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SUBCHAPTER M. DISCRETIONARY CLAUSES
28 TAC §§3.1201 – 3.1203

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts new Subchapter M, §§3.1201 - 3.1203, relating to discretionary clauses in insurance policy forms and health maintenance organization (HMO) evidence of coverage forms. Sections 3.1201 – 3.1203 are adopted with changes to the proposed text published in the June 4, 2010 issue of the *Texas Register* (35 TexReg 4585).

2. REASONED JUSTIFICATION. The new subchapter prohibiting the use of discretionary clauses in certain insurance policy forms and HMO evidence of coverage forms is necessary to protect insurance and HMO consumers from the possibility of incorrect and unfair coverage determinations by insurers and HMOs (carriers) without a subsequent opportunity for a full and independent review under a non-deferential standard. Discretionary clauses are contractual provisions that purport or act to reserve for carriers the discretion to interpret the terms of an insurance contract or HMO evidence of coverage and alter the judicial standard of review upon appeal. For instance, a health insurance form reviewed by the Department contained language stating “[w]e have complete discretionary authority, subject to Texas and Federal law, to review all denied claims for benefits under this policy. In performing its review, [w]e shall have discretionary authority to determine whether and to what extent [employees] and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this policy.” A disability income insurance policy reviewed by the Department stated:

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Except for those functions which this Policy specifically reserves to the Policyholder or Employer, the Company has sole authority to manage this Policy, to administer claims, to interpret Policy provisions, and to resolve questions arising under this Policy. The Company's authority includes (but is not limited to) the right to: 1. establish and enforce procedures for administering this Policy and claims under it; 2. Determine Employees' eligibility for insurance and entitlement to benefits; 3. Determine what information the Company reasonably requires to make such decisions; and 4. Resolve all matters when a claim review is requested. Any decision the Company makes in the exercise of its authority shall be conclusive and binding.

Another disability income insurance policy reviewed by the Department contained the statement that "benefits under this Plan will be paid only if the Plan Administrator or its designee (including [the insurer]), decides in its discretion that the applicant is entitled to them."

The Employee Retirement Income Security Act (ERISA) is located at 29 U.S.C. §§1001 *et seq.* The United States Supreme Court has specified that in appeals of coverage determinations governed by the Employee Retirement Income Security Act (ERISA), the appropriate standard of review is *de novo* unless the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms, in which cases a deferential standard of review is appropriate. *Firestone Tire & Rubber Co v. Bruch*, 489 U.S. 101, 115 (1989). The Department's position is that a carrier may have a conflict of interest in coverage determinations resulting in adverse financial consequences to the carrier, and therefore it is of vital importance to ensure that insureds and enrollees are provided an opportunity for a full benefit determination review by an independent decision maker. Carriers may have a conflict of interest in coverage determinations because they may result in adverse financial consequences for their company. See *Metropolitan Life Ins. v.*

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Glenn, 554 U.S. 105, 108 (2008):

Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case.

Because a carrier may have a conflict of interest in coverage determinations, it is possible that such decisions may result in unfair and inequitable outcomes for insureds and enrollees. Carriers using discretionary clauses may then unfairly benefit from a deferential appellate standard of review should an insured or enrollee choose to seek judicial review of the coverage determination. In light of the United States Supreme Court opinion in *Firestone*, the use of a discretionary clause by a carrier in a coverage determination governed by ERISA has the effect of changing the appellate standard of review from *de novo* to “arbitrary and capricious”. A *de novo* standard of review allows for a full independent examination of claim determinations without affording deference to a carrier’s determination. See *Firestone*, 489 U.S. at 113 (“The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefits plans prior to the enactment of ERISA. Actions challenging an employer’s denial of benefits . . . were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee’s claim as it would have any other contract claim — by looking at the terms of the plan and other manifestations of the parties’ intent.” (citations omitted)); and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 – 386 (2002).

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("Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the [ERISA] statute was silent, we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion Nothing in ERISA, however, requires that these kinds of decisions be so "discretionary" in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract." (citations omitted)); *c.f. Pierre v. Conn. Gen. Life Ins. Co.*, 932 F.2d 1552, 1553 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991) (holding that *Firestone* does not require *de novo* review for factual determinations). By contrast, an "arbitrary and capricious" appellate standard of review is a less detailed and more deferential review. *See Meditrust Financial Services Corp. v. Sterling Chemicals, Inc.*, 168 F.3d 211, 215 (5th Cir. 1999) ("When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence. A decision is arbitrary only if "made without a rational connection between the known facts and the decision or between the found facts and the evidence." (citations omitted)). Some courts appear to have interpreted the arbitrary and capricious standard in a manner that virtually eliminates all judicial review of a carrier's claim determination. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1050 (7th Cir. 1987); and *Graham v. L&B Realty Advisors, Inc.*, 2003 WL 22388392 at 1 and 4 (N.D. Tex. Sept. 30, 2003) (holding that if an insurer's decision is

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based on “some concrete evidence in the administrative record” it will not constitute an abuse of discretion, and recognizing that *de novo* review would have led to a different result); see also *Burton v. UNUM Life Insurance Co. of America*, 2010 U.S. Dist. LEXIS 58267 at 35 (D. Tex., W.D. 2010) (noting that the overall record plainly indicated that the insured had suffered from bipolar disorder since at least 2004 but upholding UNUM’s claim determination because the terms of the policy had not been adhered to by the insured, even though the non-compliance was arguably a symptom of the illness). The Department’s position is that a full review by an independent decision making body is necessary because of the potential conflict of interest by the carrier making the coverage determination.

Discretionary clauses are unjust, encourage misrepresentation, and are deceptive because they mislead consumers regarding the terms of the coverage. For example, a consumer could reasonably believe that if they are disabled, they will be entitled to benefits under the policy and will be able to receive a full hearing to enforce such rights in court. Instead, a discretionary clause permits a carrier to deny disability income benefits even if the insured or enrollee is disabled, provided that the process leading to the denial was not arbitrary or capricious. See *Graham*, 2003 WL 22388392 at 4; accord *Burton*, 2010 U.S. Dist. LEXIS 58267 at 35.

The applicability of the adopted rule extends beyond ERISA cases because the Department’s position is that a discretionary clause affects outcomes even in cases not governed by ERISA. As they pertain to non-ERISA cases, discretionary clauses are unjust, deceptive and encourage misrepresentation regarding the rights of the insured

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or enrollee. Discretionary clauses are unjust because they reverse the longstanding Texas common law doctrine that ambiguities in insurance contracts should be construed in favor of the insured. The Texas Supreme Court has repeatedly upheld this common law doctrine. See *Fiess v. State Farm Lloyds*, 202 S.W.3d 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.*, 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters*, 545 S.W.2d 755, 761 (Tex.1977); and *Continental Cas. Co. v. Warren*, 254 S.W.2d 762, 763 (Tex.1953). This common law doctrine also promotes the public policy of encouraging contract drafters to avoid ambiguities and to be as specific as necessary in avoiding legal disputes stemming from vague contractual language. Discretionary clauses encourage misrepresentation by portraying a carrier's determination of coverage as binding or mandatory. Because insureds and enrollees have the right to seek judicial review of a carrier's coverage determinations, a provision stating otherwise encourages misrepresentation because it is inaccurate and may dissuade an insured or enrollee from exercising such rights. Additionally, to the extent that a discretionary clause could be interpreted by a court as a contractual agreement to reverse the default common law doctrine that contractual ambiguities are to be construed against the drafter, the Department's position is that such a reversal of the common law doctrine is not warranted between parties with unequal bargaining power as to the terms of the contract. For these reasons, it is necessary that the adopted rule's applicability extend to life, accident, and health insurance forms and HMO evidence of coverage forms governed under the Insurance

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Code Chapters 1271 and 1701, including both those that are also governed by ERISA and those that are not.

On June 4, 2010, the proposed new subchapter was published in the *Texas Register* pursuant to a petition for rulemaking from the Office of Public Insurance Counsel received by the Department on October 28, 2009, requesting that the Department propose and adopt a rule prohibiting the use of discretionary clauses in life, accident, and health insurance policy forms. On December 9, 2009, the Department held a public meeting to receive comments relating to the application and use of discretionary clauses in insurance policies. On March 5, 2010, the Department made an informal posting on its website of proposed rule text and cost note estimates. Thereafter, the Department made changes to the rule text informally posted on its website on March 5, 2010, based upon both informal comments received in connection with the posting and staff recommendations. Those changes were included in the Department's proposal published in the *Texas Register* on June 4, 2010, and a public hearing on the rule was held on July 12, 2010. In response to comments received on the published proposal, both as written comments and testimony presented at the July 12, 2010 public hearing, the Department has revised some of the proposed language in the text of the rule as adopted. The Department has also made some revisions necessary to clarify the text. None of the changes made to the proposed text as a result of comment or of necessary clarification materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

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With respect to §3.1201(b), the Department received several comments supporting a need to clarify the applicability of the new subchapter to forms “offered, issued, or enforced” on or after the effective date of the adopted rule. In response to these comments asking whether actions such as renewal, delivery, and amendment of forms would trigger applicability, the Department has revised the text of §3.1201(b) to clarify that the subchapter applies to forms renewed or delivered on or after June 1, 2011, except as specified in §3.1201(c) and (d). To further clarify the intended meaning of the subsection, the Department has added new subsection (d) to the section to clarify that for forms issued or delivered prior to the effective date of the subchapter that do not contain a renewal date, the subchapter applies on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. The Department further received comments that a discretionary clause prohibition may result in unintended consequences. In response to these comments, the adopted rule implements a staggered implementation date. According to comments received by the Department, the impact of discretionary clauses appears most frequently to be an issue in disability insurance policies. Therefore, the Department has revised adopted §3.1201 by: (i) adding new subsection (c) to provide that, for forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate or rider, the subchapter applies to forms offered, issued, renewed, or delivered on or after February 1, 2011; and (ii) revising subsection (b) to provide that the June 1, 2011 applicability date applies to forms governed by the subchapter except

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as specified in subsections (c) and (d). Section 3.1201(b) is also revised to specify that forms that include premium waiver provisions based upon a disability determination are included within the scope of applicability established in the subsection, a clarification necessary to prevent any unintended ambiguity arising from the use of a staggered implementation date for disability income protection products. Using a staggered implementation provides the Department with a brief period of time to assess whether a discretionary clause prohibition will actually result in unintended consequences before its application is extended to forms other than those that include disability income protection coverage. At the same time, there will not be a delay in implementation of the prohibition with respect to forms that include disability income protection coverage, which, according to some commenters, is the insurance line for which many of the problems associated with discretionary clauses have been identified. The use in §3.1201(c) of a February 1, 2011 effective date for forms that include disability income protection coverage rather than the January 1, 2011 effective date included in the Department's published proposal is necessary to provide sufficient time for carriers to implement the changes required under §§3.1201 – 3.1203. The Department also received comments recommending that the Department specifically address severability to clarify how the subchapter will apply should any section or portion of the subchapter be held invalid for any reason. Accordingly, the Department has also revised §3.1201 by adding new subsection (e) to clarify that: (i) if any section or portion of a section of the subchapter is held to be invalid for any reason, all parts are severable from the invalid parts and remain in effect; (ii) if any section or portion of a section is held to be

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invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications; and (iii) to this end, all provisions of the subchapter are declared to be severable. Finally, the Department also revised the section title to reflect the clarified content of the section, such that the title is now “§3.1201. Applicability, Effective Dates, and Severability.”

The Department also received several comments concerning the definition of “discretionary clauses” in §3.1202 and has made responsive changes. The Department received a comment that the proposed definition provided insufficient guidance to carriers to permit an assessment of what constituted a discretionary clause due to the open-ended nature of the definition, which specified that the term includes, but is not limited to, a provision including any of five common examples of categories of discretionary clauses. The Department also received several comments recommending greater specificity with respect to the examples of discretionary clauses, such that: (i) a provision that “acts” to bind the claimant or grant deference in subsequent proceedings to the insurer’s decision, denial, or interpretation should be included, rather than only a provision that “purports” to so bind or grant deference; (ii) references to “insurers” throughout the section should also refer to “HMOs” to preclude ambiguity in application; (iii) references to “policies or contracts” throughout the section should be revised to refer to “forms” to preclude ambiguity in application; (iv) a provision that “gives rise to” a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of the state should be included, rather than only provisions that “specify” such

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standards of review; (v) provisions specifying that a policyholder or other claimant may not “appeal” a denial of a claim should be included, rather than only those provisions specifying that a policyholder may not “contest” a denial; and (vi) inclusion of common law in §3.1202(4) establishing that a provision that specifies a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state, including common law, constituted an improper delegation of rulemaking authority to the judiciary in violation of the Texas Constitution. Further, the Department received several comments recommending deletion of §3.1202(5), stating that the term “discretionary clause” includes a provision specifying that the insurer has discretion to interpret the terms of the policy or contract or determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal. The commenters stated that §3.1202(5) was not necessary to permit normal administration of claims by carriers, created internal conflict between the section and §3.1203 prohibiting discretionary clauses, and could lead to a finding of preemption based upon ERISA if a court interpreted the provision to regulate the form of a discretionary clause rather than as part of a general substantive prohibition concerning such clauses. Based upon all of these comments, the Department has clarified the definition of a discretionary clause throughout §3.1202. To address the comment that the open-ended nature of the definition provides insufficient guidance to carriers to determine what constitutes a discretionary clause, the Department has deleted part of the language in §3.1202 such

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that the section now provides that a discretionary clause is a provision that meets one of the five criteria specified in the section, rather than retaining language stating that the term “includes, but is not limited to” one of five categories of discretionary clauses, providing greater clarity concerning the scope of the definition. The Department has revised the structure of §3.1202 to accommodate this clarification, redesignating language that defined “discretionary clauses” in the first sentence of the section to the first of the five adopted paragraphs in the section and eliminating the laundry list of administrative actions that an insurer or HMO might perform in connection with a claim (“decision, denial, or interpretation on terms, coverage, or eligibility for benefits”) in favor of broader language concerning “adverse claim decisions or policy interpretations.” This clarification does not permit a carrier to reserve discretion for its determinations or interpretations or indicate the Department’s intent to regulate the form of a discretionary clause. The Department has further revised §3.1202(1) in response to comments to clarify its applicability to HMOs and to clarify that the paragraph includes a provision that acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or HMO, rather than only those provisions that purport to bind or grant deference in such a manner. As a necessary clarification resulting from restructuring of the section, the Department has: (i) redesignated §3.1201(1) as §3.1201(2) and renumbered the remaining paragraphs accordingly; and (ii) revised the paragraphs to correspond to the revised introductory sentence for the section by adding the word “specifies” to the beginning of paragraphs (2) – (5). The Department has also revised redesignated §3.1202(2) in response to

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comment by clarifying that an appeal of a denial is within the scope of the paragraph. Adopted §3.1202(2) now establishes that a provision that specifies that a policyholder or other claimant may not contest or appeal a denial of a claim is a discretionary clause. The Department has further revised redesignated §3.1202(3) and (4) in response to comment to clarify that both paragraphs apply to HMOs rather than only to insurers and to clarify that the paragraphs apply more broadly to “forms” rather than only to “policies or contracts.” These changes clarify the consistency between the paragraphs and §3.1201(a), which specifies that the subchapter applies to any form filed under the Insurance Code Chapters 1701 or 1271. The Department has further revised redesignated §3.1202(5) in response to comment: (i) to clarify that the paragraph includes a provision that “gives rise to” a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state, rather than only provisions that actually specify such a standard of review; and (ii) to delete the reference to common law. Adopted §3.1202(5) establishes that a provision that specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state is a discretionary clause. The Department has determined that the definition of “discretionary clause” as set forth in adopted §3.1202, in conjunction with the prohibition against discretionary clauses in §3.1203, will result in elimination of the deferential standard of review currently enjoyed by those insurers and HMOs that use discretionary clauses, and common law, including the longstanding Texas common law

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doctrine that ambiguities in insurance contracts should be construed in favor of the insured, will be applied as appropriate by courts in reviewing cases without the necessity for referencing common law in the paragraph. See *Fiess v. State Farm Lloyds*, 202 S.W.3d 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.*, 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters*, 545 S.W.2d 755, 761 (Tex.1977); and *Continental Cas. Co. v. Warren*, 254 S.W.2d 762, 763 (Tex.1953). The revision further clarifies that it was not the intent of the Department to delegate rulemaking authority to the judiciary. Finally, the Department has revised §3.1202 by deleting paragraph (5) in response to comment. Section 3.1202(5) included as an example of a discretionary clause a provision specifying that the insurer has discretion to interpret the terms of the policy or contract to determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal. The Department agrees that: (i) the paragraph is not necessary to permit carriers to perform initial claim administration functions; (ii) the paragraph creates internal inconsistency between §3.1202(5) and the general prohibition against discretionary clauses in §3.1203; and (iii) retention of the paragraph could lead to a finding of preemption based upon ERISA if a court interpreted the provision to regulate the form of a discretionary clause rather than as part of a general substantive prohibition concerning such clauses. *Hancock v. Metropolitan Life Insurance Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009). The Department has also revised §3.1203 in response to comment asking for clarification concerning the scope of the subchapter with respect to forms that are renewed, delivered, enforced, or

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amended. The Department determined that inclusion of this language concerning applicability was most appropriately placed in §3.1201 and that reiteration of the language in §3.1203 was both unnecessarily duplicative and increased the possibility of internal inconsistency with the subchapter. The Department has accordingly deleted such applicability language and clarified the text with respect to its purpose, the prohibition of discretionary clauses. Adopted §3.1203 provides that inclusion of a discretionary clause in any form to which the subchapter applies is prohibited.

