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DEATH BY DENIAL: PRE-EXISTING CONDITIONS AS A BAR TO ACCIDENT INSURANCE RECOVERY

Abstract: On February 4, 2020, the United States Court of Appeals for the First Circuit, in *Arruda v. Zurich American Insurance Co.*, held that an insurance plan administrator’s denial of coverage was not an abuse of discretion because the plan participant’s pre-existing medical conditions contributed to his accidental death. The First Circuit rejected the “substantial factor” test and applied a plain meaning approach. In reaching this conclusion, the court split from the Fourth, Ninth, and Eleventh Circuits’ interpretations of ERISA-covered accident policies. This Comment argues that the First Circuit should have applied the substantial factor test because, unlike the plain meaning analysis, it protects the interests of employees and their beneficiaries, promotes the uniform distribution of insurance benefits, and conforms with the doctrine of reasonable expectations.

INTRODUCTION

Millions of Americans have some type of pre-existing medical condition.¹ As such, many of these Americans are currently at risk of being denied insurance benefits in the event of an accidental death or disability.² With the explo-

¹ *At Risk: Pre-existing Conditions Could Affect 1 in 2 Americans*, CTR. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting> [<https://perma.cc/MV7N-AQDW>] (Apr. 15, 2020). The Department of Health and Human Services (HHS) defines a pre-existing condition as a medical issue that a plan participant had before the start date of a new insurance policy. *Pre-existing Conditions*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Jan. 31, 2017), <https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html> [<https://perma.cc/82K8-TJ8V>]. According to a new study by the HHS, 50 to 129 million Americans under sixty-five have a pre-existing health condition and 86% of Americans ages fifty-five to sixty-four have a pre-existing condition. *Id.* A 2019 analysis from the Kaiser Family Foundation estimates that almost 54 million Americans under sixty-five have pre-existing conditions. Craig Palosky, *Nearly 54 Million Americans Have Pre-existing Conditions That Would Make Them Uninsurable in the Individual Market Without the ACA*, KAISER FAM. FOUND. (Oct. 4, 2019), <https://www.kff.org/health-reform/press-release/nearly-54-million-americans-have-pre-existing-conditions-that-would-make-them-uninsurable-in-the-individual-market-without-the-aca/> [<https://perma.cc/DYU6-RUJ3>]. Meanwhile a recent Gallup poll found that 43% of U.S. households report having at least one member with a pre-existing condition. Justin McCarthy, *43% of U.S. Households Report Preexisting Conditions*, GALLUP (Dec. 6, 2019), <https://news.gallup.com/poll/269003/households-report-preexisting-conditions.aspx> [<https://perma.cc/5X5L-H4GJ>].

² See *infra* notes 33–39 and accompanying text. Accident insurance policies insure plan participants and their designated beneficiaries in the event of death or disability resulting from an accident. *Accident Insurance*, BLACK’S LAW DICTIONARY (11th ed. 2019); see *Beneficiary*, *id.* (defining “beneficiary” as a person designated to recover something due to the terms of a legal document, such as a contract or insurance policy); see also *Johnson v. Life Invs.’ Ins. Co. of Am.*, 98 F. App’x 814, 815

sion of the coronavirus (COVID-19) pandemic and its unknown long-term effects, the number of Americans with long-term infirmities may compound.³ In 2020, in *Arruda v. Zurich American Insurance Company*, the United States Court of Appeals for the First Circuit increased the likelihood of benefit denials when it affirmed the insurance company's denial of accidental death benefits on the grounds that the decedent's pre-existing medical condition precluded coverage.⁴ In doing so, the court declined to adopt the "substantial factor" test applied in other circuits.⁵ Under the substantial factor test, a pre-existing condition is not a cause of the loss unless it *substantially* contributed to the death or disability.⁶ This test provides more protection to claimants with pre-existing conditions and their designated beneficiaries than other methods of contract interpretation.⁷ The First Circuit used its authority to develop its own interpretation of accident policies in Employee Retirement Income Security Act (ERISA)-regulated insurance contracts to provide expansive deference to insurance companies and plan administrators with the "plain meaning" approach.⁸ *Arruda* has made it easier for insurers to deny its participants' claims

(10th Cir. 2004) (describing an accidental death policy and its monetary benefits to the decedent's beneficiary).

³ *COVID-19 (Coronavirus): Long-term Effects*, MAYO CLINIC (Nov. 17, 2020), <https://www.mayoclinic.org/coronavirus-long-term-effects/art-20490351> [<https://perma.cc/LS2L-DJ3Y>]. Coronavirus (COVID-19) is a respiratory illness that emerged in late 2019, causing more than 400,000 deaths in the U.S. to date. Heather Hollingsworth & Tammy Webber, *U.S. Tops 500,000 Virus Deaths, Matching the Toll of Three Wars*, ABC NEWS (Feb. 22, 2021), <https://abcnews.go.com/Health/wireStory/vaccine-efforts-redoubled-us-death-toll-draws-500k-76050315> [<https://perma.cc/SG5X-RUN8>] (discussing the horrific U.S. death toll from COVID-19) (discussing the horrific U.S. death toll from COVID-19). The novel virus's lingering effects remain to be seen, but scientists are concerned it will cause widespread long-term lung, kidney, heart, and brain damage. Jennifer Couzin-Frankel, *From 'Brain Fog' to Heart Damage, COVID-19's Lingering Problems Alarm Scientists*, SCI. MAG. (July 31, 2020), <https://www.sciencemag.org/news/2020/07/brain-fog-heart-damage-covid-19-s-lingering-problems-alarm-scientists> [<https://perma.cc/2ZCX-LMPA>].

⁴ See 951 F.3d 12, 25 (1st Cir. 2020) (affirming a denial of coverage due to the causal nature of the plan participant's pre-existing condition).

⁵ *Id.* at 24; see, e.g., *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 797 (4th Cir. 1990) (addressing whether a pre-existing condition precludes insurance coverage and applying the substantial factor test).

⁶ *Arruda*, 951 F.3d at 24; see also *Substantial-Factor Test*, BLACK'S LAW DICTIONARY, *supra* note 2 (defining the substantial factor test, or the "substantial-cause" test, as measuring causation by the gravity and magnitude of the defendant's conduct).

⁷ *Arruda*, 951 F.3d at 24–25 (stating that the substantial factor test conflicts with the First Circuit's law on the abuse of discretion, whose deference prevents the court from re-interpreting the policy language).

