NOTE

Lost in Translation: The Affordable Care Act's Attempt to Make Insurance-Speak Understandable

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ABSTRACT

The health insurance market is a confusing place for most consumers. When trying to determine what services are covered, an individual may have to wade through multiple plan documents and interpret unfamiliar language. Even if a consumer does make such an effort, they may be unable to really understand the terms of their coverage. In an attempt to make insurance a little more understandable, Congress created the Uniform Glossary in the Patient Protection and Affordable Care Act of 2010. This document contains approximately two dozen commonly used insurance terms with easy-to-understand definitions. Every enrollee will receive the Uniform Glossary along with official plan documents, but the terms and definitions are not plan-specific and are not legally binding. Therefore, any given definition in the Uniform Glossary could be entirely different from the actual definition used by the insurer.

This Note proposes that the Uniform Glossary provision is ineffective in its current state, particularly as it relates to employer-sponsored insurance. Although Congress explicitly intended the Uniform Glossary to be an informational tool and not binding on the terms of coverage, its intent will be meaningless if consumers cannot rely on those definitions to understand their health insurance coverage. In order to create a truly accessible marketplace, Congress must require insurance plans to use the terms as defined in the Uni-

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form Glossary in all plan documents. This will put consumers in a position to adequately assess the terms of their insurance coverage, to make better-informed purchasing decisions when seeking medical treatment, and to participate in a more efficient and transparent marketplace.

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INTRODUCTION

Sharon Mondry adopted her son Zev when he was born in 1999.[1] Zev's mental and speech development progressed normally for the first year of his life, but around the age of fourteen months he began to lose his cognitive and language skills.[2] When he was almost two years old, his pediatrician recommended further evaluation of his development and speech, which showed severe developmental impairment and a loss of vocabulary.[3] His pediatrician then recommended speech therapy.[4] At the conclusion of Zev's early intervention program—only available for those under the age of three—his mother arranged for continuing treatment at a new facility.[5] Concerned about the cost, Ms. Mondry went to the human resources department of her employer to ask whether her insurance would cover the new treatment facility.[6] Her employer told her to consult some of the insurance plan documents on the company's internal website.[7] One of those documents was the Summary Plan Description, which outlines the terms of benefits for an employer-sponsored insurance plan.[8] The Summary Plan Description said that CIGNA, the plan administrator, would cover speech therapy for a certain number of sessions if provided by a certified physician.[9] Ms. Mondry concluded that her insurance would cover her son's treatment and enrolled him in the new program.[10]

When Zev's doctor submitted a claim for payment to CIGNA, however, CIGNA denied it on the basis that the therapy was not medically necessary because it was "educational or training" and "not restorative."[11] These terms came from CIGNA's internal guidelines, but were not included in the Summary Plan Description that Mondry con-

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1 Brief and Required Short Appendix of Plaintiff-Appellant at 6, Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781 (7th Cir. 2009) (No. 07-1109), 2007 WL 781156.

2 *Id.*

3 *Id.*

4 *Mondry*, 557 F.3d at 784.

5 *Id.*

6 *Id.*

7 Brief and Required Short Appendix of Plaintiff-Appellant, *supra* note 1, at 7. CIGNA was the claims administrator—it handled the day-to-day operations of the insurance plan. *Id.* at 5. American Family Mutual Insurance Company was the underlying plan administrator—it retained the fiduciary obligations to the employees and paid CIGNA for its services. *Id*.

8 *Mondry*, 557 F.3d at 784.

9 Brief and Required Short Appendix of Plaintiff-Appellant, *supra* note 1, at 8.

10 *See id.* at 7.

11 *Mondry*, 557 F.3d at 784–85.

sulted before going to the doctor.[12] Mondry fought CIGNA on the issue and, after multiple appeals, eventually got the services covered.[13] The Seventh Circuit held that even though CIGNA and the employer had a duty to disclose the terms of coverage, the employer (through CIGNA as the plan administrator) also had discretion to interpret those terms.[14] In the end, even though Mondry had read her plan documents, there was no way for her to fully understand the terms of her coverage because the documents being used by CIGNA to interpret her plan terms had not been disclosed to her.[15] Ms. Mondry won her case on the grounds that CIGNA and her employer failed to provide those internal guidelines when she requested them, and the court also acknowledged the inadequacy of the documents she actually did receive.[16]

The confusion that Ms. Mondry faced when she sought information about her insurance coverage illustrates the complexity of the health insurance market. When Ms. Mondry tried to understand whether her insurance covered the speech therapy that Zev's doctor recommended, she did the responsible thing by talking with her human resources department. She consulted the plan documents that were available to her and made a reasonable assessment. Health care costs continue to rise and consumers are repeatedly told to be more judicious in using their health insurance.[17] A responsible consumer, the story goes, must consult her health insurance policy before deciding to seek health care services. This is precisely what Ms. Mondry did, but she still was unable to understand her coverage.

Under the Patient Protection and Affordable Care Act ("Affordable Care Act"),[18] health insurers must provide prospective and current enrollees with a Summary of Benefits and Coverage and a Uniform Glossary of Terms ("Uniform Glossary").[19] The Summary of

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12 *Id.* at 785.

13 *Id.* at 791 (explaining that CIGNA reversed the denial in an internal appeal but Mondry sued for violations of CIGNA's fiduciary duty of disclosure and statutory duty to produce plan documents).

14 *Id.* at 801.

15 *Id.* at 802–03.

16 *Id.* at 803.

17 *See, e.g.*, Reed Abelson, *Health Insurance Costs Rising Sharply This Year, Study Shows*, N.Y. TIMES, Sept. 27, 2011, http://www.nytimes.com/2011/09/28/business/health-insurance-costs-rise-sharply-this-year-study-shows.html?pagewanted=all.

18 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered titles of U.S.C.).

19 Patient Protection and Affordable Care Act § 2715, 42 U.S.C. § 300gg-15 (Supp. IV 2010).

Benefits and Coverage is a four-page synopsis of the benefits of a particular policy customized for the individual plan with which it is issued.[20] The Uniform Glossary is a standardized list of definitions that must be provided with every health insurance plan.[21] With these documents, Congress intended to help consumers better understand their health insurance.[22]

The Affordable Care Act requires an insurer to distribute the Uniform Glossary but does not require that the definitions be incorporated into the actual terms of the plan.[23] The law requires only that the Uniform Glossary be provided as a tool to explain insurance concepts—it is not intended to be evidence of coverage.[24] As the provision was drafted, consumers may not rely on the Uniform Glossary when it conflicts with definitions included in the underlying plan terms.[25] Thus, when the Uniform Glossary contains a definition that is different than the definition used in plan documents, the Uniform Glossary may be meaningless. Without a modification to allow a consumer to rely on these definitions, the Uniform Glossary will have no greater effect than marketing materials, even if consumers think that the definitions are binding coverage terms.

This Note proposes that the Uniform Glossary be given binding effect on employer-sponsored health insurance plans, as regulated by the Employee Retirement Income Security Act of 1974 ("ERISA").[26] Congress should require drafters of such plans to incorporate the Uniform Glossary definitions into the plan documents. An enrollee should be able to claim that when the Uniform Glossary conflicts with the underlying plan terms in a way that makes the policy terms contradictory, ambiguous, or inconsistent, the Uniform Glossary should control.

Part I provides background on the current employer-sponsored health insurance market and explains the impact that the Affordable Care Act will have on this system, focusing on the Uniform Glossary provision. Part II discusses the likelihood of conflict between the Uni-

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20 *Id*.

21 *Id*.

22 *See infra* Part I.B. Further, this Note will use the following terms: "benefits" are the actual medical services the plan will pay for; "plan terms" or "plan documents" are the official contractual terms of the insurance policy; and "plan administrator" is the entity or employee who has fiduciary responsibility for administering the plan.

23 42 U.S.C. § 300gg-15(b)(3)(A).

24 *Id*. § 300gg-15(g)(1)–(3).

25 *See infra* Part II.

26 Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

form Glossary and ERISA plan documents and the almost certain confusion that will result. Part III recommends that Congress enact legislation to make the Uniform Glossary a legally binding document that requires employer-sponsored insurance plans to use the Uniform Glossary definitions in other plan documents. This proposal promotes Congress's intent by giving consumers a valuable tool for understanding their health insurance coverage, while at the same time allowing employers to structure many different kinds of benefit plans. Part IV explains why leaving this issue to resolution by the courts under the framework announced in *CIGNA Corp. v. Amara*[27] or waiting for the market to correct itself will not solve the problem, and why legislation is necessary. In summary, this Note argues that given Congress's intention to increase transparency in the insurance market and improve the ability of consumers to understand the terms of their health insurance coverage, the current legislation does not go far enough. To effectively improve the current health insurance market, employer-provided health insurance plans must incorporate the Uniform Glossary.

