Ch14-A03753 12/1/06 9:56 AM Page 143

Chapter 14
Health Insurance and Professional Liability Insurance

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Health Insurance
Medical Malpractice Insurance
Formation of the Insurance Contract
Interpretation of Insurance Contracts
Fraud
Insurance Regulation
National Practitioner Data Bank
Insurance Accounting

Insurance is a form of contract under which one party protects another from risk of loss in exchange for the payment of a fee, or "premium." The insurer, in turn, pools these premiums into a coverage fund that compensates any member of the group who suffers a defined loss. The goal of this process is to minimize risk to the individual by distributing the burden of loss over a large number of contributors.

Today, insurance may be purchased to guard against virtually any risk. Life insurance, disability insurance, and casualty insurance all are widely available and purchased. This chapter will focus on the types of insurance that have had the greatest impact on the practice of medicine in this country: health insurance, which indemnifies patients for medical expenses, and medical malpractice insurance, which indemnifies health care providers against claims of professional negligence. Both have been subjects of intense legislative debate in recent years, and both promise to generate complex legal issues in the future.

HEALTH INSURANCE

Unlike other industrialized nations, the United States does not provide its citizens with comprehensive health care. Prior to the 1930s, Americans paid all of their health expenses out of pocket. The Great Depression of the 1930s prompted doctors and hospitals to establish Blue Cross and Blue Shield plans—nonprofit arrangements that financed health care for those who otherwise could not afford it. During this same period, commercial insurance companies made health coverage available to the public. Today, Americans rely primarily on employment-related group insurance for their health coverage, while specific populations benefit from government-financed health programs such as Medicare and Medicaid.[1]

Private health insurance exists today in many forms. *Indemnity* coverage reimburses the policyholder for out-of-pocket medical expenses deemed "usual and customary." These policies are unique in that they typically impose no limitations on the selection of a health care provider. *Service-benefit plans*, in contrast, require the insured to select from a pool of participating health care facilities and practitioners. These plans reimburse health care providers directly and fully for services rendered. To prevent excessive service use, many service-benefit plans require co-payments or deductibles.[2]

Health maintenance organizations (HMOs) represent an increasingly common alternative to the traditional health insurance policy. Members of these organizations receive care through a network of contracted providers who are compensated by the HMO on a fixed or per capita basis, without regard to services actually rendered. *Hybrid plans*, such as preferred provider organizations (PPOs), combine various characteristics of the service-benefit plan and the HMO. Participants may choose from a list of contracted providers, or they may seek care from an independent provider outside of the system. Reimbursement often is limited, however, if the participant selects the latter option.

In the 1990s, HMO coverage and other forms of managed care surpassed fee-for-service insurance as the predominant mode of health care financing in this country. Outraged by media reports of "drive-through" deliveries, nonreimbursed mammographies, and deaths caused by delays in treatment approval, the public soon demanded increased coverage and access to care. Legislators responded to these concerns by proposing managed care regulation in Congress and in every state. Today, health insurance of all kinds is regulated by a vast array of federal and state laws, including the Employee Retirement Income Security Act of 1974 (ERISA),[3] the Health Maintenance Act,[4] the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[5] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[6]

MEDICAL MALPRACTICE INSURANCE

Medical malpractice insurance indemnifies health care providers against claims of professional negligence.

Ch14-A03753 12/1/06 9:56 AM Page 144

Available from commercial insurance companies and joint underwriting associations, this type of coverage is required under the laws of many states as a condition of professional practice. Similarly, a hospital may require proof of malpractice insurance before appointing a physician to its staff.[7] Rates tend to vary by specialty, geographic region, and the complexity of the procedures to be covered. The amount to be paid on each claim often is limited, as is the amount to be paid in aggregate during the term of the policy.

Medical malpractice insurance has become a subject of great controversy in recent years.[8] Escalating premiums have been passed along to the public in the form of higher fees. At the same time, physicians have taken to practicing "defensive medicine," ordering tests and procedures of dubious value in an effort to "cover all bases" and avoid malpractice claims entirely. Together, these phenomena have produced skyrocketing health care costs and higher health insurance premiums.[9]

This "malpractice crisis" has had a crippling effect on the provision of health care. Unable to find affordable insurance, doctors in many parts of the country—and practitioners of high-risk specialties, in particular—have been forced to make a difficult choice: relocate to a geographical area where insurance is more readily available, change specialties, practice without insurance, or abandon medicine altogether. The resulting shortage of specialists has caused a number of trauma centers and maternity wards to close their doors. In some cities, high-risk specialties such as neurosurgery are no longer practiced at all.[10]

Physicians blame greedy lawyers for the nation's malpractice insurance woes. Many doctors are convinced that attorneys encourage patients to sue their health care providers because of the extraordinary legal fees associated with medical malpractice litigation.[11] Trial lawyers, in turn, claim that bad medicine is the real culprit. With medical errors killing more Americans each year than motor vehicle collisions, AIDS, or breast cancer, the legal profession insists that premiums will continue to rise until doctors make fewer mistakes.[12] Consumer watchdog groups, meanwhile, have uncovered evidence that the insurers themselves are at fault. In the opinion of two such organizations, insurance companies have jacked up premiums in an effort to recoup losses from a faltering economy, imprudent investment, and corporate mismanagement.[13] In truth, the malpractice crisis probably has resulted from some combination of these factors.

