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HEALTH INFORMATION PRIVACY: THE RULES GET TOUGHER

Robert W. Woody[*]

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INTRODUCTION

In recent years, consumers have begun to worry more than ever about whether personal information that they provide others will be kept private. According to several studies, a significant cause of this increased fear is a general unease about what happens to personal information disclosed over the Internet.[1] A rising tide of identity theft has also left consumers rattled. Elected officials on both the state and federal levels have responded to their constituents' concern by passing new laws and amending old ones with an eye toward providing consumers with new privacy protections. It is not surprising that the most sensitive type of personal information of all—health information—has now taken center stage.

Congress first waded into the health privacy waters with the passage of the Health Insurance Portability and Accountability Act of 1996.[2] Although HIPAA's main purpose was to ensure that workers would not lose their health insurance coverage if they changed jobs, the Act also contained provisions designed to reduce the cost of health care. One of those initiatives was to encourage and make more efficient the electronic transmission of data in connection with the provision of and payment for health care. The intention was to reduce costs by reducing paperwork and other administrative burdens (dubbed "administrative simplification"). It is not surprising, though, that the idea of personal health data traveling over wires and through cyberspace gave rise to privacy concerns. As a result,

1. *See, e.g.*, Center for Democracy and Technology, Survey Information: Americans Care Deeply About Their Privacy, *available at* http://www.cdt.org/privacy/guide/introduction/surveyinfo.htm (visited May 6, 2002).

2. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936 [hereinafter HIPAA or the Act].

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HIPAA directed the Department of Health and Human Services[3] to draft new health information privacy standards to go along with the new electronic transactions standards. The catch was that HIPAA directed HHS to act on privacy standards only if the Congress itself failed to do so within thirty-six months. So when HIPAA was enacted, the clock began to run and everyone waited to see whether Congress would act. As is so often the case, Congress did not act and the potential health privacy legislation was not adopted. Thus, HHS began the process of promulgating regulations that reflect the standards that Congress had set forth.

On December 20, 2000, after a lengthy and delayed rule-making process, President Clinton announced new final regulations to protect the privacy of personal health information.[4] Although some states had already enacted health information privacy protections, the rules are the first national, comprehensive health privacy regulations. In adopting the rules, HHS elaborated on the congressional objectives stated in HIPAA by recognizing three primary goals:

> (a) to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information;
> (b) to improve the quality of health care in the United States by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care; and
> (c) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.[5]

The rules are extremely lengthy, technical, and complex, and will be costly to implement and administer. A broad range of entities involved in the health care industry is subject to the rules, which generally cover all medical records and other personally identifiable health information, regardless of their form. Generally, entities that are subject to the rules

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3. Hereinafter HHS.

4. Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. pts. 160 and 164 (2000). The rules are one of a set of three related rule makings that HIPAA mandated. The others, which are not addressed in this article, relate to electronic transaction standards and security standards [hereinafter the rules].

5. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,463 (Dec. 28, 2000).

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(covered entities) do not need to comply with them until April 14, 2003 (the compliance date),[6] but the breadth and complexity of the rules has led most entities to begin work on their compliance plans well in advance of that date. To complicate matters further, the Bush administration recently proposed modifications and clarifications to the rules (see Section XI below). At this writing, it is not clear when or to what extent HHS will adopt these changes.[7]

For most financial service firms (e.g., insurers), this will not be the first foray into privacy compliance issues. In the summer of 2001, state and federal financial regulators began enforcing the provisions of the Gramm-Leach-Bliley Act,[8] which imposed privacy compliance obligations with respect to the disclosure to nonaffiliated third parties of nonpublic personal information as GLB defined that term. Implementation of GLB with respect to insurers was left to state insurance regulators, some of which added to their insurance privacy regulations special provisions not found in GLB. These often applied more stringent restrictions on the sharing of health information than GLB required.[9] Thus, while some insurers will have addressed privacy issues prior to the implementation of the HIPAA standards, existing state insurance regulatory requirements are generally not as stringent or detailed as the new HIPAA rules. Covered entities, including insurers, are therefore now engaged in extensive efforts to devise and implement a compliance plan that will allow them to meet the requirements of the rules by the compliance date.

This article provides an overview of the HIPAA rules in their current form, some commentary on their practical implications (especially for insurers), and a brief summary of the Bush administration's proposed revisions.

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6. Certain small entities will have an additional year until compliance is required.

7. Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. § 160.104 (2001). Section 160.104 allows the Secretary of HHS to adopt modifications any time during the first year following the initial adoption of the rules. Thereafter, the Secretary may modify the rules no more frequently than once every twelve months. 45 C.F.R. § 160.104 (2001).

8. Gramm-Leach-Bliley Act, Pub L. No. 106–102, 113 Stat. 1352 (1999) [hereinafter GLB].

9. *See, e.g.*, the National Association of Insurance Commissioners Privacy of Consumer Financial and Health Information Model Act.

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I. WHO IS SUBJECT TO THE HIPAA PRIVACY RULES?

The rules apply to "covered entities," which are identified as "health plans," "health care clearinghouses," and "health care providers."[10] The definitions of these terms are therefore very important not only because they establish who is subject to the rules but also because an entity's obligations under the rules may differ depending on its classification.

A. Health Plan

Generally, a health plan is "an individual or group plan, whether private or governmental, that provides, or pays the cost of, medical care."[11] Covered health plans include, among other things, a "health insurance issuer," defined as "an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance."[12] The term "health plan" also includes other entities even if they are not state insurance licensees. These include, among others, issuers of long-term care or Medicare supplemental policies, HMOs (i.e., those that are not "health insurance issuers" because they are not licensed by insurance regulators),[13] certain employee welfare benefit plans that provide medical care, and most government health care programs (e.g., Medicare, Medicaid, or coverage provided during active military duty).[14]

Generally, any insurance company, insurance service, or insurance organization (including an HMO) that provides or pays the cost of medical care is a "health plan" and is therefore required to comply with the rules. However, there are important exceptions. For example, the property/casualty insurance industry lobbied aggressively and with considerable success to be excluded from the scope of the rules. Thus, an insurance company is not a covered entity if it provides only coverage for

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10. § 164.104.

11. § 160.103.

12. Some insurers who write business in the "surplus lines" market lack state insurance licenses, but nevertheless write certain types of insurance coverage pursuant to state insurance law. The applicability of the rules to such insurers is open to question. *Id.*

13. Group health plans are expressly excluded from the definition of "health insurance issuers" although group plans are independently subject to the rules.

14. § 160.103. Note that government-funded programs either administered principally for purposes other than providing or paying for health care, or whose principal activities are the direct provision of health care to persons or making grants to fund such direct provision of health care are not subject to the rules.

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liability, accident or disability income, automobile medical payment, workers' compensation, or other similar coverage under which medical benefits are secondary ("excepted benefits").[15]

Although the rules do not specifically exempt life insurers from covered entity status, life insurers do not fit the definition of "health plan" because they do not pay the cost of medical care. Moreover, HHS confirms in the preamble to the rules that life insurance is considered an excepted benefit, and that life insurers are not covered entities.[16] This exception does not mean, however, that life insurers will not be affected indirectly by the rules. For example, a health care provider that obtains protected information on behalf of a life insurer by performing physicals on insurance applicants will have to obtain patient authorization to disclose the information to the insurer. In addition, many life insurers and other covered entities will be considered "hybrid entities," as discussed more fully below, because they write both covered and noncovered lines of insurance. A hybrid entity, however, must comply with the rules only with respect to its covered functions.[17]

B. Health Care Clearinghouse

A "health care clearinghouse" is an entity that converts health information that it receives from another entity into or out of a standard format such as the one that will be required by the electronic transactions standards being promulgated separately pursuant to HIPAA.[18] This means that the entity either transforms data that it receives in a nonstandard format or containing nonstandard content into a standard transaction format or, conversely, converts information that it receives in a standard format into a nonstandard format. Health care clearinghouses include such entities as billing services, repricing companies, community health information systems, and value-added networks and switches.[19] Entities that do not engage in this sort of data conversion might find that market forces will cause them to do so in the future, especially if HIPAA achieves its goal of encouraging electronic transactions in standard formats. Such entities might ultimately find that they become a health care clearinghouse and will therefore be directly subject to the rules.

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15. *Id.* (see definition of "health plan").
16. 65 Fed. Reg. 82,567 (Dec. 28, 2000).
17. 45 C.F.R. §§ 160.103, 164.504 (2001).
18. § 160.103.
19. *Id.*

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C. Health Care Provider

A health care provider is generally defined as a provider of medical or health services or an entity that "furnishes, bills, or is paid for health care in the normal course of business."[20] A health care provider is a covered entity, however, only if it transmits any health information in electronic form in connection with certain types of transactions defined in HIPPA. It is interesting to note that providers are not covered entities if they merely maintain but do not transmit information electronically. Other covered entities (e.g., health plans and health care clearinghouses) are subject to the rules if they either transmit or maintain information electronically.

D. Special Categories of Covered Entities

Some covered entities will engage simultaneously in functions that are covered and functions that are not covered under the rules. They might also engage in several different covered functions, each of which gives rise to somewhat different compliance obligations. They also might have relationships or affiliations with other covered entities that raise issues about the extent to which each entity must comply with the rules. These are known as "hybrid entities," "affiliated entities," and "multiple function entities." The rules set forth the circumstances under which such entities can and cannot use and disclose protected information. The most important requirement for such entities is to establish firewalls between functions and/or affiliates that prevent the disclosure of information in contravention of the rules. Nevertheless, the existence of these special categories provides covered entities with some options and flexibility in their approach to compliance.

1. Hybrid Entity

A "hybrid entity" is a covered entity whose primary functions are not those operations that subject it to the rules.[21] Generally, only the health care operations of a hybrid entity are covered by the rules. For example, an insurance company offering health, life, and disability insurance would be subject to the rules only with respect to its health lines and not with respect to its life and disability lines. The rules require such hybrid entities to establish firewalls between covered and noncovered entities to prevent unlawful uses and disclosures of protected information.[22] On the other

20. *Id.*
21. § 164.504(a).
22. § 164.504(c)(2).

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hand, uses and disclosures within and between noncovered functions (such as life and disability insurance) would not be directly affected by the rules. In determining whether to adopt one or more of the special categories described above, entities will need to consider the costs of establishing the necessary firewalls within joint information systems as opposed to maintaining entirely separate systems.

2. Affiliated Entities

Affiliated companies may elect to classify themselves as "affiliated covered entities" for purposes of HIPAA compliance. These are legally separate covered entities that are affiliated under "common ownership" or "common control"[23] but that choose to designate themselves as a single entity for purposes of compliance with the rules. Depending on circumstances, this designation might have the advantage of obviating the need for separate compliance plans, systems, and procedures for each affiliated company. However, the flow of information between affiliated entities would still be restricted. An example of an entity that might elect this status is a corporate hospital chain, which could designate all of its hospitals as a single affiliated covered entity. However, the hospitals would be required to segregate protected health information within their joint information systems to regulate its use and disclosure between their various covered and noncovered functions.[24]

3. Multiple Function Entities

The rules also recognize that a single covered entity might perform multiple covered functions, each of which, while subject to the rules, may have different compliance obligations.[25] In such cases, the entity must comply with the rules only to the extent that they apply to each covered function. Examples of a multiple function entity include certain integrated health plans or health care delivery systems that act as both health plans and health care providers. The rules require multiple function entities to segregate covered information among their multiple functions in much the same way as is required of hybrid and affiliated entities.[26]

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23. The rules define common ownership as 5% or more ownership or equity interest, and common control as direct or indirect power significant enough to influence actions and policies. § 164.504(a).

24. § 164.504.

25. § 164.504(g).

26. § 164.504.

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II. BUSINESS ASSOCIATES

Entities that do not fit the definition of "covered entity" are not directly subject to the rules. Nevertheless, they may be significantly affected in an indirect way if they fit the definition of a "business associate." The rules define a business associate as a person or entity that either performs certain activities on behalf of or provides certain services to a covered entity and whose activities or services involve the use or disclosure of protected health information.[27] A covered entity may be a business associate of another covered entity.

A covered entity generally may disclose protected health information to a business associate or allow a business associate to create or receive such information on its behalf, only if the covered entity obtains satisfactory assurance in the form of a written contract that the business associate will appropriately safeguard the information.[28] The contract must (1) define the boundaries of permissible use or disclosure by the business associate; (2) not allow the business associate to use or disclose the information in a manner that, if done by the covered entity, would violate the rules; (3) provide that the business associate will both safeguard against and report any unauthorized use or disclosure; and (4) allow termination by the covered entity if the business associate violates a material term of the contract.[29]

Although a covered entity is not liable for the privacy violations of its business associates, it must take reasonable steps to cure any material breach or violation by the business associate with respect to the contract. If such breach or violation cannot be cured, the covered entity must terminate the contract if feasible, or otherwise report the breach or violation to HHS.[30] Business associates themselves are not directly accountable to HHS for compliance because they are not covered entities. Their obligations arise only from the contractual commitments that they make. It seems likely that litigation eventually will arise testing the respective responsibilities of covered entities and their business associates.

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27. § 160.103.

28. However, because a business associate generally stands in the shoes of the covered entity with which it has a contract, a consent obtained by a covered entity for treatment, payment, or operations purposes also covers such use or disclosure with respect to the contracted business associate. § 164.502(e)(1).

29. § 164.502(e)(2).

30. § 164.504(e)(1).

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III. WHAT INFORMATION IS SUBJECT TO THE PRIVACY RULES?

Once entities determine whether they are covered by the rules, they must then consider what information in their possession is subject to the rules. Understanding the scope of the rules on this point involves sorting through several definitions within definitions. The rules apply to "protected health information," but before considering the definition of that term it is necessary first to consider the more broadly defined term "health information." "Health information" includes any oral or recorded information that is created or received by a covered entity or certain other entities and that relates to the past, present, or future: (1) physical or mental health or condition of an individual and the provision of health care to an individual; or (2) payment for the provision of health care to an individual.[31] "Protected health information" is that subset of health information to which the rules' restrictions on use and disclosure apply. Protected health information is: (1) "individually identifiable health information" that is transmitted or maintained in electronic media or in any other form or medium. "Individually identifiable health information" is health information that identifies an individual or that can be used to identify the individual (including demographic information).[32] Protected health information does not include health information contained in certain education records and student medical records.[33]

The preamble to the rules provides examples of modes of electronic maintenance and transmission that do and do not cause health information to become protected health information. Examples of transmissions that are covered include transmissions made via email, an Intranet or Extranet, leased lines, dial-up lines, private networks, and telephone voice response and "faxback" systems. Examples of transmissions that are not covered are paper-to-paper faxes, person-to-person telephone calls, video teleconferences, and voice mail messages.[34]

The HIPAA statute itself appears to authorize HHS to promulgate rules applicable to information that is transmitted electronically, but the regulations have expanded the scope to cover records maintained electronically as well if they are maintained by health plans or health care

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31. § 160.103.

32. § 164.501.

33. *Id.* The Family Educational Rights and Privacy Act already requires schools and colleges to protect the privacy of students' educational records.

34. 65 Fed. Reg. 82,462, 82,496 (Dec. 28, 2000).

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clearinghouses. Thus, except for the rare country doctor who never transmits health information electronically, this definition will capture virtually all medical and insurance records maintained by most providers and insurers. Interestingly, HHS acknowledges in the preamble to the rules that its authority to expand the scope of the rules in this manner might eventually be challenged in court. The preamble explains that the definition of protected health information was carefully structured to preserve the severability of unchallenged aspects of the rules in the event of such litigation.

Covered entities may use protected health information to create "de-identified health information" by removing identifiers such as names, addresses, dates, photographs, and various identification numbers.[35] De-identified health information is not protected.[36] Health information is considered de-identified only if all of the identifiers enumerated in the rules are removed, or if a statistician or similarly competent expert determines that the risk that the information could be used to identify an individual is very small.[37] What is not clear is how HHS or courts will determine whether a given statistician is competent and has performed this analysis consistent with the rules.

IV. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Financial service firms, in particular, will notice a stark contrast between the scope of the HIPAA rules and the privacy provisions of GLB. While GLB restricts only the disclosure of protected information, the HIPAA rules restrict both the internal use as well as the disclosure of protected health information. Covered entities may neither use nor disclose protected health information except as specifically permitted in the rules. This right to use or disclose information generally arises in one of two ways: (1) the covered entity has obtained an authorization or consent to use or disclose the information; or (2) the covered entity may use or disclose the information without an authorization or consent because the use or disclosure is subject to an exception to the authorization or consent requirement.

35. 45 C.F.R. §§ 164.502, 164.514 (2001).
36. *Id.*
37. § 164.514.

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A. Authorization and Consent

Unless an exception applies, a covered entity generally may use or disclose protected health information only: (1) to the individual patient; or (2) pursuant to a patient's "consent" or "authorization " as required[38] The two terms have different meanings, and it is therefore important to understand the difference.

1. Authorization

When covered entities wish to use or disclose protected health in a manner not covered by an exception (described in detail below), the entity must first obtain an "authorization" from the individual who is the subject of the information.[39] To be valid, an authorization must be written in plain language and signed by the patient. Among numerous content requirements set forth in the rules, an authorization must include a specific description of the information to be used or disclosed, specific identification of the persons authorized to make and to receive the use or disclosure, and a specific date or event that triggers expiration of the authorization.[40]

Written authorizations generally may not be combined with other documents except for other protected health information authorizations. A covered entity may not condition patient treatment, payment, enrollment, or eligibility on the provision of an authorization except under limited circumstances.[41]

The rules do not offer a sample form of authorization. Any authorization that meets the detailed requirements set forth in the rules should be sufficient.

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38. § 164.502(a)(1).

39. § 164.508(a)(1). A special category of protected information, psychotherapy notes, is generally subject to the authorization provisions of the rules, even with respect to treatment, payment, or health care operations. § 164.508(a)(2).

40. § 164.508(c). The rules require authorizations to contain additional content if a covered entity intends to use and disclose protected information for its own purposes, § 165.508(d), or if the covered entity makes the request to use or disclose the information on behalf of another party. § 164.508(e).

41. § 164.508(b)(4). For example, a health care provider treating a patient for the sole purpose of providing information to a life insurer for eligibility purposes may condition the treatment on provision of an authorization for the disclosure to the life insurer.

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2. Consent

Health care providers are somewhat more restricted than other covered entities in that they must obtain "consent" of their patients even when the use or disclosure of protected health information is covered by certain exceptions to the authorization requirement.[42] A "consent" is an abbreviated form of an authorization. A consent must be written in plain language, must be signed by the patient, and must include: (1) reference to the covered entity's use and disclosure notice regarding the covered entity's privacy practice; (2) a statement of the patient's rights to request use or disclosure restrictions; and (3) a statement of the patient's right to revoke the consent.[43] A consent is less specific than an authorization in that it does not need to describe the information to be disclosed. Under specified circumstances, a written consent may be combined with other written legal permissions received from a patient.[44] Unlike an authorization, a consent has no expiration date and is valid indefinitely unless it is affirmatively revoked.[45]

Providers have expressed concern that the "consent" requirement will impede their ability to provide effective medical care. HHS has heeded some of these concerns and has attempted to carve out exceptions to the rules to ease the burden on providers. For example, consent is generally not required in emergency situations, when a substantial communications barrier would make it difficult to obtain the consent, or when the provider is required by law to treat a patient.[46] The consent requirement also generally does not apply when the covered provider has an indirect treatment relationship with the patient, thereby exempting a provider who treats a patient at the request of, and typically reports directly to, another provider.[47]

Obviously, providers would be severely inhibited in their ability to provide health care in many circumstances if an individual were to withhold consent. Therefore, the rules provide that a covered health care

42. § 164.506(a)(1). With some exceptions, a provider generally must obtain the patient's "consent" to use or disclose protected heath information for purposes of treatment, payment, or health care operations.

43. § 164.506(c).

44. § 164.506(b)(4)(i).

45. In some circumstances, providers can obtain a verbal consent or can even assume an implied consent. These circumstances are described more fully in Section V.B.4 below.

46. § 164.506(a)(3).

47. § 164.506(a)(2).

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provider may condition treatment on the provision of consent by the patient. A health plan may also condition enrollment on the provision of consent to the provider.[48]

Covered entities other than health care providers do not need consent to use or disclose information for purposes of treatment, payment, or health care operations provided that they otherwise comply with the rules.[49] However, if a covered entity secures a patient's consent for its own use or disclosure of protected information even when the rules do not otherwise require such consent, a patient's refusal to consent is binding.[50]

It is important to note that the Bush administration has proposed to eliminate the consent requirement for providers so that they would be subject to the same requirements as other covered entities with respect to uses and disclosures made for treatment, payment, or health care operations purposes. These proposed changes are discussed more fully in Section XI below.

B. When May Information Be Used or Disclosed Without Authorization or Consent?

There are several very important exceptions to the general rule that protected health information may be used or disclosed only with authorization or consent.[51] The primary exceptions permit the disclosure of information for purposes of "treatment," "payment," or "health care operations."[52] The definition of these terms is critical to determining the circumstances under which an entity can and cannot use or disclose protected health information without consent or authorization.

1. Treatment

The term "treatment" is defined fairly broadly and much as one might expect. It is "the provision, coordination, or management of health care and related services by one or more health care providers."[53] As defined, it includes: (1) the coordination or management of care by a health care provider with a third party; (2) consultation between health care providers

48. § 164.506(b)(1)-(2).
49. § 164.506(a).
50. § 164.506(a)(4).
51. For example, in certain circumstances, protected health information may be disclosed to carry out treatment, payment, or health care operations, except with respect to psychotherapy notes. § 164.502(a)(1)(iii).
52. § 164.506.
53. § 164.501.

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relating to a patient; and (3) the referral of a patient for health care from one provider to another.[54] Uses or disclosures of information that are for the purpose of "treatment" do not require authorization. However, uses or disclosures for purposes of treatment will require consent unless the information was created or received in any of the following treatment situations: (1) an emergency situation; (2) the provider is required by law to treat the patient; and (3) there are significant barriers to communication.[55] The provider must attempt to obtain consent in all of these situations but may render care even if the consent is not obtained.

2. Payment

The "payment" exception will be of the greatest interest and use to insurers. Broadly speaking, the term describes activities that constitute the payment for health care services or activities that facilitate such payments. Specifically, the rules define "payment" as the activities undertaken by: "(i) a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (ii) a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care."[56] The rules then give a nonexclusive list of examples of activities that constitute "payment." These include: (1) determining eligibility or coverage (including coordination of benefits or the determination of cost-sharing amounts), and adjudication or subrogation of health benefit claims; (2) risk-adjusting amounts due based on enrollee health status and demographic characteristics; (3) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; (4) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (5) utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services; and (6) disclosure to consumer reporting agencies of certain protected health information relating to the collection of premiums or reimbursement. Any uses or disclosures of information that are for the purpose of "payment" do not require authorization.

54. *Id.*
55. § 164.506(a)(3).
56. § 164.501(l).

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HHS notes in the preamble that a disclosure does not qualify under the "payment" exception when it is made by a covered entity to a plan sponsor for the purpose of obtaining payment: (1) under a group health plan maintained by the plan sponsor; or (2) from a health insurance issuer or HMO with respect to a plan maintained by such sponsor. A disclosure under these circumstances will qualify under the exception, however, if the plan sponsor performs certain specified plan administration functions.[57]

3. Health Care Operations

Exceptions from the use and disclosure restrictions are also available for activities that are termed "health care operations." The preamble describes activities as being "compatible with and directly related to treatment and payment."[58] Several of these activities are critical for insurers, including, among other things; (1) underwriting, premium rating, and other activities related to the creation or renewal of a contract of health insurance or health benefits; (2) ceding health care risks to reinsurers (including stop-loss and excess-of-loss insurers); (3) quality assessment, outcomes evaluation, and, in some circumstances, development of clinical guidelines; (4) case management; (5) contacting patients or providers about treatment alternatives; (6) reviewing qualifications of providers; (7) training; (8) legal services and auditing functions, including fraud abuse, detection, and compliance programs; (9) business planning and development, including customer service; and (10) due diligence in connection with the sale or transfer or assets.[59]

The preamble also lists certain activities that expressly do not fall under the health care operations exception. These include information collected for the purposes of: (1) underwriting, enrollment, eligibility, or risk-rating determinations when an insurance product is not ultimately provided with respect to an individual; (2) marketing of health or nonhealth related products;[60] (3) sale, rent, or barter of protected health information; (4) use of protected health information by nonhealth related divisions of an entity; (5) disclosures to employers for employment determinations; and (6) fund-raising.[61]

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57. 65 Fed. Reg. 82,495 (Dec. 28, 2000).

58. 65 Fed. Reg. 82,490 (Dec. 28, 2000).

59. 45 C.F.R. § 164.501 (2001).

60. A separate marketing exception provides limited opportunities to use health information for marketing purposes.

61. 65 Fed. Reg. 82,490 (Dec. 28, 2000).

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4. Other Exceptions

The rules describe three situations in which a covered entity may use or disclose protected health information without patient consent or authorization, generally so long as the patient is given prior notice and a meaningful opportunity to agree or to object. First, a covered entity may use or disclose limited general information about patients for creation or maintenance of a facility directory.[62] Second, a covered entity may disclose protected information to certain relatives, close friends, or other designees of a patient if relevant to such persons' involvement in the care or payment for care of the patient.[63] Third, a covered entity may use or disclose protected information to notify family members or representatives of a patient of the patient's location, general condition, or death.[64] In these instances, the required notice and subsequent agreement or objection may be oral.[65]

A covered entity is required to disclose protected information upon a request by the individual pursuant to the rules, or in response to an HHS request for purposes of investigation or to determine compliance.[66]

In several specifically described situations and in observance of key national health care priorities, the rules permit covered entities to use or disclose protected health information without patient consent or authorization or an opportunity to object. These circumstances generally include uses and disclosures for purposes of important public health activities (e.g., disease control, dangerous product identification, etc.) and avoiding serious threats to health or safety; reporting victims of abuse, neglect, or domestic violence; health oversight activities (e.g., audits, licensing, etc.); specialized government functions (e.g., military, national security, etc.); organ donation; research; workers' compensation; judicial or administrative proceedings; and as otherwise required by law. Although consent, authorization, and an opportunity to object are generally not required under the described circumstances, use or disclosure in each case requires compliance with other highly restrictive provisions.[67]

Finally, subject to limited exceptions, the disclosure of psychotherapy notes is generally prohibited without an authorization.[68] It is important to

62. 45 C.F.R. § 164.510(a) (2001).
63. § 164.510(b)(1)(i).
64. § 164.510(b)(1)(ii).
65. § 164.510.
66. § 164.502(a)(2).
67. § 164.512.
68. § 164.508(a)(2).

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note that this applies only to the notes actually taken during a psychotherapy session and not to the formal medical record maintained by the psychotherapist.

a. Marketing Exception

No authorization is needed for uses and disclosures made for certain marketing purposes, but the scope of this exception is quite limited.[69] This exception applies to marketing that: (1) occurs in face-to-face communications (telephone calls are not included); (2) relates to a product or service of nominal value; or (3) concerns health-related products and services and an opt-out opportunity is provided. However, the opt-out notice provided to individuals must meet detailed requirements. Moreover, if the covered entity wishes to target marketing communications to individuals based on their health status, the covered entity must first make a determination that the product or service being offered may be beneficial to the health of the type of person being targeted. The covered entity must also explain to the individual why he or she is being targeted.

b. Minimum Necessary

Protected health information that is used, disclosed, or requested by covered entities, whether or not pursuant to an exception, may be disclosed even under an exception, but such information must be only that which is considered the "minimum necessary" to serve the purpose of the disclosure.[70] This means, for example, that covered entities may allow access to protected information only to those employees who require access to achieve the stated purpose.[71] As between two covered entities, the requesting entity has the burden of limiting its request to reasonably necessary information, allowing the disclosing entity to rely on the request as being appropriately limited.[72]

The term "minimum necessary" is not defined, and covered entities are understandably worried about how to determine what amount of information is the "minimum necessary" to disclose in a given circumstance. During the public comment period on the proposed rules,

69. § 164.514(e).

70. § 164.502(b)(1). The "minimum necessary" requirement, however, does not apply to disclosures to or requests by a health care provider for treatment purposes, to most disclosures made to a patient, to disclosures made to HHS for compliance or enforcement purposes, or to disclosures required by law. § 164.502(b)(2).

71. § 164.514(d)(2).

72. § 164.514(d)(3)(iii).

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covered entities asked HHS for further guidance, but HHS admitted in the commentary to the final rules that it was unable to provide such guidance. Instead, HHS has issued informational documents indicating that the agency will be reasonable in its enforcement of this provision. For example, the informal HHS guidance indicates that "in certain circumstances . . . covered entities may rely on the judgment of the party requesting the disclosure as to the minimum amount of information that is needed." Even this reliance, however, is permitted only when it is reasonable under the circumstances, and only when the requesting entity is a public official, a professional who is a work force member of a business associate, or an appropriately documented researcher.[73]

The rules permit covered entities to develop policies and procedures regarding repetitive and routine disclosures so that determinations as to what is the "minimum necessary" will not have to be made repeatedly with respect to each piece of information disclosed. Nonroutine disclosures must be reviewed on a case-by-case basis to avoid the disclosure of information in excess of the "minimum necessary" threshold.[74]

V. PRIVACY POLICY NOTICES

Financial institutions are now familiar with the obligation to provide their customers with a copy of their privacy policy. The institutions are now required to do so by GLB and its implementing regulations. However, the HIPAA rules contain a separate privacy notice requirement that may not mesh well with that of GLB. Under the rules, a covered entity must provide notice to patients of both the covered entitys' uses and disclosures of protected health information and the patients' rights and the covered entity's legal duties with respect to the information.[75] The notice must be written in plain language and must explain the patient's rights and the covered entity's duties with respect to protected health information, and indicate how the patient may contact or complain to the covered entity.[76] The rules provide very specific standards for the content of the notices.

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73. HHS Guidance on Final Privacy Rule, *available at* http//aspe.hhs.gov/admnsimp/final/pvcguide1.htm.

74. § 164.514(d)(3)(i)-(ii).

75. However, when a health insurance issuer or HMO providing benefits to a patient participating in a group health plan provides the required notice, the group health plan may be excepted from the notice requirement. § 164.520(a)(2).

76. The notice must include a detailed description and an example of the uses and disclosures permitted or required, and indicate whether the patient's consent or authorization is required. § 164.520(b).

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Covered entities must provide the notice initially at the time that the rules take effect and thereafter at least once every three years. In addition, a covered entity must provide the notice to any person upon request. Health plans must provide the notice to existing participants on the compliance date and thereafter, at the time of enrollment, and within sixty days of a material revision to the notice.[77] Health care providers with direct treatment relationships with an individual must provide notice at the first service delivery after the compliance date, and they must post the notice and have copies available at their service location.[78] Revised notices must be made available upon request.[79] A covered entity may provide notice electronically,[80] and a covered entity participating in organized health care arrangements[81] may provide joint notice.[82] Because the HIPAA notice has different content requirements and must be supplied at different intervals than under GLB, entities might find it difficult if not impossible to provide a single notice that satisfies both standards. At a minimum, though, the two notices will need to be harmonized so that they do not make conflicting claims or promises.

VI. PATIENT RIGHTS

The rules also create a new set of patients' rights with respect to protected health information, requiring covered entities to provide patients with benefits such as notice of privacy practices, access to health information, and accountings of health information disclosures.[83] These requirements will be new to most covered entities, although insurers in a few states will have been subject to somewhat related requirements under sporadically enforced state insurance privacy legislation that was adopted in the 1980s and 1990s.

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77. § 164.520(c)(1).
78. § 164.520(c)(2)(i)-(ii).
79. § 164.520(c)(2)(iii).
80. § 164.520(c)(3).
81. Organized health care arrangements generally include: (1) clinically integrated settings where patients obtain services from more than one health care provider; (2) an organized system of health care in which covered providers jointly participate; (3) a group health plan and a health insurance issuer or HMO that serves the group plan; (4) group health plans maintained by the same sponsor; and (5) the health insurance issuer or HMO that serves group health plans maintained by one sponsor. § 164.501.
82. § 164.520(d).
83. § 164.502.

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A. Use and Disclosure Restrictions

Within certain limits, patients are entitled to ask covered entities to restrict the use of their information even when they are otherwise providing authorization or consent for uses or disclosures.[84] Although the rules do not require the covered entity to agree to the requested restriction, it is bound by any restriction to which it does agree, except in certain emergencies.[85]

B. Patient Access to Health Information

A covered entity generally must allow a patient to inspect and to obtain a copy of protected health information that the covered entity maintains about that individual.[86] The covered entity may require the patient to make the request in writing,[87] and it must grant or deny the request, in whole or in part, in a timely manner.[88] A covered entity that denies any such request must provide a document written in plain language that states the basis for the denial, whether review rights are applicable, and how the patient may file a complaint with the covered entity or HHS.[89] When a patient requests review of a reviewable denial, the covered entity's designated reviewing official must determine in a timely manner whether to uphold the denial, and the covered entity must promptly notify the patient in writing of its determination.[90] When a covered entity grants a patient request for access, the covered entity must provide the access in the form requested and in a timely manner. The covered entity may, however, impose cost-based fees

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84. § 164.522(a)(1)(i).

85. § 165.522(a)(1)(ii)-(iii). Notably, an agreed restriction is not effective with respect to use or disclosure for a facility directory or in any case where consent, authorization, or an opportunity to object are not otherwise required.

86. § 164.524(a). A patient does not have a right to access psychotherapy notes, information compiled in anticipation of litigation, or certain research-related information. § 164.524(a)(1).

87. § 164.524(b)(1).

88. § 164.524(b)(2).

89. § 164.524(d)(2).

90. Patients have the right to have denials reviewed if (a) a licensed health care professional determines that the requested access may harm an individual, (2) the protected health information makes reference to a third party who may be harmed by release of the information to the requesting party, and (3) the individual's personal representative requests the information, and a licensed health care professional determines that release of the information may harm the individual. §164.524(a)(4).

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for copying, postage, and, if the patient agrees, a summary of the information.[91]

C. Amendments to Protected Health Information

A covered entity generally must amend protected health information that it maintains about an individual when the individual requests amendment unless the covered entity determines that the information is accurate and complete or has other permissible reasons to decline the request.[92] Obviously, this will give rise to disputes between patients and covered entities about when information is and is not accurate. The rules anticipate these disputes and establish mechanisms for dealing with them.[93]

The covered entity may require the patient to make the amendment request in writing and provide a supporting reason, but must accept or deny the amendment request, in whole or in part, in a timely manner.[94] Any denial of an amendment request must be written in plain language that states the basis for the denial, explains the patient's right to submit and how to file a written statement disagreeing with the denial, indicates how the patient may request any future disclosures of the information to include the request and denial, and informs the patient how to make a complaint to the covered entity or HHS.[95] When a patient whose request for amendment is denied submits a statement of disagreement, the covered entity must include with future disclosures of the affected information the amendment request, the denial, the statement of disagreement, and any rebuttal statement that the covered entity issues.[96] When the covered entity accepts an amendment request, it must identify the affected information, append or provide a link to the amendment, and inform other parties holding the affected information of the amendment.[97] Any covered entity receiving such notice must amend the affected information as requested.[98]

D. Accounting of Disclosures

The rules will effectively impose new recordkeeping requirements on covered entities by requiring them to provide individuals with an

91. § 164.524(c)(4).
92. § 164.526(a)(2).
93. § 164.526.
94. § 164.526(b).
95. § 164.526(d)(1).
96. § 164.526(d)(2), (3), (5).
97. § 164.526(c).
98. § 164.526.

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accounting of disclosures made about them. Subject to certain exceptions, a covered entity must provide an accounting of all disclosures of a patient's protected health information during the six years prior to the request.[99] The covered entity must provide the accounting in a timely manner and generally must include for each disclosure the date, recipient, description, and purpose.[100] A covered entity may not charge a patient for the first accounting request during any twelve-month period, but it may impose a cost-based fee for any subsequent request during the same twelve-month period.[101]

VII. PREEMPTION

Subject to exceptions noted below, state laws relating to the privacy of individually identifiable health information that are contrary to the rules are preempted.[102] There are, however, four exceptions to this general rule. HIPAA does not preempt state law where:

> (1) State laws relate to the privacy of individually identifiable health information and are contrary to and more stringent than the federal requirements;
> (2) The Secretary of Health and Human Services determines that the state laws are necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance and health plans, for state reporting on health care delivery or costs, for purposes of serving a compelling need related to public health, safety or welfare, or have as their principal purpose the regulation of controlled substances;
> (3) State laws provide for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention; and
> (4) State laws require a health plan to report, or provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.[103]

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99. § 164.528(a).
100. § 164.528(b)(2).
101. § 164.528(c)(2).
102. §§ 160.201–160.205.
103. § 160.203.

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At a minimum, litigation seems likely on the questions of when a state law "relates to the privacy of individually identifiable health information" and when a state law is "contrary to and more stringent than the federal requirements." The rules provide only minimal guidance. They say that a state law "relates to the privacy of individually identifiable health information" if its specific purpose is to protect the privacy of health information, or if it affects the privacy of health information in a direct, clear, and substantial way.[104] A state law is "contrary" to an HIPAA privacy provision if a covered entity would find it impossible to comply with both the state and the federal requirements, or if the provision of state law stands as an obstacle to accomplishing the full purposes and objectives of HIPAA rules relating to administrative simplification and privacy of certain health information.[105] A state law is more stringent than the provisions adopted by the privacy regulations if it (1) prohibits or restricts a use or disclosure otherwise permitted under the privacy regulations, (2) provides the individual greater rights of access or amendment of individually identifiable health information, (3) provides more information to the individual about use, disclosure, rights, and remedies, (4) narrows the scope or duration of a consent or authorization for use or disclosure of information, or (5) requires a longer retention of health information or more detailed information relating to accounting of disclosures.[106]

State laws must be compared with the HIPAA rules on a provision-by-provision basis to determine whether they are "contrary to" or "more stringent than" HIPAA. An overall comparison between the HIPAA rules and a comprehensive state privacy law will not suffice. This, of course, will make the preemption analysis complicated and challenging, and will cause confusion as to the applicable standards. As a practical matter, however, the typical effect of these preemption provisions will likely be to permit the law that is the most protective of an individual's privacy to control.

The author believes that it is reasonable to anticipate that HHS will attempt to resolve potential conflicts between different federal laws so that both laws apply whenever possible. The federal government will be reluctant to take the political heat for preempting state privacy laws when it can be avoided. Nevertheless, the preemption decisions made by the

104. § 160.202.
105. *Id.*
106. *Id.*

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Secretary or interpreted by private parties likely will be the subject of dispute and litigation.

VIII. ADMINISTRATIVE REQUIREMENTS

The rules impose numerous administrative requirements on covered entities to ensure compliance with these new substantive privacy and access provisions. Initially, a covered entity must designate a privacy official responsible for the development and implementation of the entity's policies and procedures for compliance.[107] (Many financial institutions will already have done so pursuant to GLB.) It also must designate a contact person or office responsible for providing information and receiving complaints about privacy and access matters.[108] A covered entity also must train each member of its work force on its policies and procedures as they relate to that member's function.[109] Further, a covered entity must establish administrative, technical, and physical safeguards to ensure the privacy of protected health information, and the covered entity must take steps to mitigate any breach of the safeguards or other violations of its policies and procedures with respect to protected information.[110] A covered entity must document its policies and procedures and all other aspects of its compliance with the rules.[111]

All covered entities (except for small health plans) must comply with the rules no later than April 14, 2003. Small health plans must comply no later than April 14, 2004.[112] Until these respective compliance dates, a covered entity may generally continue to use and disclose protected health information pursuant to a noncompliant consent, authorization, or other express legal permission that it obtains from the patient, provided that the

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107. § 164.530(a)(1)(i).

108. § 164.530(a)(1)(ii).

109. § 164.530(b)(1).

110. § 164.530(c)(1)–(2).

111. The rules require the following documentation: (1) contracts with business associates (§ 164.504(e)(2)); (2) restrictions to uses or disclosures to which the covered entity agrees (§ 164.522(a)(3)); (3) the designated record sets that are subject to access by individuals and the titles of the persons or offices responsible for receiving and processing requests for access by individuals (§ 164.524(e)); (4) information regarding a patient-requested accounting (§ 164.528(d)); (5) all complaints and their disposition (§ 164.530(d)(2)); (6) any sanctions (§ 164.530(e)(2)); and (7) policies and procedures and communications or actions, activities, or designations required by § 164.530 (§ 164.530(j)(1)).

112. Small health plans are those with annual receipts of $5 million or less. § 160.103.

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covered entity adheres to any express exclusions or limitations that the patient requests.[113]

IX. ENFORCEMENT

Enforcement authority with respect to the rules rests with the HHS Office for Civil Rights.[114] The rules state that the OCR will generally seek the pre-enforcement cooperation of covered entities to comply voluntarily with the privacy and access requirements of the rules through technical assistance and other means.[115]

The OCR will investigate complaints and conduct compliance reviews. Any person who believes that a covered entity is not complying with the rules may file a complaint with the OCR, whether or not the person suffered any harm or has any relation to the alleged violation.[116] The OCR may also initiate a compliance review at any time. A covered entity must cooperate with any investigation or compliance review, provide records and compliance reports as the OCR requests, and provide the OCR access to all information pertinent to compliance with the rules.[117]

The rules establish three specific responsibilities of covered entities. First, a covered entity must maintain records and submit compliance reports in accordance with the Secretary's requirements.[118] In case of an investigation or a compliance review, the covered entity must cooperate with the Secretary.[119] Finally, the covered entity must provide the Secretary with access to covered information that is pertinent to the Secretary ascertaining the covered entity's compliance with these regulations.[120]

If the OCR determines that a covered entity has failed to comply with the rules, the OCR will first inform the covered entity and the complainant, if any, and then seek to resolve the noncompliance by informal means.[121] However, if the OCR determines that the noncompliance cannot be so resolved, it may issue written findings that document the noncompliance,[122]

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113. § 164.532(a).
114. Hereinafter OCR.
115. § 160.304.
116. § 160.308.
117. § 160.310.
118. § 160.310(a).
119. § 160.310(b).
120. § 160.310(c).
121. § 160.312(a).
122. § 160.312(a)(2).

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seek civil monetary penalties, and refer the covered entity for criminal prosecution.[123]

Covered entities are subject to substantial civil and criminal penalties for noncompliance. The OCR may impose a civil monetary penalty of up to $25,000 per person for violations of a provision of the rules during a calendar year.[124] The potential criminal penalties are even more severe: (1) $50,000 and/or one year in prison for any person who knowingly violates the rules by using, obtaining, or disclosing protected health information; (2) $100,000 and/or five years in prison for any person who commits the violation under false pretenses; and (3) $250,000 and/or ten years in prison for any person who commits the violation with the intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm.[125]

There are no provisions in the rules for a private right of action against a covered entity for noncompliance. This is not to say, however, that creative plaintiffs' lawyers and courts might not find a private right of action. At a minimum, the HIPAA privacy standards might be invoked in state law actions alleging that these are the new "general practices" in the industry and are now the relevant state law standard.[126]

X. PROPOSED CHANGES TO THE RULES

In April 2002, the HHS announced proposed modifications[127] to the rules.[128] Although the proposed provisions are tougher in some respects than those previously adopted, privacy advocates allege that the proposed regulations weaken patients' health care information privacy rights.

The proposed regulations significantly increase the reach of the rules with regard to disclosures for marketing purposes. Under the current rules,

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123. 65 Fed. Reg. 82,472 (Dec. 28, 2000).

124. 42 U.S.C.A. § 1320d(5) and (6) (West Supp. 2001).

125. *Id.*

126. It should be noted that some of the regulatory history of the rules might suggest the lack of intent to create a private right of action. As originally proposed, the rules would have made individuals who are the subjects of protected health information a third-party beneficiary to business associate contracts. Public commenters protested that this would effectively create a private right of action by regulation when Congress had not done so legislatively. That proposed provision was removed from the final rule, and individuals are not now considered third-party beneficiaries to business associate contracts. This could bolster arguments that no private right of action is intended.

127. Hereinafter the proposed regulations.

128. Standards for Privacy of Individually Identifiable Health Information, 45 Fed. Reg. 14,776 (proposed Mar. 27, 2002) (to be codified at 45 C.F.R. pts. 160 and 164).

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covered entities may disclose information for marketing purposes without prior authorization under limited circumstances, such as in the context of marketing arrangements for health-related products and services (subject to certain conditions such as an opt-out). The proposed regulations would eliminate these exceptions and require prior authorization for all activities deemed to be marketing.[129]

The proposed regulations also expand the definition of marketing activities. The new definition would focus on the effect of the communication on the individual, without regard to the intent of the covered entity. Thus, any communication that would have the effect of encouraging the purchase of products or services would be considered marketing and would trigger the prior authorization requirements.[130]

Under the current rules, covered entities are allowed to disclose or use patient information only to the "minimum necessary" extent to achieve their intended purpose. The proposed regulations clarify that the "minimum necessary" standard can be applied with flexibility to the unique circumstances of the covered entity.[131] The HHS proposed this change partly in response to concerns from health care providers that they would be in violation of the rules if third parties overheard conversations regarding patient care. However, the federal regulators' willingness to show flexibility on the "minimum necessary" standard is an encouraging sign for other covered entities as well.

Under the current rules, covered entities are required to have contracts with business associates with whom they share personal information. The proposed regulations add new transition provisions that allow covered entities to operate under existing, noncompliant contracts until April 14, 2004. If any covered entity renews or modifies an existing contract before that date, however, the contract must comply with the rules. The proposed regulations provide model contract provisions to facilitate compliance with and reduce costs associated with this requirement.

The proposed regulations give an entity that performs both covered and noncovered functions the option to choose whether it will be a covered entity or a hybrid entity under the rules. Under the proposed regulations, an entity that wishes to avoid the burden of identifying its health care components and erecting fire walls around them may choose to be

129. *Id.*
130. *Id.* at 14,813.
131. *Id.* at 14,815.

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considered a covered entity in its entirety.[132] The proposed regulations also remove the term "primary" from the definition of hybrid entity, so that entities whose covered functions are subordinate to their noncovered functions may, at their discretion, elect hybrid status.

The proposed regulations make explicit the current HHS policy that group health insurance providers may disclose enrollment and disenrollment information to a plan sponsor without amending plan documents.[133] This policy was discussed in the preamble to the rules but was not addressed in the text of the rules.

The proposed regulations would eliminate the consent requirement for treatment, payment, and health care operations, thereby removing unintended obstacles without significantly limiting privacy protections.[134] Health care providers would be required to inform patients of their rights and the providers' disclosure policies, but could provide medical treatment without written consent so long as they made a "good faith effort" to obtain written acknowledgment that the patient received the notice.[135] Patient authorizations would continue to be required for the use or disclosure of patient information for purposes other than for treatment, payment, or health care operations, and a single authorization form could be used for different types of disclosure or for use of such disclosed information.[136]

The modified rules would clarify that state law governs disclosure of children's medical records to their parents. If state law is unclear or silent, health care providers could, at their discretion, grant parents access to their childrens' medical records.[137]

Under the proposed regulations, researchers could use a single consent form to obtain participants' informed consent and to address more general information privacy rights.[138] Other provisions of the rules would be modified to minimize the difference between federally and privately funded research.[139] Various technical modifications include: (1) upon the merger, sale, transfer, or consolidation of a covered entity's business, protected health information could be transferred to the successor-in-interest;[140] (2)

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132. § 164.504(c)(3)(iii).

133. Standards for Privacy of Individually Identifiable Health Information, *supra* note 128, at 14,812.

134. *Id.*

135. *Id.* at 14,814.

136. *Id.* at 14,813.

137. *Id.* at 14,811.

138. *Id.* at 14,813.

139. *Id.*

140. *Id.* at 14,811.

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covered entities would not be required to account for disclosures of protected health information when such disclosures are made pursuant to an authorization from the individual;[141] and (3) covered entities could disclose information related to the quality, safety, and effectiveness of FDA-regulated products and activities.[142]

CONCLUSION

The rules impose broad and complex federal obligations on providers and other covered entities to ensure the privacy of individual health information. Determining how the federal rules interact with state privacy requirements will be difficult and, in some cases, dependent on as-yet-unknown determinations by the Secretary of Health and Human Services. Implementing the policies and procedures necessary to ensure compliance with the rules, as well as applicable state requirements, will require the investment of very significant human and financial resources, and most covered entities will need substantial lead time. Moreover, all covered entities should resolve to monitor developments closely (including the Bush administration proposed amendments) as continuing consumer interest and concern in privacy issues is likely to result in further changes.

141. *Id.* at 14,815.
142. *Id.* at 14,814.

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PROTECTING PRIVACY UNDER GRAMM-LEACH-BLILEY (ACT II): THE NAIC'S MODEL SAFEGUARDING REGULATION

Thomas R. Hrdlick[*]

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INTRODUCTION

Since passage of the federal Gramm-Leach-Bliley Financial Services Modernization Act of 1999,[1] there has been substantial ink spilled and money spent explaining and complying with GLB's provisions dealing with the use and protection of nonpublic personal financial and/or health information and information that financial institutions and/or their service providers, including insurers and other state insurance licensees, routinely collect in order to market and administer various financial products. Most of that ink and money has been directed toward GLB provisions regulating the affirmative use and disclosure of such information by financial institutions; relatively little has been directed toward GLB provisions addressing how financial institutions protect such information internally. The current situation is changing with the recent adoption of the Standards for Safeguarding Customer Information Model Regulation[2] by the National Association of Insurance Commissioners.[3]

GLB leaves enforcement of its privacy protections vis-à-vis the insurance industry to state insurance authorities through state laws, regulations, or both.[4] GLB's privacy protections essentially operate on two tracks. The first track, already familiar to most practitioners in the field,

1. Gramm-Leach-Bliley Act of Nov. 12, 1999, Pub. L. No. 106–102, 113 Stat. 1338 (codified as amended in scattered sections of 12 U.S.C. and 15 U.S.C.) [hereinafter GLB].

2. *Standards for Safeguarding Customer Information Model Regulation,* NAIC MODEL LAWS REGULATIONS AND GUIDELINES (#673) [hereinafter Model Safeguarding Regulation].

3. Hereinafter NAIC.

4. GLB § 505(a)(6) (1999) (codified as amended at 15 U.S.C. § 6805 (2001)).

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concerns GLB provisions (and implementing state laws or regulations) that (1) limit the manner and instances in which a financial institution may share nonpublic personal information about a consumer with unaffiliated third parties, and (2) require a financial institution to notify its customers (and certain consumers) of its policies and practices. These rules are contained in GLB's so-called notice and disclosure provisions, found in sections 502 and 503 of GLB. To assist states with implementing and enforcing these provisions, the NAIC adopted and promulgated its model Notice and Disclosure Regulation.[5] Many states have since adopted privacy protections based in whole or in part on the model.[6]

The second track, one with which many practitioners are not yet familiar, concerns a GLB provision directing federal authorities and state insurance regulators to establish and enforce appropriate standards for financial institutions to safeguard the security and confidentiality of customer records and information. This direction is contained in GLB's "safeguarding" provision, found within section 501(b) of GLB, which provides:

> (b) Financial Institutions Safeguards. In furtherance of the policy in subsection (a), each agency or authority described in section 505(a) shall establish appropriate standards for the financial institutions subject to their jurisdiction

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5. *Model Privacy of Consumer Financial and Health Information Regulation,* NAIC MODEL LAWS REGULATIONS AND GUIDELINES (#672) [hereinafter Model Notice and Disclosure Regulation].

6. As of May 1, 2002, twenty-two states adopted the protections relative to financial and health information contained in the Model Notice and Disclosure Regulation (Arkansas, Colorado, Florida, Kansas, Kentucky, Maryland, Mississippi, Nevada, New Hampshire, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming) and fourteen states (plus the District of Columbia) had adopted at protections for financial information although some may already have or are adopting other protections for health information (Alabama, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Michigan, Missouri, Pennsylvania, South Dakota, Tennessee, and Virginia). *See* NAIC Notice and Disclosure Regulation, *available at* http://www.naic.org/1privacy/; *see also* http://www.naic.org/1privacy/privacy_map.htm. In addition, thirteen states had previously adopted a model privacy act adopted by the NAIC in 1980 and subsequently revised by the NAIC in 1982, the Insurance Information and Privacy Protection Model Act (#670) [hereinafter the 1982 Model Act] (Arizona, California, Connecticut, Georgia, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, and Oregon). *See id.* The NAIC Executive Committee considers the 1982 Model Act to be generally more protective of consumer privacy than GLB. Minutes of the December 9, 2001 Meeting of the NAIC Executive Committee, Attachment Six-A, at 1 (Dec. 9, 2001).

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> relating to administrative, technical, and physical safeguards;
> (1) to insure the security and confidentiality of customer records and information;
> (2) to protect against any anticipated threats or hazards to the security or integrity of such records; and
> (3) to protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer.

Like the Model Notice and Disclosure regulation before it, the Model Safeguarding Regulation is intended to assist the various states with implementing and enforcing section 501(b). Because of NAIC's comparatively recently action on this issue, only a handful of states have adopted the Model Safeguarding Regulation, either as drafted or in a slighly different form.[7]

This article is intended to alert insurance industry executives and lawyers about the requirements of NAIC's Model Safeguarding Regulation. Part II outlines the background, general structure, and specific provisions of the Model Safeguarding Regulation. Part III discusses some of the interpretive issues or concerns inherent in certain provisions of the regulation. Part IV provides an update of state action on GLB's safeguarding provision. Collectively, this information provides a primer

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7. As discussed in more detail below: (1) New York has adopted a formal safeguarding regulation, *see* N.Y. COMP. CODES R. & REGS. tit. 11, § 421 (2002) (N.Y. Insurance Department Regulation No. 173); (2) Oregon has issued a temporary administrative rule that follows the Model Safeguarding Regulation (with only minor deviations), *see* OR. ADMIN. R. §§ 836–081–0100 through 836–081–0125 (2002), *available at* http://www.cbs.state.or.us/external/ins/docs/rules/recent_adopt/id14–2002_rule.pdf; (3) West Virginia has issued an emergency rule that follows the Model Safeguarding Regulation (with one material deviation) to take effect no later than July 10, 2002, *see* West Virginia Secretary of State Notice of an Emergency Rule, Title 114-Series 62, §§ 114–62–1 through 114–62–6 (May 29, 2002), *available at* http://www.wvsos.com/adlaw/proposed/114–62er.pdf; (4) California has proposed a privacy regulation containing modified versions of both the Model Notice and Disclosure Regulation and the Model Safeguarding Regulation, *see* California Department of Insurance Revised Proposed Regulation Text, File No. RH01018269, §§2689.12 through 2689.20 (May 23, 2002), *available at* http://www.insurance.ca.gov/docs/FS-Regulations-Search.htm; (5) Utah has proposed a safeguarding regulation which follows the Model Safeguarding Regulation (with only minor deviations), *see* Utah Insurance Department Proposed New Rule R590–216, *available at* http://www.insurance.utah.gov/rules/revision/216txt.htm; and (6) Michigan has passed legislation that directs the Michigan insurance commissioner of insurance to adopt general safeguarding guidelines. *See* MICH. COMP. LAWS § 500.547 (2002).

for what is likely to be another source of confusion, anxiety, and cost for insurers and other state insurance licensees doing business in the post-GLB world.

I. ANALYSIS

A. Model Safeguarding Regulation

1. Background and General Structure

The Model Safeguarding Regulation is the product of the NAIC's Privacy Issues Working Group,[8] which the NAIC "reconstituted" in 2001 "in an effort to increase dialogue among regulators and interested parties . . . now that most states have privacy protections in place and are moving to the next phase involving interpretation and enforcement."[9] The Working Group first published a draft of the Model Safeguarding Regulation in July 2001 at its first official meeting after reconstitution. The organization held two official rounds of public comment, resulting in various revisions to the initial and subsequent drafts. Ultimately, the Working Group adopted the final form during its spring 2002 meeting,[10] and the Plenary of the NAIC followed suit during a conference call on April 20, 2002.[11]

The Working Group had access to earlier models, each issued by federal agencies charged with enforcing GLB's privacy protections within their respective spheres of federal authority. One model was that offered by the Securities and Exchange Commission[12] in its final GLB rule, issued June 22, 2000, and entitled Privacy of Consumer Financial Information.[13] The safeguarding provision of the SEC rule essentially reiterates the generalized language and objectives of GLB's safeguarding provision, without imposing specific policies or procedures that financial institutions should or must adopt in order to be in compliance:

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8. Hereinafter the Working Group.

9. NAIC's discussion of the Privacy Issues Working Group, *available at* http://www.naic.org/1privacy/initiatives/privacy_issues_working_group.htm.

10. Minutes of March 18, 2002 Meeting of Privacy Issues Working Group of the NAIC Executive Committee, at 2 (Mar. 21, 2002).

11. The final version of the model regulation adopted by the Working Group and the Plenary is posted on the NAIC website. *See* http://www.naic.org/1privacy/initiatives/privacy_issues_working_group.htm.

12. Hereinafter SEC.

13. 17 C.F.R. § 248.30 (2001) [hereinafter SEC rule.]

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> Every broker, dealer, and investment company, and every investment adviser registered with the Commission must adopt policies and procedures that address administrative, technical, and physical safeguards for the protection of customer records and information. These policies and procedures must be reasonably designed to:
> (a) Insure the security and confidentiality of customer records and information;
> (b) Protect against any anticipated threats or hazards to the security or integrity of customer records and information; and
> (c) Protect against unauthorized access to or use of customer records or information that could result in substantial harm or inconvenience to any customer.

This fairly light-handed approach emphasizes corporate and regulatory flexibility by allowing affected individuals and entities to craft safeguarding mechanisms appropriate to their business and corresponding risks.

The federal banking agencies offered another model in their joint final safeguarding rule, issued December 21, 2000, and entitled Interagency Guidelines Establishing Standards for Safeguarding Customer Information.[14] Like the SEC rule, the federal banking guidelines restate the generalized objectives of GLB's safeguarding provision.[15] However, contrary to the soft touch of the SEC rule, the guidelines also impose several detailed requirements that banks must satisfy to meet those objectives.[16] These requirements include, among others:

> (i) a requirement that each bank adopt a written information security program specifically approved by its board of directors (or a committee thereof), which board (or committee) shall also oversee the development, implementation and maintenance of the program and shall receive detailed annual reports describing the overall status of the program and the bank's compliance with the guidelines;[17]
> (ii) a mix of detailed requirements (and suggestions which can become requirements) as to how each bank must

14. 12 C.F.R. § 30.6 (2001) [hereinafter federal banking guidelines.]
15. *Id.*
16. *Id.*
17. *Id.*

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> assess, manage and control the risks of unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems; and[18]
> (iii) a requirement that each bank exercise due diligence in the selection of service providers and contractually require its service providers to implement appropriate measures designed to meet the objectives of the guidelines.[19]

Faced with these two options, the Working Group, and ultimately the NAIC as a whole, opted for a hybrid approach that creatively splits the difference between the SEC rule and the federal banking guidelines.[20] Like the SEC rule, the Model Safeguarding Regulation imposes only a few basic mandatory requirements, most of which essentially reiterate the generalized objectives of GLB's safeguarding provision.[21] However, the model clearly follows the lead of the federal banking guidelines by requiring licensees to adopt a formal information security program, and many of the guideline's detailed requirements were included in the Model Safeguarding Regulation as nonbinding suggestions for satisfying the requirements of the Model.[22] In this manner, the Model Safeguarding Regulation essentially requires state insurance licensees to formalize and document their plans for satisfying their safeguarding obligations, but largely leaves the details to each licensee. Consistent with the spirit of the SEC rule, this approach allows insurers and other state licensees considerable discretion to craft safeguarding approaches that reflect their unique business models, needs, and activities.

2. Specific Provisions of the Model Safeguarding Regulation

The specific provisions can be divided into four basic categories: (a) definitions, (b) mandates, (c) suggested methods of implementation, and (d) enforcement provisions.

a. Definitions

The model defines five key terms: customer, customer information, customer information systems, licensee and service provider. Each of these definitions are set forth below:

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18. *Id.*
19. *Id.*
20. Minutes of Meeting of Privacy Issues Working Group, *supra* note 10, at 2.
21. Model Safeguarding Regulation, *supra* note 2, §§ 3–4.
22. *Id.* §§ 3, 5–9.

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> "Customer" means a customer of the licensee as the term customer is defined in [cite applicable section of state regulation that corresponds with the NAIC Privacy of Consumer Financial and Health Information Model Regulation].
> "Customer information" means nonpublic personal information as defined in [cite applicable section of state regulation that corresponds with section 4(S) of the NAIC Privacy of Consumer Financial and Health Information Model Regulation] about a customer, whether in paper, electronic or other form, that is maintained by or on behalf of the licensee.
> "Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.
> "Licensee" means a licensee as that term is defined in [cite applicable section of state regulation that corresponds with section 4(Q) of the NAIC Privacy of Consumer Financial and Health Information Model Regulation], except that "licensee" shall not include: a purchasing group; or an unauthorized insurer in regard to the excess line business conducted pursuant to [cite applicable regulation or section of state insurance law].
> "Service provider" means a person that maintains, processes or otherwise is permitted access to customer information through its provision of services directly to the licensee.[23]

b. Mandates

The model imposes three basic mandates on state insurance licensees. First, it requires every "licensee" to implement "a comprehensive written information security program."[24] Second, each ISP must include "administrative, technical and physical safeguards for the protection of customer information," and those safeguards must be "appropriate to the size and complexity of the licensee and the nature and scope of its activities."[25] Third, each ISP must "be designed" to achieve the general

23. *Id.* § 2.
24. *Id.* § 3 [ISP].
25. *Id.*

"objectives" of the Model Safeguarding Regulation, which are identical to the three objectives set forth in GLB's safeguarding provision:

> Ensure the security and confidentiality of customer information;
> Protect against any anticipated threats or hazards to the security or integrity of such information; and
> Protect against unauthorized access to or use of such information that could result in substantial harm or inconvenience to any customer.[26]

Although these principles are stated as requirements, the language providing that the safeguards adopted by any particular licensee need only be "appropriate to the size and complexity of the licensee and the nature and scope of its activities" clearly suggests that the actions necessary to comply with the model will vary. Obviously, such language provides a degree of flexibility that the insurance industry generally applauds.[27]

c. Suggested Methods of Implementation

The Model Safeguarding Regulation lists several "examples of methods of implement[ing]" the requirements, methods that are expressly described as "non-exclusive illustrations" of actions and procedures that "licensees may follow" when implementing it.[28] These include the following:

> Assess risk by (i) identifying "reasonably foreseeable internal or external threats" that could cause "unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems," (ii) assessing the likelihood that such threats will actually materialize and the sensitivity of the information at risk, and (iii) assessing the sufficiency of the risk management devices already in place.[29]
> Manage and control risk by (i) designing an ISP "commensurate with the sensitivity of the information" and "the complexity and scope of the licensee's activities," (ii)

26. *Id.* § 4.

27. *See, e.g.*, Comments of the American Insurance Association in correspondence to the Working Group dated Aug. 31, 2001, at 1, and Dec. 5, 2001, at 2 [hereinafter AIA comments]; *see also* NAIC Executive Committee, *supra* note 6, at Attachment Six at 2.

28. Model Safeguarding Regulation, *supra* note 2, § 5.

29. *Id.* § 6.

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> "train[ing] staff as appropriate," and (iii) "regularly test[ing]" the key components of the ISP.[30]
>
> Oversee service provider arrangements by (i) "exercis[ing] appropriate due diligence in selecting . . . service providers," (ii) "requir[ing] . . . service providers to implement measures designed to meet the objectives of the Regulation," and (iii) "tak[ing] appropriate steps to confirm that . . . service providers have satisfied such obligations."[31]
>
> Adjust the program by "monitor[ing], evaluat[ing], and adjust[ing]" the ISP "in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements."[32]

The Working Group borrowed these examples from the federal banking guidelines,[33] but, unlike the guidelines, the Model Safeguarding Regulation does not require licensees to use these methods. Rather, such methods are offered as suggestions whose appropriateness depends on the type of entity involved and the nature and scope of its activities. The insurance industry generally applauds such flexibility although some industry representatives suggested abandoning the examples altogether in favor of a rule substantially identical the SEC rule.[34] Insurance regulators, however, expressed concern that the lack of specific, mandatory standards made it difficult to enforce the Model Safeguarding Regulation, at least in the short term.[35]

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30. *Id.* § 7.

31. *Id.* § 8.

32. *Id.* § 9.

33. 12 C.F.R. § 364.101 (2002).

34. For example, the American Insurance Association urged the Working Group to delete the examples from the Model Safeguarding Regulation altogether, expressing concern that they gave the appearance of standards that the insurance industry must follow and that the plaintiff's bar could exploit. *See* AIA comments, *supra* note 27; *see also* NAIC Executive Committee, *supra* note 6, at Attachment Six at 2. The AIA proposed that the NAIC instead consider allowing states to issue such examples and guidance through state-specific bulletins or circular letters that presumably would not be interpreted as mandatory requirements. *See* AIA comments, *supra* note 27, at 3 (Aug. 31, 2001) and 2 (Dec. 5, 2001).

35. This issue was raised in comments submitted to the Working Group by the Virginia Bureau of Insurance [hereinafter the VBI], which generally expressed concern about how a state regulator would enforce the Model Safeguarding Regulation in light of its reliance upon examples of methods for complying with the regulation. NAIC Executive Committee, *supra* note 6, at Attachment Six at 2. The VBI recommended the Working Group adopt

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d. Enforcement provisions

Finally, the Model Safeguarding Regulation contains a drafting note suggesting that states provide that any breach of the model violates either the state's Unfair Trade Practices Act or some other applicable state law.[36] The model also contains a provision by which each state adopting the regulation establishes an Effective Date (presumably a date subsequent to adoption of the regulation) by which every licensee within the state must "establish and implement an information security program . . . pursuant to this regulation."[37]

B. Interpretive Considerations and Issues

The Model Safeguarding Regulation raises several important considerations, the most notable of which are discussed below:

1. The Model Safeguarding Regulation Protects "Customers" Only.

Unlike the Model Notice and Disclosure Regulation, the Model Safeguarding Regulation protects "customers" and not the broader category of persons called "consumers."[38] As indicated above, the Model Safeguarding Regulation incorporates the definition of customer contained in the state version of the Model Notice and Disclosure Regulation,[39] which usually excludes consumers who have not established an ongoing relationship with the financial institution.[40]

The decision to limit the protection of the Model Safeguarding Regulation to customers was intentional and reflects the approach of both the SEC rule and the federal banking guidelines. According to comments accompanying the latter, federal banking regulators limited the protections of the guidelines to customers because Congress used that express term in

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specific standards for every licensee to meet. *Id.* Alternatively, a Maine representative to the Working Group recommended mixing the two approaches, "stating that there are times when flexibility is needed, and other times, such as training staff, that are too fundamental for flexibility." *Id.* at 1–2.

36. Model Safeguarding Regulation, *supra* note 2, § 10.

37. *Id.* § 11. For example, New York's safeguarding regulation was formally promulgated in February 2002 with a compliance deadline of June 1, 2002. N.Y. COMP. CODES R. & REGS. tit. 11 § 421.10 (2002) (N.Y. Ins. Dep't Reg. No. 173).

38. *Id.* § 3.

39. *Id.* § 2.A.

40. *See also* Model Notice and Disclosure Regulation, *supra* note 5, §§ 4.F(1); 4.I.

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section 501(b); which makes no reference to "consumers."[41] Moreover, federal banking regulators noted that, as a practical matter, a licensee or financial institution may design its ISP so as to provide the same level of protection to both customers and consumers, presumably to avoid the cost and difficulties of (1) separately identifying the nonpublic personal information of customers and consumers, and (2) applying different levels of protection to each of the two categories of information.[42] If this assumption is valid, there is indeed little protection lost by remaining consistent with the precise language of GLB in this regard.[43]

2. The Model Safeguarding Regulation Covers Information Held "on Behalf of" a Licensee.

The Model Safeguarding Regulation defines "customer information" as "nonpublic personal information . . . about a customer, whether in paper, electronic, or other form, that is maintained by or on behalf of the licensee."[44] The highlighted language is potentially broad enough to include nonpublic personal information in the possession of an insurer's independent retail agents, managing general agents,[45] third-party administrators[46] or other service providers.[47] Accordingly, an insurer's safeguarding obligations may extend to information in the control of unaffiliated agents or service providers regardless of whether the information is also shared with the insurer.

This aspect poses certain practical questions and difficulties for insurers, depending upon the insurer's particular business model and the extent of its reliance upon unaffiliated service providers. For example, what is meant by information that is maintained "on behalf of" an insurer? If independent insurance agents obtain and maintain customer information

41. 66 Fed. Reg. 8616, 8617–18 (Feb. 1, 2001).

42. *Id. at* 8618.

43. As discussed *infra,* however, West Virginia apparently takes a different view, as its emergency rule extends a licensee's safeguarding obligations to consumer information. West Virginia Secretary of State Notice of an Emergency Rule, *supra,* note 7, § 114–62–3.1.

44. Model Safeguarding Regulation, *supra* note 2, § 2.B.

45. Hereinafter MGA.

46. Hereinafter TPA.

47. For example, the federal banking regulators noted that this definition includes information "maintained by any service provider on behalf of an institution," 66 Fed. Reg., *supra* note 41, at 8618, and that "the term 'service provider' should be broadly defined to encompass a variety of individuals or companies that provide services to the institution. *Id.* at 8619.

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in their own capacities and also forward that same information to the insurer that ultimately provides coverage, does the insurer have a safeguarding obligation only vis-à-vis the information in its possession, or must it also take steps to safeguard such information held the independent agent? The difficulty of controlling the information gathering and safeguarding activities of hundreds and perhaps thousands of independent agents is obvious.

On the other hand, an insurer that engages in what is called program business, serving as a fronting carrier on a book of business produced, underwritten, and administered by MGAs and TPAs selected by the insurer, will typically possess very little "customer information." The MGAs and TPAs managing the business usually keep this information, arguably "on behalf of" the insurer for purposes of the Model Safeguarding Regulation. Thus, the Model Safeguarding Regulation could be interpreted as placing a direct obligation on the program insurer to affirmatively safeguard customer information maintained by its MGAs and TPAs. In theory, a failure by the program insurer to take adequate steps to safeguard such information violates the Model Safeguarding Regulation, regardless of whether the MGAs or TPAs otherwise violate state insurance law or cause actual and discreet harm to consumers.

Most program insurers understand that they face derivative legal liability for the market conduct activities of their MGAs and TPAs. However, they may be surprised to learn that they might have an affirmative obligation to assert primary control and supervision over aspects of the business operations of their MGAs and TPAs that are as the procedures utilized to maintain and protect customer information—systems that are often the most important asset or trade secret involved in the insurance enterprise. What is the scope of a program insurer's obligation in this regard? How is that obligation affected, if at all, by the fact that the MGA or TPA may itself be subject to a safeguarding regulation? These are important questions that the Model Safeguarding Regulation fails to answer.

3. Selection and Monitoring of Service Providers Is Likely to Vary Among the States.

The Model Safeguarding Regulation defines "service providers" as "any person or entity that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to

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the licensee."[48] Consistent with the notion, discussed above, that a licensee's safeguarding obligations extend to customer information in the possession of such service providers, the Model Safeguarding Regulation suggests that an ISP may need to include procedures through which the licensee "oversee[s] service provider arrangements." Specifically, the Model Safeguarding Regulation suggests that a licensee should:

> Exercise appropriate due diligence in selecting its service providers; and
>
> Require its service providers to implement appropriate measures designed to meet the objectives of this regulation, and, where indicated by the licensee's risk assessment, take appropriate steps to confirm that its service providers have satisfied such obligations.[49]

These provisions generated extensive criticism that they are either unnecessary, in the case of service providers independently subject to the safeguarding regulation, or overly burdensome and impractical.[50] The proposed remedies included (1) deleting the provisions altogether,[51] (2) retaining only the language requiring due diligence in the selection of service providers,[52] (3) limiting the provisions to apply only with respect to those service providers who are not independently subject to an appropriate safeguarding regulation,[53] and (4) deleting the requirement that licensees take steps to confirm that their service providers satisfy their safeguarding obligations.[54] Nonetheless, the Working Group, and ultimately the NAIC as a whole, did not delete or alter these provisions.

The degree of enforcement of these provisions remains to be seen and may vary from state to state. Moreover, insurance licensees may be able to argue successfully to state regulators that their particular service provider arrangements do necessitate an oversight obligation for reasons similar to those discussed above. For example, the oversight of service providers

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48. Model Safeguarding Regulation, *supra* note 2, § 2.E.

49. *Id.* § 8.

50. Comments submitted by: American Council of Life Insurers [hereinafter ACLI], at 1–2 (Aug. 31. 2001) and 1 (Dec. 5, 2001); National Association of Independent Insurers [hereinafter NAII], at 1–2 (Dec. 5, 2001); American Association of Health Plans [AAHP], at 3 (Aug. 31, 2001); AIA comments, *supra* note 27; Principal Life Insurance Co. [hereinafter Principal], at 2 (Aug. 31, 2001).

51. AIA comments, *supra* note 27.

52. AIA comments, *supra* note 27, at 3–4 (Aug. 31, 2001) and 2–3 (Dec. 5, 2001).

53. ACLI comments, *supra* note 50, at 1–2 (Aug. 31. 2001) and 1 (Dec. 5, 2001).

54. NAII comments, *supra* note 50, at 1–2; AAHP comments, *supra* note 50, at 3; Principal comments, *supra* note 50, at 2.

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generated a great deal of comment during consideration of the federal banking guidelines. In response, the federal banking agencies suggested that the level of oversight necessary will be affected by a number of factors and may vary among different types of financial institutions and different types of service providers.[55] The agencies even suggested that some factors might absolve a licensee from any obligation to monitor a service provider.[56] One such factor is where the service provider is already subject to the federal banking guidelines or a similar regulatory scheme for safeguarding customer information:

> A financial institution need only monitor its outsourcing arrangements if such oversight is indicated by an institution's own risk assessment. The Agencies recognize that not all outsourcing arrangements will need to be monitored or monitored in the same fashion. Some service providers will be financial institutions that are directly subject to these guidelines or other standards promulgated by their primary regulator under section 501(b). Other service providers may already be subject to legal and professional standards that require them to safeguard the institution's customer information. Therefore, the final guidelines permit an institution to do a risk assessment taking these factors into account and determine for themselves which service providers will need to be monitored.[57]

Because the service provider provisions of the Model Safeguarding Regulation closely follow the corresponding provisions of the federal banking guidelines,[58] and are only suggestions rather than binding requirements, an insurer or other licensee should be able to argue for a similar interpretation of any state regulation based on the model.

4. The Model Safeguarding Regulation Does Not Impose Absolute Liability.

An important question for any insurer or licensee is whether the state safeguarding regulation gives rise to absolute regulatory liability for every security breach. This precise issue was raised and decided in the negative during consideration of the federal banking guidelines.

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55. 66 Fed. Reg., *supra* note 41, at 8623–24.
56. *Id.* at 8624.
57. *Id.*
58. *Id.* at 8639.

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As initially drafted, the federal banking guidelines stated that a bank's ISP "shall" ensure the security and confidentiality of customer information and protect against anticipated threats and unauthorized access or use of such information.[59] Such mandatory language arguably imposed absolute liability for all breaches regardless of the underlying circumstances or the efforts of the bank to prevent the breach. Not surprisingly, the banks objected to the provision, pointing out that no ISP could ensure the absolute protection of customer information. In response, the federal banking agencies softened their position by stating that GLB does not "mandate a standard of absolute liability for a financial institution that experiences a security breach," and revising the guidelines to state that an ISP "shall be designed" to accomplish its objectives.[60]

The Model Safeguarding Regulation adopted the "shall be designed" language of the revised federal banking guidelines and its corresponding flexibility.[61] Thus, an ISP may satisfy the regulation even though it fails to prevent a particular security breach. This is an important component of the Model Safeguarding Regulation that should provide at least some solace to insurers and other state insurance licensees.

5. Violation May Be Unfair Trade Practice and Give Rise to Private Right of Action.

Early drafts of the Model Safeguarding Regulation provided that a violation of its requirements "shall be deemed . . . an unfair method of competition or an unfair or deceptive act and practice in the conduct of the business of insurance."[62] For obvious reasons, this provision received substantial criticism.

First, given the lack of specific standards about what constitutes a satisfactory ISP, some licensees were concerned that a single or unintentional failure would be deemed an unfair method of competition or an unfair or deceptive trade practice. They argued that such a sanction should be reserved for those instances in which a licensee consistently or intentionally fails to implement an ISP designed to meet the regulation's objectives.[63]

59. *Id.* at 8619–20.
60. *Id.* at 8620.
61. Model Safeguarding Regulation, *supra* note 2, § 4.
62. Black-lined version of the Draft Model Safeguarding Regulation (Feb. 28, 2002).
63. NAII comments, *supra* note 50, at 2.

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Second, the GLB does not create a private right of action for enforcement of its privacy protections.[64] However, some respondents noted that treating a violation as an unfair trade practice might create a private right of action against state insurance licensees because some state laws provide consumers with a private right of action to challenge unfair methods of competition or unfair trade practices.[65] In such states, the mere allegation of a violation of the Model Safeguarding Regulation, as initially drafted, could have exposed a licensee to private litigation in addition to sanctions from a state insurance department. Because this was presumably not the intent of Congress when crafting GLB's privacy provisions, some suggested that the language of the earlier drafts be deleted entirely, or at least qualified by a drafting note stating that GLB does not contemplate the availability of a private right of action for such violations.[66]

These criticisms yielded some changes to the Model Safeguarding Regulation although they failed to address the fundamental concerns that respondents raised. The Working Group eventually dropped the criticized language and substituted a drafting note in its place directing state regulators to "[c]ite [their] Unfair Trade Practices Act or other applicable state law" as the determined violation for any breach of the Model Safeguarding Regulation.[67] Thus, although state regulators are free to craft their safeguarding rules in a manner that deems any violation of those rules to be an unfair or deceptive trade practice, they are no longer required to do so. Critics of the provision view the removal of this presumption as a positive development. The Working Group essentially avoided the difficult issues of whether a single violation of the Model Safeguarding Regulation triggers a corresponding sanction or remedy, and whether that sanction or remedy includes a private right of action. Litigation is inevitable if the states also remain silent on these two issues when they adopt or modify the model regulation.

6. The Model Safeguarding Regulation Does Not Contain an Agent Exemption.

In theory, the reach of the Model Safeguarding Regulation and the Model Notice and Disclosure Regulation are identical. Both regulations

64. *See e.g.,* William Sweet, Jr., et al., *Privacy Provisions of the Gramm-Leach-Bliley Act,* SEA1 ALI-ABA 221, 231–32 (Feb. 3, 2000); Cecilia Kempler & Robert Woody, *Living with the Gramm-Leach-Bliley Act Privacy,* 1185 PLI/Corp 205, 220 (2000).

65. Sweet, *supra,* note 64, at 233; Kempler & Woody, *supra* note 64, at 220.

66. AIA comments, *supra* note 27.

67. Model Safeguarding Regulation, *supra* note 2, § 10, Drafting Note.

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impose their respective obligations on "licensees" as that term is defined in the Model Notice and Disclosure Regulation.[68] In practice, however, the Model Safeguarding Regulation will affect a larger number of licensees because, unlike the Model Notice and Disclosure Regulation, it does not contain an agent exemption. The distinction between the two regulations in this regard reflects the different objectives of each.

The general objectives of the Model Notice and Disclosure Regulation are to inform individual customers or consumers of the information-sharing practices of licensees and provide them with a means to exercise some control over their own nonpublic personal information. Accordingly, the regulation requires licensees to send initial and/or annual privacy notices that provide customers or consumers with an opportunity to opt out of such policies and practices insofar as their own nonpublic personal information is concerned.[69] The regulation expressly exempts, however, agents from these notice and opt-out requirements if (1) the agent is an employee or agent of another licensee (the principal); (2) the principal provides the notice and opt out opportunity required by the regulation; and (3) the agent does not disclose any nonpublic personal information to any person other than the principal or its affiliates.[70] The rationale is the avoidance of redundancy: If the agent is not going to disclose nonpublic personal information to anyone other than the principal, and the principal has already supplied a notice and opt-out opportunity to the customer or consumer, no purpose would be served by requiring the agent to supply another notice and opt-out opportunity.[71]

The objective of the Model Safeguarding Regulation is to protect the integrity and confidentiality of a customer's nonpublic personal information held by any licensee. A customer's nonpublic personal information may fall into the hands of many licensees over the course of the insurance relationship. A principal's compliance with the Model Safeguarding Regulation does not necessarily prevent an agent from failing to adequately protect the same information. To protect such information, the obligations of the Model Safeguarding Regulation must extend to all licensees possessing such information without exception. As a result, agents who are exempt from the notice and opt-out requirements of the

68. *Id.* § 2.D; Model Notice and Disclosure Regulation, *supra* note 5, § 4(Q).

69. Model Notice and Disclosure Regulation, *supra* note 5, §§ 5–8.

70. *Id.* §§ 4.Q(2).

71. Privacy Issues Working Group Q&A, at 1 (Mar. 18, 2001), *available at* http://www.naic.org/1privacy/naic_privacy_publications.htm.

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Model Notice and Disclosure Regulation are not exempt from the safeguarding requirements of the Model Safeguarding Regulation.

7. The Model Safeguarding Regulation May Apply to Nonpublic Personal Health Information.

A given state's safeguarding regulation may establish standards for protecting nonpublic personal health information in addition to nonpublic personal financial information. As explained above, the Model Safeguarding Regulation imposes standards for protecting "customer information,"[72] which is defined as "nonpublic personal information," as that term is defined in a state's privacy regulation corresponding to the Model Notice and Disclosure Regulation.[73] The disclosure regulation includes both nonpublic personal financial information and nonpublic personal health information.[74] Thus, if a state adopts the definition of nonpublic personal information contained in the Model Notice and Disclosure Regulation, the state safeguarding regulation, assuming that it adopts the Model Safeguarding Regulation, will protect both financial and health information.[75] However, if a state follows the lead of at least fifteen jurisdictions and adopts a definition of nonpublic personal information that is limited to financial information,[76] its safeguarding regulation will not protect nonpublic personal health information.

There may well be other statutes or regulations on the books that impose standards for safeguarding individual health information.[77] For instance, the NAIC's 1982 Model Act would apply to any individually identifiable information regardless of whether it constitutes financial, health, or some other type of information.[78] Also, in 1998, the NAIC adopted the Health Information Privacy Model Act, which focuses solely on the protection of health information and contains certain safeguarding-

72. Model Safeguarding Regulation, *supra* note 2, § 1.A.

73. *Id.* § 2.B.

74. Model Notice and Disclosure Regulation, *supra* note 5, §§ 4.S.

75. For example, New York's safeguarding regulation protects both financial and health information, *see* N.Y. COMP. CODES R. & REGS., *supra* note 7, Tit. 11, § 421.0(d) (2001), as does West Virginia's emergency safeguarding rule, *see* West Virginia Secretary of State Notice of an Emergency Rule, *supra* note 7, §§ 114–62–1.1; 114–62–2.2, and Utah's proposed safeguarding rule. *See* Utah Ins. Dep't Proposed New Rule, *supra* note 7, §§ R590–216–2(4); R590–216–3(2).

76. *See supra* note 6.

77. *Id.*

78. *See generally* 1982 Model Act, *supra* note 6.

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type provisions.[79] Licensees should conduct a thorough review of the laws in those jurisdictions in which they do business to determine the full extent of their safeguarding obligations, both generally and in connection with developing an appropriate ISP.

8. Health Insurers Beware!

Complicating matters even further is the problem that both state and federal regulations safeguarding health information of individuals may apply to health insurers, health maintenance organizations, and health insurance service providers. In addition to any applicable state regulations, these entities are also be subject to federal safeguarding rules imposed by the Department of Health and Human Services[80] under the "administrative simplification" provisions (a clear misnomer to anyone who has had occasion to review them) of the Health Insurance Portability and Accountability Act of 1996.[81] Both the final HHS rule on Standards for Privacy of Individually Identifiable Health Information,[82] and the proposed HHS rule[83] on Security and Electronic Signature Standards contain safeguarding obligations, and the latter specifically addresses electronic health information.[84] Failure to comply with these rules can expose a covered entity to substantial civil and criminal penalties.[85]

A detailed analysis of the HIPAA rules is beyond the scope of this article, but some notable aspects of the interplay between those federal rules and potential state safeguarding rules include the following:

> The HIPAA Rules, as currently issued or proposed, will not apply to certain insurers: accident and/or disability, liability (including general liability and auto), workers' compensation, credit-only, and/or other insurers who provide coverage identified as including benefits for medical care that are secondary or incidental to other insurance benefits.[86]

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79. *See generally* Health Information Privacy Model Act, NAIC Model Laws Regulations and Guidelines (#55), [hereinafter the 1998 Model Act.]

80. Hereinafter HHS.

81. 42 U.S.C. §§ 1320d through 1320d-8 [hereinafter HIPPA.]

82. 45 C.F.R. § 164.530(c) [hereinafter the HHS privacy rule.]

83. Hereinafter collectively the HIPAA rules.

84. 63 Fed. Reg. 43242–80 (Aug. 12, 1998) [hereinafter the HHS Security Rule.]

85. 42 U.S.C. §§ 1320d-5; 1320d-6. Note that most health plans and health care providers do not have to comply with the HHS privacy rule until April 14, 2003. 66 Fed. Reg. 12434 (Feb. 26, 2001).

86. 45 C.F.R. § 160.103; 42 U.S.C. § 300gg-91(c)(1).

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Entities subject to both the HIPAA rules and a state safeguarding rule applicable to health information will have to evaluate whether the state rule is preempted by the federal rule.[87] Such an evaluation will be governed by the complicated preemption analysis described in the HIPAA Rules.[88]

Some commentators suggested during the public comment period that the Model Safeguarding Regulation provide that any licensee who complies with the HIPAA rules is deemed in compliance with the Model Safeguarding Regulation.[89] The Working Group included a similar provision in the Model Notice and Disclosure Regulation,[90] but failed to do so with the Model Safeguarding Regulation.

II. STATE ENFORCEMENT AND IMPLEMENTATION OF GLB'S SAFEGUARDING PROVISION

It is important to remember that, although the GLB's privacy protections are federal mandates, their implementation vis-à-vis the insurance industry falls to the applicable state insurance authorities through the development of state laws, regulations, or both.[91]

A. Express State Action

GLB imposes certain limited consequences upon any state that fails to adopt regulations implementing the objectives of GLB's privacy provisions, including GLB's safeguarding provision, by the effective date of the Act.[92] The Act specifically precludes such states from overriding the regulation of bank insurance sales by federal banking agencies.[93] To date, only a handful of states have expressly addressed GLB's safeguarding provision, leading the General Accounting Office to express concern about the pace of state implementation in its draft report on state implementation of GLB's privacy provisions.[94] At least six states, as noted below, have take some action on GLB's privacy requirements.

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87. 66 Fed. Reg., *supra* 41, at 8624.

88. 45 C.F.R. §§ 160.201 through 160.312 (2002).

89. *See* AAHP comments, *supra* note 50, at 1 (Aug. 31, 2001); *see also* N.Y. COMP. CODES R. & REGS., *supra* note 7, tit. 11, § 421.0 (d).

90. Model Notice and Disclosure Regulation, *supra* note 5, §§ 20.

91. *See* Pub. L. No. 106–102, 113 Stat. 1338, § 505(a)(6) (1999) (codified as amended at 15 U.S.C. § 6805 (2001).

92. GLB § 505(b), (c).

93. GLB § 505(c).

94. Minutes of Meeting of Privacy Issues Working Group, *supra* note 10, at 2.

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1. New York Regulation 173

New York formally promulgated its safeguarding regulation in February 2002 although compliance was not required until June 1, 2002.[95] The New York regulation is identical to the Model Safeguarding Regulation in all material respects, with one notable exception. It maintains the language stricken from the final version of the Model Safeguarding Regulation that treats a violation of the regulation as an unfair trade practice:

> A contravention of Section 421.2, Section 421.3, or Section 421.10 of this Part shall be deemed to be an unfair method of competition or an unfair or deceptive act and practice in the conduct of the business of insurance in this state, and shall be deemed to be a trade practice constituting a determined violation, as defined in Section 2402(c) of the Insurance Law, in violation of Section 2403 of such law.[96]

A private right of action does not exist in New York for a violation of the unfair trade practices act contained in New York's Insurance Law.[97] Licensees and practitioners will need to consider, however, whether a violation of New York's safeguarding regulation could also be deemed a violation of the unfair trade practices act contained in New York's General Business Law, which does create a private right of action.[98]

2. Oregon's Temporary Administrative Rule

Oregon adopted a temporary safeguarding rule on May 20, 2002, that took effect on July 1, 2002, and is to remain in effect at least until December 15, 2002.[99] The Oregon rule is identical to the Model Safeguarding Regulation,[100] with the exception of its definition of customer information. Oregon had previously adopted the 1982 Model Act and, accordingly, has not adopted the Model Notice and Disclosure

95. N.Y. COMP. CODES R. & REGS., *supra* note 7, tit. 11, § 421.10.

96. *Id.* § 421.9.

97. Gucciardi v. Reliance Ins. Co., 84 F. Supp.2d 399, 403–04 (E.D.N.Y. 2000) (applying New York law).

98. N.Y. GEN. BUS. L. § 349 (McKinney 2002); *see also* Northwestern Mut. Life Ins. Co. v. Wender, 940 F. Supp. 62, 64–5 (S.D.N.Y. 1996) (applying New York law).

99. Or. Dep't of Consumer & Bus. Serv., Ins. Div., Certificate and Order for Filing Temporary Administrative Rules (May 20, 2002), *available at* http://www.cbs.state.or.us/external/ins/docs/rules/recent_adopt/id14-2002_c&o.pdf.

100. *See* OR. ADMIN. R., *supra* note 7, §§ 836-081-0100 through 836-081-0125.

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Regulation.[101] Consequently, Oregon's definition of customer information does not incorporate the regulation's definition of "nonpublic personal information," but instead incorporates the definition of "personal information" contained in its version of the 1982 Model Act:

> "Personal information" means information which is identifiable with an individual, which is gathered in connection with an insurance transaction and from which information judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit, health or any other personal characteristics. "Personal information" includes an individual's name and address, an individual's policy number or similar form of access code for the individual's policy and "medical record information" but does not include "privileged information" except for privileged information which has been disclosed in violation of ORS 746.665. "Personal information" does not include information that a licensee has a reasonable basis to believe is lawfully made public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law.[102]

Other notable aspects of the Oregon rule include the following:

> (1) If a licensee is domiciled in another jurisdiction or subject to the primary jurisdiction of a different functional regulator, and the rules of that jurisdiction or regulator establish safeguarding standards that are substantially similar to those established by the Oregon rule, good faith compliance with the safeguarding rules of the other jurisdiction or regulator shall constitute compliance with the Oregon rule;[103]
>
> (2) Consistent with the Model Safeguarding Regulation, the rule only applies to *customer* information but nonetheless requires licensees to "give due consideration to whether its customer information security procedures, or some modified version thereof, should also apply to

101. *See generally* OR. REV. STAT. §§ 746.600 through 746.690 (2002).
102. *Id.* § 746.600(22) (2002).
103. *Id.* § 836-081-0110(2).

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personal information and sensitive commercial information derived from non-customer sources;"[104] and
(3) Any violation of the rule is deemed an unfair trade practice, but current Oregon law does not appear to recognize a private right of action for such a violation.[105]

3. West Virginia's Emergency Rule

West Virginia filed its emergency safeguarding rule on May 29, 2002, to take effect no later than July 10, 2002.[106] The West Virginia rule is identical to the Model Safeguarding Regulation in most respects, with one material exception: it protects consumer information in addition to customer information.[107] As in Oregon, however, a foreign licensee's good faith compliance with the safeguarding rules of its domiciliary jurisdiction will suffice so long as those rules are substantially similar to West Virginia's rule. The fact that the former only extend to customer information will not render such rules dissimilar so long as "the licensee is not implementing its information security program in a manner that causes demonstrable harm to consumers who are not present or former customers."[108] Under West Virginia law, a violation of the emergency safeguarding rule may give rise to a private right of action.[109]

4. California's Proposed GLB Regulation

California formally proposed a GLB regulation implementing both the "notice and disclosure" and "safeguarding" provisions of the Act on December 4, 2001.[110] A public hearing was held on February 8, 2002, and a revised version of the proposed regulation was released for public comment on May 23, 2002.[111] The safeguarding provisions of the revised

104. *Id.* § 836–081–0110(3).

105. *Id.* § 836–081–0125; *see also* Serles v. Beneficial Oregon, Inc., 756 P.2d 1266, 1270 (Or. Ct. App. 1988).

106. *See* West Virginia Secretary of State Notice of an Emergency Rule, *supra* note 7, §§ 114–62–1 through 114–62–6.

107. *Id.* § 114–62–3.1.

108. *Id.* § 114–62–3.2.

109. W. VA. CODE § 55–7-9 (2002); *see also* Jenkins v. J.C. Penney Cas. Ins. Co., 280 S.E.2d 252, 254–58 (W.Va. 1981), *overruled on other grounds,* State *ex rel.* State Farm Fire & Cas. Co. v. Madden, 451 S.E.2d 721 (W.Va. 1994); *see also* W. VA. CODE §§ 33–3-11 and 33–12–24 (2002).

110. Cal. Dep't of Ins. Proposed Reg., File No. RH-01018269, §§2689.1 *et. seq.* (Dec. 4, 2001).

111. Cal. Dep't of Ins. Revised Proposed Regulation Text, File No. RH01018269, §§2689.12 through 2689.20 (May 23, 2002).

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version of California's proposed regulation are identical to the Model Safeguarding Regulation in all material respects.[112] Of importance, however, the initial draft of the proposed regulation departed from the Model Safeguarding Regulation in one important respect: The draft treated the examples of how to implement the Model Safeguarding Regulation as mandatory methods,[113] thus threatening to impose burdens upon California licensees similar to those imposed upon banks by the federal banking guidelines. Thus, California's decision to adopt the original approach of the Model Safeguarding Regulation is a positive development for California licensees. The revised version also provides that violations will be subject to the administrative enforcement provision of California's version of the NAIC's 1982 Model Act, which does not appear to provide a private right of action,[114] "and any other enforcement provisions available to the Commissioner."[115] This language seems to preclude any suggestion that a violation of the California safeguarding regulation, in its current form, would give rise to a private right of action.

5. Utah's Proposed Rule

Utah conducted a public hearing on its proposed safeguarding rule on June 5, 2002, and the most recent public comment period ended June 14, 2002.[116] The safeguarding provisions of Utah's proposed rule are identical to the Model Safeguarding Regulation in all material respects.[117] Moreover, a violation of the proposed rule will not give rise to a private right of action.[118]

6. Michigan's Safeguarding Legislation

Michigan passed legislation, effective June 18, 2001, that requires licensees to "adopt policies and procedures for administrative, technical, and physical safeguards for the protection of customer records and information."[119] Such policies and procedures must be based on guidelines

112. *Id.*

113. Cal. Dep't of Ins. Revised Proposed Reg., *supra* note 111, §§ 2689.16 through 2689.19.

114. CAL. INS. CODE § 791.15. (2001).

115. *See* Cal. Dep't of Ins. Revised Proposed Reg., *supra* note 111, § 2689.20.

116. *See* Utah Insurance Department's discussion of the proposed safeguarding rule, *available at* http://www.insurance.utah.gov/ruleindex.html.

117. *See* Utah Ins. Dep't Proposed New Rule, *supra* note 7.

118. *Id.* § R590–216–7; *see also* Johnson v. Life Investors Ins. Co. of Am., 996 F. Supp. 1105, 1109 (D. Utah 1998), *rev'd on other grounds,* 216 F.3d 1087 (10th Cir. 2000).

119. MICH. COMP. LAWS § 500.547 (2002).

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that the Michigan insurance commissioner is directed to develop and adopt consistent with the safeguarding provisions of GLB.[120] To date, no such guidelines had been issued.