I. Background on Employer-Sponsored Health Insurance and the Affordable Care Act

There are many ways that an individual can get health insurance in the United States today, but the most popular form is employer-sponsored health insurance.[28] Employer-sponsored insurance describes a multitude of arrangements, including coverage completely or partially funded by employers and coverage otherwise related to employment such as through a labor union.[29] In the most common arrangement, both the employer and employee pay a portion of the monthly premium.[30] These plans can take many forms, such as a tightly managed health maintenance organization ("HMO"), a flexible preferred provider network ("PPO"), or a traditional indemnity plan.[31]

The financial benefit of an employer-sponsored plan is that the employer, as a purchaser, has market and bargaining power. Employ-

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27 CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011).

28 *See* Henry J. Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits, 2011 Annual Survey 1 (2011), http://ehbs.kff.org/pdf/2011/8225.pdf.

29 *See id*. at 150.

30 *See id.* at 2.

31 Henry J. Kaiser Family Found., How Private Insurance Works: A Primer 2–4 (2002), http://www.kff.org/insurance/upload/how-private-insurance-works-a-primer-report.pdf.

ers bring hundreds or thousands of covered lives into the premium revenue of the insurance company.[32] An employer, therefore, may be able to secure lower costs, greater benefits, or a larger network of doctors than an individual could obtain on his or her own.[33] Employer-sponsored plans also tend to be more attractive than those available in the individual market because they are more affordable and offer greater benefits.[34] Individual health insurance plans tend to have higher out-of-pocket costs and deductibles, which makes these plans even less attractive.[35] Employer-sponsored insurance is also largely regulated by the federal government, rather than individual states.[36] State regulation of individual health insurance is often more demanding than federal law.[37] Rather than being subjected to each state's insurance regulation, employer-sponsored insurance is almost exclusively concerned with federal regulation.[38]

The following two Sections describe the legal background for employer-sponsored insurance and the Affordable Care Act's Uniform Glossary. Section A discusses the laws governing employer-sponsored health insurance under ERISA. Section B discusses the Affordable Care Act.

A. ERISA

Approximately fifty-five percent of the U.S. population was enrolled in an employer-sponsored health insurance plan in 2010.[39] The dominance of this market originates from employers' efforts to work around wage controls instituted during World War II; health benefits were not considered wages so employers offered health benefits

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32 *See* Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 894 (2011).

33 *Id.* at 894, 896–97.

34 AGENCY FOR HEALTHCARE RESEARCH & QUALITY, RESEARCH IN ACTION, ISSUE #17, EMPLOYER-SPONSORED HEALTH INSURANCE: TRENDS IN COST AND ACCESS 2 (Sept. 2004), http://www.ahrq.gov/research/empspria/empspria.pdf.

35 HENRY J. KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 1 (2010), http://www.kff.org/kaiserpolls/upload/8077-R.pdf.

36 *See id.* Federal authority to regulate employer-sponsored health insurance is the joint responsibility of the Department of Health and Human Services, the Department of Labor, and, occasionally, the Department of the Treasury. Deborah Shelby Dees, *Overview of ERISA Provisions and Recent Legislation Governing Group Health Plans*, 67 MISS. L.J. 695, 696–98 (1998).

37 *See* Elizabeth A. Pendo, *The Health Care Choice Act: The Individual Insurance Market and the Politics of "Choice"*, 29 W. NEW ENG. L. REV. 473, 480–82 (2007).

38 *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 393–94 (2002) (Thomas, J., dissenting).

39 U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010 at 23 (Sept. 2011), http://www.census.gov/prod/2011pubs/p60-239.pdf.

rather than raising wages.[40] Since then, employer-sponsored insurance has remained popular primarily due to its favorable tax and regulatory treatment compared to other employer expenditures.[41] An employer may also choose to sponsor health benefits to boost morale and promote health.[42] Offering a health plan to employees has become a baseline cost consideration for most employers.[43]

Individuals also have an incentive to enroll in an available employer-sponsored plan instead of other private market options, such as an individual health insurance plan.[44] Employer-sponsored health insurance may be cheaper for employees, especially if the employer has enough enrollees to have a large risk pool of insured lives.[45] Additionally, it may be more convenient to enroll in an employer's plan because the employee will not have to shop for a policy on her own.[46] Some employers, such as large corporations, may offer employees more than one option.[47] Even so, most consumers are more comfortable choosing from a small selection of options than they are wading into the entire private market.[48]

The following Sections discuss some key ERISA characteristics. Understanding the basics of ERISA and how courts have applied it clarifies why the Uniform Glossary was a necessary reform. These important ERISA characteristics are: (1) preemption of state regulation, (2) freedom of plan design, (3) judicial deference to plan administrators, (4) limitations on remedies, and (5) disclosure obligations and fiduciary duties.

1. Preemption of State Regulation

In 1974, Congress passed ERISA to establish a uniform federal regulatory scheme for employment-based insurance.[49] To ease the ability of employers to offer plans across state lines, Congress broadly preempted any state law that "relate[s] to an employee benefit

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40 *See* Moore, *supra* note 32, at 888–89. *See generally* Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, 117 MONTHLY LAB. REV. 3 (1994).

41 Moore, *supra* note 32, at 889–92.

42 *Id.* at 893.

43 *See* HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *supra* note 28, at 4 (stating that sixty percent of firms offer health benefits).

44 Moore, *supra* note 32, at 893.

45 *Id.* at 894.

46 *Id.* at 896–97.

47 *Id.* at 897.

48 *See id.* at 897 nn.65–66.

49 Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

plan."[50] The bill was primarily drafted to protect employee pension plans but it also applies to health benefits.[51] The Supreme Court routinely recognizes that ERISA was intended to create a uniform law under which employers must operate if they choose to offer health benefits.[52] Based on this interpretation, state laws regulating the "content" of health insurance (i.e., the benefits that are offered) are preempted for most employer-sponsored plans.[53] An employer may choose to self-insure to receive the benefit of ERISA's preemption clause, which excludes them from state regulation.[54] Many public health and safety laws (e.g., requirements that insurance plans cover preventive services or AIDS), therefore, do not apply to employer health plans.[55] State laws that regulate the content of insurance do not apply to employee benefit plans, only those passed at the federal level.[56]

2. Freedom of Plan Design

Employers have a great deal of flexibility when it comes to establishing, maintaining, and financing an employee health benefits plan.[57] In determining which benefits to provide and how much to pay for

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50 *Id.* § 1144(a); *see also* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1088–89 (2011).

51 *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, 30 (1999).

52 *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 393–94 (2002) (holding that "the exclusivity and uniformity of ERISA's enforcement scheme remains paramount"); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45–47 (1987) (discussing congressional intent to completely preempt the field of employer-sponsored benefits regulation); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 98–99 (1983) (discussing congressional intent in preempting state laws).

53 *See Shaw*, 463 U.S. at 98. Under ERISA § 514, state laws that relate to employer benefits are preempted, except for those that regulate insurance, but self-insured employer plans are not deemed insurance. 29 U.S.C. § 1144 (2006). Employer-sponsored insurance that is fully insured (meaning the employer retains no financial risk or fiduciary obligations) is not exempt from some state regulations that are akin to banking laws, such as reserve requirements. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008). A self-insured plan is one where the employer pays for claims administration services from the insurer, but retains financial risk and fiduciary obligations. *See* Charles D. Weller, *The Secret Life of the Dominant Form of Managed Care: Self-Insured ERISA Networks*, 6 HEALTH MATRIX 305, 312 (1996).

54 *See* Weller, *supra* note 53, at 17; *see also* Conkright v. Frommert, 130 S. Ct. 1640, 1649 (2010); *Glenn*, 554 U.S. at 105; *Shaw*, 463 U.S. at 98.

55 *See* Kennedy, *supra* note 50, at 1089–91 (explaining that preemption is being used as a "shield for plan fiduciaries and insurers to limit their liability").

56 *See id.* at 1088–89 (explaining that "ERISA prevents States from deeming employee plans as insurers . . . for purposes of regulation under state laws").