3. HOW THE SECTIONS WILL FUNCTION. New §3.1201 specifies the applicability, effective dates, and severability of the adopted rules. New §3.1202 defines discretionary clauses for purposes of the subchapter. New §3.1203 specifies that inclusion of a discretionary clause in any form to which the subchapter applies is prohibited.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments.

Comment: Several commenters state strong support for the rule.

Agency Response: The Department appreciates the supportive comments.

General Comments: Authority to Adopt.

Comment: Some commenters questioned whether the Department has the legal authority to adopt the proposed rules and asked that the statutory authority relied upon for §§3.1201 – 3.1203 be identified. A commenter opines that the Insurance Code

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§1701.060(a)(1), which authorizes adoption of rules to establish procedures and criteria under which a particular type of form will be reviewed or exempted from review, authorizes adoption of procedural rules rather than substantive rules such as the proposed prohibition concerning discretionary clauses. The commenter asserts that the rule does not specify requirements deemed appropriate by the Legislature. The commenter argues that specific statutory requirements for various lines of insurance products, including life, annuity, health, variable life, group life, credit life and disability, employer group plans, and group health plans for persons over 65 years of age, are set forth in other chapters of the Insurance Code, and that §1701.060(a)(1) only authorizes the Department to adopt procedural rules that will be followed for exempt filings, file and use, disapprovals, withdrawal of forms and approvals, and replacement or amendment of forms. Additionally, the commenter asserts that Chapter 1701 has evolved through several legislative and codification efforts, stemming from 1875, and if Chapter 1701 was intended to authorize substantive rulemaking, that authority has not been used by the agency. The commenter also asserts that the Insurance Code §1701.055(a) does not grant rulemaking authority but is a substantive statute establishing the standard of review and approval of forms. The commenter asserts that §1701.055(a) provides that a form may be disapproved if: (i) the form violates a statute or other law of the state; or (ii) the form is misleading, unjust, would constitute misrepresentations or would be deceptive. The commenter further asserts that the Department appears to be shifting interpretations through rulemaking because discretionary clauses have been approved in Texas and used by insurers for a number of years. The commenter argues that if the

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Legislature had wanted to prohibit discretionary clauses it could have done so when former Insurance Code art. 3.42 was repealed and Chapter 1701 was enacted as part of the code revision efforts of the Legislature. The commenter also disputes that discretionary clauses are inherently deceptive, misleading, or unlawful because, if they were, their usage would have been prohibited under both state and federal law. The commenter asserts that the Insurance Code §1271.056 and §1271.103 apply to HMOs and do not apply to annuities or life, accident, and health insurance governed under other sections of the Insurance Code. Further, the commenter asserts that arguments concerning the Department's authority under Chapter 1701 apply equally to Chapter 1271 and argues that §1271.103 does not grant rulemaking authority to the Department. Rather, the commenter asserts that §1271.103 authorizes the Commissioner to withdraw approval for a form that has been previously approved, after notice and hearing. The commenter questions whether the Department's reliance upon §1271.103 indicates: (i) the Department's intent to withdraw approval for previously approved forms without notice and hearing; and (ii) the Department's intent to apply the new subchapter retroactively to existing policy forms and contracts. The commenter questions whether retroactive application of the rule would violate insurer and policyholder rights against *ex post facto* laws and constitutional protections against passing laws that impair the rights of existing contracts under the United States and Texas Constitution. The commenter opines that the Insurance Code §541.401 authorizes rulemaking to regulate unfair methods of competition and unfair and deceptive acts or practices in the business of insurance but that such authority is limited

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by §541.401(b) to adoption of rules that bring Texas law into uniformity with other states and the procedures of the NAIC. The commenter asserts that the NAIC model statute applies to health insurance benefit and disability income protection coverage and is, as such, much more narrowly focused than the Department's proposal. Similarly, the commenter asserts that the states that have adopted a prohibition on discretionary clauses have tended to focus on disability income or health insurance rather than life insurance and annuities. The commenter states that: (i) there is no federal law prohibiting discretionary clauses; (ii) there is no uniformity among states concerning such prohibition; and (iii) the proposed rule does not relate to "procedures" of the NAIC. As such, the commenter argues that there is insufficient rulemaking authority for adoption of the rule under §541.401(b). The commenter additionally argues that the NAIC has adopted model language relating to unfair and deceptive acts and practices that is similar to the Insurance Code Chapter 541 and rules adopted thereunder. Because the commenter asserts that the model statute and regulation do not include a prohibition of discretionary clauses, the commenter asserts that it is unlikely that the Legislature intended to permit the Commissioner to adopt rules under Chapter 541 on any matter that the Commissioner wanted to define in an express provision. The commenter asserts that there are not a large number of complaints supporting the existence of a problem or indicating that consumers are being misled. As such, the commenter does not think authority under the Insurance Code §541.401 is appropriate authority on which to base this rule. The commenter asserts that although the Insurance Code §36.001 grants the Department rulemaking authority to implement the

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powers and duties of the Department under the Insurance Code and is routinely cited as authority by the Department on most rules, the section does not grant such broad authority that the Department can undertake rulemaking under that section alone. Instead, the commenter asserts that the section is used in the context of other statutes where clear rulemaking authority has been specifically delegated by the Legislature. The commenter opines that given the lack of references to discretionary clauses in the numerous chapters of the Insurance Code regulating the business of life, accident, and health insurance, §36.001 is insufficient authority on which to rely for adoption of this rule. The commenter argues that if §36.001 alone sufficed to authorize rulemaking concerning the use of discretionary clauses or other content of forms, then many chapters of the Insurance Code , including Chapters 1101, 1131, 1151, 1152, 1153, 1201, 1251, 1271, 1501, and 1505, would be unnecessary because the Department would have authority to determine content and prohibit provisions. The commenter opines that Chapter 1501 is of special importance because it governs insured plans subject to ERISA, including references to and definitions under ERISA. The commenter opines that the issue of discretionary clauses should more appropriately be considered by the Legislature in order to avoid unintended consequences such as: (i) uncertainty concerning court construction of the language of the rule; (ii) applicability to self-funded employer plans; (iii) applicability to life insurance, including applicability to guaranteed renewable term life policies where there has been a change in the health status of the policyholder and whether the issuer must refile all forms; (iv) applicability to guaranteed renewable individual health insurance policies, including policies where there has been

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a change in the health status of the policyholder; and (v) overbroad and vague definitions that may cause problems with interpretation by future staff that were not involved with this rulemaking process, especially because the word “discretion” need not be present in the clause in order to meet the definition of a discretionary clause. The commenter asserts that the Department held stakeholder meetings concerning the need to make a recommendation to the Legislature concerning the regulation of discretionary clauses in the past and did not thereafter make such a recommendation. The clauses have been used in the interim period, and the commenter questions why the Department now believes it has the authority to undertake such rulemaking without additional legislation. The commenter asserts that it is difficult to determine whether cases qualify for benefits as partial disability, residual disability, or total disability and notes that different definitions of these terms apply to different products that an employer may elect to buy. The commenter opines that it would be difficult to define such issues in a rule. Additionally, the commenter asserts that the Department lacks authority to adopt §§3.1201 – 3.1203 because the sections appear to be based upon a model act rather than a model regulation of the NAIC. Another commenter states that it offers no opinion on the Commissioner’s authority to adopt §§3.1201 – 3.1203 but does opine that questions raised concerning such authority, in combination with all other negative consequences of a prohibition cited by industry stakeholders, supports restraint in rulemaking. Another commenter asserts that the Department has ample authority to implement §§3.1201 – 3.1203 because: (i) the Commissioner may disapprove a policy or evidence of coverage if he finds its language is unjust,

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encourages misrepresentation, or is deceptive; and (ii) the Commissioner has authority to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701. To the extent that Chapters 1271 and 1701 are intended to prevent the use of a policy or evidence of coverage with language that is unjust, encourages misrepresentation, or are deceptive, the commenter argues that §§3.1201 – 3.1203 simply announce the Commissioner's determination that discretionary clauses do have those qualities because they mislead consumers regarding the terms of the coverage and that the sections are, therefore, within the Commissioner's authority.

Agency Response: The Department disagrees with the assertion that Chapter 1701 does not authorize adoption of §§3.1201 – 3.1203 with respect to the forms governed by that chapter. The Insurance Code §1701.060(a)(1) authorizes adoption of rules to establish not only procedures but also criteria under which a particular type of form will be reviewed or exempted from review. The Department further disagrees that the existence of discretionary clauses in forms in recent years should preclude adoption of a rule prohibiting such clauses. Some of the forms containing discretionary clauses are not reviewed on submission to the Department but are instead exempt from review. Additionally, the Department disagrees that it is inappropriate for the Department to consider new information and trends and to undertake responsive rulemaking within the scope of its authority. The Department does agree that the Insurance Code §1271.056 and §1271.103 apply to HMO forms but disagrees that rulemaking authority based upon those sections is limited to procedural rulemaking. Neither section limits the Commissioner's rulemaking authority to procedural rulemaking. Additionally, the

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Insurance Code §843.151 authorizes the Commissioner to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Department clarifies that §§3.1201 – 3.1203 are not *ex post facto* laws as contemplated under the U.S. and Texas Constitutions. An *ex post facto* law is a law passed after the commission of an act which retrospectively changes the consequences of the act. *Collins v. Youngblood*, 497 U.S. 37, 41-42 (1990); *Bowers v. State*, 914 S.W.2d 213, 216 (Tex.App.-El Paso 1996, *writ ref'd.*). As stated in *Bowers*, “a law violates *ex post facto* prohibitions if it (1) makes criminal an act that was innocent when done; (2) increases the punishment for an offense after its commission; (3) deprives one of a defense available at the time of the act; or (4) alters the legal rules of evidence and receives less or different evidence to convict than the law required at the time the act was committed.” *Bowers*, 914 S.W.2d at 216. New §§3.1201 – 3.1203 do not establish a rule in violation of the *ex post facto* prohibition under the U.S. or Texas Constitutions because: (i) the sections do not make an act criminal; (ii) the sections do not increase the punishment for an offense after its commission, but instead establish prospective prohibitions; (iii) do not deprive one of a defense available at the time of the act committed because of the prospective nature of the sections; and (iv) do not affect rules of evidence. The Department agrees that the Texas Constitution prohibits retroactive laws. “No bill of attainder, ex post facto law, or any law impairing the obligation of contracts, shall be made.” Tex. Const. art. I, §16. The Department clarifies, however, that new Subchapter M does not apply retroactively. As specified in new §3.1201(b) and (c), the subchapter applies to forms offered, issued, renewed, or

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delivered on or after the effective dates of the rule, respectively June 1 and February 1 of 2011. Further, as provided in §3.1201(d), the subchapter applies prospectively to forms that do not contain a renewal date on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. The Department further clarifies that the term "rate" in §3.1201(d), as opposed to the term "premium" precludes applicability of the subchapter to forms solely on the basis of premium increases made pursuant to a schedule that is included in the existing form. The Department acknowledges that both the U.S. and Texas Constitutions establish protection from the impairment of contractual obligations. U.S. Const. Art. I, §10, cl. 1; Tex. Const. Art. I, §16. Interpretation of the two prohibitions is nearly identical. *Liberty Mutual Ins. Co. v. Texas Dep't of Insurance*, 187 S.W.3d 808, 824 (Tex.App.-Austin 2006, *pet. den'd.*) (citing *Chandler v. Jorge A. Gutierrez, P.C.*, 906 S.W.2d. 195, 203 (Tex.App.-Austin 1995)). The interpretive commentary for Article I, §16 of the Texas Constitution states in part:

The guaranty of the Constitution is directed against the impairment of the obligation of contracts rather than the contract itself. A contract is an agreement in which a party undertakes to do or not to do a particular thing. Said party is required by duty and by law to perform his undertaking and this is known as the obligation of the contract. Any law which releases a part of this obligation, any act which to any extent or degree amounts to a material change or modifies it, must impair it. . . The obligation protected is not derived from the acts and stipulations of the parties alone, but includes also the relevant law in force at the time the contract is made. The contract clause forbids only laws which operate retroactively on contracts. (Vernon's Ann. Tex. Const., Art. I, §16).

