No. _____

In The

Supreme Court of the United States

RICK V. CALDWELL and SONYA S. CALDWELL,

Petitioners,

vs.

UNUM LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

I. UNUM (and other insurers) asserts ERISA insurers do not have a legal duty to draft unambiguous plans and policies. UNUM then argues that is has discretion to construe any ambiguities in its own favor and courts must affirm these decisions in the name of *Firestone* deference. The 10th Circuit (among others) agreed, at least for insurers whose policy includes a discretionary provision. Does construing ambiguous insurance policy terms against ERISA beneficiaries undermine the purpose of ERISA?

II. If ERISA insurers have a duty to draft unambiguous policies, should courts enforce this duty through the longstanding doctrine of *contra proferentem* regardless of whether or not the insurer has granted itself deference to interpret policy terms?

III. Did Congress intend to create two different classes of ERISA beneficiaries based on whether a plan or policy contained a grant of deference – one with the same substantive rights enjoyed before the creation of ERISA and one with less substantive rights and protections?

IV. Should the 10th Circuit's decision be reversed and judgment entered in favor of the Caldwells?

PARTIES TO THE PROCEEDINGS

Petitioners Rick V. Caldwell and Sonya S. Caldwell were the plaintiffs in the district court proceedings and appellants in the court of appeals proceedings. Respondent Unum Life Insurance Company was the defendant in the district court proceedings and appellee in the court of appeals proceedings.

RELATED CASES

Caldwell v. Unum Life Ins. Co. of Am., No. 16-CV-236-S, United States District Court for the District of Wyoming, Opinion, May 3, 2017

Caldwell v. Unum Life Ins. Co. of Am., No. 2:16-CV-0236-SWS, Opinion, September 21, 2017

Caldwell v. Unum Life Ins. Co. of Am., No. 17-8078, United States Court of Appeals for the Tenth Circuit, Opinion, September 18, 2019

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PETITION FOR A WRIT OF CERTIORARI

Rick V. Caldwell and Sonya S. Caldwell petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Tenth Circuit in this case.

OPINIONS BELOW

The Tenth Circuit's opinion is reported at *Caldwell v. Unum Life Ins. Co. of Am.*, 2019 U.S. App. LEXIS 28000 (10th Cir. 2019) and reproduced at App. 1–20. The Tenth Circuit's denial of petitioners' motion for reconsideration and rehearing *en banc* is reproduced at App. 46. The opinions of the District Court for the District of Wyoming are reproduced at App. 21 and App. 44.

JURISDICTION

The United States District Court for the District of Wyoming had subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1332. On September 21, 2017, the District Court granted Appellee's motion for summary judgment, dismissing Appellants' claims. *See* Doc. 76 [Order]; Doc. 77 [J. Civil Action]. Because the District Court entered final judgment, this Court has jurisdiction pursuant to 28 U.S.C. § 1291. Appellants' timely filed their *Notice of Appeal* to the 10th Circuit on October 19, 2017. *See* Doc. 78. This Petition for Writ

of Certiorari was timely filed within 90 days. This court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

28 U.S.C. § 1291 Final decisions of district courts:

The courts of appeals (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States.

28 U.S.C. § 1331 Federal Question:

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1332 Diversity of citizenship; amount in controversy; costs:

(a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $75,000, exclusive of interest and costs, and is between—

29 U.S.C. § 1022(a) Summary plan description:

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b) [29 U.S.C.S. § 1024(b)]. The summary plan description shall include the information described in subsection (b), shall be

written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1) [29 U.S.C.S. § 1024(b)(1)].

29 U.S.C. § 1001: Congressional Findings and declaration of policy:

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities

of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

29 U.S.C. § 1104 Fiduciary duties:

(a) Prudent man standard of care.

(1) Subject to sections 403(c) and (d), 4042, and 4044 [29 U.S.C.S. §§ 1103(c), (d), 1342, 1344], a fiduciary

shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

> (A) for the exclusive purpose of:
>
> > (i) providing benefits to participants and their beneficiaries; and
> >
> > (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
>
> (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
>
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

29 U.S.C. § 1133(1) Claims procedure:

In accordance with regulations of the Secretary, every employee benefit plan shall—

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied,

> setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and. . . .

