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The Employee Retirement Income Security Act of 1974 (“ERISA”) is a federal law that protects employees by providing minimum standards for health plans established by private employers.¹ Denials of an individual’s benefits are reviewed under a standard referred to as the arbitrary and capricious standard, which establishes whether there has been an abuse of discretion caused by a benefit plan administrator’s conflict of interest; the standard is applied in situations where the administrator of the health plan has discretionary authority to determine eligibility for benefits.² The applicable definition of a pre-existing condition in this instance is “a condition for which medical treatment or advice was rendered, prescribed or recommended within twelve months (three months for exempt employees) prior to [the] effective date of insurance.”³ An exempt employee is an employee that is “paid the same salary every week” and is “never entitled to overtime” regardless of the amount of work performed.⁴ In *Doroshow v.*

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Hartford Life & Accident Ins. Co., the United States Court of Appeals for the Third Circuit reviewed the district court’s decision granting summary judgment in favor of Hartford Life and Accident Insurance Company (“Hartford”) because according to the lower court, Hartford’s decision to deny benefits to Jay Doroshow (“Doroshow”) was not arbitrary and capricious. The court, in affirming the summary judgment, also concluded that Hartford’s decision was not arbitrary and capricious because seeking advice regarding a suspected, but not yet diagnosed ailment, may appropriately constitute a pre-existing condition.

CVS Corporation (“CVS”) offered a Long Term Disability Income Insurance Plan (the “Plan”) to its employees, and Hartford had discretion over eligibility for the Plan. Doroshow was an employee of CVS and a participant in the Plan. The Plan contained a pre-existing condition exclusion, whereby benefits will not be payable for disabilities “caused by, contributed to, or resulting from . . . a pre-existing condition.” On July 25, 2005, due to a family history of Amyotropic Lateral Sclerosis (“ALS”) and certain symptoms he was experiencing, Doroshow visited neurologist, Dr. Mark Brown (“Dr. Brown”), who conducted an electromyographic (“EMG”) test and concluded that Doroshow may have a form of ALS. Two days after the EMG test, Doroshow visited an ALS specialist, Dr. Leo McClusky (“Dr. McClusky”), who concluded that the symptoms displayed by Doroshow “[did] not support the [diagnosis] of” ALS and did not support a progressive motor neuron disorder. After a May 16, 2006 visit with his

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5 574 F.3d 230 (3d Cir. 2009).
6 Id. at 231, 235 (concluding plan administrator’s decision not without reason and not unsupported by substantial evidence).
7 Id. at 236.
8 Id. at 231. The Long Term Disability Income Insurance Plan is “a group benefit plan issued by Hartford” and available for employees of CVS Corporation. Id. Hartford had been “delegated sole discretionary authority . . . to determine [the participant’s] eligibility for benefits and to interpret the terms and provisions of the plan and any policy issue in connection with it.” Id.
9 Doroshow, 574 F.3d at 231.
10 Id. at 231. The Plan defines pre-existing condition as one “for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to [the participant’s] effective date of insurance.” Id. Doroshow was an exempt employee and therefore subject to the 3 month look-back period. Id. at 231-32.
11 Id. at 232. After the EMG test on Doroshow, Dr. Brown noted, “1. Chronic active degeneration of right leg, arm, paraspinal and bulbar muscles with near-normal nerve conduction studies. These are features of a motor neuron disease. 2. If the left Babinski sign is a consistent feature then he has the ALS form of motor neuron disease.” Id.
primary care physician, Dr. Arnold Goldstein (‘Dr. Goldstein’), Dr. Goldstein contended that Doroshow did not have ALS.\(^\text{13}\)

Doroshow’s coverage under the Plan began on July 1, 2006, and since Doroshow was an exempt employee, he was subject to the three-month look-back period, which initiated on April 1, 2006.\(^\text{14}\) Dr. McClusky diagnosed Doroshow with ALS on March 15, 2007, and Doroshow applied for disability benefits under the Plan the following day.\(^\text{15}\) Hartford denied Doroshow’s claim in writing on August 30, 2007; Hartford reasoned that Doroshow’s ALS constituted a pre-existing condition because he received advice regarding the possibility of an ALS diagnosis from Dr. Goldstein on May 16, 2006.\(^\text{16}\) Doroshow appealed Hartford’s decision without success through an internal administrative procedure.\(^\text{17}\)

Doroshow filed an action against Hartford in district court pursuant to 29 U.S.C. § 1132(a)(1)(B), and he claimed that Hartford’s determination was arbitrary and capricious.\(^\text{18}\) The district court granted summary judgment in favor of Hartford because Doroshow failed to demonstrate the decision was arbitrary and capricious.\(^\text{19}\) On appeal,

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\(^\text{13}\) *Doroshow*, 574 F.3d at 232. Dr. Goldstein’s office notes stated “[m]otor neuron disease. Lumbrosacral plexitis is the most recent diagnosis. Was not felt to be ALS.” *Id.*

\(^\text{14}\) *Id.* at 231-32. It was undisputed that the three-month look-back period applied to Doroshow as opposed to the default twelve month look-back period. *Id.*

\(^\text{15}\) *Id.* at 232.

