

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION



REPORT ON DISCRETIONARY CLAUSES

Submitted to the

House Committee On Health Care
Senate Committee on Health and Welfare
in accordance with
Act 48 of 2011, § 17

January 17, 2012

INTRODUCTION

As required by Act 48 of 2011, § 17, this Report on Discretionary Clauses addresses the advantages and disadvantages of Vermont adopting the National Association of Insurance Commissioner's (NAIC) Prohibition on the Use of Discretionary Clauses Model Act, 1 NAIC *Model Laws, Regulations and Guidelines*, 42-1 (2002, amended 2004) (the Model Act).

Discretionary clauses are contract provisions that grant an insurer, HMO or administrator the unrestricted authority to determine eligibility for benefits and to interpret terms and provisions of the policy, contract or certificate. An example is: "the company has full, exclusive, and discretionary authority to determine all questions arising in connection with the policy, including its interpretation."

The purpose of the Model Act is to prohibit clauses that purport either to (i) reserve discretion to the insurer to interpret the terms of a health or disability insurance policy, or (ii) provide standards of interpretation or review that are inconsistent with the laws of the state.

The Department recommends adoption of the Model Act.

HISTORICAL PRACTICE

For many years, the Department of Banking, Insurance, Securities and Health Care Administration has disfavored health insurance contracts containing a discretionary clause. By 2002, the Department was putting insurers on notice that discretionary clauses which purport to reserve to the insurer full discretion and authority to interpret and apply the provisions of health insurance contracts would not be approved. Although the Department rejected language that gave insurers the exclusive right to rule on all questions of coverage and eligibility, it has permitted insurers to insert a clause in its plan documents to the effect that subject to the insured's rights under the contract and to the law that allows the insured to appeal a denial of

benefits, the insurer has the right to interpret and apply the terms of the contract and to determine coverage. An example of such a clause follows:

Subject to your rights under this Contract and the law that allows you to appeal a denial of benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have coverage for a requested service, even when a Provider has prescribed or recommended the service.

ARGUMENTS IN FAVOR OF ENACTING THE NAIC MODEL ACT

Discretionary clauses are now restricted in 19 states.¹ The inclusion of strong discretionary clauses in health insurance contracts is unjust, unfair and inequitable. They place

¹ See **CALIFORNIA** – Cal. Ins. Code § 10110.6; **CONNECTICUT** – Bulletin HC-67; (March 19, 2008), available at <http://www.ct.gov/cid/cwp/view.asp?a=1255&Q=432600> (last visited Oct. 18, 2011); **HAWAII** – Commissioner’s Memorandum 2004-13H (Dec. 8, 2004), available at http://hawaii.gov/dcca/ins/commissioners_memo/commissioners_memorandum_2004 (last visited Oct. 18, 2011); **IDAHO** – Idaho Administrative Code § 18.01.29.011, available at <http://adm.idaho.gov/adminrules/rules/idapa18/18index.htm> (last visited Oct. 18, 2011); **ILLINOIS** – Ill. Admin. Code 50 § 2001.3 (2005); see also Company Bulletin 2010-05 (June 28, 2010), available at <http://www.insurance.illinois.gov/cb/cblist10.asp> (last visited Oct. 18, 2011); **INDIANA** – Bulletin 103 (May 8, 2001), available at <http://www.in.gov/idoi/2591.htm> (last visited Oct. 18, 2011); **KENTUCKY** – Advisory Opinion 2010-01 (March 9, 2010), available at <http://insurance.ky.gov/Bulletin.aspx> (last visited Oct. 18, 2011); **MAINE** – 24-A M.R.S.A. § 4303(11); **MARYLAND** – MD Code, Insurance, § 12-211; **MICHIGAN** – Mi. Admin. Code § 500.2201 *et seq.*, available at http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=50002201&Dpt=&RngHigh=79110001 (last visited Oct. 18, 2011), Mi. Admin. Code § 550.111 *et seq.*, available at http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=55000111&Dpt=&RngHigh=79110001 (last visited Oct. 18, 2011), Mi. Admin. Code § 550.301 *et seq.*, available at http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=55000301&Dpt=&RngHigh=79110001 (last visited Oct. 18, 2011); **MINNESOTA** – M.S.A. § 62Q.107; **NEW JERSEY** – N.J. Admin. Code § 11:4-58.1 *et seq.*; **NEW YORK** – Circular Letter No. 14 (June 29, 2006), available at <http://www.dfs.ny.gov/insurance/circltr/2006.htm> (last visited Oct. 18, 2011); **OREGON** – O.R.S. § 742.005 (see also Form 3172b – Standard Provisions for . . . Policies at p. 5, available at http://googlesearch.cbs.state.or.us/search?q=form+3172b&restrict=insex&output=xml_no_dtd&client=dcbs&lr=&proxystylesheet=dcbs&oe=UTF-8&ie=UTF-8&sort=date%3AD%3AL%3Ad1&entqr=0&ud=1&site=insex (last visited Oct. 18, 2011)) (Form 3631 – Standards for Accidental Death and Dismemberment . . . Policies at p. 7, available at http://googlesearch.cbs.state.or.us/search?q=440-3631&restrict=insex&output=xml_no_dtd&client=dcbs&lr=&proxystylesheet=dcbs&oe=UTF-8&ie=UTF-8&sort=date%3AD%3AL%3Ad1&entqr=0&ud=1&site=insex (last visited Oct. 18, 2011)); **SOUTH DAKOTA** – S.D. Admin. Rules § 20:06:52:01, *et seq.*, available at <http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=20:06:52> (last visited Oct. 18, 2011); **TEXAS** – 28 Tex. Admin. Code § 3.1202 *et seq.*; **UTAH** – Utah Admin. Code R590-218; See also Bulletin 2002-7, available at <http://www.insurance.utah.gov/legalresources/bulletins.html> (last visited Oct. 18, 2011); **WASHINGTON** – WAC 284-44-015, available at <http://apps.leg.wa.gov/wac/default.aspx?cite=284-44> (last visited Oct. 18, 2011), WAC 284-46-015, available at <http://apps.leg.wa.gov/wac/default.aspx?cite=284-46-015> (last visited Oct. 18, 2011), WAC 284-50-321, available at <http://apps.leg.wa.gov/wac/default.aspx?cite=284-50-321> (last visited Oct. 18, 2011), and WAC 284-96-012, available at <http://apps.leg.wa.gov/wac/default.aspx?cite=284-96-012> (last visited Oct. 18, 2011); **WYOMING** – W.S. 1977 § 26-13-301 *et seq.*

