**LINDA LINGLE**
GOVERNOR

**JAMES R. AIONA, JR.**
LT. GOVERNOR

**MARK E. RECKTENWALD**
DIRECTOR

**J. P. SCHMIDT**
INSURANCE COMMISSIONER

STATE OF HAWAI`I
INSURANCE DIVISION
DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS
P. O. BOX 3614
HONOLULU, HAWAI`I 96811-3614
335 MERCHANT STREET, 2ND FLOOR
HONOLULU, HAWAI`I 96813

December 8, 2004

MEMORANDUM 2004-13H

TO: HMSA, Mutual Benefit Societies, Health Maintenance Organizations, and Insurers Offering Health Insurance

FROM: J. P. Schmidt
Insurance Commissioner

RE: Discretionary Clauses in HMSA's Agreement for Group Health Plan and Guide to Benefits

HMSA has sent renewal contracts to employers ("Agreement for Group Health Plan") and the Insurance Commissioner has received a number of complaints regarding various provisions questioned by employers as to legality. Of particular concern is clause 15 of the Agreement for Group Health Plan entitled "HMSA Discretionary Authority" that provides:

> The Group hereby designates HMSA to be a fiduciary under the Plan solely for the purposes of (a) determining all questions of eligibility of Plan members; (b) determining the amount and type of benefits payable to any Plan members in accord with the Plan; and (c) interpreting the Plan provisions including those necessary to determine benefits. HMSA shall have complete and full discretionary authority in connection with these determinations and interpretations, and its decisions on these matters shall bind the Plan.

This grant of discretionary authority is mirrored in HMSA's Guide to Benefits as follows:

> **Interpreting this Guide**
>
> **Agreement** The Agreement between us and you is made up of all of the following:
> - This *Guide to Benefits*.
> - Any riders and/or amendments.
> - The application form submitted to us.

- The agreement between us and your employer or group sponsor.

**Our Rights to Interpret this Document**

We will interpret the provisions of the Agreement and will determine all questions that arise under it. We have the administrative discretion:

- to determine whether you meet our written eligibility requirements;
- to determine the amount and type of benefits payable to you or your dependents in accord with the terms of this Agreement; and
- to interpret the provisions of this Agreement as is necessary to determine benefits, including determinations of medical necessity.

Our interpretations and determinations are final, binding, and conclusive to the extent permitted by law. If you disagree with our interpretation or determination, you may appeal.

Discretionary clauses similar to the clauses used by HMSA that give insurance plan administrators what the U.S. Supreme Court has called "unfettered discretion" to interpret plan benefits (*Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)) are prohibited by statute in Maine and Minnesota and by Insurance Commissioners in California, Illinois, Indiana, Montana, Nevada, New Jersey, Oregon, Texas and Utah.

In 2002, the National Association of Insurance Commissioners adopted Model Act 42 titled "Prohibition on the Use of Discretionary Clauses Model Act" which recommends that each member state initiate legislation prohibiting discretionary clauses in health insurance contracts in order to "assure that health insurance benefits are contractually guaranteed, and to avoid the conflict of interest that occurs when the health carrier has unfettered authority to decide what benefits are due."

On July 29, 2002, the Utah Insurance Commissioner issued a bulletin stating:

> Discretionary clauses purport to give an insurer full and final discretion in interpreting benefits in an insurance contract. In the department's view, under Utah Code Annotated (U.C.A.) §31A-21-201(3), those clauses and provisions in accident and health, life, and annuity insurance contracts are inequitable, misleading, deceptive, obscure, unfair, not in the public interest, and otherwise contrary to law, and they encourage misrepresentation and violate a statute.

Hawaii Revised Statutes §431:13-102 prohibits unfair methods of competition or unfair or deceptive acts or practices in the business of insurance.

A "discretionary clause" granting to a plan administrator discretionary authority so as to deprive the insured of a *de novo* appeal is an unfair or deceptive act or practice in the business of insurance and may not be used in health insurance contracts or plans in Hawaii.

This decision is based upon the rationale underlying NAIC Model Act 42 – to "assure that health insurance benefits are contractually guaranteed, and to avoid the conflict of interest that occurs when the health carrier has unfettered authority to decide what benefits are due." It is also based upon the position taken by the Utah Insurance Commissioner that such clauses are "inequitable, misleading, deceptive, obscure, unfair, not in the public interest, and otherwise contrary to law, and they encourage misrepresentation and violate a statute."

In reaching this decision it is noted that insurance companies' rights to contract are subject to regulation because insurance companies are held to a broader legal responsibility than are parties to purely private contracts and the public interest in assuring integrity of insurers' relations with their insureds and in averting even the potential for conflict of interest situations must take precedence over the parties' private contractual arrangements (See, e.g., *Pennsylvania General Insurance Co. v. Austin Powder Co.*, 68 N.Y.2d 465, 502 N.E.2d 982, 510 N.Y.S.2d 67 (1986)). In Hawai'i " '... insurers have the same rights as individuals to limit their liability… and to impose whatever conditions they please on their obligations, provided they are not in contravention of statutory inhibitions or public policy.'" *First Ins. Co. of Hawai'i, Inc. v. State*, 66 Hawai'i 413, 423, 665 P.2d 648, 655 (Hawai'i, 1983) (quoting 6B Appleman, *Insurance Law and Practice* § 4255, at 40 (1979). The covenant of good faith and fair dealing that exists in every insurance contract requires that neither party will do anything to injure the right of the other to receive the benefits of the agreement, and an insurer is obligated to give the interests of the insured at least as much consideration as it gives to its own interests. *Larraburu Bros., Inc. v. Royal Indem. Co.*, 604 F.2d 1208 (9th Cir. 1979).

