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

1. INTRODUCTION. The Texas Department of Insurance (Department) proposes new Subchapter M, §§3.1201 – 3.1203, concerning discretionary clauses in insurance policies. These rules are proposed 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.

The proposed new subchapter is necessary to protect insurance consumers from the possibility of incorrect and unfair coverage determinations by insurers without a subsequent opportunity for a full and independent review under a non-deferential standard. Discretionary clauses are contractual provisions that reserve or purport to reserve for insurers the discretion to interpret the terms of an insurance contract 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, We 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:

> 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 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 v. Bruch*, 489 U.S. 101, 115 (1989) The Department's position is that an insurer may have a conflict of interest in coverage determinations resulting in adverse financial consequences to the company, and 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. Insurance companies may have a conflict of interest in coverage determinations because they may result in adverse financial consequences for their company. Because an insurer may have a conflict of interest in 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. In light of the United States Supreme Court opinion in *Firestone*, the use of a discretionary clause by an insurer 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 factual controversies, whereas an *arbitrary and capricious* appellate standard of review is a less detailed and more deferential review. 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 insurer 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 reasonable believe that if they are disabled, they will be entitled to benefits under the policy and will be able to enforce such rights in court. Instead, a discretionary clause permits an insurer to deny disability income benefits even if the insured is disabled, provided that the process leading to the denial was not arbitrary or capricious.

The applicability of the proposed rule extends beyond ERISA coverages because the Department's position is that a discretionary clause affects outcomes even in coverages not governed by ERISA. As they pertain to non-ERISA coverages, discretionary clauses are unjust, deceptive and encourage misrepresentation regarding the rights of the insured. 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, 762, 763 (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 an insurer's determination of coverage as binding or mandatory. Because insureds have the right to seek judicial review of an insurer's coverage determinations, a provision stating otherwise encourages misrepresentation because it is inaccurate and may dissuade an insured 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 rule's applicability extend to life, accident, and health insurance forms and health maintenance organization (HMO) evidences of coverage, including both those that are governed by ERISA and those that are not.

The Department has made changes to the rule text informally posted on its website on March 5, 2010. Some of these changes are a result of comments received

on the posting and other changes are a result of staff recommendations. Public comments received on the March 5, 2010 posting that resulted in changes to the proposed text are as follows.

Breadth of the Rule.

Several commenters stated that the informal text was unnecessarily broad because it applied to all life, accident, and health policies and suggested that the rule should be limited only to health and disability income insurance. Another commenter voiced support for the breadth of the rule because it applied to all forms filed under the Insurance Code Chapter 1701, including HMO evidence of coverage forms. The Department's position is that it is necessary that the rule apply to all life, accident, and health forms. However, as a result of the comments, the rule text has been changed to more specifically clarify that the rule text applies to HMO evidence of coverage forms filed pursuant to the Insurance Code Chapter 1271.

Definition of a Discretionary Clause.

The Department received numerous comments that the prohibition was vague because it failed to define what constitutes *discretion* or *discretionary clause* for the purpose of the subchapter. These comments came from both insurance-industry stakeholders and commenters not representing the insurance industry. As a result of these comments, the informal rule text has been changed to define *discretionary clause* and to provide a non-exhaustive list of five examples specifying language prohibited under the proposed rule.

Definition of a Person.

The Department received a comment that the definition of *person* was

unnecessary because only an insurer could file a form pursuant to the Insurance Code Chapter 1701. The Department has deleted this definition from the proposed rule and has clarified that the rule is applicable to any form filed pursuant to the Insurance Code Chapters 1271 and 1701. Specifying that the rule is applicable to any form filed under the Insurance Code Chapters 1271 and 1701 necessarily incorporates the definitions of those statutes.

Prohibition Prevents the Exercise of Insurer Discretion.

The Department received a comment from an insurance industry stakeholder that a discretionary clause prohibition prevents an insurer from interpreting their own contract and making initial coverage determinations. The Department does not intend this result and does not agree that a discretionary clause prohibition has this effect. A discretionary clause prohibition only bars the printing of specific language in an insurance contract. However, to clarify the Department's intent, the text as informally proposed has been changed to allow for the inclusion of a contractual provision specifying that the insurer has the discretion to interpret the terms of the policy or contract or determine the eligibility for or the amount of benefits, if the provision also clearly states that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal.

Express Mention of Common Law.

The Department received a comment that the reference to "laws of this state" should expressly specify that the phrase includes common law. The Department agrees with this comment and has made this change.

In addition to changes made a result of comments received, the Department

made the following changes to the rule text informally posted on its website on March 5, 2010, as a result of staff recommendations.