\(^\text{16}\) *Id.* Dr. Goldstein’s medical records indicated that during the May 16, 2006 meeting, “ALS was discussed” and irregular follow up updates, regarding symptoms, continued from that point on until the diagnoses in March 2007. *Doroshow*, 574 F.3d at 232.

\(^\text{17}\) *Id.*

\(^\text{18}\) *Id.* “A civil action may be brought by a participant or beneficiary . . . 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.” *See* 29 U.S.C. § 1132(a)(1)(B).

\(^\text{19}\) *Doroshow*, 574 F.3d at 232-33. The district court considered the applicable definition of a pre-existing condition and came to the conclusion that Hartford’s decision was reasonable because Doroshow received advice pertaining to ALS during the pertinent look-back period. *Id.* at 234. The district court employed the ordinary meaning of advice, as “an opinion or recommendation
the United States Court of Appeals for the Third Circuit affirmed the district court’s grant of summary judgment.20 The court agreed with the district court that “advice is a broader concept than treatment, and a doctor’s conclusion that a patient is not suffering from a certain condition constitutes an opinion or recommendation offered as a guide to action.”21 Furthermore, the court concluded that Hartford’s determination that Doroshow received advice regarding ALS was reasonable in light of the fact that two doctors considered ALS as a possible explanation for his symptoms prior to the look-back period.22

ERISA grants individuals the authority to bring civil actions to recover benefits owed to them pursuant to the terms of their benefits plan or to clarify their rights to future benefits in accordance with the health care plan.23 Health insurance policies normally cover losses incurred after the commencement of the plan, and consequently, pre-existing conditions can be the basis for the denial of the individuals’ coverage so that insurance companies can avoid paying for expensive treatment.24 As a result, federal

offered as a guide to action.” Id. “Because two doctors before Dr. Goldstein considered ALS as, at least, a possible explanation for his symptoms, we find Hartford’s determination that Doroshow received advice pertaining to ALS specifically during the look-back period was reasonable.” Id. at 235.

20 Id. at 236.
21 Id. at 235. “By stating his opinion that the motor neuron disease afflicting his patient was not ALS but rather lumbrosacral plexitis, Dr. Goldstein rendered an opinion about ALS during the three months prior to the effective date of coverage.” Doroshow, 574 F.3d at 235 (quoting Doroshow v. Hartford Life & Accident Ins. Co., 560 F. Supp. 2d 392, 400 (E.D. Pa. 2008)).
22 Id. at 235. “ALS is the most common form of motor neuron disease.” Id. “From the record and Doroshow’s family history of ALS . . . it seems that a diagnosis of ALS was repeatedly considered after he began showing symptoms of a motor neuron disease.” Id.

23 29 U.S.C. § 1132(a)(1)(b). ERISA provides remedies for participants/beneficiaries who believe their insurance denied them full benefits pursuant to their plan. See id. Section 502(a) of ERISA provides plan beneficiaries the opportunity to recover benefits owed by suing the plan directly. See Jana K. Strain & Eleanor D. Kinney, The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA, 31 LOY. U. CHI. L.J. 29, 39 (1999). Courts can review plan fiduciary determinations de novo. See id. But see id. at 40 (acknowledging deficiency of ERISA remedies because courts’ application often results in denial of recovery of damages for plan beneficiaries).
24 See Jennifer M. Franco, Note, Undermining the Protection of Health Insurance: The Preexisting Condition Clause, 30 NEW ENG. L. REV. 883, 886 (1996). “A preexisting condition clause is drafted to prohibit, restrict, or postpone coverage for an illness which either predated the insurance contract or developed during a prescribed waiting period after the insurance contract has been executed.” Id. A pre-existing condition is an ailment that an individual has acquired prior to the execution of the insurance contract. Id. “The law in each state is different for pre-existing conditions, therefore a disability claimant should consult with a disability insurance attorney prior to filing a claim for benefits.” See Posting of Gregory Michael Dell to Disability Insurance Attorneys,
courts adopted the arbitrary and capricious standard as the appropriate standard of review for challenges to benefit eligibility determinations; moreover, courts recognize the existence of a conflict of interest when benefit plans give discretion to an administrator to determine the eligibility of the plan and the authority to interpret the terms of the plan. In Metropolitan Life Ins. Co. v. Glenn, the Supreme Court rejected its previous precedent set forth in Firestone Tire & Rubber Co. v. Bruch, which contended that this conflict of interest requires a more stringent arbitrary and capricious standard. The Glenn court further clarified its holding by stating that the judge applying the