the insured at a disadvantage in any disagreement over the meaning of the insurance contract, usurp the role of the courts in deciding a matter of law (the meaning of the contract), and exacerbate the insurer's inherent conflict of interests in being both the entity that pays and the entity that decides what does or does not need to be paid.

8 V.S.A. § 4062(2) states, in part that a health policy may not contain terms that are “unjust, unfair, inequitable, misleading, or contrary to the laws of this state.”

A health insurance policy is a contract. The interpretation of a contract is a matter of law and ordinarily questions of law are for the judiciary to decide. In a court action on a contract (as when an insured sues an insurer), a court looks at the question of law *de novo*, *i.e.*, without regard for how the contract might have been initially interpreted by the insurer.²

The difficulty arises when a discretionary clause is present, usurping to a large extent the role of the courts. When a discretionary clause is present, the court gives strong deference to the insurer's interpretation of the contract and will only overturn the insurer's view if the court finds the insurer's decision was arbitrary and capricious. *See, e.g., Ball v. Standard Ins. Co.*, ___ F.Supp.2d ___, 2011 WL 2708366 (N.D.Ill. July 8, 2011). The United States Supreme Court observed in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) that discretionary clauses may give “unfettered discretion” to the insurer in questions of coverage, eligibility and interpretations and applications of the provisions of the contract. As the New York Insurance Department said when it banned discretionary clauses in 2006, where the clauses are present, “policies, contracts and certificates may be rendered illusory by nullifying the insurer's, Article

² Cf. 29 U.S.C. § 1132(a)(1)(B) (a participant in a plan may bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”)

43 corporation's or HMO's responsibility to pay.”³

In what is already a contract of adhesion, *i.e.*, one that a consumer has no choice but to accept, these clauses skew the balance of power further in favor of the insurer. In other words, the subscriber is at a severe disadvantage in any contest over questions of coverage, eligibility and interpretations and applications of the provisions of the contract for the simple reason that the insurer included a discretionary clause in the contract.

If discretionary clauses are prohibited, the court applies the *de novo* standard of review and is free to substitute its own judgment for that of the insurer. If a matter comes to court, the consumer faces a more level playing field, and is better protected, where there is no discretionary clause in the contract.

It should be emphasized that this is not to say that such disputes arrive in court frequently; they do not. What is perhaps most affected by the differing standards of review is the mindset of the insurer – its confidence that what it says goes under the “arbitrary and capricious” standard, as opposed to the more cautious approach it would take knowing that its decisions might be reviewed *de novo*.

In addition, discretionary clauses exacerbate a conflict of interest for the insurer that arises from the fact that it has a financial stake in the outcome of its benefit decisions and contract interpretations. As noted by the Supreme Court in *Metlife v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343 (2008), where an insurer both determines whether an employee is eligible for benefits and pays those benefits out of its own pocket, there is a conflict of interest. This conflict would be mitigated by prohibiting discretionary clauses and lessening the insurer's discretion to decide what the contract means.

³ Circular Letter No. 14 (2006) June 29, 2006.