Efforts to alleviate the malpractice dilemma have met with varying degrees of success. Beginning in the 1970s, insurance companies generally abandoned "occurrence-based" policies, which covered malpractice committed at any time during the policy period, in favor of "claims-made" policies, which cover only those acts and omissions for which claims are filed during the term of the policy. This change has reduced malpractice premiums, but in some cases it has left practitioners uninsured for claims filed after the expiration of their malpractice policies.

Legislative bodies, too, have taken measures to rectify the problem. More than 40 states have shortened their statutes of limitations on malpractice actions in an effort to limit the number of claims. Some states, including Massachusetts and Maryland, utilize pretrial screening panels to weed out frivolous claims. A successful, yet controversial, solution to the malpractice crisis entails the statutory capping of punitive damages. According to one study, shortened statutes of limitations, combined with statutory caps on awards, have reduced amounts paid to plaintiffs by nearly 40%.[14] Some states have dismissed such caps as unconstitutional,[15] however, and efforts to limit punitive damages at the federal level have failed entirely. Nine times the United States House of Representatives has passed bills that would have imposed a $250,000 cap on noneconomic damages nationwide, but so far, none of these bills has survived to become law.[16]

In the past, patients initiated malpractice claims only against those who had actually rendered the care. This has changed recently, with many courts extending malpractice liability to HMOs and other managed care organizations. In *Petrovich v. Share Health Plan of Illinois*, for example, the Illinois Supreme Court held that an HMO may incur vicarious liability for the malpractice of an independent-contractor physician under the doctrines of apparent and implied authority. The physician in that case had declined to order magnetic resonance imaging and computerized tomography on a patient later found to have oral carcinoma, since he believed that the HMO would not pay for the tests.[17] Similarly, in *Pappas v. Asbel*, the Pennsylvania Supreme Court held that a patient who sustained permanent quadriplegia from an epidural abscess could sue his HMO for negligently delaying his transfer to a facility where specialized neurosurgical intervention was available.[18] Other jurisdictions have allowed patients to sue managed care organizations for breaches of fiduciary duty—as, for example, where savings from denials of treatment were passed along to a physician-administrator in the form of a bonus.[19] The frequency of malpractice claims against HMOs is expected to grow as more and more of these organizations shed their images as traditional insurers and hold themselves out as full-service health care providers.

A small number of states have conferred statutory malpractice immunity on HMOs and their member physicians.[20] The goal of this immunity is to prevent HMOs from being bankrupted by huge malpractice awards that would leave great numbers of people without health coverage. In all other states, HMOs enjoy limited immunity arising from a combination of statutes and judicial decisions.[21] Also, medical malpractice claims against HMOs may be cut off by ERISA, a federal statute that "supersedes any and all State laws insofar as they. . .relate to any employee benefit plan."[22] Some courts have held that HMOs are "employee benefit plans," and that ERISA therefore invalidates malpractice claims against HMOs by preempting the state laws that make such claims possible.[23] Others have held that the relationship between a medical malpractice claim and the administration of an HMO is "too tenuous, remote, or peripheral" to trigger ERISA.[24] Whether or not ERISA preempts a particular malpractice claim depends not only on the facts of the case, but also on how broadly the court interprets ERISA's reach.

Managed care organizations have begun to protect themselves from vicarious liability claims by insisting that

physicians agree to indemnify them for negligence claims brought against the physician. Under such an agreement, the physician may incur liability for the full amount of the claim, as well as for attorneys' fees and expenses. The physician also may forfeit the right to seek contribution from the managed care organization on a cross-claim.[25] In order to avoid substantial out-of-pocket losses, practitioners must ensure that their insurance policies do not limit or exclude contractual liability coverage.

FORMATION OF THE INSURANCE CONTRACT

Insurance coverage begins with the execution of a contract between the insurer and the insured. Like all contracts, this requires a lawful object, genuine assent of competent parties, and payment of sufficient consideration.

In a typical insurance transaction, the party seeking insurance contacts a broker or agent, who in turn procures coverage from an insurance company or underwriting association. A broker usually works for the consumer, while an agent generally represents the insurer. This distinction can be an important one, because the power of these intermediaries to bind the insurer can vary drastically.[26]

Insurers sometimes authorize agents to issue "binders," or short-term guarantees of coverage, pending the execution of the complete policy. As a general rule, however, the submission of a completed application to the insurer constitutes only an offer to purchase insurance. Coverage does not begin until the insurer receives the application, reviews it, and agrees to indemnify the applicant. Even so, the majority of courts now hold that an insurer is liable under an insurance contract when it has failed to act on an application within a reasonable time.

