BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the matter of Withdrawal of Policy Form Approval for: UNUM LIFE INSURANCE COMPANY OF AMERICA; PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY; HARTFORD LIFE INSURANCE COMPANY; and HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, THE CALIFORNIA DEPARTMENT OF INSURANCE, Respondent.	)	**FILE NO. AHB-PF-04-01**

ORDER ADOPTING PROPOSED DECISION

The proposed decision of Hearing Officer Leslie Tick, dated March 19, 2005, is adopted as the Insurance Commissioner's decision in the above-entitled matter. This order shall be effective on April 22, 2005, unless the affected insurers agree in writing before that date to amend all insurance product forms to delete all discretionary clauses or other language having the same legal effect. Upon such written agreement, this order shall be held in abeyance as to the insurer or insurers agreeing to amend, pending review and acceptance by the Department of Insurance of the amendments. Upon review and acceptance by the Department of Insurance of the amendments, this order shall be vacated as to the insurer or insurers that have had amendments accepted by the Department.

Judicial review of this decision may be had pursuant to Insurance Code sections 10291.5(h) and 12940. Any party seeking judicial review of this decision shall lodge copies of the request for judicial review and the final judicial order on the request for judicial review with the Administrative Hearing Bureau of the California Department of Insurance.

The person authorized to accept service on behalf of the Insurance Commissioner is:

Senior Staff Counsel Darrel H. Woo
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

Dated: March 22, 2005

JOHN GARAMENDI
Insurance Commissioner

By:

/s/
RICHARD D. BAUM
Chief Deputy Commissioner

DEPARTMENT OF INSURANCE
ADMINISTRATIVE HEARING BUREAU
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PROPOSED DECISION

Introduction and Procedural Background

This matter concerns the California Insurance Commissioner's (Commissioner) authority to withdraw approval of certain disability policy forms pursuant to Insurance Code sections 10291.5(f) and 12957.[1]

[1] All further statutory references are to the Insurance Code unless otherwise indicated.

On February 27, 2004, the California Department of Insurance (the Department) issued a Notice to Withdraw Approval (Notice) (attached hereto as Appendix 1) of certain policy forms issued by moving parties Unum Life Insurance Company of America, Provident Life and Accident Insurance Company (Unum), and Hartford Life Insurance Company and Hartford Life and Accident Insurance Company (Hartford) pursuant to sections 10291.5(f) and 12957.

On March 26, 2004, Unum requested a hearing. On March 29, 2004, Hartford requested a hearing.

On April 15, 2004, the California Department of Insurance Administrative Hearing Bureau (AHB) issued a Notice of Hearing and PreHearing Order, which constituted the commencement of the hearing requested by the insurers. The Notice of Hearing allowed for participation of Interested Parties.[2]

In addition to Unum and Hartford, the Department's Notice to Withdraw Approval also names Metropolitan Life Insurance Company. As Metropolitan Life Insurance Company neither objected nor requested a hearing regarding the Notice, its policy forms are already withdrawn and it has no involvement in this matter.

The parties submitted substantial briefing. Rulings were made on proposed exhibits[3], and requests for official notice. Limited factual testimony (Declaration of Robert Quinn, p. 3,

[2] An Order of May 6, 2004 granted Interested Party status to the following: (1) AARP Foundation Litigation; (2) American Council of Life Insurers; (3)Joanna Baida, Beatrice Cherene, Douglas Dobson, Alvin Murphy, Mark Rosten, Gregory Rowe, East Bay Community Law Center, Families USA, and Women's Cancer Resource Center; (4) California Consumer Health Care Council; (5) Douglas deVries; (6) Legal Aid Society-Employment Law Center, Mitzi McKinney, Cynthia Anderson, Katherine and George Alexander Community Law Center; (7) Arnold R. Levinson; (8) Francis Lopes, Barbara Wessman, Barbara Darensbourg-Tillman, Karen Williston, and Cynthia Rodriguez; and (9) Robert K. Scott.

