

# **Healthcare Supplement**

to

## **Abraham's Insurance Law & Regulation (5<sup>th</sup> Edition 2010)**

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## **Note to Readers**

This Supplement integrates material addressing the U.S. healthcare reforms enacted into law in 2010 with the existing material in the casebook. The Supplement is designed to replace entirely pages 367 to the middle of page 404 of the casebook. The Supplement contains certain re-edited material that is included in the casebook (for example, the *Lawson*, *McGann*, and *Davilla* cases, as well as notes). It also contains new material concerning the healthcare legislation, interspersed at various points.

## **B. Health Insurance**

The most extensive healthcare reform legislation in United States history became law in the Spring of 2010. Some of the most important elements of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152 (collectively “PPACA”), fundamentally alter health insurance regulation. This is hardly surprising, as health insurance plays a central role in healthcare law and policy. Taken together, private health insurance and publicly-provided insurance programs such as Medicare and Medicaid fund well over two thirds of total national healthcare expenditures. See Insurance Information Institute, *The Insurance Fact Book 2010* at 14. A basic course in insurance law cannot provide a comprehensive understanding of this vast area, but it can survey the major insurance coverage issues that figure in the field.

### **1. THE BASIC STRUCTURE OF HEALTH INSURANCE MARKETS**

In many important ways, PPACA left unchanged the basic structure of health insurance markets. As was true before reform, individuals can acquire health insurance through three basic sources. First, a majority of the population – about 60% when PPACA was passed – secures health insurance through their own employer, a spouse’s employer, or a parent’s employer. Such employer-provided insurance can itself be subdivided into two categories. Some employers contract directly with a health insurer, who agrees to offer all employees a specific health insurance plan or set of plans. Alternatively, many large employers choose to “self-insure” by providing insurance directly to their employees. Even in such cases, employers often hire health insurers or other entities to administer this benefit.

The prominence of employer-provided health insurance dates back to the Second World War. At that time, wage controls and a labor shortage caused employers to compete for workers by offering group health insurance as a fringe benefit of employment. See Kenneth S. Abraham, *The Liability Century: Insurance and Tort Law from the Progressive Era to 9/11* 112-15 (2008). Between 1940 and 1960, the percentage of individuals who were covered by health insurance grew from 9 to 68 percent. Randall Bovbjerg et al., *U.S. Health Care Coverage Costs: Historical Development and Choices for the 1990's*, 21 *J. L. Med. & Ethics* 141 (1993).

There continue to be several advantages to this employer-based system that help to explain its persistence. Most importantly, employer-provided insurance enjoys various tax benefits. Employees can pay for coverage acquired through an employer with pre-tax dollars. Meanwhile, any contribution the employer makes to premiums is not treated as income to the employee and is deductible to the employer as a business expense. Employer-based coverage also generates comparatively low administrative costs because of the economies of scale that are associated with purchasing insurance on a group basis. It also helps to reduce adverse selection as being hired is a pre-condition of obtaining coverage but generally does not correlate with an individual’s health status. Finally, the

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 110 Stat. 1936, codified in various sections of Titles 18, 26, 29, and 42 U.S.C., (which predates PPACA) prohibits any underwriting within employer groups (though it does permit insurers to underwrite based on the collective characteristics of different groups). As a result, all similarly-situated employees of a given employer must be offered health insurance on the same terms, irrespective of their age, medical history, claims experience, or any other factors.

A second source of insurance is the individual market. In the individual market, individuals purchase health insurance just as they usually purchase homeowners or automobile insurance: by directly acquiring coverage from a private carrier. Unlike employer-provided health insurance, individuals must pay for such insurance with after-tax dollars, even after passage of PPACA. Additionally, the non-discrimination provisions of HIPAA do not apply to individual insurance markets. As a result, prior to PPACA, competitive pressures caused insurers to individually rate applicants based on their age, medical experience, claims history, and various other factors. Applicants with chronic, pre-existing conditions might be denied coverage entirely or offered coverage only at exorbitant rates. The only constraints on insurers' capacity to medically underwrite were state laws, which varied dramatically. Whereas some states maintained guaranteed issue laws and statutorily limited permissible underwriting factors, others gave insurers a virtual free hand in their underwriting practices. For all of these reasons, few people with access to employer-provided insurance opted to purchase health insurance in the individual market prior to PPACA. As we will see below, a core goal of PPACA is to dramatically alter the individual market for health insurance.

The third and final source of health insurance is government programs, such as Medicare and Medicaid. The common feature of all public health insurance programs is that they are only available to a sub-set of the population that meets specific eligibility criteria. Medicare, for instance, is available only to Americans who are over 65 years of age. Among those who are eligible, about 96 percent of individuals enroll, though a substantial percentage of this population has private coverage as well. Medicaid eligibility varies by state. In general, it is only available to those with very low incomes or those with disabilities, although eligibility rules are typically loosened for children. In contrast to Medicare, most people with Medicaid do not have alternative sources of insurance. Prior to PPACA, about one quarter of the population had some form of publicly-provided health insurance.

All forms of health insurance – irrespective of how they are acquired – take measures to reduce ex post moral hazard: the risk that insureds will spend too much on healthcare once they become sick. For many decades conventional health insurance was provided on a fee-for-service basis, under which insured individuals could receive care from their physician or hospital of their choice, which was then reimbursed directly by the insurer, usually according to pre-arranged fee schedules. Generally, individuals paid a specified deductible for each office visit, and sometimes paid co-insurance on costs beyond the deductible amount. As noted below, "managed care" now goes further in combating moral hazard.

## 2. THE NEED FOR REFORM

### a. AN OVERVIEW OF REFORM ISSUES

The debate over healthcare reform was, and continues to be, incredibly politically divisive. Yet this debate has also been remarkable for the common supposition, echoed by commentators on both the left and right, that comprehensive reform of some sort was necessary at the time PPACA was passed. The following Report (from which footnotes have been omitted) was prepared as the debate began, and discusses many of these issues.

#### **Congressional Research Service, Health Care Reform: An Introduction**

(Bob Lyke, April 14, 2009)

##### Introduction

Health care reform is again an issue. For the first time since 1994, when sweeping changes proposed by President Clinton and others failed to be enacted, there is demonstrable interest in reforming health care in the United States. Surveys and studies show persistent problems, political leaders are debating issues and solutions, and interest groups of all persuasions are holding conferences and staking out positions. Some states have enacted their own reforms, and others are considering doing so. The 111th Congress is already working on the issue.

Interest in reform is being driven by three predominant concerns. One is coverage. By a commonly cited estimate, more than 45 million people were uninsured at some point in 2007— more than one-seventh of the population. The recession may have increased this number. Without private insurance or coverage under government health programs, people can have difficulty obtaining needed care and problems paying for the care they receive.

A second concern is cost and spending. Health care costs are rising for nearly everyone— employers, workers, retirees, providers, and taxpayers—sometimes in unexpected, erratic jumps. Costs are a particular source of anxiety for families that are planning for retirement or where someone is seriously ill. National health care spending now exceeds \$2.2 trillion, more than 16% of the gross domestic product (GDP). Spending has climbed from over 12% of GDP in 1990 and 7% in 1970.

Third, there is concern about quality. Although the United States spends substantially more on health care per person than other industrialized countries, it scores only average or somewhat worse on many quality of care indicators. Medical and medication errors harm many people annually, sometimes resulting in death.

The three concerns raise significant challenges. For one thing, each is more complex than might first appear, which makes it difficult to find solutions, or at least simple or uniform solutions. Second, solutions to the three concerns may conflict with one another. Under

many scenarios, for example, providing coverage to the 45 million uninsured would likely drive up costs (as more people seek care) and expand public budgets (since public subsidies would be required to help them get insurance). Attempts to restrict costs may impede efforts to increase quality, since new initiatives often require additional, not fewer, resources. Other challenges involve significant stakeholder interests that reform might threaten, including those of insurers, hospitals and other health care facilities, and doctors and other providers, many of whom have substantial investments in present arrangements. \* \* \*

## Coverage

In August, 2008, the U.S. Census Bureau estimated that 45.7 million people had no health insurance at a point in time in 2007. The number had declined from 47 million the previous year, largely due to increases in Medicaid and CHIP (the State Children's Health Insurance Program) enrollment. The number may now be going back up due to the recession.

There are both higher and lower numbers that give different perspectives. Families USA, an advocacy group, recently estimated that 86.7 million people—one in three of those under age 65—were uninsured for some or all of the two-year period 2007-2008. The number indicates that many more than 45 million people are likely to be uninsured over a short time period, even if many have coverage at some point. On the other hand, the Agency for Healthcare Research and Quality (AHRQ) has estimated that 26.1 million people were uninsured for the entire two-year period 2004-2005, and that 17.4 million were uninsured for the preceding two years as well—four straight years.

Coverage is not the same as access, and it is possible to have one without the other. Some uninsured people can get care in community health clinics or from doctors providing pro bono work, even if they have no money. If people need emergency care, hospitals that participate in Medicare are required to stabilize them or provide an appropriate transfer to another facility. On the other hand, having coverage does not guarantee that one can easily find a doctor, as both Medicare and Medicaid participants sometime report. Having coverage also does not ensure that one can pay for care. People with high deductible insurance, perhaps chosen when they were healthy or because premiums were lower, may have to pay several thousand dollars out of pocket before their plan begins reimbursements. For some people, including those who lose their jobs, paying for health care is a major problem. Even people with comprehensive plans with low deductibles may have difficulty paying the ongoing costs of chronic conditions or the major costs of serious illnesses. \* \* \*

## Cost and Spending

Spending on health care in the United States has increased from 7.2% of GDP in 1970 to 12.3% in 1990 and 16.2% in 2007. Barring changes in law, the Congressional Budget Office (CBO) projected in 2008 that it would rise to 25% of GDP in 2025 and much higher levels beyond. CBO has cautioned that “as health care spending consumes a

greater and greater share of the nation's economic output in the future, Americans will be faced with increasingly difficult choices between health care and other priorities.”

The United States spends considerably more on health care than other industrialized countries: on a per capita basis, its spending is more than two times greater than the spending of the median Organization for Economic Cooperation and Development (OECD) country. It has been argued that some of the higher health care spending has added real value through medical advances. Some of it may be attributable to the higher per capita GDP in the United States, which simply allows Americans to spend more. However, its value has been questioned in light of the mixed performance of the United States on many indicators of health care quality, as described in the next section.

“Cost” and “spending” are often used interchangeably, particularly with the issues discussed in this report. Usage may reflect differences in context or perspective, not substance, though this is not always the case (for example, prices are usually described as costs and purchases as spending). It is apparent that what are called rising costs can cause serious problems for people and entities that cannot easily absorb them. Concern about costs arises from a number of trends. The average annual rate of growth in medical care prices between 1980 and 2007 was 4.7%, in contrast to 2.5% for the entire consumer price index (CPI). Health insurance premiums on average increased by 114% from 1999 to 2007, far more than increases in workers' earnings (27%). The rising cost of health insurance likely is one reason there are increasing numbers of uninsured.

Controlling cost and spending is unlikely to be easy. Many economists argue that the principal factor driving increases in health care spending is technology, both new pharmaceuticals and other products and services and wider use of existing ones. It is not obvious whether some developments can be limited or their application blocked (for example, by limiting diffusion on the basis of clinical evidence) and some would question whether they should. One challenge in controlling costs is that payers may shift burdens to others, sometimes in ways that are not clearly understood or measurable. For example, most economists argue that employer payments for health insurance are actually borne by workers through reduced wages and other forms of compensation. Attempts to limit employer-paid insurance may lead to increases in wages in ways that are difficult to predict.