57 *See id.* at 1087 (explaining that the "employer . . . defines the types and extent of employee benefits").

them, an employer has almost complete discretion.[58] In *McGann v. H&H Music Co.*,[59] the Fifth Circuit held that an employer-sponsored health plan was not required to cover treatment for AIDS even though the exclusion may have been based on a prejudicial attitude toward those who have the disease.[60] The court held that it was a "well-settled principle that Congress did not intend that ERISA circumscribe employers' control over the content of benefit plans they offered to their employees."[61] This preference for employer flexibility has been widely adopted by the courts.[62] The prevailing view is that employers should be free to create a plan that best fits their personnel and financial needs.[63]

Despite this general freedom to design plans, Congress has imposed a few coverage requirements on ERISA plans.[64] Examples include mandatory coverage of maternity and infant care[65] and payment for mental health benefits at the same level as other medical benefits.[66] Although these requirements indicate Congress's willingness to intervene in certain areas, there remains a persistent view that ERISA plans should be exempt from most benefit requirements. As discussed further below, the Affordable Care Act, widely considered the greatest pro-consumer legislation, imposes few limitations on employer freedom.[67]

3. Judicial Deference to Plan Administrators

The flexibility that employers enjoy in designing health benefit plans is supported by a powerful doctrine that gives deference to plan administrators to interpret the terms of an insurance plan. For example, the Supreme Court has concluded that when a plan administrator denies an enrollee's claim for services, the plan administrator's interpretation will be given a great deal of deference so long as the plan includes a discretionary clause granting the plan administrator the au-

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58 *See id*.

59 McGann v. H&H Music Co., 946 F.2d 401, 401 (5th Cir. 1991).

60 *Id.* at 408.

61 *Id.* at 407.

62 *See* Conkright v. Frommert, 130 S. Ct. 1640, 1646 (2010); Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115–16 (2008); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983); Krauss v. Oxford Health Plans, 517 F.3d 614, 622 (2d Cir. 2008); *McGann*, 946 F.2d at 407.

63 *McGann*, 946 F.2d at 407.

64 Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 23 (2011).

65 Newborns' and Mothers' Health Protection Act of 1996, 42 U.S.C. § 300gg-25 (2006).

66 Mental Health Parity Act of 1996, 42 U.S.C. § 300gg-26 (2006).

67 See *infra* Part II.B for a discussion of the Affordable Care Act.

thority to interpret plan terms.[68] If a plan contains such a clause, then the court is limited to an abuse of discretion standard of review.[69] This deference means that the plan administrator's interpretation will usually be controlling regardless of any alternative interpretation by the enrollee.[70] In essence, ERISA plan administrators have wide latitude in designing, writing, and interpreting what benefits a plan covers.

4. Limitations on Remedies

Another important aspect of ERISA law is the strict limitation on remedies available to employees in a lawsuit over denied benefits.[71] If an employee wants to assert that an ERISA administrator improperly denied a claim for benefits or did not provide an adequate appeals process, that employee is limited to the remedies available under ERISA § 502.[72] Those remedies include a claim for benefits due under § 502(a)(1)(B)[73] and a claim for other equitable relief under § 502(a)(3)(B).[74] The Supreme Court has interpreted these remedies to be exclusive—no other remedies are available to employees in a dispute over ERISA benefits.[75] This interpretation preempts any state-law cause of action, including contract violations or negligence, when related to an ERISA health insurance plan.[76] Coupled with the deferential standard of review, this means that ERISA enrollees have few options when an ERISA administrator denies a claim for benefits.[77]

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68 Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

69 *Id.*

70 Donald T. Bogan, *ERISA: The Foundational Insufficiencies for Deferential Review in Employee Benefit Claims*—Metropolitan Life Insurance Co. v. Glenn, 27 HOFSTRA LAB. & EMP. L.J. 147, 149 (2009).

71 *See id.* at 148–49.

72 29 U.S.C. § 1132 (2006).

73 *Id.* § 1132(a)(1)(B).

74 *Id.* § 1132(a)(3)(B).

75 Aetna Health Ins. v. Davila, 542 U.S. 200, 209 (2004) ("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* 29 U.S.C. § 1144 (preempting ERISA claimants from seeking any addition remedies under, for example, state law).

76 *See Davila*, 542 U.S. at 209, 211–13 (medical liability); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 60 (1987) (breach of contract); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1328–29 (5th Cir. 1992) (medical negligence). *But see* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 356–57 (3d Cir. 1995) (medical malpractice tort not preempted).

77 *See* Donald T. Bogan, *ERISA: State Regulation of Insured Plans After* Davila, J. MARSHALL L. REV. 693, 699, 721 (2005).

5. *Disclosure Obligations and Fiduciary Duties*

Although ERISA's content requirements are minimal, it *does* impose significant "delivery" restrictions on plan administrators—primarily, the fiduciary and statutory duties of disclosure.[78] The official and contractually binding terms for an ERISA plan are usually not provided to the enrollee absent request.[79] Instead, employers give enrollees a Summary Plan Description.[80] ERISA requires employers to draft and provide the Summary Plan Description.[81] The Summary Plan Description is a plain-language summary created to "reasonably apprise" participants of their "rights and obligations" under the plan.[82] This document was intended to be an easy reference for consumers so they do not have to consult the lengthy and technical plan documents, which comprise the official contractual terms.[83] This tool enables enrollees to understand their coverage and, in so doing, creates an obligation on enrollees to inform themselves about the terms of coverage.[84] This is both a rejection of the paternalistic notion that enrollees may enter into contracts without being bound by their terms, and a promotion of responsible decisionmaking.[85] Despite the intended goals of the Summary Plan Description, it is generally viewed as a confusing and legalese-filled document.[86] As a result, there are many disputes about whether the Summary Plan Description or the plan documents are controlling when they appear to conflict.[87]

The judicial history of ambiguous Summary Plan Descriptions demonstrates the need for provisions in the Affordable Care Act to ensure that the employer-sponsored market is transparent and understandable. Consumers needed new tools to become informed and un-

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78 *See* Jennifer A. Leahy, *ERISA's Fiduciary Provisions and the Duty to Disclose: Circumstances When an Employer Is Subject to Fiduciary Standards*, 34 SUFFOLK U. L. REV. 595, 602–04 (2001).

79 *See* Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 791 (7th Cir. 2009) (holding that informal guidelines used by plan administrators to make benefit determinations are considered terms of the plans).

80 29 U.S.C. § 1022(a).

81 *Id.*

82 *Id.*

83 *See* PETER J. WIEDENBECK, ERISA IN THE COURTS 17–18 (2008).

84 *See id*. at 16–17, 25.

85 *See id.*

86 Michael W. Wyand, *SPDs Written for Health Care Providers Do Not Help Employees, Practitioners Say*, 32 PENSION & BENEFITS REP. 1527 (2005).

87 See discussion regarding court treatment of disputes between the SPD and other plan documents *infra* Part IV.

derstand their coverage terms. The next Part describes the Affordable Care Act's efforts to provide these tools.

B. The Affordable Care Act

The Affordable Care Act,[88] as modified by the Health Care Education Reconciliation Act of 2010,[89] made a variety of changes to the health insurance industry. The legislation resulted from a tumultuous national debate[90] and underwent a highly publicized legal challenge.[91] News coverage and commentators have called it one of the greatest reform efforts since Medicare and Medicaid were enacted in 1965.[92] The Act changes the ways in which consumers interact with insurers, how employers purchase coverage for employees, the way that people receive medical treatment, and how the federal government and states interact with each of these actors.[93]

The Affordable Care Act builds on the existing private and employer-sponsored markets.[94] It largely retains these market segregations with the exception of creating state-based and national exchanges, which allow consumers to purchase individual insurance from a state-run entity that aggregates available insurance options.[95] The following Sections describe some of the major provisions of the Affordable Care Act and how they interact with employer-sponsored plans. The Sections then discuss the Uniform Glossary provision and its effect on disclosure and transparency.

1. Benefit Mandates

By retaining most of the structural framework of the existing market, the Affordable Care Act's advances are geared toward accessibility, affordability, and quality.[96] Provisions that focus on access to

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88 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered titles of U.S.C.).

89 Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered titles of U.S.C.).

90 *See* Robert Pear & David M. Herszenhorn, *Congress Sends White House Landmark Health Overhaul: House Votes on Party Lines, 219 to 212*, N.Y. TIMES, Mar. 22, 2010, at A1.

91 Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

92 Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 527, 527 (2011); *see also* Janet L. Dolgin & Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 UMKC L. REV. 45, 48–52 (2011).