HMSA, as a nonprofit mutual benefit society, should be held to at least as high a standard as a for-profit insurance company. Beyond that, however, it must be noted that HMSA is not merely a for-profit insurance company required to treat its insureds' interests on an equal basis with its own interests. HMSA has fiduciary responsibility as a mutual benefit society and has explicitly and implicitly assumed fiduciary responsibility as an administrator of a health plan. As a fiduciary its main duty is to act solely in the interests of beneficiaries. 60A Am. Jur. 2d *Pensions and Retirement Funds* § 437 citing *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794 (9th Cir. 1997).

Discretionary authority clauses in health plans sanction, and may even encourage, a breach of fiduciary duty. If HMSA is allowed discretionary authority to interpret the Plan as it wishes, HMSA's manifest interest in maximizing its income and increasing its reserves conflicts with the interests of its members in obtaining coverage for medical care.

The critical point is that discretionary authority granted to or retained by an insurer takes away what would otherwise be the insured's right to have a court review coverage decisions without bias in favor of the insurance company. In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989) the U.S. Supreme Court noted that "the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with

established principles of trust law, we hold that a denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." (489 U.S. at 115).

The legal impact of HMSA's discretionary clause is to require that a court approve HMSA's interpretation unless it can be held to be arbitrary and capricious. The arbitrary and capricious standard holds that a plan administrator's decision shall not be overturned, absent special circumstances such as fraud or bad faith, if "it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome." *Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund*, 900 F.2d 1138, 1142 (7th Cir. 1990) citing *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985). In *Pokratz*, a case involving ERISA plan benefits, the court stated:

> The "arbitrary or capricious" standard calls for less searching inquiry than the "substantial evidence" standard that applies to Social Security disability cases. 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….

*Pokratz v. Jones Dairy Farm*, 771 F.2d at 209.

By imposing the discretionary clause upon its members, HMSA takes away the members' right to *de novo* judicial review and imposes upon its members a heavy evidential burden – effectively shielding HMSA from reversal of the denial of meritorious claims. In so doing HMSA places its own interests above the interests of its members in breach of its fiduciary duty.

This decision is not affected by whether a plan is an ERISA plan. The U.S. Supreme Court in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) stated:

> 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. . . . 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. In this respect, then, [Illinois'] § 4-10 prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's terms. As such, it does not implicate ERISA's enforcement scheme at all, and is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption, such

> as mandated-benefit statutes and statutes prohibiting the denial of claims solely on the ground of untimeliness.

*Rush Prudential HMO, Inc. v. Moran*, 536 U.S. at 385-86 (citations and footnote omitted).

Additionally, it is noteworthy that for ERISA plans the Federal Regulations (29 CFR § 2560.503-1) require, among other things, an internal review procedure that does "not afford deference to the initial adverse benefit determination" – i.e., a *de novo* review. Although the regulation relates only to internal review procedures, there is no reason that the standard for internal review should differ from the standard for judicial review.

In summary, contractual provisions giving HMSA, or any health insurer, discretionary authority to interpret the plan so as to deprive the insured of a *de novo* appeal constitute unfair or deceptive acts or practices in the business of insurance in violation of HRS §431:13-102 for the following reasons:

1. Such contractual provisions are a violation of the insurer's obligation to act in good faith and deal fairly because a conflict of interest occurs when an insurer has discretionary authority to interpret the insurance contract in regards to what benefits it will pay.

2. Such contractual provisions are a breach of an insurer's fiduciary duty to act solely in the interests of its insureds who are plan participants and beneficiaries.

3. Such contractual provisions may mislead the members to believe that they have no recourse to contest an insurer's plan interpretations when, in fact, the insurer's authority regarding determinations of coverage are not complete, full, final, binding, or conclusive. For ERISA plans *de novo* internal review is required and plan beneficiaries have the right to appeal to court. And, for plans not covered by ERISA, insureds have the additional right to external review pursuant to the Hawai'i's Patients' Bill of Rights and Responsibilities Act, HRS Chapter 432E. However, a member mislead to believe that HMSA has "complete", "full", "final, binding, and conclusive" discretionary authority to interpret the Plan may well forgo the right to appeal HMSA's decisions to an impartial reviewer.

The following language is approved for use by health insurers:

> The Group hereby designates [INSURER] to be a fiduciary under the Plan solely for the purposes of (a) determining all questions of eligibility of Plan members; (b) determining the amount and type of benefits payable to any Plan members in accord with the Plan; and (c) interpreting the Plan provisions including those necessary to determine benefits. [INSURER'S] determinations and interpretations, and its decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in the Plan or as allowed by law.