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Did Smokers Catch a Break? The Eighth Circuit Interprets Exclusions of Tobacco-Related Conditions Narrowly in Christianson v. Poly-America Medical Benefit Plan

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I. INTRODUCTION

According to 2001 U.S. Census data, approximately sixty-three percent of the population receive their health care benefits from employer-sponsored health care plans.1 Recognizing the growing number and economic impact of employee benefit plans, Congress enacted

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the Employee Retirement Income Securities Act (ERISA)\(^2\) in 1974 to regulate employee pension benefit plans and employee welfare benefit plans, which include employer-sponsored health care plans. According to ERISA section 2(b), one of the Act's purposes is to protect the interests of health care plan participants and beneficiaries by requiring the disclosure of information regarding the plan and providing adequate remedies for breaches of the plan.\(^3\)

Recently the Eighth Circuit, relying in part on section 2(b)'s stated purpose of protecting plan participants, affirmed a district court's summary judgment against a health plan in *Christianson v. Poly-America Med. Benefit Plan*.\(^4\) The health plan excluded coverage for conditions related to tobacco use. The Eighth Circuit found that, despite the plan participant's tobacco use, his deep-vein thrombosis was not sufficiently "related to" his condition under the plan language.\(^5\)

However, despite section 2(b)'s directive to protect plan participants, the Supreme Court's interpretation of ERISA's preemption scheme has allowed self-insured plans to protect themselves against state laws regulating the substantive content of health plans.\(^6\) Therefore, many plans are free to completely exclude coverage to groups of individuals or for particular illnesses. Court decisions adverse to plans, such as *Christianson*, may spur self-insured plans to eliminate coverage completely for certain groups and illnesses rather than to carve out exclusions to general coverage. In addition, plan administrators' decisions are reviewed by courts under an abuse-of-discretion standard, and the most substantial costs plan sponsors could face for wrongfully denying benefits are the costs of the benefits plus attorneys' fees, court costs, and prejudgment interest. The legal system clearly favors health plans over plan participants and beneficiaries.\(^7\)


\(^3\) 29 U.S.C. § 1001(b) (2000).


\(^5\) Id. at 939.


In Part II, this Note begins with a brief discussion about how ERISA preemption and civil enforcement favor plans over participants. This Note then explains the Christianson decision in Part III, detailing the facts surrounding the case and describing Christianson's victory. The Eighth Circuit held that Poly-America's exclusion of tobacco-related conditions did not apply to Christianson's deep-vein thrombosis despite his tobacco use. Section IV.A discusses reasons why employers may target smoking and ways they will try to exclude smoking-related illnesses from health plans. Employers are not required to offer their employees health coverage, and employers will only be able to keep their plans operating if they are able to control their exposure to rising health care costs. Employers have begun to attempt to save money by limiting the coverage they provide to employees who engage in voluntary, risk-taking behavior such as smoking. Section IV.B demonstrates that, despite these efforts, employers may have a difficult time enforcing these restrictions. This Note concludes by noting that although individual smokers may have a few successes in winning benefits from their health plans, these successes will only encourage health plans to eliminate smokers as a group from any health care coverage. Although ERISA permits the exclusion of tobacco-related conditions from plan coverage, plan administrators will find it too difficult to carry out such exclusions and ultimately will be forced to terminate coverage for smokers altogether.

II. ERISA BACKGROUND

A. ERISA Preemption and Civil Enforcement

1. ERISA Preemption

Congress enacted ERISA to promote and protect the interests of participants and beneficiaries of employee benefit plans. In order to provide plan participants and beneficiaries ready access to the federal courts and appropriate remedies, ERISA delineated an expansive preemption provision in section 514(a), which essentially provides that any and all state laws relating to any employee benefit plan are

9. Id.
10. Id. § 1144(a). Ordinarily, federal preemption is a federal defense to a plaintiff's claim. According to the well-pleaded-complaint rule, a federal question has to appear on the face of a complaint for the defendant to remove a case filed in state court to federal court under federal question jurisdiction. However, when Congress has so completely preempted a particular area of law, any complaint raising a claim in that area of law is necessarily federal in character. Congress has clearly expressed its intent that ERISA civil enforcement claims are federal questions. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54–55 (1987).
preempted by ERISA. The "savings clause" found in section 514(b)(2)(A) saves any state law that regulates insurance from preemption. The "deemer clause," under section 514(b)(2)(B), prohibits self-insured plans from being deemed insurance companies that are subject to state insurance laws. Thus insured health care plans are subject to state laws regulating insurance, whereas self-insured plans are exempt from those same state laws. As a result, plans have a strong incentive to become self-insured—freedom from state regulation. The Supreme Court has given ERISA broad preemptive force through its interpretations of the scope of section 514. According to critics, ERISA generally, and section 514(a) specifically, have become "virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries," and the Supreme Court has created "a 'regulatory vacuum' in which virtually all state law remedies are preempted but very few federal substitutes are provided."16

