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CONTENTS

LIABILITY INSURANCE AS TORT REGULATION: SIX WAYS THAT LIABILITY INSURANCE SHAPES TORT LAW IN ACTION*

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INTRODUCTION

In June 2004 the European Centre for Tort and Insurance Law held a conference to consider the impact of liability insurance on the law of torts from a comparative perspective. A highlight of that conference was the

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* An earlier version of this essay was published in TORT LAW AND LIABILITY INSURANCE (Gerhard Wagner ed., 2005).

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opportunity to engage in extended conversation with Continental torts scholars. In these conversations, I was struck by the depth of feeling that accompanied the insistence that liability insurance had not had an impact on tort law and, moreover, that it would be illegitimate for liability insurance to have such an impact. I had arrived at the conference with a laundry list of what we knew and did not know about the impact of insurance on tort law, ready to discuss research agendas for extending that knowledge, and here I was confronted with a challenge to the basic premise.

My answer was less immediately persuasive to the Continental challengers than I had expected. They dismissed my explanation of the role of liability insurance in the narrowing of traditional tort immunities (e.g., intra-family, governmental, charitable) as a marginal development. Moreover, they could explain that development within their framework of law as an autonomous field. In their view, the narrowing of traditional immunities simply reflected the successful expansion of tort law into the realms of the family, the state, and the church. Insurance had little or nothing to do with it.

In addition, they dismissed as irrelevant my description of the role that insurance plays in organizing the behavior of legal actors and therefore in shaping tort "law in action." That was sociology, not law.

Crossing back over the Atlantic, I pondered my response. The challengers' point about the narrowing of tort immunities was a good one. Of course I was ready to explain how liability insurance allowed lawmakers to believe that inserting tort law into the domain of the family, the state and the church would be less disruptive than might otherwise be supposed (try telling that to the Catholic Church today) and, moreover, that liability insurance encouraged some defendants to attempt to abandon their immunity in order to force their liability insurers to compensate their victims. But I recognized that the story of cause and effect here was not a clear one, and that even a carefully argued and documented story about immunities was unlikely to persuade my Continental colleagues.

And so I resolved to rest my case on sociology, in the hope that I could persuade them to adopt a view of law that is encompassing enough to include the behavior of lawyers and litigants. Adopting that view, they could not help but see the impact that insurance has had on tort law more broadly understood.

I. A BRIEF NOTE ON METHOD

Because I am describing the behavior of litigants and lawyers, traditional legal sources such as statutes, cases, and treatises are of little assistance. Instead, drawing on a long tradition of sociological jurisprudence in the United States, I have gone into the field. The sources for the quotations that I will use to illustrate my points are the Florida and Connecticut lawyers I interviewed for the studies reported in the Wisconsin Law Review and the Law and Society Review.[1] I will also be drawing on my experience as a participant observer in a legal career that has kept me in near constant contact with lawyers, litigants, and a variety of insurance institutions.

This approach can be dismissed as anecdotal,[2] but it offers a view inside the workings of the legal system that no ordinary law book can provide. While qualitative research of this sort does not provide conclusive evidence regarding the prevalence or extent of the practices observed, it can be used to frame more systematic quantitative analysis that may provide that evidence. In the meantime, the persuasive power of qualitative research depends, like traditional doctrinal and policy argument, on the reader's response to the coherence and plausibility of the analysis.

II. THE IMPACT OF LIABILITY INSURANCE ON TORT LAW

Leaving aside the difficulty in interpreting doctrinal developments, such as the abrogation of traditional immunities, liability insurance has at least the following six impacts on tort law in action. First, for claims against all but the wealthiest individuals and organizations, liability insurance is a de facto element of tort liability. Second, liability insurance limits are a de facto cap on tort damages. Third, tort claims are shaped to match the available liability insurance, with the result that liability insurance policy exclusions become de facto limits on tort liability. Fourth, liability insurance makes lawsuits against ordinary individuals and small organizations into "repeat player" lawsuits on the defense side, making tort law in action less focused on the fault of individual defendants and more

1. Tom Baker, *Transforming Punishment Into Compensation: In the Shadow of Punitive Damages,* 1998 WIS. L. REV. 211 (1998); Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action,* 35 LAW & SOC'Y REV. 275 (2001). As part of the research protocol, participants were promised confidentiality. For quotations not previously published, I will identify the speaker simply as a plaintiffs' or defense lawyer.

2. *E.g.,* Daniel Kessler and Daniel Rubinfeld, *Empirical Study of the Civil Justice System* (Nat'l Bureau of Econ. Research, Working Paper No.W10825, Oct. 2004).

focused on managing aggregate costs. Fifth, liability insurance personnel transform complex tort rules into simple "rules of thumb," also with the result that tort law in action is less concerned with the fault of individual defendants than tort law on the books. Sixth, negotiations over the boundaries of liability insurance coverage (which appears nowhere in tort law on the books) drive tort law in action. The sections that follow briefly describe each.

A. IN PRACTICE, LIABILITY INSURANCE IS AN ELEMENT OF TORT LIABILITY

The legal elements of tort liability are well known. The defendant must have a legal duty to avoid harm to the plaintiff. The defendant must have breached the standard of care that applies in the particular situation, and that breach must have caused damage to the plaintiff. For a lawyer considering whether to take a particular case on a contingency basis, however, or for a litigant considering whether to finance a claim upon some other basis, these legal elements are only a starting point. Liability by itself is not enough. The defendant must have the ability to pay.

In typically colorful language, the tort lawyers I interviewed emphasized this basic point:

> I was taught on my first day of practice there are three things: liability, damages, collectibility. I need collectibility first. I need damages second. I'm a good lawyer, I'll prove liability.[3]

Insurance has a fundamental effect on what this lawyer called collectibility—the defendant's ability to pay and the facility with which the defendant can be made to pay.

Given the extent of consumer debt, the availability of bankruptcy to discharge civil liabilities, and the existence of limited but important exceptions to the assets that must be liquidated in a bankruptcy proceeding, the practical reality of tort litigation in the United States is that liability insurance is the only asset that plaintiffs can count on collecting.[4] As one lawyer put it:

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3. Baker, *Transforming*, *supra* note 1, at 222.

4. *See* Steven G. Gilles, *The Judgment Proof Society*, WM. & MARY L. REV. (forthcoming 2005).

> The ideal case, from a plaintiffs' perspective, would be a rear ender [auto accident], with terrible injuries, and a big insurance policy. On the other hand, if you have a fall down on a private property with no homeowners [insurance], that sounds like the worst case.[5]

My field research confirmed the obvious point that insurance is the asset that matters for all but the wealthiest of individual defendants and small organizations.[6]

There is some evidence that this is also the case in many commercial disputes. Professor Lynn Lopucki has advanced and defended the controversial but plausible thesis that corporate groups increasingly locate risk in entities with no assets and placing assets in entities with no risk,[7] with the result that the liability insurance of the risky entity is all that is available for victims if and when the risk matures into harm. He may well have overstated the case for ordinary tort litigation, but for mass tort claims he is not far from the mark. The increasing use of corporate bankruptcy as a mass tort litigation risk management tool makes liability insurance the asset that matters for mass tort victims as well.[8]

If liability insurance is a de facto element of tort liability, then people without liability insurance will not be subject to tort liability. In practice, people are required, either by law or contract in the U.S., to purchase liability insurance in a wide variety of settings (a fact that shows that lawmakers and strong contracting parties understand that liability insurance is a practical predicate for tort liability).[9] But people are not required to purchase liability insurance in all settings. For example, people who rent their home in the United States are rarely required to purchase liability insurance and rarely do so voluntarily.[10] The only liability insurance most renters purchase is automobile liability insurance.[11] As a result, most renters are, as a practical matter, immune from civil suit in the U.S., except in the case of an automobile accident.

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5. Plaintiffs' lawyer from Connecticut interviews. *See* Baker, *Blood Money*, *supra* note 1.

6. *Id. See also* Gilles, *supra* note 4.

7. *See* Lynn Lopucki, *The Death of Liability*, 106 YALE L. J. 1 (1996).

8. *See* Alan N. Resnick, *Bankruptcy as a Vehicle for Resolving Enterprise-Threatening Mass Tort Liabilities*, 148 U. PA. L. REV. 2045 (2000).

9. *See* Gilles, *supra* note 4.

10. *Id.*

11. *Id.*

This practical immunity does not show up in tort law on the books. But if broader renter's insurance were required, and if the requirement were enforced, a new domain of opportunity would open for tort lawyers, and the resulting flow of cases would surely have *some* effect on the development of tort doctrine. That effect might be as imperceptible on a day-to-day basis as the effect of lawyers' feet walking up the steps to the courthouse. But over time, pits and grooves will show. Even if they do not, however, the shape of tort law as a field of action will have changed.

B. LIABILITY INSURANCE POLICY LIMITS ARE DE FACTO CAPS ON TORT DAMAGES

In contrast to what I understand to be the case for some insurance policies in some European jurisdictions, all liability insurance policies in the United States are sold with limits on the amount of money that the liability insurer is obligated to pay for a particular claim or event, even if the damages owed by the insured are much larger. For example, as my European colleagues were shocked to learn, the limit on the mandatory automobile liability insurance policy in my state of Connecticut is $20,000 per person, $40,000 per accident, meaning that the maximum amount that the liability insurer must pay any one person is $20,000 and the maximum amount that the insurer must pay all victims from any one accident is $40,000. Of course, many people voluntarily purchase automobile liability insurance policies with limits that are much higher, but many people do not. In addition to these per-claim or per-event limits, many liability insurance policies also contain a specified dollar limit on the total amount of money that the insurer is obligated to pay for all claims or events covered by the policy. In my experience, such "aggregate" limits are nearly universal in commercial general liability policies in the U.S. (but not in automobile liability policies).

For defendants who would not be sued in the absence of liability insurance, the fact that the insurance policy limit functions as a de facto "cap" on the defendants' tort liability is obvious. What may not be quite so obvious is that the policy limit more often than not functions as a cap even for defendants who have other assets. There is good evidence that payments in excess of the policy limits are extraordinarily rare in cases involving individual defendants,[12] and nearly as rare in cases involving

12. Baker, *Blood Money*, *supra* note 1. *See generally* Bernard S. Black, Brian R. Cheffins & Michael Klausner, *Outside Director Liability* (Stanford Law and Econ. Olin, Working Paper No. 250) *available at* www.ssrn.com (reporting that directors and officers of corporations do not as a practical matter face any individual liability in securities fraud

commercial defendants.[13] I have concluded that this situation results from a combination of factors: the existence of a cause of action for breach of the insurer's "duty to settle," the anchoring effect of the policy limit during settlement negotiations, the liability insurer's power to control settlements within the policy limits but not beyond the policy limits, and the related development of settlement norms within the tort litigation bar.[14]

For present purposes, however, the reasons that liability insurance policy limits function as a cap on tort damages do not matter. What matters is the consequence. Even tort litigation against wealthy individuals and large organizations has become, in all but the unusual case, an exercise in recovering money from liability insurance companies and only from insurance companies.[15]

C. TORT CLAIMS ARE SHAPED TO MATCH THE AVAILABLE LIABILITY INSURANCE

This next effect of liability insurance on tort law in action is a corollary to the first two. If only people with insurance are sued, and if the suits are targeted at recovering insurance money, then claims that fit into one of the exclusions in the applicable liability insurance policy (and thus would not be covered by the policy) are not worth bringing. Of course there are exceptions. Some defendants have enough assets that insurance does not matter. And some plaintiffs have the interest and the means to bring a lawsuit even when the defendant is not able to pay the damages. But the existence of these exceptions does not change the effect that the general rule has on the shape of tort law in action. Exclusions in liability insurance policies create, in effect, remote islands of tort liability that lawyers and law professors know about, but almost no one goes to visit.

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actions because claims are virtually always settled within the limits of their D&O insurance policies).

13. *See* TEXAS DEPARTMENT OF INSURANCE, 2002 TEXAS LIABILITY INSURANCE CLOSED CLAIM ANNUAL REPORT 2, *available at* http://www.tdi.state.tx.us/reports/pdf/taccar2002.pdf (reporting that there was a payment in excess of policy limits in only 31 out of 9723 liability insurance paid claims in 2002 and that the total amount paid above the limits in those cases was $9 million, as compared to $1.8 billion in total liability payments in Texas in 2002; by comparison settlements by commercial insured within their deductible totaled $41 million in Texas in 2002).

14. *See generally* Baker, *Blood Money*, *supra* note 1.

15. The widespread recent publicity surrounding the fact that members of the WorldCom board of directors were paying some of their own money to settle the WorldCom securities fraud litigation provides some evidence in support of my claim.

One important example is the exclusion for intentional harm, which is nearly universal in liability insurance policies in the U.S. covering bodily injury.[16] This exclusion explains the dearth of intentional bodily injury tort actions brought in the U.S. The plaintiffs' lawyers I interviewed explained this situation as follows:

> If you allege that he intentionally whacked her over the head, say with a baseball bat, okay, then the homeowner's policy doesn't come into effect. If you say that he negligently and carelessly struck her or did something that he shouldn't have done, then the homeowner's policy comes into effect. So, you've got to be very careful about what you allege—what your facts are.
> I'm not dealing with intentional torts and when I have what I think is an intentional tort, I couch my complaint in negligence and hopefully I'll get the same efforts from personal counsel for the defendant, the individual defendant or corporate defendant, to say we didn't mean it.[17]

The defense lawyers corroborated this practice and explained that their duty to their clients means that they support the plaintiffs' effort to shape the claim to meet the coverage:

> So what does the plaintiff's lawyer do? He doesn't even bother to sue for assault and battery, if he has any sense. He just proceeds on a negligence theory and does not bring the assault and battery theory, because there's no coverage in assault and battery and he runs the risk of the jury filling in the assault and battery line instead of the negligence line, and how does he explain that to his client? He got a hundred dollar judgment. Try and collect it. There's no coverage.
> What about the scenario where the suit is just pled in negligence and it's not pled as an intentional tort? Now the insurance company hires you and you're there defending the negligence action. What are you going to do, say it wasn't negligence but he did do it intentionally?[18]

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16. *See, e.g.*, The ISO Homeowners and Commercial General Liability Forms, *reprinted in* TOM BAKER, INSURANCE LAW & POLICY: CASES, MATERIALS, PROBLEMS 338, 411 (2003).

17. Baker, *Transforming*, *supra* note 1, at 223-24.

18. *Id.* at 225.

Both legal rules and professional norms require defense lawyers to place the interests of the insured defendant ahead of the interests of the insurance company paying the defense costs.[19] As a result, defense lawyers in the U.S. to some extent cooperate with the plaintiffs' lawyer in shaping the claim to fit the available coverage.

D. LIABILITY INSURERS ARE THE ULTIMATE "REPEAT PLAYERS"

Tort doctrine treats tort liability as the responsibility of a particular defendant to a particular plaintiff for a particular wrong. Liability insurance shifts the liability of the particular defendant to an entity for which that liability is simply one among an enormous portfolio of contingent financial obligations. Legal norms obligate the insurance company, and to a greater extent the lawyer employed by the insurance company, to handle the liability claim so that the interests of the particular defendant are paramount,[20] and in my experience insurance companies largely attempt to honor that norm.

But insurance companies also recognize and act upon the fact that they hold a portfolio of claims. This means that the results in one case can affect the results in another. As a result, liability insurers have an interest in the development of tort law rules and settlement norms that goes far beyond the interests of any ordinary defendant. In the terms of Mark Galanter's classic study, liability insurers are the ultimate "repeat player."[21]

As reflected by the statement that follows, this portfolio approach to litigation management frustrates plaintiffs' lawyers, but there is little that they can do about it:

> Unless your client's a quadriplegic, they don't want to pay. And I think that's unethical, because I think what they do is they—they're supposed to be dealing with each case separately under the canons and I think what they're doing is they say—they won't verbalize this exactly—"Yes, this case is worth the policy. However, if we settle this case, then the next case will be brought, and we want to have a chilling effect on people suing our clients and reduce the overall amount we pay. And the way to do that is by using this case

19. *See generally*, Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101 (1998).

20. *Id.*

21. Mark Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 LAW & SOC'Y REV. 95 (1974).

> as an example." They definitely do that. That's unethical. That's like me saying, "I know that Mary Jones, my plaintiff here, I know that her case is worth thirty-five thousand, but I'll settle for twenty because my other client's case for the same company, I think I can get an extra ten thousand for that, so it'll wash. Plus they're a better client, because they have three cases." I don't see the difference.[22]

The repeat player phenomenon makes tort law in action less focused on the fault of individual defendants and more focused on managing aggregate costs.

Many liability insurance company executives would assert that their repeat player advantage is more than outweighed by the bias of judges and juries. Judges and juries know that defendants have insurance, and as a result they are more likely to award the plaintiff damages, or so the argument goes.[23] Interestingly, empirical research on jury behavior suggests that juries are at least as concerned with the health and other first party insurance held by the plaintiffs, and with making sure that the plaintiffs do not get a double recovery,[24] but the direction of the bias is less important than the widespread belief that it exists. Since cases are settled in the "shadow of the law" based on the parties' predictions about what will happen in court,[25] a widespread belief that juries act in certain ways has the same effect whether juries in fact act in that way or not.

Liability insurance helps transform tort litigation into a multi-player iterative game that develops and transmits beliefs and norms that become part of the rules of that game. In my view, those beliefs and norms constitute the *real* tort law for far more people than does the tort law on the books.

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22. Plaintiffs' lawyer from Connecticut interviews. *See* Baker, *Blood Money*, *supra* note 1.

23. *See, e.g.*, Kent Syverud, *On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629 (1994).

24. *See* Shari S. Diamond & Neil Vidmar, *Jury Room Ruminations on Forbidden Topics*, 87 VA. L. REV. 1857 (2001).

25. *Cf.* Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979).

E. LIABILITY INSURANCE TRANSFORMS TORT RULES INTO SIMPLE "RULES OF THUMB"

Ross's classic study of automobile accident claims handling provides the most extended account of the way that insurance adjusters transform complex tort rules into simpler and more easily administered rules of thumb.[26] In an important sense, this effect of liability insurance on tort law in action is simply an instance of the "repeat player" effect just described. But the practical implications of insurance adjustment are worth special mention. Otherwise, one might be mislead into thinking that the repeat player status of the liability insurance company primarily affects only the development of tort law on the books.

One of Ross's best examples is the rear end collision—an automobile accident in which one car hits another car from behind.[27] According to the formal tort law rule, liability depends on a careful and case-specific analysis of the accident and a consideration of whether the drivers exercised the degree of care that a reasonable person would ordinarily exercise in that situation. Ross's adjusters applied a simpler, easier to administer rule that probably had the same result as the formal rule in most situations.[28] Their rule was that the driver of the car in back was liable in all cases.[29]

Such rules are not universally applied. The greater the stakes, the more likely that the rules of thumb will give way to the particularized assessments that formal tort doctrine requires.[30] But, in the aggregate they combine to make tort law in action less focused on the individual fault of individual defendants than tort law on the books.

Ross generalized from this example as follows:

> Adjustment of insurance claims compromises the legal mandate for individualized treatment with the need of a bureaucratic system for efficient processing of cases. This compromise can be observed at many points in the processes of investigation and evaluation. Investigation is vastly simplified, for instance, by presumptions as to liability based

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26. H. LAURENCE ROSS, SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS (1970).

27. *Id.* at 98-101.

28. *Id.*

29. *Id.*

30. *Id.* at 135 ("An injury situation that can qualify a claim as a 'big case' may receive something of the individualized treatment envisaged by the appellate courts.").

> on the physical facts of the accident. Accidents are thus seldom individualized to an insurance adjuster or a claims attorney. Rather, they are rear-enders, red-light cases, stop sign cases, and the like, and the placement of an accident into one of these categories ordinarily satisfies the requirements for investigation of liability. . . .
>
> These observations are not meant as criticism of the good faith of the insurance industry or other parties associated in the handling of claims. Rather they are meant to put claims handling into proper context; to show that here as elsewhere—for example in handling pleas to criminal charges, or in making decisions as to whether a mental condition merits institutional commitment—a large scale society proceeds by routinizing and simplifying inherently complex and difficult procedures. This is how the work of the world is done. This is the law, as it is experienced by its clients rather than by its philosophers. Perhaps in the light of some kinds of legal philosophy it is bad law. In my opinion, such legal philosophy has lost contact with the reality of modern society.[31]

Ross's larger point about the nature of tort law is worth noting.[32] Ross's point has taken hold in the American legal academy, and to a lesser extent in other jurisdictions influenced by the law and society approach that Ross's classic study exemplified.

I would never argue that tort doctrine and the consistent behavior of insurance adjusters are "law" in exactly the same sense, nor would I argue that tort doctrine is irrelevant.[33] But I would argue that any law professor who thinks that the routine behavior of "street level bureaucrats"[34] like insurance adjusters is not law needs to spend some time representing real people in the ordinary, low value accident cases that constitute the bulk of the tort law universe.

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31. *Id* at 135.

32. *Cf.* PIERRE BOURDIEU, THE LOGIC OF PRACTICE 103 (1990) ("[T]he rule . . . is the obstacle *par excellence* to the construction of an adequate theory of practice").

33. *Cf. id* at 108 ("[T]he official description of reality is part of a full definition of reality . . . ."). For an extended example of research incorporating doctrinal and law-in-action analysis, see Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories and Insurance Contract Damages*, 72 TEX. L. REV. 1395 (1994).

34. *See generally* MICHAEL LIPSKY, STREET LEVEL BUREAUCRACY: DILEMMAS OF THE INDIVIDUAL IN PUBLIC SERVICES (1980).

F. NEGOTIATIONS OVER INSURANCE BOUNDARIES DRIVE TORT LAW IN ACTION.

The final way that liability insurance shapes tort law is a bit harder to describe, perhaps because this point may well be the only truly new idea in this essay. The main idea here is to generalize an implied corollary of impacts one, two and three, above. As you may recall, those three are: liability insurance is a de facto element of tort law, liability insurance limits are de facto caps on tort damages, and tort claims are shaped to match the available liability insurance coverage. Each of these, of course, overstates the case. There are exceptions.

Each of these impacts call attention to a different kind of liability insurance boundary: *who* has liability insurance, for *how much*, and with regard to *what kinds* of liabilities? Each of these kinds of boundaries exerts a shaping force on tort law.

As a philosophical and doctrinal matter, tort liability certainly exists outside the boundaries of liability insurance coverage, but we are not going to go through the effort of establishing liability "out there" very often because there is no return in it. This suggests that liability insurance coverage establishes to some extent the boundaries of tort law itself, or at the very least the boundaries of tort law in action.

Alternatively, we might say that uninsured individuals are "outlaws" with regard to tort law and that liability insurance industry practices have the effect of making people outlaws with regard to tort liabilities. The kinds of practices that turn people into tort law outlaws include exclusions in liability insurance policies, marketing practices that leave populations uninsured (e.g., redlining[35]), and the practice in the U.S. of bundling liability insurance with some kinds of property insurance but not others.[36]

As this suggests, negotiation over who gets insurance, for how much, and against which kinds of liabilities drives tort law in action. These negotiations occur in legislatures debating what kinds of liability insurance to require and when; in administrative agencies debating how much effort to devote to enforcement of the insurance mandate; within large organizations debating whether to include an insurance clause in a standard form contract, how to word the clause, and whether to allow waivers; among contracting parties negotiating whether to include insurance

35. INSURANCE REDLINING (G. Squires, ed., 1997).

36. *See* Tom Baker & Karen McElrath, *Whose Safety Net? Home Insurance and Inequality*, 21 LAW & SOC. INQUIRY 229, 235 (1996) (reporting that the basic "dwelling protection" policy, unlike a "homeowners" policy does not contain liability insurance coverage).

requirements in their deals; and in the many places in which liability insurers establish and apply rules regarding who gets insurance, for how much, and against which kinds of liabilities. These kinds of negotiations establish the boundaries of liability insurance coverage. They separate the domesticated, insurance purchasing tort law citizen from the tort law outlaw, and they mark the frontier between the lawed and unlawed activities of that tort law citizen.

A second kind of negotiation over boundaries takes place within the context of tort claims. These are negotiations over whether this particular defendant has insurance, whether the insurance is sufficient to cover the amounts claimed as damages, and whether the particular liabilities at issue are covered by the defendant's insurance policy. Because of the profoundly practical effect of these negotiations—among other things, they determine whether and how much the plaintiffs' lawyer will get paid—it is not surprising that they have spawned a host of secondary legal rules and professional norms.[37] These secondary rules and norms define the boundaries of liability insurance coverage, so that a reasonably complete understanding of tort law in action requires not only an appreciation of the formal liability rules and the shape and extent of liability insurance coverage, but also the rules and norms that govern the resolution of questions regarding people and liabilities that lie in close proximity to the liability insurance boundaries.

On the whole, my experience is that these secondary rules and norms operate to extend the liability insurance boundaries, but I would not make strong claims in that regard. My field research suggests that these norms and rules allow plaintiffs to transform uninsurable punitive damages into additional insurable compensatory damages, transform uninsurable intentional torts into insurable negligence actions, obtain a larger share of the recovery than the formal subrogation or lien rules allow, and increase the present value of the available insurance coverage by increasing the potential liability of an insurance company that refuses to offer a quick settlement.[38] On the other hand, my field research also suggests that in some circumstances plaintiffs care very deeply that the defendant pay with his or her own money—"blood money" some lawyers call it—because money from the insurance company will not adequately right the moral wrong that the defendant committed.[39]

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37. *See, e.g.*, Baker, *Blood money*, *supra* note 1.
38. *See* sources cited *supra* note 1.
39. *See* sources cited *supra* note 1.

For present purposes we need not be very precise about these secondary rules and norms because my point is simply that they exist and that they are worthy and indeed even necessary objects of study for those who seek to chart the place of tort law in society.

CONCLUSION

This essay has described six ways that liability insurance shapes tort law in action. For most practical purposes, liability insurance has become an element of tort liability for all but the wealthiest potential defendants. The contractual limits on the amount of liability insurance place a practical limit on the amount of tort damages that plaintiffs can receive. Liability is shaped to match the available insurance coverage. Liability insurance makes tort litigation into a repeat player game in which the insurance companies handle individual cases according to their long-term interest in the development of tort law rules and settlement norms. Liability insurance personnel transform tort rules into more easily administered "rules of thumb." Finally, negotiations over insurance boundaries drive the development of tort law in action.

I will conclude with a metaphor that may help to illustrate the power that liability insurance has to shape the development of tort law. Imagine a network of streams and rivers carrying water through the countryside to the sea. Water represents claims for relief. Tort law is the network of streams, rivers and lakes through which the water flows into the sea. Water that makes it into the sea represents the successful requests for tort law relief (whether by settlement, which is much more likely, or adjudication). Within this metaphor insurance is an invisible force that affects how much it rains and where, erects dams in some places, and sends huge torrents of water down others. Within this metaphor insurance is a force that turns some small tort rivulets into streams, and some tort streams into wide, straight rivers of tort liability.

Studying a snapshot of the landscape, we would clearly see how the tort law streams and rivers channel the flow of requests for relief, but we would miss the channeling force of liability insurance. Anyone who goes out and lives in the countryside would soon notice the strange pattern of rainfall, the odd placement of dams. Observing the landscape over time she might even start to wonder what, exactly, is channeling what. Does the network of tort law streams and rivers channel the requests for relief or do those requests channel the streams and rivers? And what explains why it rains so heavily on that hillside, while this other one is dry?

This metaphor is far from perfect, but it illustrates a powerful insight into the role that liability insurance plays in shaping tort law. The insight is not mine, though I may have extended it a bit. In the spirit of Nathan Isaacs, Roscoe Pound, Fleming James, and H. Laurence Ross I offer this insight across the Atlantic in the hopes of further conversations about insurance, law and society.

MARINE TITLE INSURANCE: THE DERNIER CRI IN TITLE INSURANCE

*Matthew J. Bauer**

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INTRODUCTION

What do jazz and marine title insurance have in common? Unlikely bedfellows, to be sure, but they are both unique products of New Orleans. Until 2000, the best third party title protection available to a vessel owner

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or lender was a review of the United States Coast Guard (USCG) records and a legal opinion. With the advent of marine title insurance,[1] owners and lenders of marine vessels are provided a mechanism by which they can feel secure with their investment. This article will look at marine title insurance coverage, land title insurance, differences between land title insurance and marine title insurance, and vessel title disputes.

I. TITLE INSURANCE GENERAL DISCUSSION

The insurance industry has America to thank for title insurance.[2] Title insurance's birth was in response "to the unique nature of real estate transactions and the inadequate protection afforded by the prior title assurance methods of abstractor and attorney opinions."[3] This took place in the second half of the nineteenth century.[4] Title insurance insures against title risks that are present but generally are undiscoverable through public records examinations.[5] The hidden risks include actual monetary loss because of title matters, such as defects, liens, and encumbrances.[6]

The term "title insurance" may be misleading—"the policy is an insurance product and an attempt to reconcile abstracting information but does not, by its express terms, represent the status of title."[7] The American Land Title Association (ALTA) policies, which are the most widely used title insurance contracts, are void of any assertion that they represent the condition of title.[8] In sum, title insurance policies are indemnity contracts protecting against actual monetary loss.[9]

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1. The terms "marine title insurance" and "vessel title insurance" are used interchangeably throughout this article.

2. Amy W. Beatie & Arthur R. Kleven, *The Devil in the Details: Water Rights and Title Insurance*, 7 U. DENV. WATER L. REV. 381, 392 (2004).

3. *Id.*

4. *Id.*

5. James L. Gosdin, *Title Insurance: A Comprehensive Overview*, 2000 A.B.A. SEC. OF REAL PROP., PROBATE & TRUST L. 3.

6. 1 JOYCE PALOMAR & RUFFORD G. PATTON, PATTON AND PALOMAR ON LAND TITLES § 41 (3d ed. 2002).

7. Gosdin, *supra* note 5, at 1.

8. *Id.*

9. *Id.*

A. BRIEF HISTORY

Until the advent of title insurance, titles were frequently assured through written opinions of title based upon a review of applicable records.[10] Drafting an opinion letter consists of an attorney, or, in some instances, a lay conveyancer issuing an opinion after reviewing the chain of title, in the form of a signed title abstract.[11] The opinion includes a description of "all rights, liens or ownership interests in the property."[12] Most American property law derived from England during the Colonial Era; this method of title review is no exception.[13] This system supplied the way of "securing land title throughout the United States' early years and into the twentieth century."[14] In adhering to this means of securing land title, purchasers of real estate suffered losses occasioned from title defects not reasonably discoverable, e.g., from a property inspection or public record search.[15] Additionally, the attorney or conveyancer was not held liable for losses from "discovered facts that were improperly, but nonetheless reasonably, evaluated."[16] Title insurance provided a means by which purchasers of real estate could protect themselves from undiscoverable risks, or at least risks that were not readily discoverable.[17]

In 1868, the modern title industry's origin,[18] the case of *Watson v. Muirhead*[19] "brought to light the growing need for some type of title assurance."[20] The dispute in *Muirhead* arose when a conveyancer, Muirhead, acting in good faith, failed to bring to the attention of the individual purchasing the subject real estate of a recorded judgment.[21] The purchaser was informed of the liens only after he closed on the property.[22]

Watson filed suit against Muirhead because Watson satisfied the liens.[23] However, because Muirhead acted in good faith, the Pennsylvania Supreme Court held that there was no negligence for Muirhead failing to

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10. Beatie & Kleven, *supra* note 2, at 392. *See also* Charles B. DeWitt, III, *Title Insurance: A Primer*, 3 TENN. J. PRAC. & PROC. 15, 16-17 (2000).
11. Beatie & Kleven, *supra* note 2, at 392. *See also* DeWitt, *supra* note 10, at 16-17.
12. Beatie & Kleven, *supra* note 2, at 392-93.
13. DeWitt, *supra* note 10, at 16-17.
14. Beatie & Kleven, *supra* note 2, at 393.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. Watson v. Muirhead, 57 Pa. 161 (1868).
20. DeWitt, *supra* note 10, at 17.
21. *Id.*
22. *Watson*, 57 Pa. at 161.
23. *Id.*

disclose the recorded judgment.[24] The effect of the *Muirhead* court's decision was to establish that negligence principles govern a lay conveyancer's liability.[25] Accordingly, the only recourse a purchaser who suffered losses attributable to a conveyancer's good faith mistake was to bring a negligence suit against the conveyancer.[26] Furthermore, "even in cases where a purchaser could possibly establish negligence, the cost and uncertainty of bringing such a suit would prohibit full recovery."[27] Title insurance served to remedy this problem "[b]y providing a contractual right of recovery for title defects regardless of fault (so long as it is covered by the policy) . . . ."[28]

The first title insurance underwriter, Real Estate Title Insurance Company, formed in Philadelphia in 1876 and developed as a result of this and similar cases.[29] It was of little surprise that Philadelphia was the site of the first title insurance underwriter because Philadelphia was also the location of *Watson v. Muirhead*.[30] The following few years witnessed the formation of title insurance companies in New York, Chicago, Minneapolis, San Francisco, and Los Angeles.[31] Major cities throughout the United States had title insurance companies as local residents.[32] The impetus for the title insurance industry arrived in the 1930s by way of the federal government's intervention into the housing and lending markets.[33] Because lenders required that title insurance be included in transactions where they lent money, the industry spread across the country.[34] Approximately 150 title insurance companies existed throughout the nation in 1950.[35]

Today, in a majority of the United States, title insurance remains the most common means of assuring title to real estate.[36] In some states, "attorney title opinions are still occasionally sought in rural areas for

24. *Id.*
25. *Id. See also* Beatie & Kleven, *supra* note 2, at 393.
26. Beatie & Kleven, *supra* note 2, at 393.
27. *Id.* at 394.
28. *Id.*
29. DeWitt, *supra* note 10, at 17.
30. Beatie & Kleven, *supra* note 2, at 394.
31. DeWitt, *supra* note 10, at 17.
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.*
36. Beatie & Kleven, *supra* note 2, at 394.

transactions involving farms . . . but title insurance is used for nearly all land transactions."[37]

B. OPERATION OF TITLE INSURANCE

Concisely, "title insurance is an indemnity agreement purchased for a one-time fee."[38] Title insurance is not a guarantee of title.[39] What it is, however, is protection from "discoverable and undiscoverable defects, liens, encumbrances, adverse claims and other risks to title, other than those expressly excluded or excepted from coverage, that can result in loss or damages to the insured, and that exist as of the date the policy is written."[40] Covered risks frequently include:

> [T]itle examination errors (both negligent and non-negligent) by the title company or its agent; some disclosed, minor defects such as covenants, easements, or encroachments that the title company deems negligible or unenforceable; defects not revealed because the title company intentionally restricted the scope of the title search; and defects that would not be revealed by a reasonable public records search.[41]

Title insurance routinely insures the marketability of a title.[42]

After reading the prior list of covered risks, one may realize that title insurance is "primarily intended as a method of protecting against undiscoverable, rather than discoverable, risks to title."[43] Generally, unveiling defects during a title examination or by a physical inspection/survey of the property is not covered.[44] Additionally, most title insurance underwriters also expressly disallow from coverage some undetectable title risks.[45] Such excluded risks quite often include "adverse

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37. *Id.* at 395.

38. *Id.*

39. *Id.*

40. *Id. See* 1 Palomar, *supra* note 6, § 41; Charles Szypszak, *Public Registries and Private Solutions: An Evolving American Real Estate Conveyance Regime*, 24 WHITTIER L. REV. 663, 685-86 (2003).

41. Beatie & Kleven, *supra* note 2, at 395.

42. *Id.* at 396.

43. *Id.*

44. *Id.*; Szypszak, *supra* note 40, at 686.

45. Szypszak, *supra* note 40, at 686. The "undetectable tile risks" are undetectable in the sense that they are not discoverable when a public record search is employed. Beatie & Kleven, *supra* note 2, at 396.

possession claims; unrecorded leases, liens or easements; governmental laws, ordinances, land use restrictions and rights of eminent domain; claims arising under bankruptcy or creditor laws; and problems discoverable only by survey."[46] Additionally, most title insurance policies exclude defects created after the policy date.[47]

After establishing what title insurance does not provide, it is relevant to determine what it does provide. Title insurance insures a party with two forms of protection.[48] The initial protection is such that the title insurance company has a duty to defend any claim arising from a dispute over the insured's title to ownership of property.[49] That is, if a claim is within the insuring provisions of the policy, the title insurer must pay the cost of the claimant's legal defense.[50] The insured party's contractual right to indemnification is the second form of protection under title insurance.[51] If the policy covers the matter causing loss or damages, pursuant to the insured's right to indemnification, the insured need not initiate a lawsuit to show the insurer was at fault in order to recover.[52] Should a claim prove valid, "the title insurer must reimburse the insured for actual losses, subject to the limits of the policy."[53]

Because the primary role of title insurance is to protect an insured from undisclosed risks, its process starts with a title search.[54] "The title search and examination serves an informational function that protects both the insurer and the prospective insured."[55] Should a search reveal an existing defect in a title, a title company has two options.[56] It can "either refuse to insure title or [it] can tailor its coverage by requiring removal of the defect, insuring it with adequate bonding or indemnity, or issuing the policy with an appropriate exception."[57] An insured attains the benefit of having valuable information concerning the real estate in question revealed

46. Beatie & Kleven, *supra* note 2, at 396.
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.* at 396-97.
51. *Id.*
52. *Id.*
53. *Id.*
54. *Id.*
55. *Id.* at 397.
56. DeWitt, *supra* note 10, at 18.
57. Beatie & Kleven, *supra* note 2, at 397. *See also* DeWitt, *supra* note 10, at 18.

through the employ of a title search.[58] The insured may choose not to purchase the property or may attempt to negotiate different sale terms.[59]

II. VESSEL TITLE STATUS

A. DETERMINING A VESSEL'S TITLE STATUS

Liens on ships, i.e., maritime liens, are often hidden and "ships acquire liens like dogs get fleas."[60] Maritime liens are secret and unrecorded, that is, they are valid without possession or filing.[61] Thus, a maritime lien is non-consensual and follows the vessel into the hands of even a good faith purchaser.[62] When determining the status of a vessel's title, the aforementioned liens often prove problematic.[63] Typically, the integrity of a vessel's title is determined by obtaining a title abstract, a certificate of ownership, and an attorney opinion letter.[64] The title abstract gives everything in the long history of the vessel since she was flagged.[65] It will indicate every mortgage, every lien that has been recorded, and its status.[66] The certificate of ownership provides the record owner as well as any mortgages, liens or other encumbrances against the vessel.[67] An attorney's opinion letter merely provides just that, an attorney's opinion on the status of a vessel's title.[68] These three items indicate, from a documentary perspective, if title is clean.[69] However, they do not indicate whether there

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58. Beatie & Kleven, *supra* note 2, at 397.

59. *Id.*

60. Interview with William A. Porteous, III, Member, Porteous, Hainkel and Johnson, L.L.P., in New Orleans, La. (Feb. 23, 2005).

61. G. GILMORE & C. BLACK, THE LAW OF ADMIRALTY 586-89 (2d ed. 1975).

62. FIRST AMERICAN TRANSPORTATION COMPANY, 125 PLUS WAYS FOR AN OWNER OR LENDER TO LOSE A VESSEL (2002), http://www.firstam.com/movables/pdf/WaystoLoseYour Vessel.pdf.

63. Porteous, *supra* note 60.

64. *Id.* "Attorney opinion letter" and "title opinion" are used interchangeably throughout this article.

65. Porteous, *supra* note 60.

66. *Id. See also* John R. Bass, *Vessel Ownership: Calm Seas or Surprise Squalls*, 16 ME B.J. 36, 38 (2001).

67. Porteous, *supra* note 60. *See also* Robert O. McDonald, *Documentation and Transfer of Vessels; Transfer of United States Vessels to Aliens*, 47 TUL. L. REV. 511, 527 (1973).

68. Porteous, *supra* note 60.

69. *Id.*

are any hidden liens.[70] An owner or lender can never be certain about the title of a vessel due to the hidden nature of liens.[71]

B. ATTORNEY TITLE OPINION LETTER

An attorney opinion letter is a document designed to protect a vessel owner's or a lender's expectations regarding a vessel title's status.[72] An opinion letter is drafted after an attorney has gathered and reviewed the relevant information.[73] Although title issues present the greatest risk, overall, maritime liens present the greatest potential for resulting in claims.[74] Therefore, a diligent attorney's inquiry does not terminate with a review of an abstract and certificate of ownership.[75] Accordingly, when the transaction involves a commercial vessel, the attorney investigates the seller's business transactions.[76] The attorney contacts persons and entities where the vessel conducts business, e.g., call fuel suppliers, electronic repairers, and contact insurers and inquire about accidents and coverage questions.[77] This begins the "jungle telegraph on the waterfront," i.e., every time these people are contacted and asked whether they are owed any money from the vessel; they in turn call others they know who also conduct business with the vessel.[78] This is how the attorney locates hidden liens.[79] Although this method brings many hidden liens to the forefront, it does not mean that all hidden liens have been discovered.[80] The only time a vessel will be without a lien is at her creation and when she is sold at a properly conducted maritime sale (a sheriff's sale).[81]

Another shortcoming of a title opinion is that it fails to guarantee that title is marketable.[82] It is nothing more than "the attorney's professional

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70. *Id.*

71. *Id.*

72. Robin Paul Malloy & Mark Klapow, *Attorney Malpractice for Failure to Require Fee Owner's Title Insurance in a Residential Real Estate Transaction*, 74 ST. JOHN'S L. REV. 407, 438 (2000).

73. *Id.*

74. Interview with Victor Koock, Vice President, First American Transportation Insurance Co., in New Orleans, La. (Feb. 25, 2005).

75. Porteous, *supra* note 60.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. Porteous, *supra* note 60.

81. *Id.*

82. Malloy & Kaplow, *supra* note 72, at 438.

opinion that title *appears* to be marketable or as otherwise contracted."[83] The attorney's opinion letter is the attorney's assertion that he has "done competent, professional work, complying with the opinion-writing norms established by and followed in the relevant legal community."[84] Responsibility does not befall the attorney for information that is unavailable or inaccurate because of mistake, misspelling, or misfiling.[85]

Title opinions provide a "fault-based system of title assurance."[86] Liability rests with the attorney if the attorney's efforts fall short of the appropriate standard of care in preparing and integrating the information.[87] Therefore, the title opinion is only as good as the lawyer's expertise and then only as valuable as the lawyer's malpractice insurance.[88] Risks that could not have been discovered or eliminated by adhering to appropriate search and examination standards do not render the attorney liable.[89] Losses due to forged or fraudulent documents, misfiling, mistakes made by the recording office, wild deeds, or other undetectable but known risks may escape even the lawyer using the highest standards of care and diligence.[90] Thus, the party requesting the title opinion is not protected from these risks.[91]

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83. *Id.* (emphasis added).

84. *Id.*

85. *Id.* at 438 n.196.

86. *Id.*

87. *Id. See, e.g.*, North Bay Council, Inc. v. Bruckner, 563 A.2d 428, 431 (N.H. 1989) (holding that an attorney is subject to a prudent purchaser standard and must disclose defects that would reasonably lead to refusal of the conveyance by such a prudent purchaser). *See generally* Joseph T. Bockrath, Annotation, *Liability of Attorney for Negligence in Connection with Investigation or Certification of Title to Real Estate*, 59 A.L.R. 3d. 1176 (1974) (stating that attorney liability is predicated on specific acts or omissions).

88. Malloy & Klapow, *supra* note 72, at 438-39.

89. *Id.* at 439. *See North Bay Council*, 563 A.2d at 431.

90. Malloy & Kaplow, *supra* note 72, at 439.

91. *Id.*

C. MARINE TITLE INSURANCE[92]

Much like its terrestrial counterpart, marine title insurance protects an owner or lender from unexpected title problems that may result from vessel transactions.[93] In addition to providing the costs to defend and prosecute covered matters, marine title insurance coverage includes insurance for title problems, fraud in the transaction, documentation problems, gap protection, and lack of priority of the preferred ship mortgage over statutory liens for necessaries, all of which are unaffected by the existence of an attorney opinion letter.[94] Similar to land-based title insurance, marine title insurance is an indemnity agreement and not a guarantee. The value to the vessel owners is peace of mind that any loss related to title defects will be compensated by the marine title insurer.[95] Once an insurable title has been achieved, each subsequent transaction should be more easily accomplished.[96]

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92. Due to the limited number of underwriters for vessel title insurance, this discussion is specific to First American Transportation Title Insurance Company's ("First American") insurance policies. First American offers three vessel policies: an owner's policy, a lender's policy, and a policy to cover vessels under construction. *See* First American-Press Releases, *First American Unveils New Vessel-Under-Construction Title Insurance Policy,* Nov. 1, 2004, http://www.firstam.com/faf/news/newsdisplay.cfm?id=1176. Furthermore, in addition to United States flagged vessels, First American insures foreign-flagged vessels. *See* FIRST AMERICAN CORP., SYNOPSIS OF COVERAGE, http://www.firstam.com/movables/pdf/VesselSynopsisofCoverage.pdf (last visited Feb. 10, 2006).

93. Mike Vaughn, Vessel Title Insurance, http://www.maritimelawcenter.com/html/vessel_title_insurance.html (last visited Feb. 10, 2006).

94. FIRST AMERICAN CORP., *supra* note 92. Specifically, First American covers the following risks: ownership disputes; marketability of title; document forgery; fraud or duress; incompetence or incapacity; defective filing or recording of documents; post-policy forgery; unrecorded state tax liens; labor or material liens (necessaries); preferred status of qualified mortgages; estate or inheritance tax liens; lien invalidity or unenforceability coverage; and priority of the preferred ship mortgage. *Id. See also* Appendix for a complete list of covered risks.

95. Vaughn, *supra* note 93.

96. *Id.*

III. SITUATIONS WHERE MARINE TITLE INSURANCE MAY HAVE PROVED BENEFICIAL[97]

The United States Court of Appeals for the First Circuit in *Mullane v. Chambers*[98] was asked to determine whether the recording statute relating to federally documented vessels rendered an unrecorded bill of sale or conveyance invalid as against a seller's judgment creditors who, without notice, levied the vessel.[99] The recording statute provided:

> A bill of sale, conveyance, mortgage, assignment, or related instrument, whenever made, that includes any part of a documented vessel or a vessel for which an application for documentation is filed, must be filed with the Secretary of Transportation to be valid, to the extent the vessel is involved, against any person except-
> (A) the grantor, mortgagor, or assignor;
> (B) the heir or devisee of the grantor, mortgagor, or assignor; and
> (C) a person having actual notice of the sale, conveyance, mortgage, assignment, or related instrument.[100]

In the instant case, Mullane purchased the subject vessel on July 2, 1998, and failed to record the conveyance pursuant to the United States Vessel Documentation System, 46 U.S.C. §§ 12101-12124 and 31321 (2005), until September 2, 1998.[101] Adele Chambers and Jean Farese desired to levy on the vessel to satisfy two Massachusetts state court writs of execution they held against the Murphys.[102] Mullane purchased the vessel from the Murphys, however, Chambers and Farese believed that the Murphys still owned the vessel.[103] After holding that the phrase "any person" in the recording statute includes Chambers and Farese, the court noted that the recording statute provides protection only when there is no actual notice of

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97. The cases included here are in no way intended to represent a comprehensive list of cases where marine title insurance could be applied. *See* FIRST AMERICAN TRANSPORTATION COMPANY, *supra* note 62, for a more detailed list of circumstances where such insurance may prove useful.

98. Mullane v. Chambers, 333 F.3d 322 (1st Cir. 2003).

99. *Mullane*, 33 F.3d at 329-30.

100. 46 U.S.C. § 31321(a)(1) (2000).

101. *Mullane*, 333 F.3d at 325.

102. *Id.* at 325-26.

103. *Id.*

the unrecorded conveyance at the time of the levy.[104] Finding that Chambers and Farese may not have actual notice, the circuit court remanded the case to the district court.[105] In closing, the circuit court stated that "[i]f Chambers and Farese did not have actual notice, then . . . their seizure of the vessel was valid to enforce a judgment debt against the Murphys."[106]

Possession of a certificate of documentation is not conclusive evidence of ownership.[107] In *Hozie v. The Vessel Highland Light*,[108] relying heavily on 46 U.S.C. § 12104, which provides that "[a] certificate of documentation is not conclusive evidence of ownership" in a proceeding in which ownership is in issue, the United States Court of Appeals for the Ninth Circuit ruled that a vessel's buyer, although securing documentation showing that he was the record owner, did not acquire legal title.[109] The circuit court reasoned that the buyer purchased the vessel with actual notice of the seller's prior conveyance of the vessel to another.[110]

In *Mayfield v. The Energy VII*,[111] Claude Mayfield sued the vessel ENERGY VII to recover damages for maritime personal injuries.[112] After satisfying Mayfield's claim through the sale of the vessel, funds remained in the court's registry, which WRT Energy Corporation (WRT) and General Electric Capital Corporation (GECC) sought.[113] WRT and GECC were mortgagees of the defendant.[114] Because the funds were insufficient to satisfy both claims, the rank of their mortgages was at issue.[115] WRT argued that, because it was the first to file, its mortgage primed GECC's.[116] However, the United States Coast Guard erred by misfiling WRT's mortgage so that subsequent mortgagees were not on notice of WRT's

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104. *Id.* at 333.

105. *Mullane*, 333 F.3d at 333.

106. *Id.*

107. *Synopsis of Coverage*, *supra* note 62.

108. Hozie v. Vessel Highland Light, No. 98-55451, 1999 U.S. App. LEXIS 5288 (9th Cir. Mar. 22, 1999).

109. *Id.* at *2.

110. *Id.*; *In re* Lykes Bros. S.S. Co., Inc., 196 B.R. 574 (M.D. Fla. 1996); Interpool, Ltd. v. Char Yigh Marine (Panama) S.A., 890 F.2d 1453, 1460 (9th Cir. 1989). *See, e.g.*, Jones v. One Fifty Foot Gulfstar Motor Sailing Yacht, Hull Number 01, 625 F.2d 44 (5th Cir. 1980); The Kitty C., 20 F. Supp. 173 (S.D. Fla. 1937).

111. Mayfield v. Energy VII, No. 96-1954, 1999 U.S. Dist. LEXIS 1049, (E.D. La. Jan. 27, 1999).

112. *Id.* at *2.

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

mortgage.[117] GECC filed its mortgage during the time WRT's mortgage was misfiled.[118] WRT argued that it was irrelevant that its mortgage was not filed properly.[119] The court agreed with WRT and overlooked the Coast Guard's error to the detriment of the GECC mortgage.[120] The crux of the court's decision rested with the Ship Mortgage Act.[121] WRT held a preferred mortgage because it substantially complied with the act.[122]

A lender's assertion that a judicial sale should be set aside because it had not received notice of the sale failed in *Wachovia Bank, N.A. v. M/V Sundowner.*[123] In this case, a mortgagee filed an action to enforce a ship's mortgage and, subsequently, the U.S. Marshal sold the vessel at a duly noticed judicial sale.[124] The lender filed objections arguing that it did not receive notice of the sale and that the sale price was insufficient.[125] However, these objections were filed only after the Marshal's report was issued.[126]

The winning bidder requested confirmation of the sale.[127] Thereafter, the court held an evidentiary hearing and determined that the sale price was not grossly inadequate and, accordingly, there was no reason not to confirm

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117. *Mayfield*, 1999 U.S. Dist. LEXIS 5288, at *3.

118. *Id.*

119. *Id.*

120. *Id.* at *8-9.

121. *Id.* at *8.

> Under the Ship Mortgage Act, if certain prerequisites are substantially complied with, the mortgage is deemed 'perfected' and therefore valid against third persons having no actual notice of the encumbrance. 46 U.S.C. § 31321(a)(2) (2005). Under the Act, a mortgage is perfected from the time of filing (not recordation), if it substantially complies with the filing requirements of the Act . . . . To be filed, a mortgage must: "(1) identify the vessel; (2) state the name and address of each party to the instrument; (3) state, if a mortgage, the amount of the direct or contingent obligation . . . that is or may become secured by the mortgage, . . .; (4) state the interest of the grantor, mortgagor, or assignor in the vessel; (5) state the interest sold, conveyed, mortgaged, or assigned; and (6) be signed and acknowledged." 46 U.S.C. § 31321(a)(4)(B)(b) (2005).

Id. at *7-8.

122. *Mayfield*, 1999 U.S. Dist. LEXIS 5288, at *8. *See also* Maryland Nat'l Bank v. Vessel Madam Chapel, 46 F.3d 895 (9th Cir. 1995).

123. Wachovia Bank, N.A. v. M/V Sundowner, 272 F. Supp. 2d 1322 (M.D. Fla. 2003).

124. *Id.* at 1323.

125. *Id.*

126. *Id.*

127. *Id.*

the sale of the ship.[128] The court noted that in order to have shown that the sale price was grossly inadequate, it was necessary to show that the price was unfair or that it "shocked the conscience" of the reviewing court.[129] "Gross inadequacy occurs when a substantial disparity exists between the highest bid and the appraisal or fair market value, and a reasonable degree of probability exists another sale would produce a substantially better price."[130]

The record revealed that the valuation experts failed to conduct sea trials.[131] Further, the engines did not work when the bidder tried them, the builder of the ship was unknown, and the ship had lost its Coast Guard certification, all of which decreased the value of the vessel and made valuation tentative.[132] Additionally, the court noted that there was no evidence that a new sale would have produced a higher price.[133] In conclusion, the *Sundowner* court disagreed with the lender's contentions and confirmed the U.S. Marshal's sale.[134]

In *United States of America v. Trident Crusader*,[135] the United States Court of Appeals for the Fifth Circuit was forced to answer "whether a preferred ship mortgage is void if recorded after a vessel was documented, but before the vessel construction was complete."[136] In this case, recording of the mortgage occurred on the same date that the vessel documentation was completed; sea trials were not completed until a later date.[137] The trial court held that the fact that the vessel was not complete on the date of recordation was irrelevant because from a documentary standpoint the vessel was complete.[138] Agreeing with the trial court, the *Trident* court held that an uncompleted vessel was, nonetheless, a "vessel" for preferred mortgage purposes, permitting it priority over maritime liens for necessaries.[139]

In the preceding cases, a title abstract, a certificate of ownership, and an attorney title opinion would likely not have uncovered the blemishes on the subject vessels, thereby leaving the parties with little or no recourse.

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128. *Id.* at 1324-25.
129. *Sundowner*, 272 F. Supp. 2d at 1323 (citations omitted).
130. *Id.* at 1323 (citations omitted).
131. *Id.* at 1324.
132. *Id.*
133. *Id.*
134. *Id.* at 1325.
135. United States of America v. Trident Crusader, 366 F.3d 391 (5th Cir. 2004).
136. *Id.*
137. *Id.* at 392.
138. *Id.*
139. *Id.* at 393.

Marine title insurance would have proven beneficial for the parties involved. Depending on the specific policies, the parties against whom the claims were filed in the aforementioned cases could have looked to marine title insurance to pay for the loss resulting from the title defects.[140] Furthermore, marine title insurance would have furnished the cost of defending the claims.[141] Accordingly, because maritime liens are unrecorded and vessel title defects are difficult to uncover, marine title insurance is a viable option for vessel owners to consider when seeking to protect their maritime investments.

VI. MARINE TITLE INSURANCE LIMITATIONS[142]

Although marine title insurance protects an insured against a plethora of risks, it does not protect against all risks. Most notably is the exclusion for claims arising out of a preferred maritime lien. A preferred maritime lien means a maritime lien on a vessel:

> (A) arising before a preferred mortgage was filed under section 31321 of this title;
> (B) for damage arising out of maritime tort;
> (C) for wages of a stevedore when employed directly by a person listed in section 31341 of this title;
> (D) for wages of the crew of the vessel;
> (E) for general average; or
> (F) for salvage, including contract salvage.[143]

Therefore, any lien, even one for necessaries, that attaches prior to the filing of a preferred mortgage is excluded.[144]

The United States Court of Appeals for the Fifth Circuit in *Bank One, Louisiana N.A. v. M/V MR. DEAN*,[145] determined that a breach of a time

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140. First American Transportation Company, *supra* note 62.

141. *Id.*

142. *See infra* Appendix for a detailed list of coverage exclusions. Although the policy excludes all preferred maritime liens, the underwriter has the ability to negotiate coverage for excluded risks, particularly liens for necessities. Interview with Gayle A. Poole, Vice President, First American Transportation Insurance Co., in New Orleans, La. (Mar. 30, 2005).

143. 46 U.S.C. § 31301(5) (2005).

144. In short, a preferred mortgage is a mortgage that "includes the whole of the ship." 46 U.S.C. § 31322 (2005).

145. Bank One, Louisiana N.A. v. M/V MR. DEAN, 293 F.3d 830 (5th Cir. 2002).

charter had priority over a ship mortgage.[146] In *Bank One*, a cargo company entered into a time charter with the vessel owner.[147] Subsequent to the vessel owner placing the vessel at the cargo company's disposal, the vessel was sold.[148] In an effort to finance the purchase, the buyer received a line of credit from First National Bank of Commerce (FNBC) and in return gave FNBC a preferred ship mortgage as security.[149] The buyer then failed to perform under the time charter and defaulted on the preferred ship mortgage.[150] The trial court determined that the mortgage had priority over the maritime lien.[151]

On appeal, the court found that because the vessel was at the cargo company's disposal and was employed under the time charter prior to the recordation of the preferred ship mortgage, "an inchoate maritime lien attached to the [vessel]."[152] The lien was not enforceable until the time charter was breached, only then did an enforceable maritime lien arise.[153] Therefore, a maritime lien for breach of a time charter attaches when the owner places the vessel at the charterer's disposal, rather than at the time of breach.[154] Thus, a maritime lien has priority over a preferred ship mortgage when filing of the mortgage occurs between the aforementioned two events.[155]

In another case, *Bender Shipbuilding & Repair Company v. DRIVE OCEAN V*,[156] two parties entered into a Memorandum of Agreement (MOA) for the sale of a vessel.[157] Subsequent to the effective date of the MOA and prior to passage of title and the filing of a preferred mortgage, a third party supplied necessaries to the vessel.[158] The United States District

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146. *Id.* at 838-39.

147. *Id.* at 831.

148. *Id.*

149. *Id.* Bank One was the successor by merger to First National Bank of Commerce.

150. *Id.*

151. *Bank One*, 293 F.3d at 831-32.

152. *Id.* at 838.

153. *Id.*

154. *See id.*

155. *See also* Midlantic Nat. Bank v. Sheldon, 751 F. Supp. 26 (E.D.N.Y. 1990) (under the federal admiralty scheme, a bank's preferred mortgage on a vessel would have priority over a lien held by a marina which had made certain repairs on a vessel and had stored the vessel, unless the marina's possessory lien qualified as a "preferred maritime lien;" otherwise, the marina would only have a normal "maritime lien" for providing necessaries to the vessel).

156. Bender Shipbuilding & Repair Company v. DRIVE OCEAN V, 123 F. Supp. 2d 1201 (S.D. Cal. 1998).

157. *Id.* at 1202.

158. *Id.* at 1202-04.

Court for the Southern District of California held that the supplier had a valid preferred maritime lien.[159] The fact that the MOA prohibited attachment of liens arising prior to the delivery date of the vessel was determined irrelevant as applied to the third party.[160] This was so because the contractual duty to prevent liens from attaching to the vessel was the seller's responsibility and not the supplier's.[161]

Damages arising out of a maritime tort also give rise to preferred maritime liens.[162] The United States Court of Appeals for the Fifth Circuit determined that preferred maritime liens resulting from cargo damages are tort liens and, therefore, take precedence over a preferred ship mortgage lien.[163]

CONCLUSION

Land title insurance has provided sellers and purchasers of real estate efficiency, security, and safety in property transfers.[164] It has also provided investors in remote locations the confidence to invest in property that many times they have never seen.[165] This is because an acceptable title insurance policy allows purchasers to feel secure in their investment.[166] Whether marine title insurance will result in a similar impact on maritime commerce is unclear. Marine title insurance is a departure from the status quo, and, as such, it may take some time to become an accepted insurance device.[167] Nearly a century passed before terrestrial title insurance became commonplace. Two hurdles impede the marine title insurance industry's growth: (1) Practitioners' and lenders' failure to realize the lack of

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159. *Id.* at 1206.

160. *Id.*

161. *Id. See also* Oil Shipping (Bunkering) B.V. v. Royal Bank of Scot. Plc., 817 F. Supp. 1254 (E.D. Pa. 1993), *aff'd* 10 F.3d 176 (3d Cir. 1993), *aff'd* 10 F.3d 1015 (3d Cir. 1993) (bank's mortgage on foreign vessel was a preferred mortgage, for purposes of determining priority in proceeds of sale of the vessel following an arrest; vessel was registered under laws of Panama or Turkey or both, and the bank's mortgage comported with Panamanian law.).