93 *See* Rosenbaum et al., *supra* note 92, at 528–30.

94 Moore, *supra* note 32, at 886–87.

95 Rosenbaum et al., *supra* note 92, at 550.

96 *See* Troy J. Oechsner & Magda Schaler-Haynes, *Keeping it Simple: Health Plan Benefit*

health insurance (i.e., availability of coverage) include: expansion of Medicaid eligibility,[97] extension of dependent coverage until the age of twenty-six,[98] and the creation of health insurance exchanges within each state.[99] Quality of care provisions include: prohibition of limits on coverage for preexisting medical conditions,[100] mandatory minimum essential health benefits,[101] and mandatory coverage for preventive health services.[102]

Most provisions of the Affordable Care Act apply equally to private market and employer-sponsored plans.[103] ERISA plan administrators may view the Affordable Care Act changes as substantial because those plans had been exempt from similar regulations enacted at the state level.[104] Examples of new provisions affecting ERISA plans include: the prohibition on annual or lifetime limits,[105] required coverage of dependents until age twenty-six,[106] prohibition on preexisting condition exclusions,[107] and guaranteed availability and renewability of coverage.[108] These provisions constrain employers' ability to design plans, but do not eliminate it. Congress excluded large-group ERISA plans from the essential health benefits provision, which requires plans to cover a specified list of medical services.[109] Nor does the Affordable Care Act create any new remedies for employers under ERISA.[110] This demonstrates Congress's desire to retain a great deal of flexibility and choice for employers.

Standardization and Regulatory Choice Under the Affordable Care Act, 74 ALB. L. REV. 241, 242–43 (2010–2011).

97 Patient Protection and Affordable Care Act § 2001(a)(2)(A), 42 U.S.C. § 1396(b) (Supp. IV 2010).

98 *Id.* § 2714, 42 U.S.C. § 300gg-14.

99 *Id.* §§ 1311–1314, 42 U.S.C. §§ 18031–18033.

100 *Id.* § 2704, 42 U.S.C. § 300gg-4.

101 *Id.* §§ 1301–1302, 42 U.S.C. §§ 18021–18022.

102 *Id.* § 2713, 42 U.S.C. § 300gg-13.

103 *See* Sara Rosenbaum, *Health Reform and ERISA*, HEALTH REFORM GPS (Sept. 27, 2010), http://healthreformgps.org/resources/health-reform-and-erisa/.

104 See discussion of ERISA *supra* Part I.A.

105 Patient Protection and Affordable Care Act § 2711, 42 U.S.C. § 300gg-11 (Supp. IV 2010).

106 *Id.* § 2714, 42 U.S.C. § 300gg-14.

107 *Id.* § 2704, 42 U.S.C. § 300gg-3.

108 *Id.* §§ 2702–2703, 42 U.S.C. §§ 300gg-1 to -2.

109 *See id.* § 2707(a), 42 U.S.C. § 300gg-6(a) (applying to individual and small group plans, but not large group plans, those with twenty-five or more enrollees, which generally only exist under ERISA).

110 Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 517 (2011).

2. The Uniform Glossary

In addition to the specific benefit requirements discussed above, one provision of the Affordable Care Act attempts to make insurance information more understandable to the average consumer.[111] The Affordable Care Act requires all insurance plans to provide applicants and enrollees a four-page plain-language description known as the Summary of Benefits and Coverage.[112] This document will be standardized across all plans, similar to nutrition labels on food packaging,[113] with the information tailored to a particular plan, such as the particular copayment and deductible amounts.[114] This allows for easy comparison between different plans.[115] Along with the Summary of Benefits and Coverage, plans must issue a Uniform Glossary with definitions of commonly used insurance terms drafted by the Department of Health and Human Services.[116] Together, the Summary of Benefits and Coverage and the Uniform Glossary enable consumers to compare coverage options by standardizing information in all markets and explaining insurance jargon.[117] In addition to facilitating meaningful comparisons, the Uniform Glossary is a tool that consumers might use to understand their own official plan documents.[118]

Numerous commenters have noted the usefulness of these provisions given the confusion in the insurance market.[119] Consumers have

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111 Press Release, U.S. Dep't of Health & Human Servs., Affordable Care Act Increases Transparency for Consumer in "Mini-Med" Plans (Dec. 9, 2010), http://www.hhs.gov/news/press/2010pres/12/20101209c.html; *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, HEALTHCARE.GOV (Nov. 22, 2010), http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html (the medical loss ratio provision requires health insurers to report a breakdown of premium revenue and costs and issue reports detailing where premium dollars are being spent); U.S. Dep't of Health & Human Servs., Fact Sheet on Establishing the Web Portal Called for in the Affordable Care Act (May 1, 2011), http://cciio.cms.gov/resources/files/establishing_web_portal_fact_sheet_05012011.pdf (Healthcare.gov is a mandated website which will provide detailed information about health insurance options available to individuals and small businesses in a particular location).

112 Patient Protection and Affordable Care Act § 2715, 42 U.S.C. § 300gg-15 (Supp. IV 2010).

113 *Id.*

114 *Id.*

115 *See* Press Release, U.S. Dep't of Health & Human Servs., New Affordable Care Act Policy Helps Consumers Better Understand and Compare Benefits and Coverage (Aug. 17, 2011), http://www.hhs.gov/news/press/2011pres/08/20110817a.html.

116 Patient Protection and Affordable Care Act § 2715, 42 U.S.C. § 300gg-15(g) (Supp. IV 2010).

117 *Id.*

118 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 269–72.

119 *See, e.g.*, Letter from Consumer Representatives to the National Association of Insurance Commissioners to Center for Medicare and Medicaid Services, CMS-9982-P (Oct. 21,

minimal resources for making sense of their insurance policy.[120] In the individual market, an enrollee faces a myriad of options when it comes to selecting plans,[121] and in the ERISA market, an enrollee's choices may be fewer, but the complexity of the plan terms remains. Generally, however, an individual relies on her personal understanding when making decisions.[122] Insurance marketing materials and plan documents contain language that is often difficult for many individuals and owners of small businesses to comprehend.[123] The Uniform Glossary aims to simplify some of this jargon;[124] it has potential to be a valuable document to consumers because of its simplicity.[125] It defines approximately two dozen commonly used terms, such as co-insurance, copayment, deductible, usual customary and reasonable, and rehabilitation services.[126]

3. Enforcement of the Uniform Glossary

The enforcement provision of the Uniform Glossary is exclusively concerned with a plan's failure to provide the document to enrollees and potential enrollees.[127] An employer that does not issue the Uniform Glossary is subject to fines imposed by the Secretary of Health and Human Services.[128] As far as the relationship between the Uniform Glossary and other plan documents, however, there is less gui-

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2011), *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2011-0140-0085; Letter from Families USA to Centers for Medicare and Medicaid Services, CMS-9982-P (Oct. 20, 2011), *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2011-0140-0058; Robert Pear, *Proposal Would Aid Deciphering of Benefits*, N.Y. TIMES, Aug. 18, 2011, at A14.

120 Leslie Feder & Ellen-Marie Whelan, *An Unhealthy Individual Health Insurance Market*, CTR. FOR AM. PROGRESS (Dec. 23, 2008), http://www.americanprogress.org/issues/2008/12/individual_market_brief.html ("Shopping for an individual plan can be a baffling experience."); Letter from Consumer Representatives to the National Association of Insurance Commissioners to Centers for Medicare and Medicaid Services, *supra* note 119.

121 Feder & Whelan, *supra* note 120.

122 *Id.*

123 *Id.*

124 Letter from American Heart Association to Centers for Medicare and Medicaid Services, CMS-9982-P (Oct. 21, 2011), *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2011-0140-0091.

125 The final rule issued by the Centers for Medicare and Medicaid Services implementing this provision contains specific language and examples for the Summary of Benefits and Coverage and the Uniform Glossary. *See* 77 Fed. Reg. 8668, 8702–03 (Feb. 14, 2012) (to be codified at 45 C.F.R. pt. 147).

126 *See* Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. at 8677. Definitions were developed by the National Association of Insurance Commissioners through a highly public process and submitted to the Department of Health and Human Services as required by the Affordable Care Act. *Id.* at 8670.

127 42 U.S.C. § 300gg-15(d) (Supp. IV 2010).