⁸ See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (noting that Congress intended courts to develop a body of federal common law under Employee Retirement Income Security Act (ERISA)-governed insurance plans). The court, in *Arruda*, did not explicitly label its review as a "plain meaning" interpretation. 951 F.3d at 25 n.7. The court's approach, however, is identical to the Tenth Circuit's interpretation, which the First Circuit labeled as a "plain meaning" approach. See *Plain Meaning*, BLACK'S LAW DICTIONARY, *supra* note 2 (defining "plain meaning" as the interpretation reached "by giving the words their ordinary sense" without looking at external factors). Compare *Arruda*, 951

under the pretext that the claimants suffer from pre-existing conditions, even if the condition was a remote cause of the accidental death or disability.⁹

Part I of this Comment gives an overview of the Employee Retirement Income Security Act of 1974 and its relevance to the review of insurance claim denials.¹⁰ Part I also explains the facts in *Arruda* and the First Circuit's analysis.¹¹ Part II examines the circuit split regarding two different interpretations of exemption clauses in ERISA-governed accident policies—the plain meaning approach and the substantial factor approach.¹² Finally, Part III argues that the plain meaning approach does not protect the interests of employees and their beneficiaries, obstructs the uniform distribution of insurance benefits, and fails to conform with the doctrine of reasonable expectations.¹³ Part III also asserts that all circuits should apply the substantial factor test when reviewing appeals from denied benefit claims under accidental death and disability policies.¹⁴

I. ERISA AND THE FIRST CIRCUIT'S APPROACH TO REVIEWING DENIALS OF CLAIMS FOR BENEFITS

In 2020, in *Arruda v. Zurich American Insurance Company*, the First Circuit held that pre-existing conditions may bar coverage if there is sufficient evidence to reasonably support a conclusion that the condition contributed to the accidental loss.¹⁵ Section A of this Part outlines ERISA and the principles underlying its passage.¹⁶ Section B discusses the First Circuit's review, in *Arruda*, of denied benefit claims under ERISA-governed accident insurance policies.¹⁷

F.3d at 24–25 (emphasizing that the abuse of discretion standard requires the court to accord deference to the plan administrator's reading of the policy), *with* *Kellogg v. Metro. Life Ins. Co.*, 549 F.3d 818, 829–30 (10th Cir. 2008) (holding that courts should interpret insurance contracts according to their plain meaning). Practitioners have since warned about the extreme deference given to the insurance company in *Arruda*. See Mark DeBofsky, *Accidental Death Ruling Highlights Flaw in ERISA Deference*, LAW360 (Mar. 27, 2020), <https://www-law360-com.eu1.proxy.openathens.net/articles/1257579/accidental-death-ruling-highlights-flaw-in-erisa-deference> (writing that *Arruda* shows how the deference that ERISA's standard of review requires rarely produces an outcome favorable to policyholders in employee benefit cases).

⁹ See *supra* notes 4–6 and accompanying text (discussing the First Circuit's holding in *Arruda*); see also Eric T. Berkman, *1st Circuit Reinstates ERISA Plan's Denial of Death Benefits*, NEW ENGLAND IN-HOUSE (July 29, 2020), <https://newenglandinhouse.com/2020/07/29/1st-circuit-reinstates-erisa-plans-denial-of-death-benefits/> [<https://perma.cc/PM5K-RHRE>] (discussing the difficulty of successfully appealing a denial of benefits because of the extreme deference accorded to plan administrators).

¹⁰ See *infra* notes 15–26 and accompanying text.

¹¹ See *infra* notes 27–48 and accompanying text.

¹² See *infra* notes 49–83 and accompanying text.

¹³ See *infra* notes 84–127 and accompanying text.

¹⁴ See *infra* notes 128–131 and accompanying text.

¹⁵ 951 F.3d 12, 24–25 (1st Cir. 2020).

¹⁶ See *infra* notes 18–26 and accompanying text.

¹⁷ See *infra* notes 27–48 and accompanying text.

A. Employee Retirement Income Security Act of 1974

On Labor Day, September 2, 1974, President Ford signed the Employee Retirement Income Security Act of 1974 into law.¹⁸ The Act's primary focus was to safeguard employees' retirement plans to provide greater security for American workers.¹⁹ ERISA also regulates employee benefit plans, including employer-sponsored accident insurance policies.²⁰ Congress passed ERISA with two primary policy goals: (1) to protect the interests of employees and their beneficiaries, and (2) to promote uniformity in the distribution of benefits.²¹ Section 1132(a) of the Act provides plan participants and beneficiaries with a civil cause of action in federal district court to recover benefits, enforce their rights, or explain future rights under the plan.²² Furthermore, ERISA im-

¹⁸ Gerald R. Ford, Remarks on Signing the Employee Retirement Income Security Act of 1974 (Sept. 2, 1974) (transcript available at <https://www.presidency.ucsb.edu/node/256359> [<https://perma.cc/BY46-AF56>]).

¹⁹ BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 423 (8th ed. 2018); see also 29 U.S.C. § 1001 (stating congressional objectives of ERISA, including protecting stability of plans for their beneficiaries). ERISA established standards concerning the operation, management, and provision of private retirement plans, inter alia. See PATRICK PURCELL & JENNIFER STAMAN, CONG. RSCH. SERV., RL34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 1–3 (2008) (describing ERISA's framework, function and goals). The statute shortened pensions' vesting schedules, guaranteed payment of certain benefits, and provided administrative and judicial remedies to assure compliance. U.S. DEP'T OF LAB., FAQs ABOUT RETIREMENT PLANS AND ERISA 1, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/retirement-plans-and-erisa-for-workers.pdf> [<https://perma.cc/D7CW-4598>]. It also imposed fiduciary obligations and reporting requirements upon plan administrators. *Id.* In the ERISA context, a plan administrator is anyone who manages or makes decisions regarding an ERISA-governed plan. 29 U.S.C. § 1002(21). Fiduciary obligations apply in certain relationships of trust and include duties to act solely for the benefit of the recipient and to exercise due care. See *id.* § 1104 (outlining the plan administrator's fiduciary responsibilities to plan beneficiaries).

²⁰ See Gary Schuman, *Fatal Attraction: Autoeroticism and Accidental Death Insurance Coverage*, 49 TORT TRIAL & INS. PRAC. L.J. 667, 675 (2014) (describing the ERISA principles that govern employee-sponsored accident plans). Employee benefit plans are a form of compensation that employers provide to their employees other than salary, which may include benefits such as health insurance, life insurance, and pensions. 29 U.S.C. § 1002(1). Employer-sponsored accident insurance protects employees and their beneficiaries against loss in the event of the accidental death or disability of that employee. See *Accident Insurance*, BLACK'S LAW DICTIONARY, *supra* note 2 (explaining the purpose of accident insurance).