162. 46 U.S.C. § 31301(5)(B) (2000).

163. Associated Metals & Minerals Corp. v. M/V Alexander's Unity, 41 F.3d 1007 (5th Cir. 1995). *See also* Sunrise Shipping, Ltd. v. M/V American Chemist, 1997 WL 627559 (E.D. La. 1997) (a seaman acquired a preferred maritime lien upon the injury to his eye which was not extinguished even though he did not file his claim before the cut-off date established by the court after the ship's arrest and subsequent sale.).

164. DeWitt, *supra* note 10, at 15.

165. *Id.*

166. *Id.*

167. Koock, *supra* note 74.

protection afforded by traditional methods of determining the status of a vessel's title; and (2) Society's propensity to resist change. Notwithstanding the aforementioned hurdles, owners and lenders will realize the benefits of marine title protection. Accordingly, marine title insurance will become more prevalent due to the complexity in determining the status of a vessel's title and because the affinity commercial vessels have for liens.

APPENDIX

The following "Covered Risks" and "Exclusions from Coverage" were taken from First American Transportation Title Insurance Company's sample EAGLE Protection Vessel Owner's Policy.

COVERED RISKS

1. Title to the Vessel being other than as stated herein.
2. Any defect in or lien or encumbrance on the Title.
3. Unmarketability of the Title.
4. Forgery, fraud, undue influence, duress, incompetence, incapacity or impersonation affecting the Title.
5. Unauthorized transfer or conveyance of the Title by any person, corporation, partnership, trust, limited liability company or other legal entity.
6. The invalidity of any document, upon which the Title is based because it was not properly executed, sealed, acknowledged, notarized, delivered or filed.
7. The invalidity of any document, upon which the Title is based because it was executed under a falsified, expired or otherwise invalid power of attorney.
8. The invalidity of any transfer or conveyance of the Title because it was derived through a defective judicial or administrative proceeding.
9. The invalidity of any conveyance or transfer of the Title derived through a decedent's estate.
10. Estate or inheritance tax liens on the Title.
11. Forgery, after Date of Policy, of any document or instrument by which some third party claims to own an interest in or to have a mortgage on the Title.
12. State tax liens on the Title, which do not appear in the Vessel Documentation Records. Your insurance under this Covered Risk is limited to a maximum dollar limit of liability of $2,500.

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from coverage and the underwriter will not pay loss or damage, costs, attorney's fees or expenses, which arise by reason of:

1. (a) The existence or violation of any Law relating to (i) use of the Vessel pursuant to a registry, coastwise, oil-spill response, fishery, recreational, or any other endorsement issued by any

governmental authority evidencing that the Vessel is entitled to engage in a specific trade, or (ii) environmental protection;
(b) Any governmental police power or power of confiscation, forfeiture, expropriation, requisition or eminent domain.

2. Defects, liens, encumbrances, adverse claims or other matters, whether or not filed in the Vessel Documentation Records at Date of Policy:
   (a) Created, suffered, assumed or agreed to by the Insured Claimant;
   (b) Not Known to the Company, but Known to the Insured Claimant and not disclosed in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;
   (c) Resulting in no loss or damage to the Insured Claimant;
   (d) Attaching or created subsequent to Date of Policy, except that this paragraph (d) does not limit the coverage provided under Covered Risk 11;
   (e) Resulting in loss or damage, which would not have been sustained if the Insured Claimant had paid value for the Title;
   (f) Created by a third party while the Vessel was registered under any flag other than the United States of America;
   (g) Filed or asserted in any court outside of any state of the United States of America, the District of Columbia or the territory of Puerto Rico; or
   (h) Based on the Laws of any country other than the United States of America.
3. Federal or state tax liens not appearing in the Vessel Documentation Records, except to the extent that state tax lien coverage has been provided by Covered Risk 12.
4. Forgery, after Date of Policy, of any document or instrument by which some third party claims to own an interest in or have a mortgage on the Title if at the time of the forgery the Vessel is not in the possession of the Insured because of theft or piracy.
5. Rights or claims of the party or parties in possession, custody or control of the Vessel at Date of Policy.
6. Any claim which arises out of a preferred maritime lien as defined in 46 U.S.C. § 31301(5).
7. The vessel having lost her status as a vessel documented under the laws of the United States of America for any reason

including but not limited to the failure to meet United States citizenship requirements or withdrawal from navigation.

8. Any claim, which arises out of the transaction vesting in the Insured the Title, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights Laws, that is based on:
   (a) The transaction creating the Title insured by this policy being deemed a fraudulent conveyance or fraudulent transfer; or
   (b) The transaction creating the Title insured by this policy being deemed a preferential transfer, except where the preferential transfer results from the failure:
      (i) to timely record in the Vessel Documentation Records the instrument of transfer; or
      (ii) of such recordation to impart notice to a purchaser for value or a judgment or lien creditor.

"DIMINISHED VALUE" IN AUTOMOBILE INSURANCE: THE CONTROVERSY AND ITS LESSONS

Thomas O. Farrish[*]

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INTRODUCTION

Imagine you're shopping for a car. You go to a used car lot, where the dealer has two of the model you're looking for. The cars are identical in every respect except one—one car has been in a wreck and the other has not. Although the first car has been repaired and looks great, you—and most other buyers like you—probably wouldn't want to pay as much for it as you would for the undamaged one.

The dealer probably anticipated that you would feel this way, and, as a result, she might have paid less for the car when she bought it herself. This means that the person who traded the car into the dealer may have received less for it because it had been in an accident.

When that person had the accident, an insurance company probably paid to fix the damage. Should it have paid for the car's loss of resale value too?

The reader may be surprised to discover that lurking within this humble and everyday used car transaction is a contentious and costly problem of insurance law. A disagreement over whether automobile insurance policies cover "diminished value" or "stigma damages" has produced lawsuits in dozens of states, and the states are almost evenly split over the controversy. In the twenty-eight states where the dispute has been decided by an appellate court, seventeen have held that insurers are not obligated to pay such losses,[1] and eleven have held that they are.[2]

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1. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785 (Ala. Civ. App. 2002); Johnson v. State Farm Mut. Auto. Ins. Co., 754 P.2d 330 (Ariz. Ct. App. 1988); Ray v. Farmers Ins. Exch., 246 Cal. Rptr. 593 (Cal. Ct. App. 1988); O'Brien v. Progressive N. Ins. Co., 785 A.2d 281 (Del. 2001); Siegle v. Progressive Consumers Ins. Co., 819 So. 2d 732 (Fla. 2002); Haussler v. Indem. Co. of Am., 227 Ill. App. 504 (Ill. App. Ct. 1923); Allgood v. Meridian Sec. Ins. Co., 836 N.E.2d 243 (Ind. 2005); Gen. Accident Fire & Life Assurance Corp. v. Judd, 400 S.W.2d 685 (Ky. 1966); Townsend v. State Farm Mut. Auto. Ins. Co., 793 So. 2d 473 (La. Ct. App. 2001); Campbell v. Markel Am. Ins. Cos., 822 So. 2d 617 (La. Ct. App. 2001); Hall v. Acadia Ins. Co., 801 A.2d 993 (Me. 2002); Given v. Commerce Ins. Co., 796 N.E.2d 1275 (Mass. 2003); Lupo v. Shelter Mut. Ins. Co., 70 S.W.3d 16 (Mo. Ct. App. 2002); Camden v. State Farm Mut. Auto. Ins. Co., 66 S.W.3d 78 (Mo. Ct. App. 2001); Schulmeyer v. State Farm Fire & Cas. Co., 579 S.E.2d 132 (S.C. 2003); Culhane v. W. Nat'l Mut. Ins. Co., 704 N.W.2d 287 (S.D. 2005); Black v. State Farm Mut. Auto. Ins. Co., 101 S.W.3d 427 (Tenn. Ct. App. 2002); Am. Mfrs. Mut. Ins. Co. v. Schaefer, 124 S.W.3d 154 (Tex. 2003); Bickel v. Nationwide Mut. Ins. Co., 143 S.E.2d 903 (Va. 1965).

2. MFA Ins. Co. v. Citizens Nat'l Bank, 545 S.W.2d 70 (Ark. 1977); Hyden v. Farmers Ins. Exch., 20 P.3d 1222 (Colo. Ct. App. 2000); State Farm Mut. Ins. Co. v. Mabry, 556 S.E.2d 114 (Ga. 2001); Venable v. Import Volkswagen, Inc., 519 P.2d 667 (Kan. 1974); Ciresi v. Globe & Rutgers Fire Ins. Co., 244 N.W. 688 (Minn. 1932); Potomac Ins. Co. v. Wilkinson, 57 So. 2d 158 (Miss. 1952); Eby v. Foremost Ins. Co., 374 P.2d 857 (Mont. 1962); Edwards v. Maryland Motorcar Ins. Co., 197 N.Y.S. 460 (N.Y. App. Div. 1922);

The stakes are high. While each individual diminished value loss may be small, collectively they are substantial. In Georgia, where the state Supreme Court recently upheld coverage for diminished value,[3] the State Farm and Allstate Insurance Companies alone calculate their resultant losses at $209 million.[4]

This Note examines the diminished value controversy from two perspectives. In Part I, the controversy is examined as a matter of contract interpretation and insurance policy construction. This examination begins with a review of the personal automobile insurance policy. Automobile policies typically begin with an "Insuring Agreement" in which the insurer broadly promises to pay for "direct and accidental loss" to the policyholder's car.[5] Later in the policy there are a number of provisions that purport to limit the broad grant of coverage contained in the Insuring Agreement.[6] One such limitation is a clause limiting the insurer's liability to the lesser of the value of the car or the cost of repair.[7] Insurers claim that the promise to pay for "repair" means that they are obligated to pay to fix the car and nothing more. Diminished value plaintiffs claim that the promise to "repair" includes a promise to restore the car's value as well. They claim that, if the restoration of the car's pre-accident physical condition does not also restore its value, the insurer owes cash compensation to make up the difference. Part I examines the parties' arguments through the lens of two doctrines of insurance contract construction and concludes that the insurers have the better argument under either one.

Part II considers whether the diminished value controversy has any lessons for the broader question of what risks are, or should be, appropriate subjects of insurance. In the middle of the twentieth century, there was a general consensus among insurance scholars concerning which risks of loss are best treated through insurance and which risks are best left to some

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Pierce v. Am. Fid. Fire Ins. Co., 83 S.E.2d 493 (N.C. 1954); Nat'l Farmers Union Prop. & Cas. Co. v. Watson, 298 P.2d 762 (Okla. 1956); Dunmire Motor Co. v. Oregon Mut. Fire Ins. Co., 114 P.2d 1005 (Or. 1941). *See generally* L.S. Tellier, Annotation, *Measure of Recovery by Insured Under Automobile Collision Insurance Policy*, 43 A.L.R.2d 327 (1995) (summarizing cases involving the measure of damages recoverable from automobile physical damage insurance policies).

3. State Farm Mut. Auto. Ins. Co. v. Mabry, 556 S.E.2d 114 (Ga. 2001).

4. DOUGLAS M. DIXON & GERALD DENEEN, THE MABRY DECISION AND ITS IMPACT ON DIMINUTION IN VALUE 17 (2002), http://www.geinsurancesolutions.com/erccorporate/documents/theinstitute/pc/f10end_e.pdf.

5. INSURANCE SERVICES OFFICE, INC., PERSONAL AUTO POLICY 7 (1998).

6. *Id.* at 9-11.

7. *Id.* at 9.

other method. When a risk was reckoned insurable, there was a corresponding expectation that a private insurance market would emerge spontaneously. Over the last twenty-five years, however, that consensus has eroded as scholars have begun to offer a variety of competing models of "insurability." Anytime the invisible hand of the private insurance market declines to insure a risk—as it has done in the case of diminished value—we have an opportunity to test the validity of both the older and more recent conceptions of insurability. Part II examines the peril of diminished value under the older conception and finds that it would have predicted that the private insurance market would accept the risk. The fact that it did not validates some of the more recent conceptions.

I. THE DIMINISHED VALUE COVERAGE CONTROVERSY

A. THE AUTOMOBILE INSURANCE POLICY—ITS PROVISIONS AND PRINCIPLES OF CONSTRUCTION

The starting point for a discussion of the diminished value controversy is the language of the automobile insurance policy. While not all automobile insurance policies are identical, there are substantial similarities between them. Policy provisions differ depending on whether the insured entity is an individual or a business, and they differ depending on the issuing company.[8] Three particular policies dominate the market—the Personal Auto Policy and Business Auto Policy drafted by the Insurance Services Office (ISO), and the Family Car Policy drafted by the National Association of Independent Insurers (NAII).[9] Some insurers—particularly larger ones such as State Farm or Allstate—promulgate their own policies, but even in such cases the provisions tend to track closely with the provisions of the standard form policies issued by ISO and NAII. Throughout this article, the provisions of the ISO Personal Auto Policy will be discussed except where otherwise noted.

Personal automobile insurance policies typically provide four major types of coverage.[10] Liability coverage protects the insured from bodily injury or property damage tort claims arising out of the ownership and use of a car.[11] Medical coverage—sometimes called "personal injury protection," or "PIP"—reimburses the insured for medical expenses

8. ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW 989-90 (3d ed. 2002).

9. *Id.* at 989.

10. KAREN L. HAMILTON & DONALD S. MALECKI, PERSONAL INSURANCE: PROPERTY AND LIABILITY 156 (1994).

11. *Id.*

incurred as a result of a car accident.[12] Uninsured motorists' coverage protects the insured from the financial consequences of an accident with an uninsured driver.[13] And lastly, personal automobile policies pay for damage to the insured's car.[14]

This last coverage is subdivided into two separate coverages.[15] Collision coverage pays for loss or damage arising out of an impact between the insured vehicle and another vehicle or object.[16] "Comprehensive" coverage pays for loss or damage arising out of other causes, including vandalism, flood and the like.[17] Collectively, collision and comprehensive coverage are known as "physical damage coverage,"[18] or "Coverage D," after its title in the ISO Personal Auto Policy.[19]

The physical damage portion of the personal auto insurance policy begins with an Insuring Agreement. The insurer promises that it will "pay for direct and accidental loss" to the insured's car.[20] A definitions section follows in which some terms—"collision," for example—are given precise definitions and others, including "repair" and "like kind and quality," are not.[21]

Having made a broad promise to "pay for direct and accidental loss," the policy then limits the breadth of that promise using two primary techniques. The first technique is exclusion from coverage; certain types of losses, including losses from wear and tear or mechanical breakdown, are specifically placed outside the policy's coverage.[22] Until very recently, automobile insurance policies did not expressly exclude coverage for diminished value.[23] The cases to be discussed below all involve policies issued before the exclusion was inserted.

The second technique is a limitation on the insurer's maximum liability. In a clause headed "Limit of Liability," the policy provides that the insurer's "limit of liability for loss will be the lesser of the: [a]ctual cash value of the stolen or damaged property; or [a]mount necessary to repair or replace the property with other property of like kind and

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12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.* at 179.
16. HAMILTON & MALECKI, *supra* note 10, at 179.
17. *Id.*
18. *Id.*
19. INSURANCE SERVICES OFFICE, INC., PERSONAL AUTO POLICY 7 (1998).
20. *Id.*
21. *Id.*
22. *Id.* at 8-9.
23. *Id.*

quality."[24] The Limit of Liability clause further provides that, if "a repair or replacement results in better than like kind or quality, [the insurer] will not pay for the amount of the betterment."[25]

Although the Limit of Liability clause is, for reasons to be discussed below, the primary battleground of the diminished value controversy, other policy provisions occasionally become relevant as well. One such provision gives the insurer the option to "pay for loss in money or repair or replace the damaged . . . property."[26] And another provision creates a procedure for adjustment in the event that the insured and the insurer do not agree on the amount of the loss. Under this provision, often referred to as the "appraisal clause," each party selects an appraiser to prepare a statement of the amount of the loss. The two appraisers select an umpire, and any loss amount agreed to by two of the three is binding on the insured and the insurer alike.[27]

Lastly, the policy entitles the insurer to any salvage that arises out of the claims process. The most common salvage scenario is when the insurer pays the entirety of a total loss, yet the wreck retains some value as scrap. In such cases, the insurer "may keep all or part of the property at an agreed or appraised value."[28] And if the insured disposes of the salvage before the insurer has an opportunity to take possession of it, the policy requires the insured to "[h]old in trust for [the insurer] the proceeds of the recovery."[29]

Having set out the language of the policy, we will now discuss the interpretive framework in which disputes about the policy are adjudicated. Insurance policies are, first and foremost, contracts, and they are therefore subject to ordinary principles of contractual interpretation. Like contracts generally,[30] insurance policies are typically enforced according to their terms, provided that their terms are clear.[31] Yet where the terms are unclear, the resulting ambiguity will be construed against the draftsperson in insurance contracts as well as in other contracts.[32]

Insurance contracts have two special characteristics, however, and these characteristics influence how policies are interpreted. The first

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24. *Id.* at 9.
25. *Id.* at 7.
26. *Id.* at 10.
27. *Id.*
28. *Id.*
29. *Id.* at 11.
30. RESTATEMENT (SECOND) OF CONTRACTS § 201(1) (1981).
31. *See, e.g.*, Zurich Ins. Co. v. Gladding, 739 N.Y.S.2d 699, 700 (N.Y. App. Div. 2002).
32. RESTATEMENT (SECOND) OF CONTRACTS § 206 (1981). *See, e.g.*, O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 288 (Del. 2001).

special attribute of insurance contracts is that they are aleatory—that is, they are contracts "in which at least one party's performance depends on some uncertain event that is beyond the control of the parties involved."[33] Except in the very rare instance in which an insured's loss exactly equals her premium payment, the aleatory character of insurance contracts necessarily contemplates that the benefit that one party derives from the contract will exceed the benefit derived by the other. When the insured experiences a loss, the payment she receives from the insurer will typically exceed her premium; when she has no loss, the premium received by the insurer will of course exceed what the insured receives. This unavoidable imbalance in benefits, and the incentive to self-interested behavior that it creates, is a frequently-cited reason for the additional scrutiny courts apply to the performance of insurance contracts.[34]

The second special characteristic of insurance contracts is that they are almost invariably contracts of adhesion.[35] Most mass-marketed insurance policies are "standardized contract[s] written entirely by a party with superior bargaining power. The weaker party to an adhesion contract must 'take it or leave it,' and be without opportunity to bargain."[36] Exceptions exist—in some cases, the insured is a large commercial entity at no bargaining disadvantage with respect to the insurer,[37] and in other cases the insurer does not choose its policy language because the terms of the policy are dictated by government regulation.[38] Nevertheless, nearly all automobile insurance is offered to the public on "adhesive" terms.

These two characteristics of insurance contracts have produced two interpretive doctrines. The first, often referred to as "the doctrine of *contra proferentem*," "requires that the language of an insurance policy be construed most strongly against the insurance company that drafted it."[39] Since it drafted the contract, the insurer is obligated "to state clearly the

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33. BLACK'S LAW DICTIONARY 319 (7th ed. 1999).

34. ERIC A. WIENING & DONALD S. MALECKI, INSURANCE CONTRACT ANALYSIS 14 (1992).

35 Mark C. Rahdert, *Reasonable Expectations Reconsidered,* 18 CONN. L. REV. 323, 337 (1986).

36. Ponder v. Blue Cross of S. Cal., 193 Cal. Rptr. 632, 647 (Cal. Ct. App. 1983).

37. JERRY, *supra* note 8, at 180.

38. In Massachusetts, for example, the Commissioner of Insurance sets the terms of personal automobile policies. MASS. GEN. LAWS ch. 175, § 113A (2004). "[B]ecause the approved wording of the standard insurance policy is controlled by the Commissioner of Insurance and not by any insurer . . . [the Massachusetts Supreme Judicial Court does] not construe ambiguities against the drafter." Given v. Commerce Ins. Co., 796 N.E.2d 1275, 1278 (Mass. 2003).

39. O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 288 (Del. 2001).

terms of the policy,"[40] and, if it fails to do so, the resulting ambiguity will be construed in the insured's favor.[41]

A policy provision is not ambiguous merely because the parties disagree as to its meaning, however.[42] "[A] contract is only ambiguous when the provisions in controversy are reasonably or fairly susceptible to different interpretations or may have two or more different meanings."[43] Courts disagree about the scope of the evidence that may be examined in determining whether a contract term is susceptible to two meanings; some hold that the inquiry must be confined within the four corners of the writing, whereas others will consider extrinsic evidence such as the contract's commercial setting.[44] Nevertheless courts will uniformly require that the alternative construction be a reasonable one before they will determine that the policy provision is ambiguous.

The effect of this rule is that the insured need not demonstrate that his construction is the "right" one; rather, she need only demonstrate that her construction is among the range of reasonable choices. In determining whether a construction is reasonable, courts will generally prefer layperson's terms over specialized and technical meanings.[45]

The second interpretive doctrine is the "doctrine of reasonable expectations." This doctrine holds that "[t]he objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."[46] Under this doctrine, a court will examine the purposes that the policy provision claims to serve and then ask whether a reasonable insured would expect such a provision to follow from such a purpose.[47] The doctrine therefore holds out the possibility that coverage may be found even when the applicable exclusion or limitation is clear and unambiguous. It "suggests that an insured can have reasonable expectations of coverage that arise from some

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40. *Id.*

41. *E.g.*, Hyden v. Farmers Ins. Exch., 20 P.3d 1222, 1224 (Colo. Ct. App. 2000).

42. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785, 791 (Ala. Civ. App. 2002); JERRY, *supra* note 8, at 172.

43. *O'Brien*, 785 A.2d at 288.

44. JERRY, *supra* note 8, at 172-73.

45. *Id.* at 174. *See also* Ray v. Farmers Ins. Exch., 246 Cal. Rptr. 593, 595 (Cal. Ct. App. 1988).

46. C & J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169 (Iowa 1975) (quoting Rodman v. State Farm Mut. Auto. Ins. Co., 208 N.W.2d 903, 905-08 (Iowa 1973) and Robert E. Keeton, *Insurance Law Rights At Variance With Policy Provisions: Part One*, 83 HARV. L. REV. 961, 967 (1970)).

47. *See, e.g.*, *C & J Fertilizer*, 227 N.W.2d at 169.

source *other* than the policy language itself, and that such an extrinsic expectation can be powerful enough to override any policy provisions no matter how clear."[48] The doctrine has not been recognized in every jurisdiction,[49] and there is some variety among the various state adoptions.[50]

Scholars disagree about the extent to which these two interpretive doctrines—*contra proferentem* and reasonable expectations—represent true departures from ordinary contract principles. They disagree, for example, on whether the doctrine of *contra proferentem* is truly a unique rule of insurance construction or merely an extension of the unobjectionable contract principle enshrined in Section 206 of the Second Restatement of Contracts that ambiguities in a contract are to be construed against its drafter.[51] Similarly, they debate whether the doctrine of reasonable expectations is a unique insurance rule or a mere extension of Restatement principles negating surprise terms in standardized contracts.[52]

For our purposes, however, we do not need to resolve these disputes. It is enough to set forth the two lenses through which courts will view the insurance contract. Having done so, we may now examine the diminished value cases.

B. THE DIMINISHED VALUE CASES

1. Early Cases

Diminished value litigants sometimes state that "the issue is not new—it's been around since the 1920's."[53] There is some truth to this claim; cases discussing the measure of recovery under the physical damage coverage of automobile insurance policies do indeed go as far back as 1922.[54] Yet the early cases should be used with care because in many instances the issues before the court were meaningfully different from

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48. Rahdert, *supra* note 35, at 335.

49. JERRY, *supra* note 8, at 184 & n.482.

50. *Id.* at 184-87.

51. *See id.* at 171-72.

52. *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS § 211 (1981)).

53. *See, e.g.*, Oral Argument, Allgood v. Meridian Sec. Ins. Co., 836 N.E.2d 243 (Ind. 2005), *available at* http://www.indianacourts.org/apps/webcasts (argument of Arend J. Abel).

54. *E.g.*, Edwards v. Maryland Motorcar Ins. Co., 197 N.Y.S. 460 (N.Y. App. Div. 1922).

those presented in modern diminished value litigation.[55] Some of the early cases turned on procedural questions no longer in doubt;[56] others dealt with the now largely undisputed question of the insurer's responsibility for a loss in value that arose out of a defective repair.[57] While there are older cases that do bear precisely on the current controversy,[58] our focus will be on the more recent cases.

There is, however, one aspect of the older cases that is worth remarking on before we move on to the recent ones. In most of the older cases in which a court found coverage for diminished value, the facts disclose insurer behavior that was at least self-interested if not oppressive. In the 1926 Georgia case of *USF&G v. Corbett,* for example, the insurer invoked the policy's appraisal clause and then refused to pay the figure recommended by its own appraiser, compelling its insured to litigate to recover his policy proceeds.[59] And in the 1954 North Carolina case of *Pierce v. American Fidelity*, the insurer elected to repair the insured's car itself rather than pay for the loss in money; the repairs left the car without working brakes, yet the insurer insisted that the insured release his claims against his policy before the insurer would return his car to him.[60] Similarly, in the 1974 Kansas case of *Venable v. Import Volkswagen*, the insurer-selected repairer took nine months to repair the insured's vehicle properly, yet the insurer refused to pay for the repair unless the insured agreed to release all his claims against his policy, including loss of use.[61] In each case, the insurer's conduct may have played a role in the court's adoption of the insured's position. In *Venable*, for example, the court reached its holding in part on the observation that "the repairs or workmanship are defective or the insurer has unreasonably delayed or not acted in good faith."[62] In some states, therefore, the "rule" establishing

55. For a survey of early cases and the differences between them and more recent cases, see *Culhane v. Western National Mutual Insurance Co.*, 704 N.W.2d 287, 299 n.8 (S.D. 2005).

56. *See, e.g.*, U.S. Fid. & Guar. Co. v. Corbett, 134 S.E. 336, 337-39 (Ga. Ct. App. 1926) (establishing that a limitation on liability is a special defense that can be waived if not asserted seasonably).

57. *See, e.g.*, Venable v. Import Volkswagen, Inc., 519 P.2d 667 (Kan. 1974); Pierce v. Am. Fid. Fire Ins. Co., Inc., 83 S.E.2d 493 (N.C. 1954). For an interesting—but decidedly minority—recent case holding that the insurer is not liable even for repair-related diminished value, see *Wildin v. American Family Mutual Insurance Co.*, 638 N.W.2d 87 (Wis. Ct. App. 2001).

58. *See, e.g.*, Ciresi v. Globe & Rutgers Fire Ins. Co., 244 N.W. 688 (Minn. 1932).

59. *Corbett*, 134 S.E. at 337.

60. *Pierce*, 83 S.E.2d at 494.

61. *Venable*, 519 P.2d at 670-71.

62. *Id.* at 672-73.

coverage for diminished value may be partly understandable as a reaction to substandard insurer behavior.

The more recent cases are commonly class actions, sometimes brought against a number of different insurers at the same time.[63] In such cases, insurer claim behavior figures less prominently—not, perhaps, because opportunistic insurer behavior is extinct, but rather perhaps out of the difficulty in making generalizations across different insureds and insurers. This shift in emphasis may partially explain why recent courts are more reluctant to find coverage for diminished value. It is to these more recent cases which we now turn.

2. Recent Cases

Since 2000, fourteen states have entertained the diminished value issue at the appellate court level.[64] Two—Colorado and Georgia—have found coverage for diminished value while twelve have not.

In the recent cases, the plaintiffs' claims typically fall into three classes. First, the plaintiffs claim that their insurance policies unambiguously provide coverage for diminished value.[65] Second, the plaintiffs alternatively claim that a variety of terms in the policy—chiefly, "repair" and "like kind and quality"—are ambiguous and could reasonably be read to imply such coverage. Lastly, the plaintiffs make reasonable expectations arguments, although they frequently do not label them as such. They claim that a reasonable person would expect the policy to live up to its chief promise—to pay for "loss"—and that any policy provision that substantially undoes that promise frustrates their expectations and should not be enforced.

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63. *See, e.g.*, O'Brien v. Progressive N. Ins. Co., 785 A.2d 281 (Del. 2001).

64. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785 (Ala. Civ. App. 2002); Hyden v. Farmers Ins. Exch., 20 P.3d 1222 (Colo. Ct. App. 2000); *O'Brien*, 785 A.2d 281; Siegle v. Prog. Consumers Ins. Co., 819 So. 2d 732 (Fla. 2002); State Farm Mut. Auto. Ins. Co. v. Mabry, 556 S.E.2d 114 (Ga. 2001); Allgood v. Meridian Sec. Ins. Co., 836 N.E.2d 243 (Ind. 2005); Campbell v. Markel Am. Ins. Co., 822 So. 2d 617 (La. Ct. App. 2001); Townsend v. State Farm Mut. Auto. Ins. Co., 793 So. 2d 473 (La. Ct. App. 2001); Hall v. Acadia Ins. Co., 801 A.2d 993 (Me. 2002); Given v. Commerce Ins. Co., 796 N.E.2d 1275 (Mass. 2003); Lupo v. Shelter Mut. Ins. Co, 70 S.W.3d 16 (Mo. Ct. App. 2002); Camden v. State Farm Mut. Auto. Ins. Co., 66 S.W.3d 78 (Mo. Ct. App. 2002); Schulmeyer v. State Farm Fire & Cas. Co., 579 S.E.2d 132 (S.C. 2003); Culhane v. W. Nat'l Mut. Ins. Co., 704 N.W.2d 287 (S.D. 2005); Black v. State Farm Mut. Auto. Ins. Co., 101 S.W.3d 427 (Tenn. Ct. App. 2002); Am. Mfrs. Mut. Ins. Co. v. Schaefer, 124 S.W.3d 154 (Tex. 2003).

65. *See, e.g., O'Brien*, 785 A.2d at 287 ("Appellants contend that the policies in question explicitly provide for coverage of diminished value, despite the lack of any clear statement to that effect in the policies.").

Diminished value cases sometimes involve other issues besides these three. Insurers sometimes claim, for example, that even if diminished value were a covered loss, "it would not be realized until the vehicle was sold."[66] Additionally, the insured may not sustain a diminished value loss at all if she succeeds in concealing the repairs from the buyer.[67] And serious doubts exist about the soundness of the "methodology" for calculating diminished value losses.[68] We will defer a discussion of these issues of timing, valuation, and concealability until Part II.

a. The claim that diminished value is unambiguously covered

This first claim begins with the Insuring Agreement's promise to pay for "direct and accidental loss." The plaintiffs note that diminished value is a "direct and accidental loss," and they further note that it is not expressly excluded anywhere in the policy. In *Campbell v. Markel American Insurance,* for example, the plaintiff "assert[ed] that the policy's coverage for 'direct and accidental loss' encompasses the diminished value of his [motor]cycle and that nowhere in his policy does Markel expressly exclude coverage for diminished value claims."[69] Effectively, the claim invites the court to conclude that the issue may be decided without reference to the Limit of Liability clause.

Insurers respond to this first claim in two ways. Infrequently, they claim that cars do not inherently lose value after accident-related repairs, and that therefore plaintiffs claiming diminished value have not experienced a "direct and accidental loss" as the Insuring Agreement requires. While this claim is sometimes successful,[70] more commonly it is abandoned by the time the case reaches an appellate court.[71] This is perhaps unsurprising given that appellate courts seem almost ready to take judicial notice of the proposition that cars lose value regardless of how well the repairs might have been performed. In *Allgood v. Meridian Security Insurance Co.,* for example, the Indiana Court of Appeals noted that "a

66. *Mabry,* 556 S.E.2d at 119.

67. *See, e.g., Camden,* 66 S.W.3d at 80. In *Camden,* the insured traded her car in before bringing her diminished value lawsuit, evidently without telling the dealer that the car had been in an accident.

68. *See* discussion *infra* Part II.B.

69. 822 So. 2d at 621.

70. *See, e.g., Camden,* 66 S.W.3d at 80. In *Camden,* the insured "did not seek an appraisal . . . to ascertain if there was diminished value to her vehicle" and she could not "quantify the amount of diminished value she purportedly suffered." *Id.*

71. *See, e.g.,* Hall v. Acadia Ins. Co., 801 A.2d 993, 994 n.1 (Me. 2002).

vehicle that has been involved in a collision is considered to have less value than a vehicle identical in all respects except that it has not been involved in a collision."[72]

The more common insurer response to this first claim of unambiguous coverage is to argue that the Insuring Agreement should not be read in isolation, but should instead be read in context with the Limit of Liability provision that follows. Courts generally accept this response, and for this reason the first claim has not been very successful. In *Townsend v. State Farm,* for example, the Louisiana Court of Appeal rejected a claim that the acknowledgment of diminished value as a "direct loss" decided the issue.

> Townsend argues that loss should be defined to include any loss to an insured vehicle, including loss of value caused by having been damaged. He further argues that diminished value is a direct loss to an insured vehicle. We do not dispute these assertions; however, we do not find that they resolve the issue at hand.[73]

Diminished value plaintiffs also argue that their losses are unambiguously covered because the insurer could have, but failed to, exclude the peril of diminished value specifically. While this theory has drawn an approving comment in a dissenting opinion,[74] it has yet to attract a majority of any court, evidently because it butts up against an entrenched principle of construction that coverage may not be located in the Exclusions section of a policy. In *American Manufacturers Mutual v. Schaeffer,* for example, the Texas Supreme Court rejected the claim that diminished value was covered because the insurer had failed to exclude it. "[A]n exclusion's purpose is to remove from coverage an item that would otherwise have been included. Absence of an exclusion cannot confer coverage."[75]

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72. Allgood v. Meridian Sec. Ins. Co., 807 N.E.2d 131, 138 (Ind. Ct. App. 2004), *rev'd*, 836 N.E.2d 243 (Ind. 2005).

73. Townsend v. State Farm Mut. Auto. Ins. Co., 793 So. 2d 473, 477 (La. Ct. App. 2001).

74. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785, 810 (Ala. Civ. App. 2002) (Yates, J., dissenting) ("I further note that the policy fails to specifically exclude or include diminished value. Although an insurance company is entitled to write a policy with narrow limits of liability, to do so it must use precise language . . . . Had State Farm wished to avoid paying for diminished value, it should have specifically exempted such damages from coverage as it is attempting to do in other jurisdictions.").

75. Am. Mfrs. Mut. Ins. Co. v. Schaefer, 124 S.W.3d 154, 160 (Tex. 2003).

Plaintiffs have taken note of the fact that insurers have begun to exclude diminished value specifically, and they argue that the new exclusion is an admission that the peril was previously covered. This claim, too, has met with no success. In *O'Brien v. Progressive Northern Insurance,* for example, the Delaware Supreme Court rejected the claim that an alteration of the policy was tantamount to an admission of prior coverage; to so hold would be to "penalize those parties who choose to alter their contracts in an attempt to avoid exactly the type of costly litigation before us in this case. Moreover, it would discourage insurers from clarifying language in their policies, whether ambiguous or not, for fear of negative inferences being drawn about altered terms."[76]

b. The claim that the policy is ambiguous about coverage for diminished value

The plaintiffs alternatively claim that several elements of the insurance policy are ambiguous with respect to coverage for diminished value. They claim that these ambiguities should be construed against the insurer under the doctrine of *contra proferentem,* and that diminished value is therefore covered.

The policy provision that is most commonly cited as ambiguous is the term "repair" in the Limit of Liability clause. As previously discussed, the Limit of Liability clause promises to pay "the lesser of . . . the actual cash value of the stolen or damaged property; or the amount necessary to repair or replace the property with other property of like kind and quality."[77] Plaintiffs claim that that the word "repair" means—or reasonably could mean—to restore not only the car's physical condition but also its value. Under this view, if physical repairs do not restore the car's pre-accident value, the insurer owes the insured a cash payment to compensate for the shortfall.

This claim prevailed in the Indiana Court of Appeals. Although that court's holding was later reversed, its reasoning merits examination. In *Allgood v. Meridian Security Insurance* the Court of Appeals recognized that "[t]he limit of liability provision allowing the insurer to 'repair or replace with like kind and quality' could reasonably mean, as [the insurer] posits, to restore to the insured a vehicle in a similar condition in appearance and function."[78] However, "it could also reasonably mean, as

76. O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 290 (Del. 2001).

77. *See* discussion *supra* Part I.A.

78. Allgood v. Meridian Sec. Ins. Co., 807 N.E.2d 131, 137 (Ind. Ct. App. 2004), *rev'd*, 836 N.E.2d 243 (Ind. 2005).

[the insured] urges, to restore to the insured a vehicle similar in appearance, function and value . . . . If there is diminished value even after repair, we do not consider the repairs to have been adequate."[79]

The Colorado Court of Appeals also held that the word "repair" was susceptible to latter construction. In *Hyden v. Farmers Insurance Exchange*, the court relied on a passage from the treatise *Couch on Insurance,* which states that "[a] vehicle is not restored to substantially the same condition if repairs leave the market value of the vehicle substantially less than the value immediately before the collision."[80]

Generally, however, courts have been unwilling to accept that the word "repair" is susceptible to the latter construction. In finding the word unambiguous, these courts typically rely on standard and legal dictionaries and on their own sense of the "ordinary," "common," or "generally prevailing" meaning. A passage from the Alabama Court of Civil Appeals' opinion in *Pritchett v. State Farm* is typical:

> *Black's Law Dictionary* 1298 (6th ed. 1990) defines the term "repair" as meaning "to mend, remedy, restore, renovate. To restore to a sound or good state after decay, injury, dilapidation, or partial destruction." "Repair" has been defined as "to restore by replacing a part or putting together what is torn or broken: Fix." *Merriam-Webster's Collegiate Dictionary* (10th ed. 1999) . . . . The various definitions of repair do not discuss the concept of value. We do not believe that in its common usage, the term "repair" is understood to encompass the concept of value or require a restoration of value.[81]

Some courts additionally note that a concept of value should not be imputed into the word "repair" because losses in value cannot be repaired; they can only be assuaged with money. The Delaware court held that "[a]scribing to the phrase 'repair or replace' an obligation to compensate the insured for things that cannot be reasonably repaired or replaced violates the most fundamental rule of contract construction."[82] The Louisiana intermediate appellate court agreed, noting that "[t]he very

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79. *Allgood*, 807 N.E.2d at 137.

80. Hyden v. Farmers Ins. Exch., 20 P.3d 1222, 1225 (Colo. Ct. App. 2000) (quoting L. RUSS, COUCH ON INSURANCE § 175:47 (1998)).

81. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785, 791 (Ala. Civ. App. 2002).

82. O'Brien v. Progressive N. Ins. Co., 795 A.2d 281, 290-91 (Del. 2001).

essence of a diminished value claim stems from the fact that such damage, if any, is not subject to repair."[83]

Diminished value plaintiffs claim that even if the word "repair" is not inherently ambiguous, it is rendered ambiguous by the other words in the Limit of Liability clause. As noted above, the Limit of Liability clause does not promise simply to "repair" the insured vehicle; it promises to "repair or replace the property with other property of like kind and quality." The plaintiffs claim that, even if the word "repair" does not carry a conception of value, the word "quality" does; and that, in promising to repair the vehicle to "like quality," the insurer could reasonably be viewed as having promised to pay diminished value.[84]

This argument was accepted in Colorado and by the Indiana Court of Appeals, but has not been successful elsewhere. In *Hyden*, the Colorado court agreed with the insurer "that the policy language . . . gave it the option to repair or replace the plaintiff's [car]."[85] But once the insurer made that choice, it "was responsible, under the terms of the policy, for providing plaintiff with a vehicle of 'like kind and quality.'"[86] The court noted,

> [T]he term "quality" can have a meaning different from the word "kind" . . . and it often connotes a "degree of excellence" or a "superiority in kind." Because the words "kind" and "quality" are joined together by "and" rather than by "or," ordinary purchasers of insurance could reasonably expect [the insurer] to provide them with vehicles substantially equivalent in both function and value to those which they drove prior to any accidents.[87]

The court held that "the phrase 'of like kind and quality' is ambiguous because it fails to specify the protections afforded by the policy. Accordingly, it must be construed in favor of the plaintiff and against [the insurer]."[88]

The Texas Supreme Court rejected the claim that the "like kind and quality" modifier renders the meaning of the word "repair" ambiguous.[89]

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83. Townsend v. State Farm Mut. Auto. Ins. Co., 793 So. 2d 473, 480 (La. Ct. App. 2001).

84. *See, e.g.*, Am. Mfrs. Mut. Ins. Co. v. Schaefer, 124 S.W.3d 154, 160 (Tex. 2003).

85. *Hyden*, 20 P.3d at 1222.

86. *Id.* at 1224.

87. *Id.* at 1225 (internal citations omitted).

88. *Id.* at 1225.

89. *Schaefer*, 124 S.W.3d at 160.

The court suggested that the "like kind and quality" modifier might not even apply to the word "repair;" it might only modify the word "replace." But assuming without deciding that the phrase modifies both, the court explained its view of the ordinary meaning of a "repair . . . of like kind and quality."[90]

> [T]he words "repair" and "replace," with regard to a vehicle, connote something tangible, like removing dents, fixing parts, or replacing the vehicle with a comparable substitute. Thus, if an insurer elects to repair a vehicle and must replace parts in doing so, it must use parts "of like kind and quality." Likewise, if an insurer elects to replace the vehicle, it must do so with a vehicle "of like kind and quality."[91]

Diminished value plaintiffs also claim that the term "repair" is rendered ambiguous by the betterment provision of the Limited Liability clause. As noted above, the Limit of Liability clause promises to pay to repair or replace the car with property of like kind and quality, but, if "a repair or replacement results in better than like kind or quality, [the insurer] will not pay for the amount of the betterment."[92] The plaintiffs claim that, even if the term "repair" does not ordinarily connote a restoration of value, the betterment clause imports a notion of value into the word. "By this policy provision, the insurance company is entitled to reduce its payment to an insured by depreciating a new part that would make the car more valuable. By the terms of its own policy, [the insurer] has applied market value to repair."[93]

This argument has yet to capture any court, and indeed references to notions of value elsewhere in the policy have helped the insurers more than the plaintiffs. In *Pritchett,* for example, the Alabama court noted that "[i]n other sections of the insurance policy . . . the word 'value' is used to define the insurance coverage provided under that portion of the policy."[94] The court concluded that the insurer "was aware of the concept of value and had

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90. *Id.*

91. *Id.*

92. *See supra* Part I.A; INSURANCE SERVICES OFFICE, INC., PERSONAL AUTO POLICY 7 (1998). A common example of a situation in which a repair "results in better than like kind or quality" is when a collision requires the replacement of an old, worn tire with a new one.

93. Pritchett v. State Farm Mut. Auto. Ins. Co., 834 So. 2d 785, 810 (Ala. Civ. App. 2002) (Yates, J., dissenting).

94. *Pritchett*, 834 So. 2d at 792.

used that term to define the limits of other areas of coverage it provided under the insurance policy."[95]

Insurers respond to all claims of ambiguity—whether arising out of the word "repair" itself or out of its modification by "like kind and quality" or the betterment provision—by arguing that the plaintiffs' proffered construction is not a reasonable one because it renders other portions of the contract inoperative. The policy purports to give the insurer a choice between paying for repairs or paying the car's cash value, and the insurers argue that to imply into the repair option an obligation to compensate lost value is to negate the choice they reserved to themselves. This claim has met with considerable success. In *O'Brien,* for example, the Delaware Supreme Court held that,

> [The plaintiffs'] arguments would render the policy's stated choice between the lowest of the actual cash value of the property and the amount necessary to repair or replace the damaged property both illusory and meaningless. In every instance, the amount of recovery would be the cash value of the car before the incident that caused the damage.[96]

The court noted that "an interpretation that gives effect to each term of an agreement is preferable to any interpretation that would result in a conclusion that some terms are uselessly repetitive. Contracts are to be interpreted in a way that does not render any provisions 'illusory or meaningless.'"[97] Since the plaintiffs' construction rendered the insurer's option illusory, it was an impermissible construction.

One court has held that the plaintiffs' construction does not negate the insurer's choice and is therefore not impermissible. In *Allgood*, the Indiana Court of Appeals claimed to demonstrate that the insurer's responsibility would work out differently under the "repair" and "replace" options of the Limit of Liability clause, even if diminished value was covered. The court imagined a situation in which a vehicle with a pre-accident value of $7,000 sustained $4,000 in damages and $1,000 in post-repair diminished value. "The actual cash value under the 'replace' option would require the insurer to pay $7,000. Repair plus a payment for diminution in value would

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95. *Id.*

96. O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 287 (Del. 2001); *accord Pritchett*, 834 So. 2d at 792; Ray v. Farmers Ins. Exch., 246 Cal. Rptr. 593, 596 (Cal. Ct. App. 1988).

97. *O'Brien,* 785 A.2d at 287.

require a payout of $5,000–$4,000 for repair, plus $1,000 for the diminished value."[98]

Lastly, plaintiffs sometimes argue that the mere existence of the split of authority establishes that the policy is ambiguous with respect to diminished value. While this argument has sometimes attracted judges in other contexts,[99] it has yet to prevail in a diminished value case. In *O'Brien,* for example, the Delaware Supreme Court acknowledged that the argument was "seductive" but ultimately found it to be "without merit."[100] The court reasoned that accepting this proposition would be tantamount to allowing the courts of other states to determine Delaware law.

> This Court would place itself in an untenable position if it were to recognize every split in judicial authority as prima facie evidence of ambiguity. In the context of interpreting insurance agreements, an adoption of this policy would unduly restrict the power of the Delaware courts to render decisions independent of our sister courts.[101]

c. The claim that diminished value is consistent with the reasonable expectations of the insured

Few of the diminished value cases explicitly invoke the doctrine of reasonable expectations. But the doctrine can be observed as an undercurrent in several of them. As noted above, the doctrine of reasonable expectations involves a two-step inquiry. First, a court will inquire into the purpose of the policy provision at issue. Second, the court will then ask whether an insured would have reasonably expected that provision to follow from that purpose.

Although they are arguably viewed as *contra proferentem* cases because they attempt a definition of "repair,"[102] the Georgia cases leading up to and including *Mabry* are fundamentally reasonable expectations cases. Effectively, they look to the Insuring Agreement and determine that

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98. Allgood v. Meridian Sec. Ins. Co., 807 N.E.2d 131, 137 n.6 (Ind. Ct. App. 2004), *rev'd,* 836 N.E.2d 243 (Ind. 2005).

99. *See, e.g.,* Peace v. Northwestern Nat'l Ins. Co., 596 N.W.2d 429 (Wis. 1999) (Abrahamson, C.J., dissenting) ("When numerous courts disagree about the meaning of language, the language cannot be characterized as having a plain meaning.").

100. *O'Brien,* 785 A.2d at 289.

101. *Id.*

102. *See, e.g.,* U.S. Fire Ins. Co. v. Welch, 284 S.E.2d 713, 714 (Ga. Ct. App. 1973) ("We construe repair to mean restoration of the vehicle to substantially the same condition and value as existed before the damage occurred.").

the purpose of the physical damage coverage is to pay for all losses that arise from an accident. Then they conclude that an insured could not reasonably expect the purported limitation that follows—the limitation to physical repairs only. "[T]he insurance policy, drafted by the insurer, promises to pay for the insured's loss; what is lost when physical damage occurs is both utility and value; therefore, the insurer's obligation to pay for the loss includes paying for any lost value,"[103] notwithstanding any policy provision that purports to limit the obligation at a lesser level. "That interpretation has stood for 75 years in Georgia and has become, therefore, part of the agreement between the parties when they enter into a contract of insurance which includes the promise to pay for the insured's loss."[104]

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103. State Farm Mut. Auto. Ins. Co. v. Mabry, 556 S.E.2d 114, 122 (Ga. 2001).

104. *Mabry*, 556 S.E.2d at 122. This rule has a curious and questionable history. Its roots are found in *USF&G v. Corbett*, 134 S.E. 336 (Ga. Ct. App. 1926). In *Corbett*, the insurer invoked the appraisal clause of its policy, but never told its appraiser about its Limit of Liability provision. The appraiser awarded more than the insurer thought it owed, and the insurer refused to pay its own appraiser's award. When the insured sued, the insurer raised the Limit of Liability defense for the first time in its demurrer. *Corbett*, 134 S.E. at 337-38.

The question before the *Corbett* court was a procedural one—"whether the [Limit of Liability] defense could be made by a demurrer . . . where there is nothing to show that the defendant made any contention [to the appraisers] that its liability should be fixed by the special provision." *Id.* at 338. The court held that "the undertaking of the company to insure the owner against 'actual loss or damage' must be taken as the primary obligation, under which the measure of the liability would be the difference between the value of the property immediately before the injury and its value immediately afterwards." *Id.* If the insurer wanted to include in its policy a provision changing this default rule, presumably it could; but such a provision "must be construed as a subordinate provision . . . to be pleaded defensively if the insurer would diminish or limit the amount of recover by reason thereof." *Id.*

Thirty-six years later, in *Dependable Insurance Co. v. Gibbs*, 127 S.E.2d 454 (Ga. 1962), the Georgia Supreme Court expanded this procedural point into a substantive rule governing cases in which the insurer defectively repaired the insured's car. Whereas, in *Corbett*, the insured was entitled to a diminished value measure of recovery only when the insurer failed to plead its repair limitation as a special defense, the *Gibbs* court held that the insured was entitled to such a measure of recovery "where the insurer elected to make repairs and did so defectively." *Gibbs*, 127 S.E.2d at 461. The Georgia courts reaffirmed this standard in several subsequent cases involving deficient insurer-directed repairs, including *State Farm Mutual Automobile Insurance Co. v. Simmons*, 143 S.E.2d 55 (Ga. Ct. App. 1965) and *U.S. Fire Insurance Co. v. Welch*, 284 S.E.2d 713 (Ga. Ct. App. 1973).

In *Hartford Fire Insurance Co. v. Rowland*, 351 S.E.2d 650, 652-53 (Ga. Ct. App. 1986), the Georgia Court of Appeals applied the rule for the first time to a situation in which the repairs were both satisfactory and directed by the insured. The court did not remark upon the distinction, and it should have. *Id.* In the defective repair cases, the insurer is arguably in breach of its contract, and a compelling argument could be made that it may not

Reasonable expectations thinking can also be seen in Indiana Court of Appeals' holding in *Allgood.* In that case the court paid a remarkable amount of attention not to the facts of Allgood's loss, but rather to the facts of the loss in the Colorado *Hyden* case that Allgood had offered as an authority.[105] In *Hyden*, the plaintiff had insured a Jeep Cherokee worth $23,000 with the Farmers Insurance Exchange.[106] He had an accident in the vehicle and the repairs were estimated at $16,868.96.[107] Although the vehicle was arguably a constructive total loss, and although Hyden did not want it repaired, Farmers chose to repair it anyway.[108] After the repairs were complete, a car dealer informed Hyden that his Jeep was worth no more than $7,500.[109] Reflecting on these facts, the court concluded that,

> No reasonable insured would read a policy containing a limit of liability provision like that in *Hyden* . . . and assume that, if he were involved in a collision and turned to his insurer to cover the loss, he might be left with only one-third of what he had before the collision.[110]

The court conceded that not every factual situation would be as compelling or extreme as Hyden's, but nevertheless held that there would be at least some diminution in value anytime a car had been in a collision.[111] "In undertaking to compensate Allgood for 'direct and accidental loss' to her vehicle through one of several options, [the insurer] is primarily obligated to restore to Allgood what she has lost."[112]

C. ANALYSIS AND RECOMMENDATION

Regardless of the analytical framework we apply—*contra proferentem* or reasonable expectations—the insurers have the better arguments. Consequently, courts should not hold that automobile insurance policies cover diminished value.

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claim the benefit of the Limit of Liability provision while it is in breach. *Id.* No such argument can be made in the case of a satisfactory repair. *Id.*

105. Allgood v. Meridian Sec. Ins. Co., 807 N.E.2d 131, 136-37 (Ind. Ct. App. 2004), *rev'd*, 836 N.E.2d 243 (Ind. 2005).

106. Hyden v. Farmers Ins. Exch., 20 P.3d 1222, 1223-24 (Colo. Ct. App. 2000).

107. *Id.* at 1223.

108. *Id.*

109. *Hyden*, 20 P.3d at 1223-24.

110. *Allgood*, 807 N.E.2d at 137.

111. *Id.* at 137-38.

112. *Id.* at 138.

The plaintiffs' claims that the policy is ambiguous—and that, by extrapolation, they are entitled to coverage under the doctrine of *contra proferentem*—suffer from two significant defects. First, the plaintiffs' construction does indeed negate the insurer's option to choose the lesser of two payment methods. Because it renders another portion of the contract inoperative, courts should regard it as an impermissible construction.

The Indiana Court of Appeals attempted to demonstrate that the plaintiffs' argument does not negate the insurer's choice, but the court neglected to take account of the salvage provisions of the policy. In its example, the court imagined a hypothetical vehicle that was worth $7,000 before the accident and $6,000 after repairs costing $4,000.[113] The court concluded that, under the "replace" option, the insurer would pay $7,000, and under the "repair" option, the insurer would pay $5,000 even if it paid the post-repair diminution in value.[114] Reasoning that the choice between $7,000 and $5,000 is a real one, the court held that the insurer could be required to cover diminished value without rendering its choice illusory.

But this holding neglects the fact that, had the insurer chosen the "replace" option, it would have been entitled to take the vehicle as salvage.[115] Had it done so, its ultimate liability would have been $5,000—exactly the same as it would have been under the "repair plus diminished value" option. We can infer from the court's hypothetical facts that the value of the salvage was $2,000; if an item of property is worth $6,000 after an input of $4,000, then it was almost by definition worth $2,000 prior to the input. For this reason, the plaintiffs' construction does indeed render the insurer's choice illusory, and courts should therefore regard it as impermissible.

The second defect in the plaintiffs' construction is that it violates the principle of contract interpretation preferring ordinary meanings over technical ones. The insurers' construction comports with definitions found in ordinary dictionaries and in the common usage of the words at issue; the plaintiffs' construction, by contrast, relies on specialized definitions from insurance law treatises. Ordinarily, it is the insurer who argues for a technical specialized definition of a term and the consumer who argues for the lay meaning. In diminished value cases, consumer plaintiffs find themselves oddly and unpersuasively arguing that they understood "repair" to mean not what ordinary people think it means, but rather what *Couch on Insurance* thinks it means.

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113. *Id.* at 137 n.6.

114. *Id.*

115. *See* discussion *supra* Part I.A.

Of course, under the doctrine of *contra proferentem* the plaintiffs are not required to show that the meaning they impart to a term is the best one; they need only show that it is a permissible and reasonable one. Arguably, the plaintiffs can satisfy this burden with a technical or specialized definition. Indeed, in *Hyden* the plaintiff persuaded the court that its construction was permissible because it comported with a specialized treatise.[116] But these treatises cannot be properly understood as dictionaries that attempt to define words; rather, they are recapitulations of the law. In other words, *Couch on Insurance* does not venture a definition of repair but instead restates how the courts have defined it.[117] To hold that a recapitulation of the diversity of state court definitions of "repair" is itself a definition of repair, is impliedly to hold that the split of authority among the states is dispositive of the question of ambiguity.

The plaintiffs' arguments fare no better under a reasonable expectations analysis. Again, such an analysis would begin by asking what the purpose of the policy provision is, and then ask whether an insured would reasonably expect the limitation to follow from that purpose. Determining the purpose of the policy provision raises a "level of generality" problem because we have to ask whether the "policy provision" at issue is the Limit of Liability clause or the entire physical damage coverage. But even assuming *arguendo* that the focus is properly on the entire coverage, and the "purpose" therefore the satisfaction of accident-related loss, the insured cannot reasonably claim to have expected that no limitation would follow.

Mabry and its kindred cases effectively hold that once the policy undertakes to pay loss, any subsequent provision that limits that undertaking is outside the reasonable expectations of the insured and therefore unenforceable. But insureds clearly do not expect the insurer to pay for all loss that flows from an automobile collision, regardless of form. The simple example of the deductible demonstrates this point. Although the reasoning of *Mabry* would suggest that deductible clauses are unenforceable because they limit the undertaking to "pay loss," there is as yet no class action challenging the applicability of those clauses, which suggests that insureds have acquiesced in them.

Of course, the insured's expectations about coverage may be affected by things other than the policy language. Professor Baker has detailed how insurers often create expectations through their advertising, and then proceed to frustrate some of those expectations during the claims

116. *See* Hyden v. Farmers Ins. Exch., 20 P.3d 1222, 1225 (Colo. Ct. App. 2000).

117. LEE R. RUSS, COUCH ON INSURANCE § 175:47 (3d ed. 1998).

process.[118] Among the many auto insurer advertising campaigns, however, it is difficult to locate any that could be reasonably viewed as creating an expectation that the insurance product will protect the car's value as well as its physical condition. A television advertisement for Farmers Insurance, for example, shows a car accident twice—first in forward motion and then in reverse—so the viewer can see the car coming back together again. The ad sends the message that the insurance will restore the physical condition of the car. No insurer ad shows a happy customer walking away from the car dealer with a large trade-in check.

So if the insured does not have a reasonable expectation of diminished value coverage, and if the doctrine of *contra proferentem* does not imply it into the policy, what can we do about the occasional hard case like *Hyden*? Recall that in *Hyden* the insurer elected the "repair" option under circumstances in which it was only minimally less costly than the "replace" option, if indeed it was less costly at all.[119] In the process, it inflicted a $15,500 diminished value loss on its policyholder.[120]

Perhaps the answer to such cases can be found in an analogy to the "duty to settle" imposed on liability insurers. Liability insurance policies typically give the insurer the exclusive discretion to decide whether to defend or settle a covered claim brought against its policyholder. But courts will commonly imply into this policy provision a duty to "take into account the interest of the insured and give it at least as much consideration as its own interest" when making the decision whether to defend or settle.[121]

Courts could imply a similar duty into the repair or replace decision. Had Farmers been under such a duty in *Hyden,* it might have breached it. If the plaintiff's recitation of the facts is to be accepted, Farmers inflicted a loss of $15,500 on its insured in pursuit of a mere chance at a very small recovery for itself. In contrast to cases like *Hyden*, the insurer would satisfy the duty in cases like *Pritchett* or *Camden* in which the damage was small and the "replace" option clearly inappropriate. The performance of that duty would, of course, have to be assessed on a case-by-case basis. Diminished value claims would therefore become less amenable to aggregation in class actions.

Whether such a duty is or is not ultimately adopted, courts should refuse to find coverage for diminished value in the policy. The policy

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118. *See generally* Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages,* 72 TEX. L. REV. 1395 (1994).

119. *See Hyden*, 20 P.3d at 1223-24.

120. *See id.*

121. Comunale v. Traders & General Ins. Co., 328 P.2d 198 (Cal. 1958).

unambiguously reserves to the insurer the right to limit its liability to the cost of repair, and the insured cannot credibly claim that this limitation was outside her reasonable expectation.

II. DOES THE DIMINISHED VALUE CONTROVERSY HAVE ANYTHING TO TEACH US ABOUT INSURABILITY?

One of the most remarkable aspects of the diminished value controversy is that it exists at all. The diminished value plaintiffs are, after all, consumers who are asking a business to provide them with a service. If this were any other service—maid service, let's say, or plumbing repairs—the business would surely provide the requested service if there was enough demand. Here, however, insurers have not provided the service that the market seems to be requesting.

Of course, a cynic might say that the plaintiffs only want diminished value coverage if they don't have to pay for it. But surely somewhere among the many plaintiffs there are at least a few whose experiences have sensitized them to the possibility for severe financial loss from repair-related stigma damages; experiences that have left them willing to pay for insurance to cover it. It is not surprising that insurers have declined to pay for these losses from past policies; they are of the view that the policy was not "priced" for diminished value coverage.[122] But why haven't they recognized this as a market opportunity and developed a product to fill the plaintiffs' demand?

The answer, of course, is that insurance is "different." It's not like maid service or plumbing; it does not respond to every market demand. Sometimes, the risk for which the market is requesting coverage is "uninsurable." On this much, virtually all insurance practitioners and scholars agree.

There is less agreement, however, on exactly why certain risks are "uninsurable," and even less agreement now than there was as recently as twenty-five years ago. Consequently, anytime we observe a situation in which a demand for insurance coverage goes unmet, we have an opportunity to inquire why and to test which of the competing explanations of insurability is most persuasive.

122. *See* Ray v. Farmers Ins. Exch., 246 Cal. Rptr. 593, 596 (Cal. App. Ct. 1988).