The constitutional prohibitions against impairment of contracts "is directed against the impairment of the obligation of contracts rather than the contract itself, that is, what the party to a contract is required by duty and by law to perform. Any law which releases a

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part of this obligation, any act which to any extent or degree amounts to a material change or modifies it, must impair it.” *Cardenas v. State*, 683 S.W.2d 128, 131 (Tex. App.--San Antonio 1984, no writ) (citations omitted). For the reasons outlined in this response, it is the Department’s position that new Subchapter M: (i) does not relieve a carrier, insured, or enrollee of any obligation under the insurance contract or evidence of coverage between the carrier and the insured or enrollee; (ii) does not materially change or modify that contract; and (iii) does not operate retroactively on that contract. Nothing in new Subchapter M relieves a carrier, insured or enrollee of any contractual obligation. Rather, new Subchapter M prohibits the use of discretionary clauses that serve to provide a deferential standard of review to the carrier’s determinations. The underlying contractual obligations of a carrier, insured, or enrollee are not relieved. The obligations of the parties under the contract are also not materially changed or modified; judicial review of whether the carrier has properly performed those obligations as they related to claim determinations will simply not be reviewed with deference as a result of new §§3.1201 – 3.1203. Analysis under federal law is comparable. See, e.g. *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983) (finding significance in the fact that the parties “are operating in a heavily regulated industry”). Even where a court does find that a law impairs a contract, the court will consider whether the industry the complaining party has entered has been regulated in the past. *Id.* (“The Court long ago observed: “One whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them.”) (citations omitted); accord *Liberty Mutual*, 187 S.W. 3d at 824. Finding a

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significant and legitimate public purpose, a court will determine whether “adjustment of ‘the rights and responsibilities of contracting parties [is based] upon reasonable conditions and [is] of a character appropriate to the public purpose justifying’ the adjustment.” *Liberty Mutual*, 187 S.W. 3d at 825 (citing to *Energy Reserves Group* at 412 (quoting *United States Trust Co. v. New Jersey*, 431 U.S. 1, 22 (1977))). It is the Department’s position that new §§3.1201 – 3.1203 are necessary to safeguard the interests of the public by prohibiting a deceptive practice that may lead some consumers to believe that they do not have a right to appeal a carrier’s determination and by affording consumers an opportunity for a full and independent judicial review of a claim determination under a standard that does not provide deference for the carrier’s determination. It is further the Department’s position that the prospective application of new Subchapter M and the staggered implementation established in new §3.1201 constitute reasonable conditions and are appropriate means of addressing this need for a consumer safeguard. As such, while it is the Department’s position that new §§3.1201 – 3.1203 do not impair contracts, even if a court held to the contrary, it is the Department’s position that new Subchapter M would not impermissibly violate these constitutional protections. The Department disagrees that §541.401(b) limits the authority of the Department under §541.401(a). The Department asserts that under a plain reading of the section each subsection is an independent grant of authority. Further, the Department disagrees that even §541.401(b) limits the Commissioner’s rulemaking authority to adoption of rules that bring Texas law into uniformity with other states and the procedures of the NAIC. Section 541.401(b) references rulemaking to

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achieve uniformity with the laws of other states or conformity with adopted procedures of the NAIC as authority included within the grant of authority specified in the subsection rather than as an exhaustive limitation upon that grant of authority. See Tex. Gov't Code §311.005(13) (" 'Includes' and 'including' are terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded."); *Jackson Law Office, P.C. v. Chappell*, 37 S.W.3d 15, 25 (Tex.App.-Tyler 2000, *pet. den'd.*). For this same reason, the Department also disagrees that the Commissioner's rulemaking under Chapter 541 is limited to the types of acts and practices included in model acts and regulations adopted by the NAIC concerning deceptive acts and practices. The Department's position is that there is not sufficient justification for protecting only consumers of disability income and health insurance products from the detrimental effects of discretionary clauses and not affording the same level of protection to consumers of life insurance and annuity products. Carriers may have a conflict of interest in coverage determinations because they may result in adverse financial consequences for their company. *Glenn*, 554 U.S. at 108. The Department has no reason to suppose that this potential for conflict of interest is not equally applicable to life insurance and annuity products where determinations of the carrier may result in adverse financial consequences for the company. The Department also disagrees that a particular complaint level is necessary to undertake rulemaking pursuant to §541.401. The Department's position is that the lack of complaints relating to discretionary clauses does not indicate the absence of a problem. The major impact of a discretionary clause occurs by operation of law upon

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subsequent review by a court. Understanding and identifying a discretionary clause as the source of an unfair coverage determination and subsequent lack of full independent review requires sophisticated legal knowledge and analysis. Therefore, it is unlikely that the average consumer would be able to identify discretionary clauses as a contributing cause of a negative interaction with an insurer or HMO. Further, although the Department considers complaint information when proposing rules, it is not necessary that a prohibitory rule be prompted by a certain number of complaints regarding the practice at issue. The Department's position is that regardless of insurance and HMO consumers' ability to identify discretionary clauses as a specific problem, the potential harm resulting from discretionary clauses is sufficient reason to adopt the rule. The Department further disagrees that discretionary clauses are important only in the context of determining the standard of judicial review applicable in litigation, although that result alone is unjust to consumers that are faced with a standard of review that favors the parties that drafted the language of a form in dispute. As the Department has stated previously in this order, such a result is inconsistent with the longstanding common law doctrine in Texas that ambiguities in insurance contracts should be construed in favor of the insured. *See Fiess v. State Farm Lloyds*, 202 S.W.3d, 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.*, 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters*, 545 S.W.2d 755, 762, 763 (Tex.1977); and *Continental Cas. Co. v. Warren*, 254 S.W.2d 762, 763 (Tex.1953). That inclusion of a discretionary clause in a form results in application of a deferential standard of review for a carrier for whom there is an inherent conflict of interest compounds this injustice.

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See *Firestone*, 489 U.S. 101 at 115 (holding that in appeals of coverage determinations governed by ERISA, a deferential standard of review is appropriate if the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms); and *Glenn*, 554 U.S. at 108 (holding that there is a conflict of interest where the plan administrator also pays benefits out of its own pocket). The use of such clauses is also misleading to the extent that it may lead consumers to believe that they do not have a right to appeal the claim determination. Such rulemaking is consistent with the consumer protection purposes of the Insurance Code Chapter 541, in addition to the substantive requirements concerning: (i) in the Insurance Code §1701.055, the use of forms that violate the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive; and (ii) in §1271.056, the use of a provision in an evidence of coverage that is unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Department disagrees that the Insurance Code §36.001 does not authorize rulemaking absent specific statutory references to discretionary clauses in other sections of the Insurance Code. The Department asserts that §36.001, in conjunction with each of the other authorizing sections of the Insurance Code cited by the Department as authority, is a proper basis of rulemaking authority for §§3.1201 – 3.1203. With respect to the comment that the Insurance Code Chapter 1501 governs insured plans that are subject to ERISA, the Department agrees and notes that ERISA

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specifically exempts from preemption under the statute state laws that regulate insurance. See 29 U.S.C. §1144(b)(2)(A). It is the Department's position that new §§3.1201 – 3.1203 do regulate insurance because the sections are specifically directed toward entities engaged in insurance and directly affect risk pooling. See *Standard Insurance Co. v. Morrison*, 584 F.3d 837, 845 (9th Cir. 2009) *cert. denied sub nom. Standard Ins. Co. v. Lindeen*, U.S. No. 09-885, 2010 LEXIS 4079 (May 17, 2010) (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); and *American Council of Life Insurers v. Ross*, 558 F.3d 600, 605-07 (6th Cir. 2009). The Department agrees that it is within the legislative purview to review issues concerning the use of discretionary clauses. However, the Department disagrees that legislative review is a prerequisite to the exercise of rulemaking authority by the Commissioner. The Legislature has already considered the issue of form approval and usage generally and authorized the Commissioner to adopt rules to establish criteria under which a particular type of form will be reviewed or exempted from review with respect to form governed under the Insurance Code Chapters 1271 and 1701. See, respectively, the Insurance Code §§843.151, 1271.056, and 1271.103; and the Insurance Code §1701.055(a) and §1701.060(a)(1). The Legislature has additionally considered the issues of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance and authorized the Commissioner to adopt rules necessary to accomplish the purposes of the Insurance

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Code Chapter 541. See the Insurance Code §541.401. Additional legislative action and review, while within the legislative purview, is not required. The Department further disagrees that legislative revision of the Insurance Code without amendments that specifically address discretionary clauses evidences specific legislative intent concerning the use of discretionary clauses. The Legislature repealed art. 3.42 and added new Chapter 1701 to the Insurance Code as part of a nonsubstantive code revision, and substantive amendments are not consistent with intent to enact a nonsubstantive revision. See Acts 2003, 78th Leg., R.S., chap.1274, sec. 5, effective April 1, 2005 (caption indicating that the bill relates to a nonsubstantive revision of statutes). The Department disagrees that prior legislative review will avoid all possible uncertainty related to court construction of new Subchapter M, as courts review not only regulatory but statutory language. See *Speiser v. Randall*, 357 U.S. 513, 544, n.7 (1958). The Department also disagrees that applicability is unclear. New Subchapter M applies to all forms regulated under the Insurance Code Chapters 1271 and 1701 as provided in §3.1201. In response to comment, the Department has clarified specific applicability to renewing forms in §3.1201(b) and (c), which provide that forms renewing after the applicable effective date in those provisions are subject to the subchapter. Because legislative and regulatory actions are routinely applied to renewing forms, the Department does not anticipate that insurers or HMOs will have difficulty in determining how to apply requirements of the new subchapter in those contexts. See, e.g. Acts 2007, 80th Leg., R.S., ch. 877, §9, eff. Sept. 1, 2007 (the Insurance Code Chapter 1352, related to coverage for brain injury, applies to plans that are renewed on or after

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January 1, 2008); and Acts 2009, 81st Leg., ch. 1270, §4, eff. Sept. 1, 2009 (the Insurance Code Chapter 1376, related to tests for early detection of cardiovascular disease, applies to plans that are renewed on or after January 1, 2010). The Department agrees that the word “discretion” need not be present in the text of a clause in order for the clause to qualify as a discretionary clause. *See e.g. Chevron Chemical Co. v. Oil, Chemical, & Atomic Workers Local Union 4-447*, 47 F.3d 139, 142 - 143 (5th Cir. 1995). Department staff routinely review the language of forms to determine whether there are violations of law, including regulations, and the Department anticipates that the same processes currently used by the Department, insurers and HMOs to resolve questions concerning provisions for specified types of filing will be applied in the context of discretionary clauses. Additionally, the Department has considered each of definitional comments submitted in connection with §§3.1201 – 3.1203, provided specific responses to those comments in this adoption order, and made changes as appropriate and as noted in those responses. However, the Department will monitor to determine whether additional rulemaking is required. The Department disagrees that this rule is intended to define the terms such as “partial disability,” “residual disability” and “total disability” as those terms are used in forms. The Department expects that issuers should clearly and unambiguously define terms important to a consumer’s ability to access the benefits of a bargain in a form. The Department further disagrees that consideration of inclusion of a topic as a recommendation for consideration by the Legislature is equivalent to a lack of authority to undertake rulemaking. The Department also disagrees that the inclusion of

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prohibitions of discretionary clauses by the NAIC in model statutes rather than model rules reduces or negates the Commissioner's authority to adopt rules under the statutory bases established by the Legislature in the Insurance Code. Models adopted by the NAIC are, as the name implies, models subject to tailoring as appropriate to the circumstances and existing laws of a given state. In Texas, as explained in this response, statutory authority exists to adopt §§3.1201 – 3.1203 absent the requirement of a specific statute concerning discretionary clauses. The Department agrees that adoption of §§3.1201 – 3.1203 are within the Commissioner's authority and disagrees that such authority is insufficient. As stated in the Statutory Authority section of this adoption order, the rulemaking authority for §§3.1201 – 3.1203 is as follows:

The new sections are adopted under the Insurance Code §§1701.060(a)(1), 1701.055(a), 1271.056, 1271.103, 843.151, 541.401 and 36.001. The Insurance Code §1701.060(a)(1) authorizes the Commissioner to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted will be reviewed and approved by the Commissioner or exempted under the Insurance Code §1701.005(b). Section 1701.055(a) specifies that except as provided by the Insurance Code §1701.055(d), the Commissioner may disapprove, or, after notice and hearing, withdraw approval of a form if the form violates the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1271.056 specifies that an evidence of coverage may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; encourages misrepresentation; or is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Insurance Code §1271.103(a) specifies that after notice and opportunity for hearing, the Commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the Commissioner determines that the form violates the Insurance Code Chapters 1271, 843, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the Commissioner. The Insurance Code §1271.103(b) provides that if the Commissioner withdraws approval of a form under §1271.103, the form may not be issued until it is approved. The Insurance Code §843.151 specifies that the Commissioner is authorized to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Insurance Code §541.401 specifies that the Commissioner

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may adopt and enforce reasonable rules the Commissioner determines necessary to accomplish the purposes of the Insurance Code Chapter 541 (relating to the prohibition of trade practices that are unfair methods of competition or unfair or deceptive acts or practices). The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

General Comments: Necessity for Rule.

Comment: Some commenters questioned whether the rule proposal was prompted by complaints, and, if so, whether the number of complaints was sufficient to justify a prohibition on discretionary clauses. One commenter asserted that the evidence of a need for a prohibition of discretionary clauses was limited to a clip from a television show, testimony from attorneys that litigate cases that winning is very difficult, and assertions in a rulemaking petition that the commenter asserts to be factually incorrect. Several commenters state that discretionary clauses only become important in the context of determining the standard of review that will apply in litigation and that the significant administrative undertaking that a prohibition against the clauses will entail is not warranted. A commenter asserts that the deferential standard applied to review of insurer decisions where discretion has been granted to the insurer are comparable to the discretion that is given to decisions of the Commissioner that are judicially reviewed; per the commenter, if there is a scintilla of evidence to support the findings of fact made by the Commissioner, the court will generally uphold the findings. However, the commenter asserts that insurers for an ERISA plan are additionally subject to fiduciary standards. The commenter disagrees that there is evidence that insurance companies will disregard fiduciary responsibilities to deny claims for their own benefit and argues

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that the Department's statements to the contrary in its published proposal are not substantiated. Several commenters assert that insurers are incentivized not to systematically deny meritorious claims because employers would take their business elsewhere if the plan were not administered to the actual benefit of the employees. The commenters argue that employers "have the sophistication and borrowing power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims." *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998); see also Barry D. Smith & Eric A. Wienen, *How Insurance Works* 3-4, 8-9 (2d ed. 1994). Thus, the commenters assert that a practice of denying claims improperly "would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers." *Id.* The commenter further submitted that most claims are granted, relying upon a study of claims submitted in 2002. Health Ins. Ass'n of America, *Results from an HIAA Survey on Claims Payment Processes* 10 (March 2003), available at www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurveyChartbook.pdf ("*HIAA Survey*"). The commenter states that, per the study: (i) 86 percent of claims were granted; (ii) 48 percent of the denials were duplicate submissions; (iii) and 20 percent of the denials were based upon policy lapses. *Id.* The commenter further argues that only three percent of all claims were denied because the benefit was not covered, 0.4 percent were denied for eligibility reasons, and one percent of claims were denied for other reasons. *Id.* The commenter further states that there are numerous reported cases reversing decisions by fiduciaries that demonstrate that: (i) courts are

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not reluctant to review decisions for biases or conflicts of interest; and (ii) a *de novo* standard of review is not necessary to achieve a fair adjudication. Another commenter states that in many cases claimants that have been harmed by discretionary clauses but have settled disputes with issuers are bound by confidentiality provisions in settlement agreements and therefore prevented from testifying or giving information about the claim. The commenter notes that the confidentiality provisions sometimes affect the attorney representing the claimants, as well.

Agency Response: The Department has not been made aware of significant complaints relating to discretionary clauses apart from concerns that have arisen during this rulemaking process. However, the Department's position is that the lack of complaints relating to discretionary clauses does not indicate the absence of a problem. The major impact of a discretionary clause occurs by operation of law upon subsequent review by a court. Understanding and identifying a discretionary clause as the source of an unfair coverage determination and subsequent lack of full independent review requires sophisticated legal knowledge and analysis. Therefore, it is unlikely that the average consumer would be able to identify discretionary clauses as a contributing cause of a negative interaction with an insurer or HMO. Further, although the Department considers complaint information when proposing rules, it is not necessary that a prohibitory rule be prompted by a certain number of complaints regarding the practice at issue. The Department's position is that regardless of insurance and HMO consumers' ability to identify discretionary clauses as a specific problem, the potential harm resulting from discretionary clause is sufficient reason to adopt the rule.