²¹ See 29 U.S.C. § 1001(b) (detailing the policy reasoning behind ERISA); H.R. REP. NO. 93-533, at 12 (1973) (describing the legislative history and purpose of ERISA). ERISA was designed to promote a nationally uniform regulatory scheme in light of the differing state insurance regulations nationwide. FURROW ET AL., *supra* note 19, at 423. Congress hoped that a uniform system would relax compliance burdens for employers operating in multiple states and encourage employers to provide insurance to their employees. *Id.*; see also Loretta Rhodes Richard, *ERISA: Enforcing Oral Promises to Pay Employee Benefits*, 28 B.C. L. REV. 723, 723–24 (1987) (explaining that Congress passed ERISA to protect plan participants and their beneficiaries from unfair practices by plan managers).

²² 29 U.S.C. § 1132(a); see, e.g., *Dowdy v. Metro. Life Ins. Co.*, 890 F.3d 802, 806 (9th Cir. 2018) (reviewing an alleged wrongful benefit denial under 29 U.S.C. § 1132(a)(1)(B)). ERISA generally limits remedies to plan benefits. See, e.g., *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 31 (5th

poses fiduciary duties on plan administrators, which require administrators to manage employee benefit plans in the best interests of the participants.²³

In 1989, the Supreme Court, in *Firestone Tire & Rubber Co. v. Bruch*, established the standards of review for cases challenging a benefit determination under an ERISA plan.²⁴ The Court held that courts should review insurance contracts that do not explicitly give the plan administrator discretionary authority to determine benefit eligibility *de novo*.²⁵ Conversely, courts should review insurance contracts containing language that explicitly grants discretionary review for an abuse of discretion.²⁶

B. The First Circuit's Review of Denied Benefit Claims Under ERISA

In 2014, Joseph Arruda was driving to a work event at the University of Massachusetts in Amherst when his car crossed all lanes of traffic on Route 9.²⁷ His car collided with oncoming traffic, rolled over, and landed on the other side of the highway.²⁸ Arruda was alive immediately following the accident but suffered from multiple injuries and passed away shortly thereafter.²⁹ He was covered under a Basic Accident Policy (Policy) through his employer.³⁰ Zurich

Cir. 1993) (holding that a claimant suing under ERISA cannot receive punitive damages or monetary relief beyond the scope of the insurance contract).

²³ See PURCELL & STAMAN, *supra* note 19, at 1, 26–27 (explaining the plan administrators' fiduciary duty of loyalty).

²⁴ 489 U.S. 101, 115 (1989) (addressing an alleged wrongful denial of benefits under ERISA); see also *Conkright v. Frommert*, 559 U.S. 506, 513 (2010) (noting that *Firestone* sets forth a broad standard of deference in its discussion of the appropriate standard of review for reviewing plan administrator's decisions).

²⁵ *Firestone*, 489 U.S. at 115. *De novo* review allows a reviewing court to address the matter as a trial court would. See Kelly Kunsch, *Standard of Review (State and Federal): A Primer*, 18 SEATTLE U. L. REV. 11, 25 (1994) (discussing the *de novo* standard of review). ERISA plans may grant explicit discretion to the plan administrator to interpret the terms of application of the plan. *Woods v. Prudential Ins. Co. of Am.*, 528 F.3d 320, 322 (4th Cir. 2008).

²⁶ *Firestone*, 489 U.S. at 115; see *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (reaffirming *Firestone* and stating that the abuse of discretion standard should apply when reviewing insurance contracts with discretionary authority to make benefit determinations). In 2008, in *Metropolitan Life Insurance Co. v. Glenn*, the Supreme Court held that under the abuse of discretion standard, courts must address the conflict of interest that arises when insurers make both benefit determinations and pay claims. 554 U.S. at 115. The abuse of discretion standard requires the decision to be reasonable and supported by substantial evidence in the administrative record. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 828 (2003); *O'Shea v. UPS Ret. Plan*, 837 F.3d 67, 73–74 (1st Cir. 2016); *Dutkewych v. Standard Ins. Co.*, 781 F.3d 623, 633 (1st Cir. 2015); *George v. Reliance Standard Life Ins. Co.*, 776 F.3d 349, 354 (5th Cir. 2015).

²⁷ *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 14 (1st Cir. 2020).

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 13; see *Accident Insurance*, BLACK'S LAW DICTIONARY, *supra* note 2 (defining accident insurance policy).

American Insurance Company (Zurich) issued and managed the Policy.³¹ His wife filed for accidental death benefits under the Policy.³² After reviewing the record and extensive medical testimony, Zurich concluded that the Policy did not cover the death.³³ Specifically, Zurich determined that the accidental death did not result independently from a pre-existing illness or disease and, thus, denied the insurance claim.³⁴ Mrs. Arruda appealed Zurich's decision through its internal appeals board, but Zurich's appeals committee upheld the denial.³⁵ Mrs. Arruda subsequently filed an ERISA action in the United States District Court for the District of Massachusetts, claiming that Zurich wrongfully denied her the benefits under her deceased husband's insurance plan.³⁶

³¹ *Arruda*, 951 F.3d at 13. Prior to the accident, Arruda worked for Northeast Utilities/NStar Electric and Gas. *Id.* Under the terms of the insurance contract, Zurich agreed to pay benefits if the insured died from a "Covered Injury." *Id.* at 14. The contract defined a "Covered Injury" as an accidental injury that is unrelated to other causes. *Id.* Section VII of the Policy excludes coverage for losses that result from illness. *Id.*

³² *Arruda v. Zurich Am. Ins. Co.*, 366 F. Supp. 3d 175, 178 (D. Mass. 2019), *rev'd*, 951 F.3d 349 (1st Cir. 2020). Mrs. Arruda was able to sue on behalf of her husband for accidental death benefits because she was his designated contingent beneficiary. *Id.* A contingent beneficiary is a person named on someone else's insurance policy who receives the insurance benefits in the event of the policyholder's death. *See Beneficiary*, *supra* note 2 (defining a contingent beneficiary as the recipient of the benefits of the policy when the primary beneficiary is unavailable).

³³ *Arruda*, 951 F.3d at 17. To determine Arruda's eligibility for insurance benefits under the Policy, Zurich hired an independent investigator, CS Claims Group, Inc. (CS). *Id.* at 14. CS reviewed Arruda's pre-accident medical records, his autopsy report, the police death and collision reports, and various first responder reports. *Id.* Arruda's medical history revealed that he suffered from twenty-seven medical conditions from 2004 until his death in 2014. *Id.* The pre-existing conditions from the record include, *inter alia*: hypertension, obesity, hypertrophic cardiomyopathy (heart enlargement), insomnia, fatigue, history of muscle pain and weakness, fainting spells, kidney stones, and high blood pressure. *Id.* Zurich sent the documents to two medical doctors and an independent expert to review. *Id.* at 16.