B. Alternative State Enforcement Powers?

Some state regulators believe that they can enforce GLB's safeguarding provision, even in the absence of an express state law or regulation. These regulators typically assume they can enforce GLB's safeguarding provision through the state's unfair trade practice laws,[121] an opinion that seems to be shared by the NAIC Privacy Issues Working Group. A privacy question-and-answer issued by the Working Group states that "[i]nsurers are required to comply with GLB's privacy provisions even in the absence of state regulations enforcing such provisions" and that "[s]ome states have determined that they have authority to enforce GLB's privacy provisions even in the absence of specific regulations based on state unfair trade practices laws or similar laws."[122]

This assumption is open to serious questions, particularly with respect to GLB's safeguarding provision. First, it is not at all clear that GLB's safeguarding provision can be enforced against an insurer or other licensee absent a state regulation setting forth an enforceable standard. Unlike GLB's notice and disclosure provisions, GLB's safeguarding provision does not contain detailed requirements from which a state regulator, let alone an insurance licensee, could divine, implement, or enforce an appropriate safeguarding standard.[123] Second, again unlike GLB's notice and disclosure provisions, the safeguarding provision does not place an express, direct obligation on financial institutions to safeguard customer information. Rather, while generally stating that the imposition of such "affirmative and continuing obligation[s]" on financial institutions is "the *policy* of the Congress," the safeguarding provision ultimately leaves it to federal and state regulatory authorities to craft and impose such obligations

120. *Id.*

121. For example, the author recently exchanged correspondence with a representative of the Minnesota Department of Commerce who explained that, even in the absence of a specific state statute or rule enforcing GLB, "it is our intention to allege a violation of the unfair trade practices act under [our state] statutes. . . . and/or to enforce GLB directly through action in district court."

122. *See* http://www.naic.org/1privacy/naic_privacy_publications.htm.

123. GLB § 501(b) (1999).

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through appropriate rules and regulations.[124] Indeed, Section 505(b) of the act expressly requires state insurance authorities "to implement the standards prescribed under section 501(b) [*i.e.*, the safeguarding provision] *by rule* with respect to the financial institutions and other persons subject to their respective jurisdictions . . . ."[125] Thus, absent a state law or rule of some binding authority imposing safeguarding obligations upon a state insurance licensee, it is doubtful that a state regulator has the means to enforce GLB's safeguarding provision.

CONCLUSION

If you are an executive or compliance officer for an organization that is a state insurance licensee, or if you are an attorney representing such entities, you need to understand your employer's and/or clients' obligations under the Model Safeguarding Regulation. You also need to monitor the developing response to the Model Safeguarding Regulation in those states where your employer and/or clients do business. If you work for or represent a licensee already subject to a safeguarding regulation, understand that the licensee needs to begin the process of preparing an ISP. The licensee may need to start from scratch. It may have developed isolated safeguards over the years as and when substantial risks were identified. Or it may have in place a comprehensive set of safeguards that require only minor adjustment or documentation. Whatever the current state of the licensee's safeguarding methods may be, the licensee should consult with qualified legal counsel to determine what (if anything) needs to be done to bring the organization into compliance with applicable state and federal safeguarding regulations.

124. *Id.* § 501(b) (emphasis added).
125. *Id.* § 505(b) (emphasis added).

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INSURING PRIVACY: IS YOUR COMPANY COVERED?

*Matthew J. Schlesinger and Jason M. Silverman**

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INTRODUCTION

Privacy is emerging as one of the hottest cyber-tort liability issues of the new millennium. Common law, as well as various statutes and regulations, have protected the right to privacy for years. But with the proliferation of Internet use, the public has become keenly aware of the ease with which private information can be obtained and disseminated in the e-commerce age. As a result, federal and state governments have enacted new laws that create additional potential liability for companies that transact business through the Internet, and several parties have instituted a number of high-profile breach-of-privacy lawsuits in the past few years.

In this era of increasing risk, many companies who engage in e-commerce have recognized the potential importance of insurance coverage

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for privacy claims or lawsuits. Traditional comprehensive general liability[1] policies, the most common type of business insurance, as well as new specialized Internet policies, may provide coverage for privacy claims. But the wording of particular policies is critical, and coverage disputes in this relatively untested area are likely. After briefly setting forth the most common types of privacy-related liabilities that companies face today, this article examines the potential for coverage for privacy claims and the possible battle lines along which insurers and insureds may face off as liabilities are incurred and claims are made.

I. LIABILITY FOR PRIVACY VIOLATIONS

Breach-of-privacy suits can stem from common law, as well as federal and state statutes. Under common law, privacy torts generally include the following: (1) unreasonable intrusion upon the seclusion of another; (2) appropriation of another person's name or likeness; (3) unreasonable publicity given to another's private life; and (4) portrayal of an individual in a false light.[2] At the federal level, various laws exist that protect privacy rights online. This legislation includes the Electronic Communications Privacy Act (prohibiting unauthorized access to computers);[3] the Wiretap Act (prohibiting the interception of data as well as knowing disclosure of such illegally obtained data);[4] the Children's Online Privacy Protection Act (regulating the gathering of information from children);[5] and the Gramm-Leach-Bliley Act (regulating the collection and distribution of personal and

1. Hereinafter CGL.

2. RESTATEMENT (SECOND) OF TORTS §§ 652A–652E (1977).

3. 18 U.S.C. §§ 2701–2711 (2000) (hereinafter ECPA). In addition to forbidding unauthorized access to computers, the ECPA also contains a prohibition against intentionally "[exceeding] an authorization to access" a "facility through which an electronic communication service is provided." Under the section of this statute granting a private civil right of action against violators, 18 U.S.C. § 2707 (2000), plaintiffs have alleged that the placement and subsequent access of "cookies" by an Internet site on a user's computer constitutes such unauthorized access. *In re* Intuit Privacy Litig., 138 F. Supp. 2d 1272, 1277 (C.D. Cal. 2001).

4. 18 U.S.C. §§ 2510–2522 (2000). Like the ECPA, the Wiretap Act also authorizes a private civil right of action. 18 U.S.C. § 2520 (2000).

5. 15 U.S.C. §§ 6501–6506 (2000). The statute regulates the collection of "personal information," such as the child's first and last name, home address, e-mail address, telephone number, and Social Security number. The Federal Trade Commission may add other categories of information as well. 15 U.S.C. § 6501 (2000).

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financial information by "financial institutions," including banks and insurers).[6]

A new significant bill concerning on-line privacy is currently pending in Congress, introduced in the Senate on April 18, 2002, by Sen. Ernest Hollings (D.–S.C.).[7] This bill would require website operators and Internet service providers to obtain consent from customers or users before collecting and disclosing certain types of information. The type of consent to be obtained would depend upon the degree of sensitivity of the information. Companies transacting business through the Internet would have to obtain *affirmative* consent from a consumer before collecting "sensitive personally identifiable information" from that person. "Sensitive personally identifiable information" includes race, political party affiliation, religious beliefs, sexual orientation, Social Security number, and certain financial information. For other kinds of less sensitive information (including, for example, name, e-mail address, and telephone number), Internet companies would be required to provide consumers "robust notice" and an opportunity to "opt out," or decline, consent. A private right of action would be granted to consumers to pursue alleged violations.[8] Several major high-tech firms have voiced opposition to this proposed legislative scheme,[9] and, if passed in its current form, this bill would present additional privacy liability exposure to companies doing business on the Internet.

Further, the government appears to be stepping up its privacy enforcement activity. The Chairman of the Federal Trade Commission recently stated, "I think there is a great deal we can do under existing laws to protect consumer privacy. . . . At this time, we need more law enforcement, not more laws," and "[w]e will increase our enforcement of

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6. 15 U.S.C. §§ 6801–6809 (2000). The Gramm-Leach-Bliley Act restricts release by financial institutions specifically of "nonpublic personal information" to third parties unaffiliated with the financial institution. "Nonpublic personal information" is defined as "personally identifiable financial information (i) provided by a consumer to a financial institution; (ii) resulting from any transaction with the consumer or any service performed for the consumer; or (iii) otherwise obtained by the financial institution." 15 U.S.C. § 6809 (2000).

7. Online Personal Privacy Protection Act, S. 2201, 107th Cong. (2002).

8. *Id.*

9. Andy Sullivan, *High-Tech Firms Criticize Online Privacy Bill* (Apr. 25, 2002), *available at* http://reuters.com/newsarticle.jhtml?type=technologynews&storyID=883562.

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laws protecting consumer privacy."[10] In addition to governmental enforcement of privacy laws, claims are also being asserted against companies by private individuals, alleging violations of federal and state privacy laws.[11]

Companies can expose themselves, often inadvertently, in numerous ways to the application of a myriad of privacy laws and regulations. Recently, for example, Eli Lilly & Company, manufacturer of Prozac, mistakenly released, through e-mail, the e-mail addresses of 669 people who had registered for Lilly's e-mail medication reminder service.[12] Also, domain-name registrar Network Solutions, Inc., is reported to have forwarded to some of its customers the private e-mails of other customers sent to Network Solutions' support department requesting help.[13] In this Internet age, protecting private information has indeed become a daunting task for most companies.

II. HOW MANY TYPES OF PRIVACY CLAIMS ARE COVERED UNDER STANDARD CGL POLICIES?

CGL policies provide coverage for defense costs and liabilities resulting from injury or damage to third parties allegedly caused by the insured. These policies typically cover four categories of liability: property damage, bodily injury, personal injury, and advertising injury. Invasion of privacy has been covered under CGL policies for some time under the personal and advertising injury coverage grants. Typically, CGL policies provide coverage for "injury arising out of . . . [o]ral or written publication of material that violates a person's right of privacy."

Relatively few cases discuss coverage under CGL policies for invasion-of-privacy claims. Of those decided, most arise in the context of

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10. Remarks of Timothy J. Muris, *Protecting Consumers' Privacy: 2002 and Beyond,* The Privacy 2001 Conference, Cleveland, Ohio (Oct. 4, 2001), *available at* http://www.ftc.gov/speeches/muris/privisp1002.htm; *see also* Thomas M. Regan & Matthew F. Henry, *Federal Trade Commission—Loosening the Reins on Online Privacy,* MEALEY'S LITIGATION REPORT: CYBER TECH & E-COMMERCE 35–43 (Apr. 2002).

11. *See, e.g., In re* Intuit Privacy Litig., 138 F. Supp. 2d 1272 (C.D. Cal. 2001); *In re* DoubleClick Inc. Privacy Litig., 154 F. Supp. 2d 497 (S.D.N.Y. 2001); Crowley v. CyberSource, Inc., 166 F. Supp. 2d 1263 (N.D. Cal. 2001) (Wiretap Act, *supra* note 4, and ECPA, *supra* note 3, among others).

12. *See Eli Lilly Settles FTC Charges Concerning Security Breach* (Jan. 18, 2002), *available at* http://www.ftc.gov/opa/2002/01/elililly.htm.

13. Robert Lemos, *NSI Customers Report Privacy Breach* (June 20, 2001), *available at* http://news.com.com/2100–1001–268781.html?legacy=cnet.

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various types of actions brought by employees against employers. Courts have found coverage for alleged privacy violations where, as examples, an employee was singled out for a drug test,[14] false information was placed in a personnel file,[15] and an employer threatened to disclose private information about an employee.[16]

In a case decided earlier this year, *St. Paul Guardian Insurance Co. v. Centrum GS, Ltd.*,[17] an employer that terminated an employee subsequently posted "wanted posters" with the former employee's picture, name, home address, and driver's license, automobile tag, and Social Security numbers. The poster implored anyone who saw the former employee to call security. The insurance company argued that the former employee's breach-of-privacy claim was not covered because the privacy violation did not stem from the "business activity" of the insured, a building owner/manager. The Fifth Circuit disagreed. Noting the insured's responsibility for protecting the building and the safety of its tenants, the court found as follows:

> In light of the potential duty and perceived risk, Appellants posted information concerning a perceived risk to the Centrum Building and its tenants in a place where it could be viewed and appropriately used. Giving the term "business activity" its plain meaning, Appellants' actions were consistent with their business of owning and managing property.[18]

In one nonemployment case, *St. Paul Fire & Marine Insurance Co. v. Green Tree Financial Corp.*,[19] liability for harassing telephone calls made by a debt collection agency that were said by the court to "offend a reasonable person of ordinary sensibilities" was found to trigger CGL coverage. The calls were allegedly "rude and abusive" and occurred over the course of an eight-year period.[20] The insurance policy covered personal injury arising out of "written or spoken material made public which violates an individual's right of privacy."[21] The insurer argued "that it was not obligated to defend [the insured] because the claimants' pleadings did

14. Ellis v. Transcontinental Ins. Co., 619 So. 2d 1130 (La. Ct. App. 1993).
15. City of Old Town v. Am. Employers Ins. Co., 858 F. Supp. 264 (D. Me. 1994).
16. Great Am. Ins. Co. v. Hartford Ins. Co., 621 N.E.2d 796 (Ohio Ct. App. 1993).
17. 283 F.3d 709 (5th Cir. 2002).
18. *Id.* at 714.
19. 249 F.3d 389 (5th Cir. 2001).
20. *Id.* at 394.
21. *Id.* at 393.

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not specifically allege an offense covered by the personal injury terms of its policies," such as invasion of privacy.[22] The court, however, found the allegations to trigger the insurer's duty to defend because "the factual allegations in [the] case clearly [supported] a cause of action for invasion of privacy under Texas law."[23]

III. POSSIBLE CGL POLICY BATTLEGROUNDS FOR POLICYHOLDERS AND INSURERS ON PRIVACY CLAIMS

A. The "Publication" Requirement

In the context of the Internet, the scope of privacy coverage in most CGL policies may be argued by insurers to be limited in at least two ways that could leave some e-commerce companies unprotected. First, CGL policies typically require a privacy violation to be based on an "oral or written *publication* of material." The word "publication" is undefined in CGL policies, and courts may find themselves grappling with the term's proper interpretation in the Internet age. Internet privacy "violations," for example, can often involve the sale or dissemination of private information to a discreet set of businesses or organizations, as opposed to the public at large. Does sending e-mails containing private information to a limited number of people constitute a "publication of material?"[24]

Outside the insurance context, some courts construe "publication" to include utterances to just one other person, or perhaps to a few. For example, in *Ratts v. Board of County Commissioners,*[25] the court construed the "publication" element of the tort of "false light publicity" simply as "publication of some kind to a third party." Few courts, however, have interpreted the term "publication" as it relates to coverage for privacy claims. In one recent insurance case, however, the court found that simply "*telling* members of the local community" private facts constituted "publication" for purposes of triggering CGL privacy coverage.[26]

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22. *Id.* at 394.

23. *Id.* at 394–95.

24. *See supra* notes __, __.

25. 141 F. Supp. 2d 1289, 1324 (D. Kan. 2001). *But see* L&D of Oregon, Inc. v. Am. States Ins. Co., 14 P.3d 617, 620 (Or. Ct. App. 2000) ("To constitute an actionable invasion of privacy, a disclosure of private facts must be public in the sense that it was communicated 'either to the public generally or to a large number of persons as distinguished from one individual or a few.'" (citation omitted)).

26. Marleau v. Truck Ins. Exch., 37 P.3d 148, 153–54 (Or. 2001) (emphasis added).

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Further, although decided under language slightly different from that in the standard CGL form, the Fifth Circuit decision in *Green Tree* suggests that not all courts will construe the "publication" requirement to preclude coverage even for underlying invasion-of-privacy torts for which "publication" is not an essential element.[27] In that case, the insurance policy covered "written or spoken material *made public* which violates an individual's right of privacy,"[28] as opposed to the "[o]ral or written *publication* of material that violates a person's right of privacy." Still, the court found coverage for the placement of harassing phone calls—not necessarily the "making public" or publication of private information—because such activity supported a cause of action for breach of privacy under Texas law.[29]

Another reason that the term "publication" should not be limited to the broad dissemination of information may be found in the definition of "advertisement," first found in the 1998 CGL form. In an attempt to preclude coverage for advertising injury resulting from individual sales calls, "advertisement" is defined in the 1998 form as advertising activity involving the broad dissemination of information: "'Advertisement' means a notice that is broadcast or published to the general public or specific market segments about goods, products, or services for the purpose of attracting customers or supporters." Had insurers wanted to limit the term "publication" in the same manner, they could have done so by amending the appropriate policy language.

At the very least, privacy claims involving the misuse of image and likeness on a web page or some other broad electronic dissemination of private information should meet the "publication" requirement. But companies should be aware that insurers may argue that actions that precede publication, such as the improper "gathering" and use of information about a person, are insufficient to constitute a covered CGL privacy claim. Furthermore, unless the term "publication" is construed to encompass the dissemination of information to individuals or small groups, policyholders may be deprived of coverage for a host of privacy offenses not dependent upon the broad dissemination of private information.

27. *See Green Tree Fin. Corp.*, 249 F.3d at 389.
28. *Id.* at 393 (emphasis added).
29. *Id.* at 394.

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B. The "Advertising, Broadcasting, Publishing or Telecasting" Exclusion

A second potential hurdle for e-commerce companies that seek coverage for privacy claims is the CGL policy exclusion that precludes advertising and personal injury coverage for insureds in the business of "advertising, broadcasting, publishing or telecasting."[30] Advertisers and broadcasters must typically purchase separate insurance, often referred to as media coverage, for such exposures. But courts have not yet provided guidance with regard to whether any company with a website could be construed to be an excluded "advertiser."

A company that utilizes its website as little more than an extension of its own brochures and advertisements probably will not be subject to the "advertiser" exclusion. However, as most users of the Internet are aware, the advertising conducted on the websites of companies that do not consider themselves to be "advertisers" or "broadcasters" can be extensive. The banner or pop-up advertisements that appear on many websites are an obvious example. Further, many companies with websites use "cookies" to track online behavior and target advertisements using the information gained.[31] Hence, under the 1998 and earlier CGL forms (currently in widespread use), insurers could argue that a business with a website that displays banner ads, tracks user behavior for marketing purposes, or even includes some "entertainment" component is an excluded advertiser, broadcaster, or publisher, potentially leaving a broad range of companies that transact business over the Internet with no CGL privacy claim protection at all.

Support for the position that the "advertiser" exclusion should be construed narrowly to preclude personal and advertising injury coverage only for true "advertisers, broadcasters, publishers or telecasters" can be found in *American Employers' Insurance Co. v. DeLorme Publication Co., Inc.*[32] The policy at issue in *DeLorme* contained a typical advertiser

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30. Before 1998, the standard CGL form excluded coverage for "[a]dvertising injury arising out of . . . [a]n offense committed by an insured whose business is advertising, broadcasting, publishing or telecasting." In 1998 the exclusion was expanded to include all privacy offenses by such insureds, not just those committed in the course of "advertising," as before.

31. *See, e.g.*, Theodore Grossman & Aaron Grossman, *Lifting the Veil on Internet Privacy*, MEALEY'S CYBER TECH LITIG. REP. (Sept. 2000).

32. 39 F. Supp. 2d 64 (D. Me. 1999).

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exclusion, excluding coverage for advertising injury "arising out of . . . [a]n offense committed by an insured whose business is advertising, broadcasting, publishing or telecasting."[33] The court, construing the language of the exclusion "according to its plain and commonly accepted meaning," held that the exclusion applied to "insureds whose primary, essential, chief or principal business is publishing."[34] Although the court found the exclusion to apply, it did so only because the insured was, in fact, a "publisher," its essential business being the publishing of maps.

Interestingly, too, a new CGL form, published in 2001, should alleviate policyholders' concerns about whether the operation of a website, or even conducting limited "advertising," could preclude them from having personal or advertising injury coverage under their CGL policies. In the new form, the "advertiser exclusion" is renamed as "Insureds in Media and Internet Type Businesses" and has been broadened to exclude website designers and Internet service providers. But with respect to other types of e-commerce companies, the new form also states that "the placing of frames, borders or links, or advertising, for you or others anywhere on the Internet, is not by itself, considered the business of advertising, broadcasting, publishing or telecasting."[35] Further, the definition of "advertisement" has been modified to specifically include for purposes of advertising injury coverage "material placed on the Internet or on similar electronic means of communication." Also, "that part of a web-site that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement" that is covered.[36] Accordingly, the new form clarifies that most companies whose core

33. *Id.* at 72.

34. *Id.* at 81.

35. The exclusion of personal and advertising injury in the new form specifically precludes coverage not only for those whose business is "advertising, broadcasting, publishing or telecasting," but also for those whose business is "[d]esigning or determining content of web-sites for others; or [a]n Internet search, access, content or service provider."

36. "Advertisement" is defined in the new form differently from how it was defined in the 1998 form in two important respects: "'Advertisement' means a notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters. For the purposes of this definition: (a) Notices that are published include material placed on the Internet or on similar electronic means of communication; and (b) Regarding web-sites, only that part of a web-site that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement."

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business is not advertising but who simply use their websites to advertise should not be subject to the "advertiser" exclusion.

IV. PRIVACY COVERAGE UNDER THE NEW E-COMMERCE INSURANCE FORMS

Unfortunately for policyholders, insurers are under pressure from reinsurers to "control or exclude e-commerce risks from general liability policies."[37] At the same time, insurers are marketing a number of new policy forms specifically touted as providing coverage for e-commerce risks.[38] The specialized policies are attractive to insurers because such policies permit insurers to "rate exposures separately rather than give blanket coverage for a single premium."[39] From the perspective of the policyholder, among other things, these policies specifically cover web-based activities, removing any doubt that may exist about coverage for such activities under CGL policies. But the e-commerce policies are not standardized and can vary widely from insurer to insurer. Also, as such policies are new, they are relatively untested in the courts. Accordingly, the true scope of coverage provided by the new cyber-liability policies is still less than clear.

Many of the new policies, however, provide some type of coverage for privacy claims. Also, importantly, the "publication" of private information is not required for privacy coverage under some new Internet forms. For example, one insurer covers simply "infringement of any right to privacy or of publicity," while policies sold by another are triggered by "any form of invasion, infringement, or interference with right of privacy . . . ." Thus, Internet privacy claims based upon, for example, the intrusion upon seclusion, which may not require disclosure of information, may be covered under some of the new policies. In fact, certain policies sold by insurers specifically include "intrusion" as a wrongful act that is covered.

But, as noted, not all e-commerce policies provide the same scope of coverage. At least one policy defines covered "Internet Activities" as the display or transmission of matter through the Internet, or dissemination of matter by other means as may be shown in the declarations of a particular policy. Although the policy does not extend so far as to require

37. Paul D. Winston & Gavin Souter, *Losses May Prompt Restrictions on Terms, Conditions*, BUS. INS., Sept. 24, 2001.

38. *Id.*

39. *Id.*

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"publication," on its face such a policy may allow the insurer to argue that privacy risks associated with the mere collection of private data are not covered. This situation also exists with respect to another insurer's media liability policy. Under this policy, coverage for privacy violations hinges on "making known to any person" the offending material.

Companies that do business on or through the Internet must also be aware of certain other conditions and exclusions that insurers could use to dramatically reduce the scope of coverage for privacy claims under the new Internet policies. First, the policies typically exclude claims arising from government actions, including regulatory enforcement actions.[40] For example, an Internet liability policy form excludes "claims or loss against you that is brought by or on behalf of the Federal Trade Commission (FTC), Federal Communications Commission (FCC) or any other federal state or local government agency or ASCAP, SESAC, BMI or other licensing organizations in such entity's regulatory, quasi-regulatory or official capacity, functions or duties . . . ."

The government action exclusion could prove particularly limiting as federal and state authorities expand their activities in connection with online privacy issues. The Children's Online Privacy Protection Act[41] permits enforcement by either the Federal Trade Commission or state attorneys general. The Gramm-Leach-Bliley Act may be enforced by a number of federal agencies depending upon the type of financial institution involved, including the Federal Trade Commission, the Securities and Exchange Commission, and the Boards of Governors of the Federal Reserve System or of the Federal Deposit Insurance Corporation.[42] In the past few years, the Federal Trade Commission and certain state attorneys general have pursued a number of enforcement actions against companies—Toysmart.com is one example—for collecting and using personal information about consumers.[43] The number of cases is likely to increase significantly as enforcement becomes more vigorous.

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40. In addition to this government actions exclusion, most Internet policies, like most CGL policies, exclude coverage for liability arising out of criminal acts. Because the Wiretap Act, *supra* note 4, and the ECPA, *supra* note 3, are criminal statutes, coverage for liability arising out of a violation of these laws may be excluded by most policies.

41. 15 U.S.C. § 6504 (2000).

42. 15 U.S.C. § 6805 (2000).

43. *See* First Amended Complaint for Permanent Injunction and Other Equitable Relief, FTC v. Toysmart.com LLC, No. 00–11341-RGS (D. Mass., filed July 10, 2000), *available at* http://www.ftc.gov/os/2000/07/toysmartcomplaint.htm.

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Also, at least one major insurer excludes coverage for privacy claims arising out of the "intentional violation of [a company's] privacy policy." In the face of consumer concerns and new requirements, and perhaps in an effort to ward off further regulation, many companies publish a privacy statement that includes the company's policy on collecting and sharing private information. The privacy statement itself, however, may create legal liability as it easily can be construed to be a binding promise. It is not difficult for companies to fall out of compliance with their privacy statements.

In fact, the chair of the Federal Trade Commission has indicated that enforcement of online privacy policies is a priority of the commission.[44] A number of the private and governmental Internet privacy cases filed concern the alleged violation of posted privacy policies.[45] Policyholders, accordingly, must be prepared to confront the insurer argument that any violation of a privacy statement that results in a claim is "intentional" and is, therefore, not covered, necessarily resulting in a fact-intensive and potentially expensive coverage dispute.

Finally, although not necessarily considered an "exclusion," e-commerce companies must be cognizant of the scope of the territorial provision in their policies. At least one insurer's policies apply "anywhere," but only so long as the underlying suit is filed in the "United States of America, its territories or possessions, Canada or Puerto Rico." Privacy standards are arguably stricter in Europe, and U.S.-based companies have been subject to enforcement actions or suits in foreign countries. Accordingly, when purchasing a cyber-liability policy, a policyholder must consider not only the location where alleged wrongful acts may occur but also the jurisdictions in which the company may face suits.

CONCLUSION

The facts of each individual claim and the numerous terms and conditions of the applicable policy must be examined for a full assessment

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44. Remarks of Muris, *supra* note 10.

45. One allegation in the Federal Trade Commission complaint filed against Toysmart.com was that the company had represented in its privacy policy that it would not "disclose, sell, or offer for sale" the personal information voluntarily submitted to it by customers, but offered its customer lists for sale anyway when faced with bankruptcy. *Toysmart.com LLC,* No. 00–11341-RGS. *See also* Crowley v. CyberSource, Inc., 166 F. Supp. 2d 1263 (N.D. Cal. 2001).

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of the potential for coverage for any claim. But as privacy regulations and litigation increases, companies must understand the scope of the privacy coverage afforded both by their traditional policies and by the new Internet policies on the market. One thing is sure: there will be more privacy claims, and there will be coverage disputes over which claims are covered and which are not. Policyholders that know their policies and their rights are likely to fare the best.

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THE NATIONALIZATION OF HEALTH INFORMATION PRIVACY PROTECTIONS*

*Lawrence O. Gostin,** James G. Hodge, Jr.,*** and Lauren Marks****

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INTRODUCTION

On April 14, 2001, President George W. Bush approved the Standards for Privacy of Individually Identifiable Health Information (health data privacy regulations). These regulations, which represent the first systematic national privacy protections of health information,[1] flow from a Congressional mandate in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[2] HIPAA requires the implementation of health information privacy protections, either through federal legislation or administrative regulation by the Department of Health and Human Services (HHS). These health data privacy regulations protect the privacy of individually-identifiable health records in any form (e.g., electronic, paper, oral) by limiting disclosure and use, regulating privacy and security policies, and implementing fair information practices. The provisions apply to "covered entities," including health providers, health insurance plans, and health care clearinghouses, as well as their business associates.

There are two primary justifications for safeguarding health information privacy: (1) the personal nature of health data and (2) the rapid shift from paper to electronic records. Health information used by health

1. *See* Press Release, President George W. Bush, Statement by the President, (Apr. 12, 2001), *at* http://www.whitehouse.gov/news/releases/2001/04/20010412-1.html [hereinafter Bush, Press Release]; Press Release, Secretary Tommy G. Thompson, Statement by HHS Secretary Tommy G. Thompson Regarding the Patient Privacy Rule (Apr. 12, 2001), *available at* http://www.hhs.gov/news/press/2001pres/20010412.html [hereinafter Thompson, Press Release].

2. Pub. L. No. 104-191, 110 Stat. 1936.

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providers, insurers, and data processors can include intimate details about the patient's mental and physical health as well as information about their social behaviors, personal relationships, and financial status.[3] Unwarranted disclosures of this information could lead to societal stigmatization and discrimination by employers, insurers, and others, as well as a loss of patient trust in medical providers.[4]

Privacy concerns have been compounded by the proliferation of and access to health records resulting from the shift to electronic medical record keeping within the national health information infrastructure. Health information is increasingly accessed, used, disclosed, and stored in electronic format. This does not necessarily mean health data are less secure, as electronic systems are in many ways safer than manual systems. Nevertheless, electronic data can be accessed in greater quantities and manipulated in ways that are virtually impossible for manual systems. Thus, while significant benefits may flow from the electronic health information infrastructure, the potential to disclose or reveal sensitive health data has raised individual fears of privacy violations.[5] In one recent survey, more than 80% of the public respondents felt they had "lost all control over their personal information."[6]

The new HIPAA regulations provide the most comprehensive national protection of health information. While most states have privacy safeguards, they are so variable and incoherent that they are widely regarded as inadequate. Congress' grant of authority to HHS to develop privacy regulations offered the promise of a comprehensive solution to the concerns of consumers and privacy advocates. Through the regulations, HHS attempts to protect individual privacy while recognizing legitimate needs for such data to process health claims and deliver medical care, as well as provide for communal goods (e.g., public health and health research).

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3. *See* Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 489-90 (1995) [hereinafter Gostin, *Privacy*].

4. *See id.* at 490-91.

5. *See* California HealthCare Foundation, *Americans Worry About the Privacy of Their Computerized Medical Records*, *at* http://www.chcf.org/press/view.cfm?itemID=12267 (Jan. 29, 1999).

6. Harris Equifax, *Health Information Privacy*, *available at* http://www.epic.org/privacy/medical/polls.html (1993).

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Specifically, the regulations implement fair information practices, which have long been a feature of existing federal laws.[7] Fair information practices allow patients to: (1) inspect and amend their records; (2) be notified of covered entities' privacy practices and potential uses and disclosures of health information; and (3) request confidential communications and an account of actual disclosures. The regulations also endeavor to protect patient privacy by limiting uses and disclosures of individually-identifiable medical information or "protected health information" (PHI).

Disclosure and use of PHI can only occur with patient consent, subject to several exceptions, including: (1) law enforcement: law enforcement officials may receive information from covered entities without consent pursuant to a court order, subpoena, or other legal order; (2) judicial and administrative proceedings: a covered entity may disclose PHI in a judicial or administrative proceeding without the individual's consent in response to a court order or administrative tribunal or in certain circumstances, in response to a subpoena or discovery request; (3) parents of unemancipated minors: parents are recognized as personal representatives of unemancipated minors; while the current rule restricts parents' access to the child's medical record, the Bush Administration is likely to relax those limitations;[8] (4) "significant others," including family members, friends, and caretakers of adults and emancipated minors: covered entities may disclose limited health information of an adult or emancipated minor without consent, to a relative, personal friend, or designated person in the case of an emergency or in the course of the significant other's basic care-taking duties; (5) public health: PHI can be disclosed for numerous public health purposes without consent, including: (a) to prevent or control disease, injury, or disability; (b) to report child abuse or neglect; (c) to report relevant information to the Food and Drug Administration; and (d) to report to an employer conducting medical surveillance in the workplace if the employee is notified; (6) health research: a covered entity can use or disclose individually-identifiable health information for research without consent if it obtains a waiver from an Institutional Review Board (IRB) or a privacy board; and (7) commercial marketing: covered entities may use or disclose personal health information for face-to-face commercial marketing

7. *See infra*, Part II.C.
8. *See* Thompson, Press Release, *supra* note 1, at para. 10.

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to individuals or for the marketing of products and services of nominal value.

To be effective, a comprehensive, national health information privacy policy should balance individual interests in protecting the privacy of health data with societal needs to share the data for communal purposes.[9] However, many of these provisions leave significant gaps in privacy protection. HHS admits that the regulation only sets a "floor" of protection that "balance[s] the needs of the individual with the needs of society."[10] At times, the regulation makes inappropriate trade-offs between the public welfare and individual privacy that may either fail: (1) to protect individual privacy or (2) to accomplish significant communal benefits (e.g., public health, health research).

In Part I, this Article examines the justifications for implementing comprehensive national health information privacy regulations, including the personal nature of health information, and the increasing threats to personal privacy from the shift to an electronic health information infrastructure. In doing so, it looks at historical attempts by federal and state officials to regulate the use and disclosure of personal health information, and concludes that prior standards have been largely inadequate. In Part II, this Article explains the new national health information privacy regulations: (1) what do they cover?; (2) to whom do they apply?; (3) how do they safeguard personal privacy through notice and security provisions?; and (4) do they preempt existing legal privacy protections?

Part III of this article examines two autonomy rules established in the national privacy rule: "informed consent" (for uses or disclosures of identifiable health data for health-care related purposes) and "written authorization" (for uses or disclosures of health data for non-health care related purposes). The article observes that the informed consent rule is neither "informed" nor "consensual." The rule is thus likely to thwart the effective administration of health organizations without benefiting individuals. Requiring written authorization, on the other hand, protects individual privacy to prevent disclosure of information to entities that do not perform health-related functions, such as employers and life insurers.

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9. Donna E. Shalala, *Health Care Information and Privacy*, 8 HEALTH MATRIX 223, 231 (1998).

10. *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82463 (Dec. 28, 2000), *available at* http://aspe.hhs.gov.

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Lastly, this Article also examines various contexts in which data can be shared for public purposes under the national privacy rule: to law enforcement officials; for judicial and administrative proceedings; to parents of unemancipated minors; to "significant others;" to public health authorities; for health research; and for commercial marketing.

I. PERSONAL PRIVACY IN THE ELECTRONIC HEALTH INFORMATION INFRASTRUCTURE

A. Electronic Health Data

Protecting the privacy of identifiable health information was one of Congress' key priorities in enacting HIPAA. Congress desired better privacy protections because of its concern over the proliferation of electronic health information. During the mid-1980s, fundamental shifts in the organization, delivery, and financing of health care services led to the development of more sophisticated health information systems.[11] Individual patient medical records are increasingly stored in electronic databases by the government and private medical providers. The goal of HIPAA, as expressed by the Institute of Medicine and others, was that patient medical records should be recorded in every health care setting so they could be accessed widely among health care professionals.[12] These changes are transforming the ways in which health information is acquired, used, disclosed, and stored in the modern health care system.

There are many advantages to the systemic collection and use of electronic health data. More accurate and accessible data allow consumers to make more informed decisions about their individual health care needs, including health plans, providers, diagnoses, products, and treatments. Clinical care is improved through faster and more accurate diagnoses,[13]

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11. *See* COMM. ON MAINTAINING PRIVACY & SEC. IN HEALTH CARE APPLICATIONS FOR THE NAT'L INFO. INFRASTRUCTURE, NAT'L RESEARCH COUNCIL, FOR THE RECORD: PROTECTING ELECTRONIC HEALTH INFORMATION 21-22 (1997); Lawrence O. Gostin, *Personal Privacy in the Health Care System: Employer-Sponsored Insurance, Managed Care, and Integrated Delivery Systems*, 7 KENNEDY INST. OF ETHICS J. 361, 364 (1997).

12. *See* Gostin, *Privacy*, *supra* note 3, at 452.

13. *See* Dereck L. Hunt et al., *Effects of Computer-Based Clinical Decision Support Systems on Physician Performance and Patient Outcomes*, 280 JAMA 1339, 1344 (1998).

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increased checks on medical procedures,[14] prevention of adverse drug events,[15] and the dissemination of expert medical information in areas traditionally under-served through telemedicine and other techniques. Public health surveillance of injuries and diseases in the population is facilitated.[16] Medical research on the causes of injuries and disease, and health services research concerning the quality and cost-effectiveness of health care services, are improved through increased access to (and more accurate) information. Electronic security tools including personal access codes, encryption programs,[17] and audit trials,[18] can more efficiently monitor health care fraud and abuse,[19] and protect data from unauthorized uses and disclosures.

Along with these benefits, however, come significant costs. The computerization of health data raises significant privacy concerns. Health care data concerning individuals are among the most sensitive types of personal information. These records contain large amounts of personal information which can be used to create a profile of an individual, including: (1) demographic information, such as age, sex, race, marital status, children, and occupation; (2) financial information, such as employment status, income, and methods of payment; (3) medical information about diagnoses, treatments, disabilities, end-of-life decisions, and disease histories of the individual and family members; (4) genomic information such as diagnostic tests for carrier traits and genetically-related diseases; (5) personal identifiers other than name, including social security number, addresses, and phone numbers; and (6) information about why

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14. *See* David W. Bates et al., *Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors*, 280 JAMA 1311, 1316 (1998).

15. *See* Robert A. Raschke et al., *A Computer Alert System to Prevent Injury from Adverse Drug Events*, 280 JAMA 1317 (1998).

16. *See* Lawrence O. Gostin et al., *The Public Health Information Infrastructure*, 275 JAMA 1921, 1921 (1996) [hereinafter Gostin, *Infrastructure*]; John M. Last, *Epidemiology and Ethics*, 19 LAW, MED. & HEALTH CARE 166 (1991); William L. Roper et al., *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197 (1988); *see also* Antoine Flahault et al., *FluNet as a Tool for Global Monitoring of Influenza on the Web*, 280 JAMA 1330 (1998).

17. *See* Elizabeth Corcoran, *Breakthrough Possible in Battle over Encryption Technology*, WASH. POST, July 12, 1998, at A8.

18. *See* NAT'L RESEARCH COUNCIL, COMPUTERS AT RISK: SAFE COMPUTING IN THE INFORMATION AGE 88 (1990).

19. *See* Gostin, *Privacy*, *supra* note 3, at 481.

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treatment is sought, such as being the victim of a violent crime, firearm injury, or the at-fault party in an auto accident.[20]

In a society that strongly values individual autonomy and decision-making,[21] protecting the privacy of personally-identifiable health data is critical.[22] Insufficient protection of health care information can lead to unauthorized disclosures, which in turn may subject individuals to social stigma and discrimination by insurance companies, health care professionals and institutions, and employers.[23] Patients have a reasonable expectation of privacy in their personal affairs provided the exercise of these interests does not harm others.[24] Respecting personal privacy requires that individuals maintain some degree of control over their personal information. In addition, protecting the privacy of individually-identifiable health information is important to achieving benefits for the population, such as public health surveillance and longitudinal health research. As we (and others) have stated, *protecting health information privacy* (e.g., by providing individuals some control over their health data without severely restricting warranted uses of the data) *directly improves the quality of health care and public health data* (e.g., by encouraging individuals to fully utilize health services and cooperate with health agencies).[25]

B. Existing Legal Protections

Safeguarding personal privacy through legal mechanisms allows for the creation of standards that are enforceable through courts and administrative bodies. Legal safeguards may be expressed through federal or state constitutional protections of health information privacy, case law, or

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20. *See* Lawrence O. Gostin, *Health Care Information and the Protection of Personal Privacy: Ethical and Legal Considerations,* 127 ANNALS OF INTERNAL MED. 683, 684 (1997).

21. *See generally* ALAN WESTIN ET AL., THE EQUIFAX REPORT ON CONSUMERS IN THE INFORMATION AGE (1990).

22. *See* Paul Starr, *Health and the Right to Privacy*, 25 AM. J.L. & MED. 193 (1999).

23. *See, e.g.*, Lawrence O. Gostin & James G. Hodge, Jr., *The "Names Debate": The Case for National HIV Reporting in the United States*, 61 ALB. L REV. 679, 724 (1998); Madison Powers, *Privacy and the Control of Genetic Information*, *in* THE GENETIC FRONTIER: ETHICS, LAW AND POLICY 77 (Mark S. Frankel & Albert H. Teich, eds., 1994).

24. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 126, 406-412 (4th ed. 1994).

25. James G. Hodge, Jr., Lawrence O. Gostin, & Peter D. Jacobson, *Legal Issues Concerning the Privacy of Electronic Health Information*, 282 JAMA 1466, 1470 (1999).

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legislative and administrative law. Despite the potential of the law to protect privacy, existing safeguards are inadequate, fragmented, and inconsistent. There exist major gaps in legal protection of health privacy as well as and significant theoretical problems with the structure of privacy protection.

1. Constitutional Right to Privacy

Apart from the Fourth Amendment, the Supreme Court has not articulated a clear, strong standard for a constitutional right to informational privacy.[26] Judicial recognition of a constitutional right to informational privacy is particularly important because the government is a primary collector and disseminator of health information. A constitutional right could shield individuals from unauthorized government acquisition or disclosure of personal information.

The Constitution does not expressly provide a right to informational privacy.[27] The judiciary, however, has recognized a limited right to informational privacy as a liberty interest under the substantive due process clauses of the Fifth and Fourteenth Amendments. In *Whalen v. Roe*,[28] the United States Supreme Court examined whether the constitutional right to privacy encompasses the collection, storage, and dissemination of health information in government data banks (specifically, a New York public health database containing pharmaceutical records). While the Court acknowledged a "threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks or other massive government files,"[29] it failed to tailor a constitutional remedy to meet this threat. Justice Stevens, writing for a unanimous Court, simply recognized that "in some circumstances" the duty to avoid unwarranted disclosures "arguably has its roots in the Constitution."[30] Provided the state had adequate standards and procedures for protecting the privacy of

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26. *See, e.g.*, Seth F. Kreimer, *Sunlight, Secrets, and Scarlet Letters: The Tension Between Privacy and Disclosure in Constitutional Law*, 140 U. PA. L. REV. 1 (1991); Richard C. Turkington, *Legacy of the Warren and Brandeis Article: The Emerging Unencumbered Constitutional Right to Informational Privacy*, 10 N. ILL. U. L. REV. 479 (1990); Francis S. Chlapowski, Note, The *Constitutional Protection of Informational Privacy*, 71 B.U. L. REV. 133 (1991).

27. *See* Gostin, *Privacy*, *supra* note 3, at 495-98.

28. 429 U.S. 589 (1977); *see also* Nixon v. Admin. of Gen. Servs., 433 U.S. 425 (1977).

29. *Whalen*, 429 U.S. at 605.

30. *Id.*

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sensitive medical information, the Court found no privacy violation.[31] *Whalen* has been subsequently interpreted as affording a tightly circumscribed right to informational privacy.

In general, courts have employed a flexible test balancing the government invasion of the individual's privacy against the strength of the government interest.[32] Where the government can articulate a valid societal purpose and employs reasonable security measures, traditional governmental activities of information collection do not infringe an individual's constitutional informational privacy rights. Any right to privacy under the federal or state constitutions[33] is, of course, limited to government action. Thus, collection and use of health data by private or quasi-private health data organizations, health plans, researchers, and insurers, are constitutionally unprotected.

2. Common Law Protections

Most states recognize, via common and statutory law, the legal duties of confidentiality of certain health care professionals (e.g., physicians, nurses, lab technicians) not to disclose health information. Yet, these duties are not absolute. Disclosures without individual consent may lawfully be made to: (1) protect third parties from identifiable harm, (2) report information for public health purposes as required by state law, or (3) notify in some cases of medical emergency. Unwarranted disclosures, however, may subject responsible parties to civil liability.[34]

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31. *Id.*

32. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (holding that the National Institute of Occupational Safety and Health was entitled to receive the medical records of private employees exposed to toxic substance, subject to their informed consent). The court enunciated five factors to be balanced in determining the scope of the constitutional right to informational privacy: (1) the type of record and the information it contains, (2) the potential for harm in any unauthorized disclosure, (3) the injury from disclosure to the relationship in which the record was generated, (4) the adequacy of safeguards to prevent non-consensual disclosure, and (5) the degree of need for access—i.e., a recognizable public interest. *Id.* at 578.

33. *See, e.g.*, Rasmussen v. S. Fla. Blood Serv., Inc., 500 So. 2d 533 (Fla. 1987). "Since the 1970's, more than a dozen states have adopted constitutional amendments designed to protect a variety of privacy interests, including limitations on access to personal information." Gostin, *Privacy, supra* note 3, at 498.

34. *See, e.g.*, McCormick v. Eng., 494 S.E.2d 431 (S.C. Ct. App. 1997); Gostin, *Privacy, supra* note 3, at 508-11; Lawrence O. Gostin & James G. Hodge, Jr., *Genetic Privacy and the Law: An End to Genetics Exceptionalism*, 40 JURIMETRICS 21, 46 (1999) [hereinafter Gostin & Hodge, *Genetic*].

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Although a traditional construct of privacy protections and a forerunner of modern privacy theory, the duty of confidentiality is antiquated. Confidentiality is predicated on the existence of a physician/patient relationship. Modern data collection is based only in small part on this relationship. Health records contain a substantial amount of information gathered from numerous primary and secondary sources: laboratories; pharmacies; schools; public health officials; researchers; insurers; and other individuals and institutions. Paper or electronic patient health records are kept by government agencies, regional health database organizations, and information brokers. The duty of confidentiality arising at the point of clinical care or research simply does not protect the patient from disclosure by these secondary sources of data.

3. Existing Legislative and Administrative Protections

Federal and state legislatures and executive agencies have enacted and considered a growing number of statutes and regulations to protect privacy.[35] The federal government has previously enacted several statutes and regulations to protect privacy of health information. The Privacy Act of 1974[36] requires federal agencies to utilize fair information practices regarding the collection, use, or dissemination of systematized records, including health data. The Freedom of Information Act (FOIA) of 1966[37] exempts personally-identifiable health information from public dissemination by the federal government. Other federal regulations protect health information privacy relating to the treatment of persons for drug or alcohol dependency in federally-funded facilities,[38] and the administration of human subject research.[39]

Most states have passed privacy statutes that mimic the federal Privacy Act[40] and FOIA,[41] which apply to state collections of data. A few states have enacted comprehensive medical information privacy acts.[42] These laws provide broad protections of health information acquired, collected,

35. *See* Gostin, *Privacy*, *supra* note 3, at 499-508.
36. 5 U.S.C. § 552(b)(1)-(3), (6) (2000).
37. 5 U.S.C. § 552 (2000).
38. 42 U.S.C. § 290dd-2 (Supp. V 1994).
39. 45 C.F.R. §§ 46.101 to .404 (2001).
40. *See, e.g.*, N.Y. PUB. OFF. LAW §§ 91-99 (McKinney 1988 & Supp. 1995).
41. *See, e.g.*, MISS. CODE ANN. §§ 25-61-1 to -3, -5, -7, -9 to -11, -13, -15, -17 (1991).
42. *See, e.g.*, CAL. CIV. CODE §§ 56-56.37 (West 1982 & Supp. 1995); WASH. REV. CODE ANN. §§ 70.02.005 to .904 (West 1992 & Supp. 1996).

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used, or disclosed within the state. States have also passed disease-specific privacy laws which set forth stringent privacy and security protections for certain types of information, including medical information concerning one's HIV status[43] or other communicable diseases,[44] genetic information,[45] information utilized in medical research (such as state cancer registries), or public health information.[46]

Although existing federal and state privacy statutes and regulations are meaningful and serve valuable ends, they share several weaknesses: (1) like constitutional privacy protections, most statutes apply primarily to government collections, uses, or disclosures of health information, and thus often do not confer protections to health information in the private sector; (2) they fail to address the new challenges to individual privacy arising from the automation of medical records; (3) they collectively represent a patchwork effort to address the privacy and security of specific health information; (4) some kinds of data are treated as super-confidential (e.g., HIV/AIDS), while other data are virtually unprotected, leading to inconsistencies and unfairness; (5) they do not effectively balance competing individual interests in privacy with the need to use the data for the common good; and (6) some state laws prohibit disclosures without informed consent, but make so many exceptions so as to negate the prohibition.

These weaknesses in existing law suggest the need for a comprehensive approach to privacy protection. The health data privacy regulations provide a national standard to protect health data. However, like existing privacy laws, the regulations may inadequately protect individual privacy and also fail to assure that data are shared where necessary to protect the public's welfare.

II. HEALTH INFORMATION PRIVACY PROTECTIONS UNDER THE NATIONAL REGULATIONS

The creation of national health information privacy regulations might seem uncontroversial in light of existing public apprehensions to

43. *See* Harold Edgar & Hazel Sandomire, *Medical Privacy Issues in the Age of AIDS: Legislative Options*, 16 AM. J.L. & MED. 155 (1990) (examining state legislation dealing with HIV related problems in medical privacy laws).

44. *See* Lawrence O. Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461, 463-65 (1986).

45. *See, e.g.*, Gostin & Hodge, *Genetic*, *supra* note 34, at 47-53.

46. *See* Gostin, *Infrastructure*, *supra* note 16, at 1922.

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disclosure, current gaps in legal protections, and Congress' commitment to better protect such data. However, the health privacy rule was established only after years of struggle and efforts in the legislative and executive branches. Under HIPAA, Congress created a self-imposed deadline of August 21, 1999 to pass health information privacy legislation.[47] As a result of interest group lobbying,[48] a diverse health law and policy agenda, and politics, Congress failed to pass comprehensive privacy laws by the deadline.[49] HIPAA authorized the Secretary of HHS to issue privacy regulations if Congress failed to act.[50] The initial publication, HHS' proposed regulations in November 1999,[51] garnered over 52,000 public comments.[52] The final rule was promulgated in December 2000, at the end of President Clinton's term.[53] Reflecting President Bush's promise to reassess regulations enacted late in his predecessor's term,[54] the comment period was re-opened and HHS received several thousand additional comments.[55] Although privacy advocates were concerned that the Bush Administration would scale back or eliminate the rules altogether,[56] HHS announced on April 12, 2001 that the final regulations as previously

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47. Pub. L. No. 104-191, § 264(c)(1), 110 Stat. 1936, 2033 (1996).

48. *See* Amy Goldstein & Robert O'Harrow, *Bush Will Proceed on Patient Privacy*, WASH. POST, Apr. 13, 2001, at A1, A10. This lobbying is nothing new; a 1998 Center for Public Integrity report found that "time and time again . . . Congress has put big money corporate interests ahead of the basic privacy interests of the American people." CTR. FOR PUB. INTEGRITY, NOTHING SACRED: THE POLITICS OF PRIVACY 5 (1998).

49. *See* Goldstein & O'Harrow, *supra* note 48, at A10; Bush, Press Release, *supra* note 1; Dep't of Health & Human Servs., *HHS Fact Sheet: Protecting the Privacy of Patients' Health Information, at* http://aspe.hhs.gov/admnsimp/final/pvcfact2.htm (May 9, 2001) [hereinafter *HHS Fact Sheet*].

50. § 264(c)(1), 110 Stat. at 2033.

51. Standards for Privacy of Individually Identifiable Health Information, 64 Fed. Reg. 59918-60065 (Nov 3, 1999).

52. *See* Peter A. Setness, *HIPAA and the Changing Face of Patient Privacy*, 111 POSTGRADUATE MED. (2002), *available at* http://www.postgradmed.com/issues/2002/01_02/editorial_jan.htm at para. 3.

53. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82462 (2001).

54. *See* Robert Pear, *Bush Accepts Rules to Protect Privacy of Medical Information*, N.Y. TIMES, Apr. 13, 2001, at A1 [hereinafter, Pear, *Bush Accepts*].

55. *See* Thompson, Press Release *supra* note 1; *HHS Fact Sheet*, *supra* note 49.

56. *See* INST. FOR HEALTHCARE RESEARCH & POLICY, HEALTH PRIVACY PROJECT 2-3 (2001), *at* http://www.healthprivacy.org/ usr_doc/55009.pdf [hereinafter HEALTH PRIVACY PROJECT]; *see also* Goldstein & O'Harrow, *supra* note 48, at A10; Robert Pear, *White House Plans to Revise New Medical Privacy Rules*, N.Y. TIMES, Apr. 8, 2001, at 22.

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constructed would go forward, subject to interpretive guidelines developed by HHS.[57] The first of these guidelines was released in July 2001.[58] The regulations take effect for most covered entities on April 12, 2003, and one year later for small health plans.

Though their development was convoluted, the health data privacy regulations attempt to establish a national base-line of health information privacy protection,[59] although individual privacy is both under-and-over-protected.

A. The Scope of the Standard

At least two questions are important in the development of national health information privacy regulation: (1) what information should be protected? and (2) from whose actions should the information be protected? In health data privacy regulation, these questions are partially answered by the limits of HHS' authority under HIPAA.[60]

What Information is Protected? The regulations explicitly cover health information[61] that is individually-identifiable (PHI).[62] Individually-

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57. Thompson, Press Release, *supra* note 1; *see also* Goldstein & O'Harrow, *supra* note 48, at A1, A10; Robert Pear, *Administration Clarifies New U.S. Rules Guarding Privacy of Patients*, N.Y. TIMES, July 7, 2001, at A1.

58. Office for Civil Rights, Dep't of Health & Human Servs., *Standards for Privacy of Individually Identifiable Health Information*, *at* http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm [hereinafter HHS, *Standards*]; *see* Ceci Connelly, *Guidelines on Patient Privacy Rules Issued*, WASH. POST, July 7, 2001, at A6; Pear, *Bush Accepts*, *supra* note 54, at A9.

59. To enforce these protections, Secretary Thompson can investigate complaints and conduct compliance reviews. Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160.306, 308 (2001). Violations of the standard can lead to civil and criminal penalties up to $250,000 and 10 years in prison. *See HHS Fact Sheet*, *supra* note 49. There is no private right of action for individuals to redress violations.

60. For discussion on the constitutional issues raised by the jurisdictional concerns, see A. Craig Eddy, *A Critical Analysis of Health and Human Services' Proposed Health Privacy Regulations in Light of The Health Insurance Privacy* [sic] *and Accountability Act of 1996*, 9 ANNALS HEALTH L. 1, 50-60 (2000).

61. Health information is comprehensively defined as data (1) "created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse;" and (2) "relat[ed] to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual." 45 C.F.R. § 160.103 (defining "health information").

62. *Id.* § 164.514. HHS defines individually-identifiable health information as health information which "identifies an individual . . . or with respect to which there is a

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identifiable health information includes any data that contains unique identifiable characteristics, including a name, social security or drivers' license number, fingerprint, or genetic link.[63] Where health data are truly non-identifiable (e.g., aggregate statistical data, non-linked data, or other data stripped of all individual identifiers), privacy interests are minimal. Consequently, the national privacy rules do not restrict access, use, or disclosure of non-identifiable data.[64] HHS permits covered entities to assign codes[65] to allow for later re-identification, but requires steps to prevent harmful identifications.[66]

PHI includes all forms of information, including electronic, oral, and paper communications.[67] Realistically, it is impractical to separate protections for paper-based records from electronic or oral-based data. Under HIPAA, Congress may have limited HHS's authority to regulate

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reasonable basis to believe the information can be used to identify the individual." *Id.* § 164.501. The regulatory definition limits the term to only a subset of health information, specifically that created or received by health care providers, health plans, employers, or health care clearinghouses. *Id.*

63. The health data privacy rule outlines two means for determining if health information is not individually-identifiable, or "de-identified," and thus no longer regulated by the rule. First, an expert utilizing accepted analytic techniques can conclude that "the risk is very small that the information could be used, alone or in combination with other reasonably available information" to identify the subject of the information. *Id.* § 164.514(b)(1)(i). A second permitted means of de-identification is that the covered entity can remove a comprehensive set of identifiers of the individual and of relatives, employers, and household members of the individual. These identifiers include: names, geographic subdivisions smaller than a state, dates more specific than years, contact information such as telephone and fax numbers and email addresses, identification numbers such as social security numbers, account and medical record numbers, license place numbers, and full face photographic images. *Id.* § 164.514(b)(2)(i)(1)(C).

64. *Cf.* Yaron F. Dunkel, *Medical Privacy Rights in Anonymous Data: Discussion of Rights in the United Kingdom and the United States In Light of the Source Informatics Cases*, 23 LOY. L.A. INT'L & COMP. L. REV. 41 (2001).

65. Information can be ostensibly anonymous, yet linkable to an individual because of codes frequently utilized by health care organizations, researchers, and the government. Concern is raised about deliberate or accidental disclosures of coded information, not literally protected by law, where the code is broken or inadequate. *See* Gostin, *Privacy, supra* note 3, at 520.

66. The code must not be derived from or related to information about the individual or able to be translated so that the individual can be identified. 45 C.F.R. § 164.514(c)(1). The covered entity must also not disclose or use the code for other purposes than record identification and cannot disclose the mechanism for re-identification. *Id.* § 164.514(c)(2).

67. *Id.* § 164.501 (defining "protected health information").

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non-electronic communication.[68] Although HHS maintains it has "ample legal authority" to regulate non-electronic communications,[69] provisions concerning non-electronic communications are severable from electronic communications by court action.[70] Protecting all health information enhances the efficacy of the regulation. Otherwise, a significant amount of non-electronic health communications would remain unregulated by federal law. Additional complications relate to enforcing a national regulation that applied to only some types of health data depending on how they were communicated or stored.[71]

Who is Covered? HHS regulates "covered entities," which include all possible groups that it is authorized to reach under HIPAA. These covered entities include health plans, health care clearinghouses, and health care

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68. Section 264 of HIPAA, which contains the Congressional mandate to HHS to develop the privacy standard, evolved because of the administrative simplification goals of the statute related to electronic information exchange. *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82469 (2001); Eddy, *supra* note 60, at 18. Some commentators have suggested that because section 264 was developed to counteract negative affects of the administrative simplification provisions, HHS could only regulate privacy concerns for the narrow set of electronic transactions covered in those provisions. *See* Eddy, *supra* note 60, at 18-20. However, the statute in 264 describes the scope of HHS authority in terms of regulation of individual rights over *individually identifiable health information*, not electronic transactions or administrative simplification. The statute states that if Congress doesn't meet its deadline, HHS must "at least" develop regulations that address: "(1) The rights that an individual who is a subject of individually identifiable health information should have[;] (2) The procedures that should be established for the exercise of such rights[; and] (3) The uses and disclosures of such information that should be authorized or required." Pub. L. No. 104-191, § 264(b), 110 Stat. 1936, 2033 (1996) (this subsection gives the requirements for HHS' recommendation to Congress when Congress is considering legislation before its self-imposed deadline has passed. In a cross-reference to (b), 264(c) applies these requirements to the regulations that are mandated if Congress doesn't meet its deadline.). The use of "at least" and the lack of a reference to the administrative simplification sections or electronic transactions in these detailed requirements suggests that Congress did not intend to limit HHS to protecting privacy in electronic transactions only. HEALTH PRIVACY PROJECT, *supra* note 56, at 5. Nevertheless, ambiguity remains about HHS' scope of authority.

69. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82496 (2001).

70. *Id.* In a successful court challenge to the broad coverage, then, the judge could order that the phrase "regarding non-electronic information" be struck from the regulation while the standard would remain intact for electronic communications.

71. *See* HEALTH PRIVACY PROJECT, *supra* note 56, at 6-7; Joy Pritts et al., *The State of Health Privacy: An Uneven Terrain, at* http://www.georgetown.edu/research/ihcrp/privacy/statereport.pdf (1999).

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providers.[72] Health plans, which provide or pay for the cost of medical care, are covered whether they are private entities (e.g., health insurer, managed care organization) or government organizations (e.g., Medicaid, Medicare, the Veterans Administration).[73] Health care providers (e.g., physicians, hospitals, clinics) are covered if they "transmit []any health information in electronic form in connection with a transaction covered by [the regulation]."[74] Such electronic exchanges can include billing and fund transfers in addition to health information communications.

The regulations also cover business associates of the covered entities. Business associates are lawyers, accountants, billing companies, and other contractors whose positions involve the use or disclosure of individually-identifiable health information.[75] Although HHS lacks the authority to directly regulate business associates, it requires covered entities to obtain satisfactory assurances that their business associates will comply with privacy standards.[76] Should a covered entity know of a violation and do nothing to address it, the covered entity may be considered to be violating HIPAA's privacy standards.[77] Through this oversight function, HHS is able to regulate the downstream users and processors of PHI.[78]

Although the regulations are comprehensive, not all persons or entities that regularly use, disclose, or store identifiable health data are covered. The rule does not cover groups such as life insurers and worker's compensation insurers and programs, even though these entities regularly use personal medical information.[79] Additional protections governing all identifiable health data, regardless of its holder or manner of

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72. 45 C.F.R. § 160.102.

73. *Id.* § 160.103 (defining "health plan"). Employers utilizing employer-sponsored health plans (governed by ERISA) are not considered covered entities when administering the plan (as "plan sponsors"). However, the standard outlines numerous requirements for employer-sponsored health plans, which are covered entities, to disclose PHI to plan sponsors/employers, including an agreement that the sponsor will not use or disclose the information for employment decisions. *Id.* § 164.504(f)(1), (2).

74. *Id.* § 160.102(a)(3).

75. *Id.* § 160.103.

76. *Id.* § 164.502(e)(1)(i).

77. *Id.* § 164.502(e)(iii).

78. *See* Lawrence O. Gostin, *National Health Information Privacy: Regulations Under the Health Insurance Portability and Accountability Act*, 285 JAMA 3015, 3016 (2001) [hereinafter Gostin, *National Health*].

79. *See generally* James G. Hodge, Jr., *The Intersection of Federal Health Information Privacy and State Administrative Law: The Protection of Individual Health Data and Worker's Compensation*, 51 ADMIN. L. REV. 117 (1999).

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communication, are needed to complete a national standard of health information privacy.

B. Privacy and Security Policies for Covered Entities

In addition to an individual's right to control uses and disclosures, the development of privacy and security policies for covered entities is important to prevent privacy breaches and maintain consumers' trust in the health care system. Without such policies, accidental disclosures from sloppy record-keeping and purposeful disclosures by and to unscrupulous parties may increase.[80] The health data privacy regulations mandate that covered entities develop privacy and security policies while maintaining the flexibility necessary for the large variety of participants covered by the rule.[81] Covered entities must implement policies that reasonably protect individuals from any "intentional or unintentional use or disclosure in violation of the standards, implementation specifications or other requirements."[82] Covered entities must not only guard against a deliberate attempt to use protected information, but must also endeavor to prevent accidental uses and disclosures. Procedures must be developed to allow for complaints concerning the policies or the covered entities' compliance with the policies.[83] Persons who violate privacy policies could be sanctioned.[84]

A covered entity may not require an individual to waive these rights in order to receive care, enroll in a health plan, or obtain benefits.[85] However, covered entities are not mandated to create a formal appeals process or a

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80. For more on the impact on personal privacy from security policies, *see generally* HEALTH PRIVACY PROJECT, *supra* note 56, at 20-22.

81. Specific concerns calling for flexibility include that the nature of the health information held by covered entities may differ, smaller organizations may be burdened greatly by requirements more appropriate for larger firms, and the swift changes in technology may require a fast process to update the privacy and security policies. *See* Gostin, *Privacy, supra* note 3, at 526.

82. 45 C.F.R. § 164.530(c)(2). Group health plans that provide benefits only through a health maintenance organization (HMO) or an issuer and that do not create, receive, or maintain PHI are not subject to any of the requirements under this section except documentation of their plan materials. *Id.* § 164.530(k). The issuers and HMOs must still follow all of the elements of the privacy and security policy mandates. *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82563-64 (2001).

83. 45 C.F.R. § 164.530(d). Covered entities are also forbidden from taking any "intimidating or retaliatory acts" against an individual involved in the privacy policy process, including those filing a complaint. *Id.* § 164.530(g).

84. *Id.* § 164.530(e)(1).

85. *Id.* § 164.530(h).

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form of "due process."[86] When violations occur, the covered entity must mitigate "to the extent practicable" any harmful effect known to result from the infraction.[87]

C. Fair Information Practices

Persons and entities maintaining PHI must adhere to a range of fair information practices that allow individuals to make informed choices about the delivery and financing of their health care. The health data privacy regulation proscribes several fair information practices for health consumers, including the right to: (1) notice; (2) access protected health information; (3) amend protected health information; and (4) request an account of disclosures.

Notice. Health care consumers have the right to adequate notice of the uses and disclosures of PHI that may be made by the covered entity.[88] Individuals are also entitled to know their legal rights, as well as the covered entity's privacy and security policies, including fair information practices requirements.[89] The notice must be in plain language.[90] Health plans must provide notice to covered individuals by the regulations compliance date, while health care providers must provide this notice upon

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86. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. at 82562 (2001).

87. 45 C.F.R. § 164.530(f). Balancing the protections for individuals allows flexibility for businesses. Every covered entity is not compelled to develop the same privacy and security policies. Instead, the policies must be "reasonably designed, taking into account the size of and the type of activities that relate to PHI undertaken by the covered entity." *Id.* § 164.530(i)(1). This generalized description of the requirement allows small businesses to develop plans that reflect the nature and size of their enterprise without burdening them more than necessary. Small businesses may still find some of the requirements overly burdensome. For example, a sole practitioner largely relying on paper medical records might be challenged by the need to prevent accidental disclosure from a misplaced record. As the health data privacy rule mandates that covered entities' privacy policies "promptly" comply with changes in law, *id.* § 164.530(i)(3), further difficulties can arise for small businesses with limited resources to monitor legal developments and implement swift changes. *See* Gostin, *National Health, supra* note 78, at 3018.

88. 45 C.F.R. § 164.520(a)(1). For more on the necessity of providing such notice, see generally Gostin, *Privacy*, *supra* note 3, at 522-24; HEALTH PRIVACY PROJECT, *supra* note 56, at 19-20.

89. 45 C.F.R. § 164.520(a)(1). The notice must include information about how individuals may complain about potential misuses or violations to the covered entity and the Secretary of HHS or contact the covered entity with questions. *Id.* § 164.520(b)(vi).

90. *Id.* § 164.520(b)(1).

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the first service delivery after the compliance date.[91] Additionally, consumer safeguards apply to covered entities that provide notice electronically.[92]

Access to Protected Health Information. The new regulation offers individuals a broad opportunity to access their PHI.[93] Access rights include an on-site inspection of the records and the provision of copies of their records.[94] Covered entities must act within thirty days upon the request for access to health data.[95] If the individual agrees in advance, the covered entity may provide a summary of the PHI instead of the actual documents.[96] The standard does permit narrow, unreviewable reasons for denial regarding requests for psychotherapy notes; information likely to be used in a civil, criminal, or administrative proceeding; and requests by inmates to their correctional facility or health care provider that might threaten the health or safety of the individual or others.[97] Also, in limited

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91. *Id.* § 162.520(c)(1)(i)(A), (c)(2)(i). New enrollees must get the notice at time of enrollment. At least once every three years, the health plan must notify enrollees in the plan that the notice is available and the methods by which they can obtain it. *Id.* § 164.520(c)(1)(i), (c)(2).

92. An individual must agree to obtain the notice via e-mail. A paper copy must be provided if the covered entity knows that the e-mail transmission failed. *Id.* § 164.520(c)(3)(ii). Health care providers must give electronic notice automatically and simultaneously when their first service delivery is electronic. *Id.* § 164.520(c)(3)(iii). If a covered entity maintains a web site that offers information about its benefits and services, it must also prominently post its notice on the web site as well as make it available electronically. *Id.* § 164.520(c)(3)(i).

93. *Id.* § 164.524. The covered entity may require that the request be in writing. *Id.* § 164.524(b)(1). For more on the significance of the individual's ability to access their personal medical data, see Gostin, *Privacy*, *supra* note 3, at 524; HEALTH PRIVACY PROJECT, *supra* note 56, at 18-19.

94. 45 C.F.R § 164.524(c)(1).

95. *Id.* § 164.524(b)(2)(i). Sixty days is allowed if the information is held off-site. *Id.* § 164.524(b)(2)(ii). Delay is also allowed if the covered entity informs the individual in writing of the reasons it requires more time and when the request will be granted. *Id.* § 164.524(b)(2)(iii)(A).

96. *Id.* § 164.524(c)(2)(ii).

97. *Id.* § 164.524(a)(1)(ii), (a)(2)(ii). Information obtained from another based on a promise of confidentiality that would likely reveal the identity of the source may be denied without review. *Id.* § 164.524(a)(2)(v). Health care providers may also temporarily deny access during research based on an individual's care if the individual has consented to both the research, and the denial of access during research. *Id.* § 164.524(a)(2)(iii).

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circumstances,[98] a covered entity may deny access although the individual may request a review of the grounds for denial.[99] If the covered entity decides to deny access to the individual of any part of the PHI, the health data privacy regulation ensures a fair and informed process.[100]

Amend Protected Health Information. Individuals can amend their PHI if they report inaccuracies or missing information.[101] The covered entity must act within sixty days on a request to amend.[102] If the covered entity agrees to the amendment, it must: (1) identify the records that are affected by the amendment; (2) append or provide a link to the amendment;[103] and (3) inform the individual of the amendment.[104] Additional covered entities that possess or receive the data must correctly amend their records concerning the relevant individual.[105] As with access rights, covered entities may deny amendments in certain circumstances, including upon a determination that the record is "accurate and complete."[106] The entity must then give written notice to the individual.[107]

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98. These situations include where a licensed health care professional determines that access will endanger the life or physical safety of the individual or another person. *Id.* § 164.524(a)(3)(ii).

99. *Id.* § 164.524(a)(3). This provision specifically covers determinations that references to another person will endanger that other individual, or that, if a personal representative is making the request, substantial harm will come to the individual or another person. *Id.* § 164.524(a)(3)(ii).

100. The denial must be in writing and in plain language. It must explain the reasons for the denial, any rights for review over the decision, and methods of complaint to the covered entity. *Id.* § 164.524(d)(2)(i)-(iii). Access should be granted to any information that does not meet the specific grounds for denial. *Id.* § 164.524(d)(1). If a review of the denial is warranted, it is conducted by a licensed health care professional who is designated by the covered entity but is not directly involved in the decision to deny access. *Id.* § 164.524(d)(4).

101. *Id.* § 164.526(a)(1). See Gostin, *Privacy*, *supra* note 3, at 524 and HEALTH PRIVACY PROJECT, *supra* note 56, at 19, for more on the significance of this right.

102. 45 C.F.R. § 164.526(b)(2)(i). An extension of thirty days is possible if the covered entity explains the reasons for delay and the date on which it will respond to the request in writing to the individual. *Id.* § 164.526(b)(2)(ii).

103. *Id.* § 164.526(c)(1).

104. *Id.* § 164.526(c)(2), (3)(i). It must also notify persons or entities (1) identified by the individual as needing the amended information or (2) known by the covered entity to have PHI about the individual and who may rely on the information to the detriment of the individual. *Id.*

105. *Id.* § 164.526(e).

106. *Id.* § 164.526(a)(2)(iv). Other grounds for denial are: (1) if the covered entity did not create the information or record, it may deny the request unless the individual reasonably shows that the originator of the information is no longer available to address the

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Yet, unlike disputes over access denial, there is no final review to clarify which party, the individual or the covered entity, is correct. Should the individual disagree in writing,[108] the covered entity can respond with a written rebuttal, which must be included in future disclosures.[109]

Request an Accounting of Disclosures. Patients have a limited right to receive an accounting of disclosures of their PHI (other than for disclosures related to treatment, payment and health care operations, among other exceptions[110]) over the six-year period prior to the request.[111] The accounting includes the name of the person or entity that received the information (and their address if known), the date of the disclosure, a brief description of the information disclosed, and a brief explanation of the reasons for disclosure if not authorized by the patient.[112]

D. The Effects of Pre-emption

Under HIPAA, HHS cannot preempt state health information privacy laws that are more protective of patients than the national rule.[113] Some states may offer more protections through, for example, "super-confidentiality" laws for genetic, mental health, or HIV/AIDS information. Thus, because existing federal or state laws that provide more privacy

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amendment request and (2) if the individual could not access the record because of restrictions laid out in § 164.524 (*see* Part 1 above). *Id.* § 164.526(a)(2)(i), (iii).

107. *Id.* § 164.526(d)(1). It must be in plain language and explain the reasons for the denial, any rights for review over the decision, and methods of complaint to the covered entity. *Id.*

108. *Id.* § 164.526(d)(2).

109. *Id.* § 164.526(d)(5)(i). The individual must be provided with a copy of the rebuttal. *Id.* § 164.526(d)(3). The written statement and rebuttal must then be appended or linked to the appropriate records by the covered entity, *see id.* § 164.526(d)(4), and included, when relevant, in any future disclosures. *Id.* § 164.526(d)(5)(i). If the individual has not submitted a written statement of disagreement, then the request for amendment and covered entity's denial must be included if the individual has requested such disclosure. *Id.* § 164.526(d)(5)(ii).

110. Excluded disclosures include: those for national security and intelligence purposes; to correctional institutions; and from health oversight agencies or law enforcement officials who document that the agency's officials would be impeded if the accounting revealed the disclosure. *Id.* § 164.528(a)(1)(i)-(v).

111. *Id.* § 164.528(a)(1).

112. *Id.* § 164.528(b)(2)(i)-(iv).

113. *See id.* § 160.203(b). State laws are also not preempted if they promote certain goods such public health, efficacy in payment of health care, fraud prevention, and audits and program monitoring. *Id.* § 160.203(a), (c), (d).

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protections remain, HHS' privacy regulations create a federal "floor" of protections.

This multi-level approach allows states to tailor health information privacy policies to the specific needs of their populations, but there are at least two disadvantages: (1) it allows individuals in some states to benefit from greater privacy protections than in others and (2) where most electronic health data are exchanged across state boundaries, covered entities (specifically, larger health providers, plans, and clearinghouses) must adhere to national and regional privacy standards. This results in higher costs than would occur if a uniform national standard were in place.

III. BALANCING INDIVIDUAL AND COMMUNAL INTERESTS IN HEALTH DATA: USES AND DISCLOSURES OF HEALTH INFORMATION

A. Disclosures of Protected Health Information

Under the national privacy regulations, individuals exercise some level of control over the use and disclosure of PHI, which ensures individual privacy protection from unlimited sharing of personal medical data. The principal question, however, is how much control individuals should exercise. Privacy protections that allow consumers to restrict the flow of their data through informed consent or advance authorization requirements may hinder the collection of comprehensive and accurate information that may benefit health consumers.[114]

The regulations differentiate among the various purposes for which data may be used and disclosed. Uses and disclosures for health care related purposes (e.g., provision or payment for health care services) are liberally permitted, albeit with the advance "informed consent" of each patient. Uses and disclosures of PHI for other purposes outside the health care context are limited. Disclosures may only be made pursuant to written authorization by the individual, subject to some exceptions. In either context, a minimum disclosure rule applies: when using or disclosing PHI, the covered entity must make reasonable efforts to limit the information to the minimum necessary to accomplish its purpose.[115] The minimum disclosure rule helps patients maintain privacy by enhancing patient autonomy and promoting their trust in the health care system (e.g., in

114. *See* Douglas Sharrott, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK. L. REV. 85 (1992).

115. 45 C.F.R. § 164.502(b)(1).

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reimbursement transactions, where only specific health information is needed).[116]

Rules protecting the privacy of individuals are most important when the benefit to the individual is large, and the burden on the public is small. The following sections clarify that informed consent, which applies for health care related purposes, provides little benefit to the individual at some cost to society, while written authorization, which applies for non health care related purposes, is a somewhat more effective means of protecting individual privacy.

1. Written Consent for Disclosure and Use for Health Care Purposes

The regulations presently require covered health care entities to obtain written consent from individuals before using or disclosing information for treatment, payment, or health care operations. Such consent must: (1) be in plain language;[117] (2) inform the individual that PHI may be used and disclosed to carry out treatment, payment, or health care operations;[118] (3) indicate that the individual can revoke the consent in writing;[119] and (4) request that the covered entity restrict how PHI is used or disclosed for health care purposes (though the covered entity is not required to agree).[120] Certain exceptions for specific disclosures are discussed below.

The written consent requirement for use and disclosure of PHI in health care activities is largely inadequate.[121] Consent under these circumstances

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116. *See* HHS, *Standards, supra* note 58. HHS' recent guidance has clarified a significant concern of health care providers over the permitted uses during treatment when consulting with other physicians or medical staff. The standard as written specifies that the minimum disclosure requirement applies for use of PHI during treatment by health care providers, but not disclosures. This has caused confusion about how health care providers can utilize vital health information in the course of treatment as they work with other medical professionals. In the July 2001 guidance, HHS explained that the exemption for disclosures during treatment allows health care providers to share information with other providers.

117. 45 C.F.R. § 164.506(c).

118. *Id.* § 164.506(c)(1). The consent may not be combined in a single document with the notice. *Id.* § 164.506(b)(3).

119. *Id.* § 164.506(c)(5).

120. *Id.* § 164.506(c)(4)(i). If the covered entity does agree, the agreement is binding. *See id.* § 164.522(a)(i) (restating the standard for an individual's right to request restrictions of uses and disclosures and documenting the requirements for termination of the restrictions).

121. Note that the requirement was not in the proposed rule.

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is neither informed nor consensual. A patient may sign a consent form on his first visit to a physician that applies to all future disclosures and uses. In such cases, the individual will not be aware of the substance of the data protected, because he will typically not know what information is contained in his current records or what may be contained in his future medical records.[122] At the time of consent, he will also not be aware of the specific uses or disclosures because the form need only say "treatment, payment, or health care operations." For these reasons, his execution of a written authorization prior to treatment is uninformed. Such authorization also lacks effective consent where the rule allows providers to condition enrollment in a plan or medical treatment on whether the individual signs the consent form.[123] As a result, the patient can be coerced into consenting if he wants to obtain treatment or health insurance.[124]

2. Authorization for Disclosures Not Related to Health Care

A different consent model for disclosures and uses of PHI unrelated to health care (e.g., for employment decisions or evaluation of credit status) is employed in the regulations. Prior to using or disclosing PHI for non-health care purposes, covered entities must obtain a written authorization from the individual. The authorization, unlike the written consent required for health care purposes, contains specific information to help individuals decide whether to permit disclosure or use. Such authorizations must: (1) identify the information to be used or disclosed in a "specific and meaningful fashion;"[125] (2) provide the names of the persons or organizations who will make and receive the use or disclosures;[126] (3) explain the purpose for each request; (4) notify the individual of his right to refuse to sign the authorization without negative consequences to treatment or health plan eligibility (except under specific circumstances);[127] (5) be written in plain language;[128] (6) include an expiration date;[129] and (7) explain that the individual has a right to revoke the authorization[130] at any

122. *See* Gostin, *National Health*, *supra* note 78, at 3017.
123. 45 C.F.R. § 164.506(b)(1), (2).
124. *See* HEALTH PRIVACY PROJECT, *supra* note 56, at 16; Pritts, *supra* note 71.
125. 45 C.F.R. § 164.508(c)(1)(i).
126. *Id.* § 164.508(c)(1)(ii), (iii).
127. *Id.* § 164.508(e)(1)(iii).
128. *Id.* § 164.508(c)(2).
129. *Id.* § 164.508(c)(1)(iv).
130. *Id.* § 164.508(c)(1)(v).

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time in writing except regarding actions taken by the covered entity in reliance of the authorization.[131] Unlike the informed consent requirement for health care-related disclosures, the individual's choice is respected. The exercise of the right of refusal cannot be used to deny the patient treatment or health insurance.[132]

B. Making Exceptions: Balancing Communal Goods and Personal Privacy

The privacy regulations do, however, make several exceptions to the authorization provisions related to the use and disclosure of PHI. These exceptions include disclosures: (1) to law enforcement officials; (2) for judicial and administrative proceedings; (3) to parents of unemancipated minors; (4) to "significant others," such as family members, close friends, or designated persons of an adult or an emancipated minor; (5) to authorized public health authorities; (6) for health research; and (7) for commercial marketing purposes.

Law Enforcement. A covered entity may disclose PHI to a law enforcement official without informed consent pursuant to a court order, subpoena, or administrative request, including a civil investigative demand or an administrative subpoena.[133] Judges are given no criteria from which to make their determination as they balance individual privacy and law enforcement. In addition, a covered entity may disclose limited

131. *Id.* § 164.508(b)(5)(i).

132. *Id.* § 164.508(b)(4). There are some limited exceptions. One is that health care providers may condition provision of research-related treatment on authorization. Another is that if the covered entity is gathering individually-identifiable health solely for the purposes of disclosing it to a third party, such as an employer, the covered entity may condition this care on the authorization to disclose it to the third party. Further protection is offered regarding psychotherapy notes; authorization is always required for use and disclosure of psychotherapy notes except in specified health care operations. *Id.* § 164.508(b)(5)(i)-(iv).

133. *Id.* § 164.512(f)(1). When an administrative request is utilized, the regulation lays out certain requirements: (1) the information sought must be relevant and material to a legitimate law enforcement inquiry; (2) the request must be specific and limited in scope to the extent reasonably practicable; and (3) de-identified information must not be able to be reasonably used. *Id.* § 164.512(f)(1)(C)(1)-(3). *See* Peter Van Der Goes, Jr., Comment, *Opportunity Lost: Why and How to Improve the HHS-proposed Legislation Governing Law Enforcement Access to Medical Records*, 147 U. PA. L. REV. 1009, 1065-66 (1999).

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information[134] without prior judicial approval where: (1) the information relates to a crime victim who is incapacitated and disclosure is necessary and in the best interests of the individual;[135] (2) PHI is evidence of criminal conduct that occurred on the premises of the covered entity;[136] and (3) in the course of an emergency, disclosure is necessary to alert law enforcement officials of the location, commission, and nature of the crime, victims, or perpetrators.[137]

Judicial and Administrative Proceedings. PHI may be disclosed at any judicial or administrative proceeding without the person's permission in response to a court order or administrative tribunal.[138] As in the law enforcement context, judges are given no criteria in the regulation to exercise their discretion. Covered entities may also disclose health information in response to a subpoena or discovery request if the requester (1) reasonably attempts to inform the patient of the disclosure[139] or (2) reasonably attempts to obtain a protective order to prohibit the recipients from using or disclosing the information for purposes other than the litigation.[140] Instead of placing the burden on litigants seeking the

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134. The permitted information is name, address, date and place of birth, social security number, blood type, type of injury, date and time of treatment, and a description of distinguishing characteristics. 45 C.F.R. § 164.512(f)(2)(i)(A)-(H).

135. *Id.* § 164.512(f)(3). The specific criteria are: (1) the law enforcement official represents that the information is needed to determine whether a crime occurred by an individual other than the victim and that the information will not be used against the victim; (2) the law enforcement official represents that immediate law enforcement activities would be jeopardized by waiting for consent; and (3) the covered entity determines that the disclosure is in the best interest of the individual. *Id.* § 164.512(f)(3)(iii)(A)-(C). If the patient is competent and no emergency exists, the patient must agree under the exception for the disclosure to occur. *Id.* § 164.512(f)(3)(ii).

136. *Id.* § 164.512(f)(5).

137. *Id.* § 164.512(f)(6)(i)(A)-(C).

138. *Id.* § 164.512(e)(1)(i).

139. *Id.* § 164.512(e)(ii)(A). The covered entity must obtain satisfactory assurances that the party requesting information has made a good faith attempt to provide written notice of the individual and that the notice included sufficient information about the litigation to permit the individual to raise an objection in the proceedings. The covered entity must also be given assurances that the time for the individual to raise objections to the court has elapsed and that any objections given were resolved in the favor of the requester. *Id.* § 164.512(e)(1)(iii)(A)-(C).

140. *Id.* § 164.512(e)(1)(ii)(B). The party requesting information must give the covered entity satisfactory assurances that the parties have agreed to a qualified protective order or that the requester has asked for a qualified protected order. *Id.* § 164.512(e)(1)(iv). The standard defines qualified protective order as one that prohibits the parties from using or

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information, the regulation requires that patients make objections to the court.

Minors. Disclosures to parents of unemancipated minors are exempted from consent requirements in multiple cases. If state law forbids *or requires* that parents be informed about their children's health conditions, the regulation allows state law to stand.[141] While many states permit competent minors to receive medical treatment for potentially stigmatizing conditions without parental consent,[142] states could pass laws requiring parents to be informed about their child's condition and treatment. Where no state law exists, the regulation allows parents to serve as personal representatives,[143] who generally can act on behalf of the individual,[144] with some restrictions.[145] The Bush Administration has suggested that it may modify the rule to increase parental access.[146]

"Significant Others" of Adults and Emancipated Minors. Disclosures to "significant others" (i.e., family, friends, caretakers, or health care surrogates) of adults and emancipated minors are narrowly exempted. Covered entities may disclose limited health information to "significant others" without consent if the patient is informed in advance and has the opportunity to agree.[147] The disclosed PHI must be (1) directly relevant to the person's involvement with the patient's care or payment for care[148] or (2) used to notify that person of the patient's location, general

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disclosing PHI for any purpose other than litigation or proceeding for which the information was requested and requires the PHI's return to the covered entity or destruction at the end of the proceeding. *Id.* § 164.512(e)(1)(v)(A).

141. *Id.* § 160.202 (defining "more stringent").

142. *See* Gostin, *National Health*, *supra* note 78, at 3017.

143. 45 C.F.R. § 164.502(g)(1).

144. *Id.* § 164.502(g)(2).

145. If the minor consents to the health care service, the parent agrees to confidentiality between provider and the minor, or the minor consents and does not wish the parent to be personal representative, then the parent is not considered a personal representative. *Id.* § 164.502(g)(3).

146. Thompson, Press Release, *supra* note 1, at para. 10. ("[W]e will make it clear through guidelines or recommended modifications that . . . parents will have access to information about the health and well-being of their children, including information about mental health, substance abuse or abortion"). The July 2001 guidance indicated the Secretary is still considering such action. *See* HHS, *Standards*, *supra* note 58, (indicating that Secretary Thompson is still considering actions to increase parental access).

147. 45 C.F.R. § 164.510(b)(1), (2). Disclosure is also permitted if the covered entity can reasonably infer from the circumstances that the patient does not object to disclosure. *Id.* § 164.510(b)(2)(iii).

148. *Id.* § 164.510(b)(1)(i).

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health condition, or death.[149] In cases of incapacitation or emergency, disclosures to "significant others" may be made in the patient's best interest when directly relevant to the entities' involvement with the individual's care.[150]

Public Health. The health data privacy rule broadly exempts[151] disclosures of PHI for routine public health activities.[152] This includes disclosures: (1) where federal or state law authorizes public health authorities[153] to collect PHI to prevent or control disease, injury or disability, or report child abuse or neglect; (2) to notify persons who may be at risk for or exposed to a communicable disease (e.g., partner notification provisions);[154] and (3) concerning adverse events, tracks and recalls of products, and post marketing surveillance by persons subject to the jurisdiction of the Food and Drug Administration.[155] State reporting or other public health laws are not preempted by the rule even if they offer less privacy protections,[156] thus leaving public health information privacy law to the states.

Health Research. Most federally-funded human subject research is currently subject to federal regulations known as the Common Rule,[157] which does not contain detailed privacy standards, but rather conditions institutional review board (IRB) approval of research on whether "there are adequate provisions to protect the privacy of subjects."[158] Though the

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149. *Id.* § 164.510(b)(1)(ii).

150. *Id.* § 164.510(b)(3). The rule allows relatives and close personal friends to perform common care-taking duties such as picking up prescriptions, medical supplies, etc. *Id.* § 164.510(b)(3).

151. *Id.* § 164.514(b)(2) (clarifying that all of the exceptions apply to uses of PHI as well as disclosures in the public health exemptions section).

152. *See* Gostin, *National Health*, *supra* note 78, at 3016.

153. Public health authority is expansively defined as a federal, tribal, state, or local agency, or a person or entity with a grant of authority or contract with the agency. 45 C.F.R. § 164.501 (defining "public health authority").

154. *Id.* § 164.512(b)(1)(iv).

155. *Id.* § 164.512(b)(1)(iii)(A)-(D).

156. *See id.* § 160.203.

157. *See* Protection of Human Subjects, 56 Fed. Reg. 28003 (June 18, 1991) (codified at 45 C.F.R. § 46).

158. 45 C.F.R. § 46.111(a)(7). In the Common Rule, if consent is required, the researcher must provide the subject with "[a] statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained." *Id.* § 46.116(a)(5). The Common Rule also applies to research conducted in anticipation of Food and Drug Administration approval.

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Common Rule is a helpful guide for protecting the privacy and other ethical interests of human research subjects, it does not apply to privately-funded research. The health data privacy rule closes this gap between the public and private sectors by providing more detailed requirements than the Common Rule. A covered entity may only use or disclose PHI for research without the person's permission if it obtains a waiver from an IRB or privacy board[159] that finds: (1) the use or disclosure involves no more than minimal risk; (2) the waiver will not adversely affect the privacy rights and welfare of the individual; (3) the research could not practicably be conducted without the waiver; (4) the privacy risks are reasonable in relation to the anticipated benefits to the individual, and in relation to the importance of the research; (5) a plan exists to protect the identifiable information from improper use and disclosure; (6) a plan to destroy the identifiers exists unless there is a health or research justification for retaining them; and (7) there are written assurances that the data will not be reused or disclosed to others, except for research that would also qualify for a waiver.[160] Researchers must also show that PHI is necessary for the research, will not be disclosed to outsiders, and is sought solely to prepare for the research.[161] While certain critics are concerned over the burdens imposed by the new requirements,[162] the regulation fairly ensures that there are valid justifications for utilizing PHI for research without consent.

Commercial Marketing. In contrast to some of the other exceptions, which offer either greater or similar protections than the law currently provides, the exception for commercial marketing provides for less privacy protection by condoning the use or disclosure of PHI for commercial

159. *See id.* § 164.512(b)(1)(i). The privacy board must have members with varying backgrounds, appropriate professional competency, and no conflict of interest. *Id.* § 164.512(i)(1)(i)(B). At least one member must be unaffiliated with the covered entity and research entity. *Id.* § 164.512(i)(1)(i)(B)(2). This includes relatives of individuals affiliated with the organizations. *Id.* A majority of the privacy board must be present when considering a waiver, including the unaffiliated member. *Id.* § 164.512(i)(2)(iv)(B).

160. *Id.* § 164.512(i)(2)(ii)(A)-(H).

161. *Id.* § 164.512(i)(1)(ii)(A)-(C). *See also* Mark Barnes & Sara Krauss, *The Effects of HIPAA on Human Subject Research*, 10 HEALTH L. REP. 1026, 1030-31 (2001).

162. *See, e.g.*, Barnes & Krauss, *supra* note 161, at 1031 (arguing that IRB's are ill-prepared to make the assessments now required of them by the health data privacy rule); Jocelyn Kaiser, *Researchers Say Rules Are Too Restrictive*, 294 SCIENCE 2070 (2001); J. Kulynych & D. Korn, *The Effect of the New Federal Medical-Privacy Rule on Research*, 346 NEW ENG. J. MED. 201 (2002).

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marketing without consent.[163] PHI may be used or disclosed without consent for marketing communications to the individual that occur in face-to-face encounters (whether health-related or not),[164] concern products or services of nominal value, or concern health-related products and services of the covered entity or a third party.[165] A covered entity may target persons based on their health status if the product or service may benefit them.[166] However, commercial communications must identify the covered entity, disclose whether the entity is receiving remuneration for the communication or sale, and instruct individuals how they can opt out of receiving future communications. If a covered entity targets persons based on their health status, it must pre-determine whether the product or service may benefit those persons and indicate why they have been selected.[167]

CONCLUSION

The systematic electronic collection, use, and disclosure of individually-identifiable health information are essential to achieving several important communal goals. Public health authorities and health researchers require health data to perform accurate, beneficial studies, and shape effective interventions and treatments. The exchange of electronic data can improve clinical outcomes, prevent fraud and abuse, and help consumers make informed choices about their health care. With these benefits, however, come significant threats to individual privacy and civil liberties, including discrimination and autonomy violations from unwarranted disclosures to health insurers, employers, and governmental agencies.

Through its health information privacy rule, HHS seeks to provide a national standard that balances individual interests in health information privacy with society's interests in accomplishing various communal goals. The rule provides expansive, new protections for health data privacy and security. In many ways, it improves existing privacy protections by creating an equitable, even field in which information can be responsibly exchanged. At the same time, the rule fails to provide a sufficient floor of

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163. *See* Robert Gellman, *Analysis of the Marketing Provisions of the HIPAA Privacy Rules, available at* http://www.hipaadvisory.com/action/privacy/marketing.htm (last visited April 13, 2002).

164. *See id.* at para. 7.

165. 45 C.F.R. § 164.514(e)(2)(A)-(C).

166. *Id.* § 164.514(e)(3)(ii)(A).

167. *Id.* § 164.514(e)(3)(ii)(A)-(B).

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protection for the use and disclosure of all health information. Limited by Congressional authorization under HIPAA, HHS at times trades personal privacy for public (e.g., public health exception) and non-public goods (e.g., commercial marketing exception). Reaching a final balance between individual and communal uses of health data may require additional authorization from Congress, or alternatively, new federal legislation. For now, the regulation represents a new standard in an age of increasing threats to individual interests in protecting the privacy of their health data.

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INSURANCE PRIVACY AFTER GRAMM-LEACH-BLILEY— OLD CONCERNS, NEW PROTECTIONS, FUTURE CHALLENGES

J. Stephen Zielezienski and Catherine I. Paolino***

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INTRODUCTION

> *The intensity and complexity of life, attendant upon advancing civilization, have rendered necessary some retreat from the world, and man, . . . has become more sensitive to publicity, so that solitude and privacy have become more essential to the individual.*[1]

This quote could have been written today, but it was actually part of a watershed 1890 Harvard Law Review article authored by Samuel Warren and Louis Brandeis. The Warren and Brandeis article introduced the nation to the newly-minted "right to privacy." Since that time, the privacy issue has been revisited periodically in various branches of government, often coinciding with technological advances and corresponding collisions with personal privacy.

Prior to the enactment of the Gramm-Leach-Bliley Act (GLBA) in 1999, the last resurfacing of the insurance privacy debate occurred in the late 1970s and early 1980s during the height of the federal government's Privacy Protection Study Commission[2] (Privacy Commission), a body charged with determining the need to extend privacy protections established in the federal Privacy Act of 1974[3] to the private sector. The federal Privacy Act granted certain personal privacy protections to information held by federal agencies. Among the Commission's recommendations were the establishment of mechanisms for an insurance

1. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV., 192, 196 (1890).

2. The Privacy Protection Study Commission is established by § 5(a)(1) of Pub. L. No. 93-579.

3. Privacy Act of 1974, Pub. L. No. 93-579, § 1, 88 Stat. 1896, 1905 (codified as amended at 5 U.S.C. § 552a (2001)).

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consumer to obtain and correct information in an insurance company's files, and notification to an applicant about how an insurer uses personal information in the underwriting process.[4]

This debate and the Commission's recommendations spawned a model law produced by the National Association of Insurance Commissioners (NAIC), which was finalized in 1982. That model, commonly known as the Insurance Information and Privacy Protection Act (1982 NAIC Model or 1982-based law), was substantially adopted in fifteen states.[5] Among other things, the 1982 NAIC Model—which applies to personal lines insurance transactions[6]—established standards and procedures for: (a) privacy notices to applicants and policyholders;[7] (b) access and correction rights;[8] (c) disclosure of nonpublic personal information to others;[9] and (d)

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4. U.S. PRIVACY PROT. STUDY COMM'N, PERSONAL PRIVACY IN AN INFORMATION SOCIETY: THE REPORT OF THE PRIVACY PROTECTION STUDY COMMISSION 188-220 (1977).

5. *See* ARIZ. REV. STAT. ANN. §§ 20-2101 to -2120 (West 2002); CAL. INS. CODE §§ 791.01-.26 (West 2000); CONN. GEN. STAT. ANN. §§ 38a-975 to -998 (West 2000); GA. CODE ANN. §§ 33-39-1 to -23 (Harrison 1998); 215 ILL. COMP. STAT. ANN. 5/1001-1024 (West 2000); ME. REV. STAT. ANN. tit. 24-A, §§ 2201-2220 (West 2000); MASS. GEN. LAWS. ANN. ch. 175I, §§ 1-2 (West 1998) (adopting life, health and disability insurance only); MINN. STAT. ANN. §§ 72A.49-.505 (West 1999); MONT. CODE ANN. §§ 33-19-10 to -409 (2001); NEV. REV. STAT. ANN. § 679B.135 (Michie 1997); NEV. ADMIN. CODE ch. 679B, §§ 679B.560-.750 (2001); N.J. STAT. ANN. §§ 17:23A-1 to -22 (West 1994); N.C. GEN. STAT. §§ 58-39-1 to -120 (1999); OHIO REV. CODE ANN. §§ 3904.1-.22 (Anderson 1996); OR. REV. STAT. §§ 746.600-.690 (2001); VA. CODE ANN. §§ 38.2-600 to -620 (Michie 1994). In several states, including Ohio and Massachusetts, the law does not apply to property and casualty insurance (but rather to other types of coverage, like life insurance). *See* MASS GEN. LAWS ANN. ch. 175I, §§ 1-2 (West 1998); OHIO REV. CODE ANN. §§ 17:23A-1 to -22 (West 1994). In other states, where it is applied to property and casualty insurance, the scope extends only to personal lines of coverage and not to claimants under a commercial lines policy, like workers' compensation. Also, Kansas and Wyoming only adopted portions of the 1982 NAIC Model. *See* KAN. STAT. ANN. §§ 40-2,111 to 113 (2000) (adopting adverse underwriting provisions only); Wyo. Ins. Regs. Ch. XXV (1997) (applicable only to public records). As an aside, Hawaii repealed their 1982-based law in 1993.