A. CONCEPTIONS OF INSURABILITY

1. The Conventional Conception

For most of the twentieth century, there was a general consensus among insurance scholars about the characteristics of an insurable risk. If a risk possessed five traits, scholars were confident that it could be an appropriate subject of private insurance. First, they agreed that a risk must present a *large, homogeneous group of exposure units.*[123] Successful insurance depends on the law of large numbers—the proposition that, "all other things being equal, the accuracy of loss forecasts improves as the number of exposure units in the [group] increases."[124] "To facilitate the prediction of the probable loss through use of the law of large numbers, it is essential that there be a large number of similar units exposed to the same peril."[125]

The second characteristic of an insurable risk on which scholars agreed was that it be *definite*—that is, one should be able to tell with certainty whether the insured loss has occurred or not.[126] "It must be difficult or impossible for the insured to pretend that he has suffered a loss when he has not done so."[127] Life insurance is possible in part because the occurrence of the insured event is easily determinable.[128] By contrast, early attempts at "sickness insurance" foundered because of the difficulty in determining whether an insured event had occurred.[129] Disability insurance is possible only because an elaborate set of definitions allows the parties to determine whether the insured event has taken place.[130]

The third characteristic of an insurable risk on which scholars agreed was that it be *accidental or fortuitous.*[131] This requirement has two aspects. First, it distinguishes those losses that are certain to occur from those that are not certain to occur. If an insurance company knows that an event is certain to occur—as it would, for instance, with the wearing out of an

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123. ROBERT I. MEHR & EMERSON CAMMACK, PRINCIPLES OF INSURANCE 18 (1955); ROBERT RIEGEL & JEROME S. MILLER, INSURANCE PRINCIPLES AND PRACTICES 30-31 (1966); EMMETT J. VAUGHAN & THERESE M. VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 28 (1996); FRANK JOSEPH ANGELL, INSURANCE PRINCIPLES AND PRACTICES 24 (1959).

124. BERNARD L. WEBB ET AL., INSURANCE OPERATIONS 116 (2d ed. 1992).

125. MEHR & CAMMACK, *supra* note 123, at 18.

126. ROBERT J. GIBBONS ET AL., INSURANCE PERSPECTIVES 64 (1992).

127. ANGELL, *supra* note 123, at 25.

128. MEHR & CAMMACK, *supra* note 123, at 18.

129. *Id.*

130. *See id.*

131. *Id.* at 18-19; VAUGHAN & VAUGHAN, *supra* note 123, at 28.

industrial machine—"it also knows that it must collect a premium equal to the certain loss that it must pay, plus an additional amount for the expenses of administering the [insurance] operation."[132] The premium would always exceed the cost of the hazard being run, and no advantage would be gained by insuring the risk.[133]

The other aspect of the fortuity requirement is that it insulates the insurance mechanism from those losses that are easily produced by the insured herself.[134] "Intentional losses caused by the insured are usually uninsurable because they cannot be reasonably predicted, and payment for them would violate public policy by encouraging such actions as fraud or arson."[135]

A fourth characteristic of insurable risks is that *the loss must be big enough to produce hardship, but not so big as to be catastrophic.*[136] Running an insurance company costs money, and each policy sold must recover some of the fixed costs incurred. As a result, insurance markets generally do not exist for risks where the loss is small in relation to the expense of insuring it.[137] One scholar dryly observed that "[i]nsurance against breakage of shoestrings is unknown."[138] At the other end of the spectrum, private insurance markets generally do not exist for risks that are beyond the ability of a private company to absorb, particularly where there is a risk of simultaneous loss to a large number of exposure units. The risks of nuclear accident or flood, for example, are largely borne by the government and not by the private insurance industry.[139]

The fifth characteristic of an insurable risk is that *the cost of the risk run must be calculable.*[140] Insurance companies are in the business of risk and uncertainty, and they therefore do not require that the future be predictable with perfect precision. They do, however, require that the future be amenable to mathematical expression, however accurate or

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132. VAUGHAN & VAUGHAN, *supra* note 123, at 28.

133. *See id.* The reader may ask whether uncertainty of loss is indeed a requirement, when one of the most popular insurance products—life insurance—deals with an event that is certain to occur. The general dispensability of the uncertainty requirement will be discussed further in Part II.A.2, but we can pause to observe that with life insurance, the risk insured against is not the risk of death, but rather the risk of the *timing* of death. The eventual death of the policyholder is certain, but her death at a certain point on a mortality table is not. MEHR & CAMMACK, *supra* note 123, at 18.

134. RIEGEL & MILLER, *supra* note 123, at 30.

135. DAVID L. BICKELHAUPT, GENERAL INSURANCE 13 (11th ed. 1983).

136. MEHR & CAMMACK, *supra* note 123, at 19-20.

137. *Id.* at 19.

138. *Id.*

139. RIEGEL & MILLER, *supra* note 123, at 30.

140. VAUGHAN & VAUGHAN, *supra* note 123, at 28.

inaccurate that expression may be.[141] Some losses cannot be rendered mathematically at all; others only with great difficulty. Many household items have tremendous sentimental value to their owners, but sentimental value is not susceptible to mathematical calculation. For this reason, property insurance policies typically insure heirlooms only to the extent of the market value or replacement cost, leaving the insured to bear the loss of sentimental value herself.[142]

Scholars used these five factors to predict when a given risk could be insured, but for most of this period the question of whether a risk *could* be insured was also viewed as dispositive of the question of whether the risk *should* be insured. Overhanging the application of these five factors was an atmospheric sense that the core function of insurance—spreading risk—was an unambiguously good thing, and that we should insure what we can insure, privately if possible, and publicly if not. Professors Baker and Simon describe how the twentieth century witnessed an explosion in the use of both public and private insurance to address a wide array of risks faced by individuals and businesses alike:

> From the . . . early twentieth century through at least the late 1980s, the United States and other industrializing societies socialized, or spread, more and more risks. Over this period, ever-expanding public and private insurance pools assumed . . . risks faced by individuals, families, and organizations. On the private side, the twentieth century witnessed the dramatic growth of health insurance, tort liability insurance, workers compensation insurance, and private pensions . . . . On the public side, there was the creation and perhaps even more dramatic expansion of an entirely new social insurance sector, beginning with the multifaceted Social Security program . . . and followed by Medicare, Medicaid, and natural disaster insurance . . . . "[M]ore insurance for more people" might best describe the twentieth-century U.S. domestic social policy well into the Reagan/Bush years.[143]

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141. BICKELHAUPT, *supra* note 135, at 13.

142. *See, e.g.*, INSURANCE SERVICES OFFICE, INC., HOMEOWNERS 3-SPECIAL FORM 10 (1990).

143. Tom Baker & Jonathan Simon, *Embracing Risk, in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 3 (Tom Baker & Jonathan Simon eds., 2002).

Baker and Simon acknowledge that "[t]he trend was not always uniform, and significant risks and important segments of the population were always left out."[144] Nevertheless, the spirit of the age was accurately and famously reflected by Kenneth Arrow's claim that "[t]he welfare case for insurance policies of all kinds is overwhelming."[145]

2. The Changing Conception

Late in the twentieth century the consensus surrounding the five factors began to erode. Scholars looked around them and observed that private insurance markets had developed for risks that would have been reckoned uninsurable under the conventional conception. Christian Lahnstein, for example, recently observed that the fortuity requirement is effectively disregarded in products liability insurance that covers a manufacturer with a known defective product in the field.[146] He also argues that it is effectively disregarded when insurers elect to cover the vicarious liability of employers for the intentional torts of their employees.[147] Lahnstein summarizes these observations into a conclusion that "[t]he insurability criteria usually specified for private insurance . . . are questionable, and can be refuted with facts."[148] To Lahnstein, the only one of the five factors that is indispensable is risk size; "[m]onetary limits . . . remain a decisive limit to insurability."[149]

Professor Baker has suggested that the five factors can be collapsed into a single standard of predictability, at least in the context of liability risks.[150] In an article that endeavors to explain the seemingly unconquerable unpredictability of liability loss experience and the "underwriting cycles" that result from it, Professor Baker identifies no fewer than nine discrete dimensions of liability loss exposures that make them difficult to predict.[151] He may therefore consider himself to have broken down the criteria of insurability into smaller component parts, not to have synthesized them into one larger standard. But in treating all of

144. *Id.*

145. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 961 (1963).

146. Christian Lahnstein, *The Insurability of New Liability Risks*, 29 GENEVA PAPERS ON RISK & INS.–ISSUES & PRACTICE 512, 515-16 (2004).

147. *Id.*

148. *Id.* at 515.

149. *Id.* at 516.

150. *See generally* Tom Baker, *Insuring Liability Risks*, 29 GENEVA PAPERS ON RISK & INS.–ISSUES & PRACTICE 128 (2004).

151. *Id.* at 129.

these nine dimensions as problems of predictability, he may be suggesting that many of the things that would offend the traditional analysis—insurance for intentional harms, for example, or for indefinite losses—could be insurable if we could devise ways to predict them actuarially.

One might have predicted that these evolving conceptions would lead to more insurance, not less. If, say, Lahnstein is right that fortuity is no longer the *sine qua non* of insurability, one might expect the insurance expansion of the mid-twentieth century to have continued, encompassing risks that are less fortuitous than had been thought insurable in the past. And indeed this has occurred in some instances; the 1990s saw the development of Employment Practices Liability insurance policies that cover a range of intentional behaviors.

Generally, though, the expansion has not continued. While the scope of what we *can* insure has expanded, it no longer is seen as dispositive of what we *should* insure. Scholars and policymakers no longer view the spreading of risk as unambiguously good; rather, they have become concerned "about how people reacted to being protected from risk" and have begun to focus "on the need to manage incentives to curtail what is perceived as the runaway growth of public and private insurance programs."[152] They have begun to pay considerable attention to the long-acknowledged but heretofore non-central question of "moral hazard"—the tendency of insurance and risk-spreading to reduce incentives to prevent and minimize loss,[153] and the corresponding increase in the aggregate level of loss in society.

One scholar who exemplifies the contractionary trend is Professor George Priest of the Yale Law School. Professor Priest identifies several benefits that insurance institutions provide, including the "error-canceling" effect of aggregating risks into large pools, and the ability to control "moral hazard"[154] through insurance benefit design.[155] But when, with respect to a

152. Baker & Simon, *supra* note 143, at 4.

153. TOM BAKER, INSURANCE LAW & POLICY 4 (2003).

154. The many problems posed by the term "moral hazard" have been well-documented. *See generally* Tom Baker, *On the Genealogy of Moral Hazard,* 75 TEX. L. REV. 237 (1996); Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity, in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 52 (Tom Baker & Jonathan Simon eds., 2002). Economists attempt to use the term in a value-neutral way, but Professor Stone observes that "even when economists describe moral hazard as a phenomenon of purely rational behavior, there is usually a pejorative undertone. After all, rational behavior is always self-interested, so even this form of moral hazard is motivated by greed, selfishness, and personal gain at the expense of others." *Id.* at 53. But "the core insight—that, all other things being equal, people behave differently when they bear the costs of their misfortune than when they do not—cannot seriously be questioned." Tom

given risk, these benefits are outweighed by the increase in loss produced by the disincentive effect of insurance on prevention, Professor Priest would suggest that the risk should not be insured. "Preferences for redistribution cannot be morally defended . . . where the redistributional mechanism that has been selected *increases* the frequency and magnitude of the loss to society."[156]

To sum up, then, we have on the one hand a group of traditional scholars who would predict the emergence of a private insurance market only when the peril in question satisfies five criteria. Provided that these five criteria are satisfied, however, this group would regard the emergence of that market as an unambiguously positive development. On the other hand is a group of scholars who would argue that private insurance arrangements are more easily established, but not always beneficial. What, if anything, does the diminished value controversy tell us about who is right?

B. DIMINISHED VALUE AND INSURABILITY

We begin our discussion of diminished value and insurability by asking whether the peril satisfies the conventional conception of an insurable risk.

Diminished value satisfies the first conventional criterion of insurability—a large, homogeneous pool of exposure units. The exposure base is nearly the same as the exposure base for physical damage insurance generally. In each of the past ten years there have been between six and seven million car crashes.[157] About half of these crashes involve two or more vehicles,[158] meaning that about nine or ten million cars are damaged each year. Not all of these cars are repaired, nor do all repaired cars sustain a loss in value after those repairs. Nevertheless, the exposure base is in the many millions of units and this criterion is therefore satisfied.

Diminished value losses do not satisfy the second criterion of definiteness, but as with disability insurance the problem could be conquered through contract design techniques. When a car is damaged,

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Baker, *Risk, Insurance, and Responsibility, in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 45 (Tom Baker & Jonathan Simon eds., 2002).

155. George L. Priest, *Government Insurance versus Market Insurance,* 28 GENEVA PAPERS ON RISK & INS.–ISSUES AND PRACTICE 71, 74 (2003).

156. *Id.* at 77-78.

157. Insurance Information Institute, Auto Insurance, http://www.iii.org/media/facts/statsbyissue/auto/ (last visited Feb. 10, 2006).

158. Insurance Institute for Highway Safety, Q & A: Speed and Speed Limits (Dec. 2005), http://www.iihs.org/research/qanda/speed_limits.html.

one cannot tell right away whether the owner will ever truly realize a loss of resale value. After all, the owner could keep the car until it is fully depreciated. This issue could be resolved, however, merely by stipulating in the insurance contract that a diminished value loss is deemed to have occurred at the moment of physical damage, and then pricing the coverage accordingly. While an objection might be raised that such a resolution would violate the principle of indemnity by granting a windfall to the person who keeps her car long after the accident, the violation is certainly no greater than other violations the insurance industry has tolerated. The "fair rental value" coverage found in the standard homeowners' policy, for example, can provide a windfall to the insured, as can "replacement cost" property coverage.[159]

The third criterion of fortuity is more problematic, but it too could be conquered by any insurer willing to invest some effort in program design. While the accident that creates the possibility of a diminished value loss is indeed a fortuitous event, the occurrence or non-occurrence of the diminished value loss itself is often within the control of the insured. The insured can decide whether to disclose the car's accident history or conceal it from the buyer. This prospect becomes even more likely when one considers that we are talking only about "inherent" diminished value, which presupposes a satisfactory repair that is presumably undetectable to the average buyer. Under the current motor vehicle law of many states, the seller is under no obligation to disclose accident-related repairs; statutes requiring such a disclosure typically apply only to car dealers and not to private sellers.[160] And even where such statutes are applicable, they typically contain an exception for situations in which the damage is below a certain percentage of the car's value.[161]

While no reliable data exists regarding the rate at which consumers divulge their car's accident history at time of sale, anecdotal evidence suggests that concealment is indeed widespread. In none of the fourteen cases analyzed in Part I did the record show that the insured had actually disclosed the repairs to a buyer and sustained a loss on account of the disclosure.[162] Indeed, in the *Camden* case the appellate opinion suggests that the insured had concealed the repairs and therefore could not prove a

159. *See generally* INSURANCE SERVICES OFFICE, INC., HOMEOWNERS 3–SPECIAL FORM 3 (1990).

160. *E.g.*, 815 ILL. COMP. STAT. 710/5 (West 2003).

161. *E.g.*, *id.*

162. *See* cases cited *supra* note 64.

diminished value loss.[163] And cases arising out of other physical damage coverage disputes appear to suggest that insureds frequently hide their repairs. In *Avery v. State Farm*, an important class action in the controversy over "aftermarket" auto body repair parts, the insurer evidently discovered in depositions that many class members had sold their cars for full market value after repairs.[164] And a review of a recent Sunday's classified ads in several major newspapers failed to reveal even a single disclosure of accident-related repairs.[165] Concealment seems to be the rule rather than the exception.

Two things need to be said about concealment, however. First, while it still seems easy to conceal a vehicle's repair history, it is getting less so. Buyers can now purchase a report on a vehicle's accident history from information service providers such as Carfax,[166] an option unavailable to them only a few years ago. While the purchase of a vehicle history report has yet to become part of the routine of a used car purchase, it may soon. Accordingly the concern about fortuity that arises from the insured's ability to conceal the repair decreases in some amount with each passing year.

The second thing to say about the fortuity requirement is that it could be designed around. The insurer could, for example, require an insured seeking diminished value coverage to send in the car's title prior to payment; the insurer could place a stamp on the title advising future purchasers that the car had undergone accident-related repairs. Additionally, insurers could create a central Internet registry listing the vehicle identification numbers of all cars for which they paid a repair claim, and they could give free access to any car buyer—essentially, performing for free the service for which Carfax charges.

The fourth criterion of a conventional insurability analysis—appropriate loss size—initially seems problematic but becomes less so upon closer inspection. The average loss size does indeed seem quite small, perhaps too small to support a stand-alone coverage product. While no central database of diminished value claims exists, we can infer from some of the litigation that the average claim might be less than $250. One Georgia class action—settled after *Mabry* and therefore immune from claims that the class "took a discount" because of uncertainty surrounding

163. Camden v. State Farm Mut. Auto. Ins. Co., 66 S.W.3d 78, 80 (Mo. Ct. App. 2001).

164. Avery v. State Farm Mut. Auto. Ins. Co., 746 N.E.2d 1242, 1259 (Ill. App. Ct. 2001), *rev'd*, No. 91494, 2005 Ill. LEXIS 959 (Aug. 18, 2005).

165. HARTFORD COURANT, Apr. 17, 2005; N.Y. TIMES, Apr. 17, 2005.

166. See the Carfax website, http://www.carfax.com, for a discussion of vehicle history reports.

its chances of recovery—resolved for "approximately $140–$215" per policyholder.[167] This accords with State Farm's experience after *Mabry;* State Farm estimates that it will cost $100 million to resolve 700,000 customer claims,[168] an average of $143 per claim.

In all likelihood, though, a diminished value coverage product would not be a stand-alone product. It would be an additional coverage sold alongside auto physical damage coverage, just as "loss of use" coverage is. Loss of use claims are equally small, yet this has not posed a problem for the insurability of that coverage because it is linked to the larger physical damage claim. Additionally, cases like *Hyden* remind us that diminished value losses can occasionally be quite significant.[169]

The last criterion of a conventional insurability analysis—mathematical calculability—is perhaps even more problematic than the fortuity requirement but nevertheless still soluble through product design. Diminished value losses are exceptionally difficult to quantify. Commonly, diminished value claimants attempt to prove their losses with affidavits or testimony from used car dealers.[170] But the dealer's bias is obvious; if she can help increase the insured's diminished value recovery, she increases the amount of money her customer can put into her next car purchase.

Several actors in the diminished value controversy claim to be able to infer the car's loss in value from its repair estimate, and indeed this method has been approved by the Georgia Insurance Commissioner over the dealer appraisal method.[171] But there is no reason to suppose that there is a link between repair dollars and lost value, or that the method is otherwise reliable. In fact, it is easy to imagine how a more expensive repair might pose less of a concern in the mind of a buyer than a less expensive one. If a collision requires, say, the replacement of a door, a buyer would certainly

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167. Notice of Proposed Class Action Settlement and Release of Claims, Martin et al. v. Gov't Employees Ins. Co., No. SU01CV312 (Ga. Super. Ct. Mar. 1, 2002), *available at* http://www.gardencitygroup.com/cases/pdf/GDV/GDVNotice.pdf.

168. *See, e.g.*, DIXON & DENEEN, *supra* note 4.

169. Hyden v. Farmers Ins. Exch., 20 P.3d 1222, 1223-24 (Colo. Ct. App. 2000).

170. *See, e.g., id.* at 1224.

171. Telephone Interview with Jim Balenger, Senior Investigator, Georgia Office of the Commissioner of Insurance (Jan. 12, 2004). A copy of the Georgia-approved methodology is on file with the author. Since the 2001 *Mabry* decision, a number of businesses have opened up purporting to appraise diminished value losses by proprietary methods. These methods, like the Georgia-approved method, attempt to infer the loss in value from the vehicle's repair estimate. *See, e.g.,* http://www.claimcoach.com; http://www.wreckcheck.com; http://www.diminishedvalue.com. ClaimCoach and DiminishedValue.com are Internet-only enterprises; WreckCheck operates through physical, franchised locations.

be less confident in an inexpensive repair performed with a salvage door than she would with an expensive repair performed with the original manufacturer's part.

The solution to the calculability problem is within the grasp of the insurance industry, however—in fact, more within its grasp than anyone else's. Insurance companies possess millions of bits of data about repair costs and sales prices of wrecked vehicles. They estimate repair costs on millions of vehicles each year, and they sell tens of thousands of wrecks each year as part of their salvage recovery process.[172] If there is a link to be discovered between particular repair types and value losses—say, a discovery that frame damage decreases the car's value by a factor of X but paint damage decreases it only by a factor of Y—the insurance industry is uniquely positioned to discover it.

Additionally, the calculability problem could be solved through contract design. An additional coverage for diminished value could fix the loss at a scheduled amount. While this might overcompensate some insureds and undercompensate others, it nevertheless demonstrates that the calculability problem is soluble.

We can conclude, therefore, that diminished value satisfies the five traditional requirements of an insurable risk. The scholars who advance the traditional five-factor approach would accordingly have predicted that a private insurance market for diminished value coverage would develop. The fact that it did not, vindicates the second group of scholars who argue that something other than the traditional criteria is at work.

Does the diminished value controversy have anything to teach us about what that "something" might be? Recall that these scholars often argue that private insurance markets fail to develop out of concern for "moral hazard"—the indifference to loss that insurance can produce. Additionally, recall that these scholars often have difficulty keeping value judgments out of their discussions of moral hazard. Is that what is at work with diminished value? Are insurers worried about the incentives they are creating—and, perhaps, worried that they are encouraging "immoral" behavior?

Although it is difficult to make blanket judgments about such a decentralized decision process, it appears that both phenomena may be at work. On the one hand, insurers are clearly concerned about the economic dimension of moral hazard—the incentive effects of offering coverage for a

172. For an interesting look into the big business that is automobile salvage, see the Copart website at http://www.copart.com. Copart is a large, publicly-traded provider of salvage auction services to the insurance industry. *Id.*

peril that society is only just beginning to recognize as a loss. Insureds who bring innovative causes of action are the vanguard of what Professor Baker calls an "injury developments risk"—that is, they herald a change in what the public conceives of as an injury, a change for which the insurer is frequently unready.[173] They also are an omen of change in what Professor Baker calls "claiming developments risks;" which is to say that they evidence a shift in attitudes about when it is or is not appropriate to place a claim on a common resource.[174] For these two reasons, insurers perceive these insureds to present an outsized moral hazard in the economic sense of that term. Arguably, they are the people whose behavior has been changed the most by the fact of insurance.

On the other hand, insurers also appear to be concerned about the non-economic dimension of "moral hazard" as well. Their press releases often impute a profit motive to the diminished value plaintiffs and the attorneys who bring their cases, impliedly expressing a concern that providing coverage for diminished value would reward "immoral" behavior. State Farm, for example, describes the emergence of the latest round of diminished value cases this way:

> The issue . . . attracted scant attention until the late 1990s, when a few entrepreneurial vendors began aggressively marketing "computerized" products that purportedly would help body shops and consumers figure out how much value a car had "lost" simply as a result of the stigma of having been in an accident. Before long, plaintiff attorneys recognized diminished value as a potential new arena for class-action litigation and a wave of lawsuits began.[175]

Perhaps the lesson of the diminished value controversy is that a private insurance market will not develop for a given peril unless insurers' concerns about both the economic and the non-economic dimensions of moral hazard are disarmed. Additionally, the controversy may demonstrate that insurers will consider a peril to have an unacceptable level of non-economic moral hazard if the only demand signal they are receiving is through coverage litigation. Other recent industry experiences suggest this as well. For years policyholders sued their commercial general liability

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173. Tom Baker, *Insuring Liability Risks,* 29 GENEVA PAPERS ON RISK & INS.–ISSUES & PRACTICE 128, 131 (2004).

174. *Id.* at 138.

175. State Farm Insurance, *Diminished Value: Fact or Fiction?*, INS. BACKGROUNDER, Nov. 2001, http://www.statefarm.com/media/dimvalue.htm.

insurers, seeking coverage for employment-related exposures such as wrongful termination lawsuits and sexual harassment claims.[176] And insurers resisted these suits. Employment Practices Liability insurance only developed when a substantial segment of the business community began to communicate demand to the insurance industry outside the coverage litigation context, disarming the insurers' concern that they were covering profit-motivated, "immoral" behavior. Perhaps the absence of such a demand explains the absence of diminished value coverage.

CONCLUSION

The future of the diminished value issue is unclear. Perhaps the recent promulgation of a specific exclusion will take the wind out of the issue's sails, leaving insureds and insurers to fight a few rear-guard actions over old policies until the issue flickers and dies. Or perhaps the issue will gain steam as diminished value losses increase in frequency and severity on account of increasing car prices and better informational tools for determining a car's repair history.

Two things do seem clear, however. First, courts should not imply coverage for diminished value into automobile insurance policies. The terms of the policy unambiguously entitle the insurer to limit its liability to the cost of physical repairs, and the insured cannot credibly claim that this limitation frustrates any of her reasonable expectations. Second, the diminished value issue raises interesting questions about broader problems of insurability, and in its small way calls into question the adequacy of some of the explanations we have constructed for the behavior of insurance markets.

176. *See, e.g.*, Nationwide Prop. & Cas. Ins. Co. v. Feryo Hearing Aid Serv., Inc., 895 F. Supp. 85 (E.D. Pa. 1995); Jefferson-Pilot Fire & Cas. Co. v. Sunbelt Beer Distrib., Inc., 839 F. Supp. 376 (D.S.C. 1993); Sausal Corp. v. Hanover Ins. Co., No. C 91-2956 SC, 1992 U.S. Dist. LEXIS 10685 (N.D. Cal. June 18, 1992); SL Indus. v. Am. Motorists Ins. Co., 607 A.2d 1266 (N.J. 1992).

RESOLVING MEDICAL MALPRACTICE CLAIMS IN THE MEDICARE PROGRAM: CAN IT BE DONE?

Eleanor D. Kinney, JD, MPH &*
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INTRODUCTION

There is increasing interest in an integrated approach to patient safety and medical liability among policymakers.[1] We have proposed Medicare-led malpractice reform that would provide Medicare beneficiaries with better safety, improved communication in the event of error, preservation of therapeutic relationships, timely settlement, and fair compensation at a lower administrative cost.[2] Disputes in the reformed system would be adjudicated by Medicare's existing administrative appeals system that would work together with Medicare's quality improvement regulation and payment policy to reduce errors and compensate injured patients.

Despite the laudable rationale for Medicare-led malpractice reform, important issues attend the constitutional and statutory authority for such reform. The first issue, assuming legal authority exists, is the feasibility of Medicare-led malpractice reform. Quite simply, does the Medicare program, with the primary purpose of providing acute care services to the elderly, severely disabled, and people with end stage renal disease, have the requisite infrastructure to launch such reform without compromising its central functions? Second, does the federal Congress and/or the Executive Branch, in our constitutional scheme, have the requisite authority to establish Medicare-led malpractice reform especially when states have and always have had the authority to adjudicate medical malpractice in the common law tort system?

This article explores these critical issues for Medicare-led malpractice reform. First, this article explores the infrastructure of the Medicare program and how it could accommodate Medicare-led malpractice reform without compromising its central mission. Second, the article briefly describes the elements of a Medicare malpractice adjudication and compensation system for Medicare beneficiaries. Third, the article explores the legal authority for a federal benefits program to supplant a function performed by state common law of torts in the civil judiciary and

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1. *See* JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS, SETTING THE STANDARD: THE JOINT COMMISSION AND HEALTHCARE SAFETY AND QUALITY 12 (2005), http://www.jcaho.org/accredited+organizations/patient+safety/setting_the_standard.pdf. *See generally* INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001); INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999).

2. William M. Sage & Eleanor D. Kinney, *A Malpractice System for Medicare*, *in* MEDICAL MALPRACTICE REFORM IN THE UNITED STATES: NEW CENTURY, DIFFERENT ISSUES (William M. Sage & Rogan Kersh, eds. 2006).

generally with jury trials. Finally, the article concludes with an assessment of the legal and practical feasibility of Medicare-led malpractice reform.

I. RATIONALE FOR REFORM

There are two major reasons to support Medicare-led malpractice reform. First, such reform connects malpractice policy to health policy thus bringing new considerations and dimension to consideration of malpractice reform. Second, Medicare beneficiaries are poorly served by the common law tort system and deserve better.

Medical malpractice policy has been in suspended animation for decades. Non-academic proponents of reform have hardly budged in their recommendations since 1975, and opponents have countered those proposals without offering promising alternatives.[3] The principal cause of stagnation is that medical malpractice policy has never been connected to overall health policy. In particular, the Medicare and Medicaid programs—which have shaped health policy and molded health politics since the 1960s—have never been engaged in malpractice reform. Because malpractice has not been connected to overall health policy, the politics of medical liability has been co-opted by the politics of general (non-medical) tort reform. Policy debates focus on how lawsuits destroy or preserve America's economy and social fabric, and not on reasoned discussion of the effect of liability on the quality, cost and availability of medical care.[4]

Having Medicare play a principal role could dramatically change the politics of medical malpractice. Framing liability reform around Medicare shifts power from legislative committees primarily concerned with the judicial system to committees primarily concerned with the health care system. Medicare-led malpractice reform also may recruit new political voices, such as the American Association of Retired Persons, that have a greater stake in health care generally and Medicare specifically than the general business and "consumer" lobbyists who currently control the debate. Finally, as occurred twenty years ago with respect to provider

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3. *See generally* Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF. W4-20 (2004), *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1; Eleanor D. Kinney, *Malpractice Reform in the 1990's: Past Disappointments, Future Success*, 20 J. HEALTH POL., POL'Y & L. 99 (1995).

4. *See generally* ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERV., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf.

payment reform, it is highly likely that a successful Medicare malpractice initiative can be leveraged into system-wide reform as private payers and health care providers—particularly hospitals—realize the advantages of a uniform approach to managing medical errors.

Second and perhaps more importantly, conventional medical malpractice law serves Medicare beneficiaries poorly. There is persuasive evidence that injured aged or disabled individuals are less likely than other patients to obtain compensation in the existing common law tort system.[5] In its review of the literature to date as well as independent analysis of empirical data, the U.S. Government Accountability Office (GAO) found that hospital malpractice awards paid on behalf of Medicare and Medicaid patients account for a relatively small share of total hospital malpractice losses.[6] Further, the GAO also found that Medicare and Medicaid patients received awards half as large as privately insured patients when they were successful.[7]

More recent studies have confirmed these findings.[8] Burstin and colleagues found that poor patients, uninsured patients and the elderly were significantly less likely to file malpractice claims. Similarly, in the study of claims in Utah and Colorado, Studdert and colleagues found that non-claimants with medical injuries were more likely to be Medicare recipients, Medicaid recipients and greater than seventy-five years of age. These investigators concluded that the elderly may be said to suffer a kind of "double jeopardy" because they also experience higher rates of medical injury.[9]

II. WHY ADMINISTRATIVE REFORM THROUGH MEDICARE MAKES SENSE

An administrative alternative to medical malpractice litigation linked to quality oversight and improvement attracted widespread support in the late

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5. *See* GAO, LEAFLET NO. GAO-93-126, MEDICAL MALPRACTICE: MEDICARE/MEDICAID BENEFICIARIES ACCOUNT FOR A RELATIVELY SMALL PERCENTAGE OF MALPRACTICE LOSSES 2-3 (1993); U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, DO MEDICAID AND MEDICARE PATIENTS SUE PHYSICIANS MORE OFTEN THAN OTHER PATIENTS? 3, 12 (1992).

6. GAO, *supra* note 5, at 3.

7. *Id.* at 14 (citing GAO, LEAFLET NO. GAO-87-55, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 51 (1987)).

8. Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1699-1700 (1993).

9. David M. Studdert et al., *Negligent care and malpractice claiming behavior in Utah and Colorado*, 38 MED. CARE 250 (2000).

1980s.[10] However, interest in comprehensive reform waned as malpractice insurance markets recovered and physicians' political attention turned to managed care. There remains interest in state-level systems of administrative compensation, perhaps connected to health care regulation, but little progress has been made to date.[11]

We believe that administrative reform could be launched through the Medicare program at the federal level.[12] Our proposed reform would use existing Medicare infrastructure to adjudicate claims involving Medicare beneficiaries in a manner that would both improve compensation for injury and encourage performance improvement.[13]

Medicare has an extensive administrative structure in place that could be used to implement Medicare-led malpractice reform. Medicare has the authority to require health care institutions to implement quality improvement strategies.[14] Medicare has a nationwide network of contractors that administer the Medicare program, which includes managing claims for coverage and payment and conducting medical and quality reviews of care for Medicare beneficiaries.[15] Medicare operates various programs aimed at ensuring and improving the quality of health care for beneficiaries.[16] Finally, Medicare has an independent administrative appeals system to adjudicate disputed cases.[17]

This infrastructure gives Medicare the ability to proactively detect and disclose unanticipated events rather than waiting passively for lawsuits to be filed and pursued. Thus, a Medicare-based system could enable malpractice reform that identifies and resolves potential and actual claims earlier and in a more congenial and efficient manner from the perspective of beneficiaries, providers and malpractice carriers.[18] These features enable

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10. *See generally* COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS (Physician Insurers Ass'n of America eds., 1989); AMA/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED ADMINISTRATIVE SYSTEM (1988); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1989). *See generally* Kinney, *supra* note 3.

11. *See generally* Thorpe, *supra* note 3.

12. *See generally* Sage & Kinney, *supra* note 2.

13. *Id.*

14. *See infra* notes 25-30 and accompanying text.

15. *See infra* notes 37-45 and accompanying text.

16. *See infra* notes 53-69 and accompanying text.

17. *See infra* notes 70-104 and accompanying text.

18. *See* David M. Studdert et al., *Can the United States Afford a No-Fault System for Medical Malpractice?* 60 LAW & CONTEMP. PROBS. 1 (1997).

a Medicare-led malpractice reform to connect the handling of individual injury claims to other initiatives currently under way within the Medicare program and to important health policy issues affecting that program.

III. PRACTICAL FEASIBILITY

The Medicare program's highly developed quality assurance infrastructure, which includes medical review in several contexts, as well as its administrative appeals system, makes the Medicare program an attractive venue for malpractice reform. One of the unique characteristics of the infrastructure of the Medicare program is that it is comprised primarily of different private organizations throughout the nation that contract with the Medicare program to perform specific functions. Thus, there is no monolithic federal bureaucracy that manages the program. Rather, the Centers for Medicare and Medicaid Services (CMS), the agency responsible for the Medicare and Medicaid programs within the Department of Health and Human Services (HHS), sets policy for the Medicare program and relies on its contractors to implement the policies at the state and local level. Thus, Medicare beneficiaries and providers are actually dealing primarily with contracts comprised of local and known personnel regarding the day-to-day operation of the Medicare program. These various contractual relationships that are the foundation of the Medicare infrastructure are described below.

A. MEDICARE CONTRACTS WITH SERVICE PROVIDERS

To participate in the Medicare program, institutional providers and prepaid health plans contract directly with the Medicare program and meet specific contractual requirements.[19] Also, Medicare has a contractual relationship with the physicians and suppliers serving Medicare beneficiaries by virtue of an assignment arrangement described below.[20] The contractual relationships with providers and practitioners described below are the foundation upon which any initiative to improve the quality of care for Medicare beneficiaries is predicated.

19. *See infra* notes 21-27 and accompanying text.
20. *See infra* notes 31-35 and accompanying text.

1. Medicare Contracts with Institutional Providers

The Medicare statute defines the specific types of health care institutions that can provide services to Medicare beneficiaries and defines the conditions upon which these institutions can participate in the Medicare program. CMS and its predecessors have promulgated regulations setting forth the so-called "conditions of participation" for each type of health care institution. The major health care institutions covered are hospitals,[21] extended care facilities[22] and home health agencies,[23] and ambulatory surgery centers.[24]

Any institution that wants to serve Medicare beneficiaries and thereby "participate" in the Medicare program has to enter into a contract with the federal government.[25] Contractual conditions include the specific conditions of participation that define the basic characteristics of the health care institutions needed to assure high quality care. An important issue discussed below[26] is the latitude available to the federal government to impose conditions on health care institutions that voluntarily contract with the federal government to serve Medicare beneficiaries. The Medicare statute explicitly states that that the Medicare program can impose conditions on participating hospitals: "The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals."[27]

The Medicare program has historically taken this mandate quite literally and imposed important quality improvement measures on hospitals as part of the conditions of participation. Most recently, Medicare modified its conditions of participation for hospitals to require hospitals to institute a so-called Quality Assessment and Performance Improvement (QAPI) program.[28] The new QAPI program provision focuses on "the

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21. The Health Insurance for the Aged Act, 42 U.S.C. §§ 1395x(b), 1395x(e) (2000). *See* Conditions of Participation for Hospitals, 42 C.F.R. §§ 482.11-.57 (2000).

22. 42 U.S.C. § 1395i-3 (2000); 42 U.S.C. § 1396r (2000). *See* Conditions of Participation for Extended Care Facilities, 42 C.F.R. §§ 483.1-.75 (2000).

23. 42 U.S.C. § 1395bbb(a) (2000). *See* Conditions of Participation for Home Health Agencies, 42 C.F.R. §§ 484.10-.55 (2000).

24. 42 U.S.C. § 1395k(a)(2)(F)(i) (2000). *See* Conditions of Participation for Ambulatory Surgery Centers, 42 C.F.R. § 482.51 (2000).

25. 42 U.S.C. § 1395z (2000).

26. *See infra* notes 28-47 and accompanying text.

27. 42 U.S.C. § 1395x(e) (2000); 42 C.F.R. § 482.1(a)(ii) (2005).

28. Medicare and Medicaid Programs: Hospital Conditions of Participation: Quality Assessment and Performance Improvement, 68 Fed. Reg. 3435 (Jan. 24, 2003) (to be

continuous improvement of the hospital as an organization requiring hospitals to track incidents, analyze their causes, and share and implement preventive actions and mechanisms of feedback and learning throughout the facility."[29] Specifically, the rule states the following mandate for the QAPI program:

> The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.[30]

This program requires hospitals to systematically examine quality on an ongoing basis and implement some of the patient safety strategies that have developed in recent years.

2. Medicare's Relationship with Physicians

Medicare's relationship with physicians is quite different. Theoretically, the Medicare program does not contract directly with physicians for their services to Medicare beneficiaries. Rather, Medicare's relationship is with the beneficiary enrolled in Medicare's Part B Supplementary Medical Insurance program.[31] Medicare only has a formal relationship if the physician actively accepts the assignment of the beneficiary's claim for payment under the Medicare program.[32] If a

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codified at 42 C.F.R. pt. 482). *See* Medicare and Medicaid Programs; Hospital Conditions of Participation; Provider Agreements and Supplier Approval, 62 Fed. Reg. 66,726 (proposed Dec. 19, 1997) (to be codified at 42 C.F.R. pts. 416, 482, 485 and 489).

29. 68 Fed. Reg. 3453 (Jan. 24, 2003) (to be codified at 42 C.F.R. pt. 482).

30. *Id.* at 3454. (to be codified at 42 C.F.R. pt. 482.21).

31. 42 U.S.C. § 1395u(b)(3)(c) (2000).

32. *Id.* § 1395cc (defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services).

physician accepts assignment, the physician must accept Medicare payment as full payment for the services in the claim.[33]

However, over the years, mainly in an effort to gain control over the inflation in physician payment, the Medicare program has made it extremely difficult for physicians to serve Medicare beneficiaries and not accept assignment. In 1989, Congress established a new fee schedule for physician services. Specifically, the Omnibus Budget Reconciliation Act, implemented in 1992, introduced a Resource-Based Relative Value Scale (RBRVS) to reform Medicare physician payment and align it more closely with resources used by particular physician specialties for the care of Medicare patients with specific conditions.[34] Further, the act required physicians to submit bills to Medicare on behalf of Medicare patients and greatly limited the degree to which physicians could charge beneficiaries for fees in excess of Medicare payment levels.[35] These provisions made it highly advantageous for physicians to accept assignment for all Medicare claims. Thus, as a practical matter, Medicare does have a direct contractual relationship with most physicians through the mechanism of assignment.

3. Medicare Contracts with Carriers for Medicare Administration

The Medicare program was intentionally designed from its inception to relate to providers through private insurance carriers regarding coverage and, particularly, payment matters. Indeed, Medicare is organized like the Blue Cross and Blue Shield plans that were the predominant source of private hospital and medical insurance at the time of its inception.[36] Part A (hospital insurance) is analogous to a traditional Blue Cross plan and Part B

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33. *Id.* § 1395hh.

34. Omnibus Budget Reconciliation Act of 1989 § 6102, Pub. L. No. 101-239, 103 Stat. 2111, 2169 (codified as amended at 42 U.S.C. § 1395w-4(a)).

35. *Id.* § 5201 (codified as amended at 42 U.S.C. § 1395u(b)(4)(E)).

36. PETER CORNING, THE EVOLUTION OF MEDICARE: FROM IDEA TO LAW (1969); THEODORE R. MARMOR, THE POLITICS OF MEDICARE (2d ed. 2000) (noting that the Medicare bill included two related insurance programs to finance substantial portions of the hospital and physician expenses incurred by Americans over the age of sixty-five); ROBERT J. MYERS, MEDICARE (1970) (explaining that the enactment of Medicare provided extensive coverage against the costs of medical care for persons aged sixty-five or over); HERMAN MILES SOMERS & ANNE RAMSAY SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS (1967).

(supplementary medical insurance) is analogous to a traditional Blue Shield plan.[37]

Today, working with the Blue Cross and Blue Shield Association, the Medicare program contracts with Blue Cross plans to act as fiscal intermediaries between hospitals and the Medicare program for purposes of paying and otherwise managing claims for hospital and other services paid under Part A of the Medicare program.[38] Medicare also contracts with Blue Shield plans and other insurance companies to operate as carriers to pay and otherwise manage claims for physicians and other outpatient services under Part B of the Medicare program.[39] Fiscal intermediaries and carriers are expected to operate with providers just as private Blue Cross and other private insurance plans would operate.[40]

4. Medicare Contracts with Medicare Advantage Health Plans

Medicare's relationship with health maintenance organizations (HMOs) and other health plans that serve Medicare beneficiaries is entirely contractual and voluntary. Again, the Medicare statute and regulations impose a variety of conditions on HMOs and other health plans that they must meet to provide care to Medicare beneficiaries.[41] In addition to payment terms, these contracts require health plans participating in the Medicare Advantage program (formerly called Medicare+Choice) to serve Medicare beneficiaries that choose to enroll in the health plan, as opposed to receiving their benefits and health care through the traditional fee-for-service Medicare program.[42]

Each Medicare Advantage organization that offers one or more Medicare plans must have an ongoing quality assessment and performance improvement (QAPI) program for each plan.[43] Federal regulations establish the QAPI requirements that sponsoring organizations must meet.[44] Given the pressures of implementing the Medicare Modernization Act

37. *See* 42 U.S.C. § 1395c (2000) (describing Part A); *id.* § 1395j (describing Part B). *See* SYLVIA LAW, BLUE CROSS: WHAT WENT WRONG? (2d ed. 1976)

38. *See* 42 U.S.C. § 1395d(a) (2000) (describing scope of benefits and services paid under Part A).

39. *Id.* § 1395u.

40. *Id.*

41. 42 U.S.C. § 1395w-21 (2000). *See also* 42 C.F.R. § 489 (2004) (enumerating provider agreements and supplier approval).

42. 42 U.S.C. § 1852e (2000); 42 C.F.R. § 422.2 (2004).

43. 42 C.F.R. § 422.152 to -.159 (2004).

44. *Id.*

(MMA), CMS decided that Medicare Advantage organizations did not need to implement a national QAPI project in 2005.[45]

B. MEDICARE REGULATION OF THE QUALITY OF HEALTH CARE SERVICES

Immediately after the inception of the Medicare program, Medicare expenditures began rising at an alarming rate.[46] In 1969, out of concern for escalating costs in the program, Congress required utilization review of hospital services,[47] and began Medicare's express responsibilities regarding the volume and quality of care of Medicare beneficiaries.

1. The Professional Standards Review Organization Program

In 1972, finding utilization review by hospitals ineffective,[48] Congress inaugurated the Professional Standards Review Organization (PSRO) program.[49] This program required the Medicare program to contract with independent physician-dominated organizations to review the utilization of health care services for Medicare beneficiaries. Pursuant to statute, services to Medicare beneficiaries would be paid under the following circumstances:

> (1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized

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45. Memorandum from Cynthia Moreno, Director, Health Plan Benefits Group, to Medicare+Choice/Medicare Advantage Organizations on Selection of 2005 QAPI project focus (March 3, 2004).

46. Marian Gornick et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, 6 HEALTH CARE FIN. REV. 13, 14 (1985); Margaret H. Davis & Sally T. Burner, *Three Decades of Medicare: What the Numbers Tell Us*, 14:4 HEALTH AFF. 231, 231-243 (1995) (showing data that Medicare spending had increased to forty-five percent of the nation's total elderly health care bill by 1969).

47. Social Security Amendments of 1972, Pub. L. No. 92-603, § 201(a)(2), 86 Stat. 1371 (codified as amended at 42 U.S.C. § 1395x(k)).

48. S. REP. NO. 92-1230, at 254 (1972).

49. Social Security Amendments of 1972, Pub. L. No. 92-603, § 249F, 86 Stat. 1329 (codified as amended at 42 U.S.C. §§ 1320c-1 to c-19).

> health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.[50]

This program was extremely unpopular with the medical profession and health insurers as an improper interference into medical practice.[51] In 1981, the Reagan Administration and Congress repealed the program apparently in response to concerns from the medical profession about the program's intrusiveness into medical practice.[52]

2. The Medical Utilization and Quality Control Program

In 1982, Congress, in preliminary legislation to support the move to prospective payment for hospitals, established the Medical Utilization and Quality Control program.[53] This program established Peer Review Organizations (PROs) to review the utilization of services provided to Medicare beneficiaries to ensure that they were medically necessary and met professionally recognized standards of quality. Congress adopted this program in preparation for a new prospective payment system for hospitals to counter anticipated and undesirable incentives for excessive hospital

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50. 42 U.S.C. § 1320c (2000).

51. *See Social Security Amendments of 1972: Hearing on H.R. 1 Before the S. Comm. on Finance,* 92d Cong. 2282 (1972) (statement of Richard M. Loughery, Administrator of the American Hospital Center on behalf of the American Hospital Association, acknowledging the intended goal of PSRO's but warning that "it would be a great mistake to establish a programs of such magnitude on a nationwide basis without carefully organized demonstrations or experiments to ascertain the results of such a program, the administrative problems, and the effects on the delivery of quality medical care, as well as the cost involved"). *See also id.* at 2746 (statement of Bernard R. Tresnowski, Senior Vice President for Federal Programs, Blue Cross Association, expressing "reservations about any one form of peer review fitting the entire country"); *id.* at 2645 (statement of Thomas Dorrity, M.D., President of the Association of American Physicians and Surgeons, criticizing the federal government for failing to "heal its own sickness of uncontrolled spending, which is its responsibility, instead of interfering in medical care, where it is incompetent and has no proper responsibility").

52. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2111-14, 95 Stat. 793 (codified as amended at 42 U.S.C. § 1320 (2000)).

53. Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 1511, 96 Stat. 383 (codified as amended at 42 U.S.C. § 1320c (2000)). *See* Timothy Stoltzfus Jost, *Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations*, 50 OHIO ST. L.J. 1, 5 (1989); Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 590 (1988).

admissions for Medicare beneficiaries under the new system. In 2002, CMS, pursuant to regulation, changed the name of PROs to Quality Improvement Organizations (QIOs) to reflect the new responsibilities placed upon PROs in 2001 to provide comparative information on nursing homes and hospitals.[54]

The authority for CMS to contract with QIOs and implement this program is based on the section of the Medicare Act establishing coverage criteria for the Medicare program.[55] Specifically, Section 1395y(g) provides that the Secretary, in making determinations of whether items or services meet coverage criteria and "for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services," "shall" enter into contracts with utilization and quality control peer review organizations.[56]

The powers of QIOs are broad. QIOs can retrospectively deny Medicare payment for services not meeting their utilization or quality standards.[57] The PRO can also initiate proceedings before the Office of the Inspector General (OIG) in HSS to fine or exclude a provider or practitioner from receiving payment under the Medicare program if they are found guilty of gross and flagrant violations of their obligation to provide care of acceptable quality, or are guilty of substantial violations in a substantial number of cases.[58] In 1986, Congress also required PROs (now QIOs) to review all written complaints about the quality of services not meeting professionally recognized standards of health care.[59] Today, a national network of fifty-three QIOs, located in each state, territory and the District of Columbia, review the provision of Medicare services in hospitals and other health care institutions.[60]

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54. Office of Inspector General-Health Care; Medicare & Medicaid Programs; Peer Review Organizations: Name and Other Changes-Technical Amendments, 67 Fed. Reg. 36,539 (May 24, 2002) (to be codified at 42 C.F.R. ch. IV & V) (changing name to "quality improvement organizations").

55. 42 U.S.C. § 1395y (2005).

56. *Id.* § 1395y(g).

57. *Id.* § 1320c-3(a)(2).

58. *Id.* §§ 1320c-5(b)(1) & (2)

59. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 (1986) (codified as amended at § 1320c-3(a)(14)).

60. Centers for Medicare & Medicaid Services, Quality Improvement Organizations Overview (2005), http://www.cms.hhs.gov/qio/default.asp.

3. Federal Quality Initiatives for the Health Care Sector

In recent years, CMS has launched specific quality initiatives for the major classes of providers, which involve the collection of data on quality measures and implementation of strategies to improve quality.[61] Specifically, HHS has engaged in a number of initiatives to prevent medical injury and improve the safety of Medicare beneficiaries in hospitals, other institutional providers, and Medicare health plans.

The initiatives for hospitals and health plans are especially important to a proposal for Medicare-based malpractice reform. In CMS' Hospital Quality Initiative, CMS works with the Hospital Quality Alliance (HQA), which includes the American Hospital Association and other key stakeholders with the support of Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), among other organizations.[62] Through this initiative, CMS has developed a standardized set of hospital quality measures for use in voluntary public reporting. As part of this initiative, CMS has launched the website *Hospital Compare* to provide information on the comparative performance of hospitals on health care quality.[63]

Another important project in the Hospital Quality Initiative is the Premier Hospital Incentive Demonstration.[64] This demonstration recognizes and provides financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care. The performance of participating hospitals will be posted at www.cms.hhs.gov for health care professionals. CMS selected Premier it is able to track and report data on quality measures for each of its hospitals.[65]

Similar quality initiatives are underway for health plans participating in the Medicare program. As discussed above, each participating Medicare

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61. Centers for Medicare & Medicaid Services, Quality Initiatives-General Information (2005), http://www.cms.hhs.gov/QualityInitiativesGenInfo.

62. CENTERS FOR MEDICARE & MEDICAID SERVICES, HOSPITAL QUALITY INITIATIVE OVERVIEW (2005), http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalOverview200512.pdf.

63. *See* U.S. Dept. of Health and Human Serv., Hospital Compare-A Quality Tool for Adults, Including People with Medicare, www.hospitalcompare.hhs.gov (last visited Feb. 7, 2006).

64. CENTERS FOR MEDICARE & MEDICAID SERVICES: REWARDING SUPERIOR QUALITY CARE: THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION (2005), http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalPremierFactSheet.pdf.

65. *Id.*

health plan organization must have a QAPI program in place.[66] However, at this point in time, CMS is engaged in launching the Medicare Advantage program, which has diverted attention from quality initiatives. Also, as noted above,[67] CMS has promulgated a rule instructing hospitals to develop and implement quality improvement programs to identify patient safety issues and reduce medical errors in hospitals.

Medicare also launched the National Health Information Infrastructure, a comprehensive knowledge-based network to enhance clinical decision making by providing health information when and where it is needed, with the ambitious goal of improving the efficiency, effectiveness and overall quality of health care in the United States.[68] The Food and Drug Administration (FDA), also part of HHS, promulgated a rule to reduce medication errors by requiring bar coding of drugs used in hospitals and by instituting safety reporting requirements for drugs and biologics.[69]

C. THE MEDICARE BENEFICIARY APPEALS SYSTEM

The Medicare program operates a national administrative appeals system to adjudicate disputes between Medicare beneficiaries and the program. As most beneficiary disputes involve coverage of Medicare benefits, all appeals processes have an independent medical review component that marshals medical expertise on disputed medical issues. These procedures could be adapted for use in resolving disputes over medical injury.

1. Appeal Proceedings before Medicare Contractors

There are separate systems in place for the preliminary management of appeals for each part of the Medicare program. Since 2000, the beneficiary appeals systems for Parts A and B, so-called "fee-for-service" Medicare,[70] and Part C, Medicare's longstanding HMO program (now called Medicare Advantage) all have grievance systems with independent medical review.

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66. 42 C.F.R. § 482.21 (2005). *See* 42 C.F.R. pt. 489 (2005). *See also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 61.

67. 42 C.F.R. § 482.21 (2005)

68. U.S. Dept. of Health and Human Serv., The National Health Information Infrastructure, http://aspe.hhs.gov/sp/nhii/ (last visited Feb. 7, 2006).

69. 21 C.F.R. § 201.25 (2005).

70. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, 42 U.S.C. § 1395ff (2000); Medicare Program: Changes to the Medicare Claims Appeal Procedures, 70 Fed. Reg. 11,420 (Mar. 8, 2005) (to be codified at 42 C.F.R. pts. 401 and 405).

Part D, the new Medicare prescription drug benefit, also has a grievance system that is integrated into Part C's system if the beneficiary's appeal involves a Medicare Advantage plan's action. For all parts, there is a common administrative appeals system within CMS and judicial review in federal district court.

In recent years, Congress and CMS have reformed the Medicare appeals process in important respects and in response to widespread criticism of the prior procedures.[71] Several of the reforms facilitate the potential use of the Medicare appeals process in the adjudication of malpractice claims. First, the reformed process for fee-for-service Medicare has incorporated independent medical review at the state level and independent review for Medicare Advantage and Prescription Drug Plans on a national or regional level. Second, Congress has statutorily insulated the administrative review of all appeals from CMS policy makers who have historically sought to influence appeal outcomes in favor of saving funds. The only barrier is problems with the implementation of these reforms given the financial and resource constraints on CMS.[72]

a. Fee-For-Service Medicare

Congress established the current appeals process for Part A and Part B beneficiary appeals in 2000.[73] The appeal is based on a denied claim for coverage and/or payment submitted to a Medicare contractor—fiscal intermediaries in the case of Part A and carriers in the case of Part B. With respect to a claim, the contractor makes an initial determination on coverage and/or payment.[74] If the beneficiary is dissatisfied with the initial determination, the beneficiary can seek a redetermination by the Medicare contractor.[75]

Independent review is available for reconsideration of the contractor's determination before a qualified independent contractor (QIC), independent organizations comprised of panels of physicians and other health care professionals.[76] Professional panels for medical review must have the

71. *See Medicare Appeals Processes: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 105th Cong. (1998). *See generally* Eleanor D. Kinney, *Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology?*, 60 WASH. & LEE L. REV. 1461, 1465-66 (2003).

72. GAO, LEAFLET NO. GAO-03-836, MEDICARE APPEALS: DISPARITY BETWEEN REQUIREMENTS AND RESPONSIBLE AGENCIES' CAPABILITIES (2003).

73. *See supra* note 71 and accompanying text.

74. 42 U.S.C. § 1395ff(a) (2000); 42 C.F.R. §§ 405.920-.928 (2005).

75. 42 U.S.C. § 1395ff(b) (2000); 42 C.F.R. §§ 405.940-.958 (2005).

76. 42 U.S.C. § 1395ff(c) (2000); 42 C.F.R. §§ 405.960-.978 (2005).

requisite expertise to judge the clinical experience and the medical, technical and scientific evidence associated with the appeal.[77] The QIC's written reconsideration decision must include a detailed explanation of the decision, a discussion of the pertinent facts and regulations, and, where the issue is reasonable and necessary services, an explanation of the scientific rationale.[78] QIOs are also required to maintain a database on their decisions that will essentially permit analysis of the medical issues in the cases.[79]

This process before Medicare contractors is important. Before there is even administrative review before an ALJ, the Medicare appeals system provides for independent medical review of any medical issues involved in an appeal. This infrastructure is invaluable for Medicare-led malpractice reform because it provides an informal medical review of medical issues before the initiation of more legalistic proceedings.

b. Medicare Advantage and Prescription Drug Plans

The appeals system for the Medicare Advantage program is the same as the Medicare+Choice program with some additions.[80] All Medicare Advantage plans must have "meaningful grievance procedures" to adjudicate beneficiary complaints with the health plan.[81] Because "claims" *per se* are not submitted in prepaid health plans, the precipitating event for an appeal can be any adverse action against a Medicare beneficiary—although most appeals involve denials of treatment on coverage grounds.[82] The plan must also afford beneficiaries a hearing in its grievance process.

External review for reconsiderations of the plan's final determination is available before an independent entity.[83] These entities are required to have medical expertise available for their reviews involving medical issues.[84]

The appeals process for the prescription drug benefit is the same as for Medicare Advantage plans because they administer the Medicare

77. 42 U.S.C. § 1395ff(c)(3)(A) (2000).

78. *Id.* § 1935ff(c)(3)(E); 42 C.F.R. § 405.982 (2005).

79. 42 U.S.C. § 1395ff(c)(3)(I) (2000).

80. *Id.* §§ 1395w-22(f), 1395w-22(g); 42 C.F.R. § 422.560 (2005).

81. 42 U.S.C. § 1395w-22(f) (2000); 42 C.F.R. § 422.564 (2005).

82. *See* Jennifer E. Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J.L. & MED. 61, (1996); Eleanor D. Kinney, *Medicare Managed Care from the Beneficiary's Perspective*, 26 SETON HALL L. REV. 1163, 1179-80, 1183 (1996).

83. 42 U.S.C. § 1395w-22(g)(4) (2000); 42 C.F.R. §§ 422.578-.590, 422.594 (2005).

84. 42 U.S.C. § 1395w-22(g)(4) (2000); 42 C.F.R. § 422.590(g)(1) (2005).

prescription drug benefit for enrolled Medicare enrollees.[85] Prescription drug plans must have a similar appeals process with comparable steps, timetables and other characteristics for their fee-for-service Medicare beneficiaries.[86] To initiate an appeal, the beneficiary must request a coverage determination from the plan.[87] As with fee-for-service Medicare, the Medicare Advantage program provides for independent medical review of medical issues in an informal process before more formal administrative review proceedings.

2. Administrative Review for all Medicare Beneficiary Appeals

All beneficiaries, regardless of the part of Medicare in which their appeal is generated, are entitled to administrative review before a corps of administrative law judges (ALJs) within CMS.[88] In fee-for-service Medicare, the QIC becomes a party in the ALJ hearing and prepares information that is required for the appeal including, as necessary, an explanation of the issues and the relevant policies.[89] The beneficiary may appeal an ALJ decision to the HHS Departmental Appeals Board (DAB).[90] In the MMA, Congress redesigned the Medicare administrative appeals system, moving it from the Social Security Administration (SSA) to an independent office within HHS.[91] MMA also specified with unusual detail what the transfer plan should address.[92] The most important reform of the MMA is the required independence of ALJs from CMS and its contractors by locating Medicare ALJs in an office "organizationally and functionally separate" from CMS.[93] The ALJ office reports to the Secretary but "shall

85. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101(f)-(h), 17 Stat.2066 (2003) (to be codified at 42 U.S.C. § 1395w-101(f)-(h); 42 C.F.R. § 423.562 (2005)

86. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101(f)-(h), 17 Stat. 2066 (2003) (to be codified at 42 U.S.C. §1395w-101(f)-(h)).

87. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101(g), 17 Stat. 2066 (2003) (to be codified at 42 U.S.C. §1395w-101(g)).

88. 42 U.S.C. §§ 1395ff, 1395w-101(h) (2000).

89. *Id.* § 1395ff (b)(1)(a); 42 C.F.R. § 405 (2005).

90. 42 U.S.C. §§ 1395ff(b)(1)(a), 1395w-22(g)(5) (2000).

91. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 931, 17 Stat. 2066 (2003) (to be codified at 42 U.S.C. § 1935ff); Medicare Program: Changes to the Medicare Claims Appeal Procedures, 70 Fed. Reg. 11,420 (Mar. 8, 2005) (to be codified at 42 C.F.R. pt. 401 and 405).

92. 42 U.S.C. § 1395ff (2000).

93. *Id.*

not report to, or be subject to supervision by" any other officer within HHS.[94] The Secretary must also provide for an appropriate geographic distribution of ALJs performing ALJ functions throughout the U.S. to ensure timely access for beneficiaries.[95]

3. Judicial Review of Medicare Administrative Adjudications

Judicial review in federal district court is available for all claims under all parts of the Medicare program.[96] The standards for judicial review are those for the Social Security program appeals under Title II of the Social Security Act.[97] As to facts, the standard of review is whether the agency decision is supported by substantial evidence.[98] The court can order the agency to take new evidence if there is good cause for its prior exclusion under limited conditions. In addition, there are limits on the court's review of national coverage determinations that might be relevant in a malpractice case.[99] Specifically, the courts can invalidate CMS' coverage determinations, but must remand to the agency for revision rather than establishing a binding alternative as judicial precedent.