Deletion of Certain Definitions.

The Department deleted the definitions of the terms *form, insurer,* and *person*. The terms *form* and *insurer* are defined in the Insurance Code Chapter 1701. The definition of *person* is not necessary as a result of a clarification of the rule's applicability. The rule has been amended to specify that the proposed subchapter is applicable to a form filed pursuant to the Insurance Code Chapters 1701 and 1271. Specifying that the rule is applicable to any form filed under the Insurance Code Chapters 1701 and 1271 necessarily incorporates the definitions of those statutes.

Addition of Effective Date and Clarification of Applicability to In-Force Forms.

The proposal specifies that the proposed subchapter applies to any form offered, issued, or enforced on or after January 1, 2011. This date is intended to give insurers sufficient time to revise and file modifying endorsements before the effective date of the rule. The Department also added the term *enforced* in proposed §3.1201(b) to clarify that the rule is applicable to in-force insurance forms as of January 1, 2011.

Proposed new §3.1201 specifies the applicability and the effective date of the new subchapter. Proposed §3.1201(a) specifies that the 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. Proposed §3.1201(b) specifies that the subchapter applies to any form offered, issued, or enforced on or after January 1, 2011.

Proposed new §3.1202 defines a discretionary clause as a provision that purports to bind the claimant to or grant deference in subsequent proceedings to the

insurer's decision, denial, or interpretation of terms, coverage, or eligibility for benefits. Proposed new §3.1202(1) – (5) provide a non-exhaustive list of provisions constituting discretionary clauses for the purpose of the subchapter. Section 3.1202(1) specifies that the term *discretionary clause* includes a provision specifying that a policyholder or other claimant may not contest a denial of a claim. Section 3.1202(2) specifies that the term *discretionary clause* includes a provision that the insurer's interpretation of the terms of the policy or contract or its decision to deny coverage or the amount of benefits is binding upon a policyholder or other claimant. Section 3.1202(3) specifies that the term *discretionary clause* includes a provision specifying that in any appeal the insurer's decision-making power as to the interpretation of terms of the policy or contract or as to coverage is binding. Section 3.1202(4) specifies that the term *discretionary clause* includes a provision specifying 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. Section 3.1202(5) specifies that the term *discretionary clause* includes a provision specifying that the insurer has the 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.

Proposed new §3.1203 specifies that no form offered, issued, or enforced in this state by an insurer may contain a discretionary clause.

2. FISCAL NOTE. Doug Danzeiser, Deputy Commissioner for the Life, Health & Licensing Division, has determined that for each year of the first five years the proposed sections are in effect, there will be no fiscal implications to state or local government as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Mr. Danzeiser also has determined that for each year of the first five years the proposal is in effect, the anticipated public benefit will be the increased economic welfare of insurance consumers. Medical costs are a major contributing factor to the majority of personal bankruptcies in the United States. A study published in the *American Journal of Medicine* in August 2009 conducted by professors from Harvard Medical School, Harvard Law School and Ohio University found that 62.1% of all bankruptcies in the study had a medical cause. David U. Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study,* The American Journal of Medicine, August 2009. The Department has determined that although they most often appear in disability income insurance policies, discretionary clauses also appear in health insurance policies and in waiver of premium relating to disability for life insurance policies. These types of policies or product features are purchased specifically by consumers to guard against the adverse financial consequences caused by health problems, diseases, or disabilities. As discussed previously, a prohibition on discretionary clauses ensures that consumers are provided with an opportunity for a full independent review of coverage determinations by a neutral body. The Department has

determined that the opportunity for full independent review of coverage determinations will promote fair and equitable coverage determinations by insurers and will eliminate unfair and inequitable insurer coverage determinations previously made in reliance upon discretionary clauses and the subsequent lack of full independent review. However, to the extent that unfair and inequitable coverage determinations are made following the prohibition, as a result of the rule consumers will be provided with the opportunity for a full independent review. Therefore, the prohibition will substantially contribute to the economic welfare of insurance consumers by allowing them to more accurately predict the outcome of coverage determinations and to more successfully incorporate such insurance products and features into their financial planning. It is not anticipated that the rule will result in any costs to companies that do not currently use forms containing discretionary clauses. Companies that currently use forms containing discretionary clauses will incur costs as a result of the compliance with the rule. The costs incurred will depend on the number of forms containing discretionary clauses that the company uses. Large insurers may use dozens of forms containing discretionary clauses, while a small insurer may only use one form containing a discretionary clause. The Department anticipates that the following cost components will result from compliance with the rule: (1) filing fees; (2) administrative costs; (3) notification costs; and (4) litigation costs.