³⁴ *Id.* at 17–22. Dr. Angell, one of the insurance company's medical experts, stated that at the time of the accident Arruda experienced heart failure, which resulted in his death. *Id.* at 16. On the other hand, Dr. Bell, another medical expert, stated that although Arruda's heart condition caused the accident and his death, the injury to his neck was a contributory cause of death. *Id.* at 16–17. Based on these conclusions, Zurich denied the claim because Arruda's death was not deemed accidental. *Id.* Rather, Zurich stated that Arruda's pre-existing medical conditions contributed to the accident. *Id.* at 17.

³⁵ *Id.* at 17, 20. With her appeal, Mrs. Arruda included an independent medical review from Dr. Laposata. *Id.* at 17. Dr. Laposata disagreed with the autopsy report's conclusion that heart failure was the cause of death. *Id.* at 18. Dr. Laposata opined that the correct cause of death was neck injuries from the blunt force trauma Arruda experienced during the car accident. *Id.* In response, Zurich hired a third independent medical expert, Dr. Taff. *Id.* Upon reviewing the evidence, Dr. Taff concluded that Arruda died as a result of accidental bodily injuries in addition to multiple pre-existing illnesses. *Id.* at 19. He noted that it was impossible to scientifically prove which pre-existing medical condition(s) caused him to swerve across traffic. *Id.* Recognizing Dr. Laposata's differing medical opinion, Zurich's appeals committee upheld the denial of benefits. *Id.* at 20.

³⁶ *Id.* at 13. A plan participant or beneficiary may allege that a wrongful act occurred when a plan administrator refuses to pay out insurance money that the participant or beneficiary is entitled to under the terms of the contract. 29 U.S.C. § 1132(a)(1)(B).

The district court granted summary judgment in Arruda's favor.³⁷ It held that Zurich's denial of Arruda's insurance benefits was unreasonable because the decision was not supported by substantial evidence.³⁸ The court found that there was insufficient evidence to support Zurich's conclusion that heart disease was the cause of death other than the fact that he was diagnosed with the medical condition.³⁹ Zurich then appealed to the United States Court of Appeals for the First Circuit Court.⁴⁰

The First Circuit reversed and remanded the district court's decision.⁴¹ It held that the denial of insurance benefits was reasonable and thus, not an abuse of discretion.⁴² The majority of the panel held that Zurich's determination was reasonable because there was substantial evidence in the record that Arruda's pre-existing medical conditions were contributory causes of his death.⁴³ According to the court, it was sufficient that the record reasonably showed that the cause of the accident was not independent of an illness or disease.⁴⁴ Singling out exactly which pre-existing condition contributed or to what degree it contributed to the death was not necessary.⁴⁵

The First Circuit also acknowledged that other circuits have adopted a substantial factor test in reviewing whether a pre-existing condition contributed to a covered loss under an insurance policy.⁴⁶ The court stated, however, that the substantial factor test conflicts with First Circuit precedent on the standard for abuse of discretion.⁴⁷ The court further stated that the Circuit's

³⁷ *Arruda v. Zurich Am. Ins. Co.*, 366 F. Supp. 3d 175, 187 (D. Mass. 2019), *rev'd*, 951 F.3d 349 (1st Cir. 2020).

³⁸ *Id.* at 186 (emphasizing that a pre-existing illness alone was insufficient evidence to support Zurich's conclusion).

³⁹ *Id.* at 185–86. On appeal, Zurich argued that its determination was not arbitrary, capricious, or an abuse of discretion because Arruda's heart condition caused or contributed to his death after the car accident, barring coverage. Brief for Defendant-Appellant at 15, *Arruda*, 951 F.3d 12 (No. 19-1247). For support, Zurich cited to multiple reports in the record, such as the autopsy report that listed the immediate cause of death to be hypertensive heart disease and the reports of three independent reviewing physicians who all concluded that heart disease caused or contributed to Arruda's death. *Id.*

⁴⁰ Brief for Defendant-Appellant, *supra* note 39, at 13.

⁴¹ *Arruda*, 951 F.3d at 25.

⁴² *Id.* at 21.

⁴³ *Id.* at 25. Looking at the record and the various medical opinions as a whole, the court concluded that Dr. Laposata's difference of opinion did not undermine Zurich's decision. *Id.* at 22. The panel stated that Zurich was not required to accept Arruda's contradictory medical evidence because Zurich reasonably relied on multiple independent expert opinions, Arruda's extensive medical history, and official reports of the accident that led to his death. *Id.*; *see also* *Vlass v. Raytheon Emps. Disability Tr.*, 244 F.3d 27, 30 (holding that contradictory evidence does not make the administrator's decision unreasonable in a case where the court weighed conflicting expert medical opinions with regards to the claimant's disability).

⁴⁴ *Arruda*, 951 F.3d at 22, 25.

⁴⁵ *Id.* at 19, 25.

⁴⁶ *Id.* at 24–25.

⁴⁷ *Id.* at 25. The test for an abuse of discretion in the First Circuit ultimately is whether the decision-maker's conclusion is reasonable. *See* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111

abuse of discretion test is sufficient to review ERISA plan disputes and, thus, declined to adopt the substantial factors test.⁴⁸

II. THE CIRCUIT SPLIT: DIFFERING APPROACHES TO INTERPRETING EXEMPTIONS FOR PRE-EXISTING CONDITIONS IN ERISA-GOVERNED ACCIDENTAL DEATH AND DISABILITY PLANS

Accident insurance policies generally hold the insurer liable if the insured sustains an accident that is the proximate cause of the insured's loss.⁴⁹ Accident policies commonly contain exemption clauses that bar coverage when the death or injury does not arise exclusively from accidental means.⁵⁰ Under these exemptions, the insurer may deny an insured's claim if a pre-existing medical condition contributed to the loss.⁵¹ ERISA does not provide much guidance on interpreting exemption clauses in insurance contracts.⁵² Some courts apply a sub-

(1989) (holding that the court will only overrule the plan administrator's interpretation of the insurance plan if it is unreasonable); *see also* D&H Therapy Assoc., LLC v. Bos. Mut. Life Ins. Co., 640 F.3d 27, 36 (1st Cir. 2011) (stating that when an insurance policy expressly granted discretion to the plan administrator, the court asks whether the administrator's decision to grant or deny benefits is unreasonable and therefore an abuse of discretion).

⁴⁸ *Arruda*, 951 F.3d at 25. The court did not elaborate further on this point nor provide any reason why the abuse of discretion test is sufficient in reviewing ERISA claim denials. *Id.*

⁴⁹ *See* *Johnson v. Life Invs.' Ins. Co. of Am.*, 98 F. App'x 814, 816 (10th Cir. 2004) (discussing an instance of a dispute over recovery for accidental disability benefits). An accident that is the proximate cause of a loss occurs when something unforeseen directly brings about the injury. *See Accident*, BLACK'S LAW DICTIONARY, *supra* note 2 (defining the term "accident" as "[a]n unintended and unforeseen injurious occurrence").