Disability Insurance Claims Law Blog, http://www.disabilitylawblog.com/tags/disability-insurance-attorneys-1/ (last visited Nov. 16, 2010). “A pre-existing condition can be something as common and as serious as heart disease, high blood pressure, cancer, type 2 diabetes, and asthma . . . [e]ven if you have a relatively minor condition such as hay fever or a previous accidental injury, a health plan can deny coverage.” See Michael Bihari, MD, About.com, Pre-Existing Conditions – Understanding Exclusions and Creditable Coverage, http://healthinsurance.about.com/od/healthinsurancebasics/a/preexisting_conditions_overview.htm (last visited Nov. 16, 2010). See infra notes 40-42 and accompanying text (discussing pros and cons of pre-existing condition exclusions) and notes 62-63 and accompanying text (commenting on scope of and insurance company’s use of pre-existing condition exclusions).

See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989). “ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations. To fill this gap, federal courts have adopted the arbitrary and capricious standard . . .” Id. “[T]he arbitrary and capricious standard developed under 61 Stat. 157, 29 U.S.C. § 186(c), a provision of the Labor Management Relations Act, 1947 (“LMRA”).” Id. See id. at 115. “Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighted as a “facto[r] in determining whether there is an abuse of discretion.” Id. (quoting RESTATEMENT (SECOND) OF TRUSTS §187 cmt. d (1959)). See Pinto v. Reliance Standard. Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 2000) (imposing heightened form of arbitrary and capricious review for administrators acting under conflict of interest). See RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. e (1959) (describing discretionary powers as such powers conferred upon to determine the disposition of beneficial interests). The following may be relevant circumstances when considering whether there is an abuse of discretion:

1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or nonexistence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee’s conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

See id. at cmt. d.

20 Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105 (2008). The court emphasized that the arbitrary and capricious standard of review should not be altered due to the existence of a conflict of interest. See id. at 116-17.
arbitrary and capricious standard may take into account various factors, one of which is a conflict of interest, and “any one factor will act as a tiebreaker when the other factors are closely balanced.”

Furthermore, under the arbitrary and capricious standard, the court must determine whether the plan administrator’s decision to deny benefits “was based on a consideration of the relevant factors and whether there has been a clear error of judgment.”

The court must defer to the Plan’s administrator under this standard; and as such, a court can only overturn a plan administrator’s decision if the decision is made “without reason, unsupported by substantial evidence or erroneous as a matter of law,” or it was “[ir]rational in light of the plan’s provisions.”

27 Id. at 117 (discussing review of conflict of interest). The reviewing court should consider a conflict of interest merely as one factor among several. See id. A conflict of interest “should prove less important . . . where the administrator has taken active steps to reduce potential bias and to promote accuracy . . . .” Id. A conflict of interest may have great importance “where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.” Id. at 2351. See John H. Langbein, Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, 101 NW. U.L. REV. 1315, 1317-21 (2007) (describing history of biased claims administration by insurance company).

28 See Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971). Relevant factors may include age, health, past and present health status, and an “insurance company has the right to deny you coverage, or offer you coverage with a rider that excludes coverage for a certain pre-existing medical condition.” See Alaska (AK) Individual Health Insurance Regulations, Alaska Health Insurance, http://www.healthinsurancefinders.com/healthinsurance/alaska/ (last visited Nov. 16, 2010). A pre-existing condition can affect insurance coverage because insurance companies may exclude coverage for individuals due to a pre-existing condition. See Michael Bihari, MD, About.com, Pre Existing Conditions – Understanding Exclusions and Creditable Coverage, http://healthinsurance.about.com/od/healthinsurancebasics/a/preexisting_conditions_overview.htm (last visited Nov. 16, 2010). “Depending on the policy and your state’s insurance regulations, this exclusion period can range from six to 18 months.” See id.

In 2004, the United States Court of Appeals for the Third Circuit decided *McLeod v. Hartford Life & Accident Ins. Co.*, and in concluding that the denial of disability benefits was arbitrary and capricious, the court held that symptoms for which one receives medical care, even without a diagnosis, can serve as the basis for denying benefits only when there is “intent to treat or uncover the particular ailment which causes that symptom,” but here the symptoms were non-specific and the condition was unsuspected. 30 Courts will generally interpret that an individual’s intent to obtain advice for a particular ailment has manifested when the individual seeks advice with a precise concern in mind. 31 Thus, when a patient does not have a specific concern in mind or when a patient displays non-specific symptoms, courts will generally conclude that the patient did not seek advice for a particular ailment because “there [was] no connection between the . . . advice rendered and the sickness.”32 In *Lawson v. Fortis Ins. Co.*, a child,

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30 *McLeod v. Hartford Life & Accident Ins. Co.*, 372 F.3d 618 (3d Cir. 2004). Employee was denied disability benefits due to an alleged pre-existing condition of multiple sclerosis. See id. at 628. A symptom becomes relevant in the exclusion procedure only when it is connected to the diagnosis of the ailment. See id. at 627. The court stated that it was insufficient to deny benefits based on pre-existing grounds because an individual suffered from symptoms that were later identified as consistent with cancer. See *Ermenc v. American Family Mut. Ins. Co.*, 585 N.W.2d 679, 682 (Wis. Ct. App. 1998). “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.” See id. Symptom is defined as

1. Med. A functional or vital phenomenon of disease; any perceptible change in any organ or function due to morbid conditions or to morbific influence, especially when regarded as an aid in diagnosis. Symptoms differ from signs in the diagnosis of a disease in that the former are functional phenomena, while the latter are incidental or experimental.