Of course, with most employers now offering managed care plans to their employees, many Americans never interact with an agent or broker at all. Rather, they deal directly with a representative of the employer. Often this is an individual with a background in human resources management. The employer, in turn, contracts with the HMO or PPO for the provision of services.

INTERPRETATION OF INSURANCE CONTRACTS

The language of a written contract defines the obligations of the parties. Conditions, limitations, and exceptions typically are negotiated by both sides and incorporated into the contract document. When litigation arises over one party's failure to perform, the wording of the agreement often determines the outcome.

Insurance policies differ from most contracts, however, in that they are adhesion contracts. Drafted by the insurer and submitted to the potential client on a "take it or leave it" basis, they place the insurer in a superior bargaining position by eliminating the client's opportunity to negotiate. Policyholders often do not understand terminology used by the insurer, or, indeed, they may agree to the coverage without reading the contract at all. Group policies are not adhesion contracts, but courts traditionally have treated them as such.[27]

To compensate for this inequity in bargaining power, the courts have adopted a rule of construction under which ambiguities in policy language are construed against the insurer.[28] Justified by the principles of waiver and estoppel, this rule is intended to protect the reasonable expectations of the policyholder—including the expectation that medical treatment generally will be covered. Accordingly, insurers often find themselves indemnifying policyholders as a result of contractual provisions that easily could be interpreted as creating no such obligation.[29] In *Ponder v. Blue Cross of Southern California*, for example, the California Court of Appeal allowed a patient to recover for treatment of temporomandibular joint syndrome despite language in the insurance certificate that explicitly excluded this syndrome from coverage. The court reasoned that the insurer had disappointed the expectations of the policyholder by failing to make the exclusion "plain" and "conspicuous."[30]

Much of the litigation arising from health insurance contracts revolves around eligibility for coverage. Courts often must decide whether the language of a policy obligates the insurer to indemnify a particular individual for a specific condition. The principal issue in many insurance disputes, then, is the scope of coverage intended by the parties at the time of contract formation.

In recent years, insurers have begun to include in their policies blanket exclusions for "experimental" or "medically unnecessary" services. These exclusions are meant to limit liability for expensive, and at times unproven, technology. When blanket exclusion provides the sole basis for denial of payment, the court generally will compel indemnification as long as the patient's physician has deemed the services necessary, even where the scientific community has not universally validated the service in question.[31] Courts are much more likely to uphold a denial of payment where the excluded treatments are enumerated in the policy, or where the method of determining medical necessity is clearly spelled out.[32]

Other types of exclusion clauses may appear in policies as well. Claims-made policies generally contain retroactive exclusion clauses, for example, which hold the insurer harmless for any incident that occurred before the date on which the insured first took out a policy with the company. This provision has no impact on new practitioners who take out their first malpractice policy with no preexisting claims to cover. Nor will it affect a practitioner who switches from an occurrence-based policy to any other policy, since the occurrence-based policy will cover claims made even after the policy expires. A gap can occur, however, when a claims-made policy terminates for any reason, because the former policy will not cover claims made after its effective period, and the latter policy will not cover incidents that occurred before it became effective.[33] Practitioners can avoid this kind of problem by purchasing a "reporting endorsement" from the issuer of the former policy. These endorsements amend claims-made policies to cover all incidents that occurred during the term of the policy, regardless of the date on

Ch14-A03753 12/1/06 9:56 AM Page 146

which they are reported. Effectively, these endorsements convert claims-made policies into occurrence-based policies.

Some insurance policies also deny coverage where the insured had knowledge of a claim but failed to report it during the policy period. Insurers utilize such clauses to avoid assuming known risks. Some courts have interpreted such clauses strictly, while others have been accused of converting claims-made policies into occurrence-based ones by finding the insurer liable on the basis of "excusable delay" by the insured.[34]

Parties to all contracts, including insurance contracts, must adhere to a covenant of good faith and fair dealing.[35] In the past, courts treated a breach of this covenant as a breach of contract. Recovery therefore was limited to the amount specified in the policy. During the past quarter-century, however, a number of jurisdictions have held that a breach of good faith during insurance transactions can give rise to tort actions as well.[36] This is especially true in the context of liability insurance, where the insurer's interest in defending against a third-party claim often conflicts with the interest of the policyholder in settling the claim below the policy limit.

Communale v. Traders and General Insurance Company illustrates this principle. There, the insurer wrongfully refused to defend a liability action brought by a third party against the policyholder, and then refused an offer of settlement within the policy limits. The California Supreme Court held the insurer liable for the full amount of a third-party claim—including the portion that exceeded the policy limits—because of the insurer's bad faith in handling the claim.[37]

Policyholders owe insurers a duty of good faith as well, albeit a somewhat less stringent one. As the California Supreme Court noted in *Commercial Union Assurance Co. v. Safeway Stores, Inc.*, "We have no quarrel with the proposition that a duty of good faith and fair dealing in an insurance policy is a two-way street running from the insured to his insurer as well as vice versa. However, what that duty embraces is dependent upon the nature of the bargain struck between the insurer and the insured and the legitimate expectations of the parties which arise from the contract."[38] Under this rationale, a policyholder might incur tort liability to his insurer, where, for example, the insured's refusal to cooperate in an investigation results in the unnecessary payment of a claim.