2. Civil Enforcement

Under ERISA, the doctrine of complete preemption requires that the state law claim must not only be preempted by section 514(a) but also that a substitute federal claim must exist under section 502(a) to remove a plaintiff's case to federal court. ERISA section 502(a)(1)(B), ERISA's civil enforcement mechanism, allows health

care plan participants and beneficiaries to bring civil actions against
their plan administrators. These civil actions can be brought to re-
cover benefits due under the terms of the plan, to enforce rights under
the terms of the plan, or to clarify rights to future benefits under the
terms of the plan.18 ERISA section 502(a)(3) limits the relief availa-
bile; the court can enjoin the HMO from continuing to deny benefits or
give other appropriate equitable relief,19 which does not include mone-
tary damages.20 Therefore, section 502 only allows plan participants
and beneficiaries to seek the benefits they were contractually entitled
to in the first place.21 The participants or beneficiaries also can be
awarded attorneys' fees and court costs under section 502(g)(1).22
Some circuits, including the Eighth Circuit, allow participants or ben-
eficiaries to recover prejudgment interest on denied benefits.23

Because the greatest cost a plan would face if a court ultimately
finds that the benefits should not have been denied is simply the costs
of the benefits, attorneys' fees, court costs, and prejudgment interest,
the plan administrator has strong incentives to deny claims. There-
fore, "[a]ny rational [plan administrator] will recognize that if it acts
in good faith, it will pay for far more procedures than if it acts oth-
wise."24 This scheme creates the disagreeable effect that the most
profitable plans are those that deny claims most frequently.25

If a plan administrator denies a claim for benefits under ERISA
section 503, the plan administrator must provide the plan participant
or beneficiary with adequate notice in writing, "setting forth the spe-
cific reasons for such denial, written in a manner calculated to be un-
derstood by the participant."26 ERISA section 503 also requires that
health care plans establish a reasonable procedure to review partici-
pants' and beneficiaries' appeals of denied benefits.27 Research indi-
cates that U.S. health plans process approximately 250,000 appeals

19. Id. § 1132(a)(3).
20. See Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Mertens
21. Due to ERISA's broad preemptive power under 29 U.S.C. § 1144(a), the Act's con-
tractual remedy preempts state tort remedies for medical malpractice against
plans, eliminating the possible recovery of compensatory, p.nitive, or wrongful-
death damages regardless of a plan's malfeasance. See, e.g., Davila, 542 U.S. at
204.
23. See, e.g., Mansker v. TMG Life Ins. Co., 54 F.3d 1322 (8th Cir. 1995).
25. Id. at 459.
27. Id. § 1133(2).
annually. Most plans require that a plan participant or beneficiary must exhaust the plan's internal appeal procedures before they can seek external review mechanisms. It is imperative that plan participants and beneficiaries understand the internal review process for two reasons. First, courts may dismiss claims with prejudice due to failure to exhaust the plan's administrative appeal procedure. Second, judges are generally limited to reviewing the documents that the plan administrators had before them at the time of the benefit denial.

B. Standard of Judicial Review

In the landmark *Firestone Tire & Rubber Co. v. Bruch* decision, the Supreme Court held that where an employee benefits plan gives the administrator discretion to make eligibility determinations, a court should only reverse the administrator's determination if there has been an abuse of discretion. As a result of this decision, nearly all plans include language that gives the plan administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Courts have made it easy for plans to invoke the abuse-of-discretion standard because courts do not want to interfere with the administration of the plan benefits.

The court will use a less deferential standard of review if a plaintiff can present material and probative evidence that a palpable conflict of interest or a serious procedural irregularity was tied to the denial of benefits and caused a serious breach of the plan administrator's fiduciary duty. The evidence must give the court serious concern that the plan's eligibility determination was arbitrary and capricious. However, once a plaintiff is entitled to a less deferential standard of review, courts recognize that the plaintiff more than likely has sufficient evidence to prove that the plan administrator's decision was arbitrary and capricious.

29. *Id.* at 189-90.
30. *See, e.g.*, Norris v. Citibank, N.A. Disability Plan, 308 F.3d 880, 884 (8th Cir. 2002); Layes v. Mead Corp., 132 F.3d 1246, 1252 (8th Cir. 1998).
32. *Id.*
33. *Id.* at 115.
34. *Id.*
35. *See Layes*, 132 F.3d at 1250.
37. *Layes*, 132 F.3d at 1250.
38. *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 588 n.9 (8th Cir. 1999).
C. Coverage Exclusions

ERISA section 102(a) requires that plan administrators provide plan participants and beneficiaries with a summary description of the employee health plan. The summary plan description typically explains, in three main sections, what benefits will be covered. The first section, often referred to as coverage categories, identifies the broad categories of services that the plan will cover (e.g., inpatient hospital services and maternal care). The second section, “coverage stipulations,” explains whether participants will have to share any of the costs of the services and how long they can utilize the services. The third section, often referred to as coverage criteria, attempts to distinguish between the particular services that will be covered within a coverage category and those services that will not be covered. Within their coverage criteria, summary plan descriptions often include exclusions (i.e., care the plan will not cover). Christianson involved a tobacco-related conditions exclusion and appears to be the only case in which a plan participant or beneficiary has challenged the application of this exclusion.