FUNK & WAGNALLS NEW STANDARD DICTIONARY OF THE ENGLISH LANGUAGE 2246 (1942).

31 See *Lawson v. Fortis Ins. Co.*, 301 F.3d 159, 166 (3d Cir. 2002). The court concluded that the individual had no coverage under the plan due to a pre-existing condition because she received advice about a lump. See *McWilliams v. Capital Telecomm.*, 986 F. Supp. 920, 927 (M.D. Pa. 1997). “The pre-existing-condition clause does not require a diagnosis or that the patient or her doctor have defined her illness.” See id.

32 See *Lawson*, 301 F.3d at 166. There was no evidence that the doctor believed the patient’s ailment to be leukemia; therefore, the doctor could not have provided medical advice or treatment for that disease. See id.

When a patient seeks advice for a sickness with a specific concern in mind . . .
who was eventually diagnosed with leukemia, received treatment for a respiratory tract infection. The insurance company argued the child’s ailment was a pre-existing condition because during the look-back period she received treatment for her respiratory tract infection, so as a result, the insurance company denied her health benefits. The court held, however, leukemia was not a pre-existing condition because one cannot receive advice or treatment for a genuine unsuspected condition, and here, the child did not receive treatment or advice for leukemia, as the doctor, the child, and the child’s parents did not suspect the leukemia.

Despite the Third Circuit’s interpretation of pre-existing conditions, the issue of pre-existing conditions remains unsettled, and the Federal Courts of Appeals have varied among the circuits in their interpretation of the applicable language within health insurance contracts. Reasoning that the pre-existing condition language in the contract has been ambiguous, the Courts of Appeals for the First, Fifth, and Seventh circuits

or when a physician recommends treatment with a specific concern in mind . . . it can be argued that an intent to seek or provide treatment or advice ‘for’ a particular disease has been manifested.

Id. The court deemed plaintiff’s breast lump to be a pre-existing condition because the plaintiff received treatment for the lump, which the court found not a trivial and inconclusive symptom. See Bullwinkel v. New England Mut. Life Ins. Co., 18 F.3d 429, 433 (7th Cir. 1994). The claimant was denied benefits because the doctor informed the claimant that the diagnosis of multiple sclerosis was “likely” or “most likely” prior to the effective date of policy. See Cury v. Colonial Life Ins. Co., 737 F. Supp. 847, 851 (E.D. Pa. 1990).

Lawson, 301 F.3d at 161. The child suffered symptoms of “hacking cough, a fever, an elevated pulse rate, and a swollen right eye,” and those ailments were diagnosed as an upper respiratory tract infection. Id.

Lawson, 301 F.3d at 163. “Both state and federal courts have interpreted pre-existing condition language in health insurance contracts differently.” Id.
have given deference to insured individuals by asserting that treatment or advice for a particular condition requires the insured or the physician to be specifically aware of that particular condition in order to render it a pre-existing condition.\textsuperscript{37} Alternatively, both the Seventh and Eighth circuits have argued that the pre-existing condition language does not require a diagnosis of the condition for the exclusion to be applied.\textsuperscript{38} Further adding to the circuit split, the First Circuit has concluded that a suspected condition has been manifested if advice or treatment is provided and the physician or the patient has “some awareness” of the condition.\textsuperscript{39} The circuit split is further exacerbated given the ongoing national debate regarding the costs and benefits of pre-existing condition exclusions, and specifically because insurance companies have argued against such reforms by suggesting that banning pre-existing condition exclusions would have a detrimental impact on the quality of care for policy-holders and health care costs would

\textsuperscript{37} See id. at 165. In order to receive advice or treatment for a condition, there must be some awareness on the part of the physician or the insured that the advice or treatment is for the condition itself. See Hughes v. Boston Mutual Life Ins. Co., 26 F.3d 264, 269-70 (1st Cir. 1994). “[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.” Pitcher v. Principal Mutual Life Ins. Co., 93 F.3d 407, 412 (7th Cir. 1996). “There 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.” Ross v. Western Fidelity Ins. Co., 881 F.2d 142, 144 (5th Cir. 1989). Language of the applicable pre-existing condition clause merely requires that the “claimant either (a) receive medical treatment or consultation; (b) have medical care or services; (c) have diagnostic tests, or (d) take prescribed drugs or medicine within 90 days prior to your effective date.” Cary, 737 F. Supp. at 854. “[T]here is no requirement that a diagnosis, definite or otherwise, of the pre-existing condition must be made during the pre-existing condition period.” Lawson, 301 F.3d at 163. But see id. at 854 (stating diagnosis of pre-existing condition not required during the pre-existing condition period).