D. MEDICARE'S BENEFICIARY OMBUDSMAN PROGRAM

The MMA established within HHS a Medicare Beneficiary Ombudsman to assist Medicare beneficiaries with complaints, grievances and requests for information with respect to any aspect of the Medicare program including appeals from adverse determinations by Medicare contractors.[100] The ombudsman does not serve as an advocate for any increases in payments or new coverage of services but may identify issues and problems in payment or coverage policies.[101] Presumably, under a Medicare malpractice adjudication system, the ombudsman could play a key role in assisting beneficiaries in sorting out a claim for medical injury

94. *Id.*

95. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 931(a)(1)(I), 117 Stat. 2396 (2003) (to be codified at 42 U.S.C. § 1395ff).

96. 42 U.S.C. §§ 1395ff(b)(1), 1395w-22(g)(5) (2000). *See also id.* § 405(g) (availability of judicial review under the Social Security Act referenced in § 1395ff(b)(1) and § 1395w-22(g)(5)).

97. 42 U.S.C. § 405(g) (2000).

98. *Id.*

99. *Id.* § 1395ff(b).

100. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 923(a), 17 Stat. 2066 (2003) (to be codified at 42 U.S.C. § 1395b-9).

101. *Id.*

and putting beneficiaries in touch with the relevant personnel in a provider organization, health plan, and/or Medicare contractor that could assist with the resolution of the malpractice claim.

E. MEDICARE DEMONSTRATION AUTHORITY

Medicare frequently tests innovations through pilot programs and demonstration projects. Thus, HHS could, and probably should, launch Medicare-led malpractice reform initially in a demonstration before adopting it permanently. Specifically, CMS has general authority for demonstrations and studies regarding improvements in Medicare payment methodologies and other matters related to the operation of the Medicare program.[102] CMS is currently using this authority, for example, to launch a demonstration of reinsurance payment for prescription drug plans and Medicare Advantage organizations participating in the prescription drug benefit.[103] CMS also has specific authority under Section 646 of the MMA to offer "incentives to improve safety of care provided to beneficiaries" on a demonstration basis.[104]

IV. A VISION OF A MEDICARE MALPRACTICE ADJUDICATION AND COMPENSATION SYSTEM FOR MEDICARE BENEFICIARIES

The overriding concept of Medicare–led malpractice reform is to incorporate the resolution of medical injury claims into the infrastructure that addresses concerns about the quality and safety of medical services rendered to Medicare beneficiaries. Medical injuries already are included among the problems in patient care that the Medicare quality and safety infrastructure addresses.

This section outlines the specific steps that would be needed to include the resolution of medical injury claims into the quality and safety infrastructure of institutional health care providers and health plans.[105] Some components are substantive, including provider and beneficiary participation, triggering events, and safety and compensation outcomes.

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102. 42 U.S.C. § 1395ll (2000).

103. CMS, Medicare Program; Part D Reinsurance Payment Demonstration, 70 Fed. Reg. 9360 (Feb. 25, 2005).

104. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, § 646, 117 Stat. 2066 (2003) (codified as amended at 42 U.S.C. § 1395cc-3).

105. The material in this section has also been presented in Sage and Kinney, *supra* note 2.

Other components are procedural, involving presenting evidence, adjudicating liability and damages, and the effect of decisions.

It should be emphasized that what is proposed here is in line with other progressive thinking on malpractice reform today. Specifically, progressive thinking on reform includes linking the identification of medical injury through institutional quality assurance and patient safety promotion infrastructure with an associated early offer program to compensate injuries before litigation.[106] For example, perceiving that the current medical liability system thwarted its efforts to implement effective systems in health care organizations to improve patient safety, JCAHO has recommended fundamental reforms of the medical system. The proposed reform has three major strategies: (1) creation of alternative mechanisms for compensating injured patients such as through early settlement offers, (2) resolving disputes through a so-called "no-fault" administrative system or through health courts, and (3) shifting liability from individuals to organizations.[107]

A. SUBSTANTIVE COMPONENTS

The substantive components of a reform first must address how providers and beneficiaries would participate in the system and whether their participation would be mandatory or voluntary. If participation is mandatory, as discussed below, there are some important constitutional hurdles. If the program is voluntary, the design must be enticing to both beneficiaries and providers so that they will trust the system and participate in it throughout the resolution of the claim. In addition, there are lesser substantive issues such as the definition of triggering events for compensation, scheduling of damages and promoting patient safety.

Any system must be seen as an attractive alternative to the common law tort system for both providers and, more importantly, beneficiaries. Even if it were possible to mandate participation, cooperation would be limited and

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106. *See, e.g.*, Randall R. Bovbjerg, Robert R. Miller & David W. Shapiro, *Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety-and the Need for a Third Way*, 29 J.L. MED. & ETHICS 369 (2001); Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185 (1997); William M. Sage, *Putting the Patient in Patient Safety: Linking Patient Complaints and Malpractice Risk*, 287 JAMA 3003 (2003).

107. JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 12 (2005), http://www.jcaho.org/news+room/press+kits/tort+reform/medical_liability_exec_summary.pdf.

political pressure would mount for termination of the reform. Undeniably, the strong and imaginative trial bar in this country would challenge a mandatory regime that cut off access to the courts and tort system for medically injured individuals.[108] Thus, we have conceptualized participation of providers as a voluntary incentive system in which providers would only be able to participate if they had achieved certain achievements with respect to quality and safety.[109] For beneficiaries, we have sought to emphasize speed, ease and fairness of the resolution of the adjudication and compensation process as enticements to participate.[110]

1. Criteria for Including Institutional and Professional Providers

Currently, all health care providers do not have equal capacity to deliver high-quality care. Single-threshold forms of professional qualification with *pro forma* renewal[111] such as state licensing and specialty board certification of physicians, and multiple-year reviews with nearly universal passage[112] such as JCAHO accreditation of hospitals convey a perception of uniformity. However, with greater availability of data on provider performance on quality measures,[113] major differences among institutional providers and health plans have become evident. Further, such reporting is becoming standard practice. Reporting is already a

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108. *See* ERIC NORDMAN ET AL., MEDICAL MALPRACTICE INSURANCE REPORT: A STUDY OF MARKET CONDITIONS AND POTENTIAL SOLUTIONS TO THE RECENT CRISIS 47 (2004), http://www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf (draft report presented to the NAIC's Property and Casualty Committee on July 14, 2004 arguing that "[s]ince the costs of researching and arguing a medical malpractice case can be very large, awards available once caps are introduced may not, in some cases, cover even the costs associated with pursuing a claim."). *See also* Rachel Zimmerman, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1.

109. *See supra* notes 60-68 and accompanying text.

110. *See supra* notes 69-74 and accompanying text.

111. *See* REGULATION OF THE HEALTHCARE PROFESSIONS (Timothy S. Jost ed., 1997).

112. JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, 2006 COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (CAMH) (2005).

113. Health Security Act, H.R. 3600, 103d Cong. (1st Sess. 1993). *See President Clinton's Health reform Proposal and Health Security Act as Presented to Congress on October 27, 1993* (1993), in Medicare and Medicaid Guide (CCH) (Rep. No. 773, Nov. 1, 1993).

requirement for hospital accreditation by JCAHO[114] and health plan accreditation by the National Committee on Quality Assurance (NCQA).[115]

Further, institutional providers and health plans are fast acquiring the requisite infrastructure to implement Medicare-led malpractice reform. CMS now requires hospitals to have Quality Assessment and Performance Improvement (QAPI) programs as a condition of participation in Medicare,[116] and is promoting similar infrastructure to advance the quality and patient safety in Medicare Advantage plans.[117] This quality assurance and safety promotion infrastructure required by the Medicare program for hospitals and health plans[118] is described above.

In addition, JCAHO has refocused its accreditation standards on patient safety. Since 1996, JCAHO has operated a national voluntary adverse event reporting database,[119] and has used this database to develop and incorporate into its accreditation process a series of concrete goals, specifically National Patient Safety Goals and Requirements.[120] JCAHO accreditation standards advise health care organizations to disclose unexpected outcomes and adverse events to their patients through the responsible physician.[121]

Certainly, criteria and standards must be developed and established to determine the eligibility of providers and also health plans to participate in Medicare-led malpractice reform. These criteria should address: (1) the adequacy of the institution's quality assurance and patient safety promotion infrastructure to identify and respond to medical injuries; (2) the adequacy of medical liability insurance arrangements in terms of inclusion of relevant providers; and (3) the adequacy of past performance on quality and patient safety indicators. Eligibility criteria would favor integrated delivery systems, which are likely to include all of the relevant professionals under

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114. Joint Commission on Accreditation of Healthcare Organizations, Facts About Quality Check and Quality Reports (2004), http://www.jcaho.org/news+room/press+kits/quality+check1/facts.htm. *See supra* note 62 and accompanying text.

115. NCQA, What is NCQA Accreditation?, http://hprc.ncqa.org/aboutaccred.asp (last visited Feb. 7, 2006).

116. Medicare and Medicaid Programs; Hospital Conditions of Participation: Quality Assessment and Performance Improvement, 68 Fed. Reg. 3435 (Jan. 24, 2003) (to be codified at 42 C.F.R. pt. 482). *See supra* note 30 and accompanying text.

117. *See supra* notes 42-44 and accompanying text.

118. *See supra* note 30 and accompanying text.

119. *See* JCAHO, *supra* note 107, at 5.

120. Joint Comm'n on Accreditation of Healthcare Organizations, 2006 Joint Commission National Patient Safety Goals, http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm (last visited Feb. 7, 2006).

121. *See infra* note 141 and accompanying text.

their liability insurance and have well developed infrastructure for promoting and measuring quality of care and patient safety.

The criteria regarding participating physicians and other health professionals are important. For example, participation might be limited to hospitals that provide malpractice coverage for a set percentage such as fifty percent of their medical staffs. Participating providers should also follow identified clinical and informational "best practices" for safety and quality measured by such national data systems as HEDIS[122] and CAHPS/consumer information,[123] and other measures developed by organizations such as the National Quality Forum,[124] National Patient Safety Foundation,[125] and the Leapfrog group.[126]

The real challenge is how to bring physicians into a Medicare-led malpractice reform. And historically, physicians have obtained liability insurance independently of the hospitals in which they practice.[127] Indeed, responding to earlier crises in the affordability and availability of medical liability insurance, physicians even formed their own mutual insurance companies.[128] In the current crisis, by contrast, physicians have sought assistance with liability coverage from hospitals that have greater capital and financial resources.[129] There is no reason why these types of arrangements could not be used for Medicare-led malpractice reform.

Clearly, the circumstances must be carefully defined under which enterprises eligible for Medicare-led malpractice reform may bring independent physicians under their liability umbrella. In general terms, physicians would have to agree to participate fully in the quality assurance and patient safety promotion programs of the hospital or health plan. Specifically, physicians would have to agree to report, disclose and

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122. NCQA, The Health Plan Employer Data and Information Set (HEDIS), http://www.ncqa.org/Programs/HEDIS/ (last visited Feb. 6, 2006).

123. United States Department of Health and Human Services, Agency for Health care Research and Quality, Consumer Assessment of Health care Providers and Systems (CAHPS®), https://www.cahps.ahrq.gov/content/cahpsOverview/OVER_Intro.asp?p=101&s=1 (last visited Feb. 6, 2006).

124. National Quality Forum, http://www.qualityforum.org (last visited Feb. 6, 2006).

125. National Patient Safety Foundation, http://www.npsf.org (last visited Feb. 6, 2006).

126. The Leapfrog Group, http://www.leapfroggroup.org (last visited Feb. 6, 2006).

127. Charles M. Key, *Maintaining Professional Liability Insurance Coverage: Basics for the Careful Shopper*, 12 HEALTH L. 23, 23 (1999).

128. See James A McGuire, *Establishing a Self-Governed Insurance Program Through Captives and Mutuals: A Review of Medical Professional Liability Mutual*, 303 PLI/LIT 345, 347 (1986).

129. See Michelle M. Mello et al., *Hospitals' Behavior in a Tort Crisis: Evidence from Pennsylvania*, 22 HEALTH AFF. 225, 230-33 (Nov.-Dec. 2003).

remediate specific medical errors to improve collective performance at the institutional level. A useful analogy is "clinical integration" in antitrust law, a concept newly endorsed by the federal antitrust enforcement agencies as indicating that otherwise independent providers are not merely engaged in financial collusion but are working to offer a better quality product to patients.[130] Participating physicians caring for Medicare patients at participating hospitals also would be covered by a Medicare reform demonstration's malpractice rules with respect to outpatient services associated with the same episode of care.

An important question is how to make a reformed liability system sufficiently and immediately attractive to providers to encourage their voluntary participation. One important incentive would be a subsidy for medical liability insurance that would stabilize the cost of medical liability insurance for participating institutional and professional providers. Such a subsidy would be attractive because financial strains from rising liability premiums differ between physicians and hospitals. Specifically, physicians, at least in the most exposed specialties, struggle to maintain affordable primary coverage.[131] On the other hand, hospitals can self-insure routine litigation costs but must purchase excess layers of insurance that protect against the occasional case that generates a $10 million or $20 million damage award.[132] The cost of these layers is very volatile and may not be priced competitively.[133]

A federal subsidy in the form of direct federal reinsurance of hospital liability with appropriate corridors of shared risk for participating physicians (virtually impossible for individual physicians[134]) would be an excellent incentive to encourage participation. Federal reinsurance is already used in a variety of other contexts,[135] and has done much to

130. *See* Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products, FTC, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002). *See also* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration": An Analysis of the FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L.J. 223 (2003).

131. *See* Alec Shelby Bayer, *Looking Beyond the Easy Fix and Delving Into the Roots of the Real Medical Malpractice Crisis*, 5 HOUS. J. HEALTH L. & POL'Y 111, 118 (2005).

132. *See* William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH AFF. 10 (July-Aug. 2004).

133. *Id.*

134. *See* American Academy of Actuaries, *Medical Reinsurance: Considerations for Designing a Government-Sponsored Program*, ISSUE BRIEF (January 2005), http://www.actuary.org/pdf/health/reinsurance_jan05.pdf.

135. Terrorism Risk Protection Act of 2002, Pub. L. 107-297, 116 Stat. 2322 (to be codified at 15 U.S.C. § 6701). *See also* Agriculture Risk Protection Act of 2000, Pub. L. No. 106-224, 114 Stat. 358 (codified as amended at 7 U.S.C. § 1501); Homeowners' Insurance Availability Act of 1998, Pub. L. No. 105-216, 112 Stat. 897 (codified as

stabilize the cost of liability insurance for participating insureds.[136] Such reinsurance would be valuable in connection with Medicare-led malpractice reform because the reform will tend to surface more injuries eligible for compensation than the current tort system in addition to compensating those injuries more predictably.

2. Methods for Assuring Beneficiary Participation

Ideally, the Medicare demonstration would provide an exclusive administrative remedy for Medicare beneficiaries injured by medical care from participating providers and conventional state law tort claims would be preempted. However, for constitutional and practical reasons, making the reform truly mandatory for beneficiaries may be problematic. Specifically, there are constitutional questions about Congress' authority to cut off rights to a common law tort case before a jury.[137] Even if the Supreme Court were to uphold such a regime, there is enough doubt in current law[138] that dissatisfied beneficiaries could challenge the reform judicially and severely limit full implementation of the reform. Consequently, it is best to consider from the outset that the reform is ultimately voluntary for beneficiaries. However, its design would be such that beneficiaries would recognize the advantages of participation in terms of its efficiency and fairness of adjudication and compensation.

The question of "voluntariness" is particularly difficult to factor into a Medicare demonstration that tests the concept of Medicare-led malpractice reform. The evaluation component of any demonstration is crucial and selection bias is a major threat to a good evaluation. Specifically, if decisions to participate are non-random and claims channeled into administrative resolution are representative of neither events nor disputants,[139] the evaluation is compromised.

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amended at 12 U.S.C. § 4901); Federal Agricultural Improvement and Reform Act of 1996, Pub. L. No. 104-127, 110 Stat. 888 (codified as amended at 7 U.S.C. § 7201); DAVID CUMMINS & NEIL A. DOHERTY, FEDERAL TERRORISM REINSURANCE: AN ANALYSIS OF ISSUES AND PROGRAM DESIGN ALTERNATIVES (Jan. 22, 2002), http://irm.wharton.upenn.edu/S02-Cummins&Doherty.pdf; JAY HARWOOD & JAMES L. NOVAK, CROP INSURANCE AND DISASTER ASSISTANCE (2002), http://www.farmfoundation.org/2002_farm_bill/harwood.pdf.

136. *See* GAO, LEAFLET NO. GAO-03-195T, CATASTROPHIC INSURANCE RISKS-THE ROLE OF RISK-LINKED SECURITIES AND FACTORS EFFECTING THEIR USE (2002), http://www.gao.gov/new.items/d03195t.pdf.

137. *See infra* notes 194-67 and accompanying text.

138. *See infra* notes 194-67 and accompanying text.

139. *See* THE SAGE ENCYCLOPEDIA OF SOCIAL SCIENCE RESEARCH METHODS (Michael S. Lewis-Beck, Alan E. Bryman & Tim Futing Liao eds., 2003).

There are several ways to structure voluntary participation in a demonstration of a Medicare-led malpractice reform. Specifically, Medicare beneficiaries living in the geographic area served by participating hospitals could be given notice of the demonstration rules and could make a one-time election to proceed with any claims that arise through the Medicare appeals system instead of the common law tort system with subsequent opportunities to opt out for medical care not yet received. Or hospitals and physicians participating in the demonstration could notify existing patients that they will be asked to consent to adjudication of claims through the Medicare appeals system, and new patients could be asked to consent upon the initiation of care. Patients incapable of election or consent such as those receiving emergency services would retain their existing legal rights but might be offered an opportunity to enter the reformed system for follow-up care. Similarly, the system might allow patients to retain the ability to litigate in exceptional circumstances such as willful misconduct.

Obtaining beneficiary participation should not be problematic as there is much about Medicare-led malpractice reform to entice elderly and disabled Medicare beneficiaries to participate. Further, existing data already suggests that Medicare patients file fewer tort claims than younger patients relative to the injuries they suffer, receive less in damages both in average terms and in likelihood of a very large payout, and experience similar delays in payment.[140] Non-monetary benefits such as timely, honest disclosure of error and injury and a less adversarial process that permits therapeutic relationships with familiar physicians and hospitals to continue are also likely to be valued greatly by seniors and their families.

3. Medical Injury Event Detection and Disclosure

In a Medicare malpractice system, unlike the conventional tort system, patients would not be solely responsible for determining that they had a claim for medical injury. Rather, under Medicare-led reform participating providers would actively root out medical errors and facilitate compensation rather than assuming the reactive posture of conventional tort litigation. As discussed above,[141] participating hospitals and health plans would have in place some constellation of adverse event detection systems as a condition of participating in the reformed system. These patient safety monitoring systems would be modified to connect those processes to the

140. *See supra* note 9 and accompanying text.

141. *See supra* note 119 and accompanying text.

currently independent process for identifying medical injury, assessing damages and compensating patients. Similarly, reporting systems for medical errors such as those contemplated by recent federal legislation modeled on the Aviation Safety Reporting System[142] should be configured to capture categories of events potentially eligible for compensation.

Reform would also aim to improve how patients and families learn about medical errors. Participating providers would be required to notify beneficiaries quickly and fully in the event of serious error or injury. Although JCAHO merely urges but does not require notification of patients regarding medical errors,[143] the American Medical Association has stated that disclosure is ethically required of physicians and a handful of states mandate it for hospitals.[144] Pennsylvania's statute, which requires written disclosure within seven days, is a good model.[145] With disclosure mandatory, participating hospitals and physicians would have a strong interest in productive conversations that air concerns, relate information valuable for patient safety, and reach settlements in as many cases as possible.

Information derived from these activities would also feed into other Medicare programs. Unlike tort litigation, both dispute-related data and underlying clinical information would be available to quality regulators. If data on medical malpractice claims collected in a closed Medicare system were joined with data on Medicare beneficiaries collected in these other programs, much could be learned about the epidemiology of medical injuries.

4. Determining Liability and Designation of Compensable Events

Eligibility for and amount of payment are the key questions for any administration compensation system. It is generally accepted that the negligence-based standard of care used in tort litigation functions poorly. Conceptually, a finding of professional negligence denotes a departure

142. *See* Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-44, 119 Stat. 424 (codified as amended at 42 U.S.C. § 299).

143. JCAHO, *supra* note 107.

144. Editorial, *Medical Error and Ethics: A Call for Candor without Fear*, 46 AM. MED. NEWS 14 (July 21, 2005).

145. Medical Care Availability and Reduction of Error (MCare) Act, 40 PA. CONS. STAT. § 1303.308 (2002).

from customary and reasonable practice.[146] Because physicians often practice medicine unscientifically, relying on habit rather than clinical evidence,[147] this standard excuses substantial suboptimal care. At the same time, an accusation of negligence constitutes a personal affront and reputational threat that many physicians fiercely resist because it connotes egregious conduct that violates the norms of their professional community.[148] Also, proof of negligence in traditional tort cases is offered through expensive expert testimony that adds cost and delay to claim resolution.[149]

For these reasons, most advocates of administrative compensation favor a standard of "avoidability" or "preventability" judged by scientific experts.[150] Under designated events schemes, certain events are automatically compensable on the theory that their occurrence is almost always avoidable. These "accelerated compensation events," first developed by Bovbjerg and Tancredi, initially would be identified and updated by an expert process upon which a Medicare administrative review system would rely.[151] More recently, a forum of stakeholders has established a consensus list of events that should "never" happen in the provision of care.[152]

Medicare-led malpractice reform would use designated events schemes to determine liability without further consideration of fault. Early

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146. *See* Phillip G. Peters, *The Reasonable Physician Standard: The New Malpractice Standard of Care?*, 34 J. HEALTH L. 105 (2001); Phillip G. Peters, *Empirical Evidence and Malpractice Litigation*, 37 WAKE FOREST L. REV. 757 (2002).

147. *See* INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2000); Mark R. Chassin & Robert W. Galvin, *National Roundtable on Health Care Quality: The Urgent Need to Improve Health Care Quality*, 280 JAMA 1000 (1998).

148. William M. Sage, Kathleen E. Hastings & Robert A. Berenson, *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 19 (1994).

149. *Id.*

150. *See* David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001).

151. Lawrence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 L. & CONTEMP. PROBS. 147 (1991); Randall R. Bovbjerg, Lawrence R. Tancredi & Daniel S. Gaylin, *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836 (1991); AMERICAN BAR ASSOCIATION, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY (1979).

152. NATIONAL QUALITY FORUM, SERIOUS REPORTABLE EVENTS IN HEALTHCARE: A NATIONAL QUALITY FORUM CONSENSUS REPORT (2002).

disclosure and settlement could be rewarded in a way that is similar to the incentives that O'Connell and colleagues have proposed to identify claims early and encourage payers to make early offers and injured patients to accept those offers.[153] Upon the occurrence of a designated event, the provider would notify the patient of the event, report the event to the appropriate quality oversight bodies within Medicare and elsewhere, and offer compensation without contesting eligibility. There would be strict timetables for mediation and adjudication that would ensure prompt resolution. Where avoidability of the medical injury is contested, beneficiaries and providers could appeal to the relevant Medicare contractor for an initial determination and subsequently seek administrative review in the Medicare appeals system described above.[154]

This approach to determining liability would have one major advantage over the current tort system. Information about the incidence of serious injuries would be captured immediately and used for quality improvement purposes and also for epidemiological research on the incidence and characteristics of medical injury. As a result, providers and researchers would force the health care system to deal appropriately with both avoidable and unavoidable but serious injuries—a phenomenon that does not now occur in the adjudication of malpractice claims in tort.

5. Determining Damages and Calculating Compensation Awards

A Medicare-led malpractice reform would use a uniform and predictable method of determining damages and presumably would use prospectively established schedules. With respect to non-economic damages, reformers have long suggested scheduling damages as a means of bringing rationality and consistency to injury compensation in medical malpractice.[155] Medical injuries invoke the same issues as other statutory compensation schemes—the nature, severity and permanency of the injury.

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153. *See* Jeffrey O'Connell & Geoffrey P. Eaton, *Binding Early Offers as a Simple, If Second-Best, Alternative to Tort Law*, 78 NEB. L. REV. 858 (1999); Jeffrey O'Connell & James F. Neale, *HMO's Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287 (1998); Jeffrey O'Connell, *Offers that Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589 (1982).

154. *See supra* notes 70-79 and accompanying text.

155. *See, e.g.*, James F. Blumstein, Randall R. Bovbjerg & Frank A. Sloan, *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171 (1991); Randall R. Bovbjerg, Frank A. Sloan & James F. Blumstein, *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989).

Most public compensation programs administered by agencies award benefits pursuant to schedules that have already predetermined how much should be awarded for specific types and degrees of injury or illness.[156] When an acknowledged preventable event has occurred but the parties cannot agree on an appropriate payment, beneficiaries or providers could appeal to the relevant Medicare contractor and on to Medicare's administrative review process described above.[157]

The specifics of the elements of damages and their method of calculation are open to debate. Damages would likely include all provable economic damages such as lost wages (typically low for Medicare beneficiaries) and future medical expenses. Periodic payment of future medical expenses would be allowed. Compensation would also include lump-sum non-economic damages. The maximum amount of non-economic damages for the most severely and persistently injured could not exceed a preset figure. Also, any schedule would have to address the difficult issues of causation that often attend the evaluation of medical injuries in the elderly and disabled with their multiple medical conditions. Of note, the Medicare program could deal directly with medical costs by expanding benefits to injured patients and waiving subrogation rights against liable providers.

A final consideration is the threshold degree of injury that merits payment. An administrative compensation system could be swamped by small dollar claims. For this reason, proposals for "no-fault" compensation in medical malpractice typically include an injury threshold below which compensation is unavailable regardless of injury causation.[158] Moreover, because a Medicare-led malpractice system is proactive rather than reactive with respect to event detection, it will capture a much larger number of small claims than occurs in tort and can convey that information to institutional and regulatory quality improvement efforts.

B. PROCEDURAL FEATURES

Medicare has two principal procedural advantages over generic "medical courts" for resolving malpractice claims. First, Medicare can be proactive with respect to error and injury reporting rather than simply reacting to filed claims. Second, Medicare already has in place a tested system for adjudicating beneficiary disputes with the Medicare program

156. *See* Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L.J. 45, 65 (2005).

157. *See supra* notes 70-79 and accompanying text.

158. Sage, Hastings & Brennan, *supra* note 148.

onto which a malpractice adjudication system can be grafted. Still, critical procedural elements remain to be determined. These include (1) how a claim for medical malpractice as opposed to a claim for coverage or payment would be presented, (2) what parts of the current Medicare appeals system would be involved with adjudicating malpractice claims, and (3) how evaluating claims with respect to malpractice liability and damages would differ from evaluating benefits claims.

1. Initiation of Complaints through Grievance Resolution Process

As discussed above,[159] in most cases Medicare beneficiaries or their families would receive information about unanticipated outcomes of medical care from participating providers. Or beneficiaries and/or family members could raise concerns with the provider or health plan directly. Ideally there should be an identifiable office within the institutional provider or plan, already required for Medicare Advantage plans,[160] at which beneficiaries can lodge their grievances including perceptions of medical injury. In any event, discussions would ensue with or without formal mediation in hopes of reaching a consensual settlement. Specifically, the management of the provider or health plan would endeavor to resolve the matter through the following steps: (1) disclosure of the medical injury to the patient, (2) an apology, (3) an offer of compensation, and (4) amelioration of the injury. Each of these steps would be informed by published guidance that would be accessible to beneficiaries and their families as well as to physicians and other providers.

If a beneficiary were dissatisfied with the determination of the provider or health plan, the beneficiary could appeal the decision to the Medicare carrier (for fee-for-service Medicare)[161] or medical review contractor (for Medicare Advantage plans)[162] designated to handle such events. These contractors are well positioned to handle medical injury claims as they already handle Medicare coverage disputes involving medical issues.[163] If the beneficiary were not satisfied with the determination of the Medicare

159. *See supra* note 119 and accompanying text.

160. *See supra* notes 80-82 and accompanying text.

161. *See supra* notes 73-79 and accompanying text.

162. *See supra* notes 80-87 and accompanying text.

163. *See generally supra* notes 76-79 and accompanying text. *See* 42 U.S.C. § 1395ff (2000). *See also* Eleanor D. Kinney, *The New Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology?*, 60 WASH. & LEE L. REV. 1461 (2003).

contractor, the beneficiary could appeal to the Medicare administrative appeals system and ultimately obtain limited judicial review through the Medicare appeals system described above.[164]

To ensure expeditious resolution of medical injuries cases, participating providers might be required to offer patients mediation within sixty days of disclosure of a serious event with the goal of promoting voluntary settlement in the majority of cases. A non-adversarial process that convenes the parties as soon after the episode of care as possible enables the parties to resolve situations through explanation, apology, system improvement, or monetary compensation is useful for both technical lapses and failures of communication, with one often serving as a marker for another.[165] Experience discussing both grievances and injuries with patients and families might lead providers and health plans to utilize similar mediation skills and mechanisms for both categories of dispute. Medicare is already introducing mediation at the QIC level for beneficiary complaints as an alternative to medical record review.[166]

Finally, the decision of the ALJ should be *de novo* as is the current practice for ALJs in Medicare appeals.[167] Upon judicial review, the standard for review should be based on established administrative law rather than on civil procedure. Specifically, reversal is ordered only for an unreasonable interpretation of law for legal questions,[168] or lack of substantial evidence for factual questions.[169] Otherwise, incentives will exist for parties to look to courts inappropriately for ultimate relief and shortchange the administrative process.

2. Presentation of Expert Opinion Evidence

Medicare-led malpractice reform offers an opportunity to improve the quality of expert medical opinion brought to bear in resolving medical injury claims. In the current tort system, civil procedure relies on expert witnesses selected and paid by the litigants to present factual evidence to a lay jury. This convention has been criticized as both unreliable and

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164. *See supra* notes 88-99 and accompanying text.

165. *See* Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951 (2002).

166. *See* Kathleen Scully-Hayes, *Mediation and Medicare Part A Provider Appeals: A Useful Alternative*, 5 J. HEALTH CARE L. & POL'Y 356 (2002).

167. 43 Fed. Reg. 55,349 (1978) (to be codified at 20 C.F.R. pt. 404, subpt. P (1982)).

168. MICHAEL ASIMOW, ARTHUR E. BONFIELD & RONALD M. LEVIN, STATE AND FEDERAL ADMINISTRATIVE LAW (2d ed. 1998).

169. *Id.*

expensive, and often requires the judge to exert greater control over expert testimony than he or she is comfortable with.[170] Yet malpractice litigation commonly presents difficult issues regarding the standard of care, causation of injury, and extent of damages, all of which involve medical proof.

The proposed Medicare-led malpractice reform would move away from the adversarial methods of obtaining medical opinions in the adjudication of medical injury cases. For disputed medical issues that proceed to the Medicare contractor for resolution, the relevant Medicare contractor would have access to the QICs for medical review of disputed issues.[171] Parties would be able to submit their versions of the medical facts informally as well as letters from outside experts (if desired) as part of the QIC medical review.

On appeal, the ALJ follows an inquisitorial style of legal proceeding in which the judge assumes the dominant role in developing the evidence and does not rely on the parties.[172] The use of an inquisitorial model rather than an adversarial model for the ALJ proceeding should not be problematic; research in social psychology suggests that the adversarial model was not always perceived as the most just and fair model in a health care context.[173] Specifically, Poythress and colleagues compared the conventional adversarial model in which the parties developed medical expert testimony with two hybrid models in which the judge took greater control over the development of expert testimony.[174] In one hybrid model, the judge selected the expert, and in the other the judge arranged for an empirical survey of physicians in the relevant field and geographic area to determine breach of the standard of care. Both hybrid models were perceived to be more just and fair than the purely adversarial model in which the disputants arranged for their own expert testimony. Quasi-inquisitorial procedures of this sort differ from the common law tradition by emphasizing truth finding

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170. *See* Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. HEALTH POL. POL'Y & L. 267 (2001). *See generally Special Issue: Evidence: Its Meanings in Health Care and in Law*, 26 J. HEALTH POL. POL'Y & L. 191 (2001).

171. *See supra* notes 76-79 and accompanying text.

172. Reviews of Local and National Coverage Determinations 42 C.F.R. § 426 (2005). *See* Amalia D. Kessler, *Our Inquisitorial Tradition: Equity Procedure, Due Process, and the Search for an Alternative to the Adversarial*, 90:1181 CORNELL L. REV. 1181 (2005).

173. Norman G. Poythress et al., *Procedural Justice Judgments of Alternative Procedures for Resolving Medical Malpractice Claims*, 23 J. APPLIED SOC. PSY. 1639 (1993).

174. *Id.*

over political rights of litigants yet comport with traditional principles of equity courts.[175]

Medicare-led malpractice reform, by making medical review available through QICs and administrative review in the Medicare appeals system, provides an excellent opportunity to marshal required medical expertise in a fair and expeditious manner. As described above,[176] regulations listing designated compensatory events would conclusively establish liability for certain avoidable injuries. In less clear cases of medical injury, medical practice guidelines could be used to establish a standard of avoidability. At their best, medical practice guidelines are a "standardized specification for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion"[177] and constitute the theoretical foundation of evidence-based medicine.[178] Indeed, CMS could encourage the development of medical practice guidelines and decision trees that would guide medical reviewers at QICs and Medicare ALJs in making liability determinations. Social Security Administration ALJs,[179] who until recently handled Medicare appeals, currently use detailed medical-vocational guidelines for determinations of life expectancy, degree of injury, and forgone earnings.[180] These are similar to the tools and tasks needed to resolve malpractice cases.

3. Requirements for and Effects of Decisions

As discussed above,[181] creating an information-rich environment for patient safety, quality improvement and fairness of compensation is one of the major reasons for pursuing malpractice reform through Medicare. Unlike the common law of tort, participating providers in a Medicare-led malpractice reform would be obligated to disclose medical errors to patients or their families in order to foster systematic improvement as well as to vindicate individual rights. Similarly, the public interest in safe medical care and reasonably equal treatment of Medicare beneficiaries

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175. Kessler, *supra* note 172.

176. *See supra* notes 144-54 and accompanying text.

177. Lucian L. Leape, *Practice Guidelines and Standards: An Overview*, 16 QRB QUALITY REV. BULL. 42 (1990).

178. *See* Carter L. Williams, *Evidence-Based Medicine in the Law beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479 (2004).

179. *See supra* notes 91-95 and accompanying text.

180. 43 Fed. Reg. 55,349 (1978) (codified at amended at 20 C.F.R. pt. 404, subpt. P (1982).

181. *See supra* notes 60-69 and accompanying text.

suggests that resolution of malpractice claims and the rational for resolutions, although not necessarily the identity of patients or providers, should be publicly available. Data on resolutions should include the initial decisions of the participating providers or plans, determinations by relevant Medicare contractors including decisions by any QICs that rendered medical reviews at the behest of Medicare contractors, and also decisions of the ALJ, the HHS Departmental Review Board,[182] and the reviewing court.

Whether ALJ determinations should constitute precedent in subsequent cases presenting similar facts is an open question. Because clinical circumstances vary widely in cases of medical injury, and situations requiring administrative resolution often will not involve ACEs or treatment subject to guidelines, past decisions offer valuable guidance to hearing officers. Furthermore, all prior decisions will be readily available, as will information about settlements, thereby reducing the risk that precedents will be invoked selectively.

However, it seems prudent, at least for any demonstrations of malpractice reform, to use prior decisions to improve the regulatory infrastructure of Medicare's malpractice system such as the identification of designated compensation events, scheduling of damages and referral of clinical questions for guideline development, rather than to constrain individual ALJs during periods in which experimentation and innovation are desirable. For example, HHS should review ALJ determinations annually to inform its best-practice reporting. A separate mechanism should be in place to monitor Medicare ALJ performance, which has been suggested by administrative law experts observing ALJs generally.[183] Records of settlements and hearing outcomes may also be useful in any federal clearinghouse of patient safety information that is developed.

V. LEGAL AUTHORITY

The constitutional issue presented by a Medicare malpractice proposal is whether Congress can delegate authority to a federal administrative agency charged with implementing a federal health insurance program to

182. *See supra* notes 88-90 and accompanying text.

183. Daniel J. Gifford, *Federal Administrative Law Judges: The Relevance of Past Choices to Future Directions*, 49 ADMIN. L. REV. 1 (1997); Charles H. Koch, Jr., *Administrative Presiding Officials Today*, 46 ADMIN. L. REV. 271 (1994). *See also* Admin. Conference of the U.S., Recommendations and Statements of the Administrative Conference Regarding Administrative Practice and Procedure, 57 Fed. Reg. 61,759 (Dec. 29, 1992) (to be codified at 1 C.F.R. pts. 305 and 310).

adjudicate state common tort claims as part of that federal program. In our constitutional scheme, administrative agencies have always had an uneasy role. In modern administrative law theory, which took shape with President Franklin Roosevelt's New Deal, administrative agencies must have legislative and judicial power as well as executive power to carry out their statutory assignments. In Medicare-driven malpractice reform, Congress would be delegating judicial powers to adjudicate state court claims to a federal administrative agency.

A. THE LEGAL NATURE OF MEDICARE AND STATE COMMON LAW OF TORT

To understand how Medicare-led malpractice reform could be enacted and implemented, it is necessary to examine how the legal regime for the Medicare program fits into the federal constitutional framework. It is also necessary to assess whether the federal administrative scheme complements or replaces the state tort law mechanism under which malpractice claims are currently adjudicated.

1. The Legal Basis of the Medicare Program

In 1966, Congress enacted the Social Security Amendments of 1965 that established the Medicare program and also the Medicaid programs as titles XVIII and XIX of Social Security Act.[184] Both programs were established as part of the framework established in the Social Security Act of 1935 to provide public insurance and a welfare program to protect the economic security of Americans.[185] The Social Security Act of 1935 also established income maintenance programs through social insurance and welfare for the elderly, disabled and blind. At the time of its enactment, the constitutionality of the Social Security Act of 1935, particularly with respect to its taxation provisions, was hotly debated.[186] Of note, in *Charles*

184. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395) and § 121(a) (codified as amended at 42 U.S.C. § 1396).

185. Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 300-1397). *See also* Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1 (Summer 1987).

186. *See* Barbara Nachtrieb Armstrong, *The Federal Social Security Act and Its Constitutional Aspects*, 24 CAL. L. REV. 247 (1936); Charles Denby, Jr., *The Case Against the Constitutionality of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 315 (1936); James D. Hayes, *Some Legal Aspects of the Social Security Act*, 13 NOTRE DAME L. REV.

C. Steward Mach. Co. v. Davis,[187] the United States Supreme Court ruled that the Social Security Act of 1935 did not violate the Fifth Amendment of the federal constitution and that the tax imposed to fund the program was constitutional.[188]

2. The State Common Law Tort System

The state common law tort system originated in the common law of England and was brought to the original thirteen colonies with the English colonists. The western part of the United States and Louisiana, being settled originally by countries with continental civil law, relied on civil law with respect to personal injury and property damage in non-consensual relationships. Nevertheless, the common law of torts dominates tort law in the United States today. The tort that defines medical malpractice is the tort of negligence, which, according to the Restatement (Third) of Torts, occurs when "a person does not exercise reasonable care under all the circumstances."[189]

The Restatement continues with factors to consider in determining whether the person's conduct lacks reasonable care: "the foreseeable likelihood that the person's conduct will result in harm, the foreseeable severity of any harm that may ensue, and the burden of precautions to eliminate or reduce the risk of harm."[190] To establish a *prima facia* case of negligence, the plaintiff must present evidence that the defendant had a duty not to expose the plaintiff to a reasonably foreseeable risk of injury, that the defendant breached that duty as defined by the applicable standard of care, that the breach caused the damage, and that there was actual damage.[191]

After the American Revolution, most colonies, with much contentious debate, adopted constitutional provisions or enacted statutes to recognize English common law in some fashion as the law of the new state.[192]

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272 (1938); Thomas Dennis Nolan, *Constitutional Law-Social Security Act*, 7 ALB. L. REV. 1 (1937); Harry Shulman, *The Case for the Constitutionality of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 298 (1936); Herbert O. Skalet, *Constitutional Aspects of the Federal Social Security Act*, 15 OR. L. REV. 323 (1936).

187. Charles C. Steward Mach. Co. v. Davis, 301 U.S. 548 (1937).

188. *Id.* at 579.

189. RESTATEMENT (THIRD) OF TORTS: NEGLIGENCE § 3 (Tentative Final Draft 2005).

190. *Id.*

191. *See* KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW 70-79 (1997); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30 (5th ed. 1984).

192. LAWRENCE W. FRIEDMAN, A HISTORY OF AMERICAN LAW 93-100 (1st ed. 1973).

Western states and Louisiana have comparable laws with respect to their former colonial masters.[193] As the colonies were folded into the United States in 1787, the federal constitution established the states as sovereign powers ceding derivative powers to the federal government.[194]

It is noteworthy that, over the years, states have established administrative systems to adjudicate tort matters when the legislature has concluded that the common law tort has been inadequate in assuring expeditious adjudication of tort claims. Specifically, in the early twentieth century, state legislatures sought to improve the adjudication and compensation of injuries on the job with administrative workers compensation schemes.[195] In many states, there were challenges to these schemes on grounds that they inappropriately replaced common law tort remedies.[196] When automobile accidents and insurance became problematic in the 1950s and 1960s, reformers looked to statutory no-fault compensation plans to adjudicate and compensate auto accident claims.[197]

Of interest, scholars and stakeholders have long promoted administrative systems for malpractice reform at the state level.[198] Many states have established quasi-administrative processes with such regimes as medical review prior to trial and patient compensation funds under the auspices of state agencies.[199] While these reforms have been subject to state constitutional challenges,[200] in more recent years, state courts have tended to uphold these administrative reforms.[201]

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193. *Id* at 148-56.

194. *See supra* note 130 and accompanying text.

195. ARTHUR LARSON, THE LAW OF WORKMEN'S COMPENSATION § 2.07 (2005).

196. *See* Ives v. S. Buffalo Ry. Co., 94 N.E. 431 (1911) (invalidating New York State's original workers' compensation statute). *But see* N.Y. Cent. R.R. Co. v. White, 243 U.S. 188 (1917) (upholding the amended New York workers' compensation statute). *See also* Helfrick v. Dahlstrom Metallic Door Co., 176 N.E. 141 (1931).

197. *See generally* WALTER J. BLUM & HARRY KALVEN, JR., PUBLIC LAW PERSPECTIVES ON A PRIVATE LAW PROBLEM: AUTO COMPENSATION PLANS 40 (1965); ROBERT E. KEETON & JEFFREY O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE (1965).

198. *See supra* Part IB.

199. *See* Randall R. Bovjberg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV 499, 515 (1989); Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 247 (2005).

200. JOHN F. WITT, LESSONS FROM HISTORY: STATE CONSTITUTIONS, AMERICAN TORT LAW, AND THE MEDICAL MALPRACTICE CRISIS 1 (2004), http://medliabilitypa.org/research/files/witt0304.pdf.

201. *Id.* at 6. *See generally* PAUL C. WIELER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993).

B. CONSTITUTIONAL CONSIDERATIONS

In American federalism, Article I of the U.S. Constitution limits federal legislative authority to enumerated powers,[202] and, reinforced by the Tenth Amendment, reserves residual authority to state government.[203] The federal constitution does provide for federal spending powers and regulatory powers over interstate commerce.[204] The Constitution gives Congress the power to regulate interstate commerce stating, "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[205] Also, the federal constitution provides explicitly for the preemption of state law that conflicts with federal law under the Supremacy Clause.[206]

Specifically, there are two key constitutional issues: (1) would the power delegated to the Medicare program violate the requirements in Article III of the United States Constitution, which vest judicial authority in the Supreme Court and such inferior courts as Congress may establish, and (2) would the delegated power violate the Seventh Amendment's preservation of the right to trial by jury in suits at common law. The question of delegation arises because the matter to be adjudicated is a conventional state common law tort claim that is generally adjudicated in state courts or, if federal diversity jurisdiction is invoked, by Article III courts applying state tort law.[207]

1. Adjudication by Article III Judges

The Constitution vests federal judicial power in Article III judges; specifically in "one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish."[208] The theory of the Article III requirements was to accord federal judges life tenure and other protections that insulate them from political and other employment pressures and thereby allowing them to make decisions without concern for these factors. However, it seems clear that Article III is not a bar to agency

202. *See generally* U.S. CONST. art. I.
203. *Id.* at amend. X.
204. *Id.* art. I, § 8, cl. 1-7.
205. *Id.* at cl. 3.
206. *Id.* at art. VI, cl. 2.
207. Erie R. Co. v. Tompkins, 304 U.S. 64, 80 (1938) (establishing that federal courts adjudicating state tort claims pursuant to diversity jurisdiction apply state tort law).
208. U.S. CONST. art. III, § 1.

adjudication in general or agency adjudication of matters affecting individuals.

Crowell v. Benson[209] is the most important decision regarding delegation of the authority to adjudicate state tort causes of action to a federal administrative agency. *Crowell* concerned a benefits program for seamen injured in the course of employment while working on "navigable waters" pursuant to the Longshoremen's and Harbor Workers' Compensation Act.[210] The Court upheld the delegation. However, because so-called "private rights," e.g., tort liability under common law, were implicated, the Court held that Article III judges must have independent power to decide all issues of law and "jurisdictional fact" upon review of the agency's decision.[211] Jurisdictional facts were those on which the agency's jurisdiction depended—in *Crowell*, whether an employment relationship existed and whether the injury occurred on navigable waters.[212]

The important aspect of *Crowell v. Benson* for purposes of Medicare-driven malpractice reform is that the Supreme Court sanctioned a federal regulatory scheme to supplant a common law tort schemes under federal maritime law but did not address the question whether Congress could supplant state tort law.[213] Also, because *Crowell v. Benson* concerned admiralty law, the issue of entitlement to a jury trial under the Seventh Amendment was not adjudicated.[214]

The Supreme Court revisited delegation of judicial powers of Article III courts to other governmental bodies in *Northern Pipeline Construction Co. v. Marathon Pipeline Co.*[215] and, more recently, in *Thomas v. Union Carbide Agricultural Products Co.*[216] and *Commodity Futures Trading Commission v. Schor.*[217] In *Northern Pipeline*, the Supreme Court invalidated a statute that assigned breach of contract issues in bankruptcy proceedings to bankruptcy judges not appointed pursuant to Article III.[218] In a plurality opinion, Justice Brennan ruled that contract cases involved "private rights," which could only be decided by Article III judges.[219] The

209. Crowell v. Benson, 285 U.S. 22 (1932).

210. *Id.* at 36. *See* Longshoremen's and Harbor Workers Compensation Act, Pub. L. No. 69-803, 44 Stat. 1424 (codified as amended at 33 U.S.C. §§ 901-50 (2000)).

211. *Crowell*, 285 U.S. at 92-93.

212. *Id.* at 36-37.

213. *Id.* at 39.

214. *Id.* at 45.

215. Northern Pipeline Constr. Co. v. Marathon Pipeline Co., 458 U.S. 50, 84 (1982).

216. Thomas v. Union Carbide Agric. Prod. Co., 473 U.S. 568, 594 (1985).

217. Commodity Futures Trading Comm'n v. Schor, 478 U.S. 833, 857-58 (1986).

218. *Northern Pipeline Constr. Co.*, 458 U.S. at 84.

219. *Id.* at 70.

plurality defined "public rights" as those involving the government and "private rights" as involving liability among private parties.[220]

Later, in *Thomas v. Union Carbide Agricultural Products Co.*,[221] the Supreme Court upheld a statutory scheme under the Federal Insecticide, Fungicide, and Rodenticide Act to adjudicate compensation amounts for the use of data in determining whether to approve a competitor's similar pesticide.[222] Specifically, if the competing pesticide manufacturers disputed the compensation amounts, arbitration with limited federal court review was available to adjudicate the dispute.[223] Petitioners had argued that the adjudicated matters were state law claims adjudicated under state common law.[224] The Court responded that: "Many matters that involve the application of legal standards to facts and affect private interests are routinely decided by agency action with limited or no review by Article III courts."[225] The Supreme Court further argued that a manufacturer's right to compensation was not just a "private right" but that the use of data played "an integral part" in "a complex regulatory scheme" to protect public health.[226]

The *Thomas* court made observations about *Crowell* and *Northern Pipeline* that seem apposite to the issue of Medicare-led malpractice reform. The Court, in distinguishing the statutory scheme at issue in *Thomas* from that in *Crowell*, stated:

> Most importantly, the statute in *Crowell* displaced a traditional cause of action and affected a pre-existing relationship based on a common-law contract for hire. Thus it clearly fell within the range of matters reserved to Article III courts under the holding of *Northern Pipeline*. See 458

220. *Id.* at 69.

221. *Thomas*, 473 U.S. at 594.

222. *Id.* at 605. *See* Federal Insecticide, Fungicide, and Rodenticide Act, Pub. L. No. 92-516, 92 Stat. 819 (codified as amended at 7 U.S.C. § 136 (2000)).

223. *Thomas*, 473 U.S. at 573.

224. *Id.* at 583.

225. *Id. See, e.g.*, 5 U.S.C. §§ 701(a)(1) to 701(a)(2) (2000); Heckler v. Chaney, 470 U.S. 821, 837-38 (1985); United States v. Erika, Inc., 456 U.S. 201, 206 (1982) (no review of Medicare reimbursements); Henry P. Monaghan, *Marbury and the Administrative State*, 83 COLUM. L. REV. 1, 18 (1983) (administrative agencies can conclusively adjudicate claims created by the administrative state, by and against private persons); Marvin H. Redish, *Legislative Courts, Administrative Agencies, and the Northern Pipeline Decision*, 32 DUKE L.J. 197 (1983).

226. *Thomas*, 473 U.S. at 592 (internal citations omitted).

> U.S., at 70-71, and n. 25 (plurality opinion) (noting that matters subject to a "suit at common law or in equity or admiralty" are at "protected core" of Article III judicial powers); *id.* at 90 (opinion concurring in judgment) (noting that state law contract actions are "the stuff of the traditional actions at common law tried by the courts at Westminster in 1789").[227]

Further, the Court noted that the relevant statute "limits but does not preclude review of the arbitration proceeding by an Article III court" and thereby determined that, "in the circumstances," the review afforded preserves the "appropriate exercise of the judicial function" required in *Crowell v. Benson.* The Court stated that the statute "at a minimum allows private parties to secure Article III review of the arbitrator's 'findings and determination' for fraud, misconduct, or misrepresentation under the statute."[228] The Court concluded that the statutory scheme "therefore, does not obstruct whatever judicial review might be required by due process."[229] However, the Court specifically declined to reach the issue of whether due process would require judicial review and what would be the scope of that review.[230]

The most recent case is *Commodity Futures Trading Commission v. Schor*[231] in which the Supreme Court ruled that state contract law counterclaims (by brokers against customers) in reparations proceedings initiated by the federal Commodities Futures Trading Commission (CFTC),[232] could be adjudicated by the CFTC. *Schor* delineated the degree to which Congress can delegate adjudication of traditionally common law matters to administrative agencies without violating the constitutional guarantees associated with Article III courts. Justice O'Connor, writing for the majority, stated:

> Although our precedents in this area do not admit of easy synthesis, they do establish that the resolution of claims such

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227. *Id.* at 557.

228. *Id.* at 593.

229. *Id.*

230. *Id.* at 593-94. The Court stated: "We need not identify the extent to which due process may require review of determinations by the arbitrator because the parties stipulated below to abandon any due process claims. [citations omitted] For purposes of our analysis, it is sufficient to note that FIFRA does provide for limited Article III review, including whatever review is independently required by due process considerations." *Id.*

231. Commodity Futures Trading Comm'n v. Schor, 478 U.S. 833, 857-58 (1986).

232. 31 U.S.C. §§ 5312(a)(2)-(c)(1) (2000).

> as Schor's cannot turn on conclusory reference to the language of Article III. Rather, the constitutionality of a given congressional delegation of adjudicative functions to a non-Article III body must be assessed by reference to the purposes underlying the requirements of Article III. This inquiry, in turn, is guided by the principle that "practical attention to substance rather than doctrinaire reliance on formal categories should inform application of Article III."[233]

The Court then laid out the guiding principles for when the Constitution requires adjudication of claims by an Article III court. The major concern is whether the delegation of adjudicative authority "impermissibly threatens the institutional integrity of the Judicial Branch."[234] In making this determination, the following factors are considered: (1) the extent the "essential attributes of judicial power" are reserved to Article III courts;[235] (2) the extent to which the non-Article III forum exercises a "range of jurisdiction and powers normally vested only in Article III courts;"[236] (3) the "origins and importance of the right to be adjudicated;"[237] and (4) the "concerns that drove Congress to depart from the requirements of Article III."[238]

The Court also emphasized that the CFTC's jurisdiction over the common law counterclaims under state law was necessary to the success of the regulatory scheme.[239] Further, the Court was convinced that this "little single deviation from the agency model" was not fatal. Besides the authorization of counterclaim jurisdiction, the statute "left far more of the 'essential attributes of judicial power' to Article III courts than did that portion of the Bankruptcy Act found unconstitutional in *Northern Pipeline*," which covered "all civil proceedings" arising under or related to

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233. *Schor*, 478 U.S. at 847.
234. *Id.* at 851.
235. *Id.* at 834.
236. *Id.* at 835.
237. *Id.*
238. *Id.*
239. *Id.* at 856 ("It was only to ensure the effectiveness of [the reparations] scheme that Congress authorized the CFTC to assert jurisdiction over common law counterclaims. Indeed . . . absent the CFTC's exercise of that authority, the purposes of the reparations procedure would have been confounded."). *See* Catherine T. Struve, *The FDA and the Tort System: Postmarketing Surveillance, Compensation, and the Role of Litigation*, 2 YALE J. OF HEALTH POL'Y L. & ETHICS 587 (2005).

cases under a particular section of the act.[240] The court concluded that the regime in *Schor* more closely approximated the agency model approved by the Court in *Crowell v. Benson*, which dealt only with a "particularized area of law."[241]

The Court emphasized that the CFTC's orders, like those of the agency in *Crowell v. Benson*, were only enforceable by order of the federal district court and were reviewed by the same "weight of the evidence" standard sustained in *Crowell*, rather than the more deferential standard found lacking in *Northern Pipeline*.[242] Further, the CFTC's legal rulings, also like those in *Crowell*, were subject to *de novo* review. Finally, the commission in *Schor*, unlike the bankruptcy courts in *Northern Pipeline*, did not "exercise 'all ordinary powers of district courts,' and thus may not, for instance, preside over jury trials or issue writs of habeas corpus."[243]

While acknowledging that the counterclaim was "a 'private' right for which state law provides the rule of decision," and thus was at the "core" of matters normally reserved to Article III courts,[244] the Court approved the delegation to a federal administrative agency stating:

> [W]e are persuaded that the congressional authorization of limited [the Commission's] jurisdiction over a narrow class of common law claims as an incident to the CFTC's primary, and unchallenged, adjudicative function does not create a substantial threat to the separation of powers . . . .[245]

According to the Court, the delegation was justified because Congress "intended to create an inexpensive and expeditious alternative forum through which customers could enforce the provisions of the Commodities Exchange Act against professional brokers."[246] The Court, in making its point that Congress should have flexibility to craft remedies even though they originally lie in state common law, quoted *Crowell's* conclusion that a contrary holding would "defeat the obvious purpose of the legislation to furnish a prompt, continuous, expert and inexpensive method for dealing with a class of questions of fact which are peculiarly suited to examination

240. *Schor*, 478 U.S. at 852.
241. *Id.*
242. *Id.* at 853.
243. *Id.*
244. *Id.*
245. *Id.* at 854.
246. *Id.* at 855.

and determination by an administrative agency specially assigned to that task."[247]

One important factor of the administrative proceedings that the Court emphasized in both the *Schor* and *Thomas* decisions was that they were voluntary. In *Thomas*, the Court mentioned in passing: "Congress has the power, under Article I, to authorize an agency administering a complex regulatory scheme to allocate costs and benefits among voluntary participants in the program without providing an Article III adjudication."[248] Later in the opinion, the Court observed: "The danger of Congress or the Executive encroaching on the Article III judicial powers is at a minimum when no unwilling defendant is subjected to judicial enforcement power as a result of the agency 'adjudication.'"[249] However, *Schor*, even more than *Thomas*, emphasized and indeed turned on the fact of consent to the non-Article III tribunal. As the Court emphasized:

> Schor indisputably waived any right he may have possessed to the full trial of Conti's counterclaim before an Article III court. Schor expressly demanded that Conti proceed on its counterclaim in the reparations proceeding rather than before the District Court, and was content to have the entire dispute settled in the forum he had selected until the ALJ ruled against him on all counts; it was only after the ALJ rendered a decision to which he objected that Schor raised any challenge to the CFTC's consideration of Conti's counterclaim.[250]

In a thorough and thoughtful analysis of the law in this area, Professor Catherine Struve concludes that the submission of the adjudication of private rights to a non-Article III tribunal does not "not offend *structural* Article III concerns."[251] However, since the litigant in *Schor* had consented to submit the claim to the CFTC, *Schor's* holding "did not extend to cases in which no such waiver had occurred."[252] This emphasis on the fact of consent has important implication for the design of any Medicare-led malpractice adjudication scheme.

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247. *Id.* at 856 (quoting Crowell v. Benson, 285 U.S. 22, 46 (1932)).

248. Thomas v. Union Carbide Agric. Prod. Co., 473 U.S. 568, 589. *See* Struve, *supra* note 239, at 633.

249. *Thomas*, 473 U.S. at 591.

250. *Schor*, 478 U.S. at 849 (citation omitted).

251. *See* Struve, *supra* note 239, at 634-35.

252. *Id.* at 635.

2. Seventh Amendment Guarantees of Trial by Jury

The remaining issue is the guarantee to a trial by jury in the Seventh Amendment of the federal constitution.[253] The major modern case involving an action arguably comparable to a common law cause of action is *Atlas Roofing Co. v. Occupational Safety and Health Review Commission*[254] in which petitioners challenged the authority of the enabling statute of the Occupational Safety and Health Administration (OSHA) to impose civil money penalties enforceable in federal court on employers for unsafe working conditions.[255] The Supreme Court concluded that the Seventh Amendment had not been violated as the imposition of the penalty only sought to enforce a public rather than a private right.[256] The Court concluded that:

> Congress is . . . not prevented from committing some new types of litigation to administrative agencies with special competence in the relevant field. This is the case even if the Seventh Amendment would have required a jury where the adjudication of those rights is assigned to a federal court of law instead of an administrative agency.[257]

The Court also explained in a footnote that the agency's decisions could be reviewed by the federal courts of appeals and thus the case did not present the question whether Congress could commit the adjudication of fines for the violation of public rights to the agency "without any sort of intervention by a court at any stage of the proceedings."[258]

In a later case, *Tull v. United States*,[259] involving an award of injunctive relief and monetary penalties to the government in a suit under the Clean Water Act,[260] the Court observed that an action for civil penalties under the Clean Water Act "is clearly analogous to the 18th-century action in debt, and federal courts have rightly assumed that the Seventh Amendment

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253. U.S. CONST. amend. VII.

254. Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n, 430 U.S. 442 (1977).

255. *Id.*

256. *Id.* at 455.

257. *Id.*

258. *Id.* at 456 n.13.

