THE MEDICAL DIRECTOR AND COMPANY LIABILITY BEYOND THE INSURANCE POLICY

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An insurance company is a business, a complicated and risky business. The role of the insurance company physician requires both medical knowledge and understanding of the goals and objectives of the company. The special knowledge possessed by the medical director may be employed in many facets of the business of insurance. "It is the doctor's ability to understand his company and apply his level of post graduate education and knowledge toward the company's workings in general that make him a maximally valued asset to the company and, hopefully, part of its trusted management."  

The medical director's ability to read a chart, make mortality assumptions, and factor what medical impairments could be of potential significance are very important. The medical director should also understand, however, that there can be risks beyond those bargained for by the company. This article will try to inform medical directors about some of the ways they may help their insurance companies to avoid paying for claims that were not intended to be covered when the insurance contract was drafted, underwritten, or sold.

There are several very important functions relating to life, health or disability insurance where the insurer may be exposed to claims beyond those which it intends to include in the insurance contract. These include: drafting of the insurance contract itself (including endorsements and exclusions), drafting and interpreting the application for the insurance policy, evaluating claims, and decisions made under case management plans.

There are some basic legal concepts which affect what happens when a claim is made under an insurance policy. First of all, an insurance policy is a contract. How the courts interpret contracts will obviously affect the insurance company's obligations to pay. There are duties which arise either from the common law or statutes that also determine how and when insurance companies will be liable. Finally, the equitable doctrines of waiver and estoppel can sometimes result in coverage for claims even though the insurer did not intend to cover those claims when the insurance contract was issued.

The Insurance Contract

While it would indeed be unusual for a medical director to draft an insurance policy, the wise insurer seeks input from the physician for portions of the policy.

"Product development can also be aided by an educated physician. Riders, such as an accelerated death benefit or dread disease inclusion, require a physician to use as accurate language as possible to specify which conditions will be included and which will be excluded from consideration. Without very specific language subject to legal interpretation, a company may find out its intended benefit may be abused by those circumventing its original intent, or overly strict interpretations may cause ill will by making the rider unavailable even to those it was intended to help."

Most insurance policies are interpreted using principles of state common law. A significant number of group insurance policies written for members of employee groups, however, are now subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA was enacted to protect the interests of employees covered under employee benefit plans. ERISA is federal law which preempts or supersedes most state laws which "relate to" employee benefit plans. The interpretation of an insurance policy which is part of an ERISA employee welfare benefit plan will be interpreted according to an uniform body of federal common law. Having pointed out the different bodies of common law used to interpret insurance policies, the fact is that there is not a great difference in the rules which are applied by state courts and federal courts in interpreting insurance policies.

State courts will usually read an insurance contract as a whole ascribing to each term the plain meaning which a layman would ordinarily attach to it. Policies will be read not as they might be analyzed by an attorney or an insurance expert. ERISA insurance policies will be interpreted "in an ordinary and popular sense as would a [person] of average intelligence and experience."

If there is an ambiguity in the language of an insurance policy, that is, if any portion of the policy is subject to more than one meaning, most courts will apply the contra-insurer rule. "... [W]here a policy of insurance is
so framed as to leave room for two constructions, the words used should be interpreted most strongly against the insurer. This exception rests on the grounds that the company's attorneys, officers or agents prepared the policy, and it is its language that must be interpreted.\textsuperscript{8} Simply stated, if semantically reasonable, the court will choose the interpretation of the policy which is more inclusive and more likely to result in coverage for a particular claim.\textsuperscript{9}

Many states apply the "reasonable expectations" doctrine to the interpretation of the ambiguities in the insurance policy. Under this doctrine, "the meaning of an insurance policy is determined by the insured's reasonable expectation of coverage and any uncertainty or ambiguity in peril insured against will be resolved in favor of imposing liability."\textsuperscript{10} The reasonable expectations theory is articulated by Professor Keeton of Harvard Law School in a number of law review articles. In one article he stated:

"First, as an ideal this principle incorporates the proposition that policy language will be construed as laymen would understand it and not according to the interpretation of sophisticated underwriters. . . . The principle of reasonable expectations should be extended further, protecting the policy holder's expectations as long as they are objectively reasonable from the laymen's point of view, in spite of the fact that had he made painstaking study of the contract he would have understood the limitation that defeats the expectation at issue."\textsuperscript{11}