One particular congressional concern is the cost of federal health insurance programs. In 2007, Medicare and Medicaid, the two largest programs, accounted for about 20% of the federal budget and over 27% of total national health care expenditures \* \* \*

## Quality

Despite spending more on health care than other industrialized countries, the United States scores only average or somewhat worse on many quality of care indicators. It is near the top for some measures, such as survival rates for breast and colorectal cancer, but near the bottom for others, such as mortality and hospitalization rates for asthma. A recent Centers for Disease Control and Prevention (CDC) report found that the United

States ranked 29th in the world in infant mortality in 2004. The U.S. position in rankings on this measure has been declining. Notwithstanding difficulties of cross-national comparisons, these indicators show that Americans do not receive the best value for their health care spending and that there is room for improvement.

Concerns about health care quality in the United States go beyond international comparisons, and they cannot be reduced simply to returns on the dollar. Medical errors appear to be one systemic shortcoming. An influential 1999 Institute of Medicine study found that at least 44,000 people, and perhaps as many as 98,000, die from in-patient hospital care every year. The study found that most medical errors do not result from individual recklessness or actions of a particular group; rather, they are attributable to “faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.” A more recent study estimated that if all hospitals performed as well as the best group of hospitals for patient safety, over 44,000 deaths among Medicare beneficiaries could have been avoided during the years 2002 through 2004. Another Institute of Medicine study reported in 2006 that there were more than 400,000 preventable drug-related injuries each year in hospitals alone, and that altogether medication errors harmed at least 1.5 million people.

Not adhering to evidence-based practice or clinical practice guidelines is also a problem. One 2003 study found that Americans receive recommended evidence-based care only about 55% of the time. Recommended care was provided more often for conditions such as breast cancer (75.7%) and hypertension (64.7%) than it was for others such as a trial fibrillation (24.7%) or hip fracture (22.8%). A later study using the same data found that while differences among sociodemographic subgroups were relatively small, quality problems were profound and systemic. Most studies of disparities have found significant differences by sociodemographic subgroups, with whites receiving better care on many core measures than racial and ethnic minorities. Over the past decade, there have been numerous efforts to improve quality of care in the United States. Among other things, there have been attempts to improve and refine the metrics used for measuring quality, to publicly report comparative information, and, in some cases, to use quality standards as one basis for payment policies. Despite observable progress, the most recent National Healthcare Quality Report (2006) indicated that the pace of change remains modest and that the variation in quality is still high. Among the challenges to making further improvements are disagreements about the utility or appropriateness of some measures (including concerns about how the public might interpret them), the fragmented nature of the American health care system, and barriers to access for some groups that complicate the work of providers. \* \* \*

## NOTES AND QUESTIONS

1. *Emergency Rooms and the Interrelations Among Uninsurance, Cost and Quality.* As the reading emphasizes, the problems associated with the American health insurance system prior to reform were fundamentally interrelated. To take one example, uninsured individuals tended to receive very little preventive care, meaning that potentially treatable illnesses or conditions often ballooned into serious medical conditions. When

this happened, the uninsured could seek treatment at hospitals' emergency rooms, which are required by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2005), to treat all comers, irrespective of their capacity to pay. As a result, emergency rooms often incurred substantial losses, which were then passed on to others in the form of higher costs. See Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. Rev. 223, 230-55 (2006).

Uninsurance may also have reduced the quality of care that insured individuals received. Commentators often claimed that the uninsured sought care in emergency rooms not just for emergencies, but also for more ordinary ailments that could be treated by a primary care doctor. According to many, this resulted in substantial overcrowding and long wait times in emergency rooms. Recent reviews, however, suggest that these claims have been based more on anecdotal evidence than systematic research. See generally Manya F. Newton et al., *Uninsured Adults Presenting to US Emergency Departments: Assumptions vs Data Available*, 300 JAMA 1914 (2008) (although available data suggests that increasing numbers of uninsured patients present to emergency rooms, they do not support the common "assumptions that uninsured patients are a primary cause of [emergency room] overcrowding, present with less acute conditions than insured patients, or seek [emergency room] care primarily for convenience.").

2. *Broader Economic Consequences.* These healthcare problems have had broader impacts on the American economy. For instance, faced with the prospect of uninsurance, many employees (especially those with spotty health records) may have felt that they were effectively "locked" into their jobs because they worried that pursuing a new career or small business would jeopardize their health insurance coverage. See Brigitte C. Madrian, *Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?*, 10 *Quar. J. of Econ.* 27 (1994) (estimating that health insurance reduces the voluntary turnover rate of those with employer-provided health insurance by 25%). Others have maintained that American businesses were at a comparative disadvantage to other global businesses due to the relative costs they faced in providing health insurance to their workforce. But see Uwe E. Reinhardt, *Health Care Spending and American Competitiveness*, 8 *Health Affairs* (Winter 1989) (concluding that the cost of healthcare in America does not harm American competitiveness because it simply effects the mix of income and fringe benefits that employees receive in total compensation but not the size of their total compensation itself). Finally, and perhaps most importantly, the increasing costs of medical care have also increased the cost of government healthcare programs such as Medicare and Medicaid. If costs per enrollee in Medicare and Medicaid continue to accelerate at their pre-reform rate, then these programs will increase from 5% of GDP today to 20% by 2050. See Peter Orszag, *Health Costs are the Real Deficit Threat*, *Wall Street Journal* (5/15/09).

3. *A Right to Healthcare?* The healthcare debate has been heavily influenced by the notion that there should be a *right* to healthcare. To the extent that access to healthcare becomes more formally recognized as a universal right, health insurance can be

understood not simply as a privately purchased commodity but as one of several mechanisms through which that right is vindicated. Thus, health insurance has begun to be implicated in the debate about the requirements of distributional justice and the appropriate method of providing the subsidies necessary to assure coverage for those who are currently uninsured.

b. THE PROBLEM OF UNDER-INSURANCE PRIOR TO REFORM

Approximately one-seventh of the U.S. population was uninsured prior to the passage of PPACA. This statistic may suggest that about 86% of the population possessed reliable insurance prior to reform. In fact, though, even *insured* Americans often enjoyed only tenuous protection from health risks prior to reform. Consider one study finding that about 80% of the families who turned to bankruptcy after a medical problem in 1999 had some form of health insurance. See Jacoby, Melissa Jacoby, Teresa Sullivan, and Elizabeth Warren, Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts, 76 N.Y.U. L. Rev. 375, 377 (2001). The study also found that approximately 500,000 middle-class families were forced into bankruptcy following an illness or injury in 1999 and that half of all individual bankruptcies involved a medical problem. *Id.* Bankruptcy, of course, simply represents the worst-case financial scenario for those with medical debt – a tremendous number of individuals and families struck by illness presumably saw their savings compromised and their debt soar due to healthcare expenditures even if they did not enter bankruptcy as a result. See Robert W. Seifert and Mark Rukavina, Bankruptcy Is The Tip Of A Medical-Debt Iceberg, 25 Health Affairs 89 (2006). This Section reviews several of the most important forms of under-insurance prior to reform.

(1) *Pre-existing Condition Exclusions*

Prior to PPACA, virtually all insurance policies sold in the individual market and many employer-provided policies contained pre-existing condition exclusions. Although the precise language of these exclusions varied, they generally stated that the insurer was not obligated to provide coverage for any sickness or injury that had in any way manifested itself prior to the purchase of coverage. The intent of these clauses was to limit the risk of adverse selection. But as the following case suggests, insurers could invoke these exclusions in a way that injected substantial uncertainty into the coverage that individuals thought they had purchased.

**Lawson Ex Rel. Lawson v. Fortis Insurance Company**

United States Court of Appeals, Third Circuit, 2002.  
301 F.3d 159.

■ ALITO, CIRCUIT JUDGE.

Minor child Elena Lawson ("Elena") was covered under a health insurance policy that her father bought from Defendant, Fortis Insurance Company. Two days prior to the effective date of the policy, Elena went to the emergency room for treatment of what was

initially diagnosed as a respiratory tract infection, but which was discovered to be leukemia one week later, after the effective date of the policy. Fortis denied coverage of medical expenses relating to the leukemia on the ground that it was a pre-existing condition for which Elena had received treatment prior to the effective date of the policy. Elena's parents ("Plaintiffs"), acting on her behalf, sued for breach of contract, and the District Court granted their motion for summary judgment.

In this appeal, Fortis argues that the pre-existing condition language of the insurance policy does not require accurate diagnosis of the condition, but merely receipt of treatment or advice for the symptoms of it. Fortis claims that because Elena was treated for symptoms of leukemia before the effective date of the insurance policy, the leukemia was a pre-existing condition. Plaintiffs respond that the leukemia was not pre-existing because one cannot receive treatment "for" a condition without knowledge of what the condition is. We find that Plaintiffs' reading of the pre-existing condition language is reasonable and that the ambiguity in the policy should be construed against the insurance company. Therefore, we affirm the District Court's grant of summary judgment for Plaintiffs on their claim for benefits under the policy. \* \* \*

I.

A.

On October 7, 1998, Joseph Lawson ("Lawson") purchased the Fortis short-term medical insurance policy to cover himself and his daughter, Elena Lawson. The policy became effective two days later, on October 9. On October 7, the same day Lawson applied for the insurance policy, Elena's mother, Tammy Malatak, took Elena to the emergency room at Palmerton Hospital in Palmerton, Pennsylvania. Elena had a dry, hacking cough, a fever, an elevated pulse rate, and a swollen right eye. The emergency room physician, Dr. Shailesh Parikh, diagnosed Elena with an upper respiratory tract infection and prescribed an antibiotic and anti-allergy medication. Dr. Parikh further advised Ms. Malatak to take Elena for a follow-up visit to her family physician or to bring her back to the emergency room if the symptoms did not improve in a few days. Because the symptoms persisted, on October 13, Ms. Malatak took Elena to the family physician, Dr. Narendra Ambani.

On October 14, 1998, Elena's grandmother, a registered nurse, took Elena to a pediatrician, Dr. Mira Slizovskaya ("Dr. Slizovsky"), who ordered Elena to undergo more tests and diagnosed her with leukemia. On October 15, Elena was transferred to the Children's Hospital of Philadelphia ("CHOP") under the care of Dr. Beverly Lange. At CHOP, Elena underwent chemotherapy and other treatment that has since resulted in the remission of her leukemia.

B.

The insurance policy at issue expressly excludes coverage for a pre-existing condition, which is defined as a "Sickness, Injury, disease or physical condition for which

medical advice or treatment was recommended by a Physician or received from a Physician within the five (5) year period preceding that Covered Person's Effective Date of Coverage." The policy defines "sickness" as an "illness, disease or condition which is diagnosed or treated while this policy is in force." There is no dispute that the relevant sickness here is leukemia.

Lawson and Malatak, on behalf of Elena, filed a claim for payment of the CHOP medical bills under the Fortis policy. Dr. Raymond Brumblay, Fortis's Medical Director, investigated Elena's course of treatment and concluded that "[w]hile the evaluation [at the Palmerton Emergency Department] failed to diagnose leukemia, advice and treatment for those symptoms were received from a physician. This meets the policy definition of a pre-existing condition." App. at 96. Dr. Brumblay determined that Elena had a two-and-a-half week history of fever preceding her diagnosis of leukemia, and he therefore concluded that the symptoms for which she was evaluated and treated on October 7, 1998, were those of leukemia. Fortis thus denied Plaintiffs' claim pursuant to the policy's pre-existing condition exclusion.