\textsuperscript{38} See Lawson, 301 F.3d at 165. “[T]he First, Fifth, and Seventh Circuits have followed the approach taken . . . 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.” Id. (noting Seventh Circuit contradicted itself). Even though the individual insured was not diagnosed with cancer until after the coverage began, the court concluded that the discovery of a breast lump prior to the effectiveness of coverage was a pre-existing condition because the patient was “seen,” “treated” and incurred medical expenses during this time. See Bullwinkel v. New England Mutual Life Ins. Co., 18 F.3d 429, 432 (7th Cir. 1994). The court found the existence of a pre-existing condition when the patient was treated for muscle pain prior to the effectiveness of coverage and diagnosed with chronic fatigue syndrome after coverage period commenced. See Marshall v. UNUM Life Ins. Co., 13 F.3d 282, 284-85 (8th Cir. 1994).

\textsuperscript{39} See Hughes, 26 F.3d at 269 (noting exclusion requires awareness of physician or insured that treatment for condition is being rendered).
rise to exorbitant levels.\textsuperscript{40} While concerns of heightened costs are legitimate, evidence

\textsuperscript{40} See Joshua Bachrach, \textit{Third Circuit Takes a Less Restrictive View of Pre-Existing Condition Limitations, Life, Health, Disability & ERISA Newsletter}, February 2010, http://www.wilsonelser.com/files/repository/LHDE_full_Feb2010.pdf#nameddest=TCT (introducing some of the controversy regarding health care and the issue of pre-existing condition exclusions). Health care reform has been an ongoing debate in this country and the question of pre-existing condition exclusions remains a critical element of the reform efforts. See Marc Seltzer, \textit{Pre-Existing Conditions and Health Care Reform}, POLITICS UNLOCKED, Jul. 1, 2009, http://www.politicsunlocked.com/index.php/article/pre-existing_conditions_and_health_care_reform/28034. See Nancy Metcalf, Health-care Reform: Why Not Ban Pre-Existing Condition Exclusions and Call it a Day?, CONSUMER REPORTS HEALTH BLOG, Jan. 27, 2010, http://blogs.consumerreports.org/health/2010/01/health-care-reform-why-not-ban-pre-existing-condition-exclusions-and-call-it-a-day.html (considering the pros and cons of banning the pre-existing condition exclusion). See infra notes 64-68 and accompanying text. The Democratic Policy Committee claims that the Patient Protection and Affordable Care Act, H.R. 3590, will “ban (the) pre-existing condition exclusion for all patients in the U.S.” See David Anderson, Gather, What the Health Care Bill Means For People With Pre-Existing Conditions, http://politics.gather.com/viewArticle.action?articleId=281474978121489#comments (last visited Nov. 16, 2010). “Insurance companies and health plans are concerned about their financial bottom line – it’s in their best interest, therefore, to exclude people with a pre-existing condition . . . .” See Michael Bihari, MD, About.com, Pre Existing Conditions – Understanding Exclusions and Creditable Coverage, http://healthinsurance.about.com/od/healthinsurancebasics/a/preexisting_conditions_overview.htm (last visited Nov. 16, 2010). A proposal to require insurance companies to cover individuals may detrimentally affect the quality of care enrollees receive. See John C. Goodman, \textit{Ten Small-Scale Reforms for Pre-Existing Conditions}, NATIONAL CENTER FOR POLICY ANALYSIS, Feb. 11, 2010, available at http://www.ncpa.org/pub/ba691 (addressing potential resolutions to pre-existing condition issue). Requiring coverage of pre-existing conditions would destroy the quality of care because “[w]henever people get sick, they switch to better plans, and then switch back to cheaper plans when they get well . . . this provides a strong disincentive to provide high-quality care.” See Internet Scofflaw, Pre-Existing Conditions, http://internetsofflaw.com/2010/01/ (last visited Nov. 16, 2010). See Fred Atwood, \textit{More Honor Due the Fallen}, ARKANSAS DEMOCRAT-GAZETTE, Nov. 19, 2009, at Editorial (questioning price of health insurance if insurance companies could not utilize pre-existing condition exclusion). “And if companies are required to cover pre-existing conditions, what will be allowed to charge? Affordable . . . means nothing if insurance companies are still allowed to price individuals out of the system. Give me a dollar figure.” \textit{Id.} New York state passed a law that “prohibited insurance companies from denying coverage to people with preexisting health problems,” and as a result, the “average premiums for a health plan on the individual market in New York has nearly tripled, according to the state Insurance Department.” See Noam N. Levey, \textit{Health Reform Misfired; New York Provides a Cautionary Tale that Simple Fixes can Have Unwelcome Results}, LOS ANGELES TIMES, Feb. 21, 2010, at Part A, Pg. 1. “[W]hen insurance companies don’t deny coverage to individuals with pre-existing conditions, each person has an incentive NOT to buy health insurance until they come down with a serious disease.” See Jason Shafrin, \textit{Obama’s State of the Union Address: The Healthcare Economists Take}, HEALTHCARE ECONOMIST, Jan. 28, 2010, http://healthcare-economist.com/2010/01/27/obamas-state-of-the-union-address-the-healthcare-economists-
suggests that the pre-existing condition exclusion has wreaked financial havoc on the lives of individuals who suffer from such conditions. In light of these policy concerns and the awareness regarding how pre-existing conditions affect individuals’ own health care situations, there is now a stronger demand for a consistent federal standard.