6. The Act applies to life, health, and property/casualty insurance, and is limited to personal lines of insurance coverage by the definition of an "insurance transaction." Within this context, the Act's definition of "insurance transaction" reaches to: (a) eligibility for coverage, benefit, or payment and (b) servicing during the insurance process. NAIC INS. INFO. & PRIVACY PROT. MODEL ACT, § 2(N) (NAIC 1982). The 1982 NAIC Model protects the rights of "natural persons" who are the subject of information collected, received or maintained in connection with insurance transactions, and applicants, individuals or policyholders who engage in or seek to engage in insurance transactions. *Id.* § 1.

7. *Id.* § 4.

8. *Id.* §§ 8, 9.

9. *Id.* § 13.

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information used in adverse underwriting decisions.[10] When adopted, the 1982 NAIC Model joined the existing framework of other privacy laws that impacted the insurance industry, including the federal Fair Credit Reporting Act (FCRA),[11] state fair credit reporting acts, and state medical record confidentiality laws.[12] Thus, when GLBA arrived on the scene as a federal privacy standard for financial institutions (including state-regulated insurers) in 1999, the insurance industry had already experienced two

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10. *Id.* §§ 10-12.

11. Consumer Credit Protection Act, 15 U.S.C. §§ 1681–1681u (2000).

12. At least twenty-one states have enacted legislation that expressly governs the confidentiality of medical information. States with medical confidentiality legislation are: Arizona; California; Connecticut; Florida; Georgia; Illinois; Maryland; Michigan; Minnesota; Montana; New Hampshire; North Carolina; Oregon; Rhode Island; South Carolina; Tennessee; Texas; Washington; West Virginia; Wisconsin; and Wyoming. *See, e.g.*, ARIZ. REV. STAT. § 20-2101 (2002); CAL. INS. CODE § 791.01 (West 2001); CONN. GEN. STAT. ANN. § 38a-981 (West 2001); FLA. STAT. Ch. 440.13 (2002); GA. CODE ANN. § 33-39-1 (Harrison 1998); 215 ILL. COMP. STAT. 5/1001 (2000); ME. REV. STAT. ANN. tit. 24 § 2201 (West 2000); MD. CODE ANN., INS. § 2-109, (2001); MINN. STAT. ANN. § 72A.49 (West 1999); N.C. GEN. STAT. § 58-39-1 (2001); OR. REV. STAT. § 746.620 (2001); R.I. Dep't of Bus. Regulation, Regulation 100 § 4A (2001); Wyo. Dep't. of Ins., Rules and Regulations, ch. 54 art. 2 § 5 (2002). Generally, these state statutes prohibit the disclosure of an individual's medical information unless the individual has given written authorization, or there exists a specific statutory exception. Typical statutory exceptions to the disclosure prohibition include: (a) disclosures to attending and consulting health care providers currently providing health care to the patient for diagnostic or treatment reasons; (b) disclosures to emergency care personnel (i.e., ambulance attendants) for the purpose of providing care to or transferring the patient whose records are requested; (c) disclosures to private agencies that accredit health care providers or to health care providers for the purpose of conducting utilization review, peer review and quality assurance examinations; (d) disclosures to entities that provide billing, claims management, medical data processing, utilization review or other administrative services to the patient's health care providers; (e) disclosures pursuant to compulsory process (i.e., subpoenas); (f) disclosures to a health care provider's attorney in possession of the medical record for the purpose of securing legal advice; (g) disclosures for research purposes; (h) disclosures to the personal representative or administrator of the estate of a deceased patient; or (i) disclosures to the patient's third-party payor if the payor has produced to the health care provider separate written authorization from the patient to disclose medical record information. *See, e.g.*, N.C. GEN. STAT. § 58-39-75 (2001).

A third-party payor refers to a party, other than the patient receiving treatment, who is responsible for the cost of the treatment. For example, Iowa's "Disclosure of Mental Health and Psychological Information" law defines a third-party payor as "a person which provides accident and health benefits or medical, surgical, or hospital benefits, whether on an indemnity, reimbursement, service, or prepaid basis, including but not limited to, *insurers*, nonprofit health service corporations, health maintenance organizations, governmental agencies, and self-insured employers." IOWA CODE § 228.1 (West 2000) (emphasis added).

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decades of privacy regulation in jurisdictions covering at least forty percent of the geographic market.

Notwithstanding the industry's experience with regulation of its information handling practices, a number of challenges remained. First and foremost, to place insurers on the same regulatory playing field as other financial institutions regulated at the federal level, the industry required operationally consistent and uniform implementing regulations among the fifty states, the Commonwealth of Puerto Rico, and the District of Columbia. Second, GLBA privacy standards needed to be meshed with the existing insurance privacy framework in the fifteen 1982 NAIC Model states. Third, jurisdictions without existing statutory authority to adopt GLBA privacy regulations needed enabling legislation from their respective state legislatures.

Within this context, the objective of this article is to: (a) describe the process of insurance privacy regulation in the wake of GLBA; (b) survey the privacy landscape by assessing the degree of operational uniformity and cataloging specific issues, successes and failures; (c) set forth additional privacy concerns on the immediate horizon that may influence the policy debate; and (d) provide reasons why attempts to depart from the GLBA "opt-out" approach should be rejected in favor of operational uniformity among all insurance regulatory jurisdictions. Our logical starting point is GLBA.

GLBA was the culmination of a lengthy debate and process that produced an open financial services industry, allowing for common ownership and ease of communication among the different sectors (banking, insurance, and securities). Previously, Glass-Steagall,[13] put in place in the 1930s, sought to separate the sectors into distinct silos.[14] As products and services became more integrated, and financial institutions sought consolidation, Glass-Steagall became outdated and impractical.

Discussion of consumer privacy in the context of financial services modernization came late in the game, and focused on concerns that companies in one financial services sector would take advantage of GLBA to share sensitive information with companies in another industry for inappropriate reasons without the consumer's knowledge. Such concerns

13. 12 U.S.C. § 377 (2000).

14. *See* Banking Act of 1933, ch. 89, 48 Stat. 162. *See also* Bank Holding Company Act of 1956, ch. 249, 70 Stat. 133 (codified as amended at 12 U.S.C. §§ 1841-1848 (1994)); The Securities Act of 1933 (codified as 15 U.S.C. §§ 77a-bbbb (1994 & Supp. V 1999); The Securities Exchange Act of 1934 (codified as 15 U.S.C. §§ 78a-mm. (1994 & Supp. V 1999).

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led Congress to agree on privacy protections within Title V of GLBA. While those provisions were crafted at a late stage of the legislative process, it is safe to say that Title V has captured the lion's share of public attention since GLBA became law on November 12, 1999.

Title V is targeted at the financial services "consumer." That term is defined as "an individual who *obtains*, from a financial institution, financial products or services which are to be used *primarily for personal, family, or household purposes*."[15] As a result, in the insurance context, GLBA was intended to provide privacy protection for personal lines customers (such as those who purchase life, automobile or homeowners' insurance).

Title V sets forth notice requirements and standards for the disclosure of nonpublic personal financial information of financial services consumers (i.e., those with a business relationship with a financial institution and those who apply for products or services)[16] by financial institutions. In brief, it requires financial institutions to provide consumers with an initial and annual notice of the institution's privacy policies and practices[17] and to give those consumers an opportunity to opt-out of certain information disclosures by the institution to nonaffiliates.[18] Title V contains a number of important business function exceptions[19] and a "joint marketing" exception that permits the institution to disclose a consumer's information without providing an opt-out opportunity.[20] The privacy provisions prohibit financial institutions from disclosing account or account access numbers to nonaffiliates for marketing purposes.[21] Title V also directs the functional regulators of those institutions to promulgate data security standards to protect against unauthorized access to or disclosure of nonpublic personal financial information.[22] Further, it does *not* permit restrictions on the sharing of information among a financial institution's affiliates.[23]

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15. 15 U.S.C. § 6809(9) (emphasis added).

16. GLBA, by its terms, does not specifically protect applicants, but all of the implementing regulations have applied Title V privacy standards to protect this category of individuals.

17. 15 U.S.C. §§ 6802(a), 6803.

18. *Id.* § 6802(b).

19. *Id.* § 6802(e).

20. *Id.* § 6802(b)(2).

21. *Id.* § 6802(d).

22. *Id.* § 6801(b).

23. *Id.* § 6802(b). The FCRA contains an express federal preemption on state affiliate sharing restrictions. *Id.* § 1681t (2000).

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GLBA also provides for functional financial institution regulators to implement the privacy standards in Title V for their respective regulated institutions.[24] Because the regulation of insurance is "subject to the laws of the states"[25] unless preempted by federal law specifically related to the business of insurance, implementation and enforcement of GLBA's privacy standards became a concern for each insurance regulatory jurisdiction.[26]

I. PRIVACY MODELS IMPLEMENTING GLBA STANDARDS

A. NAIC Model Privacy Regulation

Due to concerns over consistency and uniformity, and with an eye towards modifying GLBA privacy standards to provide a different level of protection to insurance consumers than conferred by Title V, the National Association of Insurance Commissioners, an organization comprised of the nation's insurance regulators, began discussions with the insurance industry, consumer advocates, and other interested parties aimed at producing a single regulatory model for privacy protection.[27] The resulting product was the NAIC's "Privacy of Consumer Financial and Health Information Regulation" (NAIC Model Regulation or Model Privacy Regulation)[28], adopted unanimously by the NAIC on September 26, 2000, nearly eleven months after the passage of GLBA. Like the regulations issued by their federal counterparts, the NAIC Model Regulation set a compliance date of July 1, 2001, in order to give regulated entities an opportunity to develop and implement compliance programs.[29]

Unlike the GLBA regulations developed by federal agencies, the NAIC Model Regulation expansively interprets GLBA in at least four areas. First, the Model Privacy Regulation subdivides the definition of "consumer" found in GLBA and expands its reach, segmenting that term into two protected categories: (a) "consumers" (defined as those who *seek to obtain,* obtain, or *have obtained* an insurance product or service primarily used for personal, family, or household purposes)[30] and (b) a

24. *Id.* § 6804(a).
25. *Id.* § 1012(a).
26. *See id.* § 1012.
27. The NAIC was formed in 1871. Its members include regulators from all fifty states, the District of Columbia, and the U.S. territories.
28. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672, (NAIC 2000).
29. *Id.* § 26B.
30. *Id.* § 4F.

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subset called "customers" (defined as consumers with a "continuing relationship" with an insurer or other licensee).[31] The impact of this definition is to provide privacy protection not only for policyholders, but to protect insurance applicants explicitly as well. Examples used to illustrate the scope of the consumer definition also make it clear that claimants can be consumers where an insurance licensee discloses nonpublic personal financial information outside the exceptions listed in the NAIC Model Regulation.[32] Second, the NAIC Model Regulation purports to cover some aspects of commercial lines insurance. Section 4F(2)(e) specifically references workers' compensation insurance, stating that workers' compensation "beneficiaries" are to be treated as consumers for purposes of the NAIC Model Regulation where a licensee fails to provide notice to the workers' compensation "plan participant" and the beneficiary's nonpublic personal financial information is disclosed outside regulatory exceptions.[33] Third, the NAIC Model Regulation specifically outlines requirements for disclosures of nonpublic personal health information, adopting a number of important business exceptions, but requiring an authorization (also known as an "opt-in") if the consumer's health information is disclosed to affiliates or non-affiliates outside those exceptions.[34] Fourth, the NAIC Model Regulation applies its standards to all those licensed under the insurance laws of a jurisdiction, rather than only to financial institutions domiciled in that jurisdiction.[35] As a result, the regulation applies not only to insurance companies, but also to agents, brokers, and others licensed under the state insurance codes. As detailed more fully below, the cumulative impact of these deviations from GLBA has been felt in a number of ways, most noticeably in differing interpretations of these provisions by certain state insurance regulators.

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31. *Id.* §§ 4I, J.

32. *Id.* § 4F(2)(d)(ii). At the same time, the NAIC Model Regulation also makes it clear that consumers who are claimants do not enter into a customer relationship with an insurance licensee. *Id.* § 4J(2)(b)(iv), (v).

33. The terms "beneficiary" and "plan participant" are not used in the workers' compensation industry. The NAIC has clarified that the workers' compensation plan participant is the workers' compensation policyholder, and a number of regulators have equated the workers' compensation beneficiary with the workers' compensation claimant. For a more detailed discussion of issues surrounding the introduction of workers' compensation insurance into the NAIC Model Regulation, see discussion *infra* pp. 344-350.

34. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672, §§ 17-21 (NAIC 2000).

35. *Id.* § 2A. GLBA applies its standards to financial institutions in their state of domicile. *See* 15 U.S.C. § 6804(1) (2000).

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B. NCOIL Privacy Model

The National Conference of Insurance Legislators' Financial Information Privacy Protection Model Act (NCOIL Model), adopted on March 2, 2001, provides a legislative alternative to jurisdictions seeking to effect GLBA privacy standards for insurance licensees.[36] The framework of the NCOIL Model is similar to the NAIC Model Regulation, but clarifies that regulation in the following ways: (a) the NCOIL Model explicitly excludes commercial lines insurance, such as activity with respect to workers' compensation claimants[37] and (b) opt-in authorization is only required where a consumer's nonpublic personal health information is disclosed for marketing purposes.[38]

While the NCOIL Model clarifies some ambiguities contained in the NAIC Model Regulation, it creates ambiguities as well. For example, the health information provisions of the NCOIL Model utilize two overlapping definitions of health information: "personally identifiable health information" and "nonpublic personal health information."[39]

II. SURVEY OF THE PRIVACY LANDSCAPE

In 2001, approximately 765 privacy-related bills and regulations were introduced in Congress and in the states. Many of the state proposals responded to GLBA, either by enabling the state insurance regulator to promulgate regulations or through direct implementation of a regulatory scheme based on the NAIC Model Regulation. Our survey focuses on the implementation and interpretation concerns that arose (and continue to arise) from the promulgation of state regulatory language patterned after the NAIC Model Regulation.

A total of forty-seven jurisdictions have either proposed or finalized GLBA privacy requirements.[40] Of the remaining five jurisdictions, all have

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36. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4F (NAIC 2000).

37. FIN. INFO. PRIVACY PROT. MODEL ACT § 103E (Nat'l Conf. of Ins. Legislators, 2001) ("In particular, this Act does not apply to commercial insurance policies issued by the licensee."). *Id.*

38. *Id.* § 501A ("A licensee shall obtain an authorization to disclose, prior to making such disclosure, any personally identifiable health information if the purpose of the disclosure is for the marketing of services or goods for personal, family or household purposes."). *Id.*

39. *Compare id.* §§ 501A, *with* 501D.

40. Included are Connecticut, Illinois, Maine, Montana, Nevada, North Carolina, Ohio, Oregon, and Virginia, all of which are 1982 NAIC Model jurisdictions that are attempting to

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previously adopted the 1982 NAIC Model.[41] Inevitably, a number of jurisdictions have implemented privacy standards in ways that threaten operational uniformity and consistency. The major implementation and interpretation issues arising during 2001 are detailed below. The following chart illustrates the pattern of privacy regulation in the states during 2001.

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incorporate GLBA privacy requirements into existing laws. *See* 215 ILL. COMP. STAT. ANN. 5/1001-1023.5 (West 2000); ILL. ADMIN. CODE tit. 50, § 4002 (2001); ME. REV. STAT. ANN. tit. 9-B, § 161 (West 2000); ME. REV. STAT. ANN. tit. 24-A, § 2201 (West 2000); MONT. CODE ANN. § 33-19-101 (2001); N.C. GEN. STAT. § 58-39-1 (2001); OR. REV. STAT. § 746.600 (2001); VA. CODE ANN. § 38.2-600 (Michie 1994); Conn. Dep't of Ins., Proposed Regulation § 38a-8-105 (Dec. 2001); Me. Bureau of Ins. Bulletin 308 (July 2001); Nev. Div. of Ins., Proposed Regulation LCB R130-01 (Oct. 2001); Ohio Dep't of Ins., LSC Draft § 3904.01 (Mar. 2002); Or. Dep't of Consumer & Bus. Servs. Ins. Div. Admin. Rules, Rules 836-080-0500 to -0540.

41. These jurisdictions are California, Georgia, Massachusetts, Minnesota, and New Jersey. *See* CAL. INS. CODE § 791.01 (West 2001); GA. CODE ANN. § 33-39-1 (Harrison 1998); MASS. GEN. LAWS ANN. ch. 175I, §§ 1-22 (West 1998); MINN. STAT. ANN. § 72A.49 (West 1999); N.J. STAT. ANN. § 17:23A-1 (West 1994).

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Survey of Privacy Landscape - 2001 Year End

	Non 1982 Act Based Jurisdiction Total = 37 (incl. DC & PR)				1982 Act Based States Total = 15			
	Mostly follows NAIC	Notable NAIC deviation	Financial & Health	Financial Only	Final or proposed	Add'l laws/regs expected	No revisions	Notable NAIC deviation
Alabama	X			X				
Alaska		X	X					
Arizona					X			
Arkansas		X	X					
California						X		X (potential)
Colorado	X		X					
Connecticut					X			
Delaware	X			X				
District of Columbia	X			X				
Florida	X		X					
Georgia							X	
Hawaii	X			X				
Idaho		X		X				
Illinois					X			
Indiana	X			X				
Iowa	X		X					
Kansas	X			X	*(Adopted only a portion of the 1982 Model Act)*			
Kentucky	X		X					
Louisiana	X			X				
Maine					X			
Maryland		X	X					
Massachusetts						X		X (potential)
Michigan	X			X				
Minnesota							X	
Mississippi	X		X					
Missouri	X			X*				
Montana					X			X
Nebraska	X		X					
Nevada					X			
New Hampshire	X		X					
New Jersey							X	
New Mexico	X		X					
New York	X			X*				
North Carolina					X			X
North Dakota	X		X					
Ohio					X			
Oklahoma	X		X					
Oregon					X			
Pennsylvania	X		X					
Puerto Rico		X	X					
Rhode Island		X (potential)	X					
South Carolina	X		X					
South Dakota	X			X				
Tennessee	X			X*				
Texas	X		X					
Utah	X		X					
Vermont		X		X				
Virginia					X			
Washington		X (potential)	X					
West Virginia	X		X					
Wisconsin		X	X					
Wyoming	X		X		*(Adopted only a portion of the 1982 Model Act)*			
TALLY	28	9	23	14	10	2	3	4

* States considering adding health related provisions.

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III. IMPLEMENTATION ISSUES AND INTERPRETATION QUESTIONS

A. Mandating Property and Casualty Insurer Compliance with HHS Regulations

The NAIC Model Regulation encompasses the treatment of both financial and health information. The health information provisions of the Model Privacy Regulation, set forth in Article V (sections 17 through 21), require insurance licensees, prior to disclosure, to obtain an authorization "from the consumer or customer whose nonpublic personal health information is sought to be disclosed."[42] This authorization, or opt-in, requirement is subject to a number of business function exceptions, such as disclosure of nonpublic personal health information for underwriting or claims administration.[43] In addition, the Model Privacy Regulation's health information provisions recognize that some segments of the insurance industry will have to comply with rules promulgated by the U.S. Department of Health and Human Services (HHS)[44] as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).[45]

While the insurance industry ultimately accepted the health information provisions of the Model Privacy Regulation and began preparations for compliance with those provisions, inclusion of the provisions in the Model Privacy Regulation extended it beyond the plain terms of Title V of GLBA. Title V does not explicitly address nonpublic personal health information and certainly does not contain an opt-in authorization requirement. Rather, GLBA refers to "nonpublic personal information" disclosed by financial institutions, which is, by definition, limited to financial information.[46] As a result, there was no need for the NAIC to promulgate health information privacy regulations (which were not contemplated by GLBA).[47] Indeed, in

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42. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672, § 17A (NAIC 2000).

43. *Id.* § 17B.

44. STANDARDS FOR THE PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, 45 C.F.R. §§ 160-164, (2001).

45. 42 U.S.C. §§ 1320d to 1320d-8 (2000).

46. 15 U.S.C. § 6809(4)(A) (2001) ("The term 'nonpublic personal information' means personally identifiable *financial* information . . . ."). *Id.* (emphasis added).

47. We do note that GLBA regulations adopted by the functional federal regulators interpreted "nonpublic personal information" to include both financial and health information, but preserved the opt-out structure for both types of information. Privacy of

many jurisdictions, medical disclosure laws already govern the handling of health information. As a result of the disparity between the scope of GLBA and the NAIC Model Regulation, a number of states decided to omit the NAIC Model's Article V relating to health information.[48]

Since the federal government has existing health privacy standards, the NAIC did not force duplicative standards. Alternatively, the NAIC decided to allow an exemption from the health portions of the Model Privacy Regulation where a licensee is in compliance with the HHS privacy rules. Specifically, section 20 of the NAIC Model Regulation provides that:

> Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act [HIPAA] privacy rule as promulgated by the U.S. Department of Health and Human Services (the "federal rule"), if a licensee complies with all of the requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provision of this Article V.[49]

In essence, the Model Privacy Regulation establishes an option for those insurers and others not subject to HIPAA: either comply with the HHS rules or comply with the terms of the Model Privacy Regulation.

Several states, when developing their regulations, drafted language that would seemingly negate this option and mandate compliance with both the HHS rules and the Model Privacy Regulation. This was problematic in several respects. Failure to alter this provision, which may be improperly

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Consumer Financial Information, 12 C.F.R. § 573 (2001). The NAIC could have followed the lead of the functional federal financial services regulators and included health information within the scope of nonpublic personal financial information, but subjected this additional information to GLBA's opt-out provisions.

48. At the time of this article, of the thirty-seven jurisdictions without a 1982-based law, fifteen have laws or regulations which address financial information privacy only: Alabama, Delaware, District of Columbia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Michigan, Missouri, New York, South Dakota, Tennessee and Vermont. *See* Ala. Dep't of Ins., Regulation 122 (Oct. 2001); Del. Ins. Dep't, Regulation 84 (July 2001); D.C. MUN. REGS. tit. 26, § 36 (2002); HAW. REV. STAT. § 431:101 (2002); Idaho Dep't of Ins., Temporary Rule IDAPA 18.01.48 (July 2001); IND. ADMIN. CODE tit. 760, r. 1-67 (2002); KAN. ADMIN. REGS. 40-1-46 (2002); LA. ADMIN. CODE tit. 37:XIII, § 99 (2002); MICH. COMP. LAWS § 500.501 (2002); MO. CODE REGS. ANN. tit. 20, § 100-6.100 (2002); N.Y. COMP. CODES R. & REGS. tit. 11, § 420 (2001) (Regulation 169); S.D. ADMIN. R. 20:06:45 (2002); TENN. COMP. R. & REGS. 0780-1-72 (2002); Vt. Dep't of Banking, Ins., Sec. & Health Care Admin., Regulation IH-2001-01 (2001).

49. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672, § 20 (NAIC 2000).

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read to require licensees not currently subject to the HHS rules to comply with those regulations, may undermine the goal of functional uniformity of state privacy regulation. The federal government specifically governs the use of health information by "covered entities" under the oversight of HHS. Property and casualty and life insurers are not "covered entities" under the federal HHS requirements and treating them as such would impede routine disclosures of information in the workers' compensation context and would be inconsistent with existing policy. HHS has made a determination that HIPAA does not contemplate applicability to the property and casualty sector.[50]

States where this became an issue in 2001 include Washington, Florida and Colorado. Washington departs from the Model Privacy Regulation by referring to HHS regulations as well as to the state's Patient Bill of Rights[51] (neither of which apply to property and casualty or life insurance companies). The "HHS rule" provision of the Washington Administrative Code reads:

> All licensees shall develop and implement written policies, standards and procedures for the management of health information, including policies, standards and procedures to guard against the unauthorized collection, use or disclosure of nonpublic personal health information by the licensee *consistent with regulations adopted by the U.S. Department of Health and Human Services governing health information privacy (45 CFR 160 through 164)* which shall include . . . .[52]

The "consistent with" language can be read in one of two ways: (a) to impose HHS health privacy standards on *all* licensees, without regard to whether they are "covered entities" under the federal rule or (b) to apply HHS standards only to those licensees that are covered entities (and to give other licensees an exemption from those standards consistent with their treatment under the HHS rules). The latter interpretation makes more sense, as the intent of the regulatory language is to create health

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50. *See* Standards for the Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160-164 (2001).

51. Section 284-04-510 of the Washington Administrative Code proposes regulatory standards similar to the Washington Patient Bill of Rights. While the scope and application issues arising from this section have not yet been resolved with the Department of Insurance, this language does not become effective until December 30, 2002. WASH. ADMIN. CODE § 284-04-620(4) (2002).

52. *Id.* § 284-04-500 (emphasis added).

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information privacy standards that parallel the HHS rule. At this time, the Washington Department of Insurance has not confirmed either reading of the language, but has been urged to apply a reading that does not attempt to expand the scope of the federal rule.[53]

Similarly, the proposed privacy rule in Florida contained an effective date provision that could have been interpreted to require all licensees (rather than only "covered entities") to comply with the HHS privacy rules by April 14, 2003.[54] Furthermore, it differed from the Florida Workers' Compensation Act, which requires health care providers to make disclosures to workers' compensation carriers.[55] The ambiguity concerning this provision of the Florida proposed privacy rule was resolved in two ways. First, the Florida Insurance Department issued a question-and-answer document, which clarified that licensees not subject to the HHS rules could, but were not required to, comply with the federal standards.[56] Second, the Department adopted an amendment to section 4-18.020(2) of the Florida Administrative Code to limit the scope of the HHS provision to health insurers and HMOs:

> (2) Effective April 14, 2003, with respect to health insurance coverage issued by a health insurer or contracts issued by a health maintenance organization such licensees must be in actual compliance with the Health and Human Services rules in order to be considered in compliance with this Part. As of such date, any other licensee that would satisfy the requirements of the HHS rules if it were subject to such rules will be considered to be in compliance with this part.[57]

The Department's solution, therefore, clearly limits the scope of this provision to covered entities under the HHS rules, thus preserving the exemption for property and casualty and life insurance companies.

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53. Aside from this important interpretation issue, the regulatory reference to the HHS rule produces an odd result because a possible reading would require insurance licensees to comply with an HHS privacy standard *that is not yet effective.*

54. "Effective April 14, 2003, . . . [a licensee] must be in actual compliance with the Health and Human Services rule in order to be considered in compliance with this Part." FLA. ADMIN. CODE ANN. § 4-128.020 (proposed July 17, 2001).

55. FLA. STAT. ANN. § 440.13 (West 2001).

56. Fla. Dep't of Ins., Questions on Emergency Privacy Regulation, Questions 14 & 15, *at* http://www.doi.state.fl.us/Consumers/Alerts/press/indextest.html (revised Aug. 2001).

57. Fla. Dep't of Ins., Notice of Proposed Changes to Fla. Admin. Code § 4-128, at 2 (Sept. 7, 2001) (on file with author).

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The proposed amended Colorado privacy regulation tied its HHS rules provision to the draft federal rules promulgated in December 2000, rather than to the final amended rules issued in 2001. That regulation foreclosed inclusion of later versions of the HHS rules by adding that "this rule does not include later amendments to, or editions of, the above-referenced regulations."[58] Fortunately for those exempt from the HHS rules, the final version of the Colorado regulation not only solves this problem, it specifically provides that

> [n]othing in this regulation is intended to require a carrier that is not subject to the federal Health Insurance Portability and Accountability Act privacy rules as promulgated by the U.S. Department of Health and Human Services, 'Standards of Privacy of Individually Identifiable Health Information' to comply with the federal regulation.[59]

B. 1982 NAIC Model States and GLBA Privacy Implementation

The fifteen states with an existing insurance privacy law based on the 1982 NAIC Model presented the industry with a unique compliance dilemma: how to prepare for an impending July 1, 2001 GLBA effective date while complying with the existing privacy standards. An analysis of differences between the 1982 NAIC Model and the Model Privacy Regulation reveals that the compliance concerns centered on two areas: notice standards and disclosure exceptions.

1. Privacy Notices

The 1982 NAIC Model included a section requiring insurers and agents to provide a notice of their information handling practices to applicants and policyholders.[60] When the 1982 NAIC Model was adopted, the rationale for including a notice section was to allow applicants and policyholders to be made aware of "the uses made of the information collected about them in connection with insurance transactions," "compare the information practices of different insurers," and "make informed choices based on privacy concerns they may have."[61]

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58. *Id.*

59. 3 COLO. CODE REGS. §§ 6-4-1, -20A(2) (2001).

60. *See* PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4B (NAIC 2000).

61. NAIC, A DESCRIPTION AND EXPLANATION OF THE NAIC INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT 17 (NAIC Dec. 1982) (on file with author).

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Section 4 of the 1982 NAIC Model requires that insurers and insurance producers give applicants and policyholders a written description of their: (1) "personal information" collection practices; (2) disclosure practices for "personal" and "privileged" information; and (3) access and correction rights as provided by the Act.[62] While section 4 allows for an abbreviated notice to be given, that section requires that the individual be informed that a comprehensive notice will be forwarded upon request.[63] The comprehensive notice must state:

> (1) [w]hether personal information may be collected from persons other than the individual or individuals proposed for coverage; (2) [t]he types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information; (3) [t]he types of disclosures identified in . . . [Section 13] and the circumstances under which such disclosures may be made without prior authorization; provided, however, only those circumstances need be described which occur with such frequency as to indicate a general business practice; (4) [a] description of the [access and correction] rights established under Sections 8 and 9 and . . . [the manner in which such rights may be exercised]. . . and (5) [t]hat information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.[64]

As a practical matter, the 1982 NAIC Model notice differs from GLBA both in form and degree. The Model Privacy Regulation contains a provision entitled "short-form initial notice" that functions like the 1982 NAIC Model "abbreviated" notice, but does not refer to access and correction rights and may only be given to "non-customers" (as opposed to policyholders) when the licensee delivers an opt-out notice.[65] In addition,

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62. NAIC INS. INFO. & PRIVACY PROT. MODEL ACT § 4(C)(1)-(4) (NAIC 1982).

63. *Id.*

64. *Id.* § 4(B).

65. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 7(D) (NAIC 2000). The NAIC Model Privacy Regulation does contain a provision permitting insurance licensees to give their customers a "simplified" notice, but this form of notice only applies to licensees that do not share nonpublic personal financial information for marketing purposes with affiliates or non-affiliates. *Id.* § 7(C)(5). Moreover, GLBA simplified notice to customers is a shorter version of the GLBA privacy notice (shortened to

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GLBA notice requirements, as implemented by the NAIC Model Regulation,[66] embrace only nonpublic personal *financial* information, while the 1982 NAIC Model's notice provisions cover *all types* of nonpublic personal information.[67] Further, the content of the two notices vary. For example, section 4B(4) of the 1982 NAIC Model requires insurers and agents to describe access and correction rights available to applicants and policyholders, while the NAIC Model Regulation contains no such provision.

Finally, and perhaps most importantly, the combination of the July 1, 2001 GLBA compliance deadline and the existing 1982 NAIC Model notice requirements produced a need to permit insurers and agents to satisfy notice standards through the issuance of separate notices. Neither the 1982 NAIC Model nor the NAIC Model Regulation accounted for this compliance dilemma. As a result, the industry produced a model law in March 2001 that contains separate, but linked notice provisions that mirror the standards of the 1982 NAIC Model and GLBA. That model, known as the "Industry Reconciliation Model," expressly allows for the option of providing separate, but compliant, privacy notices: "[a]n insurance institution or agent may satisfy the notice requirements of Sections 4 and 5 through the use of separate or combined notices."[68]

Resolution of this concern in states with laws based on the 1982 NAIC Model has been uneven. Virginia became the first 1982 NAIC Model jurisdiction to functionally integrate the requirements of the 1982-based law and GLBA. Modifications to Virginia's insurance information privacy law, adopted early in 2001 (and prior to the final version of the Industry Reconciliation Model), contain two separate notice provisions: one tracking Virginia's existing privacy law and the other mirroring the notice provisions of the NAIC Model Regulation.[69] Further, the amended Virginia law specifically allows insurers and agents to issue separate or

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reflect the more restrictive information sharing practices), rather than a form putting applicants and policyholders "on notice" of the availability of a long-form notice.

66. *Id.* § 7A.

67. *Compare* NAIC INS. INFO. & PRIVACY PROT. MODEL ACT § 4(B) (NAIC 2000) *with* PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION § 7A (NAIC 2000).

68. NAIC INS. INFO. & PRIVACY PROT. MODEL ACT § 5(H) (NAIC 1997) (Draft Industry Revisions Mar. 5, 2001). This Reconciliation Model was a jointly-produced effort of all the life, health, and property and casualty insurance trades, along with member and non-member companies.

69. VA. CODE ANN. §§ 38.2-604 to -604.1 (Supp. 2001).

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combined privacy notices.[70] North Carolina resolved the notice dilemma in a similar fashion.[71]

Both Ohio and Oregon are presently struggling with the issue of how to integrate the notice provisions. In August 2001, the Ohio Insurance Department prepared a legislative draft that integrated the notice provisions of GLBA and Ohio's insurance privacy law.[72] That provision triggered a number of comments asking the Department to consider revising the draft to include two separate notice provisions, one that would codify GLBA notice standards and another to reconfirm Ohio's current privacy notice language. Because Ohio's 1982-based law applies to life and health insurance and not to property and casualty coverage, the Department has been proceeding carefully with their implementation of new requirements, including the notice provisions of the draft. The latest legislative draft issued for public comment by the Department in March 2002 contains separate notice sections that roughly track the corresponding sections of the Industry Reconciliation Model.[73] The most substantive distinction between the two drafts appears to be that the Ohio GLBA-based notice includes all nonpublic personal information in its scope, whereas the Reconciliation Model is limited to nonpublic personal financial information. During 2002, Ohio will become a testing ground for successful resolution of this issue.

Oregon Senate Bill 269, passed during the 2001 legislative session, enables the Insurance Administrator to adopt GLBA privacy regulations.[74] In addition, the bill modifies Oregon's 1982-based law provisions to incorporate GLBA privacy standards, including an integration of GLBA notice provisions.[75] The new integrated notice provision covers both nonpublic personal financial and health information.[76]

Initial proposed regulations from the Oregon Insurance Division implementing this section of Senate Bill 269 do not explicitly permit the issuance of either separate or combined notices. The regulation is being finalized, and it is believed that the final version will enable insurance licensees in Oregon to provide separate compliant notices.[77] Such a

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70. *Id.* § 38.2-604.1(G).

71. N.C. GEN. STAT. § 58-39-27(c) (2001) ("An insurance institution or agent may satisfy the notice requirements of G.S. 58-39-25 and G.S. 58-39-26 through the use of separate or combined notices.").

72. Ohio Dep't of Ins., First Draft § 3904.01 (July 2001).

73. Ohio Legislative Serv. Comm'n, LSC 124 1172-1 § 3904.041 (Mar. 2002).

74. *See* Or. S.B. 269, 71st Or. Leg. Assem., Reg. Sess. (2001).

75. *See id.*

76. OR. REV. STAT. § 746.620 (2001).

77. *See* Or. Dep't of Consumer & Bus. Servs., OR. REG. 1475 (proposed Aug. 1, 2001).

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resolution of this notice issue would be consistent with Senate Bill 269. Under Oregon Revised Statutes section 746.620(6)(a), the Division may adopt rules that "[f]acilitate compliance with requirements in federal law and the laws of other states that establish protections of nonpublic personal information."[78] Further, the Division may "[e]stablish separate and discrete requirements relating to the privacy notice and its contents and delivery for customers and consumers, so that the requirements provide reasonable notice and facilitate compliance with requirements in federal law and in the laws of other states."[79]

2. Disclosure Exceptions

The other area of apparent distinction between the 1982 NAIC Model and GLBA involves the scope of the respective exceptions permitting licensee disclosure of nonpublic personal information without obtaining consent from the insurance consumer. In reality, the difference between the two privacy laws is minimal. Both incorporate a number of reasonable "business function" exceptions that preserve an insurance licensee's ability to share information to conduct the business of insurance. For example, both GLBA (as implemented by the NAIC Model Regulation) and the 1982 NAIC Model contain provisions preserving the ability of insurance licensees to disclose nonpublic personal information to others to determine eligibility for insurance or to prevent insurance fraud.[80]

The only significant distinctions between the two disclosure exception provisions involve the treatment of affiliate sharing and the sharing of personal financial information for marketing purposes. The NAIC Model Regulation, following GLBA, places no restrictions on the disclosure of nonpublic personal financial information with affiliates, and permits insurance licensees to share nonpublic personal information with unaffiliated financial institutions pursuant to a joint marketing agreement.[81] The 1982 NAIC Model, on the other hand, allows information disclosures to affiliates to market *insurance* products or services, but requires an insurer or agent to give a consumer an opt-out opportunity where non-medical personal information is disclosed to affiliates and non-affiliates to

78. OR. REV. STAT. § 746.620 (2001).

79. 2001 Or. Laws 377 (S.B. 269) (revising OR. REV. STAT. § 746.620(6)(b) (1999)).

80. *Compare* NAIC INS. INFO. & PRIVACY PROT. MODEL ACT § 13B(1)(b)(i), (ii)(b) (NAIC 2000) (discussing eligibility and fraud) *with* PRIVACY OF CONSUMER FIN. & HEALTH INFO. REGULATION, No. 672 § 17B (NAIC 2000) (discussing underwriting and fraud).

81. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, NO. 672 § 14B, C (NAIC 2000).

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market other products or services.[82] Thus, in order to reconcile the "disclosure exception" provisions of these laws, the 1982 NAIC Model would need to be amended to incorporate a joint marketing exception and to remove any limitations on financial information disclosures to affiliates.

During 2001, these disclosure exception integration issues arose in several 1982 NAIC Model jurisdictions. Montana amended its 1982-based law to fix an onerous 1999 amendment requiring separate written authorization for releasing information in connection with a wide variety of insurance operations.[83] That same amendment also represented a departure from GLBA requirements with respect to affiliate sharing: if a licensee is going to share nonpublic personal financial information for marketing purposes with an affiliate who is not a licensee, a written agreement must be obtained stating that such affiliate will not further disclose the information and that the affiliate will only use the information for the marketing of insurance or financial products or services.[84] While the technical requirements of the Montana law differ from the NAIC Model Regulation, in the final analysis the distinctions do not appear to be major.

North Carolina amended its 1982-based law in a unique way to integrate GLBA, but in a manner that departs from functional uniformity in one aspect. The rules on affiliate sharing for marketing purposes differ depending on whether disclosures are to an insurance affiliate or to another financial institution affiliate. With respect to an insurance affiliate, the North Carolina rule corresponds to the NAIC Model Regulation.[85] With another financial institution affiliate, an affiliate may share, as with a non-affiliate, under a marketing agreement where specified conditions are met.[86]

C. Interpretation Issues

1. Agent Renewal Activities

The handling of agent shopping (agent disclosures of customer nonpublic personal financial information to search for better coverage among appointed insurers on renewal) has been approached differently in

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82. NAIC INS. INFO. & PRIVACY PROT. MODEL ACT §§ 13K, L (NAIC 1982). It is questionable whether the 1982 NAIC Model affiliate sharing restriction provisions are effective in view of the preemption provisions of the federal Fair Credit Reporting Act.

83. *See* MONT. CODE ANN. § 33-19-101 (2001).

84. *Id.*

85. N.C. GEN. STAT. § 58-39-75(12) (2001).

86. *Id.* § 58-39-75(12).

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some states and by the NAIC. [87] The draft NAIC Privacy Issues Working Group Questions and Answers (Q&A) document issued in December 2001 considers agent shopping of policies at renewal. It states that an agent may no longer rely on the agent exemption set forth in section 4Q(2) of the Model Privacy Regulation[88] and may only rely on the Regulation's section 15A(1) exception if the customer has requested that the agent shop the policy or the agent has obtained a specific authorization from the customer to do so.[89] In reading the explanation to this Q&A, the concern seems to be that, at or before the time of renewal, an independent agent may be sharing a policyholder's nonpublic personal financial information with *all* of the insurers with whom that agent has appointment contracts without either: (1) first obtaining the policyholder's authorization or being directed to do so by the policyholder or (2) providing a separate privacy notice to the policyholder where the policyholder is not aware of this sharing activity.

Requiring prior authorization or request before permitting agents to disclose information to shop for better coverage on renewal is a flawed approach since it: (a) is inconsistent with both the Model Privacy Regulation and 1982 NAIC Model; (b) conflicts squarely with the law of agency and insurance law; (c) erodes the ability of agents to provide customer services; and (d) undermines a core function of the independent insurance agent.

There are at least two exceptions in the Model Privacy Regulation that would allow independent insurance agents to disclose nonpublic personal financial information to shop for coverage on renewal without obtaining a specific and separate authorization. Both are found within section 15(A). The relevant portions, part of what is often referred to as "processing and servicing exceptions," state:

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87. A number of regulators do not view these agent disclosures as a privacy concern.

88. Section 4Q(2), commonly referred to as the "agent exemption," states:

> A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and: (a) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and (b) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4Q(2) (NAIC 2000).

89. *Id.* § 15A(1).

> A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in Section 5A(2), the opt out in Sections 8 and 11, and service providers and joint marketing in Section 14 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with: (1) Servicing or processing an insurance product or service that a consumer requests or authorizes; (2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity . . . .[90]

A faithful interpretation of the section 15(A)(1) exception would encompass, within the scope of servicing or processing an existing product, disclosures to appointed insurers with the intent of getting a better rate or more favorable terms. As a result, the disclosing agent would not need an additional customer request or authorization; rather the original request for coverage would include this expected service.

An essential part of the service provided by the independent agent (consistent with insurance law) involves ensuring that policyholders are properly advised of their options on renewal. Section 15(A)(2) contemplates this activity. In order to accomplish this function, some nonpublic personal financial information needs to be shared with insurers. More importantly, policyholders expect this when they contact an independent agent; policyholders do not expect their independent agents to fail to explore coverage and pricing options, whether initially or upon renewal. The exception outlined in section 15A(2) allows policyholder expectations to be satisfied, consistent with the agent's legal obligations and responsibilities.

The 1982 NAIC Model supports this view. Section 13C of that Model permits agents to share protected information with insurance institutions for insurance-related activities without an authorization.[91] The same theory

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90. *Id.* § 15A(1), (2).

91. Section 13C of the 1982 NAIC Model Act permits disclosure

> [t]o an insurance institution, agent, insurance support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary: (1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or (2) *For either the*

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underlies section 15A(2) of the NAIC Model Regulation: the opt-out requirement does not apply when a licensee is performing insurance-related activities that are integral to providing a customer with an insurance product or service or maintaining a customer's policy or account. Disclosures to other insurance institutions, specifically to the insurers by whom an independent agent is appointed, to shop a customer's policy for purposes of renewal or replacement meet this standard.

In addition, a reasonable reading of the structure of section 15 dictates that separate authorizations should not be required. The "general rule" of the NAIC Model Regulation, set forth in section 11A, conditions disclosures outside the enumerated exceptions on the provision to consumers of: (a) initial notice and (b) a reasonable opportunity to opt-out of any such disclosures. Requiring an agent to obtain a separate, affirmative authorization (or opt-in) from a policyholder does not follow from the broader context of the less rigorous section 11A conditions: an agent would have to obtain opt-in permission from the policyholder in order to avoid giving that same policyholder an opt-out right.[92]

Interpreting the Model Privacy Regulation to create multiple and inconsistent consent requirements—when an agent is shopping initially for coverage and again upon renewal—undercuts these relationships and elevates privacy concerns to such a level that such concerns interfere with, and supplant, the proper operation of the law of agency and insurance law. Moreover, such a strict interpretation undermines the traditional function of the independent insurance agent: to search for the insurance products that best meet the individual needs of the consumer. It is the ultimate goal of the Model Privacy Regulation to protect sensitive nonpublic personal information provided by the applicant or insured. Allowing information to be shared in the shopping process does not compromise this privacy objective. The insurers who receive nonpublic personal information are licensees with an obligation to maintain the privacy of the information and to comply with applicable laws and regulations. To impose additional and, in some cases, duplicative paperwork on an applicant in order to obtain

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disclosing or receiving insurance institution, agent or insurance support organization to perform its function in connection with an insurance transaction.

(emphasis added.) NAIC INS. INFO. & PRIVACY PROT. MODEL ACT §§ 13C(1), (2) (NAIC 2000).

92. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, NO. 672 § 11A (NAIC 2000).

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coverage will not afford the individual any greater protection than already exists.[93]

Florida responded to questions of agent shopping by granting agents permission to disclose nonpublic personal information for the same kind of coverage on renewal.[94] Originally, the Florida Insurance Department's proposed privacy regulations required independent agents, as a matter of course, to obtain a policyholder's authorization prior to using their nonpublic personal financial information to shop for coverage with other appointed carriers.[95] Discussions with the Department, however, revealed a concern about using personal information to shop for a different line of coverage than that held by the policyholder. Ultimately, that issue was resolved by requiring agents to give policyholders notice and an opt-out opportunity (or by otherwise meeting one of the regulatory exceptions to this rule) prior to sharing information with another appointed carrier to shop for coverage in a different line of insurance.[96] In the Florida Department's view, sharing personal financial information to shop for coverage among appointed carriers in the same line of insurance fell within a business function exception to the opt-out requirement.[97]

Connecticut will likely resolve this issue in a manner that permits independent agents to disclose personal financial information without the need for an opt-out, although the Connecticut Insurance Department has taken a different route. The Department has preliminarily interpreted the "agent exemption" in section 4Q(2) of the NAIC Model Regulation to permit agent disclosures to appointed carriers without prior authorization, reasoning that an independent agent's appointed insurers are functionally "principals" within the meaning of that section.[98]

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93. In fact, it may result in making it more expensive and burdensome for a person to obtain and maintain insurance. It is critical to remember that it is in consumers' interest to obtain the best possible coverage at the lowest possible price.

94. Fla. Dep't of Ins., Second Notice of Change (Oct. 24, 2001) [hereinafter Second Notice] (on file with author).

95. Fla. Dep't of Ins., Notice of Changes, Corrections and Withdrawals (Sept. 7, 2001) (adding language after § 4-128.015(1)(d)).

96. Second Notice, *supra* note 94.

97. *Id.*

98. *See* Informal Letter from L. Wolfgang, Conn. Dep't of Ins. to W. Ruppar, Independent Insurance Agents of Connecticut, Inc., "Re: Enforcement of the Federal Gramm-Leach-Bliley Act (Sept. 6, 2001) (on file with author). *See also* Conn. Ins. Dep't, Proposed Regulation § 38a-8-106(17) (Dec. 2001). In this same letter, the Department "expressly reserves the right to reevaluate at a later date the positions set forth" therein. *Id.* While not finalized at the time of publication of this article, it is anticipated that Arkansas

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The industry will face some difficulty on this issue, as the NAIC Privacy Working Group chose in March 2002 to uphold its interpretation of this issue. As we have discussed, some state insurance regulators have already signaled a willingness to interpret the NAIC Model Regulation in a way that excepts "agent shopping" disclosures from the Model Privacy Regulation's general opt-out requirement. To the extent other state regulators rely on the draft NAIC interpretation, differing interpretations will perpetuate an uncertain and uneven regulatory environment for independent agents and the carriers they represent. The NAIC has acknowledged the uneven regulatory climate on this issue, agreeing to add a disclaimer to its interpretive Q&A document that notes that states are not required to follow the NAIC Q&A.

2. Definitions of "Customer" and "Consumer"

Under the NAIC Model Regulation, a licensee's obligation to follow notice and opt-out requirements depends on an individual's status as a "consumer" or "customer." This is an expansion of GLBA notice requirements, which apply to insurance consumers, but define those individuals as *customers* of a financial institution who obtain financial products or services for "personal, family or household purposes."[99] The scope of GLBA privacy protection is underscored by the definitions of "consumer" and "customer relationship":

> (9) Consumer
>
> The term "consumer" means an individual who obtains, from a financial institution, financial products or services which are to be used primarily for personal, family, or household purposes, and also means the legal representative of such an individual.
>
> . . . .
>
> (11) Customer relationship
>
> The term "time of establishing a customer relationship" shall be defined by the regulations prescribed under section 6804 of this title, and shall, in the case of a financial institution engaged in extending credit directly to consumers to finance purchases of goods or services, mean

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will also provide for agent shopping via the addition of a specific exemption, though apparently tying it to a consumer's written request. *Id.*

99. 15 U.S.C. § 6809(9) (2000). Under GLBA, a privacy notice is only required "[a]t the time of establishing a customer relationship with a consumer" and at least annually thereafter. *Id.* § 6803(a).

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> the time of establishing the credit relationship with the consumer.[100]

The NAIC Model Regulation bifurcates the GLBA definition of "consumer" into two definitions: "consumer" and "customer." The customer definition follows GLBA's framework, and the "consumer" definition expands that framework by providing privacy protection to those who "seek[] to obtain . . . or ha[ve] obtained an insurance product or service" from a licensee for "personal, family, or household purposes."[101] The applicable definitions are found in sections 4F, 4I, and 4J of the NAIC Model Regulation and include a number of illustrative examples that have caused compliance confusion among the industry.

a. "Customer" and Continuing Relationship

The examples under section 4J(2) of the Model Regulation are divided into two sections: those under section 4J(2)(a) describe when a consumer has a continuing relationship with an insurance licensee and those under section 4J(2)(b) describe when a consumer does *not* have a continuing relationship. Several states initially drafted their privacy requirements in a manner that would seemingly require that claimants who received structured settlements be treated as customers, although this category of consumers clearly are not treated as customers under the NAIC Model Regulation.[102] The provision in question reads as follows: "[t]he consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an on going relationship with the licensee."[103]

While this issue was ultimately resolved with all state insurance regulators, treatment of any claimant as an insurer's customer, regardless of the mode of settlement, would have contradicted reality and created privacy compliance problems for insurers. Insurers would have been required to

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100. *Id.* §§ 6809(9), (11).

101. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4F(1) (NAIC 2000). We note again that the inclusion of applicants as protected consumers is consistent with regulations adopted by the functional federal agencies. However, difficulties arise when the NAIC Model Regulation attempts to cover claimants as consumers under certain circumstances. This is a departure both from the scope of GLBA and implementing federal regulations.

102. This was an issue in New York, Utah and Nevada. *See* N.Y. COMP. CODES R. & REGS. tit. 11, § 420 (2001) (Regulation 169); UTAH ADMIN. CODE R590-206 (proposed May 2001); Nev. Div. of Ins., Proposed Regulation (Aug. 2001).

103. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4J(2)(b)(iv) (NAIC 2000).

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provide initial and annual notices to consumers based solely on their choice of claim settlement option. Historically, third party claimants under a property and casualty policy have *never* been policyholders of the insurer, but rather are receiving claims service due to a tort or other third party claim asserted *against* the insurer's policyholder. Neither the insurer providing the claim service nor the claimant chooses to enter into a business relationship; the service is a result of a contractual obligation to the insured arising from a liability insurance policy. The New York Insurance Department, reversing its position on the claim settlement option issue, stated its reasoning clearly:

> [t]he Department has made this change for two reasons. First, the change brings the regulation into full conformity with the NAIC model, an overall objective in drafting the regulation. Second, the change accurately reflects the realities of the marketplace. As a general rule, neither claimants nor beneficiaries enter voluntarily into their relationship with the licensee. The need for providing an initial and annual notice when nonpublic personal information is not being shared by the licensee is unnecessary for the simple reason that neither the claimant or beneficiary does not have the ability to choose another company to provide the financial services provided by the licensee.[104]

The operational problems caused by treating long-term claimants as an insurer's customers are significant. For example, privacy statements are most likely to be issued through the marketing or underwriting departments, not the claims department, which is likely to be the property and casualty carrier's only point of contact with the claimant. In addition, there is often no direct, long-term contact between the insurer and the third party claimant receiving a periodic settlement payment: all that is likely to occur is the deposit of funds into a checking/savings account accessible only by the claimant. Moreover, if state privacy regulations had treated structured settlement claimants as "customers" for privacy purposes, property and casualty insurers would have had a strong incentive to favor lump sum settlements for all claims, regardless of the particular circumstances. The NAIC Model Regulation closes the door on this issue by providing that consumers who choose *either* "a settlement option

104. Rule Making Activities, 23 N.Y. St. Reg. 30 (Apr. 18, 2001).

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involving an ongoing relationship with the licensee"[105] or "a lump sum settlement option"[106] do *not* have a "continuing relationship" with the licensee.[107]

b. "Consumer" and Disclosures

Wisconsin's implementation illustrates how expansion of the "consumer" definition can lead to compliance confusion. Under the examples found in section 4F(2)(d) of the NAIC Model Regulation, individuals are considered a licensee's "consumers" if: (1) they have a specified connection to a licensee (such as a claimant under an insurance policy) and (2) the licensee shares their nonpublic personal financial information outside of the NAIC Model Regulation's business function and joint marketing/service provider exceptions found in sections 14 through 16.[108] Under the definition of "consumer" found in the Wisconsin privacy regulation, however, claimants are automatically treated for privacy purposes as "consumers" without the additional hurdle (i.e., sharing outside of the regulatory exceptions) found in the NAIC Model Regulation.[109] Left unchanged in the final version of the Wisconsin regulation, Wisconsin insurance licensees now must treat claimants differently than they would treat them in other states. Disclosing any claimant's nonpublic personal financial information pursuant to a joint marketing agreement with a financial institution or otherwise using the "service provider" exception now triggers a requirement to send GLBA privacy notices to those individuals.[110]

Still other states have departed from the traditional terms "customer" and "consumer," establishing new categories of protected parties. For example, Rhode Island's health privacy regulation requires an authorization before sharing any "individual's" nonpublic personal health information for a purpose not excepted by that regulation.[111] Texas's proposed health privacy regulation takes the definitional problem one step further: the "consumer" definition applies to all "persons" and covers both personal

105. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4J(2)(b)(iv) (NAIC 2000).
106. *Id.* § 4J(2)(b)(v).
107. *Id.* § 4J(2)(b).
108. *Id.* § 4F(2)(d).
109. *Id.*
110. WIS. ADMIN. CODE § 25.04(6)(a) (2002).
111. R.I. Dep't of Bus. Regulation, Regulation 100 § 4A (2001).

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and commercial lines of insurance.[112] Such changes from the NAIC Model Regulation potentially inject ambiguity into a complex set of requirements and make uniform compliance a trickier proposition.

c. "Consumer" and Workers' Compensation

Workers' compensation issues arising from the NAIC Model Regulation originate from the definition of "consumer" in a provision we refer to as the "workers' compensation safe harbor," contained in sections 4F(2)(e) and (f) of the Model Privacy Regulation. The "safe harbor" reads:

> (e) *Provided that the licensee provides* the initial, annual and revised *notices* under Sections 5, 6 and 9 of this regulation *to the* plan sponsor, group or blanket insurance policyholder or group annuity contractholder, *workers' compensation plan participant, and further provided* that the *licensee does not disclose to a nonaffiliated third party* nonpublic personal financial information about such an individual *other than as permitted* under Sections 14, 15 and 16 of this regulation, *an individual is not the consumer of the licensee solely because he or she is:*
>
> (i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;
>
> (ii) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee; or
>
> (iii) *A beneficiary in a workers' compensation plan.*
>
> (f) (i) The individuals described in Subparagraph (e)(i) through (iii) of this paragraph *are consumers* of a licensee *if the licensee does not meet all the conditions* of Subparagraph (e).
>
> (ii) *In no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through*

112. Proposed 28 TEX. ADMIN. CODE § 22.52(3) states that a consumer means a "person or that person's representative who seeks to obtain, obtains or has obtained an insurance product or service from a covered entity, and about whom the covered entity has nonpublic personal health information." 27 Tex. Reg. 35, 36 (Jan. 4, 2002), *available at* 2002 WL 23626. Interestingly, the Texas Department of Insurance's financial information privacy regulation contains a definition of consumer patterned after the parallel definition in the NAIC Model Privacy Regulation. 28 TEX. ADMIN. CODE § 22.2(8) (2000), *available at* WL 28 TAC § 22.2.

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(iii) above, be deemed to be customers for purposes of this regulation.[113]

Including workers' compensation insurance within the scope of this provision presents three concerns.[114] First, and as previously discussed, commercial lines are not explicitly covered under GLBA. Second, the NAIC Model Regulation uses ambiguous terms to describe the treatment of workers' compensation insurance. Third, recent interpretations by the NAIC and state regulators have raised questions as to who must get privacy notices.

The inclusion of workers' compensation insurance, a commercial line, within the scope of this safe harbor provision seems out of place. Group and blanket policies, along with "plans," are typically mentioned as personal lines insurance. As a result, workers' compensation insurance seems to stretch the boundaries of the NAIC Model Regulation beyond personal lines to cover commercial lines issues. This is not consistent with the section 4F(1) "consumer" definition, which is limited to products or services for personal, family, or household use.

Significant confusion has also resulted from the use of phrases that are not terms of art in the workers' compensation field, such as workers' compensation "plan participant" and workers' compensation "beneficiary." Clarifying those terms in a manner consistent with industry parlance may be accomplished by amending the Model Privacy Regulation as follows: (1) replacing "workers' compensation plan participant" with "workers' compensation policyholder" in section 4F(2)(e); (2) revising "beneficiary in a workers' compensation plan" to read "claimant under a workers' compensation policy" in section 4F(2)(e)(iii); and (3) changing "workers' compensation plan" to "workers' compensation policy" in section 16A(8). In the context of the safe harbor, these changes make sense. Plan sponsors, group/blanket policyholders, and group annuity contract holders are typically employers. Likewise, the employer in a workers' compensation

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113. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4F(2)(e), (f) (NAIC 2000) (emphasis added).

114. A discussion of interpretation of workers' compensation language found in the Model Regulation is irrelevant in a number of states. Some explicitly exclude workers' compensation insurance from the scope of their insurance privacy requirements or from the definition of "consumer." Others omit references to workers' compensation from their privacy requirements. The treatment in these jurisdictions indicates an affirmative step to remove workers' compensation from the purview of their privacy regulation. In addition, there are states acting consistently with the actual text of the NAIC Model Regulation. Finally, consideration of the issue is superfluous for monopolistic state workers' compensation funds where there is no private market.

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context is the policyholder.[115] "Beneficiary" in a workers' compensation plan literally means one who receives benefits under a workers' compensation policy. Clearly, an injured worker receives benefits under a workers' compensation policy and that worker is a "claimant." Therefore, amending section 4F(2)(e)(iii) as suggested makes sense.

States have worked through these ambiguous terms in different ways. The Connecticut proposed regulation highlights the uncertainty over the use of these terms. The Connecticut proposed regulation uses the phrase "*employee* covered by a workers' compensation plan" in place of "*beneficiary* in a workers' compensation plan."[116] The proposed regulation also removes section 4F(2)(f) of the NAIC Model Regulation, which mandates treatment of such "employees" as consumers if a workers' compensation insurer fails to meet the conditions set forth in the opening paragraph of section 4F(2)(e).[117] Thus, the Connecticut Department has preliminarily interpreted the workers' compensation safe harbor to provide Connecticut licensees protection from having a workers' compensation policyholder's employees treated as consumers when they meet the two conditions.[118] Otherwise, the status of an employee for privacy purposes would be determined by reference to the "consumer" definition in section 4F(1).

On the other hand, one might legitimately read this new provision to require *all employees* of a workers' compensation policyholder to be treated as "consumers" for privacy purposes if their financial information is shared outside of the regulatory exceptions or the licensee fails to give privacy notices to the workers' compensation policyholder. Interpreted this way, workers' compensation carriers might be unable to satisfy the rule's notice requirements. Absent a claim, a policyholder (company) merely needs to disclose to the workers' compensation carrier the number of employees, as opposed to the names, addresses or other personal information of the individual employees. Such personal information is only provided upon submission of a claim and only with respect to the claimant. In this regard, workers' compensation differs from a typical

115. The NAIC Frequently Asked Questions (NAIC FAQ) document, issued in January 2001, lends guidance (in company issue 10). It indicates that the "plan participant" is an employer and the employer in the workers' compensation arena is the policyholder. NAIC, FREQUENTLY ASKED QUESTIONS 18 (2001), *available at* http://www.naic.org/1privacy/publications/1-4-01_FAQ.pdf.

116. Conn. Ins. Dep't, Proposed Regulation § 38a-8-107(7)(D)(iii) (Dec. 2001).

117. *Id.* § 38a-8-107(7).

118. *Id.*

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health insurance policy under which all of the covered employees would be identified. For these reasons, the option of providing notice to an employee in a workers' compensation setting would not be practical because the workers' compensation carrier would not know where to send privacy notices.[119]

Beyond ambiguous terminology, compliance issues with the workers' compensation safe harbor have been heightened by recent interpretations of this provision by the NAIC Privacy Issues Working Group and a few state regulators. The Working Group's draft Questions and Answers document, issued in December 2001, states that "the model regulation *requires* that licensees send notices to certain group policyholders," including "workers' compensation plan participants."[120] This answer is explained as follows:

> [t]he NAIC's intention was to provide relief for licensees by permitting them to treat [workers' compensation beneficiaries] as consumers rather than customers, *provided* notice is given to the [workers' compensation] policyholders. The goal was to ensure that the individual has access, through the group policyholder, to the licensee's privacy policies so the individual can find out how his nonpublic personal financial information is being used, if he so desires.[121]

The Q&A thus advises that: (a) workers' compensation policyholders are *required* under the Model Privacy Regulation to be given the same privacy notices that are provided to personal lines customers, and (b) if licensees do not give these notices to workers' compensation policyholders, workers' compensation beneficiaries will be treated as *customers*.

These interpretations run counter to the plain language of the NAIC Model Regulation for a number of reasons. *First*, the NAIC Model Regulation explicitly states that provision of such notice to workers' compensation policyholders is *optional*. Under the plain meaning of section 4F(2)(e), a licensee can choose to provide privacy notices to its workers' compensation plan participants and not disclose beneficiaries' nonpublic personal financial information outside the regulation's listed exceptions *or* the licensee can forego compliance with these two conditions

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119. This does not mean an insurer can never send a notice to an individual. Once a claim is filed, the insurer has the information to provide a privacy notice to the claimant employee (if this option is selected).

120. Privacy Issues Working Group, NAIC, Draft Questions & Answers (Dec. 2001) (on file with author).

121. *Id.*

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and treat all workers' compensation beneficiaries as "consumers" under the NAIC Model Regulation. As a result, a licensee may choose not to provide privacy notices to its workers' compensation plan participants, but must understand the consequences (i.e., workers' compensation beneficiaries are treated as "consumers"). The plain meaning of section 4F(2)(e) is confirmed by the immediately following subsection, which states: "The individuals described in Subparagraph (e)(i) through (iii) of this paragraph [4F(2)] are consumers of a licensee *if the licensee does not meet all the conditions of Subparagraph (e).*"[122]

Contrary to this precise language, the Working Group's draft Q&A would replace "consumer" in section 4F(2)(f)(i) with the word "customer." The placement of the provision as an example under the "consumer" definition makes this conclusion illogical. Even assuming *arguendo* that the intent of the drafters should trump actual model regulatory language, the Working Group's position would expressly contradict section 4F(2)(f)(ii), which states that "[i]n no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through (iii) above, be deemed to be customers for purposes of this regulation."[123]

Second, section 4F(2)(e) is an *example* under the "consumer" definition of the NAIC Model Regulation, *not an alteration of the definition itself.* As such, the definition of consumer, which begins section 4F and is limited to individuals "who seek to obtain, obtain, or have obtained an insurance product or service from a licensee that is to be used primarily for *personal, family or household purposes*," does not include either individuals or businesses that purchase commercial lines insurance, like a workers' compensation policy. Nor can workers' compensation policyholders be included as "customers," which is a subset of "consumer" under the Model Privacy Regulation. An example cannot expand the NAIC Model Regulation's provisions, but may only illustrate those provisions. This is especially important where the expansion goes beyond the personal lines parameters of the Model Privacy Regulation and seeks to impose requirements on insurance licensees with respect to commercial lines.

Third, section 2B(1) of the NAIC Model Regulation, setting forth the scope of the Regulation, strengthens this point by explicitly stating that "[t]his regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or

122. PRIVACY OF CONSUMER FIN. & HEALTH INFO. MODEL REGULATION, No. 672 § 4F(2)(f)(i) (NAIC 2000) (emphasis added).

123. *Id.* § 4F(2)(f)(ii).

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agricultural purposes."[124] As a result, any interpretation that requires notice to workers' compensation policyholders or otherwise turns the optional language of section 4F(2)(e) into a mandate defies the language and structure of the NAIC Model Regulation.

Fourth, a schism between the actual Model Privacy Regulation language and any belatedly expressed drafting intent is not without consequence: it creates severe difficulties for those who read the provisions and adhered to its language. Insurers and their counsel have relied on this plain meaning in privacy compliance planning and implementation efforts. They have already made the decision to either send privacy notices to workers' compensation policyholders (and not disclose nonpublic personal financial information outside listed exceptions) or simply treat workers' compensation claimants as "consumers."

Equally important, strict state enforcement of the NAIC's strained interpretation of this provision could penalize insurance licensees that have more restrictive information sharing practices than their competitors. For example, an insurer that has a policy of not sharing any personal information for marketing purposes could be deemed "out of compliance" if that insurer chose not to give the now "required" privacy notices to workers' compensation policyholders (i.e., employers). Likewise, an insurer that wanted to go beyond the options provided in section 4F(2)(e) might decide to give those whose information is at risk(i.e. workers' compensation claimants) privacy notices, instead of providing notices to workers' compensation policyholders. As a matter of public policy, it makes little sense to penalize insurers that arguably have better privacy policies and practices than others.

Arkansas reversed field on this issue and chose to remove workers' compensation insurance references from section 4F altogether. Last summer, the Arkansas Insurance Department revised its proposed insurance privacy regulation to explicitly require insurance licensees to treat workers' compensation policyholders as "customers" under the regulation. The Department adhered to this view as recently as January 2002. However, in February, the Department decided to treat other group and blanket policyholders as customers, but to take workers' compensation insurance out of the equation. As a result, the concerns raised with the NAIC Q & A in this article do not apply in Arkansas.

Apparently recognizing their interpretive error, the NAIC Privacy Issues Working Group abandoned this Q&A in March 2002, instead opting

124. *Id.* § 2B(1).

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to re-open this provision of the NAIC Model Privacy Regulation to make the language coincide with the intent expressed by that working group in the draft Q&A. This latest development should be disturbing to all interested parties. For more than 18 months, insurance licensees have developed and implemented privacy policies based on unwavering language in the NAIC Model Privacy Regulation. For the NAIC to suddenly revisit the regulatory language after-the-fact draws the entire process into question, especially where the overwhelming majority of states have adopted the NAIC Model Regulation. Moreover, it is unclear that the NAIC Privacy Issues Working Group has the unilateral authority to reopen the Model Privacy Regulation. The Working Group's charge when it was reconstituted in July 2001 centered on interpreting existing model regulatory language, not on changing that language. Whatever the outcome of this particular provision, the NAIC's willingness to disregard clear language when it does not fit regulatory intent does not bode well for other serious privacy issues. It does neither regulators nor insurance licensees any good to advance interpretations that do not square with routine industry practice or that elevate privacy to a level that clouds the ability of agents or insurers to use information in their normal business operations.

IV. OTHER CURRENT AND ANTICIPATED PRIVACY ISSUES ON THE HORIZON

A. "Opt-in" vs. "Opt-out"

Opt-in versus opt-out is the privacy battle presently being waged in a number of state legislatures and insurance departments. Recently, Vermont and New Mexico finalized privacy regulations that roughly follow the NAIC Model Regulation, but which provide for opt-in consent for disclosures that fall outside the regulatory exceptions.[125] Other states have introduced legislation that would codify an opt-in approach to privacy regulation, but may fall short of providing the necessary business exceptions. In California last year, Senator Jackie Speier shepherded

125. *See* Vt. Dep't of Banking, Ins., Sec. & Health Care Admin., Regulation IH-2001-01 (2001). On January 30, 2002, five insurance trade associations filed a complaint against BISHCA, seeking declaratory and injunctive relief and alleging that the Commissioner lacked authority under Vermont law and constitutional principles to impose and opt-in privacy regime on insurance licensees with respect to their disclosures of nonpublic personal information. *See* Am. Council of Life Insurers v. Vt. Dep't of Banking, Ins., Sec., & Health Care Admin., No. 56-1-02 WNW (Vt. Sup. Ct. 2002). *See also* N.M. ADMIN. CODE tit. 13, § 1.3.1-11 (2002).

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Senate Bill 773 (requiring an opt-in for third party disclosures of information and an opt-out for affiliate disclosures unless specifically excepted) to the final stages of the legislative process, and will likely make another push to pass that bill again this session.[126] More than a dozen privacy bills have been introduced in Massachusetts, with at least one bill requiring an opt-in for nonpublic personal financial information.[127]

Requiring consumers to specifically opt-in to disclosures of personal information remains the standard for most consumer privacy advocates. Those advocates argue that an opt-in mechanism will provide the greatest privacy protection for consumers and ensures that the default position will be to respect privacy. Admittedly, this argument has facial appeal to many legislators, regulators, and consumers. Opt-in has become the media's privacy darling, and op-ed pieces in major regional newspapers touting opt-in have become commonplace. On February 1, 2002, for example, the Seattle Post-Intelligencer Editorial Board declared that companies "should have to ask their customers' permission before disclosing their personal information. Conversely, customers should not be required to ask companies' permission for their personal information to be kept personal."[128]

At first, this sounds intuitive, but the realities are more complex. Requiring a consumer to specifically authorize information disclosures in advance does not provide greater privacy protection, but instead only an automatic standard. It actually provides less choice to consumers because it automatically assumes that consumers value sharing restrictions over the benefits of product and service choice facilitated by reasonable sharing for marketing purposes.

Professor Fred Cate of the Indiana University School of Law has written a number of articles cataloguing the detrimental impact of shifting to an opt-in privacy system. A recent document completed on behalf of the Financial Services Coordinating Council, a group composed of the principal national trade associations from each of the four financial services sectors,[129] identifies a number of reasons why state and federal government

126. S.B. 773, 2001 Leg., Reg. Sess. (Cal. 2001).

127. H.B. 229, 2001 Leg., Reg. Sess. (Mass. 2001).

128. Editorial, *Opt In, Not Out, for Consumer Privacy*, SEATTLE POST-INTELLIGENCER, Feb. 1, 2002, at B6.

129. The trade association members of the Financial Services Coordinating Council (FSCC) are the American Bankers Association, the American Council of Life Insurers, the American Insurance Association, and the Securities Industry Association.

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should reject the opt-in approach to privacy regulation.[130] First, consumers retain the same level of control over the use of their personal information under either system because both systems leave the final decision to the consumer. This responds to concerns in many privacy bills over the need to vest control of personal information use in the individual, rather than the company.[131]

Second, an opt-in system is inherently more costly to implement and administer than an opt-out approach because it requires companies to make specific contact with each individual customer in order to secure consent instead of informing all consumers at once of the informational use and allowing those consumers to decide whether to opt-out.[132] More fundamentally, according to Professor Cate, an opt-in approach reduces a company's ability to engage in target marketing based on personal information and ultimately *increases* the amount of direct marketing material sent to consumers (which in turn generates an added cost ultimately funded by those same consumers through increased product price).[133]

Third, an opt-in system actually generates more contacts with each customer because companies would need to obtain permission before using personal information to determine an individual's eligibility for a product or service offering.[134] As a result, studies cited by Professor Cate indicate that customers viewed an opt-in approach as more intrusive than other alternatives.[135]

Fourth, the opportunity for consumers to opt-in to information disclosures is a fiction. Where the cost of obtaining specific consumer consent outweighs the economic viability of a product or service offering, many businesses will decide not to offer the product or service, and the consumer's choice of products and services will decline.[136] Further, where information disclosures are prohibited absent an opt-in consent and those disclosures subsidize other important uses of information (such as to detect and prevent fraud), these other uses of information will also decline.[137]

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130. FRED H. CATE, FIN. SERV. COORDINATING COUNCIL, OPT-IN EXPOSED, *at* http://www.fsccnews.com/articals/Cate_Opt-in_FA.pdf (2001).

131. *See id.* at 2 (quoting S. 30, 107th Cong. § 2 (2001); H.R. 89, 107th Cong. § 2(b)(1) (2001); H.R. 347, 107th Cong. § 2(b)(1)(A)) (2001).

132. *Id.* at 2-3.

133. *Id.* at 3.

134. *Id.* at 4.

135. *Id.* (citing United States West, Inc. v. FCC, 182 F.3d 1224, 1239 (10th Cir. 1999).

136. CATE, *supra* note 130, at 5.

137. *Id.* at 6.

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Fifth, opt-in assumes that all consumers do not want their personal information shared for marketing purposes and that those consumers value privacy above all other factors, including maximization of product choice, low cost, and efficient delivery of services. On the other hand, as Professor Cate aptly notes, "[a]n opt-out system presumes that consumers *do* want the convenience, range of services, and lower costs that a free flow of personal information facilitates, and then allows people who are particularly concerned about privacy to block the use of their information."[138]

Sixth, an opt-in regime may stifle competition by raising artificial entry barriers to additional competitors. Potential competitors often rely on the free flow of information to market their products and services effectively. Where that information flow slows to a trickle or is cut off, smaller businesses will be unable to afford the costs of entering the market and will be unable to defray the costs through outsourcing that function.[139]

Professor Cate's study cites two other reasons, the European Union privacy experience and infringement on free speech rights, to question opt-in privacy approaches.[140] In 2001, Ernst and Young compared the opt-in structure of the European Union Privacy Directive to the opt-out structure found in GLBA.[141] Their analysis concluded that the opt-in approach provides customers no greater protection than GLBA, and that an opt-in structure results in lost benefits.[142] These lost benefits fall into three broad categories: (1) companies' increased cost of doing business (which the firm conservatively estimates at $16 billion annually); (2) companies' increased investment of time (which the firm conservatively estimates at an additional 305 million hours annually); and (3) consumers' lost opportunities (which can be expressed both in terms of money and time).[143]

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138. *Id.* at 7.

139. *Id.* at 8.

140. *Id.* at 9-10.

141. ERNST & YOUNG, FIN. SERV. COORDINATING COUNCIL, HIGH COST, LOW BENEFIT: THE EUROPEAN UNION PRIVACY DIRECTIVE AND THE POTENTIAL IMPACT OF A SIMILAR LAW IN THE UNITED STATES 8-9 (2001). The EU Directive 95/46, "On the Protection of Individuals with Regard to the Processing of Personal Data and on the Free Movement of Such Data," was adopted on October 24, 1995. *Id.* at 8.

142. *Id.* at v.

143. The study states:

> [t]hese lost customer benefits encompass a wide variety of services. They include money currently saved . . . due to outsourcing to third parties, relationship pricing, and proactive offers. In addition, they include current time savings from

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The U.S. Court of Appeals decision in *United States West, Inc. v. FCC*[144] is also instructive on the opt-in versus opt-out debate, supporting Professor Cate's view that an opt-in scheme may create serious constitutional problems. In that case, United States West challenged rules promulgated by the Federal Communications Commission pursuant to the Telecommunications Act of 1996[145] that would have required telecommunications carriers to obtain opt-in consent from their customers prior to using "customer proprietary network information" (CPNI, which includes "when, where, and to whom a customer places calls")[146] to market "categories of services to which the customer does not already subscribe."[147]

The Tenth Circuit found that United States West's use of CPNI for marketing products and services constituted commercial speech subject to protection under the First Amendment to the United States Constitution,[148] and that the FCC's opt-in regulatory scheme restricted the ability of United States West to engage in that speech. As a result of the apparent regulatory infringement on United States West's free speech rights, the Tenth Circuit did not analyze the regulation under a typical administrative review standard, but subjected the regulation to the four-part test first articulated in *Central Hudson Gas & Electric Corp. v. Public Services Commission of N.Y.*:[149]

> (a) Is the commercial speech lawful and not misleading?
> (b) Is there a substantial state interest in regulating the speech?
> (c) Does the regulation directly and materially advance that interest?
> (d) Is the regulation no more extensive than necessary to serve that interest?[150]

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information sharing due to efficiencies achieved by call centers, Internet based services, third party services, proactive offers and pre-filled applications. *Id.*

144. 182 F.3d 1224 (10th Cir. 1999).

145. 47 U.S.C. § 222(c)(1) (2000). According to the Tenth Circuit, "the essence of the statutory scheme requires a telecommunications carrier to obtain customer approval when it wishes to use, disclose, or permit access to CPNI in a manner not specifically allowed under § 222." *West*, 182 F.3d at 1229.

146. *West*, 182 F.3d at 1228-29 n.1.

147. *Id.* at 1230.

148. *Id.* at 1233. "It is well established that nonmisleading commercial speech regarding a lawful activity is a form of protected speech under the First Amendment, although it is generally afforded less protection than noncommercial speech." *Id.*

149. 447 U.S. 557, 564-66 (1980).

150. *West*, 182 F.3d at 1233 (citations omitted).

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Significant to our discussion of the merits of opt-in versus opt-out, the Court of Appeals determined that the FCC approach failed the final three parts of the *Central Hudson* test.[151] In doing so, the Court concluded that:

> In the context of a speech restriction imposed to protect privacy by keeping certain information confidential, the government *must show* that the dissemination of the information desired to be kept private would inflict *specific and significant harm on individuals*, such as undue embarrassment or ridicule, intimidation or harassment, or misappropriation of sensitive personal information for the purposes of assuming another's identity. . . . *A general level of discomfort from knowing that people can readily access information about us does not necessarily rise to the level of a substantial state interest* under *Central Hudson* for it is not based on an identified harm.[152]

Throughout its discussion, the Court appeared to focus on the failure of the FCC to support the opt-in rule through an evidentiary record.[153] This focus became evident when the Court considered whether the FCC rule materially advanced the governmental interest: "The government presents no evidence showing the harm to either privacy or competition is real. Instead, the government relies on speculation that harm to privacy and competition for new services will result if carriers use CPNI."[154]

Perhaps most importantly, the Court determined that the FCC rule was not narrowly tailored to meet the governmental interest because the FCC had failed to consider the more obvious and less restrictive opt-out alternative:

> It is difficult, if not impossible, for us to conduct a full and proper narrow tailoring analysis, given the deficiencies that we have already encountered with respect to the previous portions of the *Central Hudson* test. Nevertheless, on this record, the FCC's failure to adequately consider an obvious and substantially less restrictive alternative, an opt-out strategy, indicates that it did not narrowly tailor the CPNI regulations regarding customer approval. . . . [T]he FCC record does not adequately show that an opt-out

151. *Id.* at 1235-39.

152. *Id.* at 1235 (emphasis added).

153. Indeed, the Court noted that it "would prefer to see a more empirical explanation and justification for the government's asserted interest." *Id.*

154. *Id.* at 1237.

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> strategy would not sufficiently protect customer privacy. The respondents merely speculate that there are a substantial number of individuals who feel strongly about their privacy, yet would not bother to opt-out if given notice and the opportunity to do so. Such speculation hardly reflects the careful calculation of costs and benefits that our commercial speech jurisprudence requires.[155]

The *United States West* court's thorough Constitutional scrutiny of opt-in regulations does not bode well for the viability of the Vermont or New Mexico privacy regulations. Subjected to similar scrutiny, both of these opt-in rules fail the *Central Hudson* test for identical reasons: (a) they are not based on specific record evidence amounting to anything more than anecdotes or conjecture; (b) they fail to consider either the costs and burdens imposed by an opt-in system or the less restrictive GLBA opt-out alternative; and (c) they are based on, at best, questionable statutory authority. Time will tell whether either regulation will be challenged successfully in court. In the interim, the authors remain convinced that open, rational, and non-politicized debate over the costs and benefits of an opt-in system will ultimately lead policymakers and business to conclude that an opt-out process fairly balances business interests in maintaining the flow of personal information for business function and marketing purposes and the public interest in maintaining a measure of control over the unrestricted flow of that information.

B. Identity Theft

Identity theft occurs when one person wrongfully takes and exploits another's identity by using personal information, often benefiting financially by doing things like making fraudulent credit charges or bank account withdrawals. Thieves obtain personal information through a number of methods, including: (1) directly obtaining physical documents by stealing mail, purses or wallets as well as by sifting through trash; (2) abusing technology to acquire electronic information either from the Internet, for example from records provided to an unsecured site or from a more interactive scam or scheme, or from an institution's computers, for example where a hacker has gained access to a company's databases; and (3) "pretexting," where the thief misrepresents or lies to an institution in

155. *Id.* at 1238-39.

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order to gain personal information (i.e., where the thief poses as someone with a valid purpose for the data).[156]

Numerous laws are in place to protect consumers from identity theft and to penalize those who perpetrate this crime.[157] Legislators continue to search for additional means to address this problem. Insurers have a strong interest in reducing identity theft, preventing insurance fraud, and maintaining secure information.[158] Existing laws should be enforced against criminals and any new laws must be careful not to restrict insurers' access to and use of information, which serves an important function in the industry. Law enforcement agencies, at all levels of government and in different nations, should coordinate their efforts to combat identity theft. Emphasis should be placed on educating consumers about identity theft and the steps they can take to minimize the risk of identity theft in order to help the victims understand the process, reduce the cost for businesses, and help consumers restore their pre-theft financial status. Although many appropriate mechanisms are in place, there may be other ways that the government could bolster consumer protections to both prevent the identity theft from occurring and punish criminals in the event that the theft occurs.

1. Data Security

GLBA provides a sweeping array of consumer protections, as discussed *infra*, and many of the privacy provisions center on appropriate disclosure of personal information. Subsection 501(b) of GLBA[159] directs the functional financial services regulators to promulgate data security standards to protect against unauthorized access to or disclosure of nonpublic personal financial information. Based on this directive, the New

156. Several agencies of the federal government provide resources, some of which are available on the Internet, for victims of identity theft or those looking to learn more about this issue. These agencies include: the Federal Trade Commission, the Social Security Administration and the Department of Justice.

157. The vast majority of states have laws relating to identity theft. Further, there are several applicable federal laws, including the Identity Theft and Assumption Deterrence Act of 1998, 18 U.S.C. § 1028 (2000); the Fair Credit Reporting Act, 15 U.S.C. § 1681 (2000), and the Electronic Fund Transfer Act, 15 U.S.C. § 1693 to 1693(r) (2000). GLBA also contains a provision on pretext calling. *See* 15 U.S.C. § 6821 (1999).

158. *See* Henry Stimpson, *Identity Theft: Nothing Personal–Crooks Targeting Auto Insurers in Growing Scam Wave*, INS. FRAUD WEEKLY REPORT, *at* http://www.insurancefraud.org/feature_id_theft.htm (last visited Mar. 1, 2002). *See also Hearing on Protecting Privacy and Preventing Misuse of Social Security Numbers Before the Subcomm. on Social Security of the House Comm. on Ways and Means*, 107th Cong. (2001) (statement of John C. Dugan on behalf of Financial Services Coordinating Council).

159. Codified as 15 U.S.C. § 6801(b) (2000).

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York Insurance Department issued a proposed rule that contains a general data security standard and includes a set of non-exclusive "examples" purportedly to guide insurance licensees. A model regulation substantially similar to the New York rule has recently been adopted by the NAIC.[160]

State regulation in this area should afford an insurance licensee flexibility to develop and implement personal information safeguards that are tailored to the needs of the licensee, patterned after those issued by the Securities and Exchange Commission (SEC).[161] The SEC rule requires financial institutions to adopt policies and procedures that address administrative, technical and physical safeguards for the protection of customer records and information. The policies and procedures must be reasonably designed to ensure the security and confidentiality of customer records and information, protect against any anticipated threats or hazards to the security or integrity of customer records and information, and protect against unauthorized access to or use of customer records or information that could result in substantial harm or inconvenience to any customer. The SEC's approach essentially codifies the requirements of section 501(b).

A flexible approach is consistent with the approach followed by two examination handbooks (market conduct and financial condition) developed by the NAIC.[162] Both handbooks provide specific guidance on data security parallel to the flexible approach. The NAIC Financial Condition Examiners Handbook includes a detailed list of company standards for examiners to review in evaluating internal computer controls.[163] The Financial Condition Handbook also directs the "examiner-in-charge" to "[p]rovide for the security of company records and information."[164]

The NAIC Market Conduct Examiners Handbook gives similar direction. The Market Conduct Handbook's examination guidelines instruct examiners to inspect computer systems as follows: "The examiners should determine the types of controls, safeguards and procedures for

160. *See* NAIC, NAIC STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION (Feb 28, 2002) (on file with author). *See also* N.Y. Dep't of Ins., Regulation 173, N.Y. COMP. CODES R. & REGS. tit. 11, § 421 (2002).

161. 17 C.F.R. § 248.30 (2001).

162. NAIC, EXAMINERS HANDBOOK, VOLUME I: FINANCIAL CONDITION EXAMINERS HANDBOOK (Rev. ed., 1998) [hereinafter HANDBOOK VOL. I]; NAIC, EXAMINERS HANDBOOK, VOLUME II: MARKET CONDUCT EXAMINERS HANDBOOK (Rev. ed., 1998) [hereinafter HANDBOOK VOL. II].

163. HANDBOOK VOLUME I, *supra* note 162, at 1-51 to 1-55.

164. *Id.* at 1-8.

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protecting the integrity of the computer information."[165] This standard for addressing a company's operations is classified as an "essential" priority, as opposed to a "recommended" priority.[166] Examiners are specifically advised to: (a) review the company's computer security procedures; (b) verify compliance with all applicable statutes, rules, and regulations; and (c) review the company's central recovery and backup plans and procedures to assure they are valid and up-to-date.[167] These examination handbooks, which are specifically referenced in many state examination statutes, ensure that data integrity is preserved, and do so in a way that mirrors the SEC rule.

Adopting the SEC's flexible approach is also supported by the manner in which Congress directed the state insurance authorities to implement section 501(b). Under section 505(c) of GLBA, the *federal banking agencies* are to adopt the standards as *guidelines*, while the *state insurance authorities*, the SEC and the FTC adopt the standards as *regulations*. This establishes a difference between the treatment of banking organizations and other financial institutions such as insurers. In view of the fact that a violation of a rule has potentially more severe consequences than a violation of a guideline, this calls for additional flexibility in the manner in which the state insurance authorities implement section 501(b).

Both the New York proposed rule and the NAIC data security model regulation contain sections allowing insurers broad flexibility to implement technical, administrative, and physical safeguards for personal information. However, this flexible rule is followed by a set of illustrative examples that provide further detail on those safeguards. Though both the New York proposed rule and the NAIC data security model regulation are generally acceptable, two issues remain unresolved. First, both include a provision dealing with data security in service provider arrangements under the "example" heading. That provision should be deleted because it seemingly imbeds a *mandate* that requires licensees to oversee service providers to ensure that they implement appropriate data security protection. Even where retained, "examples" should not be framed as requirements. In addition, this portion of the proposed rule attempts to regulate non-licensees (i.e., service providers) by imposing standards on insurers.

Second, the New York rule contains a provision which makes a violation of sections 3, 4, or 11 an unfair method of competition or unfair

165. *See* HANDBOOK VOLUME II, *supra* note 162, at VI-3, VII-3 (emphasis added).
166. *Id.*
167. *Id.* at VI-5.

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or deceptive trade practice under applicable state law.[168] In certain insurance regulatory jurisdictions, making a violation of the proposed data security regulation an unfair trade practice may have unintended consequences. While some state laws do not contain a private right of action for unfair methods of competition or unfair trade practices, other state laws do. In contrast, GLBA does *not* create any private right of action for violations of its standards. Enforcement of privacy standards under GLBA is the exclusive province of the functional financial services regulator. In addition, making a private right of action available under the proposed regulation creates significant costs and burdens on insurance licensees that are foreign to other federally-regulated financial institutions.

2. Social Security Number Restrictions

Property-casualty insurers have been using social security numbers (SSNs) for years in their business operations to verify the identity of a particular individual and should continue to be able to use and share SSNs in an appropriate manner to carry out business functions. For example, during the claims process, the claimant's social security number is used to verify his or her identity, and to prevent insurance fraud. Proposed restrictions on SSNs typically cite identity theft as the primary reason for the restriction.[169] Ironically, restrictions against legitimate insurer use actually may increase the risk of identity theft.

Social Security numbers represent the only comprehensive nationwide tool for insurers to verify the identity of an individual. As a result, preserving the appropriate business use and disclosure of SSNs is critical. Government should seek to preserve appropriate access to and uses of personal identifiers, including SSNs, as it strives to eliminate and prevent inappropriate access and use. Indiscriminate and across-the-board bans on access to and use of personal identifiers must be avoided. Access to public records containing personal identifiers should be preserved where the purpose in accessing the information is related to a legitimate business need. With respect to protecting the privacy of personal identifiers and other personal information, including SSNs, the information security requirements of GLBA and of regulations promulgated pursuant to GLBA should continue to serve as the basic framework for all government initiatives affecting financial institutions subject to GLBA.

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168. N.Y. Dep't of Ins., Regulation 173, N.Y. COMP. CODES R. & REGS. tit. 11, § 421.9 (2002).

169. *See* Stimpson, *supra* note 158, at para 24.

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C. Privacy Notice Content

The readability and understandability of privacy notices came to the forefront after the first wave of GLBA privacy notices was sent to customers from financial institutions in order to meet the July 1, 2001 GLBA privacy implementation deadline. At that time, this issue received extensive media attention, and continues to top the agenda for regulators and legislators. Creating a simple notice, one that is considered comprehensible to the average reader and explains key regulatory terms (such as, what is meant by disclosures "permitted by law"), is a challenge given all of the information that a privacy notice must contain. The Federal Trade Commission held a workshop in December 2001 to review ways to address this challenge. Similarly, the NAIC has established a Privacy Notice Content Task Force to review the issue from the insurance perspective.[170]

Starting from an assumption that further exploration in this area is preferable, there are a number of options. First, some argue that imposing a mandatory uniform notice to apply to all companies is the best tactic. The benefit of this approach is the security it provides companies by minimizing the risk of litigation arising from allegedly misleading or deceptive notices. The drawback to this approach is that it prohibits companies from maintaining the flexibility to explain the marketing benefits of the privacy policy (either showcasing the advantages to sharing such information or highlighting a limited amount of information sharing). Second, others advocate for notice content to be prescribed by regulators as an "example" or "safe harbor" for companies. Under this scenario, the regulator-endorsed notice content would serve as one way, but not the only way, to present the text of the notice. This option addresses the shortfalls of the mandatory notice content approach since it would allow adequate flexibility. Third, still others may prefer preamble language, either fixed or recommended by regulators, that would accompany the company-specific notice. This preamble might function similar to the 1982 NAIC Model abbreviated notice and broadly describe the privacy protections afforded consumers in understandable terms. However, in the case of the GLBA notice, the preamble would not supplant the actual notice; the full notice would follow the preamble in order to meet the obligations of the NAIC Model Regulation and GLBA as well as to preserve flexibility for the company and to provide information to consumers interested in learning

170. The authors participated on this Task Force.

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more about the company's information handling practices. Industry and regulators are working together to explore all of these ideas, in order to increase consumer understanding of privacy notices.

CONCLUSION

As the last several states complete regulation or legislation addressing GLBA's privacy requirements, as states with requirements in place face issues of interpretation, and as new privacy initiatives are presented, critical threshold principles must guide resolution of these matters. First, any requirement that offers different, non-uniform standards should consider the impact on compliance and the resulting costs. Second, new obligations or restrictions must leave the industry with the tools necessary to accomplish business functions and to compete effectively against federally-regulated entities. Third, the consumer benefits of new products and services resulting from a reasonable flow of information warrant consideration. Fourth, proposals ought to focus only on narrowly-tailored meaningful consumer protections and leave behind the opportunity for political exploitation of this complex issue. As the Warren and Brandeis article demonstrates, privacy is not a new issue. It is a recurring one that must take into account the modern and technologically-advanced business environment, but not outstrip the consumer and business benefits of financial services modernization. This is especially true for the insurance industry, where the opportunity for misunderstanding occurs at least fifty-two separate times.

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HIPAA PREEMPTION IMPLICATIONS FOR COVERED ENTITIES UNDER STATE LAW*

*Adam Butera***

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INTRODUCTION

The computerization of medical records has greatly improved clinical care. Faster and more accurate diagnoses, instant medical record retrieval and improved safeguards from harmful drug interactions are a few examples of the transforming advances patient care has undergone.[1] Information technology comes at a price, however. It threatens privacy by making personal information the object of unintended distribution and increasingly sophisticated levels of malicious intrusion. It comes as no

1. James G. Hodge, Jr. et al., *Legal Issues Concerning Electronic Health Information: Privacy, Quality, and Liability*, 282 JAMA 1999, 1466.

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surprise, therefore, that the public is anxious about personal information uploaded into electronically stored or transmitted records.[2]

Given the highly personal and sensitive nature of health information, individuals desire reassurances that their records are adequately protected.[3] Those reassurances are necessary because patients are well aware that multiple organizations have access to their medical records in order to provide quality care and carry out claim payment. Anecdotes of improper medical record use can be found throughout the country. In New York, for example, a local pharmacy allegedly sold its customers' prescription records without their permission to CVS pharmacy's parent corporation, which then downloaded the information into a computer database.[4] The patients' medical histories thereby became available to "ten[s] of thousands of CVS store employees and the health-care plans and managed care providers that contract with CVS."[5] In the Midwest, a banker who happened to sit on his county's health board gained access to patient data, cross-referenced the names with his mortgage holders, and called due the mortgages.[6] In Florida, a disgruntled Health Department employee absconded with a computer disk containing the names of 4,000 people who tested positive for HIV, the virus that causes AIDS.[7]

The trust implicit in the doctor/patient relationship is the first casualty of a privacy breach. Quality health care is dependent upon individuals' willingness to discuss private details with their health care providers. Indeed, the consequences of wrongful disclosure are harmful for society as a whole, not just the patient. It is easy to envision that patients to whom medical record confidentiality is a serious issue will be less forthright with their physicians, particularly when the patient suffers from a socially stigmatizing affliction like HIV, alcoholism, or a mental health disorder. In

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2. Harris Equifax, *Health Information Privacy*, *at* http://www.epic.org/privacy/medical/polls.html (last visited Apr. 13, 2002).

3. *See* Lawrence O. Gostin, *Health Care Information and the Protection of Personal Privacy: Ethical and Legal Considerations,* 127 ANNALS OF INTERNAL MEDICINE 683, 683-90 (1997), *available at* http://www.acponline.org/journals/annals/supplement/protect.htm (last visited Apr. 13, 2002).

4. Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 335 (2001); *see also* John Markoff, *Used Computer Bares Old User's Secrets*, N.Y. TIMES, Apr. 3, 1997, at A16.

5. *CVS*, 728 N.Y.S.2d at 335-36.

6. Marianne Lavelle, *Health Plan Debate Turning to Privacy: Some Call for Safeguards on Medical Disclosure. Is a Federal Law Necessary?*, 16 NAT'L L.J., May 30, 1994, at A17.

7. John Bacon, *Aids Confidentiality*, U.S.A. TODAY, Oct. 10, 1996, *available at* 1996 WL 2071449.

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fact, one in six Americans has reportedly taken evasive action to avoid improper use of their health information by providing inaccurate data.[8] Additionally, inadequate privacy protections lead some patients to hide or misrepresent their medical data to the detriment of research initiatives aimed at improving public health.[9]

Before the Health Insurance Portability and Accountability Act of 1996 (HIPAA) became law, state and federal laws designed to prevent such abuses were often highly variable and outdated.[10] Federal law, for instance, protected only the medical information of specific groups—such as individuals with HIV, or those who participate in Medicare—thereby putting the onus on states to enact comprehensive privacy laws.[11] Yet most states have inadequate or non-existent privacy laws.[12] Only a handful of states have passed comprehensive privacy legislation and most allot protection only for government-held data.[13] Today, medical data is used for purposes beyond immediate assessment and treatment. Alternative uses include financial administration (data exchanged in self-funded employer-sponsored plans, managed care and hospital billing), regulatory compliance (quality assurance and utilization review) and research initiatives. As such, a professional code of ethics may not guide third parties—most notoriously marketing firms and information brokers—from obtaining or using individually identifiable medical records illegally.[14] It is perfectly reasonable that a patient may not wish to share their medical information with various ancillary organizations for reasons of personal privacy. Given the irregularity of privacy protections and the availability of computerized medical data, comprehensive federal legislation became necessary. Under the authority vested in HIPAA, the Department of Health and Human

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8. PRINCETON SURVEY RESEARCH ASSOCIATES, MEDICAL PRIVACY AND CONFIDENTIALITY SURVEY: SUMMARY AND OVERVIEW 2 (1999), *available at* http://www.chcf.org/documents/ihealth/survey.pdf (last visited Apr. 13, 2002).

9. *See* OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, PROTECTING PRIVACY IN COMPUTERIZED MEDICAL INFORMATION 5 (1993), *available at* http://www.wws.princeton.edu/~ota/disk1/1993/9342_n.html (last visited Apr. 13, 2002).

10. WORKGROUP FOR ELECTRONIC DATA INTERCHANGE, EXECUTIVE SUMMARY 77 (1993), *at* http://www.wedi.org/public/articles/full1993report.doc (last visited Apr. 13, 2002).