[3] Proposed Exhibits 1-3, 5-9, 100, 102-114, 202, and 306 were admitted into evidence. Proposed Exhibits 308-311 were admitted for the limited purposed that the document was filed in court, and not for the truth of any statements contained therein. Official Notice was taken of Proposed Exhibit 200 and Hearing Officer Exhibit 1.

paragraph 12 – p. 6, paragraph 25) was admitted.[4]

Oral arguments were heard by Hearing Officer Leslie E. Tick on January 12, 2005. Steven Weinstein, Barger & Wolen, argued on behalf of Unum. Pamela Cogan, Ropers, Majeski, Kohn & Bentley, argued on behalf of Hartford. Donald Hilla, California Department of Insurance argued on behalf of the Department. Theresa Renaker, Lewis, Feinberg,Renaker & Jackson, argued on behalf of interested parties Joanna Baida, Beatrice Cherene, Douglas Dobson, Alvin Murphy, Mark Rosen, Gregory Rowe, East Bay Community Law Center, Families USA, and the Women's Cancer Resource Center. John Metz argued on his own behalf and on behalf of the California Consumer Health Care Council. Each side argued for one hour, divided as they saw fit.

None of the parties requested additional briefing.

For the reasons that follow, the Commissioner's Notice is *affirmed* and approval of the policy forms at issue remains withdrawn.

Issue Statements

Did the Commissioner exceed his authority in withdrawing approval of the policy forms listed in the Notice?

Do the policy forms at issue violate California law?

Parties' Contentions

Unum and Hartford contend that the policy forms at issue do not violate California law and that the Commissioner does not have authority to withdraw permission to use such policy forms by a Notice to Withdraw Approval pursuant to sections 10291.5(f) and 12957.

[4] Order re. Motions to Strike Declaration of Charles Hunt, Haavi Morreim, Robert Quinn, Mark Schmidke, October 18, 2004.

The Commissioner contends that the policy forms at issue violate California law. The Commissioner contends that withdrawal of approval of such forms through the Notice is proper.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

There are no factual issues to be determined

The Department agrees with the insurers that the policy *language* itself is not ambiguous or misleading. All issues to be determined in this matter are legal. There are no factual matters at issue that need to be resolved herein.

The policies at issue in this matter and the policies to which this Decision applies, are those listed in the Notice, which is attached as Appendix 1 to this Decision.

The insurers have the burden of proof

As set forth in the Order of September 8, 2004, the insurers, as petitioners, have the burden of proof in this matter. This is not a matter of discipline or license revocation that begins with an accusation and affects someone's right to earn a living. Rather, the insurers here are challenging the Commissioner's decision to withdraw approval of insurance policy forms, a process which is more akin to applying for a business license. In cases both applying for a business license and challenging the revocation of a business license, the burden of proof lies with the applicant (*Hora v. City & County of San Francisco* (1965) 233 CA2d 375, 379 [43 Cal. Rptr. 527]}. Accordingly, as the challenging parties, the insurers have the burden of proof.

The Commissioner has the authority to withdraw a disability policy form after it has been

approved

Disability insurance policy forms are subject to the Commissioner's approval.

> No group disability policy shall be issued or delivered in this state nor…shall an insurer provide or agree to provide group disability coverage until a copy of the form of the policy is filed with the Commissioner and approved by him …

Section 10270.9 (Group disability policy; prerequisites to issuance).

The Commissioner shall not approve *any* disability policy form that he finds misleading or otherwise in violation of California law. It does not matter whether the disapproved policy forms are subsequently sold as individual disability policies, group disability policies, or group disability policies that fund an ERISA[5] plan.

(a) The purpose of this section is to achieve both of the following:

(1) Prevent, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve any disability policy for insurance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(13) If it fails to conform in any respect with any law of this state.

[5] Employee Retirement Income Security Act (ERISA) (29 U.S.C. §1001).

Section 10291.5 (Fraudulent or unsound disability insurance).[6]

The Commissioner has the authority to withdraw approval of any policy form that he could have disapproved at the time of initial submission.

