


2010

Readability, Contracts of Recurring Use, and the Problem of Ex Post Judicial Governance of Health Insurance Policies

John Aloysius Cogan, Jr.
University of Connecticut School of Law

Follow this and additional works at: https://opencommons.uconn.edu/law_papers

 Part of the [Contracts Commons](#), [Health Law and Policy Commons](#), [Insurance Law Commons](#), [Medical Jurisprudence Commons](#), and the [Social Welfare Law Commons](#)

Recommended Citation

Cogan, Jr., John Aloysius, "Readability, Contracts of Recurring Use, and the Problem of Ex Post Judicial Governance of Health Insurance Policies" (2010). *Faculty Articles and Papers*. 59.
https://opencommons.uconn.edu/law_papers/59

HEINONLINE

Citation: 15 Roger Williams U. L. Rev. 93 2010



Content downloaded/printed from
HeinOnline (<http://heinonline.org>)
Mon Aug 15 16:49:28 2016

- Your use of this HeinOnline PDF indicates your acceptance of HeinOnline's Terms and Conditions of the license agreement available at <http://heinonline.org/HOL/License>
- The search text of this PDF is generated from uncorrected OCR text.
- To obtain permission to use this article beyond the scope of your HeinOnline license, please use:

[https://www.copyright.com/ccc/basicSearch.do?
&operation=go&searchType=0
&lastSearch=simple&all=on&titleOrStdNo=1090-3968](https://www.copyright.com/ccc/basicSearch.do?&operation=go&searchType=0&lastSearch=simple&all=on&titleOrStdNo=1090-3968)

Readability, Contracts of Recurring Use, and the Problem of Ex Post Judicial Governance of Health Insurance Policies

John Aloysius Cogan Jr.*

INTRODUCTION

The recently enacted Patient Protection and Affordable Care Act¹ and Health Care and Education Reconciliation Act of 2010² mark the most significant reform of the nation's health care system since President Lyndon Johnson signed legislation creating the Medicare and Medicaid programs in 1965.³ Although efforts to overhaul the U.S. health care system have arisen periodically since former President Theodore Roosevelt's Bull Moose Party campaign of 1912,⁴ never have those efforts been undertaken in a health care environment as complex as it is today. Skyrocketing health care costs, advances in technology and medical science, and increased pressure on consumers through

* John Aloysius Cogan Jr., Esq., is the Executive Counsel and Executive Assistant for Program and Policy Review of the Rhode Island Office of the Health Insurance Commissioner. Mr. Cogan is also an adjunct Professor at the Roger Williams University School of Law. The author would like to thank Mya Poe, Ph.D. for her invaluable assistance with this Article.

1. Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. Pub. L. No. 111-152, 124 Stat. 1029 (2010).

3. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965).

4. For a concise overview of health reform efforts in the United States over the last century, see CATHERINE HOFFMAN, THE HENRY J. KAISER FAMILY FOUND., NATIONAL HEALTH INSURANCE—A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S. (2009), *available at* <http://www.kff.org/healthreform/upload/7871.pdf>.

consumer-directed health plans⁵ have created a health care system that places a premium on consumer information. In the months leading up to the passage of the new reform acts, political dialogue and media coverage that focused on “health care reform” typically referred to core issues such as cost, quality, and access to care. Yet, the dialog rarely acknowledged a key problem—the fact that most Americans do not understand their health insurance. Simply put, consumers do not fully grasp their health insurance coverage because the jargon found in many health insurance

5. It has long been recognized that health insurance creates additional demand for health care. The additional consumption of health care attributed to health insurance is referred to as “moral hazard,” or the additional health care that an insured consumer purchases, that would not have been purchased if she had been insured. See John A. Nyman, *American Health Policy: Cracks in the Foundation*, 32 J. HEALTH POL. POL’Y & L. 759, 760 (2007) [hereinafter Nyman, *American Health Policy*]. According to conventional wisdom, moral hazard is responsible for the significant increase in health care expenditures. Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 J. ECON. PERSP. 3, 6-7 (1992). This view has, in turn, created a “preoccupation” with moral hazard and a broad range of efforts to reduce moral hazard through managed care strategies and the development of consumer-driven health care. John A. Nyman, *Consumer-Driven Health Care: Moral Hazard, the Efficiency of Income Transfers, and Market Power*, 13 CONN. INS. L.J. 1, 4-5 (2006). The effects of this theory and preoccupation have been profound for consumers. Health insurance contracts are more complicated to use. See Jessica Greene et al., *Comprehension and Choice of a Consumer-Directed Health Plan: An Experimental Study*, 14 AM. J. MANAGED CARE 369, 369, 374 (2008) (arguing that consumer-directed health plans are more complex than other forms of health insurance and that consumers with low-numeracy skills have greater difficulty making the type of cost-effective medical care decisions that consumer-directed health plans were designed to promote); Peter J. Cunningham et al., *Do Consumers Know How Their Health Plan Works?*, 20 HEALTH AFF. 159, 163 (2001) (finding that less than one-third of surveyed adults understood certain basic features of their health plans related to network coverage, out-of-network coverage, primary care physician requirements and specialist referrals). Moreover, increased use of complex cost control and cost-sharing mechanisms (higher deductibles, higher coinsurance, increased utilization reviews, etc.) burdens consumers with increased health care costs. See Nyman, *American Health Policy*, *supra*. The influence of the moral hazard theory has transformed health insurance “from a solution into a problem,” *id.* at 765 (citing Malcolm Gladwell, *The Moral Hazard Myth*, THE NEW YORKER, Aug. 29, 2005, at 44, available at http://www.newyorker.com/printables/fact/050829fa_fact), and provided intellectual support for the proliferation of health insurance policies that focus on the reduction of moral hazard through cost control features and cost-sharing mechanisms, and which have led to the current interest in consumer-driven health care and health savings accounts. *Id.* at 761.

contracts is impenetrable to most Americans.⁶ This is disconcerting because consumer-oriented information is central to our increasingly consumer-directed health care system; consumers are expected to make cost-effective choices among the array of health insurance plans that may be available to them, utilize health care services in a cost-effective manner, navigate provider networks, minimize their out-of-pocket expenses, and effectively appeal denials of coverage.

While the problem is especially acute for the elderly and low-income populations,⁷ the complexity of health insurance information challenges even those who read at the college level. For example, a health insurance contract recently approved for use in Rhode Island contains the following provision, part of a "coordination of benefits" clause, which explains when the insurance company will pay a claim if a child is also covered by a second insurance policy:

The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar

6. See Cunningham, *supra* note 5 (finding that less than one-third of surveyed adults understood certain basic features of their health plans related to network coverage, out-of-network coverage, primary care physician requirements and specialist referrals); Deborah W. Garnick et al., *How Well Do Americans Understand Their Health Coverage?*, 12 HEALTH AFF. 204, 208 (1993) (finding that fewer than one-third of enrollees surveyed could correctly answer basic questions about their coverage); Judith H. Hibbard et al., *Can Medicare Beneficiaries Make Informed Choices?*, 17 HEALTH AFF. 181, 190-91 (1998) (finding that Medicare HMO enrollees have "less-than-adequate knowledge" about their plans); David E. Nelson et al., *What People Really Know About Their Health Insurance: A Comparison of Information Obtained From Individuals and Their Health Insurers*, 90 AM. J. PUB. HEALTH 924, 926 (2000) (concluding that "individuals have a poor understanding of their health insurance benefits"); see also Anna Wilde Mathews, *The Importance of Deciphering Your Insurance*, WALL ST. J., June 4, 2009, at D1, available at <http://online.wsj.com/article/SB124407903047283723.html> (providing examples of consumers confused by health insurance policies); Kerry Hall Singe, *No Insurance Against Confusion*, CHARLOTTE OBSERVER, Oct. 25, 2009, available at <http://www.actforasheville.com/newsArticle.jsf?documentId=8a785691248a48cc01248b0ef92b0395> (noting that most consumer complaints filed with the North Carolina Department of Insurance "stem from a consumer's misunderstanding of their policy").

7. See Jane Root & Sue Stableford, *Easy-To-Read Consumer Communications: A Missing Link in Medicaid Managed Care*, 24 J. HEALTH POL. POLY & L. 1, 2 (1999).

year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e., stepparent), shall be primary over the plan covering the patient as a dependent of the parent without legal custody.⁸

Here is another example. This passage explains an insurance company's right to recover the claims it pays:

In the event a third party, including your employer/agent, is or may be responsible for causing an illness or injury for which we provided any benefit or made any payment to you, we shall succeed to your right of recovery against such responsible party. This is our right of subrogation. If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name).⁹

The language used in these provisions begs the obvious question: Would the average Rhode Islander be able to read and understand these passages? According to the Flesch-Kincaid formula,¹⁰ a commonly used measure of readability that estimates the reading grade level of a document, the answer is no. On average, Rhode Islanders, like most Americans, read at the eighth grade level. Worse yet, forty-seven percent of Rhode Island's adult population reads at the sixth grade level or below.¹¹ These provisions are written at the twenty-fourth and thirteenth grade levels, respectively.

When asked why health insurance policies are written with such complex language, insurance companies, lawyers, or industry insiders might give the following kinds of responses:

8. John Aloysius Cogan Jr., Op-Ed., *Plain English is the Best Policy*, N.Y. TIMES, Aug. 19, 2009, at A24.

9. *Id.*

10. See *infra* notes 107-10 and accompanying text.

11. *Rhode Island Addressing Illiteracy*, PROVIDENCE J., July 17, 2005, available at http://www.projo.com/news/content/projo_20050717_litside.232e346.html.