1. Filing fees. The Department anticipates that most insurers with discretionary clauses in their current policy forms will choose to file one or more endorsements with the Department that will then be attached to their current policy forms to override the discretionary language in the forms. Some carriers might also choose to refile each

previously filed form that contains discretionary clause language to remove the discretionary language. The filing fees are $100 for forms subject to review and $50 for forms exempt from review, such as disability policies. It is anticipated that if a carrier does not file a single endorsement for use with all policies, the number of re-filings per insurer will depend on the size of the insurer. A large insurer may have dozens of forms impacted, whereas a smaller insurer may have very few forms. Therefore, it is anticipated that large insurers could incur the highest filing fee costs as a result of the proposed rule.

2. Administrative costs. Additionally, carriers will incur administrative costs through the use of staff time in preparing and sending the filings to the Department. The Department anticipates that various types of employees may be involved in the process of revising forms or drafting endorsements and filing them with the Department. In total, the Department estimates that on average 2 to 10 total employee hours will be necessary to prepare each filing with the Department. The Department anticipates that the types of employees that may be involved include operations managers, supervisors, and office clerks. According to wage data obtained from the Texas Workforce Commission website, the average salary of an operations manager working at an insurance carrier in Texas is $56.50 per hour, the average salary of a supervisor is $25.53 per hour, and the average salary of an office clerk is $12.21. Accordingly, the Department estimates the administrative cost of filing at between $24.42 and $565 per form.

3. Notification costs to in-force policyholders. The Department assumes that insurers may incur costs resulting from notifying affected policyholders about

endorsements or policy language revisions in in-force policies containing discretionary clauses. The Department assumes that such notification can be provided on a single page and will not weigh more than one ounce. The costs relating to notification will consist of printing a notification and mailing it to affected policyholders. The Department estimates that the printing of a single page will cost $0.08 and first class postage will cost $0.44. The total estimated cost of $0.52 will be a cost for each affected policyholder. Therefore, the total estimated notification cost for an insurer is dependent on the number of policyholders.

4. Litigation costs. A 2005 report by Milliman, Inc., commissioned by America's Health Insurance Plans, a national association representing approximately 1,300 health insurance companies, indicated that a ban on discretionary clauses would increase disability insurance premiums by between three percent and four percent based upon anticipated increases in litigation, higher costs of litigation, and more cautious carrier behavior in managing claims. Milliman, Inc., *Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance* (Nov. 14, 2005). The report does not specify whether the entire increase in premiums would be attributable to increased costs, but the Department assumes so for purposes of this rule proposal. However, the Department notes that the study was commissioned by an insurance industry trade group, based on anticipated future experience, and that its conclusions have been questioned in light of the experience of other states that have enacted prohibitions on discretionary clauses. Additionally, the Department's position is that predicting whether and the extent to which a discretionary prohibition ban would increase costs relating to litigation is dependent upon numerous additional variables not

specifically considered by the Milliman study. These factors include the overall legal climate of an individual jurisdiction; the specific contractual language at issue and any revisions a company makes in response to a discretionary clause prohibition; the egregiousness of a company's bad faith coverage denial; and an insurer's disposition towards litigation in general. The Department's position is that the estimate provided by the Milliman study is the highest probable cost that may result from a discretionary clause prohibition; however, the Department's position is also that the costs resulting from a discretionary clause prohibition may be significantly less than estimated in the Milliman study. Thus, for the purpose of this cost note, the Department assumes an increased cost of between zero percent and four percent of premiums paid on policies from which discretionary clauses are removed.

With the exception of the notification costs to in-force policyholders, the cost elements and estimates identified in this cost note are reproduced from the March 5, 2010 informal posting on the Department's website. The costs relating to notification of in-force policyholders were added as a result of the clarification in the rule text that the discretionary clause prohibition applies to in-force policies. In its March 5, 2010 posting, the Department sought additional information on the above cost estimates and components. Insurance industry stakeholders provided general affirmation that the prohibition will result in additional litigation costs, but did not provide specific dollar amount cost estimates. Other non-insurance industry commenters discounted the objectivity of the Milliman study because it was commissioned by America's Health Insurance Plans, a national association representing approximately 1,300 health insurance companies. Several commenters cited information published by the

Washington State Office of Insurance Commissioner in its rulemaking proceedings prohibiting discretionary clauses stating that the prohibition would result in a decrease in litigation. One commenter also stated that insurance premiums have not risen as a result of a discretionary clause prohibition in several other states.