128 *Id.* § 300gg-15(f).

dance. The statute provides that "the coverage document itself should be consulted to determine the governing contractual provisions."[129] Although this language refers only to the Summary of Benefits and Coverage, it suggests that Congress did not intend to have the Uniform Glossary be binding on insurance plans or employers. This means that employers are free to use different definitions throughout plan documents, regardless of the Uniform Glossary definitions. Although Congress intended these summaries and definitions to benefit consumers by informing their purchasing decisions, the statutory language and subsequent rulemaking dictate that the Uniform Glossary does not change the underlying contract terms.[130]

The final rule issued by the Department of Health and Human Services ("HHS") says that consumers must consult plan documents, including the Summary Plan Description, to "get an accurate description of their actual plan."[131] Although the Uniform Glossary is not binding on plans or consumers, Congress must not have intended these terms to be of no consequence.[132] Part II discusses the conflicts that will arise in implementing the Uniform Glossary provision, the strong likelihood of conflict as demonstrated by the Summary Plan Description, and how the current legislation and jurisprudence inadequately address this likelihood.

II. Problems with the Uniform Glossary as it Applies to Employer-Sponsored Insurance

As the statute was written, an employer's plan documents may use different terms from the Uniform Glossary, and it is unclear whether a consumer can use the Uniform Glossary as evidence of the terms of coverage in a lawsuit.[133] Congress authorized HHS to draft the Uniform Glossary definitions with consultation from the National Association of Insurance Commissioners.[134] HHS issued a final rule containing definitions and instructions to insurance companies and

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129 *Id.* § 300gg-15(b)(3)(H).

130 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. at 8678 ("At the same time, the document specifically cautions that it is intended to be a general educational tool and that individual plan terms may differ (and refers consumers to the SBC for information on how to get an accurate description of their actual plan or policy terms).").

131 *Id*.

132 *See, e.g.*, Letter from Senator John D. Rockefeller IV and Congresswoman Rosa L. DeLauro to Kathleen Sebelius, Sec'y, U.S. Dep't of Health and Human Servs., et al. (Nov. 22, 2011), *available at* http://rockefeller.senate.gov/public/index.cfm/files/serve?File_id=b74f8890-4369-4ac6-bec3-2eaa0e147f7b&SK=4D443394AB386DB74467EBAF0F4411AC.

133 *See supra* Part I.B.3.

134 42 U.S.C. § 300gg(b)(3)(A).

employers for complying with the related provisions.[135] A health insurer is responsible for providing the Uniform Glossary unless the plan is self-insured, in which case the employer's plan administrator has responsibility for providing the required documents.[136]

A. Flaws in the Uniform Glossary

There are two substantial flaws in the Uniform Glossary provision. First, employers must distribute documents that they did not write. Although the insurance and employer associations were heavily involved in the public comment period of HHS's drafting process, insurers must ultimately endorse a document that they did not write by providing it with other plan documents.[137] This could cause concern for an insurer who disagrees with the way the definitions were written in the Uniform Glossary. For example, if an insurer does not want to use the Uniform Glossary's definition of "preauthorization" because it believes the definition is too complicated, too generalized, too misleading, or any other host of complaints, its unappealing options are to distribute the glossary as is or violate the law.[138]

The second problematic aspect of the Uniform Glossary is that insurers are not required to incorporate the Glossary's definitions into their own plan terms.[139] The statute requires "a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing con-

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135 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668 (Feb. 14, 2012) (to be codified at 45 C.F.R. pt. 147); Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials; and Guidance For Compliance, 77 Fed. Reg. 8706 (Feb. 14, 2012) (to be codified at 45 C.F.R. pt. 147).

136 42 U.S.C. § 300gg-15(d)(3)(A)–(B).

137 *See* Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. at 8670. The NAIC charged its Consumer Information (B) Subgroup with drafting NAIC's submission to the Department of Health and Human Services regarding its proposed regulation. *Id.* The Subgroup solicited comments and edits from members of the public, including consumer advocacy organizations, insurance companies, employer associations, and interested parties. *Id.* Draft documents, comment letters, meeting minutes, and summaries chronicling the drafting process can be accessed on the NAIC website. *See Committees & Activities: Consumer Information (B) Subgroup*, NAT'L ASS'N OF INS. COMM'RS, http://www.naic.org/committees_b_consumer_information.htm (last visited Jan. 28, 2013).

138 U.S. DEP'T OF HEALTH AND HUMAN SERVS., GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS 3, http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf (defining preauthorization as "[a] decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.").

139 42 U.S.C. § 300gg-15(b)(3)(H).

tractual provisions."[140] HHS clarified in the final rule that the Uniform Glossary terms are not plan- or policy-specific.[141] The Uniform Glossary also contains the following disclaimer:

> These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.[142]

In other words, HHS has stated clearly that these terms are not binding.[143]

The fact that insurers cannot change the Uniform Glossary and are not required to change plan documents to match the Uniform Glossary creates the almost certain likelihood that multiple definitions will emerge. An easy-to-understand glossary will help consumers learn the basics of the health insurance market,[144] but consumers will consider a document that "looks official" to be authoritative or legally binding, even if it contains a disclosure saying otherwise.[145] Although it is true that these definitions are generally applicable across the *industry*, they are not necessarily applicable to *any one plan*.[146]

B. High Likelihood for Conflicting Definitions

It is reasonable for a consumer to read the Uniform Glossary with the belief that it defines her personal terms of coverage as compared to any definitions in the Summary Plan Description or Summary of Benefits and Coverage. The Summary Plan Description is plan-specific and describes how much an insurance plan will pay for doctor visits, hospital visits, medical equipment, and other covered services.[147] The Summary of Benefits and Coverage is also plan-specific, with a table presenting the cost of co-insurance, copayments, and deductibles.[148] The Uniform Glossary, on the other hand, is not plan-

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140 *Id.*

141 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. at 8678.

142 U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 138, at 1.

143 *See id.*

144 *See* HENRY J. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL 5 (November 2011), http://www.kff.org/kaiserpolls/upload/8259-F.pdf (finding that eighty-four percent of poll takers considered a requirement to provide easy-to-understand plan summaries in the Affordable Care Act "very" or "somewhat" favorable).

145 *See* WIEDENBECK, *supra* note 83, at 136 ("Where general fiduciary communications are issued in a way that makes them appear authoritative, workers will naturally credit them.").

146 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. at 8678.

147 *See supra* notes 80–84 and accompanying text.

148 *See supra* notes 20, 112–15 and accompanying text.

specific, but provides industry-wide definitions that may conflict with the definitions used by the consumer's insurance plan.[149]

In the case of Ms. Mondry, the Uniform Glossary could potentially have been a helpful document. The HHS definition of "medically necessary" services provides a general understanding that a medically necessary procedure is one "needed to prevent, diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."[150] Her plan, however, used a different definition, one that included the term "restorative."[151] The Summary Plan Description's definition of "medically necessary" is the following:

> [S]ervices and supplies are provided by a hospital, doctor, or other licensed medical provider to treat a covered illness or injury. The treatment must be appropriate for the symptoms or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of the patient, doctor, hospital, or other licensed professional.[152]

The insurance company denied the claim for Zev's therapy, finding that the speech services were not medically necessary because they were "educational or training" and "not restorative."[153] As the Seventh Circuit noted, these terms were not in the Summary Plan Description's definition of "speech therapy" or "medically necessary."[154] Without these qualifiers, the court held, Ms. Mondry did not know the true extent of her coverage, which was a violation of the plan's fiduciary duty.[155]

Although Ms. Mondry's lawsuit concerned the Summary Plan Description, it parallels future conflicts in the Uniform Glossary. Ms. Mondry's Summary Plan Description had a clear definition of medically necessary services.[156] She reasonably believed, on the basis of her doctor's recommendation, that Zev's treatment was medically necessary.[157] Her insurance plan, however, had a discretionary clause

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149 *See supra* notes 21, 24–25 and accompanying text.

150 U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 138, at 2.

151 Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 784–85 (7th Cir. 2009).

152 *Id.* at 785.

153 *Id.* at 783–84.

154 *Id.* at 784–85.

155 *Id.* at 808 (holding that Ms. Mondry's insurer violated its fiduciary duty to disclose and to provide a full and fair review even though the insurer had already reversed its initial denial for the speech therapy).

156 *Id.* at 785.