29 C.F.R. § 2520.102-2(b) Style and format of summary plan description:

(b) General format. The format of the summary plan description must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

29 C.F.R. § 2520.102-3(l) Contents of summary plan description:

(1) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial,

loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. In addition to other required information, plans must include a summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated; a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan 29 C.F.R. 2520.102-3 on termination of the plan or amendment or elimination of benefits under the plan, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. Plans also shall include a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan. The foregoing summaries shall be disclosed in accordance with the requirements under 29 C.F.R. 2520.102-2(b).

29 C.F.R. § 2560.503-1(b)(5) and (m)(8)(iv) Claims procedure:

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information—

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such

advice or statement was relied upon in making the benefit determination.

STATEMENT OF THE CASE

William Caldwell purchased an accidental death and dismemberment policy[1] from UNUM through his employer Sinclair Refinery. Will died in a one-car accident on a gravel road outside Rawlins, Wyoming. Will was the only occupant. Rick and Sonya Caldwell, his parents and beneficiaries, made a claim on the policy. UNUM's adjuster Tracy McKenzie denied the claim asserting Will was committing a crime when he died by travelling too fast for conditions.

The Caldwells appealed the denial, UNUM ignored their arguments based on common law protections of insureds and maintained the denial because speeding is a misdemeanor in Wyoming. Neither Ms. McKenzie nor Ms. Legendre (who denied the Caldwells' appeal) had any legal training and were not instructed on the legal principles relevant to interpreting ERISA plans or insurance policies.

The Caldwells exhausted their administrative remedies and filed suit in USDC Wyoming. This District Court affirmed UNUM's denial and found the term "crime" to be unambiguous. As such, the District

[1] The Summary Plan Description provided by UNUM was the Policy and Plan. 29 C.F.R. § 2520.102 speaks to the requirement for summary plan descriptions.

Court did not meaningfully address the concept of *contra proferentem*. The 10th Circuit affirmed summary judgment in favor of UNUM, but acknowledged that in light of this Court's decision in *U.S. v. Stitt*, 139 S. Ct. 399, 405 (2018), it could not affirm the opinion based on the District Court's determination that the term "crime" was unambiguous. With that caveat, the majority essentially rubber-stamped the District Court's order. Curiously, despite acknowledging the ambiguity of the policy's crime exclusion, the Circuit Court did not discuss the issue of *contra proferentem*. It therefore refused to answer four of the five issues raised by the Caldwells as well as the following important question:

> If an unbiased, disinterested court undermines ERISA by construing policy terms against a beneficiary, how can a court approve the same decision made by a conflicted insurance company who owes a fiduciary duty of loyalty to beneficiaries?[2] *The end result is exactly the same*. Surely, a fiduciary that undermines the purpose of ERISA acts unreasonably and abuses its discretion.[3] Congress did not intend a futile Act.

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[2] In *Miller v. Monumental Life Ins. Co.*, 502 F.3d 1245, 1254 (10th Cir. 2007), the 10th Circuit held that it would undermine the purposes of ERISA if it construed ambiguous policy terms against the insured beneficiary.

[3] *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 133 (2008).

In reality, a court cannot answer this question without admitting it is a slave to deference even where the result is to undermine the purposes of ERISA.

A. The Accident

On June 28, 2015, Will died in a one-vehicle accident on County Road 605N, a gravel road southwest of Rawlins. There were no other vehicles or witnesses around. According to the initial police report, Will was travelling at 61 MPH in a 30 MPH zone (the speed limit was actually 55). No citation was issued, and the investigator did not suspect drugs or alcohol. The report indicated Will drove too fast for conditions and oversteered/overcorrected; yet, does not explain why Will oversteered—whether it was to negotiate the curve, avoid an antelope, or otherwise. Notably, Will was not fleeing from a bank robbery or evading police nor was he drunk, stoned, or at war.

B. The Policy

The Policy,[4] which provides $250,000 of accidental death coverage, excludes "accidental losses caused by, contributed to by, or resulting from. . . . An attempt to commit or commission of a crime."[5] "Crime" is not defined. The Policy does not exclude coverage for

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[4] The Policy is actually a Summary Plan Description. There is no separate Plan document.