> The commissioner shall not withdraw approval of a policy theretofore approved by him except upon those grounds as, in his opinion, would authorize disapproval upon original submission thereof. Any withdrawal of approval shall be in writing and shall specify the ground thereof. If the insurer demands a hearing on a withdrawal, the hearing shall be granted and commenced within thirty days of filing of a written demand therefore with the commissioner…
>
> This section shall not apply to policies subject to the provisions of subdivision (f) of Section 10291.5[7]…

Section 12957 (Withdrawal of approval of policy form).

The Notice states reasons for the withdrawal that fall within section 10291.5 in subdivisions (b)(1) and (b)(13). Therefore, the Notice properly put the insurers on notice of their right to a hearing for both group and individual disability policies as both sections 12957 and 10291.5(f) were cited in the Notice.

Section 10291.5(f) requires that the notice be in writing and that it specify reasons. The Commissioner has fulfilled those requirements. Section 12957 requires that the notice of withdrawal be in writing and specify grounds. The Commissioner has complied with these requirements as well. See Appendix 1.

[6] Note that sections 10291.5(a), (b)(1) and (b)(13) apply to group as well as individual disability policies. Section 10270.95.

[7] The Commissioner's authority to withdraw approval of policy forms under section 10291.5(f), does not apply to group disability policies (Ins. Code §10270.95). Therefore, section 10291.5(f) gives the Commissioner the authority to withdraw individual disability policies, and section 12957 gives the Commissioner the authority to withdraw approval of group disability policies.

The discretionary clauses cause the policies to be legally ambiguous, uncertain or likely to mislead the insured

The very existence of an insured's "rights" under an ERISA plan depends on the degree of discretion lodged in the administrator. The broader the discretion of the administrator, the less solid an entitlement the insured has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance (*Herzberger v. Prudential insurance Company of America* (7th Cir. 2000) 205 F.3d 327).

This uncertainty, affecting the ability to collect on a policy, is precisely why discretionary clauses make the policies internally inconsistent and therefore misleading and ambiguous. Although the parties stipulate that the *language itself* is not ambiguous or misleading, it is the effect of the uncertainty caused by the discretion that creates ambiguity in the policy as a whole and may mislead the insured as to his or her rights under the policy.

The notice is clear that the policy forms' approval was withdrawn because the discretionary clause contained therein creates a legal ambiguity and is likely to mislead the insured. Although the plain meaning of the words of the discretionary clauses may be clear, the legal effect of that language cannot be understood on its face by the insured, and is therefore in violation of section 10291.5. Neither the employer nor the insured can reasonably know, from the discretionary clause, that except in very limited circumstances, if the insured's claim is denied and the insured tries to make his case in court (a daunting enough proposition) that the appellate courts will give the matter only the most limited review.

Firestone Tire & Rubber Company v. Bruch, (1989) 489 U.S. 101 [109 S.Ct. 948; 103 L.Ed.2d 80] holds that when an ERISA plan administrator has discretionary authority, the usual *de novo* review of a denial of benefits will not apply. The *Firestone* case involved the denial of

severance benefits provided pursuant to an ERISA plan. Although no insurance was involved in *Firestone,* other courts have extended its holding to include ERISA plans that are funded by insurance policies that contain discretionary clause language. There is nothing in *Firestone* that requires insurance policies that fund ERISA plans to include discretionary language.

Unum and Hartford's arguments that the discretionary clauses make no practical difference in the way that they interpret individual claims against their policies makes no difference in this analysis. The fact that the language exists gives them the ability to ignore other policy clauses and to substitute the insurer's judgment for that of treating physicians, for example.

Insurance policies condition the payment of benefits on the occurrence of certain events or conditions. For example, Exhibit 104 at p. 19:

DISABILITY BENEFITS

When do benefits become payable?
You will be paid a monthly benefit if:
1. you become Disabled while insured under this plan;
2. you are Disabled throughout the Elimination Period;
3. you remain Disabled beyond the Elimination Period;
4. you are, and have been during the Elimination Period, under the Regular Care of a Physician; and
5. you submit proof of loss satisfactory to The Hartford.

The presence of the discretionary clause makes the policy benefit rights uncertain; the insurer is ultimately obligated to pay only where its failure to do so amounts to an abuse of discretion. The insured may fulfill the four requirements set forth above, but the insurer, in its discretion, can still deny the claim. The denial will be upheld in court as long as the insurer did not abuse that discretion - that is, as long as the insurer has any arguable basis for the denial.