Discretionary clauses are also unjust and arguably contrary to the laws of this state because the deferential standard of review is opposed to the common law doctrine that ambiguities in insurance contracts are to be construed in favor of the insured. *See, e.g., Northern Sec. Ins. Co., Inc. v. Rossitto*, 171 Vt. 580, 762 A.2d 861 (2000); *Chamberlain v. Metropolitan Property and Cas. Ins. Co.*, 171 Vt. 513, 756 A.2d 1246 (2000); *Cooperative Fire Ins. Ass'n of Vt. v. Bizon*, 166 Vt. 326, 693 A.2d 722 (1997).

Discretionary clauses in health insurance contracts are also misleading because subscribers may not understand from reading these clauses that they are giving up the right to a neutral, merits-based review of the insurer's decisions and the meaning of the policy, and that the insurer as a practical matter could proceed with essentially absolute discretion as to what the policy means.

ARGUMENTS AGAINST ENACTING THE NAIC MODEL ACT

The Department invited comment on Model Act from MVP Health Care (MVP), Blue Cross Blue Shield of Vermont (BCBSVT) and CIGNA Healthcare (CIGNA).

CIGNA provided no comments to the Department on the legislation.

MVP acknowledged that where a discretionary clause exists an insurer's decision may only be overturned under the highly deferential "arbitrary and capricious" standard of review, whereas in cases where there is no discretionary clause the matter is reviewed by a court *de novo*. MVP further commented that it is a matter of having consistency in state laws, but conceded that there would be little impact on the market in the event the Model Act is adopted in Vermont and that it had no strong view on the matter. As to consistency with state laws, Vermont's neighbor and MVP's home state of New York has prohibited discretionary clauses since 2006.

BCBSVT expressed its opposition to a ban on discretionary clauses in a written submission to the Department, in which it asserted that health plans use these clauses in order to

avoid member and provider confusion, inconsistent treatment, increased costs and waste, delays and unpredictable utilization. It elaborated on each of these points. It also contended in an oral communication that barring discretionary clauses would prejudice private insurers since self-insureds would allegedly not be subject to the bar.

BCBSVT argues that a ban on discretionary clauses would lead to member and provider confusion because health insurance certificates would become increasingly more detailed and complex. It is difficult to see how exactly health insurance certificates would be impacted at all, except for deleting the language granting deference to any plan decision. BCBSVT would still make the initial determination of what benefits are provided under the plan and apply the usual standard of whether a treatment or procedure is “medically necessary”, the only difference being that BCBSVT would not have unfettered discretion to interpret the contract. BCBSV also argues that without discretionary clauses medical advances would have to wait on plan amendments. That result is not self-evident; plans do not attempt to catalog the current state of medical science. No evidence is offered of medical advances that have been delayed in New York, California, or the 17 other states that prohibit discretionary clauses.

BCBSVT next argues that discretionary clauses avoid inconsistent results and that if discretionary clauses are prohibited, each court review of a similar request for a benefit is handled anew and could potentially have a different outcome, resulting in unpredictable utilization of health care services. First, few policy disputes go to court.⁴ Further, the argument of inconsistency ignores the fact that courts seek to decide like cases alike and are guided (or controlled) by prior judicial decisions, and Vermont in any case has only two court systems – the unified state system and a single federal district. Finally, any concern about consistency in

⁴ There are internal and external administrative appeal procedures a subscriber can invoke when a benefit is denied; this largely avoids the need for litigation.

standard of review should be mitigated by the fact that states are trending toward prohibiting discretionary clauses.

BCBSVT argues that the highly deferential standard of review keeps costs down for both insurers and insureds, a conclusion it bases on the proposition that without discretionary clauses “nearly every claim denial [would result in] a *de novo* review” by a court. There is no basis for this proposition and no evidence is offered of increased litigation or costs in states that ban the clauses. We note that New York-based MVP expressed no concern on this count.

The argument that barring discretionary clauses will prejudice private insurers since self-insureds would not be subject to the bar reflects a misplaced concern. While the analysis is beyond the scope of this report, courts have found the ban applies to self-insureds. *See, e.g., Standard Ins. Co. v. Morrison*, 537 F.Supp.2d 1142 (D. Mont. 2008).

BCBSVT asserted that discretionary clauses avoid delay. It rested its argument on the proposition that the ban would result in lengthy litigation over claim denials, a proposition addressed above.

Finally, BCBSVT contended that discretionary clauses avoid unpredictable utilization, saying that a plan “will be less able to predict its costs if each of its decisions can be reviewed *de novo*.” This, it says, will lead to increased premiums. Again, the premise is that banning the clauses will lead to much litigation and, secondarily, that the litigation will lead to inconsistent results. As discussed above, no evidence of those outcomes has been presented. MVP, based in a state that bans the clauses, did not express any concern over an increase in litigation or a resulting inability to predict its costs as a result of the New York ban.

Respectfully submitted.