[5] Interestingly, the Policy pays an additional seatbelt benefit; although, not wearing a seatbelt is a "crime" per UNUM. WYO. STAT. ANN. § 31-5-1402(c).

accidental death caused by "the insured's negligence," "any violation of law," "all traffic violations," or "any act classified as a misdemeanor in your state."[6]

C. The Claims Manual

While "crime" is not defined in the Policy, it is discussed in UNUM's Claims Manual.[7] ERISA requires insurers, like UNUM, to establish and maintain reasonable claims procedures. 29 C.F.R. § 2560.503-1(b). These procedures must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in

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[6] The Policy does not exclude coverage for ***illegal acts***, but some policies do. *See Tourdot v. Rockford Health Plans, Inc.*, 357 F. Supp. 2d 1100, 1104 (W.D. Wis. 2005) ("Illegal acts is a simple concept, referring to acts that the legislature has prohibited by law."); *Sledge v. Cont'l Cas. Co.*, 639 So. 2d 805, 812–13 (La. Ct. App. 1994) ("To read 'an act . . . in violation of a law or ordinance' to encompass all breaches of the Highway Regulatory Act . . . would do considerable violence to the obvious intent of the parties to the insurance contract before us, and, in the process, ***reduce indemnity to a mere facade***." (emphasis added)).

[7] The 10th Circuit majority refused to give any meaningful consideration to the Claims Manual even though, ERISA requires administrators to adopt and follow claims procedures, which should assist in uniform application and enforcement. *See* 29 C.F.R. § 2560.503-1(m)(8)(iv). This was error since trust principles instruct "[W]hether a breach of trust has occurred depends on the prudence or imprudence of the trustee's conduct, not on the ***eventual results***. . . ." RESTATEMENT (THIRD) OF TRUSTS § 77 cmt. a (2012). UNUM's failure to consider the Claims Manual was a breach of trust. Further, as the dissent below recognized, it provided compelling evidence of UNUM's intent regarding the meaning of the crime exclusion. Such extrinsic evidence was admissible once the majority determined the crime exclusion was ambiguous.

accordance with governing plan documents and that, where appropriate, ***the plan provisions have been applied consistently***. . . ." *Id.* § 2560.503-1(b)(5). Presumably, this is why UNUM developed a Claims Manual with a crime exclusion section. Yet, the claims department never considered that guidance described below.

Crime Exclusion—Policy

> Our policies generally contain language that excludes disabilities/losses arising out of criminal activity. When administering a crime exclusion, consider the following:
>
> . . . .
>
> "Attempt to commit" or "commission" policy language was intended to exclude disabilities/losses which result from an activity that would typically be classified as a crime (or felony, depending on policy language) under state or federal law.
>
> "Attempt to commit" or "commission" policy language was not intended to apply to activities which would generally be classified as traffic violations.
>
> We will generally exclude benefits on claims where a disability/loss results from the claimant's operating under the influence or driving while intoxicated since these offenses are typically classified as crimes (or felonies, depending on the policy language).

The emphasized language does not reference state law but discusses the *general understanding* of terms. The exclusion was not intended to apply to traffic infractions. This evidences the drafters' intent to give words their generally understood meaning and not look to specific state law.[8]

Nevertheless, UNUM wrote a final denial letter that completely contradicted the Claims Manual, stating "Even if crime were classified as a violation or infraction (rather than a misdemeanor as it is under Wyoming law), it would still be a crime."

D. UNUM Actually Uses the Crime Exclusion to Exclude All Claims Where Its Insured is Negligent.

In a classic example of post-claim underwriting, UNUM's claims department has expanded "crime" to include negligence; thereby significantly increasing the number of accident claims denied and effectively removing ALL single-vehicle accidents from coverage. While the District Court forbid discovery designed to flesh this topic out, we have one example.

In 2014, Tracy McKenzie paid an AD&D claim where a Texas insured failed to yield to a tractor trailer, was involved in an accident, and died. She was criticized for missing that the insured was the driver and she failed to obtain a toxicology screen. More

[8] Compare *Harrison v. UNUM*, 2005 U.S. Dist. LEXIS 6292 (D.N.H. Apr. 11, 2005) where UNUM argued state law definitions are irrelevant (there DUI was an infraction, not a misdemeanor).

importantly, she did not appreciate the insured was *at fault* for failing to yield. When UNUM evaluated her performance on that claim, she received a low score because of these failures. This was just two months before Will's accident. Ms. McKenzie exercised sound discretion in the Texas case by paying the claim where the insured was involved in an accident. Yet, she was chastised for not following UNUM's unwritten internal claims rule to deny all claims where the insured was negligent and the negligence was a cause of the accident, among other things. Obviously, in traffic accidents, negligence is determined by breaching some duty described in a state's traffic statutes. She was sure not to make the same "mistake" in the Caldwell claim.