III. CHRISTIANSON V. POLY-AMERICA MEDICAL BENEFIT PLAN

A. Facts and Background

Richard Christianson worked for Up North Plastics in Minnesota, a subsidiary of Poly-America, Inc., and had health care coverage through Poly-America’s Medical Benefit Plan. Christianson’s job required him to stand on a concrete floor for over fifty hours a week, with very little walking. On January 18, 2001, Christianson visited his primary physician, complaining of painful swelling in his left leg. Christianson’s primary physician sent him to Regina Hospital for an ultrasound. The ultrasound revealed that Christianson suffered from deep-vein thrombosis of the lower leg. Deep-vein thrombosis is the development of a blood clot in the deep veins of the body. The legs are particularly vulnerable to blood clots because blood stops or

43. Id. at 992.
44. Id.
45. Id.
slows down in this part of the body. The most significant danger posed by deep-vein thrombosis is that the blood clot will break loose and travel to the brain or lungs. Risk factors for deep-vein thrombosis include, among other things, restricted mobility, genetic coagulation disorders, obesity, and smoking.

Dr. Georgia Taggart admitted Christianson to United Hospital for treatment and noted that Christianson was a healthy, forty-six-year-old man with minimal risk factors for deep-vein thrombosis other than prolonged standing and tobacco abuse. She requested that Christianson be tested for the factor V Leiden mutation, the most common genetic cause of deep-vein thrombosis, which suggests that Dr. Taggart did not believe Christianson's smoking caused his deep-vein thrombosis. Christianson underwent a left-leg thrombolysis and six days of lytic therapy to break up the blood clot. Dr. Charles Terzian treated Christianson at the hospital, giving him a primary diagnosis of deep-vein thrombosis and a secondary diagnosis of tobacco abuse. He noted that Christianson had no risk factors for deep-vein thrombosis.

Christianson submitted his medical bills for nearly $50,000 to Poly-America's medical benefit plan. The plan included language that gave the plan administrator discretion to make coverage determinations and included the following plan provision: "Charges related in any way, shape or form to, or complicated by, the use of tobacco products or for treatment of an ailment or condition associated with the use of tobacco [are excluded from coverage]." On June 1, 2001, the plan administrator sent Christianson a letter denying coverage for his hospital bills based on Poly-America's determination that his medical expenses were related to smoking. In accordance with plan appeal procedures, Christianson requested a review of the coverage denial. On June 30, 2001, he wrote,

My doctors have assured me that while occasional tobacco use may be a risk factor for [deep-vein thrombosis] it is impossible to determine if it had an impact in this instance .... There is no way to determine one way or the other if

47. Christianson, 288 F. Supp. 2d at 992.
49. Id.; Christianson, 288 F. Supp. 2d at 992.
51. Id.
52. Id.
53. Id.
54. Id.
56. Christianson, 412 F.3d at 937; Christianson, 288 F. Supp. 2d at 992–93.
57. Christianson, 412 F.3d at 937; Christianson, 288 F. Supp. 2d at 993.
58. Christianson, 412 F.3d at 937; Christianson, 288 F. Supp. 2d at 993.
smoking was a factor and so I feel it is unconscionable for Poly-America, my long term employer, to deny coverage.\textsuperscript{59}

Poly-America revisited its decision, requesting the medical opinion of Dr. Jerry Gurkoff, an osteopath and orthopedic surgeon not affiliated with Poly-America.\textsuperscript{60} Dr. Gurkoff reviewed Christianson’s medical records, and without evaluating Christianson himself, concluded that Christianson’s deep-vein thrombosis fell within the tobacco-related conditions exclusion of Poly-America’s health plan.\textsuperscript{61} Based on Dr. Gurkoff’s opinion and Christianson’s medical records, Poly-America again determined that Christianson’s hospitalization would not be covered.\textsuperscript{62} Poly-America sent Christianson a letter confirming the original denial, explaining that Christianson’s medical records indicated that his condition was related to his tobacco abuse and that an independent doctor came to the same conclusion.\textsuperscript{63}

After this second denial, Christianson sent Poly-America letters from two physicians, Dr. Robyn Oliver and Dr. Terzian.\textsuperscript{64} Both physicians treated Christianson in the hospital for his deep-vein thrombosis, and their letters explained that they had not determined that Christianson’s condition was related to or caused by smoking. In Dr. Oliver’s opinion, Christianson’s deep-vein thrombosis was of unknown origin; in Dr. Terzian’s opinion, nothing in Christianson’s medical records indicated that his condition was related to his tobacco use.\textsuperscript{65} Poly-America did not respond to these submissions.\textsuperscript{66}

Christianson filed a suit against Poly-America under ERISA section 502(a)(1)(B) in the United States District Court for the District of Minnesota.\textsuperscript{67} During a preliminary hearing, the district court sought Poly-America’s interpretation of the phrase “related to.” The court posed a hypothetical to Poly-America, asking how the plan would determine when lung cancer is “related to” tobacco use.\textsuperscript{68} Poly-America’s attorney interpreted the tobacco-related conditions exclusion as requiring the plan “to show a direct link between a particular beneficiary’s problem and their use of tobacco.”\textsuperscript{69} As a result, the district court found that Poly-America conceded that a direct link be-

