. Unum Life and the Hartford requested an

administrative hearing, and submitted briefing. The American Counsel of Life Insurers, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans all submitted additional information to the Department. By Order dated March 18, 2005, the Administrative Hearing Officer affirmed the Commissioner's Notice and approved withdrawal of the policy forms specified. Interestingly, the Hearing Officer agreed with the insurers that the policy language was not ambiguous or misleading.

The Officer identified two issues: whether the Commissioner had exceeded his authority in withdrawing approval of the policy forms, and whether the forms violated California law. With respect to the first issue, the Officer held that California Insurance Code Sections 10270.9 and 12957 provide the Commissioner with the authority to withdraw approval of group disability policies. The insurers argued that the Notice to Intention to Withdraw Approval constituted an "underground regulation," i.e., the creation of a new insurance law without the benefit of California's administrative procedures as set forth in the Administrative Procedures Act, California Government Code § 11340 et seq. The Officer held that, under *Tidewater Marine Western, Inc. v. Bradshaw*, 14 Cal.4th 557 (1996), there are two tests for whether an agency ruling or directive may be considered a "regulation": (1) the agency must intend the rule to apply generally, rather than in a specific case; (2) the rule must implement or make specific the law enforced or administered by the agency. The Officer held that, because the Notice applied only to Unum, Provident, Hartford, and MetLife, the insurers had not established that the Department intended the rule to apply generally. This ruling is inconsistent with the broad language of the Notice, which was addressed to "All Disability Insurers Doing Business in California" and which discusses the Department's issues with discretionary clauses generally (rather than limiting itself to the specific language used by the targeted insurers). It is also noteworthy that the Department, in its closing brief, "reiterated its longstanding policy of disapproving discretionary clauses and put on notice all disability insurers in California that policies of insurance containing discretionary clauses are subject to withdrawal of approval under the Commissioner's interpretation of California law." *See, e.g.*, California Department of Insurance closing Brief in the Matter of Withdrawal of Policy form Approval for Unum Life Ins. Co. et al., File AHB-PF-04-01 Before the Insurance Commissioner of the State of California, filed 12/13/04. It is clear that the Notice, by declaring that any clause which grants discretion to the insurer renders policies uncertain and misleading, effectively proscribes any and all such clauses. The Officer's conclusion that the Department did not ban discretionary clauses generally is not supported by the record.

With respect to the second issue, the Officer found that discretionary clauses violate California insurance law, specifically California Insurance Code Section

10291.5(b) (13). The Officer concluded that the fact that discretionary language requires a reviewing court to uphold a claims denial absent abuse of discretion creates an uncertainty regarding the participant's rights that renders the policy form ambiguous. The Officer also held that discretionary language creates an ambiguity because the legal effect of the language cannot be understood on its face by the insured. This conclusion is curious in that in *Farrow v. Montgomery Ward*, *supra*, the California Court of Appeal did not find that the policy's discretionary clause rendered the coverage "uncertain" or the policy "ambiguous." The Court had no difficulty in reviewing the claims decision for arbitrariness, which it did not equate with "unfettered" discretion (in the words of the Commissioner). The Court also did not interpret this standard as requiring it to uphold the decision as long as the "insurer has any arguable basis for the denial," as set forth by the Officer. Rather, the California Court of Appeal described the standard as follows:

"To determine whether the action was arbitrary or capricious, we must first decide whether the trustees' decision was supported by substantial evidence. (*LeFebre v. Westinghouse Elec. Corp.*, *supra*, 747 F.2d 197, 204.) 'Substantial evidence, it has been held, is evidence which a reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance. If there is evidence to justify a refusal to direct a verdict were the case before a jury, then there is "substantial evidence.'" *(LeFebre, supra*, at p. 208, quoting from *Laws v. Celebrezze* (1966 4th Cir.) 368 F.2d 640, 642.) The *LeFebre* court also observed that, pursuant to this standard, the scope of review is a narrow one under which the court is *not* empowered to substitute its judgment for that of the plan administrators. (Id., at p. 204) [Footnote omitted.] 'A federal court is to focus on the evidence before the trustees at the time of their final decision and is not to hold a *de novo* factual hearing on the question of the applicant's eligibility. [Citation.]'"--176 Cal.App.3d at 658.