Plaintiffs appealed the denial to Fortis's Appeal Review Committee, which concluded that the definition of a pre-existing condition does not require a correct diagnosis of the condition at the time that it is treated. Fortis thus denied Plaintiffs' appeal. \* \* \*

## II.

Fortis argues that the insurance policy's exclusion of pre-existing conditions contains no requirement that the condition be accurately diagnosed or appropriately treated before the effective date of the policy. Fortis claims that the pre-existing condition exclusion applies when a claimant receives medical treatment for the symptoms of a condition that later proves to be one for which coverage is sought under the policy. Thus, Fortis asserts that the District Court's decision contravened the plain meaning of the policy, principles of contract construction, and clear legal precedent. We disagree. \* \* \*

## B.

Both state and federal courts have interpreted pre-existing condition language in health insurance contracts differently. The District Court relied most heavily on *Hughes v. Boston Mutual Life Insurance Co.*, 26 F.3d 264 (1st Cir.1994). In *Hughes*, the insured claimant suffered from and was treated for non-specific symptoms of multiple sclerosis prior to the effective date of his disability policy, but the condition was not diagnosed until after the policy took effect. The First Circuit found both the insurance company's and the claimant's interpretations of the policy to be reasonable, and it therefore concluded that the pre-existing condition exclusion was ambiguous. *Id.* at 269–70. In particular, the ambiguity was due to the lack of clarity regarding what constitutes treatment "for" a condition. *Id.* at 269.

*Hughes* notwithstanding, some courts have interpreted language similar to the pre-existing condition provision at issue in this case not to require a diagnosis of the condition. See, e.g., *Bullwinkel v. New England Mutual Life Insurance Co.*, 18 F.3d 429 (7th Cir.1994) (holding that discovery of a breast lump before the defendant's insurance coverage began triggered the pre-existing condition exclusion although the lump was not definitively diagnosed as cancer until after coverage began) \* \* \* The Seventh Circuit in *Bullwinkel* reasoned that "even though [the claimant] did not know the lump was cancerous in July [before the effective date of her insurance policy], her visit with the doctor in that month concerning the lump actually concerned cancer. It follows that [the claimant] was 'seen' and 'treated' and incurred medical expenses for her cancer in July." Therefore, the court concluded, "any post-policy treatment concerning the same condition is not covered." 18 F.3d at 432. In *Cury*, the District Court similarly held that "[b]ecause a diagnosis during the pre-existing condition period is not necessary," the only issue was whether "plaintiff received treatment, consultation, medical care, medical services, diagnostic tests, or prescribed drugs during the pre-existing condition period." 737 F.Supp. at 855. The reasoning underlying these decisions is that the pre-existing condition language is clear and unambiguous that treatment for a condition does not require accurate diagnosis of the condition.

Other courts, however, like the First Circuit in *Hughes*, have reached a different result and found that treatment for a condition requires some awareness on the part of the insured or the physician that the insured is receiving treatment for the condition itself. See, e.g., *Pitcher v. Principal Mutual Life Insurance Co.*, 93 F.3d 407, 412 (7th Cir.1996) ("[W]e hold that Pitcher did not receive a 'treatment or service' for breast cancer prior to September 17, 1992 because—as the district court found—she was being monitored for the longstanding fibrocystic breast condition and not cancer during the pre-coverage period."); *Ross v. Western Fidelity Insurance Co.*, 881 F.2d 142, 144 (5th Cir.1989) ("[T]here is at least a reasonable argument that, under [a pre-existing condition exclusion], treatment for a specific condition cannot be received unless the specific condition is known.") \* \* \*

All of these cases involve insurance policies with substantially similar pre-existing condition language and similar factual scenarios. Of the federal courts of appeals, the First, Fifth, and Seventh Circuits have followed the approach taken in this case by the District Court, finding the contract language ambiguous. The Seventh and Eighth Circuits, however, have gone the other way and interpreted pre-existing condition language not to require diagnosis of the condition being treated. Thus, the relevant cases do not dictate a clear answer here.

C.

In this case, Elena did not receive advice or treatment for leukemia before the effective date of coverage, so Plaintiffs' interpretation of the pre-existing condition language in the Fortis insurance policy should prevail. At a minimum, the contract language is ambiguous, and thus it should be construed against Fortis.

The Fortis insurance policy excludes coverage for a "Sickness, Injury, disease or physical condition for which medical advice or treatment was recommended by a Physician or received from a Physician within the five (5) year period preceding that Covered Person's Effective Date of Coverage." There is no doubt that the "sickness" here is leukemia. Therefore, the key word in the pre-existing condition exclusion for our purposes is "for." Elena received treatment "for" what were initially diagnosed as symptoms of a respiratory tract infection. Therefore, the treatment she received was not "for" leukemia, but "for" a respiratory tract infection.

The word "for" connotes intent. Webster's Dictionary states that "for" is "used as a function word to indicate purpose." Webster's Ninth New Collegiate Dictionary 481 (1986). Black's Law Dictionary similarly states that the word "connotes the end with reference to which anything is, acts, serves, or is done. In consideration of which, in view of which, or with reference to which, anything is done or takes place." Black's Law Dictionary 579–80 (5th ed.1979). The word "for" therefore has an implicit intent requirement. Applied to this case, none of Elena, her parents, and the treating physician, Dr. Parikh, intended or even thought on October 7, 1998, that Elena was receiving medical advice or treatment "for" leukemia. In short, it is hard to see how a doctor can provide treatment "for" a condition without knowing what that condition is or that it even exists. Thus, in our view, the best reading of the contract language in this case is for coverage of Elena's leukemia treatment. At worst, the language is ambiguous and must therefore be read in favor of the insureds.\*\*\*

Although we base our decision on the language of the policy, we note that considering treatment for symptoms of a not-yet-diagnosed condition as equivalent to treatment of the underlying condition ultimately diagnosed might open the door for insurance companies to deny coverage for any condition the symptoms of which were treated during the exclusionary period. "To permit such backward-looking reinterpretation of symptoms to support claims denials would so greatly expand the definition of preexisting condition as to make that term meaningless: any prior symptom not inconsistent with the ultimate diagnosis would provide a basis for denial." *In re Estate of Monica Ermenc*, 585 N.W.2d at 682. In *Ranieli v. Mutual Life Insurance Company of America*, 271 Pa.Super. 261, 413 A.2d 396 (1979), the Pennsylvania Superior Court held that recovery under a pre-existing condition clause was "conditioned on the fact that prior to the stipulated date, the sickness was not manifest, nor could it have been diagnosed with reasonable certainty by one learned in medicine." *Id.* at 401. The court found such a policy to be "reasonable and salutary" because "[t]o deny coverage because of an incipient disease that has not made itself manifest ... is to set an unconscionable trap for the unwary insured." *Id.*

At a minimum, the pre-existing condition language in Fortis's insurance policy is susceptible to more than one reasonable interpretation and is therefore ambiguous. *See Myrttil v. Hartford Fire Insurance Co.*, 510 F.Supp. 1198, 1202 (E.D.Pa.1981) ("If reasonably intelligent people differ as to the meaning of a policy provision, ambiguity exists."); *Cohen v. Erie Indemnity Co.*, 288 Pa.Super. 445, 432 A.2d 596, 599 (1981) ("The mere fact that several appellate courts have ruled in favor of a construction denying

coverage, and several others have reached directly contrary conclusions, viewing almost identical policy provisions, itself creates the inescapable conclusion that the provision in issue is susceptible to more than one interpretation."). Therefore, we construe the insurance policy strictly against Fortis and find that Elena's leukemia was not a pre-existing condition under the language of the policy. \* \* \*

## Notes and Questions

1. *HIPAA and Pre-existing Condition Exclusions.* Prior to PPACA, insurers in the individual market were free to include pre-existing condition exclusions in almost every state. By contrast, HIPAA limited the capacity of employers and group insurers to include pre-existing condition exclusions in their policies. Under HIPAA, once an insured had been covered for 12 months, no pre-existing condition exclusion could be applied. Additionally, coverage could not be denied for pre-existing conditions where medical advice, diagnosis, care or treatment was recommended or received more than six months before enrollment in the plan. Finally, HIPAA also required some health insurance policies and self-insured plans to give an insured "credit" for the amount of time she was previously covered under another policy or plan. 29 U.S.C. §1181.

2. *Combating Adverse Selection.* If pre-existing condition exclusions were intended to prevent adverse selection, why did the court not inquire into the motivation of the Lawsons in applying for health insurance? In the next to last paragraph of the opinion, did the court understand the pre-existing condition clause as being designed to combat adverse selection, or merely as a neutral way of identifying losses that do not trigger the coverage provided by the policy? Is there a parallel between this problem and the *MacKenzie* case in Chapter One, dealing with the obligation of an applicant for coverage to report changes to answers provided on an application prior to the date a policy is issued?

3. *Overreaching?* Even where insurers are entitled to protect themselves against adverse selection with pre-existing condition clauses, the 5 year period specified in the Lawson policy seems excessive in the extreme. To what extent does this suggest that the insurer may have had other motivations?

4. *Bootstrapping.* To what extent does the fact that courts have divided about the meaning of a policy provision indicate that that provision is ambiguous? If such disagreement does establish ambiguity, should any future policyholder in an identical dispute over the same provision automatically prevail?

### (2) *Changes in Employer-Provided Coverage and ERISA*

Recall that the primary source of coverage for most Americans, both before and after PPACA, is employer-provided coverage. However, this type of coverage is inherently subject to a fundamental source of insecurity: most employees work "at will," meaning that they can be fired or laid off for any reason. This reality was particularly problematic for those with spotty health records. Despite HIPAA, insurers on the

individual market could often effectively refuse to issue insurance to those who had recently lost employer-provided coverage by charging very large premiums (an especially daunting prospect for someone who just lost their job). And even those able to find new jobs might find that illnesses from pre-existing conditions were not covered under their new employer's plan, subject to the HIPAA provisions described above.

As the following case suggests, the loss of one's job was not the only way in which employer-provided coverage was less secure than many imagined.

**McGann v. H & H Music Company**

United States Court of Appeals for the Fifth Circuit, 1991.

946 F.2d 401.

■ GARWOOD, CIRCUIT JUDGE:

\* \* \*

McGann, an employee of H & H Music, discovered that he was afflicted with AIDS in December 1987. Soon thereafter, McGann submitted his first claims for reimbursement under H & H Music's group medical plan, provided through Brook Mays, the plan administrator, and issued by General American, the plan insurer, and informed his employer that he had AIDS. McGann met with officials of H & H Music in March 1988, at which time they discussed McGann's illness. Before the change in the terms of the plan, it provided for lifetime medical benefits of up to \$1,000,000 to all employees.

In July 1988, H & H Music informed its employees that, effective August 1, 1988, changes would be made in their medical coverage. These changes included, but were not limited to, limitation of benefits payable for AIDS-related claims to a lifetime maximum of \$5,000.<sup>1</sup> No limitation was placed on any other catastrophic illness. H & H Music became self-insured under the new plan and General American became the plan's administrator. By January 1990, McGann had exhausted the \$5,000 limit on coverage for his illness.

In August 1989, McGann sued H & H Music, Brook Mays and General American under section 510 of ERISA, which provides, in part, as follows:

"It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, \* \* \* or for the purpose of interfering with the

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<sup>1</sup>Other changes included increased individual and family deductibles, elimination of coverage for chemical dependency treatment, adoption of a preferred provider plan and increased contribution requirements.

attainment of any right to which such participant may become entitled under the plan." 29 U.S.C. § 1140.

McGann claimed that defendants discriminated against him in violation of both prohibitions of section 510. He claimed that the provision limiting coverage for AIDS-related expenses was directed specifically at him in retaliation for exercising his rights under the medical plan and for the purpose of interfering with his attainment of a right to which he may become entitled under the plan.