\textsuperscript{59} Christianson, 412 F.3d at 937.
\textsuperscript{60} Id. at 938; Christianson, 288 F. Supp. 2d at 993.
\textsuperscript{61} Christianson, 412 F.3d at 938. Dr. Gurkoff initially provided his opinion to Poly-America via phone, but after Poly-America denied Christianson coverage a second time, Dr. Gurkoff submitted his formal opinion in writing. Id.
\textsuperscript{62} Id.; Christianson, 288 F. Supp. 2d at 993.
\textsuperscript{63} Christianson, 412 F.3d at 938; Christianson, 288 F. Supp. 2d at 993.
\textsuperscript{64} Christianson, 412 F.3d at 938; Christianson, 288 F. Supp. 2d at 993.
\textsuperscript{65} Christianson, 288 F. Supp. 2d at 993.
\textsuperscript{66} Christianson, 412 F.3d at 938.
\textsuperscript{67} Christianson, 288 F. Supp. 2d 991.
\textsuperscript{68} Christianson, 412 F.3d at 938.
\textsuperscript{69} Id. The district court also relied on the definition of “related” in Webster’s dictionary: “connected by reason of an established or discoverable relation.” Chris-
tween a medical condition and tobacco use must exist for the plan to preclude coverage under the "related to" language of the exclusion.70

The court also found that the appeal procedures for the plan failed to delineate when an administrative file was closed to additional materials.71 Therefore, Dr. Oliver and Dr. Terzian's letters were considered part of Christianson's file even though they were submitted after Poly-America had notified Christianson that they had confirmed their original denial determination. Because Poly-America failed to argue that the letters should not be admitted, the court found that Poly-America waived any objections to the court considering those documents.72

Furthermore, the court found that it did not need to determine whether to deviate from the abuse-of-discretion standard of review because the outcome would be the same under any standard of review.73 Therefore, even under the abuse-of-discretion standard, the court found that barely a scintilla of evidence existed to support a finding that Christianson's condition was related to his smoking behavior.74 The court acknowledged that smoking is a risk factor for deep-vein thrombosis but pointed out that risk factors merely increase the likelihood of a medical condition.75 The court stated that further evidence, such as competent expert testimony, is needed to show a risk factor is the cause of a medical condition in a specific case.76 The district court granted summary judgment to Christianson and awarded him past-due benefits, attorneys' fees, prejudgment interest, and costs.77

70. Id.
71. Id. at 993 n.2.
72. Id.
73. Id. at 994. The court cited Barnhart v. UNUM Life Insurance Co., 179 F.3d 583, 588 n.9 (8th Cir. 1999), for its finding that a plaintiff who satisfies the requirements for a less-deferential standard of review "will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious once the sliding scale is invoked to lessen the court's deference for the administrator's decision." On appeal, Poly-America claimed that the district court applied a less-than-deferential standard of review, but the Eighth Circuit rejected that argument. Christianson v. Poly-America Med. Benefit Plan, 412 F.3d 935, 939 n.5 (8th Cir. 2005).
75. Id. at 996.
76. Id. at 997. Christianson's attorney pointed out that Poly-America appears to have relied on a faulty syllogism: Some people have deep-vein thrombosis that is related to tobacco abuse. Mr. Christianson is a smoker. Therefore, his deep-vein thrombosis is related to smoking. The court found that "[t]his sort of flawed thinking represents exactly the sort of arbitrary and capricious administrative decision-making that judicial review is designed to unseat." Id.
77. Id. at 998.
B. The Eighth Circuit's Decision

Poly-America appealed the district court's finding, claiming that the district court erroneously interpreted the policy's "related to" language as requiring a causal link, and erred in considering Dr. Oliver and Dr. Terzian's medical opinions and in awarding attorneys' fees, court costs, and prejudgment interest. The Eighth Circuit affirmed the district court's findings, reviewing the grant of summary judgment de novo and applying the same abuse-of-discretion standard of review.

In response to Poly-America's contention that the district court constructed its own definition of "related to," the Eighth Circuit responded by pointing out that Poly-America's own counsel acknowledged that the "related to" language requires "a direct link between a particular beneficiary's problem and their use of tobacco" in response to the hypothetical posed by the district court. Poly-America tried to deny this definition, claiming that its counsel's statement should not be applied to the present case. The Eighth Circuit concluded that there was no logical reason why the "related to" language would require a direct link for a participant who has lung cancer but not for a participant that has deep-vein thrombosis.

The district court found that insufficient evidence existed to support a finding that Christianson's condition was related to his smoking behavior. At oral argument, Poly America's counsel even admitted that it might be impossible to demonstrate a direct link between smoking and any health condition: 

"[H]ow does anybody prove, given, you know, that tobacco use causes so many disorders that have so many causal contributing factors, how does anybody prove that tobacco use definitely caused a particular episode of an illness."