157 *Id.* at 784.

authorizing CIGNA to interpret the plan documents, which meant CIGNA could rely upon internal guidelines in court.[158]

The Uniform Glossary includes three definitions relevant to Zev's speech therapy: "habilitation services," "rehabilitation services," and "medically necessary."[159] "Habilitation services" are defined as "[h]ealth care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age."[160] "Rehabilitation services" are defined as "[h]ealth care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled."[161] "Medically necessary" is defined as "[h]ealth care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine."[162]

These definitions are overlapping, and any combination could describe Zev's condition. He had begun to develop speech and cognitive abilities, but they deteriorated shortly thereafter,[163] suggesting that "habilitation services" coverage would be appropriate. Any therapy to regain the development he had made, however, would be rehabilitative. Ms. Mondry's Summary Plan Description would have added to the confusion because neither term is used. She might have seen or known that her plan requires speech therapy to be "medically necessary," but if she looked at both the Uniform Glossary and her Summary Plan Description she would find two different definitions for that term as well.[164]

In that scenario, the consumer faced many different and potentially conflicting definitions. If plans are not required to incorporate the Uniform Glossary into their contract terms, this confusion will persist. In the development of the Uniform Glossary regulation, the National Association of Insurance Commissioners—the organization responsible for submitting a draft of the Uniform Glossary to HHS—considered several versions of both the Summary of Benefits and Cov-

158 *Id* at 798–99. For further discussion on the impact of discretionary clauses and deference on ERISA plan jurisprudence, see *supra* Part II.A.

159 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8705 (Feb. 14, 2012) (to be codified at 45 C.F.R. pt. 147).

160 U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 138, at 2.

161 *Id.* at 3.

162 *Id.* at 2.

163 Brief and Required Short Appendix of Plaintiff-Appellant, *supra* note 1, at 6.

164 *See supra* notes 151–52, 162 and accompanying text.

erage and the Uniform Glossary.[165] Advocates for transparency in health insurance have long acknowledged the difficulty of drafting highly technical documents in a way that most people can understand.[166] As noted in a report funded by the Robert Wood Johnson Foundation, a prominent health care think tank, "Reading a health insurance contract requires a sophisticated level of health insurance literacy that most people do not have."[167] Providing consumers with multiple definitions will exacerbate the confusion.[168] In states where summaries are currently required, there are often errors that result in a conflict between beneficiaries and insurers.[169]

The legal history of the Summary Plan Description predicts discrepancies between the Uniform Glossary and plan terms.[170] Summary Plan Descriptions were intended, like the Uniform Glossary, to help consumers understand the content of their employer-sponsored health insurance coverage.[171] The Fifth Circuit noted that the Summary Plan Description must be considered a contractually binding plan term because "[a]ny other rule would be, as the Congress recognized, grossly unfair to employees and would undermine ERISA's requirement of an accurate and comprehensive summary."[172] Although the Summary Plan Description has helped individual consumers make some sense of the terms of coverage, it is still a confusing document.[173] The difficulties Ms. Mondry had in understanding her coverage, for example, were the result of a confusing Summary Plan Description.[174]

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165 *See Consumer Information (B) Subgroup 2011 Meeting Documents*, NAT'L ASS'N OF INS. COMM'RS, http://www.naic.org/committees_b_consumer_information_2011_call_archive.htm (last visited Jan. 28, 2013).

166 *See* KAREN POLLITZ ET AL., COVERAGE WHEN IT COUNTS: WHAT DOES HEALTH INSURANCE IN MASSACHUSETTS COVER AND HOW CAN CONSUMERS KNOW? 15 (2009), http://naic.org/documents/committees_b_consumer_information_coverage_facts_paper.pdf (funded by the Robert Wood Johnson Foundation).

167 *Id.*

168 *See* Letter from Consumer Representatives to the National Association of Insurance Commissioners to Center for Medicare and Medicaid Services, *supra* note 119, at 16 (noting that state-regulated insurance plans may be subject to state-specific regulation that requires particular definitions for terms like "medical necessity").

169 Letter from Families USA to Centers for Medicare and Medicaid Services, *supra* note 119, at 20.

170 See *supra* Part II.A for discussion.

171 Letter from Consumer Representatives to the National Association of Insurance Commissioners to Center for Medicare and Medicaid Services, *supra* note 119, at 3.

172 Hansen v. Cont'l Ins. Co., 940 F.2d 971, 982 (5th Cir. 1991).

173 *See* Michael A. Valenza, *Accuracy Is Not a Lot to Ask: Decisions in the Second and Third Circuits Set the Tone for Litigation over Conflicts Between ERISA Plan Documents and Summaries*, 6 TRANSACTIONS: TENN. J. BUS. L. 361, 368 (2004).

174 *See* Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 784 (7th Cir. 2009).

C. *Potential Remedies Under ERISA*

Cases in which the Summary Plan Description differs from plan terms, creates ambiguity, or is internally inconsistent demonstrate that simplifying health insurance is complicated.[175] The Summary Plan Description case law suggests that even when insurance companies can draft summaries specifically tailored to their own plans, they sometimes get it wrong or write things in a way that is so confusing as to leave the contract open to multiple interpretations.[176] As a result, courts have repeatedly held that an ERISA Summary Plan Description should be binding over other plan documents so that consumers who relied on the summary do not bear the cost of this confusion.[177]

The Uniform Glossary provision continues to provide employers the freedom to draft plan documents without having to adhere to any uniformity. If Ms. Mondry were to file a lawsuit for a claim for benefits due under ERISA § 502(a)(1)(B) based on her reading of the Uniform Glossary, she would have to establish that the insurance company wrongly denied her claim because it used the wrong definition of "habilitation services."[178] She might argue that she reasonably relied on the Uniform Glossary as a term of her plan coverage and, therefore, the insurance company should be bound by it.[179] The Supreme Court has concluded that equitable relief stemming from reliance on plan documents may be a basis for a remedy under ERISA.[180]

The Affordable Care Act does not provide guidance as to whether a consumer can legally rely on the Uniform Glossary as evidence of plan coverage when it conflicts with other plan documents. The rule says only that the Uniform Glossary definitions are not binding on ERISA plans.[181] This suggests that a consumer does not have a legal remedy when the Uniform Glossary contradicts the contractual terms of an ERISA plan.[182]

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175 Valenza, *supra* note 173, at 368.

176 *See, e.g.*, *Mondry*, 557 F.3d at 784.

177 *See, e.g.*, CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1874–75 (2011).

178 If Mondry's plan were not an ERISA plan, but rather some other individual or state-regulated plan, then she may have other causes of action available. Because ERISA plans are limited to those remedies laid out in § 502, however, there can be no other cause of action under state or federal law. *See supra* Part I.A.1, 4.

179 *See Amara*, 131 S. Ct. at 1876.

180 *Id. at* 1878–80.

181 Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8678 (Feb. 14, 2012) (to be codified at 45 C.F.R. pt. 147).

182 29 U.S.C. § 1022(a) (2006) (requiring ERISA plans to distribute Summary Plan Descriptions, lacking any indication that consumers could hold an insurance company responsible for what was contained therein if it conflicted with plan documents). As will be discussed further

This is problematic for ERISA plan enrollees. Because an employer that chooses to offer health insurance to employees need not make available more than one option, an ERISA enrollee may not have very many options for plan enrollment—it may be all or nothing.[183] Given that ERISA beneficiaries can only choose from those plans offered by their employers, they should be able to assume that the documents they receive in connection with the plan are accurate, internally consistent, and legally binding.[184] To do otherwise would force them into a plan without providing them a way to understand it. The best way to ensure that employees can rely on the Uniform Glossary is to revise the provision in the Affordable Care Act to require all insurance plans to use the same terms and definitions in all plan documents.

III. Congress Must Require Employer-Sponsored Plans to Use Uniform Glossary Terms in All Plan Documents

Congress's goal in creating the Uniform Glossary was to make insurance documents more accessible to consumers.[185] To accomplish this, the legislation must be amended to require every employer-sponsored plan to use the Uniform Glossary definitions in all plan documents and communications. Currently, a plan need not incorporate the Uniform Glossary terms into the actual plan documents—it must only supply consumers with the Uniform Glossary.[186] Requiring such incorporation would ensure that the Uniform Glossary creates meaningful transparency.[187]

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below, however, courts have consistently interpreted Summary Plan Descriptions as trumping the plan documents. *See* Michael C. Joyce*, Setting a Standard to Rely on: ERISA Benefit Claims Where the Summary Plan Description and Plan Document Conflict,* 90 Iowa L. Rev. 765, 768 (2005).