Usually, exclusionary clauses or exceptions to coverage will be read even more strictly by the courts. Exclusionary clauses must be conspicuous, clear and plain and will be construed strictly against the insurer and liberally in favor of the insured.\textsuperscript{12} Where a strict, literal interpretation of a clause would unreasonably restrict coverage of the policy, such an interpretation cannot be foisted onto a layman nor can it be defended in terms of the risks which the layman sought to insure against.\textsuperscript{13} When exclusionary language gets lost in a "sea of print" or "rivers of print", courts may find that an exclusion is not sufficiently conspicuous so that it is of no effect.\textsuperscript{14}

As a practical matter, what happens when these rules are applied? Here are some examples. An insured made a claim for treatment of autism under a group health and medical policy which included a limitation of benefits to $10,000 per calendar year for "mental illness or nervous disorders." Ironically, both sides used doctors as expert witnesses to determine the "plain and ordinary" meaning of the term "mental illness." The insured's experts testified that "mental illness" refers to "a behavioral disturbance with no demonstrable organic or physical basis . . . it stems from reaction to environmental conditions as distinguished from organic causes." The insurance company's expert offered a definition of "mental disorder" found in the American Psychiatric Association's Psychiatric Glossary. This defined "mental disorder" as "an illness with . . . impairment in functioning due to a social, psychologic, genetic, physical/chemical or biologic disturbance . . . . The illness is characterized by symptoms and/or impairment in functioning." The court rejected the definition that was taken from the American Psychiatric Association's Glossary, concluding that it could include a myriad of ailments that would never be considered mental illnesses by the average person. These could include such things as cancer or a broken leg. The court found that the mental illness limitation did not apply to a patient who suffered from autism.\textsuperscript{17}

In another case, a Florida insured suffered from breast cancer. She sought benefits under a major medical insurance policy to cover high dose chemotherapy with autologous bone marrow transplant ("HDC/ABMT"). The insurance policy covered "medically necessary services" and excluded "experimental" services. The insurance company refused coverage stating that HDC/ABMT was not medically necessary and was experimental. The trial court found that the term "experimental" was not ambiguous. The insured appealed. The appellate court found that since at least one other federal court had ruled that HDC/ABMT was not considered experimental, the policy was ambiguous. The court found that there was genuine uncertainty about who would determine whether a particular treatment was experimental. Since the policy failed to define the term "experimental" in any way, the policy was ambiguous.\textsuperscript{18}

The California Court of Appeal found that an exclusion for temporomandibular joint syndrome ("TMJ"), while not ambiguous, was not sufficiently conspicuous so that a reasonable person would find it. It appeared in a clause in a paragraph labeled "Dental Care," was printed in 2,000 words per page print size, and the page on which the exclusion appeared actually contained over 2,000 words. The exclusion also failed the "plain
and clear" test because the undefined technical terminology was not part of the vocabulary of an average layperson. The court found that the exclusion was simply ineffective because it contained undefined technical terminology and was buried in "rivers of print."19

The language in the policy, including all of the riders to the policy, must not only be accurate, it must be clear to the average person who buys the policy. The language must be specific, but not overly technical. Exclusionary language should not be surrounded by a "sea of print" or contained in "rivers of print." The medical director should be involved in the drafting process to the extent that his or her knowledge and skills are used to draft the language of medically related issues of coverage or exclusion so that the plain meaning can be clearly expressed.

The Application

The application for a life, health or disability policy is as important as the contract of insurance itself. In fact, the application is usually a part of the contract with the insured. The medical director should be involved in the drafting of application forms and in reviewing completed applications. This does not necessarily mean that the medical director drafts every word of the application, or that the medical director reviews every application that is submitted to the company. It does mean that the medical director should provide guidance to assure that the application is clear and unambiguous and that those reviewing applications have a clear understanding of what is material to the underwriting of the insurance policy. This is important because, if an applicant conceals or misrepresents information material to the underwriting of the policy, the insurance company may rescind the policy. When a contract is rescinded it is annulled and the parties are returned to the status quo as if the contract had never existed. 20 In most states insurance companies may rescind the policy on the grounds of misrepresentation or concealment even if the insured did not act with a fraudulent intent.21

While in theory the rule is that the insurance company must prove only that an insured's misrepresentations or non-disclosures were material to the underwriting of the risk, most often the insurance company will encounter difficulty in rescinding a policy if the information that was not disclosed was not encompassed by the questions asked on the application. 22 Like the language in the insurance contract itself, the questions asked on an application must be clear and understandable by the average person.