In addition, the Eighth Circuit concluded that it was proper for the district court to consider Dr. Terzian and Dr. Oliver's medical opinions. In a footnote in its brief, Poly-America argued that the letters were not entitled to any weight because they were submitted after Poly-America had confirmed its decision to deny coverage. The court construed Poly-America's argument to be a challenge to the weight accorded to the opinions, but not to the admissibility of the

78. Christianson, 412 F.3d at 939.
79. Id. at 939, 941.
80. Id. at 939.
81. Id.
82. Id.
84. Id.
85. Id. (alteration in original).
86. Christianson, 412 F.3d at 939-40.
87. Id. at 940.
opinions. The court held that the plan language did not necessarily prohibit consideration of letters after a denial confirmation. Poly-America pointed out that the plan's sixty-day review process had been completed two months before the medical opinions were submitted and that the plan did not allow a second review of coverage denials. However, because the plan accepted Dr. Gurkoff's letter after the confirmation denial, the plan was still open to additional materials.

Although ERISA gives federal district courts broad discretion to award reasonable attorneys' fees and court costs to either party for claims brought under Title I of the Act, the Eighth Circuit no longer presumes that a prevailing plaintiff is entitled to attorneys' fees and court costs. The Eighth Circuit upheld the district court's award of attorneys' fees, court costs, and prejudgment interest to Christianson, citing to authority that a district court's award will not be overturned unless there has been an abuse of discretion. In considering whether to award attorneys' fees and costs, the district court considered the five factors set out in Lawrence v. Westerhaus:

1. the opposing party's culpability or bad faith;
2. the opposing party's ability to pay an award of attorney fees and costs;
3. the likelihood that the award of attorney fees and costs would deter other persons under similar circumstances;
4. the likelihood that the cause of action might benefit all participants and beneficiaries of an ERISA plan or resolve a significant legal question regarding ERISA; and
5. the relative merits of the parties' cases.

The district court concluded that Poly-America perpetrated a "serious" breach of its fiduciary duty, Poly-America could afford the attorneys' fees and costs, the award would deter future breaches, the cause of action benefited all plan participants and beneficiaries by producing a judicial interpretation of a policy provision, and Christianson's claim "clearly" had more merit than Poly-America's. Poly-America claimed that if it could no longer exercise discretion in applying its tobacco-related conditions exclusion, it would be forced to deny cover-

88. Id.
89. Id. at 940 n.6.
90. Id.
91. Id.
92. Martin v. Ark. Blue Cross & Blue Shield, 299 F.3d 966, 970–72 (8th Cir. 2002) (overruling Landro v. Glendenning Motorways, 625 F.2d 1344 (8th Cir. 1980)).
93. Christianson, 412 F.3d at 940–41.
95. 749 F.2d 494, 496 (8th Cir. 1984).
The district court pointed out that this response would still benefit all plan participants because they would know that they needed to purchase additional insurance. Because all the factors weighed in Christianson’s favor, the district court awarded Christianson nearly $20,000 in attorneys’ fees and costs. Poly-America argued that the district court failed to evaluate the degree of Poly-America’s culpability or bad faith, but the Eighth Circuit held that the district court considered all the relevant factors and did not abuse its discretion by awarding attorneys’ fees and costs. Furthermore, the Eighth Circuit acknowledged that the district court does not have to consider all five factors in every case.

The Eighth Circuit also affirmed the district court’s award of prejudgment interest. Poly-America argued that because Christianson never paid the medical bills for his hospitalization, the award of prejudgment interest created a windfall to Christianson to the detriment of other plan participants and beneficiaries. The purpose of awards for prejudgment interest is not only to provide equitable relief to plan participants for the financial damages they suffer from improperly denied benefits, but also to deter plan sponsors from reaping financial benefits by drawing out litigation. Otherwise, the wrongdoer would be unjustly enriched through their use of the withheld benefits and retention of the interest accumulated during the course of litigation. The Eighth Circuit held that the district court did not abuse its discretion in awarding prejudgment interest in this case because the purpose of the award was satisfied. Even though Christianson did not pay for his medical bills, there is no dispute that Poly-America retained the withheld benefits during the dispute.

IV. ANALYSIS

Christianson demonstrates the tension between employers’ valid attempts to reduce their exposure to rising health care costs and their misguided methods for controlling those expenses. According to a survey by the Kaiser Family Foundation and Health Research and Educational Trust, employer health insurance premiums grew by eleven

97. Id. at 998 n.9.
98. Id.
100. Id.
101. Id.; see also Beatty v. N. Cent. Cos., 282 F.3d 602, 605 (8th Cir. 2002) (reaching same conclusion in a prior case).
102. Christianson, 412 F.3d at 941.
103. Id.
104. See Kerr v. Charles F. Vatterott & Co., 184 F.3d 938, 946 (8th Cir. 1999); Stroh Container Co. v. Delphi Indus., 783 F.2d 743, 752 (8th Cir. 1986).
105. Christianson, 412 F.3d at 941.
106. Id.
percent between 2003 and 2004, marking the fourth consecutive year of double-digit increases.\textsuperscript{107} The premiums for employer-sponsored health plans have been increasing at approximately five times the rate of inflation.\textsuperscript{108} As a consequence, employers are increasingly concerned that they will not have sufficient funds to meet the costs of their health care plans.\textsuperscript{109} Employers attempt to control their costs in a variety of ways, such as imposing preexisting condition limitations and utilization review.\textsuperscript{110} One clear-cut way to control exposure to rising health care costs is to incorporate coverage limitations and exclusions in health care plans.