The Hearing Officer cited to *Jordan v. Northrop Grumman Corporation Welfare Benefit Plan*, 370 F.3d 869 (9th Cir. 2004) for the proposition that, under abuse of discretion, a denial of benefits will be upheld unless the decision was not grounded on any reasonable basis. This is an accurate citation of the language of *Jordan*; however, in light of the fact that the Jordan court had no trouble interpreting the policy provisions and making a determination as to the claimant's entitlement to benefits, this opinion does not clarify the manner in which a grant of discretion makes the policy form ambiguous or misleading. Moreover, the Officer's apparent assumption that "any arguable basis" and "any reasonable basis" are synonymous is questionable. At a minimum, it appears that the Officer's conclusion (i.e., that discretionary language violates California law) was reached without the support of California case law and is based upon a flawed

understanding of the nature of discretionary review.

It is generally understood that the *sole* effect of discretionary language is to obtain a more favorable standard of review (for the claims reviewer) of a denial in the event that the participant brings a lawsuit under (a)(1)(B). Because policy forms generally, and the policy forms identified by the Commissioner in particular, do not address the standard of judicial review at all, it is unclear how the impact of the standard of review makes the policy form itself ambiguous and misleading, or how policy rights become uncertain. The participant's right to submit a claim; the conditions that the participant must satisfy in order to obtain benefits; the rights of the participant in the event that the claim is denied (including at least one level of appeal with no deference afforded to the initial decision); and the participant's right to file a lawsuit, are all required by federal law and specified in the policy forms. *See, e.g.*, 29 Code of Federal Regulations § 2560.503-1(d), (h) (in California, participants are also informed of their right to file a complaint with the DOI). The argument that insureds don't know that discretionary language affects the standard of review begs the question of what role, under State law, policy forms are supposed to play in explaining the litigation process. Under this rationale, policy forms could equally be deemed "misleading" for failing to inform claimants that ERISA claims do not entitle the claimant to a jury trial, or failing to explain the remedies available under the statute.

With respect to the issue of ERISA preemption, the Officer acknowledged "[t]here is no dispute here that once a policy form, approved by the California Department of Insurance, becomes part of an ERISA plan, the resolution of disputes arising from the administration of that plan would be governed by Federal ERISA law." However, the Officer concluded that because Insurance Code Sections 10290, 10291.5, and 10270.9 are laws that "regulate insurance" and as such are saved from pre-emption, the Commissioner's action in issuing the Notice pursuant to these statutes is likewise saved from pre-emption. These two points are internally inconsistent. Because the Officer correctly states that the resolution of disputes arising under these policy forms is governed by Federal law, the clarity of the clause under State law is irrelevant. Had the Officer taken Utah's approach of approving the forms for use with ERISA plans but banning their use in connection with non-ERISA plans, the Order would have made sense. However, in light of the fact that the raison d'etre for discretionary language is a higher standard of review under federal law, the notion that the Commissioner's underground regulation does not "relate to" ERISA is disingenuous at best.

The Supreme Court's most recent pronouncement on the issue of ERISA preemption of state insurance law came in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003). In *Miller*, the Court held that in order for a state law to be saved from preemption, "it must

satisfy two requirements. First, the state law must be specifically directed towards entities engaged in insurance. [Citations omitted.] Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured." Id., at 341-342. The insurers argued in the Hearing that, based on the Ninth Circuit's holdings in *Security Life Ins. Co. v. Meyling*, 146 F.3d 1184 (9th Cir.
1998), and *Serrato v. John Hancock Life Ins. Co.*, 31 F.3d 882 (9th Cir. 1994), the statutes at issue are general laws of contract interpretation (even though directed at the insurance industry) and therefore are not laws which "regulate insurance." Unfortunately, the Officer did not address *Meyling* and *Serrato* in the Order. However, four months after the Order, a United States District Court Judge specifically cited Meyling and *Serrato* in holding that Ins. Code § 10291.5 is preempted by ERISA because it does not regulate insurance. *Hansen v. Unum Life Ins. Co.*, 2004 U.S. Dist. LEXIS 22995, *32-34 (E.D. Cal. October 21, 2004):