Even though in many states the failure to disclose is improper even when there is no attempt to deceive, the courts will consider the applicant's knowledge and belief at the time the application was completed. If the applicant is ignorant of relevant information, the insurer will not be allowed to rescind even if material information was not disclosed. There is no breach of the duty to disclose if the applicant, acting in good faith, does not understand the significance of the information he or she fails to disclose.23

The questions on an insurance application must be composed so that the applicant understands the information that is sought by the insurance company, and the application must be read by the insurance company so that the company appreciates the information that is provided. An example of how carefully and strictly these rules can be applied is found in a California case where the applicant for life insurance answered "no" in his application to the questions which asked whether he had ever had "high blood pressure," whether he ever had a "pain in his chest," or any "illness" or "disease" other than as specified in the application. The applicant answered no to these questions although he had been informed by his doctor that he had a "mild hypertension." The court found that there was no evidence that the applicant knew what the term "mild hypertension" meant, and, "as a layman, he might reasonably have failed to understand that it had any relation to blood pressure."24 Similarly, the court found that the applicant did not have a duty to disclose that he had experienced a "heavy feeling" in his chest when he had consulted the same doctor who told him he had "mild hypertension."25 "It has been held that questions concerning illness or disease do not relate to minor indispositions, but are to be construed as referring to serious ailments which undermine the general health."26

In Louisiana, an insurer refused to pay death benefits on the grounds that the insured had concealed the fact that he was a diabetic on his application. The Louisiana Court of Appeal ultimately found that the insurer had failed to establish that the insured had concealed his diabetes at the time of his application. The insurer could not produce a witness who could say with certainty that the insured knew of his diabetes on the date he made the application.27

When a Virginia insured was killed, a life insurer refused to pay, and attempted to rescind the policy on the grounds that in the application the insured had answered "no" to a question asking whether he had been treated by a physician within the last five years for "epilepsy or nervous disorder." The insured had in fact been admitted to a hospital for depression after he had
accidentally shot and killed his wife. In later therapy sessions the insured had told his doctor that he had considered committing suicide. Notwithstanding the fact that the insured had failed to disclose his treatment for depression in the application, the Virginia Supreme Court found that the insured’s answers on the application did not provide grounds for rescission of the policy. The court found that the phrase "nervous disorder" was a general term which could include physical or mental disorders, or both. The court found that the phrase as used in the application question was ambiguous; it could have referred to physical disorders only.28

Since medical directors are often asked to form an opinion and testify concerning the materiality of the answers to questions on the applications for insurance, the medical director must understand that the questions on the application must be clear and unambiguous to the reasonable person of average intelligence. Questions which are too technical, or on the other hand, too general, are less likely to be found adequate when an insurer seeks to rescind the policy because of misrepresentation.

Claims

The medical director’s input, whether by directly reviewing medical charts or by establishing criteria for reviewing charts, is sometimes crucial. The duty of the insurance company to investigate and to make a timely decision is established by the laws of nearly every state. In fact a majority of the states have adopted either all or substantial portions of the National Association of Insurance Commissioners’ (NAIC) model legislation which proscribes certain claims settlement acts as well as unfair and deceptive practices.29

The insurer has a duty of the utmost good faith to its insureds. If an insurer does not conduct a reasonable investigation of a claim in a timely manner, the insurance company may be found not only to be in breach of the insurance contract, but to have committed the tort of "bad faith." This subject is addressed in another article in this issue.