Defendants, conceding the factual allegations of McGann's complaint, moved for summary judgment. These factual allegations include no assertion that the reduction of AIDS benefits was intended to deny benefits to McGann for any reason which would not be applicable to other beneficiaries who might then or thereafter have AIDS, but rather that the reduction was prompted by the knowledge of McGann's illness, and that McGann was the only beneficiary then known to have AIDS.<sup>2</sup> On June 26, 1990, the district court granted defendants' motion on the ground that they had an absolute right to alter the terms of the plan, regardless of their intent in making the alterations. The district court also held that even if the issue of discriminatory motive were relevant, summary judgment would still be proper because the defendants' motive was to ensure the future existence of the plan and not specifically to retaliate against McGann or to interfere with his exercise of future rights under the plan.

## DISCUSSION

McGann contends that defendants violated both clauses of section 510 by discriminating against him for two purposes: (1) "for exercising any right to which [the beneficiary] is entitled," and (2) "for the purpose of interfering with the attainment of any right to which such participant may become entitled."

\* \* \*

Thus, in order to survive summary judgment McGann must make a showing sufficient to establish that a genuine issue exists as to defendants' specific intent to retaliate against McGann for filing claims for AIDS-related treatment or to interfere with McGann's attainment of any right to which he may have become entitled.

Although we assume there was a connection between the benefits reduction and either McGann's filing of claims or his revelations about his illness, there is nothing in the record to suggest that defendants' motivation was other than as they asserted, namely

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<sup>2</sup>We assume, for purposes of this appeal, that the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses, that this knowledge was obtained either through McGann's filing of claims or his meetings with defendants and that McGann was the only plan beneficiary then known to have AIDS.

to avoid the expense of paying for AIDS treatment (if not, indeed, also for other treatment), no more for McGann than for any other present or future plan beneficiary who might suffer from AIDS. McGann concedes that the reduction in AIDS benefits will apply equally to all employees filing AIDS-related claims and that the effect of the reduction will not necessarily be felt only by him. He fails to allege that the coverage reduction was otherwise specifically intended to deny him in particular medical coverage except "in effect." He does not challenge defendants' assertion that their purpose in reducing AIDS benefits was to reduce costs.

Furthermore, McGann has failed to adduce evidence of the existence of "any right to which [he] may become entitled under the plan." The right referred to in the second clause of section 510 is not simply any right to which an employee may conceivably become entitled, but rather any right to which an employee may become entitled pursuant to an existing, enforceable obligation assumed by the employer. "Congress viewed [section 510] as a crucial part of ERISA because without it, employers would be able to circumvent the provision of *promised benefits*." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 485, 112 L.Ed.2d 474 (1990) (emphasis added).

McGann's allegations show no *promised* benefit, for there is nothing to indicate that defendants ever promised that the \$1,000,000 coverage limit was permanent. The H & H Music plan expressly provides: "Termination or Amendment of Plan: The Plan Sponsor may terminate or amend the Plan at any time or terminate any benefit under the Plan at any time." There is no allegation or evidence that any oral or written representations were made to McGann that the \$1,000,000 coverage limit would never be lowered. Defendants broke no promise to McGann. The continued availability of the \$1,000,000 limit was not a right to which McGann may have become entitled for the purposes of section 510.<sup>3</sup> To adopt McGann's contrary construction of this portion of section 510 would mean that an employer could not effectively reserve the right to amend a medical plan to reduce benefits respecting subsequently incurred medical expenses, as H & H Music did here, because such an amendment would obviously have as a purpose preventing participants from attaining the right to such future benefits as they otherwise might do under the existing plan absent the amendment. But this is plainly not the law, and ERISA does not require such "vesting" of the right to a continued level of the same medical benefits once those are ever included in a welfare plan. *See Moore v. Metropolitan Life Insurance Co.*, 856 F.2d 488, 492 (2d Cir.1988).

McGann appears to contend that the reduction in AIDS benefits alone supports an inference of specific intent to retaliate against him or to interfere with his future exercise of rights under the plan. McGann characterizes as evidence of an individualized intent to discriminate the fact that AIDS was the only catastrophic illness to which the \$5,000

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<sup>3</sup>McGann does not claim that he was not fully reimbursed for all claimed medical expenses incurred on or prior to August 1, 1988; or that the full \$5,000 has not been made available to him in respect to AIDS related medical expenses incurred by him on or after July 1, 1988.

limit was applied and the fact that McGann was the only employee known to have AIDS. He contends that if defendants reduced AIDS coverage because they learned of McGann's illness through his exercising of his rights under the plan by filing claims, the coverage reduction therefore could be "retaliation" for McGann's filing of the claims. Under McGann's theory, any reduction in employee benefits would be impermissibly discriminatory if motivated by a desire to avoid the anticipated costs of continuing to provide coverage for a particular beneficiary. McGann would find an implied promise not to discriminate for this purpose; it is the breaking of this promise that McGann appears to contend constitutes interference with a future entitlement.

McGann cites only one case in which a court has ruled that a change in the terms and conditions of an employee-benefits plan could constitute illegal discrimination under section 510.<sup>4</sup> *Vogel v. Independence Federal Sav. Bank*, 728 F.Supp. 1210 (D.Md.1990). In *Vogel*, however, the plan change at issue resulted in the plaintiff and only the plaintiff being excluded from coverage. McGann asserts that the *Vogel* court rejected the defendant's contention that mere termination of benefits could not constitute unlawful discrimination under section 510, but in fact the court rejected this claim not because it found that mere termination of coverage could constitute discrimination under section 510, but rather because the termination at issue affected only the beneficiary. *Id.* at 1225. Nothing in *Vogel* suggests that the change there had the potential to then or thereafter exclude any present or possible future plan beneficiary other than the plaintiff. *Vogel* therefore provides no support for the proposition that the alteration or termination of a medical plan could alone sustain a section 510 claim. Without necessarily approving of the holding in *Vogel*, we note that it is inapplicable to the instant case. The post-August 1, 1988 \$5,000 AIDS coverage limit applies to any and all employees.

McGann effectively contends that section 510 was intended to prohibit any discrimination in the alteration of an employee benefits plan that results in an identifiable employee or group of employees being treated differently from other employees. The First Circuit rejected a somewhat similar contention in *Aronson v. Servus Rubber, Div. of Chromalloy*, 730 F.2d 12 (1st Cir.1984), *cert. denied*, 469 U.S. 1017, 105 S.Ct. 431, 83 L.Ed.2d 357 (1984). In *Aronson*, an employer eliminated a profit sharing plan with respect to employees at only one of two plants. The disenfranchised employees sued their employer under section 510, claiming that partial termination of the plan with respect to employees at one plant and not at the other constituted illegal discrimination. The court rejected the employees' discrimination claim, stating in part:

"[Section 510] relates to discriminatory conduct directed against individuals, not to actions involving the plan in general. The problem is with the word 'discriminated.' An overly literal interpretation of this section would make illegal any partial termination,

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<sup>4</sup>We assume that discovery of McGann's condition—and realization of the attendant, long-term costs of caring for McGann—did in fact prompt defendants to reconsider the \$1,000,000 limit with respect to AIDS-related expenses and to reduce the limit for future such expenses to \$5,000.

since such terminations obviously interfere with the attainment of benefits by the terminated group, and, indeed, are expressly intended so to interfere \* \* \* This is not to say that a plan could not be discriminatorily modified, intentionally benefitting, or injuring, certain identified employees or a certain group of employees, but a partial termination cannot constitute discrimination per se. A termination that cost alone independently established lines—here separate divisions—and that has a readily apparent business justification, demonstrates no invidious intent." *Id.*, at 16 (citation omitted).

The Supreme Court has observed in dictum: "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 2897, 77 L.Ed.2d 490 (1983).

\* \* \*

To interpret "discrimination" broadly to include defendants' conduct would clearly conflict with Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefits plans without governmental interference.

The Sixth Circuit, in rejecting a challenge to an employer's freedom to choose the terms of its employee pension plan, stated that

"[i]n enacting ERISA, Congress continued its reliance on *voluntary* action by employers by granting substantial tax advantages for the creation of qualified retirement programs. Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide. In particular, courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation. Absent a violation of federal or state law, a federal court may not modify a substantive provision of a pension plan." *Id.* (citation omitted) (emphasis in original).

As persuasively explained by the Second Circuit, the policy of allowing employers freedom to amend or eliminate employee benefits is particularly compelling with respect to medical plans:

"With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. Automatic vesting was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and

technology, and increases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir.1988) (*Metropolitan Life*).

In *Metropolitan Life*, the court rejected an ERISA claim by retirees that their employer could not change the level of their medical benefits without their consent. The court stated that limiting an employer's right to change medical plans increased the risk of "decreas[ing] protection for future employees and retirees." *Id.* at 492; *see also Reynolds Metals*, 740 F.2d at 457 ("judicial interference into the establishment of pension plan provisions \* \* \* would serve only to discourage employers from creating voluntarily pension plans") (footnote omitted).

McGann's claim cannot be reconciled with the well-settled principle that Congress did not intend that ERISA circumscribe employers' control over the content of benefits plans they offered to their employees. McGann interprets section 510 to prevent an employer from reducing or eliminating coverage for a particular illness in response to the escalating costs of covering an employee suffering from that illness. Such an interpretation would, in effect, change the terms of H & H Music's plan. Instead of making the \$1,000,000 limit available for medical expenses on an as-incurred basis only as long as the limit remained in effect, the policy would make the limit *permanently* available for all medical expenses as they might thereafter be incurred because of a single event, such as the contracting of AIDS. Under McGann's theory, defendants would be effectively proscribed from reducing coverage for AIDS once McGann had contracted that illness and filed claims for AIDS-related expenses. If a federal court could prevent an employer from reducing an employee's coverage limits for AIDS treatment once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alteration or termination of ERISA plans would be sorely tested.

As noted, McGann has failed to adduce any evidence of defendants' specific intent to engage in conduct proscribed by section 510. A party against whom summary judgment is ordered cannot raise a fact issue simply by stating a cause of action where defendants' state of mind is a material element. *Clark*, 854 F.2d at 771. "There must be some indication that he can produce the requisite quantum of evidence to enable him to reach the jury with his claim." *Id.* at 771 (quoting *Hahn v. Sargent*, 523 F.2d 461, 468 (1st Cir.1975), *cert. denied*, 425 U.S. 904, 96 S.Ct. 1495, 47 L.Ed.2d 754 (1976)).

Proof of defendants' specific intent to discriminate among plan beneficiaries on grounds proscribed by section 510 does not enable McGann to avoid summary judgment. ERISA does not broadly prevent an employer from "discriminating" in the creation, alteration or termination of employee benefits plans; thus, evidence of such intentional discrimination cannot alone sustain a claim under section 510. That section does not prohibit welfare plan discrimination between or among categories of diseases. Section 510 does not mandate that if some, or most, or virtually all catastrophic illnesses are covered, AIDS (or any other particular catastrophic illness) must be among them. It does not prohibit an employer from electing not to cover or continue to cover AIDS, while

covering or continuing to cover other catastrophic illnesses, even though the employer's decision in this respect may stem from some "prejudice" against AIDS or its victims generally. The same, of course, is true of any other disease and its victims. That sort of "discrimination" is simply not addressed by section 510. Under section 510, the asserted discrimination is illegal only if it is motivated by a desire to retaliate against an employee or to deprive an employee of a existing right to which he may become entitled. The district court's decision to grant summary judgment to defendants therefore was proper. Its judgment is accordingly

AFFIRMED.

## Notes and Questions

1. *ERISA's Procedural Protections.* The Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (ERISA), is the principal federal statute regulating employee benefit plans. The statute defines employee benefit plans broadly, to encompass all plans that provide "medical, surgical, or hospital care or benefits for plan participants or their beneficiaries through the purchase of insurance or otherwise." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 651–57, 115 S.Ct. 1671, 1674–1769, 131 L.Ed.2d 695 (1995). Despite the absence of any affirmative coverage requirements in ERISA, the statute does provide beneficiaries of employee benefit plans with important procedural protections. The Supreme Court has explained that:

The federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, as by imposing reporting and disclosure mandates, funding standards, and fiduciary standards for plan administrators. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. It also pre-empts some state law.