In Doroshow v. Hartford Life & Accident Ins. Co., the United States Court of
Appeals for the Third Circuit applied the arbitrary and capricious standard, considered conflicts of interest only as a consideration among many factors, and concluded that the decision by the plan administrator could only be overturned if it was “without reason, unsupported by substantial evidence or erroneous as a matter of law.” The insurance contract provision at issue stated that receiving advice for a condition prior to the effective date of insurance constituted a pre-existing condition, and the court determined that the ordinary meaning of the term “advice” was “an opinion or recommendation offered as a guide to action.” The court considered the district court’s conclusion that when Doroshow’s primary care doctor incorrectly ruled out ALS as a possible condition, it constituted a pre-existing condition, reasoning that this was an opinion rendered concerning ALS during the look-back period. While the court did not generally accept the contention that ruling out a condition constitutes advice, the court considered Doroshow’s complete medical narration and concluded that the ruling out of ALS in his situation did in fact constitute advice because during the look-back period, doctors considered ALS as a diagnosis and provided specific advice to Doroshow regarding that particular ailment.

The court considered cases cited by Doroshow to support his contention that “advice” does not encompass “ruling out” a condition. However, unlike in McLeod v...
Hartford Life & Accident Ins. Co., where the employee sought benefits for cancer treatment, yet was arbitrarily and capriciously denied benefits due to pre-existing symptoms of multiple sclerosis, Doroshow sought advice for a particular condition and was denied benefits related to treatment for that same condition.\(^{48}\) The court came to this conclusion because Doroshow was aware of his family history of ALS and also because Doroshow’s medical history indicated that ALS was considered as a potential diagnosis for his ailments since as early as 2005.\(^{49}\) Moreover, unlike in Lawson v. Fortis Ins. Co., where a child was misdiagnosed and deemed not to have received medical advice because neither the doctor nor the parents ever suspected the ailment to be leukemia, Doroshow was not misdiagnosed; he had a “suspected condition without a confirmatory diagnosis.”\(^{50}\) In fact, Doroshow’s doctors determined that he suffered from motor neuron disease and possibly suffered from ALS, but at no time did his doctors inform him that he definitively did not have ALS.\(^{51}\) Therefore, the court concluded that a “suspected condition without a confirmatory diagnosis” can be classified as a pre-existing condition because here Doroshow sought and received advice pertaining to ALS during the look-back period of his plan.\(^{52}\)

In Doroshow v. Hartford Life & Accident Ins. Co., the court seemingly took the middle road between the opposing circuits in concluding that no diagnosis is required in order to deem a condition pre-existing, as long as either the patient or the physician suspected the condition.\(^{53}\) The Third Circuit deemed a suspected condition to be one in which “a patient seeks advice for a sickness with a specific concern in mind” or when a

constitute advice, cites two of our cases, McLeod v. Hartford Life & Accident Ins. Co. . . . and Lawson v. Fortis Ins. Co.”\(^{\text{Id.}}\)

\(^{48}\) Doroshow, 574 F.3d at 236 (concluding Doroshow sought advice for ALS during look-back period).

\(^{49}\) Id. at 235-36. In July 2005, Doroshow’s neurologist informed him that he “showed signs of motor neuron disease and possibly ALS” and then suggested that he meet with an ALS specialist.\(^{\text{Id.}}\) at 232, 235. Doroshow had a family history of ALS.\(^{\text{Id.}}\) at 235.

\(^{50}\) Id. at 236. A child was later diagnosed with leukemia but prior to the effective date of the insurance, no one deemed leukemia as a possible diagnosis. Lawson v. Fortis Ins. Co., 301 F.3d 159, 166 (3d Cir. 2002).