259. Tull v. United States, 481 U.S. 412 (1987).

260. Clean Water Act, Pub. L. No. 845, § 418, 62 Stat. 1155 (1948).

required a jury trial."[261] The Court ruled that the defendant had a right to a jury trial on the question of whether civil penalties should be imposed but not on the amount of the penalties to be imposed. Some have suggested that the right to a jury trial under the Seventh Amendment might depend on whether it is the agency that sets the penalty as in the case of *Atlas Roofing* rather than the court.[262]

A subsequent decision, *Granfinanciera, S.A. v. Nordberg*[263] raised the question of "whether a person who has not submitted a claim against a bankruptcy estate has a right to a jury trial when sued by the trustee in bankruptcy to recover an allegedly fraudulent monetary transfer." The Supreme Court held that the Seventh Amendment entitled one to a jury trial notwithstanding Congress' designation of fraudulent conveyance actions as "core proceedings" under the Bankruptcy Act.[264]

In outlining its rationale for the right to the jury trial in this case, the Court observed that it had consistently interpreted the phrase "[s]uits at common law" in the Seventh Amendment to refer to "suits in which legal rights were to be ascertained and determined, in contradistinction to those where equitable rights alone were recognized, and equitable remedies were administered."[265] Continuing, the court stated that, while the "thrust" of the Seventh Amendment "was to preserve the right to jury trial as it existed in 1791,"[266] the Seventh Amendment "also applies to actions brought to enforce statutory rights that are analogous to common-law causes of action ordinarily decided in English law courts in the late 18th century, as opposed to those customarily heard by courts of equity or admiralty."[267]

The Court then proceeded to outline the analysis for determining the application of the Seventh amendment. The Court stated that the first step is comparing "the statutory action to 18th-century actions brought in the courts of England prior to the merger of the courts of law and equity" and then examining "the remedy sought and determine whether it is legal or equitable in nature."[268] The Court would conclude that, if "on balance, these two factors indicate that a party is entitled to a jury trial under the Seventh Amendment, we must decide whether Congress may assign and has assigned resolution of the relevant claim to a non-Article III

261. *Tull*, 481 U.S. at 420.
262. Asimow, Bonfield & Levin, *supra* note 168, at 428-35.
263. Granfinanciera, S.A. v. Nordberg, 492 U.S. 33, 36 (1989).
264. *Id.* (citing 28 U.S.C. § 157(b)(2)(H) (1982 ed., Supp. V)).
265. *Id.* at 41 (quoting Parsons v. Bedford, 3 Pet. 433, 447 (1830)).
266. *Id.* at 41-42.
267. *Id.* at 42 (citing Curtis v. Loether, 415 U.S. 189, 193 (1974)).
268. *Id.* (citing Tull v. United States, 481 U.S. 412, 417-18 (1987)).

adjudicative body that does not use a jury as factfinder."[269] The court basically concluded that the claim involved was a private right and thus could not be assigned to a non-Article III tribunal and adjudicated without a jury.[270]

Granfinanciera has important implications for the flexibility of Congress to assign traditionally private law claims arising under common law to administrative tribunals to which adjudication of facts by a jury is not available. Professor Catherine Struve has concluded that: "in the absence of litigant consent, a private-rights claim of that that would carry a jury right if litigated in federal court is not assignable to a non-Article III tribunal for juryless adjudication" and that "the *Granfinanciera* Court explicitly equated the scope of the Seventh Amendment constraint with that of the Article III constraint."[271] Consequently, she concludes that, although "*Schor* indicates that private-rights disputes may be assigned to non-Article III tribunals when the litigants consent, *Granfinanciera* indicates that absent litigant consent, a case must fall within the public-rights category (or another traditional exception) in order to be validly assigned to a non-Article III tribunal."[272]

3. Federal Preemption of State Tort Law

There have been numerous instances where Congress has enacted federal laws that have preempted state tort law both in terms of substantive issues in tort law and also in terms of tort remedies in state courts. The most notable example is the Employee Retirement Income Security Act of 1974 (ERISA), which established a federal scheme for the adjudication of claims against employer sponsored benefit plans.[273] Furthermore, ERISA located regulation of employer-sponsored health insurance—the predominant source of health insurance for the non-elderly—in the federal government and removed it from state insurance regulation.

ERISA establishes requirements for employee benefit plans that are eligible for favorable federal tax treatment. ERISA establishes the plan's administrator as a fiduciary with associated duties and liabilities to plan participants and beneficiaries (dependents of employees).[274] ERISA

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269. *Id.*

270. Struve, *supra* note 239, at 635.

271. *Id.*

272. *Id.*

273. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832 (codified as amended at 29 U.S.C. § 1001 (2000)).

274. 29 U.S.C. § 1102 (2000); 29 U.S.C. § 1104 (2000, Supp. 2001 & Supp. 2002).

requires that plan fiduciaries act solely in the interest of plan participants and beneficiaries and imposes sanctions and limited liability for failure to do so. For qualified ERISA plans,[275] ERISA preempts state laws that would otherwise relate to the plans.[276] However, ERISA explicitly excludes state insurance codes from preemption,[277] but then provides that ERISA plans will not be deemed insurers for purposes of state insurance regulation.[278]

ERISA has very specific enforcement provisions. All plans must maintain internal review procedures.[279] ERISA authorizes civil actions against plan fiduciaries for any breaches of ERISA requirements including plan fiduciary determinations under ERISA's internal review procedures.[280] ERISA also authorizes equitable relief as well as damages although damage awards are limited essentially to the recovery of lost benefits only.[281] In *Pilot Life Insurance v. Dedeaux*, the Supreme Court ruled that ERISA's enforcement remedies preempted state remedies.[282]

The jurisprudence on the ERISA preemption is convoluted. Courts have historically interpreted the ERISA preemption broadly.[283] In *Pilot Life Insurance Co. v. Dedeaux*,[284] the Supreme Court ruled that ERISA preempted state causes of action in tort for bad faith breach against employee welfare benefit plans and the commercial insurers that funded these plans.[285] From time to time, the Court has re-evaluated the

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275. 29 U.S.C. § 1102(b) (2000).

276. *Id.* § 1144(a).

277. *Id.* § 1144(b).

278. *Id.*

279. *Id. See* Richard Rouco, *Available Remedies Under ERISA Section 502(a)*, 45 ALA. L. REV. 631 (1994).

280. 29 U.S.C. § 1132(a)(3) (1998 & Supp. 2005).

281. *Id.* § 1132(a)(6).

282. Pilot Life Ins. Co v. Dedeaux, 481 U.S. 41, 45 (1987).

283. *See, e.g.*, Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case of Managed Federalism*, 23 AM. J.L. & MED. 251 (1997); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption: A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996); Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998); Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998).

284. *Pilot Life Ins. Co.*, 481 U.S. at 41.

285. *See, e.g.*, Karen A. Jordan, *Tort Liability for Managed Care: The Weakening of ERISA's Protective Shield*, 25 J.L. MED. & ETHICS 160, 163 (1997); Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7 (1997). *See also* U.S. GEN. ACCT. OFF., EMPLOYER-BASED MANAGED CARE PLANS: ERISA'S EFFECT ON REMEDIES FOR BENEFIT DENIALS AND MEDICAL MALPRACTICE (1998).

boundaries of ERISA preemption more narrowly and precisely,[286] but has never wavered as to its validity. Under current law, ERISA routinely extinguishes tort claims for medical injury that otherwise would be available in state court.[287]

The issue of federal preemption of tort remedies has arisen in other contexts. With respect to the Federal Employees Health Benefit Plan, the federal government typically asserts that state law tort causes of action are preempted by federal law. However, courts are split as to whether such preemption exists.[288] Some courts also have recognized that Medicare beneficiaries may bring state tort claims against Medicare HMOs, notwithstanding the regulatory scheme contained in the Medicare statute.[289]

C. STATUTORY AUTHORITY

In addition to the constitutional issues, the question of statutory authority is also important. There are two dimensions to this question. First, does the current Medicare statute contain the requisite authority to launch Medicare-led malpractice reform or at least an initial demonstration testing the concept? Second, if not, what changes to the statute are required to launch Medicare-led malpractice reform, first as a demonstration project and then as a permanent reform?

Congress has extraordinary latitude to legislate for the Medicare program. First of all, the legality of the Social Security Act in which the Medicare program's enabling legislation resides is not in doubt.[290] Congress has also exercised this latitude in the Medicare statute particularly with respect to initiatives to improve the quality of care accorded Medicare beneficiaries.[291] Indeed, the statutory foundations for

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286. Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002); De Buono v. NYSA-ILA Med. and Clinical Serv's Fund, 520 U.S. 806 (1997); Cal. Div. of Labor Standards Enforcement, N.A., Inc., 519 U.S. 316 (1997); Boggs v. Boggs, 520 U.S. 833 (1997). *See also* N.Y. State Conference of Blue Cross Blue Shield Plans v. Travelers Ins., Inc., 514 U.S. 645 (1995); Karen A. Jordan, *Recent Modifications to the Preemption Doctrine & Their Impact On State HMO Liability Laws*, 1 IND. HEALTH L. REV. 51 (2004).

287. *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) (invalidating as preempted by ERISA a state law allowing claims for medical complications arising from a benefits determination).

288. Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 56 (1999).

289. *Id.*

290. *See supra* notes 106-15 and accompanying text.

291. *See supra* notes 37-45 and accompanying text.

the infrastructure for the Medicare program described above[292] have rarely been challenged judicially.

Despite this expansive flexibility, it is important to point out the first section of the Medicare statute as it might pose a barrier to Medicare-led malpractice reform. Mindful of the ideological controversy over design and implementation of the Medicare program, particularly within the provider community,[293] Congress opened Title XVIII of the Social Security Act with an admonition about federal interference in the practice of medicine or the management of health care institutions:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, . . . or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[294]

While this provision seems quaint today given the complex role of the Medicare program in the business of physicians and other providers, it could be a basis for challenge to Medicare-led malpractice reform from the provider community.

1. Judicial Review of Medicare Statutory Provisions

The Supreme Court and lower federal courts have been remarkably deferential to Congress, HHS, and the Medicare program in reviewing challenges to legislation, regulation and policy under the Medicare program. In a superb review of Supreme Court and lower court decisions on the Medicare program since its inception, Professor Tim Jost identifies three categories of Supreme Court decisions on challenges to the Medicare program's enabling legislation and its implementation.[295] The first category, which occurred early in the Medicare program, considered challenges to the constitutionality of specific provisions of the Medicare statute. With respect to these cases, Jost observes that the Supreme Court denied relief in two early cases and thus "set the tone for the lower courts,

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292. *See supra* notes 19-105 and accompanying text.

293. *See* Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, 6 HEALTH CARE FIN. REV. 3, 4 (Supp. 1985) (describing the ideological controversy over the Medicare program).

294. 42 U.S.C. § 1395 (2000).

295. Jost, *supra* note 288, at 46-54.

which soon lost their own early hospitality to constitutional claims in Medicare cases."[296]

An early case in which the courts rejected constitutional challenges to the Medicare statute is *Association of American Physicians and Surgeons v. Weinberger.*[297] In this case, a medical organization challenged the PSRO program claiming that it violates rights guaranteed the plaintiff physicians and their patients by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution. The United States District Court for the Northern District of Illinois, affirmed by the Supreme Court six months later,[298] ruled that the PSRO program was constitutional.

Association of American Physicians and Surgeons is instructive because the court responded to the logical constitutional arguments that would likely be invoked in a legal challenge to any Medicare regime to regulate quality and certainly Medicare-led malpractice reform. The ease with which these constitutional claims were rejected suggests that, from a constitutional perspective, there exists wide latitude to establish quality improvement programs through the Medicare program as a condition of participation.

The district court ruled that the fact that the statute set forth conditions for being compensated by federal funds under the Medicare and Medicaid programs did "not bar physicians from practicing their profession" and further, that the statute was not so "patently arbitrary and totally lacking in rational justification" as to violate the due process clause of the Fifth Amendment.[299] The court also dismissed other specific constitutional claims.[300]

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296. *Id.* at 46-54. *See* Schweiker v. McClure, 456 U.S. 188 (1982); Mathews v. Diaz, 426 U.S. 67 (1976).

297. Ass'n of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd per curium*, 423 U.S. 975 (1975). *See* Jost, *supra* note 288, at 57 (commenting on the significance of this decision); Marilyn Kuhr, *PSRO: A Status Report on Medical Peer Review under the 1972 Social Security Act Amendments*, 6 LOY. U. CHI. L.J. 90, 105-06 (1975) (describing similar litigation by state medical associations against state PSROs on similar grounds with similar results).

298. Ass'n of Am. Physicians & Surgeons v. Mathews, 423 U.S. 975 (1975).

299. *Weinberger*, 395 F. Supp. at 132.

300. Specifically, the court rejected the argument that the law prohibited physicians from performing surgical operations deemed necessary in exercise of professional skill and judgment, pointing out that the statute provided only that a physician must comply with certain guidelines and procedures enumerated in statute if that physician wished to be compensated by federal government for services. *Id.* at 134. Thus, the legislation did not violate Fifth Amendment by unconstitutionally interfering with right to practice. The court also rejected the argument that the system of norms to be established under statute would violate the Fifth Amendment by unconstitutionally interfering with the physician-patient

In its rejection of the substantive due process claim, the court emphasized that the statute's "primary purpose" was to "control rapidly rising cost of governmental health care delivery systems" and thus was "not arbitrary for lacking reasonable relationship to end within competency of government."[301] The court concluded that the intent of Congress to "achieve better cost control in the field of health care" was within the competency of the federal government and that this economic goal was neither "arbitrary and totally lacking in rationality" nor a violation of the Fifth Amendment as an "inefficient and unnecessary interference with right

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relationship, in light of the legislative standards of reasonableness and statutory flexibility that take into account various methods of treatment. *Id.*

The court rejected the allegation that the statute infringed the right of privacy of doctors and their patients as guaranteed by First, Fourth, Fifth and Ninth Amendments, concluding that the statute sought information for legitimate government purpose, that the manner in which information was to be gathered and maintained was reasonable, and that proper confidentiality was assured. *Id.* at 135-36.

Claimants asserted that the statute was unconstitutionally vague in violation of the Fifth Amendment as members of medical profession would necessarily have to guess at meaning of phrases set forth in statute, such as "medically necessary," "professionally recognized health care standards," and "proper care." *Id.* at 138-39. The court concluded that, while such phrases were not highly specific, language of legislation was not impermissibly vague or uncertain. *Id.* at 138-39.

Claimants also asserted that the statute unconstitutionally expose plaintiffs to civil liability. *Id.* at 139. *See also* 42 U.S.C. § 1320c-6(c) (2000). The court reasoned that, where norms to be established for physicians under the program were "by definition, typical medical practices," risk of civil liability would arise from common law standards of negligence and not from the statute. *Weinberger*, 395 F. Supp. at 139. Further, the court concluded that the possibility of exposure to civil liabilities sometime in the future due to compliance with norms would not amount to that type of real and immediate threat of injury giving rise to actual case or controversy under Article III of the constitution. *See id.*

The court also rejected the allegation that the statute, by "merely" requiring practitioners to furnish evidence of their services in order to be compensated, violated the Fifth Amendment by creating presumptions inconsistent with competence, good moral character and regularity of motive and conduct inherent in medical licensure. *Id.*

Further, the court rejected the allegation that the fact that PSROs were required to be nonprofit organizations paid by the Secretary for their expenses did not mean that PSROs would have a financial interest in retaining their contractual relationships with the government, and thus the legislation unconstitutionally empowered biased private organizations to exercise quasi-judicial authority in violation of Fifth Amendment. *Id.* at 140.

Finally, the statute did not violate procedural due process requirements as it apprised the practitioner or provider of adverse determinations and accorded an opportunity to be heard before the Secretary or by judicial review. *Id.* at 133.

301. *Weinberger*, 395 F. Supp. at 133.

to practice medicine."[302] Of interest, the court justified its decision on the following finding of the Senate Finance Committee:

> The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of over-utilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.[303]

The second group of Supreme Court and lower court decisions regarding the Medicare program that Jost identifies involves challenges to the restrictive jurisdictional, ripeness and exhaustion requirements for appeals under the Social Security Act.[304] Specifically, the Social Security Act expressly bars federal question jurisdiction[305] for all challenges to claims that are not brought under grants of authority for judicial review under the Social Security Act.[306] For both the Medicare program and all other programs under the Social Security Act, the Supreme Court has been relentless in its insistence that litigants proceed through the statutory procedures under the Act.[307] Only in two quite extraordinary cases,

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302. *Id.* at 140.

303. *Id.* at 128-29 (citing Sen. R. No. 92-1230, 92d Cong., 2d Sess. 254 (1972)).

304. Jost, *supra* note 288, at 46-47.

305. 28 U.S.C. § 1331 (2000).

306. 42 U.S.C. § 205(b) (2000). *See* Eleanor D. Kinney, *The Role of Judicial Review Regarding Medicare and Medicaid Program Policy: Past Experience and Future Expectations*, 35 ST. LOUIS U. L.J. 759 (1991); Kinney, *supra* note 185, at 91-95.

307. *See* United States v. Erika, 456 U.S. 201 (1982) (rejecting Court of Claims jurisdiction in Part B cases); Califano v. Sanders, 430 U.S. 99 (1977) (ruling that the Administrative Procedure Act did not confer federal question jurisdiction for Social Security Act claims); Weinberger v. Salfi, 422 U.S. 749, 756-63 (1975) (a Title II Social Security benefits case rejecting general federal question jurisdiction in Social Security Act cases); Jost, *supra* note 288, at 47.

Bethesda Hospital Association v. Bowen[308] and *Michigan Academy of Family Physicians v. Blue Cross & Blue Shield of Michigan*,[309] did the Supreme Court even consider deviating from the strict limits on judicial review under the Social Security Act as interpreted in its prior cases.[310] More recently, in *Shalala v. Illinois Council for Long Term Care, Inc.*,[311] the Supreme Court got squarely back on track in sharply limiting *Michigan Academy* and reinstating the jurisdiction, exhaustion and ripeness requirements of the Social Security Act for all practical purposes.[312]

This line of cases is important for Medicare-led malpractice reform for it represents a strong inclination on the part of courts to hold challengers to the jurisdiction, exhaustion and ripeness requirements of the Social Security Act. Such strict limits could be very useful in a Medicare system for malpractice adjudication, assuming Social Security Act § 405(b)[313] applied to the regime. Specifically, claimants would have difficulty proceeding to court and leaving the reformed adjudication system. However, an important question in designing Medicare-led malpractice reform is determining whether and how this restriction in § 405(b) should apply to the reformed system.

A third group of decisions involves provider payment disputes in which the Supreme Court has been very deferential to the agency with respect to its regulations, interpretative policy statements and other practices regarding the payment of providers for the service to Medicare beneficiaries. This is probably due in part to the extreme complexity of the payment methodologies and their implementation. Of note, the Supreme Court has consistently denied that providers have a property interest in Medicare payment, which would entitle them to procedural due process as a matter of constitutional law in their dealings with the Medicare program.[314] (In only one case, *Fischer v. United States*,[315] and in dicta, did the Court even suggest otherwise.)

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308. 485 U.S. 399 (1988) (permitting providers to pass over some administrative procedures before the fiscal intermediary where the intermediary had virtually no authority to rule on the validity of the challenged payment regulation).

309. 476 U.S. 667 (1986) (holding that federal question jurisdiction existed for review of the "method" under which Part B benefits were determined).

310. *See* Jost, *supra* note 288, at 47.

311. Shalala v. Ill. Council for Long Term Care, Inc, 529 U.S. 1 (2000).

312. *See* Virginia Burke, *Violate, Incur Sanctions, and Exhaust: The Steep Price of Judicial Review under Illinois Council*, 36 J. HEALTH L. 403, 409-20 (2003).

313. 42 U.S.C. § 205(b) (2000).

314. *See, e.g.*, St. Francis Hosp. Ctr. v. Heckler, 714 F.2d 872 (7th Cir. 1983), *cert. denied*, 465 U.S. 1022 (1984); Geriatrics, Inc. v. Harris, 640 F.2d 262, 265 (10th Cir. 1981), *cert. denied*, 454 U.S. 832 (1981).

2. Judicial Review of Medicare Regulations and Program Guidance

Much of the Medicare program has been implemented through legislative rules, interpretative rules and policy statements. It is likely that any permanent Medicare-led malpractice reform will be implemented in the same matter. Another important theme in the judicial review of the Medicare program has been the legality of these regulations and other guidance, both in terms of their substance and the procedures by which they were promulgated. Because of the scope and complexity of the Medicare program, CMS and its predecessors have issued numerous legislative rules and even more program guidance.[316]

The Secretary of HHS has broad rulemaking authority to make rules for the Medicare program.[317] Further, because the programs under the Social Security Act are benefits programs, rulemaking for these programs is exempt from notice and comment rulemaking procedures under § 553(a)(2) of the Administrative Procedure Act.[318] Like many other agencies following recommendations from the Administrative Conference of the United States,[319] HHS has agreed to follow notice and comment rulemaking procedures when making legislative rules for its programs, including the Medicare and Medicaid programs.[320] In 1982, HHS tried to rescind this policy.[321] In 1986, however, Congress codified the requirement with respect to certain Medicare program regulations and also specified detailed procedures for Medicare rulemaking.[322]

The Supreme Court and lower federal courts have been relatively, but not universally, deferential in reviewing Medicare program legislative rules, interpretative rules, statements of policy and other program

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315. Fischer v. United States, 529 U.S. 667 (2000).

316. *See* CMS, The CMS Online Manual System, http://www.cms.hhs.gov/manuals/ (last visited Feb. 6, 2006). *See generally* ELEANOR D. KINNEY, PROTECTING AMERICAN HEALTH CARE CONSUMERS (2002) (describing Medicare's policies and policymaking processes).

317. 42 U.S.C. § 1395hh(b) (2000).

318. 5 U.S.C. § 553(a)(2) (2000).

319. ACUS, Recommendation No. 69-8, Elimination of Certain Exemptions from the APA Rulemaking Requirements, 1 C.F.R. § 305.69-8 (1994). *See* Arthur E. Bonfield, *Public Participation in Federal Rulemaking Relating to Public Property, Loans, Grants, Benefits, or Contracts*, 118 U. PA. L. REV. 540 (1970).

320. Public Participation in Rule Making, 36 Fed. Reg. 2532 (Feb. 5, 1971).

321. Administrative Practices and Procedures, 47 Fed. Reg. 26,860 (June 22, 1982) (to be codified at 45 C.F.R. pt. 2).

322. 42 U.S.C. § 1395hh(b) (2000).

guidance.[323] In that regard, with few exceptions, the Court has willingly followed the prescription of *Chevron Inc. v. Natural Resources Defense Council, Inc.*[324] to defer to the agency's reasonable interpretation of the statute in legislatives rules unless Congress has clearly indicated otherwise.[325] In part, this willingness is probably due to the fact that most agency rules and guidance pertain to Medicare payment to providers, which is arcane, dense and boring.[326] The lower federal courts have taken their cue from the Supreme Court regarding *Chevron* deference and have generally deferred to HHS rules and other guidance.[327]

CONCLUSION

In a modern democratic state, it should be possible to implement a well-conceived and beneficial solution to a major societal problem. This principle has attended the interpretation of constitutional law when Congress has sought to address problems with the common law tort system in the past through federal statutory reforms.[328] The principle should apply equally to Medicare-led malpractice reform—an innovative but pragmatic approach to addressing the inadequacies of conventional malpractice litigation.

The major impediment to mandatory Medicare-led malpractice reform is the guarantee to a jury trial in the Seventh Amendment of the federal constitution. As discussed above,[329] the Supreme Court revisits this issue sporadically, and a well developed jurisprudence offering clear guidance does not exist. It is not clear, therefore, whether Congress has the authority to enact a mandatory malpractice adjudication system in a federal benefits program that is ancillary to the program's mission but replaces the state common law tort system for malpractice claims.

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323. Jost, *supra* note 288, at 54-55.

324. Chevron, Inc. v. Natural Res's Def. Council, Inc., 467 U.S. 837 (1984). *See* Peter H. Schuck & E. Donald Elliott, *To the Chevron Station: An Empirical Study of Federal Administrative Law*, 1990 DUKE L.J. 984 (1990).

325. Jost, *supra* note 288, at 49-55. In *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988), the Court refused to give *Chevron* deference to a statutory interpretation that CMS's predecessor, the Health Care Financing Administration, developed in the course of litigation to justify the promulgation of a payment policy as a legislative rule with retroactive effect.

326. Jost, *supra* note 288, at 54.

327. *Id.* at 55-65.

328. *See supra* notes 129-205 and accompanying text.

329. *See supra* notes 172-89 and accompanying text.

Consequently, we believe that Medicare-led malpractice reform should be voluntary, allowing beneficiaries to opt out if they so desire. This model has been used in special federal compensation schemes in the past.[330] This voluntary character, however, puts the onus on the designers of Medicare-led malpractice reform to establish a system that will truly benefit the beneficiary and make it clear to beneficiaries that, when they sustain a medical injury, it is in their best interest to proceed through the Medicare malpractice resolution system rather than seek common law remedies in court.

It is essential to test any program of Medicare-led malpractice reform in demonstration projects in which various approaches to reform can be evaluated. These experiments will elucidate how health care providers can use their mandatory quality assurance and patient safety promotion programs to identify medical injuries early, and to facilitate their resolution and subsequent prevention.

Clearly, any malpractice reform of this magnitude and originality will generate legal challenges. A carefully designed, transparent demonstration project also can convince stakeholders that the proposed reform is indeed what it purports to be—a way to resolve medical claims of Medicare beneficiaries expeditiously and fairly while eliminating undue burdens on patients, health care providers, and medical liability insurers from costly, protracted tort litigation.

330. *See supra* note 158 and accompanying text.

EMPLOYER BY NAME, INSURER BY TRADE: SOCIETY'S OBESITY EPIDEMIC AND ITS EFFECTS ON EMPLOYERS' HEALTHCARE COSTS

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INTRODUCTION

Obesity is more than a fashion *faux pas*—it is a fatal epidemic affecting one third of the nation's population and twenty-two percent of the country's workforce.[1] As a result of its far reaching effects, obesity costs employers $13 billion annually in healthcare and loss of productivity costs.[2] Therefore, obesity not only clogs the arteries of its victims, it also clogs the nation's economic and commercial "arteries." This steady buildup of healthcare costs poses a substantial threat to the country's workforce, and can only result in one outcome if not treated immediately—a blockage of employers' resources and the consequential death of the nation's competitive reputation in the international market.

This Note will look at the obesity epidemic and its effects on employers' healthcare costs. Part I consists of general background

1. Peter Neurath, *Insurers Tackle Weight Issue with Obesity Programs*, PUGET SOUND BUS. J., July 30, 2004, *available at* http://seattle.bizjournals.com/seattle/stories/2004/08/02/focus8.html.

2. Krukowski & Costello, S.C., *Tipping the Scales: Weighing the Business Costs of Obesity*, WASH., D.C. EMP. L. LETTER, Dec. 2003, at 1.

information regarding obesity. Part II discusses the exact costs incurred by employers, and suggests various methods employers can use to reduce increased healthcare costs associated with obesity. Finally, Part III discusses methods and efforts used by entities other than employers to assist in reducing healthcare costs associated with obesity.

I. GENERAL BACKGROUND ON OBESITY

A. OBESITY: DEFINITION, PREVALENCE, CAUSES, AND CONSEQUENCES

A person is obese if he or she has a body mass index of 30 or greater.[3] According to the National Institutes of Health, approximately 22.3% (39.8 million adults) of the nation's population over the age of twenty are obese.[4] Astonishingly, the percentage of obese adults within the United States doubled between 1980 and 2000.[5] Similarly, there was a fifty percent increase in the number of obese adults worldwide from 200 million in 1995 to 300 million in 2000.[6] In light of such data, the U.S. Center for Disease Control concluded that obesity has reached epidemic proportions.[7]

Obesity is caused by a combination of medical and cultural factors including the following: excessive eating, lack of exercise, genetic predisposition, endocrine disorders, and suburban living.[8] However, the recent dramatic increase in obesity incidence is largely a result of changes in diets and an overall decrease in levels of physical activity.[9] Accordingly,

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3. Sally Roberts, *More Employers See Risks, Costs of Obesity: Perception of Disease is Changing*, BUS. INS., Apr. 22, 2002, at 1, 32. Morbid obesity is defined as a body mass index of forty or greater. *Id.* A person with a body mass index between twenty-five and thirty is merely considered overweight. Charles Fleming, *Costlier Insurance May Lie Ahead for the Overweight*, WALL ST. J., Apr. 6, 2004, at D5.

4. Roberts, *supra* note 3.

5. Leslie Gross Klaff, *Weighing the Pros and Cons of Paying for Gastric Bypass Surgery; Although the Surgery is Popular, Some Health Plans and Employers are Refusing to Pick up the Tab,* WORKFORCE MGMT., June 1, 2004, at 88.

6. Kiernan McHugh, *Employers Face Fallout as Workers Grow More Obese; as Obesity Levels Continue to Rise, Kiernan McHugh Warns That the Problem is Also One for Employers,* THE IRISH TIMES, Apr. 20, 2004, at 52. As of 1999, ten percent of European adults were obese, twenty percent of the adult population in the United Kingdom was obese, and 30.5% of the population in the United States was obese. *Id.*

7. Roberts, *supra* note 3. While obesity incidence increased, the number of Americans with diabetes also rose forty-nine percent during the time period from 1991 to 2000. *Id.*

8. Anne Mayberry, *Health Issues: It's Not the Money*, MGMT. Q., Summer 2004, at 10, 11-12.

9. Krukowski & Costello, S.C., *supra* note 2.

society generally considers obesity to be a lifestyle condition that is triggered by the choices we make on a day-to-day basis.[10]

Although the majority (three quarters) of those characterized as obese fall within the age range of fifty-one to sixty-nine, more than fifteen percent of children between the ages of twelve and nineteen are obese as well.[11] This percentage does not include the number of children who are merely overweight. According to a recent study by the Center for Disease Control, fourteen percent of children and twelve percent of adolescents are overweight.[12] These numbers are significant because overweight children and adolescents are more likely to be overweight in adulthood.[13] These numbers are particularly important to employers because currently obese children are the future of the country's workforce.[14]

Several factors contribute to overweight among children and adolescents including the following: parental weight, socioeconomic status, early childhood nutrition, level of physical activity, and engagement in sedentary activities.[15] It is essential to prevent and treat overweight in childhood and adolescence because it is near impossible for adults to achieve sustained weight loss.[16] For example, sixty percent of children who lose weight maintain such loss, as compared to only ten percent weight loss maintenance in adults.[17] Accordingly, lawmakers have been attacking the country's obesity epidemic by focusing on children's health via the regulation of snack foods, school lunches, and physical activity.[18]

Obesity claims one life every ninety seconds and about 300,000 lives annually.[19] Additionally, obesity can shorten an individual's lifespan by twenty years.[20] The number of annual preventable deaths caused by

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10. Mayberry, *supra* note 8, at 11.

11. *Id.* at 16.

12. Jennifer S. Haas et al., *The Association of Race, Socioeconomic Status, and Health Insurance Status with the Prevalence of Overweight Among Children and Adolescents*, 93 AM. J. PUB. HEALTH 2105 (2003).

13. *Id.*

14. Kelley M. Blassingame, *Employers, Government Fight to Curb Obesity Epidemic*, EMP. BENEFIT NEWS, Aug. 2003, at 37.

15. Haas et al., *supra* note 12.

16. *Id.*

17. Lola Butcher, *Insurers, Docs Debate Adding Obesity to Menu*, KAN. CITY BUS. J., June 4, 2004, at 1, *available at* http://kansascity.bizjournals.com/kansascity/stories/2004/06/07/story4.html.

18. Sally Roberts, *Florida Seeking to Reward Investment in Wellness Plans*, BUS. INS., Aug. 9, 2004, at 4.

19. Blassingame, *supra* note 14.

20. *Id.*

obesity is only surpassed by preventable deaths caused by smoking.[21] This high number of preventable deaths is a result of the vast number of illnesses and health conditions caused directly and indirectly by obesity.

Obesity is a known risk factor for over thirty medical conditions including diabetes, hypertension, cardiovascular disease, respiratory problems, musculoskeletal disorders, fatigue, wheezing, and depression.[22] Additionally, obese adults are more likely to be severely disabled than non-obese adults.[23] Consequently, "obesity has more negative health consequences and affects a larger percentage of Americans than smoking, alcohol abuse, or poverty."[24] Fortunately, overweight individuals may reduce the risk for some chronic obesity-related disorders by losing a mere five to fifteen percent of their weight.[25]

B. OBESITY-RELATED COSTS

Obesity costs the United States over $117 billion annually,[26] accounting for 12% of the national health care budget[27] and 9.1% of total annual medical care expenses.[28] This enormous expenditure is a result of a combination of various medical costs directly related to obesity: medical insurance, hospitalization, physician visits, outpatient testing/treatment, laboratory and radiology tests, and prescription drugs.[29] Additionally, the

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21. Roberts, *supra* note 3.

22. Mayberry, *supra* note 8. According to the National Institutes of Health, obesity is linked to heart disease, hypertension, some cancers, diabetes, stroke, arthritis, breathing problems, and depression. Neurath, *supra* note 1. Obesity also increases an individual's likelihood of suffering kidney disease. McHugh, *supra* note 6. Furthermore, obesity leads to certain orthopedic conditions, including the need for joint replacement resulting from carrying too much weight. Dyke Hendrickson, *Obesity 'Disease' Could Open Doors for Reimbursement, Businesses*, MASS HIGH TECH., Sept. 27, 2004, *available at* http://www.masshightech.com.

23. Mayberry, *supra* note 8.

24. Chandra Harris, *Employers Tackling Weighty Matters; St. Mary's Hosts Summit on Fighting Obesity*, KNOXVILLE NEWS-SENTINEL, Jan. 28, 2004, at C1.

25. Krukowski & Costello, S.C., *supra* note 2. This conclusion came from a Department of Health and Human Services report. *Id.*

26. Mayberry, *supra* note 8.

27. Amy Joyce, *Companies Take Staff Weight Loss Programs to Heart: Wellness I Employers Find That Healthy Employees Cut Insurance Costs*, VANCOUVER SUN, Mar. 27, 2004, at I6. This percentage was estimated by World Bank. *Id.*

28. *Id.*

29. *Workforce Health Improvement Program Act: Healthy Employees; Healthy Bottom Line: Subcomm. On Tax, Fin. and Exports of the H. Small Bus. Comm.*, 108th Cong. 35 (2004) [hereinafter *Hearings*] (prepared remarks of Edwin Foulke, Jr., Esq., Jackson Lewis, LLP).

following percentages of annual medical costs associated with particular diseases are attributable to obesity: sixty-one percent of the $2.4 billion spent on type-2 diabetes; almost twenty-five percent of the $57 million on osteoarthritis; and seventeen percent of the $1.6 billion spent on hypertension.[30] These costs are covered by a combination of health insurance,[31] life insurance,[32] and disability insurance.[33]

In addition to its effect on government spending, the country's obesity epidemic results in increased costs to both obese and non-obese individuals. Obese individuals have high annual costs for medications,[34] and incur higher health costs than smokers or drinkers.[35] Overweight and obese Americans spend about $93 billion per year more than non-overweight and non-obese Americans.[36] Costs associated with obesity and related illnesses are passed on to all Americans, including non-obese individuals, via greater premiums and co-payments for health insurance plans.[37] Additionally, the average taxpayer spends between $150 and $200 annually to finance obesity-related medical expenses for Medicare and Medicaid recipients.[38]

II. THE OBESITY EPIDEMIC AND ITS EFFECT ON EMPLOYERS

A. OBESITY COSTS INCURRED BY EMPLOYERS

The country's recent unprecedented weight increase has serious ramifications on employers' health care costs, employee productivity,

30. Roberts, *supra* note 3. These numbers were estimated by Watson Wyatt Worldwide. *Id.*

31. *Hearings*, *supra* note 29 (stating health insurance is responsible for $7.7 billion annually towards these costs).

32. *Id.* (stating life insurance is responsible for $1.8 billion annually towards these costs).

33. *Id.* (stating disability insurance is responsible for $800 million annually towards these costs).

34. Krukowski & Costello, S.C., *supra* note 2 (stating expensive obesity-related medications include those for diabetes and cardiovascular diseases).

35. Neurath, *supra* note 1. *See also* Marie Suszynski, *A Weighty Issue: Health Insurers are Helping Policyholders Lose Weight to Help Trim Claims Costs*, BEST'S REV., May 2002, at 99 (stating obese individuals spend thirty-six percent more on inpatient and outpatient care and seventy-seven percent more in medications than smokers or problem drinkers).

36. Sharon Epperson, *The Obesity Charge*, TIME, Sept. 8, 2003, at 100.

37. *Id.*

38. *Id.*

absenteeism, workplace injuries, morale, and employment discrimination.[39] On average, at least twenty-two percent of employees at any given workplace are overweight or obese.[40] Healthcare costs for obese employees cost thirty-six percent more than such costs incurred by normal weight employees. [41] Because healthcare care costs are detrimental to a company's financial health, employers are asking employees to lose weight.[42]

Employers spent $13 billion in 1994 for the following costs associated with obesity-related health problems:[43] (1) higher use of health care services; (2) lowered productivity; (3) increased absenteeism; (4) higher health and disability insurance premiums; and (5) other weight-related conditions.[44] This exorbitant amount was broken up as follows: $8 billion was paid by health insurance, $2.4 billion for sick leave, $1.8 billion for life insurance, and $1 billion for disability insurance.[45] Employee overweight and obesity comprise eight percent of private employer medical claims, and cost employers an average of $8,720 per claimant per year for wage indemnity.[46] In addition to its consumption of billions of dollars in health care costs, obesity is associated with thirty-nine million lost work days, 239 million restricted activity days, ninety million bed days, and sixty-three million physician visits.[47] Moreover, a quarter of obese workers under-perform due to weight-related infirmities.[48]

B. METHODS EMPLOYERS CAN USE TO PREVENT INCREASED HEALTHCARE COSTS ATTRIBUTED TO EMPLOYEES' OBESITY AND OVERWEIGHT

Employers mainly battle insurance costs due to obesity in the two following ways: (1) eliminate or trim benefits; and (2) require employees to pay more of the costs in the form of (a) higher premiums, (b) deductibles,

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39. *Hearings, supra* note 29.

40. Neurath, *supra* note 1.

41. *Hearings, supra* note 29.

42 Lisa Yoon, *Employers Look to Trim Fat*, CFO.COM, July 17, 2003, http://www.cfo.com/printable/article.cfm/3009696.

43. Krukowski & Costello, S.C., *supra* note 2.

44. Yoon, *supra* note 42.

45. Krukowski & Costello, S.C., *supra* note 2.

46. NATIONAL BUSINESS GROUP ON HEALTH, HEALTHY WEIGHT, HEALTHY LIFESTYLES PRIMARY FACT SHEET FOR THE INSTITUTE ON THE COSTS AND HEALTH EFFECTS OF OBESITY (2005), http://www.wbgh.org/pdfs/obesity_factsheet.pdf.

47. *Hearings, supra* noted 29, at 36.

48. *Id.*

and (c) co-payments.[49] However, there are several other means of reducing obesity-related healthcare costs available to employers, including the utilization of anti-obesity employment policies, providing coverage for bariatric surgery, utilization of employee health risk appraisals, and implementing employee wellness programs.[50] Each of these methods, as well as its advantages and disadvantages, are discussed below.

1. Anti-obese Employment Policy

The simplest way for employers to avoid escalating healthcare costs associated with obesity is to fire or refuse to hire obese individuals. Unfortunately, employers employing this method may meet adversity on the part of obese applicants claiming discrimination. Because there is no federal legislation prohibiting discrimination on the basis of appearance, obese individuals often seek redress from discriminating employers via the Rehabilitation Act or the Americans with Disabilities Act.[51]

a. The Rehabilitation and Americans with Disabilities Acts

Title I of the Americans with Disabilities Act ("ADA") prohibits employers from discriminating against disabled individuals by requiring such employers to "adopt unbiased hiring and promotion criteria and make reasonable accommodations" for qualified employees with disabilities.[52] According to the ADA, disability is defined as follows: "(A) a physical or mental impairment[53] that substantially limits one or more of the major life activities[54] of such individual; (B) a record of such an impairment; or (C)

49. Krukowski & Costello, S.C., *supra* note 2.

50. Terri Goveia, *Self Help*, CANADIAN HEALTHCARE MANAGER, Aug. 1, 2004, at 12, 13-15, *available at* www.chmonline.ca/images/August 2004/selfhelp.pdf. According to a Watson Wyatt/National Business Group on Health study, employers who raised deductibles or co-payments and implemented wellness programs expected a seven percent increase in healthcare costs as compared to the fourteen percent expected increase for companies not taking any such measures. *Id.*

51. Jennifer Shoup, Comment, *Title I: Protecting the Obese Worker*, 29 IND. L. REV. 206, 214 (1995).

52. *Id.* at 209-10.

53. The Act further defines a physical or mental impairment as "any physiological disorder or condition . . . affecting one or more of [several] body systems . . . or any mental or psychological disorder." *Id.* at 211 (alteration in original).

54. The Act further defines major life activities as "basic activities that the average person . . . can perform with little or no difficulty . . . including caring for oneself,

being regarded as having such impairment."[55] The Rehabilitation Act provides the same protection for individuals employed by the federal government or by entities receiving federal assistance.[56] Therefore, in order to succeed in a suit brought pursuant to either Act, obese individuals must prove that their obesity is an actual or perceived disability as defined by such Acts.

b. The *Cook* Case

The first federal appellate court to recognize that an employer violated the law by refusing to hire an obese individual was the Court of Appeals for the First Circuit in 1993.[57] In *Cook v. Rhode Island*, the defendant refused the plaintiff employment on the grounds that the plaintiff's obesity impaired her ability to work and increased her risk of developing serious medical problems that would result in absenteeism and increased worker's compensation claims.[58] The trial court held that obesity can be both an actual and perceived disability within the definition of the Rehabilitation Act.[59] However, the court noted that, in order to qualify as a disability, obesity must be a physiological disorder and cannot be a transitory or self-imposed condition resulting from an individual's voluntary actions or inactions.[60] The jury found in favor of the plaintiff on the ground that the defendant discriminated against her despite the fact that she otherwise qualified for employment with the defendant.[61] Subsequently, the defendant appealed the court's judgment of $100,000 awarded to the plaintiff in compensatory damages.[62]

In response to the defendant's appeal, the Equal Employment Opportunity Commission ("EEOC") filed an amicus brief with the First Circuit in which it urged that the question of obesity as a disability under the Rehabilitation Act and the ADA must be determined on a case-by-case

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performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. This list is not exhaustive." *Id.*

55. *Id.* at 210-11.
56. *Id.* at 208.
57. *Id.* at 214.
58. *Id.* at 214-15.
59. *Id.* at 215.
60. *Id.*
61. *Id.* at 215-16.
62. *Id.* at 216.

basis.[63] Furthermore, the EEOC argued that obesity may constitute a disability under the appropriate circumstances.[64]

Despite not being a psychological disorder, obesity may still meet the requirements of a physical impairment.[65] According to the Commission's interpretative guide on Title I of the ADA, physical characteristics, such as weight, are not impairments if they are not the result of a physiological disorder.[66] However, the EEOC argued that morbidly obese individuals do not have to suffer from a physiological disorder in order to qualify as disabled because morbid obesity falls outside the limits of the "physical characteristics" provision.[67]

In order to determine whether obesity is substantially limiting, the EEOC argued that the impairment should be analyzed by considering the following factors:[68] "(1) the nature and severity of the impairment; (2) the duration or expected duration of the impairment; and (3) the permanent or long-term impact, or the expected permanent or long term impact of, or resulting from, the impairment . . . . The determination of whether an individual is substantially limited in a major life activity must be made on a case-by-case basis."[69]

Additionally, the EEOC argued that neither the Rehabilitation Act nor the ADA's language requires the consideration of how individuals become impaired.[70] The EEOC stressed that "voluntariness" should not preclude the protection of obese individuals under either Act, and should only be relevant if the individuals could quickly "change the condition by altering their behavior."[71] In support of its argument, the EEOC compared obesity with other impairments covered by both Acts that may be caused by voluntary conduct including the following: alcoholism, diabetes, emphysema, and heart disease.[72]

The First Circuit Court of Appeals adopted the EEOC's reasoning by rejecting the trial court's holding that "obesity must necessarily be an involuntary and an immutable physiological disorder to qualify for coverage under the Rehabilitation Act."[73] Furthermore, the court held that

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63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.* at 216-17.
67. *Id.* at 217.
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.* at 218.

an employer cannot deny employment on the grounds that an employee increases an employer's health care costs and results in increased absenteeism and worker's compensation. In doing so, the First Circuit Court of Appeals provided morbidly obese individuals with a means of redress for employment discrimination based on their actual or perceived obesity.

c. Employment Discrimination Against the Obese in a Post-*Cook* World

Although the *Cook* decision applies only to the Rehabilitation Act, the language of the ADA supports the finding that the ruling should be similarly applied to the ADA.[74] The ADA requires that both Acts be considered in tandem.[75] With regards to cases in which complaints are filed under both Acts, the ADA requires enforcement agencies to promulgate procedures in order to avoid "duplications of effort and conflicting standards.[76] Accordingly, the *Cook* case's holding that obesity may constitute a disability is applicable to cases brought under the ADA.

There have been several cases post-*Cook* that have applied and discussed the First Circuit's holding.[77] The majorities in these cases

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74. *Id.* at 219.

75. *Id.* "Except as otherwise provided in this Act, nothing in this Act shall be construed to apply a lesser standard than the standards applied [under the Rehabilitation Act.]" *Id.*

76. *Id.*

77. *See, e.g.,* Furst v. Unified Court Sys., No. 97-CV-1502, 1999 WL 1021817, at *3-4 (E.D.N.Y. Oct. 18, 1999) (holding that the plaintiff's weight was not a physical impairment that substantially limited a major life activity because plaintiff failed to allege (1) that he suffered from morbid obesity; (2) that he has ever been clinically diagnosed as obese; (3) that he has experienced medical problems due to his weight; and (4) that his weight interferes in any way with any of his major life activities); Hazeldine v. Beverage Media, Ltd., 954 F. Supp. 697 (S.D.N.Y. 1997) (holding that plaintiff failed to establish a threshold element of her ADA case because she did not present sufficient evidence that she was disabled under the ADA due to her obesity substantially limiting a major life activity or because of defendant's perception of plaintiff as disabled); Fredregill v. Nationwide Agribusiness Ins. Co., 992 F.Supp. 1082 (S.D. Iowa 1997) (holding that "evidence that employee was not promoted to senior management position because his weight was not consistent with "corporate image" failed to establish claim under ADA."); Smaw v. Va. Dep't of State Police, 862 F. Supp. 1472 (E.D. Va. 1994) (holding that the Virginia State Police did not violate either the Rehabilitation Act or the ADA when it reemployed plaintiff as a dispatcher due to her obesity and resulting inability to satisfy the maximum weight required for her former position as a trooper because the police regarded plaintiff's obesity as an impairment preventing a particular position of institutional attendant, rather than an impairment barring plaintiff from a large class of jobs as was the case in *Cook*).

distinguished their respective facts from those in the *Cook* case, and held that the plaintiffs' obesity failed to meet the definition of a disability under the Rehabilitation Act or the ADA.[78] As demonstrated by these cases, it is very difficult for obese individuals to bring a successful case against an employer for discrimination based on an individual's obesity. Accordingly, although employment discrimination against obese individuals is morally questionable, it is not likely that employers will meet an abundance of litigation or adverse judgments for employing anti-obesity employment policies.

2. Healthcare Coverage for Bariatric Surgery

A second way employers can reduce healthcare costs associated with obesity-related illnesses and injuries is by providing employees with health care coverage for bariatric surgery. Because such surgery results in a substantial weight reduction, employers providing coverage for the surgery may save the money they would have otherwise spent on health care costs associated with an employee's obesity or overweight.

The National Institute of Health maintains that gastric bypass surgery should be limited to three groups of people: (1) those with a BMI above 40; (2) those that are 100 pounds overweight; and (3) those that are less obese but have life-threatening complications such as high blood pressure or coronary disease.[79] During the surgery, a surgeon attaches the patient's small intestine to a small pouch in the stomach.[80] Because food bypasses part of the small intestine, the body absorbs a reduced amount of calories and nutrients.[81] A surgeon does not become competent to perform gastric bypass surgery until he or she completes more than 100 procedures.[82] However, a doctor is capable of performing gastric bypass surgery after attending only one weekend seminar.[83]

Bariatric surgery is extremely expensive and can result in serious complications. Each gastric bypass surgery costs between $25,000 and $40,000.[84] Despite such expense, the surgery fails to guarantee weight loss and results in fatalities during or after two percent of all such surgeries.[85]

78. *See, e.g.*, cases cited *supra* note 77.
79. Klaff, *supra* note 5.
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.*
85. *Id.*

For example, patients can bypass the purpose of the surgery by eating very small amounts of food throughout the day, thereby eating the same amount of food as consumed pre-surgery. Accordingly, many health insurance companies and employers have recently dropped coverage of bariatric surgery, including Blue Cross Blue Shield of Florida, United Healthcare, and Humana Inc.[86]

However, the disadvantages of bariatric surgery have not dissuaded many Americans from obtaining such surgery. According to the American Society of Bariatric Surgery, 103,200 bariatric surgeries were performed in 2003, as compared to the 16,200 performed in the early 1990s.[87] Without assistance from employers and insurers, many gastric bypass surgery patients are using personal funds to pay for the costs of the surgery.[88]

Employers may be hesitant to cover bariatric bypass surgery because they are waiting for further research on complications and death rates associated with such surgery.[89] However, the costs and risks associated with gastric bypass surgery may prove less harmful to employers than the costs attributed to obesity-related health problems that such surgery would treat. Furthermore, employers that refuse to pay for employees' bariatric surgeries may be subject to lawsuits on the ground that such refusal is contrary to state law or the language in the employer-issued health insurance. Fortunately for employers, employees have generally been unsuccessful in such suits.[90]

A 2003 survey conducted by Mercer Human Resource Consulting concluded that forty-eight percent of employers offer insurance coverage

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86. *Id.*

87. *Id.*; Susan J. Alt, *Bariatric Surgery May Become a Self-Pay Service*, STRATEGIC MGMT., Dec. 2003, at 12 (The number of such surgeries performed in 2002 rose by sixty-four percent in 2003).

88. Alt, *supra*, note 87.

89. *Id.*

90. *See* Manny v. Cent. States, S.E. and S.W. Areas Pension and Health and Welfare Funds, 388 F.3d 241 (7th Cir. 2004) (holding that trustees of multi-employer employee benefit plan acted reasonably under ERISA when they denied coverage for gastric bypass surgery sought by morbidly obese participant under the plan's cosmetic-care exclusion); Sprague v. U.S. Bakery, 116 P.3d 251 (2005) (holding that employer did not have to provide coverage for employee's gastric bypass surgery because under Oregon law, such surgery was not a compensable injury that was caused in material part by the employee's knee condition for which the employer did provide coverage). *But see* Hopp v. Grist Mill, 499 N.W.2d 812 (Minn. 1993) (holding that evidence was sufficient to support compensation judge's determination that under Minnesota law, gastric bypass surgery was necessary to cure or relieve effects of claimant's compensable thrombosis of the right leg (causally related to a work injury) because weight reduction was essential to improvement of claimant's condition).

for bariatric surgery.[91] By covering employees' bariatric surgery, employers avoid potential future medical costs for obesity-induced problems such as high blood pressure, high cholesterol, heart problems, and diabetes.[92] If employers do not offer gastric bypass coverage, they will pay higher health care and disability costs for obesity-related conditions.[93] Furthermore, such employers will be hit with various indirect costs for absenteeism due to sickness.[94] These costs include lost productivity, increased training, and lower morale among coworkers covering for their sick colleagues.[95] Unfortunately, fully insured employers do not have the authority to decide whether to provide coverage for bariatric surgery because such decisions belongs to the insured employers' health care providers.[96] Self-insured employers, however, can and must weigh such considerations upon making a decision regarding whether or not to provide employees coverage for bariatric surgery.[97]

The National Business Group on Health recommends that companies deciding to cover gastric bypass surgery should participate in "bariatric networks with access to top surgical centers."[98] The First Health Group Corporation started the first nationwide bariatric network for its member companies in 2004.[99] In order to be a member in the network, surgeons must have: (1) annually performed more then 100 surgeries for two years; and (2) have a record of low post-procedure complication rates and minimal weight gain.[100] Additionally, First Health has dropped the cost of the procedure to $15,000 by negotiating discounts of up to fifty percent with in-network surgeons.[101]

Unfortunately, gastric bypass surgery has not yet proven to remedy the obesity epidemic and its resulting increase in employers' health care costs. As demonstrated in the following description of Cingular Wireless'

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91. Klaff, *supra* note 5. One third of these employers only covered such surgery if the employee also participated in behavior-modification programs. Jen Haberkorn, *Obesity's New Status Will Not Affect Insurers; But Employers May Pay More*, WASH. TIMES, July 16, 2004, at A12.

92. Klaff, *supra* note 5.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

experience with gastric bypass surgery coverage, employers may be better off refraining from providing such coverage to employees.

Prior to August 2003, Cingular Wireless provided full gastric bypass surgery coverage to its employees. As a result, one hundred Cingular employees underwent gastric bypass surgery in 2002.[102] This number rose to nearly four hundred employees in the first half of 2003.[103] The drastic increase in obesity surgery cost Cingular $6 million in medical claims.[104] Furthermore, the company experienced a high number of absenteeism problems at its call centers due to the large number of employees recovering from such surgery on short-term disability.[105]

Because of steep costs and severe risks associated with gastric bypass surgery, Cingular stopped offering its employees coverage for the surgery in August 2003.[106] Cingular explained that the surgery is not the "silver bullet" employers hoped for in terms of solving the obesity epidemic because gastric bypass surgery has not proved to be a permanent, long-term fix.[107] Furthermore, the surgery cost was not justified because the majority of employees getting the surgery worked in call centers where turnover was a problem.[108]

However, gastric bypass surgery coverage may still prove to be beneficial to employers' health care costs if provided on a limited basis. For example, Highmark Inc. provides bariatric surgery coverage for its 12,000 employees pursuant to recently tightened eligibility requirements.[109] An employee must satisfy the following criteria to qualify for coverage: he or she must (1) be morbidly obese; (2) have undergone and failed a weight-loss and nutrition program; and (3) received psychiatric counseling.[110] As a result of such tightened requirements, only ten Highmark employees had the operation in 2003 as compared to the hundreds of Cingular employees that had the operation pursuant to Cingular's less-stringent coverage requirements.[111] By setting strict coverage standards, a company can better

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102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* One Cingular employee died from the procedure, one employee had serious complications, and another had to have the procedure reversed. *Id.*

107. *Id.*

108. *Id.* For example, twenty percent of the 374 employees who had the surgery during the first half of 2003 were no longer with the company at the end of the year. *Id.*

109. *Id.* Highmark Inc. is an independent licensee of Blue Cross Blue Shield Association. *Id.*

110. *Id.*

111. *Id.*

manage its health care costs by assuring that only the employees that truly need the surgery are getting such treatment.

3. Health Risk Appraisals

Because employers can better manage costs of health care by managing the risks associated with health care costs, there has been a shift among employers in terms of overall health care strategy from a wellness focus to health risk appraisals.[112] The goal of health risk appraisals is to identify employees' individual health care needs and to steer employees into programs that are tailored to their needs, interests, and willingness to participate.[113] Accordingly, employers can use such appraisals as a gateway to behavior change in their employees.[114]

The process associated with health risk appraisals is cost effective and easy for employers to administer. Employers employ vendors who establish appraisal programs that are primarily available online.[115] In turn, employees answer medical questions that are designed to identify individuals with specific health risk factors such as smoking, asthma, depression, diabetes, or obesity.[116] Additionally, appraisals may ask employees about their interests or hobbies.[117] Post appraisal, employees are given a health condition status report.[118] This report provides an employee with information tailored to his or her individual problem.[119] An online appraisal costs between $2 and $6 per appraisal, whereas a paper-based appraisal costs between $12 and $15.[120] Depending on the services rendered, the total annual cost of a health risk appraisal program costs employers between $40 and $100 per employee.[121]

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112. Meg Fletcher, *Health Risk Appraisals Address Employees' Individual Problems*, 38 BUS. INS., Nov. 8, 2004, at T3.
113. *Id.* at T3.
114. *Id.*
115. *Id.* at T9.
116. *Id.*
117. *Id.*
118. *Id.* at T10.
119. *Id.*
120. *Id.* at T9.
121. *Id.*

4. Employee Wellness Programs

a. General Information

Employers currently promote healthy lifestyles through various overall wellness programs that are designed to manage obesity and related medical conditions.[122] Employee wellness programs yield large dividends resulting in a rate of return from $1.49 to $4.91 for every dollar spent.[123] In addition to saving health care costs, wellness programs result in healthier employees who have better morale, more self-confidence, and who are more productive.[124]

The following is a list of programs or benefits to be used by employers to promote employee health and wellness, while at the same time reducing company health care costs. This list is based on the list compiled by Krukowski & Costello, S.C. in its article *Tipping the Scales: Weighing the Business Costs of Obesity*, which was published in the December 2003 issue of the Washington, D.C. Employment Law Letter.

- Work-site fitness programs, including a well-equipped fitness facility with licensed trainers. If feasible, an onsite gym. If not feasible, subsidize gym membership;
- Educational programs and/or counseling on weight management and cholesterol management;
- Financial incentives to employees who participate in weight-loss programs;
- Incentives for employees to walk and take steps during the workday. For example, make parking and elevator use less convenient or provide attractive walking paths near the facility;
- Educational programs on disease management and stress management;
- Complimentary annual flu immunizations;
- Cancer and other health screenings;
- Ergonomics programs;
- Employee assistance programs; and

122. Roberts, *supra* note 3. According to a 2003 benefits survey conducted by the Society for Human Resource Management, fifty-seven percent of employers offer wellness programs, resources, or information. Joyce, *supra* note 27. Additionally, thirty one percent of employers offered a fitness-center subsidy, while twenty four percent offered a weight-loss program. Roberts, *supra* note 3.

123. Krukowski & Costello, S.C., *supra* note 2.

124. *Id.*

- Flexible work schedules and leave policies that give employees an opportunity to take time off from work to obtain preventable medical care and attend wellness programs.[125]

Although employee wellness programs result in excellent rates of return and are easy to administer, such programs have several disadvantages. In particular, employers face two major problems while determining which approach to employee wellness provides the best return on investment. First, weight management has a large individual behavioral component; and second, there is no specific identifiable medical obesity treatment.[126] Furthermore, employers often fail to intervene in employees' obesity problems on the ground that such problems result from personal lifestyle choices.[127]

Additionally, employers are pursuing a health benefit strategy approach to health and health care management rather than a risk management approach.[128] Under health care management approaches, employers spend company resources on employees who volunteer for wellness programs, such as corporate gyms, and on unlimited health care coverage for employees.[129] Because the resources are not directed towards the people who would benefit most from such wellness programs, this allocation of corporate resources is inadequate.[130] As demonstrated by the results of a study conducted by William M. Mercer Inc. for the purpose of identifying costs for preventable conditions and qualifying potential savings opportunities, approximately thirty to forty percent of total benefit expenses are associated with preventable conditions.[131] Accordingly, it makes more sense for employers to take a risk management approach to disease prevention by focusing on the following three factors: (1) the small percentage of people and conditions associated with most illnesses; (2) the greatest use of services; and (3) the biggest productivity losses.[132]

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125. *Id.*

126. Roberts, *supra* note 3.

127. Sally Roberts, *Employers Weigh in on Obesity Risks*, BUS. INS., Nov. 17, 2003, at 4, 35.

128. Bruce Kelley, *Employer Wellness Programs Failing*, NAT'L UNDERWRITER, April 24, 1995, at 13.

129. *Id.*

130. *Id.*

131. *Id.* Less than five percent of health benefit expenses are invested in health prevention. *Id.*

132. *Id.*

b. Model Wellness Program

In order to provide companies with a model wellness program, the National Business Group on Health has posted Pitney Bowes' obesity initiative and proposed strategy on the Group's website.[133] This model is broken up into three phases each lasting one year.[134] Each phase is further broken up into three sections: (1) Supportive Corporation; (2) Healthy Work Environment; and (3) Personal Responsibility.[135]

Phase One of the model strategy lays out the overall foundation of the program, whereas the remaining two phases impose greater responsibilities and stricter standards for the programs implemented in the first phase.[136] The "Supportive Corporation" section of Phase One calls for the implementation of the following services and programs: an e-health platform;[137] preventative services and screenings; behavioral health and disease management programs; weight loss, fitness and nutrition education; and a registered dietician.[138] The Supportive Corporation efforts are supplemented with a Health Work Environment consisting of (1) health professionals that teach and counsel employees in on-site medical clinics; and (2) regular healthy choices on the menu provided by local food services that work with dieticians.[139] Finally, the Personal Responsibility section of Phase One suggests that Pitney Bowes provide the following programs for its employees: numerous well-attended and well-received health and fitness seminars; Weight Watcher programs at worksite locations; fitness centers at the world head quarters and Shelton locations in Connecticut; and activity and exercise fitness programs through worksite initiatives.[140]

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133. National Business Group on Health, Pitney Bowes: Obesity Initiative, http://www.wbgh.com/healthy/pitneybowes_obesityinitiative.cfm (last visited Jan. 6, 2005).