Id.

2. *The General Problem.* Prior to PPACA, would *any* insured who suffered a long-term illness be protected against the kind of reduction of benefits that occurred in *McGann*? What are the arguments for and against a rule requiring a health insurer to maintain the same level of benefits (in return for the same level of premiums) for the duration of an insured's illness or injury, regardless of whether the policy period has expired? See Larry Gostin and Alan I. Widiss, What's Wrong with the ERISA Vacuum, 269 JAMA 2527 (1993). If such coverage is desirable, why did the market not already provide it?

3. *Other Federal Protections?* The federal circuits are divided on the question whether the Americans with Disabilities Act, or ADA, 42 U.S.C. § 12101 *et seq.*, prohibits discrimination against the disabled as to the terms of health insurance, though

most have held that it does not. *Compare Kolling v. Blue Cross & Blue Shield of Michigan*, 318 F.3d 715 (6th Cir. 2003) (ADA only applies to public accommodations and not to employee benefit plans) with *Pallozzi v. Allstate Life Insurance Company*, 198 F.3d 28 (2d Cir. 1999) (Title III of ADA does apply to the underwriting practices of insurers, but classifications based on actuarial data do not violate the Act).

The Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, limits the capacity of employer provided plans to impose certain limits on mental health benefits. In particular, it requires that all cost-sharing provisions and treatment limitations for mental health benefits be no more restrictive than the predominant provisions applicable to other medical benefits. However, the act does not mandate that employer plans provide benefits. Instead, it merely requires that any provision of mental health benefits be provided on the same terms and conditions as other health benefits. It is therefore possible that the act will have the perverse effect of causing employers to drop mental health benefits altogether.

4. *State Protections and ERISA Conflict Preemption.* Although ERISA did not provide McGann protection against the reduction in benefits at issue, and (as the preceding note indicates) other federal protections are uncertain, individual states are still free to enact such protections, at least to the extent that they are not preempted by ERISA. As briefly mentioned on pages 75-78, ERISA explicitly pre-empts state laws that “relate to” employee benefit plans. 29 U.S.C. § 1144(b)(2)(A). The basic purpose of such “conflict preemption” is to “avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee-benefit plans.” *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 651–57, 115 S.Ct. 1671, 1674–1769, 131 L.Ed.2d 695 (1995) [citations omitted].

ERISA does not, however, preempt all state laws that relate to an employee benefit plan. Even states laws that “relate to” an employee benefit plan are “saved” from preemption if they “regulate... insurance.” Acting under this so-called “savings clause,” most states mandate that a wide variety of benefits be included in any policy of health insurance. See generally Amy Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 *University Illinois Law Review* 1361. Literally hundreds of such mandates have been enacted over the past two decades. In *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), the Supreme Court confirmed that such laws do indeed regulate insurance, and are therefore saved from ERISA conflict preemption. Although this holding is still good law, the particular test the court used to determine whether a law regulates insurance for purposes of the savings clause is not. In *Metropolitan Life*, the court adopted a test that relied on the definition of the McCarran–Ferguson Act's “business of insurance,” detailed in the *Pireno* and *Royal Drug* cases discussed in Chapter Three.

The Court modified this test in *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003). In that case, Kentucky passed an “Any

Willing Provider" statute prohibiting health plans from discriminating against any health services provider who was willing to meet the terms and conditions established by the insurer. Ky. Rev. Stat. Ann. § 304.17A–270 (2001). The Court concluded that the state law did indeed regulate insurance, and thus was saved from preemption. In doing so, however, it rejected reliance on the McCarran–Ferguson "business of insurance" definition. Instead, it adopted a two-pronged test: "[f]irst, the state law must be specifically directed toward entities engaged in insurance. Second ... the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* at 342 (citations omitted). The new test detailed in *Miller* probably will involve little substantive difference from the *Metropolitan Life* test as it applies to mandated benefits, though cases over the next decade will no doubt determine its exact scope. Particularly important will be the scope of the second prong of the test, exempting state laws that "substantially affect the risk pooling arrangement," as this prong is doing virtually all the work and has not yet been well-defined. Lower courts have begun to interpret this requirement, but there is not yet a coherent and accepted analysis for determining when a law "substantially affect[s] the risk pooling arrangement." See, e.g., *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138 (9th Cir. 2003); *Waters v. Kemper Ins. Cos.*, 2004 WL 2700914 (W.D. Pa. 2004).

Irrespective of the scope of the savings clause, states are not free to regulate employer-provided health insurance that is self-insured. Recall that many large employers choose to directly bear the financial risk that their employees will incur greater than expected healthcare costs, even if they contract with insurers to administer these plans. Under ERISA's "deemer clause," even state laws that regulate insurance cannot be applied to such self-insured plans. As a result, state attempts to protect employees like McCann will not extend to employees who work for employers that self-insure. Does this fact help to explain why McGann became self-insured immediately after it changed the scope of the insurance coverage that it provided to employees?

5. *Health Insurance for Retired Employees.* Just as changes in health insurance coverage for employees are permitted absent a contractual or statutory restriction, coverage that employers sometimes provide for retired employees may be changed in the absence of a contractual or statutory restriction. In fact, many employment contracts expressly reserve the employer's right to change the terms of coverage, including coverage provided to retirees. ERISA itself has been held not to restrict the employer's right to make such changes, although providing misleading information about retirement coverage may be an ERISA violation. See *James v. Pirelli Armstrong Tire Corporation*, 305 F.3d 439 (6th Cir. 2002). In an important case involving approximately 50,000 early retirees from General Motors, the court held that because General Motors had not expressly contracted to provide them health benefits for life at no cost, their benefits could be reduced or eliminated. See *Sprague v. General Motors Corporation*, 133 F.3d 388 (6th Cir. 1998).

6. *Coverage for Domestic Partners.* Employment-based health plans often provide coverage to families of the employee, and increasingly to domestic partners—sometimes depending on the duration or closeness of their relationship with the insured

employee. A number of suits have been brought against state or municipal governments regarding the validity of the governmental provision of such benefits on both equal protection and statutory grounds. See, e.g., *National Pride at Work, Inc. v. Governor of Michigan*, 732 N.W.2d 139 (Mich. 2007) (providing health insurance benefits to same-sex domestic partners of public employees violates Michigan's marriage amendment which states that "the union of one man and one woman in marriage shall be the only agreement recognized as a marriage or similar union for any purpose"); *Lewis v. New York State Department of Civil Services*, 872 N.Y.S.2d 578 (N.Y. App. Div. 2009) (permitting state to extend health insurance benefits to spouses of public employees following such couple's out-of-state same-sex marriage). On the other hand, suits challenging the denial of such benefits have thus far met with mixed success. See, e.g., *Alaska Civil Liberties Union v. State of Alaska and Municipality of Anchorage*, 122 P.3d 781 (Alaska 2005) (denial of health insurance and death benefits to the same-sex domestic partners of public employees violates the equal protection clause of the Alaska Constitution); *Rutgers Council of AAUP Chapters v. Rutgers, The State University*, 298 N.J.Super. 442, 689 A.2d 828 (1997) (denial of health insurance coverage under state plan to same-sex domestic partners of employees did not violate state or federal law). Occasionally similar suits have been brought against private insurers, though these have not met with any success. See, e.g., *Beaty v. Truck Ins. Exchange*, 6 Cal.App.4th 1455, 8 Cal.Rptr.2d 593 (1992) (insurer's refusal to issue unmarried homosexual couple a joint umbrella policy under same terms as offered married couples did not violate state law forbidding discrimination based on sexual orientation).

Berkeley, California, was the first community to extend benefits to domestic partners in 1984. In June, 2010, President Obama ordered federal agencies to extend various benefits to the same sex domestic partners of federal employees. However, his order did not make domestic partners of employees eligible for federal health insurance, as that would require legislation. Such legislation is currently under consideration through the proposed Domestic Partnership Benefits and Obligations Act. For discussion of some of the issues surrounding domestic partner benefits, see Janice Kay McClendon, *A Small Step Forward in the Last Civil Rights Battle: Extending Benefits Under Federally Regulated Employee Benefit Plans to Same-Sex Couples*, 36 N.M. L. Rev. 99 (2006); Emily V. Griffen, "Relations Stop Nowhere": ERISA Preemption of San Francisco's Domestic Partner Ordinance, 89 Cal. L. Rev. 459 (2001); Jeffrey G. Sherman, *Domestic Partnership and ERISA Preemption*, 76 Tul. L. Rev. 373 (2001).

### (3) *Other Sources of Under-Insurance: Rescissions, Annual and Lifetime Limits*

Prior to reform there were various additional sources of health insurance insecurity other than those generated by pre-existing condition exclusions and changes in employer plans and employment status. Several of these merit brief discussion.

First, like other types of insurers, health insurers prior to reform were free to rescind coverage on the basis of misrepresentations made by policyholders at the time they applied for coverage. However, an investigation and hearing by the House Committee on Energy and Commerce in 2009 found that insurers often abused this

authority to rescind policies in order to avoid paying expensive claims. It uncovered substantial evidence that insurers often engaged in post claims underwriting (See Chapter One at 22-23), targeting patients with breast cancer, lymphoma and numerous other serious conditions for rescission and praising employees for terminating the coverage of such policyholders. Additionally, it concluded that insurers frequently rescinded coverage based on trivial omissions in policyholders' applications that were often unrelated to the policyholder's illness. See Committee on Energy and Commerce, Case Studies: Examples of Health Insurance Companies Rescinding Individual Policies (7/27/09).

Second, prior to reform, many insurance policies in both group and individual markets contained annual or lifetime limits of coverage. Although systematic information about the prevalence of these terms is limited, one study estimated that about 55 percent of individuals with employer provided health insurance were subject to lifetime limits, usually of either \$1 million or \$2 million. See Price Waterhouse Coopers, *The Impact of Lifetime Limits* (March 2009). It is likely that such limits were even more common in the individual market. These limits had the effect of cutting off health insurance coverage for people with chronic illnesses who required consistent care, such as those with Hemophilia, Cystic Fibrosis, or Multiple Sclerosis.

## B. THE POST-REFORM LANDSCAPE

The principle goals of PPACA are to guarantee the availability of health insurance, to close gaps in coverage, and to make health insurance affordable for individuals. Many critics rightly point out that PPACA does much less to directly address either the cost or quality issues identified in the Congressional Research Services report above. Although, PPACA does contain various important reforms, grants, and projects designed to address the cost and quality of healthcare, these reforms are clearly less central and more uncertain in their prospects for success than the law's coverage-oriented reforms. At the same time, it is important to remember that cost and quality are both interrelated with coverage. It is therefore likely that PPACA's coverage improvements will have both positive and negative spillover effects on cost and quality.

An even more important concern about PPACA is that it creates a massive new source of government spending that may negatively influence the country's long-term fiscal health. A very important report from the Congressional Budget Office, produced shortly before PPACA was finally enacted, concluded that PPACA was fully paid for by its revenue-raising provisions and will ultimately reduce the size of the federal deficit. However, critics have raised various legitimate concerns about the CBO report. See Douglas Holtz-Eakin, *The Real Arithmetic of Health Care Reform*, N.Y. Times, March 20, 2010, p. WK12. In particular, the CBO projections were based on crucial assumptions that everyone agrees are unrealistic – for example, it assumed that employers will not change the healthcare options they offer in response to new taxes on expensive plans. In fact, some of the criteria that the CBO is required to use to project costs were explicitly gamed by the bill itself. For instance, the CBO's projections were

based on a ten year time horizon. Knowing this, the drafters of reform defrayed at least some important costs until after the ten year time period.