"The statute before the court illustrates the enormity of the loophole a contrary holding would create. Cal. Ins. Code. § 10291.5(b)(13) provides that the "Insurance Commissioner shall not approve any disability policy for insurance or delivery in this state . . . (13) if it fails to conform in any respect with any law of this state." The Letter Opinion specifically notes that, by virtue of this subsection, California insureds are entitled to all the protections of California law, including "the covenant of good faith and fair dealing, the principles of contract interpretation such as the rule of reasonable interpretation or the law of adhesion contracts under which ambiguities are resolved in favor of the insured." (Letter Opinion at 2.) Many of the protections mentioned, specifically the covenant of good faith and fair dealing and general principles of contract interpretation have been held expressly preempted by ERISA. *See, e.g., Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 494 (9th Cir. 1988) (holding that "California's common law of contract interpretation is not a law that 'regulates insurance,' and therefore is not saved from preemption."); *Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 897 (9th Cir. 1990) (holding that ERISA preempts common law theories of breach of contract implied-in-fact, as well as state claims for breach of implied covenants of good faith and fair dealing); *Serrato v. John Hancock Life Ins. Co.*, 31 F.3d 882, 884 (holding that state law requires insurers to pay benefits to employees with 'vested' rights preempted by ERISA). To hold that a statute such as Cal. Ins. Code 10291.5(b)(13) 'regulates insurance' would permit the legislature to avoid the broad preemptive force of ERISA merely by codifying any generally applicable law within the Insurance Code. [Footnote omitted.] Consequently, like the insurance code provisions held preempted in *Meyling*, § 10291.5 is not "specifically directed toward entities engaged in insurance."

In the omitted footnote, the *Hansen* court declined to specifically address the issue of whether the legislature or the Commissioner "may expressly prohibit insurance

companies from including discretionary clauses in disability insurance policies sold in this state." However, by holding that the statute relied upon by the Commissioner does not "regulate insurance," it is clear that the court has held that this statute is not saved from preemption by ERISA's savings clause. Accordingly, it would appear that under the *Hansen* rationale, any effort to ban discretionary language may not be based on § 10291.5. To the extent that the Commissioner based the Notice to Withdraw on this statute, and the Officer found that this statute is saved from preemption, *Hansen* provides a contrary view.

The following month, a different District Judge reviewing the same issue concluded that ERISA does not preempt § 10291.5. In *Fenberg v. Cowden Automotive Long Term Disability Plan*, 2004 U.S. Dist. LEXIS 22927, * 6-7 (N.D. Cal. Nov. 2, 2004), the Court (without mentioning Hansen) concluded that the savings clause applies to this statute:

"Defendants assert that ERISA preempts the protections under state law asserted by the General Counsel because they are not limited to insurance law; therefore, the state law fails the *Kentucky Association test*. Under the *Kentucky Association* test, a state law avoids preemption by ERISA only if: '1) The state law is specifically directed toward entities engaged in insurance and 2) The state law substantially affects the risk pooling arrangement between the insurer and the insured.' *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-2, 155 L.Ed.2d 468, 123 S.Ct. 1471 (2003).

"The Court finds that ERISA does not preempt California Insurance Code § 10291.5. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386, 153 L.Ed. 2d 375, 122 S.Ct. 2151 (2002) (holding that state prohibition on insurance contract terms granting "unfettered discretion" is not preempted by ERISA). California Insurance Code § 10291.5 regulates the operations of insurance companies and their contractual agreements with customers. It is not a 'general' provision of the law. Therefore, the first requirement of Kentucky Association is met. The law also substantially affects the risk pooling arrangement between the insurer and the insured, which satisfies the second *Kentucky Association* requirement. By preventing discretionary clauses, Section 10291.5 shifts the risk pooling arrangement in favor of the insured because the insurer can no longer review its own decisions on the payment of benefits. This increased oversight over the payment of benefits will lead to increased payments for the insured."

This opinion, like the Order, does not discuss *Meyling* and *Serrato*, or for that matter any other California case law addressing the analysis needed to determine whether a statute "regulates insurance." Moreover, it appears inconsistent in two regards with prior case law addressing the notion of "risk pooling." First, courts have held that the relevant risk is the risk that certain plan participants will need

the plan benefit insured, and that this risk is "pooled" when the insurance is purchased. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130 (1982). As such, any law or regulation that affects subsequent judicial review does not affect the spreading of risk. This has long been one of the bases upon which courts have held that "bad faith" laws, while they may increase the insurers' costs of doing business and/or place an additional burden on insurers to act in good faith, are simply too attenuated to the transfer of risk from insurer to insured which occurs when the policy is issued. Similarly, the statute herein that is being construed to generally ban discretionary language does not increase the number of claims which must be accepted by the insurer (as does the "notice-prejudice" rule from *Ward v. Unum*), or alter the scope of permissible bargains between insurers and insureds (like the "any willing provider" statute in *Kentucky Association*). While it may be true (as posited by Judge Susan Illston in *Fenberg*) that plaintiffs may have more success under *de novo* review than under review for abuse of discretion, neither the Commissioner nor the Officer have demonstrated any evidence establishing that litigation results "substantially" affect the risk pooling arrangement.