11. *See* Hodge, *supra* note 1, at 1466-71.

12. Joy Pritts et al., *The State of Health Privacy: An Uneven Terrain*, 32-34 (1999), *at* http://www.georgetown.edu/research/ihcrp/privacy/statereport.pdf (last visited Apr. 13, 2002).

13. *Id.*

14. *See* OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 9, at 14.

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Services (HHS) promulgated the Final Privacy Rule in December 2000 to fill these perceived privacy gaps.[15] Certain state laws are not preempted, however; specifically, state privacy laws that provide "more stringent" privacy protections are untouched and effective. Covered entities must assess now and in the future whether any of their respective state's medical privacy laws are the exception that proves the rule.

The purpose of this article is to provide an overview of some preemption issues that HIPAA covered entities (CE's) may encounter in their analysis of relevant state privacy law. Though this article analyzes the impact of HIPAA on Connecticut state law, similar issues will arise under the law of every state. Part II of this article summarizes the HIPAA Privacy Final Rule, including who and what is covered, and the lengths to which CE's must modify current policies to satisfy HIPAA. Further, it identifies the Final Rule's major compliance burdens, which demand a cultural change within each covered health care entity, compounded by rather intimidating enforcement penalties for non-compliance. Part III explores the details of the Final Rule and how it relates, preemptively speaking, to Connecticut privacy laws governing health records. Included is analysis of potentially murky preemption compliance issues for CE's. Part IV explores the various Connecticut disease-based confidentiality protections and the Final Rule's "hands-off" approach to certain provisions that relate to public health regulations. Finally, Part V describes the enforcement penalties available under HIPAA and Connecticut privacy law.

II. SUMMARY OF THE HIPAA PRIVACY RULE

HIPAA (Title II) provides a comprehensive, national privacy rule for health information that replaces and sometimes supplements current state and federal law.[16] The Rule provides the first uniform and systematic *foundation* for the protection of health information. Still, HIPAA is not monolithic—it takes a "hands-off" approach to certain activities traditionally regulated by states, including public health, law enforcement

15. *See* Press Release, U.S. Dept. Health & Human Servs., HHS Announces Final Regulation Establishing First-Ever National Standards to Protect Medical Records (Dec. 20, 2000), *available at* http://www.hhs.gov/news/press/2000pres/20001220.html (last visited Apr. 13, 2002).

16. Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Kennedy-Kassebaum Act), 42 U.S.C. § 132D(d) (Supp. V 1999).

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and financial auditing.[17] Furthermore, any conflicting state privacy law that is "more stringent" than the Federal Rule will continue in force.[18] On the whole, the Rule attempts to balance the public benefit of improved clinical care, research and safety, while protecting the privacy rights of individuals. Therefore, the myriad state laws that provide more stringent privacy protections for stigmatizing conditions, like HIV/AIDS, alcoholism and genetic disorders, will remain intact. Additionally, it appears the Privacy Rule may not preempt other federal privacy laws.[19] Critics of the Rule acknowledge that it provides greater privacy protection, but argue that its adoption is at the expense of regulatory uniformity, making implementation, whether by a state or national organization, difficult and costly.

HIPAA imposes a national privacy standard upon five organizational types: *first*, directly-regulated covered entities, consisting of health plans,

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17. A state law is not preempted if: (1) it is necessary to prevent fraud and abuse, (2) to regulate insurance or health plans, (3) is designed to report health care delivery or costs, (4) is designed to serve a compelling need related to health, safety and welfare or (5) is designed to regulate controlled substances. 45 C.F.R. § 160.203(a) (2001). In addition, a state law is not preempted if it: (1) provides for the reporting of disease, injury, child abuse, birth, or death; (2) provides for the conduct of public health surveillance, investigation, or intervention; or (3) requires a health plan to report, or provide access to, information for management or financial audits, program monitoring and evaluation or the licensure or certification of people or facilities. *Id.* §160.203(c)-(d) (2001).

18. *See* 45 C.F.R. § 160.202 (2001). The stringency test is explained at length in the Privacy Rule. In comparing the Privacy Rule with state law, a state privacy law is more stringent if it: (1) prohibits or restricts use or disclosure of PHI that is otherwise permitted under the Privacy Rule; (2) grants greater rights to access or amend an individual's protected health information (PHI); (3) requires individuals to whom the PHI relates to be given a greater amount of information about use, disclosure, rights, remedies; (4) provides requirements that "narrow the scope or duration, increase the privacy protections afforded . . . or reduce the coercive effect of the circumstances surrounding the authorization or consent;" (5) provides for the retention or reporting of more detailed information with respect to record-keeping or accounting disclosures or for longer periods; or (6) provides for greater overall privacy protection for an individual's PHI. *Id.* The March 27th proposed rule modification reworded the second prong, and the fourth prong made no reference to the abandoned consent requirement. *See id.*

19. *See generally* The Privacy Act of 1974, 5 U.S.C. § 552a(6) (2000); The Family Educational Rights and Privacy Act of 1974 (FERPA), 20 U.S.C. 1232g (2000); Public Health Services Act, 42 U.S.C. 292 (2000); Clinical Laboratory Improvement Amendments of 1988, 42 U.S.C. 263a (2000); Freedom of Information Act (FOIA); 5 U.S.C. § 552 (2000). Where there appears a conflict between an older federal statute and the Privacy Rule, the Rule enables a CE to follow the older law "to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 C.F.R. § 164.512 (2001).

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health care clearinghouses and health care providers, and *second,* business associates and employers.[20] HIPAA affects only those health care providers that transmit health information in electronic form in connection with a transaction.[21] For example, a nursing home that transmits health plan participants' information electronically to an auditor triggers HIPAA, whereas one that submits only paper copies does not. Despite a less than transparent statutory mandate, however, HHS decided that once an organization constitutes a covered entity under HIPAA, all individually identifiable health information, maintained or transmitted in any medium—electronic, paper or oral—deserves protection.[22] Nevertheless, this choice is consistent with HIPAA's underlying purpose: to fill gaps in medical privacy where no protection currently exists.[23] Thus, once triggered as a covered entity, telephone communications in a doctor's office are covered as long as a risk exists that the orally-relayed information could identify an individual, or if obvious identifiers such as name, telephone or social security numbers are used in the conversation. The Rule does not exhaustively define what makes a medical record "individually identifiable;" therefore, the covered entity's reasonable judgment must be

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20. 45 C.F.R § 160.103(3) (2001). Employers that are group health plan fiduciaries, such as self-funded plans, constitute quasi-health plans. *Id.* If an employer encounters Public Health Information as a plan administrator, the employer must follow the rules relating to business associates. *See infra*, sec. III.B. Additionally, government agencies or programs operated thereunder may constitute health plans, clearinghouses or providers for purposes of HIPAA, unless they qualify under certain express exemptions. 45 C.F.R. § 164.512.

21. *Id.* § 160.103 (2001). All health plans and health care clearinghouses are subject to HIPAA. Health Care Clearinghouses are defined as public or private entities that process or facilitate the processing of nonstandard data elements (e.g. billing services, repricing companies). *Id.* HIPAA did not authorize HHS to regulate other entities that use personal medical data, such as worker's compensation programs and life insurers. *Id.* § 164.502(e)(1). Additionally, third party contractors (auditors, lawyers, billing companies, etc.) are not directly regulated, but instead fall under the rule regarding business associates. *See id.* § 164.502(e).

22. Protected health information is defined as encompassing individually identifiable health information that is transmitted by electronic media, *id.* § 164.501, maintained electronically (including the Internet), extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media), and transmitted or maintained in any other form or medium. *Id.* § 162.103.

23. *See* HEALTH PRIVACY PROJECT, COMMENTS ON FINAL STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION 14 (2001), *at* http://www.healthprivacy.org/usr_doc/55009.pdf (last visited Apr. 13, 2002).

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relied upon.[24] Recent HHS clarification statements specifically reject the need to build private rooms or sound proof walls to comply with the Rule.[25] On March 21, HHS proposed new rules to "increase the confidence of covered entities"[26] that certain oral communications in routine provider settings do not violate HIPAA.[27]

The following are the principle burdens the Privacy Rule imposes on covered entities:

- Patient Control: Under the Privacy Rule, *providers* must obtain written consent before using or disclosing protected health information (PHI) for treatment, payment or health care operations.[28] Generally, all other disclosures require an authorization.[29] For purposes of payment or other health care operations, covered entities must use and disclose only the minimum necessary to achieve the purpose at hand. Additional policies and procedures must be implemented to standardize appropriate provider behavior.[30]
- Business Associate Contracts: Covered entities must draft and implement contracts with business associates who are provided access to PHI.[31]
- Right to Access, Inspection and Amendment: Patients are entitled to access, inspect and sometimes amend their health information, subject to limitations for safety and data integrity.[32]

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24. *See* 45 C.F.R. § 164.501 (2001) ("individually identifiable health information" must identify the individual or leave "a reasonable basis to believe the information can be used to identify the individual"). *Id.*

25. *See* OFFICE FOR CIVIL RIGHTS, STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, ORAL COMMUNICATIONS para. 2 (2001), *at* http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm (last visited Apr. 13, 2002).

26. *Id.*

27. *Id.*

28. HHS proposed a rule modification on March 21, 2002, that expressly rejects the consent requirement. Under the proposal, providers must give patients notice of their privacy rights and provider practices only. Dep't of Health & Human Servs., *HHS Fact Sheet, Standards for Privacy of Individually Identifiable Health Information—Proposed Rule Modification*, para. 2 (Mar. 21, 2002), *at* http://www.hhs.gov/news/press/2002pres/20020321.html [hereinafter *HHS Fact Sheet*]; Standards for Privacy of Individually Identifiable Health Information Proposed Rule (Proposed Rule); 67 Fed. Reg. 14776 (Mar. 27, 2002).

29. 45 C.F.R. § 164.506 (2001).

30. *Id.* § 164.502(b).

31. *Id.* § 164.502(d).

32. *Id.* §§ 164.524, 164.526.

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- Administrative Requirements: Implementation of the Rule must include training personnel, instituting appropriate safeguards, accommodating complaints, imposing internal sanctions and adopting policies and procedures.[33]
- Accommodation of State Public Health Objectives: The Rule specifically permits CEs to report to state health authorities in order for state agencies to continue, *inter alia*, routine reporting, surveillance and outbreak investigations. Furthermore, the majority of state agencies that implement public health objectives are not CEs under the Privacy Rule, and thus are exempt from complying with HIPAA. Certain component programs within an agency may constitute a CE.
- Enforcement: HHS is empowered to conduct general compliance reviews. A violation may result in civil or criminal penalties, with the stiffest penalty possible at $250,000 and ten years in jail.[34]

III. RECONCILING THE PRIVACY RULE'S QUALIFIED PREEMPTION WITH CONNECTICUT MEDICAL PRIVACY LAW

A. Patient Control: Limitations on Disclosure

1. HIPAA Privacy Rule

One of HIPAA's primary purposes is to put patients back in control of their health information—a recurring concern voiced by most Americans.[35] Under the Rule, providers must obtain the individual's consent prior to the use or disclosure of health information for treatment, payment or health care operations (e.g. quality assessment review, underwriting, audits and customer service).[36] Consent requires that covered entities draft and present a standard, plainly written consent form, which informs the patient that her health information may be used or disclosed.[37] In addition, it must advise the patient that she has a right to review the covered entity's privacy notice before signing the consent form, and that she may request a

33. *Id.* § 164.530.

34. 42 U.S.C. § 1320(d)(6) (Supp. V 1999).

35. Harris Equifax, *supra* note 2.

36. 45 C.F.R. § 164.506(a) (2001). Worth noting is the lower threshold for relatives, personal friends or representatives of the patient. These parties may have access to limited PHI, without a patient's consent or authorization as long as the individual is informed in advance and has the opportunity to allow or disallow disclosure. *Id.* § 164.510(b).

37. *Id.* § 164.506(c).

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restriction on the use of that information. If a patient denies or restricts consent, however, a provider may withhold treatment.[38] Lastly, the consent may be revoked if it is in writing, "except to the extent that the covered entity has taken action in reliance thereon."[39]

There are a number of caveats to the consent requirement, however. First, health plans and health care clearinghouses are not subject to the consent provision.[40] By signing a provider's consent form, the individual gives affiliated health plans and clearinghouses permission to use or disclose the information for treatment, payment or health care operations. Second, a provider needs to obtain a patient's consent only once, regardless of whether the consent emerged from related or unrelated treatment.[41] Consulting with another health care provider about a patient's care does not require consent, even if no direct treatment relationship exists.[42] Third, consent is not needed in the event of emergency treatment situations, if the patient is unable to communicate consent or the patient is a prison inmate.[43] Fourth, certain disclosures to law enforcement for purposes of public health and safety are permissible or in response to a court order or subpoena.[44]

Despite some exceptions for administrative convenience, the consent requirement's days may be numbered. In the Rule's first clarification, HHS acknowledged that it was reconsidering the consent provision, and on March 21, 2002, proposed shelving it completely.[45] Noting the unintended interference the consent provision would have on filing prescriptions, referring patients to specialists, and providing treatment over the telephone, HHS acknowledged that a privacy notice served as an adequate surrogate.[46] As such, patient acknowledgment of the provider's privacy policy, rather than a provider's receipt of written consent, may be enough to satisfy HIPAA. Following a public comment period of thirty days, HHS will issue a Privacy Rule to decide the matter.

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38. *Id.* § 164.506(b).

39. *Id.* § 164.506(b)(5).

40. *Id.* § 164.506(a)(2); OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Consent* para. 2.

41. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Consent* para. 2. "A provider will need to obtain a new consent from a patient only if the patient has revoked the consent between treatments." *Id.* at *Consent* para. 39.

42. *Id.* at *Consent* para. 22.

43. 45 C.F.R. § 164.506(a)(2)(ii), (a)(3)(i).

44. *Id.* § 164.512(f).

45. *HHS Fact Sheet*, *supra* note 28, at 1; Proposed Rule, 67 Fed. Reg. 14812 (Mar. 27, 2002).

46. *HHS Fact Sheet*, *supra* note 28, at 1.

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Still, HHS chose not to substantively dilute the related authorization requirement—the most vigilant protection from wrongful disclosure that HIPAA provides. Unlike consent, authorization is a document tailored to give covered entities permission only to use specific information for specific purposes.[47] As a general rule, authorization is required for uses or disclosures other than for treatment, payment or health care operations.[48] What distinguishes consent from authorization is the length to which covered entities must go to forewarn individuals of the use or disclosure of their information. Therefore, consent and authorization requirements will not overlap, since different circumstances require either heightened or lowered levels of permission.

Authorization is also required to disclose PHI to a third party specified by the individual. The individual's permission covers only the uses and disclosures stipulated in the authorization form. Also, unlike consent, treatment may never be conditioned on an individual's grant or denial of authorization.[49]

Marketing of PHI acquires special attention in the Privacy Rule and received clarification recently.[50] The Rule attempts to draw a bright line between the otherwise gray area separating marketing communications and treatment.[51] Once a communication is defined as marketing, it becomes subject to either the consent or authorization requirements. A covered entity is subject to the lesser consent requirement if the communication meets the high hurdle prescribed by the standard, at which time it is technically treated as a health care operation.[52] Otherwise, a covered entity

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47. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Consent* para. 22.

48. 45 C.F.R. § 164.508.

49. *Id.*§ 164.508(b)(4).

50. *See* OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Health-Related Communications and Marketing*.

51. The Privacy Rule defines marketing as "a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service." 45 C.F.R. § 164.501. The Rule carves out certain communications otherwise falling under marketing. Excluded from the definition of marketing are: (1) certain CE or services provided therein; (2) tailored communications by a health care provider as part of a treatment to the individual; and (3) tailored communications by providers or health plans designed to direct or recommend alternative treatments, therapies, health care providers, or care settings. *Id.* § 164.501; Proposed Rule 67 Fed. Reg. 14813 (Mar. 27, 2002).

52. Consent is limited to marketing that (1) occurs face to face with the individual; (2) concerns products or services of nominal value (e.g. calendars, pens or other promotional items); or (3) concerns products and services that identifies the individual making the communication (while stating prominently whether direct or indirect remuneration was

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must receive a patient's authorization before it may use or disclose PHI for marketing purposes.[53] Importantly, CE's may disclose PHI to business associates who assist in the communications, but are still subject to the contract requirements, discussed in Part III.B of this article.[54] CE's may not sell patient lists without obtaining authorization from each person on the list.[55]

Importantly and potentially most transforming is the minimum necessary standard, which requires covered entities to develop and implement policies and procedures designed to limit the internal use of medical data.[56] Covered entities must exercise reasonable efforts not to use or disclose more than the minimum information necessary to achieve the disclosure's purpose.[57] This standard applies to almost all uses and disclosures of PHI, unless the information relates to a direct treatment relationship with a provider.[58] The decision whether to use or disclose may at times require individual review. Because implementing and monitoring compliance will be challenging, HHS has indicated it will clarify the minimum necessary standard as questions continue to emerge.[59] The first proposed modification, issued in March 2002, clarified that physicians could discuss patient treatment without implicating the standard in the event they were overheard by a third party.[60]

2. Connecticut Privacy Law

In 1999, the Connecticut legislature opted to become one of the few states to enact a privacy law designed to foreclose the sale of medical

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involved and how an individual may opt out of future communications). *Id.* §§ 164.514(e)(1), 164.501 (defining health care operations). Communications contained in a newsletter or medium of broad exposure to a cross-section of patients are exempt from the opt out condition. *Id.* § 164.514(e)(3)(i)(C). If the individual is targeted based on health status, the covered entity must determine whether the product or service will benefit him or her and also provide the reason for the targeted communication. *Id.* § 164.514(e)(3)(ii).

53. *Id.* § 164.514(e)(1).

54. *See id.* § 164.514(e)(2); *infra*, Part B.

55. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Health-Related Communications & Marketing* para. 7.

56. 45 C.F.R. § 164.502(b).

57. *Id.*

58. *Id.* § 164.502(b)(2)(ii).

59. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Minimum Necessary* para. 1.

60. *HHS Fact Sheet*, *supra* note 28, at 1; Proposed Rule, 67 Fed. Reg. 14812 (Mar. 27, 2002).

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records.[61] Marketing-related uses and disclosures also acquired new restrictions, paving the way for a requirement that patients give written consent before their records may be used for profit.[62] The legislation targets insurers,[63] health care professionals and universities specifically, but in reality the regulation broadly applies to anyone with access to medical data.[64] Nevertheless, health care providers receive express assurances that they may still transfer medical records for purposes of improving patient care and administration.[65]

a. Employer Restrictions

Connecticut law requires a written authorization before the disclosure of individually identifiable information, regardless of its nature, may be made to any person not employed or affiliated with the employer in an employment setting.[66] The law's application is limited to information stored in the employee's personnel file or medical records.[67] The law accommodates practical administrative needs, however, by providing extensive exceptions[68] including disclosures for the purpose of verifying employment dates, title or position and salary information.[69] Additional

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61. An Act Concerning Managed Care Accountability, Conn. P.A. 99-284 § 18a (codified at CONN. GEN. STAT. § 38a-988a (2001)).

62. *Id.*

63. Insurance institutions, agents and insurance-support organizations, as mentioned in the legislation, CONN. GEN. STAT. § 38a-976 (2001), are collectively referred to as "insurers" hereinafter for the purpose of simplicity.

64. For purposes of the Connecticut Insurance Information and Privacy Protection Act, CONN. GEN. STAT. §§ 38a-975 to -998 (2001), Medical-Record Information is individually identifiable personal information which

> [(1)] relates to the physical, mental or behavioral health condition, medical history or medical treatment of an individual or a member of the individual's family, [and (2) is] obtained from a medical professional or medical-care institution, from a pharmacy or pharmacist, from the individual, or from the individual's spouse, parent or legal guardian or from the provision of or payment for health care to or on behalf of an individual or a member of the individual's family.

Id. § 38a-976(r).

65. *Id.* § 38a-988a.

66. *See, e.g.*, CONN. GEN. STAT. §§ 31-128a to -128h (2001).

67. *See id.* §§ 31-128b to -128c.

68. Permissible unauthorized disclosures may include: administrative summons or judicial orders, government audit, defense or prosecution of personnel-related complaints, law enforcement agency requests, in response to a medical emergency, federal, state, or local law, or pursuant to the terms of a collective bargaining agreement. *Id.*

69. *Id.* § 31-128f.

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exceptions are provided if the information is made available to a third party who maintains or prepares labor personnel files for the employer.[70]

b. Government-maintained Records

All information procured by the Connecticut Department of Public Health (DPH) in connection with mortality studies must remain confidential and shall be used solely for the purposes of medical and scientific research and disease control.[71] Such information is inadmissible as evidence in any civil, criminal or administrative setting.[72] Furthermore, the state's Freedom of Information Act exempts from disclosure, medical records maintained by any public agency. However, DPH may exchange the data with any other governmental agency, private organization, or individual for research purposes provided they agree not to disclose the data.[73] Lastly, "any person, hospital, sanitarium, rest home, or nursing home"[74] that furnishes any information to DPH or any other agency cooperating in a research project cannot be the subject of any action for damages or other relief because of disclosure.[75]

Individuals with communicable diseases also receive special protection for their medical records. Any record created as a result of examination or treatment in a communicable disease control clinic must be held confidential by the local health director and may not be released to the public.[76] However, the statute provides a wide array of exceptions, including: statistical record-keeping of non-identifiable information if it is essential to protect the health or life of a medical emergency victim or to report the abuse or neglect of minors.[77] Also, similar to the minimum necessary standard, agencies must maintain only that information about a person, which is "relevant and necessary" to accomplish the agency's purpose.[78]

70. *Id.*
71. *Id.*
72. CONN. AGENCIES REGS. § 19a-25-3(c) (1998).
73. *Id.* § 19a-25-3(a)(3).
74. CONN. GEN. STAT. § 19a-25 (2001).
75. *Id.*
76. *Id.* § 19a-216a(b).
77. *Id.*
78. *Id.* § 4-193(e).

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c. Insurance Entities

Insurers must receive a written authorization from the patient before any personal or privileged information collected or received is disclosed in connection with an insurance transaction.[79] The law exempts a number of entities and individuals from this authorization requirement.[80] For instance, disclosures made to persons other than insurers, which are "reasonably necessary" to enable the recipient to perform a business, professional or insurance function for the insurer, need no authorization.[81] Certain third-party recipients must agree not to disclose the information without the individual's written authorization.[82] Similar to the Privacy Rule, the statute codifies the specific content required in the disclosure authorization form.[83] However, the law specifically exempts medical providers, insurance regulators, marketers, professional peer review organizations, and law enforcement officials from the authorization requirement.[84]

d. Select Providers

In addition to the marketing restrictions imposed on providers generally, pharmacists are also singled out for special disclosure limitations. They must receive a patient's written or oral consent, duly noted in the records, before disclosing any records to a third party.[85] Exceptions delineating individuals with whom pharmacists may share the data is fairly extensive, however.[86] In addition, nursing homes must also assure confidential treatment to residents' medical records, including the power to refuse releasing them. With limited exceptions, provider-patient

79. *See* CONN. GEN. STAT. § 38a-988 (2001).

80. *See id.* § 38a-988(a) to (s). Unauthorized disclosures made to third parties are allowed as long as they are "reasonably necessary" to perform a function for the disclosing insurer, provided the third party recipient agrees not to disclose the information without the individual's written authorization. *Id.* § 38a-988(b).

81. *Id.* § 38a-988(b).

82. *Id.*

83. *See id.* § 38a-981.

84. *See id.* § 38a-988.

85. *Id.* § 20-626.

86. Pharmacists may provide pharmacy records to: 1) the patient; 2) the prescribing physician or another pharmacist; 3) a registered or licensed agent of the physician; 4) third-party payors; 5) any governmental agency with statutory authority to review or obtain the information; 6) an individual, state or federal government official or court pursuant to a subpoena; and 7) any individual or legal entity which has a written agreement with a pharmacy to access the pharmacy's database provided the data is not individually identifiable. *Id.* § 20-626(b).

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privilege is also statutorily enshrined as a legitimate restriction on disclosure. Healthcare providers are exempt from the consent requirement insofar as the information is used for clinical research, utilization research, performance improvement, billing, or other functions in support of direct patient care.[87]

e. Employers

Generally permissive provisions exist for employment-related third party access. While an employer must receive a written authorization before individually identifiable disclosures may be made to persons not affiliated with the employer, the law provides an exception to third parties that "maintain[] or prepare[] employment records or perform[] other employment-related services for the employer."[88] Other written authorization caveats include the issuance of an administrative summons or judicial order or in response to a medical emergency.[89]

3. Preemption Issues

A quick glance at the Connecticut privacy laws demonstrates general similarities between the Privacy Rule and Connecticut law. Yet, the dissimilarities in focus, structure, and express exemptions denote diverging purposes: HIPAA focuses on the nature of the information and its electronic transmission, whereas Connecticut law focuses principally on the parties to whom the individually identifiable information may be disclosed.[90] For instance, Connecticut protects individuals from wrongful disclosure by insurers specifically, whereas the Privacy Rule focuses on what information a patient's consent enables a CE to use or disclose, e.g., PHI for treatment, payment, and other health care operations. Additionally, the sheer complexity and breadth of the Privacy Rule will likely preempt most of Connecticut's narrowly focused, but watered-down compliance requirements.

Second, the Connecticut Office of Policy and Management finalized its assessment of which agencies constitute or contain CE programs.[91] State

87. *Id.* §§ 19a-550(b)(9), 38a-988a(a).

88. *Id.* § 31-128f.

89. *Id.*

90. 45 C.F.R. § 164.501 (2001) (defining protected health information as individually identifiable health information that may be transmitted and/or maintained in any medium by a CE).

91. *See id.* at § 160.103 (defining covered entity). To date, twelve Connecticut state agencies or departments constitute or contain a CE. These include: the Department of

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agencies that are CE's or have component programs that fall within the definition of a CE are subject to the Privacy Rule, unless they qualify for express disclosure exemptions, or the state statute that authorizes their activities is not preempted.[92] It is important to remember, however, that if an agency or it's programs are not considered a CE, state and local law is left unchanged and remains enforceable.

Moreover, the Privacy Rule appears to impose conflicting standards for agency CE's. While CE's are given a general exemption to report to state health oversight agencies as authorized by law, including administrative investigations, this right is apparently circumscribed if the disclosure is not accompanied by an administrative order.[93] These subsections arguably conflict, unless the latter subsection is read to relate only to administrative tribunals whose purpose is not health oversight.[94] In addition, some otherwise "less stringent" Connecticut confidentiality protections afforded to government-held data are specifically exempt from Privacy Rule preemption because these agencies are not CE's.[95] Therefore, it is not clear whether the Privacy Rule or Connecticut law constitutes the privacy floor for government-held data.

Conversely, DPH regulations prohibit the use of agency disclosures of certain medical records obtained through a subpoena or other compulsory process as evidence in any civil, criminal, or administrative setting.[96] As noted, the Privacy Rule allows such disclosures insofar as it is accompanied by a judicial order.[97] As such, certain medical records in agency possession are subject to heightened disclosure rules. Thus, preemption will require the synthesis of numerous variables into a cohesive agency policy.

Administrative Services, Department of Social Services, Teacher's Retirement Board, Department of Children and Families, Department of Mental Health and Addiction Services, Department of Mental Retardation, Department of Public Health, Veterans' Affairs, Department of Corrections, Department of Information Technology, and the University of Connecticut (including University of Connecticut Health Center). Telephone Interview with Donna Brewer, Director of Public Health Hearing Office, Connecticut Department of Public Health (March 15, 2001); Telephone Interview with Elisa Chase, State HIPAA Program Coordinator, Connecticut Office of Policy and Management (March 15, 2001).

92. *See id.* § 164.512(b).
93. *Id.* §§ 160.203(c), 164.512(d)–(e) (2001).
94. *Id.*
95. *See id.* § 160.203(c).
96. CONN. AGENCIES REGS. § 19a-25-3(c) (2000).
97. 45 C.F.R. § 164.512(e)(1) (2001).

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Third, the Privacy Rule accommodates certain practical exceptions, otherwise inconsistent with the Rule, which some Connecticut privacy laws do not recognize.[98] For instance, the Privacy Rule allows pharmacists to release an individual's prescription to an alleged friend or family member.[99] While the Privacy Rule states that an individual must be informed in advance of the disclosure, their subsequent right to agree or object to disclosure can be trumped by a pharmacist's professional judgment and experience that suggests disclosure of an individual's pharmaceutical record to a friend or family member would be in the individual's best interest.[100] In contrast, Connecticut law precludes revealing such records without an oral or written consent even in emergency circumstances.[101]

Fourth, the Connecticut employment disclosure protections use "consent" and "authorization" synonymously, which renders the application of the stringency test problematic.[102] Similarly, the state's marketing restriction for insurers, which requires written consent (undefined), is sufficient only when the disclosure constitutes a "treatment" or "health care operation." Under the Rule, written consent with regard to marketing uses is insufficient.[103]

Lastly, reconciling the divergent definitions of "protected" medical records deserves special attention. While Connecticut law mirrors the Privacy Rule by addressing past, present or future physical and mental health[104] conditions and treatments, Connecticut law gives special attention to genetic history,[105] a subject the Privacy Rule ignores, instead giving protection to payment information.[106] In addition, the Privacy Rule contains a catch-all phrase that provides for liability under the Rule when a "reasonable basis" exists to believe that the information could identify an

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98. CONN. GEN. STAT. § 20-626(b) (2001); *see generally* OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Consent* para. 22.

99. 45 C.F.R. § 164.510(b)(1)(i) (2001).

100. *Id.* § 164.510(b)(3); *see also HHS Fact Sheet*, *supra* note 28, at para. 2 (proposing the rejection of the Final Rule written consent requirement); Proposed Rule, 67 Fed. Reg. 14812 (Mar. 27, 2002).

101. CONN. GEN. STAT. § 20-626(a) (2001).

102. *See id.* § 31-128f.

103. *Id.* § 38a-988a(a).

104. *See id.* § 38a-976(r). Protection is given to "behavioral health," which is not defined, but could arguably fall in between physical and mental health to facilitate analysis.

105. Medical-record information includes "medical history or medical treatment of an individual or a member of the individual's family . . . ." *Id.*

106. *See* 45 C.F.R. § 164.501 (2001).

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individual.[107] In contrast, Connecticut law imposes no such explicit objective standard of accountability.[108]

B. Business Associate Contracts

1. HIPAA Privacy Rule

The Final Rule indirectly regulates business associates—entities that use PHI to perform certain services for a CE.[109] It requires CE's to receive "satisfactory assurances" from business associates that they will comply with the limited uses for which the Rule expressly provides. These contractual assurances are much narrower than the provisions of the Rule given that the business associate has access to PHI for a specific purpose.[110] New private contracts between covered entities and business associates must be drafted to embody these assurances.[111] To ease the transition, HHS has proposed a one-year extension beyond the original April 14, 2003 compliance deadline for most CE's to work out the details with their business associates. CE's that disclose PHI to providers for treatment purposes are exempt from the business associate requirement.[112]

While the Rule delineates numerous requirements that the contracts must now embody, there are four primary provisions which a contract must contain. It must *first,* establish how protected health information may and will be used; *second,* require appropriate safeguards to prevent improper use or disclosure; *third*, require a report of any contractual breach to the covered entity; and *fourth*, ensure that the business associate's contracts with third parties (encountering PHI), apply the same restrictions on the third party that are applied to the business associate.[113]

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107. *Id.* (defining individually identifiable health information).

108. *See* CONN. GEN. STAT. § 38a-976 (2001).

109. Business Associates include persons who do not serve as members of the CE's workforce yet assist on behalf of the CE in a function or activity involving the use or disclosure of individually identifiable information, including "claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing." 45 C.F.R. 160.103 (2001). Additionally, business associates include persons that provide "legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services." *Id.*

110. *See* OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Health Related Communications and Marketing* para. 1.

111. C.F.R. § 164.502(e)(2) (2001).

112. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Health Related Communications and Marketing* para. 4.

113. *See* 45 C.F.R. § 164.504(e)(2) (2001).

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Generally speaking, CE's are not liable for the privacy breaches of business associates.[114] A covered entity is considered in violation of the Rule only if it fails to take action despite its *knowledge* that a business associate with whom it was contracting was exercising a pattern of activity that constitutes a *material* breach of the contract.[115] Actual knowledge may not be necessary, however, if the covered entity has "substantial and credible evidence" of a violation.[116] In the event that a complaint or evidence of a breach emerges, the covered entity must investigate. Furthermore, it must take reasonable steps to cure the breach or to end the violation.[117] If such attempts are unsuccessful, the contract must be terminated if feasible; otherwise, the covered entity must report the problem to HHS.

2. Connecticut Law

a. Insurance Entities

Connecticut insurance law states that as long as an unauthorized disclosure is "reasonably necessary" to perform a function for the disclosing insurer, rendering it to a third party is permissible without a contract.[118] Where third party disclosure agreements are required, the specific agreement need not be in writing, and the details of written agreements are left to the discretion of the insurers.[119] Third party business associates to whom unauthorized disclosures may be made without a contract include: law enforcement and other governmental authorities, peer review organizations and parties to a "proposed or consummated sale, transfer, merger or consolidation"[120] when such disclosures are limited to information reasonably necessary to make proper business decisions.[121]

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114. *See* OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Health Related Communications* para. 4.

115. 45 C.F.R. § 164.504(e)(1) (2001).

116. ROBERT J. (MIKE) RYAN, HOW HEALTH PLANS AND HEALTH CARE PROVIDERS ARE IMPLEMENTING HIPAA, *in* THE NEW HIPAA PRIVACY RULE: GUIDING YOUR CLIENTS THROUGH THE IMPLEMENTATION PROCESS, PRACTICING LAW INSTITUTE 277 (Dorthula H. Powell-Woodson ed., 2001).

117. 45 C.F.R. § 164.504(e)(1)(ii) (2001).

118. CONN. GEN. STAT. § 38a-988(b) (2001).

119. *See id.*

120. *See id.* at § 38a-988(o) to (p).

121. *Id.* § 38a-988(f), (j).

b. Government-Maintained Records

The Public Health Commissioner is also entitled to share identifiable health data procured by the Agency with other governmental agencies or private research organizations for medical or scientific research, provided that the third party does not further disclose the personal data.[122] The third party must enter into a written agreement, which is satisfactory to the Department, stating that the information will be used solely for medical or scientific purposes.[123] Furthermore, the third party must receive departmental approval before the information may be disclosed again, and the informational records may be subject to compelled destruction following a set period of time.[124]

3. Preemption Analysis

Connecticut law places little emphasis on business associate agreements; instead, it imposes broad prohibitions on all unauthorized disclosures, and regulates the circumstances which warrant limited exceptions.[125] Unlike Connecticut law, the Privacy Rule acknowledges that medical records are increasingly sent off-site in order to reduce administrative costs and the Rule acts to protect such records.[126] While it is difficult to speculate, the absence of such provisions in Connecticut may reflect the result of a political compromise.

Connecticut insurance privacy law requires the use of third-party agreements, however, in situations where the possibility of abuse increases and the likelihood that external agreements exist diminishes. For instance, agreements are unnecessary if the third party serves a business function for the insurer, if it is designed to prevent fraud or verifies insurance coverage.[127] While the Privacy Rule embodies some of these exceptions,[128] it is more stringent for business contractors. Furthermore, the business associate contract requirements are quite extensive, in part because CE's must decide whether they have received from the business associate the

122. CONN. GEN. STAT. § 19a-25 (2001); *see also* CONN. AGENCIES REGS. § 19a-25-2, -3(a)(3) (2000).

123. CONN. AGENCIES REGS. § 19a-25-3(a)(3)(A) (2000).

124. *Id.* § 19a-25-3(a)(3)(D).

125. *See* CONN. GEN. STAT. § 38a-988(b) (2001).

126. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Parents and Minors* para 2.

127. CONN. GEN. STAT. § 38a-988(b)(c) (2001).

128. *See* 45 C.F.R. §§ 164.502(e)(1), 164.512 (2001).

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requisite "satisfactory assurance" above and beyond the standard requirement.

In addition, state agency CE's that share data for research purposes must employ the more stringent business associate contract standard.[129] While the Connecticut regulation requires the receipt of "a written agreement satisfactory to the department,"[130] the details of the contract must at the very least mirror the stringency of the Privacy Rule's requirements.[131] The data destruction requirement may be preempted since under the public health regulation the decision to destroy documentation is contingent upon department discretion (duly noted in the contract) *after* a set period of time.[132] The Privacy Rule, however, queries exclusively into the feasibility of returning or destroying the PHI, which must be noted in the written contract *before* any permitted use or disclosure.[133] This appears stricter because departmental discretion must be exercised before the transaction, which eliminates countervailing expectations of the data's future use.

C. Right to Access and Amend

1. HIPAA Privacy Rule

HIPAA also gives patients a right to access their health information, unless the information falls under the special rules for psychotherapy notes.[134] They may inspect, obtain a copy, and seek to amend the information contained in the record for as long as the entity maintains the information.[135] Health care providers and health plans are expected to have procedures in place to enable such access.[136] The CE must *act* on a request for access no later than thirty days from receipt of the request.[137] Upon receipt of a request to amend health information, a CE has the power to deny the request if it determines the information in dispute is accurate and complete. If the individual still disputes the information, the individual may thereafter file[138] a complaint with the Secretary of Health and Human

129. CONN. AGENCIES REG. § 19a-25-3(a)(3) (2000).
130. *Id.* § 199-25-3(a)(3)(c).
131. 45 C.F.R. § 164.504(e)(2) (2001).
132. *See* CONN. AGENCIES REGS. § 19a-25-3(a)(3)(D) (2000).
133. 45 C.F.R. § 164.504(e)(2)(ii)(H)(1) (2001).
134. *See id.* § 164.524(a)(1)(i).
135. *Id.* § 164.526(a).
136. *Id.* § 164.530(i)(1).
137. *Id.* § 164.524(b)(2).
138. *Id.* § 164.526(d).

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Services.[139] In addition to access to their own health information, patients may also receive a history of all disclosures except for those relating to treatment, payment, or health care operations.[140]

2. Connecticut Law

a. Government-Maintained Records

Upon written request, a state agency must disclose whether it maintains an individual's personal data and must provide a copy of that information in an understandable format.[141] The agency may, however, refuse to disclose medical, psychiatric or psychological data to a person if it determines such disclosure would be detrimental or otherwise prohibited by law.[142]

Agencies must have procedures in place to allow the person to contest the accuracy, completeness, or relevancy of the information.[143] Furthermore, these procedures must also enable the individual to amend the record when the agency concurs in the proposed correction and allow the aggrieved individual to add a statement to the record setting forth what is believed to be accurate in the personal data.[144] Such a statement shall become a permanent part of the agency's personal data system.

b. Health Care Providers

Health care providers must enable access to "complete and current" patient records concerning any diagnosis, treatment or prognosis of the patient.[145] Within thirty days of receiving the patient's written request, the provider must also furnish a copy of their health record, unless disclosure is viewed as detrimental to the patient's or another's physical or mental health, in which case the information may be given to a third party through whom the disclosure will be made.[146]

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139. *Id.*
140. *Id.* § 164.528.
141. CONN. GEN. STAT. § 4-193(f) to (g) (2001).
142. *Id.* § 4-194.
143. *Id.*
144. *Id.* § 4-193(h)(2) to (3).
145. *Id.* § 20-7c(a)(1) to (2). This statutory provision does not apply to information relative to a psychiatric or psychological condition. *Id.* § 20-7c(d).
146. *Id.* § 20-7c(b) to (c).

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c. Hospitals and Other Health Care Institutions

Upon the written request of a patient, all licensed health care institutions, including hospitals, nursing homes, mental health facilities, and substance abuse facilities, must furnish to the patient a copy of these health records.[147] The patient must be furnished with her records within thirty days of her request.[148] Health records include bills, lab reports, prescriptions, and other technical data used in assessing a health condition. No institution may deny a copy of the health record for inability to pay.[149]

d. Hospitals Receiving State Aid

Hospitals that receive state aid must provide a discharged patient with the right to examine and copy her hospital records, including the history, bedside notes, charts, pictures, and plates kept in connection with the treatment of such patient.[150] These records are subject to subpoena in connection with any court proceeding, except where such records relate to a mentally ill patient.[151] The record must be sealed and closed to outside inspection except by order of the judge overseeing the proceedings.[152]

e. Insurance Entities, Including HMOs

Within thirty days of receiving a request, an insurer must provide the individual with the nature and substance of his or her recorded personal information.[153] This may be relayed by either written or oral means. The insurer must permit the individual to see and duplicate the information in person or receive a copy by mail.[154] Lastly, the insurer must respond to the request with a summary of the procedures in place to correct, amend or delete the recorded personal information.[155]

Connecticut law specifically allows insurers to whom the request was sent to shift the disclosure responsibility to an agent insurer or consumer reporting agency acting on its behalf. The agent must copy and disclose the information pursuant to the insured's request.[156] In addition, these

147. *Id.* § 19a-490b(a).
148. *Id.* § 19a-490b(b).
149. *Id.* § 19a-490b(d).
150. *Id.* § 4-104.
151. *Id.*
152. *Id.*
153. *Id.* § 38a-983(a).
154. *Id.*
155. *Id.*
156. *Id.* § 38a-983(e).

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rights of access are not afforded to information that is the subject of a civil or criminal proceeding involving the insured.[157]

f. Mental Health Facilities

Following discharge from a mental health facility,[158] a patient who submits a written request to inspect and make copies of his hospital records must be afforded the right to do so.[159] Any facility may refuse to grant access to any portion of a patient's record when it determines that disclosure would: (1) create a substantial risk that the patient would inflict life-threatening injury to himself or others; (2) cause a severe deterioration in mental state; (3) invade the privacy of another person; or (4) breach the confidentiality assured to another person.[160] Such exceptions to the rule do not apply when the information is requested in connection with hospitalization litigation.[161]

g. Employers

In addition to providers and insurers, Connecticut requires employers to provide their employees (or employee's physician) with a copy of their personnel and/or medical file.[162] The access must be provided within a reasonable time after receipt of the written request, provided that such request identifies the materials to be disclosed.[163] The employer may charge a reasonable fee for the duplicates.[164]

Moreover, when an employer requests that an employee authorize the disclosure of their medical records[165] to an unaffiliated third party, the employee (or employee's physician) must be informed of their right to

157. *Id.* § 38a-983(f).

158. Defined as any "inpatient or outpatient hospital, clinic, or other facility for the diagnosis, observation or treatment of persons with psychiatric disabilities."

159. CONN. GEN. STAT. § 17a-548(b) (2001).

160. *Id.*

161. *Id.*

162. *Id.* § 31-128g.

163. *Id.*

164. *Id.*

165. "'Medical records' means all papers, documents and reports prepared by a physician, psychiatrist or psychologist that are in the possession of an employer and are work-related or upon which such employer relies to make any employment-related decision." *Id.* § 31-128a(4). For purposes of employee drug testing, the results of urinalysis is subject to the same protections as medical records. *Id.* § 31-51w. While unauthorized disclosure is allowed in order to comply with federal, state, and local law, section 31-51w specifically prohibits use of drug testing urinalysis for a criminal proceeding.

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inspect and correct the information, to withhold authorization, and the effect any withholding will have upon the respective employee.[166]

If, upon inspection, the employee disagrees with any information contained in the record, the employer and employee may jointly agree as to its removal or correction.[167] If they cannot agree upon the removal or correction, then the employee may submit a written statement explaining his position, which must be kept in the employee's personnel file and shall accompany any record disclosure thereafter made to a third party.[168]

3. Preemption Issues

Connecticut law requires that where access to government-maintained records is at issue, the agency shall retain discretion as to whether such access would be harmful to the individual.[169] The Privacy Rule leaves this question to licensed health care professionals.[170] It is important to point out that these exceptions to open access are narrow, and HHS anticipates that CE's will rarely use them.[171] However, it is unclear whether health care professionals are "better" decision-makers, such that their decision to render access provides "greater rights of access or amendment."[172] Particularly where disclosure would endanger the life of another or reveal the source of confidential communication, agencies may have experience in these matters that physicians do not.

Moreover, Connecticut law also appears to prescribe a retention policy for providers of at least seven years for patient health records.[173] This seems more stringent than the open-ended access right "for as long as the PHI is maintained in the designated record set" standard set out in the Privacy Rule.[174] In addition, Connecticut's requirement that health care providers "respond" within thirty days is more stringent than the Privacy Rule's requirement that a CE merely "act on" a request within thirty days.

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166. *Id.* § 31-128f.

167. *Id.* § 31-128e.

168. *Id.*

169. *Id.* § 4-194(a).

170. Presumably, a non-health care providing CE must consult with a health care professional before denying access to PHI for any reviewable reason. 45 C.F.R. § 164.524(a)(3) (2001).

171. 65 Fed. Reg. 82733 (Dec. 28, 2000).

172. 45 C.F.R. § 160.202 (2001) (defining what is "more stringent" for laws governing access or amendment).

173. CONN. AGENCIES REGS. § 19a-14-42 (2000).

174. 45 C.F.R. § 164.524(a) (2001).

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Lastly, Connecticut's codification of patients' rights legislation for persons with psychiatric disabilities conflicts at points with the Privacy Rule. These include the Privacy Rule's access exception for psychotherapy notes, as well as an exception for hospital records compiled "in reasonable anticipation of civil, criminal, or administrative action."[175] The Connecticut law's focus is on accountability and patient protection, whereas the Rule concentrates on balancing psychological harm with sustaining the doctor-patient relationship through continued trust. Especially since these permissible denials are not mandatory, but rather means to preserving CE flexibility and judgment, the Connecticut law providing greater patient access is in all likelihood "more stringent."[176]

D. Policies and Procedures

1. HIPAA Privacy Rule

To implement and monitor HIPAA requirements, CE's must have a privacy officer on staff.[177] A privacy officer's primary responsibility is to ensure regulatory compliance. This individual must develop and implement policies to safeguard protected information from intentional or inadvertent disclosure.[178] Staff with access to protected information must receive training on the entity's new policies and procedures.[179] The privacy officer must design a system for receiving and responding to complaints, and appropriate sanctions must be designed and implemented in the event of a privacy breach.[180]

Also conferred is the right to receive an accounting of disclosures for purposes other than treatment, payment or health care operations.[181] CE's are required to retain these records for at least six years.[182] This required retention includes disclosures made to a CE's business associates.[183] In addition to identifying the PHI recipient, the accounting must include the date of the disclosure and a brief accounting of the nature of the PHI and the basis for its disclosure.[184]

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175. *Id.* § 164.524(a)(1).
176. 65 Fed. Reg. 82,733 (Dec. 28, 2000).
177. 45 C.F.R. § 164.530(a)(1).
178. *Id.* § 164.530(a)(1), (i)(1).
179. *Id.* § 164.530(b).
180. *Id.* § 164.530(d)(1), (e)(1).
181. *Id.* § 164.528(a).
182. *Id.* § 164.528(b)(1).
183. *Id.* § 164.528(b)(1).
184. *Id.* § 164.528(b)(2).

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2. Connecticut Law

a. Insurance Entities

Insurers that regularly collect, use, or disclose medical record information (MRI) must develop and implement written policies and procedures for the management, transfer, and security of medical records, including policies and procedures to guard against unauthorized collection, use, or disclosure by the insurer.[185] Importantly, an insurer must disclose the identity of every recorded individual to whom the insurer disclosed the information.[186] If this is not recorded, the insurer must provide the names of those to whom such information is *normally* disclosed.[187]

b. Government-Maintained Records

Agencies are required to maintain a complete record of every individual, agency, or organization that has accessed or received personal data as well as the reasons for the disclosures.[188] The agency must maintain the records for at least five years from the date of access or disclosure or for the life of the record, whichever is longer.[189]

3. Preemption Issues

State agency retention policies encounter interesting hurdles with respect to preemption. As noted, HIPAA requires the retention of PHI for at least six years. Yet the state law requires the "maintenance" of the records for at least five years from the date of access or disclosure *or* for the life of the record—whichever is longer. In other words, the statute appears to envision agency discretion to destroy documents after five years

185. *Id.* § 38a-999. These policies and procedures must include (a) limits on access to medical records to those persons who need the information to perform their jobs; (b) training of all employees authorized to use or disclose medical records; (c) disciplinary measures for violations of medical record policies and procedures; (d) identification of employees authorized to use or disclose medical records; (e) procedures for authorizing and restricting the collection, use or disclosure of medical records; (f) methods for handling disclosing, storing and disposing of medical records; (g) periodic monitoring of employee compliance with the policies and procedures; (h) additional protections against unauthorized disclosure of sensitive medical records; (i) disclosure of policies and procedures to state Insurance Department; and (j) a summary of the policies and procedures made available to enrollees upon enrollment and upon request. *Id.*

186. *Id.*

187. *Id.*

188. *Id.* § 4-193(c).

189. *Id.*

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toll from the date of access or disclosure. For preemption purposes, agencies are subject to the more stringent Privacy Rule if either: (1) their policy is to destroy unaccessed or undisclosed documents less than six years old or (2) their policy is to destroy records at the five-year anniversary of its access or disclosure. Conversely, state law becomes "more stringent" if the agency chooses to retain documents for longer than six years, whether by virtue of agency policy or because of a *second* access or disclosure within the past five years.[190] Thus, as it stands, the statute can be both less and more stringent depending upon the agency policy or the number of times the records have been used or accessed.

IV. HIPAA'S RELATION TO CONNECTICUT PUBLIC HEALTH LAWS AND REGULATIONS

A. HIPAA Privacy Rule

The Privacy Rule provides broad accommodation for state public health laws and regulations, principally by foregoing the consent and authorization requirements for PHI.[191] A covered entity may disclose PHI to: (1) a state public health authority[192] collecting information to prevent or control disease, injury, or disability; (2) a public health authority receiving reports of child abuse or neglect;[193] (3) a person subject to the Food and Drug Administration requirements to report adverse events, track and recall products, and conduct post-marketing surveillance; (4) a person who may have been exposed to a communicable disease, or otherwise at risk of contracting or spreading a disease; and (5) an employer conducting medical surveillance of the workplace or determining whether an individual has a work-related illness or injury, provided that the person is notified.[194]

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190. 45 C.F.R. § 160.202 (2001) (defining "more stringent" for record keeping as providing "for the retention or reporting of more detailed information *or for a longer duration*." (emphasis added)).

191. *Id.* § 164.512.

192. The Privacy Rule defines public health authority as

> an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents . . . or its contractor . . . .

Id. § 164.501.

193. Note the Department of Children and Families (DCF) receives child abuse complaints, rather than the DPH.

194. 45 C.F.R. § 164.512(b).

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Moreover, the Rule specifically exempts from federal preemption state laws and regulations whose purpose is to serve public health, safety, and welfare needs.[195] This permissive exemption enables state health authorities to remain flexible to evolving public health concerns. Privacy concerns that public health information is vulnerable is remedied by the traditionally strong state privacy protections regarding stigmatizing conditions. As such, state public health regulations, requiring everything from partner notification to outbreak investigations, appear to have weathered the Privacy Rule unscathed.

In addition, the Rule explicitly enables states to decide the issue of disclosure of a minor's PHI to a parent.[196] For purposes of defining to whom the PHI "belongs," the Privacy Rule does not preempt state laws that specifically address disclosure of a minor's health information to a parent. It makes no presumption that parents are the appropriate persons to act on behalf of the minor. Rather, the Rule looks to whether state law enables the minors to obtain health care without the consent of a parent, or where the parent assents to a confidential relationship between the minor and the provider. Principally, circumstances that enable minors to seek confidential treatment involve contraception, abortion, drug or physical abuse, and emergency care.[197] Similarly, parents may be denied access when the provider believes abuse has occurred or disclosure could harm the child.[198] With the change in administrations, however, HHS appears to be taking a more "family-oriented" approach and recently suggested a modification to the Rule in order to accommodate parental access for the "health and well-being of their children."[199]

B. Connecticut Law

1. HIV and AIDS

Due to the deference HHS has given states to collect PHI for public health purposes, some privacy advocates have urged these states to fill the gap with privacy legislation of their own.[200] Connecticut law already

195. *Id.* § 160.203(a)(1)(iv).
196. *Id.* § 160.202.
197. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Parents & Minors* para. 1.
198. *Id.*
199. *Id.* at para. 7.
200. Lawrence O. Gostin, *National Health Information Privacy: Regulations Under the Health Insurance Portability and Accountability Act*, 285 JAMA 3015, 3019 (June 20, 2001).

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imposes comparatively strong privacy safeguards on the collection of HIV-related PHI. Connecticut requires the patient's written or oral informed consent before performing HIV-related testing.[201] What constitutes "consent" under the statute is similar to the Final Rule's authorization requirement. The entity must explain the test fully, state that consent is not a precondition to receiving care, explain the procedures to be followed (including its voluntary nature and anonymity), and explain the confidentiality protections afforded the individual's PHI.[202] The explanation must also state that while known partners of the individual may be warned of their potential risk of infection, such warning will not identify the individual to whom the infection relates.[203] An infected individual may be identified to the local health director and Public Health Department, however, patients can opt out of the Public Health Department's name-based reporting if they are over thirteen years old and do not have an HIV/TB co-infection.[204]

Connecticut law also provides strong protection against disclosure of PHI for individuals diagnosed with HIV.[205] Notably, when HIV transmission appears to be an imminent threat to a co-worker, Connecticut law mirrors the Final Rule's "minimum disclosure" standard by enabling certain PHI repositories to decide whether to disclose the PHI for prevention/containment purposes. The law allows disclosure only when "no reasonable alternatives exist" to render the situation safe.[206] Once disclosure is made, it must be limited to only those employees with a direct need to receive the information.[207]

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201. CONN. GEN. STAT. § 19a-582 (2000).

202. *Id.* § 19a-582(b).

203. *Id.* § 19a-584(b).

204. CONN. AGENCIES REGS. § 19a-36-A4(a)(1) (2000). ("Each report of reportable findings shall include the name, address, age sex, and, if known, race/ethnicity of the person affected, the name and address of the attending physician, the identity of the infectious agent or other reportable laboratory findings, and the method of identification.") *Id.* § 19a-36-A2(b)(1).

205. CONN. GEN. STAT. § 19a-583(1)-(12) (the disclosure provisions do not apply to the individual to whom the PHI relates, to providers for purposes of the individual's medical treatment, to a medical examiner, an accreditation or oversight review organization, providers and certain employees at risk of occupational exposure, pursuant to court order, and to life and health insurers. The Privacy Rules exemptions, 45 C.F.R. § 160.203(a) (2001), are aligned with Connecticut's general exemptions, [although disclosure to courts must be looked up].

206. CONN. GEN. STAT. § 19-583(8) to (10).

207. *Id.*

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Moreover, rights of partners to be notified similarly balances privacy and public health interests. The treating physician may notify the partner of possible HIV exposure only if the physician is caring for both partners, or if the infected patient requests the disclosure. Otherwise, the physician has no recourse but to inform DPH. In order to inform the partner, DPH must ensure that: (1) a significant risk of transmission to the partner exists; (2) the infected individual was counseled, but refuses to notify the partner or has requested assistance in doing so; and (3) the infected individual has been made aware of the intention to notify the partner.

2. Mental Health

Generally, Connecticut requires that communications between a patient and psychiatrist and records resulting from mental health treatment or diagnosis remain confidential.[208] Except as expressly provided by statute, no person may disclose or transmit any individually-identifiable communications, without the patient's consent.[209] Similar to the HIPAA authorization form, the consent form must specify to whom the information is intended for disclosure and for what reasons.[210] The patient is entitled to withdraw consent at any time by providing a written revocation to the person that originally received the consent.[211]

Circumstances for which consent is not required include: the prevention of imminent physical injury to the patient or others, when the communication occurs in the course of a court-ordered mental health exam, or when a patient alleges a mental condition as a defense in a civil action.[212] In addition, a person engaged in research may have access to individually identifiable information if the research plan is submitted to and approved by the mental health facility director.[213] A hospital that receives state aid may not divulge records pertaining to mental illness in response to a subpoena.[214]

3. Alcohol and Drug Treatment

Connecticut law requires that any references to an individual's identity, diagnosis, prognosis, or treatment contained in alcohol or drug treatment

208. *Id.* § 52-146d.
209. *Id.*
210. *Id.*
211. *Id.*
212. *Id.* § 52-146f.
213. *Id.* § 52-146g.
214. *Id.* § 4-104.

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records must be held confidential.[215] Disclosure of medical records from federally funded alcohol and drug treatment centers requires patient consent.[216] Also, physicians must obtain a minor's consent in order to inform a parent or legal guardian that the minor sought treatment or rehabilitation for alcohol or drug dependence.[217]

4. Minors with Sexually Transmitted Diseases

Information regarding consultation, examination, and treatment of a minor for a sexually transmitted disease (STD) must remain confidential and disclosure requires the minor's written consent.[218] A health-care provider may not send a bill for services to any person other than the minor, unless the minor is age twelve or younger.[219] Moreover, under Connecticut law, the consent of a parent or guardian is not a prerequisite to test a minor for HIV.[220] However, a physician must notify a minor's parents before examining or treating for HIV or AIDS, unless: (1) the physician determines that such notification would result in denied treatment or the minor would stop seeking treatment and (2) that minor requests that the parents not be notified.[221] For any minor under age twelve who seeks consultation, examination, or treatment for an STD, the treating physician must report the minor's name, age, and address to the Commissioner of Children and Families.[222] If a patient, regardless of age, has contracted gonorrhea or syphilis, but refuses to follow prescribed instructions or discontinues treatment, then the treating physician must notify the local health director.[223]

V. OVERVIEW OF ENFORCEMENT PROVISIONS UNDER HIPAA AND CONNECTICUT STATE LAW

A. HIPAA Privacy Rule

HHS delegated the responsibility of enforcement to their Office of Civil Rights (OCR). Securing voluntary compliance by the HIPAA

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215. *Id.* § 17a-688; 42 U.S.C. § 290dd-2(a) (2001).
216. CONN. GEN. STAT. § 17a-688.
217. *Id.* § 17a-688(d).
218. *Id.* § 19a-216.
219. *Id.*
220. *Id.* § 582(a).
221. *Id.* § 592(a).
222. *Id.* § 19a-216; CONN. AGENCIES REGS. § 19a-36-A15.
223. CONN. GEN. STAT. § 19a-216.

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deadline is the preeminent concern of OCR. It offers technical guidance to implement required safeguards, interprets the regulation's requirements, and responds to questions.

Still, compliance with the administrative requirements is ultimately the responsibility of the covered entities and will require extensive policy and procedure development.[224] HIPAA authorizes the Secretary of HHS to conduct general compliance reviews. Covered entities must cooperate with any compliance investigation, which includes providing broad access to administrative records. This means covered entities must properly record all activities to implement, manage, and monitor HIPAA compliance.

HIPAA contains a host of civil and criminal penalties. For example, any covered entity (including employees) that unintentionally violates the privacy provisions without exercising reasonable diligence may be liable up to $100 for each violation, not to exceed $25,000 per year.[225] A civil penalty will not be imposed, however, if a person did not know, or by exercising reasonable diligence, would not have known that their action constituted a violation.

Criminal penalties are considerably more severe. Any person who *knowingly* obtains or discloses individually identifiable health information in violation of HIPAA may be fined up to $50,000 and/or imprisoned for no more than one year. If done under "false pretenses," the fine increases to $100,000 and imprisonment up to five years. The severest punishment applies to offenses done with intent to "sell, transfer, or use" individually identifiable health information for commercial advantage, personal gain, or malicious harm. This violation demands a fine not to exceed $250,000 and/or imprisonment of not more than 10 years.[226]

Neither HIPAA nor the Privacy Rule explicitly grants a private cause of action, including qui tam actions. Still, covered entities and business associates fear the plaintiff's bar, in state and federal tort actions, will use a Privacy Rule violation as evidence that the duty of care was ignored. Moreover, covered entities have increased exposure to civil and criminal actions because they may be liable for the privacy breaches of their business associates. For purposes of OCR compliance, covered entities are not expected to *guarantee* the privacy of PHI, as HHS noted in its first

224. *See* Bernadette M. Broccolo & Bradley W. Petersen, *Final HIPAA Privacy Rules: How Do We Get Started?*, 27 J. HEALTH CARE FIN. 7 (2001).

225. Health Insurance Portability and Accountability Act of 1996 (Kennedy-Kassebaum Act), 42 U.S.C. § 1320d (Supp. V 1999).

226. *Id.* § 1320d-6(b).

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clarification; however, CE's must take "reasonable" steps to protect the confidentiality of the PHI subject to business associate use.[227]

B. Connecticut Law

Connecticut law enables individuals to seek injunction, declaratory judgment, mandamus, or bring a civil action[228] for damages against any state agency that fails to adopt regulations defining the nature and purpose of an agency's personal data systems.[229] If an agency refuses to disclose personal data to a person otherwise entitled to access their records, the agency must permit a qualified physician to review the data to determine whether it should be disclosed.[230] Similarly, patients discharged from hospitals receiving state aid[231] or psychiatric hospitals[232] that are subsequently denied access to their records are entitled to judicial review.

Generally, violators of the Connecticut Insurance Information and Privacy Protect Act are subject to numerous punitive monetary penalties by the Insurance Commissioner.[233] Insurers may even face suspension or revocation of their license.[234] In addition to any victim's recovery, the Insurance Commissioner may impose a penalty maximum of $20,000 per violation, not to exceed $100,000 in the aggregate for any intentional violation of the sale and marketing provisions.[235]

Moreover, insurers who maliciously disclose medical records in order to damage an individual's reputation or character may face jail time.[236]

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227. OFFICE FOR CIVIL RIGHTS, *supra* note 25, at *Business Associates* para. 10.

228. The common law right of privacy exists in Connecticut; however, no action has been sustained for failure to establish procedure safeguards. Goodrich v. Waterbury Republican-American, Inc., 188 Conn. 107, 127, 128 n.19 (1982).

229. CONN. GEN. STAT. § 4-197 (2001). Plaintiffs who prevail in an action are entitled to recover court costs and reasonable attorney's fees. *Id.*

230. *Id.*

231. *Id.* § 4-105. Certain hospital officers may be subject to a $100 fine and/or imprisonment. *Id.*

232. *Id.* § 17a-548. Former patients may petition the Superior Court for relief. Relief includes temporary and permanent injunctions, as well as civil damages. *Id.* § 17a-550.

233. *Id.* § 38a-993. Insurers found negligent are subject to a maximum fine of $2000, not to exceed $20,000 in the aggregate; intentional violations may result in a maximum fine of $5,000 per violation, not to exceed $50,000 in the aggregate; violations of a cease and desist order may render a fine up to $100,000 depending on the whether the violations' "frequency . . . indicate[s] a general business practice." *Id.* § 38a-993(c)(2)

234. *Id.* § 38a-993(c)(3).

235. *Id.* § 38a-993(b)(2).

236. *Id.* § 38a-999a. No more than $500 and/or three months imprisonment for the first offense. For each subsequent offense, the fine increases to a maximum of $2000 and/or one-year imprisonment. *Id.*

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Even if the disclosure was not malicious, insurers may still be liable to any individual for damages sustained from disclosure violations to the extent that monetary awards match actual damages sustained.[237] A court also has discretion to award the prevailing party court costs and reasonable attorney's fees.[238] An individual harmed by the sale or marketing (without consent) of medical records may bring an action for equitable relief and/or double damages, costs, and attorneys' fees.[239]

Similarly, grounds for individual actions are available against insurers who wrongfully fail to provide access to an individual's medical records. Insurers who violate the requirements and procedures concerning the correction, amendment, or deletion of medical records are subject to equitable relief claims.[240]

CONCLUSION

Each covered entity must undergo preemption analysis to ensure their regulatory compliance by the HIPAA deadline. CE's may be forced to develop multiple policies and procedures depending on the states in which they are licensed to do business. Furthermore, analysis is complicated by shifting federal standards. With little more than a year left before the deadline, HHS continues to fine-tune the Rule.[241] Legal staff will need to reassess some of their earlier conclusions regarding state law preemption as changes are made to the disclosure, access, and administrative requirement provisions. Unfortunately, HHS has failed to clarify the preemption rules substantively.

Like other states, Connecticut has traditionally passed privacy legislation aimed at protecting individuals' records from wrongful use or disclosure by specific entities, particularly when it relates to stigmitizing conditions. Transactional efficiency and still-present privacy gaps warrant a revision of "less stringent" Connecticut privacy laws to at least match the Final Rule's stringency.

HHS discovered in 1999 that for HIPAA to be effective—to constitute a true privacy floor—it must indirectly regulate all entities that come into

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237. *Id.* § 38a-995(b).

238. *Id.* § 38a-995(c).

239. *Id.* § 38a-988a(b) (2001). The statute of limitations is five years from the date of violation.

240. *Id.* § 38a-995(a).

241. *HHS Fact Sheet*, *supra* note 28, at 1; Proposed Rule 67 Fed. Reg. 14776 (Mar. 27, 2002).

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contact with PHI, not just CE's.[242] Business associate agreements were intended to cure this, but are particularly onerous to implement and enforce.[243] Around this time, Connecticut joined thirty-four other states in introducing insurance privacy legislation designed to mirror segments of HIPAA's proposed rule.[244] By shifting the blame of costly and burdensome implementation to HHS, Connecticut is again well positioned to play a strong policy role in medical privacy. The legislature should address HIPAA's gaps—a creature of political compromise—by drafting additional privacy legislation to suit Connecticut's needs.

The Connecticut legislature should also take steps to reconcile the obstacles the stringency test has created for Connecticut entities. There currently exist two sets of *enforceable* privacy rules. That states or entities may request an exception to state law preemption does not ease implementation—it merely begs the question whether the state law is worth retaining.[245] Despite HHS's attempt to clarify the meaning of "more stringent" in the Final Rule, a CE is left with state and federal definitions that differ or do not exist, divergent legislative purposes, and an amalgamation of both more and less stringent requirements within the same state statutory provision. CE's must pick-and-choose from seldom crystal clear provisions in order to develop a coherent policy. Further case-by-case technical clarification is necessary to reinforce Connecticut CE confidence that their newly issued and untested HIPAA policies and procedures are in compliance.

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242. *See* OFFICE FOR CIVIL RIGHTS, *supra* note 25.

243. *See id.* Some critics of the Privacy Rule argue that the business associate agreements exceed HHS's statutory authority.

244. Chad Bowman, *Uneven State Medical-Record Laws Offer Potential Pitfalls for Health Plans*, 8 BNA HEALTH L. REP. 1787 (Nov. 11, 1999), *available at* WESTLAW, 8 BHLR 1787.

245. 45 C.F.R. § 160.204(a) (2001).

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THE JUDICIAL TRANSFORMATION OF SOCIAL SECURITY DISABILITY: THE CASE OF MENTAL DISORDERS AND CHILDHOOD DISABILITY

Jennifer L. Erkulwater[*]

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INTRODUCTION

An acute observer of American political culture, Alexis de Tocqueville once stated, "[t]here is hardly a political question in the United States

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which does not sooner or later turn into a judicial one."[1] Though he made this statement in 1840, Tocqueville might as well have been speaking of America today. Indeed, legal scholar Robert Kagan calls this American penchant for settling disputes through the legal process "adversarial legalism."[2] While legalistic forms of conflict resolution are, as de Tocqueville notes, an integral part of American democracy, Kagan asserts that adversarial legalism has become an increasingly prominent part of political and policy conflict in the United States over the course of the last thirty years.[3]

Nowhere has the growth of this peculiar culture of legalism been more evident than in the transformation of Social Security disability policy in the past two decades. During the 1980s and 1990s, the federal courts were frequent and aggressive participants in Social Security disability policy making, and they were instrumental in driving the growth of disability benefit programs at a time when there was not a consensus in favor of Social Security expansion in either Congress or the White House. More importantly, however, not only did the courts expand the disability programs; they also changed the composition of the Social Security rolls and opened the door to a quandary of political and administrative troubles in an effort to make the disability certification process more "accurate." In the past, the strict administrative regulations governing the certification of disability excluded the vast majority of adults with mental disorders and disabled children. Throughout the mid-1980s and early 1990s, advocates for the mentally disabled and disabled children contested those regulations in court. They succeeded in convincing federal judges to strike down a host of these regulations and force the Social Security Administration (SSA) to revise its standards for childhood and mental disability.

Most studies of growth in disability programs tend to focus on economic factors. Nevertheless, while the ups and downs of the business cycle undoubtedly influence expenditures for disability programs, they

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1. ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 270 (George Lawrence trans., Harper Perennial 1969) (1835-40).

2. *See generally* Robert A. Kagan, *Adversarial Legalism and American Government*, 10 J. POL'Y ANALYSIS & MGMT. 369, 369-406 (1991); Robert A. Kagan, *Adversarial Legalism and American Government, in* THE NEW POLITICS OF PUBLIC POLICY 88-118 (Marc K. Landy & Martin A. Levin eds, 1995) [hereinafter Kagan, *Adversarial Legalism*, 1995]; Robert A. Kagan & Lee Axelrad, *Adversarial Legalism: An International Perspective, in* COMPARATIVE DISADVANTAGES? 146-202 (Pietro S. Nivola ed., 1997).

3. Kagan, *Adversarial Legalism*, 1995, *supra* note 2, at 92-93.

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leave a significant portion of the growth unexplained.[4] In order to understand that which economics cannot explain, we must turn to politics, the political struggle over the proper legal and administrative definition of disability. Legalism, therefore, provides a useful framework for an analysis of both the transformation of disability programs and the corresponding challenges that have arisen in Social Security disability policy in recent years because of those changes.

A full account of the judicial influence on Social Security disability programs would require a book-length, perhaps even encyclopedia-length, treatise and would take us far afield from our present concern. This article focuses narrowly on the activities of Legal Services attorneys, mental health reformers, and children's advocates. Although mental health reformer groups are only one of many antipoverty organizations involved in advocacy efforts on behalf of the disabled poor, they have been among the most persistent, the most active, and the most successful in using a litigation strategy to achieve their larger policy goals. According to one Social Security official, though there were "pockets of spokespersons for other disabilities," no other disability group presented, as concerted an effort as did mental health reformers.[5] As this article argues, their success and the corresponding transformation in Social Security disability raises a number of policy and administrative challenges that Congress has yet to address.

I. THE GROWTH AND TRANSFORMATION OF SOCIAL SECURITY DISABILITY

The two disability programs of Social Security, Disability Insurance (DI) and Supplemental Security Income (SSI), have changed dramatically in the past two decades. Together the two programs function as an income floor for the disabled.[6] DI provides cash payments to disabled workers who have paid into the disability trust fund through the payroll tax. The amount of the benefit depends on the amount of the past wage contribution. SSI supplements the income of disabled workers whose contributions are

4. *See* David C. Stapleton et al., *Empirical Analysis of DI and SSI Application and Award Growth, in* GROWTH IN DISABILITY BENEFITS: EXPLANATIONS AND POLICY IMPLICATIONS 31-92 (Kalman Rupp & David C. Stapleton eds. 1998).

5. Telephone Interview with Patricia Owens, Associate Commissioner, Office of Disability, Social Security Administration (Apr. 25, 2000).

6. SSI also aids the aged, but expansion in that portion of the program has been negligible.

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so minimal that their incomes fall below the poverty line. The SSI program also provides up to $500 per month in income support to poor disabled individuals who fail to qualify for DI because they have no history of workforce attachment.

Both DI and SSI have experienced rapid expansion since the mid-1980s. At its peak in 1994, the number of disabled persons receiving DI, SSI, or both, reached 7.2 million, an increase of 70% since 1985.[7] In 1985, approximately 92,000 workers received disability payments; by 1998, that number had more than quadrupled to almost 450,000.[8] Though a smaller program than DI, SSI presented an even more pronounced pattern of growth. Between 1985 and 1998, the number of disabled adults receiving SSI payments nearly doubled from 1.9 million to 3.6 million, while similarly, the number of disabled children rose fourfold from a mere 227,000 in 1985 to a high of 1 million recipients by 1996.[9] Throughout the 1990s, DI experienced an average growth of seven percentage points each year. Meanwhile, between 1990 and 1996 SSI's disability rates averaged 6.5% annually for adults and 20.7% annually for children between 1990 and 1996.[10] Enrollment and application for SSI has dropped off sharply since 1996. This is no doubt a result of the changes Congress made to the program as part of its welfare reform initiative.

Even more significant than the number of disabled persons enrolled in SSI and DI is the type of disabilities that beneficiaries present. Since the 1980s, the proportion of Social Security beneficiaries drawing payments because of a mental disorder as opposed to a physical impairment, has more than doubled. This transformation is especially stark in SSI beneficiaries. In 1981, allowances based on a mental disorder comprised 10% of all DI awards; after 1986, between 20% and 25% of all allowances were made because of a mental disorder. In 1981, only one out of every

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7. U.S. GEN. ACCT. OFF., GAO/T-HEHS-95-97, FEDERAL DISABILITY PROGRAMS FACE MAJOR ISSUES 3 (1995).

8. SSA, *5.D OASDI Disabled Workers,* ANN. STAT. SUPPLEMENT 191 tbl.5.D1 (2001), *available at* http://www.ssa.gov/statistics/Supplement/2001/5d.pdf (last visited March 2, 2002) [hereinafter SSA, *Disabled*].

9. SSA, *SSI Annual Statistical Report 1998,* SSI ANN. STAT. tbl.2 (1999). The figure of one million children enrolled in SSI is reported in SSA, *SSI Recipients with Federal Benefits in Current-Payment Status as of December,* 1998 SSI ANN. REP. tbl.IV.B4 (1998), *available at* http://www.ssa.gov/OACT/SSIR/SSI98/ssiIV.html (May 29, 1998) [hereinafter SSA, *Recipients*].

10. Author's calculations based on data in 2001 SSA, *Disabled, supra* note 8 and SSA, *Recipients, supra* note 9.

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ten persons receiving DI payments was mentally disabled;[11] in the 1990s, that figure hovered between one in four and one in five.[12]

Because SSI does not require applicants to demonstrate a history of paid employment in order to qualify for benefits (thus allowing more individuals with congenital or early-onset disabilities on the rolls), the number of individuals with mental disorders has been more pronounced in SSI than in DI. The SSA estimated that in 1977, roughly 18% of SSI applicants who were awarded benefits suffered from a psychiatric disorder, while another 13% were mentally retarded.[13] By 1986, the mentally ill comprised almost one quarter of those on the SSI disability rolls, and within ten years that proportion grew to one in three.[14] Today, mental retardation and psychiatric disorders together constitute well over half the awards made in SSI, but that figure is even higher in the case of children. Almost two-thirds of children receiving SSI are disabled due to either mental illness or mental retardation.[15]

The prevalence of the mentally disabled individuals among Social Security recipients has had profound political implications. Mental disorders are not only difficult to diagnose; in addition, measuring and predicting their effect on the functional capacity of an individual is fraught with uncertainty. This uncertainty can open the door to public perceptions that the disability programs are filled with malingerers, frauds, and welfare cheats. Moreover, because beneficiaries with mental disorders tend to be younger than their physically disabled counterparts, their presence on the rolls drives up program expenditures, now and in the foreseeable future. Many policy makers also worry that giving a younger individual cash benefits for life will encourage dependency and ruin that individual's

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11. Mental disability refers to a disability resulting from any form of a mental disorder: mental retardation, learning disabilities, psychiatric illnesses, addiction, and so forth. Mental retardation refers strictly to clinically diagnosed retardation (in SSI and DI, I.Q. below seventy).

12. U.S. GEN. ACCT. OFF., GAO/HEHS-94-34, SOCIAL SECURITY: DISABILITY ROLLS KEEP GROWING, WHILE EXPLANATIONS REMAIN ELUSIVE 40 tbl.IV.6 (1994).

13. SENATE SPEC. COMM. ON AGING, 98TH CONG., BACKGROUND INFORMATION ON SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED 164-65 (1983).

14. Sharon R. Hunt, Drug Addiction and Alcoholism as Qualifying Impairments for Social Security Disability Benefits: The History, Controversies, and Congressional Response 48 (2000) (unpublished Ph.D. dissertation, Brandeis University) (on file with author).

15. Author's calculations based on SSA, SSI ANN. STAT. REP., 2000 tbl.29 (2001), *available at* http://www.ssa.gov/statistics/ssi_annual_stat/2000/table29.html.

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chances for rehabilitation. Cash disability benefits for disabled children raise especially thorny issues since the money is spent, not by the child, but by the parent, thus creating a situation in which parents might have an incentive to keep their children functionally incapacitated and helpless. As long as the number of mentally disabled persons and disabled children on the Social Security disability rolls remained relatively small, the SSA largely swept these politically contentious questions under the proverbial rug. By the early 1990s, however, the agency and the programs it administered were beset by a host of administrative problems that, when coupled with rapid program growth, created a firestorm of political controversy. The court-driven expansion of Social Security disability made these issues all but impossible for legislators and policy makers to ignore.

II. LITIGATION AND POLICY CHANGE

Many scholars have examined the role of litigation in stimulating policy change. Some, looking back at the Warren Court's crusading liberalism, contend that the courts are only one of the many players in political drama—and frequently, a constrained one at that. For instance, using civil rights and abortion cases to illustrate his point, Gerald Rosenberg argues that the federal courts are limited in their ability to induce progressive policy change. Not only must judges base their decisions on constitutional rights and court precedent that tend to constrain governmental activism, but even if they are sympathetic to the objectives of liberal reformers, judges must avoid drawing the ire of elected lawmakers and the pubic. Indeed, in the face of intractable opposition, judges can do little to implement and enforce their own decisions without the cooperation of other political officials.[16] A number of scholars, on the other hand, argue that because of their insulation from popular pressures, courts can and do generate policy change when other branches of government are gridlocked. Through their rulings, judges can take bold, often unpopular stands that educate the public and policy makers about the justness of a litigant's claims, compel political debate on a topic that elected officials would rather dodge, and set the wheels in motion for further policy

16. GERALD N. ROSENBERG, THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? 21 (1991).

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innovation.[17] Even if courts cannot directly make policy, they can at least serve as a catalyst for larger progressive policy transforms down the road.

Of course, a number of scholars who acknowledge the judiciary's influence on policy, nevertheless remain skeptical about whether the judicial forum is necessarily a desirable place for policy making. According to Robert Kagan and his colleagues, resolving policy conflicts through litigation is expensive, time-consuming, and wasteful. Using the dredging of Oakland Harbor as one example, Kagan contends the litigants were caught in a war of attrition for many years as each side (the city of Oakland, the Environmental Protection Agency, the Army Corps of Engineers, fishermen, and environmentalists) tried to exhaust the others through endless rounds of environmental impact statements, legal motions, and courtroom maneuvers. While attorneys grew wealthy, pressing public needs remained unmet. The harbor remained undredged; jobs were lost; and cargo ships went elsewhere.[18] Similarly, both Donald Horowitz and R. Shep Melnick argue that because judges base their rulings on only the cases that come before them—cases that may or may not be representative of a wider policy problem—and because they issue their rulings on a case-by-case basis, courts are not necessarily the best place to weigh the costs and benefits of various policy alternatives.[19] Indeed, insofar as courts exist to enforce rights, the issue of costs—social or economic—is often obscured.[20] Moreover, because judges are unable to follow through on their original decisions—monitoring their implementation and modifying the remedy in light of changing circumstances or unforeseen snafus—court intervention can lead to unanticipated headaches for lawmakers and program administrators.[21]

Whether the courts had a significant effect on policy change is a question of whether we see the glass as half full or half empty. Rosenberg can hardly argue that *Brown v. Board of Education*[22] and *Roe v. Wade*[23] did

17. *Id.* at 21-26.

18. Kagan, *Adversarial Legalism*, 1995, *supra* note 2, at 98-102.

19. *See* DONALD L. HOROWITZ, THE COURTS AND SOCIAL POLICY 255 (1977); R. SHEP MELNICK, BETWEEN THE LINES: INTERPRETING WELFARE RIGHTS 108-111 (1994) [hereinafter MELNICK, BETWEEN THE LINES]; R. SHEP MELNICK, REGULATION AND THE COURTS: THE CASE OF THE CLEAN AIR ACT 13-18 (1983).

20. Thomas F. Burke, *On the Rights Track: The Americans with Disabilities Act*, *in* COMPARATIVE DISADVANTAGES? SOCIAL REGULATIONS AND THE GLOBAL ECONOMY 283-85 (Pietro S. Nivola ed., 1997).

21. MELNICK, BETWEEN THE LINES, *supra* note 19, at 108-10.

22. 348 U.S. 886 (1954).

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not matter, but proponents of litigation can not assert that these cases were all that mattered. When political and social forces are moving in the same direction as the courts, the courts are obviously, in turn, more effective as purveyors of policy change. Nevertheless, as in the example of Social Security disability, the courts can have an enormous impact on programs even if the White House opposes such change and Congress is mired in disagreement. Indeed, one seemingly small court decision can have ramifications throughout the policy process, making certain outcomes more likely than others. Cumulatively, these court decisions can push policy in directions that would seem unthinkable in the absence of judicial intervention. *Sullivan v. Zebley*,[24] for example, single-handedly transformed the SSI children's program. In the case of mental disability, mental health reformers note that two court cases, *Mental Health Ass'n of Minnesota v. Schweiker*[25] and *City of New York v. Heckler*,[26] while not necessarily changing the disability programs overnight, certainly contributed to their success in convincing members of Congress and the SSA to change the medical standards for evaluating mental disorders.

To be sure, the influence that the federal courts would come to have on Social Security disability policy was not unforeseen. During the 1980s and early 1990s, however, the relationship between the courts and the SSA took a new and fateful turn, as the courts became a catalyst for forcing policy change in the disability programs. Liberal advocates for the poor turned to the court to block policy changes with which they disagreed and, in turn, to induce expansive policy changes that they preferred. In the hands of these advocates, courts were not just there to right individual wrongs, but also to produce policies that they believed adhered more closely to the spirit of the Social Security Act.

The court cases brought by advocates on behalf of disabled claimants were a new force in Social Security policymaking. Previously, liberal advocates had pushed expansive measures in Congress, working closely with both the lawmakers who sat on the congressional authorizing committees and executives at the SSA. The disability advocates of the 1980s and early 1990s, however, brought lawsuits precisely because they believed that the channels that liberals had traditionally used were no longer available. Because members of Congress and the SSA would not

23. 410 U.S. 959 (1973).
24. 493 U.S. 521 (1990).
25. 554 F. Supp. 157 (D. Minn. 1982).
26. 578 F. Supp. 1109 (E.D.N.Y. 1984).

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listen, advocates advanced their policy arguments in the courts. Victories in the judicial venue provided advocates with the leverage needed to force the SSA to the negotiation table in order to revise its mental and childhood disability standards.

Whether we regard the courts' forays into policymaking as beneficial or detrimental depends, in large part, on whether we like the end result. Liberals, no doubt, heartily cheer the role that the federal courts have played in loosening disability standards, while conservatives would cite this as yet another example of judicial activism run amok. As the following case of Social Security disability illustrates, however, reality is often more complex. Ironically, the policy and administrative changes that resulted from the litigation made the disability process more exacting and thorough. Program administrators now collected more thorough documentation of impairments and paid greater heed to the needs of hard-to-serve populations, such as the mentally ill and children. At the same time, however, judicial intervention contributed to the administrative problems that continue to plague the SSA. Judicial activism furthered the fragmentation of Social Security disability policy and divorced policy change from congressional input. Thus, at the same time that the SSA's workload increased and its tasks grew more complex, congressional budget-cutters were scaling back on the resources available to the agency—the result: long processing times, different standards of eligibility used in different regions and at different levels of administration, and unpredictable trends in enrollment and expenditures. Although Congress enacted a number of reforms in SSI and scaled back the ability of legal services attorneys to bring far-reaching class action litigation of the kind that drove the expansion of SSI and DI in the 1980s and early 1990s, many of these expansions remain intact as do a number of the problems they created. Thus, while litigation brought many improvements to disability benefits policy, not the least of which was the refinement of a disability determination process rife with shortcomings and inaccuracies, at the same time, it also begot a number of unforeseen administrative and policy conundrums that continue to vex policy makers.

III. MENTAL DISABILITY AND CHILDHOOD DISABILITY: POLICYMAKING THROUGH LITIGATION

The judicial transformation of Social Security disability has many roots. According to Kagan, adversarial legalism is endemic to the American political system, evolving out of the nation's fragmented institutional structure and its cultural mistrust of governmental authority. The prevalence of adversarial legalism, however, increased in the 1960s

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and 1970s, when demands for increased governmental activism in consumer protection, the environment, and civil rights were channeled through the lawsuit. Rather than establish another bureaucratic agency to enforce new regulatory laws, both liberals and conservatives agreed to allow citizens to enforce those legal requirements independently through court actions.[27]

The "rights revolution" came to Social Security in the 1980s; indeed, it sprang from the collapse of the consensus that had supported system expansion since the 1950s. Even in the absence of the legal advocacy campaign waged by mental health reformers and children's representatives, the federal courts were heavily involved in Social Security disability programs for two reasons. First, determinations regarding disability are inherently subjective and difficult to make, leaving a great deal of room for disagreement between well-intentioned individuals. Though the statute and regulations provide general guidance on the definition of disability, disputes arise when the general definition is applied to specific cases. Disputes also arise over whether the standards employed by the SSA are correct in the first place; whether, in other words, the regulations that the SSA issues are in accord with the dictates of the Social Security Act. Second, the disability certification process reflects this difficulty by creating a multi-layer process replete with opportunities to second-guess previous determinations throughout the process, up through and including the federal courts.[28] Thus, even before the Reagan administration's disability reviews mobilized legal advocates, the courts were regularly involved in disability policy because they are part of the appeals process to which claimants were entitled. As the final forum for appeal for disabled Social Security claimants, the federal courts articulate standards of disability and procedural protections that they expect to be binding.

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27. Kagan, *Adversarial Legalism,* 1995, *supra* note 2, at 104-16. On the "rights revolution," see R. Shep Melnick, *The Courts, Congress, and Programmatic Rights, in* REMAKING AMERICAN POLITICS 188, 188-212 (Richard A. Harris & Sidney M. Milkis eds., 1989).

28. Disability claims pass first through the state level where a state disability determination agency makes the initial decision regarding eligibility. If the claimant disagrees with the state agency, she can ask for a reconsideration of her claim. Following reconsideration, the claimant can then appeal the denial through a complex administrative appeals process that proceeds from the state agency to a quasi-independent hearing officer—an administrative law judge—then to the SSA Appeals Council and finally to the federal judiciary starting at the district court level.

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Nevertheless, three developments in the late 1970s and early 1980s brought the "rights revolution" home to Social Security. First, by the mid-1970s, with the maturity of the social insurance programs and dismal economic and demographic forecasts, lawmakers turned from system expansion to concern over issues of cost control. Once the Social Security system entered an age of retrenchment, the judiciary became an attractive forum for progressive policy change. Mental health groups and those representing the poor had never ranked among the powerful in Congress, but the rise in concerns over cost control further narrowed legislative avenues of expansion. The Carter administration had addressed issues of cost control through the 1980 disability amendments, which contained provisions that reduced the size of benefits for younger disabled workers, and mandated a periodic review of the disability rolls to weed out cheaters and malingerers. When Reagan entered office, he stepped up the timetable and scope of these periodic reviews. Throughout the early 1980s, the Reagan administration downplayed the complaints of advocates and was determined to pursue the reviews, while Congress remained paralyzed by disagreement over how to handle the public backlash.

Unlike Congress, the federal judiciary was neither frozen by discord nor constrained by cost considerations. While Congress and the executive branch attempted to balance program spending with revenues,[29] judges were much more amenable to the arguments of advocates, which focused on individual rights and ignored the issue of overall costs. Moreover, since Congress seemed incapable, at least until 1984, of rendering a legislative remedy for the controversy over the periodic reviews, the judiciary's ability to unilaterally grant relief to denied beneficiaries made them an especially attractive forum for advocates representing aggrieved claimants. Of course, as some advocates admitted, a courtroom was not the ideal setting for pressing policy initiatives because judges lack enforcement and implementation powers.[30] But given their inability to access the executive branch and the impasse among lawmakers, advocates had little choice but to turn to the courts.

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29. MARTHA DERTHICK, POLICYMAKING FOR SOCIAL SECURITY 48-52 (1979).

30. *See* Leonard S. Rubenstein & Jane Bloom Yohalem, *The Courts and Psychiatric Disability, in* PSYCHIATRIC DISABILITY: CLINICAL, LEGAL, AND ADMINISTRATIVE DIMENSIONS 437-49 (Arthur T. Meyerson & Theodora Fine eds., 1987) (discussing the problems advocates faced when using a litigation strategy to force progressive policy change on behalf of the mentally ill).

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A second development brought the crusading litigation of the "rights revolution" to the doorstep of the SSA: the backlash among liberal advocacy groups against President Reagan's attempt to roll back "big government." Antipoverty advocates' litigation strategy grew out of the battle over the Reagan administration's disability reviews from 1981 through 1984. These reviews mobilized advocates, and, once mobilized, those advocates were determined not only to halt the reviews but also to expand the disability programs to previously excluded or underserved groups. Between 1984 and 1992, advocates for the poor used litigation to liberalize the disability criteria for the mentally ill, drug addicts and alcoholics, and disabled children.

Finally, the SSA's own initial reaction to the first disability lawsuits (which resulted not from the Reagan disability reviews but from an earlier review of SSI), intensified the advocacy crusade in the courts. During the disability reviews, the SSA asserted its long-standing policy of non-acquiescence. This policy infuriated and radicalized the lower federal courts. According to its non-acquiescence policy, the SSA refused to follow court precedent with which it disagreed, even in the circuit that established the precedent, thus violating the accepted legal tradition of *stare decisis*. While it would apply precedent from the Supreme Court, the SSA ignored decisions handed down by lower courts, except in the case of the specific litigant before the court. The agency argued that following precedent would result in eligibility standards that differed between circuits, thus contradicting Congress' intention to create nationally uniform disability programs.[31]

Non-acquiescence was a direct challenge to judicial authority that enraged many judges. While the SSA could pursue this strategy when the number of appealed cases and the attention surrounding them was minimal, the periodic reviews brought thousands of cases before federal judges, making the SSA's flouting of judicial authority obvious. As the Reagan administration's reviews wore on and the SSA hardened its non-acquiescence approach, the lower federal courts became increasingly hostile toward the agency. This hostility affected the way the courts treated the SSA as soon as administrators entered the courtroom. According to R. Shep Melnick, "[j]udges' images of the administrative process are of the

31. On the SSA's use of non-acquiescence, see generally Samuel Estreicher & Richard L. Revesz, *Nonacquiescence by Federal Administrative Agencies*, 98 YALE L.J. 679, 694-99 (1989); Miriam R. Rubin & Karen Ann Naughton, *Government Nonacquiescence Case in Point; Social Security Litigation*, 15 SOC. SEC. REP. SER. 768 (1987).

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utmost importance because the central issue in administrative law is the extent to which judges should defer to administrative judgment and expertise. Judges are unlikely to defer to administrators they do not trust."[32] Surveying the situation, one legal advocate pointed out, "[a]ll of this judicial frustration with the agency inure[s] to the benefit of claimants."[33] After the reviews were over, the courts remained antagonistic toward the SSA, much more willing to second-guess administrative actions and suggest legal remedies than they had been previously.

As the reviews proceeded, advocates for the poor became more knowledgeable about the legal arguments to which judges would respond. They also grew more attentive to implementation and more forceful in using the courts to follow through on compliance once they had secured a favorable court decision. For instance, they skillfully used class action suits to circumvent the SSA's policy of non-acquiescence. According to one attorney familiar with disability claims, "the way to ensure agency compliance with the law of the circuit is to make all decisions legally enforceable by all claimants similarly situated"[34] through the "vehicle" of the class action lawsuit. If the SSA would abide by an appellate court's ruling only in the case of the specific litigant, then the solution, advocates surmised, was to broaden the number of named litigants.[35] Throughout the 1980s, the class action lawsuit became a powerful tool for the liberalization of disability standards. Although the large number of cases brought by individual plaintiffs is not insignificant, this paper will focus primarily on class action suits.

This article discusses the transformation of Social Security disability in the areas of mental disability and childhood disability, but the findings apply to other areas of disability as well. Legalism began in 1981 with the disability reviews, and continued throughout the next fifteen years. By 1990, almost every aspect of disability was under dispute in the nation's federal courts.

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32. R. Shep Melnick, *Administrative Law and Bureaucratic Reality*, 44 ADMIN. L. REV. 245, 246 (1992).

33. *See* CAROLYN A. KUBITSCHEK, SOCIAL SECURITY DISABILITY: LAW AND PROCEDURE IN FEDERAL COURT 9 (1994) (For additional quotations demonstrating the vitriol between the judiciary and the SSA, see *id.* at n.34).

34. *Id.* at 37.

35. *Id.*.

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IV. REMAKING DISABILITY

In order to understand the effect of this litigation advocacy campaign on the disability programs, one must understand how the SSA determines disability. The steps that the SSA uses to determine whether a person is disabled under the Social Security Act are highly technical and very complicated. They also seem bureaucratically mundane. They are, however, of vital importance to the politics of Social Security disability. Subtle shifts in any one of these steps can produce vast aggregate changes in the number and type of claims approved for benefits.

According to the Social Security Act, a person is disabled if she is unable to "engage in substantial gainful activity"[36] because of a "medically demonstrable,"[37] long-term "physical or mental impairment."[38] When certifying a claimant, the SSA considers three components of the disability: 1) the medical impairment (the severity of its clinical signs and symptoms); 2) the functional impact (the extent to which the impairment prevents an individual from performing certain activities; and 3) the vocational characteristics of an individual (the extent to which her age, education, and work history will prevent her from finding a job).[39] A person is deemed "disabled" if a medical impairment is so severe that the person, given her functional and vocational profile, is unable to engage in remunerative work.[40]

Generally, the SSA deems the medical manifestations of impairment the most concrete and least subjective of the three factors. Clinical descriptions of medical signs and symptoms are catalogued in the agency's Listings of Medical Impairments.[41] On the other hand, functional capacity and vocational profile are more subjective because they are difficult to measure and because their manifestation and severity can vary widely between individuals who are otherwise similarly situated.[42] Nonetheless,

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36. Social Security Act, 42 U.S.C. § 223(d)(1) (2002).
37. 42 U.S.C. § 223(d)(1).
38. 42 U.S.C. § 223(d)(1).
39. 42 U.S.C. § 223(d)(2); 20 C.F.R. 404.1521; 20 C.F.R. § 416.921 (2002).
40. 42 U.S.C. § 223 (d)(2); 20 C.F.R. 404.1521; 20 C.F.R § 416.921.
41. 20 C.F.R. Part 404, Subpart P, Appendix 1, Part A (2002).
42. *See* Carroll M. Brodsky, *Factors Influencing Work-Related Disability, in* PSYCHIATRIC DISABILITY: CLINICAL, LEGAL, AND ADMINISTRATIVE DIMENSIONS 49-65 (Arthur T. Meyerson & Theodora Fine eds., 1987); Saad Z. Nagi, *The Concept and*

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social functional capacity and work history tend to be the most significant predictors of whether a person will actually work in the future.[43] The tension between these two goals—the desire to ground disability on something objective (like clinical observations of medical phenomena), on the one hand, and, on the other, the desire to produce an accurate judgment as to whether a particular claimant can work (taking into account functional capacity and vocational characteristics)—has long been a source of consternation within the Social Security Administration. Although policy makers operated on the assumption that Social Security's definition of disability should weigh the biological, functional, and vocational aspects of disability, the political standing of DI and SSI rests on the understanding that the more objective factors—the clinical criteria for qualification—will dominate the disability certification decision.[44]

Over time, however, the courts encouraged the SSA to adopt an interpretation of disability that was increasingly individualistic, one that incorporated greater attention to the unique circumstances of the particular claimant with greater weight placed on aspects of disability that the SSA believed to be easier for the claimant to feign or influence. Judges, for instance, required the SSA to place greater weight on functional capacity; the testimony of friends, family, and acquaintances; opinions of the physician treating the claimant (whom the SSA fears will be tempted to side with her patient); and the claimant's own statements regarding pain and discomfort. Nevertheless, to be fair, many current officials at the SSA argue that as a result the SSA adopted a framework of disability determination that was much more accurate in terms of predicting whether an applicant could actually work.[45] In a rather ironic twist, the disability determination process had to become more individualistic and subjective in order to achieve greater accuracy because disability itself is an individual and subjective phenomena.

Measurement of Disability, in DISABILITY POLICIES AND GOVERNMENT PROGRAMS 1-15 (Edward D. Berkowitz ed., 1979).

43. William A. Anthony & Mary A. Jansen, *Predicting the Vocational Capacity of the Chronically Mentally Ill: Research and Policy Implications*, 39 AM. PSYCHOLOGIST 537, 541 (1984).

44. DEBORAH A. STONE, THE DISABLED STATE 83-84 (1984).

45. Interview with Janet Bendann, Official, Office of Childhood Disability, Social Security Administration, Baltimore, Md. (Mar. 7, 2001).