ARGUMENT AND REASONS FOR GRANTING THE WRIT

A. Summary of Argument

Prior to the adoption of ERISA, *contra proferentem* (or construing ambiguities against the drafter) was the primary means by which courts protected the rights of insurance policy holders. In particular, the doctrine enforced the requirement that insurers draft unambiguous policies in language that normal people can understand. In fact, "*contra proferentem* has been described as 'the first principle of insurance law.' "[9] In 1990, the 10th Circuit adopted it as part of the federal

[9] JEFFREY E. THOMAS & FRANCIS J. MOOTZ, III, APPLEMAN, ESSENTIALS OF INSURANCE LAW, § 5.5 (LexisNexis, 2019).

common law of ERISA explaining "Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule."[10]

Indeed, Congress did not repeal *contra proferentem* or any of the common law duties imposed on insurers when it enacted ERISA. To remove such protections would have been wholly inconsistent with its stated objectives in 29 U.S.C. § 1001, which was summarized by this Court as "Congress' desire to offer employees enhanced protection for their benefits."[11] As a result, this court recognized in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) that any standard or policy that "afford[ed] less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted" was inconsistent with congressional intent and could not stand. *Id.* at 114.

Nevertheless, lower courts have used the standard as the basis to abrogate well-established common law protections enjoyed by insureds. It is important to keep in mind the two roles played by insurers in many ERISA claims. As the insurance underwriter, the insurer drafts and sells the policy. In this role, insurers owed various common law duties relating to the drafting of such policies. Breach of these duties was typically via *contra proferentem*.

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[10] *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (10th Cir. 1990).

[11] *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 114 (2008). *See also* 29 C.F.R. § 2520.102-2(b) and 102-3(l).

After ERISA some insurance adjusters also became so-called "claims fiduciaries" and, particularly after the *Firestone* decision, the insurance policies gave these adjusters discretion to interpret policy terms. But a grant of discretion cannot include license to ignore governing law, especially when the legal principle at issue serves the same basic purpose as ERISA—to protect insured beneficiaries' rights. "A mistake of law, it bears recalling, amounts to an abuse of discretion."[12] A claims fiduciary who ignores *contra proferentem* has, by definition, abused her discretion. Yet, the Circuits hold otherwise.

Lower courts simply overlook the instruction about giving too much weight to trust principles and deference. "Although trust law may offer a 'starting point' for analysis in some situations, it must give way if it is inconsistent with 'the language of the statute, its structure, or its purposes.'" *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999). This is not a unique or novel concept.

No one seriously disputes that "Failure to employ *contra proferentem* would 'afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted, a result that would be at odds with the congressional purposes of promoting the interests of employees and beneficiaries and protecting

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[12] *See*, *e.g.*, *Pierce v. Wyndham Vacation Resorts, Inc.*, 922 F.3d 741, 745 (6th Cir. 2019) (citing *Koon v. United States*, 518 U.S. 81, 100, 116 S. Ct. 2035, 135 L. Ed. 2d 392 (1996)); *Correia v. Fitzgerald*, 354 F.3d 47, 54 (1st Cir. 2003).

contractually defined benefits.' "[13] Nevertheless, following *Firestone*, the lower courts decided that the concept of *Firestone deference* meant they had to judicially abrogate the common law protections that protected the rights of insureds in ERISA cases where the insurer included a grant of deference in its policy. All of the Circuits, with some limited exception in the 5th, now find that the doctrine of *contra proferentem* is incompatible with deferential review *even though* it leaves some ERISA beneficiaries with less protection than they enjoyed before ERISA was enacted. Only this Court can correct this grave error. This is especially important where, as here, the policy was purchased by the insured—not the employer.[14]

Incredibly, all of this has led to the point where UNUM, reportedly the top disability insurer in both the U.S. and U.K., actually argued in its 10th Circuit brief that ERISA insurers do *not* have a legal duty to draft unambiguous policies. As a result, from a very realistic standpoint, millions of American employees find themselves in a position where an insurer can draft

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[13] *Miller v. Monumental Life Ins. Co.*, 502 F.3d 1245, 1254 (10th Cir. 2007).