183 Henry J. Kaiser Family Found. & Health Research & Educ. Trust, *supra* note 28, at 55. According to a 2011 report, eighty-four percent of firms offering health benefits offered one plan type, fifteen percent offered two plan types, and only one percent offered three or more plan types. *Id.*

184 *See* McKnight v. S. Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985).

185 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 243 ("The Affordable Care Act reflects a distinct move towards greater standardization.").

186 Patient Protection and Affordable Care Act § 2715, 42 U.S.C. § 300gg-15 (Supp. IV 2010).

187 This Note proposes that the legislation require all ERISA plans to adopt these definitions, but does not address other types of insurance plans. As mentioned in Part I, non-ERISA plans (such as plans purchased in the individual market) are regulated primarily by the states. Under the McCarran-Ferguson Act, 15 U.S.C. § 1011 (2006), regulation of insurance is left to the

A. Proposed Amendment

The proposed amendment to the Affordable Care Act should require all ERISA plans to incorporate the Uniform Glossary terms, as promulgated by HHS, into all plan documents and communications. This would create a common language for all employer-sponsored health insurance. For example, when any ERISA plan requires that a service be "medically necessary" it would have to use the same definition as every other ERISA plan. Such legislation promotes consistency, transparency, and predictability across and within plans.

The following addition to the current language at 42 U.S.C. § 300gg-15(c) would accomplish this goal:

> ERISA plans must use the definitions provided in the Uniform Glossary as promulgated by the Secretary of the Department of Health and Human Services, should they use any of these terms in their Summary Plan Descriptions, plan communications, and other plan documents. The effective date will be two years from the date of enactment for plans that are currently in existence, as well as those that are established between now and the effective date, and will apply to any plan established after the effective date.

This language requires any new or existing ERISA plan to use the terms and definitions provided in the Uniform Glossary.

Existing plans would have to reissue plan documents with the new definitions. Currently, ERISA plans must notify plan participants within sixty days of any material changes to benefit coverage[188] and supply an updated Summary Plan Description every five years if there have been any amendments whatsoever, even if they are not material.[189] ERISA plan administrators, therefore, are accustomed to supplying amended documents to participants. The amendment would not create an overwhelming burden. An effective date two years after enactment would give existing plans enough time to revise their current plan documents.

Congress's authority to enact such legislation stems from the same power it used in enacting ERISA: the power to regulate interstate commerce.[190] Congress has already concluded that it has the power "to protect interstate commerce and the interests of partici-

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states, with the exception of ERISA plans. This proposal is limited to federally regulated ERISA plans.

188 29 U.S.C. § 1022 (2006).

189 *Id.* § 1024(b).

190 *See id.* § 1001.

pants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto . . . ."[191] In particular, because this proposal affects only employee-benefit plans, which are not traditionally regulated by the states, there should be no difficulty in asserting Congress's commerce power.

B. The Proposed Amendment Aligns with Congress's Goals

The proposed amendment ensures that Congress's intent and goals are furthered.[192] First, a uniform language would increase transparency and efficiency in the employer-sponsored health insurance market.[193] If ERISA plans are required to use common definitions throughout all plan documents, not just provide the Uniform Glossary, then consumers will gradually become more comfortable with insurance vernacular. Because ERISA plans are more than half of the insurance market,[194] requiring the use of this common language would encourage other markets to adopt this language as well. States may also decide to incorporate the Uniform Glossary definitions into their insurance regulations as mandatory definitions. There would be better comparison shopping across health plans and better decisionmaking in seeking out health care services with this change.[195]

Second, a uniform language also promotes fairness, equality, and common sense.[196] Courts have recognized that transparency and accurate information are crucial elements of an informed consumer market.[197] A risk of disparate bargaining power arises when there is an imbalance of information.[198] In the context of ERISA, employees are likely only picking between a few plan options provided by the employer, but they still must be adequately informed to make the decision whether to enroll or what additional financial precautions might

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191 *Id.* § 1001(b).

192 *See supra* note 185 and accompanying text.

193 *See* Valenza, *supra* note 173, at 373.

194 U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, P60-239, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (Sept. 2011), http://www.census.gov/prod/2011pubs/p60-239.pdf.

195 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 244–46.

196 *See* Hansen v. Cont'l Ins. Co., 940 F.2d 971 (5th Cir. 1991); McKnight v. S. Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985) ("It is of no effect to publish and distribute a plan summary booklet designed to simplify and explain a voluminous and complex document, and then proclaim that any inconsistencies will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet.").

197 *See McKnight*, 758 F.2d at 1570.

198 Valenza, *supra* note 173, at 374.

be necessary to protect against a certain level of risk.[199] They also need clear and accurate coverage information when deciding whether to see a doctor. Especially as other reforms of the Affordable Care Act become commonplace, the ability to fully understand one's options is necessary for making appropriate insurance choices.[200]

Third, a uniform language conforms to Congress's preference for strong disclosure and informed decisionmaking over paternalistic policies isolating consumers from potentially poor purchasing decisions.[201] If insurance is to be viewed as a mechanism for enabling individuals to make better health choices,[202] then a consistent and comprehensible vocabulary furthers the ability of consumers to be efficient health care users. A uniform *language* does not mean uniform *benefits.*[203] Mandating a common language to be used by all employer-sponsored insurance plans does not disturb the current flexibility employers enjoy in structuring benefits; it merely creates a standard for talking about those benefits.[204] Standardizing the definition of "medically necessary," for example, does not mean that every benefits administrator will consider the same services for a particular individual to be medically necessary—there is still a degree of discretion and interpretation left to the employer.[205] Employers can still choose what services to pay for and what cost-sharing mechanisms to use. The major difference would be that consumers would have a level playing field when it comes to the way that insurance benefits are defined and described.

C. Illustration: The Mondry *Case*

Consider how Ms. Mondry's case might have been different if her employer had been required to use the Uniform Glossary definitions in the plan. Throughout her plan documents there would have been one definition of the term "medically necessary." The Summary Plan Description would have provided the same definition as the Uniform

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199 WIEDENBECK, *supra* note 83, at 18–19.

200 42 U.S.C. § 18031(b) (Supp. IV 2010).

201 *See* WIEDENBECK, *supra* note 83, at 115.

202 *See* Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 277–79 (2012) (arguing that insurance is a form of risk management and that standardization of plans can increase predictability).

203 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 254–55 (discussing alternative approaches toward health benefit regulation by contrasting "form and content" regulation with "standard products" or "quality control" regulation).

204 *See id.* at 311 ("The ACA uses a 'structured choice' approach, which strikes a balance between unregulated choice and strict uniformity.").

205 Kennedy, *supra* note 50, at 1159 n.400.

Glossary. If CIGNA wanted to restrict the speech therapy services to only those that were restorative, it would need to clearly include that in the provision for speech therapy, rather than building it into the interpretation of "medically necessary."[206] Thus, when Ms. Mondry consulted the speech therapy provision, she would have been immediately aware that the services might be denied if CIGNA concluded they were not restorative. With this knowledge, Ms. Mondry would have been better equipped to make a decision about whether to seek the treatment.

Applying the Uniform Glossary definitions to all plan documents not only benefits employees, but also benefits employers and insurers with an informed marketplace.[207] If a consumer has full information, she will make better decisions about receiving medical services.[208] As already mentioned, Ms. Mondry might have avoided costly speech therapy and litigation if she had known that her son's treatment would not have been covered because it was considered not restorative. Employers should support this legislation because it would encourage employees to understand their coverage. This creates a happier workforce and reduces the likelihood of conflict between the employee and the plan administrator.[209] Employers, as purchasers, would also benefit from clear and more consistent definitions. Insurers should support this legislation, too, because it would give them clear guidance; it is a bright line rule with explicit requirements. Because uncertainty can yield volatility and high litigation costs, increased predictability would lower costs and promote business development.[210]

IV. Without a Legislative Fix, Litigation Is Unlikely to Protect Employees or Employers

A congressional fix is the easiest and most logical way to prevent conflicts between the Uniform Glossary and plan terms, but there are other possible responses. First, the courts may apply existing legal theory developed for Summary Plan Description cases to Uniform Glossary cases. Second, insurers and the market might adjust to self-correct any confusion. Third, some may argue that Congress should

206 *See supra* notes 11–14 and accompanying text.

207 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 243–44.

208 *See id.*

209 *See id.* at 247.

210 *See id.* at 243–46.

refrain from policing these contracts between employers and employees.

A. Adjudication Through Individual Lawsuits Is Possible but Will Create Uncertainty for Consumers, Insurers, and Employers.