"The contract is drafted for lawyers and judges. It contains legal terms of art and passages already construed through litigation. The language is therefore necessary for uniform construction of the policy by the courts."

"The average person does not read the contract, so it does not matter if he or she understands it."

"All health insurance contracts contain the same or similar language. They are designed for predictability by the insurer, not for understandability by the insured."¹²

Such responses suggest that insurance companies and others who control health insurance information are unaware of or unwilling to acknowledge consumer needs.¹³

The readability problem is not unique to Rhode Island. Almost one quarter of the U.S. adult population is functionally illiterate and an additional quarter has poor reading and comprehension skills.¹⁴ Nearly half of the adult population has deficiencies in reading and/or computational skills,¹⁵ and it is widely acknowledged that, on average, the U.S. adult reading

12. These quotes are representative of comments that have been made to the author by industry insiders and attorneys.

13. Certainly insurance companies are aware. The industry's leading trade association, America's Health Insurance Plans, acknowledges that "most Americans . . . only understand information written at an eighth-grade level." Aileen Kantor, *A New Level of Understanding*, AMERICA'S HEALTH INS. PLANS, Nov. 2006, at 18, available at <http://www.ahip.org/content/default.aspx?bc=31|130|136|18284|18285>.

14. Donna M. D'Alessandro et al., *The Readability of Pediatric Patient Education Materials on the World Wide Web*, 155 ARCHIVES PEDIATRICS & ADOLESCENT MED. 807, 807 (2001); Frank McClellan, *Medical Malpractice Law, Morality and the Culture Wars: A Critical Assessment of the Tort Reform Movement*, 27 J. LEGAL MED. 33, 45 (2006) (citing IRWIN S. KIRSCH ET AL., ADULT LITERACY IN AMERICA: A FIRST LOOK AT THE RESULTS OF THE NATIONAL ADULT LITERACY SURVEY, xiv-xvii (3d ed. 2002), available at <http://nces.ed.gov/pubs93/93275.pdf>); David I. Shalowitz & Michael S. Wolf, *Shared Decision-Making and the Lower Literate Patient*, 32 J.L. MED. & ETHICS 759, 759 (2004).

15. Ad Hoc Comm. on Health Literacy for the Council on Scientific Affairs, Am. Med. Ass'n, *Health Literacy: Report of the Council on Scientific Affairs*, 281 J. AM. MED. ASS'N 552, 552 (1999) [hereinafter Ad Hoc Committee].

level is eighth to ninth grade.¹⁶ In fact, studies suggest a large percentage of Americans are unable to read and understand basic health-related materials.¹⁷ Even for a consumer who possesses a higher-than-average reading ability, a health insurance contract may pose special problems. Complex financial information (i.e., the often intertwined cost-sharing information related to out-of-pocket maximums, deductibles, coinsurance percentages, and copayments), for example, can be difficult to locate in a consumer contract.¹⁸ The inability to fully comprehend one's health insurance policy can lead to poorer overall health and higher health care costs.¹⁹

The expected responses above by insurance companies, lawyers, and industry insiders are also at odds with classical notions of contracts in which parties negotiate terms, reach a "meeting of the minds," and then reduce the agreement to writing in a document called a "contract." Yet, unlike standard contracts, health insurance policies are contracts of adhesion. They contain standard, non-negotiable terms and are drafted by insurance companies that have little incentive to produce readable documents. At first blush, a hard-to-read health insurance contract may not seem to present greater problems for a consumer than a hard-to-read automobile policy. But such is not the case.

16. U.S. GOV'T ACCOUNTABILITY OFFICE, CREDIT CARDS: INCREASED COMPLEXITY IN RATES AND FEES HEIGHTENS NEED FOR MORE EFFECTIVE DISCLOSURE TO CONSUMERS, GAO-06-929, at 6 (2006), available at <http://www.gao.gov/new.items/d06929.pdf> [hereinafter GAO CREDIT CARD REPORT]; Edgar Dale & Jeanne S. Chall, *A Formula for Predicting Readability*, 27 EDUC. RES. BULL. 11, 12 (1948); D'Alessandro, *supra* note 14; Root & Stableford, *supra* note 7, at 5.

17. See NAT'L CTR. FOR EDUC. STATISTICS, U.S. DEP'T OF EDUC., THE HEALTH LITERACY OF AMERICA'S ADULTS, 6 fig.1-1, 10 (2006), available at <http://nces.ed.gov/pubs2006/2006483.pdf> (finding that only twelve percent of adults had "proficient" health literacy, as demonstrated by the ability to perform tasks like calculating an employee's share of health insurance costs for a year, finding information required to define a medical term by searching through a complex document, or determining which legal document is applicable to a specific health care situation); Ad Hoc Committee, *supra* note 15, at 552-53.

18. Elizabeth Renuart & Diane E. Thompson, *The Truth, The Whole Truth, and Nothing but the Truth: Fulfilling the Promise of Truth in Lending*, 25 YALE J. ON REG. 181, 208 (2008) (citing GAO CREDIT CARD REPORT, *supra* note 16, at 49-50).

19. See Ad Hoc Committee, *supra* note 15, at 555.

Unlike other types of insurance agreements, health insurance policies are *contracts of recurring use*. That is, they are routinely invoked by consumers who use their insurance agreements to finance their health care.

Based on concerns arising from increasing consumer responsibility for healthcare choices, the recognition that health insurance policies are contracts of recurring use, and a steady stream of consumer complaints about their health insurance policies, the Rhode Island Office of the Health Insurance Commissioner (OHIC) conducted its own investigation into the readability of Rhode Island health insurance policies. A sample of fifty-five health insurance policies, certificates of coverage, riders and endorsements was drawn from filings made with the OHIC in 2007 and approved for use.²⁰ The reading grade level of each document in the sample was estimated using the Flesch-Kincaid grade level formula, which provides an estimated reading grade level of the document tested.²¹ The results painted a bleak picture of the readability of health insurance contracts in the state. The average Flesch-Kincaid formula score for the documents in the sample was 15.45. In other words, the documents were, on average, readable by someone who reads at the fifteenth grade level—approximately a junior in college. The lowest score was 9.36 (readable by someone who reads at the ninth grade level) and the highest was 30.4 (readable by someone who reads beyond the graduate school level). Indeed, the findings suggested that insurance documents written at the advanced college level were the norm in the state, not the exception. Based on the results of our study, we concluded that most health insurance policies in the

20. All commercial health insurance policies, certificates of coverage, riders and endorsements that will be issued for use in Rhode Island must be filed with the state and approved prior to use. Minimum Standards – Health Benefit Plans, 2-30-23 R.I. CODE R. § 2 (Weil 2010), *available at* <http://www.dbr.state.ri.us/documents/rules/insurance/Refiled-Regulation23.pdf>. This rule was adopted by the R.I. Office of the Health Insurance Commissioner (OHIC) on May 17, 2006. Adoption of Existing Administrative and Health Insurance-Related Regulations of the Department of Business Regulation, 2-31-1 R.I. CODE R. § 3 (Weil 2010), *available at* <http://www.ohic.ri.gov/Regulation1AdoptingDBRRegulations.php>. Most states require health insurance forms to be filed prior to use, though not all require explicit approval prior to use. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 653 (6th ed. 2008).

21. See *infra* notes 108-10 and accompanying text.

state were likely written at a level that far exceeded the reading level of the average Rhode Island resident.²²

This Article discusses the development and implementation of the *Standards for Readability of Health Insurance Forms*,²³ the Rhode Island regulation that requires all health insurance contracts to be written at the eighth grade reading level. Section I provides a brief discussion on contracts of adhesion (the standard, take-it-or-leave-it insurance policies), their long-standing history of unreadability, how the courts have tried to address the problems caused by contracts of adhesion, and the limitations of those remedies. Section II discusses the unique nature of health insurance contracts, why they are contracts of recurring use, and why traditional notions of ex post judicial governance associated with adhesion contracts are inadequate for health insurance contracts. Finally, Section III describes the OHIC's efforts to find and implement an ex ante solution to unreadable health insurance contract: the eighth grade readability standard.

I. CONTRACTS OF ADHESION, UNREADABILITY, AND EX POST JUDICIAL GOVERNANCE

Contracts of adhesion are used for insurance,²⁴ consumer loans, mortgage agreements, software and digital music purchases, mobile phone service agreements, and just about any other contractual arrangement we enter into today.²⁵ Contracts of adhesion offer an insured no ability to negotiate the terms of the deal, there is no "meeting of the minds," and the contract is simply

22. John Aloysius Cogan Jr., Preliminary Findings of an Investigation of the Readability of Rhode Island Health Insurance Policies (Dec. 2008) (unpublished study, on file with author).

23. Standards for Readability of Health Insurance Forms, 2-31-5 R.I. CODE R. (Weil 2010), available at <http://www2.sec.state.ri.us/dar/regdocs/released/pdf/HICO/5768.pdf>.

24. Jay M. Feinman, *The Insurance Relationship as Relational Contract and the "Fairly Debatable" Rule for First-Party Bad Faith*, 46 SAN DIEGO L. REV. 553, 557 (2009) ("The insurance policy is a classic contract of adhesion.").