Second, the portion of §10291.5 relied upon by the Commissioner states merely that insurers may not sell insurance policies containing clauses that are ambiguous, uncertain, or likely to mislead the insured. A number of courts, construing similar statutes of a general nature, have held that such statutes do not transfer or spread policyholder risk. *See, e.g. Provident Life & Accident Ins. Co. v. Sharpless*, 2004 U.S. App. LEXIS 6937 (5th Cir. 2004) (Louisiana statute barring cancellation of insurance coverage due to non-material misrepresentations held not to spread the risk contracted for); *McGuigan v. Reliance Standard Life Ins. Co.*, 256 F.Supp.2d 345 (E.D. Pa. 2003) (bad faith statute permitting suits for interest and punitive damages does not substantially affect the risk pooling arrangement); *Burgos v. Group & Pension Admin*, Inc., 286 F.Supp.2d 812, 818 (S.D. Tex. 2003) (Texas statute prohibiting illegal insurance practices does not transfer or spread policyholder risk); *Letter v. UNUMProvident Corp*., 2003 U.S. Dist. LEXIS 15884 at *4 (E.D. La.2003) (same regarding Louisiana statute). To the extent that the Officer and the courts have failed to consider this body of case law in addressing the "risk pooling" issue, their analysis is incomplete.

Subsequent to the publication of the Order, two of the affected insurers (Provident Life & Accident Insurance Company and Unum Life Insurance Company of America) reached a global settlement with the California DOI in which, among other things, these insurers agreed to withdraw discretionary language from their policy forms. On April 21, 2005, Hartford Life & Accident Insurance Company filed a Petition for Writ of Mandate/Prohibition in the Superior Court of the State of California in and for the County of San Francisco. That action is currently pending as case number 505218. Hartford sought and obtained a stay of

enforcement of the Order through December 2005, pending the hearing on Hartford's Petition.

The DOI, by letter dated October 3, 2005, scheduled a meeting with all disability carriers doing business in the State, in order to discuss the discretionary clause and other policy provisions that the Department believes violate California law. The meeting was scheduled for November 17, 2005. The industry believes that the Department intends to require all other disability carriers to conform their policies to the agreement between the Department on the one hand, and Unum Life Insurance Company of America and Provident Life & Accident Insurance Company on the other hand, that discretionary language will no longer be enforced.

The courts, in the interim, have held for the most part that the Letter Opinion and the withdrawal of approval of discretionary language apply prospectively only, and do not affect policies that are currently in force. *See Moscowite v. Everen Capital Corp. Grp. Disability Income Plan*, 2005 U.S. Dist. LEXIS 20842 (N.D. Cal. 2005); *Mitchell v. Aetna Life Ins. Co.*, et al., 359 F.Supp.2d 880 (C.D. Cal. 2005); *Firestone v. Acuson Corp. Long Term Disability Plan*, 326 F.Supp.2d 1040 (N.D. Cal. 2004); *Washington v. Standard Ins. Co.*, 2004 U.S. Dist. LEXIS 22975 (N.D. Cal. 2004); *Horn v. Provident Life & Accident Ins. Co.*, 351 F.Supp.2d 954 (N.D. Cal. 2004). *Contra*, *Fenberg v. Cowden Automotive Long Term Disability Plan*, 2004 U.S. Dist. LEXIS 22927 (N.D. Cal. Nov. 2, 2004)

3. The Future

The battle lines are clearly drawn on the issue of discretionary language. Congress and State Legislatures (to the extent that they have not already enacted legislation) appear to have lost interest in this issue. Conversely, at the State Insurance Commissioner level the degree of activity and focus is quite high. The NAIC has communicated an antipathy to discretionary clauses, and its members have picked up the scent.