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Additionally, the Department notes that the *HIAA Survey* submitted by commenters indicates that 20 percent of claim denials are based upon whether the benefit is covered. *HIAA Survey* at 10. The number of coverage determinations that may potentially benefit from adoption of §§3.1201 – 3.1203 is therefore significant. The Department further disagrees that discretionary clauses are important only in the context of determining the standard of judicial review applicable in litigation, although that result alone is unjust to consumers that are faced with a standard of review that favors the parties that drafted the language of a form in dispute. The use of such clauses is also misleading to the extent that it may lead consumers to believe that they do not have a right to appeal the claim determination. The Department also disagrees that there is no evidence that insurers ever make claim determinations for the benefit of the insurer because of the existence of fiduciary standards. In *Lain v. UNUM Life Ins. Co. of America*, 279 F.3d 337, 347 (5th Cir. 2002), the court held that UNUM abused its discretion where the record contained “an overwhelming amount of medical evidence supporting [the] claim of disability” and “a complete absence in the record of any “concrete evidence” supporting UNUM’s determination that [the insured] was not disabled.” *Lain* concerned a long-term disability insurance policy selected by a firm for its employees in Houston, Texas and governed under ERISA. *Id.* at 340 - 342. In a footnote, the *Lain* opinion also notes that the district court stated that “UNUM infused its inherent, institutional conflict of interest into its employees by providing substantial financial bonus incentives based partially on UNUM’s financial achievement and its net earnings per share.” *Id.* at 348, n.7. Additionally, the Department notes that a multistate

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market conduct examination of three disability insurers owned by UnumProvident Corp., joined by all 50 states and the District of Columbia, identified several claims handling practices that were of concern, including: (i) excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits; (ii) unfair evaluation and interpretation of attending physician or independent medical examiner reports; (iii) failure to evaluate the totality of the claimant's medical condition; and (iv) an inappropriate burden placed on claimants to justify eligibility for benefits. See Press Release on Multi-State, Federal Settlement Addresses Concerns Regarding UNUM Provident Claims Handling (November 18, 2004), available at http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Government&L2=Our+Agencies+and+Divisions&L3=Division+of+Insurance&L4=Archive+of+DOI+News+%26+Updates&L5=2004+DOI+Press+Releases&sid=Eoca&b=terminalcontent&f=doi_Media_media_press56&csid=Eoca. See also *Glenn*, 554 U.S. at 118 (holding that a greater weight was attributable to a conflict of interest where the insurer of a long term disability plan governed under ERISA encouraged the insured to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in so arguing, and then ignored the agency's finding in concluding that the insured could in fact do sedentary work because the seemingly inconsistent positions were both financially advantageous to the insurer). While the Department agrees that there are cases indicating that courts are willing to consider whether the insurer making a claim determination has a conflict of interest, the Department does not agree that it is appropriate that an insured or enrollee should have to meet this additional burden of

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proving the extent of such conflict. Even a judicial finding that a conflict of interest does exist will only count as a factor in the application of the arbitrary and capricious standard of review, and the significance of the factor will depend upon the circumstances of the particular case. See *id.* at 108; see also *Corry v. Liberty Life Assur. Co. of Boston*, 499 F.3d 389, 398 (5th Cir. 2007) (“only a modicum less deference” is appropriate where the only evidence of a conflict was the dual role of Liberty as administrator and insurer and that the review “need only assure that the administrator’s decision fall somewhere on a continuum of reasonableness—even if on the low end.”)(citations omitted). The Department acknowledges that the existence of confidentiality provisions in settlement agreements may additionally impede some parties and their representatives from filing complaints concerning the detrimental effects of discretionary clauses.

Comment: Some commenters stated that the rule is unnecessary because: (i) ERISA provides a framework sufficient to protect insureds; (ii) the presence of a discretionary clause does not void the applicability of federal law; and (iii) the use of a discretionary clause does not void the applicability of state consumer protection laws such as those that prohibit deceptive trade practices and regulate claim settlement practices. The commenters assert that plan fiduciaries under ERISA must act prudently and solely in the interest of plan participants and use discretion in interpreting provisions. When discretion is granted, the commenter asserts that a court must find that the decision to deny benefits was not supported by the evidence and was arbitrary and capricious. Another commenter asserts that the claim decision must be fair and reasonable. A commenter states that when the plan administrator is also the insurer, the court will

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consider whether a potential conflict of interest is a factor in determining whether there has been abuse of discretion. Further, the commenter asserts that participants and beneficiaries are granted the explicit right to sue to recover benefits or clarify their rights under a plan by ERISA and that ERISA assures an appeal process that is fair, independent, and protects consumers by requiring that: (i) the appeal be decided by a fiduciary who is neither the initial claim reviewer or a subordinate of that person; (ii) the appeal not give deference to the original claim decision; (iii) the claimant have a right to be represented; and (iv) the claimant have a right of access to information. *29 CFR Part 2560*. A commenter asserts that discretionary clauses neither affect claim administration nor limit the right of insureds to seek judicial relief. A commenter asserts that a ban on discretionary clauses will only serve to eliminate a mechanism endorsed by the United States Supreme Court. The commenter asserts that the Department regulates unfair trade practices, deceptive acts, and claim settlement practices of insurers as specified in 28 Tex. Admin. Code §21.1 *et seq.* and §21.201 *et seq.* Based upon existing federal and state protections that apply to claim fiduciaries, the commenter asserts that the fiduciaries do not have unfettered discretion in adjudicating claims.

Agency Response: The Department disagrees that the consumer protection framework within ERISA negates the need for §§3.1201 – 3.1203. Although ERISA prescribes certain protections for enrollees, the Department's position is that these protections are insufficient to provide the necessary consumer protections in all instances. The U.S. Supreme Court has acknowledged that the duties prescribed by

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ERISA may be insufficient to fully protect enrollees when an insurer faces a conflict of interest: *"Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion."* *Firestone*, 489 U.S. at 115. The Department agrees with the Supreme Court that there is a possibility that an insurer may have a conflict of interest in making coverage determinations resulting in adverse financial consequences to the company. Therefore, it is of vital importance to ensure that insureds are provided an opportunity for a full benefit determination review by an independent decision maker. Because an insurer may have a conflict of interest in making coverage determinations, it is possible that such decisions may result in unfair and inequitable outcomes for insureds. Companies using discretionary clauses may then unfairly benefit from a deferential appellate standard of review should an insured choose to seek judicial review of the coverage determination. Additionally, the applicability of the rule extends beyond cases governed by ERISA. The Department also disagrees that the existence of state consumer protection laws concerning deceptive trade practices and claims settlement practices negates the need for §§3.1201 – 3.1203. It is the Department's position that adoption of §§3.1201 – 3.1203 is necessary to protect consumers from the possibility of incorrect and unfair coverage determinations without a subsequent opportunity for a full and independent review under a non-deferential standard and to notify insurers and HMOs that the Department also finds the use of discretionary clauses to be unjust, encourage misrepresentation, and be deceptive because they mislead consumers regarding the terms of the

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coverage. The Department does agree that it has the authority to regulate the conduct of insurers under 28 Tex. Admin. Code §21.1 *et seq.* and §21.201 *et seq.* Adoption of a prohibition concerning discretionary clauses is an effective and efficient way to exercise such authority and will provide clear guidance and notice for regulated entities to use in drafting forms.

Comment: Several commenters state that the Department should not adopt §§3.1201 – 3.1203 because consumers already have access to substantive judicial review. Per the commenters: (i) a denial of benefits is not an abuse of discretion if supported by substantial evidence and not arbitrary and capricious; (*Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 273 (5th Cir. 2004); (ii) “[s]ubstantial evidence . . . is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion;” (*Id.*); (iii) the existence of substantial evidence must be considered “in the light of all the evidence;” (*Corry*, 499 F. 3d at 399); and (iv) a decision is arbitrary if “made without a rational connection between the known facts and the decision.” (*Meditrust Fin. Servs. Corp.*, 168 F.3d at 215 (quotation marks and citation omitted)). The commenters therefore assert that the arbitrary and capricious standard of review is substantive in nature and suffices to protect consumer interests. Another commenter states that a prohibition on discretionary clauses is a necessary and proper consumer protection measure that will reduce the potential for bad faith claim denials that are nearly unchallengeable. Several commenters assert that discretionary clauses create a conflict of interest for insurers by reserving to the insurer the right to interpret the terms of a policy drafted by the insurer, placing the insurer in a position to deny benefits that a

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reasonable insured person would believe fall within the terms of the policy. The commenters assert that discretionary clauses make this problem worse by giving rise to the “arbitrary and capricious” standard of review, as demonstrated in *Firestone*, 489 U.S. at 115, making it more difficult for an insured to challenge a denial that may have been made in bad faith or with bias. Another commenter asserts that: (i) discretionary clauses are unjust, encourage misrepresentation, and deceptive; and (ii) a prohibition against discretionary clauses is necessary to protect consumers from incorrect and unfair coverage determinations by allowing consumers to seek a full and independent review of the claim under a non-deferential standard. Some commenters state that the NAIC adopted model laws in 2002 and 2004 prohibiting discretionary clauses in health and disability policies, and one commenter asserts that the impetus for this adoption was the NAIC position that: (i) discretionary clauses are inequitable, deceptive, and misleading to consumers; and (ii) banning discretionary clauses prevents the conflict of interest that occurs when the insurer responsible to provide benefits has discretionary authority to determine the benefits that are due. The commenter supports that position and argues that the economic security of a family can hang in the balance as coverage determinations are made. Several commenters assert that Texans should enjoy the protections available to consumers in 22 other states that have taken action to prohibit the use of discretionary clauses. A commenter asserts that the financial and emotional toll on individuals and families attempting to challenge a benefit determination in court under a standard of review that favors insurers is significant and lasting. Another commenter supports a prohibition on discretionary clauses because: (i) the commenter

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opines that the clauses violate common law principles concerning contracts of adhesion; (ii) the commenter's experience indicates that insurers who have discretionary clauses are the most difficult to work with in resolving claims; and (iii) the commenter refuses to sell individual disability insurance forms with discretionary clauses because of this experience. The commenter opines that insurers will benefit from the prohibition because experienced disability insurance agents who have refused to sell products containing discretionary clauses will consider those insurer's products to be legitimate options for consideration in advising clients after such clauses are removed. Another commenter states opposition to inclusion of discretionary clauses in any type of insurance policy because: (i) the commenter believes that insurers can state in plain language the terms and conditions under which claims will be paid; (ii) the commenter opines that discretionary clauses represent subterfuge; and (iii) the commenter believes that if insurance companies cannot provide the same degree of transparency that is provided by the Social Security Administration, which makes its criteria for disability determinations readily available, the company should not be permitted to operate in Texas. Another commenter states that a recent Texas case, *Burton v. Unum Life Insurance Co.*, 2010 U.S. Dist. LEXIS 58267 (W.D. Tex. June 14, 2010), demonstrates that courts may determine that an insurer's claim determination is not fair and reasonable but still find that the adverse determination does not constitute an abuse of discretion, the standard of judicial review applicable in cases in which the underlying form includes a discretionary clause. The commenter notes that the court in *Burton* stated as follows:

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However, the Court notes in conclusion that the overall record in this case plainly indicates Burton suffers from bipolar disorder, and has so suffered since at least 2004. Although the illness is episodic, and may have waned at times, it is obvious Burton has a mental illness and should have remained on medication for that illness. The SSA, considering the exact same evidence as Unum, held Burton was totally disabled as of March 2007. Unum has ignored this finding and denied Burton's claim. This Court upholds Unum's determination because of the clear terms of its Policy, with which Burton was not in compliance. Nonetheless, the Court laments the unfortunate result of this case and the fact Unum has escaped payment to a man who is clearly mentally ill by rigidly and aggressively enforcing the terms of its Policy against him, even though his non-compliance may arguably have been a symptom of his illness. However, the fix for this is not in the Court--as neither the Court nor Burton can deny he is bound by the Policy's plain terms--but in the marketplace, where Unum's aggressive claims administration seems already to have reaped it a befitting reputation. See, e.g. *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 137 (2d Cir. 2008) (Unum "reveals a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.")

The commenter argues that abuse of discretion reviews do not consider whether an insurer's actions were fair and reasonable but whether there is a scintilla of evidence to support the action. A commenter cites to a 7th Circuit court opinion addressing the arbitrary and capricious standard as follows: "Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan. . . .(citations omitted)." *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985). Another commenter agrees and states that the arbitrary and capricious standard of review addresses whether the claimant's due process rights were violated rather than whether the decision made by the insurer was correct. A commenter argues that employers and claimants deserve the benefit of the bargain they

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have made, and they should be able to access such benefits for legitimate claims without having to overcome a deferential standard that favors insurers by requiring the claimant to demonstrate that a decision was arbitrary and capricious. A commenter states that a prohibition on discretionary clauses will return to individuals the common law and statutory rights to file a lawsuit and prove before a jury by a preponderance of the evidence whether the individual is entitled to benefits under the terms of a first-party insurance contract. The commenter opines that issuers favor discretionary clauses as a method of getting rid of juries, creating an unlevel playing field by limiting judicial review to abuse of discretion. The commenter submits that a prohibition against a provision specifying a standard of interpretation or review that is inconsistent with laws of this state should be adopted.

Agency Response: The Department agrees that the arbitrary and capricious standard of review is a substantive standard of review but disagrees that the arbitrary and capricious standard of review suffices to serve the consumer protection purposes of new §§3.1201 – 3.1203 as explained in this response and throughout this adoption order. The Department appreciates the supportive comments concerning the need for this rule and agrees that a prohibition of discretionary clauses as established in new §§3.1201 – 3.1203 is both necessary and proper in order to protect consumers from incorrect, unfair, biased and/or bad faith coverage determinations. The prohibition also serves the purpose of helping to prevent consumers from believing that they lack access to appeal based upon statements concerning the binding nature of a carrier's determination in a form. The Department further agrees that new §§3.1201 – 3.1203

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will result in increased consumer access to full and independent review of claim determinations under a non-deferential standard. The Department does not agree that the deferential “arbitrary and capricious” standard of review requires only a scintilla of evidence in support of the carrier’s determination. The Fifth Circuit explained the standard in *Corry*, 499 F.3d at 397 - 398:

Under the abuse of discretion standard, “[i]f the plan fiduciary’s decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail.” *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 273 (5th Cir.2004). “Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Id.* (quotation omitted). “An arbitrary decision is one made without a rational connection between the known facts and the decision or between the found facts and the evidence.” *Bellaire Gen. Hosp. v. Blue Cross Blue Shield of Mich.*, 97 F.3d 822, 828 (5th Cir.1996).

The Department does, however, acknowledge that application of the abuse of discretion standard, which “need only assure that the administrator’s decision fall somewhere on a continuum of reasonableness--even if on the low end” sometimes makes it difficult to distinguish from the *scintilla of evidence* standard of review. See *id.* at 398.

General Comments: Uniform Administration.