⁵⁰ J.A. Bock, Annotation, *Pre-existing Physical Condition as Affecting Liability Under Accident Policy or Accident Feature of Life Policy*, 84 A.L.R.2d 176 (1962). Policies commonly provide clauses that affect coverage for pre-existing conditions, such as clauses that the policy only insures against losses "exclusively" or "solely" from accidental means and that the policy requires the loss to be "directly caused by accidental means." *See, e.g., Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 14 (D. Mass. 2019) (reviewing an exemption provision that precludes coverage for losses if illness or disease is a contributing factor); *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 794 (10th Cir. 2010) (analyzing a benefit denial under a policy that required the accident to be the loss's only source); *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 795 (4th Cir. 1990) (examining an accident policy that covered losses caused only by an accident that occurs during the policy term).

⁵¹ *See, e.g., Arruda*, 951 F.3d at 12, 14 (reviewing insurance company decision to deny benefits due to the participant's pre-existing condition's role in causing the loss).

⁵² *See* 120 CONG. REC. 29,942 (1974) (statement of Sen. Jacob Javits) (stating that Congress intends courts to develop a body of "federal substantive law" to interpret obligations under ERISA-governed plans); *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1041 (11th Cir. 1998) (emphasizing that federal common law may reflect state law as a model for interpreting insurance contracts). Courts often draw from ERISA's spirit and purpose to help guide their review. *See Tippitt v. Reliance Standard Life Ins. Co.* 457 F.3d 1227, 1235 (11th Cir. 2006) (noting that when a federal court is deciding whether it should incorporate a rule into ERISA's federal common law, it must consider if the rule would align with the statute's intentions, including the protection of employee interests and the uniform administration of benefit plans); *see also Arruda*, 951 F.3d at 25 (noting that

stantial factor test and will only uphold a denial of benefits if the pre-existing condition substantially contributed to the accidental death, injury, or disability.⁵³ Other courts apply the literal meaning of the exemption clause, generally upholding a denial of benefits if it finds that a pre-existing condition caused or somehow contributed to the loss.⁵⁴ Section A of this Part discusses the substantial factor test and why courts continue to apply it.⁵⁵ Section B reviews the plain meaning approach and the arguments in favor of maintaining its application.⁵⁶

A. The Substantial Factor Test

In 1990, in *Adkins v. Reliance Standard Life Insurance Co.*, the United States Court of Appeals for the Fourth Circuit held that a pre-existing condition should not preclude coverage under an accident policy, unless the condition substantially contributed to the loss.⁵⁷ The court in *Adkins* described its approach as a “middle ground” between an overly narrow and an exceedingly broad construction of the exemption clause.⁵⁸ Furthermore, the Fourth Circuit emphasized that the causal relationship between the pre-existing condition and the cause of death must be certain.⁵⁹

The insurance company originally denied Adkins’ claim for benefits because the accident that led to the claimant’s disability was not independent of all natural causes.⁶⁰ The United States District Court for the Southern District of West Virginia agreed with the insurer that Adkins’s previous back injuries

when Congress passed ERISA, it desired to create a system that encouraged employers to offer ERISA plans while also reducing administrative costs and litigation expenses).

⁵³ See *supra* note 6 and accompanying text (defining the substantial factors test).

⁵⁴ See *supra* note 8 and accompanying text (defining plain meaning interpretation).

⁵⁵ See *infra* notes 57–73 and accompanying text.

⁵⁶ See *infra* notes 74–83 and accompanying text.

⁵⁷ 917 F.2d 794, 797 (4th Cir. 1990). In the ERISA context, the Fourth Circuit rule is known as the substantial factor test. See *Arruda*, 951 F.3d at 24 (acknowledging the Fourth Circuit’s substantial factor test); see also *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1135 (9th Cir. 1996) (recognizing the Fourth Circuit’s approach with approval and consequently adopting the rule). This approach comes from a 1982 Kentucky state law case. See *Colonial Life & Accident Ins. Co. v. Weartz*, 636 S.W.2d 891, 894 (Ky. Ct. App. 1982) (holding that the plan participant’s previous back injury did not bar recovery for accidental disability benefits because it did not substantially contribute to the disability), *overruled by* *Mifflin v. Mifflin*, 170 S.W.3d 387 (Ky. 2005).

⁵⁸ 917 F.2d at 796–97. The court noted in *Adkins* that the plaintiff’s request for a but-for application would be an overly broad construction of the accident policy’s language, whereas the lower court’s plain meaning interpretation was too stringent. *Id.*

⁵⁹ *Id.* The court also noted that a predisposition to further injury resulting from a previous injury or sickness does not equate to a sufficient contributing cause. *Id.* at 797.

⁶⁰ *Id.* at 795. In 1974, Adkins injured his back while he was working, which necessitated a spinal fusion. *Id.* In 1977, he obtained accidental disability insurance through his employer. *Id.* Adkins suffered from three additional work-related back injuries in 1979, 1982, and 1985, becoming permanently disabled. *Id.*

caused his disability and, therefore, barred recovery.⁶¹ The Fourth Circuit, by reason of the substantial factor test, subsequently disagreed.⁶² In deciding to move away from the district court's narrow interpretation of the accident policy, the Fourth Circuit reasoned that such a strict construction would essentially require the plan participant to be in perfect health at the time of the accident for the policy to provide coverage.⁶³ The court also cited ERISA's primary legislative purpose for support: namely, that Congress enacted the statute to protect employees with employee-sponsored benefit plans.⁶⁴ Although the court warned that this language should not imply a re-writing of insurance provisions, it noted that a literal interpretation would rarely result in a finding of liability.⁶⁵

A few years later, in 1996, in *McClure v. Life Insurance Co. of North America*, the Ninth Circuit followed in the Fourth Circuit's footsteps and applied the substantial factors test to review a denied claim.⁶⁶ It clarified the analysis, establishing a two-step review where reviewing courts ask: (1) whether the claimant had a pre-existing condition; and (2) whether the pre-existing condition was a substantial cause of the loss.⁶⁷

In 2004, in *Dixon v. Life Insurance Company of North America*, the Eleventh Circuit, persuaded by the Fourth and Ninth Circuits' interpretation, adopted the substantial factor test as a part of its federal common law.⁶⁸ Similar to

⁶¹ *Id.* at 795. The district court interpreted the policy language "independently of all causes" to mean only due to "accidental means." *Id.* at 796. Therefore, a pre-existing condition could not play any role in causing the disability to receive coverage under the plan. *See id.* at 795–96 (explaining the district court's strict interpretation of the policy).