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V. MENTAL DISABILITY

When, in March of 1981, the Reagan administration attempted to purge the disability rolls of beneficiaries the SSA found to be "no longer disabled," mental health reformers believed that the SSA had adopted an unrealistically strict interpretation of disability. They mobilized to enforce what they believed was the proper interpretation of the statutory standard of disability, but they eventually accomplished much more. Ultimately, they convinced the SSA to completely rewrite its mental disability standards and, in the process, succeeded in establishing an entirely new way of classifying mental disorders. The SSA's review of the Social Security disability rolls had a devastating impact on mentally ill beneficiaries. Though they comprised only 11% of DI beneficiaries and 18% of SSI recipients, persons with mental illness constituted 26% of the terminations.[46] *Mental Health Association of Minnesota v. Schweiker*[47] was the first of the lawsuits brought by mental health reformers, followed shortly by another class action lawsuit, *City of New York v. Heckler*.[48]

As reports of the large numbers of mentally disabled beneficiaries who had been cut from the rolls poured into their offices, attorneys for the Bazelon Center for Mental Health Law scoured the records of terminated individuals for patterns that could serve as the basis for a legal challenge. Under its evaluation practices at the time, the SSA presumed that, with the exception of persons over the age of fifty, all claimants alleging mental disability whose clinical signs and symptoms were not as severe as the medical standards contained in its Listings of Medical Impairments were capable of performing at least unskilled work. The practical effect was to discount the test of functional and vocational factors in the case of younger claimants and to reduce the disability determination to a simple question of whether the claimant demonstrated the medical findings catalogued in the Listings. The effect was to make eligibility all but impossible for younger claimants, many of whom had qualified under the much looser interpretation of mental disability in place in the early 1970s, before the retrenchment ethos of the late 1970s and early 1980s. Mental health reformers decided to contest the SSA's process for weighing evidence,

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46. *Social Security Reviews of the Mentally Disabled: Hearing Before the Special Committee on Aging*, 98th Cong. 164-65 (1983).

47. 554 F. Supp. 157 (D. Minn. 1982).

48. 578 F. Supp. 1109 (E.D.N.Y. 1984).

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arguing that the evaluation violated the Social Security Act because it did not pay enough attention to functional and vocational capacity. It seemed a subtle shift in emphasis, but it had a profound effect on how loosely the standard of disability was applied in the case of the mentally ill.[49]

The Bazelon Center and Legal Services filed suit challenging the psychiatric evaluation practices in Minnesota and New York State. Attorneys argued that this practice failed to provide the individualized assessment mandated by the authorizing statute. To bolster their case, they enlisted the aid of mental health professionals who were troubled by the reviews, and who testified that the SSA's disability criteria were not sufficient to judge the true work capacity of a mentally ill individual. The mental health advocates were successful in both suits. In 1982, the Minnesota District Court overturned the SSA's psychiatric rating policy, calling it "arbitrary, capricious, irrational, and an abuse of discretion."[50] Judge Jack Weinstein, the judge in the New York case, was even more stinging in his rebuke of the SSA. He characterized the evaluation process for mentally disabled claimants as a "paper charade," and castigated the SSA for relying on "bureaucratic instructions rather than individual assessments."[51] In both cases, the courts found that the SSA had used an improper standard when adjudicating the claims of mentally ill individuals and had therefore wrongfully terminated or denied benefits to thousands of individuals. Both courts enjoined further use of the SSA's psychiatric evaluation standards and ordered the agency to reverse all denials to class members and re-adjudicate claims under a court-imposed standard of disability.

At the same time that the Bazelon Center pushed class action challenges to the SSA's evaluation of mental disability, legal services agencies focused on the procedural protections afforded to claimants with mental disabilities—or more precisely, the lack thereof. In the early 1980s, the SSA maintained a strict policy of termination for non-cooperation. If a beneficiary whose file was pulled for review or a claimant who had applied for benefits failed to comply with the agency's requests for additional information, the SSA reserved the right to terminate or deny benefit

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49. Leonard S. Rubenstein et al., *Protecting the Entitlements of the Mentally Disabled: The SSDI/SSI Legal Battles of the 1980s*, 11 INT'L J.L. & PSYCHIATRY 269, 271 (1988); Leonard S. Rubenstein, *Science, Law, and Psychiatric Disability*, 9 PSYCHOSOCIAL REHABILITATION J. 1, 7-21 (1985).

50. *Mental Health Ass'n of Minn.*, 554 F. Supp. at 166.

51. *Heckler*, 578 F. Supp. at 1124.

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payments. Legal advocates argued that the non-cooperation policy was unfair to individuals with mental illness because it did not take into account the unique vulnerabilities of the mentally ill, thus violating their due process rights. Individuals with mental illness, advocates contended, frequently did not answer the SSA's mailed notices for information because their disorders made them too confused or paranoid to respond. Their silence, however, should not mean they were being uncooperative.

A New York District Court agreed. In *Schisler v. Heckler*, the court held that the SSA's non-cooperation policy was unfair to the mentally ill.[52] In keeping with its emphasis on individualized justice, the court asserted that due process required that "procedures be tailored . . . to the capacities and circumstances of those who are to be heard, to insure that they are given a meaningful opportunity to present their case."[53] The SSA, however, had not altered its notification procedures "to the capacities and circumstances of mentally impaired individuals."[54] The court ruled that the SSA could not withhold payments on grounds of non-cooperation if an individual's failure to cooperate could be attributed to her mental disorder unless the agency followed certain procedural safeguards. These safeguards included visits to the claimant at home and efforts to contact family members and acquaintances to obtain the information needed.[55] On similar grounds, several other courts ordered the SSA to re-open and re-investigate the files of thousands of mentally disabled individuals who had failed to appeal their terminations and denials.[56] Although the procedural changes seem small, these decisions made it extremely difficult for the SSA to continue its review of mentally disabled benefit applicants because they made benefit termination administratively cumbersome.[57]

Through the *Mental Health Association of Minnesota*, *City of New York*, and *Schisler* cases, as well as other similar class action suits, the federal courts pushed the SSA toward the adoption of a more individualized and comprehensive disability certification process, one that

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52. Schisler v. Heckler, 574 F. Supp. 1538 (W.D.N.Y. 1983).

53. *Id.* at 1549-50 (quoting Mathews v. Eldridge, 423 U.S. 319, 349 (1976)).

54. *Id.* at 1550.

55. *Id.*

56. Penner v. Schweiker, 701 F.2d 256, 257 (3d Cir. 1983); Brittingham v. Schweiker, 558 F. Supp. 60, 60-62 (E.D. Pa. 1983); Kapp v. Schweiker, 556 F. Supp. 16, 23 (N.D. Cal. 1981).

57. Many of these procedural protections were later codified in the Social Security Act in the 1983 amendments and in the SSA's regulations.

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placed greater emphasis on the particular circumstances of the claimant: his actual functional capacity, his work history, and his particular ability to navigate the bureaucratic process of disability application. Standardized processes and rules, like the non-cooperation policy and the use of the Listings, had to take into account the specific circumstances of each mentally disabled claimant.

However, mental health reformers were not satisfied with simply tinkering with the rules of disability certification. They wanted to change the rules themselves so that the individualized emphasis that the courts demanded was codified in the statute and regulations. In this regard, the litigation battle in the courts played to their advantage in Congress. By 1984, public backlash against the reviews, the sheer number of lawsuits, and open warfare between the courts and the SSA over the non-acquiescence policy compelled Congress to act. In the fall of 1983, the SSA confronted 95 pending class action lawsuits challenging some aspect of disability determination.[58] Secretary of Health and Human Services, Margaret Heckler, announced a moratorium on further reviews, and later that year, Congress enacted the 1984 Disability Benefits Reform Act, legislation that built upon the complaints that advocates had voiced through their litigation. The law gave advocates much of what they wanted, including a provision requiring that the SSA rewrite its medical Listings for mental disorders with input from advocacy representatives.[59] A one-two punch of litigation plus legislation, the revision of the Listings of mental disorders further loosened the standards of mental disability, thus hastening the enrollment of large numbers of individuals with mental retardation and mental illness. After the publication of the revised adult Listings of mental disorders in 1985, much of the litigation diminished, but did not disappear entirely. Instead, the courts continued to remain active in disability issues. The judicial liberalization of mental disability after 1984 took many forms, and was accomplished through both class action and individual lawsuits. Although the number of class action suits declined, individual suits took on added importance once the SSA gave up non-acquiescence in 1988.

In some cases, judges loosely interpreted the types of information claimants were required to present in order to justify a claim. For example, the SSA has long maintained that a claimant alleging a disability due to

58. KUBITSCHEK, *supra* note 33, at 37- 38.

59. *See* H.R. CONF. REP. NO. 98-1039, pt. 5, at 31 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3080.

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pain must provide evidence of a medical condition or source that might serve as the cause of that pain. In 1988, however, a district court ruled that psychosomatic pain, pain that an individual with a mental disorder believes he feels, could be debilitating enough to justify a claim, even if no objective evidence for the pain existed.[60] "[I]f in a person's mind, he suffers pain," the court held, "then he truly suffers whether the cause and justification are there."[61] Another court ruled that occupational stress, which the SSA defined as the "demands of work,"[62] was not characteristics of the job, but rather, the claimant's subjective reactions to the job. Thus, though vocational experts might not consider a particular job too stressful for a claimant with a mental disorder, if the claimant believed otherwise, he might not possess the functional capacity to cope with workplace demands.[63] Other courts held that the mere diagnosis of a severe mental illness along with the subjective testimony of the claimant, was sufficient to justify an award.[64] This, however, flew in the face of the SSA's assertion that what counted was not the diagnosis of a disorder itself, but the limitations that that disorder placed on the claimant's ability to function and earn a living through gainful employment, a determination that, the SSA argued, it alone had the prerogative to make.

In other mental disability cases, federal judges increased the burden of proof that the SSA had to satisfy in order to deny or terminate payments. For instance, courts held that if a claimant stated that he was mentally ill, the SSA had to treat those statements as evidence of a mental disorder and weigh it in its adjudication.[65] On the other hand, if a claimant denied that he suffered from a mental illness and refused to seek treatment, those denials could not be taken at face value since mentally ill claimants "may be unable to recognize the need to seek treatment."[66]

Another important line of mental disability court cases developed in the area of alcoholism and drug addiction, where again the courts loosened the disability standard. Before Congress eliminated substance abuse as a

60. Bolling v. Bowen, 682 F. Supp. 864, 867 (W.D. Va. 1988).
61. *Id.* at 867.
62. Lancellotta v. Sec'y of Health & Human Servs., 806 F.2d 284, 285 (1st Cir. 1986).
63. *Id.*
64. Luna v. Bowen, 641 F. Supp. 1109, 1116 (D. Colo. 1986).
65. Miller v. Bowen, 703 F. Supp. 885, 888-89 (D. Kan. 1988).
66. Caldwell v. Sullivan, 736 F. Supp. 1076, 1082 (D. Kan. 1990); *see also* DeLeon v. Sec'y of Health & Human Servs., 734 F.2d 930, 935-36 (2d Cir. 1984).

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qualifying impairment for Social Security disability benefits in 1996,[67] the SSA classified these disorders as mental disorders. Similar to other mental disorder Listings, the substance addiction standards were revised in 1985, but this set of Listings differed dramatically from the Listings for other mental disorders. Claimants could not qualify for disability benefits based on their addiction alone; instead, they had to satisfy the medical standards for one of nine referenced impairments.[68] A claimant could also be found to be disabled by his addiction if he showed "end-organ" damage, that is, damage to the eyes, heart, brain, or kidneys.[69]

Several district and appellate courts, however, refused to adopt the SSA's characterization. They ruled instead that chronic addiction was a medical impairment, and therefore, could serve as an independent source of disability regardless of whether the claimant satisfied the medical criteria contained in the Listings.[70] According to these decisions, addiction alone was disabling if it was uncontrollable and it prevented the claimant from engaging in gainful employment. The claimant did not have to prove "end-organ" damage or any other physiological or anatomical abnormality.

Other courts, while not explicitly contradicting SSA rulings, narrowed or expanded the evidence that the SSA could weigh when determining whether an addicted claimant could work in a manner that tipped the balance of adjudication to his or her benefit. For instance, according to the

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67. The Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat 847 (codified at 42 U.S.C.A. § 422 (1996)).

68. Those impairments included: organic mental disorders, depressive disorders, anxiety disorders, personality disorders, peripheral neuropathies, liver damage, gastritis, pancreatitis, or seizures.

69. Employees' Benefits, 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.09 (2001).

70. Thompson v. Sullivan, 957 F.2d 611, 614 (8th Cir. 1992); Arroyo v. Sec'y of Health & Human Servs., 932 F.2d 82, 87-88 (1st Cir. 1991); Lubinski v. Sullivan, 952 F.2d 214, 217 (8th Cir. 1991); Shelltrack v. Sullivan, 938 F.2d 894, 897 (8th Cir. 1991); Nelson v. Bowen, 855 F.2d 503, 505-06 (7th Cir. 1988); Wilkerson v. Bowen, 828 F.2d 117, 121-22 (3d Cir. 1987); Cooper v. Bowen, 815 F.2d 557, 560-61 (9th Cir. 1987); LeMaster v. Sec'y of Health & Human Servs., 802 F.2d 839, 841-42 (6th Cir. 1986); Purter v. Heckler, 771 F.2d 682, 697-98 (3d Cir. 1985); Ferguson v. Heckler, 750 F.2d 503, 505 (5th Cir. 1985); Metcalf v. Heckler, 800 F.2d 793, 796 (8th Cir. 1985); Ferguson v. Schweiker, 641 F.2d 243, 248-49 (5th Cir. 1981); DeCarolis v. Sec'y of Health & Human Servs., 724 F. Supp. 71, 74 (W.D.N.Y. 1989); Johnson v. Sullivan, 749 F. Supp. 664, 670 (E.D. Pa. 1990); Cooper v. Bowen, 707 F. Supp. 260, 262 (N.D. Tex. 1989); Koszewski v. Bowen, 700 F. Supp. 10, 11 (W.D. Pa. 1988); Hall v. Bowen, 669 F. Supp. 976, 978 (N. D. Cal. 1987); Brown v. Bowen, 672 F. Supp. 1268, 1271-72 (W.D. Mo. 1987); Murphy v. Heckler, 613 F. Supp. 1233, 1234 (W.D. Pa. 1985); Migneualt v. Heckler, 632 F. Supp. 153, 156 (D.R.I. 1985); Burton v. Heckler, 622 F. Supp. 1140, 1145-46 (D. Utah 1985).

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Seventh Circuit, ability to engage in normal daily activities is not indicative of an addicted individual's ability to work because the conditions of work "are not identical to home life."[71] The D.C. Circuit, on the other hand, ruled that the SSA must consider the detrimental effect of a claimant's alcohol related arrests on his desirability as a job candidate.[72] Thus, while the SSA could not look at daily activities, it had to consider arrest records when determining an individual's work capacity. Similarly, other courts held that failure to complete a treatment program could be proof of chronic and disabling addiction,[73] but bouts of sobriety and past success in a treatment program could not be treated as indicative of an individual's ability to control his alcohol intake.[74] In the hands of some courts, therefore, evidence that could help a claimant qualify for benefits had to be considered, while evidence that could damage a claimant's application was ignored or downplayed. Thus, the scale tipped ever so slightly in favor of the claimant, but in a system adjudicating hundreds of thousands of claims, even a slight tip translated, in the aggregate, into a huge expansion in the disability rolls.

VI. CHILDHOOD DISABILITY

The most significant Social Security case is *Sullivan v. Zebley*,[75] a Supreme Court decision that struck down the SSA's procedures for determining disability in children after having determined that they were inadequate.[76] The case vastly expanded eligibility for SSI's program for disabled children and brought with it all types of political controversy and administrative difficulty. The Social Security Act allows disabled children to receive SSI payments if they have an impairment of "comparable severity" to one that would prevent an adult from working. Because children do not work, the SSA decided to limit its determination to its catalog of medical impairments. Because individualized testing of function and vocational characteristics was used to determine the work capacity of a particular claimant, the SSA decided that it was not applicable to a child

71. O'Connor v. Sullivan, 938 F.2d 70, 73 (7th Cir. 1991).

72. Cunningham v. Heckler, 764 F.2d 911, 925 (D.C. App. 1985).

73. *Purter*, 771 F.2d at 698 n.19.

74. *Burton*, 622 F. Supp. at 1147; Simmons v. Sec'y of Health & Human Servs., 621 F. Supp. 1174, 1176 (W.D.N.Y. 1985).

75. 493 U.S. 521 (1990). This was a 7-2 decision with Justice Blackmun writing the opinion of the Court and Justices White and Rehnquist dissenting.

76. *Id.* at 522.

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who was not expected to engage in paid work activity. The children's determination process, therefore, was a one-step process limited to a determination of whether the child satisfied the medical criteria in the agency's Listings.

By the late 1980s, Legal Services attorneys were well versed in the minutiae of disability determination and they built upon their successes as they pressed for the expansion of children's disability. In 1987, Community Legal Services (CLS) of Philadelphia filed a class-action lawsuit in the Third Circuit, alleging that the SSI children's program was much more restrictive than the adult program because it did not provide an individualized test of a child's functioning. CLS attorneys argued that comparable results required a comparable process. The procedural differences between the adult and children's program meant that the SSA was not identifying children whose impairments were of "comparable severity" to an impairment that would disable an adult. When the Third Circuit sided with CLS, the SSA appealed to the Supreme Court. In 1990, in *Sullivan v. Zebley*, the Supreme Court ruled that the SSA had erred in not providing an individualized functional evaluation for children.[77] While a vocational assessment was clearly impossible since children did not work, Justice Blackmun reasoned that the SSA could still assess function by examining a child's ability to feed herself, dress herself, learn, and play—activities that Blackmun deemed the "work" of children.[78] Shortly thereafter, the SSA added an individualized functional assessment (IFA), thus weighing for children, as for adults, the functional capacities of the individual claimant.

Nevertheless, with *Zebley* the litigation strategy hit its limits. Unlike the case of adult mental disability in the 1980s, Congress had not sanctioned the liberalization of eligibility criteria for children. While some lawmakers had considered passing legislation to create a functional test for children in the late 1980s, liberals had failed to cobble together a majority sufficient to back the proposal.[79] After *Zebley*, legal advocates did not need congressional sanction; *Zebley* made the IFA a fait accompli. But, as will be discussed below, *Zebley*, along with the numerous other class actions, contributed to a "crisis" in the disability programs. By 1993, the

77. *Id.* at 540-41.

78. *Id.*

79. SSI Disabled and Blind Children Act of 1989, H.R. 868, 101st Cong. (1989); Supplemental Security Income Reform Act of 1989, S. 665, 101st Cong. (1989) (amending supplemental security income program to increase limits).

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exponential growth in DI and SSI expenditures (especially for children), allegations from congressional watchdog agencies that the SSA was not properly administering the disability programs, and media stories describing children coached by their parents to "act crazy" in order to secure benefits, became too much for lawmakers—especially the Republicans who gained control of Congress—to stomach. In 1996, Congress eliminated the IFA as part of its welfare reform initiative.

VII. OTHER DISABILITIES

Mental disability and childhood disability were not the only areas in which legal advocates utilized their litigation strategy. Numerous boutique law firms specializing in Social Security cases and organizations defending disabled claimants, groups like the SSI Coalition for a Responsible Safety Net and the National Organization of Social Security Claimants Representatives (NOSSCR), sprang up around the country. Attorneys published case material manuals and swapped legal strategies. They established toll-free numbers through which claimants could seek legal aid and share "horror stories."

Moreover, throughout the late 1980s and early 1990s, the federal courts issued rulings that touched every aspect of the DI and SSI programs. Legal advocates brought a number of class action suits challenging the criteria used to evaluate cardiovascular disease,[80] AIDS and HIV,[81] chronic alcoholism and drug dependency,[82] pain,[83] diabetes, and hypertension.[84] Attorneys also disputed routine administrative details, including the methods for calculating the amount of SSI payments,[85] counting veteran's benefits,[86] determining whether the claimant's impairment has lasted for twelve months or longer,[87] and the meaning of a "severe" impairment.[88] By the end of 1992, the SSA confronted forty-six threatened or pending

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80. New York v. Sullivan, 906 F.2d 910 (2d Cir. 1990) (resulting in the reopening of thousands of claims).

81. Rosetti v. Sullivan, 788 F. Supp. 1380 (E.D. Pa. 1992).

82. Schoolcraft v. Sullivan, 971 F.2d 81 (8th Cir. 1992).

83. Hyatt v. Sullivan, 899 F.2d 329 (4th Cir. 1990); Luna v. Bowen, 834 F.2d 161 (10th Cir. 1987); Polaski v. Heckler, 739 F.2d 1320 (8th Cir. 1984).

84. *Hyatt*, 899 F.2d at 329.

85. Farley v. Sullivan, 983 F.2d 405 (2d Cir. 1993).

86. White v. Shalala, 7 F.3d 296 (2d Cir. 1993).

87. Titus v. Sullivan, 4 F.3d 590 (8th Cir. 1993).

88. Bowen v. Yuckert, 482 U.S. 137 (1987). *See also* Bailey v. Sullivan, 885 F.2d 52 (3d Cir. 1989); Dixon v. Sullivan, 792 F. Supp. 942 (S.D.N.Y. 1992).

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class action lawsuits dealing with issues related to its disability programs.[89] Indeed, that year, the Congressional Research Service observed, "[t]he Federal courts' influence is so extensive that SSA has difficulty contesting the many decisions rendered against it."[90] More than ever, by the late 1980s and early 1990s, policy change in Social Security disability was driven by the courts rather than Congress.

VIII. THE TRADEOFFS OF LEGALISM

Despite the changes in disability determination that resulted from their litigation campaign, advocates remained dissatisfied with the process. The drive to reform Social Security disability through the courts spawned its own problems. Gay Gellhorn writes:

> Disability determination has to change. The process costs too much and takes too long . . . . Although the system accomplishes its purpose of sustaining millions of very poor, disabled people, it does so at costs that are unacceptable to nearly everyone. From the claimants' point of view, there is a crisis of confusion and delay. They do not understand how to navigate the system successfully, why it takes so long and why different levels of the same agency reach opposite conclusions.[91]

Gelhorn's sentiments were not confined to the advocacy community; both within Congress and the SSA, policy makers, especially during the 1990s, expressed concern that the administration of the disability programs was on the verge of collapse, and that major reforms were needed to bring the programs under control. Although this is not entirely the fault of the courts, the judicially driven nature of DI and SSI's expansion certainly exacerbated the inherent weaknesses of disability determination and gave rise to current concerns. The accumulating layers of court decisions and *ad hoc* administrative responses to court decisions resulted in fragmented disability standards, uncertain and confusing administration, an overall lack of policy coherence, and unpredictable expenditures.

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89. DAVID KOITZ, et al., CONGRESSIONAL RESEARCH SERVICE, STATUS OF THE DISABILITY PROGRAMS OF THE SOCIAL SECURITY ADMINISTRATION, 1994, 1-3 (1994).

90. *Id.* at 4-5.

91. Gay Gellhorn, *Disability and Welfare Reform: Keep the Supplemental Security Income Program but Reengineer the Disability Determination Process*, 22 FORDHAM URB. L.J. 961, 968-69 (1995).

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IX. FRAGMENTATION OF POLICY

The American federal judicial system is highly fragmented. The judges who sit on the nation's district courts and circuit courts set precedent in their regions with relatively little oversight from the Supreme Court. Only the decisions of the Supreme Court apply nationwide; otherwise, the legal precedent is binding only within the district or circuit in which it is issued.

> The balkanization of the federal court system is one of the reasons that the SSA strongly resisted judicial intervention into disability policy, and why it clung to non-acquiescence despite staunch public opposition to the policy. According to the SSA, this fragmentation had the potential to replicate itself in a fragmentation of policy, as the courts became more insistent in articulating their own alternative standards of disability. The SSA argued that Congress had charged it with administering a nationally uniform program and that it would be "abdicating its responsibility if it turned over the determination of agency policy to each of the 94 district courts or 12 circuit courts that might render an opinion on the issue."[92] Trying to tailor administrative practices to the controlling precedent in each region would be difficult, confusing, and inefficient. As the acting commissioner explained to Congress: There would be enormous practical problems with circuit-by-circuit acquiescence since we would need to keep track of applicants as they move through the decisionmaking process, determine which circuit law should apply, and separately handle claims by jurisdiction. Special problems could arise where there are conflicting decisions within a single circuit, or a claimant or beneficiary changes residence while a decision on appeal is pending.[93]

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92. *Social Security Disability Insurance: Hearing Before the House Subcommittee On Social Security of the Committee On Ways & Means*, 98th Cong. 37 (1983) (statement of Paul B. Simmons, Deputy Commissioner for Programs and Policy, Social Security Administration).

93. *Social Security Disability Insurance Program: Hearing on S. 476, H.R. 4170 and H.R. 3755 Before the Subcom.. on Finance,* 98th Cong. 106 (1984) (statement of Hon. Martha McSteen, Acting Comm'r, Social Security Administration).

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Judges, of course, were focused on individual justice, not administrative convenience, but this left them free to ignore the extent to which fragmentation was itself a disservice and an injustice to the claimants they sought to protect.

Fragmentation, moreover, was not simply a matter of administrative inconvenience; it contravened everything the SSA and the concept of Social Security represented. For SSA officials, social insurance was an improvement on public assistance precisely because it did not entail the interstate variations in benefits levels and eligibility requirements that characterized the state assistance programs. National uniformity, in other words, was the distinguishing characteristic of Social Security, embodying the respect and dignity that SSA officials believed beneficiaries should be accorded.[94] From the standpoint of equity, the SSA argued, it would be confusing as well as unfair to claimants and beneficiaries "to subject claims to different standards depending on where they reside."[95]

Congress did not settle the issue of non-acquiescence when it enacted the 1984 disability amendments. But under mounting pressure from the courts, the SSA finally capitulated and adopted a policy of intra-circuit acquiescence in late 1988.[96] As a result, the fragmentation of policy standards intensified. Martha Derthick explained that from then on "there were to be two disability determination processes—one bureaucratically controlled and nationally uniform in application, the other judicially controlled and potentially varying among the circuits."[97] In 1992, surveying the state of the Social Security disability programs, investigators at the Congressional Research Service reported to Congress, "[d]ifferent standards are now in operation across the country depending on the judicial circuit in which someone lives."[98]

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94. MARTHA DERTHICK, AGENCY UNDER STRESS 141-42 (1990). Even though it was a means-tested program, these nationalizing goals had been folded into SSI when that program was created in 1972.

95. *Social Security Disability Reviews: A Federally Created State Problem: Hearing Before the House Comm. On Aging,* 98th Cong. (1983) (statement of Paul B. Simmons, Deputy Commissioner, Social Security).

96. Federal Old Age, Survivors, and Disability Insurance Benefits; Black Lung Benefits; Supplemental Security Income for the Aged, Blind, and Disabled; Organization and Procedures; Application of Circuit Court Law, 53 Fed. Reg. 46,628 (Nov. 18, 1988) (to be codified at 20 C.F.R. pts. 404, 410, 416 & 422). Advocates disagree over whether the SSA acquiesces in deed as well as word.

97 DERTHICK, *supra* note 95, at 149.

98 KOITZ, *supra* note 89, at 4-5.

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X. UNCERTAIN AND CONFUSING ADJUDICATION

Extensive judicial involvement in disability adjudication also contributes to the present uncertainty and confusion in the disability determination process. Judges enjoy a great deal of decisional autonomy. While this frees them to make tough, unpopular choices, it can also prevent them from providing clear and consistent guidance as to what practices constitute proper standards for evaluating disability. While judges are technically bound by precedent, they still do not speak with one voice. A judge can always change her mind, and the decision in a particular case can hinge on which judges happen to be sitting on the panel. It comes as no surprise, therefore, that courts within the same circuit sometimes establish internally conflicting standards.

For example, in the early 1980s, the Second Circuit was unable to articulate a consistent rule regarding the evaluation of disability in which pain was a factor. In 1980, it held that allegations of pain need not "necessarily [be] supported by 'objective' clinical or laboratory findings"[99] and that "subjective pain may serve as the basis for establishing disability, even if such pain is unaccompanied"[100] by clinical findings. Three years later, however, it retreated from this position, ruling instead that "some impairment [relating to the pain] must be medically ascertain[ed]."[101] That same year, the court changed course again, restating that pain could serve as the basis for an award even if unsupported by objective medical evidence.[102] In addition, in mental disability cases, judges have struck down medical conclusions that administrative law judges (ALJs) have drawn from the evidence, ruling that it is inappropriate for lay hearing officers to play "amateur doctors."[103] Meanwhile, others have held that it is perfectly acceptable for ALJs to draw reasonable conclusions regarding a

99. McLaughlin v. Sec'y of Health, Educ., and Welfare, 612 F.2d 701, 704 (2d Cir. 1980) (quoting Cuter v. Weinberger, 516 F.2d 1282, 1286-87 (2d Cir. 1975)).

100. *Id.* at 704 (quoting Marcus v. Califano, 615 F.2d 23, 27 (2d Cir. 1979)).

101. Gallagher v. Schweiker, 697 F.2d 82, 84 (2d Cir. 1983).

102. KUBITSCHEK, *supra* note 33, at 240-41 (discussing McLaughlin v. Sec'y of Health, Educ., and Welfare, 612 F.2d 701 (2d Cir. 1980)); *see also* Gallagher v. Schweiker, 697 F.2d 82 (2d Cir. 1983); Rivera v. Schweiker, 717 F.2d 719 (2d Cir. 1983).

103. Kuwahara v. Bowen, 677 F. Supp. 553 (N.D. Ill. 1988); *see also* McAdams v. Sec'y of Health & Human Servs., 726 F. Supp. 579 (D.N.J. 1989); Bolling v. Bowen, 682 F. Supp. 864 (W.D. Va. 1988); Milonas v. Heckler, 626 F. Supp. 1192 (D. Mass. 1986).

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claimant's medical condition based on the evidence available.[104] What is a disability examiner or ALJ to do given these contradictory signals?

Federal judges might not be overly troubled by intra-circuit conflict, believing that it will eventually be sorted out. But in the interim, internal conflict leads to confusion among state disability examiners and ALJs. Since they do not know beforehand what the judge who might eventually hear the case will think or expect they have no assurance that their decisions will withstand judicial scrutiny. Thus, even if adjudicators wanted to follow the dictates of overseeing judges, they still might not know which judges to follow. Moreover, when courts are inconsistent, claimants and their legal representatives are at a loss as how to prepare their cases, and thus, may conclude that the process is arbitrary and unfair.

XI. LACK OF POLICY COHERENCE

In his influential book on the effect of courts on social policy, Donald Horowitz argues that judges tend to tackle social problems in a discrete fashion. By presenting only one aspect of a policy question that often requires comprehensive solutions, litigation "isolate[s] artificially what in the real world is merged."[105] Because the remedies that courts provide fail to take into account the complex connections between social problems, they can result in incoherent policy at best, unforeseen and detrimental results at worse.

This lack of coherence and its political consequences can be readily seen in the controversy that engulfed the SSI program in the early 1990s. The courts focused their rulings on the standards for a disability determination: whether the SSA used the right standards or whether the agency had gathered appropriate evidence when making decisions regarding eligibility for payments. But for the SSA, adjudication of initial disability claims was only one of the many responsibilities that accompany the administration of DI and SSI. In the early 1990s, the agency was also charged with conducting periodic reviews of the disability rolls, referring disabled addicts to treatment programs, and referring younger disabled claimants to vocational rehabilitation programs. Lawmakers saw these obligations, not as separate from, but as an integral part of the Social Security entitlement. Retaining these corresponding obligations, they

104. *See* Ray v. Bowen, 843 F.2d 998 (7th Cir. 1988); Milano v. Bowen, 809 F.2d 763 (11th Cir. 1987); Cameron v. Bowen, 683 F. Supp. 73 (S.D.N.Y. 1988).

105. HOROWITZ, *supra* note 19, at 73.

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hoped temporarily disabled claimants would not look at the disability check as a way of life, but rather as a stopgap measure that allowed the claimant to rehabilitate.

The numerous court decisions handed down in the early 1990s, however, severely compromised the SSA's ability to perform these functions well or at all. They bombarded the SSA with additional administrative tasks that taxed its capacity to do anything other than process the claims that the courts foisted onto the agency. As part of the settlement in *Zebley*, for instance, the district court overseeing the case ordered the SSA to contact each of the approximately 450,000 children it had denied between 1980 and 1990, and offer them the opportunity to re-determine eligibility. It also required the SSA to conduct a publicity campaign informing disabled children and their parents of the liberalization in program standards. The campaign was so successful that in 1994 alone, SSA field offices received almost a half million applications from children. Because of the retroactive and new claims arising from the publicity campaign, the SSA faced a backlog of over 500,000 children's claims to be adjudicated that year. This represented four times the children's caseload the SSA was accustomed to handling in a typical year. Several other courts during the same time period ordered the SSA to re-open and re-adjudicate the claims of tens of thousands of class members, some with claims stretching as far back as a decade.[106]

At the same time that the courts and a downturn in the economy produced an increase in initial and retroactive claims to be processed, the SSA was massively downsizing, leaving it ill-prepared to handle the surge in applications.[107] Administrative capacity was not, however, a factor that courts considered when they handed down their decisions. Indeed, many legal scholars argue that it should not be.[108] Failure to consider capacity, nevertheless, can wreak havoc on program administration and policy outcomes. For instance, congressional investigators estimated that in 1993, the SSA confronted a backlog of well over one million disability claims.

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106. *See, e.g.*, New York v. Sullivan, 906 F.2d 910 (2d Cir. 1990); Stieberger v. Sullivan, 792 F. Supp. 1376 (S.D.N.Y. 1992).

107. Staff at state disability determination agencies has remained fairly constant, but applications have increased from about 1.2 million to close to 2 million between fiscal years 1988 and 1993. *See generally* Notices: Process Reengineering Program; Disability Reengineering Project Plan, 59 Fed. Reg. 47887, 47891, 47893-94 (Sept. 19, 1994).

108. *See, e.g.*, Patricia M. Wald, *Judicial Review in a Time of Cholera*, 49 ADMIN. L. REV. 659, 659-70 (1997).

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This was an unprecedented situation. It represented four times the number of backlogged cases the SSA carried during the workload crisis of the mid-1970s when the agency struggled to implement SSI.[109] Because of these workload pressures, the SSA diverted its resources away from its periodic reviews. The same staff that processed initial applications also processed the reviews, and the SSA simply did not have the resources to do both simultaneously. Other important responsibilities—the referral of applicants to vocational rehabilitation and of addicts to treatment programs—never high priorities of the agency in the first place, fell by the wayside.[110]

The workload crisis was not only the result of the courts—Congress contributed by repeatedly cutting the SSA's administrative budget throughout the late 1980s and early 1990s. But the courts—by rendering their decisions absent consideration of what other courts were doing, of the economic context in which they operated, and of the complexities of disability adjudication—remained blithely inattentive to practical administrative constraints. While insulation from the rough and tumble of politics can be a virtue of the courts, it can also become a liability when judges are insensitive to the ways in which their decisions can dictate agency priorities and, in turn, affected program politics. In the case of SSI, rushed processing of applications and neglect of the periodic reviews helped fuel media allegations of fraud and abuse, of parents coaching their children to "act crazy" to win awards, and of addicts shirking requirements that they attend treatment programs.[111] The allegations of fraud and abuse abetted conservative attempts to retrench SSI, and in 1996, Congress restricted eligibility for disabled children and addicts. Moreover, this disjointed approach to disability—in which awards were divorced from corresponding obligations, treatment, rehabilitation, and review (functions that ensured program integrity and responsible behavior on the part of recipients)—was not what lawmakers envisioned for the Social Security disability programs. It is also likely not what judges would have wanted had they stopped to ponder disability holistically.

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109. KOITZ, *supra* note 89, at 17-18, 60.

110. *See* SOCIAL SECURITY ADVISORY BOARD, 2000 SSI ANNUAL REPORT (2000) (detailing the problems within the SSA), *available at* http://www.ssa.gov/OACT/SSIR/SSI00/ssiV_A.html.

111. *See generally* U.S. GEN. ACCT. OFF., GAO/HEHS-95-66, NEW FUNCTIONAL ASSESSMENTS FOR CHILDREN RAISE ELIGIBILITY QUESTIONS (1995); U.S. GEN. ACCT. OFF., GAO/HEHS-94-128, MAJOR CHANGES NEEDED FOR DISABILITY BENEFITS FOR ADDICTS (1994).

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XII. UNPREDICTABLE EXPENDITURES

A final drawback to the court-inspired transformation of Social Security disability was its isolation from the very officials who would have to allocate money to pay for that expansion. Because DI and SSI are entitlements, any person whom the SSA found to have met the disability criteria was "entitled" to benefit payments. Throughout the late 1980s and early 1990s, the courts added more and more claimants to the category of persons entitled to benefits, sometimes little by little as in the case of individual lawsuits. On other occasions, hundreds, if not thousands, were added at one time through class action challenges. By one estimate, the case of *Sullivan v. Zebley* alone approximately led to the enrollment of 130,000 disabled children in SSI.[112]

Unpredictable judicial action made forecasting program expenditures a frustrating exercise. Spending for both DI and SSI increased unexpectedly in the late 1980s and early 1990s. In 1985, the SSA paid out nineteen billion dollars for DI benefits and seven billion dollars for SSI payments. By 1994, expenditures for disability benefits had reached thirty-eight billion dollars for DI and nineteen billion dollars for SSI. In real dollars, this represented an increase in spending of 59% over ten years for both programs. Considered separately, after controlling for inflation, spending for DI increased by 45% while spending for SSI doubled. When the costs of Medicare and Medicaid (for which DI and SSI beneficiaries, respectively, are eligible) were added, spending for the disabled during the ten year period from 1985 through 1994 had doubled to well over 107 billion dollars.[113] Neither the policy makers at the SSA nor lawmakers in Congress had foreseen these developments.

Caught by surprise, lawmakers were greatly troubled by the surge in disability spending.[114] By 1992, the rapid growth in the disability programs

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112. This number is from March 1, 1994, during which time, the SSA had re-adjudicated 287,900 of the 321,600 children who were members of the *Zebley* class. It had 33,700 cases left to re-adjudicate. U.S. GEN. ACCT. OFF., GAO/HEHS-94-225, RAPID RISE IN CHILDREN ON SSI DISABILITY ROLLS FOLLOWS NEW REGULATIONS 8 (1994).

113. U.S. GEN. ACCT. OFF., GAO/T-HEHS-95-97, FEDERAL DISABILITY PROGRAMS FACE MAJOR ISSUES 95, 97 (1995).

114. The expansion in spending that took place after the passage of the 1984 amendments to reform the periodic review process was not unexpected. Although the growth in spending that took place as a result of the revision of the mental disorders listings was difficult to predict—and in fact Congress did not attempt to project costs of this measure—it had provided cost estimates for the other statutory changes.

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finally pushed DI and SSI reform onto the congressional agenda. In April of that year, actuarial projections predicted the trust fund for DI could become insolvent in three years if lawmakers took no corrective action. The event focused lawmakers' attention on DI and, by extension, SSI. Though the funding crisis in DI was resolved by reallocating money from the retirement insurance trust fund to the disability trust fund, policy makers and members of Congress continued to voice concern centering on the long-term implications of the expansion in the Social Security disability programs.[115] Indeed, Senator William Cohen, a strong supporter of the disability programs throughout the 1980s, argued that the pace of expansion was both unsustainable and inequitable. "At the same time we have been assuring senior citizens that we will leave Social Security alone," he explained, "a very real threat has been silently creeping up on the solvency of the Social Security trust funds—namely, the unfettered growth of the Social Security Disability Insurance program."[116] The proposals to restrict disability benefits for substance abusers, legal immigrants, and children, that eventually were enacted as part of the Contract with America and welfare reform, gained political momentum as lawmakers considered various ways of reining in the Social Security disability programs.

CONCLUSION

In the hands of mental health reformers and children's advocates, litigation became a tool for leveraging progressive change in the Social Security disability programs. Because of their efforts, DI and SSI became much more liberalized programs, especially for the mentally ill and poor disabled children—two groups of the disabled that in the past generally lacked a strong political presence on Capitol Hill. Not only did advocates manage to expand the disability standards for DI and SSI, but by pushing for an increased emphasis on individual functional capacity, they have also opened the door to individuals who were previously excluded from Social Security through the SSA's restrictive interpretations of mental and childhood disability. Without question, because of the litigation efforts of

115. Stanford Ross, *The Perspective of a Public Trustee, in* GROWTH IN DISABILITY BENEFITS: EXPLANATIONS AND POLICY IMPLICATIONS 319-24 (W.E. Upjohn ed., 1998).

116. *Problems in the Social Security Disability Programs: The Disabling of America: Hearing Before the Special Comm. on Aging,* 104th Cong. 1 (1995) (statement of Sen. Cohen, Member, Special Comm. on Aging).

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advocates, the Social Security disability certification process is more exacting and more thorough today than in 1980. Moreover, thousands more disabled children and adults are provided a measure of income security through the two disability benefit programs.

These positive developments, however, have not come without costs as well. Because the political debate over program expansion occurred within the courtroom rather than Congress, issues of costs and the corresponding balance of the entitlement with certain behavioral requirements (like treatment for addicts) were not considered. This is not to say that Congress would necessarily have considered these larger systemic issues, but they are much more likely to be addressed in the legislature than in the courts, which tend to focus narrowly on individualized justice. Moreover, the courts were unable to articulate coherent criteria for determining disability, leaving disability standards fragmented from one circuit to the next, and from one judge to the next within the same circuit.

Despite all of the tradeoffs associated with legalism, the question is not so much: "How do we undo all the bad things that the courts have done?" In fact, the courts have done many good things as well, for they have improved the disability determination process by making it more rigorous (albeit in part because they do not become bogged down in disagreement over how to pay for these more exacting procedures). They have opened the disability benefit programs to vulnerable individuals who cannot lobby on their own behalf because they lack the political clout, not to mention—because of their disabilities—the cognitive or emotional wherewithal to succeed in such activities. Those improvements came part and parcel with judicial activism in Social Security disability policy. The real challenge of reforming the disability benefit programs, therefore, is how to create a disability determination system that is timely, easy to use, consistent, and uniform without sacrificing the protections for the mentally disabled and disabled children that were put in place and are enforced today by the federal courts. It is a tall order indeed.

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VISUALIZING ADVERSE SELECTION: AN ECONOMIC APPROACH TO THE LAW OF INSURANCE UNDERWRITING

*Seth J. Chandler**

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INTRODUCTION

We enter this world with characteristics that create different risks for various sorts of losses. The underwriting laws of free market societies often permit insurers to charge individuals different prices for identical insurance against these losses based on these individual characteristics. The result is often an inequality of opportunity not based on any choices that we can ascribe to the individuals involved. Commentators often justify this inequality by the counterbalancing needed to stamp out a process known as "adverse selection"—the proclivity for people of greater than average risk to purchase greater than average amounts of insurance. Unchecked, adverse selection creates an upward force on prices that drives many individuals and businesses out of the insurance market, which can result in the impoverishment of society. This Article uses computer simulations and visualization technology to help determine the circumstances under which the law should support insurer efforts to classify individuals, and under which circumstances it should oppose such efforts. It thus develops a rigorous economic framework for analyzing problems of adverse selection. This framework can be used to analyze the contemporary debate regarding access by life and health insurers to genetic test information.

Private insurance transfers risk most effectively in a world of symmetric uncertainty in which the insured and insurer are equally ignorant of the probabilities of future events. Superior predictive abilities on the part of the insured shrink a private insurance market through a process known as adverse selection or, as it is sometimes known, anti-selection.[1] In essence, insureds with probable futures most likely to trigger an indemnity provision of an insurance agreement purchase that insurance disproportionately. This disproportionate purchase, coupled with high risk, exerts a powerful torque on insurance prices, which in turn drives those less likely to trigger the indemnity provision out of the insurance market. These individuals exit the market because it is no longer cost-effective for them to transfer their risks to insurers.

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1. The seminal articles in the field include: Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976) and George Akerlof, *The Market for "Lemons:" Quality, Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970).

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In response, society often enlists the legal system in order to recreate symmetry in the predictive abilities of insured and insurer.[2] We enforce doctrines such as fraud and warranty that prevent the insured with superior predictive skills from enjoying the rewards stemming from the resulting information imbalance. We give legal sanction to investigative techniques such as common data banks or old fashioned snooping that cheapen the cost of acquiring predictive information, even as their use conflicts with the privacy interests of prospective insureds. We trumpet "freedom of contract" as a basis for permitting insurers to classify individuals according to prospective risk and to price policies accordingly. And many think it "fair" that those who have truly higher risk pay more for insurance rather than be cross-subsidized by those of lower risk.[3]

The legal buttressing of a private insurance market has costs, however; first, risk classification means that those who we would label faultless are nonetheless disadvantaged in the current economic environment, and are further disadvantaged by a reduced ability to transfer risk. This inability can have drastic financial and health consequences.[4] Second, investments by the insureds in acquiring information are riskier if the insurer can punish or reward the insured based on the results. If that information has social value, as it often does, this increased risk will reduce the acquisition of useful information.[5] Third, to the extent prospective insureds still acquire

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2. For a discussion of the ways in which legal rules recreate symmetry, see Seth J. Chandler, *Insurance Regulation*, *in* 3 ENCYCLOPEDIA OF LAW AND ECONOMICS 837, 844 (Boudewijn Bouckaert & Gerrit De Geest eds. 2000).

3. Arguments for the fairness of risk classification and examination of the legal efforts to enforce it are found prominently in the work of Robert J. Pokorski. *See, e.g.*, Robert J. Pokorski, *Insurance Underwriting in the Genetic Era*, 60 AM. J. HUM. GENETICS 205 (1997).

4. Arguments against risk classification based on genetics abound. *See, e.g.*, Wendy L. McGoodwin, *Genetic Testing: A Tool for Doctors, Not for Insurers*, 15 J. INS. REG. 71 (1996). For an excellent discussion of these arguments, see Mark A. Hall, *Restricting Insurers' Use of Genetic Information: A Guide to Public Policy*, 3 N. AM. ACTUARIAL J. 34 (1999).

5. The prospect of cheaply available testing that helps predict an individual's medical future by decrypting her nuclear genetic structure transforms these concerns from the realm of theory into a central problem of capitalist economies as we start the new millennium. It is a problem to which American governments and some foreign governments have already reacted. Several governments in Europe have already banned private insurers' use of genetic tests. In the United States, the Health Insurance Portability and Accountability Act (HIPAA) generally prohibits insurers involved with employment-based health plans from underwriting based on as of yet asymptotic genetic proclivities. (The most relevant provisions of HIPAA may be found at 29 U.S.C. § 1181(b)(1)(B) and 29 U.S.C. §

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information, the result of unearthing particular unfortunate signals is that some insureds will be priced out of the insurance market altogether or compelled to reduce their purchases. The consequence of laws guarding against adverse selection thus may be a process of "financial de-selection," that in its own way threatens to diminish desired transfers of risk.

This article attempts to clarify the tradeoffs involved in sculpting laws governing the ability of insurers to access predictive information.[6] It does so first by filling a gap in the current literature[7] by coupling economic theory to computer-based visualization technology[8] to facilitate a clear yet

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1182(a)(1)(F)). Many states have enacted legislation barring health insurers from using genetic information in underwriting, and approximately nine states place at least some limits on life insurers' use of genetic tests. *See generally* Hall, *supra* note 4. Most of the commentary and much of the legislation treat genetic tests in a uniform manner, leaving insurer access to the information revealed invariant to the accuracy of the test or the characteristics of the particular insurance market involved. *See* Mark Hall, *Insurers' Use of Genetic Information*, 37 JURIMETRICS J. 13 (1996).

6. For the best existing literature on the subject see generally KENNETH ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 64-100 (1986). This article develops and complements Abraham's work by using mathematics and visualization technology to set forth with greater specificity the circumstances under which governments may wish to control the private market's proclivity for refined underwriting. While many of the results obtained in this article do not contradict Professor Abraham's insights, on occasion they do.

7. Professor Russell Korobkin is responsible for one outstanding recent effort to plug that gap. Russell Korobkin, *Determining Health Care Rights From Behind A Veil of Ignorance*, 1998 U. Ill. L. Rev. 801 (1998). In his article, Professor Korobkin reviews Professor Richard Epstein's provocative book, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE (1997). Korobkin carefully evaluates at a philosophical level what sort of insurance system individuals might choose when placed behind a Rawlsian veil of ignorance. He concludes, contrary to Epstein that individuals might well opt to prohibit underwriting for health insurance. This article should be thought of as both complementary and complimentary to Korobkin. It is complementary in that it attempts to couple analytic mathematics with computer simulation to probe the sort of choices rational individuals might make when placed behind a veil of ignorance, not only with respect to health insurance but with respect to many forms of insurance. It thus provides a quasi-empirical complement to Korobkin's theorizing. It is implicitly complimentary in that the analysis here tends to confirm much of Korobkin's argument regarding the likely preferences of individuals and the importance of adverse selection effects on insurance markets.

8. The modeling work and simulation is done using the Mathematica system for doing mathematics by computer. *See* STEPHEN WOLFRAM, THE MATHEMATICA BOOK (4th ed. 1999). The computer code I have written for this article is approximately twenty pages and is available on request. The following excerpt from the code exemplifies the style of programming used.

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rigorous understanding of adverse selection. It uses a relatively simple model and relatively simple mathematics to create an "adverse selection laboratory" in which one can explore the dynamics of an insurance market with varying characteristics. Although the article and model are motivated significantly by an interest in the debate over access by life and health insurers to genetic test information,[9] the analysis it develops is in fact far more general and applies to all forms of insurance and risk transfer contracts. The diagrams and analyses employed should help those involved in the field to better understand when it is sensible for the law to support insurance classification of individuals according to perceived risk, and when it is sensible for the law to oppose such efforts. To demonstrate the power of this method, I conclude the article by demonstrating that denying life insurers access to genetic test information is far more dangerous than denying such information to health insurers. I further suggest that even within the health insurance market, it is unwise to regulate insurer access to genetic test information through highly general laws. Rather, regulation in this field needs to take into account the salient features of both the genetic test and the particular risks it is intended to predict.

```
equilibriumpricelist[data_, choices_,
  substitutions_ : {}, expr_: selfnormalizedposition,
  startfunction_ : Function[Tr[#] /Length[#]],
  test_ : Function[Abs[#1-#2] > 0.001], maxiters_: 7] :=
Module[{s, a, startguess},
  s = selfperception /. data;
  a = actualrisk /. data
  startguess = startfunction[s];
  NestWhileList [With[{op = optimalpurchaseslist [data,
       choices, Join [{p-> #}, substitutions], expr]},
    Check [op.a / Tr[op] , #]] &, startguess, test, 2, maxiters]]
```

9. Much has been written on the subject of insurer access to genetic testing results, so much so that a single footnote compendium would not be appropriate. The following articles represent some of the major recent articles on the subject. They contain references to the "older" works. Colin S. Diver & Janet Maslow Cohen, *Genophobia: What is Wrong With Genetic Discrimination?*, 149 U. PA. L. REV. 1439, 1472 (2001); Chetan Gulati, *Genetic Antidiscrimination Laws in Health Insurance: A Misguided Solution*, 4 QUINNIPIAC HEALTH L.J. 149, 151 (2001); *see also* Deborah J. Chollet, *Consumers, Insurers, and Market Behavior*, 25 J. HEALTH POL. POL'Y & L. 27 (2000); Mark A. Hall & Stephen S. Rich, *Laws Restricting Health Insurers' Use of Genetic Information: Impact on Genetic Discrimination*, 66 AM. J. HUM. GENETICS 293 (2000); Jon Beckwith & Joseph S. Alper, *Reconsidering Genetic Antidiscrimination Legislation*, 26 J.L. MED. & ETHICS 205 (1998); Onora O'Neill, *Insurance and Genetics: The Current State of Play*, 61 MOD. L. REV. 716 (1998) (reviewing British policy).

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I. A BASIC UNDERSTANDING OF ADVERSE SELECTION

A. The Type of Modeling Used

The model employed here is typical in many ways of those most often used in the economic analysis of law. It assumes that people are rational profit or utility maximizers.[10] It does not rely in any direct way on "real world" data or on econometric studies, but instead uses computer generated agents with characteristics that are drawn from distributions believed to illustrate those of actual humans in specified scenarios.[11] The idea is not to replicate precisely all aspects of human behavior or insurance markets, but to use simplified models to understand in a conceptual way the basic forces at work in their interactions.[12] This approach, though it loses the wonderful complexity of real human beings, permits perfectly controlled experiments to be run repeatedly (and without risk to the subjects), and creates tremendous flexibility in the sort of experiments that can be performed, and avoids the frailties of econometric or statistical analysis.[13]

The model employed here differs, however, from much work in law and economics in that it is not generally amenable (even with powerful

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10. A useful and meritorious critique of this methodology may be found in Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CAL. L. REV. 1051 (2000) (enumerating a dozen different flaws). Korobkin and Ulen believe as I believe that the traditional methodology still has its uses and virtues; I employ that methodology here.

11. Because the number of heterogeneous characteristics of the agents is small and because they are significantly constrained in their choices of behavior, the analysis here is closer to traditional "top-down" economic modeling than the sort of agent-based modeling being done at places like the Santa Fe Institute.

12. For an excellent discussion of the virtues and deficiencies of using mathematics and simulation in the social sciences, see DUNCAN J. WATTS, SMALL WORLDS: THE DYNAMICS OF NETWORKS BETWEEN ORDER AND RANDOMNESS (1999):

> The devil here is in the details because there is apparently no consistent and comprehensive method of characterising all human values, idiosyncrasies and foibles that then aggregate to produce equally enigmatic human relationships . . . . This, of course, is always a central problem in any mathematical modeling assignment: to abstract the essence of the phenomenon to be described by stripping away detail without stripping away essential detail. If all the detail is essential, then either the problem is a hopeless one, immune to mathematical analysis, or else we are asking the wrong question.

Id. at 43.

13. These frailties include problems with data collection, and often-arbitrary selection of regression hypothesis.

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mathematics) to the extraction of tidy "closed form" solutions. One cannot, in the typical way, use calculus or similar tools as a shortcut to move from the specification of the model to optimality conditions stated in a universal and general way. In part because of the complexity of the issues involved and in part because problems of this nature address the interactions of a system of agents, simulation must be coupled with analytic technique and used to suggest likely outcomes. Thus, while the results may in some respects lack the elegance of purely calculus-based analyses, this hybrid methodology, made possible only recently by the combination of modern computer hardware and computer algebra software, opens the door to exploration of complex and important problems otherwise impenetrable by anything other than intuition and surmise.

B. The Model

1. Positions of the Insured

In my model world, people generally have three characteristics of particular interest: actual risk (a), perceived risk (f) and risk aversion (k). By actual risk, I mean a likelihood between 0 and 1 of suffering a loss.[14] By perceived risk, I mean the insured's estimate of the actual risk. Risk aversion (k) is measured as a number between 0 and 1 inclusive, in which 0 denotes no aversion to risk and 1 denotes severe aversion to risk.

In this model, an entity faces a risk of something "bad" happening. I normalize the position of the entity by saying that, if it buys no insurance and the bad event does not occur, it has wealth 1; if the bad event does occur, the entity has wealth 0. I let the entity purchase insurance that will pay zero if nothing bad happens and some contractually set amount λ if the bad event does occur. The cost of the insurance is p per unit of insurance.[15] Thus, if nothing bad happens, the position of the entity is its wealth of 1

14. I will later relax the single loss assumption, creating a three-state world in which two risks can materialize. One of the risks (an inability to afford beneficial medical treatment) cannot be separately insured against.

15. In this model, the insurer is required to price policies on a linear per unit basis. That is, if it charges a particular subpool 0.13 per unit of insurance, it must charge the applicant seeking two units 0.26 and the applicant seeking three units 0.39. The linear assumption is realistic at least for life insurance because an individual can stack life insurance policies, and would respond to non-linear pricing by spreading their insurance purchases among multiple insurers. *See generally* Mattias K. Polborn et al., *Information and Dynamic Adjustment in Life Insurance Markets* (Oct. 29, 1999), *at* http://www.ssc.uwo.ca/economics/econref/html/WP99/wp9911.pdf.

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less the amount it paid for insurance, or $1 - p\ \lambda$. If the bad event materializes, the position of the entity is its wealth of 0 plus the insurance λ less the amount it paid for insurance $p\ \lambda$, for a total of $\lambda - p\ \lambda$. The expected position of such an entity is a weighted average of its position if nothing bad happens and if the bad thing happens. Thus, I can write its perceived expected position as follows:[16]

16. This formulation differs from the conventional "expected utility" model under which I might assume some utility function u and write the perceived expected position of the insured as $(1 - f)\ u[1 - p\ \lambda] + fu[\lambda - p\ \lambda]$. I would obtain the optimal purchasing decision by finding the values of λ for which the first derivative of the expression with respect to λ was zero and for which the second derivative of the expression with respect to λ was negative. I would then also compare the values of the expression at these points with those at the boundaries of the domain of λ. There are several problems with this approach. First, most utility functions with constant absolute or relative risk aversion do not handle negative wealth well. The problem posed here sometimes confronts negative wealth. Second, when one performs this procedure with respect to the most common utility function used when risk aversion is at issue, $\frac{x^{1-k}}{1-k}$, one finds that there is no tidy closed form solution for the optimal purchase of λ as a function of perceived risk and risk aversion k. One does find, however, that if λ^* is the optimal purchase of insurance then, for a given price level p, one can write the level of perceived risk f as a function of k and λ^*: $\frac{1}{1 - \frac{(-1+p)(1-p\lambda^*)^{-k}(\lambda^*-p\lambda^*)^{-k}}{p}}$. Using this expression, I can then draw the graphic below showing optimal insurance purchases as a function of f and k. Darker shades of gray represent increased purchases of insurance. The graphic shows that insurance purchases under the conventional model have the same characteristics as under my simpler model. As the perception of the probability of an accident grows, so too does the purchase of insurance. When insurance is perceived as a "bad deal" (f<p), increases in risk aversion increase purchase of insurance. When insurance is perceived as a "good deal" (f>p), increases in risk aversion decrease purchase of insurance. The conventional model should thus yield qualitatively similar results to those extracted using the simpler model I employ.

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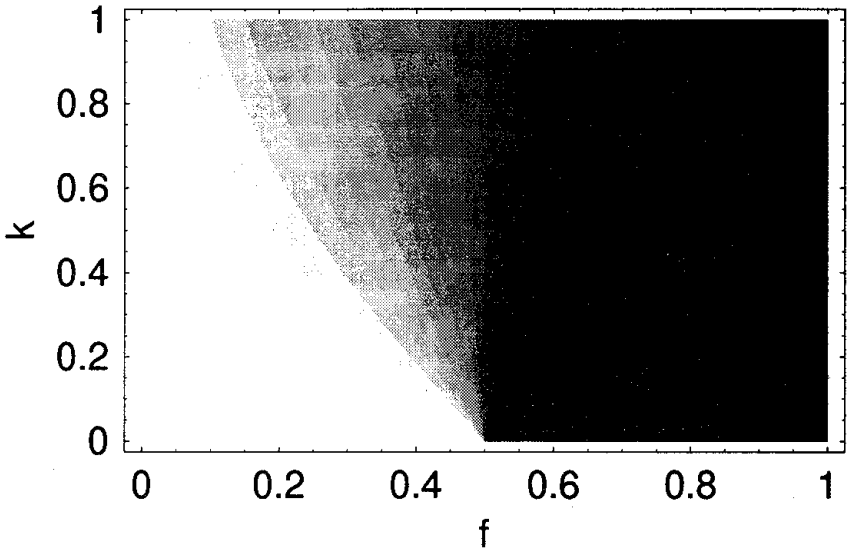
$$\text{perceived expected position} = (1-f)(1-p\,\lambda)+f(\lambda-p\,\lambda)$$

The actual expected position of the insured is similar to the perceived expected position, except that the actual risk a is substituted for the perceived risk f.

$$\text{actual expected position} = (1-a)(1-p\,\lambda)+a(\lambda-p\,\lambda)$$

The perceived (ex ante) valuation such an insured places on its situation is in turn a weighted average. It is the weighted average of its perceived expected position and its position in the worst possible case, with the weighting determined by a "risk aversion" parameter of k.[17] For risk aversion 0, the entity values its position at its perceived expected position. For risk aversion 1, the entity values its position at its worst case. Notice that if the entity is fully insured, its perceived valuation is equal to its perceived expected position: its position if a bad thing happens is the same as its position if a bad thing does not happen; thus, the minimum of these positions is its expected position.

$$\text{perceived valuation} = (1-k)\overbrace{((1-f)(1-p\,\lambda)+f(\lambda-p\,\lambda))}^{\text{expected position}} + k\overbrace{\text{Min}[1-p\,\lambda,\ \lambda-p\,\lambda]}^{\text{worst case}}$$



Optimal insurance purchases under conventional expected utility model for p = 0.5. Darker areas imply larger purchases.

17. In my model, the insured makes its insurance purchasing decisions prospectively by using its perceived risk, but its wealth is determined retrospectively by using its actual risk.

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Again, the actual (ex post) valuation an insured places on its situation is similar to its perceived valuation except that the actual risk a is substituted for the perceived risk f.[18] I will use the term "wealth" as shorthand for the actual ex post valuation. "Total wealth" refers to the sum of wealths of a population.

$$\text{wealth} = (1-k)\overbrace{((1-a)(1-p\lambda)+a(\lambda-p\lambda))}^{\text{expected position}} + k\overbrace{\text{Min}[1-p\lambda,\ \lambda-p\lambda]}^{\text{worst case}}$$

By knowing the current price of insurance (p), an entity's perceived probability of a bad event materializing (f), and the entity's coefficient of risk aversion (k), I can now determine the amount of insurance the entity will perceive as optimal. With some mathematics, one can show that a rational, knowledgeable entity will maximize its valuation by using the following purchasing rules in which the up-carat denotes the logical (Boolean) "And" and the down-carat denotes the logical (Boolean) "Or." The term "no insurance" means precisely what one might think. "Full insurance" means that the insured is in the same position whether or not the bad event materializes. "Maximum insurance" means the most insurance that the insured is permitted to purchase. It is generally an amount equal to or greater than full insurance.

Conditions	*Choice*
$0 \le f < p \bigwedge 0 \le k < \frac{f-p}{f-1}$	no insurance
$0 \le f \le p \bigwedge \frac{f-p}{f-1} \le k \le 1 \bigvee p < f \le 1 \bigwedge \frac{f-p}{f} \le k \le 1$	full insurance
$p < f \le 1 \bigwedge 0 \le k < \frac{f-p}{f}$	maximum insurance

Table 1: Rules for determining optimal insurance purchasing decisions.

18. There is an additional intuitive explanation for this partitioning. Both underinsurance and overinsurance create the possibility of different financial consequences depending on whether an accident occurs. With underinsurance, an accident results in lesser wealth than no accident. With true overinsurance, an accident results in greater wealth than no accident. People with high degrees of risk aversion dislike either form of gambling. Thus, even among people for whom insurance is a bad deal (i.e. $f < p$), they will buy full insurance if their risk aversion level is high enough. And even among people for whom insurance is a good deal (i.e. $f > p$), they will only buy full insurance if their risk aversion level is high enough. Only people with relatively low levels of risk aversion will gamble on either underinsurance or overinsurance.

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I can restate the relationships between the perceived probability of the bad event materializing and the unit price of insurance in relatively plain English. If insurance is perceived as a "bad deal" (the perceived probability of the bad event materializing is less than the unit price of insurance), the entity will not buy insurance if its risk aversion is low, but will buy full insurance if its risk aversion is relatively high. The amount of risk aversion required before full insurance is purchased diminishes as insurance becomes less and less of a bad deal. If insurance is perceived as a "good deal" (the perceived probability of the bad event materializing is greater than the unit price of insurance), the entity will buy maximum insurance if its risk aversion is low, but will buy full insurance if its risk aversion is relatively high. The amount of risk aversion required before full insurance is purchased diminishes as insurance becomes less and less of a good deal.[19]

These optimal purchasing decisions can be shown graphically by creating a two-dimensional space in which the perceived probability of a bad thing happening appears on the horizontal x-axis and the entity's level of risk aversion appears on the vertical y-axis. I color light gray the zone in which no insurance is purchased, medium gray the zone in which full insurance is purchased, and dark gray the zone in which the maximum possible amount of insurance is purchased. Within each zone I state the required conditions, with the top line specifying whether the rows of conditions are in the disjunctive ("Or") or the conjunctive ("And"). The graphic below shows the partitioning when the unit price of insurance is 0.45.

19. Computer animations of this equilibration process are available from the author on request.

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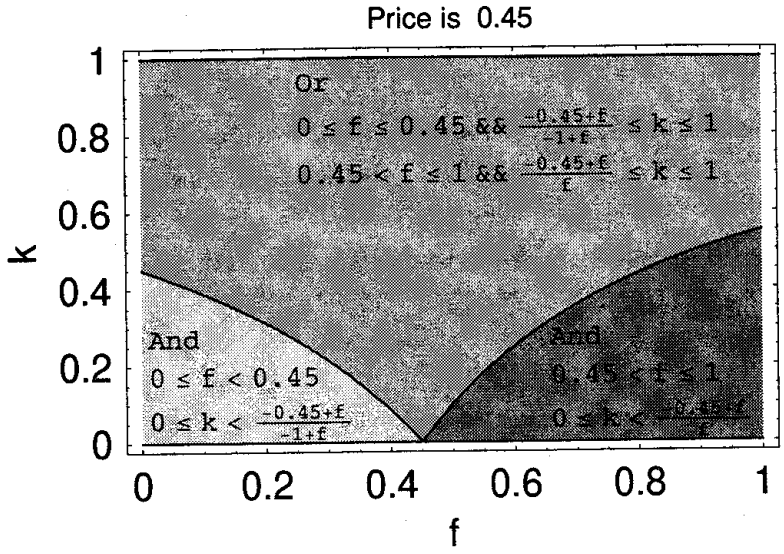
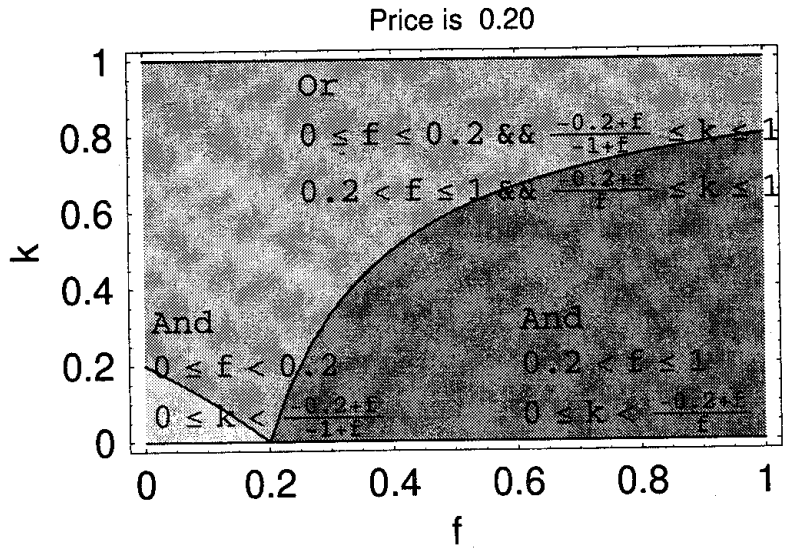
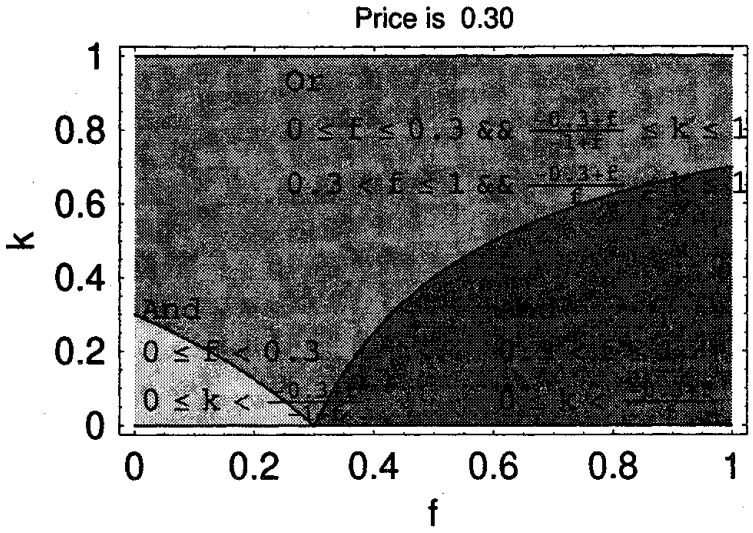


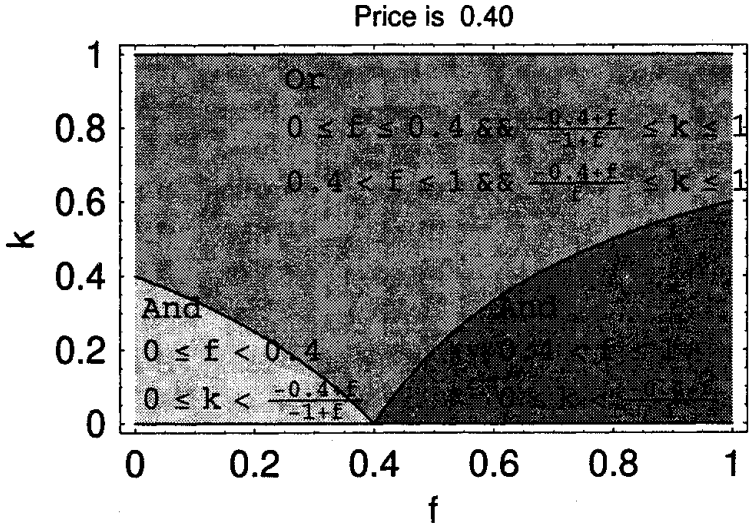
Figure 1: Partitioning of f – k space when price is 0.45.

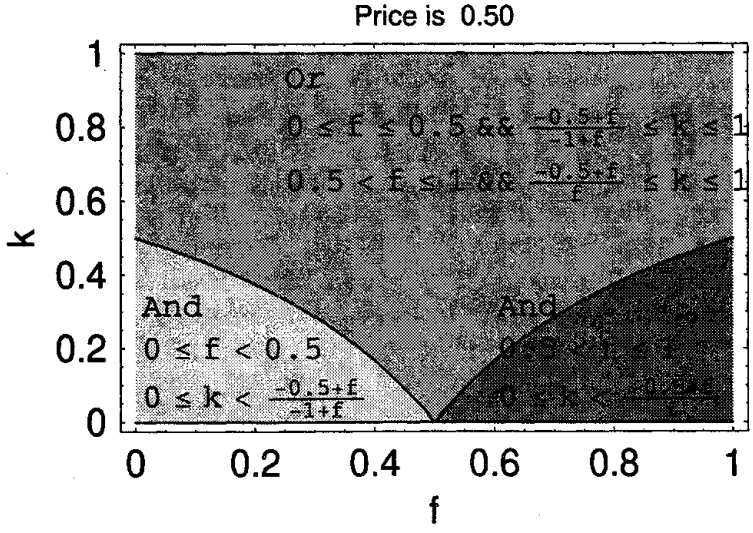
I now demonstrate how changing the unit price of insurance changes this partitioning and the associated optimal insurance purchasing decisions. In the following graphic, the price of insurance increases from 0.2 to 0.6. Notice that the medium gray wedge-shaped zone of full insurance is pushed rightwards, the light gray zone of no insurance grows and the dark gray zone of maximum insurance shrinks.



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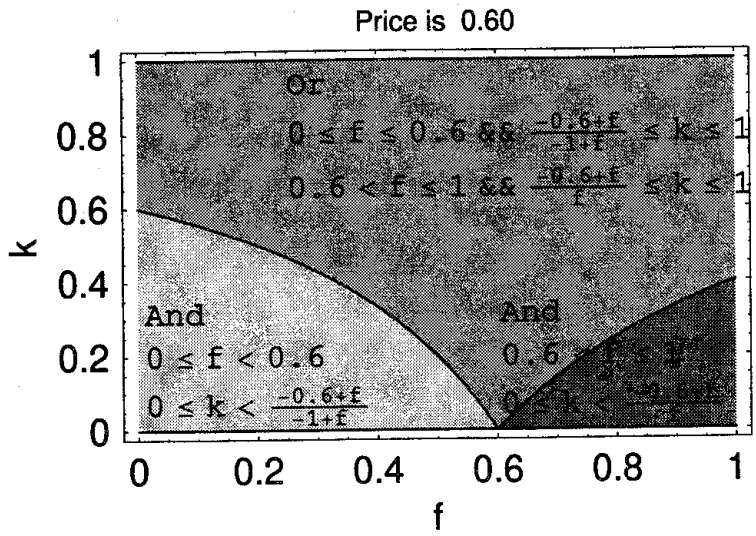


Figure 2: How changes in the price of insurance affect optimal purchasing decisions.

2. The Demand for Insurance

Thus far I have shown the way in which the price charged for insurance affects optimal insurance purchasing decisions. In essence, I have created the foundations from which the demand for insurance in any given population may be derived. To determine actual demand, I need data as to the distribution of *f* (perceived probability of loss) and *k* (coefficient of risk aversion) in the population. I also need to know the maximum amount of insurance that an entity can purchase. Insurance law and the financial resources of the entity combine to create this limit.

Consider a toy population of 10 entities with values for actual risk, perceived risk, and risk aversion as set forth in the table below. The last four columns show the optimal purchasing decisions of the entities when the unit price of insurance is 0.1, 0.3, 0.5 and 0.7. As the table below demonstrates, different prices generate far different purchasing decisions.

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id	actual risk (a)	perceived risk (f)	risk aversion (k)	demand at unit price 0.1 (d[0.1])	demand at unit price 0.3 (d[0.3])	demand at unit price 0.5 (d[0.5])	demand at unit price 0.7 (d[0.7])
1	0.08	0.08	0.25	1	1	0	0
2	0.20	0.20	0.46	2	1	1	0
3	0.22	0.22	0.06	2	0	0	0
4	0.27	0.27	0.53	2	1	1	0
5	0.27	0.27	0.20	2	1	0	0
6	0.28	0.28	0.10	2	1	0	0
7	0.35	0.35	0.48	2	1	1	0
8	0.39	0.39	0.18	2	2	0	0
9	0.72	0.72	0.01	2	2	2	2
10	0.90	0.90	0.39	2	2	2	1

Table 2: Demands for Insurance from the Toy Population at Different Unit Prices.

The figure below helps show why these choices are being made. Each entity in the toy population is shown as a labeled point. As the price of insurance changes, the optimization zone into which each point falls is likewise subject to change.

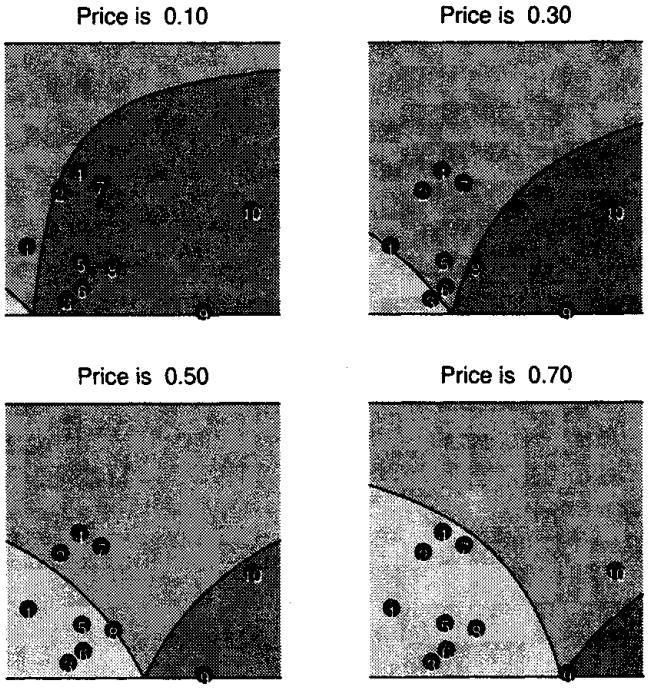


Figure 3: Different prices result in different purchasing decisions.

The aggregate demand is shown in the table below.

	Total Demand for Insurance
Price is 0.1	$\sum_{i=1}^{10} (d[0.1])_i = 19$
Price is 0.3	$\sum_{i=1}^{10} (d[0.3])_i = 12$
Price is 0.5	$\sum_{i=1}^{10} (d[0.5])_i = 7$
Price is 0.7	$\sum_{i=1}^{10} (d[0.7])_i = 3$

Table 3: Total demand for insurance in toy population.

These purchasing decisions in turn generate different expected indemnity payments by the insurer. Consider the situation in which the unit price for insurance is 0.1. The insurer's expected payment is the actual risk of the first entity, 0.08, multiplied by that entity's demand of 1, plus the actual risk of the second entity, 0.2, multiplied by that entity's demand of 2, and so on for all the entities. The total expected payments are thus approximately 7.26. The table below summarizes this computation for the different unit prices.

	Insurer's Expected Payments
Price is 0.1	$\sum_{i=1}^{10} a_i (d[0.1])_i = 7.26$
Price is 0.3	$\sum_{i=1}^{10} a_i (d[0.3])_i = 5.45$
Price is 0.5	$\sum_{i=1}^{10} a_i (d[0.5])_i = 4.05$
Price is 0.7	$\sum_{i=1}^{10} a_i (d[0.7])_i = 2.34$

Table 4: Expected payments by insurer in toy population.

If I then divide these expected payments by the total units of insurance purchased, I obtain the unit price needed for the insurer to break even. For the unit price of 0.1, the break-even price is 7.26 divided by the aggregate demand of 19, or 0.382. To restate the matter, the break-even price of 0.382 multiplied by the 19 total units of insurance purchased yields 7.26, which is the amount the insurer expects to pay. The table below shows the computation for all of the unit prices.

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	Break even price
Price is 0.1	$\frac{\sum_{i=1}^{10} a_i (d[0.1])_i}{\sum_{i=1}^{10} (d[0.1])_i} = 0.38$
Price is 0.3	$\frac{\sum_{i=1}^{10} a_i (d[0.3])_i}{\sum_{i=1}^{10} (d[0.3])_i} = 0.45$
Price is 0.5	$\frac{\sum_{i=1}^{10} a_i (d[0.5])_i}{\sum_{i=1}^{10} (d[0.5])_i} = 0.58$
Price is 0.7	$\frac{\sum_{i=1}^{10} a_i (d[0.7])_i}{\sum_{i=1}^{10} (d[0.7])_i} = 0.78$

Table 5: Break even prices for proposed unit prices.

Thus, for any given population, each initial price for insurance, coupled with the population's self-perception of risk, generates the individual demands for insurance. When this information is coupled with information regarding the population's actual risk, one can determine the amount of money the insurer can expect to pay. This expected payment divided by the aggregate of insurance units purchased generates the price the insurer would have needed to charge in order to break even.

3. From Demand to Equilibrium

In a competitive and unregulated insurance market, one would expect the insurer to break even. A higher unit price would induce entry by price cutting insurers. A lower unit price would drive insurers out of the market. Thus, no unit price for insurance is an equilibrium price unless the optimal purchasing decisions it generates are such that the insurer can charge that price and break even.

One algorithm for determining an equilibrium unit price starts with an initial guess as to that value, perhaps the minimum level of actual risk in the population. Using that unit price, the break-even price is determined. One then makes the break even price the new guess and determines the new break-even price. One repeats this process until (one hopes)[20] the break-

20. It turns out that in populations with few members, sometimes no single valued equilibrium is reached. Instead, we may see multiple equilibriums or "equilibria" consisting of cycles. To illustrate this point, consider the graphic below. It shows that this equilibrium price of 0.59 is not completely invariant to the choice of an initial price. The horizontal x-axis shows the iteration in the equilibration process. The vertical y-axis shows the price being charged. When a low initial price is selected, the price usually converges to 0.59. When a high initial price is selected, the price converges to 0.89, the perceived risk level of

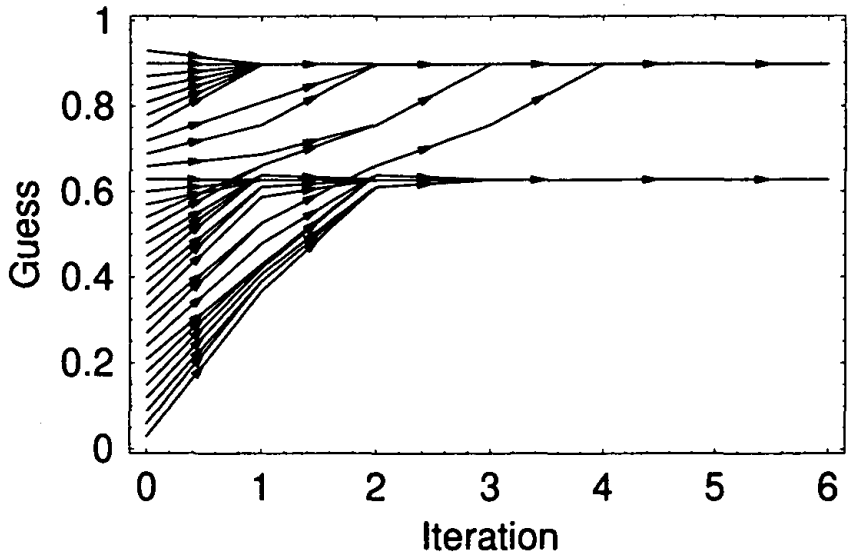
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even price is equal to the guess, whereupon an equilibrium has been reached.

The figure below illustrates this equilibration of an insurance market. I start with an initial price of 0.08, the actual risk level of the person with the lowest actual risk in the toy population. This generates a break-even price of 0.38, which drives some entities out of the market. The new break-even price is 0.52, which further changes optimal purchasing decisions. The process continues until the break even price reaches about 0.59. At a price of 0.59, the purchasing decisions are such that 0.59 is a break-even price. The market has reached equilibrium. The process by which rising prices drive entities out of the insurance market is known as an adverse selection spiral.

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the riskiest entity in the population. In general, I will select the lowest equilibrium price as the relevant equilibrium price.



Dependency of equilibrium found on initial guess.

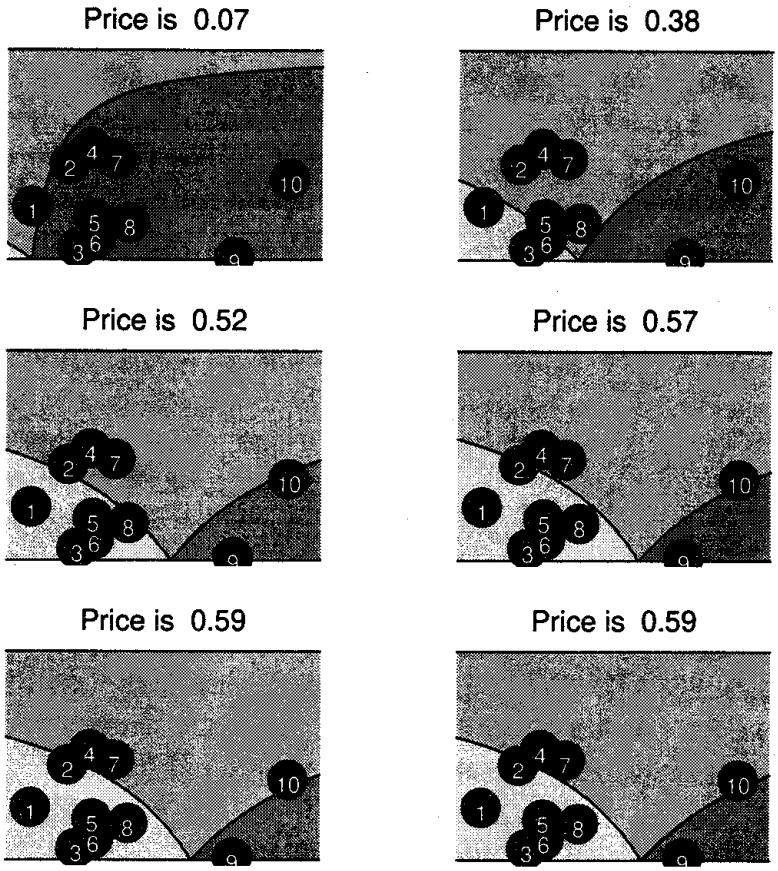


Figure 4: The equilibration of the market created by the toy population.

4. The Basic "Physics" of Adverse Selection

A closer examination of the above figure helps explain the "physics" of adverse selection. Two factors, a large number of people in the "maximum insurance zone" and a ceiling on the amount of insurance an entity can purchase combine to create a significant "torque" on prices; this "torque" indicates that[21] high-risk people are buying lots of insurance. In order for the insurer to break even in such a world, it will have to charge a high

21. I borrow the physics term "torque" deliberately. Torque is generally thought of as a force exerted at some point relative to some fulcrum. The greater the force and the greater the distance from the fulcrum, the greater is the torque. Here, I think of torque as a force exerted on the "fulcrum" of prices. Purchase of maximum insurance exerts a force on prices, with the extent of the force growing as the distance (rightwards) from the pre-existing price increases. Non-purchase of insurance exerts a sort of "negative" torque on prices, with the extent of the negative torque in turn growing as the distance (leftwards) from the pre-existing price grows.

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premium. Similarly, having a lot of people in the no-insurance zone also tends to drive up the break-even price. The existence of large numbers of low-risk people who do not purchase insurance means that the average level of risk among those remaining will increase, as will the price needed for the insurer to break even. Thus, particularly where the maximum amount of insurance that may be purchased is large, heterogeneous levels of perceived risk in the population will, all else being equal, tend to increase the torque on prices exerted by adverse selection.

The figure also suggests that low levels of risk aversion exacerbate the problem of adverse selection. When people in an insurance pool have low levels of risk aversion, they are more likely to be in either the "no insurance" or "maximum insurance" zones, both of which, as just discussed, are the zones that cause adverse selection. The intuition here is again relatively straightforward: the existence of low levels of risk aversion means that people who perceive insurance as a "bad deal" are more likely to live with the risk of being uninsured, while people who perceive insurance as a "good deal" are more likely to gamble with a purchase of "maximum insurance." High levels of risk aversion, by contrast, increase the likelihood that entities will purchase full insurance and that serious problems of adverse selection will not occur.

An additional factor bearing on the extent of an adverse selection spiral is the maximum amount of insurance that can be purchased. If that amount is, for example, no greater than full insurance, the torque on prices exerted by high-risk, low risk aversion individuals is eliminated. In general, several circumstances can reduce the maximum amount of insurance that can be purchased. First, the law may intercede with doctrines such as the insurable interest doctrine[22] that ex-post restrict the amount of money the insurer may pay when a loss occurs. Second, private insurers fearing adverse selection (and also moral hazard)[23] may try to determine what "full

22. The insurable interest doctrine generally gives insurers the right to refuse to pay the insured more than what the law takes as the insured's value in the thing destroyed. The insurer is given this right even where its contract provides to the contrary. Thus, an insurer could decline to pay out on a life insurance policy taken out by one of my students on my life because the law deems students to have no insurable interest in my continued existence. And this is true even where the insurer could have discovered the absence of a required relationship before hand. For a useful recent discussion of the insurable interest doctrine, see Roy Kreitner, *Speculations of Contract, Or How The Law Stopped Worrying And Learned to Love Risk*, 100 COLUM. L. REV. 1096 (2000).

23. Moral hazard is the proclivity for people who have purchased a contract providing at least partial indemnification against some adverse contingency to relax their precautions against the advent of that contingency or, in the case of more-than-full insurance to actually

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insurance" is for the individual and write a contract that provides for payment of no more than that amount.[24] Third, for expensive risks, the liquidity and resources of the individual may limit the maximum amount of insurance purchased.[25]

C. The Effect of Classification

Thus far, I have implicitly assumed that the insurer has no information about the risk posed by the prospective insured, and therefore, is able to charge only one price for insurance. I now relax that assumption and permit the insurer, through a process of "underwriting," accurately to partition the population into certain risk categories. The insurer may not be able to tell the precise risk posed by a particular entity, but it can flawlessly determine that the risk posed lies between certain bounds. Alternatively, the insurer may be able to determine the precise risk posed by a particular entity, but for administrative or legal reasons is impelled to treat that individual identically to others with similar, but not identical, levels of risk. The important thing, however, is that the insurer is permitted to charge a different price for each risk category. Underwriting schemes that place individuals into many categories are called "refined." Underwriting schemes that establish few categories are called "coarse."

To illustrate the process, consider a relatively coarse underwriting regime that I will call "5-5," in which the entities in the toy population with the five lowest levels of risk as perceived by the insurer are placed in one category and charged one price, whereas the entities with the highest five levels of risk as perceived by the insurer are placed in a different category and charged a different (higher) price. The figures below show how this system would equilibrate and its final equilibrium. The top figure shows the equilibration of the low-risk group. The bottom figure shows the equilibration of the high-risk group.

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work toward having the contingency occur. Arson with respect to overinsured buildings is a leading example of the latter alternative.

24. Most insurance policies, for example, contain "coordination provisions" that prevent the insured from purchasing multiple policies covering the same event and then collecting fully on both when a covered event occurs. *See* KENNETH ABRAHAM, DISTRIBUTING RISK 137-38 (1986).

25. *See infra* pp. 468-472.

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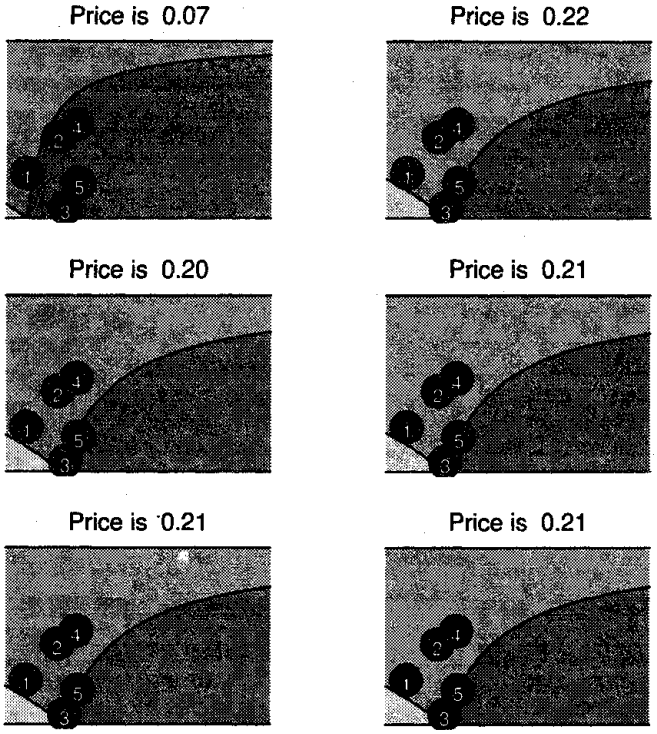


Figure 5: Equilibration of low-risk submarket in toy population.

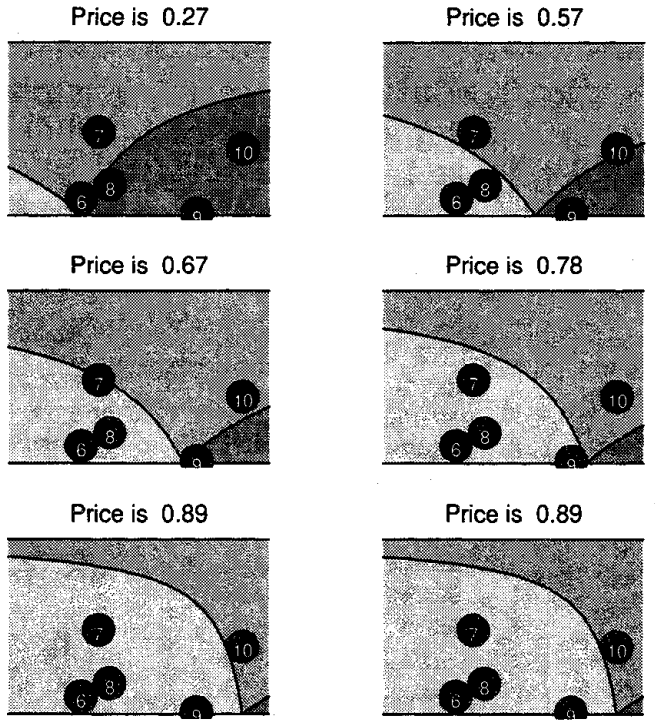


Figure 6: Equilibration of high-risk submarket in toy population.

The system ends up in equilibrium with prices of 0.21 for the five individuals perceived by the insurer as low-risk, and prices of 0.89 for the five individuals perceived by the insurer as high risk. The low-risk entities now face a lower unit price for insurance than existed prior to classification. Thus, those entities willing to purchase insurance at this lower price are significantly advantaged by classification. By contrast, entities with higher risk face a higher unit price for insurance than existed prior to classification. And, indeed, adverse selection in this subgroup has pushed the unit price of insurance so high that only the person with the highest level of risk in the subgroup is willing to purchase it.

The figure above, along with figure 4, suggests that each partitioning of the population by the insurer creates different valuations (or "wealths") for the different members of the population. Consider the actual position of entity 1 in the toy population. When no underwriting (or what I may now call "10 underwriting") occurred, the entity ended up facing a unit price of 0.59 and decided under those circumstances not to purchase insurance. When 5-5 underwriting occurred, it ended up facing a price of 0.22 and decided under those circumstances to purchase full insurance.

I can compute the wealth of entity 1 in the toy population under each of these underwriting regimes. Using Equation 4 and substituting in the appropriate values for a, p, k and λ into this expression, entity 1 has a wealth under the no underwriting regime of 0.69 and a wealth under the 5-5 underwriting regime of 0.78. The tables below show the computations.

Using this formula
$(1-k)((1-a)(1-\lambda p)+a(\lambda-\lambda p))+k\,\mathrm{Min}[1-\lambda p,\ \lambda-\lambda p]$
Make these substitutions
$\{k \to 0.253133,\ a \to 0.0784314,$
$f \to 0.0784314,\ p \to 0.590588,\ \lambda \to 0\}$
$(1-0.253133)((1-0.0784314)(1-00.590588)+$
$0.0784314(0-00.590588))+$
$0.253133\,\mathrm{Min}[1-00.590588,\ 0-00.590588]$
0.688289

Table 6: Computation of value for no underwriting.

Using this formula

$$(1-k)((1-a)(1-\lambda p)+a(\lambda-\lambda p))+k\,\text{Min}[1-\lambda p,\ \lambda-\lambda p]$$

Make these substitutions

$$\{k \to 0.253133,\ a \to 0.0784314,\ f \to 0.0784314,\ p \to 0.590588,\ \lambda \to 0\}$$

$$(1-0.253133)((1-0.0784314)(1-00.590588)+0.0784314(0-00.590588))+0.253133\,\text{Min}[1-00.590588,\ 0-00.590588]$$

$$0.688289$$

Table 7: Computation of value for 5-5 underwriting.

When I perform similar computations for all the entities in the toy population, I obtain the following results.

id	Valuation for no underwriting	Valuation for 5-5 underwriting
1	0.69	0.78
2	0.44	0.78
3	0.73	0.78
4	0.41	0.78
5	0.58	0.78
6	0.65	0.65
7	0.41	0.34
8	0.50	0.50
9	0.53	0.28
10	0.41	0.10

Table 8: The effect of underwriting on individual welfare.

The main and relatively simple point for now is that different partitioning of the population resulting from various underwriting regimes determine the valuations of each entity in the population.

D. From Valuations to Normative Evaluation of an Underwriting Regime

What I have done thus far is to impose a one-to-many mapping of underwriting regimes onto a listing of wealths for the population. While such data may be interesting, there is little one can do by glancing at it except to say that some entities are better off under some underwriting

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regimes, while others are better off under alternative underwriting regimes. I now want to take the analysis to a higher level and develop a mapping between underwriting regimes and two powerful compositive statistics that should be of interest to many. More specifically, I want to examine the total wealth generated by an underwriting regime and at the distribution of wealth generated by that underwriting regime. In common terms, the first statistic measures the "size of the pie." The second measure looks at the distribution of wealth—how the pie is distributed.

Determining the first statistic is straightforward: I add the wealths of each entity in the population for a total wealth. Thus, for my toy population, no underwriting yields a total wealth of 5.35 whereas underwriting yields a higher total wealth of 5.78. The second statistic is known as the "Gini Coefficient," which is frequently used in analyses of wealth distribution.[26] The Gini Coefficient is a measure from 0 (perfect equality) to 1 (all wealth held by the wealthiest person). A formula for it is shown below.[27]

$$\text{Gini Coefficient} = 1 - \left(\frac{n}{\sum_{i=1}^{n} w_i} \sum_{j=1}^{n} \frac{\sum_{i=1}^{j} w_i}{j} \right) \qquad (1)$$

The Gini Coefficient for no underwriting is 0.12 while the Gini Coefficient for 5-5 underwriting is 0.22. Thus, no underwriting creates greater equality of wealth than does 5-5 underwriting. In choosing between the two underwriting regimes, therefore, one must trade off the size of the pie against a more equal distribution of the pie.