134. *Id.* Phase One: 2003-2004; Phase Two: 2004-2005; and Phase Three: 2005-2006. *Id.*

135. *Id.*

136. *Id.*

137. This platform consists of WebMD Tool, which expands personal health information access via the Internet. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

c. A Survey of Wellness Programs and Other Initiatives Offered by Employers

In order to provide a better picture of wellness programs and their success, the following is a survey of wellness programs provided by a variety of companies.[141]

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141. In addition to the detailed wellness programs discussed above, the following companies offer less detailed, yet successful programs: General Motors Corporation, Johnson and Johnson, Motorola, and Blue Cross Blue Shield of Rhode Island.

The number one health risk among employees at General Motors Corporation is obesity. Roberts, *supra* note 3, at 32. According to data from health risk appraisals of General Motors' employees conducted a few years ago, sixty-three percent of the Company's employees were considered overweight, while twenty-five percent of employees were obese. *Id.* General Motors reacted to such increased health risks by providing its employees with short-term weight loss programs. *Id.* Unfortunately, a heath risk appraisal conducted one year after the implementation of such programs found that General Motors employees put the weight back on. *Id.* Consequently, the company is currently working on a long-term weight loss model that would include peer-to-peer support groups, ongoing nutrition, exercise counseling, and nutrition classes. *Id.* General Motors provides limited coverage for obesity-related medical costs under its health and welfare benefits. *Id.* The company covers gastric bypass surgery for the following employees: (1) those with a BMI of forty or greater; and (2) those with a BMI of thirty-five to forty in addition to a co-morbid condition such as diabetes. *Id.* However, General Motors does not cover obesity-related drugs for its salaried employees. *Id.*

Johnson and Johnson first introduced its "Live for Life" program in 1979. Goveia, *supra* note 50, at 15. The company revamped the program in 1995 by focusing on prevention, self-responsibility, and offering financial incentives in the form of a medical plan credit to participating employees. Roberts, *supra* note 3. Johnson & Johnson measured the impact of the new program in 2000 by comparing thirteen risk factors identified in 1995 with those measured in 1999. *Id.* The study concluded that seven of the thirteen categories experienced an improvement in risk. *Id.*

Motorola has adopted a comprehensive wellness program for its employees that includes the following services: (1) disease management; (2) flu immunization; (3) cancer screenings; (4) smoking cessation classes; (5) health screenings; (6) health fairs; and (7) stress management. Krukowski & Costello, S.C., *supra* note 2. Proving to be very cost effective, the program saved Motorola $3.93 for every $1 invested in wellness benefits. Roberts, *supra* note 3. Additionally, participating employees only experienced a 2.4 percent increase in health care costs compared to the 18 percent increased experienced by nonparticipating employees. *Id.*

In order to induce members to commit to their own health, Blue Cross Blue Shield of Rhode Island created HealthMates Personal Choices. This plan rewards health-conscious, active members by providing benefit discounts. Goveia, *supra* note 50, at 13. Blue Cross tested the program on its own 1,100 employees in January 2004, resulting in a ninety-five percent participation rate. Roberts, *supra* note 3. Under the program, participants must sign a wellness pledge, choose from twenty-one HealthMates electives to customize a program, and track their progress. *Id.* In order to remain in the program, participants must

i. Coors Brewing Company

Coors Brewing Company has implemented a combination of wellness programs and health and welfare benefits to combat its employees' medical and lifestyle risks.[142] The top four medical risk factors at Coors Brewing Company in Golden, Colorado are weight, cholesterol, blood pressure, and blood sugar.[143] Correspondingly, the biggest lifestyle risks among the company's employees are poor diets, lack of exercise, and stress.[144] Unfortunately, all of these risks contribute to obesity.[145]

In addition to covering obesity-related pharmaceuticals and gastric bypass surgery for employees who obtain prior authorization for such measures, Coors instituted a ten-week employee wellness program called "Weight Matters."[146] This program offers employers weekly weight management classes at various worksites.[147] An employee who has "graduated" from the initial program may take additional extended classes.[148] Coors specifically addresses obese employees by offering a "stepped-up" version of its "Weight Matters" class.[149]

Coors plans to increase physical activity among its employees by implementing its new "10,000 Steps" program.[150] In order to measure how many steps an employee takes daily, the program provides participating employees with a pedometer for the cost of ten dollars.[151] By measuring the amount of exercise exerted by an individual throughout the day, the pedometers will help employees follow the surgeon general's recommendation of thirty minutes of daily exercise.[152]

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demonstrate progress. *Id.* Employees who fail to work out, see a nutritionist, or make any changes must wait one full year before they may participate in the program again. *Id.*

142. Roberts, *supra* note 3, at 32.

143. *Id.* This data came from preliminary findings from health risk assessment tests. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.* As of April 2002, Coors had not yet marketed the "10,000 Steps" program. *Id.*

151. *Id.*

152. *Id.*

ii. Duke University

Duke University worked with Johnson & Johnson Health Care Systems over the past fifteen years to manage the University's health and wellness program and encourage a healthy workforce via Johnson & Johnson's "Live for Life" Program.[153] The program, which initially created awareness of health and fitness issues, has evolved over the years and currently offers Duke's employees more targeted and individualized intervention including: (1) individualized nutrition counseling with registered dieticians; (2) individualized fitness counseling with exercise physiologists; (3) discounts to various fitness centers in the area; and (4) training for marathons and short-distance races through participation in Duke-sponsored run/walk clubs.[154] Duke pays for the entire cost of the program, resulting in a cost to the company of approximately $73 per employee.[155]

Duke's "Live for Life" program targets more high-risk employees. [156] Under this nine to twelve month program, individuals with elevated blood pressure or cholesterol are assigned a coach.[157] All coaches participating in the program are either registered nurses or registered dieticians.[158] This specialized program provides high-risk employees with eight telephonic interventions and four one-on-one counseling sessions.[159]

The University provides a unique incentive for its employees who participate in the "Live for Life" program.[160] In exchange for healthy lifestyle practices, Duke provides participating individuals with "funny money."[161] Employees use the "funny money" in a "Live for Life" store to buy various items including tee-shirts, exercise equipment, and cookbooks.[162] This incentive seems to be effective as evidenced by the almost 50% participation rate among Duke's employees.[163]

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153. Roberts, *supra* note 127, at 4, 35.

154. *Id.*

155. *Id.*

156. *Id.* at 4.

157. *Id.* at 35.

158. *Id.*

159. *Id.* The counseling sessions are based on which stage the employee has reached in its lifestyle change. *Id.*

160. *Id.*

161. *Id.* Such lifestyle practices include wearing a seat belt and eating five fruits and vegetables everyday. *Id.*

162. *Id.*

163. *Id.*

iii. Whirlpool Corporation

In order to promote healthier lifestyles among its 2,700 employees in Benton Harbor, Michigan, Whirlpool Corporation implemented the Coronary Health Improvement Project in 2001.[164] This six-week program educates employees about lifestyle changes, including low fat diets and exercise programs, via a series of videotapes and discussions.[165] Additionally, the program provides participating employees with cooking demonstrations and recipes.[166] Because Whirlpool only subsidizes half of the program's cost, employees must pay $150 to participate in the Coronary Health Improvement Project.[167] Furthermore, this program is only provided at Whirlpool's corporate headquarters, and is offered only twice a year.[168]

In 2003, Whirlpool expanded its employee health wellness efforts by offerings its "Dump Your Plump" program to all of its employees.[169] The program costs participating employees $25 and lasts ten weeks.[170] Teams of employees participating in "Dump Your Plump" set various weight loss and exercise goals, and receive points when they accomplish such goals.[171] Whirlpool provides winning teams with various prizes, including small Whirlpool appliances, coffee mugs, and gift cards.[172] In 2003, teams from six Whirlpool divisions participated in the "Dump Your Plump" program.[173]

iv. Bank One Corporation

Bank One Corporation manages its employees' health via corporate food services.[174] The company negotiated with its vendors to provide healthier food selections in vending machines and the corporate cafeteria.[175] Furthermore, the cafeteria's wellness selection provides

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164. *Id.*
165. *Id.* at 36.
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.*
170. *Id.*
171. *Id.*
172. *Id.*
173. *Id.* Up to ten individuals formed each team. *Id.*
174. *Id.*
175. *Id.*

employees with caloric and nutritional information for entrees.[176] This information is complemented by a brochure that supplies nutritional information for selections commonly offered in the cafeteria.[177] In addition to providing healthier food selections, Bank One offers the following wellness services to employees: (1) health information via the internet; (2) employee-pay-all weight management programs; (3) fitness centers in three of its locations; and (4) a "10,000 Steps" program.[178]

III. OTHER MEANS TO DECREASE EMPLOYEE HEALTHCARE COSTS ATTRIBUTED TO OBESITY AND OVERWEIGHT

In recognition of obesity's adverse economic affects on the nation's workforce and employers, many non-commercial entities have instituted programs and services to help employees achieve and maintain healthy lifestyles. This section discusses these helpful measures by breaking them down into three separate groups: non-profit and non-government efforts, federal government efforts, and state government efforts.

A. NON-PROFIT AND NON-GOVERNMENT EFFORTS

1. Institute on the Costs and Health Effects of Obesity

The Washington Business Group on Health[179] launched the Institute on the Costs and Health Effects of Obesity in June 2003. [180] With a member pool of more than 175 of America's largest employers,[181] the Institute was designed to "help employer members reduce the impact of obesity and weight-related conditions in the workplace."[182] Accordingly, the Institute

176. *Id.*

177. *Id.*

178. *Id.*

179. The Washington Business Group on Health is a nonprofit research organization. R.J. Lehman, *Insurers and Employers Chew the Fat Over Obesity Crisis*, BESTWIRE, June 19, 2003.

180. Although its formation was first announced to the public at a press conference at the National Press Club on July 17, 2003, the institute conducted its first "brainstorming" session the following day. Lehman, *supra* note 179.

181. Founding companies include the following: Fidelity Investments, General Mills, Inc., Honeywell International, Morgan Stanley, PepsiCo, Saks, Inc., Starwood Hotels, Ford Motor Co., and IBM. Yoon, *supra* note 42. Founding agencies include U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the Institute of Medicine, the American Association of Health Plans, Aetna, Pfizer Pharmaceuticals Group, and Whole Health Management Inc. Yoon, *supra* note 42.

182. Roberts, *supra* note 3, at 37.

will (1) explore the obesity epidemic; (2) "propose solutions and strategies"; and (3) "serve as a catalyst for change."[183]

In a report discussing an overview of the organization, the Institute on the Costs and Health Effects of Obesity proposed to perform the following activities between 2003 and 2005: (1) develop and disseminate a communications toolkit for employers that will include practical, easily reproducible information on the health effects of obesity as well as innovative weight management program ideas and resources for implementation; (2) develop and disseminate a modeling tool for employers to assess the cost impact of overweight and obesity in their own workforce; (3) create a forum for large employers to brainstorm solutions and develop key messages for senior management, field human resources personnel and employees; (4) spearhead a national weight awareness initiative on the health consequences of obesity and encourage companies across the nation to participate; (5) develop a series of Issue Briefs that focus on topics related to obesity and its impact on large employers and the workforce. Topics will include bariatric surgery, food at work, stress and weight, and ROI evidence for weight management programs; (6) sponsor an April 2004 Summit to provide a venue for large employers to explore the health and cost challenges related to obesity as well as share effective solutions and strategies; and (7) build and maintain an online resource that large employers can access to explore the implications of recent research findings related to obesity and research innovative weight management initiatives and the "lessons learned" by other large employers that implemented the initiatives at their work sites.[184]

Pursuant to its proposal, the group recently released a "toolkit" for large employers, detailing the "best practices and strategies in weight management in the workplace." [185] With the collaboration of Weight Watchers Corporate Solutions, the Institute created its *Checklist for Weight Management in Your Company: Weigh Your Options.*[186] This document

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183. Yoon, *supra* note 42. In order to propose solutions and strategies for obesity-related problems, the Institute will analyze input and data from various groups including employers, insurers, medical professionals, and health-care agencies. Lehman, *supra* note 179. Such obesity-related problems include lower productivity, higher premiums, and increased absenteeism. *Id.*

184. National Business Group on Health, The Institute on the Costs and Health Effects of Obesity at the National Business Group on Health, http://www.wbgh.org/docs/Obesity InstituteOverview.doc (last visited Feb. 10, 2006).

185. Roberts, *supra* note 127.

186. NATIONAL BUSINESS GROUP ON HEALTH, CHECKLIST FOR WEIGHT MANAGEMENT IN YOUR COMPANY, http://www.wbgh.org/healthy/checklist_obesity.pdf (last visited Feb. 10, 2006).

can be found on the Institute's website and lists ten areas that organizations must focus on in order to achieve a healthier workforce.[187] Also pursuant to its 2003 – 2005 proposal, the Institute sponsored its Leadership Summit on Obesity in June 2004.[188] The Institute's website provides members with Summit presentations and summarized highlights of breakout sessions.[189]

In order to spur competition and innovation, the Institute created its "Best Employers for Healthy Lifestyles Awards." These awards serve two main purposes: (1) they "acknowledge and reward those organizations that apply creative solutions to improving the health of employees," and (2) they "serve as a channel for sharing and comparing successful interventions, programs, and services."[190] In order to be eligible for the award, an employer must be a member of the National Business Group on Health, and have "initiated a lifestyle improvement program designed to reduce the prevalence of overweight and density in the workplace."[191]

Within the overall program, the Institute offers three separate levels of awards. First, the platinum award is given to organizations with mature "Healthy Weight, Healthy Lifestyles" programs.[192] Second, the gold award is given to organizations that are "creating cultural and environmental changes that support employees who have made a commitment to long-term behavioral change."[193] Lastly, the silver award is given to organizations that have fulfilled the following criteria: (1) obtained high level executive support; (2) selected a dedicated steering committee or team to advance initiatives; (3) undertaken a health-risk assessment or claims analysis to capture employer-specific data; and (4) launched programs or services that contribute to "Healthy Weight, Healthy Lifestyles."[194] All awards were presented by the Institute at a ceremony on June 21, 2005.[195]

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187. *Id.*

188. National Business Group on Health, Leadership Summits on Obesity (June 2004), http://www.wbgh.org/healthy/summit_summary0604.cfm.

189. *Id.*

190. INSTITUTE ON THE COST AND HEALTH EFFECTS OF OBESITY, BEST EMPLOYERS FOR HEALTHY LIFESTYLES (2005), http://www.wbgh.org/healthy/bestemployersbrochure.pdf.

191. *Id.*

192. *Id.* A "mature program" is further characterized as one in which "[s]uccess has been measured, outcomes are documented, and [return on investment] is proven. Documented examples of changes . . . are expected." *Id.*

193. *Id.* Such cultural and environmental changes include cafeteria and vending machine audits and changes, redesigned stairwells or walking routes, and incentives for attaining and maintaining healthy weight. *Id.*

194. *Id.* Such programs include organized walking programs, on-site support, and company sponsored fitness classes. *Id.*

195. *Id.*

2. California Fit Business Award

Similar to the Institute's Healthy Lifestyle Award, two groups in California, the California Task Force on Youth and Workplace Wellness and the California 5 a Day-Be Active! Worksite Program, will present the second annual California Fit Business Award in 2005.[196] First awarded to seven California companies in 2003, the award recognizes employers who support and promote health among their workers.[197] The sponsoring groups determine an employer's fitness by examining the following criteria: (1) healthy food options; (2) whether the employer supports physical activity during working hours; and (3) whether provisions are made for health promotion programs on company time. [198] In order to be eligible for the Fit Business Award, applicants must employ California workers and submit the web-based application by January 15, 2005. Companies of all sizes are eligible for the award.[199]

B. FEDERAL GOVERNMENT EFFORTS: WORKFORCE HEALTH IMPROVEMENT PROGRAM ACT

The Workforce Health Improvement Program Act, introduced by Chairman Toomey to the House of Representatives on April 11, 2003, complements healthier lifestyle programs already implemented by employers.[200] The purpose of the Act is to "expand workplace health incentives by equalizing the tax consequences of employee athletic facility use."[201] Accordingly, the Act provides tax incentives for both employees and employers.[202]

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196. *Employers Urged to Apply for California Fitness Business Award; California Task Force on Youth and Workplace Wellness to Recognize Employers Who are Countering the Cost of Obesity at the Workplace with Healthy Work Environments,* PR NEWSWIRE U.S., Oct. 13, 2004.

197. *Id.*

198. *Id.*

199. *Id.* The applicants are broken up into five size categories to ensure fair competition: employers having over 1,000; 300-399; 100-299; 25-99, and fewer than 25 employees compete distinctly. *Id.*

200. *Hearings, supra* note 29, at 29-30 (opening statement by Hon. Patrick J. Toomey).

201. Workforce Health Improvement Program Act of 2003, H.R. 1818, 108th Cong. (2003).

202. *Hearings, supra* note 29, at 29-30.

The Workforce Health Improvement Program Act amends the Internal Revenue Code by extending "nontaxable fringe benefit coverage to qualifying off-premises fitness or athletic club services provided by an employer."[203] Because employees will often choose not to receive benefits provided by their employers on which employees must pay taxes,[204] the Act excludes the wellness benefit from being considered income for the employees.[205] However, the Act is limited in scope with respect to the types of athletic or fitness facilities it covers. Section 2(b) defines the applicable athletic or fitness facilities, excluding such facilities as those that offer golf, hunting, sailing, riding facilities, and whose health or fitness facilities are incidental to its overall function and purpose.[206]

The numerous health benefits resulting from the passage and implementation of this bill will result in substantial savings on employers' health care costs.[207] Employees who take advantage of the bill's provisions by joining health clubs will suffer less health-related on-the-job injuries.[208] Employees strengthening their muscle tone via exercise are less susceptible to back injuries and muscle strain, the leading workplace injuries.[209] Additionally, employees will be less likely to sustain musculoskeletal injuries because exercise increases strength and stamina in the lower extremities.[210] Furthermore, increased exercise reduces risk factors for heart disease, thereby reducing the number of deaths from heart disease and strokes.[211] Lastly, by helping employees cope with job-related stress, increased exercise will decrease heart attacks, strokes, diabetes, and epileptic seizures.[212] In addition to reducing health-related injuries, increases in circulatory and respiratory movement will result in more alert and more productive employees.[213]

Despite its advantages, the Act has received little to no attention from either the House or the Senate since its introduction to Congress. The House has failed to take any action on H.R. 1818 with the exception of the

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203. Thomas, Bill Summary and Status for the 108th Congress, H.R. 1818, CRS Summary, *available at* http://thomas.loc.gov/bss/d108query.html.

204. *Id.*

205. *Id.*

206. *Id.*

207. *Hearings, supra* note 29 (testimony of Edwin Foulke, lawyer, Jackson Lewis, LLP).

208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

bill's introduction to the House of Representatives and referral to the House Committee on Ways and Means on April 11, 2003.[214] The House did, however, introduce and refer to the House Committee on Ways and Means a nearly identical bill, H.R. 1634, on April 14, 2005.[215] Similarly, with the exception of introductory remarks on measure and referral to the Committee on Finance on July 30, 2003, the Senate has failed to take further action on S.1491, a bill identical to H.R. 1818.[216] Also similar to the House, the Senate introduced and referred to the Committee on Finance a near identical bill, S. 772, on April 13, 2005.[217]

C. STATE GOVERNMENT EFFORTS

State legislators are focusing their attention on initiatives that will curb rising obesity rates,[218] and consequentially, the insurance costs associated with these increased rates. In 2004 and 2005, State lawmakers primarily focused on preventing child and adolescent obesity through the regulation of food choices and physical activity within the school system.[219] In

214. *Id.*

215. *Compare* Workforce Health Improvement Program Act of 2003, H.R. 1818, 108th Cong. (2003) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use), *with* Workforce Health Improvement Program Act of 2005, H.R. 1634, 109th Cong. (2005) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use).

216. *Compare* Workforce Health Improvement Program Act of 2003, H.R. 1818, 108th Cong. (2003) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use), *with* S. 1491, 108th Cong. (2003) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use).

217. *Compare* Workforce Health Improvement Program Act of 2003, H.R. 1818, 108th Cong. (2003) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use), *with* S. 772, 109th Cong. (2005) (proposing to amend Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use).

218. HEALTH POLICY TRACKING SERVICE, STATE ACTIONS TO PROMOTE NUTRITION, INCREASE PHYSICAL ACTIVITY AND PREVENT OBESITY: A LEGISLATIVE OVERVIEW (July 11, 2005), *available at* http://www.rwjf.org/files/research/July%202005%20-%20Report.pdf.

219. *Id.* As of July 1, 2005, forty states introduced roughly 200 bills that provide some type of nutritional guidance for schools. *Id.* In the same time period, thirty-two states introduced legislation that set guidelines for physical education classes. *Id.* Additionally, twenty-three states introduced legislation that called for schools to educate children about "nutrition or the benefits of physical activity as part of the health education curriculum." *Id.* Finally, eighteen states introduced legislation that provides for BMI reporting. *Id.*

addition to this regulation, legislators are also focusing on regulating the food industry, particularly through obesity liability bills and accompanying nutritional information requirements for chain restaurants, as well as measures that tax snacks and sodas in order to provide funds for public health campaigns targeting nutrition and obesity.[220] In the insurance arena, states have introduced legislation requiring both private and public health care plans to cover obesity-related treatments and procedures.[221] Finally, state legislatures are trying to create healthy, active communities through bills that (1) improve access to, or safety of, public fitness, walking, and biking facilities; and (2) "appropriate general fund dollars to support access to fresh produce for low-income WIC recipients and seniors."[222]

The following are examples of a State initiative and a County initiative enacted to prevent obesity and its associated costs.

1. The 2004 Affordable Health Care for Floridians Act

In order to mitigate the overall growth in health care costs and address the underlying cause of prohibitively expensive increases in health insurance premiums, Florida enacted its 2004 Affordable Health Care for Floridians Act in July 2004.[223] Specifically with respect to the benefits it provides for employers, the Act was enacted in order to address the following healthcare problems experienced by employers and employees: (1) "average health insurance premium increases for the last two years have been in the range of ten to twenty percent for Florida's employers;"[224] (2) "an increasing number of employers are opting to cease providing insurance coverage to their employees due to high cost;"[225] and (3) "an increasing number of employers who continue providing coverage are

220. *Id.* In 2005, forty obesity liability bills were introduced in twenty-six states, and twenty states already have those laws "on the books." *Id.* Although not enacted, other menu-labeling measures were introduced in twelve states, thereby providing a "public forum for debate and development of future public policy affecting the restaurant industry." *Id.* Lawmakers continue to introduce legislation of snack and soda taxes, even though no new snack or soda tax measures have been enacted in 2004 or 2005. *Id.*

221. *Id.* In 2005, the Colorado governor signed a measure establishing an Obesity Treatment Pilot Program for Medicare beneficiaries over the age of fifteen who have a minimum BMI of thirty. *Id.* Five states introduced legislation that requires insurers to "provide or offer coverage for surgical procedures used to treat obesity." *Id.*

222. *Id.*

223. H.B. 1629, 106th Legis., Reg. Sess. (Fl. 2004).

224. *Id.*

225. *Id.*

forced to shift more premium costs to their employees, thus diminishing the value of employee wage increases."[226]

Pursuant to the Act, health insurers and managed care companies must reduce employers' premiums by 10% when a majority of employees in a fully insured health plan have enrolled and participated in an employer-sponsored wellness, health maintenance, or improvement program.[227] Employers must prove that their employees are maintaining and improving their health in order to receive the rebate.[228] Such evidence is ascertainable through certain health status indicators agreed upon by the employer and insurer, including weight reduction and smoking cessation.[229] Florida is the first state to offer a rebate program like this in the country.[230]

2. Bright Start Wellness Program

In order to assist its citizens in achieving better health and reduce healthcare costs related to obesity and smoking, Knox County has implemented its Bright Start Wellness Program. Patterned after the book, "The Town that Lost a Ton", this program reduces medical insurance payments for participants by $120, and provides an additional $120 annual discount for nonsmokers or those who "agree to complete a smoking cessation class."[231]

The goal of the program is to "focus on a different aspect of . . . health and wellness each year and to reward employees by offering a discount."[232] Such discounts are offered on a year-to-year basis, but are not guaranteed.[233] In addition to insurance discounts, the program provides incentives for its participants via a point system.[234] A participant receives points in exchange for submitting a monthly activity form detailing his or her progress in several categories, including exercise, community service, relaxation, and self-development.[235] Points can be accumulated throughout

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226. *Id.*

227. Roberts, *supra* note 18.

228. *Id.*

229. *Id.*

230. *Id.* Accordingly, the state expects problems with the implementation and administration of the rebate plans. *Id.*

231. Knox County Government, Human Resources: Health Insurance Discounts, http://www.knoxcounty.org/hr/benefits/insdiscounts.php (last visited Feb. 10, 2006).

232. Knox County Government, Bright Start Wellness Program: FAQ's, http://www.knoxcounty.org/hr/bstartfaq.php (last visited Feb. 10, 2006).

233. *Id.*

234. *Id.*

235. *Id.*

the year and exchanged for various prizes, such as gift cards, movie tickets, lunch paid for by the county and time off with pay. [236] The program's incentives have proved to be successful in recruiting participants, as evidenced by the participation of nearly 3,000 Knox County employees.[237]

In order to enroll in the program, applicants must attend an orientation and meet the basic enrollment requirements based on age and sex. [238] All applicants must submit to a routine physical exam and obtain his or her health care provider's permission to join the wellness program. [239] Women may substitute a routine physical exam for a well-woman routine gynecological visit. [240] There are additional enrollment requirements for men over fifty[241] and woman over forty.[242] The program is open to all Knox County employees, regardless of whether such employees have health insurance through the County.[243]

D. INSURERS' OBESITY DISEASE MANAGEMENT PROGRAMS

Health insurers have recently taken an active role in battling employers' obesity-related insurance costs by creating obesity disease management programs. These programs are aimed at reducing the incidence of obesity through a combination of diet, exercise, and surgery.[244] Insurers that have built their own programs borrowed techniques from successful programs that address other chronic conditions.[245] Those insurers who do not want to develop their own program can turn to companies that specialize in disease management, such as Cardiocom, LLC.[246] Although insurers are making great strides in developing and implementing obesity disease management programs, insurers say that few mature obesity disease management programs are available.[247]

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236. *Id.* Prizes are distributed on a quarterly basis. *Id.*

237. Harris, *supra* note 24.

238. Knox County Government, *supra* note 232.

239. *Id.*

240. *Id.*

241. Men age fifty and older must get an annual prostate examination comprising of digital rectal exam and PSA test. *Id.*

242. Women age forty and older must get a mammogram. *Id.*

243. *Id.*

244. *Disease Management: Insurers Build Obesity Disease Management Programs, Eye Employer Reimbursement*, MANAGED CARE WEEK, June 28, 2004.

245. *Id.*

246. *Id.*

247. *Id.*

The following is a brief description of three disease management programs offered by Aetna, Horizon Blue Cross Blue Shield, and Cardiocom, LLC.[248]

1. Aetna

Aetna was scheduled to pilot its disease management program, Healthy Body/Healthy Weight, with enrollees from four plan sponsors in October 2004.[249] In order to achieve its objective for Aetna members to achieve overall better health, the program provides incentives for (1) participation in increased physical activity; (2) discounts to community-based weight-loss programs; (3) outreach and support from nurses and weight loss counselors; and (4) coordination with primary-care physicians.[250]

The insurer planned to identify many enrollees via its health risk assessment program, which allows patients to report to Aetna their height and weight, comorbid conditions, and prescribed medications.[251] Aetna will use this reported information, as well as available medical and pharmacy claims data, to risk-stratify patients into three categories.[252] By following the enrollees for one year, Aetna planned on tracking measures for medication compliance, overall health management, and total hospitalizations.[253] Aetna planned on using the outcomes from the obesity pilot to determine how to charge employers, if at all, for the program.[254]

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248. In addition to the programs discussed in this article, CIGNA HealthCare, Health Management Corp. ("HMC"), and First Health Group all offer or are currently developing some type of obesity disease management program. *See id*; *Disease Management Programs Target Obesity, Metabolic Syndrome,* MANAGED CARE WEEK, Feb. 7, 2005, *available at* http://www.choosehmc.com/press/2005.02.07_mcwreprint.pdf; Virginia Association of Health Plans, CIGNA Healthcare to Launch New Programs to Address Obesity (Feb. 1, 2005), http://www.vahp.org/news/cigna.shtml.

249. *Disease Management: Insurers Build Obesity Disease Management Programs, Eye Employer Reimbursement, supra* note 244.

250. Elizabeth T. Beckley, *Assessing the Condition: Hesitant to Label Obesity a Disease, Health Care Insurers Grapple With Coverage*, DOC NEWS, Mar. 1, 2005, *available at* http://docnews.diabetesjournals.org/cgi/content/full/2/3/8.

251. *Insurers Build Obesity Disease Management Programs, Eye Employer Reimbursement, supra* note 244.

252. *Id.* The high-risk group will consist of patients who (1) have a BMI greater than thirty-five and have been hospitalized; or (2) have significant multiple comorbid conditions such as diabetes or cardiovascular disease. *Id.* The medium risk group will consist of patients who have a BMI greater than thirty and comorbid conditions. *Id.*

253. *Id.*

254. *Id.* Aetna may sell its obesity disease management program in "a way similar to Aetna's other disease management programs, for which plan sponsors must pay a separate fee." *Id.*

2. Horizon Blue Cross Blue Shield

Having already designed programs for asthma, chronic kidney disease, diabetes, multiple sclerosis, and other conditions, Horizon Blue Cross Blue Shield opted to build an obesity program internally.[255] Horizon will offer its pilot program to enrollees in its HMO product line, consisting of 180,000 of the insurer's 600,000 members.[256] In addition to looking for enrollees who "already participate in one of Horizon's other disease management programs and for whom the insurer already has data indicating obesity," Horizon will identify potential enrollees by using pharmacy claims data to identify those on weight loss drugs.[257] Interested enrollees will (1) be placed into prevention programs; and (2) be contacted via telephone by a nurse, dietician, social worker, or other staff member who would offer health coaching and exercise coaching.[258]

3. Cardiocom, LLC

In January 2004, Cardiocom, LLC, a disease management firm, launched its obesity disease management program, Thin-Link.[259] Designed for health plans, employers, and individuals, the obesity program has four focal areas: lifestyle and behavioral changes, assistance with meal planning, personal accountability, and home monitoring tools.[260] Members on this program go through a specific lesson plan daily, and use a personal link device in their homes that transmits data to Cardiocom's call center.[261] Registered dieticians at the call center review and use this data to formulate coaching and behavioral counseling for the patient.[262] In its six-month pilot program, individuals lost between ten and forty pounds during the first ninety days.[263]

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255. *Id.* Horizon contracts with an outside vendor for its heart failure disease management program. *Id.*

256. *Id.*

257. *Disease Management: Insurers Build Obesity Disease Management Programs, Eye Employer Reimbursement, supra* note 244.

258. *Id.*

259. *Id.*

260. *Id.*; *Interactive Obesity Management Program Introduced*, MED. DEVICES & SURGICAL TECH. WEEK, June 20, 2004, 2004 WLNR 633726.

261. *Disease Management: Insurers Build Obesity Disease Management Programs, Eye Employer Reimbursement, supra* note 244.

262. *Id.*

263. *Interactive Obesity Management Program Introduced, supra* note 260.

CONCLUSION

In summation, the obesity epidemic poses a substantial threat to the country's workforce, and consequently to its competitive reputation in the international market. Fortunately for both employees and employers, obesity is both curable and preventable. Therefore, the $13 billion question is the following: how can employers motivate their employees to achieve and maintain healthy weights, effectively resulting in a decrease in obesity-related healthcare costs? Although there is no clear answer to this question, there are several methods and courses of action available to both employers and the nation at large. Through a combination of such measures, it is possible that nation's currently "clogged arteries" will become clear and manageable in the future.

EMPLOYMENT PRACTICES LIABILITY INSURANCE: ARE EPLI POLICIES A LICENSE TO DISCRIMINATE? OR ARE THEY A NECESSARY REALITY CHECK FOR EMPLOYERS?

Nancy H. Van der Veer *

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INTRODUCTION

In response to the advent of various statutes guarding against discrimination, the workplace has become a much more controversial venue with regard to virtually every employment decision. Savvy employers must continually protect themselves against allegations and charges of discriminatory or illegal employment practices in the hiring, promotion, treatment, and firing of employees. Not only must employers

beware with regard to their own activities and those of supervisory personnel, but they must also guard against actions by coworkers. In addition, as a result of the 1991 amendments to the Civil Rights Act, which granted employees the right to jury trials and the ability to recover compensatory and punitive damages, employment litigation claims are on the rise and news coverage of large verdicts in employment suits are a constant reminder that employers must search for ways to limit their liability and avoid potentially crippling jury verdicts.

In response to the growing number of employment-related lawsuits and the issues associated with seeking coverage for these suits under various forms of liability insurance policies, many insurance companies have begun issuing policies, called Employment Practices Liability Insurance or "EPLI" policies that specifically cover employment practices. These policies, which developed as a byproduct of Commercial General Liability ("CGL") and Directors and Officers ("D&O") insurance,[1] make delegable the damage award accompanying an adverse judgment in an employment law case by covering sexual harassment, discrimination, wrongful termination, and other employment-related claims. Employers began purchasing these policies in the mid-1990s to secure their businesses from the potentially devastating effects of discrimination lawsuits and, over the next decade, EPLI became a staple for most businesses.

EPLI policies, however, were a cause of distress for the advocates who had worked so diligently in the fight to expand both Title VII's coverage and its potential penalties. Almost immediately after the Supreme Court intensified employer liability to strengthen the incentive to curb discriminatory conduct, an insurance product emerged that potentially allowed employers to pass the risk of discrimination and harassment penalties to insurance companies who would, in turn, charge a premium to offset their liability. Serious criticism erupted stemming from a fear that these new EPLI policies would, at worst, eliminate the deterrent effect of the new Title VII provisions or, at the very least, allow the policyholder to be less diligent in taking steps to safeguard employees from the evils of employment discrimination.[2] Questions arose regarding whether transferring the risk of damages for discriminatory acts via EPLI conflicted with the increasingly stringent standards the law imposed on employers.

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1. *See* Simon J. Nadel, *Employment Practices Liability Insurance Makes Some Headway with Employers*, 66:18 U.S.L. WK. 2275, 2275 (Nov. 11, 1997).

2. *See* Joan Gabel et al., *Evolving Conflict Between Standards for Employment Discrimination Liability and the Delegation of that Liability: Does Employment Practices Liability Insurance Offer Appropriate Risk Transference?*, 4 U. PA. J. LAB. & EMP. L. 1, 1 (Fall 2001).

Would EPLI policies undermine the statutory protections in place for the employee?

Part I of this note will discuss the statutory protections that exist for employees in the employment context. Part II will trace the rise of EPLI policies and their coverage limitations as defined by both insurance providers and the courts. Part III will outline some of the most important factors underwriters consider when employers attempt to both purchase EPLI policies and renew current EPLI policies, paying close attention to the aspects of the underwriting process that require employers to have risk prevention programs in place and hold employers accountable for their current risk prevention strategies. In Part IV, I will discuss the ways in which insurance companies act as a resource for insureds' human resources departments once a policy is written through continuing outreach in the area of risk prevention and through services offered to keep employers abreast of the latest court decisions and the crippling damage a successful employment discrimination claim can have on a business. In conclusion, I will suggest that EPLI does not act as a license for companies to discriminate, but instead creates a relationship between employers and their insurance providers that forces employers to take employment discrimination claims more seriously, to consider affirmative defenses before claims arise, and to continuously update their knowledge and understanding of employment discrimination law. By discussing employers' exposure before claims arise, EPLI providers are able to offer a service that benefits both employers and their employees. Because both insurance providers and insureds have an interest in avoiding risk and loss, EPLI cannot afford to provide companies with an opportunity to discriminate without penalty. Instead, providers endeavor to increase employers' awareness of the risks associated with employment discrimination claims and the importance of maintaining a prevention program that will reduce employment practices liability exposure.

I. STATUTORY PROTECTION FOR EMPLOYEES

Employment discrimination and other wrongful employment practices occur everyday. These acts have been either criminalized or sanctioned through common law, federal, state, and local statutes.[3] The federal statutory scheme provides a multi-faceted basis for discrimination claims,

3. *See* W. Muzette Hill, *Employment Practices Liability: The Other Year 2000 Problem?*, 584 PLI/LIT 293, 299 (1998).

including: Title VII of the Civil Rights Act of 1964 ("Title VII");[4] the Age Discrimination in Employment Act ("ADEA");[5] the Americans with Disabilities Act ("ADA");[6] the Civil Rights Act of 1991 ("1991 Act");[7] the Pregnancy Discrimination Act of 1978 ("PDA"); the Equal Pay Act ("EPA"); and the Vocational Rehabilitation Act of 1973 ("Rehab Act").

A. EMPLOYMENT PRACTICES PROHIBITED BY TITLE VII

Title VII, as amended, is often the statute of choice for plaintiffs filing discrimination lawsuits. Title VII applies to employers with fifteen or more employees and prohibits discrimination by employers based on race, color, religion, sex, or national origin.[8] All employees, including part-time and temporary workers, are counted for purposes of determining whether an employer is covered. Title VII protects an employee from discrimination that would impact his or her compensation, terms, conditions, or privileges of employment and extends to the hiring and discharge of an individual.[9]

Varying types of discrimination can be proven through allegations of disparate treatment and disparate impact and can be established through either direct evidence of intent to discriminate or indirect (circumstantial) evidence. Disparate treatment is the most frequently used theory of liability for discrimination cases. A disparate treatment claim involves an employer making certain decisions based on race, age, gender, disability, or another protected attribute.[10] In such a situation, the plaintiff must prove that the defendant had the intent to discriminate based on the plaintiff's protected classification.[11] Disparate impact cases, on the other hand, concern acts or practices that are facially neutral "but that in fact fall more harshly on one group than another and cannot be justified by business necessity."[12] In a disparate impact case, the plaintiff is not required to prove discriminatory animus on the part of the employer.[13] An employer

4. 42 U.S.C. § 2000e (2000).
5. 29 U.S.C. § 621 (2000).
6. 42 U.S.C. § 12101 (2000).
7. *Id.* § 1981(a).
8. *Id.* § 2000e.
9. *Id.*
10. *See* Hazen Paper Co. v. Biggins, 507 U.S. 604, 609 (1993) (discussing the distinction between disparate treatment and disparate impact theories of liability).
11. *Id.*
12. *Id.*
13. *Id.*

may bring a claim under one or both of these theories of liability, despite any distinctions between the two theories of liability.

The courts take a broad view of "race" in discrimination claims. The U.S. Supreme Court has ruled that it includes all ancestral and ethnic characteristics, whether or not the category is supportable by modern scientific theory.[14]

In addition, the term "religion" is broadly defined. The Equal Employment Opportunity Commission guidelines state that "the Commission will define religious practices to include moral or ethical beliefs as to what is right or wrong which are sincerely held with the strength of traditional religious views."[15] Employers must also make reasonable accommodations of an employee's beliefs, which include allowing employees to miss work, rearrange work schedules, and avoid office turmoil caused by religious conflicts.[16]

Generally, remedies for unlawful employment discrimination include reinstatement or hiring, court orders to eliminate discriminatory practices, lost wages (including benefits), damages, and attorneys' fees. Based on amendments enacted as part of the Civil Rights Act of 1991, compensatory and punitive damages are also available from private employers. The size of the employer determines the maximum compensatory and punitive damages available: $50,000 for employers with 15 to 100 employees; $100,000 for employers with 101 to 200 employees; $200,000 for employers with 201 to 500 employees; and $300,000 for employers with more than 500 employees.[17]

B. GENDER AND SEXUAL HARASSMENT AS DISCRIMINATION

It is well settled that employers may not make employment decisions based on the gender of the applicant or employee.[18] The critical issue "is whether members of one sex are exposed to disadvantageous terms or conditions of employment to which members of the other sex are not exposed."[19]

One well-known category of gender discrimination is sexual harassment. Sexual harassment is defined as:

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14. *See* Saint Francis Coll. v. Al-Khazraji, 481 U.S. 604, 613 (1987).
15. 29 C.F.R. § 1605 (2004).
16. *See* Wilson v. U.S. W. Commc'ns, 58 F.3d 1337, 1340-41 (8th Cir. 1995).
17. 42 U.S.C. § 1981a(b)(3) (2000).
18. *Id.* § 2000e-2(a)(1).
19. Harris v. Forklift Sys., Inc., 510 U.S. 17, 25 (1993) (Ginsburg, J., concurring).

> unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature where submission to or rejection of such conduct is used as the basis for employment decisions or where such contact has a purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.[20]

The Supreme Court has found that Title VII protects against both sexual harassment by the opposite sex and sexual harassment by the same sex (e.g., male-on-male sexual harassment).[21]

Employees who believe that they are victims of sexual harassment in the workplace may avail themselves of two claims recognized by the United States Supreme Court: a quid pro quo claim or a hostile work environment claim.[22] In a *quid pro quo* claim, the employee asserts that the employer has made unwelcome sexual advances, requests for sexual favors, or other conduct that becomes a condition of the employee's continued employment. In most jurisdictions, the employer is held strictly liable for *quid pro quo* harassment and a single physical advance can support an employee's claim.[23] The courts hold the employer liable "regardless of whether the specific acts complained of were actually authorized or forbidden by the employer, and regardless of whether the employer knew or should have known of their occurrence."[24] The employer is strictly liable because it gave the supervisor the means and authority to extort sexual favors from employees.[25]

A hostile work environment is the second type of sexual discrimination recognized by the Supreme Court. Such an environment is created when the workplace is plagued with severe discriminatory or harassing behavior that unreasonably interferes with an individual's work performance.[26]

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20. *See* Michael Brady et al., *Insurance Coverage Issues Arising From Workplace Tort Claims: Employment-Related Suits May Pose Many Liability Theories, and Whether the Claims are Covered by Insurance Will be Thorny Problems*, 62 DEF. COUNS. J. 354, 355 (1995).

21. *See* Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75 (1998).

22. *See* Burlington Indus., Inc. v. Ellerth, 524 U.S. 742, 751-52 (1998) (distinguishing between the multiple categories of sexual harassment claims and holding that sexual harassment victims can recover without showing tangible job detriment).

23. *See* Brady et al., *supra* note 20, at 355.

24. *Id.*

25. Henson v. City of Dundee, 682 F.2d 897, 910 (11th Cir. 1982).

26. *See* Meritor Sav. Bank, F.S.B. v. Vinson, 477 U.S. 57, 65 (1986) (outlining elements necessary to maintain a cause of action for hostile work environment).

These activities can include the telling of "dirty" jokes and/or the display of sexually inappropriate images in the workplace. An employer, however, need not require "asexuality nor androgyny in the workplace" and need only forbid "behavior so objectively offensive as to alter the 'conditions' of the victim's employment."[27] Unlike *quid pro quo* harassment, a single incident will not generally be sufficient to prove a claim of hostile environment, and, instead, the employee will have to show that the conduct was continuous and non-trivial, resulting in a pattern of harassment.[28] This conduct, whether known or unknown to the employer, may provide grounds for liability.[29] The employer has a defense if he or she is able to show that he or she exercised "reasonable care to prevent and correct promptly any sexually harassing behavior" and if the victim-employee "unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer . . . ."[30]

C. AGE DISCRIMINATION

The ADEA protects against age discrimination for persons over forty years of age.[31] It prohibits employers with twenty or more employees from failing or refusing to hire or discharging any individual or otherwise discriminating against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of that individual's age.[32] The Act was enacted to protect "older workers [from] being deprived of employment on the basis of inaccurate and stigmatizing stereotypes."[33] Instead, employers or potential employers must "evaluate [older] employees . . . on their merits and not their age."[34] Pursuant to this Act, a successful plaintiff's remedies may include back pay, reinstatement, lost benefits, and, under limited circumstances, attorneys' fees.[35] If the

27. Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75, 81 (1998).

28. Moylan v. Maries County, 792 F.2d 746, 749-50 (8th Cir. 1986).

29. *See* Faragher v. City of Boca Raton, 524 U.S. 775, 805-10 (1998) (noting that the City did not take reasonable action to prevent sexual harassment because it did not distribute information on its anti-harassment policy and failed to monitor conduct of supervisors).

30. *Id.* at 807.

31. *See* Hill, *supra* note 3, at 299.

32. *Id.*

33. *See* Hazen Paper Co. v. Biggins, 507 U.S. 604, 610 (1993) (noting intent of Congress in enacting the ADEA).

34. *See id.* at 611.

35. 42 U.S.C. § 2000e-5(g) (2000).

employment practices are found to have been willful, the plaintiff may also recover double damages.[36]

Significantly, the ADEA does not require an employer to provide equal health insurance, life insurance, or disability benefits to older workers if it costs more to do so, provided that the employer spends the same amount on both older and younger workers. The ADEA poses particularly difficult problems in the context of hiring practices and reductions in force, as these events typically impact older workers more than other workers.

The Supreme Court has held that the ADEA does not provide a cause of action to a relatively younger employee who allegedly has been discriminated against in favor of older employees.[37] The Court reached the conclusion that the ADEA does not prohibit discrimination against relatively younger workers under the age of forty in favor of relatively older workers over the age of forty largely based upon the history of the ADEA, which demonstrated that the statute was designed to protect older employees against discrimination in favor of younger employees, and not the other way around.[38]

D. DISABILITY DISCRIMINATION

Upon finding that some 43 million Americans have one or more physical or mental disabilities, a number that is increasing as the population as a whole is growing older, Congress enacted the Americans with Disabilities Act ("ADA"), which prohibits employment discrimination against an individual because of the person's disability.[39] Protected disabilities are not merely physical handicaps, but also include mental and psychological illnesses. The ADA applies to employers that have employed fifteen or more full-time and/or part-time employees in each of twenty or more calendar weeks during the current or preceding calendar year.[40] The ADA has no minimum service requirement before an employee is protected and it applies to applicants for employment as well as current employees.

Under the ADA, disability is defined as: "(A) a psychological or mental impairment that substantially limits one or more of the major life activities of an individual; (B) a record of such an impairment; or (C) being

36. 29 U.S.C. § 216(b) (2000).
37. *See* Gen. Dynamics Land Sys., Inc. v. Cline, 540 U.S. 581 (2004).
38. *See id.*
39. 42 U.S.C. § 12101 (2000).
40. *Id.* § 12111(5)(A).

regarded as having such impairment."[41] An employee or prospective employee must be able to "perform the essential functions" of the employment, with or without reasonable accommodations, and the employer must make reasonable accommodations for an employee with a real or perceived disability.[42] Reasonable accommodations are required to allow individuals with disabilities to perform the essential functions of their job, including (1) making existing facilities used by employees accessible to and usable by individuals with disabilities, (2) job restructuring, (3) modifying schedules, or (4) reassignment to vacant positions.[43] An employer is required to participate in a good-faith interactive dialogue with the disabled individual in order to determine the appropriate accommodation in a given situation. Employers may be excused from providing reasonable accommodations if the employer can show that to do so would impose an "undue hardship," which is defined as an action requiring significant difficulty or expense, taking into account the employer's size and resources.[44]

In order for an employee to be "disabled" in the employment context, the employer must have reason to believe that the employee has a substantial impairment.[45] An employee is also protected by the ADA if the employer believes that the employee is disabled and fails to take action to accommodate the disability. The ADA requires that the disability be the primary cause of the adverse action and does not require that it be the sole cause.[46]

E. EQUAL PAY DISCRIMINATION

The Equal Pay Act (EPA) makes it unlawful to pay employees at a rate less than the rate applicable to "employees of the opposite sex" for "equal work" on jobs requiring "equal skill, effort, and responsibility, and which are performed under similar working conditions."[47] There are a number of exceptions where a differential can be justified, most significantly where a

41. *Id.* § 12102(2).

42. *Id.* § 12111(8). *See* Hill, *supra* note 3, at 300 (an employer is not obligated to provide reasonable accommodations, however, if such accommodations would work an undue hardship upon the employer's business).

43. 42 U.S.C. § 12111(9) (2000).

44. *Id.* § 12111(10).

45. Wooten v. Farmland Foods, 58 F.3d 382, 385 (8th Cir. 1995).

46. McNely v. Ocala Star-Banner Corp., 99 F.3d 1068, 1076-77 (11th Cir. 1996).

47. 29 U.S.C. § 206(d)(1) (2000).

wage differential is based on some "factor other than sex," such as seniority. The EPA applies to most employers.

F. FAMILY AND MEDICAL LEAVE ACT DISCRIMINATION

The Family and Medical Leave Act (FMLA) provides eligible employees with up to twelve weeks of unpaid leave in a twelve month period.[48] The FMLA, which creates protections for employees before, during and after FMLA leave, is significant in three respects. First, the FMLA creates an absolute entitlement to leave for eligible employees in those circumstances covered by the FMLA. Second, an employee is entitled to health benefits while on FMLA leave on the same terms and conditions as if the employee was still working.[49] Third, upon returning from leave, an employee is entitled to be reinstated to the same or equivalent position with equivalent pay and benefits.[50]

The FMLA applies to employers that have employed fifty or more employees for twenty or more calendar weeks during the current or preceding calendar year.[51] Public agencies, regardless of size, are covered by the FMLA.[52]

An employee is eligible for FMLA leave if the employee (1) works at a work site at which fifty or more employees are employed or that is within seventy-five miles of such a site, (2) has worked for the employer for twelve months, and (3) has worked at least 1,250 hours in the year before the leave commences.[53]

Once eligible, an employee can take FMLA leave for childcare following the birth of a child or placement of a child for adoption or foster care; care for a spouse, child, or parent of the employee who has a serious health condition; or for a serious health condition that makes the employee unable to perform an essential function of his or her job.[54]

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48. *Id.* § 2612(a)(1).
49. *Id.* § 2614(c)(1).
50. *Id.* § 2614(a).
51. *Id.* § 2611(4)(A).
52. *Id.* § 2611 (4)(A)(iii).
53. *Id.* § 2611(2)(A).
54. *Id.* § 2612(a)(1).

G. DISCRIMINATION AGAINST IMMIGRANTS

The Immigration Reform and Control Act of 1986 ("IRCA")[55] made employers directly responsible for curtailing the employment of illegal aliens. The federal agencies charged with enforcing IRCA have stepped-up efforts to ensure employer compliance. At the same time, certain reforms to the immigration laws, including the Immigration Act of 1990 ("IMMACT 90")[56] and the North American Free Trade Agreement ("NAFTA"),[57] have made it far easier for employers to recruit, hire, train and retain foreign workers in many occupations. As a result, a basic knowledge of immigration law can help employers comply with IRCA's requirements, avoid costly fines or litigation, and take advantage of the opportunities that exist for hiring foreign workers for positions within U.S. companies.

IRCA makes it unlawful for employers to (1) knowingly hire or continue to employ an alien hired after November 6, 1986 who lacks authorization to work in the United States;[58] (2) hire any person (after November 6, 1986) without verifying that individual's identity and employment eligibility;[59] (3) discriminate in hiring and firing decisions on the basis of citizenship status;[60] (4) discriminate on the basis of national origin if the employer employs between three and fifteen workers or is not otherwise covered by Title VII of the Civil Rights Act of 1964;[61] (5) knowingly forge, counterfeit, alter or falsely make any document for the purpose of satisfying any immigration-related requirement;[62] and (6) knowingly use, accept or receive any false document for the purpose of satisfying any immigration-related requirement.[63]

IMMACT 90 added additional provisions to strengthen IRCA's prohibitions against discrimination. These include a prohibition from requiring an employee to present more difficult documents than are minimally required for the employment verification process, refusing to honor documents tendered by an employee that reasonably appear to be

55. 8 U.S.C. §§ 1324a-c (2000).
56. *Id.* § 1324b(a)(6).
57. 19 U.S.C. § 3301 (2000).
58. 8 U.S.C. § 1324a (2000).
59. *Id.* §§ 1324a(a)-(b).
60. *Id.* § 1324b(a)(1).
61. *Id.* § 1324b(a)(2).
62. *Id.* § 1324c(a)(1).
63. *Id.* §§ 1324c(a)(2)-(4).

genuine, or not specifying which documents an employee must present to prove identity or employment eligibility.[64]

H. STATE STATUTES AND LOCAL ORDINANCES REGULATING EMPLOYMENT

State legislatures have imposed a variety of regulations on employers. Generally, these laws apply to employees located within that state, although some state employment laws have been applied to out-of-state employees when the employer is based in that state. State laws often apply to smaller employers that may be exempt from federal law and may create additional protected classes, such as sexual orientation, marital status or residency. They also may provide for damages beyond those available under federal law.

II. EMPLOYERS' LIABILITY

A. THE RISE OF EPLI POLICIES

Insurers first began offering EPLI policies in the early 1990s. The political and social climate at the time was "volatile in the aftermath of Supreme Court Justice Clarence Thomas' 1991 conformation hearings, when law professor Anita Hill accused him of sexually harassing her while he was head of the Equal Employment Opportunity Commission."[65] As previously mentioned, the Civil Rights Act was amended during this time to allow juries to award compensatory and punitive damages to plaintiffs in employment-related civil cases.[66] With sexual harassment and employment practices continually in the news and on television, claims began to rise steadily in the early 1990s. According to the Equal Employment Opportunity Commission, there were 87,000 discrimination claims reported to them in 1993, and between July 1, 1992 and January 31, 1994 there were 27,000 ADA claims.[67]

Individual claims have resulted in extremely large jury awards. On February 12, 1998, a jury awarded $80.7 million to a former UPS employee who said she was punished by management after accusing a coworker of

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64. *See id.* § 1324b(a)(6).

65. Shaheena Ahmad, *Get Your Sex Insurance Now*, U.S. NEWS & WORLD REP., Mar. 2, 1998, at 61.

66. 42 U.S.C. § 1981a (2000).

67. *See* Paul E.B. Glad & Richard V. Rupp, *Employment Law Liability Claims: What You Need to Know about Insurance Coverage*, 716 PLI/Comm 121, 123 (1995).

poking her in the breast.[68] The week before that, "Astra U.S.A., the American subsidiary of Sweden's largest pharmaceutical company, settled a sexual harassment lawsuit brought by a former employee for $9.85 million."[69] The 1990s also saw an explosion of employment discrimination class action lawsuits that have been resolved through record breaking settlements. The best known of these cases is the $176 million settlement involving Texaco, which resulted from tape-recorded meetings that indicated the use of explicit racial epithets by management-level employees.[70] There have also been substantial settlements involving Coca-Cola ($192 million), Home Depot ($104 million), Shoney's ($105 million), Publix Markets ($81 million), and State Farm Insurance Co. ($157 million).[71] A recent study indicated that the average employment practices award is now $536,000 and, if defense costs are added, the amount would be in the $1 million range.[72]

The first insurance markets to be hit with these types of employment related claims were General Liability (GL) carriers under the theory that these claims were somewhat "bodily" in nature and therefore should be covered under the GL policy. The GL markets responded by using "employment related claims exclusions" in their policy forms after they realized that they were paying claims that they had no intention of covering.[73]

Some professional liability carriers began endorsing their D&O policies to provide non-entity employment practices liability coverage, offering coverage for named insureds in their individual capacity for employment practices liability claims.[74] The inadequacies of this coverage

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68. *See* Joe Niedzielski, *Employers Wary of Juries as Costs Rise,* NAT'L UNDERWRITER: PROP. & CAS./RISK & BENEFIT MGMT. ED., June 8, 1998, at 27.

69. Ahmad, *supra* note 65, at 61.

70. *See* Hubert B. Herring, *Negative Action; The Texaco Iceberg,* N.Y. TIMES, Nov. 17, 1996, at p.2 sec.3 (stating that reports of racial slurs caught on tape were a major motivation for the multi-million dollar settlement); *Texaco Stock Skids After Settlement Terms Disclosed,* N.Y. TIMES, Nov. 19, 1996, at D4 (reporting that Texaco shares fell by $2.75 after the $175 million was disclosed).

71. *See* Lynne Duke, *Shoney's Bias Settlement Sends $105 Million Signal,* WASH. POST, Feb. 3, 1993, at A1; Philip Hager, *State Farm to Pay Women $157 Million for Job Bias,* L.A. TIMES, Apr. 29, 1992, at A1; Allen R. Myerson, *Supermarket Chain to Pay $81 Million to Settle a Bias Suit,* N.Y. TIMES, Jan. 25, 1997, at A1; Henry Unger, *Coke to Settle Racial Suit with $192.5 Million Deal,* ATLANTA J.-CONST., Nov. 17, 2000, at A1.

72. Duke, *supra* note 71.

73. *See* Jeffrey P. Klenk, *Emerging Coverage Issues In Employment Practices Liability Insurance: The Industry Perspective On Recent Developments,* 21 W. NEW ENG. L. REV. 323, 324 (1999).

74. *Id.* at 324-25.

soon became apparent due to the fact that claims tend to be brought against the corporation itself and not individuals within the corporation. Without coverage for the corporation, the endorsements were useless.[75]

Following these failed attempts, EPLI emerged as a new stand-alone form of coverage designed to cover employment practices liability claims exclusively.[76] Providers' initial offerings shared significant similarities providing coverage for employment law judgments, bonds and post-judgment interest.[77] Initially, all carriers also covered back pay, but coverage was narrow.[78] Typical policies excluded coverage for fines and penalties with all but one carrier excluding punitive damages.[79] Almost all carriers excluded intentional acts rendering moot any debate over whether insurance coverage should exist for employment claims involving punitive damages.[80]

Market competition in more recent years has resulted in significant product differentiation.[81] "Enhanced" EPLI policies emerged covering various forms of discrimination, sexual harassment, wrongful discharge, defamation, and negligent hiring.[82] EPLI carriers began offering catastrophic coverage, higher coverage limits and coverage for punitive damages where state law allowed.[83] This expansion was primarily driven

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75. *Id.* at 325.

76. *Id.*

77. Gordon M. Park & Michele F. Lyerly, *Employment Practices Liability Policy: Real Cure or Costly Placebo*, 29 BRIEF 38, 40 (1999).

78. *Id.*

79. *See* Klenk, *supra* note 73, at 325 (stating that the insurance industry did not develop a comprehensive and saleable EPLI product until 1996).

80. Sandra Jane Meindersma, *Employers Under Fire: Managing Employment Practice Liability*, RISK MGMT., Jan. 1. 1996, at 25.

81. *See* GARY GRIFFIN & RACHEL MCKINNEY, EMPLOYMENT PRACTICES LIABILITY INSURANCE: BUILDING A THREE-LEGGED STOOL OF PROTECTION (Aug. 27, 1999), *available at* http://www.Imms.com (noting both that the number of insurers offering such coverage has increased dramatically and that there is much variation in the degree of protection offered as evidenced by the wide variation in EPLI policy forms). *See generally*, SETH B. SCHAFLER, SEA OF EPLI CONFUSION (Aug. 27, 1999), *available at* http://www.proskauer.com (reprinted with permission of Risk & Ins. Magazine, Apr. 1, 1999) (asserting that the profusion and vagueness of many EPLI policy forms create a serious risk for employers considering coverage).

82. *See, e.g., Hartford Expands EPLI Coverage*, BEST'S INS. NEWS, Nov. 12, 1999 ("Hartford . . . has expanded its . . . [EPLI] to cover several new areas, such as intentional acts and emotional distress . . . . Highlights of Hartford's revamped EPLI coverage include coverage for damages, such as judgments, settlements, awards, and compensatory damages, as well as claim expenses such as defense costs and related expenses.").

83. *See* Insurance Services Office, Inc., ISO Introduces First Standardized Insurance Program for Employment Practices Liability (Mar. 23, 2001), http://www.iso.com. The Insurance Services Office, Inc. ("ISO"), the country's largest provider of property/casualty

by anxious employers seeking new ways to cover the increasing risk of employment related liability.[84]

Employers justify the greater transfer of risk to third-party insurers by noting that "employment law has made them more and more liable for acts less and less within their direct control."[85] And the resulting response from insurance companies in offering policies to cover these risks makes some people nervous. Have these insurance policies allowed employers to take less care in providing for their employees? Just how much do these policies cover? And are insurance companies regulating employers through the risk assessment and loss prevention activities required prior to writing the policy and throughout the time insured?