\(^{51}\) Doroshow, 574 F.3d at 232, 235-36. Doroshow’s primary care physician wrote that his features “do not support the diagnosis of amyotropic lateral sclerosis or a progressive motor neuron disorder.”\(^{\text{Id.}}\) at 232. “ALS is the most common form of motor neuron disease.”\(^{\text{Id.}}\) at 235.

\(^{52}\) Id. at 236.

\(^{53}\) See id. at 235-36. A “suspected condition without a confirmatory diagnosis” may “appropriately be deemed a pre-existing condition.”\(^{\text{Id.}}\) at 236. Doroshow’s family history of ALS may have “tainted the majority opinion’s objectivity” when it concluded that ALS was a suspected condition. See Health Plan Law, Third Circuit Takes Expansive View of Preexisting Condition Exclusion, Aug. 3, 2009, http://www.healthplanlaw.com/?p=1447.
physician renders advice likewise. The Court of Appeals for the Third Circuit in *Doroshow* utilized a subjective interpretation of “suspected condition,” which allowed the court to consider a patient’s family medical history and assertions of potential diagnosis when determining whether a patient sought advice with a particular condition in mind, and this broadened interpretation will likely benefit insurance companies when they deny claims for health benefits.

In deciding that Doroshow was appropriately denied benefits due to a pre-existing condition, the court misconstrued policy language set forth in its previous rulings. The court’s expansive definition of “for” is at odds with its earlier precedent set forth in *Lawson*. In *Lawson*, this same court rejected the broad definition of “for,” arguing that it would allow insurance companies the authority to deny claims based on the subjective reinterpretation of symptoms during the look-back period, and this would have the potential effect of rendering the term pre-existing condition meaningless.

In *Lawson*, the court concluded that treatment for a condition required “some awareness

54 See *Lawson*, 301 F.3d at 166.

When a patient seeks advice for a sickness with a specific concern in mind . . . or when a physician recommends treatment with a specific concern in mind . . . it can be argued that an intent to seek or provide treatment or advice ‘for’ a particular disease has been manifested.

*Id.*

55 *Doroshow*, 574 F.3d at 235-36. See infra note 62-63 and accompanying text.

56 *Doroshow*, 574 F.3d at 237 (Rendell, J., dissenting). “[T]he majority here has fallen into this very trap by essentially concluding that, because Doroshow likely had ALS all along, ALS was a ‘pre-existing condition.’ In so reasoning, the majority does a disservice to the policy language, to our precedent in *Lawson*, and to Doroshow himself.” *Id.*

*Id.* (Rendell, J., dissenting).

57 *Id.* The court noted “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,” and “[t]o 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.” *Lawson*, 301 F.3d at 166.
that the disease existed at the time . . . [the] advice was rendered,” and here it was the insurance company’s position that Doroshow received such advice during the look-back period when he visited his primary care physician on May 16, 2006. The court in Doroshow neglected the fact that not only was Doroshow’s primary care physician unaware of Doroshow’s ALS diagnosis, but the primary care physician actually asserted that his condition “was not felt to be ALS.” By minimizing the statements of Doroshow’s primary care physician, disregarding the court’s earlier instructions, and broadly interpreting the term “for,” the court’s opinion here undoubtedly conflicts with its earlier precedent.

The Third Circuit’s broadened interpretation will have the effect of greatly expanding the scope of what constitutes a pre-existing condition because insurance companies within the Third Circuit’s jurisdiction can simply claim that because of a patient’s family medical history or inconclusive statements the patient received from his or her doctor, the patient was aware of the condition he or she was eventually diagnosed with, and thereby, the condition will be deemed pre-existing. As insurance companies