25. Nearly forty years ago, Professor David Slawson observed that ninety-five percent of all contracts we enter into are standard form contracts of adhesion. See David Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 HARV. L. REV. 529, 529 (1971). There is no reason to think that the number has decreased in the intervening period.

presented to the insured, who must either “take it or leave it.”²⁶

A. Health Insurance Contracts as Contracts of Adhesion

Health insurance contracts have historically been recognized as contracts of adhesion.²⁷ As such, the terms of health insurance contracts are never fully discussed between the parties. In the case of individual market health insurance policies, the contract is always “off the rack.” It is sold “as is” with no negotiation. In the case of group-based health insurance policies, the kind of health insurance an employee might obtain from her employer, for example, the ability to meaningfully negotiate terms is negligible. While there may appear to be some room for negotiation by the employer (the entity actually purchasing the insurance) and some variability as to terms (e.g., cost-sharing components, such as copayments and deductibles, and network requirements), in reality, there is no opportunity for significant bargaining as to standard terms.²⁸ Thus, regardless of the source of one’s health insurance, there is severely limited opportunity for negotiation as to the standard terms of the health insurance contract.²⁹

26. *Pacheco v. Nationwide Mut. Ins. Co.*, 337 A.2d 240, 242 (R.I. 1975); *Pickering v. Am. Employers Ins. Co.*, 282 A.2d 584, 593 (R.I. 1971) (recognizing that “[a]n insurance contract is not the end result of the give-and-take that goes on at a bargaining table” and “is not a true consensual arrangement but one that is available to the premium-paying customer on a take-it-or-leave-it-basis.”). This lopsided arrangement has led one scholar to remark, “[a]dhesion contracts are a bullying device, and ‘consent’ to a bully is no consent at all.” Peter Linzer, “*Implied, “Inferred,” and “Imposed”: Default Rules and Adhesion Contracts – The Need for Radical Surgery*,” 28 PACE L. REV. 195, 204 (2008).

27. See Peter D. Jacobson & Stefanie A. Doebler, “*We Were All Sold a Bill Of Goods:*” *Litigating the Science of Breast Cancer Treatment*, 52 WAYNE L. REV. 43, 100 (2006) (“State courts have traditionally viewed health insurance policies as contracts of adhesion . . .”).

28. See Feinman, *supra* note 24 (“[T]he insured may be offered varying policy limits, riders, and amendments, but those are also adhesion alternatives that do not dramatically expand the range of choices available.”).

29. In fact, those who receive their health insurance through an employer have no opportunity to negotiate at all, since the employer is the actual purchaser of the contract. Since most Americans receive their health insurance through an employer, this means that most Americans have no say as to the terms contained in their health insurance contract. For data on the number of Americans who receive their health insurance through an employer, see Health Insurance Coverage of Nonelderly – Kaiser State Health Facts (2008),

B. Unreadability

One of the defining characteristics of contracts of adhesion, and insurance contracts in particular, is that they are unreadable. There appears to be total consensus on this point. Law professors,³⁰ treatises,³¹ commentators³² and the *Restatement*

<http://www.statehealthfacts.org/comparetable.jsp?ind=126&cat=3> (concluding that in 2008, approximately sixty percent of this country's nonelderly population was covered by an employer-based health plan). The detachment of the employee from the negotiation process also exists in the case of self-funded employer health plans, since the plan documents, with their standard terms, are typically generated by a third-party administrator, usually an insurance company. A self-insured plan is not based on an insurance contract with an insurer, but is instead funded by an employer (i.e., the employer pays claims covered by the benefit plan from its own money). Courtney Lyons Snyder, *Cost Containment May Have A Price, But Is It A Crime? Analyzing The Basis For Criminalizing Managed Care Conduct*, 70 U. PITT. L. REV. 301, 315 n.95 (2008).

30. See, e.g., Feinman, *supra* note 24 ("The document typically is not read by the insured and, in significant part, is not likely to be understood if it is read . . ."); John Dwight Ingram, *The Insured's Expectations Should Be Honored Only If They Are Reasonable*, 23 WM. MITCHELL L. REV. 813, 841 (1997) ("We probably must accept the fact that most insureds will not voluntarily read their policies and, at most, merely will scan the first page."); Robert H. Jerry II, *Consent, Contract, and the Responsibilities of Insurance Defense Counsel*, 4 CONN. INS. L.J. 153, 171 (1997) ("Insureds rarely read their policies until they have a reason to do so, and even then they are unlikely to understand much of what they read."); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against The Drafter*, 30 GA. L. REV. 171, 174 (1995) ("Most consumers do not read their policies and would not understand them if they did.").

31. 16A JOHN ALAN APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 8843, at 231 (West Publishing Co., rev. vol. 1981) ("[T]he great majority of persons never read their [insurance] policies, and 90% of those who do read them, including attorneys and jurists, would not understand them.").

32. See Amy D. Cabbage, *The Interaction of the Doctrine of Reasonable Expectations and Ambiguity in Drafting: The Development of the Kentucky Formulation*, 85 KY. L.J. 435, 436 (1997) ("Given the incomprehensibility of the language in many insurance policies, it is not surprising that most people do not even bother to read their policies."); James A. Collier, *Readability in Insurance: An Analysis of the Comprehension of New Policies*, 8 J. INS. ISSUES 79, 79 (1985) ("Nobody really believes that insurance policyholders read their policies when they are delivered . . ."); Forrest E. Harding, *The Standard Automobile Insurance Policy: A Study of its Readability*, J. RISK & INS. 39, 39 (1967) (finding that the reading level of the standard automobile insurance policy "was well beyond the reading ability of a significant percentage of the United States adult population.").

(*Second*) of *Contracts*³³ all concede that people do not read their insurance contracts, due in large part to the complexity of the contracts. Perhaps the most colorful explanation of why an insured might not read her insurance contract was written over a hundred years ago by Justice Doe of the New Hampshire Supreme Court at a time when the U.S. insurance industry was still in its adolescence:

Forms of applications and policies (like those used in this case), of a most complicated and elaborate structure, were prepared, and filled with covenants, exceptions, stipulations, provisos, rules, regulations and conditions, rendering the policy void in a great number of contingencies. These provisions were of such bulk and character that they would not be understood by men in general, even if subjected to a careful and laborious study; by men in general, they were sure not to be studied at all. The study of them was rendered particularly unattractive, by a profuse intermixture of discourses on subjects in which a premium payer would have no interest. The compound, if read by him, would, unless he were an extraordinary man, be an inexplicable riddle, a mere flood of darkness and confusion. Some of the most material stipulations were concealed in a mass of rubbish, on the back side of the policy and the following page, where few would expect to find anything more than a dull appendix, and where scarcely any one would think of looking for information so important as that the company claimed a special exemption from the operation of the general law of the land relating to the only business in which the company professed to be engaged. As if it were feared that, notwithstanding these discouraging circumstances, some extremely eccentric person might attempt to examine and understand the meaning of the involved and intricate net in which he was

33. RESTATEMENT (SECOND) OF CONTRACTS § 211 cmt. b (1981) ("A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even to read the standard terms. . . . Customers do not in fact ordinarily understand or even read the standard terms.").

to be entangled, it was printed in such small type, and in lines so long and so crowded, that the perusal of it was made physically difficult, painful, and injurious. Seldom has the art of typography been so successfully diverted from the diffusion of knowledge to the suppression of it.³⁴

Sadly, this sorry state of affairs has not changed much since Justice Doe wrote his assessment of insurance policies in 1873. Similar sentiments (though slightly less effusive) have been echoed by many other judges, who have readily recognized that insureds rarely, if ever, read their policies and would not understand them if they did.³⁵

Despite the universally held understanding that insurance contracts are unreadable, there have only been limited efforts to address the problem *ex ante*.³⁶ Quite to the contrary, unreadable insurance contracts have been allowed to proliferate, subject only to *ex post* judicial governance through two main canons of

34. *DeLancey v. Insurance Co.*, 52 N.H. 581, 587-88, 1873 WL 4180 at *7 (N.H. June, 1873).

35. *See, e.g.*, *State Security Life Ins. Co. v. Kintner*, 185 N.E.2d 527, 532 (Ind. 1962) (Arterburn, C.J., concurring) ("even if the insured had the inclination to attempt to read the policy, I doubt that he would gain much more knowledge than he previously had because of the technical language he would encounter. I doubt that most lawyers or even judges (who say one is presumed to have read his insurance policy) ever read them."); *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169, 174 (Iowa 1975) ("It is generally recognized the insured will not read the detailed, cross-referenced, standardized, mass-produced insurance form, nor understand it if he does."); *John Hancock Mut. Life Ins. Co. v. Schwarzer*, 237 N.E.2d 50, 53 n.3 (Mass. 1968) (recognizing that the "everyday" purchaser of insurance "seldom reads the policy and application, either because he cannot understand its detailed and technical terms, or because of a failure to realize its importance."); *Rory v. Continental Ins. Co.*, 703 N.W.2d 23, 56 (Mich. 2005) (Weaver, J., dissenting) ("Even if the insured were to read the policy, insurance policies are not easy to understand and contain obscure provisions, the meaning of which requires legal education to grasp."); *Atwater Creamery Co. v. W. Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 277 (Minn. 1985) (recognizing that a layperson may not be able to read and understand insurance policies); *Kelly v. Painter*, 504 S.E.2d 171, 176 n.2 (W.Va. 1998) ("We do not seriously expect that an insurance consumer will carefully read and understand an insurance policy."); *Dowhower ex rel. Rosenberg v. West Bend Mut. Ins. Co.*, 613 N.W.2d 557, 567 (Wis. 2000) ("Even people who do read their insurance policies often do not understand these contracts.").