Comment: Several commenters state that discretionary clauses arise from a judicial requirement for specific reservation of a plan’s discretion to fulfill its statutory mandate to act as a fiduciary in establishing standards and ensuring equity and non-discrimination in making uniform and consistent coverage determinations for the protection of employers and consumers. Several commenters express particular concern about the possibility of disparate results in claim determinations for persons covered under the same plan, possibly residing in different states, and the consumer

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confusion that the commenters assert will follow. As such, the commenters assert that the clauses are necessary for the provision of reliable and uniform benefits to employers and consumers, and should not be prohibited. A commenter additionally asserts that insurers require discretion to: (i) underwrite risks; (ii) set premiums; (iii) process changes; (iv) make claim determinations concerning total, partial, residual, permanent, or concurrent disability; (v) make claim determinations concerning decreases in earnings or income as test of disability; (vi) consult with professionals such as treating physicians, insurer physicians, physicians that have offered opinions without examining the insured, and occupational therapists; (vii) consider expert testimony, presumptions, and opinions of physicians; (viii) consider issues relating to the existence of other insurance and its impact on earnings; (ix) consider issues relating to vocational retraining and rehabilitation; and (x) consider issues related to when the particular disability occurred and whether it was in the policy period. The commenter opines that each of these factors affect the ability and willingness of insurers to underwrite and service disability insurance in Texas. The commenter asserts that prudent underwriting requires caution in both underwriting and benefit determination. Another commenter argues that uniformity and consistency in decisions concerning benefit determinations should not take precedence over whether decisions are ultimately correct. The commenter opines that the unique circumstances of each claimant merit judicial review under a non-deferential standard that does not protect issuers from poor decisions.

Agency Response: The Department disagrees that discretionary clauses are a judicial requirement needed to fulfill a statutory mandate under ERISA. As stated by the United

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States Supreme Court in *Rush*, 536 U.S. at 385 – 386: “Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the [ERISA] statute was silent, we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan’s benefit determinations were matters of high or unfettered discretion. . . . Nothing in ERISA, however, requires that these kinds of decisions be so “discretionary” in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract.” (citations omitted)); *c.f. Pierre*, 932 F.2d at 1553 (holding that *Firestone* does not require *de novo* review for factual determinations). The Department disagrees that the prohibition of discretionary clauses will decrease the uniformity of an insurer’s or administrator’s claims review process. The Department’s position is that because a discretionary clause prohibition allows an insured a subsequent opportunity for a full and independent review of coverage determinations, such a prohibition may encourage insurers to implement more uniform claim review procedures. Additionally, carriers have an opportunity and incentive to include consistently applied interpretations in the body of a form to ensure that insureds and enrollees, rather than only claims handlers, are equally aware of the constructions routinely applied to a plan’s terms. Such action would enhance uniformity and reliability in benefit provision and reduce potential confusion for not only individuals covered under the same plan but for all individuals receiving coverage under the same form. The Department also disagrees that §§3.1201 – 3.1203 will impede a carrier’s ability to

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perform underwriting, set premiums, process changes, or perform basic administrative functions associated with underwriting and servicing insurance and HMO coverages. Carriers can perform these functions without the necessity of a special grant of discretion. The Department notes a lack of evidence that such functions of a carrier appear to have halted in those jurisdictions that have already taken action of some kind to prohibit discretionary clauses. The Department does not agree that §§3.1201 – 3.1203 will preclude an insurer from exercising prudence in underwriting or benefit determination. The Department does, however, assert that the tension between this stated goal of prudence in benefit determination and the fact that discretionary clauses result in a deferential standard of review for the carrier making the benefit determination provides for a foundation that does not best protect the interests of a consumer. It is the Department's position that the adoption §§3.1201 – 3.1203 is necessary to ensure that consumers are afforded the opportunity for full, fair, and independent review under a standard that does not provide deference to the carrier. The Department agrees that potentially incorrect or unjust determinations of carriers should not be given deference in judicial review.

General Comments: ERISA Preemption

Comment: A commenter asserts that prohibitions on discretionary clauses in plans governed by ERISA are preempted because ERISA authorizes plan administrators to delegate discretionary authority to interpret plan terms. The commenter argues that in *Firestone*, 489 U.S. at 110, the United States Supreme Court made it clear that ERISA allows plans to exercise discretionary authority in determining benefits and interpreting

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policy terms through the use of discretionary clauses. Another commenter agrees and states further that the United States Supreme Court's decision in *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004) supports this position in finding that benefit determinations under ERISA are fiduciary acts and that HMOs must make discretionary decisions. *Id.* at 2501 – 2502. The commenter urges that *Davila*, in conjunction with “Congress’ creation of a ‘carefully integrated’ civil enforcement scheme’ that is “one of the essential tools for accomplishing the stated purposes of ERISA’, supports the argument that a prohibition on discretionary clauses restricts a fiduciary or administrator’s ability to fulfill the role intended by ERISA and affirmed by courts. *Id.* at 2495; *Ingersoll Rand v. McClendon*, 498 U.S. 133, 137 (1990)(citations omitted). The commenter argues that the Fifth Circuit Court of Appeals has not considered the issue of whether a prohibition on discretionary clauses violates ERISA’s preemption provisions by supplanting, supplementing or duplicating ERISA’s remedies provisions. *Davila*, 124 S. Ct. at 2488. The commenter asserts that the issue is ripe for review by the Supreme Court. Other commenters state that legal challenges to rules broadly prohibiting discretionary clauses have been unsuccessful. *Ross*, 558 F.3d at 605 - 607 (upholding Michigan’s rule prohibiting the use of discretionary clauses in insurance products because the rule was directed toward entities engaged in insurance, finding the rule essentially imposed a condition on the insurer’s right to issue a policy and substantially affected the risk pooling arrangement between the insurer and insured because the rule altered the scope of permissible bargains between the insurer and insureds by prohibiting discretionary clauses); *Morrison*, 584 F.3d at 845 (upholding

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Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); *McClenahan v. Metropolitan Life Ins. Co.*, 621 F.Supp.2d 1135, 1138-42 (D. Colo. 2009) (holding statute not preempted but not retroactively applicable). The commenter asserts that these cases have held that state laws effectively prohibiting discretionary clauses in insurance contracts were not preempted under the Supreme Court's analysis in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (holding that laws regulating insurance are saved under ERISA). A commenter emphasizes that the court has narrowed what will be preempted and expanded what will be saved under the insurance clause under ERISA over the last 15 years, citing to *Travelers* and *Miller*. The commenter opines that the United States Supreme Court's determination not to grant certiorari in *Morrison* is consistent with precedent and with the trend in the court to find fewer laws to be preempted under ERISA. A commenter also opines that, respectively, *Morrison* and *Ross* further rejected arguments that the Montana and Michigan laws prohibiting discretionary clauses were preempted under ERISA because they implicated ERISA's civil enforcement provisions. *Morrison*, 584 F.3d at 846 ("there is no additional remedy. Insureds may only recover the value of the denied claim from their insurers."); *accord*, *Ross*, 558 F.3d at 607-08. Finally, the commenter asserts that both courts rejected the argument that a state's prohibition of discretionary clauses conflicts with ERISA's purposes. Instead, the commenter asserts that the courts relied on the Supreme Court's decision in *Rush*:

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In *Rush Prudential*, the insurer argued that deferential review was a substantive rule intended to be preserved by the system of uniform enforcement. 536 U.S. at 384. The Court made quick work of this argument: Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations. *Id.* at 385.

Morrison, 584 F.3d at 848 (internal quotations omitted); *accord*, *Ross*, 558 F.3d at 608.

The commenter therefore argues that the states have clear authority to prohibit discretionary clauses because such actions are saved as regulating insurance and are not preempted under ERISA. A commenter asserts that the decision of the United States Supreme Court not to grant a petition for *certiorari* in *Morrison* is particularly important because such a grant will only be issued for compelling reasons at the discretion of the court under Supreme Court Rule 10. The commenter asserts that two of three possible bases for seeking review might have been involved in *Morrison*: (i) decisions of federal courts of appeal are in conflict with one another under Rule 10(a); and (ii) under Rule 10(c), the case presents important questions of federal law that have not been, but should be, decided by the Court or that have been decided in a manner that conflicts with relevant decisions of the Supreme Court. (Eugene Greesman et al., *Factors Motivating the Exercise of the Court's Certiorari Appellate Jurisdiction*, SUPREME COURT PRACTICE at 234276 (9th ed. 2007)). The commenter relates that Standard Insurance Company filed for *certiorari* of the *Morrison* decision based upon the alleged conflict that the prohibition caused with ERISA's civil enforcement provisions, recent Supreme Court decisions on the standard of review, and ERISA's purposes. The commenter further relates that the NAIC filed an *amicus* brief in support

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of denial of *certiorari*. The court denied *certiorari* in an order that states no reason for the denial, but the commenter, noting the lack of a court split on the issue, notes further that the court had previously rejected arguments similar to those raised in Standard's petition in *Rush-Prudential v. Moran*. A commenter additionally asserts that the United States Supreme Court recognized in *Rush*, 536 U.S. at 385, that ERISA permits but does not require discretionary review. The commenter therefore argues that "deferential review . . . is not a settled given." *Id.*

Agency Response: The Department disagrees that prohibitions on discretionary clauses are generally preempted by ERISA. ERISA specifies an exemption to preemption, known as the savings clause. The ERISA savings clause specifies: "*Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.*" See 29 U.S.C. §1144(b)(2)(A). The Supreme Court has specified that to fall within the ERISA savings clause exception, an insurance action must: (i) be specifically directed toward entities engaged in insurance; and (ii) substantially affect the risk pooling arrangement between the insurer and insured. See *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003). The Department's prohibition on discretionary clauses is specifically directed towards insurers, and substantially affects the risk pooling arrangement between the insurer and the insured because it alters the permissible scope of the bargain between the two entities. See *Ross*, 558 F. 3d at 605-07 (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products because the rule was directed toward

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entities engaged in insurance, finding the rule essentially imposed a condition on the insurer's right to issue a policy and substantially affected the risk pooling arrangement between the insurer and insured because the rule altered the scope of permissible bargains between the insurer and insureds by prohibiting discretionary clauses); *Morrison*, 584 F. 3d at 842-45 (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); and *McClenahan*, 621 F.Supp. 2d at 1141, 1143 (holding statute not preempted but not retroactively applicable). The Department additionally agrees that: (i) §§3.1201 – 3.1203 do not violate ERISA by conflicting with ERISA's civil enforcement provisions (*Morrison*, 584 F. 3d at 586; *accord Ross*, 558 F. 3d at 607-08); and (ii) §§3.1201 – 3.1203 do not conflict with ERISA's purpose (*Morrison*, 584 F. 3d at 848; *accord Ross*, 558 F. 3d at 608). The Department does not agree that ERISA mandates that discretionary authority be granted to insurers or that *Davila*, 542 U.S. at 220, represents this principle. Instead, the Department agrees with the United States Supreme Court that ERISA permits, but does not require, such a grant of discretion. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385–86 (2002). The Ninth Circuit considered and rejected the argument that the Montana policy prohibiting discretionary clauses in insurance forms conflicts with ERISA's exclusive scheme of civil enforcement, specifically considering the issue in light of *Davila*:

“[T]he detailed provisions of § [29 U.S.C. §1132](a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in

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encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Aetna Health v. Davila*, 542 U.S. 200, 208-09. Accordingly, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted." *Aetna Health*, 542 U.S. at 209. In *Aetna Health*, the Court declared preempted a state law which allowed insureds to receive damages when insurers failed to "exercise ordinary care when making health care treatment decisions." *Id.* at 205, (quoting Tex. Civ. Prac. & Rem. Code Ann. § 88.002 (1997)). ERISA already provides several remedies for disgruntled litigants, including preliminary injunctions and restitution under 29 U.S.C. § 1132(a)(1)(B). *Aetna Health*, 542 U.S. at 211. However, only the value of the lost claim is recoverable under the statutory remedies. Because the state statute allowed for recovery of a greater scope of damages, it upset "the careful balancing" Congress engaged in when crafting the "limited remedies under ERISA"; the state law may have "ensur[ed] fair and prompt enforcement of rights" but at the cost of discouraging employers from creating plans. *Id.* at 215. The state could not second-guess Congress's weighing of these factors by allowing for enhanced recoveries.

Morrison, 584 F. 3d at 846 (internal citations, quotes, and quotation marks omitted).

The Ninth Circuit continued its analysis by determining that the policy of prohibiting discretionary clauses in insurance forms, while it would lead to *de novo* review in federal courts, could not be said to "duplicate[], supplement[], or supplant[] the ERISA remedy. *Id.* at 846-47. Similarly, the Department's position is that §§ 3.1201 – 3.1203 provide "no additional remedy" but instead "force[] ERISA suits to proceed with their default standard of review." *Id.* at 846; *accord* *Ross*, 558 F.3d at 607-08. It is the Department's position that the prohibition falls within the ERISA savings clause and is not preempted by ERISA.

General Comments: Litigation, Delay in Claims Process, Small Business Impact, Premium Increase.

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Comment: Several commenters state that any prohibition on discretionary clauses will have unintended consequences that will be harmful to Texas consumers and employers and should not be adopted. The commenters state that a prohibition will increase and expand litigation and delay the claims process, resulting in higher health care costs and consequently higher premiums for employers and individuals. A commenter asserts that additional or more protracted litigation is not necessarily more efficient litigation. A commenter also asserts that disability insurance generates much litigation even without a prohibition on discretionary clauses because: (i) most policies and cases involve total disability; and (ii) even carefully drafted definitions may be litigated due to the cost of the insurance and consumer expectations that may vary from the actual policy. Another commenter asserts that elimination of the preferential review standard that arises from inclusion of discretionary clauses in forms will result in added expense due to the need for parties to hire experts and that this cost will be passed on to purchasers. The commenters assert that small employers are particularly vulnerable to price increases and will bear the brunt of higher costs due to a lack of resources and infrastructure to self-fund their health benefit plans. The commenters also assert that even modest premium increases in disability income insurance products lead to employer determinations to drop or forgo including the product in plans, to reduced purchasing by individuals, and to reduced options for consumers. A commenter states that the cost estimate in the Department's proposal, based on a study by Milliman, Inc., estimates that premiums will increase 3 to 4 percent "based upon anticipated increases in litigation, higher costs of litigation, and more cautious carrier behavior in managing

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claims.” The commenter asserts that studies have found that increased premium costs result in reduced coverage. See *Jonathan Gruber, “How Elastic is the Firm’s Demand for Health Insurance? Journal of Public Economics, 88 (2004) (“Gruber study”)*. The commenter states that the *Gruber* study estimates the impact of premium increase to coverage varies between 0.2 to 0.7 percent depending upon the size of the employer. A commenter states that employers may avoid the prohibition against discretionary clauses by self-funding plans or by purchasing a product in another state in which the employer operates that does not prohibit discretionary clauses. The commenter asserts its understanding that there are 15 jurisdictions that have taken some action with respect to prohibitions against discretionary clauses. Another commenter asserts that 22 states currently prohibit the use of discretionary clauses in insurance policies in some way, with: (i) four states taking action through statute (Colorado at Colo. Rev. Stat. §10-3-1116 (2008); Maine at Me. Rev. Stat. Ann. Tit. 24-A, §4303(11) (2003); Minnesota at Minn. Stat. §62Q.107 (1998); and Wyoming at Wyo. Stat. §§26-13-301 to 26-13-305); (ii) eight states taking action through regulation (Idaho at Admin. Pro. Act §18.01.29 (2009); Illinois at Admin. Code Title 50 §2001.3 (2005); Michigan at Admin. Code r.500.2201 – r.500.2202, (2007), Admin. Code r.550.111 – r.550.112 (2007), and Admin. Code r.550.301 – r.550.302 (2007); New Hampshire at Admin. Rules Ins. 401.03(1) (2006); New Jersey at Admin. Code Title 11: Insurance §§11:4-58.1 – 11:4-58.4 (2007); South Dakota at Admin. Rules Ch. 20:06:52 (2008); Utah at Admin. Code r.590-218-1 – 590-218-7 (2003); and Washington at Admin. Code 284-44-015 (2009); (iii) six states taking action through published commissioner bulletin or opinion