At times, the doctrines of election, waiver, and estoppel can alter rights established by the written contract. Election is a choice between available rights that extinguishes the right not chosen. A policyholder may have a contractual right to receive disability benefits in a lump sum, for example, or in annual payments, or in the form of an annuity. Under the doctrine of election, a policyholder who has elected one of these methods of payment loses the right to demand a different method where a changing economic climate renders the original choice undesirable.[39]

A waiver is an intentional relinquishment of a known right.[40] Waivers may be written into the insurance contract, or their existence may be inferred from circumstances.[41] One type of waiver common to insurance policies is a "waiver of premium" that suspends the insurer's right to collect premium payments for a specified period of time—as, for example, where the policyholder becomes disabled and cannot work. Insurers typically offer this type of waiver to policyholders in exchange for slightly increased premiums during the life of the policy.[42] Once granted, an express waiver can be rescinded only by mutual agreement of the parties. Even a letter of notification does not restore the right previously waived.

Estoppel, in the context of insurance law, is a representation of fact, which, when relied upon by another party, renders any subsequent denial of obligation based on that representation unfair. The party claiming estoppel must show that the representation pertained to a material fact; that the reliance was reasonable; and that detriment resulted.[43] Thus, an insurer that erroneously names a party as an additional insured in an insurance certificate is estopped from denying coverage to that party.[44] Similarly, an insurer is estopped from denying coverage for nonpayment of premiums when it fails to send the insured a cancellation notice, after having done so on previous occasions.[45]

Insurers sometimes guard against estoppel-based obligations through the use of reservation-of-rights notices and nonwaiver agreements. The reservation-of-rights notice informs the policyholder that the insured intends to conduct an investigation for the purpose of determining coverage eligibility, and that the insurer's activities do not necessarily represent a defense against a third-party claim or a waiver of any future rights to deny coverage. This notification may prevent the insured from claiming that he relied on the insurer to defend against the claim, and that the insurer is therefore estopped from denying coverage. Because it is a unilateral action, however, a reservation-of-rights notice is not always effective. To be fully protected, the insurer may incorporate a nonwaiver agreement into the insurance contract. This agreement indicates that neither party will waive its rights under the policy as a result of an investigation or initial defense of the action until the extent of coverage has been determined.

FRAUD

Fraud renders an insurance contract voidable. In the context of an insurance contract, fraud exists where one party knowingly misrepresents a material fact with intent to deceive or with reckless indifference to the truth, thereby causing reliance and injury.[46] A material fact, in turn, is one that induces the other party to enter the contract. False statements of opinion generally do not constitute fraud.[47]

In the past, insurers often used their clients' misrepresentations to their advantage. The insurer would collect premiums over a long period of time, then deny a claim on the basis of some earlier misrepresentation by the insured.[48] State legislatures responded to the resulting widespread public suspicion of the insurance industry by requiring insurance contracts to include an "incontestability clause," under which the parties agree that the validity of the contract cannot be challenged after a specified period. These clauses do not bar all validity contests, of course. To the contrary, courts often permit insurers to challenge claims for nonpayment of premiums, or where the eligibility of the insured or the occurrence of a covered

Ch14-A03753 12/1/06 9:56 AM Page 147

event is questioned, notwithstanding the existence of an incontestability clause.[49] These clauses originated in life insurance contracts. Today, however, many states require them by law to appear in health insurance policies as well.[50]

Most courts have held that insurance applicants retain a duty to disclose changes in material facts discovered prior to the onset of coverage. The courts generally agree, however, that this obligation ceases once the policy takes effect.

INSURANCE REGULATION

Prior to World War II, the courts did not treat insurance sales as transactions in commerce. As a result, the insurance industry enjoyed immunity from federal antitrust laws.[51] Insurers worked in conjunction with rating bureaus to gather actuarial data and to establish uniform rates and policies.

A 1944 Supreme Court decision, *South-Eastern Underwriters Association v. U.S.*, temporarily disrupted this practice. In *South-Eastern*, the Court expanded the definition of commerce and held that insurance transactions were subject to federal regulation.[52] Congress recognized that state regulation of the insurance industry already was firmly established, however, and less than a year later, the McCarron-Ferguson Act effectively returned control to the states, subject to the limited applicability of federal antitrust laws.[53]

Today, state governments grant charters to insurance companies and license their agents, establish standards for the content and filing of policy forms, regulate marketing and claims practices, and investigate consumer complaints within the industry. States also strive to protect the solvency of insurers by imposing controls on insurers' financial reserves and investments—a role that is especially important given the aleatory nature of the insurance contract. In so doing, the state may prevent policyholders who pay premiums for many years from being disappointed by insurers that cannot meet their financial obligations upon the filing of a claim.