[14] This further calls into question the reliance on trust principles in cases where the employer did not purchase the policy for the employee or otherwise fund the benefit plan. This policy is just a simple group insurance policy offered through the employer. If we try to pigeon hole this specific scenario into trust principles, each participating employee is both the settlor and the beneficiary, which makes no sense. Asking an insured to grant the insurer discretion to abrogate important legal protections is unconscionable on its face.

ambiguous policies, grant itself discretion to interpret the policy terms, and then make a decision in its own favor with near impunity.

And it has a real impact in this case and elsewhere. It is not far-fetched to suggest that in every case, in every state and federal jurisdiction, an insured would prevail on a claim with facts similar to those here just so long as the policy at issue was not an ERISA policy where the insurer had discretion to interpret policy terms. Surely Congress did not intend to grant insurers such a disproportionate and unconscionable advantage over American employees.

Yet, that is exactly where many beneficiaries across the country find themselves—less protection for their benefits because of ERISA. Given the current state of the law, only this Court can correct this injustice.

B. The Importance of *Contra Proferentem*, the First Principle of Insurance Law.

For over a century, courts have faced the challenge of how to interpret insurance policies and adequately protect insureds from any unconscionable advantage insurers may reap from drafting an extremely technical document that most people simply cannot understand.[15] On one hand, an insurance policy is a contract

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[15] *See generally* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES 628–29 (West Pub., 1988) and JEFFREY E. THOMAS & FRANCIS J. MOOTZ, III, APPLEMAN, ESSENTIALS OF INSURANCE LAW, § 5.01-5.08 (LexisNexis, 2019), Chapter 5.

such that a court's goal should be to determine the intent of the parties from the four corners of the document. Early on, however, courts realized this approach was insufficient as insureds generally do not have the control, information, expertise, or knowledge to form such intent.[16] Moreover, insurance policies are rarely negotiated and do not represent a meeting of the minds. Rather, they "are almost always standardized forms offered on a take-it-or-leave basis, an archetypal example of an 'adhesion contract.' "[17] As a result, courts developed a set of rules, duties and doctrines designed to level the playing field.

Contra proferentem or construing ambiguities against the drafter was "one of the first, and continues to be one of the most widely used, approaches which courts employ to ameliorate harsh effects that would otherwise result from insurance policy terms."[18] "The canon *contra proferentem* is more rigorously applied in insurance than in other contracts in recognition of the difference between the parties in their acquaintance with the subject matter."[19] In insurance law, "it is used as a primary rule (perhaps even *the* primary rule) of interpretation for insurance policies."[20]

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[16] JEFFREY E. THOMAS & FRANCIS J. MOOTZ, III, APPLEMAN, ESSENTIALS OF INSURANCE LAW, § 5.5 (LexisNexis, 2019)

[17] *Id.*, supra, at § 5-4.

[18] ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES 628–29 (West Pub., 1988).

[19] *Gaunt v. John Hancock Mut. Life Ins. Co.*, 160 F.2d 599, 602 (2d Cir. 1947).

[20] APPLEMAN, *supra* § 5.02.

C. Courts Must Apply *Contra Proferentem* in ERISA Cases to Fulfill Congress' Intent to Protect Beneficiaries' Contractually Defined Benefits.

In 1990, the 10th Circuit explained that *contra proferentem* should be applied in ERISA cases as well.

> As we noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason. 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. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; 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. Were we to promulgate a federal rule, we would find these common-sense rationales sound. ***Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule.***

Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 540 (10th Cir. 1990) (emphasis added). Undoubtedly, similar passages can be found in other circuits. Seventeen years later the 10th Circuit quoted this passage with approval and further explained

> Strictly construing ambiguities against the drafter comports with our precedent. Our court has ***never*** construed the ambiguities of an ERISA plan against a beneficiary. **Doing so would undermine the policies underlying ERISA**, which Congress enacted "to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits." ERISA also gives significant benefits to providers by preempting many "state law causes of action . . . which threaten considerably greater liability than that allowed by ERISA." In light of the Act's balancing of interests, "[a]ccuracy [in drafting] is not a lot to ask. And it is especially not a lot to ask in return for the protections afforded by ERISA's preemption of state law causes of action."
>
> Failure to employ *contra proferentem* would "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted, a result that would be at odds with the congressional purposes of promoting the interests of employees and beneficiaries and protecting contractually defined benefits."