All of the analyses in this cost note are equally applicable to and do not vary for small or micro businesses.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on approximately 18 to 53 small or micro-businesses that are required to comply with the proposed rules. The Department does not have precise information regarding the number of small or micro life, accident and health insurers doing business in Texas or currently using discretionary clauses. However, for the purpose of this estimate, the Department assumes that between 10 to 15 percent of the 703 life, accident, and health insurers and health maintenance organizations (650 life, accident and health insurers and 53 health maintenance organizations) licensed in Texas as of April 30, 2010, are small or micro businesses, and that approximately one-quarter of these small or micro businesses currently use discretionary clauses. The cost of compliance with the proposal will not vary between large businesses and small or micro-businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro-businesses. However, as noted in the Public Benefit/Cost Note portion of this proposal, the costs associated with filing fees, administrative costs, and notification of in-force policyholders are anticipated to be contingent upon the number of forms containing discretionary clauses that the insurer currently uses. Therefore, to the extent that a small or micro business uses fewer forms containing discretionary clauses, these costs are expected to be lower than they would be for a larger insurer. The costs relating to litigation identified in the Public Benefit/Cost Note portion of this proposal are not anticipated to vary for small or micro businesses.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the proposal may have an adverse economic effect on small or micro-businesses that are required to comply with the proposal, the proposal does not require a regulatory flexibility analysis that is mandated by §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires that a state agency, before adopting a rule that may have an adverse economic effect on small businesses, prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The purpose of this proposal is to protect the economic welfare of Texas life, accident, and health insurance consumers. The financial devastation that can occur from unforeseen medical events can be significantly mitigated through the use of insurance. Medical costs are a major contributing factor to the majority of personal bankruptcies in the United States. A study published in the *American Journal of Medicine* in August 2009 conducted by professors from Harvard Medical School, Harvard Law School and Ohio University found that 62.1% of all bankruptcies in the study had a medical cause. Himmelstein, et al., *supra*. The Department has

determined that although they most often appear in disability income insurance policies, discretionary clauses also appear in health insurance policies and in waiver of premium relating to disability for life insurance policies. These types of policies or product features are purchased specifically by consumers to guard against the adverse financial consequences caused by health problems, diseases, or disabilities. As discussed previously, a prohibition on discretionary clauses ensures that consumers are provided with an opportunity for a full independent review of coverage determinations by a neutral body. The opportunity for full independent review of coverage determinations will promote fair and equitable coverage determinations by insurers, and will eliminate unfair and inequitable insurer coverage determinations previously made in reliance upon discretionary clauses and the subsequent lack of full independent review. However, to the extent that unfair and inequitable coverage determinations are made following the prohibition, as a result of the rule consumers will be provided with the opportunity for a full independent review. Therefore, the prohibition will substantially contribute to the economic welfare of insurance consumers by allowing them to more accurately predict the outcome of coverage determinations and to more successfully incorporate such insurance products and features into their financial planning.

Therefore, the Department has determined in accordance with §2006.002(c-1) of the Government Code, that because the purpose of the proposal is to protect consumer economic interests, there are no regulatory alternatives to the required notices in this proposal that will sufficiently protect the economic interests of consumers purchasing insurance from small or micro-business insurers.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on Monday, July 5, 2010, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be simultaneously submitted to Doug Danzeiser, Deputy Commissioner for the Life, Health & Licensing Division, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed new sections in a public hearing under Docket Number 2713, at 9:30 a.m. on July 12, 2010, in Room 100 at the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas 78701. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The new sections are proposed under the Insurance Code §§1701.060(a)(1), 1701.055(a), 1271.056, 1271.103, 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, or Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, 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 §541.401 specifies that the Commissioner may adopt and enforce reasonable rules the Commissioner determines necessary to prevent 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.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§§3.1201 - 3.1202	Insurance Code §§1701.055, 1701.060, 1271.056, and 1271.103.

9. TEXT.

§3.1201. Applicability and Effective Date.

(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) This subchapter applies to any form offered, issued, or enforced on or after January 1, 2011.

§3.1202. Discretionary Clauses Defined. For the purpose of this subchapter, a discretionary clause is a provision that purports to bind the claimant to or grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation on terms, coverage, or eligibility for benefits. The term includes, but is not limited to, a provision specifying:

(1) that a policyholder or other claimant may not contest a denial of a claim;

(2) that the insurer's interpretation of the terms of the policy or contract or its decision to deny coverage or the amount of benefits is binding upon a policyholder or other claimant;

(3) that in any appeal the insurer's decision-making power as to the interpretation of the terms of the policy or contract or as to coverage is binding;

(4) 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; or

(5) 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.

§3.1203. Discretionary Clauses Prohibited. No form offered, issued, or enforced in this state by an insurer may contain a discretionary clause.