Employers rarely eliminate coverage for a particular illness or condition; instead, they limit certain kinds of treatments, such as cosmetic surgery or experimental procedures.\textsuperscript{111} Nevertheless, there have been instances where employers have targeted specific conditions. For example, in the late 1980s and early 1990s, several employers excluded coverage for acquired immunodeficiency syndrome (AIDS) in their group health insurance plans.\textsuperscript{112} Recently, many employers have begun to focus on smoking as a way to reduce their health care costs.

Some employers have adopted the position that they should not have to cover treatment of conditions that are caused by voluntary, risk-taking behaviors such as smoking.\textsuperscript{113} In addition, employees who avoid risky health behaviors may feel that they should not have to pay higher premiums because other employees who chose to act irresponsibly need costly medical treatments.\textsuperscript{114} On the other hand, some have argued that it is morally reprehensible to consider whether an individual "deserves" his or her medical condition when deciding coverage limitations because it is often difficult to determine the precise


\textsuperscript{108} Id.


\textsuperscript{110} Charles P. Hall, Jr., Designing Medical Care Expense Plans, in 1 THE HANDBOOK OF EMPLOYEE BENEFITS 189, 189–91 (Jerry S. Rosenbloom ed., 3d ed. 1992); William G. Williams, Medical Care Cost-Containment Techniques: An Overview, in 1 THE HANDBOOK OF EMPLOYEE BENEFITS, supra.

\textsuperscript{111} See Zelda Lipton, Supplemental Major Medical and Comprehensive Plans, in 1 THE HANDBOOK OF EMPLOYEE BENEFITS, supra note 110, at 251–53.

\textsuperscript{112} Sohlgren, supra note 109, at 1247.

\textsuperscript{113} See, e.g., Robert M. Veatch, Voluntary Risks to Health: The Ethical Issues, 243 JAMA 50, 50 (1980) (describing a fire department which does not hire smokers in an effort to keep health care costs low).

cause of an illness and to decide which risk-taking behaviors should be punished.115

A. Reducing Costs by Targeting Smokers

According to the Department of Health and Human Services, smokers are responsible for eight percent, or $75 billion worth, of the United States’ health care expenditures.116 Health insurance costs are six to twenty-two percent higher for smokers than nonsmokers.117 It may seem unfair to target smokers when there are several other preventable, lifestyle-related illnesses, but there is extensive scientific literature showing a direct link between smoking and decreased health.118 Smoking is the leading cause of preventable illnesses—such as lung cancer, emphysema, heart disease, and stroke—in the United States.119 Smoking not only increases health costs for employers, but smokers are less productive while they are alive and create lost years of productivity due to premature death.120 According to the Centers for Disease Control and Prevention, smokers cost the United States $80 billion in lost productivity.121

Because nearly a quarter of the adult population smokes,122 employers can significantly reduce their health care costs by targeting smokers. Some states, such as Minnesota, allow employers to charge smokers higher insurance premiums than nonsmokers as long as the difference reflects actual increases in cost.123 Employers reason that

115. Id. at 694–96.
120. See Dorothy P. Rice et al., The Economic Costs of the Health Effects of Smoking, 1984, 64 MILBANK Q. 489 (1986).
121. Gunn, supra note 116.
123. See Jeremy Olson, Smokers May Pay More than a ‘Fee’: Some Employers Want Workers Who Smoke to Pick up Part of Health-Care Tab, PIONEER PRESS (St. Paul, Minn.), July 18, 2005, at 1A.
smokers should pay more for health care because they will require more expensive care over time.

Employers have adopted several techniques for reducing the costs of smoking. Employers have been able to reduce the prevalence of smoking and the daily cigarette consumption of their employees by restricting the places where employees can smoke.124 For example, Lowe's Home Improvement stores do not permit employees or customers to smoke anywhere on their store premises, including the parking lots.125 Alaska Airlines applicants must pass a nicotine test before they can be hired.126 Union Pacific began providing prescription coverage for drugs that treat nicotine addiction and offering smoking cessation programs; as a result, the number of employees who smoke decreased by thirteen percent between 1990 and 2003 and the number of lifestyle-related health care claims decreased by thirty-five percent between 1990 and 2001.127 Recently, Union Pacific has implemented a smoking ban that prohibits smoking on all its property nationwide and a hiring policy that automatically rejects job applicants that indicate they are smokers, at least in states where such hiring practices are permitted.128