36. *See e.g.*, *infra* note 105 and accompanying text (although many states have enacted readability standards, those standards are universally higher than the reading level of the average adult).

contract construction: *contra proferentem* and the doctrine of reasonable expectations.

1. Contra Proferentem

Although the *contra proferentem* doctrine “has long existed in most Romanistic, common law, and code-based regimes,”³⁷ the ascent of the U.S. insurance industry in the nineteenth century, the proliferation of standard form agreements in the U.S. economy in the early twentieth century, and an influential 1943 law review article by Friedrich Kessler³⁸ propelled the doctrine to prominence.³⁹ Kessler’s article highlighted the economic disparity between the drafters and recipients of contracts of adhesion, which, in Kessler’s view, gave rise to oppressive contract terms.⁴⁰ Kessler’s view struck a chord with judges, “who began to regard mass-produced form contracts with skepticism,”⁴¹ and began to apply *contra proferentem* against the drafters of such contracts. *Contra proferentem* remains a popular approach to the judicial governance of adhesion contracts and is used by virtually all courts,⁴² including Rhode Island.

Under the doctrine, once a court determines that a term in a contract is ambiguous or susceptible of more than one meaning, the term is construed against the drafter.⁴³ However, unless a

37. David Horton, *Flipping the Script: Contra Proferentem and Standard Form Contracts*, 80 U. COLO. L. REV. 431, 438 (2009).

38. Friedrich Kessler, *Contracts of Adhesion – Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 629 (1943).

39. Horton, *supra* note 37, at 440-44.

40. *Id.* at 444.

41. *Id.* at 444-45.

42. Stephen J. Ware, *A Critique of the Reasonable Expectations Doctrine*, 56 U. CHI. L. REV. 1461, 1464-65 (1989). *See also* Ingram, *supra* note 30, at 816 (explaining that “most, if not all, courts apply the rule of *contra proferentem*” to adhesion contracts).

43. *See* R.I. Hosp. Trust Nat’l Bank v. McKee Bros. Oil Corp., 649 A.2d 511, 511 (R.I. 1994); West v. Commercial Ins. Co. of Newark, N.J., 528 A.2d 339, 341 n.2 (R.I. 1987) (noting that insurance policy language that is ambiguous or susceptible of more than one reasonable interpretation will be strictly construed against the insurer); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 206 (1981) (“In choosing among the reasonable meanings of a promise or agreement or a term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.”); Kelly E. Noble, *National Refrigeration, Inc. et al. v. The Travelers Indem. Co. of America et al.*, 14 ROGER WILLIAMS U. L.

court finds that the term in question is ambiguous, normal contract rules apply.⁴⁴ If the term is not ambiguous, the court will apply the contract term as written, and the parties will be bound by that term.⁴⁵ Thus, the doctrine will not apply to a dispute arising from an unambiguous term, even if the term is unreadable, buried in the contract, or cannot be understood by an insured.⁴⁶ In other words, a term such as subrogation that is unambiguous technically but not understandable by many insureds may be the subject of a dispute, but *contra proferentem* will not help the insured. This creates a paradox or perhaps a convenient fiction.

Even judges agree that insurance contracts are contracts of adhesion, that they are not the product of a “meeting of the minds,” that they are the product of uneven bargaining power, that they are sold on a take-it-or-leave-it-basis, and that they are unreadable. Nevertheless, unless the terms of a policy are ambiguous, courts will enforce the terms of the policy as if it were a contract that was the product of negotiation by parties on a level playing field. To make matters worse, even if courts could maintain the fiction that insurance policies are contracts for the purposes of enforcement, there is the additional fact that anyone who has ever purchased insurance can attest to: Insurance contracts are not delivered to the insured until after the policy has been purchased.⁴⁷ Thus an insured never has the opportunity to read and agree to the terms of the contract before they bind her.

2. Reasonable Expectations

The reasonable expectations doctrine, first articulated by

REV. 417, 424 (2009) (noting that Rhode Island courts typically construe contracts of adhesion against the drafter).

44. *West*, 528 A.2d at 341 n.2.

45. *Malo v. Aetna Cas. & Sur. Co.*, 459 A.2d 954, 956 (R.I. 1983).

46. *See Rivera v. Gagnon*, 847 A.2d 280, 285 (R.I. 2004) (“[I]t is well established that ‘a party who signs an instrument manifests his assent to it and cannot later complain that he did not read the instrument or that he did not understand its contents.’” (quoting *Kottis v. Cerilli*, 612 A.2d 661, 668 (R.I. 1992))).

47. *See* Feinman, *supra* note 24; Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 968 (1970); Slawson, *supra* note 25, at 540.

Robert Keeton⁴⁸ in his seminal 1970 Harvard Law Review article,⁴⁹ attempts to honor the “objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts . . . even though painstaking study of the policy provisions would have negated those expectations.”⁵⁰ Under the doctrine, courts can “ignore terms that the insured had justly not thought to be part of the policy.”⁵¹ Since a major justification of the doctrine of reasonable expectations is the universally accepted idea that most policyholders do not read their policies after they receive them,⁵² the reasonable expectations doctrine appears to address the gaping deficiency of the doctrine of *contra proferentem*. This, however, is not the case in Rhode Island.

Although initially accepted⁵³ and recognized in the *Restatement (Second) of Contracts*,⁵⁴ courts “began to invoke the reasonable expectations doctrine in wildly different ways.”⁵⁵ Some courts applied a hypothetical reasonable expectation, some applied the insured’s own subjective expectations, some used the doctrine to exclude unambiguous but hidden provisions, and others required an ambiguity before the doctrine could be applied.⁵⁶ Rhode Island has embraced the last of these approaches.

The Rhode Island Supreme Court first recognized the doctrine in *Elliott Leases Cars, Inc. v. Quigley*.⁵⁷ In *Elliott*, the Court found that the contract of adhesion in question created “a reasonable expectation of coverage,” despite contradictory language and held that the contract obligated the drafter to provide insurance to the purchaser.⁵⁸ As a result, Rhode Island

48. Horton, *supra* note 37, at 449.

49. Keeton, *supra* note 47.

50. *Id.* at 967.

51. Horton, *supra* note 37, at 446.

52. Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders’ Objectively Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L.J. 335, 363 (1998).

53. Horton, *supra* note 37, at 450.

54. RESTATEMENT (SECOND) OF CONTRACTS § 211(3) (1981).

55. Horton, *supra* note 37, at 450.

56. *Id.* at 450 & nn.104-08 (collecting cases).

57. 373 A.2d 810, 814 (R.I. 1977).

58. *Id.* at 814 n.1 (“[T]he objectively reasonable expectations of one who enters a contract of adhesion will be enforced, despite the existence of

initially appeared to have adopted without limitation the doctrine of reasonable expectations with respect to contracts of adhesion.⁵⁹ This precedent would not last. The doctrine was subsequently watered down and its application limited to insurance contracts requiring the interpretation of ambiguous or conflicting provisions,⁶⁰ thereby blending the doctrine of reasonable expectations with the doctrine of *contra proferentem*.⁶¹ In the end, Rhode Island's reasonable expectations doctrine suffers from the same disability as its doctrine of *contra proferentem*; the reasonable expectations doctrine does nothing to address problems arising from an unreadable insurance policy.

3. The Limits of Ex Post Judicial Governance

The doctrine of reasonable expectations and the doctrine of *contra proferentem*, ex post judicial interventions intended to remedy the harm to consumers from contracts of adhesion, spring from a vision of contract law that seeks to "identify conditions under which opportunism is likely to flower and . . . emphasize[s] the role of contract institutions and contract law as ex post governance mechanisms for controlling opportunism."⁶² While commentators have argued that these doctrines encourage

contrary contract provisions.").

59. *Id.* (noting that the result "is consistent with the position adopted in a growing number of jurisdictions that the objectively reasonable expectations of one who enters a contract of adhesion will be enforced, despite the existence of contrary contract provisions.") (citing Keeton, *supra* note 47, at 967 and cases from other jurisdictions). Oddly, though, the Court seemed to simultaneously embrace the doctrine and hold it at arm's length when it stated at the bottom of the same footnote:

In the present case there is no need to pass on the general validity of the above rule of law, and reference to the foregoing cases is not intended as an unequivocal endorsement. We do feel, however, that those cases reflect the importance which should be attached to the objectively reasonable expectations of purchasers in situations such as that presented in the case at bar. *Id.*

60. *St. Paul Fire & Marine Ins. Co. v. Russo Bros., Inc.*, 641 A.2d 1297, 1300-01 (R.I. 1994).

61. *Anderson & Fournier*, *supra* note 52, at 353 & n.57 (noting that Rhode Island and several other states combine the two doctrines and providing a list of states that recognize some variation of the reasonable expectations doctrine).