Miller v. Monumental Life Ins. Co., 502 F.3d 1245, 1254 (10th Cir. 2007) (alterations in original) (citations omitted). Simply put, "strictly construing ambiguous

terms presents ERISA providers with a clear alternative: draft plans that reasonable people can understand or pay for ambiguity."[21]

Incredibly, despite the soundly reasoned and emphatic language of the *Miller* court, the 10th Circuit (and others) somehow summoned the requisite degree of "arrogance" to judicially abrogate the 'first principle of insurance law.' Somehow, it became permissible to afford less protection to *some* employees and their beneficiaries than they enjoyed before ERISA was enacted, *even though* that result that was at odds with the Congressional purposes of promoting the interests of employees and beneficiaries and protecting contractually defined benefits.

The Circuits who have judicially abrogated *contra proferentem* in the name of deference do so via the misinterpretation and misapplication of this court's decisions in *Firestone*[22] and *Glenn*.[23] Neither case instructs the lower courts to abrogate this doctrine. Neither case even suggests that the standard of review should trump the substantive protections intended by Congress and provided for decades by the common law. Rather, this Court provided guidance and caution

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[21] *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789, 805 (10th Cir. 2010); *see also Kellogg v. Metro Life Ins. Co.*, 549 F.3d 818, 829–30 (10th Cir. 2008). While *Kellogg* found procedural irregularities sufficient to employ *de novo* review in a case where discretion was granted, the court did not have to resort to *contra proferentem* to find for the beneficiary.

[22] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[23] *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

that, if employed, should not have resulted in a situation where millions of ERISA insureds enjoy less protection that they did before ERISA was enacted.

D. Purposes of ERISA.

Congress enacted ERISA "'to promote the interests of employees and their beneficiaries in employee benefit plans' and 'to protect contractually defined benefits.'" *Firestone*, 489 U.S. at 113 (emphasis added) (citations omitted). Courts recognize other competing policies to justify deference, including a desire to encourage employers to offer benefit plans and a need to avoid complex review procedures, which also allows employers to administer their own plans. While these goals are laudable, the *Glenn* Court warned lower courts not to overemphasize these considerations at the expense of Congressional intent. **"As to all three taken together, we believe them outweighed by 'Congress' desire to offer employees *enhanced* protection for their benefits.'"** *Glenn*, 554 U.S. at 113 (citation omitted). These are important guiding principles as courts develop ERISA common law, but rarely followed by the lower courts where deference typically eviscerates all other principles.

Obviously, Congress knew insurance law incorporated the doctrine of *contra proferentem* when it adopted ERISA. There is nothing in the act that authorizes courts to discard this important principle. It is the primary tool available to enforce the requirement to draft unambiguous policies, to use language that can be understood by the reasonable insured, to

combat unconscionability and overreaching, and to protect the reasonable expectations of the insured. 29 C.F.R. § 2520.102-3(l). In fact, Congress *extended* the requirement to draft unambiguous terms to Summary Plan Descriptions. 29 C.F.R. § 2520.102-2(b).[24]

Importantly, the *Glenn* Court[25] recognized Congress wanted to ***enhance*** protections, not just maintain and enforce those already in place. This was not new. Any standard or policy that "afford[ed] less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted" was inconsistent with congressional intent and could not stand. *Firestone*, 489 U.S. at 114.

No one disputes that "Failure to employ *contra proferentem* would 'afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted, a result that would be at odds with the congressional purposes of promoting the interests of employees and beneficiaries and protecting contractually defined benefits.'"[26] Lower courts often times pay lip service to various rules of interpretation, but only enforce them in *de novo* cases.[27] Yet, the

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[24] These regulations on SPDs apply here since the SPD is the policy.

[25] *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

[26] *Miller*, 502 F.3d at 1254 (quoting *Masella v. Blue Cross & Blue Shield of Conn., Inc.*, 936 F.2d 98, 107 (2d. Cir. 1991) (internal quotation marks omitted)).

[27] Insurance policies are also contracts, but because they are adhesion contracts, the common law developed special rules to offset the unequal bargaining power. *Kellogg*, 549 F.3d at 829–30.

lower courts routinely fail to enforce the doctrine when reviewing for an abuse of discretion. What makes this even more puzzling is that a mistake of law is tantamount to an abuse of discretion.[28] Yet, in these cases, discretion allows the insurer to ignore the law.