Many states dictate the premiums charged by property-casualty insurers. Rates for health and liability insurance, in contrast, are typically regulated only indirectly, through the application of Unfair Trade Practice Acts and requirements that policy forms be approved by the state insurance commissioner. The goal of this regulation is to strike a balance between affordability and availability. When malpractice premiums climb too high, physicians tend to migrate to other states, or to abandon the relevant area of practice altogether. This can lead to a shortage of specialists within the region.[54] Similarly, when health insurance premiums rise to a critical level, patients on fixed incomes may be left without access to health care. On the other hand, if premiums drop too low, the insurer risks insolvency, and it may elect to stop issuing certain kinds of insurance altogether. This, in turn, may leave practitioners without liability insurance, and patients without health insurance.

Despite these efforts, insolvencies sometimes do occur. To protect policyholders, states have established guarantee funds to ensure that claims will be paid even after insolvency. All states currently have property-casualty guarantee funds, and many states have created life and health funds as well. Through these funds, the rest of the insurance industry shoulders the burden of the insolvent company to ensure indemnification.

State legislatures have imposed thousands of mandates upon insurers and health plans that are unrelated to premium rates.[55] *Mandated provider laws* require insurers to pay specified practitioners if they would pay a medical doctor for the same service. *Mandated coverage laws* limit insurers' ability to cancel or refuse to renew policies. *Mandated benefit laws* require payment for certain types of claims and, with regard to health insurance, payment for certain conditions. Some states have bolstered their mandated benefit laws through antidiscrimination statutes. Toward this end, insurance commissioners in New York and Massachusetts attempted to ban the use of HIV tests in determining insurability, but courts in both states subsequently invalidated the regulations.[56]

Most states have retained authority to oversee rate classification systems, which require policyholders with similar risks to pay the same premiums.[57] An emerging controversy in this area involves classification based on genetic characteristics.[58] Now that genetic markers make it possible to predict medical problems even before birth, insurers argue that they should be able to factor this information into risk classification. To ignore such predictors, they say, would be unfair to policyholders with favorable genetic characteristics, whose premiums will be inflated by the claims of those with poor genes. Consumer, disability, and privacy advocates, on the other hand, feel that insurers should not penalize afflicted individuals for conditions over which they have no control. Allowing genetic information to be used in such a way, they suggest, will result in more frequent insurance denials and increased dependence on public health insurance programs.

Federal statutes, too, have affected insurance in the health care setting. Congress passed the Employee Retirement Income Security Act of 1974 (ERISA) in response to fraud and mismanagement of employee pension funds. Because it governs employee welfare benefit plans, however, ERISA also covers employer-provided health insurance.[59] Congress intended ERISA as a regulatory statute, but its effects on health insurance have been principally deregulatory. By preempting state law, it precludes many actions that once could be brought in state courts. Excluded by ERISA, for example, are common law bad faith claims against ERISA-qualified health plans,[60] actions to compel referral to a specialist,[61] and actions to compel payment for a particular type of treatment[62] or condition.[63] The courts have distinguished between "quantity of benefits" issues and "quality of benefits" issues, however, and most jurisdictions have held that issues pertaining to the caliber of insurer-provided care are properly addressed by the states.[64] Moreover, ERISA establishes universal requirements regarding claims procedures,[65] determination review,[66] fiduciary obligations,[67] and disclosure of benefits to plan participants.[68]

The Comprehensive Omnibus Reconciliation Act of 1985 (COBRA) amended ERISA to mandate the continuation of group insurance for those who otherwise would lose such coverage as a result of layoffs, loss of dependent status, or other changes.[69] Applicable to entities that sponsor a group health plan and employ 20 or more persons on an

Ch14-A03753 12/1/06 9:56 AM Page 148

average day, COBRA protects "qualified beneficiaries" whose insurance lapses because of a "qualifying event." Qualifying beneficiaries include employees and their spouses and dependent children who were covered under the terminated insurance as of the day before the qualifying event, as well as children born or adopted during the continuation period.[70] Qualifying events for employees include reduction of hours and termination of employment for reasons other than gross misconduct.[71] Qualifying events for dependents include loss of coverage due to death of the employee, termination of the employee, or reduction in hours; loss of coverage due to divorce or legal separation from a covered employee; loss of coverage due to eligibility of the employee for Medicare; and loss of coverage due to changing status as a dependent of the covered employee.[72] Filing for bankruptcy can serve as a qualifying event where the covered employee has retired.[73] The duration of continuation coverage under COBRA ranges from 18 months to 36 months, depending on the qualifying beneficiary and event.[74] COBRA beneficiaries are entitled to the same health insurance coverage as regular plan participants,[75] and when the continuation period expires, the beneficiary may enroll in any conversion health plan that would have been available within the previous 180 days.[76]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) represents an effort by Congress to reduce health care fraud, simplify health care financing, establish more favorable tax treatment for medical savings accounts, and improve the portability and continuity of health insurance.[77] It limits the use of preexisting conditions clauses,[78] prohibits discrimination by insurers against individuals with regard to group health plan enrollment eligibility and premiums,[79] and limits the ability of insurers to deny coverage to small employers[80] and previously insured individuals.[81] HIPAA preempts state law, except where the state legislation affords equal or greater protection to the insured. Enacted along with HIPAA was one statute requiring group health plans to cover hospitalization for specified minimum periods in the event of childbirth,[82] and another that prohibits health plans from restricting annual or lifetime mental health benefits to a greater extent than physical health benefits.[83]