62. Bob Works, *Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as Test Case*, 5 CONN. INS. L.J. 505, 553-55 (1998-99).

insurers to draft better, less surprising or ambiguous contracts in order to avoid liability, the limitations of both doctrines are apparent.⁶³ Moreover, such arguments offer little consolation to an insured since “she still has to go to court and litigate the issue against the drafter, who is probably a repeat player and thus has economies of scale and a much greater incentive to litigate the specific issue.”⁶⁴

Yet, this burden on insureds does not seem to generate much sympathy in the courts. After all, contracts of adhesion do provide some benefits. Standardized terms reduce transaction costs, stabilize business practices, ensure consistency, and promote predictability for the drafter. In theory, this saves the drafter time and money.⁶⁵ Perhaps courts consider these efficiencies as a counterbalance to the pitfalls and inequities of contracts of adhesion. Indeed, one might ask, “Why then do we care if health insurance contracts are readable or not?” After all, insurance contracts are all equally unreadable and health insurance contracts should be treated no differently by the courts than other types of insurance contracts. However, as discussed in the next section, health insurance contracts are fundamentally different from all other insurance contracts in that they are *contracts of recurring use*. Consequently, ex ante governance is needed—health insurance contracts must be made readable in the first instance.

II. HEALTH INSURANCE AND CONTRACTS OF RECURRING USE

There are several commonly understood ways in which health insurance differs from other kinds of insurance. For example, health insurance provides the types of benefits we do not expect from other types of insurance contracts. Health insurance also typically requires that its benefits be obtained from a limited list

63. See, e.g., Keeton, *supra* note 47, at 968 (reasonable expectations); Noble, *supra* note 43, at 424-25 (“Construing contracts against the insurance company forces the insurance company to swallow any ambiguities, driving them to be the more responsible and careful party in the transaction.”) (*contra proferentem*).

64. Linzer, *supra* note 26, at 207-08.

65. See RESTATEMENT (SECOND) OF CONTRACTS § 211 cmt. a (1981); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1174, 1221-22 (1983).

of health care providers because insurers and health care providers enter into relationships that are not present between insurers and third parties for other types of insurance. Finally, health insurance provides insureds continuous coverage.

Health insurance is also different from other types of insurance in less commonly understood ways. For example, health insurance contracts are repeatedly referenced. In other words, health insurance contracts (and their supporting materials, such as “quick references” or “benefit summaries”) are used repeatedly as reference guides. Consumers, especially when they are sick, reference their health insurance policies repeatedly to determine what is and what is not covered. Health insurance policies also operate as financing mechanisms for health care—i.e., they dictate the terms under which medical diagnoses, tests, and procedures are covered and then finance those covered procedures.

A. Commonly Understood Reasons Why Health Insurance is Different

Health insurance,⁶⁶ unlike automobile insurance, typically covers the cost of predictable expenses and maintenance care. If this were also the standard for automobile insurance, we would expect an automobile insurer to cover the cost of a tune-up, installation of an alternator belt, the purchase of new tires, or the replacement of a burned out headlight. In the health insurance context, routine health care, such as checkups, child “well visits,” mammograms, maternity-related care, and cholesterol screenings are commonplace.⁶⁷ Indeed, potential purchasers of health

66. The term health insurance generally refers to insurance providing so-called “comprehensive coverage.” Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL’Y 1, 27 (2005). Of course, the term “comprehensive” has different meanings under different policies. There is still, however, a viable market for limited benefit health insurance products. These products include so-called “dread disease” policies, which are similar to life insurance and provide a stipulated benefit upon the diagnosis of certain “dread” diseases, and specified disease policies, which provide coverage for the treatment of a specific disease. These limited benefit plans are intended to supplement comprehensive coverage. Tara Arschin, *Battling Breast Cancer: New York’s Laws Are Not Enough*, 13 CARDOZO J.L. & GENDER 579, 588 (2007).

67. See, e.g., *Health Insurance Not Like Other Insurance*, UPI, Sept. 14,

insurance often look for and expect such predictable and recurring coverage.⁶⁸

Another commonly understood difference between health insurance and other types of insurance centers on the relationship between the insurers and the providers of services. Unlike automobile insurance where you may take your car to any number of collision repair centers, health insurance often limits whom we may use as providers. In automobile insurance, there are no networks or other limiting relationships that exist between insurer and a repair shop that affect the amount paid by the insured under the policy. Such policies only create a relationship and a set of obligations between the insured and the insurer. Thus, if an automobile is involved in an accident, the insured and an adjuster determine the cost of the repair. The insured (or the repair shop) is then either paid the negotiated amount (less any deductibles, which are the responsibility of the insured), or if the accident is major, the automobile is declared a total loss, the owner is reimbursed the book value of the automobile, and the automobile is sold by the insurer for salvage.⁶⁹ On the other hand, today most health insurance involves at least some aspect of managed care—the integration of health insurers and providers through networks of preferred providers⁷⁰—the purpose of which

2009, available at http://www.upi.com/Health_News/2009/09/14/Health-insurance-not-like-other-insurance/UPI-77921252954497; Larry Van Horn, *What If Health Coverage Was Like Other Insurance?*, MODERN HEALTHCARE, Oct. 6, 2009, available at <http://www.modernhealthcare.com/article/20091006/REG/910069997>; Zach Krajacic, *Why Can't Health Insurance Be More Like Auto Insurance?*, CHRISTIAN SCI. MONITOR, Aug. 5, 2009, available at <http://www.csmonitor.com/Commentary/Opinion/2009/0805/p09s02-coop.html>.

68. See Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1969 n.142 (2003) (noting that healthy patients tend to investigate managed health care quality in terms of low cost, standard offerings like vaccinations, well-visits, and maternity-related care (citing Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 40-44, 60-62 (1999))).

69. David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance* 34 (Nat'l Bureau of Econ. Research, Working Paper No. 7176, 1999), available at <http://www.nber.org/papers/w7176>.

70. Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About*

is "to allow the insurer to cover its beneficiaries' expenses on a negotiated schedule below the prevailing market rate."⁷¹ This integration "is virtually unheard of in insurance of other types"⁷² and places an increased burden on those with health insurance to use their health coverage in a way that will maximize their benefits. In other words, insureds must understand their network and its limitations or they risk reduced or denied benefits.⁷³

This scenario raises yet a third commonly understood difference between health insurance and automobile insurance—continuing coverage. A crashed automobile can be "totaled." When this happens, an insured does not collect more than the actual cash value of the automobile but is instead restored to approximately the same financial position she had before the accident—i.e., she is paid the book value. This is not the case with health insurance. While an automobile insurer can avoid cost-ineffective repairs to a severely damaged automobile by declaring it a total loss and making a fixed payment, this type of claims system cannot work with health care. "Totaling" a human body is not an option for the very sick.⁷⁴ Even in the case of high-cost chronically ill, severely injured, or dying patients, covered claims are required to be paid up to any annual or lifetime caps.

In addition to the three properties described above (coverage for predictable and recurring claims, network limitations that constrain coverage, and continuing coverage for high-cost patients), there is another reason why health insurance is different—we use it constantly. Unlike an automobile policy that

"Managed Care", 32 U. MICH. J.L. REFORM 661, 669-70 (1999) (noting an industry estimate that only two percent of private health plans are traditional fee-for-service indemnity insurance, another sixteen percent are fee-for-service but employ some form of utilization review and concluding that "between eighty and ninety-eight percent of today's private health insurers appear to fall into the broad category of managed care.").

71. *Geddes v. United Staffing Alliance Employee Med. Plan*, 469 F.3d 919, 930 (10th Cir. 2006). See also Cutler & Zeckhauser, *supra* note 69, at 35 ("Managed care partly represents a price club. In exchange for an up-front fee, the patient gets to purchase goods at a significant discount. The discounts are secured through bulk purchase bargaining, or by directly hiring the sellers. In exchange for lower prices, patients precommit to receive care from a limited set of providers, or to pay harshly for the privilege of going elsewhere.").

72. Cutler & Zeckhauser, *supra* note 69.

73. See *id.* at 35.

74. See *id.* at 34.

may be used only a few times over the life of an automobile, if at all, a health insurance policy is a *contract of recurring use*. Claims are made more frequently under health insurance policies than under any other types of insurance policies because our use of health care services is routine. Some basic statistics bear this fact out. Eighty-three percent of Americans had contact with a health professional in 2006.⁷⁵ In that same year, the average American saw a doctor three times,⁷⁶ 119.2 million people went to the emergency room,⁷⁷ and 34.9 million people were admitted to (and were discharged from) a hospital. Their average length of stay was nearly five days.⁷⁸ In most of these instances, consumers relied on their health insurance to cover the cost of medical procedures. Given that consumers repeatedly draw on their health insurance in such instances, the ability to understand and use a health insurance contract—with all of its terms of coverage, network constraints, cost sharing requirements (e.g., deductibles and coinsurance), exclusions, riders, endorsements and coverage limits—is critical for insureds. Health insurance requires *continued and repeated efforts to understand the terms and limits of the policy in order to ensure that services will be covered*.

B. Less Commonly Understood Reasons Why Health Insurance is Different

Yet, there is an even more fundamental set of reasons why health insurance is different from other types of insurance—reasons that focus on the economics behind health insurance coverage. Health insurance contracts not only provide a hedge against risk but they also finance health care. Standard economic theory suggests that, subject to budget constraints, risk-averse individuals will purchase insurance to maximize their utility in the face of uncertainty. In other words, in the face of an unknown future, individuals would rather purchase insurance and take a

75. NAT'L CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH: UNITED STATES 340 (2009), *available at* <http://www.cdc.gov/nchs/fastats/docvisit.htm> (last visited Mar. 24, 2010).