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(California, Notice to Withdraw Approval (Feb. 27, 2004); Connecticut, Bulletin HC-67 (March 19, 2008); Hawaii, Memorandum 2004-13H (Dec. 8, 2004); Indiana, Bulletin 103 (May 8, 2001); Kentucky, Advisory Opinion 2008-05 (2008); and New York, Circular Letter No. 14 (2006); and four states taking unpublished commissioner action of some type (Alaska, Group Health Policy Form Checklist; Montana, *Standard Ins. Co. v Morrison*, 584 F.3d 837 (9th Cir. 2009); Nevada, Proposed Regulation of the Commissioner of Insurance R074-2; and Oregon, Standard Provisions for Small Employer Health Benefit Plans). The commenter further argues that the only measure of increased costs that will result from the proposed rule that have been presented by industry is a study performed in 2005 that has not been updated. The commenter further asserts that in each of the jurisdictions that have taken action regarding the use of discretionary clauses, insurance industry comments predicted higher insurance premiums, frivolous law suits, failure of small businesses, and a mass exodus of insurers. The commenter emphasizes that over a decade of experience in states that have imposed bans upon discretionary clauses has failed to support these predictions, citing to Washington State Office of the Insurance Commissioner, *Concise Explanatory Statement; Responsiveness Summary; Rule Development Process; and Implementation Plan Relating to the Adoption of WAC 284-44-010, 284-46-015, 284-50-321, 284-96-012 Discretionary Clauses Prohibited*, at 9 – 10, August 5, 2009: “Most western states have discretionary prohibition clauses in law or rule, without reported evidence of cost increases or market withdrawal based on discretionary clauses.” As such, the commenter urges that these concerns should not preclude adoption of a

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prohibition in Texas. Another commenter, noting reliance by industry stakeholders upon a report prepared by a benefit consulting firm, Milliman, for the proposition that premiums will increase as a result of a prohibition of discretionary clauses, found such reliance problematic. The commenter notes that the Milliman report estimates that the cost to litigate group disability claims would be similar to individual claims. Robert W. Beal & Daniel D. Skwire, Milliman, Inc., *Impact of Disability Insurance Policy Mandates Proposed by California Department of Insurance* 8 - 9 (Nov. 14, 2005), available at <http://ahip.org/content/default.aspx?docid=13557> ("Milliman Report"). The commenter submits that such estimate is too high because a claimant suing under an individual policy might be entitled to a jury trial and punitive damages, while a claimant suing under an ERISA plan is not so entitled. See generally *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Mass. Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144 (1985). Compare with Tex. Ins. Code §§542.003; 542.051 and 542.055 (permitting statutory penalties, treble damages and attorney fees). The commenter further asserts that California has not experienced an exodus of insurers or an increase in premiums resulting from the prohibition of discretionary clauses since instituting its prohibitions in 2004. Similarly, the commenter argues that it is unaware of any studies evidencing an increase in litigation due to this prohibition or a significant increase in costs or litigation from any state which has approved the prohibition of discretionary clauses. A commenter further asserts that under plans governed by ERISA, claimant remedies are limited to benefits under the plan and, at the discretion of the court, attorney fees. The commenter asserts

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that compensatory and punitive damages are not available and that, as such, the monetary amounts at issue as a result of a prohibition concerning discretionary clauses are relatively small. The commenter further asserts that a prohibition against discretionary clauses will lead to better, correct decisions and eliminate lawsuits based upon poor decisions. As such, the commenter estimates that costs associated with lawsuits should not increase. Similarly, another commenter opines that elimination of discretionary clauses will incentivize insurers to review claims more thoroughly, resulting in a reduced number of claims that need to be appealed. The commenter also asserts that such prohibition will eliminate the need for discovery concerning the impact of the inherent conflict of interest that an insurer has in determining benefits, leading to reduced litigation costs. A commenter opines that the cost of disability coverage is only approximately 1/20 of the amount that employers and employees pay, on average, for all employer-based coverages, and as such, any increases in cost resulting from a ban on discretionary clauses are likely to be negligible. The commenter also opines that the likely increase in cost of coverage related to a prohibition of discretionary clauses does not appear to outweigh the anticipated benefits of such a prohibition. Another commenter opines that it is not ethical to sell policies that contain discretionary clauses. A commenter asserts that a prohibition on discretionary clauses has become even more necessary due to a recent U.S. Supreme Court holding that is resulting in a greater number of remands to plan administrators even where the court finds an ERISA violation. *Conkright v. Frommert*, 130 S. Ct. 1640 (April 2010). In *Conkright*, the commenter asserts that the court held that: (i) a plan administrator's interpretation of a

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retirement plan is entitled to deference where there is a discretionary clause in the plan, even when a court finds that the administrator has previously offered an erroneous reading; and (ii) a trial court should reject the administrator's construction of the plan terms only if the administrator "acted in bad faith or would not fairly exercise his discretion to interpret the terms of the Plan." *Id.* at 1648. The commenter asserts that representatives of employers and plans are heralding *Conkright* for its expansion of the deference to which plan administrators are entitled and the resulting increase in remands to plan administrators. Heather G. Magier, *Supreme Court Rules That "Single Honest Mistake" Does Not Justify Stripping Administrator Of Judicial Deference*, PROSKAUER ROSE THE ERISA LITIGATION NEWSLETTER (May 2010) ("the Supreme Court extended the reach of the deferential standard of review it established 20 years ago for ERISA plan administrators"; "[t]he likely outcome of this broad endorsement of deference principles is that district courts will more frequently remand benefit claims to the plan administrator for additional consideration, rather than rule outright against the plan"), available at <http://www.proskauer.com/publications/newsletters/erisa-litigation-newslettermay-2010/>; see also Mayer Brown, *US Supreme Court Releases Opinion in Conkright v. Frommert*, available at <http://www.mayerbrown.com/publications/article.asp?id=8898&nid=6>; Jenner & Block, *Client Advisory: Supreme Court Rules in Conkright v. Frommert: "People Make Mistakes" Ruling Strengthens Firestone Administrative Deference Standard*, available at http://www.jenner.com/news/pubs_item.asp?id=15379224; Groom Law Firm, Client

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Memorandum, *Supreme Court Decision in Conkright v. Frommert* (April 23, 2010), available at <http://www.groom.com/resources-484.html>; Kutak Rock, *Supreme Court Reaffirms Deferential Standard Applied to Plan Interpretation by Plan Administrators* (May 24, 2010), available at www.kutakrock.com/publications/employee_benefits/CA052410.pdf. The commenter asserts that a pattern of increased remands is already materializing. *E.g.*, *Goletz v. Prudential Ins. Co. of Am.*, No. 084740, 2010 U.S. App. LEXIS 11501, at *1, 10 (3d Cir. June 7, 2010) ("Also waived is Goletz's argument that, because Prudential's handling of this case has already been faulted once by the District Court, we should now forego extending any deference to Prudential's decision and subject it to de novo review. This position was all but rejected by the Supreme Court in *Conkright*, in which the Court explained that ERISA plan administrators "make mistakes" and that a "single honest mistake in plan interpretation" does not justify "stripping the administrator of . . . deference for subsequent related interpretations of the plan."); see also *Fortlage v. Heller Ehrman, LLP*, No. C 08-3406 VRW, 2010 U.S. Dist. LEXIS 50634, at *1,8 (N.D. Cal. Apr. 27, 2010). The commenter argues that those courts that have not remanded incorrect claims have done so where the claimant has shown a pattern of deliberate actions. *E.g.*, *Nolan v. Heald College*, No. C 05-3399 VRW (JL), 2010 U.S. Dist. LEXIS 53997, at *1, 2 (N.D. Cal. May 6, 2010) (citing *Conkright* and refusing to remand to the administrator, "[t]his case involves not "a single honest mistake," but a number of deliberate actions by the plan administrator."). The commenter states that this trend will present insurers with even more opportunities to determine claims that have already been decided incorrectly.

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Agency Response: The Department does not agree that a discretionary clause prohibition will necessarily result in an increase in litigation and consequent delay in claim resolution. The Department anticipates that a discretionary clause prohibition will likely result in: (i) an increase in the uniformity of claims review procedures; and (ii) a decrease in questionable coverage determinations made by insurers in reliance upon the subsequent lack of a subsequent full and independent review. The Department does agree that even very careful drafting will not eliminate all litigation. However, many of the concerns expressed by the commenters may be addressed through the use of clearer drafting in forms to reduce potential ambiguity and confusion, rather than reliance upon a deferential standard of review during litigation. Absent the ability to rely upon such a deferential standard of review, carriers will have incentive to include consistently applied interpretations in the body of forms, through enhanced definitions, examples, terms, or otherwise. Such inclusion would enhance uniformity and reliability in benefit provision, reduce the likelihood of litigation by providing clarity concerning benefits and provisions in the body of forms for easy access by all parties to the agreement, and provide a clear basis for the carrier's determinations in the event that there is litigation. Similarly, an increase in the uniformity of claims review processes will accelerate, rather than delay, the claims review process. The Department does agree that for those cases that are litigated under a *de novo* review rather than the deferential arbitrary and capricious standard of review, there may be greater expenses on a case-by-case basis. However, the Department does not agree that this factor outweighs the benefits of §§3.1201 – 3.1203 in providing consumers with an opportunity for full, fair,

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and independent review of claim determinations and reducing the potential for consumers to be misled concerning their rights of appeal. Further, the Department agrees that plans governed by ERISA have more limited relief available even in the context of litigation. See ERISA §502(a)(1)(B) (permitting a participant or beneficiary to bring a civil action to recover benefits due under the terms of the plan, to enforce rights under the plan, or to clarify rights to future benefits under the plan); see *also* ERISA §502(a)(3) (permitting a participant or beneficiary to sue to enjoin an act or practice that violates a provision of ERISA or to obtain other appropriate equitable relief to redress violations of ERISA or enforce provisions of ERISA or the terms of the plan); and ERISA §502(g) (permitting the recovery of attorney's fees and costs). Unless excepted, common law causes of action are expressly preempted under ERISA. *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 48 (1987). The Department, therefore, agrees that the adoption of §§3.1201 – 3.1203 will not result in additional litigation costs arising from successful state law claims. With respect to the potential effect of a prohibition of discretionary clauses upon premium, while some commenters jointly submitted a report from Milliman, Inc. analyzing the estimated actuarial impact of disability insurance policy mandates proposed by the California Department of Insurance in October 2005, including an estimate that premiums would rise 3 – 4 percent due to a prohibition of discretionary clauses, the commenters did not provide evidence of the actual results of the prohibition and the subsequent effect upon premium. The Department agrees that it is possible that some prospective purchasers will base the decision to purchase or not purchase an insurance or HMO product on price alone. However, the Department

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anticipates that multiple factors may affect decisions concerning the purchase of insurance and HMO products. Along with premium price, the Department anticipates that some purchasers consider the scope of transparency concerning the terms of the bargain and the existence of an opportunity for full, fair, and independent judicial review as appropriate. For those prospective purchasers, the factors concerning transparency and the opportunity for a more favorable standard of judicial review should there be a difference of opinion concerning the terms of the bargain may actually tip the scale in favor of purchase. The Department's position is that the benefits of a prohibition concerning discretionary clauses makes adoption of new §§3.1201 – 3.1203 a necessary consumer protection. The Department further disagrees that only litigation under a deferential standard of review is efficient, because it is the Department's position that efficiency includes access to full independent review under a non-deferential standard in reviewing the terms of a bargain drafted by the party that is determining application of benefits under those terms. The Department agrees that employers considering the purchase or retention of disability income protection for employees want to protect employees that become disabled. The Department recognizes that some carriers that use discretionary clauses in forms likely do so without any intent to undertake ethically questionable behavior. However, it is the Department's position that the use of discretionary clauses creates an environment that may foster unethical behavior. It is the Department's position that §§3.1201 – 3.1203 will reduce that potential. The Department further disagrees that unintended consequences may result from the rule because the use of discretionary clauses is

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relatively new, since the *Firestone* decision, and the rule merely returns the market to where it was previously. Nevertheless, the rule has been revised to provide for staggered implementation. Using a staggered implementation provides the Department with a brief period of time to assess whether a discretionary clause prohibition will actually result in unintended consequences before its application is extended to forms other than those that include disability income protection coverage.

General Comments: Additional Expense to Courts.

Comment: Some commenters asserted that a discretionary clause prohibition will cause courts to expend additional resources.

Agency Response: The Department disagrees. The comment that courts will be required to expend additional resources is premised on the belief that a discretionary clause prohibition will increase litigation. However, the Department does not agree that a discretionary clause prohibition will increase litigation. The Department acknowledges that courts may expend more time and resources in a *de novo* review than they would in a deferential arbitrary and capricious review. However, as stated previously in this adoption order, absent the ability to rely upon a deferential standard of review when a claim determination is appealed, issuers will have incentive to include consistently applied interpretations in the body of forms, through enhanced definitions, examples, terms, or otherwise. Such inclusion would reduce the likelihood of litigation by providing clarity concerning benefits and provisions in the body of forms and provide a clear basis for the issuer's determinations in the event that there is litigation. The additional resources required in *de novo* reviews will, therefore, be mitigated by the overall

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decrease in litigation resulting from the discretionary clause prohibition that the Department anticipates. Additionally, the Department disagrees with the premise that the expenditure of additional resources by the courts is a basis for rejecting a prohibition on discretionary clauses.

§3.1201(a): Applicability to Different Types of Coverage.

Comment: A commenter asserts that §3.1201(a) includes applicability language broad enough to encompass life, accident and health insurance forms/policies and HMO evidence of coverage forms. The commenter supports this broad applicability and recommends its retention because the commenter believes it is vital for consumers to understand the nature of the coverage offered in order to: (i) assess the value of the coverage offered; and (ii) access the benefit of the bargain. Absent such understanding, regardless of the type of coverage, the commenter asserts that a consumer's benefits are uncertain and/or illusory. The commenter asserts that broad applicability is necessary because potential conflicts of interest may arise from the presence of a discretionary clause in a form regardless of the type of coverage. Another commenter urges that the Department revise the rule to more closely track NAIC model language by restricting applicability to health and/or disability policies. The commenter asserts that the applicability is overly broad because it extends to individual and group life, credit life, disability income, accident, individual and group health, annuities, credit disability, endowment and any other form required to be filed under Chapter 1701, which may include noninsurance benefits.

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Agency Response: The Department appreciates the commenter's statement of support for broad applicability of new §§3.1201 – 3.1203 and agrees that consumer understanding of coverage terms and benefits is important. The Department also agrees that the need for a prohibition of discretionary clauses stems in part from the potential for conflict of interest rather than the type of coverage in question. The Department disagrees that applicability of Subchapter M should be restricted to health and/or disability coverage products. The Department's position is that there is not sufficient justification for protecting only consumers of disability income and health insurance products from the detrimental effects of discretionary clauses and not affording the same level of protection to consumers of life insurance and annuity products. The Department does clarify that new Subchapter M does not apply to credit life or credit accident and health policies at this time. Such policies and forms are governed under the Insurance Code Chapter 1153 rather than Chapters 1271 or 1701, and as such the forms do not fall within the scope of Subchapter M.

§3.1201(b) and §3.1203: Applicability to Forms.