Thirty states have “lifestyle” laws that protect smokers against employment discrimination.129 For example, Minnesota enacted a statute providing that an employer may not refuse to hire a job applicant or discipline or discharge an employee because the applicant or employee engages in or has engaged in the use or enjoyment of lawful consumable products, if the use or enjoyment takes place off the premises of the employer during nonworking hours.130

These laws, however, cannot protect many smokers against restricted coverage of tobacco-related conditions. ERISA itself does not regulate the substantive content of employee welfare plans,131 and because of ERISA’s preemption scheme, state insurance laws cannot regulate the substantive content of self-insured plans.132 Therefore, an employer that wishes to eliminate its exposure to certain conditions

125. Gunn, supra note 116.
126. Id.
127. Id.
128. Union Pacific estimates it saves $992 for each nonsmoker it hires instead of a smoker. Olson, supra note 123, at 8A; see also Gunn, supra note 116 (discussing the Union Pacific ban); Ozols, supra note 107 (same).
129. Olson, supra note 123, at 1A; Ozols, supra note 107; see also Sculco, supra note 117, at 879–80 (analyzing smokers’ rights laws).
131. Davidson, supra note 6, at 205.
needs only to be self-insured and stipulate an exclusion in the plan’s summary plan description. As health care costs continue to rise, employers might start excluding coverage for treatment related to other voluntary, risk-seeking behavior, such as poor eating habits, alcohol consumption, and extreme sports. Nevertheless, as Christianson demonstrates, it is difficult for plans to administer exclusions of coverage for lifestyle-related conditions.

B. Problems with Administering Exclusions of Tobacco-Related Conditions

Christianson demonstrates the importance of the need for clear language in plan documents and reasonable administration of plan decisions. Rather than enacting national health care reform, the federal government has elected to regulate the American health care industry primarily through informing consumers of their rights and obligations regarding health care coverage. By requiring health care insurers and providers to disclose material information to patients, the federal government has attempted to increase consumer knowledge while protecting America’s commitment to patient autonomy and self-determination.

For employer-sponsored health plans, Congress requires that plan administrators give plan participants and beneficiaries a summary plan description of the employee benefit plan. Accordingly, the summary plan description “shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.” Plan administrators may have a difficult time drafting summary plan descriptions because the documents must serve two conflicting purposes. The need for the summary plan description to precisely inform plan participants and beneficiaries of their rights and responsibilities regarding their health care plan implies that it should be a technical and comprehensive description. However, the summary plan description also must be comprehensible to plan participants and beneficiaries, which suggests that it should be free of jargon and be as concise as possible.

Within Poly-America’s summary plan description, the language excluding tobacco-related conditions was expansive: “Charges related in any way, shape or form to, or complicated by, the use of tobacco prod-
ucts or for treatment of an ailment or condition associated with the use of tobacco [are excluded from coverage]." Poly-America failed to take advantage of the broader plan language; instead of claiming Christianson’s deep-vein thrombosis was “complicated by” or “associated with” his smoking, Poly-America claimed Christianson’s condition was “related to” his smoking. The district court reasoned that the clause was so broad that a plan beneficiary did not even need to be a smoker to be denied coverage under the clause—that is, a non-smoker with heart disease “undoubtedly” has a condition associated with smoking. Therefore, unlike the “related to” language, the “associated with” language did not require a causal nexus.

At oral argument, the attorney for Poly-America explained that the plan used this broad language to give it flexibility in benefit determinations. The district court had a harsh response:

The problem with this sort of unfettered discretion, of course, is that it gives rise to the kind of arbitrary and capricious decision-making forbidden by ERISA. Moreover, the uncertain application of the exclusion—seemingly antithetical to the sort of planning insurance is designed to facilitate—raises questions as to whether the exclusion renders the policy coverage illusory.

The district court, however, did not have to determine if the broad “associated with” language was invalid, because Poly-America relied solely on the limited “related to” language of the tobacco-related condition exclusion to deny Christianson coverage. In both denial letters, the plan administrator explained that the hospitalization was not covered because Christianson’s deep-vein thrombosis was related to his tobacco abuse.

It appears that Poly-America’s tobacco-related conditions exclusion was not going to serve its intended purpose either way. If the plan administrator had denied Christianson coverage based on the broad “associated with” language, it is likely that the district court would

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139. At oral argument, the attorney for Poly-America claimed that a letter subsequent to the original denial did rely on the “associated with” language, but the only letters in the record relied on the “related to” language. Christianson v. Poly-Am. Med. Benefit Plan, 288 F. Supp. 2d 991, 995 n.4 (D. Minn. 2003). The court explained that even were the plan administrator to subsequently invoke the ‘associated with’ clause, his obligation through the appeals process is to justify his initial decision as communicated to the plan participant, not to play a kind of shell game with the beneficiary in which he invokes different policy provisions as the appeal proceeds.

140. Id. at 995 n.3. The court explained how it would have reacted if the plan administrator had relied on the “complicated by” language. The court’s reaction probably would have been similar to its impression of the “associated with” language because both phrases are broad and appear not to require a causal connection.