Another federal regulation, the Health Maintenance Act, governs HMOs. Amended several times since its adoption in 1973, this statute imposes a wide array of medical and organizational duties on qualified plans. Qualified plans obligations include providing health services "with reasonable promptness;" reimbursing members for emergency treatment obtained outside of the plan; accepting Medicaid beneficiaries; and taking precautions against insolvency.[84] HMO regulations of various types also have been enacted by every state.

NATIONAL PRACTITIONER DATA BANK

Since 1990 the medical and dental boards of the states have been required to report to the National Practitioner Data Bank certain disciplinary actions taken against the professionals they license. Professional societies, too, must report adverse actions taken against their members,[85] while insurers must report all malpractice payments.[86] The U.S. Department of Health and Human Services makes this information available to state licensure boards and certain health care entities to facilitate the tracking of professionals who are disciplined in one state, then seek licensure in another. Health care facilities must query the Data Bank at least every two years regarding each member of their staff.[87] Many states now post this information on public websites as well, allowing patients to consider the legal history of practitioners when choosing a health care provider.[88]

Created by Congress as part of the Health Care Quality Improvement Act of 1986, the Data Bank immediately became the subject of controversy. The Department of Health and Human Services requires state licensure boards to report all revocations, suspensions, censures, reprimands, probations, and license surrenders, as well as revisions to such actions, including reinstatements.[89] Denials of initial applications and fines unaccompanied by licensing restrictions need not be reported, however.[90] This has caused some observers to speculate that state licensing boards are tailoring penalties so as to avoid the reporting requirement.[91]

Controversial, too, has been the Data Bank's role in the issue of closure. In the past, settlement provided physicians with peace of mind over malpractice claims. Now, though, with practitioners precluded by law from contesting the merits of any claim mentioned within the Data Bank, malpractice settlements become a permanent part of the practitioner's record. And while insurers do not have access to information contained within the Data Bank, some physicians have claimed that they have been required to produce their own Data Bank records as a condition of coverage.[92] If true, this means that an insurer's decision to settle a malpractice claim—which may have more to do with finances than the actual wrongdoing of the defendant practitioner—will leave a permanent scar on the practitioner's record, which in turn can affect the ability of the practitioner to obtain malpractice insurance in the future. Unfortunately, most policies allow the insurance carrier to make settlements without the consent of the insured physician. In addition, insurance carriers are unwilling to relinquish control of their ability to induce settlement. The federal government has passed a regulation that prohibits settlements from being construed as evidence of medical wrongdoing, but this frequently overlooked rule has done little to ease the fears of the medical establishment.[93]

INSURANCE ACCOUNTING

Insurers must provide accurate financial information to a number of interested parties, including the state insurance commissions that have jurisdiction over their activities. The National Association of Insurance Commissioners has assisted insurers in this role by establishing uniform accounting standards for use by insurers when filing statements with government entities. Unlike other businesses, insurers often do not become aware of revenues and losses until

many years after the relevant accounting period has closed. This is especially true with regard to "long-tail" lines of insurance, such as medical malpractice insurance. By the time a patient detects a problem, files a claim, and litigates it to completion, 25 years may have elapsed since the policy terminated. Insurance accounting therefore requires unique practices.

The most important of these practices entails the creation of loss reserves. To ensure that sufficient assets will be available to pay future claims, the insurer must estimate those claims as accurately as possible. Insurers often base their reserves on average claim values, or on the typical ratio between premiums and losses for a particular type of claim. Where a type of claim tends to be large and relatively infrequent, however, an insurer generally will include in its loss reserve an estimate of the amount necessary to ultimately settle each claim. Because of their size, medical malpractice claims usually rate this type of individualized attention.

When establishing loss reserves, insurers must consider not only known losses, but also losses that are incurred and not reported. Fewer than 10% of all medical malpractice claims are reported during the policy year in which they occur, and almost none of these claims result, in final payment during that period. To avoid understating its financial position, an insurer often will employ the services of an actuary, who can analyze past reporting trends to determine the percentage of claims likely to be filed after the close of a particular policy year. The insurer then can add this amount to estimated known losses to create a more realistic loss reserve.