Many provisions of PPACA go into effect six months after enactment, or September 2010. All reforms described below as being effective immediately fall within this category. Most, but not all, provisions of PPACA that are not immediately effective are slated to become effective on January 1, 2014.

a. ACCESS TO CARE

Numerous provisions in PPACA seek to increase consumers' access to care in response to the uninsurance and underinsurance problems outlined above. Broadly speaking, these reforms can be divided into two basic categories: (i) reforms of insurance regulation and (ii) mandates and subsidies.

(1) *Reforms of Health Insurance Regulation*

PPACA includes a broad range of new laws that regulate the terms and the sale of health insurance policies. Unlike state insurance regulations, most of these reforms apply to any "group health plan," including those that are self-insured, as well as "an insurance issuer offering group or individual health insurance coverage." (Collectively these are referred to below as "all health insurance plans."): Where this is not true, the reason is often that prior federal law already required group health plans to meet either the standards articulated in PPACA or even higher standards. For instance, PPACA explicitly limits the criteria that insurers can use to determine premiums to factors such as age, geography, and smoking history. This provision does not extend to group health because such plans were already subject to even more restrictive premium-setting restrictions under HIPPA, as explained earlier.

*Prohibition of Pre-Existing Condition Exclusions.* Starting in 2014, all health insurance plans are prohibited from including pre-existing condition exclusions in their policies. At this time, HIPPA's provisions limiting pre-existing condition exclusions and requiring credit for previous coverage will be moot. Effective immediately, insurers are prohibited from applying pre-existing condition exclusions to anyone under the age of 19. Within 90 days of PPACA's passage, the law requires The Secretary of Health and Human Services (SHHS) to establish a temporary insurance program for those with pre-existing conditions or who have been uninsured for six months. It permits SHHS to accomplish this in part by contracting with states to maintain high-risk pools that were already established under state law. Funding of this program is capped at \$5 billion.

*Prohibition of Rescissions.* All health insurance plans are immediately prohibited from rescinding or cancelling coverage, except for fraud or an intentional misrepresentation of a material fact.

*Prohibition on Annual and Lifetime Limits.* All health insurance plans are immediately prohibited from imposing lifetime limits. Starting in 2014, all health

insurance plans are prohibited from imposing annual limits. Prior to 2014, all health insurance plans may only impose “restricted annual limits,” a term that SHHS is empowered to define based on various relevant criteria in PPACA. In a potentially important exception to this provision, PPACA explicitly permits health insurance plans not required to provide essential health benefits (see below) to establish annual or lifetime limits with respect to specific benefits, to the extent that those benefits are not themselves required by PPACA or applicable state or federal law.

*Cost-Sharing for Preventive Care:* Effective immediately, all health insurance plans are required to cover without any cost-sharing certain preventive care (e.g., immunizations and certain kinds of health screening).

*Restrictions on Discrimination in Premium Setting.* Beginning in 2014, health insurers in the individual and group market may condition premiums only on age, rating areas, individual or family enrollment, and tobacco use. However, premium discounts of up to 30 percent are permitted for employees who participate in certain “wellness” programs, as long as these are not a subterfuge for discriminating on the basis of health status. These provisions do not apply to group health plans, as HIPAA imposes more stringent prohibitions on the discrimination, prohibiting, for instance, discrimination on the basis of age.

*Guaranteed Issue and Renewal:* Except in limited cases, insurance issuers offering group or individual health insurance coverage must offer and renew coverage to any individual or employer who applies. HIPAA already requires guaranteed issue and renewal for any group health plan.

*Extension of Dependent Coverage:* Effective immediately, all health insurance plans must permit policyholders to claim children up to 26 years old, who do not have their own coverage, as dependents on their own policies.

*Uniform Standards for Health Plan Summary of Benefits and Coverage:* Within 12 months of the passage of PPACA, SHHS must develop standards for plan summaries that employ uniform definitions and format and easily understood language. All health insurance plans must provide consumers with these uniform descriptions within 24 months of the passage of PPACA.

*Essential Health Benefits:* All health insurance coverage offered in the individual or small group market must provide “Essential Health Benefits,” or EHB. SHHS will promulgate regulations specifying the contents of an EHB package. However, PPACA requires an EHB to (i) provide specific categories of benefits, (ii) meet certain cost-sharing requirements, and (iii) provide specific levels of coverage. Examples of items and services included in EHB are hospitalization, emergency services, prescriptions drugs, laboratory services, and preventive services. The cost-sharing provisions limit out of pocket expenses – including all copayments, coinsurance, and deductibles – to an amount set by the rules governing Health Savings Accounts. In 2010, the maximum out of pocket limits were \$5,950 for self-only coverage and \$11,900 for families.

Additionally an EHB must be at least as generous as a “typical employer plan,” which will be determined via a survey to be conducted by the Department of Labor. Group health plans are not required to provide EHB, but they are required to provide coverage that contains the annual cost-sharing limitations of an EHB package.

*State Health Insurance Exchanges:* Starting in 2014, each state must establish an “exchange,” to be administered either by a government agency or non-profit corporation, which will facilitate the purchase of health insurance by both individuals and small groups (employers with fewer than 100 employees). If a state does not choose to establish an exchange, the federal government is authorized to establish one for that state’s residents. Only “Qualified Health Plans” may be offered on an exchange, and such plans must include “Essential Health Benefits.”

*Grandfathered Plans:* Individuals who were enrolled in coverage at the time of PPACA’s enactment are generally not required by PPACA to alter their coverage, despite the above requirements. There are a few exceptions: grandfathered plans are subject to the rules governing rescissions, lifetime limits, and the extension of coverage to dependents. Grandfathered plans that are also group plans are also subject to the provisions governing annual limits.

## *(2) Health Insurance Mandates and Subsidies*

Beginning in 2014, and with exceptions that are intended to be limited, every U.S. citizen and legal resident will be required to have health insurance. For those not covered by a public plan, such as Medicare or Medicaid, this will mean private health insurance. The mechanisms for implementing this requirement are often referred to as the “employer mandate” and the “individual mandate.” Strictly speaking, neither are actual “mandates,” since in each instance paying a tax in the nature of a penalty is a specified alternative. However, the statutory scheme is designed to create strong incentives to opt for coverage.

*The Individual Mandate.* Starting in 2014, most individuals must either have “minimum essential coverage” or pay a “shared responsibility payment.” One potentially important exception to this requirement is that individuals are not required to acquire minimum essential coverage if they cannot afford such coverage. The statute defines a person as being unable to afford coverage if that person’s required contribution exceeds 8 percent of household income. Individuals who receive subsidies to purchase coverage (described below) may find that they can indeed “afford” coverage under this provision. But it is entirely possible that individuals and families who just miss receiving subsidies, or who receive only small subsidies, may find that they cannot, in fact, acquire coverage for less than 8% of their income.

PPACA defines “minimum essential coverage” very broadly. It includes both any employer sponsored plan “offered in the small or large group market within a state” and any health plan offered in the individual market in a state. The shared responsibility payment will eventually be the greater of \$695 per adult (and a lesser sum for each child)

or 2.5 percent of the excess of household income over the threshold that requires filing a federal income tax return.

*Individual Subsidies.* For eligible individuals, PPACA makes available a sliding-scale tax credit for premium reductions. It also includes additional subsidies designed to reduce cost-sharing for such individuals, both by limiting out-of-pocket expenses and by further procedures to be determined by SHHS. All individuals with incomes between 100 percent and 400 percent of the federal poverty line are eligible for these subsidies, with the subsidy level increasing as income decreases. Currently the federal poverty line for a family of four is \$22,000 a year in income, meaning that a family of four earning up to \$88,000 would be eligible for subsidies. These subsidies are only available to individuals who purchase individual insurance through an exchange.

*The Employer Mandate.* Starting in 2014, employers with at least 50 employees will be subject to a shared responsibility payment if any of their employees purchase insurance through an exchange and receive individual subsidies. For those employers who do not offer their employees the opportunity to enroll in “minimum essential coverage” (which need not include “Essential Health Benefits”) through an employer sponsored plan, they must make a payment determined by multiplying the total number of all employees, less thirty, by \$2000 a year. For employers who do offer this opportunity, the amount of their shared responsibility payment is determined by multiplying the number of employees who receive individual subsidies on the exchange by \$3000 per year. The amount of this payment is capped at the amount the payment would be if the employer did not offer its employees the opportunity to enroll in minimum essential coverage.

Employers who comply with the mandate are also required to offer eligible employees “choice vouchers” equal to the portion of the cost of the insurance that would have been paid by the employer if the employee had opted for coverage through that employer. Employees are eligible if their income is below 400 percent of the federal poverty line (thus entitling them to subsidies through the exchange) and their required contribution toward the cost of the employer-provided insurance would exceed 8 percent of their income (thus exempting them from the mandate in the absence of the voucher). These employees are then entitled to use the vouchers to purchase individual coverage through an exchange.

*Small Employer Subsidies:* An eligible small employer may claim a sliding scale tax credit, up to 35%, for premiums it pays towards health coverage for its employees if it pays up to 50% of health insurance premiums. Employers are eligible if they have 25 or fewer full time employees and the average annual compensation of these employees is less than \$50,000. Once the insurance exchanges are established in 2014, small employers must participate in the exchange in order to receive this credit. Starting in 2014, an employer is only eligible to receive this credit in two tax years.

## Notes and Questions

1. *Purpose of the Individual Mandate.* In many ways, the central element of healthcare reform is the individual mandate. This provision requires most individuals to have “minimum essential coverage” or pay a substantial monetary fine. Of course, this mandate helps to limit the number of uninsureds, which itself has larger benefits in terms of both increasing preventive care and improving emergency room service. But the key purpose of the individual mandate is to prevent adverse selection. How does the mandate accomplish this? Why is the individual mandate so important to prevent adverse selection within the PPACA scheme, given that insurers did not struggle unduly with adverse selection prior to reform?

2. *Constitutionality of the Individual Mandate.* Various state Attorneys General have instituted lawsuits claiming that the individual mandate exceeds Congress’s Constitutional power. Congress, of course, can only act pursuant to specific constitutionally-enumerated powers, the broadest of which is the power to regulate interstate commerce. Precedent makes clear that this power includes the power to regulate intrastate economic activity that substantially affects interstate commerce. PPACA itself states that the individual mandate falls within this power because health insurance and healthcare is “commercial and economic in nature, and substantially affects interstate commerce.” Critics contend, however, that this mandate does not regulate an economic activity at all, but rather economic inactivity. An alternative argument is that the individual mandate falls within the constitutional power of Congress to tax. Recall, after all, that the individual mandate simply imposes a tax on individuals who do not purchase minimum essential coverage. To what extent could healthcare reform be salvaged if the Supreme Court (which most observers expect to ultimately decide the issue) determines that the mandate is unconstitutional?

3. *Success of the Individual Mandate.* Recall that the individual mandate does not apply when the required contribution to health insurance would exceed 8 percent of household income. Currently health insurance in the individual market for a family of four with no deductible has an average premium of roughly \$12,000 a year, although prices vary widely depending on numerous factors. To what extent is there a risk that many will not ultimately be required to comply with the mandate? Recall that families can receive generous subsidies if they make up to 400% of the poverty line. Is there, however, a risk that those slightly above the 400% level may not ultimately be subject to the mandate?