⁶² *Id.* at 797. The panel held that the district court erred in affirming the insurer's denial of benefits because it failed to consider whether the 1973 back injury substantially contributed to Adkins' disability. *Id.* at 795. If the 1973 injury he sustained prior to the coverage term substantially contributed to Adkins' disability, the insurance policy would not cover the loss because he had a pre-existing medical condition. *Id.*

⁶³ *Id.* at 796.

⁶⁴ *Id.* at 795–96. The panel emphasized that interpreting the exemption clause by adhering to its plain meaning would be deeply unfair to any person with any long-term medical condition and would not reflect the legislative purpose of ERISA. *See id.* at 796 (noting the unfairness of a literal interpretation of the exemption clause).

⁶⁵ *Id.* at 796.

⁶⁶ 84 F.3d 1129, 1135–36 (9th Cir. 1996). The Ninth Circuit also noted that it would consider the reasonable expectations of the insured if the exemption clause was buried in general contract language. *Id.*

⁶⁷ *Id.* at 1135. The two-step test also includes considering whether the claimant had a predisposition or susceptibility to injury. *See id.* (detailing the Fourth Circuit's two-part test). For the purposes of this Comment the term "pre-existing condition" functionally subsumes the court's additional language. The Ninth Circuit went further in its interpretation when it imposed a reasonable expectations analysis in cases where the exemption clause is buried in the contract. *Id.* at 1136. If the language is inconspicuous the Ninth Circuit applies the Fourth Circuit's substantial factor test. *Id.* Ultimately, in *McClure*, the Ninth Circuit could not determine which standard of interpretation to apply because the parties never submitted the full text of the insurance policy as evidence. *Id.*

⁶⁸ 389 F.3d 1179, 1184 (11th Cir. 2004).

the decedent in the First Circuit's 2020 case, *Arruda v. Zurich Life Insurance Company*, the insured in *Dixon* suffered from hypertension and other pre-existing heart conditions.⁶⁹ In *Dixon*, however, there was undisputed evidence in the record that Dixon's cause of death was directly due to his heart condition and not the car accident itself.⁷⁰ The Eleventh Circuit affirmed the lower court's decision to deny Dixon's beneficiary any accidental death benefits on the grounds that Dixon's pre-existing heart condition substantially contributed to his death.⁷¹ The court reasoned that the substantial factor test allows the exemption clause to maintain its function without being unreasonably restrictive.⁷² Moreover, the court emphasized that this method of interpretation promotes ERISA's policy goals of advancing the interests of employees and their beneficiaries.⁷³

B. The Plain Meaning Approach

Although the First Circuit in *Arruda* recognized the different approach of the Fourth, Ninth, and Eleventh Circuits, it declined to follow suit.⁷⁴ Instead it decided to track the Sixth, Seventh, and Tenth Circuits in their stringent construction of accidental death and disability policies.⁷⁵ For example, in 1992, in

⁶⁹ Compare *Dixon*, 389 F.3d at 1181 (discussing Dixon's underlying heart conditions), with *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 14 (1st Cir. 2020) (detailing *Arruda*'s underlying heart conditions and other medical and psychological ailments).

⁷⁰ 389 F.3d at 1181. Dixon's cause of death was heart failure due to atherosclerotic and hypertensive heart disease—a fact the two parties did not dispute. *Id.* Dixon did not sustain any other external injuries from the car accident. *Id.*

⁷¹ *Id.* at 1184–85. The court acknowledged that extreme emotional and psychological distress likely triggered Dixon's heart failure. *Id.* at 1181. The panel, however, determined that his heart failure substantially contributed to his passing, regardless of whether the car accident was the immediate cause of the heart attack. *Id.* at 1184–85.

⁷² *Id.* at 1184.

⁷³ *Id.* (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989)); see also *Bradshaw v. Reliance Standard Life Ins. Co.*, 707 F. App'x 599, 609–10 (11th Cir. 2017) (holding that the link between a healthy pregnancy and a later stroke is too attenuated and unreasonable as a matter of law in light of ERISA's goal of promoting employee interests).

⁷⁴ *Arruda*, 951 F.3d at 24; see *Dixon*, 389 F.3d at 1183–84 (11th Cir. 2004) (applying the Fourth Circuit's substantial factor test); *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1135 (9th Cir. 1996) (adopting the substantial factor test to decide whether a pre-existing condition should bar coverage); *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 797 (4th Cir. 1990) (establishing the substantial factor test). The First Circuit in *Arruda* declined to apply the rule that requires pre-existing conditions to substantially contribute to the disability, injury, or death at issue because it conflicts with the circuit's law on the abuse of discretion. See 951 F.3d at 25 (emphasizing that the abuse of discretion test does not require the courts to determine the "best reading of the ERISA plan" (quoting *D&H Therapy Assocs., LLC v. Bos. Mut. Life Ins. Co.*, 640 F.3d 27, 35 (1st Cir. 2011))).

⁷⁵ See, e.g., *Pirkheim v. First UNUM Life Ins.*, 229 F.3d 1008, 1010–11 (10th Cir. 2000) (holding that the contract was unambiguous and, thus, interpreting it plainly without regards to the reasonable expectations of the policyholder); *Mers v. Marriott Int'l Grp. Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1024 (7th Cir. 1998) (upholding a denial of coverage because there was sufficient evidence that the accident was not the *only* cause of death); *Criss v. Hartford Accident & Indem. Co.*, No. 91-2092, 1992 WL 113370, at *6 (6th Cir. May 28, 1992) (holding that there was suffi-

Criss v. Hartford Accident & Indemnity Company, the Sixth Circuit held that because the insured's death was at least partially due to his pre-existing heart condition, the unambiguous policy precluded coverage for the loss.⁷⁶ Similar to the facts in *Arruda*, the decedent's death occurred from a combination of underlying medical conditions and injuries sustained in a car accident.⁷⁷ The Sixth Circuit emphasized the importance of strictly adhering to the plain language of accident insurance contracts, except in cases where public policy considerations require a different interpretation.⁷⁸

Likewise, in 2000, in *Pirkheim v. First UNUM Life Insurance*, the Tenth Circuit held that the insurance company did not err when it denied accidental death benefits because the insured's death did not occur independent of all other causes.⁷⁹ The decedent was born with a genetic heart defect, which required the installation of a pacemaker.⁸⁰ Tragically, the pacemaker failed, and the 5-year-old boy died.⁸¹ Despite the death report stating that his cause of death was pacemaker failure, the Tenth Circuit held that, due to his hereditary heart disease, his death did not occur independent of all other causes.⁸² The court supported its decision with a general reference to unspecified ERISA principles and stressed that these principles do not permit the courts to redraft the terms of an insurance contract.⁸³

cient evidence to conclude that the policyholder's heart disease was at least partly responsible for his death, thereby barring coverage).