76. *See id.*

77. *Id.* at 341.

78. Hospital Utilization (in Non-Federal Short-Stay Hospitals), Centers for Disease Control and Prevention, <http://www.cdc.gov/nchs/fastats/hospital.htm> (last visited Mar. 24, 2010).

certain, moderate monetary loss in exchange for a hedge against a large financial loss resulting from an unexpected accident, illness, or injury.⁷⁹ The risk that any one individual will need expensive health care in any given year may be fairly small, yet the potential financial consequences associated with that risk could be great. An otherwise healthy individual can have an accident, break a few bones, and spend few weeks in the hospital and, without health insurance, might have to use up her life savings to pay for her health care.⁸⁰

In this respect, health care stands in stark contrast to many of life's necessities, such as food, clothing and shelter. An individual's need for these necessities is quite foreseeable and, therefore, her expenditures on these things can be predicted.⁸¹ On the other hand, except for those with chronic conditions, an individual's expected health care expenditures are largely unknown beyond routine care, such as yearly check-ups.⁸² Thus, in one respect, an individual buys health insurance for the same reason she buys comprehensive automobile insurance: to protect against risk.⁸³ In the case of automobile insurance, a purchaser is insuring against the risk of financial consequences that could result from future damage to her automobile. In the case of health insurance, she is insuring against the risk of financial consequences that might result from future illness or injury.⁸⁴ This is the so-called *risk-avoidance value* of purchasing insurance⁸⁵ and is a common basis for the purchase of insurance.

The decision to purchase health insurance, however, involves much more than fear of large financial loss. One feature that distinguishes health insurance from other types of insurance—and makes it attractive to a potential purchaser—is its capability to

79. See Todd Gilmer & Richard Kronick, *It's the Premiums, Stupid: Projections of the Uninsured Through 2013*, HEALTH AFF., Apr. 5, 2005, at W5-143, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.143v1.pdf>.

80. Cutler & Zeckhauser, *supra* note 69, at 9.

81. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 943 (1963).

82. See *id.* at 941.

83. Willard G. Manning & M. Susan Marquis, *Health Insurance: The Tradeoff Between Risk Pooling and Moral Hazard*, 15 J. HEALTH ECON. 609, 609-10 (1996).

84. John A. Nyman, *The Value of Health Insurance: The Access Motive*, 18 J. HEALTH ECON. 141, 141-42 (1999). See Arrow, *supra* note 81.

85. Nyman, *supra* note 84, at 142.

finance health care through transfers of income within a given risk pool. This capability offers putative health insurance consumers two additional values beyond risk avoidance: access value and a security value.

1. The Access Value of Health Insurance

Health insurance offers access to expensive health care that would not otherwise be affordable to an individual.⁸⁶ This *access value* of health insurance is different from the *risk-avoidance value* of health insurance because, for all but the very wealthy, there is no financial risk for extremely high-cost health care purchases. Most people simply cannot afford to purchase such care and the typical means of accumulating money to purchase an expensive medical procedure are not typically available when health care is needed. In other words, there may not be sufficient income or time to save for a high-cost health care purchase. A bank is likely to be reluctant to lend money for a high-cost health care purchase, particularly when the borrower's ability to secure the loan or repay is limited. Thus, health insurance is, in most cases, the only mechanism available for accessing such health care.⁸⁷ This situation creates a value to and a demand for health insurance that is non-existent in other types of insurance.⁸⁸ Recall that most other types of insurance act to indemnify against a loss; they are designed to restore the insured to the financial position she enjoyed just prior to the loss. This is not the case with health insurance, which is typically designed to cover the cost of health care that is "medically necessary" to the diagnosis or treatment of an injury or illness covered by the insured's policy.⁸⁹

86. *Id.* at 142-43.

87. *Id.*

88. See Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Health Care Spending*, 11 YALE J. ON REG. 455, 460 (1994) ("[T]he uncertainty of the need for medical care, coupled with the devastatingly high cost of treatment, creates a vigorous demand for health insurance.").

89. CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 125-32, 140-43 (Am. Enter. Inst. Press 1995) (most health insurance contracts cover medically necessary services subject to specific coverage exclusions); Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1376 (1994) ("The language of

Absent the financial limitations typically present in other types of insurance, health insurance becomes a means of access to high-cost, otherwise unaffordable health care. Consequently, people finance their health care purchases through additional health insurance-generated income obtained from the risk pool (i.e., the other insureds they are grouped with by the insurance company).⁹⁰ An extreme example would be someone who requires multiple organ transplants (e.g., a heart-lung transplant) and years of follow-up care. Very few can afford such treatment absent health insurance, yet we would expect our health insurance to cover precisely that type of health care if we need it.

Thus, the benefits of health insurance exceed mere avoidance of financial risk by a risk-averse purchaser; the benefits of health insurance include access to health care that would not otherwise be accessible, hence the *access value* of health insurance.⁹¹

2. The Security Value of Health Insurance

Health insurance is also purchased to protect against the risk of persistently higher future expenses in the case of chronic illness.⁹² This *security value* of health insurance is somewhat similar to the access value of health insurance in that it ensures future access to high-cost health care, but the type of care that is made available through the *security value* of health insurance is not necessarily the completely unaffordable health care the *access value* targets. Instead, the *security value* provides access for expected high (but not necessarily astronomical) costs, like those associated with a chronic condition. Indeed, obtaining insurance as a hedge against the expected costs of a chronic condition is a central reason why Americans purchase health insurance. According to the federal Centers for Disease Control and Prevention, the risks posed by chronic conditions are staggering: Almost half of all Americans live with at least one chronic

'medically necessary' is currently common in health insurance contracts, and 'medically necessary' is often interpreted broadly as meaning 'medically appropriate' rather than 'medically imperative.'").

90. John A. Nyman, *Is 'Moral Hazard' Inefficient? The Policy Implications of a New Theory*, 23 HEALTH AFF. 194, 196 (2004).

91. See Nyman, *supra* note 84, at 142-45.

92. Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, HEALTH AFF., Oct. 21, 2008, at W534, <http://content.healthaffairs.org/cgi/content/abstract/27/6/w533>.

condition, chronic diseases account for seventy percent of all deaths in the United States, and health care costs associated with chronic diseases account for more than seventy-five percent of the nation's health care costs.⁹³ For those with chronic conditions who are able to obtain health insurance, coverage can provide significant financial security in the face of predictable, expensive health care costs. For insureds who suffer chronic conditions, the value of health insurance is not only measured in terms of its risk and access values, it is also measured in terms of the expected security value against predictable, long-term, and expensive health care costs.

3. Health Insurance as a Financing Mechanism

Recognition of the access value and security value of health insurance leads to the inescapable conclusion that health insurance does much more than provide a hedge against risk: It operates as a financing mechanism. National data on health care spending confirms this conclusion. The data demonstrate that health insurance has displaced out-of-pocket expenses as the dominant source of private payments for health care. In 1960, out-of-pocket payments accounted for over two-thirds of the private payments spent to provide all health care to individuals, while health insurance accounted for a little over one-quarter of such payments. Less than fifty years later, these proportions are completely reversed. In 2007, out-of-pocket payments only accounted for about a quarter of the private payments spent to provide all health care to individuals, while health insurance payments had grown to about two-thirds of all private health expenditures to provide health care to individuals.⁹⁴

93. Chronic Diseases and Health Promotion, Chronic Disease Overview, Centers for Disease Control and Prevention, <http://www.cdc.gov/NCCdphp/overview.htm> (last visited Mar. 24, 2010).

94. CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, NATIONAL HEALTH EXPENDITURES, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (follow "National Health Expenditures by type of service and source of funds, CY 1960-2008 (ZIP, 41KB)" hyperlink). The figures reflect "Personal Health Care Expenditures." *See also* CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, NATIONAL HEALTH EXPENDITURES ACCOUNTS: DEFINITIONS, SOURCES, AND METHODS 3 (2007), *available at*

The problems associated with contracts of adhesion (uneven bargaining power, oppressive terms, and widely recognized lack of readability), the lack of effective ex post judicial governance of such contracts, and the constellation of factors that set health insurance apart from other types of insurance (coverage for predictable claims, network limitations, the access and security values, the financing function, and the recurring use of health insurance contracts) make imperative a “front-end” effort to provide more robust protections for consumers of health insurance. This need for an ex ante solution was the impetus for the development of Rhode Island’s requirement that insurers improve the readability of health insurance contracts.

III. RHODE ISLAND’S READABILITY REQUIREMENT FOR HEALTH INSURANCE POLICIES

Under the *Standards for Readability of Health Insurance Forms*, beginning in August 30, 2010, all health insurance policies issued or renewed in Rhode Island will have to be written at the eighth grade level.⁹⁵ At that time all health insurance companies will be required to certify that the text of any policy⁹⁶ “does not exceed the eighth-grade reading level as measured by the Flesch-Kincaid formula.”⁹⁷ All policies will also have to meet other requirements, such as a minimum font size, designed to improve readability.⁹⁸

http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (follow “Definitions, Sources, Methods (PDF, 35KB)” hyperlink) (defining “Personal Health Care Expenditures”).

95. Standards for Readability of Health Insurance Forms, 2-31-5 R.I. CODE R. (Weil 2010), *available at*

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/HICO/5768.pdf>.