59 Doroshow, 574 F.3d at 232, 237. See Lawson, 301 F.3d at 162.
60 Doroshow, 574 F.3d at 238 (Rendell, J., dissenting).
61 Id. at 236-38. “Today, the majority inexplicably casts these precedents aside, referring to their dicta without discussing their holdings.” Id. at 238. “The dissenting opinion found the outcome at odds with prior precedent.” See Health Plan Law, Third Circuit Takes Expansive View of Preexisting Condition Exclusion, http://www.healthplanlaw.com/?p=1447 (last visited Nov. 16, 2010).
62 See Posting of Gregory Michael Dell, Disability Insurance Attorneys, Disability Insurance Claims Law Blog, (Feb. 4, 2010), http://www.disabilitylawblog.com/tags/disability-insurance-attorneys-1/ (stressing decision favors insurance companies). The dissenting judge claimed that the majority opinion “would strengthen the tendency for insurance companies to look at any symptom that an insured person has during the look-back period as demonstrating a pre-existing condition.” Id. “We can expect to see more cases that test the definition of what a pre-existing condition really is.” Id. “People who have family histories of cancer, diabetes, or any disease that is considered genetic have a higher rate of denials than those with a healthy family. In these cases, the individual is not evaluated based on their own health but on how healthy family members are.” Lisa S. Simmons, The Reasons Why People are Denied Medical Insurance, Ezine Articles, http://ezinearticles.com/?The-Reasons-Why-People-Are-Denied-Medical-Insurance&id=2263888 (last visited Nov. 16, 2010). Insurance companies treat family medical history with the “same level of caution” as conditions such as obesity, cancer, AIDS, diabetes, past heart attack, etc. See Wall Street Weather, The Healthcare “Haves” Don’t Realize Their Risks, http://www.wallstreetweather.net/2009/07/healthcare-haves-dont-realize-their.html (last visited Nov. 16, 2010). “People with a family history of genetic disease are often discriminated against by insurance companies and their relatives and friends . . . .” Science Daily, Individuals With Family History of Genetic Disease at Risk of Discrimination, June 12, 2009, http://www.sciencedaily.com/releases/2009/06/090609220605.htm. But see California Health Insurance, Group Health Plans and Pre-Existing Conditions in California,
continue to rely on this broadened scope of pre-existing conditions in their pursuit of increasing their bottom line profit, the well-being of individuals seeking health care for debilitating and often life threatening ailments is denigrated as a secondary concern. On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act ("PPACA"), which included provisions that, as of January 1, 2014, would prohibit insurance companies from denying coverage based on pre-existing conditions. The PPACA remains a polarizing topic in the United States; however, even some of its opponents in the House of Representatives, who aim to "defund" or repeal the law, agree with portions of the pre-existing condition provisions contained in the Act. Despite this modest consensus, the Congressional supporters and opponents

http://www.california-health-insurance.com/pre-existing-conditions/ (last visited Nov. 16, 2010) (claiming "having a family history of a condition" is not necessarily a pre-existing condition).

63 See InsuranceAgents.com, Pre-Existing Condition Health Insurance Options, http://www.insuranceagents.com/existing-health-condition.html (last visited Nov. 16, 2010) (stating goal of insurance companies is to make profit). “[T]he insurance industry is a business like any other and like any other business their primary goal is turning a profit and insuring those with certain pre-existing conditions just isn’t good business.” Id. “Many families have some form of pre-existing condition that’s not covered . . . [t]his shows just how broken the current system has become, representing the blatant manipulation of insurance companies who not only profit but benefit because so many laws allow them to get away with such actions.” Kimberlee Curran-Leto, Health Care Reform: America’s Pre-Existing Condition or . . ., Our Time Press, October 22, 2009, http://ourtimepress.com/2009/10/22/health-care-reform-now-america-%E2%80%98s-preexisting-condition/. “Health insurance companies are for-profit entities. When they agree to insure you, they are betting that you will pay more into the company in the form of premiums than they will pay out for your medical claims.” SmartHealthPlans.net, High Deductible Insurance, High Deductible Plan, http://www.smarthealthplans.net/ (last visited Nov. 16, 2010).


of the PPACA nonetheless disagree over the measures to be implemented in order to confront the issues associated with the pre-existing condition exclusion. The courts, the supporters, and the opponents of the PPACA have all acknowledged the dilemmas associated with pre-existing conditions, yet due to their disjointed efforts and interpretations, the issue of pre-existing conditions remains uncertain, and this will likely continue to be the status-quo until a cohesive approach can prevail.

For this reason, the Doroshow opinion is especially worrisome, because until there is such a unitary solution, insurers in the Third Circuit will have wide-ranging latitude to go against the Congressional intent behind passing ERISA, to protect employees with minimum standards; moreover, insurers will continue to deny benefits to insured people desperately in need of health care services for supposed “pre-existing” conditions.

In Doroshow v. Hartford Life & Accident Ins. Co., the United States Court of Appeals for the Third Circuit reviewed the lower court’s decision granting summary judgment in favor of Hartford Life and Accident Insurance Company. The court had to determine whether Hartford’s decision to deny health coverage to Doroshow was “based on a consideration of the relevant factors and whether there [had] been a clear...
error of judgment,” thereby rendering the decision arbitrary and capricious.\textsuperscript{70} In affirming the lower court’s decision, the court concluded that Doroshow had a “suspected condition without a confirmatory diagnosis” which “may appropriately be deemed a pre-existing condition.”\textsuperscript{71} In reaching its affirmation, the court diverged from its prior precedent and broadened the scope of what constitutes a pre-existing condition.\textsuperscript{72} This decision has the potential to provide insurance companies with wide-ranging autonomy when making decisions to deny health coverage to those insured based on their supposed pre-existing conditions.\textsuperscript{73}

\textsuperscript{70} Id. at 233-34. See Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971); see also supra notes 24-29 and accompanying text.
\textsuperscript{71} Doroshow, 574 F.3d at 236. See supra notes 50-52 and accompanying text.
\textsuperscript{72} Doroshow, 574 F.3d at 236. See supra notes 53-61 and accompanying text.
\textsuperscript{73} See supra notes 56, 62-63 and accompanying text.