Congress knew the state of existing contract and insurance law when it enacted ERISA. Congress knew how the common law enforced failures to draft

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Terms must be interpreted in the proper context. If a word has two meanings, but only one satisfies the context requirement, then the term is unambiguous and there is no need to strictly construe it against the drafter. *See Atain Specialty Ins. Co. v. Tribal Constr. Co.*, 912 F. Supp. 2d 1260, 1268 (W.D. Okla. 2012) ("The test for ambiguity is whether the language 'is susceptible to two interpretations on its face . . . from the standpoint of a reasonably prudent layperson, *not from that of a lawyer*.' " (emphasis added) (alterations in original) (citations omitted)).

"These rules of construction apply equally to ERISA cases governed by federal common law." *Kellogg*, 549 F.3d at 830. "[F]ederal common law—from *pre-Erie* diversity cases to present day ERISA cases—focuses upon the expectations and intentions of the insured." *Id.* (alterations in original) (citation omitted). "[T]he Supreme Court has directed us to interpret an ERISA plan like any contract, by examining its language and determining the intent of the parties to the contract." *Fulghum v. Embarq Corp.*, 778 F.3d 1147, 1153–54 (10th Cir. 2015) (citation omitted).

One of the chief goals of accident insurance is to protect insureds from the effects of their own acts. Even if an accident results from the insured's own fault, the insured still expects to receive coverage. *See LaAsmar*, 605 F.3d at 811 ("The insurer assumes the risk of the insured's negligence."); *Van Riper v. Constitutional Gov't League*, 96 P.2d 588, 591 (Wash. 1939).

[28] *See*, *e.g.*, *Cardoza v. United of Omaha Life Ins. Co.*, 708 F.3d 1196, 1201–02 (10th Cir. 2013) (emphasis added) (quoting *Graham v. Hartford Life & Accident Ins. Co.*, 589 F.3d 1345, 1357 (10th Cir. 2009)).

unambiguous policies and did nothing to abolish these protections in the ERISA text. Of course, that would be an odd step to take when unequivocally trying to protect contractual rights. Nor did Congress mandate deferential review or even discuss the concept. Sensibly, the protections that insureds enjoyed before ERISA should be available to ALL employees and apply to ALL plans.

E. The Standard of Review Cannot Undermine the Purpose of ERISA.

Congress did not include a standard of review in ERISA. *See Firestone*, 489 U.S. at 108–09. Because Congress incorporated the language of trust law into various sections of the Act, especially with respect to fiduciary duties, the courts chose to borrow trust principles when deciding ERISA actions. Obviously, the development of the common law must bear in mind the special nature and purpose of ERISA plans. *See*, *e.g.*, *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). "We also recognize, however, that trust law does not tell the entire story. After all, ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection." *Varity*, 516 U.S. at 497. "Although trust law may offer a 'starting point' for analysis in some situations, it must give way if it is inconsistent with 'the language of the statute, its structure, or its purposes.'" *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999).

Deferential review serves the following policy objectives, (1) avoid complex review proceedings,[29] (2) a desire not to deter employers from creating benefit plans,[30] and (3) ERISA's provision that allows employers to administer their own plans, which implicates objectives such as predictability and consistency. *Glenn*, 554 U.S. at 113. While these objectives are important, the *Glenn* Court also held, "[a]s to all three taken together, we believe them outweighed by 'Congress' desire to offer employees enhanced protection for their benefits.'" *Id*. at 113–14 (quoting *Varity*, 516 U.S. at 497 (discussing "competing congressional purposes" in enacting ERISA)). Simply put, "[w]e need not follow trust law principles where trust law is 'inconsistent with the language of the statute, its structure, or its purposes.'" *Glenn*, 554 U.S. at 113 (citation omitted).

What is puzzling is why courts treat discretionary review as if it is the be-all-end-all of ERISA jurisprudence.

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[29] There is no evidence that applying insurance rules would make review proceedings more complex nor would it require more discovery since interpreting a contract is a question of law. If anything, it would simplify the proceedings because insurers would draft understandable policies in the first instance.

[30] Logically, this is *not* an important factor when the relevant portion of the plan is funded by employees who pay insurance premiums and benefits are paid by the insurer. In reality, this AD&D policy is not at all different from any insurance policy except that it is offered at the workplace.

F. The Many Differences Between Trusts and Insurance Policies.

There are many differences between trust law and insurance law. Consideration of these differences shows that deferential review should not change the substantive law applicable to insurers and insurance policies.