Comment: Several commenters state their support for applicability of new §§3.1201 – 3.1203 to forms enforced on or after January 1, 2011 and recommend that the Department explicitly address in §3.1201(b) and §3.1203 applicability to forms renewed and delivered on or after January 1, 2011 in addition to those forms offered, issued, or enforced. One commenter requests expansion of this applicability to forms advertised on or after January 1, 2011. The commenter asserts that the language is otherwise too limited and may not capture every potential use of a discretionary clause that could

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negatively affect consumers. Another commenter urges the Department to clarify applicability of new §§3.1201 – 3.1203 to ensure application to policies that are amended or renewed. The commenter notes that in *Golden v. Guardian Life Ins. Co.*, No. 09 C 865, 2010 U.S. Dist. LEXIS 55683 at 1 (N.D. Ill. June 1, 2010), the court held that: (i) regulations promulgated by the Illinois Department of Insurance prohibiting discretionary clauses did not apply to policies that predated the effective date of the regulation; and (ii) the addition of an addendum to the policy did not constitute a renewal of the policy and, therefore, did not suffice to bring the policy within the scope of the prohibition. The commenter states that courts have required specificity in regulatory language concerning application of prohibitions to policies that have renewed, rather than merely been issued or delivered. A commenter supports application of the subchapter to forms that do not have renewal dates. Another commenter requests that applicability to policies governed by ERISA be prospective in nature. The commenter additionally asserts that applicability to forms as the forms are renewed is not appropriate in the context of life and health insurance, especially with respect to guaranteed renewable policies, because of the potential for uncertainty. The commenter therefore requests that the rule should not apply to guaranteed renewable policies. The commenter also questions whether the broad applicability applies to form filings that are intended only to update other information in a policy such as a guaranteed interest rate provision or to add a mandate required in a health policy.

Agency Response: The Department agrees that the applicability of new §§3.1201 – 3.1203 to forms offered and issued includes application to forms renewed and delivered

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on or after the specific effective date applicable to the form, and the Department has revised both §3.1201 and §3.1203 to clarify this applicability and reduce duplicative language. The Department also agrees that language in §3.1201 concerning applicability to policies “issued, delivered, or enforced” is unclear as to whether the terms encompass the amendment of a form that contains a discretionary clause. The Department, therefore, has revised §3.1201 to address applicability to forms that are issued and delivered prior to the effective date of the subchapter and have no renewal date. Specifically, to clarify applicability to forms enforced after the applicable effective date, the Department has revised §3.1201 by: (i) clarifying in subsection (b) that the subchapter applies to forms offered, issued, renewed, or delivered on or after June 1, 2011, including forms that include premium waiver provisions based upon a disability determination, except as otherwise provided; (ii) added new subsection (c) to clarify that for forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate, or rider, the subchapter applies to forms issued, renewed, or delivered on or after February 1, 2011; and (iii) added new subsection (d) to clarify that for forms issued or delivered prior to the effective date of the subchapter that do not contain a renewal date, the subchapter applies on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. Because of the clarifications made to §3.1201 to clarify applicability, the Department has determined that language concerning dates of offer, issuance, and enforcement in §3.1203 would be duplicative and unnecessary. As such

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the Department has revised §3.1203, and the section now provides that inclusion of a discretionary clause in any form to the subchapter applies is prohibited. As a result of this revision, additional changes to conform §3.1203 to applicability as specified in §3.1201 are not necessary. The Department does not agree that inclusion of forms advertised is a necessary addition to the terms of applicability in §3.1201 or the prohibition in §3.1203. Instead, the Department's position is that §3.1201 and §3.1203 as adopted will best afford protection to those insureds and enrollees who would be subject to the potential harmful effects of a discretionary clause in a form. However, the Department will monitor to determine whether future rulemaking is necessary. To the extent that any commenters request that applicability of the subchapter be prospective in nature, the Department disagrees that any further limitation on applicability is appropriate or would be consistent with the consumer protection purposes of the subchapter. The Department disagrees that applicability of Subchapter M to forms renewed on or after the effective date specified in new §3.1201 is inappropriate for policies that are guaranteed renewable because such applicability creates uncertainty. The Legislature and the Commissioner routinely enact legislation and adopt rules, respectively, that apply to such policies on renewal. The Department therefore anticipates that carriers and HMOs have experience with implementation of new requirements applicable to guaranteed renewable products on renewal. The Department clarifies that for forms that are issued or delivered prior to the effective date of the subchapter as specified in §3.1201 that do not contain renewal dates, Subchapter M applies to the form on or after the effective date of any rate increase applicable to the

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form or any change, modification, or amendment of the form occurring on or after June 1, 2011, as specified in §3.1201(d). The Department further clarifies that for all other forms subject to Subchapter M, the subchapter applies when such forms are offered, issued, renewed, or delivered as provided in §3.1201(b) and (c).

§3.1202: Definition of Discretionary Clause.

Comment: A commenter submits that §3.1202 gives insufficient guidance to insurers as to what constitutes a discretionary clause because: (i) it encompasses any provision that purports to grant deference to an insurer's decisions, denials, or interpretations of terms, coverage or eligibility for benefits; and (ii) the provision does not limit the definition but instead specifies that it "includes but is not limited to" several examples of such provisions. The commenter asserts that a provision in a form that implies that the insurer will make decisions in the administration of the coverage could fall within the definition of a discretionary clause. Similarly, the commenter questions: (i) whether an insurer's discretion to determine investments in a universal life policy or with respect to rate matters in a guaranteed renewable individual health policy would qualify as a discretionary clause; (ii) whether an insurer could perform determinations of medical necessity to determine benefit eligibility in a health plan without exercising discretion in violation of the prohibition; (iii) whether an insurer may determine eligibility for group plans as permitted by federal law without exercising discretion in violation of the prohibition; and (iv) whether an insurer may make complex determinations under disability income products that may involve unique medical situations, work environment, available workplace accommodations, and potential for vocational

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rehabilitation over an extended period of time as a claimant recovers from a disability.

The commenter expresses concern that the definition of “discretionary clause” may prevent insurers from interpreting a policy even where there is no express “discretionary clause” in the policy.

Agency Response: The Department agrees that additional clarification concerning the limits of what constitutes a discretionary clause is appropriate. Specifically, the Department agrees that the additional sentence stating that the term “includes, but is not limited to” certain provisions should be modified and clarified to provide more certainty for carriers. The Department has accordingly revised the section such that it no longer contains this language of inclusion but instead emphasizes the limits of what constitutes a discretionary clause. Section 3.1202 now provides greater specificity by providing that a discretionary clause is a provision that meets one of five qualifying criteria included as paragraphs of the section. The Department does agree that carriers and the Department will need to review any provision on a case by case basis in order to determine whether the provision meets the definition established in §3.1202. This is consistent with the judicial findings in *Walley v. Interhealth, Inc.*, 1999 WL 33537135 (D. Miss. N.D. 1999), that “. . . the Supreme Court surely did not suggest [in *Firestone*] that ‘discretionary authority’ hinges on the incantation of the word ‘discretion’ or any other ‘magic word.’ Rather, the Supreme Court directed lower courts to focus on the breadth of the administrator’s power their ‘authority to determine eligibility for benefits or to construe the terms of the plan’. . . *Chevron Chemical Co. v. Oil, Chemical, & Atomic Workers Local Union 4-447*, 47 F.3d 139, 143 (5th Cir. 1995) (citations omitted).” *Walley*

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at 2. Because a case by case approach focused upon specific language is required, it is not appropriate for the Department to make statements concerning applicability with respect to broad categories of possible provisions. The Department does clarify that the definition of “discretionary clause” does not encompass general, as opposed to discretionary, provisions concerning plan administration and consequent performance of initial determinations. The Department further notes that no evidence has been submitted indicating that insurers have been precluded from such plan administration in jurisdictions that have already prohibited the use of discretionary clauses.

Comment: A commenter recommends that §3.1202 be modified to clarify that a discretionary clause is not only a provision that purports to bind a claimant to or grant deference in subsequent proceedings to the insurer’s decision, denial, or interpretation on terms, coverage, or eligibility for benefits, but also to a provision that “acts” in the same manner. The commenter asserts that *Webster’s Dictionary* defines the term “purport” as: “(i) to profess or claim as its meaning; and (ii) to give the appearance of, often falsely, of being, intending, etc.” To clarify that intent is not required for the prohibition to be triggered and to clarify the scope of the definition, the commenter believes this modification is necessary. The commenter further asserts that this clarification will serve to ensure consumer protection in substantive effect instead of limiting the protection to restriction of misleading language.

Agency Response: The Department agrees that the suggested change is an appropriate clarification of the type of provision that constitutes a discretionary clause. It is not merely the professed or apparent purpose of a provision that characterizes a

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discretionary clause, but additionally the resultant effect of the language. The Department has revised §3.1202(1) accordingly to specify that a discretionary clause is a provision that purports or acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim determinations or policy interpretations of the insurer or HMO.

Comment: Some commenters recommend that the Department include references to HMOs in all provisions of §3.1202 that reference insurers for internal consistency with language concerning applicability to forms filed under Chapter 1271.

Agency Response: The Department agrees that the addition of references to HMOs in addition to insurers will clarify the scope of the rule and reduce possible confusion. The Department has accordingly revised §3.1202(1), (3), and (4) as adopted to specifically reference HMOs. Because §3.1202(5) is deleted for reasons unrelated to this comment, addition of the term to that paragraph is not necessary.

Comment: A commenter recommends modification of the definition of a discretionary clause in §3.1201(1) to include provisions specifying that a policyholder or other claimant may not “appeal” a denial of a claim. The commenter states its belief that appeals of claims are encompassed by the term “contest” as used in the provision but urges that inclusion of the term “appeal” would preclude confusion as to the breadth of the provision. The commenter further requests that the Department define the term “appeal” for purposes of the subchapter similarly to the definition used in Michigan’s regulatory prohibition on discretionary clauses, located at *Mich. Admin. Code R. 500.2201(a)*, to mean “an appeal by a policyholder or other claimant of a claim denial by

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an insurer or health maintenance organization. It includes appeals to administrative agencies, arbitrators, courts and mediators.”

Agency Response: The Department agrees that: (i) inclusion of the phrase “or appeal” will clarify that an appeal is within the scope of a contest as that term is used to define a discretionary clause in §3.1202(1) as proposed; and (ii) inclusion of the phrase will serve to reduce potential ambiguity. The Department has revised the paragraph, adopted as §3.1202(2), accordingly. The Department disagrees that inclusion of a definition for the term “appeal” is necessary. Section 3.1202(2) as adopted provides that a provision specifying that a policyholder or other claimant may not contest or appeal a denial of a claim is a discretionary clause. The Department believes that this language is plain, is clearly broad in scope, and does not require further clarification.

Comment: Some commenters recommend that all references to the terms “policy or contract” within §3.1202 be replaced with the term “form” to ensure correct application of discretionary clause definition and internal consistency within §§3.1201 – 3.1203. A commenter notes that §3.1201 provides that the discretionary clause prohibition applies to “any form filed under the Insurance Code Chapters 1701 or 1271” and asserts that these forms include: (i) under Chapter 1701, a policy, contract or certificate of insurance; an application attached or required to be attached to the policy contract, or certificate; and a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate; and (ii) additionally, under Chapter 1271, an HMO evidence of coverage. The commenter notes that states such as Michigan have acknowledged the importance of consistency in terminology in their own

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regulatory provisions at, e.g. Mich. Admin. Code R. 500.2201, 500.2202, 550.111, and 550.112.

Agency Response: The Department agrees with the suggested change. Replacing the phrase “policy or contract” with the term “form” in §3.1202 is a clarification that will: (i) promote internal consistency between the section and adopted §3.1201, which refers to “forms;” and (ii) reduce potential confusion and ambiguity concerning whether the paragraphs referencing the term are intended to vary in scope from the broader scope established in §3.1201. Accordingly, the Department has revised §3.1202(3) and (4) as adopted by substituting the term “form” for the phrase “policy or contract.” Section 3.1202(5) as proposed has been deleted for reasons unrelated to this comment and therefore does not require revision.

Comment: Some commenters recommend modification of §3.1202(4) to provide that a discretionary clause includes a provision “giving rise to” a deferential standard of review in addition to a provision that “specifies” a deferential standard of review. A commenter asserts that this is a necessary change to capture the effects of a provision that fails to “specify” a deferential standard of review but nonetheless results in the court’s application of a deferential standard of review. The commenter notes that *Walley v. Interhealth*, 1999 WL 33537135 (N.D.Miss.) demonstrates that a plan need not specify the standard of review in order to “expressly” confer discretionary authority and obtain the benefit of a deferential review. The commenter therefore recommends that the Department acknowledge this distinction in a manner similar to Michigan in Mich.

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Admin. Code R. 500.2201(c)(vi) and Mich. Admin. Code R. 550.111(c)(vi) by including provisions that “give rise to” a deferential standard of review in the definition.

Agency Response: The Department agrees that the suggested revision is an appropriate clarification of the type of provision that constitutes a discretionary clause because it is not only the fact of specification of a deferential standard in a form that characterizes a discretionary clause but the resultant effect of the language in question. The Department has revised the paragraph, adopted as §3.1202(5), accordingly.

Comment: A commenter asserts that defining a discretionary clause as a provision that specifies a standard of review that gives deference to any original claim decisions that are inconsistent with the laws of this state, including common law, is problematic. The commenter opines that the reference to common law is an unlawful delegation of authority to the courts because common law is that body of law that has developed through the judicial branch and subject to change by the judiciary. Common law is regularly amended by the Legislature. Courts also do not follow the requirements of the Administrative Procedure Act in the Texas Government Code Chapter 2001, such as publication in the Texas Register and opportunity for comment, in determining changes to common law. The commenter argues that delegation of authority from an administrative agency to the judiciary violates the Texas Constitution. The commenter recommends deletion of the reference to common law.

Agency Response: The Department agrees that ambiguity as to whether §3.1202(4) improperly delegates rulemaking authority to the judiciary may arise from the inclusion of the term “common law” in the definition of a discretionary clause in that paragraph,

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and the Department has furthermore determined that inclusion of the term in the scope of the definition is not necessary to the definition. It is not the Department's intent to delegate rulemaking authority as queried by the commenter. "Common law" is "the body of law derived from judicial decisions, rather than from statutes or constitutions." See *Black's Law Dictionary* 270 (7th ed. 1999). The Department anticipates that the definition of "discretionary clause" as set forth in §3.1202, in conjunction with the prohibition against discretionary clauses in §3.1203, will result in elimination of the deferential standard of review currently enjoyed by those carriers that use discretionary clauses, and common law, including the longstanding Texas common law doctrine that ambiguities in insurance contracts should be construed in favor of the insured, will be applied as appropriate by courts in reviewing cases without the necessity for referencing common law in the paragraph. See *Fiess v. State Farm Lloyds*, 202 S.W.3d, 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.*, 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters*, 545 S.W.2d 755, 762, 763 (Tex.1977); and *Continental Cas. Co. v. Warren*, 254 S.W.2d 762, 763 (Tex.1953). Accordingly, the Department has revised §3.1202(4), redesignated as §3.1202(5), by deleting the reference to common law.

Comment: A commenter recommends the addition of a new paragraph to §3.1202 to include within the definition of a discretionary clause provisions that "give rise to a standard of review on appeal other than *de novo* review." The commenter asserts that inclusion of this provision within the definition will eliminate use of the arbitrary and capricious standard of review that creates such an obstacle for consumers seeking to

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challenge an insurer's determinations and notes that the suggested addition closely tracks usage in Michigan's regulation concerning discretionary clauses at Mich. Admin. Code R. 500.2201(c)(vii) and Mich. Admin. Code R. 550.111(c)(vii). Because the commenter asserts that §§3.1201 – 3.1203 closely track Michigan's regulation, the commenter questions the Department's rationale in failing to include this provision in §3.1202.