Some mistakes that give rise to tort damages may originate from bad record-keeping by the treating physician. The author has had the unhappy experience of defending an insurance company that denied coverage under an accident policy because medical history information found in the patient’s chart indicated an overuse syndrome not covered by the accident policy. The problem was that the insured patient had a very common name, and the medical records of another, older, patient had found their way into his chart. More careful reading of the chart would have indicated inconsistencies in the history and treatment which would have lead the company to further inquiries. It sounds simple, but it is important to insure that those conducting the investigation at the insurance company verify that they are reading the right records.

A subject which can be particularly tricky is the exclusion for pre-existing conditions. In a decision that gathered a lot of attention because of its finding that the Mississippi law of punitive damages did not violate the U.S. Constitution, the U.S. Supreme Court found that an insurance company was properly found in bad faith for denying a claim on the opinion of its medical director that the cause of an insured’s amputation was not the accident claimed by the insured, but rather a pre-existing condition of arteriosclerosis. The insurance company stood by its denial of coverage even after the insured furnished statements signed by three doctors who had treated him in the hospital which stated that the arteriosclerosis was "an underlying condition and not the immediate cause of the gangrenous necrosis. The precipitating event must be considered to be the trauma which initially brought him to the emergency room on 9 January." The insurance company medical director and a company analyst concluded that that statement was inconsequential. They had not, however, reviewed the emergency room records. The policy in question in this action was an accident policy which covered "injury . . . directly and independently or all other causes." The court found that the insurance company’s files were incomplete with respect to the claim and that the investigation had been inadequate. The insured was not only awarded $20,000 in actual damages, the court further assessed punitive damages of $1.6 million.

Case Management And Pre-Certification

Case management and the pre-certification before hospitalization can also present special problems. Obviously, the question of who or what determines "medical necessity" and what charges are "reasonable and customary" in the community are all issues which must be clearly set out if problems are to be avoided. Case management presents a special set of problems.30 Procedures for case management and pre-approval of procedures under health plans will obviously save money and avoid claims for uncovered treatment, but only if the procedures established are clear, logical, and most important, followed.

The equitable concepts of waiver and estoppel can come into play during the certification process and can result in liability to the insurer for treatments and procedures
HDC/ABMT, the HMO responded in a way that
financial stake in Oxford or the recommended proce-
dure." In sum, after the insured followed the proper
procedure was not specifically listed as one requiring a
second opinion, and that the HMO's response to the
followed the instructions of the plan handbook, that the
insured properly
informed on the telephone that certification for the
hospital. On the day when HDC/ABMT was to begin,
insured telephoned to request pre-certification for both
Following the prescribed procedures of the plan, the
insured telephoned to request pre-certification for both
a bone marrow biopsy and HDC/ABMT. The company's health services coordinator pre-certified the
bone marrow biopsy, but informed the insured that she
could not assign a pre-certification number for the
HDC/ABMT at that time because more information
was needed concerning dates and names of the physi-
cians. The coordinator also suggested that the insured
explore bone marrow transplant programs at another
hospital. On the day when HDC/ABMT was to begin,
the insured again telephoned the coordinator and was
informed on the telephone that certification for the
HDC/ABMT at the selected hospital was denied. The
insured went forward with treatment as scheduled.

In a lawsuit brought for benefits against the HMO, the
court found that there was coverage for the
HDC/ABMT. The court found that the insured properly
followed the instructions of the plan handbook, that the
procedure was not specifically listed as one requiring a
second opinion, and that the HMO's response to the
insured's request for pre-certification breached the
terms of its own plan. The court
estopped the HMO from relying on its claim that the
insured had failed to obtain pre-certification, because
the procedure that was followed in denying pre-certifi-
cation did not follow the terms of the plan.

Courts will apply the doctrine of waiver or estoppel
when an insurer, an HMO, or a third party administra-
tor engages in some act or omission which causes the
insured to rely on a reasonable belief that coverage will
be provided. Once again, clear and simple language and
following the rules is a key to avoiding extra liabilities.

In all of the matters discussed above, one of the prin-
cipal skills a physician can bring to an insurance company
is the ability to translate medical knowledge into rules
and agreements which will be understood by a reason-
able person of average intelligence. Armed with this
knowledge, the insurance company can communicate
with its insureds and avoid liability for claims which it
had never intended or expected to cover.

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