4. *Continued Prevalence of Employer-Provided Coverage.* One very important unknown in the healthcare debate is whether employers will continue to provide coverage to their employees or will drop such coverage and pay any resulting fine. On the one hand, the availability of improved coverage on the individual market decreases the worker backlash that employers would experience from dropping coverage. Indeed, some employees might be grateful to their employers for dropping coverage, because the employer would presumably redirect the money it was spending on healthcare back into employee salaries. On the other hand, even after reform, all of the tax advantages

associated with employer-provided coverage still remain. And of course, employers who do not provide coverage are subject to the fines discussed above. A third potential result is that employers will continue to offer coverage, but that such coverage will contain limited benefits. A recent poll may shed some light on these questions. In mid 2010, various employers were asked to state their level of agreement with the statement that "Our organization would be better off if we dropped employee healthcare coverage and simply paid the fine." 52.5% surveyed strongly disagreed, 15.3% somewhat disagreed, 18% somewhat agreed, and 14.1% strongly agreed. See *Poll: Most Employers Likely to Continue Offering Health Care Coverage*, Business Insurance, Apr. 12, 2010, p. 28.

5. *Role of SHHS.* As the above description makes clear, PPACA leaves an extraordinary amount of work to be done by SHHS in upcoming years to implement healthcare reform. In most cases, SHHS is also directed to seek the input of the states, usually through the NAIC. To what extent does the success of healthcare reform ultimately turn on the success of SHHS's implementation efforts? With respect to the reforms described above, where is the SHHS's authority to promulgate rules and regulations particularly important?

#### b. CHALLENGING COVERAGE DENIALS UNDER ERISA

PPACA did not substantially impact federal laws governing coverage denials. Under ERISA, employees receiving health insurance as an employee benefit plan have the right to federal judicial review of a denial of benefits. Although ERISA itself does not establish the standard of review applicable to such challenges, in *Firestone Tire & Rubber Company v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed.2d 80, (1989), the U.S. Supreme Court held that "a denial of benefits... is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary [the employer or insurer] discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Where such discretion is in fact reserved, review takes place under an abuse of discretion standard. Even then, the reviewing court may take into account as a factor in determining whether there was an abuse of discretion the fact that the administrator may have a conflict of interest, for example, when the administrator of the plan is the insurer that will have to pay a claim if it finds that the claim is covered. *Metropolitan Life Insurance Company v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343 (2008).

When the employer or insurer has no such discretion, however, there is a *de novo* review under ERISA that is in essence an inquiry into whether there has been a breach of contract. Although the lower courts apply the deferential standard of review when they feel compelled to do so, see *Mario v. P & C Food Markets, Inc.*, 313 F.3d 758 (2d Cir. 2002), the case law reflects a decided judicial tendency to attempt to find a reason that *Firestone* does not apply and to review the denial of benefits *de novo*. See, e.g., *Jebian v. Hewlett-Packard*, 349 F.3d 1098 (9th Cir. 2003) (plan reserved discretion, but the court found that because the claim was denied before discretion was exercised, it would review the denial *de novo*); *Waupaca Foundry, Inc. v. Gehlhausen*, 104 F.Supp.2d 1052 (S.D. Ind. 2000) (plan reserved discretion but because plaintiff sought injunctive relief the *Firestone* standard did not apply).

**Aetna Health, Inc. v. Davila**

Supreme Court of the United States, 2004.

542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312.

■ JUSTICE THOMAS delivered the opinion of the Court.

In these consolidated cases, two individuals sued their respective health maintenance organizations (HMOs) for alleged failures to exercise ordinary care in the handling of coverage decisions, in violation of a duty imposed by the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem.Code Ann. §§ 88.001–88.003 (2004 Supp. Pamphlet). We granted certiorari to decide whether the individuals' causes of action are completely pre-empted by the "interlocking, interrelated, and interdependent remedial scheme," *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), found at § 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, as amended, 29 U.S.C. § 1132(a) *et seq.* 540 U.S. 981, 124 S.Ct. 462, 463, 157 L.Ed.2d 370 (2003). We hold that the causes of action are completely pre-empted and hence removable from state to federal court. The Court of Appeals, having reached a contrary conclusion, is reversed.

I

A

Respondent Juan Davila is a participant, and respondent Ruby Calad is a beneficiary, in ERISA-regulated employee benefit plans. Their respective plan sponsors had entered into agreements with petitioners, Aetna Health Inc. and CIGNA Healthcare of Texas, Inc., to administer the plans. Under Davila's plan, for instance, Aetna reviews requests for coverage and pays providers, such as doctors, hospitals, and nursing homes, which perform covered services for members; under Calad's plan sponsor's agreement, CIGNA is responsible for plan benefits and coverage decisions.

Respondents both suffered injuries allegedly arising from Aetna's and CIGNA's decisions not to provide coverage for certain treatment and services recommended by respondents' treating physicians. Davila's treating physician prescribed Vioxx to remedy Davila's arthritis pain, but Aetna refused to pay for it. Davila did not appeal or contest this decision, nor did he purchase Vioxx with his own resources and seek reimbursement. Instead, Davila began taking Naprosyn, from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization. Calad underwent surgery, and although her treating physician recommended an extended hospital stay, a CIGNA discharge nurse determined that Calad did not meet the plan's criteria for a continued hospital stay. CIGNA consequently denied coverage for the extended hospital stay. Calad experienced postsurgery complications forcing her to return to the hospital. She alleges that these complications would not have occurred had CIGNA approved coverage for a longer hospital stay.

Respondents brought separate suits in Texas state court against petitioners. Invoking THCLA § 88.002(a), respondents argued that petitioners' refusal to cover the requested services violated their "duty to exercise ordinary care when making health care treatment decisions," and that these refusals "proximately caused" their injuries. *Ibid.* Petitioners removed the cases to Federal District Courts, arguing that respondents' causes of action fit within the scope of, and were therefore completely pre-empted by, ERISA § 502(a). The respective District Courts agreed, and declined to remand the cases to state court. Because respondents refused to amend their complaints to bring explicit ERISA claims, the District Courts dismissed the complaints with prejudice.

## B

Both Davila and Calad appealed the refusals to remand to state court. The United States Court of Appeals for the Fifth Circuit consolidated their cases with several others raising similar issues. The Court of Appeals recognized that state causes of action that "duplicat[e] or fal[l] within the scope of an ERISA § 502(a) remedy" are completely pre-empted and hence removable to federal court. *Roark v. Humana, Inc.*, 307 F.3d 298, 305 (2002) (internal quotation marks and citations omitted). After examining the causes of action available under § 502(a), the Court of Appeals determined that respondents' claims could possibly fall under only two: § 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, and § 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan. \* \* \*

Congress enacted ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for employee benefit plans and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA § 514, 29 U.S.C. § 1144, which are intended to ensure that employee benefit plan regulation would be "exclusively a federal concern." *Alessi v. Raybestos–Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981).

ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Russell*, 473 U.S., at 147, 105 S.Ct. 3085 (internal quotation marks and citation omitted). This integrated enforcement mechanism, ERISA § 502(a), 29 U.S.C. § 1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans. As the Court said in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987):

"[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others

under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted \* \* \* provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly." *Id.*, at 54, 107 S.Ct. 1549 (quoting *Russell, supra*, at 146, 105 S.Ct. 3085).

Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted. See 481 U.S., at 54–56, 107 S.Ct. 1549; see also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143–145, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

The pre-emptive force of ERISA § 502(a) is still stronger. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65–66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987), the Court determined that the similarity of the language used in the Labor Management Relations Act, 1947 (LMRA), and ERISA, combined with the "clear intention" of Congress "to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of the LMRA," established that ERISA § 502(a)(1)(B)'s pre-emptive force mirrored the pre-emptive force of LMRA § 301. Since LMRA § 301 converts state causes of action into federal ones for purposes of determining the propriety of removal, see *Avco Corp. v. Machinists*, 390 U.S. 557, 88 S.Ct. 1235, 20 L.Ed.2d 126 (1968), so too does ERISA § 502(a)(1)(B). Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Metropolitan Life*, 481 U.S., at 65–66, 107 S.Ct. 1542. Hence, "causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court." *Id.*, at 66, 107 S.Ct. 1542.

### III A

ERISA § 502(a)(1)(B) provides:

"A civil action may be brought—(1) by a participant or beneficiary— ... (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to "enforce his rights" under the plan, or to clarify any of his rights to future benefits. Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan "giv[e] the administrator or fiduciary

discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls "within the scope of" ERISA § 502(a)(1)(B). *Metropolitan Life, supra*, at 66, 107 S.Ct. 1542. In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).

To determine whether respondents' causes of action fall "within the scope" of ERISA § 502(a)(1)(B), we must examine respondents' complaints, the statute on which their claims are based (the THCLA), and the various plan documents. Davila alleges that Aetna provides health coverage under his employer's health benefits plan. App. H to Pet. for Cert. in No. 02–1845, p. 67a, & ¶ 11. Davila also alleges that after his primary care physician prescribed Vioxx, Aetna refused to pay for it. *Id.*, at 67a, & ¶ 12. The only action complained of was Aetna's refusal to approve payment for Davila's Vioxx prescription. Further, the only relationship Aetna had with Davila was its partial administration of Davila's employer's benefit plan. See App. 25, 31, 39–40, 45–48, 108.

Similarly, Calad alleges that she receives, as her husband's beneficiary under an ERISA-regulated benefit plan, health coverage from CIGNA. *Id.*, at 184, & ¶ 17. She alleges that she was informed by CIGNA, upon admittance into a hospital for major surgery, that she would be authorized to stay for only one day. *Id.*, at 184, & ¶ 18. She also alleges that CIGNA, acting through a discharge nurse, refused to authorize more than a single day despite the advice and recommendation of her treating physician. *Id.*, at 185, & ¶ ¶ 20, 21. Calad contests only CIGNA's decision to refuse coverage for her hospital stay. *Id.*, at 185, & ¶ 20. And, as in Davila's case, the only connection between Calad and CIGNA is CIGNA's administration of portions of Calad's ERISA-regulated benefit plan. *Id.*, at 219–221.

It is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction, see *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (C.A.3 2001) (giving examples where federal courts have issued such preliminary injunctions).

Respondents contend, however, that the complained-of actions violate legal duties that arise independently of ERISA or the terms of the employee benefit plans at issue in these cases. Both respondents brought suit specifically under the THCLA, alleging that petitioners "controlled, influenced, participated in and made decisions which affected the

quality of the diagnosis, care, and treatment provided" in a manner that violated "the duty of ordinary care set forth in §§ 88.001 and 88.002." App. H to Pet. for Cert. in No. 02–1845, at 69a, & ¶ 18; see also App. 187, & ¶ 28. Respondents contend that this duty of ordinary care is an independent legal duty. They analogize to this Court's decisions interpreting LMRA § 301, 29 U.S.C. § 1081, with particular focus on *Caterpillar Inc. v. Williams*, 482 U.S. 386, 107 S.Ct. 2425, 96 L.Ed.2d 318 (1987) (suit for breach of individual employment contract, even if defendant's action also constituted a breach of an entirely separate collective bargaining agreement, not pre-empted by LMRA § 301). Because this duty of ordinary care arises independently of any duty imposed by ERISA or the plan terms, the argument goes, any civil action to enforce this duty is not within the scope of the ERISA civil enforcement mechanism.

The duties imposed by the THCLA in the context of these cases, however, do not arise independently of ERISA or the plan terms. The THCLA does impose a duty on managed care entities to "exercise ordinary care when making health care treatment decisions," and makes them liable for damages proximately caused by failures to abide by that duty. § 88.002(a). However, if a managed care entity correctly concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity's denial of coverage would not be a proximate cause of any injuries arising from the denial. Rather, the failure of the plan itself to cover the requested treatment would be the proximate cause.<sup>1</sup> More significantly, the THCLA clearly states that "[t]he standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity." § 88.002(d). Hence, a managed care entity could not be subject to liability under the THCLA if it denied coverage for any treatment not covered by the health care plan that it was administering.