Under the abuse of discretion standard, where the policy contains discretionary language,

a denial of benefits will be upheld unless the court finds that the decision was not "grounded on any reasonable basis" (*Jordan v. Northrop Grumman Corporation Welfare Benefit Plan,* (9th Cir. 2004) 370 F.3d 869, 875).

> "Conflict of interest," for purposes of determining whether de novo review is appropriate despite an unambiguous conferral of discretion, does not mean that the plan has an interest that conflicts in the ordinary sense of the word with the interest of the claimant. Although an apparent conflict exists where, as here, the insurance policy is both issued and administered by the same party, in order to establish a "serious" conflict of interest -- and thus to substitute a heightened standard of review for abuse of discretion review in ERISA cases -- "the beneficiary has the burden to come forward with material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." Though the claimant obviously has a financial interest in getting the money, while the plan has a financial interest in keeping it, that alone cannot establish conflict of interest in the administrator, because it would leave no cases in the class receiving deferential review under *Firestone*.

Jordan v. North Grumman, supra, 370 F.3d, 869, 875-76.

In sum, discretionary language in a policy has the effect of significantly favoring the insurer and disadvantaging the insured.

<u>The discretionary clause causes the policy to violate California law - section 10291.5(b)(13)</u>

This uncertainty about outcome makes the policy as a whole ambiguous and misleading, in violation of section 10291.5. In eliminating discretionary clauses in disability insurance policies, the Commissioner is fulfilling the statute's direction that he is to assure that all insurance policies can be readily understood and interpreted.

Discretionary clauses cause the policies to violate California law that requires that in the case of any uncertainty, the language of a contract shall be interpreted most strongly against the party who caused the uncertainty to exist. (Civ. Code §1654.) This tenet, *contra proferentem,* is

one of the basic foundations of contract and insurance law. According to the law of California and every other state, ambiguities in insurance contracts must be construed against the insurer (*Kunin v. Benefit Trust Life Insurance Company* (9th Cir. 1990) 910 F.2d 534, 538-39).

> Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. …. an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

(*Ibid.)*

The 9th Circuit ruled later, however, that where an insurance policy contains a discretionary clause, this protection does not apply (*Winters v. Kostco Wholesale Corp.* (9th Cir. 1995) 49 F.3d 550, 554).

Neither the Commissioner's action, nor the California laws upon which he based his action, are preempted by ERISA

The California Department of Insurance examines disability policy forms pursuant to section 10270.9 without knowledge of whether that policy will become part of an ERISA plan or not. There 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 (See *Aetna Health v. Davila*, (2004) –U.S.-, 124 S. Ct. 2488 [159 L.Ed. 312]). While *Davila* reiterates that state law seeking to create new causes of action against ERISA plans are preempted by ERISA, the Commissioner has not created any new causes of action here, and so *Davila* does nothing to change the outcome of the matter at hand.

The regulation of insurance, moreover, is saved from ERISA preemption. The Employee Retirement Income Security Act of 1974 (ERISA) pre-empts all state laws "insofar as they relate to any employee benefit plan," (29 U.S.C. §1144(a)), but saves from pre-emption state "laws …which regulate insurance…" (29 U.S.C. §1144(b)(2)(A)).

State regulation of discretionary clauses is specifically saved from ERISA preemption. "While the statute…undeniably eliminates whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials, this effect of eliminating an insurers' autonomy to guarantee terms congenial to its own interests is the stuff of garden variety insurance regulation through the imposition of standard policy terms" (*Rush Prudential HMO, Inc. v. Moran,* (2002) 536 U.S. 355, 387 [122 S.Ct.2151, 153 L.Ed. 375]).