So far, I have compared two underwriting regimes: no underwriting and 5-5 underwriting. There are a lot of other possibilities, however. I

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26. The statistic is used, for example, by the United Nations in assessing inequality of wealth. *See* Soc. Dev. & Poverty Elimination Div., United Nations Univ. World Inst. for Dev. Econ. Research, *World Income Inequality Database (WIID): Measuring Inequality*, *at* http://www.undp.org/poverty/initiatives/wider/wiid_measure.htm (last visited Mar. 2, 2002).

27. The formula derives from the construction of what is referred to as a Lorenz curve. This curve shows what percentage of income (or wealth) is held by each percentage of people, ranked from poorest to richest. In a population whose members had equal wealth, the Lorenz curve would be a line. In a population with highly unequal distributions of wealth, the Lorenz curve would start at zero, stay relatively low over most of its length and rise sharply to 1 at the end. The "Gini Coefficient" is computed as one minus the ratio of the area under any given Lorenz curve to the area under the Lorenz curve for a perfectly equal society. N.C. Kakwani, *Application of Lorenz Curves in Economic Analysis*, 45 ECONOMETRICA 719, 719-21 (1977).

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could, for example, examine 2-5-3 underwriting, in which the two individuals with the two lowest insurer perceived risk are placed in one underwriting category, the next five are placed in a second underwriting category and the three with the highest insurer perceived risk are placed in yet a third category. In fact, for a population of n individuals there are 2^{n-1} possible underwriting regimes.

Exploiting the computational power of modern computers, I can determine the total wealth-Gini Coefficient pairs for all 512 possible underwriting regimes available for use on the 10-member toy population. I assume for now that the maximum amount of insurance that can be purchased is twice full insurance. The graphic below, an "Underwriting Map," shows the result, with each point representing an underwriting regime and the gray line representing the "hull" of these points. A point is on the "hull" (sometimes called a "frontier") if there is no alternative-underwriting regime that both increases wealth and lowers the Gini Coefficient. Being on the hull is "good" because it means that there is no way of increasing both total wealth and equality of wealth. Points inside the "hull" are inferior because it means that either goal of increasing total wealth or increasing equality of wealth can be obtained without sacrificing the other goal.

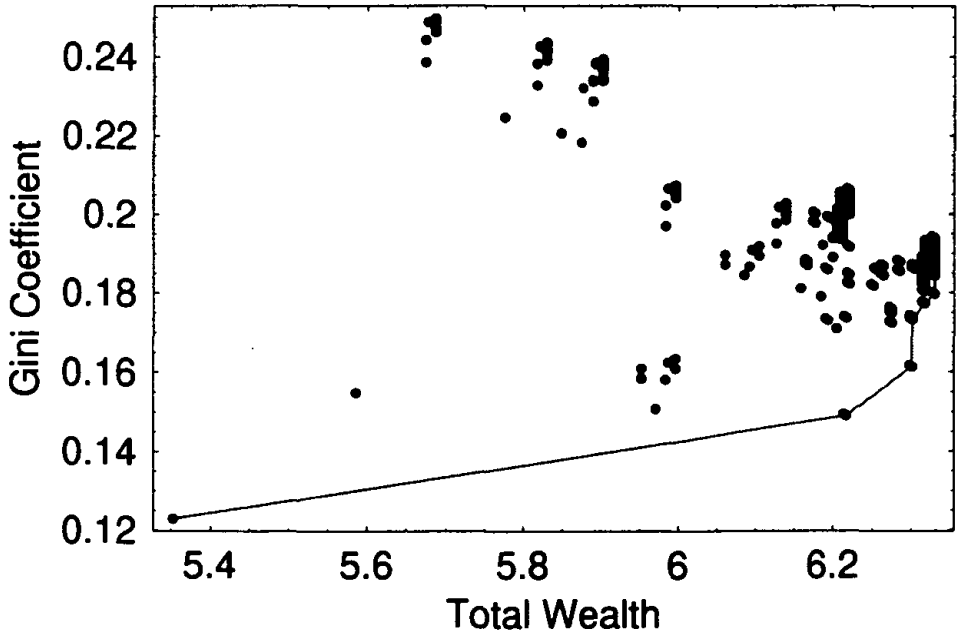


Figure 7: Underwriting map for 512 underwriting regimes when toy population is evolved with full and perfect information; maximum insurance purchase is 2.

Statistics for the regimes on the hull are shown in the following table.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{10}	{5.353, 0.123}
{8, 1, 1}	{6.217, 0.149}
{7, 1, 1, 1}	{6.301, 0.161}
{4, 4, 1, 1}	{6.317, 0.177}
{1, 6, 1, 1, 1}	{6.329, 0.18}

Table 9: Underwriting regimes on the hull for the toy population when the maximum insurance that may be purchased is 2.

The table shows that no underwriting ("{10}" underwriting) minimizes inequality while {1,6,1,1,1} underwriting maximizes total wealth without requiring a sacrifice in inequality. The latter regime maximizes total wealth because all members of the population now buy full insurance. The result is that all entities have valuations equal to the expected value of their position, which, as explained above, is as high as valuation can go for any non-negative level of risk aversion. Indeed, everyone ends up in the same position they would have been in if they were not risk averse.

It is worth noting that "perfect {1-1-1-1-1-1-1-1-1-1} underwriting," in which the premium each individual pays for insurance is determined by their individual risk, is *not* on the hull. While this underwriting regime does lead to a maximum value of 6.329 for total wealth, it results in a Gini Coefficient of 0.194,and thus needlessly increases inequality above that created by 1-6-1-1-1 underwriting. The reason is that 1-6-1-1-1 underwriting is sufficient to cause all members of the population to purchase full insurance. Further refinements of the classification system thus increase inequality (because different premiums are charged to the 6 entities formerly lumped together) without any increase in aggregate wealth.

A basic principle emerges from this experiment with a toy population. Classification that does not increase the number of people purchasing full insurance tends not to increase total wealth but does increase wealth inequality. Thus, those who have any preference for equal treatment of those who are unequal only through nothing we would call "fault" should not endorse classification for its own sake. Classification makes sense only to the extent that it materially increases the number of people induced to purchase full insurance—and does so to an extent that outweighs the costs

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of classification itself.[28] If, for example, it was the case that people's genetic characteristics resulted in different and largely unalterable levels of health risk, and if some subset of those people would make the same health insurance purchasing decisions regardless of how finely they were classified by the insurer, refinements in classification would likely decrease total wealth and increase inequality of opportunity.

1. A Note on Compulsory Insurance

Thus far, I have considered systems in which the insured may choose how much insurance to purchase. While ordinarily such economic freedom is valued, it is worth comparing these various underwriting regimes to one in which the population binds itself in advance (through a legislative process) to purchase full insurance at a uniform premium regardless of individual entity's perceived or actual risk. The result is that collective wealth is maximized[29] and the inequality created by the unequal endowments of actual risk and risk aversion moves to zero. With compulsory full insurance, everyone is in the same position because, regardless of their initial levels of risk and risk aversion, they are now in identical positions. All of the members of the population have eliminated

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28. This is not the conventional wisdom, which often advances categorization as a good in and of itself. *See* GEORGE E. REJDA, PRINCIPLES OF INSURANCE 537 (3d ed. 1989) ("*A final underwriting principle is equity among the policyowners.* This means that equitable rates should be charged, and each group of policyowners should pay its own way in terms of losses and expenses. Stated differently, one group of policyowners should not unduly subsidize another group."). Another example may be found in Herman T. Bailey, Theodore M. Hutchison, & Gregg R. Narber, *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779 (1976). The economic efficiency of classification is discussed further in Keith J. Crocker & Arthur Snow, *The Efficiency Effects of Categorical Discrimination in the Insurance Industry*, 94 J. POL. ECON. 321 (1986). Crocker and Snow conclude that classification never decreases efficiency ("total wealth") but the authors restrict themselves to a model in which there are only two sorts of people, in which risk aversion is constant, and in which wealth distribution is not relevant. Other important work includes, Michael Hoy, *Categorizing Risks in the Insurance Industry*, 97 Q.J. ECON. 321 (1982); Samuel A. Rea, Jr., *Insurance Classifications and Social Welfare*, *in* CONTRIBUTIONS TO INSURANCE ECONOMICS 377 (Georges Dionne ed., 1992), which conclude that classification is not always efficient in cases of asymmetric information.

29. Determining the risk levels of individuals is often quite expensive, with increasing accuracy in prediction attained at increasing costs. The real total wealth associated with a system of underwriting is thus the wealths of the individuals less the cost of sorting. Since no sorting occurs with compulsory insurance, in reality, it is likely to produce greater total wealth than perfect insurance. To date, for simplicity, I have assumed that underwriting is itself a costless process. This, of course, is not really the case. I relax this assumption below.

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their risk, and their risk aversion becomes irrelevant as a result of the payment of a risk-invariant, uniform premium. Thus, a society that values both wealth and equality should perhaps prefer a world of compulsory insurance.[30]

A large caveat is appropriate here. The suggestion in the preceding paragraph is that, placed behind a Rawlsian veil of ignorance,[31] and knowing that we will be subject to some risk and some level of risk aversion, we would try to bind ourselves to a commitment to purchase full insurance.[32] Such a collective commitment would both maximize total wealth and minimize inequality. This is true, however, only if risk is truly beyond the control of the individual. If the risk faced by an entity is not some constant, as supposed in this model, but rather the result of choices the insured can make, broad underwriting categories can decrease total wealth by inducing certain individuals to engage in riskier behavior more frequently, thus increasing their level of risk beyond "baseline" or optimal levels.[33] To explain further, with perfect insurance, the insured internalizes the costs of anything that increases his or her risk because he or she pays a correspondingly higher insurance premium. Further, with narrow underwriting categories, the insured can only increase its risk slightly without similarly increasing its premiums. The costs of risk are thus

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30. See Korobkin, *supra* note 7, at 825-28 (discussing virtues and potential problems with compulsory insurance).

31. JOHN RAWLS, A THEORY OF JUSTICE 12 (1971). Also worth consulting in this regard is the work of Nobel Prize-winning economist, John C. Harsanyi, who in his book, RATIONAL BEHAVIOR AND BARGAINING EQUILIBRIUM IN GAMES AND SOCIAL SITUATIONS (1977), advances game theory to analyze the sort of bargains people might wish to make in advance. The relationship between Rawlsian philosophy and the game theory of John Harsanyi is treated in book-length form in KEN BINMORE, GAME THEORY AND THE SOCIAL CONTRACT: PLAYING FAIR (1994).

32. The implied consent suggested here is a partial answer to the charge of some recent scholars who claim that policies forbidding the use of information relevant to an insured's risk "conscripts private parties into the process of subsidizing that individual." Diver & Cohen, *supra* note 9, at 1472; Gulati, *supra* note 9, at 151. It is not conscription if people consent to granting the subsidy. The reason that "consent" is not a full answer to the charge is that the consent here is hypothetical. Use of "implied consent" as a justification for legal rules is a tricky proposition in that it requires a whole set of assumptions about the knowledge and characteristics of the individual involved. Rampant implication of consent can be a big step on the road to tyranny and thus must be used with great care.

33. *See* Epstein, *supra* note 7, at 126 (arguing that an absence of underwriting—or community rating, as it is sometimes called—might induce individuals to eat fatty foods and engage in risky activities). *But see* Korobkin, *supra* note 7, at 821-25 (arguing that this effect is likely to be small).

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imperfectly internalized. With broad underwriting categories, by contrast, the insured may be able to significantly increase his or her risk without having to bear the additional costs.

This problem with compulsory insurance could be eliminated if we could somehow determine each member of society's "baseline" risk level, i.e., how much risk they would face if they took reasonable or optimal levels of precaution. We could then condition the insurer's duty to pay on the insured's meeting these optimal precaution levels. We could even affirmatively punish the insured for violating these norms. Unfortunately, determining this baseline on an individual basis is often likely to be costly, and punishment of an insured that has suffered a loss is unlikely to be very palatable.

II. REAL EXPERIMENTS

As useful as the toy population is in elucidating some basic principles of insurance underwriting, the real world is, of course, not comprised of tidy "toy populations" on which complex computer experiments can be performed. We cannot find the absolute optimum of the virtually infinite classification schemes that will exist when the population consists of well more than 10 entities. Thus, we need to develop some principles that suggest when classification is likely to be helpful and when it is not. In those latter instances, it may make sense to use law to prohibit various classifications that a private market system might develop. It turns out, however, that the mathematics and intuitions that facilitated study of the "toy model" are useful in developing these sets of principles. It is thus to these more sophisticated experiments that I now turn.

A. Underwriting in a World with Low Susceptibility to Adverse Selection

I first study a world that the principles above suggest has low susceptibility to serious adverse selection. This world has a population of 100, in which perceived risk levels are fairly heterogeneous, risk aversion levels are relatively high, and the maximum amount of insurance that can be purchased is only 125% of full insurance. While the insurer has perfect knowledge about the risk posed by the individual, I restrict it to 8 possible underwriting regimes, which represent the 8 different ways in which

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quartiles[34] can be merged. By way of example, the insurer could choose a "1-2-1" scheme in which the first quartile of entities (ranked by insurers' perception of risk level) pays one unit price for insurance, the next two quartiles pay a second unit price, and the final quartile pays a third unit price. As a second example, the insurer could choose a "1-1-2" scheme in which the first quartile of entities (ranked by insurers' perception of risk level) pays one unit price for insurance, the next quartile pays a second unit price and the third and fourth quartile pay a third unit price.[35]

The figure below shows the Underwriting Map for this scenario.

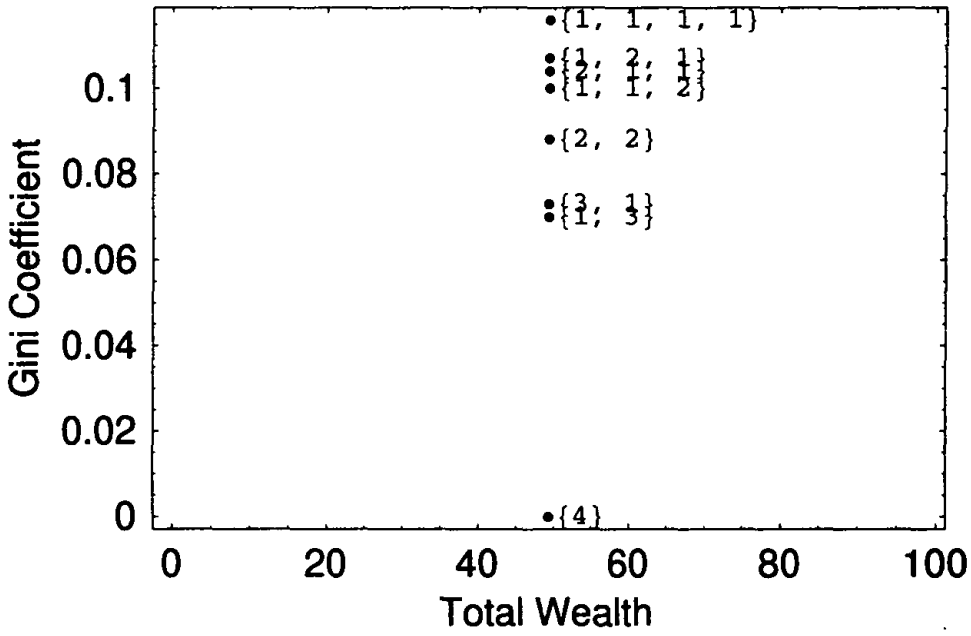


Figure 8: Underwriting map for 8 underwriting regimes when toy population is evolved with full and perfect information; maximum insurance purchase is 2.

The table below shows the single underwriting regime that lies on the hull: no underwriting.

34. A quartile represents a grouping of 25% of a population sorted on some basis. The first quartile of a population is thus the first 25%, the second quartile is the next 25%, etc.

35. To explicate the notation further, a "2-2" scheme is one in which the first two quartiles pay one price and the next two quartiles pay a second price. A "4" scheme is one in which all four quartiles pay the same price.

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Underwriting Regime	{Total Wealth, Gini Coefficient}
{4}	{49.365, 0.}

Table 10: The Hull when the Toy Population is Evolved with Full and Perfect Information; Maximum Insurance Purchase is 2.

The figure below shows why a no underwriting regime is the optimal choice. Underwriting does not increase total wealth because, as shown in the figure below, everyone is already purchasing full insurance even without classification. It does, however, increase inequality in the distribution of wealth because now some insureds pay more than others for insurance.

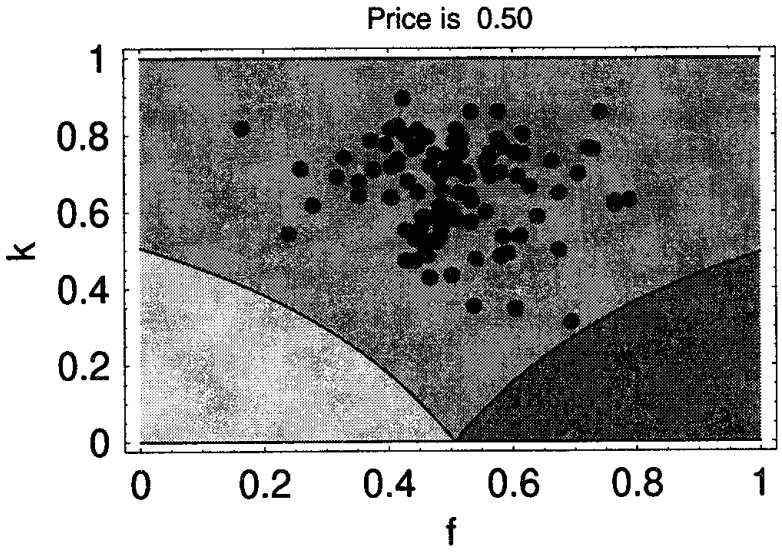


Figure 9: Equilibrium demand in low-potential population with no underwriting.

Therefore, the law should be reluctant to support classification by insurers in markets in which there is little susceptibility to adverse selection spirals and in which the risks involved are largely unalterable by individuals. Such intervention will not substantially increase the total wealth of society, but it will increase inequality of opportunities without those disadvantaged having done anything particularly blameworthy.

B. Underwriting in a World with High Potential for Adverse Selection

I now examine a world with high potential for adverse selection. This entails the study of a population of 100 in which perceived risk levels are relatively heterogeneous, risk aversion levels are relatively low, and the

maximum amount of insurance that can be purchased is four times greater than full insurance. The permissible underwriting regimes are the same as in the preceding subsection.

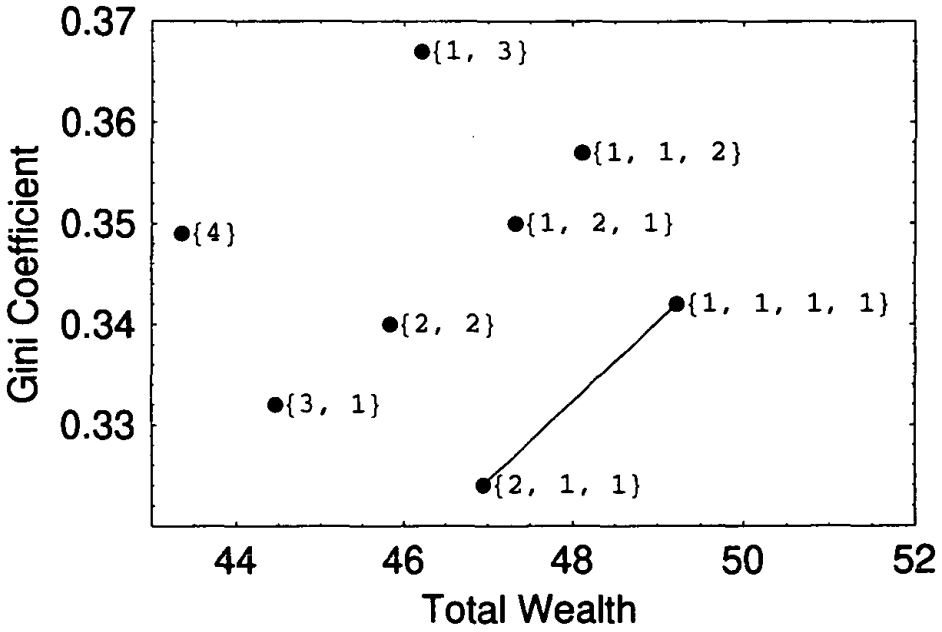


Figure 10: Underwriting map for 8 underwriting regimes when potential population is evolved with full and perfect information; maximum insurance purchase is 4.

The table below shows the underwriting regimes that lie on the hull: {2,1,1} underwriting to minimize inequality without needless sacrifice of total wealth, and {1,1,1,1} underwriting to maximize total wealth without needless sacrifice of inequality.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{2, 1, 1}	{46.948, 0.324}
{1, 1, 1, 1}	{49.227, 0.342}

Table 11: The hull when there is high susceptibility to adverse selection.

In contrast to the world where little adverse selection occurs, here the absence of underwriting is demonstrably a bad idea. The absence of underwriting ("4" underwriting) leads to a total wealth of 43.35 and wealth inequality of 0.348. The figure below suggests why this is the case. In the absence of underwriting, an insurance market susceptible to serious adverse selection enters into a death spiral in which virtually no one purchases insurance. Thus, the inequalities with which the entities were endowed go

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unrelieved by insurance and the wealth-increasing effects of insurance are eliminated. Those who favor more equal distribution of wealth in society should not, therefore, always advocate broader underwriting schemes. Sometimes discrimination leads to greater equality. Consistent with this goal, in a population highly susceptible to adverse selection, legislation should generally support efforts by insurers to classify. By way of example, if people differ widely in their likelihood of death in some finite period and can purchase widely varying amounts of life insurance, prohibiting insurers from classifying based on the likelihood of death both reduces total wealth and can increase inequality. This is true even where the differing risks of death arises from nothing we would term "fault" on the part of the insured.

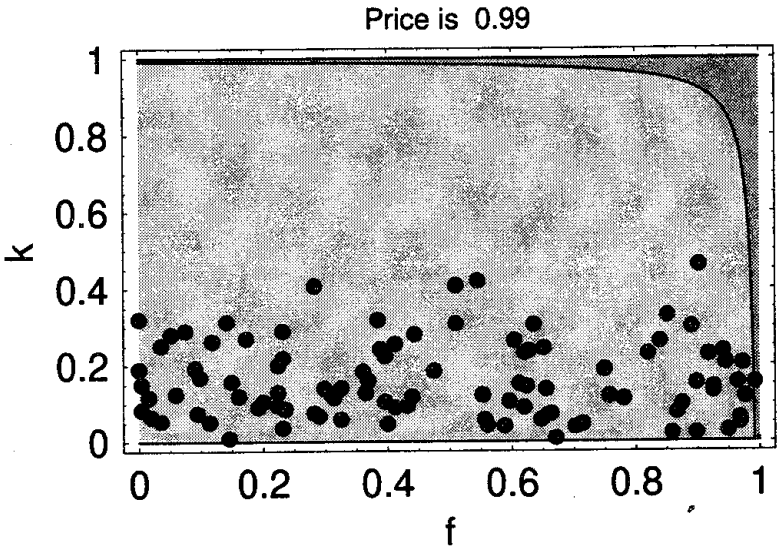


Figure 11: Equilibrium demand in high-potential population with no underwriting.

C. Financial Constraints

Up to this point, this analysis has implicitly assumed that entities have enough money to purchase at least the maximum amount of insurance regardless of its price. However, this assumption is unrealistic in many markets such as the health insurance market. The following section explores the optional underwriting rules where the amount of insurance that an individual can purchase is limited by their financial situation.

By way of example, consider the population with a high susceptibility to adverse selection. The lesson from the preceding section is that refined classification schemes are likely to lie on the hull. Coarser schemes cause an adverse selection death spiral. But what if people are unable to afford

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high premiums? When classified as high risk, they now simply drop out of the insurance market altogether. Thus, while classification may abate adverse selection, it may also spur financial de-selection.

The Underwriting Map in the figure below considers this issue. It shows what occurs when I impose a modest financial constraint by assuming that each entity has no more than a particular amount (drawn from a uniform random distribution on [0,1]) to spend on insurance. I permit entities to choose insurance purchases of anywhere from 0 to 4, in increments of 0.2.

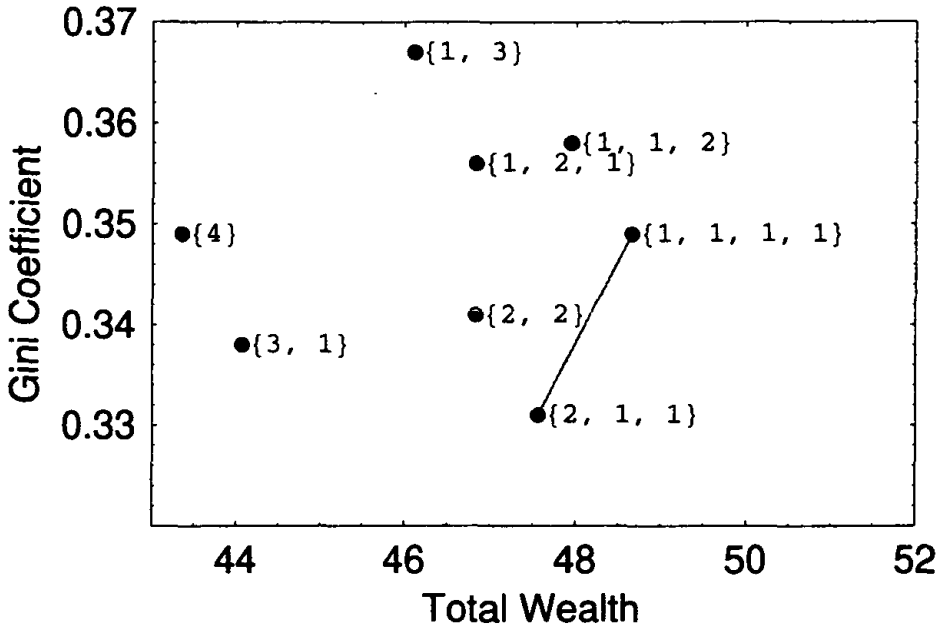


Figure 12: Underwriting map for 8 underwriting regimes when high-potential population is evolved with full and perfect information but with a modest finance constraint; maximum insurance purchase is 4.

The table below provides details regarding the underwriting regimes that now lie on the hull.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{2, 1, 1}	{47.56, 0.331}
{1, 1, 1, 1}	{48.66, 0.349}

Table 12: The hull when financial constraints exist on purchase of insurance.

In some ways, the results look similar to those generated when no financial constraints existed on the purchase of insurance. The same two

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underwriting schemes are on the hull. Thus, where, as here, entities are permitted to purchase incomplete insurance, the existence of financial constraints does not grossly change the sort of underwriting regimes that make sense in a population highly susceptible to adverse selection. Refined underwriting schemes continue to be preferable. The tradeoffs made between perfect underwriting and the slightly coarser 2-1-1 underwriting have changed, however. Before, when one moved from 1-1-1-1 underwriting to 2-1-1 underwriting, one sacrificed 2.28 units of total wealth in order to gain 0.18 in the Gini Coefficient. In this experiment, however, one sacrifices only 1.1 in order to gain the same 0.18 in the Gini Coefficient. This difference exists because of the financial constraints that impact the range of underwriting regimes differently. For highly refined classifications, the result is simply to reduce total wealth because less insurance can be purchased. For less refined classifications, however, there are two effects. On the one hand, total wealth may be reduced because less insurance can be purchased, at least among entities classified as high risk. On the other hand, prices for insurance tend to be lower and more people are able to participate in the market because the torque on prices created when large amounts of insurance are purchased has been disproportionately restrained by financial limits. Thus, underwriting regime 2-1-1 actually generates greater wealth when people are poorer because of financial constraints, than it did when entities had unlimited budgets to spend on insurance. On balance then, the existence of financial constraints argues for somewhat coarser underwriting regimes than might otherwise be appropriate, but should not cause radical change.

A significant change results when both insurance purchasing options and financial constraints, are altered. The figure below shows the results of an experiment in which the same individuals, as in the immediately preceding experiment, can purchase only zero insurance or full insurance. Incomplete insurance does not exist and more-than-full insurance is prohibited.

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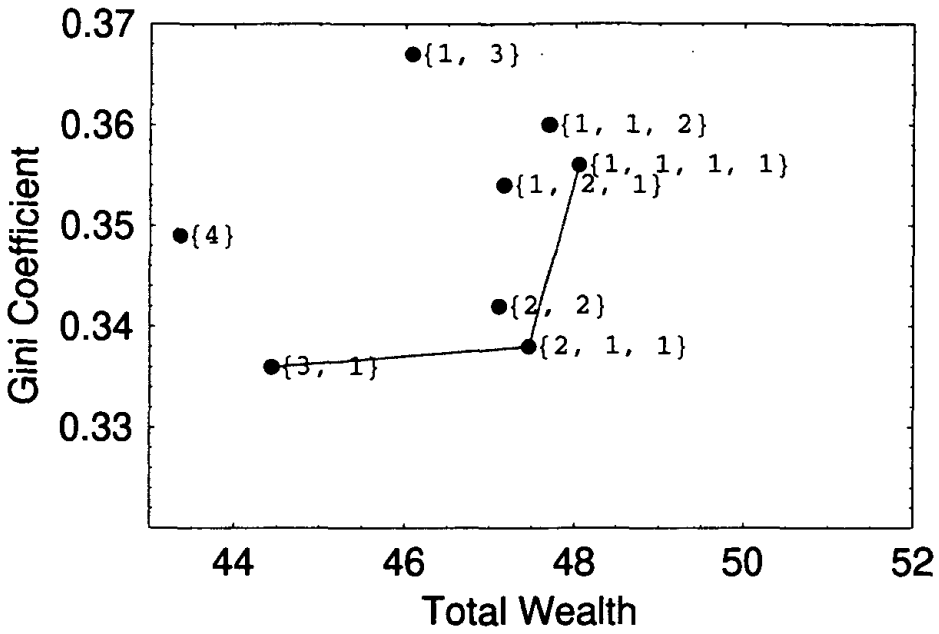


Figure 13: Underwriting Map for financial constraints and the unavailability of incomplete insurance.

The table below confirms that a fairly coarse underwriting scheme "3-1" is now on the hull. What has happened? First, prohibiting people from purchasing maximum insurance has decreased the susceptibility of the population to adverse selection spirals, and has thus made coarse underwriting schemes comparatively more attractive. Second, financial constraints have likewise dampened the ability of some to make widely varying purchasing decisions based on their perceived level of risk. This ability, recall, lies at the root of the adverse selection problem that refined classification is intended to control. For, in some ways, financial constraints make the market more closely resemble compulsory insurance where purchasing variation tends to decrease. Here, as with compulsory insurance, the result is that coarse underwriting schemes make more sense. Finally, the elimination of incomplete insurance has meant that more individuals classified as high risk are priced out of the insurance market, which makes refined underwriting schemes comparatively less attractive. Thus, in situations in which both adverse selection susceptibility and financial constraints threaten to shrink the insurance market and in which insurance purchasing decisions tend to be binary, policymakers should feel somewhat more comfortable in relying on coarser underwriting schemes. Some would argue that health insurance might be an example of such a

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market. As discussed below,[36] the susceptibility to adverse selection may be low, it is somewhat difficult to get highly incomplete insurance, and high prices for full insurance may result in some people simply becoming uninsured.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{3, 1}	{44.439, 0.336}
{2, 1, 1}	{47.462, 0.338}
{1, 1, 1, 1}	{48.047, 0.356}

Table 13: The hull with financial constraints and the unavailability of incomplete insurance.

D. Costly Sorting

I have assumed thus far that the process of underwriting is itself costless. This, of course, is not correct. Obtaining reliable information about individuals takes resources, either through direct investigation or through information transfer systems reinforced by legal doctrines like warranty and representation. Presumably, the cost of underwriting increases in some fashion as the number of underwriting categories increases and as the amount of data needed to determine the underwriting category likewise increases. Suppose, for example, the cost of a given underwriting scheme applied to some particular population is determined by the following formula, in which q is the number of underwriting categories, and α is some constant. Thus, the cost of underwriting increases with the square of the number of categories.

$$\text{sample underwriting cost function} = \alpha q\,(\text{categories} - 1)^2$$

Thus, for 1-2-1 underwriting in a population of 100, the sample cost of underwriting is 0.4 if α is 0.001 ($0.001 \times 100 \times (3-1)^2$).

The graphics below show the evolution of the hull for the population highly susceptible to adverse selection as the constant factor α increases. Notice that when underwriting costs are low, refined underwriting regimes such as {1,1,1,1} or {2,1,1} make sense. As underwriting costs grow, however, {1,1,1,1} becomes disfavored; simpler regimes with fewer underwriting categories begin to make their appearance on the hull as plausible choices. Indeed, when underwriting costs grow very high, the simplicity of scheme {4} (no underwriting) becomes the wealth

36. *See infra* pp. 484-497.

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maximizing choice even though it leads to the collapse of the insurance market. The point here is not to demonstrate that a particular underwriting regime is good or bad, but to highlight that the cost of sorting people into categories must, in the real world, be respected as a factor in determining the sensible underwriting regimes that the legal system ought to favor. By way of example, if obtaining the sort of genetic information needed to finely forecast an individual's health risk was extremely expensive, it might make sense to suffer some adverse selection from a course classification scheme rather than spend the money necessary to accurately conduct refined classification.

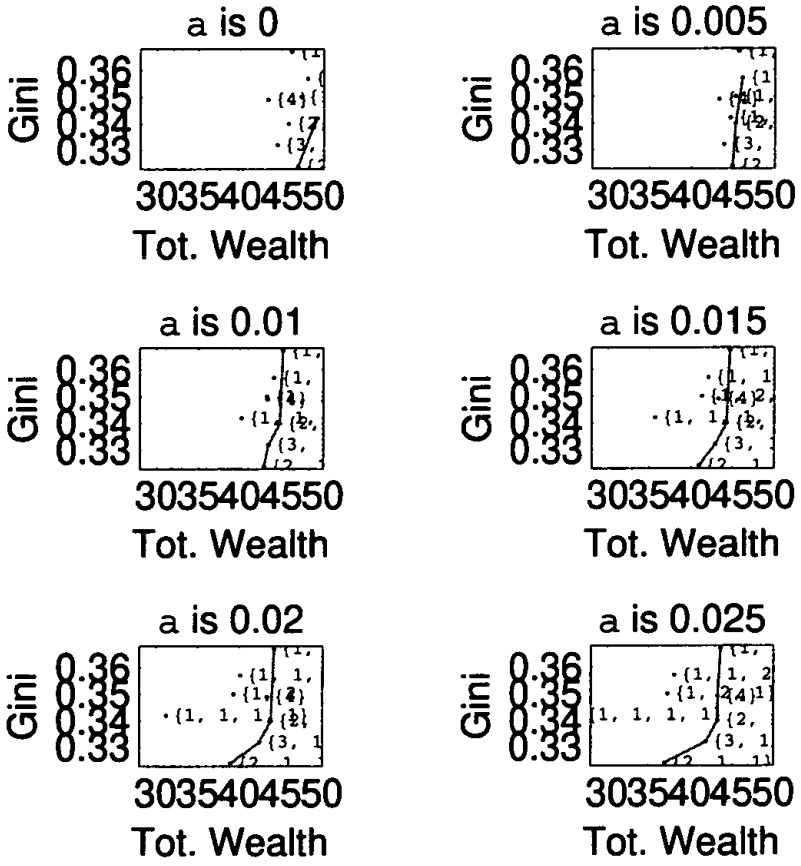


Figure 14: Underwriting maps showing the effect of costly sorting on the comparative virtues of various underwriting schemes.

E. Inaccurate Classification Schemes

Thus far, I have assumed that insurers are able to precisely determine the risk posed by an individual—or at least to do so as well as the insured. This is unlikely to be the case. Instead, the costs associated with sorting

forces insurers to observe only certain individual characteristics and then map those characteristics to some estimate of the individual's risk.[37] If done properly, this estimate will be unbiased, i.e., the mean actual risk posed by the population pool will be equal to the predicted level of risk,[38] but the actual risks posed by entities in each risk group will be more heterogeneous (have a higher variance) than would exist were the insurer able to observe all characteristics of the insured and make perfect predictions. Thus, if individuals have greater predictive ability than do insurers, the risk categories established by the insurer will actually be wider than would otherwise be the case. The insured may believe, for example, that the risk that some group will develop breast cancer is between 10% and 15%, but if insureds have access to accurate genetic tests and need not disclose the results of those tests to insurers, the actual risk levels for people in that underwriting category may range from, say 8% (for those who test negative) to 70% (among those who test positive).

1. Symmetric but Imperfect Risk Information

The model used thus far can be extended to consider the consequences of imperfect risk assessment. I first assume that insureds and insurers have equal but imperfect access to information about risk. I do so by supposing that actual risk is determined by attaching weights to some finite number of factors. The insurer and insured can see only some subset of these factors. Both insurer and insured then perform a linear regression of their observations of this subset of factors onto the actual risk, and develop a linear model that attempts to predict risk. The insurer classifies on the basis of predicted risk and the insured makes optimal purchasing decisions based on his or her own prediction of risk.

To be more concrete, suppose that actual risk is determined by the following expression, in which the various factors can take on values 1 (if present) and 0 (if not present).

$$\text{actual risk} = \frac{1}{255}\,(128\,\text{factor}_1 + 64\,\text{factor}_2 + 32\,\text{factor}_3 + 16\,\text{factor}_4 + 8\,\text{factor}_5 + 4\,\text{factor}_6 + 2\,\text{factor}_7 + \text{factor}_8)$$

Thus, if all factors are not present, the actual risk is zero. Similarly, if all factors are present, the actual risk is one.

37. *See* George J. Benston, *The Economics of Gender Discrimination in Employee Fringe Benefits: Manhart Revisited*, 49 U. CHI. L. REV. 489, 498 (1982).

38. *See* GEORGE E. REJDA, PRINCIPLES OF INSURANCE 537 (3d ed. 1989).

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Suppose, however, that the insured and insurer see only the values of factors 1, 4, and 8. They regress these factors against the risk they perceive. The table below compares the truth for the "low susceptibility" population with the results of the model developed by the insurer and the model developed by the insured.

The Truth	$0.501961\ factor_1 +$ $0.25098\ factor_2 +$ $0.12549\ factor_3 +$ $0.0627451\ factor_4 +$ $0.0313725\ factor_5 +$ $0.0156863\ factor_6 +$ $0.00784314\ factor_7 +$ $0.00392157\ factor_8$
Insurer's Model	$0.374102 + 0.188802\ factor_1 +$ $0.0535648\ factor_4 +$ $0.020283\ factor_8$
Insured's Model	$0.374102 + 0.188802\ factor_1 +$ $0.0535648\ factor_4 +$ $0.020283\ factor_8$

Table 14: Regressions for the low susceptibility population.[39]

The model developed by the insurer and insured fails to accurately capture what is actually causing risk. The result is that too little weight is accorded to factor 1 and too much weight is accorded to factor 8.

If I evolve the system as before, the figure below shows the total wealth-Gini Coefficient pairs for the 8 possible underwriting regimes. The figure below shows the results for the population with low potential for adverse selection.

39. The tables illustrating regressions for high susceptibility population, regressions for highly imperfect information in the high susceptibility population, and regressions with asymmetric information in low susceptibility population are on file with the author.

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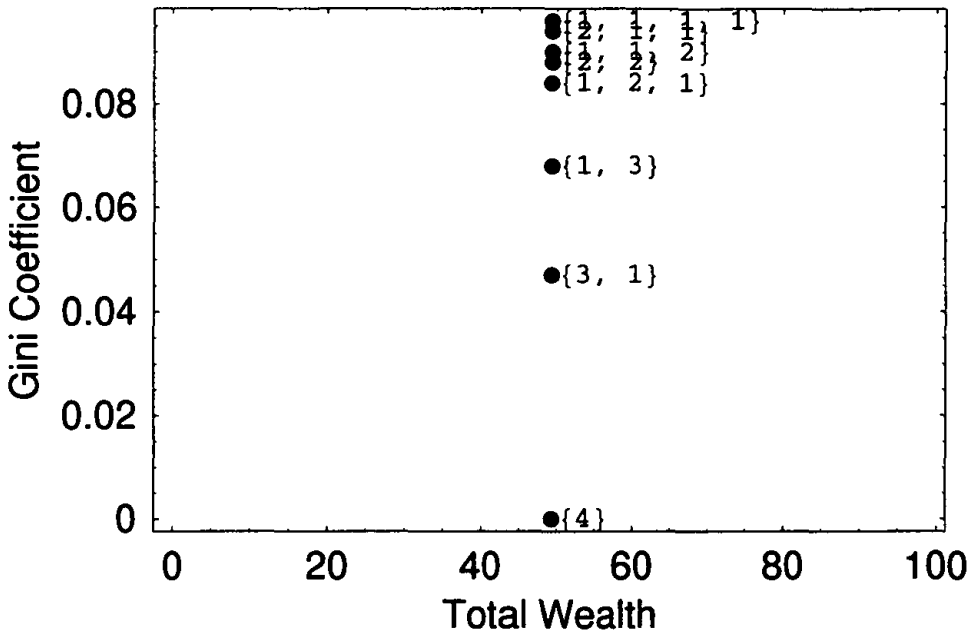


Figure 15: Underwriting map for symmetric imperfect information in the low susceptibility population.

The table below shows the hull.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{4}	{49.365, 0.}

Table 15: The hull with symmetric imperfect information in the low susceptibility population.

Thus, when the potential for adverse selection is small, symmetric imperfections in information do not change the optimal underwriting regime.

The figure below shows the results of the same experiment when the potential for adverse selection is high.

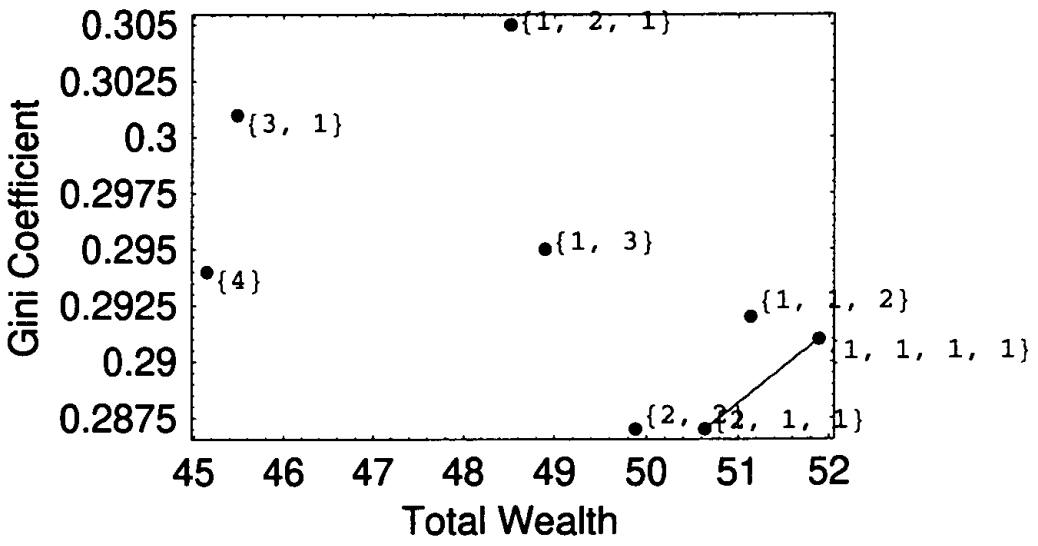


Figure 16: Underwriting map for symmetric imperfect information in the high susceptibility population.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{2, 1, 1}	{50.636, 0.287}
{1, 1, 1, 1}	{51.892, 0.291}

Table 16: The hull with symmetric information in the high susceptibility population.

Although the same underwriting regimes as before are on the hull for both the low potential and high potential populations, the destruction of information has created something rather remarkable: when the optimal underwriting regimes are used, the destruction of information has both created wealth and lowered inequality. An understanding of the physics of adverse selection created from the study of the toy population makes clear why this somewhat paradoxical result occurs. It illustrates, for example, why, if there was nothing one could do to reduce risk following acquisition of risk-related information, it would probably be better—at least from an insurance perspective—not to obtain the information at all. Genetic information regarding diseases whose risks cannot be altered is arguably an example of information best left unearthed.

The inability of either the insurer or the insured to see what is really causing risk creates a false homogenization of the population that, whatever its other detriments, actually helps the insurance market by recreating the

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symmetry of ignorance in which it functions best. The variance of the actual risk level of the low-potential population, for example, is 0.013, whereas the variance of the insurer-perceived risk level is 0.008. The variance of the actual risk level of the high potential population is 0.095, whereas the variance of the insurer-perceived risk level is 0.074. The greater perceived homogeneity of the population means, first of all, that the premiums charged to the different underwriting categories are likely to be closer together, leading to greater equality of wealth. The greater insured-perceived homogeneity of risk means that fewer will either go without insurance or purchase maximum insurance. Thus, the world more closely resembles the happy state of compulsory insurance—although the prevalence of full insurance comes from symmetric ignorance rather than governmental compulsion.

Consideration of a second scenario involving even more imperfect but symmetric information highlights this finding. Suppose the insurer, instead of seeing some of the important factors such as factors 1 and 4, sees only minor factors 5, 6, 7 and 8. The table below shows the results of regression when applied to the high adverse selection population. Notice that the insurer is now getting the signs of some of the coefficients incorrectly. Its perception of risk is, as suspected, highly distorted. The variance of risk in the population drops, however, from its actual value of 0.095 to a perceived value of 0.005.

The Underwriting Map in the figure below shows how total wealth and the Gini Coefficient vary according to the underwriting regime employed.

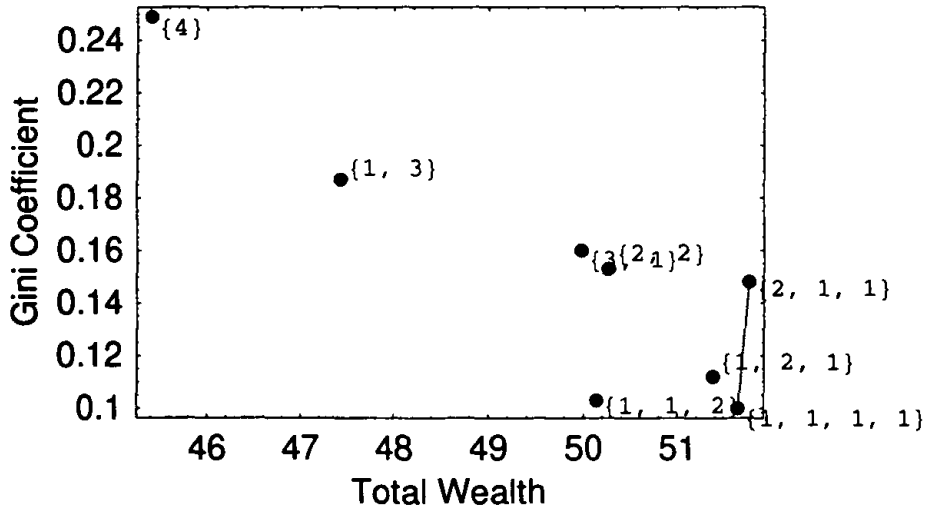


Figure 17: Underwriting map for highly imperfect information in the high susceptibility population.

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Underwriting Regime	{Total Wealth, Gini Coefficient}
{1, 1, 1, 1}	{51.642, 0.1}
{2, 1, 1}	{51.762, 0.148}

Table 17: The hull with highly imperfect information in the high susceptibility population.

The results largely confirm the hypothesis. Further destruction of information again raises total wealth and decreases inequality, although, in a somewhat bizarre twist, the most refined underwriting regime 1-1-1-1 actually creates the least amount of inequality.

2. Asymmetric but Imperfect Risk Information

I now examine the economic effects of different underwriting regimes when information is imperfect and asymmetric: when the insured knows things that the insurer does not. I first consider the population with low susceptibility to adverse selection. I imagine that the insured has access to full information but the insurer has access only to factors 5,6,7 and 8. As shown above, this indicates serious misperceptions by the insurer of the risks posed by the entities in the population.

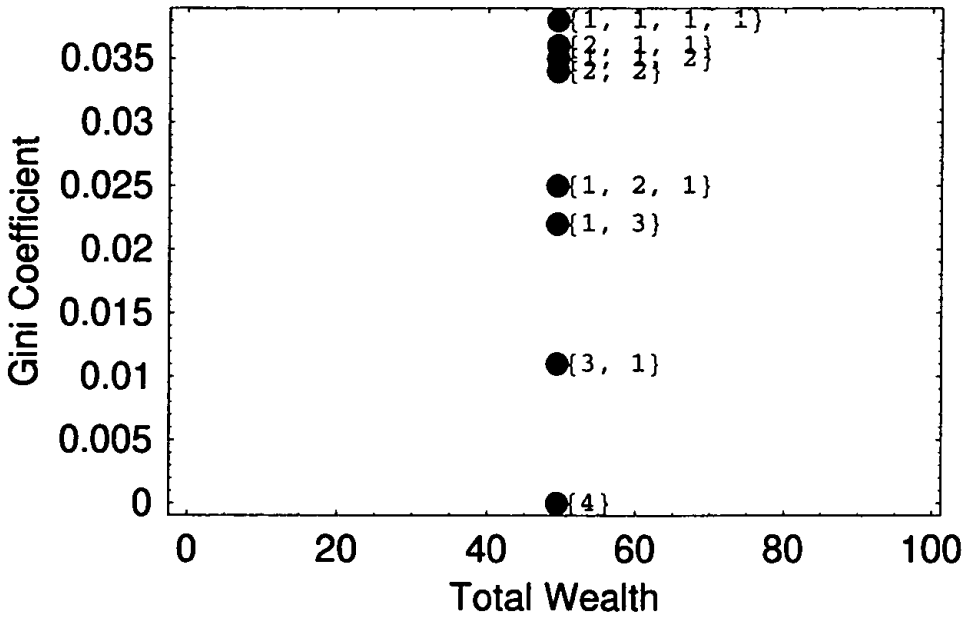


Figure 18: Underwriting map for asymmetric information in low susceptibility population.

The asymmetry in information has not lead to anything very interesting occurring. No underwriting is still the best idea because, even though the

insurer's classification model is flawed, insureds still have no great incentive either to decline insurance or gamble on maximum insurance.

Underwriting Regime	{Total Wealth, Gini Coefficient}
{4}	{49.365, 0.}

Table 18: Hull with asymmetric information in low susceptibility population.

With the high-potential population, however, the story changes a great deal. As before, the insurer's beliefs are highly distorted. The figure below shows the effects of the eight underwriting regimes.

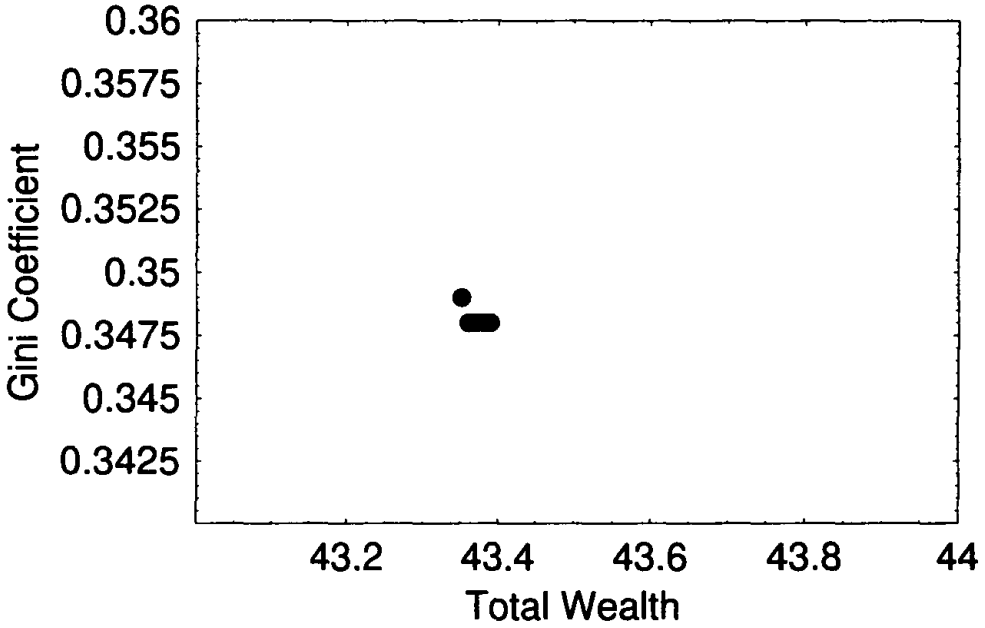


Figure 19: Underwriting map for asymmetric information in high susceptibility population.

Although a magnified view of this graphic shows that underwriting regime 1-1-1-1 is the only one on the hull, the "big picture" is that all underwriting regimes lead to essentially the same result. The points are all extremely close to each other. An examination of 1-1-1-1 underwriting suggests why this is so. The figure below shows the equilibration of the market for each of the four underwriting categories. Basically, notwithstanding the attempt at refined underwriting, the market goes into a

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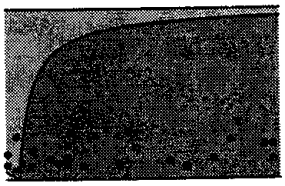
death spiral in all four categories. The result of these "avalanches"[40] is that almost no one has insurance. Coarser underwriting categories lead to essentially the same result.

Thus, if the insurer lacks access to important information that the insured possesses, efforts at classification may, despite their costs, be unable to rescue the market from an adverse selection death spiral. Efforts to rescue the insurance market will require that insurers be given greater and/or lower-cost access to information possessed by the insured. By way of example, consider a life insurance market in which individuals were permitted to hide the results of genetic tests from insurers. Because the actual risk posed by individuals within each underwriting category would be very broad (depending on the results of the genetic tests), such a market would be in danger of collapse. And this would be true even if life insurers were permitted to classify on the basis of risk, computed without regard to the genetic information. Permitting insurers to access the same genetic information acquired by prospective insureds would have the chance of saving such a market.

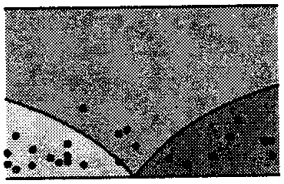
40. Use of the term "avalanche" is intended to evoke a metaphor to the wide class of processes in the physical and social sciences that result when a complex system interacts in such a way that it essentially collapses. *See generally* PER BAK, HOW NATURE WORKS: THE SCIENCE OF SELF-ORGANIZED CRITICALITY (1996).

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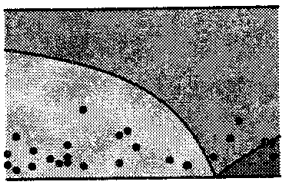
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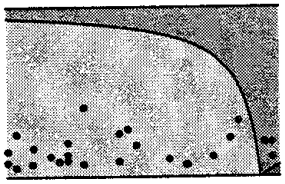
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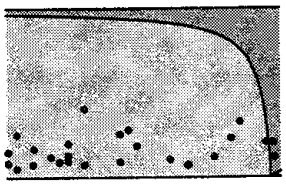
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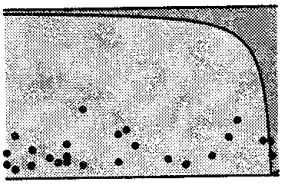
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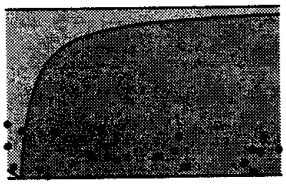
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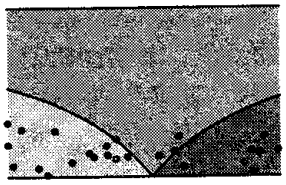
Price is 0.97



Price is 0.04



Price is 0.52



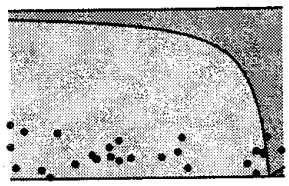
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Price is 0.96



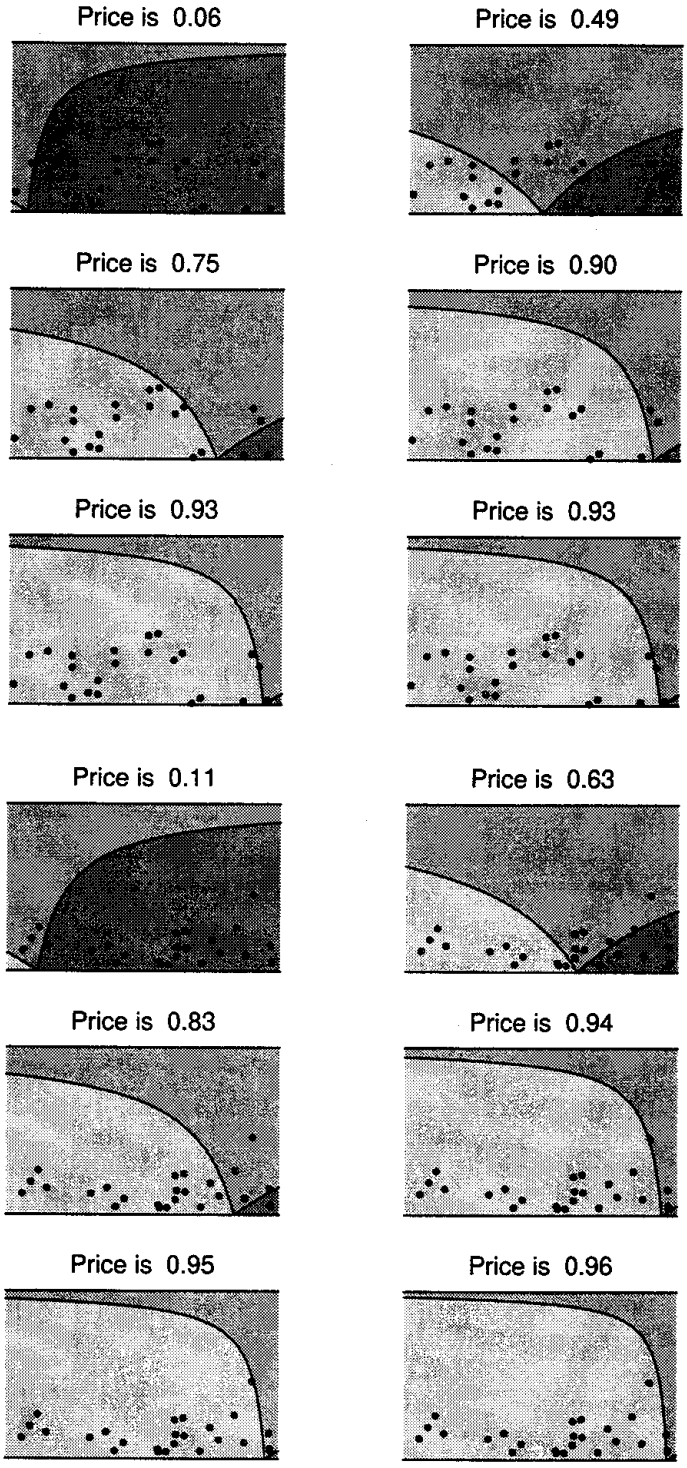


Figure 20: An adverse selection death spiral when refined underwriting data is used in a population with high susceptibility to adverse selection but asymmetric information.

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F. Risks that Can Only Be Indirectly Insured Against

There is one additional complication I would like to explore in this article. It relates primarily to health insurance—an area in which concerns about adverse selection are particularly salient. In the United States, when someone lacks full health insurance they actually face two risks. The first risk, which can be directly insured against, is that they will have to pay for the medical care they receive out of their own pocket. One insures against this risk by purchasing health insurance that effectively reimburses one for the cost of medical care. The second risk, which I assume cannot be directly insured against, is that when illness strikes, one will be unable to purchase medical care in the private market, and instead be relegated to the various safety nets of coverage provided by government and charity. Often, safety net coverage is less desirable.[41] The existence of private insurance confirms that it is certainly perceived that way by many. This latter risk can be indirectly insured against, however, by the purchase of health insurance. The more health insurance one has, the less likely it is that the insured will not have other financial resources with which to pay the bill for non-safety net care.

A modest extension of my basic model permits exploration of such an insurance market. The equation below shows the perceived expected position of the insured in this double loss scenario. The variable ω shows the loss the insured suffers from being thrown into the safety net relative to the financial loss the insured would suffer if the insured had to pay for the cost of the bad event. Thus, if the insured regards being thrown into the safety net as three times worse than having to pay for medical care, ω would be three. The function $g(\lambda)$ shows the risk that one will be relegated to the safety net in the event a "bad thing" such as sickness occurs. This probability is a function of λ, the amount of insurance purchased, because, as the amount of health insurance purchased increases, the odds that one will lack the financial resources to pay for non-safety net care decline. I assume that for $\lambda > 1$, $g(\lambda)$ is zero because with full insurance or more, there is no risk of being relegated to the safety net.

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41. It is not my purpose to consider here just how "second class" this world is, but simply to note that many people consider it a substantial risk to one's health to lack health insurance. A good discussion of the health care safety net as it currently exists in the United States may be found in JOAN HENNEBERRY, NAT'L GOVERNORS ASS'N, PRIMER ON THE HEALTH CARE SAFETY NET (Oct. 25, 2000), *available at* http://www.nga.org/cda/files/001025HEALTHPRIMER.PDF.

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$$\text{Perceived expected position}_2 = (1-f)(1-p\lambda)+f((\lambda-p\lambda)(1-g(\lambda))+(-p\lambda+\lambda-\omega)g(\lambda))$$

I can similarly compute the insured's perceived valuation (wealth) of their position.

$$\text{wealth}_2 = (1-k)\overbrace{(1-f)(1-p\lambda)+f((L-p\lambda)(1-g(\lambda))+(-p\lambda+\lambda-\omega)g(\lambda))}^{\text{expected position}}+k\overbrace{\text{Min}(1-p\lambda,\ \text{If}[g(\lambda)>0,\ -p\lambda+\lambda-\omega,\ \lambda-p\lambda])}^{\text{case worst}}$$

With some advanced mathematics, I can show that, with this additional risk accounted for, the insurer now does best by purchasing some amount of insurance between no insurance and full insurance (inclusive) or by purchasing the maximum amount of insurance available. The insured will purchase maximum insurance if, and only if, the insured would do so in the absence of this additional risk.[42] All insureds that purchased full insurance in the absence of the additional risk will continue to do so in the presence of the additional risk. Some insureds who would not have purchased insurance at all in the absence of this additional risk, however, will now purchase either full insurance or partial insurance, although the circumstances under which partial insurance will be purchased are usually extremely rare. Some insureds will continue to forgo all insurance coverage.

For insurance purchases in excess of full insurance, this expression is precisely the same as the expression for wealth when there is no uninsurable state (because no uninsurable state can materialize when the insured is at least fully insured). We know, therefore, that wealth is maximized either at no insurance, some intermediate value between no insurance and full insurance, full insurance, or maximum insurance. Using some substitutions and some algebra, I can thus write expressions for wealth at the possible maximum values for λ, $\{0, \lambda^*, 1, \text{or } \lambda_{max}\}$, where λ^* denotes a value of λ between 0 and 1 for which the derivative of wealth with respect to λ is zero and as to which the second derivative of wealth with respect to λ is negative. The expression λ_{max} denotes the maximum amount of insurance that can be purchased.

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42. There is an intuitive explanation for this conclusion. Once one has full insurance or more, the risk of falling into the safety net disappears. Thus, if one prefers maximum insurance to full insurance in the absence of an uninsurable state, one should likewise prefer it when an uninsurable state theoretically exists (but cannot materialize).

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Insurance Purchased	Wealth
0	$-k\omega + (-1+k)\,(-1+f+f\,\omega\,g[0])$
λ^*	$1-p\,\lambda^*+f\,(-1+k+\lambda^*-k\,\lambda^*)+$ $k\,(-1+\lambda^*-\omega)+f\,(-1+k)\,\omega\,g[\lambda^*]$
1	$1-p$
λ_{max}	$1-p\,\lambda_{max}+f\,(-1+k+\lambda_{max}-k\,\lambda_{max})$

Table 19: Wealth at various levels of insurance given the risk of an uninsurable state.

I can now use an advanced technique known as cylindrical algebraic decomposition of a system of inequalities (implemented using *Mathematica*)[43] to determine when each of the four possibilities for the optimal level of insurance is in fact best. The symbol "&&" denotes the Boolean "and." The symbol "||" denotes the Boolean "or." The table below shows the results.

43. D.S. Arnon, G.E. Collins & S. McCallum, *Cylindrical Algebraic Decomposition I: The Basic Algorithm*, 13 SIAM J. COMPUTING 865 (1984). *See also* D.S. Arnon, G.E. Collins & S. McCallum, *Cylindrical Algebraic Decomposition II*, 13 SIAM J. COMPUTING 878 (1984).

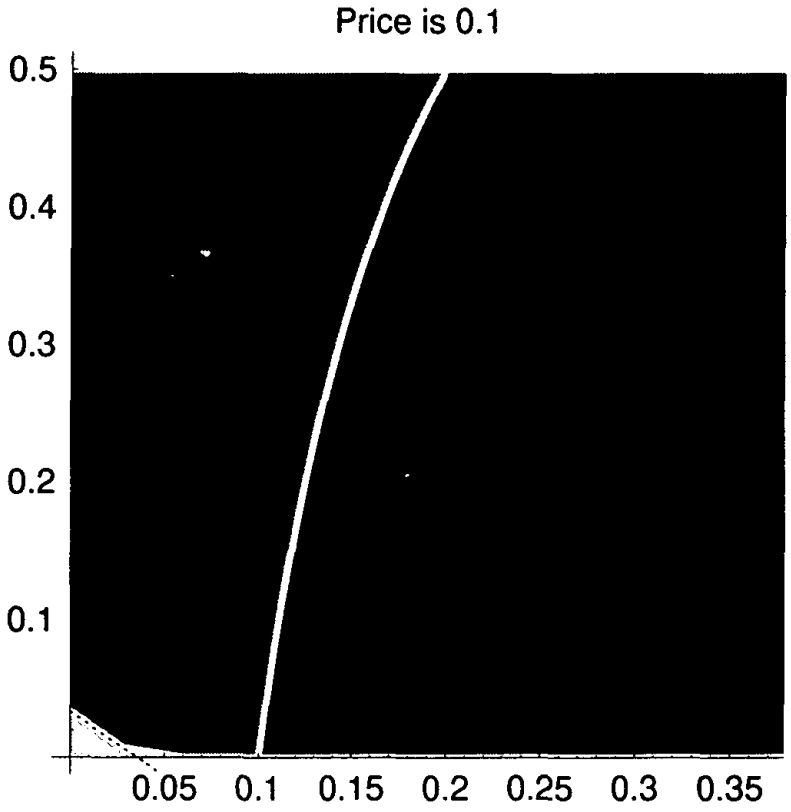
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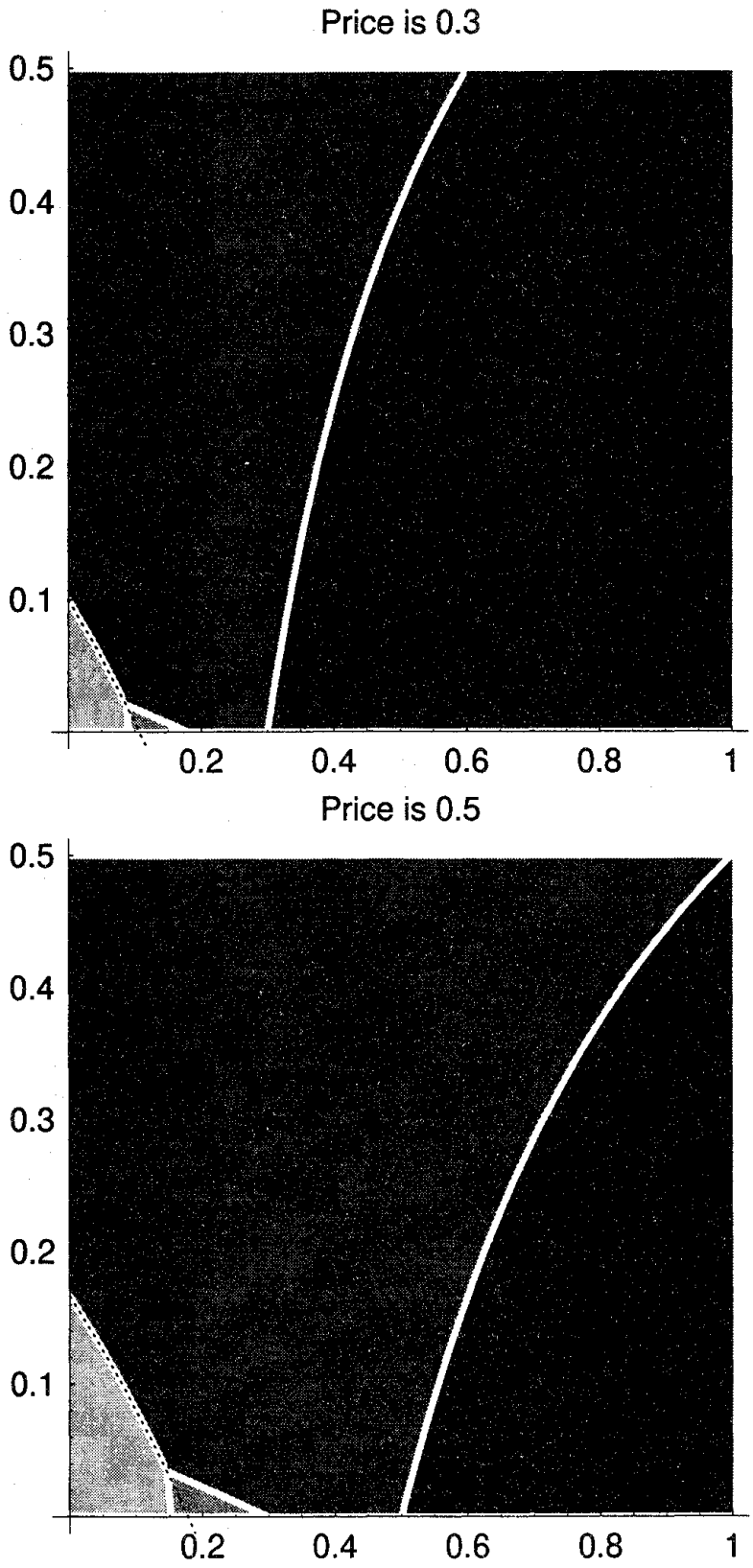
Zero Insurance	$0 < f < \frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}$ && $0 < f < \frac{p}{1+\omega g[0]}$ && $0 < k < \frac{f-p+f\omega g[0]}{-1+f-\omega+f\omega g[0]}$ && $0 < k < \frac{f\lambda^*-p\lambda^*+f\omega g[0]-f\omega g[\lambda^*]}{-\lambda^*+f\lambda^*+f\omega g[0]-f\omega g[\lambda^*]}$
Incomplete Insurance	$0 < f < \frac{-p+p\lambda^*}{-1+\lambda^*-\omega g[\lambda^*]}$ && $0 < k < \frac{-f+p+f\lambda^*-p\lambda^*-f\omega g[\lambda^*]}{1-f-\lambda^*+f\lambda^*+\omega-f\omega g[\lambda^*]}$ && $\left(0 < f \le \frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}\right.$ && $\frac{f\lambda^*-p\lambda^*+f\omega g[0]-f\omega g[\lambda^*]}{-\lambda^*+f\lambda^*+f\omega g[0]-f\omega g[\lambda^*]} < k < 1$ || $\frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]} < f < p$ && $0 < k < 1$ || $p == \frac{\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}$ && $\left(0 < f \le \frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}\right.$ && $\frac{f\lambda^*-p\lambda^*+f\omega g[0]-f\omega g[\lambda^*]}{-\lambda^*+f\lambda^*+f\omega g[0]-f\omega g[\lambda^*]} <$ $k < 1$ || $\frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]} <$ $f < \frac{\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}$ && $\left.0 < k < 1\right)$ || $0 < f \le \frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]}$ && $\frac{f\lambda^*-p\lambda^*+f\omega g[0]-f\omega g[\lambda^*]}{-\lambda^*+f\lambda^*+f\omega g[0]-f\omega g[\lambda^*]} < k < 1$ || $\left.\frac{p\lambda^*}{\lambda^*+\omega g[0]-\omega g[\lambda^*]} < f < p$ && $0 < k < 1\right)$
Full Insurance	$p < f < 1$ && $\frac{f-p}{f} < k < 1$ || $\left(0 < f \le \frac{p}{1+\omega g[0]}\right.$ && $\frac{f-p+f\omega g[0]}{-1+f-\omega+f\omega g[0]} < k < 1$ || $\left.\frac{p}{1+\omega g[0]} < f < p$ && $0 < k < 1\right)$ && $\left(0 < f \le \frac{-p+p\lambda^*}{-1+\lambda^*-\omega g[\lambda^*]}\right.$ && $\frac{-f+p+f\lambda^*-p\lambda^*-f\omega g[\lambda^*]}{1-f-\lambda^*+f\lambda^*+\omega-f\omega g[\lambda^*]} < k < 1$ || $\left.\frac{-p+p\lambda^*}{-1+\lambda^*-\omega g[\lambda^*]} < f < 1$ && $0 < k < 1\right)$
Maximum Insurance	$p < f < 1$ && $0 < k < \frac{f-p}{f}$

Table 20: Optimal Purchasing Rules with the risk of an uninsurable state.

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I can illustrate these purchasing rules with the following diagram, which shows how the zones vary as the price of insurance varies. The lightest zone on the lower left is, as before, the zone in which the insured does best to purchase no insurance. The smallish triangular zone on the bottom (colored slightly darker) shows the zone in which the insured does best to purchase incomplete insurance. The larger zone in the center that looks like a truncated wedge (a piece of pizza with a big and little bite taken out) and that is colored an intermediate shade, shows the zone in which the insured does best to purchase full insurance. The dark zone on the right shows where the insured does best to purchase maximum insurance. Each graphic also contains a thin dashed line showing the divider between zero insurance and full insurance were the option of incomplete insurance unavailable. This line is useful both for approximation purposes and in instances in which incomplete insurance is unavailable.





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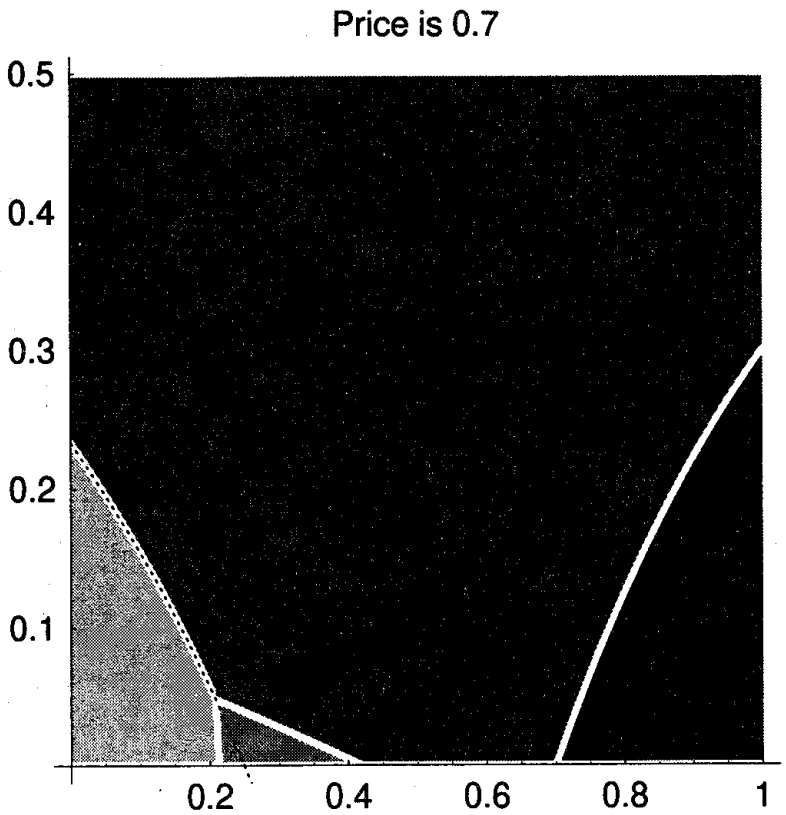
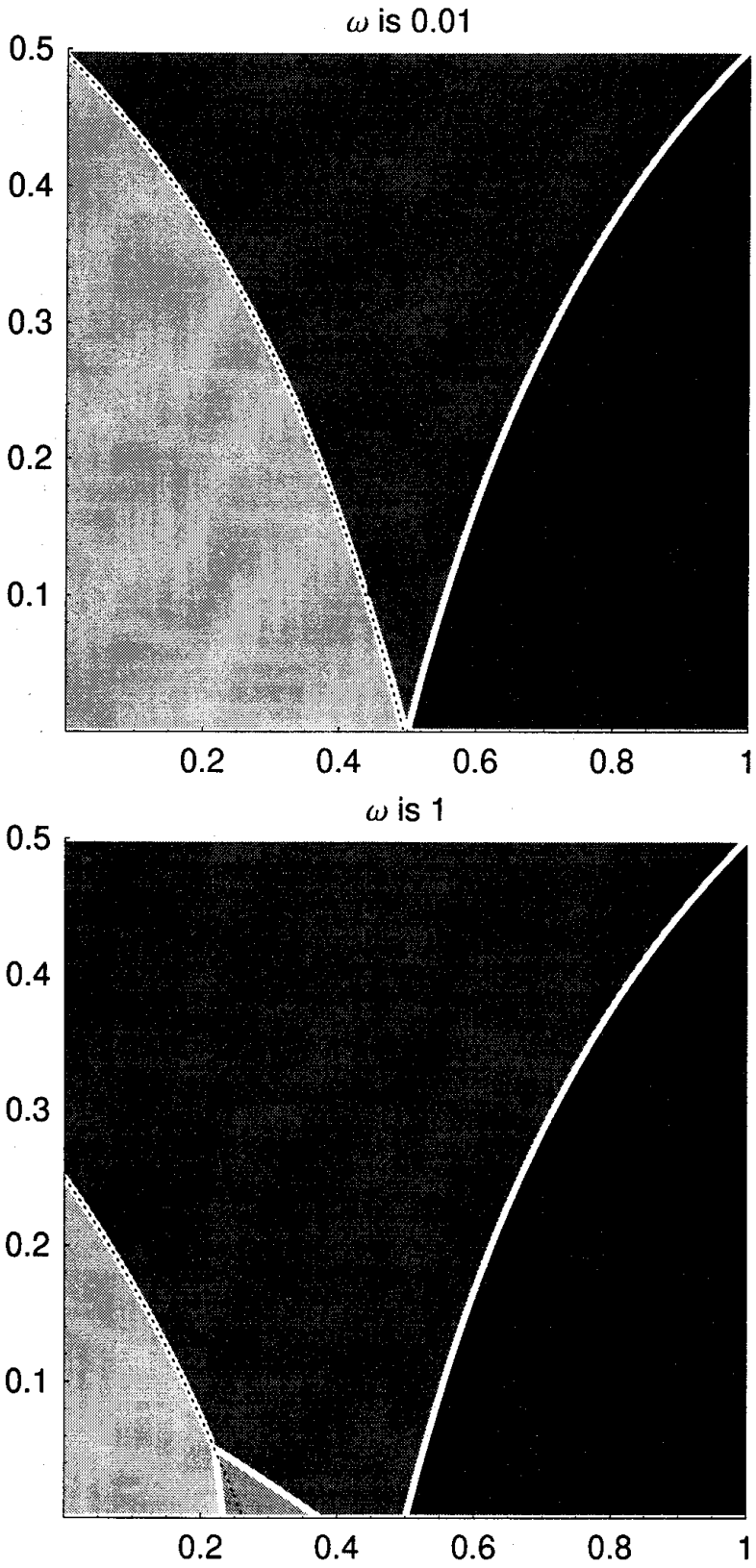


Figure 21: Variations in optimal purchasing rules as price of insurance changes in model with uninsurable risk.

The figure below helps visualize these formulae by showing how increasing the loss (ω) suffered by a fall into the "safety net" alters optimal insurance purchasing decisions. I arbitrarily set $g(0)$, the likelihood of falling into the safety net if no insurance is purchased, equal to 0.75. As before, light gray denotes the zone in which insurance is not purchased. A medium gray denotes the zone in which full insurance is purchased. A dark gray denotes the zone in which maximum insurance is purchased. Notice that the larger ω becomes, the larger the zone in which full insurance is purchased and the smaller the zone in which no insurance is purchased. Thus, the existence of an additional risk against which no direct insurance is available increases the number of people purchasing insurance that indirectly insures against this new risk.

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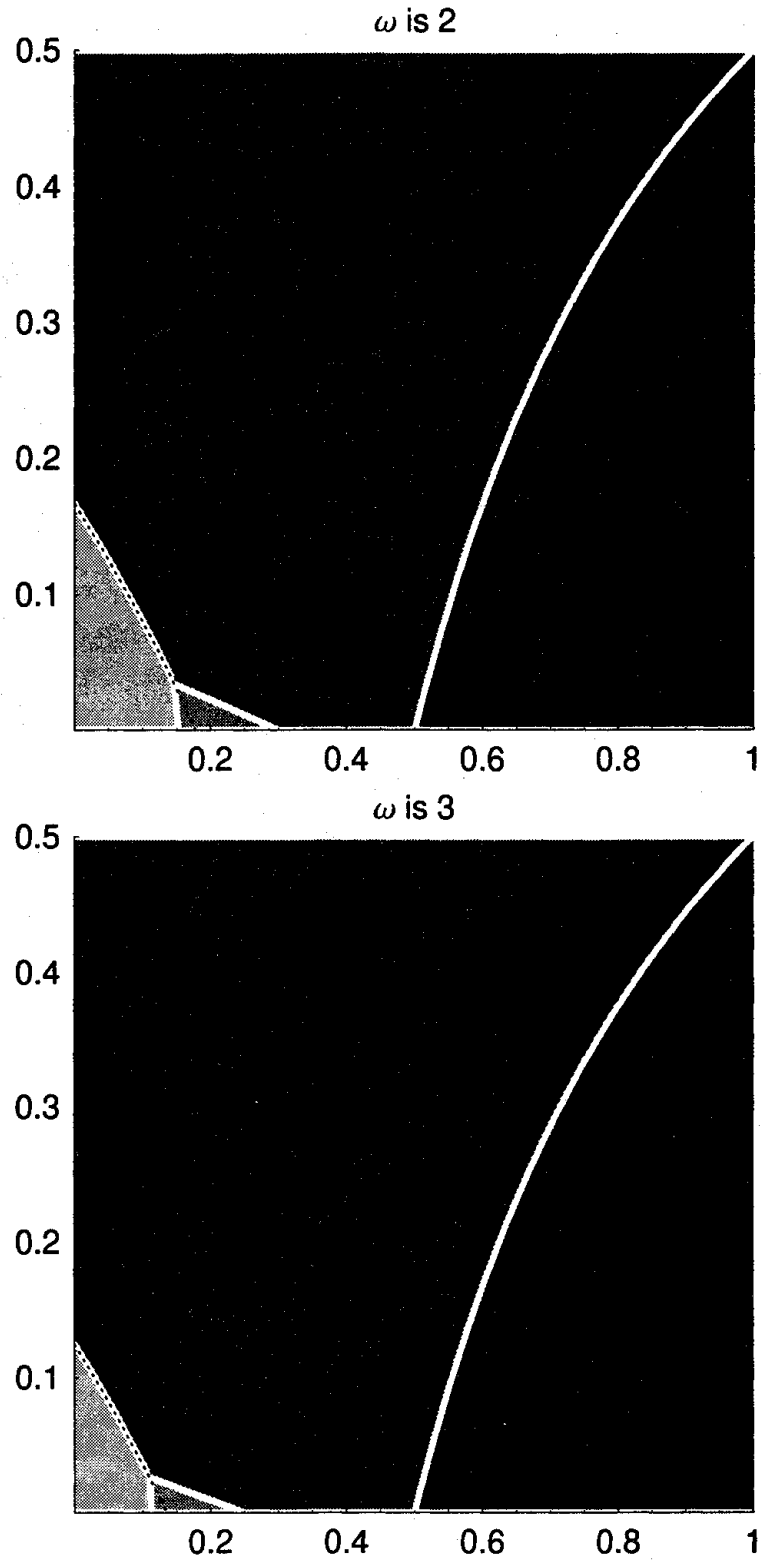
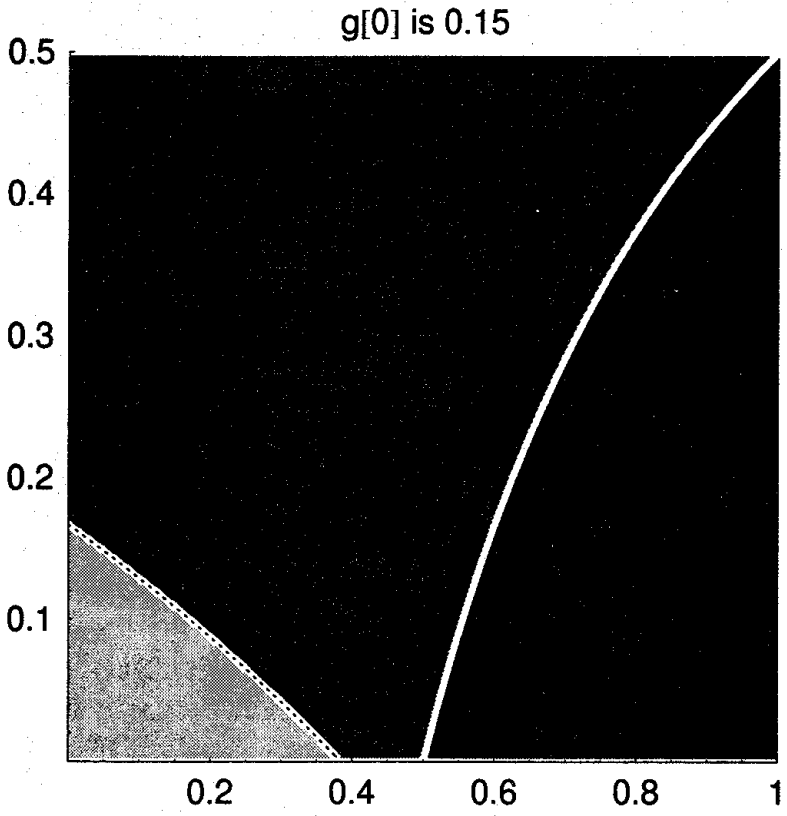
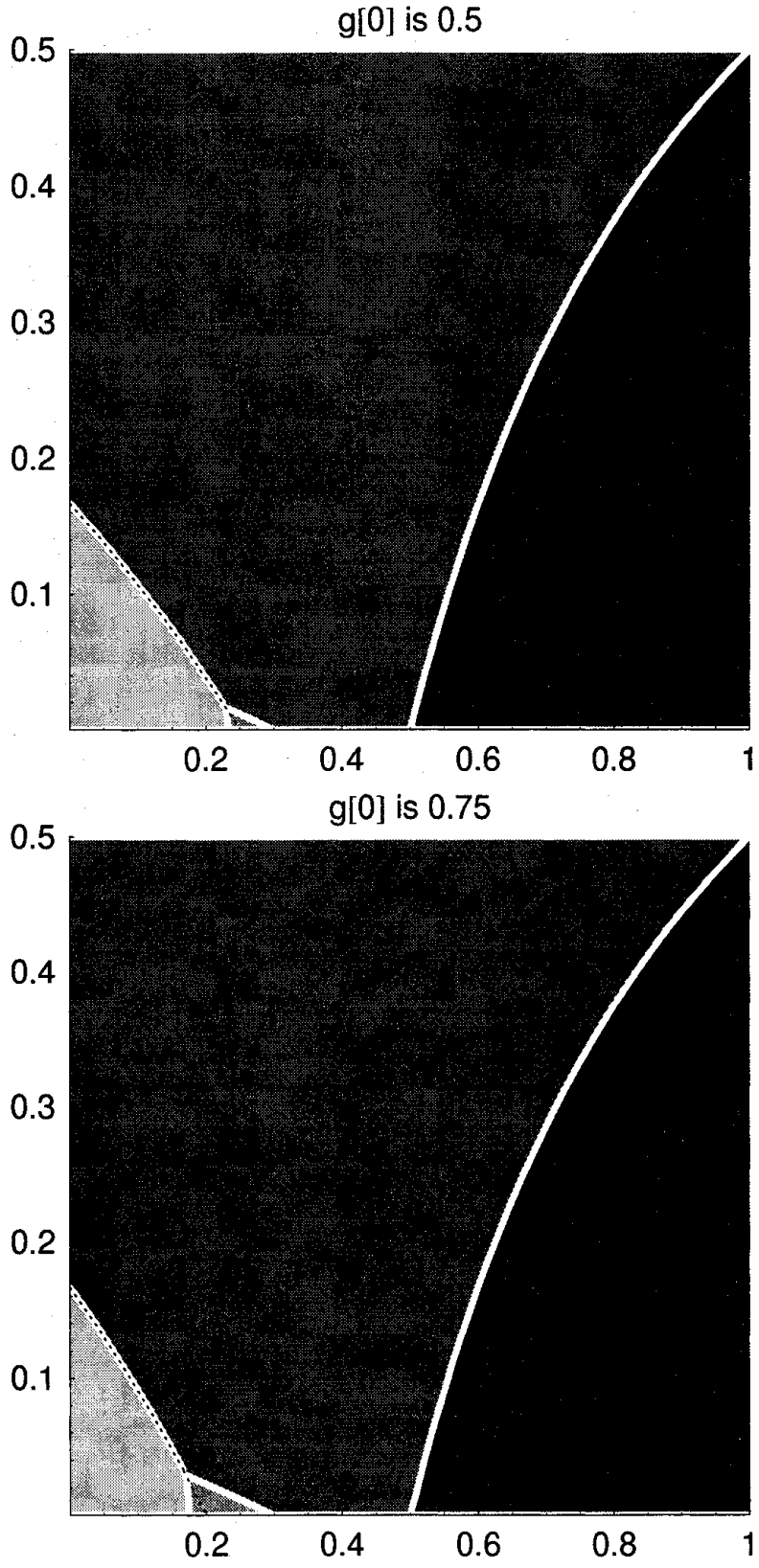


Figure 22: The effect of increasing the harm from falling into the safety net on optimal insurance purchasing decisions.

I can similarly show that increasing g[0] (the odds of falling into the safety net) likewise expands the full insurance zone. The figure below illustrates the concept when ω is 2 and g[0] takes on values of 0.15, 0.5, 0.75 and 0.9.





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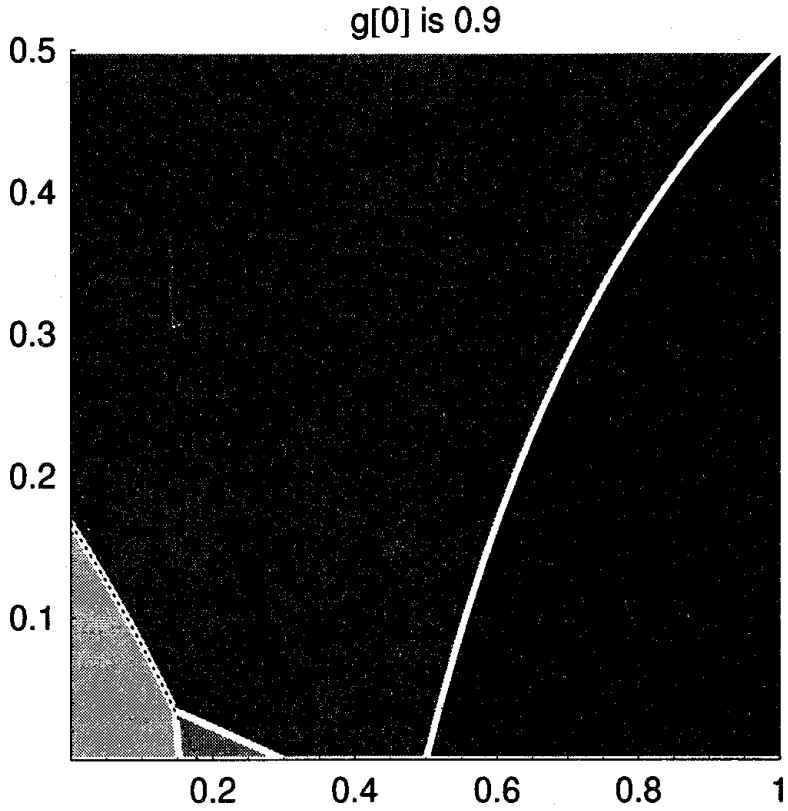


Figure 23: The effect of increasing the odds of falling into the safety net on optimal insurance purchasing decisions.

Whether the result of an increase in ω (the uninsurable loss suffered by falling into the safety net) or an increase in g[0] (the likelihood of falling into the safety net if an accident occurs), the expansion of the full insurance zone renders the population less susceptible to adverse selection problems. As figure 24 confirms, this lesser susceptibility to adverse selection problems makes coarse underwriting schemes more sensible. It presents the total wealth-Gini Coefficient pairs (along with the corresponding hull) for eight underwriting schemes using the population with high potential for adverse selection. The figure on the top reprises figure 22 above and illustrates the tradeoffs involved when ω is zero. The figure on the bottom illustrates the tradeoffs involved when ω is set to 2. I have set g[0] equal to 0.75.[44]

44. In my example, I use the following function for g: $\frac{1}{2}(2.-e^{3.9204\lambda}(0.500001-0.765161\lambda+0.304826\lambda^2))$, provided $0<\lambda<1$. Otherwise g is zero.

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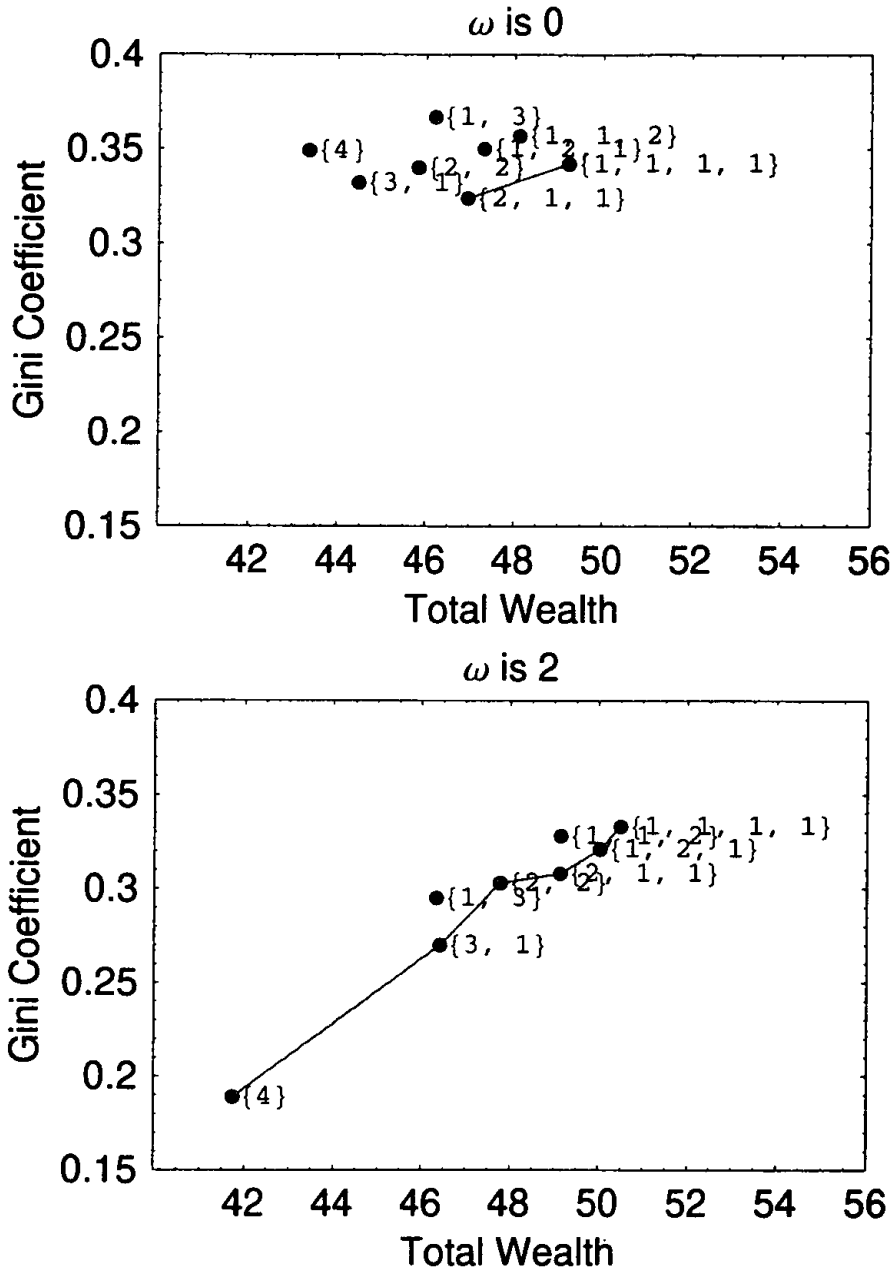


Figure 24: Underwriting maps for varying harms of falling into the safety net.