96. The term “policy” means “all health insurance forms” required to be submitted to OHIC for approval, including, but not limited to “certificates of coverage, subscriber agreements, endorsements and modifications to contracts, policies, benefits booklets, and summary plan descriptions.” *Id.* § 3(a).

97. *Id.* § 5(a)(1). An insurer may use an alternate method or formula for assessing readability as long as the insurer can demonstrate that the alternate method or formula can be used to determine a reading level at or below the eighth grade reading level. *Id.* § 5(b).

98. The policy may not contain text of less than twelve-point type (with some exceptions), may not give undue prominence to any portion of the text, and must include a table of contents or an index if the policy has more than 3,000 word or is longer than three pages. *Id.* § 5(b)-(d).

Although Rhode Island is not the first state to impose a readability requirement on insurance contracts, it is the first state to impose a readability requirement for all health insurance policies that approaches the actual reading ability of its citizens. While readability formulas have been a mainstay of insurance regulation since the 1970s, most states have established a readability requirement well above the reading level of the average American adult.

A. Readability and Insurance Regulation

States began to first employ readability requirements for insurance contracts in the mid to late 1970s as a reaction to state and federal initiatives to promote subjective “plain language” standards for consumer contracts.⁹⁹ Insurance companies, however, were concerned about the possible imposition of subjective readability standards and were fearful that differing subjective standards in each state could lead to different readability determinations of the same policy language by different states. In 1977, the National Association of Insurance Commissioners (NAIC) created a task force to study and develop uniform standards for language simplification in life insurance policies.¹⁰⁰ At the time, three states had already begun to use an objective standard, the Flesch Reading Ease (FRE) formula,¹⁰¹ and the task force determined that the FRE should be part of the

99. Michael S. Friman, *Plain English Statutes*, 7 LOY. CONSUMER L. REP. 103, 105-106 (1995); Calvin J. Karlin, *Readability Statutes—A Survey and a Proposed Model*, 28 U. KAN. L. REV. 531, 532-535 (1980). For a brief history of the federal government’s use of plain language see Joanne Locke, *A History of Plain Language in the United States Government* (2004), <http://www.plainlanguage.gov/whatisPL/history/locke.cfm>.

100. Karlin, *supra* note 99, at 537 n.40.

101. *Id.* at 535. The FRE formula calculates readability using two variables: the average number of syllables per word in texts and average sentence length measured in terms of the number of words per sentence. WILLIAM H. DUBAY, *THE PRINCIPLES OF READABILITY* 21-22 (2004), *available at* http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/1b/bf/46.pdf. The FRE formula yields a numeric index of reading difficulty ranging from 0 (unreadable) to 100 (very readable). The formula for the FRE is $206.835 - (84.6 * ASW) - (1.015 * ASL)$, where ASW is the average number of syllables per word and ASL is the average sentence length, determined by the number of words per sentence. *Id.*

NAIC's model act.¹⁰² However, the new model act required only a score of 40 on the FRE¹⁰³—i.e., a thirteenth grade reading level.¹⁰⁴ While this score resulted in somewhat improved readability of policies, policies remained written at a college reading level, far above the reading level of most average policyholders. Since then, thirty-three states (not including Rhode Island) have adopted objective readability standards based on the FRE, with scores generally ranging from fifty to forty.¹⁰⁵ These

102. Karlin, *supra* note 99, at 534-36.

103. *Id.* at 536.

104. DUBAY, *supra* note 101, at 22. A forty on the FRE is equivalent to a thirteenth grade level, that of a college freshman. *See Id.* Apparently, the task force was concerned that requiring a higher score, which would indicate a lower reading level, "might cause contrived sentence structure and word selection, thereby reducing clarity." Karlin, *supra* note 99, at 536. There is no indication how or why the committee came to this conclusion.

105. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1110.01 (2009) (Flesch score of 40 established by ARIZ. ADMIN. CODE §§ R20-6-201(C)(2), R20-6-213(C)(1)(a) (2008)); ARK. CODE ANN. § 23-80-206(a)(1) (2009) (Flesch score of 40); CONN. GEN. STAT. § 38a-297(a)(1) (2008) (Flesch score of 45); DEL. CODE ANN. tit. 18, § 2741(a) (2009) (Flesch score of 40 or more, however 40 or less may be approved provided the length of sentences and words comply with other standards); D.C. CODE § 31-4725(a)(1) (2009) (Flesch score of 40); FLA. STAT. § 627.4145(1)(a) (2009) (Flesch score of 45); GA. CODE ANN. § 33-3-25(b) (Flesch score of 40); HAW. REV. STAT. § 431:10-104(1) (2009) (Flesch score of 40); IND. CODE § 27-1-26-3(1) (2009) (Flesch score of 40); KY. REV. STAT. ANN. § 304.14-440(1) (LexisNexis 2009) (Flesch score of 40 established by 806 KY. ADMIN. REGS. 14:121 § 5(1)(2010)); ME. REV. STAT. ANN. tit. 24-A, § 2441.1.A (2009) (Flesch score of 50); MASS. GEN. LAWS ch. 175, § 2B(1)(a) (2009) (Flesch score of 50); MICH. COMP. LAWS § 500.2236(3)(a)-(c) (2009) (Flesch score of not less than 45); MONT. CODE ANN. § 33-15-325(1)(a) (2009) (Flesch score of 40); NEB. REV. STAT. § 44-3405(1)(a) (2009) (Flesch score of 40); NEV. REV. STAT. § 687B.124(1)(a) (2009) (Flesch score of 40); N.H. REV. STAT. ANN. § 420-H:5(I)(a) (2009) (Flesch score of 40); N.J. STAT. ANN. § 17B:17-21(a)(1) (West 2009) (Flesch score of 40); N.M. STAT. § 59A-19-4(A)(1) (2009) (Flesch score of 40); N.Y. INS. LAW § 3102(c)(1)(D) (Consol. 2009) (Flesch score of 45); N.C. GEN. STAT. § 58-38-30(b)(1) (2009) (Flesch score of 50 or more); N.D. CENT. CODE § 26.1-36-14(1)(a) (2009) (Flesch score of 40); OHIO REV. CODE ANN. § 3902.04(A)(1) (LexisNexis 2010) (Flesch score of 40); OKLA. STAT. tit. 36, § 3645(A)(1) (2009) (Flesch score of 40); OR. REV. STAT. § 743.106(1)(a) (2007) (Flesch score of 40 or more); S.C. CODE ANN. § 38-61-30 (2009) (Flesch score of 40 established by S.C. CODE ANN. REGS. 69-5.1(D)(1)(a) (2008); *but see* S.C. CODE ANN. 37-4-105(B) (2009) (seventh grade on the Flesch-Kincaid readability formula for credit life insurance and credit accident and sickness insurance)); S.D. CODIFIED LAWS § 58-11A-3(1) (Flesch score of 40); TENN. CODE ANN. § 56-7-1605(a)(1) (2009) (Flesch score of 40); TEX. INS. CODE ANN. § 1201.101 (2009) (Flesch score of 40 established for health benefit plans by 28 TEX. ADMIN. CODE § 3.602(b)(1) (2010); ninth grade readability standards

scores equate to tenth to thirteenth grade reading levels, respectively.¹⁰⁶ Again, even though these are improvements over policies written at a college or graduate reading level, they remain two to five reading grade levels above that of the average American adult.

B. Rhode Island's Standard

Committed to making health insurance policies that were truly readable, Rhode Island chose to chart a new path when establishing its *Standards for Readability of Health Insurance Forms*. One of the key decisions in developing the new regulation was in selecting the Flesch-Kincaid grade level formula rather than the FRE formula. The Flesch-Kincaid formula was chosen over the FRE because it is a more user-friendly measurement and a more accurate readability measurement for assessing complex technical writing, like that found in health insurance policies.

Like the FRE formula, the Flesch-Kincaid formula is calculated using two variables: the average number of syllables per word in texts and average sentence length measured in terms of the number of words per sentence.¹⁰⁷ The Flesch-Kincaid formula, a reformulation of the FRE formula originally developed to assess the readability of Navy technical manuals, converts the FRE's 0 to 100 score into an American grade level.¹⁰⁸ As such, the results of a calculation of the Flesch-Kincaid formula do not have to be correlated to a table to be understood. Thus, for example, a document that scores 8.2 using the Flesch-Kincaid formula is readable at the eighth grade level. Moreover, although the FRE is

using various formulae for individual accident and health policies established by 28 TEX. ADMIN. CODE § 3.3092(c)(1)-(2) (2009)); VA. CODE ANN. § 38.2-3735(F) (2009) (Flesch score of 40 or more); W. VA. CODE § 33-29-5(a)(1) (2009) (Flesch score of 40); WIS. STAT. § 631.22(2) (2009) (Flesch score of 50 for Medicare supplement policies and Flesch score of 40 for all other policies established by WIS. ADMIN. CODE INS. § 6.07(4)(a)(1) (2009).

106. DUBAY, *supra* note 101, at 27, 35-36, 38-44.

107. DUBAY, *supra* note 101, at 50. The formula for the Flesch-Kincaid score is $(0.39 * ASL) + (11.8 * ASW) - 15.59$, where ASL is the average sentence length, determined by the number of words per sentence, and ASW is the average number of syllables per word.