Although *Kentucky Association of Health Plans, Inc., v. Miller* (2003) 538 U.S. 329, [123 S.Ct. 1471, 155 L.Ed. 468], clarified the sometimes conflicting tests used to determine whether a state law regulating insurance is saved from ERISA preemption, *Kentucky Association* does not change the holding in *Rush Prudential*. The Court held that the Kentucky law at issue, which prohibited health insurers from discriminating against any willing provider, is saved from ERISA preemption because it (1) regulates insurance and (2) it affects the risk-pooling arrangement. "We have never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws…which regulate insurance"…it suffices that they substantially affect the risk pooling arrangement between insurer and insured" (*Kentucky v. Miller, supra,* 538 U.S. 329, 338). The Court found that by expanding the number of providers, the Kentucky law altered that scope. (*Ibid).*

The Court in *Kentucky Association* found that the Kentucky law at issue passed the test and was saved from ERISA preemption because it altered the scope of permissible bargains

between insurers and insureds in a manner similar to the laws upheld in *Unum v. Ward*[8] and *Rush Prudential*[9] Section 10291.5, in mandating that the provisions of a policy may not be uncertain or misleading, both controls the terms of the policy and affects the conditions under which the insurer must pay for the risk it has assumed. Section 10290 requires that insurers file their disability policies for approval, including specification of the risk that is covered. Section 10270.9 requires that group disability policies be filed and approved in advance. Therefore the statutes at issue herein, pursuant to which the Commissioner issued his Notice, are saved from ERISA preemption pursuant to the test set forth in *Kentucky Association.* Those statutes give the Commissioner authority to impact *every* aspect, including the risk written and the scope of permissible bargains between insurer and insured, of the disability insurance policy submitted for his approval. Although the *Kentucky* Court "made a clean break" from the sometimes confusing tests articulated in *Unum*, *Rush* and *Pilot Life*[10] in order for a state law to be saved from ERISA preemption, the Court did not overrule these cases. The insurers' argument that the California law does not meet the two part test in *Kentucky* is unpersuasive.

Insurers cannot be allowed to avoid State regulation by subsequently marketing an approved disability policy form to fund an ERISA plan. The Commissioner regulates all California insurance policies, whether they end up funding an ERISA plan or not. If an approved policy subsequently funds an ERISA plan, that may affect the remedies and forum available to a dissatisfied insured, but it does nothing to affect the Commissioner's ability to

[8] *Unum v. Ward*, (1999) 526 U.S. 358, [119 S.Ct. 1380, 143 L.Ed. 462], found that the Notice prejudice rule was saved from ERISA preemption. The notice prejudice rule governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk it has assumed.

[9] As discussed herein, in *Rush Prudential*, the Court held that State regulation of discretionary clauses is specifically saved from ERISA preemption.

[10] 481 U.S 41 (1987) [107 S.Ct.1549, 95 L.Ed. 39]

regulate, pursuant to California law, the terms of that policy.

The insurers' claim that the Commissioner's action cannot withdraw approval of their policy forms because such action is preempted by ERISA is disingenuous at best. Neither Unum nor Hartford has tried to assert that they need not submit disability policy forms for the Commissioner's approval prior to marketing such policies to fund ERISA plans.

The insurers also cite *Boggs v. Boggs* (1997) 520 U.S. 833, 841 [117 S.Ct. 1754, 138 L.Ed.2d 45], as authority for ERISA having preemptive power over the Commissioner's Notice herein. *Boggs*, however, is not applicable. *Boggs* says that ERISA preempts state laws to the extent that they conflict with ERISA provisions or operate to frustrate its objectives. ERISA, however, does not mandate or even encourage discretionary clauses. ERISA does not even mention discretionary clauses. *Firestone v. Bruch, supra*, (1989) 489 U.S.101, mandates that policies that contain discretionary clauses receive a lesser standard of review on appeal, but neither *Firestone* nor any other case says that insurers are entitled to discretionary clauses or that ERISA mandates their use. It is the insurer's option as to whether or not to include such language in its policies.

The Commissioner has no option – he "shall" not approve a policy form that he determines is in violation of California law (Ins. Code §10291.5(b)). Even if a state regulator's actions, and not just state laws, can be preempted by ERISA, the Commissioner's Notice is "saved" from ERISA preemption per *Kentucky Association*, as discussed above.