B. EMPLOYMENT PRACTICES COVERED BY EPLI POLICIES

There is no standardized EPLI policy. EPLI coverage was initially written primarily by larger insurers. Now there are more than fifty carriers offering EPL insurance.[86] Because of the interest and significant differences between EPLI policies on the market, Insurance Services Office ("ISO") introduced a standardized policy in April of 1998, which they called the "Employment Related Practices Liability" form.[87] Even so, there is no standard policy form to date so each insurer develops their own form creating substantial differences in the coverage offered and the rating plans used.[88]

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information services, introduced the first standardized insurance program for employee lawsuits for discrimination. ISO filed its Employment-Related Practices Liability Program with state insurance regulators for approval. *Id.* Injury may result from discrimination that results in refusal to hire, failure to promote, termination, demotion, act, work-related sexual harassment, or verbal, physical, mental, or emotional abuse. *Id.* The ISO program excludes criminal, fraudulent, or malicious acts, violations of the accommodations requirement of the ADA, liability of the perpetrator of sexual harassment, and injury arising out of strikes and lock-outs, employment termination from specified business decisions and retaliatory actions taken against "whistle-blowers." *Id.*

84. Griffin & McKinney, *supra* note 81 (asserting that "over the last twenty years, wrongful employment practice claims have risen at a rate eighteen times faster than the proliferation of the federal court docket").

85. Joan Gabel et al, *Evolving Conflict Between Standards for Employment Discrimination Liability and the Delegation of That Liability: Does Employment Practices Liability Insurance Offer Appropriate Risk Transference?*, 4 U. PA. J. LAB. & EMP. L. 1, 30 (2001).

86. CLARANCE E. HAGGLUND ET AL., EMPLOYMENT PRACTICES LIABILITY GUIDE TO RISK EXPOSURES AND COVERAGE 66 (1998).

87. *Id.*

88. Glad & Rupp, *supra* note 67, at 140.

EPLI policies are currently written on a claims-made basis, providing coverage for claims reported during the policy period.[89] Most EPLI policy forms contain the following items:

Named Insured
Basic Coverage Provided
Claims Made Provisions
Defense and Claims Settlement Provisions
Limits Available
Deductibles and Co-Payment Provisions
Exclusions
Territory
Premiums/Rates

Many EPLI policies are "duty to defend" or have a defense option. With a duty to defend, the carrier is obligated to appoint adequate and skilled defense counsel to conduct the defense of the insureds under the policy. The insurer retains the counsel and pays the legal bills thereby giving them the power to make all defense decisions.

C. EXPANSION OF THE THREE ORIGINAL CAUSES OF ACTION COVERED BY EPLI

Three types of employment claims were covered in the original EPLI policies: sexual harassment, discrimination, and wrongful termination.[90] "Discrimination has been fairly consistently defined in EPLI policies since their development, but the legal definition of discrimination has expanded."[91] For example, "federal and state governments have continued to expand the categories that are considered 'protected classes.'"[92] Because of these changes, most policies contain a "catch all" provision at the end of their discrimination definition such as: "because of such person's race, color, religion, age, sex, national origin, disability, pregnancy, sexual orientation or preference, or other status protection pursuant to any applicable federal, state, or local statute or ordinance."[93]

Wrongful termination was originally designed to cover only the termination of an individual that violated law or an implied agreement to continue employment.[94] This narrow view has been replaced by a focus on

89. *Id.*
90. Klenk, *supra* note 73, at 325-26.
91. *Id.* at 326.
92. *Id.*
93. *Id.* (quoting Executive Risk's EPLI policy, II(D) (2/97 ed.)).
94. *Id.* at 326.

the employee's loss of "position," resulting in wrongful termination being defined in terms such as: "the actual or constructive termination of the employment of, or demotion of, or failure or refusal to promote, any *Employee* which is in violation of law or is against public policy, or is in breach of an implied agreement to continue employment."[95] The definition above makes clear that the termination need not be actual, but can also be constructive. The reality of many wrongful employment claims is that employees are not fired outright, but are instead given the signal that they should find employment elsewhere, without being fired. The more expansive definition of wrongful termination allows employers to be covered in the situations where a person's position within the organization is changed, not only when the employee is terminated.

Sexual harassment liabilities have also substantially changed since 1991 to include more than traditional *quid pro quo* cases. Hostile work environment claims, which were not included in the original definition of sexual harassment coverage under EPLI policies, are also included in many policies.

D. EXPANSION OF CLAIMS COVERED BY EPLI

In addition to the expansion of the three original areas of coverage for EPLI policies, additional coverage areas have been added.

Retaliation (including lockouts) as a claim began gaining popularity around 1995 and has been added to policies accordingly.[96] Harassment coverage has been broadened to include harassment of a non-sexual nature. Broadened definitions of harassment often include coverage for harassment, which creates a work environment that interferes with performance, or creates an intimidating, hostile, or offensive work environment.[97] Defamation, invasion of privacy, intentional infliction of emotional distress, and invasive surveillance or investigation coverages have also been added in response to changes in state, local, and federal policy.[98]

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95. *Id.* (quoting Executive Risk's EPLI Policy, II(R) (2/97 ed.)).
96. Klenk, *supra* note 73, at 327. *See also* HAGGLUND, *supra* note 86, at 67.
97. Klenk, *supra* note 73, at 327.
98. *See id.* at 328-30.

E. COMMON EXCLUSIONS IN EPLI POLICIES

"Most EPLI policies exclude intentional acts, ADA, contractual liability, workers compensation, crime and fraud."[99] Others, including the ISO policy, go further by excluding a wider range of claims.[100]

Under the ISO policy, it is the definition of "injury" that determines coverage. In order to be covered by the policy, the injury must arise from one or more of the following offenses:

a. Refusal to employ the person, termination of the person's employment, demotion or failure to promote, negative evaluation, reassignment, discipline, defamation or humiliation of the person, based on "discrimination" directed at that person;
b. Coercing that person to commit an unlawful act or omission within the scope of that person's employment;
c. Work-related "sexual harassment"; or
d. Other work-related verbal, physical, mental or emotional abuse directed at the person with respect to that person's race, color, national origin, religion, gender, marital status, age, sexual orientation or preference, physical or mental condition.

"[Originally,] exclusions to EPLI policies were many and severe. During the more recent evolution of the product, these exclusions have begun to disappear."[101] The remaining core group of exclusions is designed to prevent EPLI from picking up damages unrelated to employment practices liabilities. An exclusion that remains in today's EPLI policies "mainly addresses liabilities arising under the Employee Retirement Income Security Act ("ERISA"), workers' compensation, unemployment, and other related laws."[102] The statutorily mandated damages under these laws typically are covered by another form of insurance. Additionally, the damages under the statutes tend to be collateral to the core issues and damages in employment cases, and are therefore properly regarded as better covered elsewhere.[103] Standard exclusions found in most EPLI policies in the mid 1990's were:

- Claims arising out of prior or pending litigation
- Claims covered by workers' compensation
- Claims involving the ERISA Act of 1974
- Claims caused by bodily injury or property damage

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99. HAGGLUND, *supra* note 86, at 69.
100. *Id.*
101. Klenk, *supra* note 73, at 333.
102. *Id.* at 335.
103. *Id.*

- Claims caused by intentional acts to cause harm
- Claims caused by contractual liability
- Claims resulting from pollution
- Claim amounts involving fines and criminal penalties
- Non-standard exclusions found in EPLI policies during the same time period include:
- Claims for injunctive relief (non-monetary damages & fines)
- Claims resulting from bankruptcy
- Claims resulting from the Workers Adjustment & Retraining Notification Act
- Claims for Insurance Benefits after termination
- Claims arising from strikes or lockouts
- Claims resulting from any purposeful violation of any statute, rule, or agreement
- Securities Act violations
- Claims resulting from the financial impairment of the Insured Organization
- Claims resulting from criminal acts
- Claims resulting from collective bargaining
- Claims involving the National Labor Relations Board
- Claims resulting from a reduction in force of more than 20%
- Claims involving false arrest, libel, slander, invasion of privacy, wrongful eviction, assault & battery
- Claims involving the Racketeer Influence & Corruption Act (RICO Act)
- Claims involving building modification for disabled access
- Claims involving retaliation for whistleblowing
- Claims resulting from acts which are covered under any other policy issued by this insurance company
- Claims involving a class action suit
- Claims for punitive damages

F. PUBLIC POLICY EXCLUSIONS

Despite coverage by some insurance policies of intentional acts or conduct, public policy may prevent the coverage of claims for intentional conduct on the part of the insured.[104] Prohibiting insurance coverage for intentional conduct is based on two premises. First, no individual or entity

104. *See* Hill, *supra* note 3, at 305.

should profit from his own malfeasance.[105] Second, many courts will declare void any coverage for acts or conduct that harms others.[106]

The public policy against insuring for intentional torts is generally grounded in a fear of moral hazard, the danger that insurance may encourage wrongful or negligent behavior. For example, one Arizona state court has noted: "We conclude that there is no coverage for an insured's intentional acts, wrongful under the law of torts, because contractual intent and public policy coincide to prevent an insured from acting wrongfully knowing his insurance company will pay the damages."[107] Even so, an employer's insurance against intentional acts of an employee does not violate public policy.[108] In Massachusetts, statutory law prevents a company from insuring "any person against liability for causing injury, other than bodily injury, by his deliberate or intentional crime or wrongdoing."[109] The statute, however, only denies coverage of any act done with the specific intent to do something unlawful.[110] Because of this, an insurer is not precluded from defending an intentional injury claim if the insured committed an intentional act but the injuries sustained were unintended.

III. THREE AREAS IN WHICH INSURERS EXERCISE CONTROL OVER EMPLOYMENT PRACTICES

Insurance companies have three separate methods thought which they are able to exercise control over the employment practices of insureds. The first is the application process employers must complete to be considered by an EPLI provider. The application requires that the employer disclose, in detail, information about all policies relating to discrimination and wrongful employment practices as well as a copy of the company's employee handbook. Second, EPLI providers offer a variety of services that are used to keep employers abreast of all recent court cases and law changes relating to employment practices and employer liability. These include websites, newsletters, phone links to law offices, and comprehensive guides to rewriting handbooks and providing sensitivity and anti-discrimination training classes for employees. Finally, renewal

105. *Id.* at 307.

106. *Id.*

107. Cont'l Ins. Co. v. McDaniel, 772 P.2d 6, 9 (Ariz. Ct. App. 1988).

108. 43 AM. JUR. 2D *Insurance* § 708 (2004).

109. MASS. GEN. LAWS ch.175, § 47, Sixth(b) (2005).

110. *See* Andover Newton Theological Sch., Inc. v. Cont'l Cas. Co., 930 F.2d 89 (1st Cir. 1991).

applications require employers to disclose all previous litigation, administrative proceedings, demand letters, formal or informal government investigations or inquiries, and EEOC investigations that have occurred in the previous policy period. This holds employers accountable for their wrongful employment practices with the potential penalty being non-renewal of the policy or increased premiums.

A. EPLI INSURERS' PRESCRIPTIONS-WHAT INSURANCE COMPANIES DO IN TERMS OF RISK ASSESSMENT AND LOSS PREVENTION

1. What Underwriters Consider-the Application Process

The underwriting process for EPLI policies tends to be more complex than that used for underwriting other commercial liability lines because of the vast number of documents policyholders are required to provide to prove that the employer has policies and procedures in all areas central to the employment discrimination context.[111] Because EPLI is one of the fastest growing lines of insurance today, companies such as General Reinsurance offer suggestions about how underwriters should think about EPLI issues. General Reinsurance suggests that underwriters study the demographics, legal foundations, and ongoing legal developments and issues pertinent to human resources management.[112] Issues General Reinsurance is currently watching include:

a. Class and Mass Actions:

In the last several years, a rise in class and mass actions has occurred with employees seeking redress for widespread discrimination, sexual harassment, unequal pay, and other workplace wrongs. Suits against Wal-Mart for using and underpaying illegal aliens for custodial work are examples of well-publicized class and mass actions. When accumulated, the damages in these suits can be substantial.[113]

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111. Lorelie S. Masters, *Protection from the Storm: Insurance Coverage for Employment Liability,* 53 BUS. LAW. 1249, 1275-76 (1998).

112. Elizabeth Benet, *Employment Practices Liability Insurance,* GEN RE UNDERWRITER'S UPDATE, Jan. 2004, http://www.genre.com/sharedfile/pdf/UndUpdateEPLIJan2004.pdf.

113. *Id.* at 2.

b. Benefits Discrimination:

The basis for many class and mass actions is discrimination against a certain segment of employees, and recently these suits have included claims linked to age and duration of employment. As companies begin to restructure benefits like retiree medical and pension plans, there is a high probability that some groups of employees will be adversely affected.[114]

c. Employee Privacy:

Statutory and common law privacy rights are expanding and playing out in the workplace. Access to employee e-mail is one of the more visible tests of employer authority over conduct in the workplace. However, issues may arise involving drug and health testing and other information that employees may rightfully expect to remain private.[115]

d. Whistleblower Actions:

The large corporate scandals of Enron and its progeny have focused more attention on corporate behavior. Employees are encouraged to disclose improprieties and state laws have come into existence to protect the employee from retaliation. Retaliation suits, unlike wrongful discrimination suits, have the potential for punitive damages. For these reasons, underwriters must be aware and prepared for additional whistleblower actions.[116]

2. Analyzing Individual EPLI Applications

In order to understand what factors are actually considered by underwriters when writing EPLI policies, one must look to the application itself and the information required by each provider. To understand how underwriters project a targeted revenue and assess risk, and how employers learn what business practices and risk management tools are important to providers and, therefore, should be considered by the employer, the EPLI applications of the following seven providers will be examined in this section: American International Group ("AIG"), Casualty & Surety, Inc. ("C&S"), NAS Insurance Services, Inc. ("NAS"), Target Insurance

114. *Id.*
115. *Id.*
116. *Id.*

Services ("Target"), Chubb Group of Insurance Companies ("Chubb"), Philadelphia Insurance Companies ("Philadelphia"), and CNA Insurance Companies ("CNA").

3. Initial Disclaimers

The AIG mainform application for their "Employment Liability Protector" policy begins by giving companies notice that the policy provides that "the limit of liability available to pay judgments or settlements shall be reduced by amounts incurred for legal defense" and further notes that "amounts incurred for legal defense shall be applied against the deductible amount."[117] Policies issued are on a claims-made basis.

Similarly, Chubb notes that:

> The employment practices liability coverage section of this policy provides claims made coverage, which applies only to "claims" first made during the "policy period," or any extended reporting period. The limit of liability to pay damages or settlements will be reduced and may be exhausted by "defense costs," and "defense costs" will be applied against the retention amount. The coverage afforded under this coverage section differs in some respects from that afforded under other policies. Read the entire application carefully before signing.[118]

Philadelphia and C&S applications contain similar initial disclaimers, while NAS and CNA do not. Target offers the most comprehensive notice to the proposed insured, which includes a page-long description of which claims may be covered and the limits of coverage after the policy period has ended.[119]

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117. AMERICAN INTERNATIONAL GROUP, INC., EMPLOYMENT LIABILITY PROTECTOR: EMPLOYMENT PRACTICES LIABILITY INSURANCE POLICY MAINFORM APPLICATION 1 (1999), http://www.aignationalunion.com/nationalunion/public/natfiledownload/0,2138,1915,00.pdf.

118. CHUBB GROUP OF INSURANCE COMPANIES, EXECUTIVE PROTECTION PORTFOLIO: EMPLOYMENT PRACTICES LIABILITY COVERAGE APPLICATION 1 (Nov. 2002), *available at* http://www.chubb.com.

119. TARGET INSURANCE COMPANIES, EMPLOYMENT PRACTICES LIABILITY INSURANCE: APPLICATION AND UNDERWRITING INFORMATION FORM 1 (Jan. 2002), *available at* http://www.target-capital.com.

4. General Information

In the general information section, applicant employers must describe their type of business, locations of offices by city and state, and the products and services offered. This section is fairly similar for all applications reviewed and simply gives the underwriter an idea of what type of employer he or she is reviewing.[120]

5. Information About Employees

a. Number of Employees

This section sets the stage for whether or not each business is liable under each of the federal discrimination acts outlined in Part I. Employers must provide an employee count for the current year, as well as the previous year and often up to two years prior to the submission of the application. These employee counts are broken down into full-time, part-time, volunteer, temporary, and leased employees, and occasionally include non-U.S.-based employees. Some providers, such as Chubb and AIG, require employers to give the percentage of employees who are union or non-union.[121]

C&S requests information on the current number of employees by length of employment, beginning with those who have worked less than two years, 2–5 years, 6–10 years, 11–20 years, and concluding with over twenty years.[122]

b. Annual Compensation

Most providers reviewed ask for information about the salaries or annual compensation for current employees. Some, like Philadelphia, request information only for those with an annual compensation greater

120. *Id.* *See also* CHUBB GROUP OF INSURANCE COMPANIES, *supra* note 118; AMERICAN INTERNATIONAL GROUP, INC., *supra* note 117.

121. *See* CHUBB GROUP OF INSURANCE COMPANIES, *supra* note 118, at 2; AMERICAN INTERNATIONAL GROUP, INC., *supra* note 117, at 2.

122. CASUALTY & SURETY, INC., APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE (CSIEPLLF2/01) 1 (Feb. 2001), *available at* http://www.csiapex.com.

than $100,000.[123] Others, like Chubb, Target, and C&S, request information at all salary levels.[124]

c. Employee Turnover & Termination

In this section of the application, underwriters obtain information about the hiring, firing, and lay-offs an employer has engaged in during the past year to three years. Employers are required to outline their employment turnover in great detail, including the number of employees hired, the number of employees terminated, and any consolidations, lay-offs, or closures prior to the application period as well as any which are potentially looming. Philadelphia requires information on the number of employees who have been demoted in the past twelve months as well.[125]

6. Information About Human Resource Departments

The Human Resources portion of EPLI policy applications provides vital information for the underwriter to assess what risk management techniques an employer currently has in place. The section provides an employer with a list of policies and documents that it should likely either review or consider creating in order to put forth a more comprehensive application and a better loss prevention program. Questions included in the applications reviewed include the following:

Does the Applicant:

- Have a standard employment application for all applicants?
- Have an employment handbook?
- Document the receipt of the employee handbook by the employee?
- Require that employees sign and acknowledge receipt of the handbook?
- Have an "at will" provision in the employment application?
- Have a written policy with respect to sexual harassment?
- Have a written policy with respect to discrimination?
- Have written annual evaluations for employees?
- Have a written policy on progressive discipline for employees?

123. PHILADELPHIA INSURANCE COMPANIES, APPLICATION FOR PRIVATE COMPANY PROTECTION PLUS: EMPLOYMENT PRACTICES LIABILITY INSURANCE 4 (Mar. 2003), *available at* http://www.phly.com.

124. *See* CHUBB GROUP OF INSURANCE COMPANIES, *supra* note 118, at 2; TARGET INSURANCE COMPANIES, *supra* note 119, at 2; CASUALTY & SURETY, INC., *supra* note 122, at 2.

125. PHILADELPHIA INSURANCE COMPANIES, *supra* note 123, at 4.

- Have a written policy for the FMLA?
- Have a written policy for the ADA?
- Have a formal out-placement program to assist former employees in obtaining alternative employment?
- Have a written human resources manual or guidelines?
- Use outside counsel for employment advice?
- Use any tests to screen applicants or employees for continued employment?
- Utilize any form of alternative dispute resolution or have an arbitration policy?
- Offer severance arrangements in return for a release from future litigation?
- Provide formal training for its supervisors in administering employment procedures?
- Provide formal diversity or cultural sensitivity training for all of its employees?
- Utilize any other form of risk management with regards to employment practices?
- Have written procedures in place with regard to termination?
- Require terminations to be reviewed by outside counsel in addition to its human resources department?

This list of questions serves a vital role in allowing underwriters to assess an employer's current risk management strategies and potential for loss within the wrongful employment practices context. In addition, it gives the underwriter an idea of which risk management services offered by the insurer will benefit the employer.

7. Details of Past and Pending Activities and Lawsuits

Each application reviewed contained a section for employers to outline their past activities, lawsuits, and proceedings. The types of proceedings most frequently asked about are EEOC and NLRB administrative proceedings, employment-related civil suits, conciliation, settlement, U.S. Department of Labor disputes, Fair Labor Standards Act violations, Title VII claims, ADEA claims, ADA claims, EPA claims, FMLA claims, or consent agreements with the OFCCP, and actions brought by third parties concerning civil rights violations.[126] If an employer answers that, yes, he or

126. *See* CHUBB GROUP OF INSURANCE COMPANIES, *supra* note 118, at 4; CNA MANAGEMENT AND PROFESSIONAL LIABILITY, APPLICATION: EMPLOYMENT PRACTICES LIABILITY 2 (2005), http://www.insurance-applications.com/apps_generic/a.epli.pdf.

she has been involved as a defendant or respondent in any of these situations within a specified length of time prior to the application period, the employer is then required to identify the claimant and the nature of the claim and describe the result of the claim.

The employer is also required to disclose any claims for wrongful employment practices either pending or having to do with a fact, circumstance, or situation indicating the probability of a claim being brought against any proposed insured. NAS includes a supplement to the application specifically for the purposes of disclosing any prior activities information in greater detail.[127]

These questions serve both to allow the underwriter to assess the potential risk factors of an employer and to establish which claims are already in existence and are therefore not covered by the policy.

B. SUBMISSION REQUIREMENTS

All applications reviewed include submission requirements. The following chart outlines the submission requirements of each provider.

Requirements	Provider Name						
	AIG	Chubb	Philadelphia	C&S	CNA	NAS	Target
Most recent EEO-1 report	X	X	X				
Latest annual report	X		X		X		
Employee handbook	X	X	X		X		
Discrimination-related training opportunities		X					
Employee applications		X	X				
Employee performance evaluation forms	X						
Employee disciplinary termination and/or out placement procedures	X	X					
Procedure for handling complaints of discrimination	X	X					
ADR policies		X			X		
Procedure for handling complaints of sexual harassment	X	X					
Affirmative Action Plan		X					

127. NAS INSURANCE SERVICES, INC., SUPPLEMENTAL CLAIM/WRONGFUL ACT/INCIDENT FORM 1-2 (2003), http://www.nasinsurance.net/asp/contracts/general/CLSUPP.pdf.

Requirements	Provider Name						
	AIG	Chubb	Philadelphia	C&S	CNA	NAS	Target
Loss History including all claims for the past 5 years		X			X		X
Information on any pending or potential claims					X		X
Completed Application	X	X	X	X	X	X	X

IV. THE WAYS IN WHICH EPLI PROVIDERS BENEFIT BOTH EMPLOYERS AND EMPLOYEES

Employment Practices Liability Insurance provides benefits to both employers and their employees. By providing cost-effective risk management services to employers, EPLI providers are able to give employers easy access to current trends in employment law and tried and true methods of lowering risk.[128] Employees become the beneficiaries of these programs as employers learn that managing risk is necessary to avoid increasing settlement costs, larger jury awards, and the rise in insurance premiums with each additional discrimination claim.

A. RISK MANAGEMENT SERVICES OFFERED TO INSUREDS

When an EPLI policy is written, the employer gains access to many different risk management services offered to both help insureds avoid claims and to protect the provider from having to cover a number of avoidable claims. Risk management is a systematic process of managing exposures to risk. It involves planning, organizing, and controlling activities in a business with specific risks so as to minimize their cost and maximize the value of the business.[129]

128. It is estimated that only 3-30% of employers actually take advantage of all of the risk management services offered by their EPLI provider. *See* Interview with Elizabeth Napoli, FPS-EPL, St. Paul Travelers (Jul. 28, 2005). A study analyzing whether use of the services leads to a lower loss ratio would be useful in either promoting more widespread use by employers or assisting providers in improving their offerings to make the products more desirable to employers.

129. Francis Achampong, *Legislating Risk Management in Federal Employment As a Matter of Public Policy: An Analysis of Regulations Mandating Risk Management of Employment Practices Liability in Federal Agencies*, 27 SETON HALL LEGIS. J. 89, 90 (2002).

1. Websites

EPLI providers often offer web-based EPL resources as part of their Loss Prevention Program. These free websites are created specifically for employment practices liability insurance customers to assist with employment issues. An example of such a website is www.chubbworks.com[130] provided by Chubb, which offers convenient online access to a wide range of loss prevention tools.

Once an employer self-registers, web-based "best practices" training modules are available, which outline the best practices for preventing sexual harassment and workplace discrimination, terminating employment, and creating an ethical workplace. The training websites are interactive and provide both pre- and post-assessments and online training summaries.

The website also offers model employment policies, procedures and forms meant to be reviewed, downloaded or printed by employers and used to rewrite and review their own policies, procedures and forms.

In addition, an extensive online library catalog is available that offers access to publications such as "The Loss Prevention Journal for Human Resources," "The Loss Prevention Journal for Managers and Supervisors," and "Leadership." All of the information provided by employers on this website, including employer materials that have been downloaded onto the website, is protected by a confidentiality agreement.

2. Toll-Free Hot Lines

Toll-free hot lines are offered by providers to put employers in direct contact with law firms or lawyers who can provide immediate answers to EPL questions. By doing so, employers have access to professional responses to their questions and are provided with a brief overview of the employment law that best relates to the employer's unique situation. By allowing employers to investigate issues through the use of trained legal professionals, EPLI providers are able to help their insureds answer pressing legal questions *before* a decision is made that could result in litigation.

Aon Insurance Services offers a toll-free hot line that provides legal advice to help avoid employment-related lawsuits as a policyholder

130. Additional information about www.chubbworks.com is provided by Chubb Group of Insurance Companies and is available at http://www.chubb.com.

benefit.[131] Reasons that are given to access the hotline include assurance that an employer's reasons for terminating an employee are legal, compliance updates about the ADA, FMLA, and state-specific Pregnancy Leave Laws, advice in how to handle a complaint notice from the EEOC, learning how to conduct an investigation should an employee complain about sexual harassment, and questions on good employment practices such as employee handbooks, employment applications, and legal hiring practices.[132]

3. Newsletters

There are many services on the web offered by EPLI insurers, law firms, and reinsurance companies that provide newsletters for employers outlining timely EPLI issues.

AICPA Insurance Groups provides copies of *EmployerGardian,* which publishes articles on employment practices risk reduction strategies, to all website visitors. Articles in the past issues include: *Minimizing Some of the Risks Involved in Background Screening,*[133] *Recognizing the Need for an Investigation,*[134] and *The Perils of Office Romance.*[135]

4. Handbooks and Manuals

EPLI providers often offer sample handbooks and manuals for employers to use to compare and review their personal employee handbooks.

CNA, for example, offers discounted handbooks, employment applications, and Employment-At-Will statements through FPHR Consulting.[136] It additionally offers numerous articles, booklets and services through Fisher & Phillips, LLP, a prominent labor and

131. AON Insurance Services, CPA EmployerGuard: Risk Management Assistance Hotline, *available at* http://www.cpai.com/riskmgt/cpaeplhotline.php (last visited Feb. 10, 2006).

132. *Id.*

133. *Minimizing Some of the Risks Involved in Background Screening,* EMPLOYERGARDIAN, Summer 2004, http://www.cpai.com/pdfs/N-2417-604.pdf.

134. *Recognizing the Need for an Investigation,* EMPLOYERGARDIAN, Summer 2004, http://www.cpai.com/pdfs/N-2417-604.pdf.

135 *The Perils of Office Romance,* EMPLOYERGARDIAN, Fall 2002, http://www.cpai.com/pdfs/EGard_Fall2002.pdf.

136 CNA Management and Professional Liability, Risk Management Services, http://www.cnapro.com/html/riskmanagement.html (last visited Feb. 10, 2006).

employment law firm.[137] Fisher & Phillips, LLP's Employment Practices Audit and Handbook Questionnaire provides an avenue for employers to assess their own risk and make informed changes within their human resources departments and throughout their overall businesses.[138]

Chubb also offers access for all who are interested to their Employment Practices Loss Prevention Guidelines Manual, a free booklet that discusses key employment issues in layman's terms and offers proactive ideas for avoiding EPL lawsuits.[139]

5. Consultant Services

EPLI providers also offer their insureds access to consultant services. An example of this is CNA's Risk Management Services, which includes access to consultant services through the AGOS Group/Labor Consultants of America, a human resources consulting firm. Advice is often offered via a toll-free phone number staffed by trained consultants who will answer specific questions and provide pertinent human resources information. This provides yet another avenue for the insured to receive information from the human resources perspective in addition to information from the employment law perspective offered through the toll-free hot lines that place employers in contact with legal representatives.

Employers also often have the opportunity to undergo a confidential audit by a third-party vendor. The audit is often used by employers who want an attorney to analyze their human resources department practices and their company paperwork for holes within their handbooks and policies. The auditor then offers employers advice as to changes that can be made within the organization to better protect against discrimination claims.

V. EPLI POLICY RENEWAL-THE APPLICATION PROCESS

When applying for a renewal of an EPLI policy, employers are asked far more pointed questions about the internal controls that have been maintained or modified within the previous policy period. Employers now answer questions such as the following:

> Have all supervisors and officers attended training of sexual harassment and discrimination within the last twelve months?

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137 *Id.*

138 *Id.*

139 SEYFARTH SHAW LLP, EMPLOYMENT PRACTICES LOSS PREVENTION GUIDELINES: A PRACTICAL GUIDE FROM CHUBB (Jan. 2005), http://www.chubb.com/businesses/csi/chubb2215.pdf.

- Does the labor relations counsel review the employment policies/procedures at least annually?
- Have there been any changes to the employee handbook in the last twelve months? If "Yes," please provide the details of these changes.
- Are all mandatory federal and state posting requirements met?
- Have there been any changes in the application for employment?
- Are terminations reviewed by human resources, senior management or outside labor relations counsel?
- Are orientations conducted for all new employees?

In asking these questions, underwriters are able to assess the extent to which employers have engaged in the risk assessment and loss prevention strategies offered during the previous coverage term. Because the provider has worked with the employer during the previous coverage term, the underwriter needs only contact the employer to check-in and revisit unresolved issues from the previous coverage term.

If an employer is non-renewed, it is often because of bad faith action on the part of the employer, a trend of extremely bad claims, refusal to settle claims, or failure to pay their premium. If an employer is non-renewed, this information must be disclosed on all future applications for EPL insurance. A history of being non-renewed could make it more difficult for an employer to obtain a favorable quote in the future.

CONCLUSION

Employment law is increasingly complex. EPL issues are rapidly changing and continuing education for both employers and EPLI providers is essential for both parties to profit and survive. With the rising dollar amount of awards given to successful plaintiffs, the rising number of complaints made, and EPLI providers' exclusions and thorough application processes, an employer cannot expect EPLI to function as a "ticket to discriminate" as was once feared. The stakes are far too high. Through careful underwriting, intensive risk management options, and thorough renewal applications, insurance companies are able to promote compliance with safeguards that, in turn, protect the employee. Employers and EPLI providers know that developing sound employment practices now and in the future will pay dividends in preventing employment-related allegations and lawsuits. This knowledge drives the insurance industry to take all action possible to make employers aware of their exposure and ways to manage risks. In turn, employers' desire to remain profitable and avoid the damage a negative employment discrimination lawsuit can have on stock

prices and public perception motivates them to work to ensure that important information related to managing risk and changes in employment law are passed between the company's management, general counsel, risk management office, and human resources department. The reality check employers receive when purchasing EPL insurance allows them to fully grasp how financially devastating an employment discrimination claim can be in a way that is more immediate and personal than a simple knowledge of the federal regulations in place to protect employees. By placing the ramifications of failing to comply with federal regulations in a personal light, EPLI providers allow employers to take a real look at their policies and practices and make changes that benefit themselves monetarily and, in turn, benefit their employees.

ARE THE REGULATORY FRAMEWORKS IN ASIAN EMERGING MARKETS EQUIPPED TO HANDLE THE INFLUX OF FOREIGN INSURERS?

Shanil R. Vitarana *

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INTRODUCTION

The era of globalization and internationalization is well underway, the effects of which can be seen when one goes into a Wal-Mart and buys a Barbie doll made in Guangzhou, China or receives a telemarketing call

* Candidate for Juris Doctor, University of Connecticut School of Law, May 2006; Bachelor of Arts, Rutgers University-New Brunswick, May 2003. The author would like to thank the members of the *Connecticut Insurance Law Journal* for their editing of this Comment.

from someone based in Bangalore, India. These global trends have become commonplace in the retail, electronics, textiles, and IT markets largely due to the advent of the free market mentality that has spurred liberalization and deregulation over the last two decades in many developing countries. One industry that has been slow to deregulate until recent years, however, has been the insurance industry. Now, mainly due to the adoption of the General Agreement on Trade and Tariffs (GATT) and the accession to the World Trade Organization (WTO), many developing countries in regions such as Latin America, the Middle East, Eastern Europe, and Asia are beginning to implement open-door policies with regard to their respective insurance industries, causing large foreign insurers to seek entrance into these vast and largely untapped markets.[1]

Two countries that are primed for increased foreign insurer activities include China and India, whom collectively have by far the most growth potential of any other emerging insurance markets.[2] These two countries have yet to experience much foreign insurer penetration, as they have only recently begun to liberalize and deregulate their insurance markets.[3] They, therefore, fall under the classification of "incipient" insurance markets, as compared to others in the region such as Japan which has a "fully mature" insurance market and South Korea which can be classified as a "transient" insurance market.[4] As incipient markets, China and India face hurdles in transforming their previously state-owned and monopolized insurance markets into free and competitive markets. Some of these hurdles include concerns as to whether the Chinese and Indian markets are prepared to adequately address the impact that foreign insurers are likely to have on their domestic markets. Many of these foreign insurers, usually consisting of large North American and European insurance and financial services companies, have received or are awaiting licenses to sell their insurance and investment products in these emerging markets. They are eager to market their products to consumers with penchants for saving and desires

1. Foreign insurers are aided largely by the 1997 World Trade Organization (WTO) negotiations that were seen as an important first step in achieving trade liberalization and market access for the financial services industry. In addition, the General Agreement on Trade in Services (GATS) 2000 negotiations in the WTO have provided an opportunity for further insurance market liberalization and deregulation amongst WTO members. *See* YONG-DUCK KIM, WTO NEGOTIATIONS, FINANCIAL CRISIS, AND EFFICIENCY AND PRODUCTIVITY IN THE KOREAN INSURANCE MARKET 3 (July 2002), http://www.iisonline.org/pdf/Y.D.pdf.

2. *See infra*, Part I.a.

3. *See infra*, Part I.a.

4. JULIA F. CHU, MILLIMAN USA, THE MAKINGS OF IMMINENT INSURANCE MARKETS IN ASIA 1 (2001), http://www.milliman.com/pubs/InsuranceMktsAsia.pdf.

to increase wealth through a broad array of investment vehicles that limited state-sponsored companies have been unable to provide.[5]

In order to handle the influx of foreign insurers and the growing domestic demand for new and varied insurance products, state actors such as China and India will be forced to adopt and reorganize their legal and regulatory frameworks. The question lies: can these burgeoning economic superpowers modernize their regulatory codes and oversight procedures to handle the rapidly internationalizing insurance industry? To answer this question, this Comment will comprehensively examine the catastrophe that arose in South Korea with respect to the massive regulatory changes that took place in that country after its financial crisis in 1997. Through this lens, the argument will be put forth that regulators and lawmakers in China and India should heed lessons from the Korean situation which was caused in part by overzealous liberalization without the adequate modernization of the country's regulatory framework, which then left the industry in chaos until a new systematic reform process was undertaken.[6] There is pressure on China and India to rapidly incorporate the free market mentality and open their markets; however, this Comment advocates that caution should be taken by regulators to ensure that legal and regulatory structures are sufficiently prepared to accommodate the influx of foreign insurers.[7] In order not to make the same mistakes that Korean policymakers made in the 1990s, this Comment puts forth the argument that the most appropriate regulatory framework to be followed by Chinese and Indian policymakers should consist of a predominantly *ex post* approach that allows for prudent governmental supervision and also insurer self-regulation and accountability.[8] In other words, a sound legal regime and regulatory

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5. *See* SWISS RE, EXPLOITING THE GROWTH POTENTIAL OF EMERGING INSURANCE MARKETS-CHINA AND INDIA IN THE SPOTLIGHT 7 (2004), http://www.swissre.com.

6. *See infra*, Part II.

7. Other common areas of insurance regulatory oversight include: the filing and approval of insurance rates, insurance product and company taxation, formation and licensing of insurers, the licensing of agents and brokers, unauthorized insurance and unfair trade practices, insurer financial reporting, examining and other financial requirements, rehabilitation and liquidation of insurers, guaranty funds, and the filing and approval of proposal material and policy forms. *See* ROBERT W. KLEIN ET AL, CTR. FOR RISK MGMT. AND INS. RESEARCH, GA. ST. UNIV., RESTRUCTURING REGULATION FOR DEVELOPING INSURANCE MARKETS 12 (1997), http://rmictr.gsu.edu/ Papers/o_report97-1.pdf

8. Governments usually regulate the insurance industry using a combination of *ex ante* and *ex post* approaches. An ex ante approach refers to the practice of setting, often stringent, rules that insurers must abide by. For example, a government may impose rigid market entry barriers, limit the types of ownership structures, detail the scopes of insurer operations and investments, and specify premium rates and policy designs. In contrast, the *ex post* approach focuses on correcting distortions in the market once a signal leading to

framework should not only include effective mechanisms for disclosure and transparency maintained by domestic regulators, but it should also allow the open market to take its course and encourage foreign insurers to use their knowledge and expertise to create an atmosphere of mutual gain that will provide benefits to be passed on to consumers.

The organization of this Comment is as follows: Part I will serve as a background on foreign insurers in emerging markets, specifically discussing the growing importance of emerging markets and the multitude of issues and concerns that arise with it. Next, Part II will consist of a case study on the South Korean insurance market, with focus given to the insurance reforms implemented in that country. Lastly, Part III will focus on China and India and generally compare and contrast the South Korean model to those respective markets with the purpose of determining whether they are adequately established to handle the influx of foreign insurers.

I. BACKGROUND: FOREIGN INSURERS IN EMERGING MARKETS

The expansion of large North American and European insurance companies into foreign markets is not a new phenomenon. Many large insurers have joint ventures as well as wholly-owned subsidiaries in many foreign markets around the world.[9] However, until recently, many of these markets included only European markets and more well established foreign markets such as Japan, Hong Kong and Argentina. However, dozens of countries in locales all over the globe have recently undertaken, or are considering undertaking, economic reforms to open up their markets to foreign insurance firms.[10] This interest has been spurred by a multitude of

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such a distortion has been identified. A country relying on *ex post* measures allows the regulator to set the minimum entry barriers, but conducts rigorous monitoring of insurer activities. It may allow incumbent insurers to operate and invest freely, but subject them to stringent solvency margins or risk-based capital standards. Self-regulatory approaches such as corporate governance and self-regulation by industry associations are increasingly observed in the markets subject to *ex post* regulatory measures. *See generally* W. JEAN KWON, SCH. OF RISK MGMT., ST. JOHN'S UNIV., TOWARD FREE TRADE IN SERVICES: EMERGING INSURANCE MARKETS IN ASIA 2 (2001), http://www.iisonline.org/pdf/W.pdf.

9. For example, American International Group (AIG), arguably the leading insurance firm in the world, has a global business network that includes: Africa, China, Latin America, the Middle East, South Asia and Southeast Asia. *See* AIG, http://www.aigcorporate.com (last visited Jan. 10, 2006).

10. The most important emerging insurance markets in the regions, ordered by their total insurance premiums in 2003, are: (1) Asia: South Korea, China, Taiwan, India, Hong Kong, Singapore, Malaysia, Thailand, Indonesia and Vietnam, (2) Latin America: Brazil, Mexico, Chile, Argentina, Venezuela and Colombia, (3) Eastern Europe: Russia, Poland,

factors. For instance, foreign direct investment, once shunned, is now sought after. Tariff and non-tariff barriers have fallen. Furthermore, state owned ventures have now been privatized.[11] In addition, many governments have deregulated industry, commerce, and domestic finance.[12] Countries that have recently undertaken these reforms are collectively referred to as "emerging markets"[13] and they are located predominantly in regions such as Latin America, Asia, Eastern Europe, and the Middle East.

A. GROWING IMPORTANCE OF EMERGING INSURANCE MARKETS

Economic growth of emerging markets has time and again outpaced that of industrialized nations.[14] Growing at a precipitous rate alongside the general economies of these emerging markets are their respective insurance sectors. For instance, life and non-life insurance premiums in emerging markets have grown annually by 10.4% and 7.3% respectively in real terms over the past 10 years against industrialized nations' average of 3.4% and 2.6%.[15] Further liberalization and deregulation of emerging markets, when compared to the growing market saturation in industrialized nations, offers a bright future for foreign insurers seeking to capitalize on tremendous overseas growth.[16] Foreign insurers also find better risk diversification overseas, while at the same time fulfilling the need to service their global clientele beyond national borders.[17]

The trend toward investing in emerging insurance markets has a fairly long history and has been quite advanced in Latin America and Eastern Europe due to a rapid pace of liberalization and deregulation. In Asia, foreign insurer activity has been growing at a slower pace, given the multitude of financial crises such as the Asian currency crisis of 1997.[18]

Czech Republic, Hungary, Ukraine, Slovenia and Slovakia, (4) Africa: South Africa, Morocco and Egypt, and (5) the Middle East: Turkey, Iran, United Arab Emirates, Saudi Arabia, Lebanon, Kuwait. *See* SWISS RE, *supra* note 5, at 4.

11. *See* SWISS RE, *supra* note 5, at 3.

12. *Id.*

13. Emerging markets are broadly defined as a country seeking to make an effort to change and improve its economy with the goal of raising its performance to that of the world's most advanced nations. Emerging markets however are not necessarily small or poor. China, for example, is considered an emerging market. *See* EMDirectory.com, Emerging Markets Directory: What is an Emerging Market?, http://www.emdirectory.com/definition.html (last visited Jan. 10, 2006).

14. SWISS RE, *supra* note 5, at 3.

15. *Id.*

16. *Id.*

17. *Id.* at 5.

18. *Id.*

Since 1997, however, foreign insurers have bolstered their market shares in nearly every Asian country.[19] In the life insurance sector, the share of foreign companies has doubled in Indonesia while substantial increases have been seen in Malaysia and the Philippines.[20] Foreign life insurers have also been able to gain a foothold in Japan and South Korea partly because some domestic life insurers were weakened substantially by the 1997 crisis and subsequently offered themselves as acquisition targets.[21] This trend of foreign insurer investment is growing as other Asian emerging markets such as China and India move to further liberalize and deregulate their insurance industries.[22] Considering that emerging markets are home to 86% of the world's population, including two of the most populous nations in China (1.3 billion) and India (1.1 billion), the opportunities seemingly are plentiful.[23] Collectively, emerging markets account for twenty-three percent of global economic output with China and South Korea having some of the biggest economies in the world.[24] Furthermore, in 2003, emerging markets accounted for ten percent of global non-life and eleven percent of life insurance premiums collectively.[25] Experts argue that because these percentages are clearly lower than the emerging markets' share in output (GDP), not to mention population, this implies a tremendous potential for growth.[26] This potential for growth is most evident in Asia. Containing the two goliaths, China and India, Asia is now by far the most important region in the emerging world, accounting for 62% of the emerging world's population, 47% of its GDP and non-life premiums, and a remarkable 73% of its life insurance premiums.[27]

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19. SWISS RE, INSURANCE MARKETS IN ASIA: SANGUINE OUTLOOK DESPITE SHORT-TERM UNCERTAINTIES 22 (2001), http://www.swissre.com (search "Insurance Markets in Asia"; then follow "Insurance Markets in Asia" hyperlink).

20. *Id.*

21. *Id.*

22. *Id.* at 23. For example, China has witnessed fast growth of its insurance sector since opening up its market in the past two years following commitments to its accession to the Word Trade Organization (WTO). As of early 2004, nine foreign insurance firms had entered the Chinese market since accession, bringing the total of foreign insurers operating there to thirty-seven. They include twenty life insurance joint-ventures, fourteen non-life branches of foreign insurers, and three foreign reinsurers. *Foreign Insurers in China Witness Fast Growth*, PEOPLE'S DAILY, Jan. 23, 2004, *available at* http://english.people.com.cn/200401/19/eng20040119_132992.shtml. *See also infra* Part III, Section ii.

23. *See* SWISS RE, *supra* note 5, at 5.

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

Asia, however, should not be considered in isolation when discussing emerging insurance markets because foreign insurance companies are expanding worldwide and doing so with tactical poise and strategic goals. For instance, Latin America is also increasingly targeted as a favorite destination for foreign insurer expansion. The region is generally regarded as the second most important region in the emerging world.[28] It is dominated by the "Big Six" of Argentina, Chile, Brazil, Colombia, Venezuela, and Mexico, with premium volume totaling approximately $32 billion in 1995 amounting to a world-market share of 1.5%.[29] By 2010, it is projected that Latin America's total premium volume will be about $90 billion, but with a world-market share of still only 2.5%, there certainly exists enormous potential for growth in this region.[30]

Foreign insurers plan to take advantage of this growth potential in both Asia and Latin America by choosing to target specific population dynamics within these markets, and therefore, many markets in the emerging world find that their insurance business is concentrated in a few areas.[31] Life insurance, for instance, plays a larger role in these markets than in "other markets with a similar per capita income."[32] Countries with a higher per capita income on average spend a larger share of income on insurance, and as income increases, insurance penetration is also expected to rise.[33] In Asia, people tend to spend significantly more on life insurance than in countries with a comparable per capita income.[34] This advanced level of consumer awareness of life insurance in Asian markets can be attributed largely to relatively high life expectancy, the modest scale of public retirement schemes, and the significant rate of household savings.[35] In the Middle East, in contrast, life insurance is largely undeveloped.[36] The reasons for this are the traditionally close family ties and religious-based

28. *Id.* at 4.

29. Press Release, Business Insights, Latin America: An Emerging Giant in the Insurance Market (June 2000), http://www.globalbusinessinsights.com/rbi/content/rbfs0031p.pdf.

30. *Id.*

31. *Id.*

32. SWISS RE, *supra* note 5, at 6, 8.

33. *Id.* at 6.

34. *Id.* at 7-8. For instance, in 2003, South Korea, Hong Kong, and Singapore all had GDP per capita ranging from approximately $20,000 to $40,000 and their citizens spend approximately six percent to seven percent of this GDP on life premiums. In comparison, Slovenia, Kuwait, and the United Arab Emirates all have similar GDP per capita ranges to the aforementioned Asian countries, however, their citizens spent approximately 0% to 1.5% of their GDP on life premiums. *Id.* at 8.

35. *Id* at 7.

36. *Id.*

reservations about insurance.[37] In these markets, one tends to see non-life insurance such as property and casualty insurance dominating the insurance sector.[38] This non-life market is also strong in Eastern Europe and Latin America. In Eastern Europe, changes in regulations as these countries approached inclusion into the European Union has stimulated growth in these segments of the insurance industry.[39] In Latin America, non-life insurance such as accident and health insurance as well as motor insurance dominates the sector.[40] Growth of non-life premiums in the region is forecasted to be between six and eight percent on average, and is particularly strong in markets such as Argentina, Brazil, and Mexico.[41]

Foreign insurers are targeting these emerging markets in both areas of life and non-life insurance with the hopes of tapping into high-growth segments and diversifying their risk. This activity is beginning to take place in China and India, which are the emerging markets focused on throughout this Comment. Experts believe that China and India are poised for "spectacular" growth.[42] The acceleration in economic momentum and nascent insurance industries, coupled with increased consumer risk awareness, seemingly pave the way for tremendous growth potential in both these countries.[43] The reasons for this anticipation are that both China and India are undergoing greater liberalization of regulatory restrictions and a change in legal and policy frameworks to increasingly entice foreign insurers to think hard about investing.[44] Experts point to China's structural changes coupled with strong economic growth leading to life insurance premium growth rates expanding in excess of twenty percent per annum, with volumes more than doubling within the next five years to $100 billion.[45] In addition, non-life operations appear poised to expand beyond $20 billion by 2010.[46] India, on the other hand, is spurred by a brisk

37. SWISS RE, *supra* note 5, at 7. Markets include Morocco, Egypt, Lebanon, Turkey, Kuwait, Saudi Arabia, United Arab Emirates and Iran.

38. *Id.*

39. *See id.* at 10. Markets include Slovenia, Ukraine, Hungary, Poland, Czech Republic, Russia and Slovakia.

40. *Id.*

41. *Id.*

42. *See Insurance Markets in China and India Poised for 'Spectacular' Growth*, FINANCIAL INSIGHTS-RESEARCH NEWS, October 10, 2005, *available at* http://www.industryanalystreporter.com/T2/Analyst_Research/ResearchAnnouncementsDetails.asp?Newsid=5935.

43. *Id.*

44. *See id.*

45. *Id.*

46. *Id.*

economic environment, expanding affluence and higher risk awareness.[47] Like China's, India's life insurance sector is also expected to expand at circa twenty percent per annum over the medium term.[48] Both the regulatory frameworks and legal regimes of China and India will be discussed in depth in a subsequent portion of this Comment in order to delve into the structural support mechanisms are in place to support this "spectacular" growth.

Prior to discussing the legal and regulatory frameworks of China and India, it is important to keep in mind that many emerging market countries in not only Asia, but Latin America, the Middle East and Eastern Europe have only recently begun the process of opening their insurance markets to large North American and European insurers. Therefore, there are considerable issues and concerns that can arise on the part of all parties involved. The subsequent section will address these issues and concerns so that more perspective can be had to dissect the rules, regulations and requirements that policymakers and lawmakers in China and India have adapted to handle the influx of foreign insurers.

B. FOREIGN INSURER ACCESS: ISSUES AND CONCERNS

With all the positives that can come from the expansion of foreign insurers into emerging markets, concerns persist that certain aspects of this liberalization and deregulation euphoria will carry unwanted risks and drawbacks. Understanding these issues and concerns is vital to understanding how regulatory frameworks, particularly those in China and India, should be structured to promote the development of the insurance industry within the financial system as well as to protect consumers.[49] Before discussing these concerns that are facing foreign insurer expansion into emerging markets, it is helpful to first note the benefits.

As aforementioned, the specific arguments favoring greater foreign insurer participation in emerging markets are that countries could realize: improvements in their customer service and value, increased domestic savings, transfers of technological and managerial know how, gaining of additional external financial capital, improvements in the quality of their insurance regulation, and creation of high quality jobs in the domestic

47. *Id.*

48. *Insurance Markets in China and India Poised for 'Spectacular' Growth*, *supra* note 42.

49. KLEIN ET AL., *supra* note 7, at 3.

insurance sector.[50] Economists and insurance experts also believe that insurance aids economic development in several ways:

> *First*, insurance promotes financial stability and reduces anxiety . . . . *Second*, private insurance can substitute for government security programs . . . . *Third*, insurance facilitates trade and commerce . . . .
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> *Fourth*, insurance mobilizes national savings . . . .
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> . . . .
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> *Fifth*, insurers enable risk to be managed more efficiently . . . .
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> . . . .
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> *Sixth*, insurers and reinsurers have economic incentives to help insured's reduce losses . . . . [Lastly], the *seventh* benefit of insurance to economic development is that insurers foster a more efficient allocation of a country's capital.[51]

These positive factors are important because emerging market populations could stand to gain tremendously if these economic developments actually take place. The problem is that the precise linkages between insurance and economic development are poorly understood.[52] There simply is not the large body of supportive research done in this area as there is in the area of banks and their role in economic development.[53] Therefore, lawmakers have expressed reservations about foreign insurer participation in their domestic markets because they cannot truly be sure as to whether their domestic economies will see the types of economic advantages to warrant making dramatic changes to their regulatory codes and legal infrastructures.[54]

One such reservation critics and some policymakers have expressed is that foreign insurers might dominate the domestic market and in doing so may cause adverse microeconomic (less consumer choice and value) or macroeconomic (failure to contribute adequately to economic development) effects.[55] Critics argue that, if an emerging market offers

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50. CHU, *supra* note 4, at 4.

51. HAROLD D. SKIPPER, FOREIGN INSURERS IN EMERGING MARKETS: ISSUES AND CONCERNS 2-5 (1997), http://rmictr.gsu.edu/Papers/FOREIGN.pdf.

52. *Id.* at 2.

53. *Id.*

54. *See id.* at 6-9.

55. *Id.* at 6-7.

growth potential and if domestic insurers are inadequate and unsophisticated, that would leave the market open for abuse by foreign insurers.[56] This argument is viable, and that is why a strong legal regime and regulatory framework is essential to police the activities of foreign insurers adequately.

A second reservation is that foreign insurers might market insurance selectively, thereby leading to adverse micro and macroeconomic effects.[57] This concern arises from the belief that foreign insurers will market insurance only to the most profitable segments of society such as to multinational corporations, the commercial sector or high net worth individuals. Critics argue that this behavior would distort the market and cause harmful divides within emerging market societies.[58] Proponents of this selective marketing behavior argue that, in fact, specialization and market segmentation lead to efficiency improvements.[59] Furthermore, they argue, foreign insurers can be enticed into neglected segments such as low-income populations through subsidies and other benefits offered by domestic governments.[60]

A third reservation is that foreign insurers might fail to make lasting contributions to the local economy.[61] Ideally, a multinational corporation doing business in an emerging market would attempt to make a positive presence in society and go beyond short-term profit goals. Naturally, this is quite a controversial topic and one where there is little factual basis as to what exactly the term "a lasting contribution" actually entails.

The fourth reservation for limiting foreign insurer access to emerging markets is that some domestic markets may already be well served by locally owned insurers or through reinsurance.[62] These concerns need to be addressed on a country-by-country basis because there could be some markets in which consumers are satisfied with the insurance products available and the prices at which they are sold. However, one could infer that consumer dissatisfaction with the domestic insurance and financial services markets as a whole in many of these emerging markets presumably plays a role in the government's decision to open up their market barriers to entry in the first place.

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56. *Id.* at 7.
57. SKIPPER, *supra* note 51, at 7.
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 8.
62. *Id.*

Lastly, and of particular relevance to this Comment, a fifth reservation is that full market liberalization should await insurance law and macroeconomic regulatory reforms in hopes of minimizing the chances of market disruptions.[63] This is a very legitimate reservation, particularly with regards to adequate governmental supervision, competition, regulation, pricing controls and overall market conduct oversight. If an emerging market does not have reasonable insurance laws and an adequate regulatory framework established, then foreign insurers should not be allowed entry. Ideally, they should exist prior to a full market liberalization to avoid abuse by unscrupulous investors.[64] A fine line needs to be drawn between excessive government regulation and decision making and excessive insurer influence. The ideal regulatory framework, as previously discussed, will allow for an *ex post* model consisting of adequate government intervention and oversight with the addition of allowing for market-based policies that give insurers some avenue of autonomy in their decision making processes.

Regardless of the regulatory framework that emerging market nations choose to implement, this section is intended to bring attention to the significant issues and concerns that can arise with regards to foreign insurer expansion into emerging markets. While the opening of insurance markets to qualified foreign insurers is likely to aid economic development and enhance overall social welfare, there are some drawbacks and concerns to this activity. The best way to address these concerns is to develop sound legal and regulatory frameworks so that both the foreign insurer and the emerging market populations are protected, if and when things go badly.

II. SOUTH KOREAN INSURANCE MARKET: LESSONS TO BE LEARNED

Asia's insurance markets are simultaneously in a state of change and growth. Deregulation has been a driving factor behind the opening of Asia's most promising insurance markets, with further measures to be enacted in the future to allow insurers more freedom in pricing, product design, and investment activities to spur development in the region.[65] As this Comment has argued, this relative freedom for insurer activities must go hand-in-hand with prudent governmental supervision and transparency, thus allowing emerging Asian markets such as China and India to adopt

63. SKIPPER, *supra* note 51, at 8.
64. *Id.* at 9.
65. KWON, *supra* note 8, at 2. *See also* SWISS RE, *supra* note 5, at 25.

predominantly *ex post* regulatory frameworks.[66] The emerging markets need to walk a tightrope between allowing enough operational freedom to entice foreign insurers to invest and protecting their domestic economies from moral hazards and improper activities. The key to doing so is installing an effective legal regime and regulatory framework to govern the activities of these Asian emerging insurance markets for the benefit of all parties involved.

One Asian market that did not discover how to properly administer its regulatory framework until it was already too late was South Korea. Only until after South Korea endured its catastrophic financial crisis of 1997 has the nation learned that a well developed legal and regulatory infrastructure should exist in the financial services and insurance sectors as well as throughout the economy as a whole to ensure a healthy, vibrant, and stable marketplace.[67] There are many lessons that regulators in China and India can learn from not only the mistakes made by Korean regulators and lawmakers but also by the framework set up by the country since its 1997 financial crisis. The purpose of the following case study is to apply the mistakes learned in Korea to the current deregulation that is being seen in China and India to ensure that appropriate measures are being taken in those emerging markets to construct viable and effective regulatory frameworks.

A. CASE STUDY: SOUTH KOREA

1. Introduction

South Korea embarked on an accelerated liberalization program in the early 1990s but did so without adequate structural mechanisms in place. While the country experienced tremendous prosperity and lured significant foreign investors to its domestic markets, South Korea's regulatory framework, supervisory system, and disclosure standards were generally weak.[68] Prudential regulation of financial institutions was, at the time, generally considered discretionary and inadequate.[69] Furthermore, implicit government insurance for the financial institutions created the moral hazard of domestic participants and foreign creditors, thus causing the financial institutions to develop risky asset-liability structures.[70] In 1997, South

66. KWON, *supra* note 8, at 2.
67. *Id.*
68. *Id.*
69. KIM, *supra* note 1, at 4.
70. *Id.*

Korea along with other Asian nations such as Thailand, Malaysia, and Indonesia underwent a systematic financial crisis blamed largely on the devaluing of currencies, which led to foreign capital pullout in domestic markets.[71] This pullout led these Asian market economies to tumble and caused havoc on many of their industries, including the insurance industry of South Korea.[72] Many academicians argue that the crisis resulted in part from the inappropriate management of the financial system, which led to poor corporate governance of various sectors including the insurance industry.[73] This poor corporate governance eventually left South Korea vulnerable to the volatilities of the international capital markets.[74]

2. South Korea's Old Insurance Regulatory Framework

In South Korea, prior to the 1997 financial crisis, the insurance regulatory framework was structured to provide Korean regulators with tremendous responsibilities and did not allow insurers much flexibility.[75] The structure consisted of two main bodies of law that regulated the insurance industry: the Insurance Business Law (IBL) and the Insurance Contract Law (ICL).[76] The IBL applied only to private insurance companies in Korea.[77] The ICL was a part of the Korean general commercial law and regulated the contract making process in the insurance business.[78] The Insurance Supervisory Board (ISB), a sub-agent of the Minister of Finance, was the sole insurance regulator in charge of supervising the industry and setting many of the economic restraints.[79] It was responsible for establishing and executing insurance policies, granting licenses to qualified companies, and approving insurance products and rates.[80] It was usually entrusted with full authority over decision making regarding Korea's insurance industry, a tremendous amount of

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71. ERIC SHIUNG, THE ASIAN CURRENCY CRISIS: FROM THAILAND TO JAPAN, THE DOMINO EFFECT LEAVES NATIONS REELING (1997), *available at* http://www.columbia.edu/cu/ccba/cear/issues/fall97/graphics/regional/shiung/shiung.htm

72. *See id.*

73. *See id.*

74. *See id.*

75. *See id.*

76. Swiss Re, *Regulation of the Insurance Industry in Korea*, 6 D.C.L. J. INT'L L. & PRAC. 29, 35 (1997).

77. *Id.* at 36.

78. *Id.*

79. *Id.*

80. *Id.*

responsibility to say the least.[81] The regulatory framework also had a unique provision—allowing the Governor of the ISB to re-delegate much of his authority under the law to non-profit insurance associations, such as the Korean Life Insurance Association and the Korean Non-life Insurance Association, in order to foster self-regulation of the industry.[82] This provision in the Korean law is interesting because it addresses the need for self-regulation that is crucial in a liberalizing and emerging market.[83] This need is crucial centerpiece of the new regulatory framework that now governs the Korean insurance market.

Other duties of the ISB included responsibility for inspecting the insurer's business practices and its finances.[84] The inspection extended to all aspects of business operations including insurance solicitation, premium collection, use of premium assets, and settlement of claims.[85] The ISB would, at any time, require the insurers to submit certain reports and documents related to their business and conditions of company assets and even request other related institutions to furnish supporting documents in their possession.[86] In addition, the ISB could require the persons concerned, such as the foreign insurer, to present books, documents and other materials necessary for the investigation.[87] When the ISB determined an insurer violated laws, regulations or specific orders by the Minister, or that it committed an act that injured the public, it had the authority to require the insurer to censure the responsible officers, suspend part or all of the insurer's business, and even propose to the Minister to cancel its license altogether.[88] Finally, the ISB had the authority to evaluate the insurer's performance every year through the Management Evaluation System for growth, productivity, profitability, and stability of the insurer.[89] After the evaluation, the ISB could publicly announce a list of well performing

81. *Id.*

82. Swiss Re, *supra* note 76, at 37.

83. *See* PATRICK LEVY, BRAZIL'S INSURANCE REGULATOR SUSEP AIMS TO FURTHER DEREGULATE THE INSURANCE MARKET BY GRADUALLY TRANSFERRING CERTAIN DUTIES HELD BY THE REGULATOR TO THE INSURERS THEMSELVES (July 15, 2004), http://strategis.ic.gc.ca/epic/internet/inimr-ri.nsf/en/gr121937e.html. This type of self-regulation is also a topic of note in Latin American insurance markets such as those in Brazil, although in that case, the insurance regulator (SUSEP) is discussing whether to gradually transfer certain duties held by the regulator to the insurers themselves. Such duties would include the creation of new products, ombudsman duties, and advertising approvals. *Id.*

84. *Id.*

85. *See* Swiss Re, *supra* note 76, at 37.