As can be seen in the bottom figure, when a risk of an uninsurable loss is caused by the absence of complete insurance for an insurable loss, coarse underwriting schemes may make sense, even when the population involved is otherwise highly susceptible to adverse selection death spirals. In the bottom figure, for example, underwriting scheme "4" (which corresponds to no underwriting at all) lies on the hull. So long as one is willing to trade total wealth for greater equality, it now makes sense to prohibit insurers

from establishing numerous underwriting categories. This is so because the risk of an uninsurable loss acts as a drag on the upward spiral of prices that adverse selection would otherwise cause. If underwriting costs are not too large, greater wealth can, of course, be achieved by use of refined underwriting schemes such as "1-1-1-1," but only at the expense of greater inequality. These conclusions are in contrast to the situation depicted in the top figure which, recapitulating the analysis in Section E above, shows that when populations are highly susceptible to adverse selection, and that propensity is unrelieved by the existence of uninsurable losses, coarse underwriting schemes do not advance wealth creation or equality.

III. IMPLICATIONS

If nothing else, the modeling done in this article emphasizes that courts and legislatures should not treat all forms of insurance alike when considering restrictions on underwriting freedom. Unthinking acceptance of platitudes such as "insurers should not discriminate" or "everyone should pay for their own risk" can result in severe social harm. Moreover, we can now get at least somewhat beyond the notion of "underwriting up until it is cost effective." Instead, we can now consider the following eight factors as relevant to the debate about classification. The factors, which should provide a vocabulary for discussions of insurance underwriting, are summarized in the table below.

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Factor	Effect	Comments
heterogeneity of self-perception of risk	homogeneity decreases susceptibility to adverse selection; heterogeneity increases susceptibility to adverse selection	
risk aversion of population	low risk aversion increases susceptibility to adverse selection	
maximum amount of insurance lawfully purchased	high maximums increase susceptibility to adverse selection	can be controlled using insurable interest doctrine and insurer policing
financial constraints on insurance purchases	financial constraints dampen adverse selection	have greater effect on where incomplete insurance is not available
cost of classification	costly classification suggests more coarse classification schemes	
symmetric imperfections in information	does not usually affect optimal classification schemes	but may increase total wealth and decrease inequality
asymmetric imperfections in information	increases susceptibility of market to adverse selection	market may be rescued only by making information more symmetric
uninsurable states	Decreases susceptibility of market to adverse selection	
insured control over risk		if insured can control risk concern over equality of outcomes should decline and refined classification schemes are more palatable

Table 21: A summary of conclusions.

To illustrate how this framework may aid analysis, consider the current debate over insurer access to the results of genetic tests.[45] Until recently,

45. Yet another problem is the meaning of the term "genetic test." As has been recently argued, "with the exception of the relatively rare single-gene diseases, it is difficult, if not impossible, to distinguish genetic from nongenetic diseases." Beckwith & Alper, *supra* note 9, at 205. And as a recent scholar has argued, "[t]he difference between a blood test and family history inquiry, on one hand, and a genetic screen on the other, has to do with the accuracy of the result and not whether or not the differentiation is *genetic*."

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our inability to determine our own genetic code meant that neither insured nor insurer had access to important factors that influence lifespan. It was as if we saw only a small portion of the factors determining lifespan. While hardly perfect or determinative, genetic tests may well provide information on at least some of the previously unknown factors that affect lifespan. Estimates of future lifespan will be made more heterogeneous than they presently are, as a result of the newly available information. One of the factors making a population more susceptible to adverse selection is increased heterogeneity in self-perception of risk. Moreover, life insurance is an area in which the maximum amount of insurance that can be purchased is large and variable. Many people can purchase more in life insurance coverage than they could realistically hope to save if they lived the expected amount of time. There is thus the potential for people who learn of adverse results to "load up" on life insurance and thereby exert a huge torque on prices. Thanks to state anti-forfeiture laws and viatical settlement companies, insureds need not wait until they die in order to realize the profits that can result from the revelation of their previously private information. Finally, for most age groups, there are not huge financial constraints against the purchase of large amounts of life insurance. Many people can afford the premiums if they choose to allocate their money in that fashion. All of these factors suggest that genetic tests will increase the susceptibility of the life insurance market to adverse selection. If insurers have access to this information and can classify thereon, they may well be able to tame this problem. Otherwise, there is the potential for a serious adverse selection spiral.

An examination of the impact of genetic tests on the health insurance market provides a nice contrast to the life insurance scenarios laid out above. While it is true that genetic tests might increase the heterogeneity in self-perceptions of future health expenses and thus render the population more susceptible to adverse selection spirals,[46] it is difficult to "load up" on health insurance. Coordination clauses make it difficult for someone to profit from incurring a medical expense (at least without fraud). Thus, the sort of torque that exists with respect to life insurance is not present here. Moreover, health insurance is precisely the sort of area where people worry

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Gulati, *supra* note 9, at 178. Indeed, life and health insurers use one "genetic test" in underwriting all the time, usually without criticism: it is called gender. *Id.*

46. The significant possibility of such a spiral is identified in Diver & Cohen, *supra* note 9, at 1457-58. As the authors acknowledge, however, and as this article further suggests, the existence of such a spiral depends on unsubstantiated empirical assumptions.

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about uninsurable states and may thus purchase health insurance to prevent being thrown into the safety net. This too reduces susceptibility to adverse selection. Finally, health insurance is expensive; classification thus creates the possibility of financial de-selection. Thus, without opining on whether restrictions on access by health insurers is a good idea or not—an issue that is complicated because the use of genetic tests may depend on the rules regarding insurance underwriting—it is clearly a better idea for health insurance than for life insurance.[47] In a world of genetic tests, coarse classification may still make sense for health insurance when it no longer makes any sense for life insurance. The two markets must be thought of very differently.

The analysis in this article further suggests that even within the market for health insurance, however, those who regulate insurer access to predictive medical information should not— as they largely have to date— treat all genetic tests alike. The problem is a quite difficult one. Medical tests are most useful when they yield highly predictive information: those who test positive are highly likely to develop one set of risks; those who test negative are highly unlikely to do so. Such tests permit people who test positive, often with the help of modern medicine, to re-optimize behaviors, biochemistry and environment so as to actually reduce their risk. The woman who tested positive, for example, on a highly predictive genetic test for breast cancer could, for example, endure the cost, unpleasantness and risk of more frequent mammograms, take medications with possible side effects, or even consider prophylactic mastectomy. Such behaviors might not be optimal if the woman was ignorant of her genetic predisposition for breast cancer. And even if there was nothing medically that the person testing positive could do to reduce his or her risk, such tests might yield information useful to family and financial planning.

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47. Current law in the United States inadequately reflects this conclusion. Although a few states have statutes that could be interpreted to prohibit use of genetic tests in life insurance underwriting, most do not. However, many states do have statutes that greatly restrict the use of genetic tests in health insurance underwriting. *See* Joseph J. Wang, *Genetic Nondiscrimination Laws in Health Insurance*, HEALTH L. PERSP., Aug. 31, 2001, *available at* http://www.law.uh.edu/healthlawperspectives/Genetics/010831HealthIns.html (providing a recent summary of these laws). It may be that some of these restrictions will prove overly broad and that regulation of genetic testing will need to be done on a case-by-case basis for each market; nonetheless, the law seems generally to be far more averse to imposing underwriting regulation on the life insurance industry than the health insurance industry.

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Unless the new optimizations taken in response to the highly predictive genetic test significantly lower the risk initially associated with a positive result, however, such tests are precisely the ones that it is most dangerous to permit the insurance applicant to keep private from the insurer. Such tests move the population from a state of symmetric ignorance in which coarse classification may well be appropriate, to one of significant heterogeneity in which, as I have shown, asymmetric information can lead to serious adverse selection. To be sure, the harms associated with a fall into the safety net are likely to temper this problem for the health insurance market, but it seems unlikely that they will eliminate the problem. Thus, if insurers are barred from access to the results, the tests that yield the most economic benefit are also the ones most likely to hurt the insurance market. But, if insurers are granted access to the results of most predictive tests, some will be discouraged from taking tests that yield the greatest economic benefit.[48]

The extent of this discouragement in a legal regime that permitted insurer access to information that increased the ability to predict risk is both extremely important and extremely difficult to predict. It depends heavily on the dynamics of people's perceptions as to the response of insurers to both positive and negative information and the actual evolving response of insurers acting within an economic and regulatory environment. It may well be subject to path dependence and tipping phenomena.

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48. Diver & Cohen argue that actually giving insurers access to the results of predictive tests simply forces prospective insureds to internalize all the costs of taking such tests. Diver & Cohen, *supra* note 9, at 1465. Denying access, they contend, "encourages overconsumption of genetic testing" in the same way that subsidized flood insurance encourages building in flood plains. *Id.* at 1469. This analogy is intriguing but partly flawed. The failure of a pricing system to internalize costs creates inefficiency when people alter their behavior in inefficient ways in response. Subsidized flood insurance—a very dubious program I agree—creates inefficiencies because people respond by inefficiently purchasing homes for which there is high risk of flood. However, individuals cannot currently alter their genes. Thus, rather than causing inefficient behavior, subsidized insurance may merely transfer wealth. The analogy is not completely flawed, however, in that subsidized health insurance may decrease incentives that would otherwise exist to reduce the risks associated with at least certain genetic predispositions. Moreover, if one is willing to extend the notion of economic efficiency to highly personal decisions, health insurance premiums that are insensitive to genetic predispositions could be said to create inefficiency by encouraging people with genes poorly adapted to the current environment to reproduce excessively.

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All of this suggests, though it does not prove, that tentative experimentation in the field on a state-by-state basis is likely to yield the sort of information that will be most helpful in developing an appropriate balance in an economic system committed to private, voluntary health insurance.[49] State-by-state legal experimentation is likely to develop a decent empirical basis on which to conduct this compromise of competing values: use of helpful genetic tests and an insurance market unwithered by adverse selection. It further suggests that regulators view health insurer access to genetic information more favorably when, at least for the time being, there is little people testing positive can do to seriously alter their fate. Denying access to such tests threatens significant adverse selection; any deterrence as to the use of such tests resulting from insurer access would have significantly milder consequences.[50] And federal legislation that creates some sort of uniform ban on health insurer access to genetic tests cripples the sort of natural experiment that would result from differing state laws.[51] It would prevent us from achieving an empirical basis from

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49. In a recent law review article, Chetan Gulati renews the argument that, in a world in which genetic testing will make it impossible to regard most individuals as having homogeneous health risks, genetic anti-discrimination laws will prove unable to staunch the unavoidable conflict between reliance on private insurance markets and any commitment to roughly equal opportunities for health. "Genetic differentiation should not be tolerated, not because there is anything unique about genes, but because no one should be a citizen of the United States and be forced to sacrifice their economic security for the sake of obtaining necessary medical services." Gulati, *supra* note 9, at 210. The analysis in this article suggests that there may be somewhat greater room than Gulati believes for private health insurance and genetic anti-discrimination laws to co-exist, but he is certainly correct in noting the very serious tension between them.

50. The case is thus stronger for denying health insurer's access to the results of genetic tests for breast cancer than it is for Huntington's disease. There are steps a woman informed of a genetic proclivity for breast cancer can take to reduce her risk. At the moment, it is generally thought that there is little someone learning of a genetic proclivity for Huntington's disease can do to reduce his or her risk. *See* Mark A. Rothstein & Sharona Hoffman, *Genetic Testing, Genetic Medicine, and Managed Care*, 34 WAKE FOREST L. REV. 849, 874 (1999). This inability to reduce risk could, of course, change in the future, which is precisely why uniform treatment of genetic tests such that insurers are always prohibited from accessing the information or always permitted to access the information, is unlikely to appropriately balance the competing objectives.

51. One recent call for federal treatment of this issue justifies overriding the traditional role of American states in regulating insurance reified by the McCarran Ferguson Act, 15 U.S.C. § 1011 (2000), on two grounds: (1) genetic privacy is a universal concern and (2) the federal government funded the Human Genome Project. *See* Meredith A. Jagutis, Comment, *Insurer's Access to Genetic Information: The Call For Comprehensive Federal Legislation*, 82 MARQ. L. REV. 429, 443-45. However, the fact that something is a universal

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which to conduct sensible insurance regulation, leaving the field instead either to surmise or to the frailties of economic analyses, even those as careful as that done here.

CONCLUSION

The analysis provided in this article does not, of course, definitively resolve the extent to which insurers should be able to underwrite. It does, however, provide three things of value. First, it provides a scientific model for thinking about the problem of adverse selection that can replace intuition and prejudice. Second, it provides a set of open, falsifiable, and extensible experiments for examining the dynamics of adverse selection in numerous settings, which is valuable in and of itself and as an example of the way in which law should be rigorously studied. Finally, its conclusions provide a practical framework for thinking about issues of insurance underwriting in a variety of settings. The existence of such a framework is essential given the importance of insurance underwriting policy to the welfare of people in a modern economy.

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concern—the nature of family relationships, the stability of title to land—neither proves nor disproves that a universal solution is required. Even if the preferences of the populace in the different states were identical, it might prefer experimentation with different solutions to the problem to see which worked best, and thus use state-by-state regulation as a convenient vehicle for this exploration. *Cf.* New State Ice Co. v. Liebmann, 285 U.S. 262, 280-311 (1932) (Brandeis, J., dissenting) (arguing that states can serve as "little laboratories" to help solve new problems). And, of course, if preferences vary from state to state, more people will be satisfied if regulation is decentralized. *See* William W. Bratton & Joseph A. McCahery, *The New Economics of Jurisdictional Competition: Devolutionary Federalism in a Second-Best World*, 86 GEO. L.J. 201 (1997) (summarizing arguments for and against regulatory competition within a federal system). Thus, there seems to be nothing special about genetic testing that suggests any special alteration of the conventional balancing that goes on in allocating power between the states and the federation they have joined. The fact that the government helped fund research on genetics appears to be a non sequitur.

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LANDER V. HARTFORD LIFE & ANNUITY INSURANCE CO.: VARIABLE ANNUITIES AND THE FUTURE OF MARKET CONDUCT CONTROLS POST-SLUSA

Robin Generous[*]

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INTRODUCTION

The drain on insurer resources in responding to class action discovery orders presents a formidable threat, even in situations where the complaint has little or no merit. Congress has acknowledged this problem in the securities context and responded with the passage of the Private Securities Litigation Reform Act of 1995 (PSLRA)[1] and the subsequent Securities Litigation Uniform Standards Act of 1998 (SLUSA).[2] In *Lander v. Hartford Life & Annuity Insurance Co.*,[3] the United States Court of Appeals for the Second Circuit held, in a case of first impression, that variable annuities were "covered securities" under SLUSA and, as a consequence, state law class actions were preempted.[4] The court based its holding upon a determination that, given congressional awareness of Supreme Court precedent defining variable annuities as "securities" in the application of federal securities law, Congress intended SLUSA to reach such annuities in order to prevent plaintiffs from doing an end-run around the heightened pleading standards mandated by PSLRA.[5]

However, despite concerns to the contrary, critics present persuasive evidence that class actions were not as widely abusive as purported to be.[6] Significantly, it has been class actions, and not state insurance department reviews, that have uncovered the majority of the past decade's most

1. Pub. L. No. 104-67, 109 Stat. 737.
2. Pub. L. No. 105-353, 112 Stat. 3227.
3. 251 F.3d 101 (2d Cir. 2001).
4. *Id.* at 104.
5. *Id.* at 114.
6. Critics point out that data does not demonstrate widespread abuse of securities class action litigation. *See, e.g.*, Steven P. Marino & Renee D. Marino, *An Empirical Study of Recent Class Action Settlements Involving Accountants, Attorneys, or Underwriters*, 22 SEC. REG. L.J. 115 (1994); Joel Seligman, *The Merits Do Matter*, 108 HARV. L. REV. 438 (1994). Data presented to Congress was based largely on a study involving only eight computer company IPOs analyzed by Professor Alexander. Janet C. Alexander, *Do the Merits Matter? A Study of Settlements in Securities Class Actions*, 13 STAN. L. REV. 497, 507 (1991). Even Professor Alexander concedes that "[i]t is possible that the phenomenon of settlements that do not take the merits into account is confined to the IPO cases examined." *Id.* at 597.

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significant insurance fraud cases.[7] Heightened pleading standards and restrictions on discovery, intended to curb abusive class actions, also affect meritorious suits.[8] While individual state lawsuits are certainly still available, reduced economies of scale raise feasibility concerns. Given the economic impracticalities of individual state law suits, a more balanced approach could be struck between the twin goals of providing consumers redress for market conduct abuses and providing insurers protection from resource draining discovery abuses through the use of a federally codified self-critical analysis privilege. Such a privilege would protect internal quality reviews from discovery by plaintiffs.[9]

At first glance this privilege appears to only further tip the scales in the insurer's favor. However, several benefits could be realized under the privilege that ultimately result in a balancing of the interests. At the outset, insurance companies would have greater flexibility and incentive to design strong oversight controls without fear of liability since oversight practices would be protected from discovery. On an ongoing basis, such a privilege would encourage open communication between the industry and state regulators, thus enhancing the likelihood that proactive responses to control problems would occur more frequently than nondisclosure and inaction.[10] Ultimately, consumers would benefit from purchasing products in improved control environments; in addition, consumers would have access to critical data in the event companies do not address problems in a timely manner.[11]

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7. Rob Gurwitt, *The Riskiest Business*, GOVERNING, Mar. 2001, *available at* http://governing.com/3insure.htm. *See generally* Diane Acker Nygaard, *Class Actions Against Insurance Companies: Class Actions Have Become the Preferred Method for Compensating Victims of Insurance Sales Fraud*, TRIAL, Oct. 1998, at 75.

8. The *Lander* court acknowledged the likely consequences, stating "[PSLRA] mechanisms were intended to 'enact reforms to protect investors and maintain confidence in our capital markets' by 'discourag[ing] frivolous litigation.' PSLRA also has the effect, however, of discouraging non-frivolous litigation." *Lander*, 251 F.3d at 107 (citing H.R. CONF. REP. NO. 104-369 (1995)).

9. This Note assumes that Congress is unwilling, or politically unable, to enter repeal or make fundamental changes to PSLRA. However, such changes are unnecessary. Rather, this Note argues that both consumer protection and safeguards against discovery abuses can be achieved through federal adoption of a self-critical analysis privilege.

10. A self-critical analysis privilege statute would need to expressly provide that disclosure to regulators would not destroy the privilege, and the information would not become public subject to qualifications for lack of timely follow-up to control deficiencies.

11. Admittedly, lack of timely response to control issues would require monitoring by potentially resource-strained insurance departments; in addition, the potential for disclosure may also serve to reduce the incentive for more open communication between insurers and

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This Note addresses the impact of the *Lander* decision and attempts to define a future that best balances the interests of consumers and insurers. Section I provides a brief overview of variable contracts, including the concept of suitability, and explores the basics of internal control in order to appreciate the challenges insurers face in developing and maintaining strong market conduct controls. Next, this Note outlines the law concerning class action requirements and defenses to discovery. Traditional defenses are summarized, including attorney-client privilege, work product and trade secret; in addition, both common law and existing state statutory versions of the more recently developed self-critical analysis privilege are reviewed.

After analyzing the Second Circuit's *Lander* decision in Section II, Section III assesses the potential of the self-critical analysis privilege for protecting consumers by allowing insurers greater flexibility to support strong market conduct oversight controls. This assessment also considers potential options for future federal legislation. Finally, Section IV concludes with a call for uniform legislation to secure an appropriate balance between public disclosure and insurer confidentiality. Adoption of a federally codified self-critical analysis privilege would strike a more balanced approach by protecting consumers from control failures and protecting insurance companies from discovery extortion.

I. BACKGROUND

A. The Variable Annuity Product

1. Product Features

Annuities are a vehicle generally used to set up a stream of income during retirement years.[12] In exchange for a lump sum payment or series of payments, the purchaser obtains the right to receive a stream of periodic payments over a fixed term during the life of the purchaser or other designated beneficiary. Fixed annuities are traditional insurance products with a defined, fixed amount paid over the life of the purchaser. The

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regulators. However, these difficulties could be overcome by the benefits of active disclosure of audit results accruing to the insured: by initiating disclosure to the regulators, the insured has opportunity to correct instances and at the same time has the ability to block the plaintiff's bar from accessing and using the audit results against the insurer.

12. *See generally* SEC, *Variable Annuities: What You Should Know*, *at* http://www.sec.gov/investor/pubs/varannty.htm (last modified Apr. 5, 2001).

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insurer bears both investment risk, including exposure to market fluctuations, and mortality risk, encompassing the risk that the purchaser will outlive the underlying assets. Variable contracts, including variable annuities and variable life, are considered hybrid products with both security and insurance features. Insurance features generally include the traditional insurance risks that insurers typically bear under annuity contracts, such as policyholders outliving expected returns. However, similar to traditional security products, the purchaser of the variable annuity bears the investment risk of the product's underlying assets.[13]

2. Suitability

Suitability rules require that National Association of Securities Dealers (NASD) members "when recommending the purchase, sale, or exchange of any security to a customer, have reasonable grounds for believing that the recommendation is suitable for the customer upon the basis of the facts disclosed by the customer."[14] Variable product customers should be able to bear the investment risks and must understand the implications of poor market performance.[15] The NASD requires "reasonable efforts" be made in order to understand the customer's situation by obtaining information regarding "(1) the customer's financial status; (2) the customer's tax status; (3) the customer's investment objectives; and (4) such other information used or considered to be reasonable by such member or registered representative in making recommendations to the customer."[16]

The incremental costs and benefits of tax-deferred products are important considerations in suitability analysis. With variable annuities, taxes are assessed only when the money is actually paid out; however, if tax-deferred dollars, such as funds from a 401(k), are used to purchase a variable annuity, no additional tax benefit is obtained. Suitability analysis also must consider the costs and benefits of any additional product features. As competition increased in the last ten years, variable contracts were

13. The underlying assets supporting the variable annuity are maintained by the insurer in an account separate from the insurer's general assets, referred to as a "separate account." *Lander*, 251 F.3d at 105 n.3. "While variable annuities are primarily sold by insurance companies, the policies must be offered though 'separate accounts.' These separate accounts must be registered under the Investment Company Act of 1940." *Id.* at 105.

14. NASD Regulation, Inc., NASD Notice to Members 00-44 299-303 (July 2000) (referring to NASD Conduct Rule 2310), *available at* http://www.nasdr.com/pdf-text/0044ntm.pdf.

15. *Id.*

16. NASD Regulation, Inc., *NASD Conduct Rule 2310*, *at* http://www.nasdr.com/conrule_2310.htm (last visited Mar. 2, 2002).

enhanced to attract consumers, with added features such as increased underlying fund options, guaranteed living benefit riders, minimum death benefit riders, and bonus contracts.[17] With such product developments, suitability analysis increases in complexity and requires additional agent and consumer education.[18]

3. Dual Regulation

The McCarran-Ferguson Act preserves state regulation of the "business of insurance" from inadvertent preemption, providing that "[n]o Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . . ."[19] While federal securities laws regulate investments, regulation of insurance business is left largely to the states. As discussed earlier, variable annuities are hybrid products with both investment and insurance attributes; as a result, both state and federal regulations are applicable.[20]

B. The Control Environment

1. Definition

Internal control is defined as "a process, effected by an entity's board of directors, management and other personnel, designed to provide reasonable assurance regarding the achievement of objectives in the following categories: effectiveness and efficiency of operations, reliability of financial reporting[, and] compliance with applicable laws and regulations."[21]

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17. Stephen E. Roth, *Variable Contracts: The Emerging Tensions Between Product Innovation and Suitability*, *in* THE '40 ACT INSTITUTE 2000, at 139, 141 (PLI Corp. Law. & Practice Course, Handbook Series No. 1182, 2000), WL 1182 PLI/Corp 139.

18. *Id.* at 144-53.

19. 15 U.S.C. § 1012 (2000).

20. For example, variable annuity separate accounts are considered investment companies and must adhere to federal filing requirements with the SEC. At the same time, state law requires approval of rates and licensing of issuers.

21. Committee of Sponsoring Organizations of the Treadway Commission (COSO), *Key Concepts: COSO Definition of Internal Control*, *at* http://www.coso.org (last visited Mar. 2, 2002). COSO, which included representatives from industry, public accounting, investment firms, and the New York Stock Exchange, developed this widely accepted definition of internal control. *Id.* Also included in the definition of internal control is the following statement of key concepts:

> Internal control is a *process*. It is a means to an end, not an end in itself. Internal control is effected by *people*. It's not merely policy manuals and forms, but people at every level of an organization. Internal control

Insurers are faced with implementing and maintaining controls to ensure the business achieves its objectives specific to variable annuity sales. Numerous risks need to be identified and managed in the sales process to ensure compliance with applicable laws and regulations, including market conduct suitability requirements. For example, the risk that registered representatives sell unsuitable policies to customers can be mitigated by preventive controls including training and supervision, and can be managed by detective controls including timely review of suitability documentation and monitoring of excessive or unusual replacement activity with appropriate corrective action.

2. Oversight Functions

As one commentator has summarized, oversight functions are essential to a strong control environment:

> An effective compliance system involves two important steps: the first, is obviously to design a good compliance system, but second, devoting the necessary resources to make sure that the system is working. As insurance companies devote more and more resources to new product development and marketing, it is also essential that they devote substantial resources to compliance.[22]

To ensure designed controls operate as intended, insurers must establish compliance programs conducted by employees separate from the marketing/sales organizational areas in order to self-evaluate the effectiveness and efficiency of controls. In addition, audit functions are typically established to opine on the company's overall control environment, with reporting channels to both the Chief Financial Officer and the Board of Director's Audit Committee.

Companies have also promoted collective self-regulation in an effort to respond to market conduct matters. The Insurance Marketplace Standards Association (IMSA), a voluntary industry association, was founded in 1998

> can be expected to provide only *reasonable assurance*, not absolute assurance, to an entity's management and board. Internal control is geared to the achievement of *objectives* in one or more separate but overlapping categories.

Id.

22. Paul F. Roye, Fostering Integrity and Ethical Standards: A Prescription for Success, Before the Life Insurance Marketing and Research Association (Nov. 2, 2000), *at* http://www.sec.gov/news/speech/spch417.htm.

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to promote ethical market conduct.[23] IMSA adopted an ethical market conduct code, and independent certification of compliance with the code is needed to gain membership.[24] "As of February 2001, 234 insurers are now members of IMSA, representing 79% of the life insurance industry's business."[25]

C. Litigation Considerations

1. Class Actions

Class actions are powerful litigation tools. One commentator recently stated that "[n]o single device has influenced the litigation landscape for life, health, and disability insurers in recent years more than the class action. A single claimant can use this device to challenge sales of thousands of policies to hundreds of thousands of policyholders over long periods of time."[26] Class actions are suits brought by one or more individuals on behalf of themselves and all other persons similarly situated and are generally governed by Rule 23 of the Federal Rules of Civil Procedure or its counterpart in the various states.[27]

In class actions, the persons who begin the suit, referred to as the "named plaintiffs," ask the court to appoint them as representatives of the class. If the court determines that it is proper for the suit to proceed as a class action, the members of the class are notified of the suit. Most often, persons who do not wish to be members of the class are given the right to be excluded; however, they will remain in the suit if no action is taken, thus passive members default to support of the class.

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23. Insurance Marketplace Standards Association, *Fact Sheet on Success*, *at* http://www.imsaethics.org/p_m_fss.html (last visited Mar. 2, 2002).

24. *Id.*

25. *Id.*

26. Frederick N. Egler Jr., *Can You Keep a Secret? Preserving Confidentiality in Life, Health, & Disability Insurance Litigation*, 29 THE BRIEF 8, 9 (2000).

27. FED. R. CIV. P. 23(b)(1)(B). Rule 23 states prerequisites in order to bring a class action, requiring "(1) the class is so numerous that joinder . . . is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses . . . are typical . . . of the class, and (4) the representative parties will fairly and adequately protect the interests of the class." FED. R. CIV. P. 23(a). The rule was designed to "avoid a multiplicity of actions[;] allow small claimants to present claims that for economic reasons might not otherwise be brought[;] achieve economies of time and effort[;] prevent inconsistent and varying adjudications[;] provide a common binding adjudication[; and] ward off collateral attacks on class judgments." LEE R. RUSS, 16 COUCH ON INSURANCE § 232:29 (3d ed. 2000).

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Critics of class actions have posited that individual claimants frequently receive nominal settlements while the plaintiffs' attorneys reap substantial legal fees.[28] However, class actions can serve objectives of practicality and fairness, providing a "convenient and economical means for disposing of similar lawsuits" and helping to achieve "the spreading of litigation costs among numerous litigants with similar claims."[29] Plaintiffs benefit from the opportunity to initiate legitimate claims that might not be economical to press individually, and may benefit all individuals in a broad sense by curbing abuses at large. Defendants, although faced with a formidable threat, can also benefit from the class action device by avoiding inconsistent demands and duplicative costs of defending numerous separate cases. Clearly, the power of class actions has captured the attention of both the industry and its regulators.

2. Federal Law: PSLRA and SLUSA

PSLRA amended federal law to require, among other measures, heightened pleading requirements, a stay of discovery pending motions to dismiss, and heightened judicial scrutiny of settlement terms.[30] Concerned that a loophole existed whereby the plaintiffs' bar could avoid stringent PSLRA requirements by filing in state court,[31] SLUSA was adopted to confer exclusive federal jurisdiction for class action suits involving "covered securities," and preempted state and common law based claims.[32]

Data supporting the perceived abuses of class actions that prompted passage of PSLRA is murky at best, with heavy reliance by Congress upon

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28. *See generally* Jonathan R. Macey & Geoffrey P. Miller, *The Plaintiffs' Attorney's Role in Class Action and Derivative Litigation: Economic Analysis and Recommendations for Reform*, 58 U. CHI. L. REV. 1 (Winter 1991).

29. United States Parole Comm'n v. Geraghty, 445 U.S. 388, 402-03 (1980).

30. *See* 15 U.S.C. § 78u-4(b) (2000) (pleading requirements for securities fraud actions); §§ 77z-1(b), 78u-4(b)(3)(B) (stay of discovery); §§ 77z-1(a)(7), 78u-4(a)(7) (judicial scrutiny of settlement terms).

31. *See* 144 CONG. REC. S4778, S4781 (daily ed. May 13, 1998) (statement of Sen. D'Amato) ("The problem to which I refer is a loophole that strike lawyers have found in the 1995 [Reform Act] . . . .").

32. 15 U.S.C. § 77p(c) (2000). "Covered security" is defined as "a security that satisfies the standards for a covered security specified in paragraph (1) or (2) of section 77r(b) of this title, at the time during which it is alleged that the misrepresentation, omission, or manipulative or deceptive conduct occurred . . . ." *Id.* § 77p(f)(3). "[A] covered security . . . is a security issued by an investment company that is registered, or that has filed a registration statement, under the Investment Company Act of 1940." *Id.* § 77r(b)(2).

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narrowly focused data.[33] Studies prompting passage of SLUSA have also been criticized. Congress was presented with statistics showing an increase in state class actions in the year following adoption of PSLRA, suggesting a loophole to evade PSLRA requirements; however, other studies suggest that the increase was temporary and not directly related to PSLRA avoidance.[34]

Regardless of the past shortcomings or successes of class actions, Congress' adoption of PSLRA and SLUSA have significantly altered the class action litigation landscape. Plaintiffs are now required to plead the defendant's state of mind with particularity; simultaneously, a stay of discovery is imposed during the pendency of any motion to dismiss. The stay presents a serious obstacle to plaintiffs from discovering the specific facts needed to survive the motion to dismiss.[35]

3. Traditional Defenses to Discovery

Under Rule 26(b)(1) of the Federal Rules of Civil Procedure, "parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action . . . ."[36] "[T]he term 'not privileged . . . refers to 'privileges' as that term is understood in the law of evidence."[37] Rule 501 of the Federal Rules of Evidence provides that "the privilege of a witness, person, government, State, or political

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33. *See generally* Marino & Marino, *supra* note 6.

34. *See generally* Richard W. Painter, *Responding to False Alarm: Federal Preemption of State Securities Fraud Causes of Action*, 84 CORNELL L. REV. 1 (1998).

> The statistical evidence that plaintiffs fled to state courts following the 1995 Reform Act is at best ambiguous. Other statistical evidence, including studies prepared by National Economics Research Associates and Price Waterhouse L.L.P., suggests that the 1996 increase in state court litigation was temporary and that the number of state court securities class actions filed in 1997 returned to pre-1995 levels.

Id. at 9.

35. *See generally* Hillary A. Sale, *Heightened Pleading and Discovery Stays: An Analysis of the Effect of the PSLRA's Internal-Information Standard on '33 and '34 Act Claims*, 32 SEC. L. REV. 485 (2000). Sale's analysis

> highlights an implicit condition—that in order to survive a motion to dismiss, plaintiffs must plead internal company information . . . . This internal-information standard, when combined with the new stay-of-discovery provision, creates a requirement that if strictly applied is outcome determinative and likely to be overinclusive in its elimination of such claims.

Id. at 542.

36. FED. R. CIV. P. 26(b)(1).

37. United States v. Reynolds, 345 U.S. 1, 6 (1953).

subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."[38]

Several protections are available, including attorney-client privilege, attorney work-product, trade secret and self-critical analysis; each protective device is summarized, *infra.*

a. Attorney-Client Privilege

The attorney-client privilege is one of the oldest recognized privileges for confidential communications.[39] The privilege shields communications between an attorney and a client, in the context of the attorney's provision of legal services, in order "to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and the administration of justice."[40] The privilege applies only if:

> (1) the asserted holder of the privilege is or sought to become a client; (2) the person to whom the communication was made (a) is a member of the bar of a court, or his subordinate and (b) in connection with this communication is acting as a lawyer; (3) the communication relates to a fact of which the attorney was informed–(a) by client (b) without the presence of strangers (c) for the purpose of securing primarily either (i) an opinion on law, or (ii) legal services, or (iii) assistance in some legal proceeding, and not (d) for the purpose of committing a crime or tort; and (4) the privilege has been (a) claimed and (b) not waived by the client.[41]

Significantly, the Supreme Court in *Upjohn v. United States*[42] declined to establish the precise boundaries of the attorney-client privilege, and

38. FED. R. EVID. 501. Note that while the Federal Rules of Evidence do not apply to suits in state courts, many states have rules closely modeled on the federal rules.

39. Upjohn v. United States, 449 U.S. 383, 389 (1981).

40. *Id.*

41. Alvin K. Hellerstein, *A Comprehensive Survey of the Attorney-Client Privilege and Work Product Doctrine, in* CURRENT PROBLEMS IN FEDERAL CIVIL PRACTICE 1996, at 589, 605-06 (PLI Litig. & Admin. Practice Course, Handbook Series No. 540, 1996) (citing United States v. United Shoe Mach. Corp., 89 F. Supp. 357, 358-59 (D. Mass. 1950)), WL 540 PLI/Lit 589.

42. 449 U.S. 383 (1980).

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instead stated that a "case-by-case" approach best effectuates the purpose of the privilege.[43]

b. Attorney Work-Product Doctrine

The attorney work-product doctrine protects material prepared in anticipation of litigation from discovery, including "tangible and intangible material which reflects the attorney's efforts at investigating and preparing a case, including one's pattern of investigation, assembling of information, determination of relevant facts, preparation of legal theories, planning of strategy, and recording of mental impressions."[44] Work-product materials are protected from discovery unless the opposing party demonstrates substantial need with regard to subsequent litigation.[45] The Supreme Court has stated attorney work-product protection is necessary because if "such materials [were] open to opposing counsel on mere demand, much of what is now put down in writing would remain unwritten. . . . Inefficiency, unfairness and sharp practices would inevitably develop . . . ."[46] Notably, work related to the "ordinary course of business" does not qualify for protection.[47]

c. Trade Secret Protection

Trade secret protection is defined as "any formula, pattern, device or compilation of information which is used in one's business, and which gives . . . an opportunity to obtain an advantage over competitors who do not know or use it . . . . A trade secret is a process or device for continuous use in the operation of the business."[48] In addition, the Uniform Trade Secrets Act (UTSA), widely adopted by the states, defines trade secrets as:

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43. *Id.* at 396-97.

44. *In re* Grand Jury Subpoena, 622 F.2d 933, 935 (6th Cir. 1980) (citing Hickman v. Taylor, 329 U.S. 495, 511 (1947)).

45. FTC v. Grolier Inc., 462 U.S. 19, 26 (1983) (quoting Hickman v. Taylor, 329 U.S. 495, 511 (1947)).

46. *Id.* at 25 (citing *Hickman*, 329 U.S. at 511).

47. Nat'l Ass'n of Ins. Comm'rs, *Winter 1998 National Meeting: Special Insurance Issues Committee*, 1998 NAIC PROC. 4TH QTR. 874, 884 (citing Bank Brussels Lambert v. Credit Lyonnais, 160 F.R.D. 437, 449 (S.D.N.Y. 1995)), WL 1998 NAIC Proc. 4th Qtr. [hereinafter NAIC].

48. Katherine Schulze, *Insurance Marketplace Standards Association: "Now That We've Raised the Bar, How Do We Keep From Tripping Over It?"—Access and Privilege Issues Pertaining to Documentation Assembled To Maintain the Company's IMSA Membership*, SE 24 ALI-ABA 281, 328 (1999) (referring to the First Restatement of Torts § 757), WL SE24 ALI-ABA 281.

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> [I]nformation, including a formula, pattern, compilation, program, device, method, technique or process that (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value [from] its disclosure or use, and (iii)[sic] is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.[49]

Trade secret protection derives from property theory, including "the right to exclude others," and liability theory, including "misappropriation of trade secret information as a tort founded in unfair competition principles."[50] Under the UTSA, two elements must be met for protection to apply: one, reasonable efforts must be made to retain secrecy, and two, the information to be protected must be of some value.[51] Notably, disclosure to a third party may waive the protection.[52]

4. Self-Critical Analysis

Self-critical analysis is a relatively new privilege that "shield[s] certain institutional self-analyses from discovery."[53] In general, three elements must be met:

> first, the information must result from a critical self-analysis undertaken by the party seeking protection; second, the public must have a strong interest in preserving the free flow of the type of information sought; finally, the information must be of the type whose flow would be curtailed if discovery were allowed.[54]

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49. *Id.*
50. NAIC, *supra* note 47, at 886-87.
51. Schulze, *supra* note 48, at 328.
52. *Id.* at 331.
53. Note, *The Privilege of Self-Critical Analysis*, 96 HARV. L. REV. 1083, 1083 (1983).
54. *Id.* at 1086.

> Implicit in any application of the privilege is an acknowledgement of the self-defeating nature of allowing discovery of frank self-analyses: in the long run, denying protection will stifle more information than will applying the privilege . . . . Long-term accessibility to vital information must not be sacrificed on the altar of immediate discovery needs.

Id. at 1087-88.

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In the Ninth Circuit, the privilege also requires that the document be created "with the expectation that it would be confidential, and has in fact been kept confidential."[55]

The seminal case first recognizing the privilege involved a suit for medical malpractice.[56] The court in *Bredice v. Doctors Hospital, Inc.* determined that, absent extraordinary circumstances, a hospital has a common law qualified privilege to retain the minutes and reports of medical staff meetings during which doctors critically analyzed the hospital's medical care for the purpose of self-improvement.[57] Concerned that a lack of confidentiality would destroy "constructive professional criticism" that is "essential to the continued improvement in the care and treatment of patients," the court concluded that "[t]here is an overwhelming public interest in having those staff meetings held on a confidential basis so that the flow of ideas and advice can continue unimpeded."[58]

The privilege is not uniformly recognized.[59] Courts that have adopted the privilege have done so when the public interest in preserving confidentiality outweighs the benefits of discovery.[60] Public interest may be found when disclosure of self-critical documents might have a "chilling effect" on an organization's future evaluation of its actions affecting health, safety or other public concerns. As one court stated, the self-critical analysis privilege "protects an organization . . . from the Hobson's choice of aggressively investigating accidents or possible regulatory violations, ascertaining the causes and results, and correcting any violations or dangerous conditions, but thereby creating a self-incriminating record . . .

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55. Michelle R. Mosby-Scott & Michael Todd Scott, *Protecting Evidence of Self Critical Analysis From Discovery in Illinois,* 88 ILL. B.J. 648, 649 (2000) (citing Dowling v. Am. Hawaii Cruises, Inc., 971 F.2d 428 (9th Cir. 1992)).

56. Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970).

57. *Id.* at 250-51.

58. *Id.*

59. At the federal level, the self-critical analysis privilege has been more extensively developed and has been relied on in the areas of accounting records, academic peer reviews, railroad accident investigations, product safety assessments, products liability, and assessment of equal employment opportunity/discrimination practices. Mosby-Scott & Scott, *supra* note 55, at 649-50. At the state level, New Jersey, Kentucky, Indiana, Florida, Colorado, California, Delaware, Massachusetts, Connecticut and New York have rejected the common-law self-critical analysis privilege, while Kentucky and Pennsylvania have recognized the privilege. *Id.* at 650. *See also* Gary J. Cohen, *A Guide Through the Morass of the Self-Critical Analysis Privilege*, 35 ARIZ. ATT'Y 34 (1999) (discussing nationwide uncertainty about the self-critical analysis privilege), WL 35-JUL AZATT 34.

60. Schulze, *supra* note 48, at 292.

or deliberately avoiding making a record . . . in order to lessen the risk of civil liability."[61]

Following *Bredice*, statutory privileges were adopted in the medical peer review context in many states.[62] With respect to insurance, in 1997 Illinois "enacted the first insurance-specific self-critical analysis insurance statute,"[63] and New Jersey and North Dakota enacted similar laws later in the same year.[64] The Illinois statute's opening language states:

> To encourage insurance companies . . . to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with State and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communications relating to voluntary internal compliance audits. The General Assembly hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this State's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance issues. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.[65]

The Illinois statute provides for *in camera* review.[66] In both civil and criminal proceedings, disclosure can result if a fraudulent purpose is found, the material is not subject to the privilege, or the material shows evidence of noncompliance and reasonable corrective action was not taken.[67] In criminal proceedings, disclosure can also be required if there is compelling

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61. Reichhold Chems., Inc. v. Textron, Inc., 157 F.R.D. 522, 524 (N.D. Fla. 1994).

62. Schulze, *supra* note 48, at 293.

63. Phillip E. Stano, *The Case for Uniformity in Self-Critical Analysis Legislation*, NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERVICES EDITION, Dec. 6, 1999, at para. 4, *available at* 1999 WL 30517531.

64. *Id. See also* Schulze, *supra* note 48, at 298-99, n.70.

65. 215 Ill. COMP. STAT. ANN. 5/155.35(a) (2001).

66. *Id.* § 155.35(c)(2), (3).

67. *Id.*

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need, the information is not available otherwise, and the substantial equivalent of the information would not be available without unreasonable cost and delay.[68] The statute also provides that voluntary submissions to the Department of Insurance do not waive the privilege.[69] However, the statute states that "[n]othing contained in this subsection shall give the Director any authority to compel a company to disclose involuntarily or otherwise provide an insurance compliance self-evaluative audit document[,]" thus information can be shielded from state insurance department review.[70]

The North Dakota and New Jersey statutes are similar to Illinois, however the consequences for problems identified in the self-audits differ. Privilege can be lost in Illinois "if the company fails to 'eliminate the non-compliance within a reasonable time[,]'" whereas in North Dakota the standard is "clear and convincing evidence that the insurer failed to undertake reasonable corrective action."[71] These differing standards contrast sharply with New Jersey, where "even if corrective action is timely taken . . . such action is only a 'mitigating factor.'"[72] In New Jersey the mitigating factor provision can also be lost even in situations where the insurer takes corrective action but "does not timely disclose the findings . . . to the (insurance) department," defined as "within 90 days of completion of the review or within 20 days of a request by the department."[73]

II. *LANDER V. HARTFORD LIFE & ANNUITY INSURANCE CO.*

A. Facts and Procedural Posture

In *Lander*, a nationwide class action was filed in state court against Hartford Life and Annuity and Hartford Life Insurance (Hartford Life). The plaintiffs alleged fraud in the marketing of variable annuities as a tool to fund the plaintiffs' qualified retirement plans.[74] State and common law causes of action were raised, including deception and misconduct in

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68. *Id.* § 155.35(c)(3)(D)(iii).

69. *Id.* § 155.35(b)(3). "A company may voluntarily submit . . . an insurance compliance self-evaluative audit document to the Director, or his or her designee, as a confidential document . . . without waiving the privilege . . . ." *Id.*

70. *Id.*

71. Stano, *supra* note 63, at para. 10.

72. *Id.* at para. 11.

73. *Id.* "[L]egislative balkanization of the self-critical analysis privilege is well underway." *Id.*

74. Lander v. Hartford Life & Annuity Ins. Co., 251 F.3d 101, 103 (2d Cir. 2001).

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violation of the Connecticut Unfair Insurance Practices Act (CUIPA), the Connecticut Unfair Trade Practices Act (CUTPA), and "common law prohibitions against insurance fraud, fraudulent concealment and deceit, negligent misrepresentation, negligence, breach of fiduciary duty/constructive fraud, and unjust enrichment for restitution of insurance fees and other relief."[75] The plaintiffs alleged that they were induced to fund tax-deferred retirement plans with inappropriate, unsuitable variable annuities that offered no additional tax benefit.[76] The plaintiffs claimed that the true nature of the investment was not disclosed to them, resulting in high fees and loss of liquidity in exchange for unnecessary tax deferral.[77]

Hartford Life successfully removed the case to federal court, justified on grounds that original jurisdiction existed and also because SLUSA was applicable, which states "any covered class action brought in any State court involving a covered security . . . shall be removable to the Federal district court for the district in which the action is pending . . . ."[78] The plaintiffs filed a motion to remand back to state court on the basis that Congress did not intend to include variable annuities in the "covered securit[ies]" definition.[79] However, relying on the plain language of SLUSA, the district court held that variable annuities are "covered

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75. Brief for Plaintiffs-Appellants at 5-7, Lander v. Hartford Life & Annuity Ins. Co., 251 F.3d 101 (2d Cir. 2001) (No. 00-7849).

76. *Lander*, 251 F.3d at 106.

77. *Id.*

> The plaintiffs claim that they relied upon the advice and expertise of Hartford Life representatives who misrepresented the suitability of variable annuities and failed to warn consumers of the tax redundancy that occurs when the products are purchased with already tax-deferred dollars. Moreover, the plaintiffs allege that the fees associated with variable annuities exceeded those of other investments that they otherwise would have utilized. They allege that the fees assessed by variable annuities resulted in the loss of up to one-third of the value of their accounts, as compared to straight investment products such as mutual funds. . . . [T]hese misrepresentations deceived the plaintiffs into paying higher fees for tax benefits that Hartford Life knew the plaintiffs would not realize.

Id.

78. *Id.* (alteration in original) (quoting SLUSA, 15 U.S.C. § 77p(c) (2000)). The case was removed "pursuant to 28 U.S.C. § 1441(b) which allows 'any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the . . . laws of the United States' to be removed from state to federal court. Removal was also justified under the text of SLUSA . . . ." *Id.* at 106.

79. *Id.*

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securit[ies]," and thus SLUSA applied.[80] The plaintiffs' motion to remand was denied and the claims were dismissed given the SLUSA preemption of state and common law causes of action.[81] Subsequently on appeal, the Second Circuit reaffirmed the district court's dismissal of the case.[82]

B. The Opinion

The appeal raised two issues of first impression: "(1) [w]hether Congress intended variable annuities to be a 'covered security' under SLUSA, and thereby preempt class actions based on state law that allege fraud in the sale of such instruments. (2) Whether the McCarran-Ferguson Act precludes the application of the preemptive provisions of SLUSA to variable annuities."[83]

With respect to the first issue, under *de novo* review the court held that variable annuities fell under the definition of "covered securities." [84] The court based its holding on textual analysis of the statute and further rationalized its holding based on legislative intent. Following a plain meaning approach, the court found that the definition of "covered security" was met: first, variable annuities are securities,[85] and second, "variable annuities are sold by companies registered under the Investment Company Act of 1940."[86]

The plaintiffs argued that although the plain language of the statute would include variable annuities, the "structure, history and purpose of SLUSA demonstrate that Congress never intended class action litigation

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80. *Id.* at 107.

81. *Id.*

82. *Id.* at 104.

83. *Id.*

84. *Id.* at 104, 107. "[A] covered security . . . is a security issued by an investment company that is registered, or that has filed a registration statement, under the Investment Company Act of 1940." 15 U.S.C. 77r(b)(2) (2000).

85. *Lander*, 251 F.3d at 109 (citing SEC v. Variable Annuity Life Ins. Co. of Am. (VALIC), 359 U.S. 65 (1959) (holding that although possessing some insurance characteristics, variable annuities are properly classified as securities and thus subject to the federal securities statutes)).

86. *Lander*, 251 F.3d at 109 (citing *VALIC*, 359 U.S. at 70-71 (holding that issuers of variable annuities must comply with the Investment Company Act of 1940)); Prudential Ins. Co. of Am. v. SEC, 326 F.2d 383, 388 (3d Cir. 1964) (holding that although insurance companies are not investment companies themselves, they may sell variable annuities only through separate investment accounts that must be registered with the SEC pursuant to the 1940 Act). "[B]ecause variable annuities are securities, and because the separate accounts used for marketing these products are registered with the SEC under the Investment Company Act, the removal clause of the statute is satisfied." *Lander*, 251 F.3d at 109.

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concerning variable annuities to be preempted by SLUSA."[87] The court did not find clear legislative intent to rebut the plain language of the statute; rather, the court determined that legislative findings provided further support that variable annuities were included.[88] Specifically, Congress sought to reach "nationally traded securities;" Hartford Life sells nationally, thus it is included in the group intended to be regulated.[89] In addition, many variable annuity class actions were filed in federal court prior to PSLRA and following PSLRA were filed in state court, thus following the "pattern . . . of the suits targeted by Congress in SLUSA."[90] Next, the court found that the legislative intent to include variable annuities was consistent within the larger statutory context, including PSLRA, the National Securities Market Improvement Act, the Securities Act of 1934, and the Investment Company Act of 1940.[91] Finally, the court rejected the plaintiffs' claim that "the history of regulation of variable annuities compels the conclusion that Congress could not have intended SLUSA to preempt state insurance law."[92] The court reasoned that the long history of dual federal and state authority would not be disrupted by the narrow focus of SLUSA, applicable only to private plaintiff class actions alleging fraud based on state laws.[93] The court stated:

> To illustrate the limited reach of SLUSA, it is helpful to note what is *not* preempted by the statute: (1) Individuals may still bring suits based on state law or in state court for fraudulent sales of variable annuities, but not in a class action context. (2) All state regulation of variable

87. *Lander*, 251 F.3d. at 110.

88. *Id.*

89. *Id.*

90. *Id.* at 111. Plaintiffs argued SLUSA was targeted to prevent securities from migrating from federal court to state court, whereas "insurance fraud litigation has routinely occurred in state court, and it certainly did not migrate to state court to avoid the PSLRA." Brief for Defendants-Appellees at 36, Lander v. Hartford Life & Annuity Ins. Co., 251 F.3d 101 (2d Cir. 2001) (No. 00-7849). However, defendant's brief counters with "prior to SLUSA, Plaintiff's own lead counsel brought claims involving these so-called 'insurance products' in federal court, using the federal securities laws as a basis for federal jurisdiction." *Id.* at 24.

91. *Lander*, 251 F.3d at 111. The court rationalized that the larger statutory context does not expressly exempt variable annuities; rather, "for over forty years, variable annuities have been subject to the 1933 Securities Act and the 1940 Investment Company Act. There is no indication in SLUSA, NSMIA, or PSLRA that Congress intended to alter this longstanding state of affairs." *Id.* at 112.

92. *Id.* at 113.

93. *Id.*

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> annuities not relating to fraud in the sale of such contracts remains in full force and effect. (3) The statute explicitly excepts . . .
> • certain actions based upon the law of the state in which the issuer of the security is incorporated . . .
> • actions by states, political subdivisions, and state pension plans, so long as the entity is a named plaintiff and has authorized participation in the action . . .
> • actions by an indenture trustee against an issuer seeking to enforce contractual provisions of the indenture . . . .
> With such a narrow preemptive effect, the plaintiffs' claim that SLUSA would eviscerate the longstanding federal-state regulatory relationship for variable annuities rings hollow.[94]

With respect to the second issue, the court held that the McCarran-Ferguson Act[95] does not preclude application of SLUSA to variable annuities because SLUSA contains an explicit provision preempting state law in order to address a national concern.[96] In addition, SLUSA does not conflict with any state statute regulating insurance.[97] The court emphasized that "because SLUSA applies only to class actions brought by private individuals, the administrative regime of Connecticut is left entirely untouched."[98] The court continued by pointing out that state regulator enforcement powers are preserved under the statute, referring to SLUSA's text stating that "[t]he securities commission (or any agency or office performing like functions) of any State shall retain jurisdiction under the laws of such State to investigate and bring enforcement actions."[99] Since state enforcement powers were untouched, the court reasoned that the state regulatory regime would not be inhibited, nor was any statute frustrated

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94. *Id.*

95. Given the hybrid insurance and security attributes of variable annuities, the court expressly declined to hold that variable annuities are not "categorically . . . for the purposes of the McCarran-Ferguson Act . . . not the business of insurance." *Id.* at 116. Thus, McCarran-Ferguson analysis was relevant.

96. *Id.* at 117, 120.

97. *Id.* at 117. The McCarran-Ferguson Act "seeks to protect state regulation against inadvertent federal intrusion." *Id.* at 116 (citing Barnett Bank of Marion County, N.A. v. Nelson, 517 U.S. 25, 39 (1996)).

98. *Id.* at 118.

99. *Id.* (quoting 15 U.S.C. § 77p(e) (2000)).

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that specifically provided for private causes of action in the insurance context.[100]

III. ANALYSIS

Lander presents a potential turning point in variable annuity control environments by expressly providing, in a case of first impression, that state class actions alleging variable annuity market conduct abuses are preempted and heightened federal class action requirements exclusively apply. The *Lander* case was correctly decided based on the strong textual support and legislative intent found in both SLUSA and the statutory context. Its McCarran-Ferguson analysis was based on the explicit preemptive effect of SLUSA, rather than the court's less persuasive argument that SLUSA does not interfere with a state's insurance regulatory regime as discussed below. However, the court mischaracterized the impact of its decision on variable annuity control environments as discussed, *infra*.

A. Critique of the Lander *Opinion*

1. The Insurance Aspects Were Not Fully Explored

The court and both parties agreed that variable annuities are hybrid products, possessing both insurance and investment attributes. The investment regulatory objectives were fully considered by the SLUSA and PSLRA plain language review and legislative intent analysis. However, the state-regulated insurance aspects were not as thoroughly examined.[101] Specifically, the *Lander* court stated in its McCarran-Ferguson analysis that the state regulatory regime was left "untouched" since state agencies would not be precluded from bringing state suits. However, no consideration was given to the possibility that the state regulatory enforcement regime, including allocation of state resources, relies to some degree on private suits. Thus, whether or not the state regulatory regime is actually "untouched" or the degree to which state regulation has been affected, was not adequately considered.

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100. *Id.* at 118-19.

101. Interestingly, the court invited both the NAIC and the SEC to submit *amicus curiae* briefs; the NAIC declined, while the SEC submitted a brief arguing that a variable annuity is a covered security and SLUSA preempts class actions involving variable annuities. *Id.* at 103.

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2. The Reach of SLUSA Does Not Have a "Narrow Preemptive Effect"

The court listed actions that were not preempted by SLUSA in order to illustrate a supposed narrow reach by the statute, including the continued availability of individual suits not brought in a class action context.[102] However, the economic realities of bringing individual meritorious suits as opposed to a more cost-effective class action are likely to deter individual filings. This shortcoming of federal class action requirements was briefly acknowledged early in the *Lander* opinion, when the court stated that the "PSLRA also has the effect, however, of discouraging non-frivolous litigation."[103] Although SLUSA has a similar "chilling effect," the court did not consider this effect when characterizing the reach of SLUSA as narrow.

The court's application of SLUSA may also have broader effect to the extent that it causes an imbalance between consumer and insurer interests. Considering the underlying statistics that prompted Congress to pass both PSLRA and SLUSA as discussed previously,[104] critics present a persuasive argument that the data presented to Congress was not representative of the overall securities market, nor was data assessed specific to insurance class actions. Simply stated, the benefits derived from reducing frivolous lawsuits and stemming discovery abuses may not outweigh the additional costs imposed on plaintiffs trying to bring meritorious suits, either within the insurance market or within the securities market overall.

B. The Future of Market Conduct Controls Post-SLUSA

The threat of class actions is part of the control environment. Controls may be added by companies in the sales process to reduce exposure to litigation. Perhaps significantly, even the threat of a class action suit effectively functions as a control by deterring selling agents from engaging in unsuitable sales practices. Post-SLUSA and post-*Lander,* companies

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102. The *Lander* court also listed "state regulation of variable annuities *not relat[ed] to fraud in the sale of such contracts* remains in full force and effect." *Id.* at 113 (emphasis added). Given the prominent role of state insurance regulation of market conduct, this far-reaching limitation would significantly alter the dual state/federal insurance regulatory system. However, no support for this statement exists in either the plaintiff or defendant's briefs; furthermore, the text of SLUSA expressly preserves state fraud authority at 15 U.S.C. § 77r(c)(1) (2000).

103. *Lander*, 251 F.3d at 107.

104. *See supra* notes 6, 30 and accompanying text.

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marketing variable annuities have a reduced threat from all class actions, regardless of the suit's merit. Class actions have power, and the consumer's hand has been dealt a blow by preempting state law class actions thereby subjecting such suits to the heightened requirements applicable to federal class actions.

Given the changes in the class-action litigation landscape, consumers would be well served by an environment that encourages insurers to improve oversight of selling practices. However, current methods to protect oversight practices from discovery may deter insurers from implementing robust oversight controls. IMSA provides a positive example of insurer action to improve market conduct controls, yet also illustrates how the threat of liability can impede efforts to self-evaluate. Insurers are presented with a "catch-22": steps taken to develop and maintain a strong market conduct control environment also have the potential to fuel lawsuits against the insurer. Confidentiality and privilege have been extensively analyzed by the NAIC Access to Information Working Group, although no definitive model act has been defined.[105] At an industry conference, Katherine Schulze discussed access and privilege issues regarding IMSA membership.[106] Schulze's analysis is useful for practical considerations in assessing options for managing litigation exposure in the self-evaluation context.

As gleaned from Schulze's analysis, multiple avenues of protection should simultaneously be asserted, however none provide guaranteed protection from discovery. Attorney-client privilege and the work-product doctrine both require special attention to the capacity the attorney acts in. In a sense, a legal fiction is created by structuring a review, such as IMSA, to fall under the protections of the doctrines. For example, to protect a communication under attorney-client privilege, "the communication must be made for the purposes of seeking legal advice, to an attorney or his subordinate, acting in their capacity as an attorney or subordinate to the attorney."[107] Under the work-product doctrine, there must be "a substantial probability of litigation and . . . the documentation prepared would not have

105. NAIC, *supra* note 47, at 879. The NAIC task force prepared a white paper that reviewed several options for asserting confidentiality or privilege. *Id.* at 878. The NAIC "decided to limit its work to developing a 'set of principles' for states to follow in deciding on a self-critical analysis privilege. . . . [and] chose not to pursue a model act." Fran Matso Lysiak, *NAMIC Urges States to Assure Confidentiality of Internal Audit Reports*, BEST'S INS. NEWS, July 12, 2001, *available at* 2001 WL 24724001.

106. Schulze, *supra* note 48, at 285-86.

107. *Id.* at 310.

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been so prepared but for that litigation."[108] Under both theories, self-audits do not naturally meet the historical purposes of these doctrines; however, internal oversight reviews could be artificially structured to maximize the possibility that the protections will apply. Schulze provides, throughout her analysis, many instances of discrepancies between courts' applications of the theories and varying levels of strictness, however attorney-client privilege and work-product doctrine do appear to have more stable application by the courts as compared to trade secrets and self-critical analysis.

Schulze states trade secret protection has been asserted by insurers for "rates and form filing information and support justification for the filing, policyholder/agent listings, marketing strategies, premiums by territory, [and] underwriting guidelines . . . ."[109] With respect to IMSA, trade secret protection may apply to "methods or programs for monitoring various aspects of business that are unique . . . software developed to assist the field offices in the marketing and sale of the companies products . . . . [and] software, methods or tools developed . . . in connection with the Independent Assessment . . . ."[110] Use of trade secret protection for oversight controls has a more narrow application as compared to attorney-client privilege and work-product doctrine since the subject matter is limited to practices involving secrecy and value. In addition, even when secrecy and value are present, "[c]ourts have frequently afforded a limited protection."[111]

The self-critical analysis privilege, designed to allow self-analysis and evaluation of compliance with legal and regulatory requirements, squarely addresses the type of work actually performed in conducting self-evaluative oversight reviews. However, the protection under the common-law version of the privilege is perhaps the weakest as compared to attorney-client privilege, work-product doctrine, and trade secret protection. Schulze states that because "there is not uniform acceptance of the doctrine," case law "has been applied in an ad hoc manner."[112] With regard to IMSA, Schulze expressly cautions that "[a] company cannot depend upon the existence of this doctrine to protect self-critical analysis of its compliance

108. *Id.* at 320.
109. *Id.* at 329.
110. *Id.*
111. *Id.* at 330.
112. *Id.* at 292-93.

with insurance or securities laws."[113] Clearly, the common-law self-critical analysis privilege is presently not a viable means to protect confidentiality.

C. Proposed Adoption of a Federal Self-Critical Analysis Privilege for Insurers

A federal statutory version of the self-critical analysis privilege would alleviate the ad hoc, varying interpretations found under the common law and provide for uniform application by the states. The self-critical analysis privilege, similar to its common law counterpart, offers intellectual-honesty appeal in recognizing the protected conduct for what it actually is, removing the need to create legal fictions and construe communications in order to maximize coverage by the traditional privileges.[114]

The federal version could be modified to leverage from existing state insurance regulatory structures and provide consumers with limited discovery if insurers failed to adequately address deficiencies.[115] The privilege would improve the consumer's position in three areas: (1) encourage insurers to improve both oversight of selling practices and responses to deficiencies; (2) promote consumer confidence in insurer selling practices by increasing transparency to state regulators; and (3) provide consumers with the means to meet heightened pleading standards under limited conditions.

With respect to the first benefit, the privilege would protect self-critical internal reviews from the plaintiffs' bar. However, a critical difference from the Illinois version is state regulator access. State insurance departments already have responsibility for regulating insurer market conduct practices. By allowing regulator access, the insurers response to deficiencies could be monitored and would likely result in more proactive

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113. *Id.* at 304.

114. "Unlike the attorney-client privilege or the work product doctrine, lawyers or lawsuits are not required for the privilege to attach." Cohen, *supra* note 59, at para. 4.

115. Sale points out that even under the PSLRA stay of discovery mandate, judges arguably have the discretion to manage discovery now, however "those involved in litigation and discovery disputes know that judges generally dislike the discovery process and prefer not to become involved in it." Sale, *supra* note 34, at 529-30. Sale proposes, in the context of general securities litigation, a sweeping change: repeal of the PSLRA stay-of-discovery requirements and adopt "[m]anagerial-judge legislation, with explicit managed-discovery provision." *Id.* at 488. While Sale's legislative changes are targeted at limiting discovery abuses while allowing opportunity to meet heightened pleading requirements, this Note proposes a solution more narrowly tailored to the business of insurance, with emphasis on leveraging from state insurance regulators as opposed to broad changes to PSLRA and additional mandates on the judiciary.

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responses to deficiencies. State regulator access also provides the means to achieve the second and third benefits listed above. In a sense, state regulators would manage the discovery process: access to protected documents is similar to *in camera* review, and monitoring insurer responses to deficiencies provides critical information to a judge controlling the gateway to discovery. If deficiencies were not resolved timely as defined by the statute and overseen by the state, the protection would be lost and consumers would have access to the information to pursue redress. Qualifying the discovery protection benefits consumers in situations where the self-critical analysis protection is lost since the PSLRA heightened pleading requirements could be met using the same information the insurer failed to respond to.

An obvious response to this proposal is that insurers would simply "opt out" of utilizing the privilege given the risks for both state regulator sanctions and potential loss of the privilege leading to class action exposure. Yet another "catch-22" is presented, with insurer's actions to improve selling practices having the potential to fuel lawsuits. However, the solution lies in the ground rules defining how the privilege is lost. Care must be taken in narrowly defining what constitutes a failure to "timely respond" to control deficiencies. Insurers in turn would gain the ability to adopt robust oversight controls that have more definitive protection from discovery under the federal self-critical analysis privilege.

CONCLUSION

The *Lander* court appropriately concluded variable annuities were "covered securities" under SLUSA, thus preempting state law class actions. Post-SLUSA, the market-conduct control environment has been significantly altered, with more stringent class action requirements imposed on consumers. As discussed previously, the legislative histories leading to the adoption of both PSLRA and SLUSA were based on narrowly focused data concerning class action abuses. Congress reacted with heightened pleading requirements and stays on discovery to correct the perceived imbalance of power between plaintiffs and defendants. However, the balance of power shifted to the defendant without regard to the merits of future cases.[116] This power shift has added significance given that class

116. Class action litigants in annuity cases also face an interesting situation post-*Lander*. While state insurance department oversight of the business of insurance remains applicable to both variable and fixed annuities, consumer class actions have been split between federal and state jurisdiction. Variable annuity class actions must be brought under exclusive

actions have been a prominent means for uncovering fraud in the insurance industry.[117]

A more balanced approach to achieving the twin goals of providing consumers redress for market conduct abuses and providing insurers protection from resource draining discovery orders could be attained through the use of a federally-codified self-critical analysis privilege. Uniform legislation that strikes an appropriate balance between public disclosure and insurer confidentiality in both state and federal suits would allow insurers the flexibility to improve controls for the benefit of consumers, and consumers would have redress if deficiencies were not timely addressed. Consumers and insurers would both benefit from an environment that encourages continuous monitoring and improvement of market conduct controls.

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federal jurisdiction, whereas fixed annuity class actions under state and common law remain viable.

117. *See supra* note 7.

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WADING IN THE POOL: INTERLOCAL COOPERATION IN MUNICIPAL INSURANCE AND THE STATE REGULATION OF PUBLIC ENTITY RISK SHARING POOLS—A SURVEY

Jason E. Doucette[*]

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INTRODUCTION

As an outgrowth of American "anti-sprawl" movements, numerous commentators on local government and land use law have advocated

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* B.A., Cum Laude, 1999, Washington University in St. Louis. J.D. expected 2003, University of Connecticut School of Law. The author wishes to thank Dr. Peter Young, Professor Terry Tondro, Mr. Harold Pumford, and Mr. Stewart Diamond for their ideas and their comments.

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various forms of regionalization including revenue sharing, regional service providers, and regional regulatory agencies to address metropolitan, suburban, and regional problems.[1] These forms of interlocal contract, the theory goes, are mutually desirable arrangements for all municipalities involved because they allow for the collectivization of resources across town borders thereby expanding the tax base and providing a wider range of services than any single municipality could provide independently.[2] Furthermore, some proponents claim that interlocal agreements have the potential to act as a panacea for the local self-interest and intra-regional disparity that currently reflects the relationship between central cities and their suburbs.[3] Some states and regions have made genuine efforts toward regionalization and interlocal cooperation and have met with moderate success,[4] while in others, where municipalities are more reluctant to surrender autonomy, the politics of parochialism and "home rule" remain the standard for municipal governance.[5]

Intergovernmental cooperation has a particularly useful and important application in the municipal insurance context. As a result of the widespread abrogation of governmental immunity in most states throughout the 1970s and early 1980s and the attendant growth of municipal liability, many insurers increased insurance premiums significantly for cities and towns, and became reluctant or unwilling to underwrite many municipal activities.[6] Consequently, many municipalities, particularly those with smaller tax bases, were forced either to go without insurance or risk bankruptcy.[7] These diminishing defenses and immunities, together with expanding liability, necessarily meant greater insurance costs.

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1. *See generally* Richard Briffault, *Surveying Law and Borders: The Local Government Boundary Problem in Metropolitan Areas*, 48 STAN. L. REV. 1115 (1996); Richard Briffault, *Our Localism*, 90 COLUM. L. REV. 1 (1990) [hereinafter Briffault, *Our Localism*]; Clayton P. Gillette, *Regionalization and Interlocal Bargains*, 76 N.Y.U. L. REV. 190 (2001).

2. Gillette, *supra* note 1, at 192.

3. *See id.* at 214-15.

4. Oregon's efforts toward regional planning, codified in their Statewide Planning Act, serve as a good example. *See* Henry R. Richmond, Symposium, *From Sea to Shining Sea: Manifest Destiny and the National Land Use Dilemma*, 13 PACE L. REV. 327, 339 (1993).

5. *See* Briffault, *Our Localism*, *supra* note 1, at 10-17.

6. Louis P. Vitullo & Scott J. Peters, *Intergovernmental Cooperation and the Municipal Insurance Crisis*, 30 DEPAUL L. REV. 325, 329 (1981). *See also* James R. Hackney, *A Proposal for State Funding of Municipal Tort Liability*, 98 YALE L.J. 389, 392 (1988) (discussing the history of sovereign immunity).

7. *See* Hackney, *supra* note 6, at 389.

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Typically, the funds available to pay a tort judgment when a municipality is found liable to a third party are a function of the governmental unit's tax base. Obviously, the larger the tax base, the easier it is for that governmental body to meet the costs imposed by the judgment. Thus, after the demise of sovereign immunity and the resulting increase in insurance costs, small municipalities, lacking a sufficiently broad tax base, would be caught in a difficult position in which they could neither afford commercial insurance coverage nor expose themselves to large judgments.[8] In response, many states began to experiment with intergovernmental risk sharing pools, often through their state municipal leagues, that helped to shield municipalities from the traditional insurance market's cyclical problems of cost, capacity, and uncertainty.[9] These agreements are devices both for risk sharing and for spreading risk of pecuniary loss among individual policyholders.[10] Thus, the fundamental purpose of risk pooling is not unlike that of conventional insurance.

Interestingly, while public entity risk sharing pools have existed in many states since the late 1970s, the nature and extent of state regulation of such pools is widely varied. Some states, most notably Indiana, Utah, and Wisconsin, choose to regulate their pools as they do insurance companies. In contrast, the majority of states have gone the other way, choosing not to place public entity pools under the regulatory purview of the state insurance commissioner, and in some cases have defined the pools as self-insurance, and therefore, not really insurance at all.[11] But are these pools really self-insurance? In one respect, each member of the pool acts as both insured (when it makes a claim) and insurer (in that it, through contribution to the pool, shares the risk with other members). On the other hand, in the case of a risk sharing arrangement, there are payments of "premiums" and a

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8. Vitullo & Peters, *supra* note 6, at 334.

9. *See* Tenn. Mun. League Risk Mgmt. Pool, *Creation of the TML Pool, at* http://www.tmlrmp.org/GetContent.asp?doc=1Pool_Info\1Creation.htm (last visited Mar. 2, 2002) [hereinafter TML Pool, *Creation*]; *see also* Nat'l League of Cities, *National League of Cities Risk Information Sharing Consortium (NLC-RISC), at* http://www.nlc.org/nlc_org/site// display.cfm?id=87342520-7CAA-4615-A63F93899A92A7F0 (last visited Mar. 2, 2002).

10. David Lincoln Ader & Stewart H. Diamond, *An Outline: Visionary Coverage for Pools—Where Others Fear to Tread—Land Use Takings, Before the Public Risk Management Association*, at para. 1, *at* http://www.agrip.org/services/articles/landuse.doc (last visited Mar. 2, 2002).

11. City of Arvada v. Colo. Intergovernmental Risk Sharing Agency, 19 P.3d 10, 15 (Colo. 2001); Eakin v. Ind. Intergovernmental Risk Mgmt. Auth., 557 N.E.2d 1095, 1102 (Ind. Ct. App. 1990).

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subsequent transfer or distribution of risk to a second party (the pool or risk sharing agency), similar to ordinary insurance.

Out of this ambiguity, numerous problems and questions have arisen in state courts regarding whether a state insurance commission can regulate a pool or risk sharing agency. Recently, in *City of Arvada v. Colorado Intergovernmental Risk Sharing Agency*,[12] the Colorado Supreme Court held that Colorado's largest risk sharing agency was in fact not an actual insurer but was instead a self-insurance pool, based on the fact that it was a not for profit association and thus not in the business of making contracts of insurance.[13] As a result of this holding, the risk-sharing agency was spared from regulation under the statutory requirements of Colorado's insurance code, which would have placed the member entities in the position of having the same duties and obligations as commercial insurers. Requiring compliance with the statutory scheme, the court found would adversely affect the pool's ability to provide members with cost-effective liability coverage, thereby defeating the very purpose and intent of these self-insuring programs. On the other hand, some state courts have said exactly the opposite, deciding that these pools exhibit enough of the characteristics of "regular" insurance to be regulated as such and thus must at least be registered as mutual insurance companies.[14]

This Comment will compare those states that choose to classify municipal risk sharing pools as a sort of self-insurance, thereby evading regulation by the state insurance commissioner, and those that consider public risk sharing entities to be the equivalent of mutual insurance companies. This distinction can be significant in that it directly affects the cost-effectiveness and general efficiency of the pools, and further impacts the pools' ability to achieve their primary objective of saving municipalities money and encouraging interlocal cooperation.

I. WHAT IS A RISK POOL?

A public entity pool is "a risk financing mechanism whereby a group of public entities contribute to a shared fund that in turn pays claims for and provides services to the participating entity."[15] Pooling is essentially the aggregation of powers and resources of individual entities collectively to

12. 19 P.3d 10, 15 (Colo. 2001).
13. *Id.* at 13.
14. *See* IND. CODE ANN. § 27-1-29-5(a) (1999).
15. Harold Pumford, The Structure of Public Entity Pools, Address at the PRIMA Governmental Risk Mgmt. Seminar (1992), at para. 7 (on file with author).

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address the insurance needs of member or participant entities.[16] As previously stated, the fundamental purpose of risk pooling is not unlike that of conventional insurance. In both risk pooling and conventional insurance, the pecuniary losses protected against result from risks basically outside the control of the members or policyholders and not expected to occur.[17] The purpose of any insurance is to protect insureds against unknown risk, and pools, like conventional insurance, often transfer risk to a separate entity (a central risk sharing authority), while in essence, aggregating and sharing the risk.[18]

Pools are structured as both risk-financing and risk-transfer mechanisms. The member entities of the pools transfer their exposure for financial loss to the pool, sharing with others in the transfer of related risks. The services related to the transfer of that risk are provided by the new entity, the pool, or by third parties (underwriters, excess carriers, etc.) retained by the pool.[19] In some cases this includes individual stop loss and/or aggregate stop loss conventional insurance, where coverages are purchased at an amount determined by pool administrators or consultants in the commercial insurance market to deal with large losses or unexpected aggregation of smaller losses. Increasingly, many pools have also begun to function as risk management entities, not only providing risk financing arrangements for its member entities, but also risk assessment, control, and management services.[20]

Pools typically issue a coverage or plan document as opposed to an "insurance policy," whereby a contract to indemnify is formed once the member public entity pays contributions into the pool. Most pools define a coverable "occurrence" as an event that results in personal injury or property damage which was neither expected nor intended by the pool member.[21] Among those things that constitute a "personal injury" covered by most pools are wrongful entry and eviction, acts held to be wrongful under Sections 1981 or 1983 of the federal Civil Rights Act, race/age/sex discrimination, false arrest or false imprisonment, malicious prosecution,

16. *Id.*

17. *See* Ader & Diamond, *supra* note 10, at para. 2.

18. *Id.* (citing Appalachian Ins. Co. v. Liberty Mut. Ins. Co., 676 F.2d 56, 63 (3d Cir. 1982)); *Id.* at para. 3 (citing LEE R. RUSS, 16 COUCH ON INSURANCE §§ 101:1, 101:2. (3d ed. 1997)).

19. Pumford, *supra* note 15, at para. 8.

20. Peter Young, Ph.D., *Risk Pooling*, *in* ENCYCLOPEDIA OF PUBLIC ADMINISTRATION AND PUBLIC POLICY, at para. 8 (forthcoming 2002) (on file with author) [hereinafter Young, *Risk Pooling*].

21. Ader & Diamond, *supra* note 10, at para. 4.

and assault and battery.[22] Included among "property damage" are physical injury to or destruction of tangible property.[23] As with most insurance contracts, many pools list coverage exclusions, which may often include liability arising out of eminent domain, condemnation, or inverse condemnation proceedings.[24]

Workers' compensation and property/liability risks are the most common coverages offered by pools, although in many states the largest risk sharing organizations offer multiple coverage programs including employee benefits, unemployment compensation, bonds, as well as automobile and equipment liability. Property and liability programs may encompass a whole host of traditional casualty insurance special policy forms. Pools providing only one line of coverage (i.e., the Regional Workers' Compensation pool) are referred to as "monoline" pools.[25] "Multiline" or multiple coverage pools (in which workers' compensation and property/liability are administered under the same plan) are those that offer two or more lines of coverage and typically require that members participate in all lines.[26] Finally, "fleet" pools are those that offer two or more lines of coverage where members may choose which lines to participate in.[27]

Most pools have a governance structure that is organized around a board of directors/chief executive form of organization.[28] The boards, which are typically made up of representatives of pool members, are elected boards in about half of the pools in the United States, appointed boards in about a quarter, and partially elected and partially appointed in the last quarter.[29] Another important distinction in the governance of risk sharing pools is between sponsored and non-sponsored pools. Sponsored pool boards (i.e., pools that are organized under a sponsoring organization like a league of cities, municipal league, or association of counties) typically will draw some of their board members from the sponsoring organization and some from the pool's membership, while non-sponsored pools' boards are derived entirely from the membership.[30] However, the

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22. *Id.*
23. *Id.*
24. *See* Town of Cumberland v. R.I. Interlocal Risk Mgmt. Trust, C.A. No. 99-0023, 2000 R.I. Super. Ct. LEXIS 107, at *20 (R.I. Super. Ct. Oct. 2, 2000).
25. Young, *Risk Pooling*, *supra* note 20, at para. 19.
26. *Id.*
27. *Id.*
28. *Id.* at para. 23.
29. *Id.*
30. *See generally* Pumford, *supra* note 15.

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dynamics within the governing board of a non-sponsored pool can at times be problematic, as "[a]ssociation interests and member interests . . . do not always coincide, and the governance processes by which these conflicts are resolved is not widely known or understood."[31] Another important legal distinction is that between pools with a board of directors as opposed to pools with a board of trustees.[32] Generally, trustees are expected to maintain a higher fiduciary duty to the members of the pool.[33] Finally, while many pools are classified as nonprofit entities for purposes of the federal and state tax codes, there is still some ambiguity as to the tax status of risk sharing pools in general.[34]

Most pools are self-funded, meaning that the pool draws on both member premiums and on other resources, including pre-funding bonds or other investments, the purchase of excess or reinsurance coverages, or other risk financing methods.[35] Historically, pool rates were derived from insurance industry data (usually from the Insurance Services Office) because pools had little or no past data from which to estimate claims. Recently, most pools have begun to move away from insurance industry-based pricing and now increasingly rely on their own loss experience. In calculating premiums, Dr. Peter Young indicates at least four fundamental differences between pools and commercial insurers:

> 1) most pools do not have to pay federal or state income taxes, 2) most pools do not have to pay insurance premium taxes, 3) most pools do not have to make participation commitments to state guaranty funds, high risk pools, or other arrangements mandated by the state insurance commissioner, and 4) most pools do not have to make allowances for agent and broker commissions.[36]

As will be discussed in greater detail below, the legal distinction between those states that require public entity pools to be regulated by the state insurance commissioner and those that do not can be a very important one that accounts for a ten to twenty percent difference between pool premiums and commercial insurance premiums.[37]

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31. Young, *Risk Pooling, supra* note 20, at para. 25. An example is a sponsored pool whose board decides premium rates for members based on rate and risk relationships.

32. *See* Pumford, *supra* note 15, at para. 49.

33. *Id.* at para. 53.

34. *Id.* at para. 39.

35. *Id.* at para. 23.

36. Young, *Risk Pooling, supra* note 20, at para. 39.

37. *Id.*

II. THE HISTORY OF MUNICIPAL LIABILITY AND THE EMERGENCE OF RISK POOLING

A. Sovereign Immunity

Under the common law, and with recent notable exceptions, governmental entities have traditionally been immune from tort liability.[38] The doctrine of sovereign immunity has its derivations in Roman law and developed in medieval England as a corollary to the concept of the divine right of kings.[39] The belief was that "the king could do no wrong, and certainly a king who could do no wrong had no business being hauled into his own courts to answer to subjects over whom his rule was supreme."[40] In America, the doctrine of sovereign immunity was adopted because it was believed that suits against the government would hamper it from performing its public duty and would deplete public funds.[41] In the case of the states, this immunity is, to some extent, expressly conferred by the Eleventh Amendment.[42] Although sovereign immunity has been oft criticized since its entrenchment in American common law, the doctrine survived remarkably untouched into the 1960s.[43] At that point, the balance of the debate shifted in favor of increased governmental liability after Fleming James introduced the concept of loss spreading.[44] Indeed, loss spreading has been the primary reason given by contemporary scholars and courts for abolishing sovereign immunity.[45] As some of the protections of sovereign immunity have lapsed, municipalities have found themselves exposed to tort claims, principally those arising out of the activities that they perform as a matter of custom.[46] Initially, in an effort to comply with the trend toward abolishing tort immunities, some state legislatures sought to completely deny the protections of sovereign immunity to those

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38. *See* Hackney, *supra* note 6, at 392; Patti Owen Harper, *Statutory Waiver of Municipal Immunity Upon Purchase of Liability Insurance in North Carolina and the Municipal Liability Crisis*, 4 CAMPBELL L. REV. 41, 44-45 (1981).

39. Harper, *supra* note 38, at 44.

40. *Id.* at 44-45.

41. Hackney, *supra* note 6, at 392 (quoting Owen v. City of Independence, 445 U.S. 622, 645 n.28 (1980)).

42. *See* KENNETH CULP DAVIS & RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE § 18.6 (3d ed. 1994).

43. Hackney, *supra* note 6, at 392.

44. *Id.*

45. *Id.*

46. *Id.* at 393.

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municipalities that had purchased liability insurance.[47] Most states, however, opted for some form of the "public duty doctrine," which essentially provides that in order to recover from a governmental entity, a claimant must show that the government owed a duty to the person injured and not just to the public generally.[48] There is currently a split among state courts as to the validity of the public duty doctrine following the abrogation of governmental immunity by a state. While some states have declared that the public duty doctrine is no longer to be given effect,[49] others have retained the doctrine, but have modified it by decreasing the burden on plaintiffs who wish to show they were owed a "special duty" or "private duty" by the governmental entity.[50]

B. The Genesis of Public Entity Risk Pooling

Since 1970, state and local governments have experienced two "insurance crises." The first, detailed above, involved the abrogation of sovereign immunity and the concomitant expansion of municipal liability. The second crisis simply involved the fiscal adjustments associated with state and local governments entering the insurance market. Suddenly, public entities were vulnerable to downturns in the insurance market related to cyclical market problems, insurance industry management practices, inherent insurance pricing problems, as well as the perceived riskiness of insuring state and local governments as evidenced by the increasing number of lawsuits.[51] Beginning in the mid to late 1970s, liability insurance for many state and local governmental entities was either unaffordable or unavailable.

In response to this crisis, state legislatures began to discuss the feasibility of municipal risk sharing pools. Beginning in large part in the early 1970s, many states took steps to permit a general exemption on the

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47. *See* Harper, *supra* note 38, at 54-55.

48. INSURANCE AND RISK MANAGEMENT FOR STATE AND LOCAL GOVERNMENTS, § 6.02(1) (Matthew Bender & Co., Inc. 2000), *available at* LEXIS, 1-6 RSKMGT § 6.02 [hereinafter INSURANCE AND RISK MANAGEMENT]; Scott J. Borth, *Municipal Tort Liability for Erroneous Issuance of Building Permits: A National Survey*, 58 WASH. L. REV. 537, 548 (1983).

49. Adams v. State, 555 P.2d 235, 241-42 (Alaska 1976); INSURANCE AND RISK MANAGEMENT, *supra* note 48, at § 6.02(1) (citing Coffey v. Milwaukee, 247 N.W.2d 132, 139 (Wis. 1976)).

50. INSURANCE AND RISK MANAGEMENT, *supra* note 48, at § 6.02(1).

51. *See* Young, *Risk Pooling, supra* note 20, at para. 9; Steven Waldman et al., *The Surge in Self-Insurance*, NEWSWEEK, Mar. 7, 1988, at para. 3 *available at* LEXIS, Individual Publication, Newsweek; TML Pool.

co-mingling of public funds between municipalities by enacting what is referred to by many states as an Interlocal Cooperation Act.[52] The most common reason for the creation of an interlocal cooperative program is the need to respond to a problem that is best addressed on a multi-town basis.[53] Examples of these programs include regional recycling efforts, multi-town transportation districts and specialized inter-town equipment and staff sharing agreements.[54] These programs may be initiated because the problem requires a larger geographic response (e.g., rural transportation) or because financial reality dictates a shared or common approach.[55] In either case, the desire to respond in an operationally efficient manner and to function in a cost-effective framework offers a compelling reason to initiate cooperative approaches to common problems.[56] Since their inception, many commentators have argued that greater use of interlocal agreements can cure fragmented and parochial local jurisdictions that reduce regional wealth, intensify intraregional distributional inequities, create uncoordinated and inefficient service provision, and increase the costs of creating an informed citizenry.[57]

Those states that already had Interlocal Cooperation Acts or similar statutory provisions began drafting enabling legislation to specifically include public entity risk pooling.[58] The vast majority of pools, 75 percent, are organized this way.[59] Other forms of organization include non-profit trusts (20 percent), corporations (5 percent), and mutual or reciprocal insurance companies (less than 5 percent).[60] From a policy standpoint, the creation of a pool under the interlocal agreement seems to be the easiest and most efficient way to form a public entity risk sharing arrangement. This is primarily because most states delegate broad powers to

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52. Vitullo & Peters, *supra* note 6, at 325-29.

53. DAVID W. RUSSELL ET AL., OFFICE OF POLICY AND MGMT., LOCAL GOVERNMENT COOPERATIVE VENTURES IN CONNECTICUT, at para. 21 (2000), *available at* http://www.opm.state.ct.us/igp/acir/coopvnt.htm.

54. *Id.*

55. *Id.*

56. *See generally id.*

57. Gillette, *supra* note 1, at 191.

58. *See, e.g.*, CONN. GEN. STAT. §§ 7-479a-7-479i (2001).

59. *See* Peter C. Young, Ph.D., *Local Government Risk Financing and Risk Control Pools: Understanding Their Forms, Functions, and Purposes*, at para. 35, *available at* http://www.stthomas.edu/risk/White%20Paper%20%20Local%20Government%20Risk%20Financing%20and%20Risk%20Control%20Pools.htm (last visited Mar. 2, 2002) [hereinafter Young, *Local Government*].

60. Young, *Risk Pooling, supra* note 20, at para. 17.

municipalities to share resources and because such statutes often do not specify how the pools must operate, leaving the day-to-day oversight functions to the municipalities or to the sponsoring organization. All of the pools referred to in this Comment, unless otherwise noted, are interlocal agreements.

C. Regulation

Although the use of public entity pools across the country greatly increased in the 1980s, most state insurance commissioners were slow to notice their existence, and when they did, often chose not to push for regulatory authority.[61] In 1991, The National Association of Insurance Commissioners (NAIC) formed a committee to undertake a study the extent of regulation of governmental self-insured pools and determine if model regulations were needed.[62] Regulatory concerns related to public entity pools arose around this time as a result of their increased presence throughout the country and as a result of solvency problems of a number of specialized public and private self-insurance pools.[63] Insurance regulators worried about protecting the insurance market from under funded pools over which the states had little control, both for the protection of consumers and for encouraging market competition.[64] Furthermore, it was argued, insurance commissioners in many states were already frequently asked by their legislature or attorney general to explain these problems even though the commissioner may have no regulatory authority over the pools.[65]

On the other hand, the National League of Cities (NLC), on behalf of its member pools, questioned whether a lack of uniformity of state regulations was really a problem considering that the pools in question did not operate across state lines, and that the various regulations that had developed reflected varying state laws, local governmental organization

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61. Nat'l Ass'n of Ins. Comm'rs, *1992 Summer National Meeting*, Executive Committee 10, *70-71, LEXIS 1992-2 NAIC Proc. 10 [hereinafter NAIC, *Summer*].

62. Nat'l Ass'n of Ins. Comm'rs, *1991 Winter National Meeting*, Commercial Lines—Property and Casualty Insurance (D) Committee 822, *825, LEXIS 1991-1 NAIC Proc. 822 [hereinafter NAIC, *Winter*].

63. *See generally* Linda J. Collins, *Pool Reforming after State Investigations*, BUS. INS., Feb. 5, 1990, at 28 *available at* LEXIS, Individual Publication, Business Insurance; Meg Fletcher, Pooling Conference; *Public Entity Pools Facing Increased State Scrutiny*, BUS. INS., Mar. 21, 1988, at para. 14 *available at* LEXIS, Individual Publication, Business Insurance.

64. Fletcher, *supra* note 63, at para. 14-18.

65. NAIC, *Summer*, *supra* note 61, at 71.

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and structure, and other localized circumstances.[66] Furthermore, pooling proponents argued that public entity pools, unlike private self-insurance pools, had the distinct inability to "skip town" as a private insurer might, were more likely to be securely capitalized as a result of their taxing authority, and in some instances had substantially less risk to assume because of the continued existence of governmental immunity to some types of claims.[67] Generally, the pooling community across the country adopted these arguments and lobbied against such full-scale regulation of public entity pools.[68] In many respects, their reasoning was persuasive. The cost associated with regulation was, especially for small municipalities, prohibitively expensive.[69] For instance, state insurance regulators might require posting of guarantees of financial security, licensing of pool employees, submission of annual financial documentation to regulators, compliance with rating guidelines, compliance with policy wording guidelines, participation in state guaranty funds, participation in assigned risk plans, and payment of premium taxes, all of which are normally required of private insurance companies.[70] Pooling proponents and municipal officials argued to subject a small municipality to this level of regulation, that it would be unfair because the added costs of compliance would undermine the cost-sharing purpose of the entire pooling arrangement.

Instead, argued the NLC and other pooling proponents, the need for state regulation could be obviated by the adoption of uniform operating standards.[71] Such standards would promote the establishment of good management practices among pool membership, and provide a uniform framework for state regulators to analyze when localized problems with the pools arose. These uniform standards included requirements that each pool comply with all filing requirements imposed by state insurance departments, perform annual audits and issue financial reports to members, other investors, and regulators, obtain actuarial certification of loss reserves, and draft written policies towards cash management, investments, claims settlement, and other vital operating procedures.[72] Indeed, by the mid-1990s, the Association of Governmental Risk Sharing Pools (AGRIP)

66. NAIC, *Winter*, *supra* note 62, at 825.
67. Fletcher, *supra* note 63, at para. 32.
68. NAIC, *Winter*, *supra* note 62, at 825.
69. *Id.*
70. *See* Young, *Local Government*, *supra* note 59, at para. 35.
71. *See* NAIC, *Winter*, *supra* note 62, at 826-27.
72. *Id.*

had adopted similar basic uniform pooling standards, outlining basic procedures such as regulatory compliance, coverage, claims management, financial management, and organizational structure, all of which generally encourage and promote compliance with the generally accepted practices of the industry. AGRIP and its predecessor, PRIMA, originally promulgated these standards in the 1980s, and since 1994 have had a formal evaluation program in place for assessing compliance with these standards, often referred to as "AGRIP Recognition."[73]

After a generally unsuccessful effort to obtain nationwide data on pool regulatory requirements and operating procedures, the NAIC abandoned its efforts to establish model regulations for public entity pools.[74] Apparently, the NAIC found the job of researching state regulations too daunting a task, and discovered that nearly one-third of the states either had no regulations concerning pools, or had not officially recognized them as being under the jurisdiction of the state insurance department.[75] Specifically, their research found that only about ten states had any sort of capitalization or surplus requirements for public entity pools and that only fifteen states had any reinsurance or excess coverage requirements, with only eight of these fifteen specifying the minimum amounts of coverage.[76] However, the survey found that most states did require at least some minimal reporting to state departments of insurance, including the filing of an annual report and audited financial statements. Altogether, the committee determined that the degree of regulation of public entity pools varied from being non-existent in some states to comprehensive in others, and that because of time restraints and the overall size and scope of the project before them, the committee was not able to make any progress toward reaching a conclusion. Finally, the special committee disbanded and abandoned the project.[77]

By the time the next comprehensive study of public entity pools was attempted by A.M. Best in 1998, little had changed over the patchwork regulatory landscape nationwide. That survey revealed a "striking disparity" of reporting requirements and regulatory oversight from state to

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73. Interview with Harold Pumford, CEO, Assoc. of Governmental Risk Pools (AGRIP) (Nov. 17, 2001); *see* Advisory Standards at Ass'n of Governmental Risk Pools, *AGRIP Advisory Standards for Intergovernmental Pools*, *at* http://www.agrip.org/services/pooladv/default.html (last visited at Mar. 2, 2002).

74. *See* NAIC, *Summer*, *supra* note 61, at 70.

75. *See* NAIC, *Winter*, *supra* note 62, at 838.

76. *Id.*

77. NAIC, *Summer*, *supra* note 61, at 71.

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state.[78] First, the report noted that many of the pools it had wished to include in its study, and ultimately rate, were not governed by the state insurance department, but instead were regulated by other state agencies such as the Department of Labor, Workers' Compensation Board, or Department of Education.[79] For those pools that were regulated by the Department of Insurance, the level of oversight A.M. Best concluded, fell "short of comparable reviews performed on traditional insurance companies,"[80] which it found to be problematic given the competitive pricing by traditional companies that had been trying to climb back into the governmental insurance market.[81] The result, A.M. Best cautioned, should be cause for concern for consumers, investors, and regulators, because it left a large percentage of pools with questionable financial backing and no guaranty fund or excess coverage protection should difficulties regarding the pools arise. Specifically, Best's survey found that while more than 50% of the states required an independent actuarial or auditors' study to be filed, and closer to 60% required actual assessable policies, only about 20% required a Claims Study, and only 15% had any sort of minimum capital requirements.[82] Furthermore, it noted that a sizable percentage of those states that actually enforced reporting requirements gave no indication that those reports underwent any kind of comprehensive review by regulators rather than simply being kept on file.[83]

As was suggested in the A.M. Best report, the reemergence of private insurers into the municipal insurance markets has been a cause for concern for many within the public entity pooling community. A soft commercial insurance market in the late 1990s allowed major companies such as Aon, St. Paul, and the Hartford, to develop products to serve the governmental entities market.[84] With costs under control for a period of time in the late

78. Michelle Baurkot, *Into the Pool; Self-Insurance Pools: Special Report Excerpt: "Self-Insurance Pools: Shedding Light on a Little Understood Market,"* BEST'S REV., PROP./CASUALTY INS. EDITION, Apr. 1998, at 47, para. 18, *available at* 1998 WL 5978840 (1998).

79. To date, the majority of public entity pools are workers compensation or school employees' funds. *Id.* at para. 3.

80. *Id.* at para. 18.

81. *Id.* at para. 18.

82. *Id.* at para. 27.

83. *Id.* at para. 23.