1. Trusts are not a bargained for exchange, it does not require a meeting of the minds, there is no mutual consideration, and no reason for the beneficiaries to have a reasonable expectation of anything. Insurance policies are governed by a wholly different set of facts and circumstances.

2. Trust law does not impose a duty on the settlor to draft unambiguous trusts. Insurance law imposed such a duty on insurers before ERISA and still does. In fact, Congress extended the requirement to Summary Plan Descriptions.

3. Settlors are motivated to draft unambiguous trusts because they want the trust proceeds to be distributed according to their wishes. There is nothing to gain by using ambiguous terms. Insurers may benefit from ambiguities in the absence of *contra proferentem*.

4. Trust documents are not interpreted from the standpoint of the reasonable beneficiary. Insurance policies are interpreted in accordance with the understanding a reasonable insured would give the terms.

5. Trust law is concerned with giving effect to the intent of the settlor. Contract law is concerned with enforcing an agreement between two or more parties and, in cases involving insurance policies, protecting the reasonable expectations of the insured.

6. Trust law is not concerned with unequal bargaining power between the settlor and beneficiaries. As such, there is no need to level the playing field. Insurance law is very concerned.

7. Trust law does not construe ambiguous trust terms against the settlor, which would undermine the law of trusts. Insurance law does not construe ambiguous policy terms against the insured, which would undermine the law of insurance.

8. The trustee rarely, if ever, has the burden of proof in a dispute between beneficiaries and the trustee over the operation of the trust provisions. In insurance law, insureds must prove a loss falls within the insuring clause, but insurers must prove the applicability of an exclusion. Plus, insuring clauses are construed broadly and exclusions are interpreted narrowly.

9. Settlors choose a trustee that they believe will distribute proceeds in accordance with their wishes. They expect the trustee to discharge her duties accordingly. They expect the trustee to seek court guidance if there is truly an ambiguous term. Insurers want the freedom to interpret policy terms to their own

> advantage. *Contra proferentem* has never been popular among insurers.
>
> 10. Where the insured pays the insurance premium, the insured essentially becomes both the settlor and the beneficiary. In reality, this is just another group insurance policy. It is unclear how trust principles can or should apply in such cases.

Simply put, while there is some overlap in trusts and self-funded employee benefit plans, the difference between a trust and an insurance policy is much more pronounced. If beneficiary rights are to be protected, the law governing insurance policies must remain intact. While this Court approved the continued use of trust principles in ERISA insurance cases, it never held the standard of review abrogated duties imposed on insurers or rendered all insurance law inapplicable. Indeed, *Glenn* reaffirmed the proposition that trust law may not provide the answers in all situations and that insurers are held to higher-than-marketplace standards.

This does not mean deference must be abandoned in cases involving insurance policies, but that a claims administrator never has the discretion to ignore insurance law that provides protection for insured beneficiaries. There are still many aspects of the claims review process, particularly with respect to fact finding, where deferential review may be appropriate.

Of course, it is unrealistic to expect any insurer to construe ambiguous policy terms against itself. Rather,

acknowledging the need for *contra proferentem* will again encourage ERISA insurers to draft unambiguous policies. Additionally, knowing that *contra proferentem* is available will encourage insurers to draft claims manuals that explain to lay adjusters how terms are intended to be interpreted. More importantly, it will encourage claims departments to follow such guidance when it is available. Making objectively fair claims decisions instead of post-claim underwriting should reduce rather than increase resulting litigation.

CONCLUSION

The common law recognized the need to protect the rights of insureds long before Congress enacted ERISA. The use of *contra proferentem* is perhaps the most important tool in that regard. With the knowledge of the existing protections for insureds afforded by the common law, Congress enacted ERISA with a desire to not just preserve, but to enhance those existing protections. For that reason, neither Congress nor this Court has evidenced an intent to abrogate *contra proferentem* and thereby leave some insured beneficiaries with less protection than they enjoyed before ERISA. Yet, the Circuits have held otherwise and approved claims decisions that undermine the purpose of ERISA all in the name of deference. This works a grave injustice on millions of beneficiaries and turns ERISA into an Act that benefits only insurance companies at the expense of American workers. Because this

error has been so pervasive, only this Court can prevent further usurpation of Congressional intent.

For the foregoing reasons, the Court should grant a writ of certiorari.

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Respectfully submitted,

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