141. Id.
have found the clause invalid and awarded Christianson summary judgment. Although the district court and the Eighth Circuit did not question the validity of the “related to” language, they required the plan to demonstrate a causal nexus between Christianson’s smoking and his condition to uphold the coverage denial. It is extremely difficult to demonstrate a causal connection between symptoms and conditions. Poly-America would have to invest a lot of effort and expense to prove a participant or beneficiary’s smoking caused his or her medical condition.

Poly-America claimed that if the court found that it could no longer exercise discretion in applying its tobacco-related conditions exclusion, it would be forced to deny coverage to smokers altogether. A spokesperson for Poly-America declined to disclose whether the tobacco-related conditions exclusion still exists. Other employers may eliminate their coverage for smokers as a result of the holding in Christianson. However, as the district court pointed out, even if Poly-America chooses to deny coverage to smokers altogether as a result of the court’s interpretation of the plan exclusion at issue in Christianson, such a reaction would still benefit plan participants because at least then they would know they need to purchase additional insurance. Although employees who smoke may not feel that the need to purchase additional insurance is a benefit, there is value in knowing the limits of one’s coverage if supplemental coverage is available. The additional cost of supplemental health insurance for smokers may even encourage some smokers to quit.

The second mistake the plan made was hiring Dr. Gurkoff to review the denial. Although courts often examine benefit denials under an abuse-of-discretion standard, previous case law has determined that the court can nevertheless examine the quality of the evidence the plan uses to make its decisions. The district court found it was unreasonable for Poly-America to rely on Dr. Gurkoff’s opinion for several reasons. First, as an oesopath and orthopedic surgeon, Dr. Gurkoff’s expertise is limited to the musculoskeletal system, and deep-vein thrombosis is a disease of the vascular system. Second, Dr.

142. Hoffman, supra note 114, at 695.
143. Olson, supra note 123, at 8A.
145. Phillips-Foster v. UNUM Life Ins. Co. of Am., 302 F.3d 785, 798 (8th Cir. 2002).
146. Christianson, 288 F. Supp. 2d at 996 n.5.
Gurkoff's opinion merely repeated the language of the tobacco-related conditions exclusion and offered a "bald-faced" conclusion devoid of any explanation.\textsuperscript{147} In contrast, Christianson's treating physicians opined that Christianson's deep-vein thrombosis was of an unknown origin. These factors combined to lead the district court to conclude that, even though it did not need to determine the proper standard of review for Poly-America's decision, Christianson had a strong argument for lowering the standard of review.

This case demonstrates the danger of inadequate counsel when dealing with ERISA law, and both sides are guilty. The district court noted that neither party challenged the timing and admission of the medical opinions.\textsuperscript{148} Christianson's lawyer could have pointed out that Dr. Gurkoff's formal medical opinion was dated a month after Poly-America sent Christianson a letter claiming that their second denial was based in part upon it. Without this opinion, Christianson would have had an even stronger case that his deep-vein thrombosis was not related to his tobacco abuse. Poly-America's lawyer could have claimed that the court should not have considered Dr. Oliver or Dr. Terzian's letters because they were not part of the administrative record at the time Poly-America made its decision to confirm their coverage denial. Without these opinions, the court may not have been so quick to conclude that there was insufficient evidence to demonstrate that Christianson's condition was related to his smoking.

Because Poly-America's appeal procedures did not set a deadline after which additional materials would not be accepted or reviewed by the plan administrator, Dr. Oliver and Dr. Terzian's letters became a part of Christianson's administrative file. The absence of a deadline is poor drafting on the part of the health plan. To take advantage of the abuse-of-discretion standard of review, plans must be clear about what documents will be considered as part of the administrative record. Because neither party in the Christianson case challenged the admission of the medical opinions, the court regarded any objections to the use of this information as waived: "The trial judge should not have to assume the role of an advocate on behalf of a litigant whose counsel has failed to assert a legal theory or argument."\textsuperscript{149}

V. CONCLUSION

The Christianson facts demonstrate how difficult it is for a plan to exclude coverage for treatments relating to a behavior. Yet, if plans must reduce coverage, it seems most fair that they first target illnesses resulting from voluntary, risk-taking behavior. Although

\textsuperscript{147} Id. at 997 (quoting Richardson v. Cent. States, 645 F.2d 660, 665 (8th Cir. 1981)).

\textsuperscript{148} Id. at 993 n.2.

\textsuperscript{149} Id. (citing Stafford v. Ford Motor Co., 790 F.2d 702, 706 (8th Cir. 1986)).
ERISA permits self-insured plans to completely exclude coverage to groups of individuals or for particular illnesses, the Eighth Circuit's interpretation of Poly-America's exclusion of tobacco-related conditions essentially makes such exclusions meaningless. If the exclusion is worded too broadly, the court will likely hold it invalid, and if the exclusion is worded too narrowly, the plan will find it nearly impossible to demonstrate that its decision met the requirements of the exclusion. If plan administrators cannot enforce specified exclusions to coverage, they cannot predict and control their costs. As a result of the holding in Christianson, plans may decide to terminate coverage for smokers altogether. Thus, one smoker's victory may come at the cost of coverage for smokers everywhere.

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