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13. *See* Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates* (2002); *Waging Uphill Battle*, Business First, Nov. 15, 2002, at A1; M. Hassan, *How Profitable Is Medical Malpractice Insurance?* 28 Inquiry 74 (1991); Norbeck, *supra* note 10.
14. *See* Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. Health Pol., Pol., & Law 663 (1989).
15. *See, e.g., Ferdon v. Wisconsin Patients Compensation Fund*, No. 2003AP988 (Wisc. 2005) (equal protection violation); *Lakin v. Senco Prod., Inc.*, 987 P. 2d 463 (Ore. 1999) (holding that caps violate plaintiffs' right to jury trial); *Smith v. Schulte*, 671 So. 2d 1334 (Ala. 1995) (equal protection violation); *Knowles v. U.S.*, 544 N.W. 2d 183 (S.D. 1996) (substantive due process violation).
16. *See, e.g.*, H.R. 4280 §4, 108th Cong. (2004).
17. *Petrovich v. Share Health Plan of Illinois, Inc.*, 719 N.E. 2d 756 (Ill. 1999). *But see Jones v. U.S. Healthcare*, 723 N.Y.S. 2d 478 (N.Y. App. Div. 2001) (vicarious liability held not to exist where insurance document expressly described defendant HMO's physicians as "independent contractors").
18. *Pappas v. Asbel*, No. 98 E.D. App. Dkt. 1996 (Pa. Apr. 3, 2001).
19. *Herdrich v. Pegram*, 154 F. 3d 362 (7th Cir. 1998).
20. *See, e.g.*, Mo. Rev. Stat. §354.125.
21. In Colorado and Texas, for example, HMOs are prohibited by statute from engaging in the practice of medicine. Colo. Rev. Stat. ¶10-17-125(3) et seq.; Tex. Ins. Code §843.055. The courts of these states have held that HMOs are therefore incapable of committing medical malpractice as a matter of law. *See Freedman v. Kaiser Foundation Health Plan*, 849 P. 2d 811 (Colo. Ct. App. 1993); *Williams v. Good Health Plus, Inc.-Health America Corp.*, 743 S.W. 2d 373 (Tex. App. Ct. 1987). The legislature of New York, too, has enacted a statute that prohibits HMOs from practicing medicine. N.Y. Pub. Health Law §4410(1). It has opened the door to vicarious liability, however, by adding a provision that allows employees and agents of an HMO to be held personally liable for negligence committed while in the service of the HMO. *See Wisholek v. Douglas*, 280 A. 2d 220 (N.Y. App. Div. 2001). In addition, virtually all malpractice claims against HMOs are subject to an ERISA preemption challenge. *See, e.g., Neely v. U.S. Healthcare*, 844 F. Supp. 966 (S.D.N.Y. 1994).
22. 29 U.S.C.A. §1144(a).
23. *See Neely v. U.S. Healthcare H.M.O.*, 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993); *Pomeroy v. Johns Hopkins Medical Servs.*, 868 F. Supp. 110 (D. Md. 1994).
24. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).
25. *See Dunn v. Praiss*, 656 A. 2d 413 (N.J. 1995).
26. *County Forest Prod., Inc. v. Green Mountain Agency, Inc.*, 758 A. 2d 59 (Me. 2000).
27. *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434 (N.D. Cal. 1983).