<u>The Commissioner's past actions, or lack thereof, regarding disapproval of discretionary clauses is of no consequence.</u>

There was some amount of dispute about whether or not, as the Department argued, it had been disapproving disability policy forms with discretionary clauses since the 1990's, and

that all insurers' policies that had been so disapproved had voluntarily deleted the discretionary language. However, evidence was not taken regarding this dispute because it is irrelevant.

The statute clearly contemplates a situation in which the Commissioner withdraws approval of a previously approved form. It is therefore of no consequence that the policy forms at issue had been previously approved and that other policies containing discretionary clauses had been approved or disapproved in the past. The Commissioner has the authority to withdraw approval of a policy form as long as he could have done so at the time of the initial approval.

The Notice does not constitute a regulation.

There was also dispute as to whether the Notice actually constituted a regulation. The Commissioner, through this Notice, has withdrawn approval of only the policies submitted by the insurers named therein. In order for an agency ruling or directive to be considered a regulation, (1) the agency must intend its rule to apply generally, rather than in a specific case, and (2)the rule must implement, interpret or make specific the law enforced or administered by the agency. "Of course, interpretations that arise in the course of case-specific adjudication are not regulations, although they may be persuasive as precedents in similar subsequent cases." *(Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557,571 [59 Cal.Rptr.2d 186, 927 P.2d 296]). Accordingly, as the Commissioner's Notice applies to those insurers named therein only, the Notice does not constitute an underground regulation. The inclusion of Part II, Order for Information, in the Notice, which orders all insurers to provide data on other disability policies that contain discretionary clauses, is likewise not an underground regulation, as a data request is not a regulation.

No evidence was taken on whether or not, in the past, the Commissioner told other insurers that he would not approve policies containing discretionary clauses and they voluntarily

withdrew that language. It has no bearing in the matter at hand and these insurers have no standing, in this proceeding, to challenge what has happened to other insurers.

Failed legislation to bar discretionary clauses has no bearing on this matter

Unum and Hartford have both provided evidence of various failed federal and state legislative attempts to bar discretionary clauses from insurance policies. There is no way to know what inference should be given to a bill that fails to become law. Unpassed bills, as legislative intent, are of little value (*Grupe Development Company v. Superior Court* (1993) 4 Cal.4th 911, 922-23 [16 Cal.Rptr.2d 226, 844 P.2d 545], see also *Firestone v. Bruch, supra,*, 489 U.S. 101, 114).[11]

The Department and Interested Parties represented by Theresa Reneker submitted National Association of Insurance Commissioners Model Act #42 that would prohibit discretionary clauses in disability policies evidence. Official notice of this exhibit was taken.

[11] Congress' failure to adopt legislation mandating de novo review of ERISA benefits decisions does not imply legislative approval of deferential review.

Again, this is of very little value here, except to show that other state regulators agree that discretionary clauses should not be included in disability insurance policies.

Conclusion

Discretionary clauses have the effect of giving the insurer broad discretion to interpret its own policy provisions, while at the same time offering the narrowest judicial review (insured must show not only that the decision to deny disability claim was wrong, but also that it was unreasonable). For these reasons and the others discussed herein, the Commissioner finds that the discretionary clauses at issue herein make entitlement to benefits uncertain and make the policies that include these clauses legally ambiguous and misleading. Accordingly, the Commissioner's Notice was proper and approval of the policy forms referenced therein is withdrawn.

DETERMINATION OF ISSUES

The Commissioner had the authority to withdraw approval of the policy forms at issue. The insurers failed to meet their burden of proof. The Commissioner's finding that the discretionary clauses made the policies uncertain and ambiguous in violation of section 10291.5, was proper. Sections 10290, 10291, 10291.5 and 12957 are not preempted by ERISA. The Commissioner's Notice, therefore, was proper.

ORDER

Approval of the policy forms listed on the Notice attached as Appendix 1, remains withdrawn.

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I submit this proposed decision on the basis of the record before me and I recommend its adoption as the decision of the Insurance Commissioner of the State of California.

DATED: March 18, 2005

_____/s/_____
LESLIE TICK
Hearing Officer
California Department of Insurance