86. *Id.*

87. *Id.* at 38.

88. *Id.*

89. *Id.*

companies and take corrective actions with others not faring as well. This is considered an early warning system.[90] In more serious cases, the ISB could direct the insurer to dismiss its responsible officers or to take other necessary measures, or it could even cancel the insurer's business license altogether.[91]

As one can see from this look at South Korea's primarily *ex ante* insurance laws and regulatory framework prior to the 1997 financial crisis, the industry was tightly controlled by the regulators. It is uncertain whether the regulators actually implemented the authority given to them; however, it is certain that foreign and domestic insurers were not given much room to maneuver in conducting their various business objectives. Some of the above mentioned powers granted to the ISB were certainly valid and needed, such as the insurer examinations. These are particularly useful for consumer protection purposes to ensure that abuse is not taking place. However, the structure of the ISB also arguably led to tremendous inefficiencies and over-regulation, particularly concerning the Management Evaluation System and Economic Needs Tests.[92] Put simply, South Korea's old regulatory framework was too controlling in areas that should have been left to be determined by the open market. When South Korea opened its insurance industry to the world in the early 1990s, it did so with a legal regime and regulatory framework that was established to suit state-controlled insurance players and not large, sophisticated international corporations. These pre-WTO standards had very strict limitations on, for example, foreign ownership of Korean joint ventures and the ability to quote insurance rates from abroad.[93] Lawmakers and regulators knew that once the 1997 financial crisis took place, significant changes would have to occur in order to put South Korea back on the path to becoming a hot emerging insurance market.[94]

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90. *Id.*

91. *Id.*

92. South Korea's Management Evaluation System (MES) and Economic Needs Tests (ENT) essentially were nondiscriminatory limitations that Korean regulators used to wield strict control over the activities of foreign and domestic insurers. They have been largely discouraged by those advocating for increased foreign insurer participation in emerging markets. *See* Insurance Services Roundtable Report, January 12, 2005, at 2, *available at* http://ita.doc.gov/td/SIF/Insurance%20Roundtable%20Report.Final%20after%20GC%20comments.pdf.

93. *See* KIM, *supra* note 1, at 4.

94. *Id.*

3. South Korea's New Insurance Reforms

The unprecedented financial crisis in 1997 brought into sharp focus the need for a completely new and integrated *ex post* regulatory framework capable of reinforcing market mechanisms and discipline.[95] To address this need, in April 1999, South Korea consolidated its four separate supervisory agencies, including the Insurance Supervisory Board (ISB), and established the Financial Supervisory Service (FSS), which now had the purpose of regulating Korea's insurance, banking, and securities sectors.[96] In addition, the Financial Restructuring Unit (FRU) was established under the FSC to install reform programs aimed at creating new prudent regulations adjusted to WTO international standards.[97] One such new standard set by the FSC included setting stricter solvency margin requirements, which directly affect an insurer's ability to meet insurance claims.[98] This new FSC standard is an example of a good *ex-ante* approach to prevent future offensive activity on the part of foreign insurers.[99] As a result of these stricter solvency margin requirements, a number of insurers failed to meet these stricter requirements and were forced to close, be absorbed, or merge.[100] For example, twelve non-viable life insurers out of thirty-three total foreign insurers were expelled from the market in the reform process from 1998 to 2001.[101] This proactive approach by the South Korean government, after the financial crisis, gave a clear signal to the market that, unless insurers were well managed, they would be expelled from the market.[102] Some other reforms regulators made in the immediate aftermath

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95. FINANCIAL SUPERVISORY COMMISSION, FINANCIAL REFORM & SUPERVISION IN KOREA 8 (2001), http://www.fsc.go.kr/eng/final.pdf.

96. *Id.* at 8.

97. *Id.*

98. DONGBU INSURANCE, THE KOREAN INSURANCE INDUSTRY AND ECONOMY: ANNUAL REPORT 2001 6, http://www.idongbu.com/ir/eng/pdf_eng/fy2k/3_TheKoreanInsurance Industry.pdf.

99. As this Comment has stated previously, many countries use a combination of ex-ante and ex-post measures to regulate their insurance markets. Ex-ante models involving setting insolvency ratios and requiring licenses, etc., are good minimum requirements to prevent foreign insurers from committing offensive activities. An emerging market nation, however, must be careful in relying heavily or exclusively on a stringent ex-ante approach, and rather should use a combination of approaches that will allow for market-based forces to interact openly and freely to the benefit of the consumer. *Id.* at 7.

100. *Id.* at 3.

101. KIM, *supra* note 1, at 5.

102. *Id.*

of the financial crisis took place in a variety of areas within the industry.[103] They were aimed at allowing increasing flexibility in the life and non-life insurance markets including permitting representative offices, branches, subsidiaries and joint ventures of foreign insurers and eliminating the Economic Needs Tests.[104] In the life insurance market, Korean regulators eliminated the restrictions on foreign equity participation and allowed multiple foreign shareholders in joint ventures.[105] In non-life insurance, they eliminated the restriction on the quoting of insurance rates from abroad, eliminated a duopoly in fidelity and surety insurance, and allowed the cross-border supply of marine cargo and aviation insurance.[106] Furthermore, Korean regulators eliminated the stringent Economic Needs Tests in reinsurance as well as in brokering and agency and the priority given to reinsurance companies established in Korea.[107] They also allowed the establishment of independent insurance agencies and the commercial presence of foreign insurance brokerage firms.[108] Lastly, Korean regulators agreed to allow the cross-border supply of life insurance and the commercial presence of foreign claims settlement and actuarial businesses.[109]

These reforms clearly were meant to further deregulate South Korea's insurance industry while eliminating perceived inefficiencies. In September 2000, regulators built on this trend of deregulation in the attempt to increase competition in the insurance industry.[110] The FSC continued to overhaul regulations pertaining to premiums for insurance services and new insurance products.[111] As a result, insurance companies are now given significant latitude in marketing new insurance products and in setting premium rates.[112] The management directives issued to automobile insurance companies were also rescinded to lower the cost of entry and help stimulate greater competition in the non-life insurance

103. These changes were made as part of the 1997 GATS negotiations which outlined a basic package of commitments under the name of "Understanding" that were aimed at promoting greater liberalization of existing insurance policies in South Korea. *Id.* at 3.

104. *Id.* at 4.

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* at 4.

109. *Id.*

110. FINANCIAL SUPERVISORY COMMISSION, *supra* note 95, at 13.

111. *Id.*

112. *Id.*

sector, a sector that lags behind its life counterpart in South Korea due to security concerns and so forth.[113]

Korean lawmakers certainly would not propose the aforementioned regulatory changes without addressing the concerns over prudent oversight and consumer protection. Protecting consumers from malpractice and other abuses by insurance companies has been a priority.[114] As a better way to protect consumers, insurance companies must now provide the terms of the insurance policies in "plain, understandable language."[115] Furthermore, the contestable period during which medical insurance claims can be denied by the insurance companies has been removed for all medical conditions except cancer.[116] With regards to the strengthening of prudent oversight regulations, also in September 2000, the FSC added some revised insurance supervisory regulations known as Forward Looking Criteria (FLC).[117] The revisions set ceilings on the credit risks and market risks to which insurers are exposed.[118] In addition, the revised regulations also barred insurance companies from holding more than thirty percent of their total assets in stock.[119] Also, to better control insurers' risk exposures to real property (often a concern in emerging market nations such as South Korea), insurers were barred from holding more than fifteen percent of their assets in real estate and more than five percent in any single real property.[120] Lastly, and very importantly, the mandatory criteria for profit distribution by life insurance companies was also amended to reflect adoption of the European Union (EU) solvency margin system in 1999, which requires higher accumulation of premium reserves than before.[121] In essence, the Korean regulators are ensuring that foreign, as well as domestic insurers, have the capability to make claim payments and cannot renege on their contractual obligations to make payments due to a lack of reserves. This prudent oversight and other similar regulations are essential to maintaining a healthy and vibrant Korean insurance market for decades to come.

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113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. *Id.*
120. *Id.*
121. *Id.*

4. The Results: Has the Regulatory Overhaul Worked?

A resounding yes! Since 1997, the market share of foreign insurers in the Korean life insurance industry has increased rapidly, jumping from 1.35% in 1997 to 9.42% in 2001 alone.[122] Today, South Korea's insurance market is the world's seventh largest in life insurance and twelfth largest in terms of premiums received.[123] It is also now Asia's second-largest insurance market after Japan.[124] Foreign life insurers such as New York Life, AIG, and Prudential make up approximately nineteen percent of the Korean life insurance market—a percentage that was boosted when MetLife agreed to purchase local life insurance giant SK Life for $290 billion in January of 2005.[125] Foreign insurers such as MetLife and ING Life, a Dutch insurance company, are in a heated battle with local insurers such as Samsung Life Insurance, Korea Life Insurance, and Kyobo Life Insurance.[126] To compete with the increasing foreign insurer presence, strategists have advised the big local insurers to put diverse and inexpensive products on the market and the smaller local insurers to develop niche products to survive the upcoming face-off with foreign insurers.[127] Yoon Seng, general manager of the Korea Life Insurance Association (KLIA) states: "Foreign insurers brought advanced insurance products and know-how to Korea but they are still lacking in understanding of the local market. But they are getting more localized to lure as many local customers as possible."[128] This comment by Mr. Seng shows the determination of foreign insurers to make an impact on the domestic insurance landscape. They bring with them some name recognition and advanced products but they realize local customers, such as those in Korea, are not going to easily entrust their hard earned savings to a foreign competitor who does not understand the local customs and behavioral norms. Korean lawmakers and regulators have the task of continuing to monitor these foreign insurers to ensure that they not only are qualified to do business in the market but also act in a responsible, competitive, and ethical manner.

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122. *See* KIM, *supra* note 1, at 6.

123. *See MetLife to buy SK Life for W290 Bil.* KOREA TIMES, Jan. 14 2005, *available at* http://www.skc.co.kr/skhp/ko/info/indexnewsdis.jsp?dataId=890.

124. *See Id.*

125. *See id.*

126. *Id.*

127. *See id.*

128. *See id.*

Since 1997, South Korea has established a comprehensive approach to not only policing its insurance industry, but also allowing it the room to grow independently. Doing so is vital because the Korean insurance industry is now making a full-scale entry into the era of competition.[129] Over the next few years, the industry is expected to be dominated by numerous mergers and acquisitions and strategic alliances between financial institutions, both domestic and foreign.[130] These new developments are expected to lead to a shift in the entire insurance landscape in South Korea.[131] A loosening of the barriers to business entering the insurance market and a parallel widening of the business scope of the industry has opened the door to the entry of diverse new potential competitors into the market.[132] It is vital that South Korea's new legal regime and regulatory frameworks not only adequately supervise these new developments in an atmosphere of transparency and disclosure, but also allow the open market to take its course and allow foreign insurers the flexibility they need to be successful. The contrast between the older ISB framework and the newer FSC structure detailed above in this Comment is meant to represent a shift in the paradigm of regulation for emerging insurance markets that is to follow in the future. We will now apply the general foundations of this South Korean framework to analyze the adequacy of the frameworks in place for the Chinese and Indian emerging markets.

B. EMERGING MARKET DEREGULATION: CHINA AND INDIA IN THE SPOTLIGHT

China and India are two countries that currently attract a lot of attention, mainly due to their size, their strong growth performance and recent favorable regulatory changes. Not only are China and India the most populous countries in the world but both nations have sustained impressive economic growth in the last decade. For example, between 1993 and 2003, annual real GDP growth averaged 8.9% in China and 5.9% in India.[133] Today, both markets are going through a period of liberalization that has allowed greater foreign participation in them while former controls on

129. *See* Dongbu Insurance, *supra* note 98, at 7.

130. *See Id.*

131. *Id.*

132. *Id.*

133. Interview with Clarence Wong, Head of Economic Research & Consulting, Swiss Re Hong Kong (April 2004), *available at* http://www.swissre.com/INTERNET/pwswpspr.nsf/fmBookMarkFrameSet?ReadForm&BM=../vwAllbyIDKeyLu/csti-65kf9x?

competition and business practices are gradually giving way to a regulatory regime based on prudential supervision of insurance solvency and adherence to market-orientated principles.[134] These developments have unveiled the huge potential of their insurance sectors, and foreign companies have since been flocking to Asia seeking to tap into these vast markets.[135]

1. China: Can Red really mean Green for Insurers?

This Comment has stressed the belief that emerging insurance markets will be poised for success if domestic policymakers and regulators implement some combination of adequate supervisory mechanisms along with allowing insurer self-regulation. This approach is commonly referred to as *ex post* in nature.[136] South Korea made the mistake of allowing excessive government intervention and paid dearly when the 1997 financial crisis occurred. The question now is: will future emerging markets such as China follow suit or will they avoid the mistakes of their fellow Asian neighbor and implement insurance laws and a regulatory system that will enable their enormous population to benefit from the rewards of a competitive, vibrant and diverse insurance industry?

Thus far, it appears as though China is instituting a regulatory framework very similar to South Korea's post-1997 model. In 1999, the China Insurance Regulatory Commission (CIRC) began oversight of the then fledgling insurance sector.[137] In 2001, China, after a years-long campaign, was invited to join the WTO.[138] This entry into the WTO has served as a key catalyst that has led to the opening of the national market. To tackle this new influx of foreign insurers, which actually began in 1992 when the Shanghai market was opened to foreign companies, China enacted the Insurance Law of The People's Republic of China in 1995, and

134. *Id.*

135. *Id.*

136. *See* KWON, *supra* note 8, at 2.

137. Jennifer C. Rankin, *A World of Opportunity: Local national and foreign insurers are taking advantage of new opportunities in South Korea, India, and China. Here's a look at who's doing what and why*, RESOURCE MAGAZINE, September 2004, *available at* http://www.loma.org/res-10-04-world.asp. *See also* Tony Allison, *Risks and Rewards in China's Insurance Market*, ASIA TIMES ONLINE-SPECIAL REPORTS, February 16, 2001, *available at* http://www.atimes.com/reports/ CB16Ai01.html#top3.

138. Rankin, *supra* note 137.

subsequently amended it in 2002.[139] Since its promulgation, the Insurance Law has played an important role in the development of the insurance industry in China. From 1995 to 2001, China saw its number of insurance companies grow from nine to fifty-two, resulting in a premium increase from 68 billion RMB in 1995 to 210 billion RMB in 2001.[140] The Insurance Law has caused financial regulation to broaden and has emphasized the role of market mechanisms.[141] However, once the CIRC came into formation, the Insurance Law had to be amended due to discrepancies between its requirements and those instituted via the WTO's international standards.[142] These amendments, which took effect on January 1, 2003, stated in principle that provisions inconsistent with China's WTO commitments would be amended to ensure compliance with international standards.[143] These commitments to the WTO were vital to spearheading the deregulation of China's emerging insurance market. As part of China's WTO agreement, China could no longer impose different regulations for Chinese insurers and for foreign insurers, and instead had to maintain a unified legal framework.[144] In addition, non-life insurers would now be allowed to insure not only foreign invested businesses through a branch or joint venture but Chinese businesses as well.[145] Furthermore, life insurers are allowed to offer insurance policies to individuals but not group insurance policies through a joint venture (not a branch or subsidiary), but in the future, group life insurance policies would also be allowed.[146]

China of course would not engage in these deregulatory practices without still maintaining an active supervisory role through the CIRC. Even though China, through its WTO ascension, has agreed to liberalize foreign access to its insurance sector and to issue insurance licenses without Economic Needs Tests or quantitative limits, it has placed certain preconditions both on the entry requirements and the establishment criteria on foreign insurers.[147] Firstly, in order to gain permission to conduct

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139. *See* LEHMAN, LEE & XU, INSURANCE & RISK MANAGEMENT, *available at* http://www.chinalaw.cc/FAQ/faq/IN.htm. *See also Insurance Law Amended*, CHINA DAILEY, October 29, 2002, *available at* http://www.china.org.cn/english/China/47096.htm.

140. *See* LEHMAN, LEE & XU, *supra* note 139.

141. *See id.*

142. *See id.*

143. *See id. See also China's Insurance Sector Grows Amid Ups and Downs*, PEOPLE'S DAILY ONLINE-BUSINESS, October 07, 2004, http://english.people.com.cn /200410/07/eng20041007_159214.html.

144. *See* LEHMAN, LEE & XU, *supra* note 139.

145. *See id.*

146. *See id.*

147. *See id.*

insurance business in China, foreign insurers must have more than thirty years of experience, have had a representative office in China for two consecutive years, and must have had total assets of more than 5 billion RMB ($605 million USD) at the end of the year prior to filing an application.[148] These entry requirements seem to be commensurate with China's preference to have experienced and financially stable foreign insurance companies doing business in their market. Many of the large North American and European insurers each have over one-hundred years of experience selling policies and have amassed total assets in the hundreds of billions.[149] Next, regarding regulations on how foreign insurers may conduct business once they have gained permission to enter the market, Chinese regulators have mandated that foreign non-life insurers could establish branches or enter into joint ventures with equity interest of up to fifty-one percent.[150] Foreign life insurers can set up joint ventures in China with equity interest of up to fifty percent upon accession.[151] Within two years of accession, foreign investors will be able to create a wholly foreign-owned entity (WFOE) non-life insurance company.[152]

Overall, the CIRC's new Insurance Laws, which became effective January 1, 2003, enable China to shift its insurance legal regime to an *ex post* market-oriented and policy-based approach—very similar, in fact, to the approach followed by South Korea following its 1997 financial crisis.[153] For instance, the CIRC will carefully monitor the solvency capability of insurance companies according to benchmarking standards across the industry.[154] The amended laws also partially lift restrictions against insurance enterprises and their business operations. Under China's old legal regime, regulators set insurance clauses and insurance premium rates for most insurance products.[155] Presently, the new legal regime stipulates that only clauses and premiums for policy-mandated insurance and new

148. *See id.*

149. *See id.*

150. *See id.*

151. *See id.*

152. *See id.*

153. *See Insurance Law Amended*, supra note 139. In addition, a second revision has been in preparation and the draft will be submitted to the National Congress at the end of 2006 and the beginning of 2007. It deals in part with the handling of insurance adjudications which appear with the rapid development of China's insurance industry. *See* THE SECOND REVISION OF THE INSURANCE LAW HAS BEGUN AND THE REVISED DRAFT WILL BE SUBMITTED TO THE NATIONAL CONGRESS, CHINA LEGAL PUBLICITY (Sept. 27, 2004), *available at* http://www.legalinfo.gov.cn/english/LegislativeDeve/legislativedeve4_37.htm.

154. *See* LEHMAN, LEE & XU, *supra* note 139.

155. *See id.*

types of life insurance products need prior approval from Chinese regulators.[156] Clauses and premium rates of other types of insurance products need only be reported to the CIRC for filings made on record.[157] In addition to these insurance reforms, China is also phasing out geographical restrictions and allowing foreign insurers into group, health and pensions sectors.[158]

China is well on its way to making the necessary insurance reforms to meet the tremendous demand for entrance by foreign insurers into its vast untapped insurance market. Since many of the aforementioned reforms went into effect, China has granted permission to large foreign insurers such as AIG, Cigna, ING, John Hancock, Manulife, MetLife, New York Life and Nippon Life to enter its market through joint ventures.[159] In 2003, China's total premium volume stood at $46.9 billion USD, a 25.5% increase from 2002.[160] According to Charles E. Boyle, an analyst with the *Insurance Journal*, "the [Chinese] insurance sector has grown steadily along with the economy."[161] Although China has been criticized for being slow in making further deregulatory changes to spur the insurance market, foreign insurers keep vying for a piece of the pie. By mid-2004, there were twenty-nine foreign life insurers in China[162] and this number is expected to grow dramatically as the future looks bright for all parties involved.

2. India: Can there be a Changing of the Guard?

The previous section on China showed that policymakers and regulators are following in South Korea's post-1997 footsteps and readying their domestic insurance market for a healthy, vibrant and competitive 21st century. Now we must ask whether India is also taking the appropriate steps to economic growth and prosperity for its insurance market. Since late 1999, the Indian insurance market has undergone major structural changes. The government monopoly under the General Insurance Corporation (GIC), which has operated since 1972, was dissolved in 1999 to allow private insurance companies as well as brokers to operate.[163] This

156. *See id.*
157. *See id.*
158. *See* Rankin, *supra* note 137.
159. *See id.*
160. *Id.* This figure is adjusted for inflation.
161. *Id.*
162. *Id.*
163. CLIVE BAKER, GUY CARPENTER VIEWS, THE LIBERALIZATION OF INDIA'S INSURANCE INDUSTRY 1 (June 2004), http://www.guycarp.com/portal/extranet/pdf/ExtPub/Clive_Baker_June_2004.pdf;jsessionid=%402de6b6%3a108fec9188c?vid=1.

was a tremendous step forward for allowing foreign insurer access into India, a country of one billion people with a growing middle class of 200–300 million people that have an increasing amount of disposable income.[164] Foreign insurance companies are seeing enormous potential for growth and profit in the emerging Indian insurance market, but will Indian lawmakers and regulators continue to take appropriate deregulatory action to allow large-scale foreign investment? The answer is that, while the Indian insurance sector currently is experiencing unprecedented growth, there are still impediments to an open and competitive market in the form of restrictions on foreign investments, compulsory tariffs and mandatory reinsurance cessions.[165]

India has taken steps toward *ex post* market-oriented and policy-based policies similar to those seen in South Korea and China; however, it is lagging far behind in terms of its rate of deregulation. In 1999, India passed the Insurance Regulatory and Development Authority (IRDA) Act.[166] The purpose of this Act, which took years of deliberation, was to open up the Indian insurance industry to help the economy meet its growing insurance needs, spark the growth of rural areas, and promote India as a regional insurance hub.[167] To do so, the Act established the IRDA to oversee and regulate insurance operations, re-designated the GIC as a national reinsurer to which all of the country's direct insurers must cede twenty percent of their business, lifted the ban on domestic private insurance companies, and opened the market to foreign participants—albeit with restrictions, which will be discussed shortly.[168] More generally, the IRDA was put in charge of: protecting the interest of policyholders, establishing guidelines for the operations of insurers, reinsurers, and brokers; setting code of conduct and training requirements for insurance intermediaries and agents; regulating the investment funds by insurance companies; specifying insurance business percentages in rural sectors; and handling disputes between insurers and insurance intermediaries.[169]

While these deregulatory measures created by the IRDA Act of 1999 are a positive step in the right direction for India's burgeoning insurance

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164. *See id.*

165. *Id.*

166. *Id. See also* Insurance Regulatory and Development Authority Act (1999), *available at* http://www.irdaindia.org. *See also* David C. Mulford, U.S. Ambassador to India, Remarks at the conference on "Building a Vibrant Insurance Market in India" (October 6, 2005), http://newdelhi.usembassy.gov/amboct062005.html.

167. BAKER, *supra* note 163, at 2.

168. *Id.*

169. *Id.* at 2-3.

industry, critics argue that they do not go far enough to truly promote foreign insurer entrance into the Indian market.[170] For instance, foreign companies are denied majority control because their equity participation is capped at twenty-six percent for joint ventures.[171] This figure is extremely low when compared to South Korea and China, which allow foreign insurance companies to own fifty percent of the joint ventures in their respective markets. What this means to foreign insurers is that, to participate in the Indian market, they must depend on Indian partners to invest the remaining funds more so than foreign insurers in South Korea and China must. Often times, large U.S. and European foreign insurers prefer to have a higher equity stake in the market because they can control more of the operation and ensure that their best practice methods are being adhered to.[172] The equity investment limit on the Indian reinsurance market is similar to the insurance market; however, the foreign insurer is required to put up approximately $45 million USD in order to establish a domestic company.[173] This foreign investment limitation has had a negative impact upon foreign insurers attempting to enter the market, as evidenced by the fact that, since the IRDA Act came into effect, only eight new global non-life and thirteen new life insurance companies have entered the market.[174] Many experts in the field argue that these figures are sure to rise dramatically if and when Indian lawmakers raise the twenty-six percent equity ownership limitation figure to at least forty-nine percent.[175] Some argue that the figure should be raised to fifty percent within a short period so that foreign investors would have management control commensurate with their investment.[176] Doing so would also ensure that leading foreign companies bring more than capital to the insurance industry.[177] They would also bring generations of successful experience in managing and growing the industry.[178] With Dr. Manoman Singh, the architect of Indian liberalization, now the new Prime Minister, proponents of raising the

170. *See* BAKER, *supra* note 163.

171. Thomas Holzheu, Address at Casualty Actuaries of Greater New York Spring Meeting 2004: Indian Insurance Markets (June 3, 2004) (presentation available at http://www.casact.org/affiliates/cagny/0604/holzheu.ppt#1).

172. *See* BAKER, *supra* note 163, at 7.

173. *Id.* at 4.

174. *Id.*

175. *See also* David C. Mulford, Remarks at Taj Mansingh Hotel, New Delhi: Building a Vibrant Insurance Market in India (Oct..6. 2005) (transcript available at http://newdelhi.usembassy.gov/amboct062005.html).

176. *Id.*

177. *Id.*

178. *Id.*

equity level could see their wishes come to fruition sooner rather than later.[179]

In addition to the foreign equity investment limitation, Indian lawmakers still insist upon a tariff structure that sets prices for businesses such as fire, aviation, engineering, auto, marine and workers compensation.[180] The only insurance business lines that are allowed to have market-determined prices are liabilities, indemnity, and personal lines such as health insurance.[181] Critics of India's slow deregulatory pace argue that these tariff structures do not reflect international market conditions and should be scrapped.[182] There is also concern that the mandatory twenty-percent reinsurance cessions are far too strict and are impending significant growth in this aspect of the industry.[183] Nevertheless, experts are in agreement that the Indian emerging insurance industry seems poised for future success.[184] Because such a small segment of India's insurance market has been tapped into, the growth potential is staggering—especially considering that rural segments of the Indian landscape have yet to open up.[185]

As one expert in the field states: "Indian consumers are increasingly aware of risk and insurance. When this growing knowledge is considered in light of the low penetration levels of insurance and reinsurance in this country, the potential opportunities going forward are immense."[186] These potentially immense opportunities will only be realized if the IRDA seeks to create a regulatory regime that promotes efficient use of capital, eliminates avoidable micromanagement of business practices, allows companies to price their products prudentially, and levels the playing field between private and state-owned insurance companies.[187] After all, when markets are competitive and responsive to consumer demands and preferences, it is the consumer that benefits via lower costs and increased ability to manage risks.[188] If Indian regulators follow the predominantly

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179. Interview with Sam Ghosh, Manager, Allianz Joint Ventures in India (Mar. 2, 2004) (transcript available at http://www.allianz.com/azcom/dp/cda/0,,268036-44,00.html).

180. BAKER, *supra* note 163, at 9.

181. *Id.*

182. *Id.*

183. *Id.* at 3, 11.

184. *Id.* at 11.

185. *Id.*

186. BAKER, *supra* note 163, at 12.

187. David C. Mulford, Remarks at Taj Mansingh Hotel, New Delhi: Building a Vibrant Insurance Market in India (Oct. 6. 2005) (transcript available at http://newdelhi.usembassy.gov/amboct062005.html).

188. *Id.*

ex-post model of prudent supervision in combination with the market-oriented self-regulation established in South Korea and China, then this prediction of immense opportunities is certain to come true in the not-too-distant future.

CONCLUSION

The purpose of this Comment is to bring to light the developments of emerging insurance markets, with particular focus on the Asian nations of South Korea, China and India. This Comment advocates that South Korea's legal regime and insurance regulatory framework should serve as a model for policymakers and regulators in China and India because the country has endured a painful reform process after its 1997 financial crisis. By following South Korea's new predominantly *ex-post* model, China and India could structure their burgeoning insurance markets for success that would benefit not only their domestic economies and foreign insurance companies, but also consumers themselves who will see an increase in competition, lower premiums, and a diversified array of advanced life and non-life insurance products. The time has come for emerging markets, not only in Asia but also in the Middle East, Latin America, and Eastern Europe, to adopt legal regimes and frameworks based upon prudent supervision and oversight with a mix of market-oriented and policy-based approaches that will allow their respective insurance markets to grow to the benefit of the world community. The overseas insurance and financial services markets are only scratching the surface in terms of their potential. Only time will tell whether these countries are able to create infrastructures to support this growth, but thus far, it seems as though they are on the path towards success.

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

Edited by Emmanuelle Regine Francois[*]

PROPERTY

John F. Dobbyn, *Subrogation and the Innocent Spouse Dilemma*, 78 ST. JOHN'S L. REV. 1095 (2004)

This article analyzes the problem that courts have faced when one spouse sets fire to a home or property that is jointly owned by the married couple and the innocent spouse tries to collect on the fire insurance policy. In assessing this issue, courts have tried to balance three interests: ensure the arsonist does not profit from the crime, preserve fairness to the innocent spouse, and protect the insurer's contracted interest. The courts are concerned with this phenomenon because, although they want to compensate the innocent party, they also want to be certain that the innocent party is truly innocent. Courts want to avoid compensating one who was complicit with the arsonist spouse or one who continues to be married to the arsonist spouse so that the arsonist spouse does not reap the benefit of the policy directly or indirectly.

As a result, courts have taken different approaches in deciding whether to grant or deny relief to the innocent spouse. The traditional approach is based on contract law. The interests of the spouses are usually viewed as one indivisible joint interest. Thus, the courts have been unwilling to sever the contract. In such a case, the innocent spouse would not collect on the fire insurance policy. Another approach has been to focus on the insurance policy, and specifically the insurance contract. This approach focuses on the contractual obligation of the insurer to the insured and on meeting the insured's loss up to the policy limits. Lastly, courts may rely on the reasonable expectation doctrine. Here the court looks at the reasonable expectations of the insured, especially the innocent spouse.

The author of this article suggests an equitable step where the insurer brings an action in subrogation against the guilty spouse. Subrogation arises from contract law termed in the policy or under common law known

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as "legal" subrogation. The underlying principles behind subrogation in the collection on a fire insurance policy are that the insurer should be reimbursed by the wrongdoer and that the innocent spouse should not recover twice. Although some courts have found this policy valid because it places the loss on the guilty party, subrogation may create a total loss for the innocent spouse. For example, if the guilty spouse and innocent spouse have joint assets, the truly innocent spouse will lose the net of the proceeds from the insurance company.

Nevertheless, the benefits of subrogation are considerable. Insurance companies may be more prompt in paying proceeds to the innocent if they are able to recoup some of their loss from the arsonist. Other benefits include lessening the burden on the courts and reducing bad faith causes of action between the same parties. Therefore, subrogation provides the best method of balancing the equities among the innocent, the guilty insured, and the insurer.

Ruwantissa Abeyratne, *Synergies and Problems in Outer Space Insurance and Air Transport Insurance*, 30 TRANSP. L.J. 189 (2003)

The author discusses the problem the air transport and space industries have faced when trying to purchase insurance in light of the events of September 11, 2001. As a result of this catastrophe, both the air and space industries have suffered an economic gloom due to the high number of claims that has reduced the capital set aside by underwriters. Stringent measures are needed in order to restore these industries to pre-September 11 levels.

The space insurance industry, which primarily insures communication satellites, has faced some set-backs in recent times. The liability for space insurance finds its principles in two treaties: the Outer Space Treaty of 1967 and the Liability Convention of 1972.

The air space insurance industry also is facing a crisis in risk management, particularly in transferring the risk of loss to third parties. On September 17, 2001, the international insurance market gave notice that in seven days it would to cancel all third party war risk liability insurance because the exposure in terms of third party damage was unquantifiable. As a result, the President of the International Civil Aviation Organization ("ICAO"), stepped in to address all the ICAO contracting states in order to prevent air transport services from coming to a standstill. Shortly thereafter states began to provide excess insurance coverage to carriers to replace the cancelled third party risk effective September 24, 2001. The actions of the contracting ICAO states is based in two international

conventions, the Rome Convention of 1952 and the Montreal Convention of 1999. The ICAO and the International Air Transport Association have suggested that the governments should act as a multilateral guarantor covering certain risks. This scheme would allow contracting states to act as insurers, but, if a claim arises, the states' responsibility would equate to its percentage of participation in the ICAO contribution. This would be a voluntary effort aimed at replacing the coverage that was reduced as a result of the events of September 11.

In sum, the air and space insurance industries face enormous risks. However, both of these industries provide an important public service. Supporting these industries requires cooperation among nations to act as a regulator and sustain the industries' development.

MEDICAL MALPRACTICE

Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501 (2004).

This article brings to light the medical liability crisis and the manner in which it is affecting the medical community. The authors are concerned with the effect that the increased price for medical liability insurance has on the system as a whole, including patients and providers alike.

Providers and the insurance companies have been seeking alternatives to the high cost and high risk practice of medicine. The authors described the concern as a "vicious circle of injury" characterized by "lawsuit, premium increase, and crisis."

Although some state legislatures have tried to respond to this crisis through a variety of healthcare reforms, such efforts have been temporary and have not addressed medical error, the root of the problem that plagues our health care system.

States such as California, Indiana, Colorado, and Wisconsin have been described as non-crisis states since they have reformed their malpractice tort law. These reforms have focused on reducing the costs of healthcare by eliminating punitive damages or by providing non-economic damages for patients who have been injured. Although these states are putatively called non-crisis states, their reforms are short-sighted and have not necessarily addressed the high medical liability premiums.

Ohio, Texas and Florida were used as examples of states that are in crisis. The primary reason is that, although these states have tried to enact

laws similar to those of non-crisis states, parts or all of the reform laws were invalidated by courts as contrary to the respective state constitution.

The authors add unintentional medical error to the negative factors that complicate the system. The medical system is controlled by a "shame-and-blame" mechanism that is ineffective and contrary to error reduction. The medical arena, unlike other fields, individualizes error and therefore does not create an atmosphere where lessons are learned from mistakes so that such errors can be prevented in the future. When mistakes occur in the field, the blame and shaming effect allows the finger pointing to work, rather than encouraging cooperation of physician and patients as partners while rapidly compensating the patient for the unintentional medical error.

The authors view medical liability reform as a partnership of obligations and rights between providers, insurance companies and patients. Medical liability reforms help to erase the shame and blame mechanism while improving the system. At this point, the medical system becomes a healthcare team, not simply separate entities interacting in the delivery of quality service. There would be several components of this proposed system that would serve to effectively reduce error and increase accountability. First, an error disclosure team would be trained in opening the lines of communication between all involved. The team will investigate the error initially, and subsequently defuse information collection during the investigation to the patient as soon as possible.

The next component would be the patient care liaison, which is charged with keeping the family and patient involved with the progress of the error investigation. The last component would be the disclosure record, part of the record keeping process that is designed to keep all parties objectively informed. This record would be used to assess the effectiveness of the system's approach to the error.

The authors conclude by highlighting their concern that high costs in the healthcare industry are generally associated with high payout from patient injury; thus, patient injury is the true root of the medical liability crisis. Therefore, one way to reduce injury and its associated costs is not to hide the circumstances surrounding injury, but rather to move towards a collaborative effort among the different components of the system in order to eliminate errors and prevent injury.

Richard E. Anderson, M.D., Response, *Case Study Question: How can the Current State of Medical Malpractice Insurance be Improved?*, 5 YALE J. HEALTH POL'Y L. & ETHICS 341 (2005).

Anderson presents the effect of the malpractice insurance crisis that the United States is facing today as more doctors are forced to retire, relocate or give up practicing medicine entirely. The crisis has been exacerbated by the prevalence of malpractice litigation and the growing size of awards. First, litigation has aggravated the problem because of its high risk. Physicians are sued at an inordinate rate, which is a very costly and lengthy process. Second, due to the high risk of litigation, many physicians often face meritless claims and these claims unnecessarily burden the current medical liability system. The total cost of medical malpractice is estimated to be around $24 billion and continues to spiral out of control.

One state has found a solution to the crisis through effective tort reform. California, through the Medical Injury Compensation Reform Act (MICRA), has stabilized its insurance system. There are four primary components to MICRA. First, it provides a cap on non-economic damages that eliminates the inordinate amount that may be awarded for pain and suffering. Second, it allows the defendant to introduce evidence of other compensation for the injury that has already been paid. This ensures no duplication of awards. Third, MICRA allows for periodic payments of the awards in order to stabilize the insurance industry and prevent insurer insolvency. Last, there is a provision that limits contingency fees for attorneys. This benefits the patients and provides a disincentive for attorneys to finance massive frivolous claims.

As a result of MICRA, malpractice premiums for California physicians has declined and the industry is more stable. In the wake of the malpractice insurance crisis, the author suggests that other states adopt legislation similar to California in order to counter the practice of defensive medicine, because of the high risks and inordinate costs that come with an unstable malpractice insurance market.

Melissa Patterson, Note, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health,* 8 QUINNIPIAC HEALTH L.J. 109 (2004)

The author analyzes the ongoing debate regarding the medical liability crisis and its effects on women's health. Historically, the United States has undergone cyclical periods during which medical malpractice claims have significantly burdened the country's medical system. Recently, the medical

insurance and legal communities have determined that the country is suffering its third wave of a medical malpractice insurance crisis. Many states are suffering from this crisis. Some of these states have enacted legislation reforming tort liability for medical malpractice damages. One type of legislation that is continually amended is the cap for non-economic damages in medical malpractice claims. For example, California has enacted reform legislation in this area through the Medical Injury Compensation Reform Act of 1975 (MICRA). The Act limits California's non-economic damages to $250,000 for each separate claim, though other states have found similar statutes unconstitutional.

The root of the medical malpractice crisis is still debated because there is no one accepted solution to the crisis. Several actors have tried to evaluate the crisis and they have determined various factors that may attribute to the crisis. For example, the American Medical Association supports the adoption of caps on non-economic damages as a solution to the crisis, similar to California's approach. In contrast, the American Bar Association argues that the root of the problem stems from insurance companies making bad investments, thus passing on losses to the insureds. Even the federal government analyzed the issue. Its reports have concluded differently as to the existence of a crisis.

The author asserts that the medical malpractice crisis disproportionately affects women. Additionally, she points to research that indicates insurance companies are responsible for their own downfall resulting from poor investments and a failure to adjust premiums. Even as malpractice claims were on the rise, many insurance companies failed to correspondingly raise premiums in an effort to remain price competitive with other insurance companies. Many were not able to sustain this trend and began to advocate for relief in the form of non-economic damages caps.

The obstetrical field has been especially affected by increases in malpractice insurance. Insurance companies are pressuring obstetricians to increase their patient load to bring in more fees to offset the increase in malpractice insurance rates. The increased number of patients and the imposition of a non-economic damages cap have created an incentive for some doctors to refuse services to low income women or women on Medicare because the higher malpractice insurance costs cannot be passed on to them.

Although damage caps have been identified as a possible solution for the supposed medical malpractice crisis, these caps appear to create more problems than they solve. For example, as previously mentioned, they may cause doctors to refuse services to low income or high risk patients because

of medical malpractice problems associated with certain patients. Additionally, the caps do not afford victims the ability to receive compensation according to the extent of the medical error. Finally, the caps do not freely allow doctors to acknowledge or report mistakes, even though such reporting may start to address the root cause of the medical malpractice crisis.

GENERAL INSURANCE

Douglas R. Richmond, *Insurance Agent and Broker Liability*, 40 TORT TRIAL & INS. PRAC. L.J. 1 (2004)

Richmond illustrates the importance of brokers and agents as intermediaries in the insurance industry. As a result of the integral role these intermediaries play, they often find themselves liable to various parties such as the insured, insurers, or even third parties.

There are two major types of intermediaries: agents and brokers. An agent is a salaried insurance company employee or an intermediary who sells one insurance company's products exclusively. There are different types of agents, such as a general agent, managing agent or special agent. Each type of agent varies according to the level of risk and the amount of decision-making that the agent is authorized to exercise on behalf of the insurance company. A broker, on the hand, is an independent salesperson who usually contracts with an insurance company and is paid a commission based on sales.

Intermediaries may face liability to an insured based on both tort and contract theories. There are a variety of claims that an insured may bring against an intermediary from simple negligence to fraudulent misrepresentation. The claims are more difficult for courts when an insured holds the intermediary liable for failure to procure insurance. Although a duty does not arise simply because a customer discusses prices or options with the intermediary, a duty arises when there is an express promise to procure coverage at a particular rate. The various courts deciding this issue have been reluctant to impose such a duty on brokers. However, if such a duty was recognized, the broker's liability would be limited to those losses that would have been covered by the subject policy. Other issues that could arise in potential litigation are whether intermediaries should have a duty to disclose their compensation or whether the insurance coverage was adequate for the insured.

Along with all these potential liabilities, the intermediaries have one defense against an insured: the insured has a duty to examine their policies

and to reject it prior to a loss if it does provide adequate coverage. However, this defense is not available if the agent held himself out as an expert, or there is a special relationship that warrants a heightened scrutiny.

Intermediaries may also owe a duty to the insurer since their relationship is governed by contract. Thus, liability may exist for the intermediaries if there is a breach of contract. For example, if an agent issued a policy that was not approved by the insurer and there is a loss, the court may hold the intermediary liable on the theory of respondeat superior. Insurers also seek to hold intermediaries liable under a theory of negligence in failing to remit premiums. Richmond notes that it is more difficult for an insurer to discover this type of negligence because, as independent middlemen, the insurer-broker relationship is not governed by contract.

Intermediaries may also be liable to third parties. This usually occurs when the third party asserts that the intermediary failed to procure insurance, thus resulting in a negligence action. In order for a third party to have standing to assert the claim, it must have been the intended beneficiary of the coverage at the onset of the policy. The invocation of a duty to third party is usually recognized.

Litigation involving insurance intermediaries is a reality, especially in light of the integral role that intermediaries play in the sale of coverage. Therefore, there is a risk that an intermediary may be sued by different actors such as the insured, insurer and even third parties for a variety of claims such as negligence, breach of contract and breach of fiduciary duty.

Brannon P. Denning & Michael D. Ramsey, *American Insurance Association v. Garamendi and Executive Preemption in Foreign Affairs*, 46 WM. & MARY L. REV. 825 (2004)

The Supreme Court's decision in *American Insurance Ass'n v. Garamendi*, 539 U.S. 396 (2003), comes as a surprise for various reasons. The Court invalidated California's Holocaust Victim Insurance Relief Act (HVIRA) because it unconstitutionally interfered with the foreign powers of the national government. The HVIRA required insurance companies doing business in California to disclose policies they sold in Europe between 1920 and 1945. The *Garamendi* Court's decision is contrary to two precedents that disallowed the President to undermine state laws with foreign affairs implications simply because the President though it was bad policy.

The author in this article indicates that the *Garamendi* decision has several detrimental effects on our constitutional structure. First, the decision creates an executive preemption that concentrates foreign affairs

in the hands of the President. Second, *Garamendi* undermines the role of the Senate to create legislation. Third, this decision implicates the separation of powers and the states' constitutional protections.

In fact, *Garamendi* displaces three accepted notions of federalism; specifically, when courts can invalidate state laws if they conflict with federal foreign affairs. The first notion is through Article VI preemption. Federal laws and treaties preempt state laws if they conflict. The second notion comes from the Dormant Commerce Clause doctrine, which restricts states' ability to regulate this sphere, even where there is no federal regulation in the area, if the law may discriminate against out-of-state commerce. Lastly, there is an exclusionary Dormant Commerce Clause doctrine which applies when a state law conflicts with foreign policy. Through a case called *Zschernig v. Miller*, 389 U.S. 429 (1968), the Court reasoned that a state law may still be invalidated if it has "more than some incidental or indirect effect in foreign countries."

The California HVIRA came into effect due to Holocaust victim claimants' inability to recoup from insurers overseas during the Holocaust. In response, in 1998, California, together with other states and European insurance companies, passed legislation in order to facilitate collection of such insurance claims. Furthermore, in 2000, the governments of Germany and the United States negotiated a settlement under a "foundation" in order for German companies to compensate slave labor victims and to include insurance and other financial and property claims that arose during the Holocaust era. These agreement imposed upon the United States several obligations, including the provisions stating that the "foundation would be the exclusive remedy from claims arising from this era, and the courts would be instructed of this settlement and would be encouraged to dismiss such cases because it was in the foreign policy interest of the country."

Subsequently, the executive branch attempted to nullify the HVIRA, thus resulting in the *Garamendi* litigation. In its 5-4 decision, the Court, according to the author, failed to follow precedent and expanded the scope of the executive branch lawmaking authority in contrast to any prior decision. The Court indicated that the President's foreign policy could preempt state laws. Thus, through the German foundation agreement, the executive branch agreement could preempt the California' HVIRA, even though each policy had common goals. Also, the Court balanced competing interests, such as maintaining relationships with European allies, the survivors, and the insurers in resolving this issue. In contrast, the dissent would have upheld HVIRA because the executive branch had not spoken on the issue. According to the author, in its *Garamendi* reasoning,

the Court utilized several precedential decisions disingenuously and failed to follow authority that was on point.

The article argues that *Garamendi* was wrongly decided. First, the Court could have upheld California's law using the McCarrran Act, which permits the state to regulate the business of insurance. Because the HIVIRA would be deemed to regulate the insurance industry, the state arguably derived its authority from this federal legislation. Second, this decision signals concern with using common law constitutional interpretation as controlling authority, rather than utilizing the Constitution to bolster the Court's analysis of the federalism issue involved in this case.

The author suggests that *Garamendi* can be described as the Court's adjudication by intuition. In this reasoning, the Court did not rely on established principles to defend its decision. The Court pursued a pro-executive foreign affairs stance by invalidating a state law, in spite of the state's traditional regulatory scope. *Garamendi*, according to the author, may have serious implications, especially in the directing of foreign affairs as an executive-lawmaking position, which is contrary to the Constitution.

LIABILITY

Jeff Hawkins, Comment, *Which Faultless Party will be Forced to Pay for Another's Failure? A Proposal for Legislatively Extending the Use of State Guaranty Funds to Absorb the Orphan Shares of Long-Tail Claims,* 37 TEX. TECH. L. REV. 215 (2004).

The insurance industry has been experiencing a rise in insolvencies. This issue involves many actors sharing liability for long-tail claims such as asbestos, silicosis and pollution claims. The reason for this rise in insolvencies is that, in agreeing to provide joint liability for a single long-tail claim, different insurers provide coverage for these types of risk over different time periods. In many cases, at some point one of the insurance carriers becomes insolvent, thereby creating an orphan share that must be absorbed by the other insurers.

The author, Jeff Hawkins, presents the different manners in which courts often deal with these long-tail claims when other parties are called to pay for the insolvent carrier's share of the loss. However, the primary purpose of this comment is to present a more efficient manner in which to deal with long-tail claims when there is an orphan share that needs to be paid to the insured.

One way in which courts have dealt with this problem is to require the excess carrier to drop down and fill the coverage gap when the primary

carrier insolvent. In deciding whether the excess carrier will take on the payments of the insolvent carrier, the courts generally look to the language of the policies to make such determination.

The second option that courts have used to absorb the orphan share of the insolvent carrier is to turn to the other primary carriers that provided coverage during the loss. In essence, the courts hold other carriers jointly and severally liable to the insured for the loss since that would be within the expectation of the insured. The first way in which to assess liability to all the carriers is to require all or some of them to pay the whole sum due to the insured. The other method used to hold the remaining carriers jointly and severally liable is recognized as "pro-rata." This formula allocates the percentage of liability to each carrier based on the number of years that the specific carrier provided coverage in respect to the total number of years of coverage for the insured. This formula helps to alleviate the burden on everyone and allocates the burden according to years of coverage.

The third option that can be utilized to absorb the orphan share of the insolvency is through a state guaranty fund. Most states have an enabling statute based on the National Association of Insurance Commissioners model act. The statute provides safeguards to existing policies at the time of the impairment [insolvency]. The state guaranty does not require payment of all sums that the insolvent carrier cannot pay, but only the sum that is defined within the statutory language. The state guaranty fund is usually triggered only when other coverage is unavailable, thereby not benefiting the other carriers. This option has been debated vigorously in the courts because, at times, state guaranty funds try to deny payment on the grounds that the other carriers should be held jointly or severally liable or that this type of benefit should not be applicable to long-tail claims.

Eric W. Collins, Note, *Level 3 v. Federal Insurance: Do you Know What is in Your Directors and Officers Liability Insurance Policy?*, 73 UMKC L. REV. 199 (2004)

Historically, whether insurance coverage for directors and officers was available under the directors and officer's ("D&O") insurance policies in securities fraud cases was not a hotly contested issue. However, the Seventh Circuit's decision in *Level 3 Communications v. Federal Insurance Company* created an atmosphere of uncertainty for directors and officers facing securities fraud and hoping to receive coverage from their policies. The Court of Appeals for the Seventh Circuit reasoned that a D&O policy did not cover payments made to settle securities fraud claims brought by shareholders against the directors and officers. The ruling in

this case was reached by looking at the language of the policy. The article's author, Eric W. Collins, asserts that by looking at the language of Level 3's policy, a fair reading would provide that the settlement payments of Level 3 fell within the policy's definition of loss, which is contrary to the court's ruling. The Seventh Circuit narrowed its interpretation of 'loss' by excluding the coverage of ill-gotten gains such as those alleged by the shareholders in the securities fraud claim.

Other jurisdictions have decided similar cases to *Level 3* and have ruled in the manner that the author advocates, by distinguishing the language that was found in the policies. The operative terms in these policies were "damages" rather than "loss" and, according to these courts, could be read more broadly.

There are certainly significant implications that derive from the Seventh Circuit's ruling in *Level 3*. For one thing, it may have created an incentive for directors and officers not to 'steal' from its shareholders by misrepresentation. That is because D&O carriers might not obligated to cover that loss, especially if the language of the policy can be read in that restrictive manner and, because covering that loss could be considered against public policy. The second implication is that this ruling creates an illusory contract in which the director's inability to provide restitution to its shareholders will leave the shareholders with the loss that they originally complained about. This could result in bankruptcy for the officers and director that will negatively affect shareholders. Moreover, Collins indicates that in response to *Level 3*, D&O providers are changing the language of their policies so that they further limit the risk they choose to absorb. Thus, the decision rendered by the Seventh Circuit may have more devastating results, leaving both the shareholders and directors without any protection from the coverage at times when it is most essential.

TERRORISM

Tara Zager, Note, *Terrorism Coverage and the United States Insurance Industry: An International Inquiry in Search of a Long-Term Solution*, 53 DRAKE L. REV. 545 (2005)

After the terrorist attacks of September 11, 2001, the United States economy suffered tremendously and the insurance industry felt this burden. Immediately following the events, insurance carriers assured policyholders they would not invoke the war exclusions provisions in their policies. However, the insurance companies indicated that terrorism exclusion

provisions would be introduced in new and renewed policies. This new position made insurance premiums prohibitively costly for businesses.

In response, the United States government enacted a temporary law, The Terrorism Risk Insurance Act of 2002 (TRIA) in order to stabilize the United States after the attacks. This law enabled the federal government to act as a reinsurer for three years to cover acts of foreign terrorism. The government obligated entities meeting the definition of insurers to participate by paying a deductible. Since its enactment, the TRIA has received mixed reviews. First, there is a concern that requiring insurers to make terrorism available is compelling insurers to take on more risk. Others criticize TRIA because it creates the potential for an economic moral hazard where individuals are more willing to take on riskier behavior because of the government intervention in the insurance realm. In contrast, supporters of TRIA indicated that government intervention has made it possible for some trophy properties such as the Empire State Building to purchase terrorism insurance.

The author is concerned with the temporal nature of this legislation and suggests that the United States model its terrorism insurance coverage after some European countries by making the law permanent. In countries such as Germany, Spain, United Kingdom and France, the governments act as a reinsurer for damages resulting from damages from acts of terrorism. However, no two countries have the same coverage solution. For example, the United Kingdom, following the terrorist event of 1992, identified the need for the government to intervene through the Pool Reinsurance Company Limited ("Pool Re"). This was an initially temporal measure that would last until intervention was no longer necessary. Pool Re was to provide reinsurance for commercial and business properties. The British government was to provide coverage only as a last resort, thus making the government liable only when the Pool Re exhausted its resources. If a claim did not exceed a certain limit, then the losses would be borne directly by the insurer. If the claim exceeded that limit, Pool Re (which is guaranteed by the government) would step in and cover the losses.

In contrast, France became involved with terrorism insurance coverage in 1982 through the legislation of Caisse Central De Reassurance (CCR). Although this plan ceased due to cost concerns, the government revisited the issue after the events of September 11, 2001 through the legislation of Gestion de l'Assurance et de la Reassurance des Risques Attentats et Actes de Terrorisme (GAREAT). GAREAT provides a reinsurance pool for commercial and industrial risks arising from acts of terrorism in excess of a certain number of euros. Membership in the GAREAT is not mandatory, and unlike the TRIA, the GAREAT provides no liability cap.

This article illustrates the effects that an act of terrorism can have on a nation and its insurance industry. The author further suggests that the European terrorism insurance pool could be a model for the United States, with emphasis on preparedness and prevention as the greatest defense for the economies of these countries.

LIFE INSURANCE

Neil A. Doherty, Brian A. O'Dea & Hal J. Singer, *The Secondary Market for Life Insurance Policies: Uncovering Life Insurance's "Hidden" Value*, 6 MARQ. ELDER'S ADVISOR 95 (2004)

Life insurance carriers have long functioned in a monopsony position over the repurchase of life insurance policies they had issued. Traditionally, if one wanted to surrender their life insurance policy, they would be obliged to accept the unfavorable terms set by the insurance carriers. The market has changed with the emergence of viatical and life settlements firms that allow policyholders to surrender their policy at a fair market value. Viatical and life settlements firms have emerged to create a secondary market for life insurance policyholders with impaired policies.

Viatical and life settlements firms serve very specific markets. Viatical firms specialize in the purchase of life policies from terminally ill policyholders. This type of firm emerged during the late 1980's with the onset of the Acquired Immunodeficiency Syndrome ("AIDS") epidemic. During this time period, many people found themselves with life insurance premiums that they were unable to pay due to unplanned medical costs associated with the virus. Therefore, these people sought to liquidate their financial assets, which included their life insurance policies.

In approximately the year 2000, life settlements firms entered the secondary market. These firms purchase policies from persons who are over age 65 and have experienced a decline in health. The person must have remaining a life expectancy between six to twelve years, but this may vary. The existence of these firms in the secondary market has resulted in an increase in the liquidity of life insurance policies. Furthermore, the fact that there is a secondary market has enhanced the attractiveness of life insurance policies because the liquidity risks associated with them are no longer as high.

In response to these secondary firms entering into the life insurance equation, the insurance industry developed accelerated death benefits ("ADBs"). ADBs were created by insurance companies to re-influence the market by allowing policyholders to receive 25% to nearly 100% of the

death benefit while living. In short, ADBs entered the market in the 1990's, prior to the emergence of life settlements firms, in order to act as a close substitute to the newly formed secondary market of viatical firms. The insurance industry has proposed the expansion of the trigger events for ADBs in order to effectively compete with the settlements firms.

The secondary market, in the form of viatical or life settlements firms, has provided individual policyholders with many benefits and risks. For example, if a policyholder is no longer able to pay premiums on his policy, the secondary market provides a market where there is an economic demand for such a policy. The policyholder, in this case, receives offers from a number of buyers, thus receiving fair market value for his policy. On the other hand, the risk associated with this purchase is that a policyholder may choose to participate in the options available in the secondary market without full knowledge or comprehension of the market and without making an informed decision according to his individual needs.

All in all, with the emergence of a secondary market comprised of viatical firms, life settlements firms and ADBs, life insurance policies' traditional purpose has been greatly expanded. The secondary market provides an outlet where, if surrendering the policy makes sense, one can do so while increasing his financial outcome. Although policyholders are not encouraged to surrender their policies, the secondary market's competitive nature provides an avenue for individuals to liquidate a policy when in dire need. It remains the insurance providers' obligation to continue to disseminate accurate information regarding the secondary market in order to allow its insured to make optimal decisions in accordance with the market.

HEALTH INSURANCE

Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89 (2005)

The federal Employee Retirement Income Security Act (ERISA) applies to fringe benefits provided by private employers in the area of health insurance. ERISA has two primary clauses that shield health insurance plans from state regulation. First, the savings clause exempts state law that regulates insurance from the statute preemption clause. Second, the deemer clause prevents state insurance regulation from

affecting employer health care benefits plans ("EHCBPs") that are self-insured.

Recently, there has been some criticism of the different effects ERISA has on EHCBPs regulation, especially the gap that is created between "self-insured" and insured plans. The author reasons that Congress could do away with the gap by reinterpreting the saving and deemer clauses. However, he believes this is an unlikely to occur.

ERISA, at its inception, was created to counterbalance the failure of employer pensions plans; however, through its drafting, it reached employer health insurance plans as well. As a result, the United States Supreme Court acknowledged that employees in self-insured and third-party insured plans would be treated differently in states that give self-insured plans an enhanced level of freedom from state regulation that is not extended to third party insured plans. In its last three terms, the Supreme Court has made several rulings expanding the scope and importance of the savings clause.

First, in *Rush Prudential HMO v. Moran*, the Court faced the issue of utilization review in managed health care. Prior to this ruling, utilization review allowed a health insurer to independently review treatment proposed by physicians to determine its necessity. The review usually resulted in patients not receiving proposed treatments from physicians, thus minimizing costs for the insurer. When public outcry ensued, some states enacted external review statutes that permitted patients to appeal the decisions of the insurer's utilization review. As a result, the insurers brought suit claiming that the external review statutes were preempted by ERISA. The Supreme Court reasoned that through the savings clause the states' external review statutes were protected.

Nearly a year later, the Court in *Kentucky Ass'n of Health Plans v. Miller* favored state regulation over preemption under ERISA. At issue in this case were "any willing provider" ("AWP") state laws that require health insurers to contract with all the physicians in a state. Critics of AWP laws believed that this decision could create a monopoly benefiting the health insurer. On the other hand, patients often sided with the law because it gave them flexibility to move from one insurance company to another while retaining their physician. The Supreme Court held that ERISA does not preempt the state law. These decisions have had the indirect effect of encouraging employers to be self-insured rather than to insure through third parties because it avoids state regulations and it is cheaper to provide. As a result, self-insurance by employers is now an attractive option for both small and large companies.

There is one drawback to self-insured plans: employers with self-insured plans are at risk for an inordinate loss if such a risk presents itself. Consequently, the National Association of Insurance Commissioners (NAIC) promulgated a model statute dealing with stop-loss insurance policies. Stop-loss insurance exists to provide self-insured EHCBPs with protection against unexpected excessive costs that may be incurred by the employee. The NAIC provides regulations for stop-loss policies in order to make sure that self-insured employers did not undermine ERISA by shifting the loss from employees' risks. The NAIC requires minimum attachment point levels in order to prevent EHCBPs from avoiding costs mandated by the state regulations. Thus, the minimum attachment requirement shifted the incentive for EHCBPs for employers to have insured plans through third parties rather than to self-insured plans. After the enactment of the NAIC regulation, the Court of Appeals for the Fourth Circuit had the opportunity to analyze a state's ability to regulate stop-loss insurance. The court reasoned that ERISA preempted the regulation because it directed self-insured plans to offer certain benefits. The author asserts that this was a misinterpretation of the text and purpose of ERISA.

According to the author, although ERISA is a complex statute, it makes clear that insurance regulation does not extend to self-insured EHCBPs that are provided by employers but do not otherwise act as an insurance business. According to the author, the Fourth Circuit's misinterpretation has several drawbacks. First, because health coverage is not required by any state or federal law as a fringe benefit, the increased costs of regulating stop-loss insurance may lead some employers not to provide any health care at all. Second, some employers may initiate their contracts in states where stop-loss is not regulated in the same manner as in the employees' home state. This option would be available for employers that operate in multiple states. As a result, these employers would continue to have self-insured EHCBPs, but without stop-loss insurance. Thus, the employers would continue to expose themselves to the risk of insolvency.

In sum, ERISA affects employers who self-insure and employers who purchase third party health insurance in distinct manners, leaving self-insured EHCBPs untouched by state regulations because the deemer clause does not treat such entities as insurance companies. Although this structure provides certain incentive for employers to self-insure, courts should not allow it to undermine the scope of ERISA.