108. DUBAY, *supra* note 101, at 2; Louis J. Sirico, Jr., *Readability Studies: How Technocentrism Can Compromise Research and Legal Determinations*, 26 QUINNIPIAC L. REV. 147, 159 (2007).

widely used, it does not correlate perfectly with grade levels beyond the seventh grade. Beyond the seventh grade level, the FRE formula “increasingly underestimates the grade level” of the document tested, meaning that it could inaccurately score complex health insurance documents.¹⁰⁹ Finally, unlike the FRE formula, the Flesch-Kincaid formula was tested on technical materials¹¹⁰ and is therefore better suited for use with complex health insurance policies.

The second key decision in developing the new regulation was in mandating that all Rhode Island health insurance policies be written at or below an eighth grade reading level. As mentioned previously, most Rhode Island adults read at or below the eighth grade level. This requirement is also within the generally recommended readability standard for health-related legal documents, which generally range from fourth to eighth grade levels.¹¹¹ The readability results achievable under this standard

109. Sirico, *supra* note 108, at 159.

110. DuBAY, *supra* note 101, at 2, 51.

111. See, e.g., OFFICE OF INSPECTOR GENERAL, U.S. DEP'T HEALTH & HUMAN SERVS., REP. NO. OEI-06-01-00370, STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) RENEWAL PROCESS 3 (2002), available at <http://www.oig.hhs.gov/oei/reports/oei-06-01-00370.pdf> (noting that “[m]aterials written at the [seven]th to [eigh]th grade reading level are the standard for what is readable by and suitable for the general public.”); T. M. Grundner, *On the Readability of Surgical Consent Forms*, 302 NEW ENG. J. MED. 900, 901 (1980) (suggesting that adult consent forms should be at a maximum of a seventh or eighth grade level); Sharona Hoffman, *Regulating Clinical Research: Informed Consent, Privacy, and IRBs*, 31 CAP. U. L. REV. 71, 89 (2003) (recommending that informed consent documents be written at an eighth grade reading level); Michael K. Paasche-Orlow et al., *Readability Standards for Informed-Consent Forms as Compared with Actual Readability*, 348 NEW ENG. J. MED. 721, 725 (2003) (suggesting that a fourth to sixth grade reading level is a suitable target for consent forms for institutional review boards); Martha Williams-Deane & Linda S. Potter, *Current Analysis of Oral Contraceptive Use Instructions: An Analysis of Patient Package Inserts*, 24 FAM. PLAN. PERSP. 111, 114 (1992) (concluding that patient labeling should be drafted at the fifth or sixth grade level). A readability standard of the seventh to eighth grade level applicable to certain health coverage-related documents has already been required in some jurisdictions. See, e.g., MINN. STAT. ANN. § 144.056 (West 2010) (“To the extent reasonable and consistent with the goals of providing easily understandable and readable materials and complying with federal and state laws governing the program, all written materials relating to determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under a program administered or supervised by the commissioner of health must be understandable to a person who reads at the

can readily be seen by revisiting the examples set out at the beginning of this Article. Recall the “coordination of benefits” clause:

The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent’s spouse (i.e., stepparent), shall be primary over the plan covering the patient as a dependent of the parent without legal custody.

While a grade-level requirement can not fix everything that is wrong with this passage, the new requirement will force insurers to write shorter sentences and use smaller words, perhaps leading to a passage that reads more like this:

What happens if my spouse and I both have health coverage for our child?

If your child is covered under more than one insurance policy, the policy of the adult whose birthday is earlier in the year pays the claim first. For example: Your birthday is in March; your spouse’s birthday is in May. March

seventh-grade level”); Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carrier Performance During Fiscal Year 2004, 68 Fed. Reg. 74,613, 74,615 (Dec. 24, 2003) (noting that letters, decisions, or correspondence that go to Medicare beneficiaries from a Medicare contractor should be written below the eighth grade reading level “unless it is obvious that an incoming request from the beneficiary contains language written at a higher level”); Other Managed Care Health Plan Obligations, MINN. R. 9506.0400 (2009) (“A health plan shall provide each enrollee a certificate of coverage approved by the commissioner, a health plan identification card, a list of participating providers, and a description of the health plan complaint and appeal procedure. All written information provided enrollees must be understandable to a person reading at the seventh grade level”); Criteria for Medicaid Reimbursement of Care in Nursing Facilities, TENN. COMP. R. & REGS. 1200-13-1.10 (2010) (requiring sixth grade reading level notifications to Medicaid nursing facility residents).

comes earlier in the year than May, so your policy will pay for your child's claim first.

What happens if I am legally separated or divorced?

If your child is covered by your policy and also by the policy of your separated or divorced spouse, the policy of the parent with legal custody pays first. In other words, if you have legal custody, your plan pays first. The same rule applies even if your child is covered by a health insurance policy of a stepparent. For example: Your former spouse has legal custody, and his/her new spouse's policy covers your child. The new spouse's policy will pay your child's claim first.¹¹²

Recall the "subrogation" example:

In the event a third party, including your employer/agent, is or may be responsible for causing an illness or injury for which we provided any benefit or made any payment to you, we shall succeed to your right of recovery against such responsible party. This is our right of subrogation. If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name).

Under the new requirement, the passage might read like this:

Your injury or illness may have been caused by someone else. If so, we can collect from that person any claims we pay on your behalf. For example, if we pay for your hospital stay, we can collect the amount we paid for your hospital stay from the person who hurt you. We can also collect payment from that person even if he or she agreed to pay you directly or has been ordered by a court to pay you. If the person who caused your injury has already paid you, we can collect from you the amount he or she has already paid to you. This is called subrogation. In addition, if you do not try to collect money from the person who caused your injury, you agree to let us do so

112. Cogan, *supra* note 8.

in your name.¹¹³

Both revised passages are written at the seventh grade level.

C. Criticism of Readability Formulas

While developing this new policy, we were sensitive to the fact that readability formulas have been widely criticized.¹¹⁴ For example, critics of the formulas have argued that the readability formulas were developed for children,¹¹⁵ have never been adequately tested on adults,¹¹⁶ have not been formulated for or tested extensively on technical documents,¹¹⁷ ignore important features like content and organization,¹¹⁸ and have not been adequately validated.¹¹⁹ Many such criticisms are overstated and have been readily dismissed.¹²⁰ In fact, formulas such as the FRE and Flesch-Kinkaid formula were developed mainly for and have been extensively tested on adults.¹²¹ The Flesch-Kinkaid formula developed and tested using technical materials.¹²² Despite their limitations, the readability variables tested in the formulas remain the best predictors of text difficulty.¹²³ This does not mean that readability formulas are not without their flaws, but until a viable, objective alternate tool is developed to predict text difficulty, readability formulas like the Flesch-Kinkaid formula and FRE remain the best tools used to objectively assess the reading level of documents.¹²⁴

113. *Id.*

114. For a summary of criticisms, see DUBAY, *supra* note 101, at 27.

115. Jack Selzer, *Readability is a Four-Letter Word*, J. BUS. COMM., Oct. 1981, at 25-26.

116. *Id.* at 26

117. Janice C. Redish & Jack Selzer, *The Place of Readability Formulas in Technical Communication*, TECHNICAL COMM., Fourth Quarter 1985, at 47.

118. BERTRAM BRUCE ET AL., WHY READABILITY FORMULAS FAIL: READING EDUCATION REPORT NO. 28 4-5 (1981), *available at* http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/2e/30/47.pdf.

119. *Id.* at 5-6.

120. See DUBAY, *supra* note 101, at 27, 35-36, 38-44.

121. *Id.* at 27.

122. *Id.*

123. *Id.* at 36.

124. There is little doubt that the clarity of a document depends on factors that cannot be readily tested, such as "the intellectual complexity of the contents and the syntactical complexity of the writing style." Sirico, *supra*

CONCLUSION

Given the current complex health care environment, the widespread use of complicated cost-sharing mechanisms by health insurers, and the growing demand for consumers to take responsibility for their own health care, it is more important than ever for consumers to be able to read, understand, and effectively use their health insurance policies. Since health insurance contracts are quite different from other insurance contracts, traditional *ex post* judicial governance mechanisms associated with adhesion contracts, such as *contra proferentem* and the doctrine of reasonable expectations, provide inadequate protection for health insurance consumers. Thus, an *ex ante* solution is needed. Rhode Island's *ex ante* solution is a requirement that all health insurance policies be written at the eighth grade reading level, as measured by the Flesch-Kinkaid formula. Commercially available readability software not only makes this approach efficient for insurers and OHIC, it eliminates subjective judgments as to whether a policy is readable in the first instance. While an eighth grade readability requirement alone cannot fix all the problems associated with health insurance contracts, readability is a prerequisite to understandability and an appropriate starting point for determining whether a health insurance policy should be marketed in Rhode Island.¹²⁵

note 108, at 149. Furthermore, no one disputes that clarity can be achieved by using simple and familiar words, avoiding jargon, using culturally neutral language, using correct grammar and punctuation, using an active voice and present tense, and using simple graphic elements such as bulleted lists. DUBAY, *supra* note 101, at 2. In the case of state regulators, who must review and approve hundreds or thousands of submitted policies each year, an objective standard is the only practical approach to addressing readability.

125. See Root & Stableford, *supra* note 7, at 9 (discussing the need for appropriate readability levels in Medicaid managed care contracts they note, "[a]ppropriate readability does not assure a seal of approval, but without it, nothing else matters.").