⁷⁶ 1992 WL 113370, at *6. The policy language explicitly precluded coverage if illness caused the loss. *Id.*

⁷⁷ Compare *Criss*, 1992 WL 113370, at *1 (stating that the decedent's death occurred because of a combination of underlying medical conditions and injuries in a car accident), with *Arruda*, 951 F.3d at 14 (concluding that both physical trauma and underlying health conditions caused the policyholder's death after the car accident).

⁷⁸ *Criss*, 1992 WL 113370, at *5; see also *Mers*, 144 F.3d at 1024 (holding that although none of the doctors could definitively say which pre-existing condition assisted in causing the injury, there was substantial evidence that the accident was not the only cause of death, and thus, it was reasonable for the insurer to deny benefits).

⁷⁹ 229 F.3d at 1010–11. The court also discussed the doctrine of reasonable expectations in insurance law, stating that courts will construe contract terms broadly to protect the reasonable expectations of policyholders and their designated beneficiaries. *Id.* at 1011. It then proceeded to reject the doctrine's application because the policy's exemption clause was unambiguous. *Id.*

⁸⁰ *Id.* at 1009.

⁸¹ *Id.* At the time of the boy's death, his father's employee-sponsored accidental death policy also covered his son. *Id.*

⁸² *Id.* at 1010–11. Once the pacemaker started to fail due to battery depletion, the boy began to experience arrhythmic seizures, which the pacemaker was implanted to prevent, and died. *Id.* at 1009.

⁸³ *Id.* at 1011. *Contra* *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1011 (10th Cir. 2004) (per curiam) (holding that the policy's language cannot exempt coverage if a pre-existing condition is one of many contributing causes of disability), *abrogated in part on other grounds by* *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

III. THE PLAIN MEANING APPROACH IS UNREASONABLE

Congress enacted ERISA to protect the interests of employees and their beneficiaries and to promote uniformity in the distribution of insurance benefits.⁸⁴ The First Circuit's approach stands in the way of these policy goals and risks barring coverage for those that need it the most.⁸⁵ Americans with an accidental death and disability policy reasonably expect that simply having an ongoing health issue is insufficient to deny an accident claim.⁸⁶ Yet, under *Arruda v. Zurich Insurance Company*, which the First Circuit decided in 2020, this is not the case.⁸⁷ Whether it is hypertension, diabetes, or countless other life-long conditions, courts' stringent interpretation of the plain meaning of insurance contracts severely limits coverage for claimants with pre-existing conditions.⁸⁸

⁸⁴ See 29 U.S.C. § 1001b(c)(3) (explaining ERISA's policy goals); see also *Conkright v. Frommert*, 559 U.S. 506, 516 (2010) (emphasizing that Congress passed ERISA to protect employee benefits); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 357 (2002) (noting that Congress intended ERISA to create a more consistent benefit scheme); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (declaring that Congress enacted ERISA to protect employees and their designated beneficiaries). Other relevant goals of ERISA include preventing plan administrators from evading their obligation to pay benefits, encouraging employers to provide employee benefit plans, and increasing the likelihood that plan participants and their beneficiaries receive full benefits. See generally 29 U.S.C. § 1001 (detailing congressional findings and declarations of policy).

⁸⁵ See *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 14 (1st Cir. 2020) (taking into account Arruda's numerous chronic health conditions in determining whether the insurance company's decision to deny benefits was reasonable). Chronic health conditions include diseases such as heart disease, asthma, cancer, and diabetes. WORLD HEALTH ORG., INNOVATIVE CARE FOR CHRONIC CONDITIONS 11 (2002), https://www.who.int/chp/knowledge/publications/icc_ch1.pdf?ua=1 [<https://perma.cc/B4U8-TYX5>]. A chronic health condition is an ongoing health issue that the person needs to cope with over a long period of time. *Id.* Chronic health conditions are most prevalent among low-income populations. See Leah J. Tulin, *Poverty and Chronic Conditions During Natural Disasters: A Glimpse at Health, Healing, and Hurricane Katrina*, 14 GEO. J. POVERTY L. & POL'Y 115, 125 (2007) (establishing the continuing connection between poverty and chronic health conditions); *Chronic Diseases and Health Promotion*, WORLD HEALTH ORG., https://www.who.int/chp/chronic_disease_report/part2_ch2/en/ [<https://perma.cc/5SFY-443N>] (explaining how chronic diseases are concentrated among low-income households and that chronic disease can further cause poverty among individuals and families). Because chronic health conditions are more prevalent in low-income populations, the very people that cannot afford healthcare are also the people that are denied coverage from their insurance. See Tulin, *supra*, at 141–42 (explaining that people with more resources and access to preventive healthcare are more likely to avoid chronic medical conditions).

⁸⁶ See *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 796 (4th Cir. 1990) (acknowledging that someone would have to be in perfect health to recover under a strict plain meaning interpretation); see also *Kievit v. Loyal Protective Life Ins. Co.*, 170 A.2d 22, 26 (N.J. 1961) (noting that policyholders deserve coverage that aligns with their reasonable expectations).

⁸⁷ See 951 F.3d at 21, 25 (holding that pre-existing conditions may bar coverage if there is sufficient evidence to reasonably support a conclusion that the condition contributed to the accidental loss).

⁸⁸ See *Pirkheim v. First UNUM Life Ins.*, 229 F.3d 1008, 1010–11 (10th Cir. 2000) (upholding the denial of benefits for the accidental death of a boy with a genetic heart disorder). Existing ailments may be life-long, but they can also be manageable and have little effect on individual's day-to-day health. See, e.g., Jayne Leonard, *What Is It Like to Live with HIV?*, MED. NEWS TODAY (Jan. 28,

When the First Circuit split with the Fourth, Ninth, and Eleventh Circuits and rejected the substantial factor test, it adopted an unreasonable interpretation of clauses precluding coverage for pre-existing conditions.⁸⁹ Section A of this Part explains how the plain meaning construction fails to protect the interests of employees and their beneficiaries.⁹⁰ Section B argues that the plain meaning approach impedes the uniform distribution of insurance benefits.⁹¹ Lastly, Section C asserts that, unlike the substantial factor test, the plain meaning approach conflicts with the doctrine of reasonable expectations.⁹²

A. The Plain Meaning Approach Fails to Protect the Interests of Employees and Their Beneficiaries

The plain meaning approach ignores the interests of employees and favors insurance companies by providing insurers with another excuse to escape liability.⁹³ ERISA promotes the interests of employees and their beneficiaries by imposing fiduciary responsibilities on plan administrators.⁹⁴ One of the most important fiduciary responsibilities is the duty of loyalty.⁹⁵ When an insurance company denies a claim for benefits because a pre-existing condition marginally contributed to the loss, it breaches its duty of loyalty.⁹⁶ The plain meaning

2020), <https://www.medicalnewstoday.com/articles/323981> [<https://perma.cc/B9CA-QQSG>] (explaining how people with HIV can manage the virus via treatment and lifestyle changes with few side effects).