Thus, interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners' administration of ERISA-regulated benefit plans. Petitioners' potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. So, unlike the state-law claims in *Caterpillar, supra*, respondents' THCLA causes of action are not entirely independent of the federally regulated contract itself. Cf. *Allis—Chalmers Corp. v. Lueck*, 471 U.S. 202, 217, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985) (state-law tort of bad faith handling of insurance claim pre-empted by LMRA § 301, since the "duties imposed and rights established through the state tort ... derive[d] from the rights and obligations established by the contract"); *Steelworkers v. Rawson*, 495 U.S. 362, 371, 110 S.Ct. 1904, 109 L.Ed.2d 362 (1990) (state-law tort action brought due to alleged negligence in the

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<sup>1</sup>To take a clear example, if the terms of the health care plan specifically exclude from coverage the cost of an appendectomy, then any injuries caused by the refusal to cover the appendectomy are properly attributed to the terms of the plan itself, not the managed care entity that applied those terms.

inspection of a mine was pre-empted, as the duty to inspect the mine arose solely out of the collective-bargaining agreement).

Hence, respondents bring suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA. We hold that respondents' state causes of action fall "within the scope of" ERISA § 502(a)(1)(B), *Metropolitan Life*, 481 U.S., at 66, 107 S.Ct. 1542, and are therefore completely pre-empted by ERISA § 502 and removable to federal district court.<sup>2</sup> \* \* \*

Respondents also argue—for the first time in their brief to this Court—that the THCLA is a law that regulates insurance, and hence that ERISA § 514(b)(2)(A) saves their causes of action from pre-emption (and thereby from complete pre-emption).<sup>3</sup> This argument is unavailing. The existence of a comprehensive remedial scheme can demonstrate an "overpowering federal policy" that determines the interpretation of a statutory provision designed to save state law from being pre-empted. *Rush Prudential*, 536 U.S., at 375, 122 S.Ct. 2151. ERISA's civil enforcement provision is one such example. See *ibid.* \* \* \*

As this Court stated in *Pilot Life*, "our understanding of [§ 514(b)(2)(A)] must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." 481 U.S., at 52, 107 S.Ct. 1549. The Court concluded that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.*, at 54, 107 S.Ct. 1549. The Court then held, based on

"the common-sense understanding of the saving clause, the McCarran–Ferguson Act factors defining the business of insurance, and, *most importantly*, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, ... that [the plaintiff's] state law suit

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<sup>2</sup>Respondents also argue that ERISA § 502(a) completely pre-empts a state cause of action only if the cause of action would be pre-empted under ERISA § 514(a); respondents then argue that their causes of action do not fall under the terms of § 514(a). But a state cause of action that provides an alternative remedy to those provided by the ERISA civil enforcement mechanism conflicts with Congress' clear intent to make the ERISA mechanism exclusive. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990) (holding that "[e]ven if there were no express pre-emption [under ERISA § 514(a)]" of the cause of action in that case, it "would be pre-empted because it conflict[ed] directly with an ERISA cause of action").

<sup>3</sup>ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), reads, as relevant: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A)." *Id.*, at 57, 107 S.Ct. 1549 (emphasis added).

*Pilot Life's* reasoning applies here with full force. Allowing respondents to proceed with their state-law suits would "pose an obstacle to the purposes and objectives of Congress." *Id.*, at 52, 107 S.Ct. 1549. As this Court has recognized in both *Rush Prudential* and *Pilot Life*, ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

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We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA § 502(a)(1)(B), and thus removable to federal district court. The judgment of the Court of Appeals is reversed, and the cases are remanded for further proceedings consistent with this opinion.

*It is so ordered.*

Justice GINSBURG, with whom Justice BREYER joins, concurring.

The Court today holds that the claims respondents asserted under Texas law are totally preempted by § 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA or Act), 29 U.S.C. § 1132(a). That decision is consistent with our governing case law on ERISA's preemptive scope. I therefore join the Court's opinion. But, with greater enthusiasm, as indicated by my dissenting opinion in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002), I also join "the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime." *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (C.A.3 2003) (Becker, J., concurring).

Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the "equitable relief" allowable under § 502(a)(3), a "regulatory vacuum" exists: "[V]irtually all state law remedies are preempted but very few federal substitutes are provided." *Id.*, at 456 (internal quotation marks omitted).

A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief. First, in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), the Court stated, in dicta: "[T]here is a stark absence—in [ERISA]

itself and in its legislative history—of any reference to an intention to authorize the recovery of extracontractual damages" for consequential injuries. *Id.*, at 148, 105 S.Ct. 3085. Then, in *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), the Court held that § 502(a)(3)'s term " 'equitable relief' ... refer [s] to those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.*, at 256, 113 S.Ct. 2063 (emphasis in original). Most recently, in *Great-West*, the Court ruled that, as "§ 502(a)(3), by its terms, only allows for *equitable* relief," the provision excludes "the imposition of personal liability ... for a contractual obligation to pay money." 534 U.S., at 221, 122 S.Ct. 708 (emphasis in original).

As the array of lower court cases and opinions documents, see, e.g., *DiFelice; Cicio v. Does*, 321 F.3d 83 (C.A.2 2003), cert. pending *sub nom. Vytra Healthcare v. Cicio*, No. 03–69, 72 USLW 3093 (2003), fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order. See 321 F.3d, at 106, 107 (Calabresi, J., dissenting in part) ("gaping wound" caused by the breadth of preemption and limited remedies under ERISA, as interpreted by this Court, will not be healed until the Court "start[s] over" or Congress "wipe[s] the slate clean"); *DiFelice*, 346 F.3d, at 467 ("The vital thing ... is that either Congress or the Court act quickly, because the current situation is plainly untenable."); Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell*, *Mertens*, and *Great-West*, 103 Colum. L.Rev. 1317, 1365 (2003) (hereinafter Langbein) ("The Supreme Court needs to ... realign ERISA remedy law with the trust remedial tradition that Congress intended [when it provided in § 502(a)(3) for] 'appropriate equitable relief.' "). \* \* \*

## Notes and Questions

1. *A Patchwork Quilt of ERISA Doctrine.* Because the Supreme Court has waded into ERISA doctrine only selectively, the overall portrait of what forms of state regulation of the behavior of HMO's and other health insurers are pre-empted, and what forms of regulation are permitted, is not entirely clear. For example, in *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000), the Court held that there was no ERISA cause of action against a physician employed by an HMO and acting as an administrative-fiduciary for what the Court called "mixed" decisions involving both eligibility and treatment. In that case a malpractice judgment (involving what the Court would have called a "pure" treatment decision) under state law had already been obtained. It seemed undeniable, however, that a state cause of action on the eligibility ground was pre-empted. Then, in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), the Court held that an Illinois statute providing for independent administrative review of HMO coverage eligibility decisions was not pre-empted by ERISA. What state-law-based remedies do you think that these decisions, together with *Davila*, leave open to a disappointed healthcare claimant?

2. *The Underlying Dilemma.* To the extent that ERISA's purpose has turned out to be to address employment-based healthcare plans (as distinguished, for example, from pensions), the core of that purpose is to adopt a uniform scheme that pre-empts individual

remedial differences across the states. Thus, it makes sense to say that state law governing coverage (or as the Court calls them, "eligibility") issues should be pre-empted by ERISA. Similarly, it makes sense to say that state law governing the quality of care delivered (malpractice, or "treatment") issues should not be pre-empted. This may well include a claim against an HMO or health insurer seeking to impose vicarious liability for physician malpractice. See, e.g., *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995). And it may make sense to say that "mixed" coverage and treatment decisions are also pre-empted, because of the difficulty of ever separating the two. As Justice Ginsburg's concurrence indicates, however, ERISA's array of remedies does not include the right to recover consequential or tort damages (for pain and suffering, mental anguish, or punitive damages, for example) for breach of a contract governed by ERISA. Thus, clearly pre-empted from the arsenal of remedies that would otherwise be available under state law, and not available under ERISA itself, is the right to sue an HMO or health insurer for extra-contractual damages resulting from the denial of coverage—i.e., for something more than the benefits that were improperly denied. The decision in *Pilot Life* referred to by the Court in *Davila* and set out in below Section D of this Chapter reflects this arrangement. An amendment to ERISA itself—perhaps in the nature of the "Patients Bill of Rights" that has been before Congress in a number of versions over the last decade—would seem to be necessary to assure that there is such a right.

#### c. COST CONTAINMENT

As described above, PPACA's primary goal can fairly be described as increasing access to care. At the same time, PPACA does contain numerous provisions aimed at containing the rate of healthcare inflation in coming years. In fact, in terms of pure numbers, it is probably the case that more of PPACA's individual provisions are aimed at this goal than the access goal. In part, however, this reflects the fact that there is much less consensus among policymakers about what approaches will ultimately succeed in containing healthcare costs. As a result, PPACA contains numerous provisions establishing experimental programs and grants designed to test different approaches to cost containment. Unfortunately, it does little to establish a roadmap for implementing more wide-scale cost cutting reforms on the basis of lessons learned from these various test programs and grants. However, PPACA does contain several very important provisions that may indeed help to contain costs in the near future.

*Regulation of Medical Loss Ratios.* Effective in 2011, each insurer (but not employers with self-funded plans) must provide SHHS with a report documenting their Medical Loss Ratio (MLR). The MLR is equal to the percentage of total premium revenue that the insurer expends "(1) on reimbursement for clinical services ...; (2) for activities that improve health care quality; and (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees." Claims costs include the administrative expenses of processing claims, including legal fees. Insurers must provide rebates to their policyholders when their MLRs drop below 85% in the large group market or 80% for small group and individual plans. SHHS, in consultation with the NAIC, is tasked with establishing detailed regulations on the calculation of MLR, and the issue has already provoked extensive

debate about how to account for expenses such as disease management programs, nurse hotlines, quality assurance oversight, health information technology expenses and fraud prevention.

*Rate Regulation.* SHHS, in conjunction with the states, is directed to establish a process for the annual review of “unreasonable” premium increases. The states are to implement whatever process is developed. Exactly what this process will look like and how it will function are unclear, especially since the statute refers to premium “increases” rather than to premiums themselves. However, PPACA does make clear that each insurer must submit to SHHS and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase and must prominently post this information on its websites.

*Cadillac Tax.* Starting in 2018, a 40% tax will be imposed to the extent that the aggregate value of an employer sponsored health plan exceeds a threshold level. The threshold limits are \$10,200 multiplied by a health cost adjustment measure for an individual plan and \$27,500 multiplied by a health cost adjustment measure for a family plan. Adjustments to these amounts are also included to ensure that employers with a comparatively old or sick workforce are not disadvantaged by this provision.

## Notes and Questions

1. *Design of the Cadillac Tax.* Why is the Cadillac tax directed only at employer provided plans, but not individual plans? How could it theoretically help to reduce costs of healthcare delivery?

2. *MLR restrictions and Improving Healthcare Quality.* A number of seemingly administrative costs for health insurers may arguably help to improve healthcare quality. For instance, utilization review – wherein an insurer reviews a request for medical treatment to determine if it is medically necessary or appropriate – is an administrative expense that may help to improve healthcare quality. Should expenses that insurers incur in conducting utilization review count as medical expenses or claims expenses for purposes of determining the MLR? Does the fact that greater use of utilization review actually harms policyholders by making doctor-recommended treatments less likely to be paid for impact your answer? Should it?

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Aside from some of the experimental programs referenced above, PPACA does very little to alter many of the key drivers of excessive healthcare inflation. First, it does not alter the fact that providers are generally paid based on the quantity of services they render rather than the quality of those services. Second, it does little to change the ex post moral hazard that patients experience in seeking medical services and choosing among alternative treatment and testing options. At least for now, the primary constraints on these problems are those that existed prior to healthcare reform. These constraints are described in the main textbook starting on page 404.