Ch14-A03753 12/1/06 9:56 AM Page 150

28. Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 Harv. L. Rev. 961 (1971). See *Ponder v. Blue Cross of Southern California*, 193 Cal. Rptr. 632 (Cal. Ct. App. 1983).
29. *Providence Hosp. v. Morrell*, 427 N.W. 2d 531 (Mich. 1988).
30. *Ponder*, *supra* note 28.
31. *See* Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637 (1992).
32. *Stock v. SHARE*, 18 F. 3d 1419 (8th Cir. 1994).
33. *See Gereboff v. Home Indemnity Co.*, 383 A. 2d 1024 (R.I. 1978).
34. *Stine v. Continental Cas. Co.*, 315 N.W. 2d 887 (Mich. Ct. App. 1982).
35. *Communale v. Traders & Gen. Ins. Co.*, 328 P. 2d 198 (Cal. 1958).
36. *See Frazier v. Metropolitan Life Ins. Co.*, 214 Cal. Rptr. 883 (Cal. Ct. App. 1983).
37. *Communale, supra* note 35.
38. *Commercial Union Assurance Co. v. Safeway Stores, Inc.*, 610 P. 2d 1038 (Ca. 1980).
39. *See Biggus v. Ford Motor Credit Co.*, 613 A. 2d 986 (Md. App. 1992).
40. *Wadia Enterprises, Inc. v. Hirschfeld*, 618 A. 2d 506 (Conn. 1992).
41. *Novella v. Hartford Accident & Indem. Co.*, 316 A. 2d 394 (Conn. 1972).
42. *See Protective Life Ins. Co. v. Sullivan*, 682 N.E. 2d 624 (Mass. 1997).
43. *Grimberg v. Marth*, 659 A. 2d. 1287 (Md. App. 1985).
44. *Lenox Realty, Inc. v. Excelsior Ins. Co.*, 679 N.Y.S. 749 (N.Y. App. Div. 1998).
45. *Minnick v. State Farm. Mut. Auto Ins. Co.*, 174 A. 2d 706 (Del. 1961).
46. *Zimmerman v. Continental Cas. Co.*, 150 N.W. 2d 268 (Neb. 1967).
47. *Vackiner v. Mutual of Omaha Ins. Co.*, 137 N.W. 2d 859 (Neb. 1965).
48. *Powell v. Mut. Life Ins. Co. of N.Y.*, 144 Ill. 825 (Ill. 1924).
49. *Crawford v. Equitable Life Assurance Soc'y of United States*, 305 N.E. 2d 144 (Ill. 1973).
50. *See, e.g.*, Mass. Gen. Laws ch. 175, §108 (2002).
51. *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868).
52. *South-Eastern Underwriters Ass'n v. U.S.*, 322 U.S. 533 (1944), *reh'g denied*, 323 U.S. 811 (1944).
53. McCarron-Ferguson Act, 15 U.S.C. §1011.
54. Goldstein, *supra* note 8.
55. *More Mandates on Their Minds*, 17 Bus. & Health 20 (1999).
56. *Health Ins. Ass'n of America v. Corcoran*, 551 N.Y.S. 2d 615 (N.Y. App. Div. 1990); *Life Ins. Ass'n of Mass. v. Comm'r of Ins.*, 530 N.E. 2d 168 (Mass. 1988).
57. *See, e.g., Colonial Life Ins. Co. of America v. Curiale*, 617 N.Y.S. 2d 377 (N.Y. App. Div. 1994).
58. Barbara Berry, *The Human Genome Project and the End of Insurance*, 7 U. Fla. J. L. & Public Pol'y 205 (1996).
59. 29 U.S.C.A. §§1003(a), 1002(1).
60. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
61. *Pell v. Shmokler*, 1997 WL 83743 (E.D. Pa. 1997).
62. *Parrino v. FHP, Inc.*, 146 F. 3d 699 (9th Cir. 1998) (claim for denial of proton beam therapy for brain tumor held precluded).
63. *Brandon v. Aetna Servs., Inc.*, 46 F. Supp. 2d 110 (D.C. Conn. 1999) (claim against plan administrator who refused to pay for treatment of anxiety disorder held preempted).
64. *Dukes v. U.S. Healthcare, Inc.*, 57 F. 3d 350 (3d Cir. 1995).
65. 29 C.F.R. §2560.503-1.
66. 29 U.S.C.A., §1132(a)(3).
67. 29 U.S.C.A. §1104.
68. 29 C.F.R. §2520.102-2 to -4.
69. 29 U.S.C.A. §§1161–68.
70. 29 U.S.C.A. §1167(3); 42 U.S.C.A. §300bb-8(3).
71. 29 U.S.C.A. §1163(2); 42 U.S.C.A. §300bb-3(2).
72. 29 U.S.C.A. §1163; 42 U.S.C.A. §300bb-3.
73. 29 U.S.C.A. §§1163(3)(C); 1163(6).
74. 29 U.S.C.A. §1162(2)(A)(ii); 42 U.S.C.A. §§300bb-2(2)(A)(ii).
75. 29 U.S.C.A. §1162(1); 42 U.S.C.A. §300bb-2(1),
76. 29 U.S.C.A. §1162(5); 42 U.S.C.A. §300bb-2(5).
77. 29 U.S.C.A. §§1181–82; 42 U.S.C.A. §300gg-41.
78. 29 U.S.C.A. §§1181(a)(1), 300gg(a)(1).
79. 29 U.S.C.A. §1182(a), (b).
80. 42 U.S.C.A. §§300gg-11(a).
81. 42 U.S.C.A. §§300gg-41(a), (b).
82. 42 U.S.C.A. §1185a.
83. 42 U.S.C.A. §1185a(a).
84. 42 U.S.C. §§300e to 300e-17.
85. 42 U.S.C.A. §11132.
86. 45 C.F.R. §60.7.
87. 42 U.S.C.A. §11135(a).
88. *See, e.g.*, http://profiles.massmedboard.org (maintained by the Massachusetts Board of Registration in Medicine, this site contains information about malpractice payments, state discipline, hospital discipline, and criminal convictions for each licensed physician during the preceding ten-year period).
89. 45 C.F.R. §60.8.
90. Department of Health and Human Services, *National Practitioner Data Bank Guidebook Supplement* (August 1992).
91. Fitzhugh Mullan et al., *The National Practitioner Data Bank: Report from the First Year*, 268 J.A.M.A. 73 (1992).
92. Brian McCormick, *Debate on Data Bank Reveals Physicians' Frustrations*, 34 Am. Med. News 5(1) (July 8, 1991).
93. 45 C.F.R. §60.7(d).