Federal courts, by and large, do not appear to be convinced by the argument that discretionary clauses violate public policy. They have, for the most part, simply ducked the issue by ruling that the prohibition operates only prospectively and therefore does not affect current cases. As shown above, however, the better reasoned opinions have held that discretionary language does not violate Ins. Code § 10291.5, and that this statute (to the extent that it may be construed to affect the language of ERISA plan documents) is preempted by ERISA. It is expected that Hartford and the Commissioner will obtain a ruling from the San Francisco Superior Court some time in the early Spring of 2006; it is fair to anticipate that the losing party will seek appellate review. While the current California Supreme

Court is fairly construed as being "pro-business," it is not generally considered to be "pro-insurer." Thus, it is less likely that the California state court system will substantially overturn the findings of the Commissioner and the Officer. Should an insurer choose to pursue the preemption question in federal court, it is much more likely that a federal tribunal might find that the statute in question is not saved from preemption by the Savings Clause.

Also, the jurisdiction of the Commissioner is limited to insurance policy forms. Under ERISA, a grant of discretion will be respected as long as it appears in any Plan document. Many sophisticated employers currently prepare and transmit their own summary plan descriptions ("SPDs"). These SPDs inform the employees that the Plan Administrator has granted discretionary authority to the insurers that act as claims review fiduciary. One such example, which is available on the Internet, is the ERISA Summary Plan Description prepared and circulated by the University of Southern California. This document contains information relating to medical, dental, life, and severance pay coverages, and includes the following language:

"Any insurance carrier, as a claims review fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation, and application of the group insurance policy. Any and all of the claim fiduciary's decisions with respect to the group insurance policy shall be conclusive and binding on all persons."

The California Department of Insurance has no ability to regulate the contents of Master Plan documents. As such, these documents are beyond the reach of state regulation. We expect claimants to argue that where the Master Plan document contains discretionary language, and the Plan has purchased an insurance policy that does not, a "conflict" exists between Plan documents, and therefore under *Bergt v. Retirement Plan for Mark Air, Inc.*, 293 F.3d 1139 (9th Cir. 2002), the document more favorable to the claimant controls (at least in the Ninth Circuit). To the extent that defense counsel can convince the Courts that there is no "conflict" when one document addresses a topic and another document is silent on the same topic, sophisticated employers and Plan Administrators may well continue to obtain the abuse of discretion standard of judicial review. Conversely, small employers and Plan Administrators who are less sophisticated, and therefore rely more heavily on their insurance carriers to administer the coverages, may be unable to obtain the higher standard of judicial review.

More than one insurer has remarked that they are simply tired of fighting over the abuse of discretion standard of review. Although on its face the higher standard would appear to favor insurers, it has generated a plethora of opinions, discovery,

and ancillary battles over purported "conflicts of interest." Moreover, a review of published opinions certainly supports the notion that Article III judges will rule in favor of ERISA claimants when they feel that the evidence does not support the denial, without serious regard to the standard of review that applies. To date, we have come across no published opinion in which a court has stated that it is ruling in favor of the Plan because its discretion was not abused, but if the standard were *de novo* the same ruling would favor the claimant. Compare this lack to, for example, the willingness of the courts to criticize the limited scope of ERISA remedies in other contexts. *See, e.g., Bast v. Prudential Ins. Co.,* 150 F.3d 1003 (9th Cir. 1998); *Dishman v. Unum Life Ins. Co., et al.*, 21 Employee Benefits Cases (BNA) 2941 (1997).

While the impact of discretionary language upon judicial review of benefits denials is unclear, the impact upon the evidentiary record has been substantial. Numerous cases have held that under the "abuse of discretion" standard of review the court is limited to the administrative record. This has obviated the need for discovery (other than discovery limited to the "conflict of interest" issue) and for law and motion practice relating to the admissibility of extraneous evidence at trial. It can fairly be expected that elimination in California of the "abuse of discretion" standard of review will lead to a significant increase in the cost of litigating ERISA cases. This would be an unfortunate outcome, particularly in light of ERISA's goal of resolving claims disputes expeditiously and inexpensively. However, it must also be noted that litigation without discovery runs counter to the notion generally held by jurists that wide ranging discovery is the only way that litigants may avoid "trial by ambush."

Contrary to the view of the Commissioner and the Officer, in our view discretionary language neither renders insurance policy forms "ambiguous" nor makes the benefits available "uncertain." Rather, this language serves a valuable purpose in helping to expedite the resolution of benefits litigation. Elimination of this language, and the attendant limits on litigation activity, will have the unfortunate effect of driving up the litigation costs, extending the time from filing the lawsuit to resolution thereof, and increasing the uncertainty of litigation outcomes. Such a result benefits neither policyholders nor claimants. The attorneys may end up driving nicer cars, but the litigants will pay the bill.