84. *See* Roberto Ceniceros, *Market Conditions Putting Squeeze on Public Entities,* BUS. INS., June 11, 2001, at 10, *available at* LEXIS, Individual Publication, Business Insurance; Rodd Zolkos, *Individual Pools Make Their Own Future: Panel Advises*

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1990s, there was, at least in some cases, little political urgency for municipalities to pool to obtain lower coverage costs—which was, of course, the primary reason that many pools were developed. Furthermore, the convergence of the banking and insurance industries during this time meant that the increased use of investment capital by large financial institutions could be used to help municipalities streamline the financing of risk across the board.[85] As a result of this increased involvement by private insurers in the market, either directly or as excess carriers or fund managers for the pools, at least some pools have lost the advantage they previously held over private insurers—i.e., a specific understanding of the financial workings of municipal government. But as with any market, upswings are often closely followed by downturns—all indications are that 2001 was a devastating year for the insurance industry, especially in the area of public risk financing.[86] Although there is (at last count) about six billion dollars in premium generated by the approximately 500 public entity pools, there are indications that the cost of property and liability coverage for municipalities are up an average of fifteen percent from the previous year, causing many private insurers to lose business, and prompting some to abandon their public risk pooling products altogether.[87] All of this would seem to suggest that demand for member-run public entity risk pools will continue to rise over the next few years.

III. STATE REGULATION OF PUBLIC ENTITY POOLS

A. States in Which Pools Are Not Insurance

With regard to pools formed under the State Interlocal Cooperation Act, two basic kinds of enabling legislation have been drafted to create public entity pools: (1) enabling legislation expressly exempting the pools from most of the statutory requirements of the state insurance code; and (2) legislation expressly providing that the pools are to be treated as if engaged in the business of transacting insurance and requiring that the states be registered as mutual insurance companies. The vast majority of the states (forty-five of the forty-eight where governmental risk pooling is allowed)[88]

Municipal Self-Insurance Pools to Meet Members' Needs, BUS. INS., June 22, 1998, at 13 *available at* LEXIS, Individual Publication, Business Insurance.

85. *See* Zolkos, *supra* note 83, at 13.

86. Ceniceros, *supra* note 83, at 10.

87. *See* Zolkos, *supra* note 83, at 13.

88. Delaware and Hawaii are the only two states that have yet to authorize the practice of risk pooling. *See* Interview with Harold Pumford, CEO, Assoc. of Governmental Risk

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fall into the first category, although the procedures put in place by state legislatures for the oversight and regulation of the pools varies greatly from state to state.

1. California: The Prototype

Although several states lay claim to being the first in the country to delegate to municipalities the power to pool tax revenues into a self-insurance pool,[89] California is one state that has long been fertile ground for public entity pools. California first enacted its Interlocal Cooperation Act, the Joint Exercise of Powers Act, in 1949 to create "joint powers authorities" to enable two or more municipalities to join together to exercise any power that each has the power to exercise individually.[90] Beginning in 1975, legislators, prompted by town officials and the California Contract Cities Association, undertook a study to explore the feasibility of a collective insuring arrangement for municipalities to be administered under the Joint Exercise of Powers Act.[91] Upon review of the study, the California Department of Insurance stated that the Department would regard such risk sharing arrangements as "a clear situation of transacting insurance."[92] Because subjecting the pools to the statutory requirements of the insurance code would place member entities in the position of having the same duties and obligations as commercial insurers and would thus adversely affect the pool's ability to provide members with cost-effective liability coverage, legislators proposed an amendment that would expressly provide that the pools would not be considered insurance.[93] The resulting statute, California Government Code section 990.8 delineates the specific provisions of the program to be administered

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Pools (AGRIP) (Nov. 17, 2001); *see generally* Risk Pools, *at* http://www.riskpools.com (last visited Mar. 13, 2002); Ass'n of Governmental Pools *at* http://www.agrip.org (last visited Mar. 13, 2002); Nat'l League of Cities *at* http://www.nlc.org/nlc_org/site/membership/state_municipal_leagues/risc_members.cfm (last visited Mar. 13, 2002).

89. Young, *Local Government, supra* note 59, at para. 8; Vitullo & Peters, *supra* note 6, at 325 (giving Illinois the distinction of first state in the country to allow municipality self-insurance); Tenn. Mun. League Risk Mgmt. Pool, *Historical Summary, at* http://www.tmlrmp.org/GetContent.asp?doc=1Pool_Info\2TML_Pool_History.html (last visited Mar. 2, 2002) (asserting two Tennessee cities, Athens and Hendersonville, were the first to establish a statewide municipal liability pool).

90. *See* City of S. El Monte v. S. Cal. Joint Powers Ins. Auth., 45 Cal. Rptr. 2d 729, 730 (Cal Ct. App. 1995).

91. *See* City of S. El Monte, 45 Cal. Rptr. 2d at 730-32 (citations omitted).

92. *Id.* at 731 (citations omitted).

93. *Id.* at 732 (citations omitted).

by the joint powers authorities designed to provide risk sharing services. As a result, the California pools are legally regarded as quite different from commercial insurers, requiring courts to apply general contract law before the law of commercial insurance.

The California courts first discussed the legal implications of public entity pooling in *City of South El Monte v. Southern California Joint Powers Insurance Authority.*[94] In that case, the California Court of Appeals found that the Joint Powers Insurance Authority (the "Authority") did not have a duty to defend and indemnify for damages allegedly resulting from the city's passage of a municipal ordinance that a resident claimed was enacted only to shut down her business in violation of her federal civil rights as protected by 42 U.S.C. §§ 1983, 1985, and 1988.[95] Upon the city's attempt to make a tender of defense, the Authority rejected the claim, arguing that a Section 1983 suit arising out of the passage of an ordinance did not constitute an "occurrence" under the definitions set forth in the memorandum of coverage. The city, in contesting this argument, claimed that the basic tenets of insurance law should govern the conflict, and that the terms of the agreement between the Authority and its member cities "created a contract of indemnity between the two entities, under which the Authority was obligated, pursuant to a 'benefit of any doubt' standard of review, to reimburse [the] City for defense and settlement costs."[96]

The court concluded that although the pooling arrangement utilized by the Authority and its member municipalities closely resembled an insurance policy, the history of public entity pooling in California and the resulting legislation, California Government Code section 990.4, specifically provided that the pools were not to be considered insurance or subject to the regulations of the California Insurance Code.[97] Instead, the court stated that any disputes arising under the pool coverage document should be construed using the strict principles of contract law, rather than the somewhat higher protection afforded to the insured under a traditional insurance contract.[98] The pooling arrangement, unlike a traditional insurance policy, exhibited more of the characteristics of a typical commercial contract because the terms of the coverage offered were decided by the members themselves, acting through the Authority's Board

94. 45 Cal. Rptr. 2d 729 (Cal. Ct. App. 1995).
95. *Id.* at 736.
96. *Id.* at 737.
97. *Id.* at 732.
98. *Id.* at 735.

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of Directors, which was comprised of representatives from each municipality. Municipalities, the court stated, have more motivation to manage their own risk because they presumably have "a sense of ownership in the pool endeavor"[99] and indeed were expected to bear individual responsibility for losses incurred up to the first $10,000.[100] Thus, the court continued, "[g]iven a local entity's broad power to insure against all potential liabilities and to do that through joint power pooling arrangements, principles governing insurance carriers and insurance law have no applicability . . . ."[101] The court also rejected the city's argument that it should receive coverage under the excess carriers' policies because the language in those policies was nearly identical to the language of the underlying coverage memorandum, and thus the "occurrences" involved in the underlying lawsuit were also not covered under the definition of "occurrences" in the excess carrier policies. The result in *South El Monte* is one that can only be seen as fully favorable to pool administrators and pool members. Although the member municipality was not afforded coverage under the language of the policy, the court determined that the pool itself was not within the jurisdiction of the state insurance department, and was therefore not under the same obligations as a traditional commercial insurer under California law. The pool should be allowed, the court stated, to operate as its own super-municipal entity—because it was still essentially assuming its own risk and was determining its own lines of coverage through the approval of its Board of Directors, the pool was an autonomous unit with the power to pool and distribute its premiums any way it saw fit.

As a result of this special treatment under California law, risk-sharing pools have flourished there since the early 1980s.[102] One recent survey found at least fifty-seven different public entity pools operating under the Joint Powers Act in California.[103] The California Joint Powers Insurance Authority (JPIA) is a good example of how efficiently pools may be managed in a state that requires little by way of formal regulation. First, in order to be considered for membership into a JPIA pool, a municipality must submit a formal application and application fee. Upon payment of the application fee, the JPIA conducts a risk management audit of the agency or municipality for submission with recommendations to the Executive

99. *Id.* at 734-35 (citations omitted).
100. *Id.* at 734-35 (citations omitted).
101. *Id.* at 735.
102. Young, *Risk Pooling, supra* note 20, at para. 16.
103. Baurkot, *supra* note 78, at para. 28.

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Committee. After consideration, the Executive Committee may recommend admission to membership of the Board of Directors for formal approval.[104] Once admitted, the municipality is eligible for up to $50 million per occurrence for liability coverage and for property coverage up to the declared value of the property.[105] All premium reserves are invested and all annual earnings credited to members in proportion to their equity. The pool employs its own staff and retains the services of several professional claims administrators, actuaries, financial auditors, and specialty insurance brokers.[106] Finally, the JPIA issues its own set of uniform pooling standards and requires accreditation through the Joint Powers Authority before a pool may begin to operate. One can only assume that the JPIA and the Joint Powers Authority enjoy a close relationship with the state government and thus state officials have long felt comfortable knowing that the JPIA has a high level of internal oversight practices.

2. Colorado: *City of Arvada v. Colorado Intergovernmental Risk Sharing Agency*

Colorado is an example of another state that follows the California model, although at a somewhat higher level of regulation by the state. For instance, pools in Colorado are first required to submit a written proposal to the Department of Insurance detailing the "administration, claims adjusting, membership, and capitalization of the pool."[107] If acceptable, the Department will issue a certificate of authority within thirty days. Once up and running, a pool must submit detailed annual reports to the Department, and must undergo an audit conducted by the Department at least once a year.[108] The Department reserves at all times the right, after a hearing, to revoke or suspend the pool's certificate of authority if the pool violates any of the regulations outlined in the state insurance code pertaining to pools.[109] In return for its compliance with these regulations, the state exempts the pools from the definition of insurance under state law, and allows the pools a fair degree of autonomy to operate freely, generally setting their own

104. *See* Cal. JPIA, *General Information, at* http://www.cjpia.org/4dcgi/about/general_info.shtml (last visited Mar. 2, 2001).
105. *Id.*
106. *Id.*
107. COLO. REV. STAT. § 24-10-115.5(3) (2001).
108. *Id.* § 24-10-115.5(5).
109. *Id.* § 24-10-115.5(6); *see also id.* § 29-13-102.

minimum and maximum levels of coverage and allowing a wide range of investment practices.[110]

The Supreme Court of Colorado recently had an opportunity to review the regulations set in place by the insurance code, and to comment generally on the concept of public entity pooling in the case of *City of Arvada v. Colorado Intergovernmental Risk Sharing Agency.*[111] In *Arvada*, the court considered whether the pool (CIRSA) had a duty to defend a claim against the city arising out of an alleged breach of a commercial lease. Specifically, the city argued that pursuant to a specific provision of the Colorado Insurance Code, the pool must defend and indemnify the city for its losses because it failed to notify the city of a change in the excess carrier policy excluding coverage for breach of contract claims.[112] Indeed, the provision of the insurance code in question did in fact invalidate coverage reductions included in renewal policies absent explicit notice.[113] The ultimate question, then, was whether the section of the insurance code that provided public entity pools were not to be considered insurance companies should preclude application of the rest of the restrictions in the code that were intended for commercial insurers. The court agreed with CIRSA that it should.

First, the court reasoned that the pool should not be considered an insurer under the Code because it was not "in the business of making contracts of insurance."[114] This was obvious from the fact that the pool was a not-for-profit association. For its authority on this point, the court cited the Missouri Court of Appeals' opinion in *Crist v. Missiouri. Intergovernmental Risk Management Ass'n.*,[115] which involved a workers' compensation appeal. There, the court concluded that self-insurance is not insurance at all and could not be held to any other statutory requirements other than that expressly proscribed.[116] The *Arvada* court continued its analysis by noting similarities between its pooling statutes and California's, and then by citing the *South El Monte* case, which yielded similar results.[117]

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110. *Id.* § 24-10-115.5(8); *id.*§ 29-13-102(2); *id.* § 29-13-102(6).

111. City of Arvada v. Colo. Intergovernmental Risk Sharing Agency, 19 P.3d 10 (Colo. 2001).

112. *Id.* at 12.

113. *See* COLO. REV. STAT. § 10-4-110.5 (2001); *Arvada*, 19 P.3d at 12.

114. *Arvada*, 19 P.3d at 13.

115. WD No. 39,286, 1988 Mo. App. LEXIS 203, at *1 (Mo. Ct. App. Feb. 16, 1988).

116. *Id.* at *9; *Arvada*, 19 P.3d at 14-15 n.8.

117. *Arvada*, 19 P.3d at 14.

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Finally, the court explained why it made good sense to exempt public entity pools from the restrictions placed on commercial insurers.

> To subject the pools to the statutory requirements of the Insurance Code would place member entities in the position of having the same duties and obligations as commercial insurers. Such an arrangement would adversely affect the pool's ability to provide members cost-effective liability coverage and subsequently defeat the purpose and intent of these self-insuring groups.[118]

The court held that CIRSA did not violate any duty owed to the city by failing to notify it of the change in the excess carrier's policy.

While CIRSA continues to operate today as Colorado's most comprehensive public risk-pooling agency, in terms of the amount of coverage and capitalization, it serves as an example of a more intermediate, mid-level pool as compared to California's JPIA. For instance, under the pooling agreement, individual members of the pool maintain a self-insured retention (SIR) amount ranging from $1,000 to $150,000, for which they are responsible before the pool's coverage becomes applicable.[119] Above each member's SIR, CIRSA only covers losses up to $400,000.[120] "For losses greater than $400,000, CIRSA [has] purchased excess insurance from Lloyd's of London[,] . . . which covers losses up to $1 million."[121] This sort of excess carrier coverage is quite common for most property-liability coverage public entity pools.[122] In fact, many states specify the exact amounts of excess coverage that must be made available, ranging from $1 million in Georgia,[123] to $5 million in Louisiana and Michigan, where pools are required to show actuarial certification of such coverage, or deposit that amount with the state insurance department.[124]

3. Illinois: *Antiporek* and *Lombard*

Some states have had considerable difficulty in determining whether governmental risk-sharing pools created under the state Interlocal

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118. *Id.* (quoting City of S. El Monte v. S. Cal. Joint Powers Ins. Auth., 45 Cal. Rptr. 2d 729, 731 (1995)).

119. *Arvada*, 19 P.3d at 11.

120. *Id.*

121. *Id.*

122. At least 60% of the states have pools, which have a similar arrangement with excess carriers. *See* Risk Pools, *at* http://www.riskpools.com (last visited Mar. 2, 2002); *see* NAIC, *Winter*, *supra* note 62, at 838.

123. *See generally* NAIC, *Winter*, *supra* note 62, at 838.

124. NAIC, *Winter*, *supra* note 62, at 838.

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Cooperation Act should be regulated and treated as insurance and insurance contracts under state law. Illinois, a state that also counts itself among the first to become active in public entity risk-sharing, serves as an example. In 1973, Illinois incorporated an intergovernmental cooperation clause into its state constitution,[125] and then followed up with an Intergovernmental Cooperation Act in 1978.[126] The statute tracked the language of the 1973 constitutional amendment, granting unlimited authority to municipalities and school districts to "contract or otherwise associate to obtain or share services and to exercise, combine or transfer any function, in any manner not prohibited by law or by ordinance."[127] Public entity risk pools came into use beginning in 1979, and in 1986 their validity was recognized by the Illinois Appellate Court in *Antiporek v. Village of Hillside.*[128]

In *Antiporek*, the court found that the member municipality, Hillside, had not waived its governmental immunity by purchasing liability insurance from the pool, the Illinois Intergovernmental Risk Management Agency (IRMA). At this time, Illinois was among at least a half dozen states with a statute providing that the purchase of insurance by a municipality served as an implied waiver of that municipality's sovereign immunity if that defense was otherwise available.[129] The court reasoned that the pool was a form of self-insurance because ultimately the member municipalities continued to bear the risk given that any settlements or awards would come directly from government coffers, and would therefore not frustrate the purpose of the governmental immunity statute, to protect government funds.[130] Therefore, the court determined that risk management pools in Illinois were not "insurance companies," and thus, the participation in a self-insurance pool would not result in a waiver of governmental immunity.[131] As one commentator pointed out, the *Antiporek* decision likely would substantially reduce the number of lawsuits brought against governmental entities in Illinois because now municipalities had the ability to safely self-insure through the pools without forfeiting their sovereign immunity defenses to lawsuits.[132]

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125. ILL. CONST. art. VII, § 10 (2001).
126. 5 ILL. COMP. STAT. ANN. 220/1 (1993).
127. ILL. CONST. art. VII, § 10a (2001).
128. 114 Ill. 2d 246 (Ill. App. Ct. 1986).
129. *See* Harper, *supra* note 38, at 52, 53 n.70.
130. *Antiporek*, 114 Ill. 2d at 250.
131. Thomas W. Kelty, *Insurance Redefined: Case Comment on* Antiporek v. Village of Hillside, 24 TORT & INS. L.J. 517, 517 (1989).
132. Kelty, *supra* note 129, at 521 (1989).

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Shortly after the *Antiporek* case, the legislature amended the Intergovernmental Cooperation Act to

> authorize public agencies to jointly self-insure and authorize each public agency member of the contract to utilize its funds to pay to a joint insurance pool its costs and reserves to protect, wholly or partially, itself or any public agency member of the contract against liability or loss in the designated insurable area.[133]

While the statute does require that public entity pools file an annual report with the state insurance commissioner, it does not expressly grant any state agency the power to regulate the pools, nor does it state whether the pools should be regarded as an insurer for the purposes of future litigation, presumably because *Antiporek* and its progeny have already decided the question.[134] While the drafting of the statue may appear to grant broad discretion to public entity pools in carrying out their business, courts in Illinois have recently struggled with the question of which standards should be utilized in evaluating a coverage decision by a pool where the insured had a right to participate in the determination, and whether strict insurance law should apply in such cases. For instance, in *Village of Lombard v. Intergovernmental Risk Management Agency*,[135] the appellate court of Illinois held that courts should not apply strict insurance law in cases where a member of the pool is technically considered an insured and, by virtue of the fact it was part owner in the pool, an insurer.

In *Lombard*, the plaintiff city argued that although the pool coverage plan provided that the pool had no duty to defend a punitive damages claim against the member city, the court should apply the law used in the majority of Illinois insurance cases, which have held that an insurer has an obligation to defend all covered and non-covered claims under a single suit in which the underlying occurrence would otherwise be covered.[136] Furthermore, the city argued, allowing the pool to defend one claim but not the other created a conflict of interest, because the pool would defend the covered compensatory claims in a manner that would be harmful to Lombard's position with respect to the non-covered claims.[137]

After an analysis of the insurance law, which the plaintiff city argued controlled the case, the court found that no conflict of interest would be

133. 5 ILL. COMP. STAT. ANN. 220/6 (1993).
134. *Id.*
135. 288 Ill. App. 3d 1003 (1997).
136. *Id.* at 1011-13.
137. *Id.* at 1013.

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created by the pool defending one claim and not the other, primarily because Lombard had a right to participate in the management and the policy-writing function of the pool, thereby making Lombard partially responsible for the contractual language of which it was complaining.[138] The *Lombard* decision does indeed seem to be a double-edged sword for the member municipalities. On the one hand, the court expanded the self-autonomous nature of the governmental pooling movement in Illinois by limiting coverage to the insured municipalities to only that which the pool acting as a whole agrees to cover. On the other hand, the decision makes defending cases such as *Lombard* much costlier for the member municipalities, which would have to retain separate counsel for the punitive damages claim, in addition to the counsel appointed by the pool.

4. States on the Line: Washington and New York

Although the state of Washington, like each of the aforementioned states, does not consider public entity pools to be insurers,[139] the state Insurance Department retains close control over the operation of the state's primary governmental risk pooling authority, the Local Government Self-Insurance Program (LGSI). The LGSI is officially administered by the Washington State Department of General Administration.[140] The LGSI is itself overseen by two advisory boards, one for property and liability programs and one for municipal employee benefits, consisting of the Insurance Commissioner, the "State Risk Manager," five individuals appointed by the governor, and four representatives of member municipalities.[141] These advisory boards determine reporting, examination, and other regulatory processes to "prospectively assure approved programs are financially sound and stable, have an informed membership and adhere to public agency contracting processes."[142] While the LGSI states that it is not its "intent to require a certain program format or approach, but instead to prospectively assure programs have a considered strategy to ensure successful operation,"[143] this assertion seems to be undermined by the length and breadth of the regulations governing the LGSI's procedures for

138. *Id.*

139. WASH. REV. CODE ANN. § 48.62.041(1) (1999).

140. *See* Risk Mgmt. Program, Wash. State Dep't of Gen. Admin., *Local Government Self-Insurance Program (LGSI), at* http://www.ga.wa.gov/risk/lgsi.htm (last modified Dec. 17, 2001) [hereinafter LGSI].

141. WASH. REV. CODE ANN. § 48.62.041(1).

142. *See* LGSI, *supra* note 143.

143. *Id.*

monitoring pools. In fact, Washington's regulations governing pools appear to among the lengthiest of any state not requiring pools to register as mutual insurance companies.[144] Among the more detailed provisions of the section of chapter 48.62 of the Washington statutes governing Local Government Insurance Transactions are those requiring pools to make regular public disclosures regarding its insureds,[145] and those requiring pools to obtain surety bonds for "mismanagement or malfeasance in investing and managing program funds."[146] Although there is every indication that the Washington pools are efficiently run and are sufficiently safe and secure, one can only guess that the length and the scope of the LGSI regulations inhibit the growth of the pooling movement in the state and allow more established, highly capitalized pools to corner the municipal insurance markets.

A situation somewhat similar to that of Washington can be seen in New York, where pools can be organized as "municipal insurance reciprocals."[147] Analogous to the definition of a "pool" in most states, a "reciprocal" is simply defined as an association of individuals who join together for the purpose of providing insurance among themselves.[148] The reciprocal association, however, typically acts through a person or corporation serving as attorney-in-fact for the organization.[149] In New York, a reciprocal is actually a licensed insurance company, even though, much like other public entity pools across the country, it is owned by its members and is, in the eyes of the state, a non-profit association and therefore distinguishable from a commercial insurer.[150] However, New York, like Washington, has a lengthy set of regulations pertaining specifically to the operation of municipal insurance reciprocals that would appear to make compliance much more involved in New York than it is in many other states.[151] Indeed, from a regulatory perspective, the reciprocal model in New York would seem to balance on the fine line between self-insurance pools and mutual insurance corporations.

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144. *See generally* WASH. REV. CODE ANN. § 48.62.041

145. *Id.* § 48.62.101(2).

146. *Id.* § 48.62.111(3).

147. N.Y. INS. LAW § 6102 (McKinney 2000).

148. 18 JOHN ALAN APPLEMAN, INSURANCE LAW AND PRACTICE §§ 10121-10125, at 224-240 (1945).

149. *Id.* at §10121.

150. *See* N.Y. Mun. Ins. Reciprocal, *Who We Are*, *at* http://www.nymir.org/who.htm (last visited Mar. 2, 2002).

151. *See generally* N.Y. INS. LAW §§ 6102.

B. A Note on Capitalization Requirements

Generally, capitalization or solvency requirements also vary greatly from state to state. Some states, such as Nebraska, leave wide discretion and require only that the amount be "adequate"[152] while some states, such as Louisiana, Massachusetts, and Minnesota, require only that the pools collect premiums of at least $200,000 to $300,000 annually.[153] Other states, such as Connecticut, are significantly more precise. Connecticut requires that its property/liability pools maintain, during the first year of operation, a reserve for contingencies at a minimum of $500,000, and thereafter increase such reserve by an amount equal to five per cent of the total contribution of members for each ensuing year until the ratio of contribution of members for the then current year to the amount of the reserve for contingencies is no greater than three to one.[154] In fiscal year 2000, this amount was $1,823,878.[155] However, it should also be noted that Connecticut subsidizes its primary provider of public entity pooling, the Connecticut Interlocal Risk Management Agency (CIRMA) through a statutorily provided loan from the state's Municipal Liability Trust Fund, which in fiscal year 2000 was $8.6 million.[156] This particular arrangement between the state and a public entity pool is somewhat anomalous, and is perhaps what makes Connecticut more comparable to those states that, while exempting pools from the provisions of the state Insurance Codes, maintain a close relationship with the state's primary pool. Examples of these states include Washington and New York, discussed above. Overall, while capitalization requirements remain a primary concern of state regulators, the disparity between these regulations from state to state would further seem to support the "patchwork" theory of the state regulation of public entity pools.

152. *See* NEB. REV. STAT. § 44-4307(2)(b) (1998); NAIC, *Winter*, *supra* note 62, at 838.

153. NAIC, *Winter*, *supra* note 62, at 838.

154. CONN. GEN. STAT. § 7-479e (2001).

155. CONN. INTERLOCAL RISK MGMT. AGENCY, CONN. CONF. OF MUNICIPALITIES, ANNUAL MEETING 10 (2001).

156. *See id.*; CONN GEN. STAT. § 7-479s.

IV. STATES IN WHICH POOLS ARE CONSIDERED INSURERS

A. Indiana: Eakin v. Intergovernmental Risk Management Authority *and its Aftermath*

The state of Indiana requires its pools to be registered as mutual insurance companies, and has accordingly promulgated a lengthy set of regulations outlining precisely how the pools are to operate.[157] These regulations came about as a result of a great deal of confusion during the mid-1980s, culminating in an appellate court decision, *Eakin v. Indiana Intergovernmental Risk Management Authority,*[158] in which the Indiana Insurance Commissioner brought an action against the defendant public entity pool to determine whether IIRMA was operating without a certificate of authority from the state insurance commission. The suit was apparently prompted by the insurance commission's adoption of new regulations in 1986, clamping down on the previously existing practice of public entity pools' organization under Indiana's Interlocal Cooperation Act.[159] Read broadly, the Indiana Interlocal Cooperation Act arguably could have provided for the use of public entity pools, because the Act states simply that "a power that may be exercised by an Indiana political subdivision"[160] can be exercised jointly with other entities. Because the statute invited such a broad interpretation, pools such as IIRMA began to operate, as they had in neighboring states such as Illinois.[161] The situation presented in *Eakin* was similar to most of the cases discussed above; indeed, much of the court's decision focused on the Illinois court's decision in *Antiporek.* In fact, the *Eakin* court acknowledged many of the similarities between the Illinois program and Indiana's.[162]

However, the *Eakin* court chose to distinguish *Antiporek* on two primary grounds. First, the Indiana program, said the court, could not properly be called self-insurance because the risk and costs of civil liability are not completely internalized, but rather are retained, in part, by an excess carrier which paid for all losses exceeding $250,000. Of course, this

157. *See generally* IND. ADMIN. CODE tit. 760, r. 1-37-1 to 1-37-12 (2001); *Id.* tit. 762, r. 1-1-1.

158. 557 N.E.2d 1095 (Ind. Ct. App. 1990).

159. *See generally* IND. CODE ANN. § 36-1-7 to 36-1-7-15 (Michie 2000).

160. *Id.* § 36-1-7-2.

161. Indiana's pools were similar to the model provided by the Illinois Risk Management Authority (IRMA); *see Eakin*, 557 N.E.2d at 1102-1103.

162. *Eakin*, 557 N.E.2d at 1099-1101.

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distinction, as noted above, is one that the vast majority of states do not find precludes courts from classifying public entity pools as self-insurance. Secondly, the *Eakin* court distinguished *Antiporek* on the grounds that the pooling arrangement here involved "nongovernmental participants."[163] Specifically, the court found important the participation of the excess carrier, a consulting agency that advised in the drafting of the pooling coverage plan, and an agency that received a commission to solicit townships for membership in the pool.[164] Although the Indiana court found the pool's association with these parties to be a case-breaker, it may be assumed that most other states use or have used similar services from third parties to create their pools. Finally, the court concluded by noting that its disapproval of the pool was primarily based on the fact that the pooling arrangement "exhibits characteristics of ordinary insurance"[165] and that the "evidence reveals that IIRMA's program is actually offering insurance rather than providing for self-insurance."[166] The lone dissenter, Justice Conover, argued that the Indiana plan was identical to the Illinois plan in *Antiporek*, and that the Inerlocal Cooperation Act had previously been construed broadly by the court to permit any power that can be exercised by a single political subdivision to be exercised jointly with other entities.[167] Obviously, Justice Conover could not persuade the rest of the court to follow this rationale, and the *Eakin* case effectively put an end to any pools organized under the Interlocal Cooperation Act. Interestingly, as a result of *Eakin*, public risk sharing seems to have nearly fallen off the map in Indiana.

Instead, to regulate pools, the state legislature created the Political Subdivision Risk Management Commission. The Indiana Political Subdivision Risk Management Commission is, in the words of the enabling statute, "created as a separate body corporate and politic, constituting an instrumentality of the state . . . but not a state agency."[168] The commission is distinct from the state in its corporate and sovereign capacity. The purpose of the commission is to "[aid] political subdivisions in protecting themselves against liabilities."[169] The commission itself "has no obligation

163. *Id.* at 1101.
164. *Id.* at 1101-02.
165. *Id.* at 1102.
166. *Id.*
167. *Id.* at 1102-03.
168. IND. CODE ANN. § 27-1-29-5(a) (1999).
169. *Id.*

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to its insureds or claimants."[170] The commission consists of the Insurance commissioner, who serves as chairman, and ten other commission members appointed by the governor for a term of four years.[171] The commission oversees a statutorily-created risk management fund that is first and foremost reserved for catastrophic events but may also make disbursements or payments to political subdivisions for loss of real or personal property, or for liabilities.[172] Pursuant to state statute, the commission imposes an assessment to be paid by each member of the fund. The assessments paid by members of the fund are "set in fairness to all members, based upon the uniform application of actuarial principles and underwriters' rating principles."[173] However, the statute only provides that assessment for the first twelve months of a political subdivision's membership in the fund shall be no greater than the payment made by the political subdivision to a commercial insurer for like coverage for the twelve month period immediately preceding the political subdivision's application to become a member.[174] The maximum amount payable from the fund for any liability is $300,000 for injury, death, or damage suffered by any one person as a result of an act or omission from which the liability arises. A cap of one million dollars is set for all injury, death, or damage suffered by all persons as a result of the act or omission from which the liability arises.[175]

The restrictions imposed on members of the Political Subdivision Risk Management program, together with the costs and amount of coverage, make it obvious that a municipality in Indiana is better off shopping for commercial insurance than it is in relying on the state administered fund. There is no indication as to why Indiana chose to go the way it did, or why the *Eakin* case had to come out the way it did, but one can only imagine that the state vests a considerable amount of power in the state Insurance Commissioner, and that the interests of the insurance industry lobby are probably quite strong in the state legislature.

B. Other States: Utah and Wisconsin

At the present time, Utah and Wisconsin are the only two states that regulate their pools in the same manner as Indiana, although, over the past few years, other states have begun to explore the option of bringing their

170. *Id.*
171. *Id.* at 5(b).
172. *Id.* § 27-1-29-7.
173. *Id.* § 27-1-29-12.
174. *Id.*
175. *Id.* § 27-1-29-14.

pools under a separate regulatory system.[176] In Wisconsin, the primary provider of intergovernmental risk pooling is the Wisconsin County Mutual Insurance Corporation.[177] The corporation was created by the Wisconsin Counties Association but is now wholly administered by Aegis.[178] The corporation offers liability coverage up to $5 million. In Utah, the primary provider of pooling services is the Utah Association of Counties Insurance Mutual (UACIM).[179] Although this organization is also registered as a mutual insurance company, it appears to function as most other pools in those states that are organized under the Interlocal Cooperation Act, and provides liability coverage of up to $2.5 million.[180] When the mutual was organized, the state insurance department granted an extension of three years to build the amount of surplus required by statute. "During the first three to four years of operation, the mutual struggled to build enough surplus to meet state requirements and provide security for the members,"[181] but apparently, has since built enough reserve funds to meet state regulations and function normally. County membership appears to be high in both of these companies, although it is of course entirely possible that some, if not most of the municipalities in these states, have separate private insurance or simply self-insure on their own.

CONCLUSION

In sum, it would appear that the "patchwork" regulation of public entity pools across the country is exactly the same today as when the NAIC commissioned, and then disbanded, its study on the matter in 1991-1992. As noted, while the vast majority of public entity pools are created under Interlocal Cooperation Acts and are not included under the definition of "insurance" under state law, the similarities between organizational form and regulatory oversight seem to end there. Some states have experienced great successes with their pooling, while others, due to either the pressures of the commercial market or the strong grip of the state insurance

176. Pumford, *supra* note 15, at para. 26.

177. *See generally* Wis. County Mut. Ins. Corp., *at* http://www.wisconsincountymutual.org (last modified Oct. 27, 2001).

178. *See* Wis. County Mut. Ins. Corp., *General Administration*, *at* http://www.wisconsincountymutual.org/providers/genadmin.html (last visited Mar. 20, 2002).

179. *See generally* Utah Ass'n of Counties Ins. Mut., *Organization History*, *at* http://www.uacim.org/about/history/organization.htm (last visited Mar. 2, 2002).

180. *Id.*

181. *Id.*

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commissioner have not. Still, other states appear to have not bothered to develop any sophisticated infrastructure to administer pooling whatsoever. At the same time, however, organizations such as the Public Risk Management Association (PRIMA), and the Association of Governmental Risk Pools (AGRIP), have made great advances in the field by attempting to unify pool administrators around the country, and encourage compliance with their uniform operating standards.

From the cases explored above, it certainly seems as if state regulation can make or break the success of the pooling movement in a given state– the perfect example being the situation in Indiana. On the other hand, there is little indication that the mutual insurance corporations in Wisconsin or Utah operate any less effectively than the pools in Colorado or California. Although they differ in their organizational structure, and in the case of California, in the infrastructure and resources available to the members, the end result is the same—municipalities are provided with risk financing and risk management services at a cost which is significantly less than that which might be available from a commercial insurer. The caveat, of course, is that, due to the cyclical upswings and downturns of the domestic insurance market, this can change from time to time. Thus, while a pooling community may be insulated from the outside market forces that can drive up premiums, it is also true that at a time when the cost of commercial insurance is low, a public entity pooling arrangement might not be the most cost-effective arrangement for a governmental unit.

An argument can also be made that by definition, a mutual insurance company is no different than the majority of the public entity pools discussed in this paper. The only difference is that those states that require public entity risk sharing arrangements to be registered as mutual insurance companies simply have a jurisdictional hook by which they may regulate the pools. Therefore, it is not clear why pools should be treated differently than mutual insurance companies if their goals are substantially the same. Although a mutual insurance company can, in theory, be arranged as a for-profit enterprise, a public entity-owned and operated pool also requires a certain amount of "profit" to defray its operating costs—e.g., a pool administrator/manager, staff, consultants, etc. Perhaps the only conceivable difference arises in the case of those pools that are demonstrably the risk manager of their members, as opposed to simply the insurer. In other words, a pool that attempts to reduce its members' risk, with the ultimate goal of controlling municipal liability, or even the behavior of the member municipalities, is arguably in a better position to ask for favorable regulatory treatment because it benefits our communities and our society as a whole. On the other hand, an equally compelling

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argument might be made that these sorts of incentives create governmental pools that compete with private insurers and should not be created by the state when the already existing private market has generally proven itself to perform adequately over time.

Furthermore, it is questionable just how far public entity pooling arrangements go to break down political boundaries that regional government activists and state legislators, intended when they enacted their Interlocal Cooperation Acts. If the pools operate effectively and cover an optimal amount of risk, then the size of a municipality's tax base becomes less of a factor in its ability to absorb risk, and goes toward leveling the playing field between rich communities and poor communities–this was in many cases the very purpose of intergovernmental cooperation movements. If, on the other hand, the pools do not absorb a sizable amount of governmental risk or use the protection of the law (i.e., the classification of self-insurance discussed in *Arvada* and *Lombard* above) to minimize the pools' liability for the acts or omissions of its members, then the pools could frustrate the interlocal cooperation purpose of the pooling arrangement.

In any event, the area of public entity pooling is one that continues to develop and change the way that municipalities finance risk. At their best, the pools greatly decrease the cost of public entity insurance and thus conserve local tax revenues while providing quality coverage and services for the member municipalities. Regardless of the manner in which they are regulated, state insurance commissioners would ultimately be wise to nurture their development.

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FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Heidi Lee De la Rosa**

AUTOMOBILE INSURANCE

Matthew W. Rearden, *OEM or Non-OEM Automobile Replacement Parts: The Solution to* Avery v. State Farm, 28 FLA. ST. U. L. REV. 543 (2001).

This Note analyzes the Illinois case *Avery v. State Farm Mutual Automobile Insurance Co.*, No. 97-L-114, 1999 WL 955543 (Ill. Cir. Ct. Oct. 8, 1999), which effectively mandated the use of Original Equipment Manufacturer (OEM) parts when insurance companies repair damaged vehicles. Rearden explains that the plaintiffs in *Avery* were State Farm policyholders who claimed that by repairing their wrecked vehicles with non-OEM automobile parts rather than OEM parts, State Farm failed to return their cars to "pre-loss condition" as required by their insurance contracts. The jury rendered a verdict in favor of the plaintiffs, finding that State Farm breached its contracts with the plaintiffs, and awarded the largest judgment ever against an insurance company in the United States.

Rearden states that *Avery* has spawned an important debate regarding the use of non-OEM parts. He analyzes the issues associated with the use of non-OEM parts, and reaches the conclusion that their use should be retained. Rearden states that the key difference between non-OEM and OEM parts is the distributor. The automobile manufacturer distributes OEM parts. However, most automobile manufacturers hire subcontractors to fabricate their parts. Rearden asserts that some of the same subcontractors that manufacture OEM parts also manufacture non-OEM parts. To determine whether OEM parts are actually superior to non-OEM parts, Rearden examines the issues of safety, warranty, price, and competition. He determines the following: 1) studies have shown that non-OEM parts do not affect vehicle safety; 2) the use of non-OEM parts to repair a vehicle does not void the manufacturer's original warranty on the remaining parts; 3) non-OEM parts are significantly less expensive than

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OEM parts, though longer installation time may offset some of the savings; and 4) supporting the market in non-OEM parts keeps OEM prices down.

Rearden contends that *Avery* may lead to a substantial increase in premiums to offset the cost of more expensive OEM parts. In order to avoid this detrimental effect, Rearden proposes a two-tiered approach to insurance policies that would permit the use of both OEM and non-OEM parts without subjecting insurers to lawsuits like *Avery*. He suggests that insurance companies should offer two types of insurance policies, a "standard" policy and an "OEM" policy. The "standard" automobile policy would be essentially the same as the typical policy used today. However, it would add specific language that clarifies that "functionally equivalent" parts may be used to repair the automobile. The "OEM" policy, at an additional cost, would consist of the "standard" policy plus an endorsement that repair would consist of only OEM parts. Rearden contends that this two-tier system would benefit both the insurers and the insureds. Insurance companies would be able to defend lawsuits like *Avery* on the basis that the insureds agreed to have non-OEM parts installed in their cars when they chose the "standard" policy. Consumers who are willing to have their automobiles repaired with non-OEM parts can continue to enjoy lower premiums, while those who are willing to pay higher insurance rates can ensure their automobiles are repaired with OEM parts.

BAD FAITH CLAIMS

Lynnette L. Cox, Overcast v. Billings Mutual Insurance Co.: *Defamation or Vexatious Refusal to Pay?*, 69 UMKC L. REV. 927 (2001).

This Note analyzes the Missouri Supreme Court's decision in *Overcast v. Billings Mutual Insurance Company*, 11 S.W.3d 62 (Mo. 2000). Cox states that prior to *Overcast*, Missouri insurance law did not recognize tort claims by insureds against their insurers. Missouri courts had consistently held that when an insurer refused to pay a claim without good reason, the insured should be awarded contract damages plus statutory damages for "vexatious refusal to pay." Cox states that the statutory damages were not to punish an insurer in tort; rather, they were enacted to compensate an insured who is forced to recover contractual damages. Moreover, Missouri courts had held that the vexatious refusal statute preempted most tort claims by insureds against their insurers.

Cox states that the Missouri Supreme Court broke new ground in *Overcast*. In *Overcast*, a fire destroyed the insured's home and the insurer refused to pay the insured's claim on the grounds that the loss had resulted

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from arson. The insurer's conclusion was based solely on an inadequate investigation. The insured sued the insurer for breach of contract, vexatious refusal to pay, and defamation. The vexatious refusal statute did not apply to the insurer because it was a county mutual insurance company. Nevertheless, the jury awarded the insured contract damages and interest as well as actual and punitive damages. The Missouri Supreme Court held that the vexatious refusal statute did not preempt all tort claims by the insured. Although the court acknowledged that Missouri does not recognize first party bad faith, and a wrongful refusal to pay warrants contract damages only, it decided that the defamation claim was somehow independent of the contract claim, even though the very basis for the alleged defamation was the refusal to pay. Essentially, the *Overcast* court found that a denial of coverage may be converted into a tort based solely upon the reason for denial. Cox contends that the court made this decision because it knew that if it was not creative, the insured in this case would have no remedy aside from contract damages, an obviously harsh result.

Cox contends that theoretically, practically any reason for denial could be cast as a defamation claim after *Overcast*. She states that the court in *Overcast* gave little guidance as to its threshold for what constitutes a defamatory statement. The court simply listed the elements of defamation. Cox also contends that the court's finding of defamation ignored Missouri insurance regulations. For example, the court promoted the idea that insurers should not send a denial letter, much less a reason for denial, without the insured's request. However, Missouri insurance regulations require insurers to provide a reason for denial. The regulations make no mention of the fact that an insured must request a reason for denial. Ultimately, Cox concludes that although it would have been unfair to the insured in *Overcast*, the court should have awarded contractual damages only, and left it to the legislature to amend the vexatious refusal statute to cover county mutual insurance companies.

Kasey D. Huebner, *In the Litigation Business: Insurance Company Liability for Acts Occurring in the Course of Litigation under the Washington Consumer Protection Act*, 76 WASH. L. REV. 927 (2001).

This Comment argues that the Washington Consumer Protection Act (CPA) establishes a cause of action against insurance companies for deceptive acts occurring after a suit has been filed by an insured. Huebner begins with a discussion of the history of the CPA. She explains that the Washington State Legislature enacted the CPA to protect consumers from unfair and deceptive business practices. Under the CPA, a consumer can

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bring a private suit against an individual or business if he shows each of the following: 1) an unfair or deceptive act or practice; 2) occurring in trade or commerce; 3) that affects the public interest; and 4) causes harm to the consumer's business or property. Private CPA suits allow for recovery of treble damages, as well as attorney's fees. Huebner states that both the Insurance Commissioner of Washington and the Washington courts have determined that private CPA suits may be brought against insurance companies.

Huebner explains that the CPA generally does not apply to acts occurring in the course of litigation. The Washington Court of Appeals has held that acts occurring in the course of litigation are private disputes that cannot support the unfair or deceptive act, trade or commerce, and public interest requirements of the CPA. Thus, acts by a business occurring after a consumer has filed a suit cannot subject the business to liability under the CPA. The court recognized an exception, however, for acts that the Legislature has determined to be per se unfair or deceptive.

Huebner argues that the litigation exception to the CPA should not apply to the insurance industry because the justification for the exception does not apply in the insurance context. She states that in the insurance company context, an insured should be able to establish the unfair or deceptive, trade or commerce, and public interest requirements for acts occurring in the course of litigation. Huebner asserts that the failure of an insurance company to provide benefits to an insured, as promised under a standardized contract, creates a capacity to deceive the general public and satisfies the unfair or deceptive requirement of the CPA. Also, since Washington courts have declared litigation to be part of the usual business of insurance, acts occurring in the course of litigation should satisfy the liberally construed Washington definition of trade or commerce. In addition, the Washington Legislature has statutorily defined the insurance business as an industry that affects the public interest, so an insured should be able to establish this element of a CPA claim as well. Even assuming that the litigation exception does apply in the insurance context, Huebner contends that insureds should still be able to bring suit against insurance companies under the exception to the litigation exception, because the Insurance Commissioner has outlined specific acts which are per se unfair or deceptive in the business of insurance.

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HEALTH INSURANCE

Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419 (2001).

This Article surveys the primarily private health insurance system of the United States, the mixed public and private health insurance systems of Australia, Chile, Germany, and the Netherlands, and the largely public systems of Canada, France, and the United Kingdom. Jost shows that countries that place significant reliance on private health insurance also regulate the private insurance market heavily. This is because unregulated private health insurance markets leave high risk individuals with very costly, often unaffordable premiums, or apply other terms and conditions, such as lengthy preexisting condition exclusions, that make affordable insurance of little value. Nations that rely on individual private insurance policies for providing primary coverage to portions of their populations almost inevitably regulate and often subsidize private insurance markets to mitigate these results. Jost states that the arguable benefits of private health care finance, namely its agility, flexibility, and capacity for innovation, are crippled as these governments increasingly dictate the terms of the insurance relationship. Only where private insurance merely supplements universal public insurance is the private market largely unregulated.

Jost concludes from his comparative analysis that market-reliant systems are unlikely to reduce the growing number of Americans who are uninsured. He contends that despite the adoption of extensive and intrusive market reforms, private markets cannot insure entire populations. This is because all markets discriminate against those who cannot pay. Public insurance systems, by contrast, are in principle more equitable in that they cover entire populations, and treat different population groups more equitable as well. Jost notes that in a public insurance system, there is still a role for private health insurance. Private insurance continues to play an important role in the United Kingdom, Canada, and France, by supplementing basic public insurance. As long as basic services are covered in a public program, a supplementary system can be maintained to respond to consumer demands for additional luxury services with minimal government regulation. Since the United States is unlikely to embrace universal public insurance and limit private insurance to the margins, Jost proposes the creation of marginal public systems that meet the needs of the uninsured without posing too great a threat to the private insurance establishment.

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David LeBolt, *Jumping Through the Hoops: Crowd-Out and the Children's Health Insurance Program*, 5 U.C. DAVIS J. JUV. L. & POL'Y 67 (2000).

This Article urges policy makers to refocus their efforts in getting people into public programs, and not out. As states expand their health care programs using money from Congress under the Children's Health Insurance Program (CHIP), many policy makers fear the "crowding-out" of private insurance. Crowd-out occurs when public health dollars replace spending on private health insurance by employers and their employees.

LeBolt explores how efforts to limit crowd-out have a deleterious effect on the health of poor children. He discusses ways in which crowd-out might occur and the perception of the amount of crowd-out prior to CHIP. LeBolt then explores mechanisms to prevent crowd-out. His article demonstrates how states are attempting ways to limit crowd-out in their CHIP programs, and the negative effects that these anti-crowd-out provisions have on the availability of health insurance to low-income children. He proposes that a subsidy program, if designed appropriately, can maximize the impact of public spending without harmful effects. He also presents data to show that the extent of crowd-out in CHIP has been minimal. Therefore, he concludes, the goal should be to enroll children in CHIP rather than keeping them away.

Nathalie D. Martin & Elizabeth Rourke, *Les Jeux Ne Sont Pas Faits: The Right to Dignified Long-Term Care in the Face of Industry-Wide Financial Failure*, 10 CORNELL J.L. & PUB. POL'Y 129 (2000).

This Article discusses the impact the Balanced Budget Act of 1997 (BBA) has had on long-term care. The authors explain that before the BBA, Medicare reimbursed nursing homes and home-health care providers for all costs incurred in caring for patients. Congress felt these reimbursement policies created the wrong incentives for homes and home-health care agencies, some of which may have been providing more care than was actually needed. As a result, Congress enacted the BBA, a prospective reimbursement system that caps the amount a nursing home or home-health care provider can be reimbursed for each particular patient. It also limits the number of rehabilitation visits each person can receive.

The authors state that the BBA has had a devastating effect on the long-term health care industry. They explain that the BBA drastically reduced Medicare funds to nursing homes and home-health care providers, causing both industries to fail. While wealthier failing businesses could

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afford to file for bankruptcy, smaller businesses were forced to close their doors. The authors state that ten percent of the nation's nursing homes are now operating under Chapter 11 of the Bankruptcy Code, and over one-third of the nation's home-health care agencies in existence at the time the BBA was passed have gone out of business.

According to the authors, these industry-wide financial problems have had a negative effect on the availability and quality of care for the elderly. They discuss a number of reasons why nursing home and home-health care bankruptcies can have a negative impact on the recipients of such care. For example, a nursing home under Chapter 11 may stay operational but offer compromised care as a result of its financial condition. In addition, the authors state that the new reimbursement scheme has made it harder for some patients to access care. Nursing homes are being far more selective in accepting patients since the enactment of the BBA. Nursing homes are now turning away sicker patients because caring for these patients could cause the provider to lose money.

The authors conclude that the BBA was not well thought-out and has created risks to long-term care recipients that were neither contemplated nor condoned. They call for discourse about our national policy with respect to both aging and funding long-term care with public funds. The authors ultimately recommend that in the very near future, policy makers develop a long-term strategy with respect to which long-term care services will by funded through Medicare.

Richard C. Parks, Doe v. Mutual of Omaha: *The Seventh Circuit Eviscerates the ADA's Protection of People with HIV/AIDS Against Insurance Policy Discrimination*, 10 LAW & SEX. 277 (2001).

This Casenote is a critical analysis of the Seventh Circuit's holding that the ADA governs only access to insurance and not the content of the policy itself. *Doe v. Mutual Of Omaha* involved a suit under the ADA by HIV infected policyholders. The policies in question contained caps upon health insurance benefits for HIV and AIDS related illnesses. The district court ruled in favor of the plaintiffs finding that the differential treatment for disabled persons with AIDS was sufficient to state a cognizable claim of discrimination in violation of Title III of the ADA. Furthermore, the court held that the McCarran-Ferguson Act did not bar the application of the ADA to the plaintiff's claim. This decision was overturned by the Seventh Circuit in an opinion delivered by Chief Judge Richard Posner. The Seventh Circuit held that the ADA requires only equal access to insurance policies and not to their actual content. Furthermore, the court held that the

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plaintiffs' claim was barred by the McCarran-Ferguson Act; reasoning that such an application of the ADA would interfere with the State's administrative regime.

Parks argues that the court's narrow reading of the ADA gives insurance companies the right to place arbitrary caps on any medical condition they choose regardless of actuarial data. He likens this right to a license to discriminate against unpopular groups such as individuals who are infected with the HIV virus. Parks contends that Congress should clarify and revise the meaning of the ADA's "subterfuge" clause to ensure that its protections govern the content of insurance policies.

Mark A. Rothstein, *Predictive Genetic Testing for Alzheimer's Disease in Long-Term Care Insurance*, 35 GA. L. REV. 707 (2001).

This Article argues that predictive genetic information regarding risk for Alzheimer's disease should not be permitted in the medical underwriting of long-term care insurance. Rothstein explains that genetic testing technology has developed at a rapid rate over the last decade. Among the genetic links to disease has been the discovery of four alleles associated with an increased risk of Alzheimer's disease. Rothstein states that tests are currently experimental and not ready for clinical application. Nevertheless, a variety of factors suggest that long-term care insurers will be tempted to use information obtained from genetic tests for these mutations or others likely to be discovered over the next several years. According to Rothstein, these reasons include the growth in long-term care insurance, the increased life expectancy of individuals, and the large increase in costs for the long-term care of individuals with Alzheimer's disease.

Rothstein states that there has been little serious debate on public policy regarding genetic testing or the use of genetic information by long-term care insurers. Genetic discrimination in health insurance and, to a lesser extent, life insurance, has been the main focus of public policy. Rothstein explains that presently, there are opposite policies for these two forms of insurance: the use of genetic information in health insurance is increasingly unlawful, but the use of genetic information in life insurance is generally lawful. Rothstein contrasts these policies to determine the appropriate policy for long-term care insurance. He is unable to determine whether long-term care insurance is more like health insurance or life insurance, finding similarities to each. Thus, Rothstein bases his policy decision on a consideration of ethical principles. He contends that assuring access to long-term care promotes autonomy and human dignity. Rothstein

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therefore concludes that policies should be adopted that encourage individuals to purchase long-term care insurance without medical underwriting based on the results of a genetic test or family history of predisposition to Alzheimer's disease.

INSURANCE – GENERAL

Carol Barrick, *Michigan Insurance Agents' Special Relationship Test Gives Way to No-Duty Rule Exceptions*: Harts v. Farmers Insurance Exchange, 17 T.M. COOLEY L. REV. 511 (2000).

This Casenote analyzes the Michigan Supreme Court's decision in *Harts v. Farmers Insurance Exchange*, 597 N.W.2d 47 (1999), which specifically addressed and modified Michigan's "special relationship" test. Barrick explains that like the majority of courts across the country, Michigan courts held that an insurance agent owes no duty to advise an insured of coverage needs unless a "special relationship" exists. Barricks states that the *Harts* court recognized the problem in interpreting the term "special relationship." Although the term is used often in court opinions, it rarely, if ever, is specifically defined. Barricks explains that the *Harts* court attempted to improve the dubious "special relationship" test and establish a bright-line rule.

The result was a "no-duty-to-advise rule" where an insurance agent functions as simply an order taker for the insurance company. However, when the nature of the relationship changes, the agent's duty may arise. The court stated that the general no-duty rule changes when: 1) the agent misrepresents the nature or extent of the coverage offered or provided; 2) an ambiguous request is made that requires clarification; 3) an inquiry is made that may require advice and the agent, though he need not, gives advice that is inaccurate; or 4) the agent assumes an additional duty by either express agreement with or promise to the insured. The court characterized these exceptions as "very limited circumstances."

Barricks argues that the no-duty rule established in *Harts* is swallowed up by its exceptions. For example, one of the exceptions, or "very limited circumstances," is when an ambiguous request is made that requires clarification. The court gave an example of an ambiguous request as one where a consumer requests "full coverage." Barricks asserts that this is hardly a "very limited circumstance." She states that the request for "full coverage" auto insurance could well be the majority of requests heard by insurance agents. Barricks contends that contrary to the court's opinion, the "very limited circumstances" outlined in *Harts* occur in the everyday

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operations of many professional insurance agents. She asserts that only when an agent is acting as a "mere order taker" would the *Harts* no-duty-to-advise rule apply. Barricks concludes that *Harts* left many questions unanswered, concerns ignored, and exceptions that could include more situations than those found under the rule.

Jeremy P. Brummond, *When Will the Smoke Clear?: Application of Waiver and Estoppel in Missouri Insurance Law*, 66 MO. L. REV. 225 (2001).

This Note analyzes the Missouri Supreme Court's application of waiver and estoppel in *Shahan v. Shahan*, 988 S.W.2d 529 (Mo. 1999). Brummond explains that although they are often used interchangeably, waiver and estoppel are two distinct legal theories. Waiver involves the intentional relinquishment of a known right and may be either express or implied. Estoppel involves action (intentional or unintentional) by one party inducing another party to rely on that action. Brummond states that the doctrines of waiver and estoppel have served as a tool for courts that want to justify particular pro-insured results in insurance cases. In *Shahan*, however, the Missouri Supreme Court applied the law of waiver and estoppel in a way that is adverse to insureds.

Brummond states that in insurance law, a court generally cannot use the doctrines of waiver and estoppel to create coverage where coverage did not previously exist under the express terms of the insurance policy. The court in *Shahan*, however, applied a waiver and estoppel analysis to a situation where a favorable ruling for the insured would contradict the general principle that waiver and estoppel cannot be used to create coverage. Therefore, Brummond states that one could argue that creating coverage through waiver and estoppel is not prohibited in Missouri. However, Brummond contends that establishing an implied waiver or proving prejudice in Missouri after *Shahan* is virtually impossible.

According to Brummond, insurance law generally states that once an insurer denies liability on a specific ground, it may not later deny liability on a different ground. In Missouri, one way to gain the benefit of this rule is to show that the insurer, initially denying liability on one ground and then subsequently denying liability on a different ground, would prejudice the insured. Brummond states that in the traditional application of this rule, prejudice was presumed. The rationale behind the presumption was that the announcement of a specific defense itself prejudices the insured merely by making him prepare to meet that particular defense, and not others. Brummond states that the majority in *Shahan* ignored this rationale, and

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instead, required a showing of additional prejudice. Thus, the court destroyed the presumption of prejudice (or presumption of implied waiver) that had long protected insureds. Brummond concludes that after *Shahan*, the possibility for a Missouri court to use waiver or estoppel to reach a favorable result for an insured seems minimal.

Daniel Gregory Sakall, *Can the Public Really Count on Insurance Agents to Advise Them? A Critique of the "Special Circumstances" Test*, 42 ARIZ. L. REV. 991 (2000).

This Note reviews the various judicial approaches to the insurance agent-client relationship. Sakall shows that despite the increasing complexity of insurance coverage and policies, the majority of courts still insist that clients can understand their insurance options and policies without assistance and that insurance agents are merely salespersons. These courts generally limit the agents' duties to those actions directly related to procuring the requested insurance policy. After having procured the policy, insurance agents generally have no additional duty to inquire further or advise a client as to coverage. Thus, as a general rule in almost every jurisdiction, insurance agents have no duty to advise absent a so-called "special circumstance." Such "special circumstances" have been found where an insurance agent has held himself out as an expert, where there has been a long-standing relationship between an agent and a client, and where an agent has provided inaccurate information to a client.

Sakall contends that the "special circumstances" test is unwieldy because it has created a seemingly multi-factored analysis that a court must address before imposing a duty to advise on an agent. Even after such an analysis, the court is still required to examine any number of possible defenses that are based upon an outdated assumption that a client can understand his policy. Furthermore, the "special circumstances" test is inefficient because courts are often required to resolve factual issues and, therefore, impanel a jury before making a baseline determination that a duty exists.

Sakall argues that courts should reject the "special circumstances" test in favor of an all-encompassing professional tort duty so that clients might be able to recover money damages if a jury determines that their insurance agents should have advised them. Sakall asserts that the "special circumstances" test has allowed insurance agents to remain, in the eyes of the law, mere salespersons while they have become, in reality, professionals. Unlike other professionals whose duties are prescribed generally, an agent may or may not have a duty to advise. This has helped

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to create an insurance system in which clients are not receiving the advice, information, and coverage that they need, and agents often have little incentive to provide any advice. Sakall states that if insurance agents truly wish to become professionals, they should agree to assume the same duties as other professionals and not hide behind the outdated "special circumstances" test.

Alan O. Sykes, *Subrogation and Insolvency*, 30 J. LEGAL STUD. 383 (2001).

This Article addresses the question that arises as to who should recover first when a tort judgment exceeds the assets of the tortfeasor and the tort victim has first-party insurance to cover a portion of the loss suffered. The common view in U.S. courts, under the "made-whole doctrine," is that the insured should be made whole before the insurer recovers through subrogation. This Article uses simple models of optimal insurance contracts to show that the opposite rule would be preferable.

Sykes explains that the reason why it is optimal for the insurer to take first depends on the reason why, in each case, the insured lacks full coverage for losses. He considers three explanations for the insured's incomplete coverage: nonpecuniary losses, actuarially "unfair" premiums, and moral hazard. Sykes offers illustrative models to examine these three justifications for underinsurance. The results are driven by the fact that the optimal amount of loss for the insured to bear does not vary according to whether an injurer happens to be liable for harms to the insured. Thus, he concludes from the models that a rule under which the insurer takes first from any damages collected from the injurer is generally optimal. This is the rule that is written into many insurance contracts in practice. Therefore, Sykes further concludes that there is minimal justification for judicial interference with freedom of contract when the insurance agreement provides that the insurer must be made whole before the insured receives any portion of the recovery.

Sykes maintains that the made-whole doctrine, which is so prevalent in the existing state of the law, is seriously at odds with sound policy. Furthermore, this conclusion is true whether the subrogation rights of the insurer arise by operation of contract or common law. Therefore, Sykes also supports the position that allowing the insurer to recover before the insured should be the default rule at common law.

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Anthony A. Tarr & Julie-Anne Tarr, *The Insured's Non-Disclosure in the Formation of Insurance Contracts: A Comparative Perspective*, 50 INT'L & COMP. L.Q. 577 (2001).

The authors conduct a comparative analysis within the Anglo-Commonwealth of England, Australia, New Zealand and Singapore, concerning the legal implications of an insured's non-disclosure during an insurance contract's formation. Disclosure requirements in insurance contracts are heightened because the insured is generally in a better position to withhold information to the insurer; thus, the allocation of risk shifts to the insurer.

The genesis of the common law duty of disclosure evolved from admiralty law and marine insurance contracts in the eighteenth century, and, the authors note, such early legal vestiges continue to cloak contemporary jurisprudence despite significant technological improvements that insurers may employ to gather important information regarding potential insureds. Accordingly, the authors submit that the harsh consequences of such early non-disclosure jurisprudence is misplaced given the availability of insurers to gather the requisite information in determining the insurability of a given insured. The authors point out that insurers can protect themselves by asking the insured specific questions. This view is bolstered by the fact that the Anglo-Commonwealth has reexamined disclosure requirements; nevertheless, the legislation and law that has since evolved is not without fault.

For example, it is incumbent upon an insured to disclose all material facts under Anglo-Commonwealth common law, and courts typically employ a prudent insurer test in assessing materiality. An insured's failure to disclose a material fact is grounds to void the contract *ab initio*. The authors argue that the prudent insurer test is onerous because facts which are material to insurers may not necessarily be material to the honest and forthright insured who did not disclose the fact at issue. As an alternative to the onerous and harsh effects of the ubiquitous prudent insurer test, the authors proffer a "reasonable insured" or "reasonable proponent" test of materiality in determining disclosure obligations in any given context. The authors argue that the supposed objectivity of the prudent insurer text can be tainted with the subjective idiosyncrasies of any given insurer. Although the authors admit that the reasonable insured test may suffer the same abuses, courts have long dealt with its counterpart, the reasonable person test, which has been applied in numerous insurance cases.

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INSURANCE REGULATION

Anthony J. Barkume & John W. Ruser, *Deregulating Property-Casualty Insurance Price: The Case of Workers' Compensation*, 44 J.L. & ECON. 37 (2001).

This Article analyzes the impact of rate deregulation in workers' compensation insurance. As an introduction, the authors conduct a brief survey of the history of the regulation and deregulation of workers' compensation insurance from the period from 1981 to 1995. After providing this historical context, the authors present a detailed econometric analysis employing empirical data obtained from the Bureau of Labor Statistics' *Employment Cost Index* and *Annual Survey of Occupational Injuries and Illness*. This data provides information on the impact of deregulation on premiums and injury rates respectively.

The authors investigate the possible impacts of deregulation upon both the price of insurance and worker injury rates. The authors examine two possible types of deregulation: plans that include eliminating both rating bureau pricing and prior approval versus plans eliminating only rating bureau pricing. The authors conclude that eliminating both rating bureau pricing and prior approval reduced long-run premiums by 13.7 percent and reduced injury rates by a maximum of 8.2 percent. In contrast, eliminating only rating bureau pricing had small effects. The results of the authors' regression analysis of the empirical data leads them to the conclusion that the elimination of both rating bureau pricing and prior approval authority has a stronger affect on premiums and injury rates than the removal of rating bureau pricing alone.

Patricia M. Danzon & Scott E. Harrington, *Workers' Compensation Rate Regulation: How Price Controls Increase Costs*, 44 J.L & ECON. 1 (2001).

Most states require employers to purchase workers' compensation insurance that covers medical expenses and wage loss for injured workers. The 1980s was a period when, in response to rising workers' compensation rates, many state regulators counteracted such increases by denying insurers premium rate increases. In response, insurers heightened scrutiny of risks they would accept in the voluntary market and shifted their unassumed risk to residual market mechanisms existing in all states and which provide coverage for those denied coverage in the voluntary market.

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It is noteworthy, however, that residual market solvency is dependent on assessing all voluntary market insurers.

By employing a sophisticated statistical analysis and methodology, the authors test their hypothesis that instead of diminishing rapidly rising loss costs, rate suppression should have the opposite effect of exacerbating loss costs which, in turn, should lead to even higher losses and rate premiums. The data confirmed the authors' hypothesis and further substantiated their hypothesis that rate suppression has the unintended effect of increasing premiums due to increased loss growth, diminished insurer loss control incentives, and increased employer moral hazard in the residual market place because losses are pooled among insurers.

The authors present the results of their research by: 1) providing a background on workers' compensation and the prior work conducted in this area; 2) developing their hypothesis on the unintended cost-increasing effects of rate suppression; 3) presenting a disciplined and unbiased review of their data and methodology; 4) providing an analysis of cost growth examining such variables as claim severity, claim frequency and premium growth; 5) providing a detailed analysis of cross subsidies by scrutinizing the effects of political influence in determining the winners and losers from workers' compensation rate regulation; and lastly 6) by offering their conclusions.

Phil Goodin, *Keeping the Foxes From Guarding the Henhouse: The Effect of* Humana v. Forsyth *on McCarran-Ferguson's Antitrust Exemption for the Business of Insurance*, 86 IOWA L. REV. 979 (2001).

This Note argues that the United States Supreme Court's decision in *Humana v. Forsyth*, 525 U.S. 299 (1999), may lead to a new or clarified interpretation of the McCarran-Ferguson Act's antitrust exemption. Goodin explains that Congress passed the Act to provide for state law primacy in the regulation of the insurance industry. However, the Act specifically provides that federal antitrust laws are applicable to the business of insurance to the extent that the business is not regulated by state law. Goodin shows that courts have been very lenient in defining what constitutes regulation under the Act. As a result, nearly all state statutes and regulations trigger the exemption from federal antitrust laws. Consequently, where states are not actively regulating prohibited activity, insurance companies are regulating themselves. Goodin contends that leaving a powerful industry such as insurance to regulate itself will ultimately result in consumer fleecing, an unlikely goal and unavoidable outcome of the Act.

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According to Goodin, the leniency in favor of state regulation may be changing. He states that in the recent case of *Humana v. Forsyth*, the Supreme Court opened the door to joint application of general federal laws and state laws that regulate the business of insurance, unless the state and federal laws "directly conflict." The *Humana* decision dealt specifically with the Racketeering Influenced and Corrupt Organizations Act, and mentioned antitrust laws only briefly. Nevertheless, Goodin argues that if the Court were to apply the same interpretive techniques employed in the *Humana* decision to the antitrust exception of the McCarran-Ferguson Act, the Court would have to redefine the antitrust immunity. Goodin maintains that *Humana*, and other interpretive trends, demonstrate that the Court may be willing to further narrow the antitrust immunity through a close textual examination of the Act, thereby eliminating unnecessary immunity from antitrust regulation.

Goodin recommends adopting the judicially created "State Action" standards for the amount of regulation required to trigger the antitrust immunity. Under the State Action doctrine, states may curtail the applicability of federal antitrust laws only where states take an active role in regulating the insurance industry. Goodin contends that this standard is consistent with the Act's original goal of allowing states to regulate only where they take the initiative to do so.

Wendy Lovejoy, *Ending the Genetic Discrimination Barrier: Regaining Confidence in Preconception, Prenatal, and Neonatal Genetic Testing*, 74 S. CAL. L. REV. 873 (2001).

This Note contends that comprehensive federal legislation prohibiting insurers' use of genetic information is needed to protect the future of genetic research and the prospects for prevention and treatment that it will bring. Lovejoy describes the problem of birth defects and the genetic tests that are available to diagnose or to prevent certain genetic diseases. She discusses how preconception, prenatal, and neonatal genetic testing can ameliorate the problem of birth defects.

Lovejoy states that despite the valuable benefits of genetic testing at the preconception, prenatal, and neonatal stages of reproduction, the threat of discrimination in insurance coverage may hamper decisions to undergo genetic testing. She explains that Americans are genuinely worried that their genetic information may not remain private and could result in discrimination. Lovejoy explains that genetic discrimination poses three potential problems. First, by deterring genetic testing, it undermines the value that those tests contribute to saving babies from genetic birth defects.

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Second, public fear of discrimination stymies the growth of genetic research and threatens to hinder the development of genetic tests. Third, it makes gaining and maintaining insurance coverage more difficult for families and individuals who may need it.

Lovejoy details how states have responded to the fear of genetic discrimination by enacting legislation. She evaluates the degree of success of these state laws, and finds that their coverage of disparate types of genetic information fails to offer insureds any consistent form of protection upon which they can rely. Lovejoy also outlines current and proposed federal legislation and highlights the gaps in protection left by these laws. According to Lovejoy, the state and federal approaches provide valuable lessons regarding what effective legislation should include. She concludes that four ideals should be engendered in federal legislation prohibiting insurers' use of genetic information: 1) a broad definition of genetic information; 2) protection for routine tests and examinations; 3) protection for scientific uses of genetic information; and 4) universal application for all insureds.

Scott A. Sinder, *The Gramm-Leach-Bliley Act and State Regulation of the Business of Insurance–Past, Present and . . . Future?*, 5 N.C. BANKING INST. 49 (2001).

This Article discusses the past, present, and possible future of insurance regulation. Sinder begins with the history of insurance regulation in the United States. He explains that historically, states exclusively regulated insurance. In the McCarran-Ferguson Act, Congress affirmatively declared a policy of not regulating insurance, and stated that it was a matter for the states. Sinder also explains the history of national bank involvement in insurance activities. He states that prior to the United States Supreme Court's decision in *Barnett Bank of Marion Co. v. Nelson*, 517 U.S. 25 (1996), national banks were routinely subject to state laws that prohibited bank insurance sales activities. However, the *Barnett* Court held that state prohibitions on bank insurance sales activity were preempted by section 92 of the Federal Reserve Act which authorizes national banks located and doing business in small towns to act as agents in the sale of insurance.

Sinder next outlines the Gramm-Leach-Bliley Act (GLBA) rules that now govern regulation of the insurance business. He explains that the primary purpose of the GLBA is to enable banks, securities firms, and insurance companies to affiliate with one another and to engage in an expanded array of specified financial activities. These activities include

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traditional banking activities, insurance sales and underwriting, financial and investment services, securities underwriting and dealing, and merchant banking. The GLBA generally mandates that all insurance activities will be "functionally regulated" by the states regardless of the entity that is engaging in those activities. However, it also incorporates the *Barnett* preemption test to limit the scope of the states' regulatory authority.

According to Sinder, enactment of the GBLA poses four challenges to the state-based system of insurance regulation it purportedly sought to preserve: 1) freezing state regulation of bank insurance activities; 2) multiplicity of state insurance requirements; 3) GBLA-mandated state privacy regulation; and 4) establishment of a National Association of Registered Agents and Brokers. In light of these challenges, Sinder considers potential alternatives to, or modifications of, the current state-based system. He discusses several regulatory options that may be a focus of Congressional activity in the near future, including a new optional federal charter for insurance companies and agencies, harmonizing current state regulatory systems to create a "super" state regulatory system, and creating a self-regulatory organization.

James A. Smallenberger, *Insurance Law Annual: Restructuring Mutual Life Insurance Companies: A Practical Guide Through the Process*, 49 DRAKE L. REV. 513 (2001).

Passage of the Gramm-Leach Bliley Financial Services Modernization Act has provided insurance companies with the increased flexibility to invest and participate in other segments of the financial services industry that once were the sole province of banks and securities firms. As a result, insurance companies, and particularly mutual life insurance companies which are the focus of this Article, must seek alternative structures in order to raise capital and facilitate growth to survive in this new dynamic of heightened competition. A mutual insurance company, unlike a stock insurance company which is owned by its shareholders, is owned by its policyholders, and accordingly, cannot raise capital by issuing shares of capital stock.

Smallenberger provides a primer for legal advisors on the nuances and financial implications involved in restructuring a mutual life insurance company and equips attorneys with an overview of the issues and concerns that generally arise when a mutual life insurance company decides to restructure into either a fully demutualized stock insurance company or, a mutual life insurance holding company (MHC). Smallenberger notes that insurance companies often opt to create an MHC rather than fully

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demutualize because, in addition to its ability to raise capital, an MHC fosters the structural flexibility to align subsidiaries and affiliates, while at the same time provides tax advantages and preserves mutuality and the company culture.

Smallenberger examines the differences between these two alternative structures and explores the reasons why mutual life insurance companies are gravitating towards restructuring. Whether restructuring into a fully demutualized stock company or an MHC, the author compares their corporate structures, management accountability, federal and state tax treatment and consequences, eligibility, forms of compensating existing policyholders when converting to the new structure, corporate governance, management compensation, board and policyholder approval and regulatory approval. Smallenberger also carefully illustrates potential federal securities law regulatory oversight issues that may arise in the issuance of stock to policy owners such as disclosure requirements, and discusses the timing and need for an initial public offering.

Nathalie Smith, *The Right to Genetic Privacy? Are We Unlocking the Secrets of the Human Genome Only to Risk Insurance and Employment Discrimination?*, 2000 UTAH L. REV. 705 (2000).

This Note analyzes genetic research and testing, potential genetic discrimination from health insurers and employers, the importance of individual privacy, and potential protection at the state and federal levels. Smith begins by explaining the basics of genetics and genetic testing and its recent emergence in the scientific and medical communities. Particularly, she focuses on the Human Genome Project, an international research initiative to sequence the entire human genome. She explains that the project's goal to discover new genetic diseases, treatments, and preventive measures also raise ethical, legal, and social issues.

Smith examines some of the potential abuses attendant to genetic testing. She explains that those who have an interest in obtaining genetic test results because of the indication of one's predisposition to particular genetic diseases may use such information against the individual in harmful ways. Specifically, health insurers that use genetic information as a risk classification may discriminate by unreasonably increasing premiums or even refusing to insure or renew an individual's policy. Employers who self-insure or who offer group employment insurance may discriminate by not hiring or by firing an individual based on the increased health insurance and employment costs that the individual may bring to the job due to positive genetic test results. Smith states that coupled with the potential for

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discrimination, people who participate in genetic testing are concerned about who will have access to their genetic information, who has a right or interest in such information, and what will be done with the information once in the hands of others.

Smith states that in response to these concerns, some states and federal legislators have recently proposed and enacted legislation to protect individual privacy and prohibit discrimination by insurers and employers. She examines such state and federal legislation, focusing primarily on Utah's Genetic Testing Privacy Act (Privacy Act). The Privacy Act proposed to protect the privacy of individuals deciding to undergo genetic testing by defining the proper restrictions on employers and health insurers. However, the Utah legislature failed to pass the Privacy Act. Smith states that Utah policy makers must be made aware that without the passage of legislation to protect individuals from genetic discrimination, research and development are hindered. She argues that because Utah is a key player in the field of genetics, as the site of the Human Genome Project and several other significant genetic research institutes, it's regulation should be extremely progressive, providing the necessary protections from genetic discrimination for its citizens. Smith proposes some revisions that are more likely to assure the Privacy Act's passage.

LIABILITY INSURANCE

Hazel Glenn Beh, *Tort Liability for Intentional Acts of Family Members: Will Your Insurer Stand by You?*, 68 TENN. L. REV. 1 (2000).

This Article explores the expansion of civil liability against family members for the crimes and intentional acts of other family members and the related insurance coverage issues. Beh first explores some of the bases of liability against family members for the intentional acts of their mates and children. She explains that many states have enacted parental liability statutes for the willful or criminal acts of their minor children, regardless of parental negligence. Further, under the common law, there has been a dramatic expansion in the potential for tort liability of family members via claims of negligent supervision, negligent entrustment, premises liability, and even spousal liability. Beh discusses the fact-driven nature of these claims.

Beh then examines typical insurance contract language that excludes coverage for intentional acts. While intentional wrongdoers are not afforded coverage under a typical homeowners' insurance contract, courts are divided as to whether those same contracts cover claims of negligence

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against coinsureds. According to Beh, innocent or negligent coinsureds pulled into tort litigation by expanding tort duties are caught between competing public policy tensions. Repugnance toward covering intentional wrongdoers and the goal of deterrence on one hand compete with victim compensation and insurance law's built-in preference toward coverage on the other. Beh concludes that the concerns against coverage are attenuated, at best, in claims against innocent or negligent coinsureds because these claims are not based on intentional conduct, but have developed wholly out of negligence law principles, even though they do spring from someone's intentional conduct. Therefore, Beh contends that the traditional default rules that favor the insured should guide courts considering coverage for innocent family members.

Beth Boggs & Dan McLaughlin, *Criminal Convictions Do Not Equal Intentional Acts: A Review of Illinois Law on the Collateral Effects of Criminal Convictions in Civil Proceedings*, 25 S. ILL. U. L.J. 281 (2001).

This Article analyzes the effects that criminal convictions have in civil proceedings under Illinois law. Specifically, it explores whether a criminal conviction collaterally estops a party from relitigating intent in a subsequent civil proceeding. The authors explain that collateral estoppel is an equitable doctrine that bars a party from relitigating an issue determined against the party in an earlier action. They state that the present trend of Illinois courts and most other jurisdictions is to apply the doctrine of collateral estoppel in civil litigation subsequent to criminal prosecutions resulting in criminal convictions.

The authors state that the general rule in Illinois was once that an insured's criminal conviction was admissible as prima facie evidence that such conduct did occur constituting a criminal or intentional act. Recently, however, the Illinois Supreme Court extended that rule by recognizing that a criminal conviction "plus more" could turn prima facie evidence into conclusive evidence. For example, an insured's guilty plea plus his judicial admissions of guilt and intent are enough for some courts to establish conclusive evidence of intentional conduct. However, the authors assert that the rights of the individuals involved in the litigation must be protected at all times. This means that in order to apply the doctrine of collateral estoppel all of its elements must be strictly met. For example, courts must make their primary inquiry whether or not the convicted party had a full and fair opportunity to litigate the issue. Also, they must look at the facts of each case to determine if the convicted party had an incentive to litigate.

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The authors also examine how other state and federal courts view the collateral effects of criminal convictions in civil matters. They state that some courts have refused to accept evidence of the earlier conviction. Others have admitted the conviction or plea of guilty as evidence but not as conclusive evidence. Still others have admitted the convictions as conclusive evidence that such criminal conduct occurred. Essentially, courts around the country have adopted a variety of positions on this issue.

The authors state that many questions have come to light regarding the application of collateral estoppel and an insurer's duty to defend its insured. They explain that many insurance policies contain provisions that exclude coverage for intentional acts committed by the insured. The authors state that as a general rule, the duty of an insurer to defend an action brought against its insured is to be determined solely from the allegations of the compliant. If the allegations are potentially within the policy's coverage, the insurer is obligated to defend. If the insurer is in doubt as to whether they must defend the insured under the insurance policy, they may defend the suit under a reservation of rights or seek a declaratory judgment declaring their duty to defend. This is exactly what the authors suggest insurers do when faced with a situation where collateral estoppel may apply. Insurers that take these steps will not be estopped from later raising policy defenses. However, insurers that choose not to defend under a reservation of rights or seek a declaratory judgment will be estopped from raising policy defenses.

Erich H. Gaston, *When Prejudgment Interest Statutes and Insurance Policy Language Collide: Should Freedom of Contract Trump Legislative Intent?*, 20 QUINNIPIAC L. REV. 359 (2001).

This Article examines the issue of liability insurers' obligations to pay prejudgment interest in excess of their policy limits under prejudgment interest statutes. Gaston explains that some earlier court decisions manipulated standard policy provisions to hold insurers liable for prejudgment interest in excess of their policy limits. Insurers responded with policy language defining prejudgment interest as "damages" subject to a policy limit defense. Courts are now faced with the issue of whether to void such language or enforce it.

Gaston analyzes various public policy arguments in favor of holding insurers liable for prejudgment interest in excess of their policy limits. One argument discussed is that insurers should be liable for prejudgment interest in excess of policy limits based upon their control of their insureds' defenses. Also, that allowing insurers to contract around the payment of

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prejudgment interest negates the incentives to settle that are created by prejudgment interest statutes. Gaston states that at first glance, these arguments seem compelling. Thus, it is not entirely surprising that several states hold insurers liable for prejudgment interest in excess of their policy limits.

Despite contrary arguments, Gaston contends that the emerging majority rule holding that liability insurers are not obligated to pay prejudgment interest in excess of policy limits, while not a perfect solution, is the better alternative given the operation of typical prejudgment statutes. He argues that courts should allow insurers to avoid the payment of prejudgment interest in excess of their policy limits through policy language. Gaston sets forth a number of reasons for his position. For example, he contends that conceptually, there is no reason to treat an insurer's obligation to pay prejudgment interest on behalf of an insured any differently than its obligation to pay any other damages on behalf of the insured. According to Gaston, if it is permissible for insurers to sell liability insurance policies that limit coverage to fixed amounts, then there is no compelling reason why insurers cannot also limit their obligation to pay prejudgment interest to whatever the applicable policy limit happens to be. He states that insureds always have the option to protect themselves against exposure for prejudgment interest in excess of policy limits by purchasing higher amounts of liability coverage.

In conclusion, Gaston suggests alternatives to the present state of the law. One suggestion is the creation of bench-made or statutory measures absolving liability insurers of the obligation to pay prejudgment interest in excess of their policy limits if they make efforts to settle cases. Gaston includes an example of how such a measure should be drafted.

Jennifer Lyn Miller, *Ethics: Is There a Realistic Approach to the Tripartite Relationship That Exists Between an Insured, the Insurer, and an Attorney under a Viable Code of Professional Conduct?*, 31 U. MEM. L. REV. 521 (2001).

This Comment discusses the ethical issues surrounding the creation of a tripartite relationship between an insurance company, the attorney that the company hires, and the insured, who is represented by that attorney. Particularly, Miller highlights issues that arise when an insurance company is permitted to audit the legal expenses of the attorney and to give directives pertaining to the defense of the insured. In some instances, auditors hired by the insurance company issue directives to the attorney concerning the attorney's efforts as to the defense of the insured. The

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Board of Professional Responsibility of the Supreme Court of Tennessee (Board) addressed two issues arising from the tripartite relationship: 1) whether disclosure of information to auditors is a violation of the insured's attorney-client confidentiality privilege and 2) whether an impermissible conflict occurs as a result of the insurer's directives to the attorney.

Miller proceeds to discuss how the laws of ethics and evidence govern the attorney-client confidences. She then describes two legal characteristics that arise from the tripartite relationship: the majority approach being the two-client model in which both the insurer and the insured are considered clients, and the one-client model, in which the insured is the only client. She points out that although the Board follows the one-client model, it is not without ethical pressures.

Allison M. Mizuo, Finley v. Home Insurance Co.: *Hawaii's Answer to the Troubling Tripartite Problem*, 22 U. HAW. L. REV. 675 (2000).

This Article discusses the Hawaii Supreme Court's response to the troubling "tripartite relationship" that exists between an insurer, insured, and insurance defense counsel. Mizuo states that this relationship presents complex ethical issues for the defense attorney that must serve the divergent interests of his two clients, the insurer and the insured. When an insurer issues a reservation of rights, to preserve the ability to deny coverage under contract, further strain is placed upon this already tenuous relationship. The insurer focuses on denying coverage, while the insured desires indemnity. Mizuo states that because of this inherent conflict of interest, the majority of courts require the insurer to pay for independent (Cumis) counsel when electing to defend subject to a reservation of rights. The minority of courts, however, reject the Cumis doctrine. These courts believe that the rules of ethics, coupled with the imposition of an enhanced duty of good faith on insurers, sufficiently protect the interests of the insured, thus making independent counsel unnecessary. Mizuo shows that the Hawaii Supreme Court adopted this view in *Finley v. Home Insurance*, 975 P.2d 1145 (1998).

Mizuo explains that consistent with the minority view, the Hawaii Supreme Court rejected the presumed necessity of Cumis counsel. The court held that in conflict situations, the insured is the sole client of the attorney and that the insurer must not interfere with the attorney's professional judgment in conducting the defense. Additionally, the court outlined compliance guidelines for defense counsel and insurers. According to Mizuo, the *Finley* court determined that the Hawaii Rules of

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Professional Conduct (HRPC), equitable estoppel, and potential bad faith and legal malpractice claims provide adequate safeguards for insureds.

Mizuo challenges the reasoning of the *Finley* court's decision, focusing primarily on the court's manipulation of the HRPC to reach its conclusion. Nonetheless, she determines that despite its analytical flaws, the court's rejection of the Cumis doctrine arguably constitutes the better solution to the tripartite problem. Mizuo contends that adoption of the Cumis doctrine creates undesirable effects in practice. Private attorneys often abuse their position as Cumis counsel, contributing to the rising costs of defense for insurance companies. The increased cost to insurers inevitably brings about increases in insurance premiums. Mizuo concludes that *Finley* avoids these problems.

Gregory S. Munro, *Defense Within Limits: The Conflicts of "Wasting" or "Cannibalizing" Insurance Policies*, 62 MONT. L. REV. 131 (2001).

This Article discusses the use of "Defense Within Limits" provisions in casualty insurance policies. Munro begins by explaining that under most liability insurance policies, the insurance carrier has the twin duties of providing defense of the claim and indemnifying the insured against liability. Such casualty policies contain a limit of liability clause that limits the amount of money the carrier will pay out under the promise to indemnify. However, there is no such limit on the amount of money the carrier promises to expend on the defense of the insured. Thus, under most standard policies, the carrier's promise to defend is essentially unlimited.

Munro explains that under a "Defense Within Limits" (DWL) policy, the limit of liability available for paying losses is reduced by the costs of defense. Munro states that DWL policy provisions appear in policies covering liabilities that might be considered high risk. Thus, they appear in medical malpractice policies, legal malpractice policies, directors and officer's liability policies and in some manuscript commercial general liability policies. Munro explains that insurers developed the DWL policy because of the increasing and uncertain cost of defense. The adoption of DWL provisions permitted insurers to transfer to the insureds the unlimited and unpredictable risk involved in the costs of defense.

According to Munro, the difficulty with the adoption of the DWL provisions is not that they attempt to contain defense expenditures, but that they create potential legal problems, especially conflicts of interest, which did not exist in the standard form policies. He states that at the outset, a potential for intentional or negligent misrepresentation exists if the insurance intermediaries doing the marketing are not careful in representing

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limits of liability. Of greatest concern, is that under a DWL policy there is an inherent conflict between the insured and the insurer in every case where payment of loss plus payment of defense costs could exceed the limits of liability, since every dollar spent on the defense of the claim is a dollar that will not be available for settlement or satisfaction of judgment. In addition, Munro states that DWL policies can present conflicts for the plaintiff's attorney whose decision to aggressively represent the claimant may exhaust the policy.

Munro analyzes alternative legal solutions to the problems created by DWL policies and makes recommendations for resolving the issues raised by these policies. These recommendations include adopting a "Limits of Defense" provision which makes clear the point at which risk of defense expenses transfers to the insured, adopting a DWL provision that limits the defense costs that apply to reduce the limit of liability, and making DWL policies indemnity policies which contain no obligation to defend on the part of the insurer.

Susan Randall, *Managed Litigation and the Professional Obligations of Insurance Defense Lawyers*, 51 SYRACUSE L. REV. 1 (2001).

This Article examines the tensions and conflicts that may arise when an insurance company and its insured share a joint insurance defense. This may arise when both parties share the status as clients and a lawyer provides dual representation because each party's interests in the litigation correspond. This Article illuminates a lawyer's concomitant professional obligations, as promulgated by the Model Rules of Professional Conduct, when providing a joint defense. Despite the conflicted obligations thrust upon the lawyer who must satisfy the needs of both clients, and at the same time rely on his or her professional judgment free from undue influence by the insurance company managing the litigation, Randall proffers an objective and realistic appraisal of the viability of dual representation arrangements. Managed litigation serves not only as a cost-containment measure, but also enables an insurance company to provide a paid defense for its insured. Absent the ability for insurance companies to manage litigation, Randall suggests, to the detriment of the insured, that insurance companies may dispense with providing a paid defense.

Randall explores this issue by providing commonly used litigation management standards and guidelines which focus on the contract between the insurer and insured as the touchstone for determining the parameters and feasibility of joint representation. She then examines the existence of any contractual language that allows the insurance company to manage

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various aspects of the defense. Randall devotes the last part of this Article to managed insurance defense activities that may or may not be proscribed by the Model Rules of Professional Conduct. She illustrates that ethical obligations differ in single client representations as opposed to joint representations and submits that a lawyer's ability to exercise independent judgement is a potential area of ethical and professional concern.

Randall concludes by examining the proposed revisions to the Model Rules and submits that the proposed revisions are overly restrictive with respect to joint defenses and as such are unnecessary and problematic. She argues that potential ethical violations can be overcome by having lawyers make full disclosures to insurers and insureds, that insurance companies should avoid unnecessary conflicts of interest in the context of a joint defense, and lastly, that the rules of professional responsibility should reflect and recognize the need for insurance companies to contain defense expenditures, especially in joint representations, and to a lesser extent in insured-only representations.

Richard B. Risk, Jr., *Structured Settlements: The Ongoing Evolution From a Liability Insurer's Ploy to an Injury Victim's Boon*, 36 TULSA L.J. 865 (2001).

This Comment reviews structured settlements, which have become an integral part of the negotiation process in settling tort type claims for personal physical injury or physical sickness. It defines a structured settlement as a settlement in which the defendant agrees to pay periodic sums to the plaintiff for a specified time. The benefits of structured settlements include income tax-free payments, spendthrift protection, guaranteed income for life, bankruptcy protection for future income, and relief from guardianship burdens for minors and incompetents. Risk believes that the advantages of structured settlements outweigh any disadvantage, especially since the IRS approval of the variable annuity as a qualified funding asset.

Risk reviews two aspects of structured settlements. First, he covers the historical evolution of the device. Structured settlements became legitimate in 1979, when the IRS issued two significant rulings that excluded from income payments received for personal injury in settlement with an insurance company. Congress passed an act in 1992 that codified these IRS rulings in section 104(a)(2) of the Tax Code. At the same time, the act added a new section 130 to the Code that allowed a "qualified assignment." Thus, an original defendant or liability insurer that agrees to a structured settlement can transfer its responsibility to a third party and

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receive a tax deduction for the amount paid to purchase the annuity or government obligation. By 1990, more than thirty states adopted some type of periodic payment legislation. In response to the laws that provided tax-free benefits, life insurance companies competed to develop flexible single-premium annuities. In light of product innovations, annuity sales have grown, the market has expanded, and structured settlements have improved over the years.

Risk notes other legal developments that have refined the concept of structured settlements. Structured attorney fees have been on the rise ever since a favorable tax ruling in 1996 by the Eleventh Circuit U.S. Court of Appeals. In 1997, Congress amended section 130 of the Tax Code so that workers' compensation payments were given similar treatment as payments for physical injury torts. One of the most significant developments in structured settlements was the IRS approval of variable annuities in qualified assignments of future liability payments. Such a variable annuity provides market growth of the asset rather than growth at a fixed rate, and retains the annuity's income tax-free status.

Second, Risk recognizes a shift in the control of the structured settlement process over its history and the inherent advantage that goes with that control. Pro-defense entities have taken steps to use the structured settlement business to their benefit. Liability insurers have done so by forming alliances with brokerages that are designed to exclude plaintiff brokers from profiting on structured settlements. The National Structured Settlements Trade Association was established and works to preserve the structured settlement concept as a defense tool and to create a barrier to entry by potential insurance competitors. Risk also provides examples of ethical abuses and malpractice risks for plaintiff attorneys that exist when the defense parties have the upper hand in the structured settlement process. Thus, he concludes that an injury victim is often victimized again through such a one-sided system.

Risk explains, however, that plaintiffs can now take back the control of the structured settlement process through a qualified settlement fund (QSF). When a QSF is used, the original defendant is no longer a party to the claim because the tort liability is transferred through a qualified assignment to the QSF. Since the claimant has already agreed to the amount paid into the QSF, there is no longer a true adversarial system. Since involvement by the defendant or liability insurer to complete a structured settlement transaction is eliminated, the risk to plaintiff's attorneys of legal malpractice is lowered. Risk identifies and rebuts the arguments by defense settlement brokers that there are unresolved tax questions regarding the QSF. He concludes that the future of structured

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settlements is bright since the control over the process is being restored to the plaintiff.

Terrence G. Stolly, *Scienter Under the Private Securities Litigation Reform Act of 1995: Unexpected Implications on Director and Officer Liability and D&O Insurance*, 29 CAP. U. L. REV. 545 (2001).

This Comment examines the impact of the Private Securities Litigation Reform Act of 1995 (PSLRA) on securities fraud litigation. Specifically, the author considers the PSLRA's ramifications on personal liability of corporate directors and officers (D&Os) and D&O liability insurance. Stolly states that Congress enacted the PSLRA in response to the perceived rise in abusive and meritless securities fraud suits. He states that Congress attempted to reduce the number of frivolous claims by raising the pleading standard in securities fraud cases. The PSLRA was intended to create a uniform "scienter" pleading standard for federal securities fraud cases initiated by private plaintiffs, and also make it more difficult for plaintiffs to survive dismissal prior to costly discovery. Stolly asserts that the PSLRA has produced an ironic result. Interpretation of the PSLRA by federal circuit courts of appeals has been inconsistent, making the PSLRA anything but uniform.

Stolly states that there are generally three constructions of the PSLRA scienter requirement. The least stringent scienter requirement has been adopted by the Second and Third Circuits. According to these circuits, plaintiffs are able to satisfy the scienter pleading requirement by alleging facts which give rise to a strong inference that defendants had a "motive and opportunity" to commit fraud. Stolly asserts that this standard is insufficient to achieve Congress' goal of reducing frivolous federal securities fraud claims. On the contrary, the Ninth Circuit has interpreted the PSLRA as creating a new heightened pleading standard requiring a plaintiff, at a minimum, to plead in great detail particular facts raising a strong inference of deliberate recklessness. Stolly states that although this rigorous interpretation will result in more cases being dismissed prior to discovery, those that are not dismissed will be very problematic. For example, the rigid Ninth Circuit requirement could implicate standard D&O insurance policy exclusions for dishonesty and fraud. This would create gaps in financial protection for D&Os, leaving them personally exposed to liability. Stolly contends that increased D&O exposure will have adverse ramifications on corporate boardrooms, and the willingness of talented management personnel to serve as D&Os.

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Stolly states that the First, Sixth, and Eleventh Circuits have adopted a "middle ground" standard that requires plaintiffs to allege facts that give rise to a strong inference of reckless or severely reckless behavior. Stolly contends that this "middle ground" construction of the scienter requirement most closely follows the underlying objectives of the PSLRA. He states that this interpretation comports with Congress' intent and the plain language of the statute. Furthermore, this interpretation alleviates many of the concerns regarding D&O liability and D&O insurance coverage that arise with more stringent scienter requirements. Stolly concludes that the Supreme Court should adopt the First, Sixth, and Eleventh Circuits' "middle ground" interpretation of the PSLRA when it decides to resolve the current conflicts between the circuit courts of appeal.

MARINE INSURANCE

Harry Apostolakopoulos, *Navigating in Perilous Waters: Examining the "Peril of the Sea" Exception to Carrier's Liability Under COGSA for Cargo Loss Resulting from Severe Weather Conditions*, 41 S. TEX. L. REV. 1439 (2000).

This Comment examines the "peril of the sea" exception to carrier's liability under the Carriage of Goods by Sea Act (COGSA). Apostolakopoulos explains that COGSA is the United States version of the Hague Rules, an international agreement dealing with cargo liability issues. He states that section 4(2)(c) of the COGSA absolves carriers from liability for cargo damage that is caused by a "peril of the sea." However, the statute does not define what constitutes a "peril of the sea," and a workable definition has remained elusive since COGSA's enactment in 1936.

According to Apostolakopoulos, the courts of the United States and other major maritime nations have frequently considered the question of how severe the weather must be in order to constitute a "peril of the sea," thereby absolving a carrier from liability; however, a consensus has not been achieved. He finds that the overwhelming majority of American courts have employed a foreseeability test when determining whether severe weather conditions constitute a "peril of the sea." Under this test, severe weather conditions must be unforeseeable or unexpected to the carrier in order to constitute a "peril of the sea." Apostolakopoulos states that Canada, France, and Belgium apply a similar foreseeability test. In contrast, England and Australia have generally been reluctant to tie the "peril of the sea" defense to the foreseeability of severe weather and have

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relied on a case-by-case determination. Other major European maritime nations follow intermediate approaches.

Apostolakopoulos presents various policy justifications for the preservation of the American foreseeability test. He states that technological advances have greatly reduced vessels' exposure to unforeseeable storms by allowing accurate weather forecasts. He contends that a storm that is almost certain to occur must not be classified as a peril when the vessel had a reasonable opportunity to avoid exposure. Apostolakopoulos also argues that eliminating the foreseeability requirement will not promote uniformity of maritime law, because countries such as Canada, France and Belgium would still be applying the foreseeability test. In addition, Apostolakopoulos contends that national commercial interests mandate the use of the foreseeability test. He states that eliminating the foreseeability factor from the "peril of the sea" defense would expand carriers' protection from liability and actually work harm to the important policy of protecting American foreign trade.

Apostolakopoulos proposes a definition of a "peril of the sea" that can be used by the courts in a predictable manner while maintaining the requisite flexibility for varying factual situations. He proposes that heavy weather conditions that are expected or foreseeable to the carrier should not constitute a "peril of the sea" exception to a carrier's liability under section 4(2)(c) of COGSA for cargo damage resulting from such conditions, unless such conditions turn out to be significantly harsher than predicted, and cannot therefore be guarded against through the exercise of normal care and skill.

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