Agency Response: The Department disagrees that the suggested provision is necessary because §3.1202(5) as adopted already includes within the definition of a discretionary clause a provision that specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state. It is the Department's position that §3.1202(5) as adopted is sufficient to address the commenter's stated concern regarding use of the arbitrary and capricious standard of review. However, the Department will monitor to determine whether additional rulemaking is needed.

Comment: Several commenters recommend deletion of §3.1202(5) because the provision is not necessary to fulfill its stated purpose, is confusing, and seems to conflict with §3.1203. By including in the definition of a discretionary clause a provision specifying that "the insurer has discretion to interpret the terms of the policy or contract or determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal," commenters opine that the Department risks evisceration of the

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protections otherwise afforded by §§3.1201 – 3.1203 as applied to plans governed by ERISA. The commenters opine that §3.1202(5), intended to create a safe harbor provision permitting insurers to continue the limited use of discretionary clauses, is not necessary to permit insurers to make initial coverage determinations. Some commenters note that paragraph (5) was included in §3.1202 specifically to address the insurance industry comment that insurers would otherwise be prevented by interpreting contracts and making such coverage determinations, as stated in the Department's proposal at 35 *TexReg* 4587. The commenters assert that such a safe harbor clause is unnecessary because jurisdictions that have not included such safe harbor language in their own regulations of discretionary clauses, including Maine, Illinois, Michigan, California, New York, Oregon, South Dakota, Idaho, and Hawaii, some of which are longstanding in duration, have not experienced the chilling effect on claim processing that the safe harbor is intended to prevent. Some commenters assert that discretionary clause provisions have been universally interpreted and applied to affect the binding nature of and deference provided to an insurer's initial coverage determinations rather than the basic ability of the insurer to make initial determinations in the first place. As another basis for deletion of paragraph (5), a commenter asserts that the concern expressed by the insurance industry stakeholder concerning the chilling effect of the Department's rule upon industry claim processing was prompted by an informal posting of the rule that was arguably broader in scope than proposed §§3.1201 – 3.1203. The commenter argues that §3.1202 as proposed has sufficiently captured the timing element of the definition by clarifying that the provisions are those that affect

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subsequent proceedings rather than initial claim determinations, rendering the need for safe harbor language superfluous. Commenters additionally assert that under the plain meaning of §3.1202, the term does not completely restrict an insurer from making initial claim determinations but rather from making claim determinations that are not subject to full challenge. More specifically, a commenter asserts that nearly identical regulations in Michigan that do not contain safe harbor language, *Mich. Admin. Code R. 500.2201* and *500.2202* and *Mich. Admin. Code R. 550.111* and *550.112*, have been implemented without a resulting impediment to initial claim determinations. Other commenters assert that paragraph (5) should be deleted from §3.1202 based upon a holding in *Hancock v. Metropolitan Life Insurance Company*, 590 F. 3d 1141 (10th Cir. 2009) that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans; in permitting discretion-granting clauses that complied with form requirements, the 10th Circuit held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. *See also Weeks v. UNUM*, No. 2:07-CV-00577DAK, 2008 U.S. Dist. LEXIS 41990, 44EBC 1575 (D.Utah 2008). Under *Hancock* at 1149, the court clarified that the Utah rule would have escaped preemption as a prohibition substantially affecting risk pooling had the rule imposed a blanket prohibition. *See also Standard Insurance Co. v. Morrison*, 584 F.3d at 845: (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products) and *American Council of Life Insurers v. Ross*, 558 F.3d at 605-07 (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products.) Citing to these

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cases, a commenter asserts that a rule preventing an insurer's decision from being reviewed under a deferential standard substantially affects the risk pooling arrangement and alters the scope of permissible bargains, while a rule permitting a "limited" grant of discretionary authority might be interpreted by a court as relating to the form, rather than the substance of the underlying coverage agreement, and thus be preempted under ERISA. The commenter therefore recommends that the Department eliminate the safe harbor provision in §3.1202(5) to ensure that the regulation will fall within ERISA's saving clause requirement. Further, the commenter argues that inclusion of a safe harbor provision defeats the purpose of prohibiting discretionary clauses. The commenter cites to *Evans v. Employee Benefit Plan, Camp Dresser & McKee, Inc.*, 311 Fed. Appx. 556 (3d Cir. 2009) for the point that a prohibition against discretionary clauses that provide "sole" discretion to a plan administrator does not apply to a provision that provided discretion, but not "sole discretion," to the administrator. See also *Baker v. Hartford Life Ins. Co.*, No. 08-cv-6382 (FLW), 2010 U.S. Dist. LEXIS 52724 (D.N.J. 2010). Based upon these cases, the commenter asserts that inclusion of the safe harbor provision language would effectively remove such forms from the scope of §§3.1201 – 3.1203 as a whole and defeat the purpose of the subchapter. Some commenters additionally assert that inclusion of §3.1202(5) creates internal inconsistency and ambiguity within the subchapter as follows. When an insurer has discretionary authority to interpret a contract or make a claim determination, a reviewing court applies a deferential standard of review to the determination. See *Firestone v. Bruch*, 489 U.S. 101, 115 (1989); and *Hancock*, 590 F. 3d at 1146, quoting *Kellogg v.*

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Metro. Life Ins. Co., 549 F.3d 818, 825 (10th Cir. 2008): (“[I]f the administrator or fiduciary has discretionary authority, ‘then, absent procedural irregularities, the denial of benefits is reviewed under an arbitrary and capricious standard.’”) Stating that an insurer has discretion that does not give rise to a deferential standard of review contradicts the United States Supreme Court’s interpretation of “discretionary authority” and, according to the commenter, creates uncertainty as to the meaning of “discretionary authority” and the impact of that clause on the coverage provided under the form. Another commenter asserts that it is inconsistent and illogical for a form to “grant discretion” if deferential treatment of discretionary authority is not intended.

Agency Response: The Department agrees with the suggested deletion of §3.1202(5). The Department agrees that it is possible that a reviewing court could find inclusion of the safe harbor provision to be cause for preemption under ERISA. *Hancock v. Metropolitan Life Insurance Company*, 590 F. 3d 1141, 1149 (10th Cir. 2009) (holding that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans). In permitting discretion-granting clauses that complied with form requirements, the 10th Circuit in *Hancock* held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. *Id*; see also *Weeks v. UNUM Group*, 585 F.Supp.2d 1305,1311 (D.Utah 2008). The Department further acknowledges that blanket prohibitions, as opposed to prohibitions providing safe harbors, have not been held to be preempted under ERISA in the cited case law. See *Morrison*, 584 F. 3d at 845 (upholding Montana’s policy prohibiting the use of

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discretionary clauses in insurance products) and *Ross*, 558 F. 3d at 605-07, (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products.) The Department additionally agrees that inclusion of §3.1202(5) creates internal inconsistency by providing a safe harbor provision that could defeat one of the purposes of the prohibition, affording consumers the opportunity for a full and fair opportunity for review of a claim determination under a non-deferential standard, creating ambiguity and uncertainty as to how such a provision would impact the coverage. The Department has determined that inclusion of a safe harbor provision is not necessary to facilitate initial coverage determinations because §§3.1201 – 3.1203 do not impede such coverage determinations and that deletion of the safe harbor provision is the best means of fully effectuating the broad consumer protection purposes of the rule. The Department has accordingly revised §3.1202 by deleting paragraph (5).

Comment: A commenter recommends that the Department add a paragraph to §3.1202 to provide that a discretionary clause is a clause that “reserves discretion to make a determination of eligibility and amount of benefits.”

Agency Response: The Department disagrees that this suggested additional language is necessary. A provision reserving discretion to make a determination of the eligibility and amount of benefits would meet the definition set forth in §3.1202(1) and (5) as adopted because such a provision would: (i) purport or act to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or health maintenance organization; and (ii) specify or give rise to a standard of review in any appeal process that gives deference to the

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original claim decision or provide standards of interpretation or review that are inconsistent with the laws of this state. Because the provision would meet the definition of a discretionary clause under §3.1202 as adopted, the additional suggested language is not necessary to bring such a provision within the scope of the adopted definition for the term “discretionary clause.”

Severability Clause.

Comment: Some commenters state support for the addition of a severability clause. A commenter asserts that potential actions of courts are never certain and clarification concerning severability in the subchapter would, therefore, be good.

Agency Response: The Department agrees that the addition of a severability clause will clarify the relationship of provisions of the subchapter and the operation of the subchapter should any portion or section of the subchapter be held to be invalid. Accordingly, the Department has added new subsection (e) to §3.1201 to provide for the severability of the provisions of the subchapter.

Discretionary Clauses Void.

Comment: A commenter recommends that the Department adopt a new section that expressly states and clarifies the effect of including a discretionary clause in a form; i.e. that such clauses are unenforceable. The commenter asserts that Michigan uses similar language in its prohibition. *See Mich. Admin. Code R. 500.2202(c).*

Agency Response: The Department disagrees because the Department does not believe that this additional provision is necessary at this time. However, the Department

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will monitor to determine whether there is a need for future rulemaking with respect to this issue.

Alternative recommendations.

Comment: A commenter notes that several states that have addressed the issue of discretionary clauses have recognized that the clauses do not limit the right to judicial remedies for consumers and have, therefore, taken steps short of prohibiting the clauses to ensure consumers are aware of those remedies, such as bulletins or requirements for greater disclosure. The commenter recommends that the Department adopt a requirement for ERISA plans that provides that the Department will approve discretionary clauses related to a health policy only when such clauses are to implement a policy governed by ERISA and in which the policies contain language consistent with the following:

“This provision only applies when the [policy] is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Your [policyholder/plan sponsor] has delegated to [insurer] the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the [policy]. In exercising [such/our] discretion, [Insurer] must act prudently and in the interest of [the insured], [the insured’s] beneficiaries and other plan participants. [Insurer] will pay benefits under the [policy] if [insurer] decides, after exercising [insurer] discretion, [the insured] is entitled to them. [Insured] [have/has] the right to request a review of [insurer’s] decision. If after exercising the [policy’s or insurer’s] review procedures [the insured’s] claim for benefits is denied or ignored, in whole or in part, [the insured] may file suit and a court will review [the insured’s] eligibility or entitlement to benefits under the [policy].”

The commenter asserts that such language would address the concerns that individuals do not know of appeal rights if the individual does not agree with a claim decision.

Agency Response: The Department disagrees that the language suggested by the commenter is the best manner to regulate the use of discretionary clauses. The use of

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such a provision could result in a finding that the provision is preempted under ERISA. *See Hancock v. Metropolitan Life Insurance Company*, 590 F. 3d at 1149 (10th Cir. 2009) (holding that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans). In permitting discretion-granting clauses that complied with form requirements, the 10th Circuit in *Hancock* held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. *Id*; *see also Weeks v. UNUM Group*, 585 F.Supp.2d 1305,1311 (D.Utah 2008). Additionally, the language suggested by the commenter would not address one of the primary concerns that is addressed by §§3.1201 – 3.1203 as adopted--the deferential standard of review that results from the inclusion of discretionary clauses in forms.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: National Multiple Sclerosis Society, three individuals.

For with changes: Office of Public Insurance Counsel, American Association of Retired Persons, Texas Medical Association, and Center for Public Policy Priorities.

Against: Texas Association of Life & Health Insurers, America's Health Insurance Plans, American Council of Life Insurers, and Texas Association of Health Plans.

6. STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code §§1701.060(a)(1), 1701.055(a), 1271.056, 1271.103, 843.151, 541.401 and

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36.001. The Insurance Code §1701.060(a)(1) authorizes the Commissioner to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted will be reviewed and approved by the Commissioner or exempted under the Insurance Code §1701.005(b). Section 1701.055(a) specifies that except as provided by the Insurance Code §1701.055(d), the Commissioner may disapprove, or, after notice and hearing, withdraw approval of a form if the form violates the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1271.056 specifies that an evidence of coverage may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; encourages misrepresentation; or is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Insurance Code §1271.103(a) specifies that after notice and opportunity for hearing, the Commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the Commissioner determines that the form violates the Insurance Code Chapters 1271, 843, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the Commissioner. The Insurance Code §1271.103(b) provides that if the Commissioner withdraws approval of a form under §1271.103, the form may not be issued until it is approved. The Insurance Code §843.151 specifies that the Commissioner is authorized to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Insurance Code §541.401

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specifies that the Commissioner may adopt and enforce reasonable rules the Commissioner determines necessary to accomplish the purposes of the Insurance Code Chapter 541 (relating to the prohibition of trade practices that are unfair methods of competition or unfair or deceptive acts or practices). The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§3.1201. Applicability, Effective Dates, and Severability.

(a) This subchapter applies to any form filed under the Insurance Code Chapters 1701 or 1271, including forms filed by Lloyd's plans and fraternal benefit societies.

(b) Except as specified in subsections (c) and (d) of this section, this subchapter applies to forms offered, issued, renewed, or delivered on or after June 1, 2011, including forms that include premium waiver provisions based upon a disability determination.

(c) For forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate, or rider, this subchapter applies to forms offered, issued, renewed, or delivered on or after February 1, 2011.

(d) For forms issued or delivered prior to the effective date of this subchapter that do not contain a renewal date, this subchapter applies on or after the effective date

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of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011.

(e) If any section or portion of a section of this subchapter is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. If any section or portion of a section is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications. To this end, all provisions of this subchapter (relating to Discretionary Clauses) are declared to be severable.

§3.1202. Discretionary Clauses Defined. For the purpose of this subchapter, a discretionary clause is a provision that:

(1) purports or acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or health maintenance organization;

(2) specifies that a policyholder or other claimant may not contest or appeal a denial of a claim;

(3) specifies that the insurer's or health maintenance organization's interpretation of the terms of a form or its decision to deny coverage or the amount of benefits is binding upon a policyholder or other claimant;

(4) specifies that in any appeal the insurer's or health maintenance organization's decision-making power as to the interpretation of the terms of a form or as to coverage is binding; or

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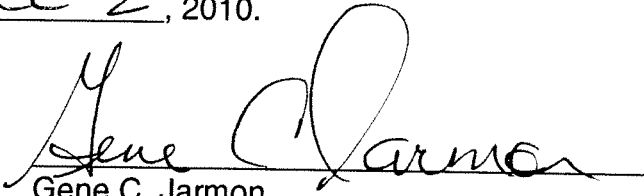
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(5) specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state.

§3.1203. Discretionary Clauses Prohibited. Inclusion of a discretionary clause in any form to which this subchapter applies is prohibited.

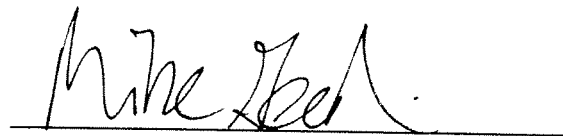
CERTIFICATION. This agency hereby certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on Dec 2, 2010.


Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that new §§3.1201 – 3.1203 specified herein, concerning discretionary clauses, are adopted.

AND IT IS SO ORDERED.

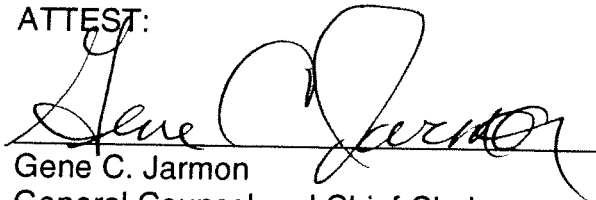

MIKE GEESLIN
COMMISSIONER OF INSURANCE

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ATTEST:


Gene C. Jarmon
General Counsel and Chief Clerk

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DEC 03 2010