Legislation would be unnecessary if the courts were equipped to handle these types of disputes over contract language. This has been the approach to inconsistencies between insurance contracts and Summary Plan Descriptions. Summary Plan Descriptions, like the Uniform Glossary, were not intended to be legally binding contractual terms.[211] As disputes arose regarding Summary Plan Descriptions, however, the circuit courts concluded that the Summary Plan Description would be meaningless if it were not considered to be part of the plan terms. The Eleventh Circuit stated that if the Summary Plan Description did not control when it conflicted with plan terms, "[u]nfairness will flow to the employee for reasonably relying on the summary booklet."[212] The court interpreted statutory silence to conclude that summaries of plan terms must be binding to give congressional intent any effect.[213] To effectuate that decision, the court has made the "other equitable relief" provision of ERISA § 502(a)(3) available to enrollees suing over conflicts with the Summary Plan Description.[214]

Although this may have been an effective framework for the Summary Plan Description, courts may be hesitant to follow the same path for the Uniform Glossary. First, unlike the Summary Plan Description, neither the employer nor the insurer wrote the Uniform Glossary. Holding them to this document without clear congressional direction may be beyond the courts' level of comfort. The Supreme Court has said that making summaries binding could "lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers."[215] This expresses a general unease with holding employers accountable for documents that are merely intended to be resources for comprehension.

Second, ad hoc case law may not resolve the underlying issue of multiple or conflicting definitions. The Supreme Court announced in

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211 *See* 29 U.S.C. § 1022(a) (2006).

212 McKnight v. S. Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985).

213 *See* Joyce, *supra* note 182, at 768.

214 *See* CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1880–81 (2011) (holding that common law equity claims of estoppel, reformation of the contract, or surcharge may be available).

215 *See id.* at 1877–78.

CIGNA Corp. v. Amara that the Summary Plan Description may not be considered a "term[ ] of the plan" for the purposes of ERISA relief under a claim for benefits due.[216] Instead, the Court made available "other equitable remedies,"[217] which means that the Summary Plan Description is binding only when employees were harmed by relying on that document.[218] Courts have varying standards for the level of harm and reliance that the employee is required to show.[219] This will result in different evidentiary burdens for beneficiaries in different jurisdictions.[220] It also means that a consumer who does their research before seeking services will never be eligible for relief because they prevented their own harm.[221]

Leaving the resolution of this issue to the courts, therefore, will not achieve the goals of uniformity and predictability. This would cause confusion not only for consumers who are unsure whether they can rely on the documents, but also for insurers who would have to litigate on a case-by-case basis the level of reliance of an individual enrollee.[222] Further uncertainty results from the fact that not all employers would have to incorporate the Uniform Glossary into the terms—only those employers who wound up in court could be bound by the Uniform Glossary.

B. It Is Unlikely That Insurers Will Adopt a Uniform Language Without a Legal Mandate.

Critics of the proposed amendment may argue that legislation is not needed because the insurance market will self-correct to address increased confusion and complexity in the market. As discussed above, it is likely that the Uniform Glossary provision in its current state will have the unintended effect of increasing confusion for con-

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216 *Id.* at 1876–77.

217 *Id.* at 1880–81.

218 *See* Michael A. Valenza, Cigna v. Amara*: Supreme Court Resolves Several ERISA Claim Issues While Leaving Others for the Lower Courts*, 13 TRANSACTIONS: TENN. J. BUS. L. 139, 162–63 (2011) (describing *Amara* as leaving open new possibilities for individualized relief).

219 *See* WIEDENBECK, *supra* note 83, at 84–87. *Compare Amara*, 131 S. Ct. at 1868–70 (holding employees should not be barred from claiming reliance even if they did not look at the summary documents), *with* Health Cost Controls of Ill., Inc. v. Washington, 187 F.3d 703, 711–12 (7th Cir. 1999) (requiring detrimental reliance along with the Third and Eleventh Circuits), *and* Burke v. Kodak Ret. Income Plan, 336 F.3d 103, 103, 112 (2d Cir. 2003), *cert. denied*, 540 U.S. 1105 (2004) (requiring prejudicial reliance along with the First, Fourth, Eighth, and Tenth Circuits), *and* Hansen v. Cont'l Ins. Co., 940 F.2d 971, 983 (5th Cir. 1991) (requiring no reliance). *See also* WIEDENBECK, *supra* note 78, at 84–87.

220 *See supra* note 219.

221 *Id.*

222 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 243–44.

sumers.[223] Without required uniformity across plans, insurance companies and employers are free to continue using whatever definitions they would like.

If, however, there is so much confusion amongst consumers who, in turn, barrage insurers and employers with appeals and lawsuits over the applicability of the Uniform Glossary, insurers and employers may choose to independently adopt those terms. Insurers benefit from transparency and uniformity when consumers appropriately seek medical treatment in compliance with their plan terms—it reduces administrative costs if consumers can predict when a certain claim will be denied.[224]

Even so, the likelihood that insurance companies will adopt each of the Uniform Glossary terms exactly as they were drafted is low. Unlike consumers, insurers have the resources to litigate and draft these insurance contracts in a way most beneficial to their own interests.[225] If insurers need only follow their own plan terms, they can adapt whatever interpretations or definitions they prefer.[226] Although insurers would benefit from the standardization of plan definitions,[227] the motivation to standardize without a legislative mandate would likely be outweighed by insurers' and employers' desire for plan flexibility.

C. Employers Will Not Suffer from a Lack of Flexibility.

There may be opposition to additional requirements on ERISA plans because of an institutional preference for giving employers the flexibility to design and administer health benefit plans.[228] The statutory and policy approach has historically been to give consumers the tools they need to make informed purchasing decisions while promoting a variety of benefit package structures.[229] A legal mandate requiring plans to adopt the Uniform Glossary terms may, on its face, seem contrary to this preference because it limits the options employers have when drafting policies. On the contrary, however, uniform lan-

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223 See discussion *supra* Part II.B.

224 *See* Oechsner & Schaler-Haynes, *supra* note 96, at 243–44.

225 Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 107 (2008).

226 *See* Conkright v. Frommert, 130 S. Ct. 1640, 1649 (2010).

227 *See* Mariner, *supra* note 202, at 277.

228 *See* Rosenbaum, *supra* note 64, at 23.

229 *See* WIEDENBECK, *supra* note 83, at 16.

guage simply enables purchasers to adequately compare what are, essentially, standard form contracts.[230]

The American Heart Association, in a letter to the Center for Medicare and Medicaid Services, cautioned, "If consumers can't understand the coverage offered by a plan, they can't make an informed selection. When consumers do not understand their choices, they often make a decision based on premium alone and find themselves in plans that don't have the coverage they need."[231] A uniform language allows employers to continue offering tailored benefit plans while enabling employees to understand the options available.

There is precedent for imposing requirements on ERISA plans despite a preference to give them flexibility.[232] Congress mandated a comparable restriction on ERISA plans when it enacted the Summary Plan Description.[233] Additionally, many states already impose readability and other similar types of provisions.[234] Uniform language and definitions still allow for many different types of plan structures and implementations.[235]

CONCLUSION

The health insurance market is a confusing place for most consumers. The employer-based system that the United States rests upon was in a dangerous state of being incomprehensible to most individuals. In the Affordable Care Act, Congress attempted to increase transparency with the addition of the Uniform Glossary. As an informative tool, the Uniform Glossary provides consumers with easy-to-understand definitions for some of the market's most complex terms. The most effective reform, however, would be a standard language for every plan to use in all insurance documents. For the Uniform Glossary to be a powerful resource, Congress must make its definitions binding on employer plans. Without having the weight of the law behind it, the Uniform Glossary might undermine its own

230 *See* Jeffrey W. Stempel, *The Insurance Policy as a Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813, 826 (2009).

231 Letter from American Heart Association to Centers for Medicare and Medicaid Services, *supra* note 124.

232 *See supra* Part I.A.5.

233 29 U.S.C. § 1022(a) (2006).

234 Randall, *supra* note 225, at 107.

235 *See* Gail B. Agrawal & Mark A. Hall, *What If You* Could *Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 284 n.167 (2003) ("Most health plan executives interviewed in this study did not complain that mandatory definitions and interpretations of medical necessity unduly hampered their cost containment objectives or their contractual options in the marketplace.").

goals by adding more information to an already saturated dialogue. The best way to remedy this undesirable situation is with federal legislation that sends a clear message to insurance companies and employers that this industry must adapt to make itself more accessible to consumers.