⁸⁹ See *supra* notes 44–48 and accompanying text (discussing the First Circuit’s rejection of the substantial factor test); *infra* notes 122–127 and accompanying text (arguing that the First Circuit’s approach to reviewing benefit denials for beneficiaries with pre-existing conditions is unreasonable).

⁹⁰ See *infra* notes 93–104 and accompanying text.

⁹¹ See *infra* notes 105–115 and accompanying text.

⁹² See *infra* notes 116–131 and accompanying text.

⁹³ See *Pirkheim*, 229 F.3d at 1010–11 (applying the plain meaning approach and denying insurance coverage because of the decedent’s heart condition). *But see* *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 797 (4th Cir. 1990) (rejecting an overly literal interpretation of the insurance contract language because it would not promote the interests of employees and their beneficiaries).

⁹⁴ See 29 U.S.C. § 1104 (creating a fiduciary relationship between plan administrators and plan participants); *Fiduciary*, BLACK’S LAW DICTIONARY, *supra* note 2 (“Someone who is required to act for the benefit of another person on all matters within the scope of their relationship; one who owes to another the duties of good faith, loyalty, due care, and disclosure.”); see also 29 U.S.C. § 1001(b) (stating that ERISA’s policy goals are to protect the financial interests of plan participants and their beneficiaries); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (emphasizing that Congress passed ERISA to protect the interests of employees and their beneficiaries).

⁹⁵ See PURCELL & STAMAN, *supra* note 19, at 27 (discussing the fiduciary duty in the context of ERISA). The duty of loyalty under ERISA requires plan administrators to manage benefit plans only for the participants’ and beneficiaries’ well-being. 29 U.S.C. § 1104. The duty of loyalty applies in situations where there is a conflict of interest, such as when the plan administrator is also the insurer. PURCELL & STAMAN, *supra* note 19, at 27; see *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 114 (2008) (explaining that a conflict of interest arises when an insurance company determines benefit eligibility and is responsible for paying the benefits out of its purse).

⁹⁶ See Peter J. Wiedenbeck, *Untrustworthy: ERISA’s Eroded Fiduciary Law*, 59 WM. & MARY L. REV. 1007, 1071 (2018) (explaining that a breach of loyalty occurs when a plan administrator makes a

approach reinforces the breach of the owed duty by consistently affirming the insurers' unreasonable decision-making.⁹⁷ In contrast, the substantial factors test provides more protection for the interests of all beneficiaries—not just those in perfect health.⁹⁸

The plain meaning approach begs the question of just how prominent a pre-existing condition needs to be before it bars recovery.⁹⁹ Applying a literal interpretation, an insurance company only needs to creatively link the condition to the loss to avoid distributing benefits.¹⁰⁰ The lack of a limiting principle to cabin the denial of benefits is even more concerning in light of the COVID-19 pandemic.¹⁰¹ The viruses' long-term health effects are undetermined, but preliminary studies reveal that there are a percentage of patients who experience symptoms, complications, or long-term damage months after testing positive.¹⁰² Lingering COVID-19 symptoms may be a pre-existing condition in ten

decision without regard to whether the result is fair to the beneficiaries); *see also* 29 U.S.C. § 1001(b) (emphasizing that ERISA aims to safeguard the distribution of benefits to plan participants and their designated beneficiaries).

⁹⁷ *See, e.g.,* *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 25 (1st Cir. 2020) (upholding a denial of coverage despite not being able to ascertain which pre-existing medical condition contributed to the accident); *Pirkheim*, 229 F.3d at 1010–11 (holding that the decedent's heart condition was a contributing cause precluding recovery despite the cause of death, identified as pacemaker failure); *Mers v. Marriott Int'l Grp. Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1024 (7th Cir. 1998) (denying coverage on the grounds that the accident was not the only cause of death, even though none of the doctors could identify which pre-existing condition contributed to causing the loss).

⁹⁸ *Adkins*, 917 F.2d at 796. The rule that a pre-existing condition must substantially contribute to the accidental loss provides some protection against unreasonable denials of coverage for those with chronic illnesses. *See id.* (requiring the plan to provide coverage despite the plan participant's numerous pre-existing conditions). The additional requirement gives teeth to judicial review of claim denials and adds a slightly higher hurdle for insurance companies to jump before they can deny coverage. *Compare id.* at 797 (reversing the district court's determination that the insurance company's denial of coverage was unreasonable because it strictly interpreted the policy to bar coverage when a pre-existing condition plays any role in causing the loss), *with Arruda*, 951 F.3d at 25 (upholding a benefit denial as reasonable because a pre-existing condition played a role in causing the loss).

⁹⁹ *Cf. Murray v. United of Omaha Life Ins. Co.*, 145 F.3d 143, 145 (3d Cir. 1998) (holding that, if the participant was managing the pre-existing condition when the accident occurred, juries should ask whether the condition was the proximate cause of the death or disability).

¹⁰⁰ *Compare Arruda*, 951 F.3d at 15 (giving weight to the fact that the autopsy report listed heart failure as a contributing cause of death), *with Pirkheim*, 229 F.3d at 1009 (dismissing the death certificate that listed the cause of death as pacemaker failure).

¹⁰¹ *See supra* note 3 and accompanying text (discussing long-term damage from the novel coronavirus); *see also supra* note 64 and accompanying text (explaining the unfairness arising from the plain meaning approach for policyholders with chronic conditions).

¹⁰² *See* MAYO CLINIC, *supra* note 3 (discussing the potential lasting, deleterious effects of COVID-19); Couzin-Frankel, *supra* note 3 (noting serious concerns regarding the long-term damage the novel coronavirus causes). Additionally, in some cases, people who caught the coronavirus twice had more serious symptoms the second time. Andrew Joseph, *Scientists Are Reporting Several Cases of Covid-19 Reinfection—But the Implications Are Complicated*, STAT (Aug. 28, 2020), <https://www.statnews.com/2020/08/28/covid-19-reinfection-implications/> [<https://perma.cc/DLN2-VWZS>].

years, possibly barring coverage under accident insurance policies.¹⁰³ Only time will tell, but the plain meaning approach may have widespread, unintended consequences down the road.¹⁰⁴

B. The Plain Meaning Approach Impedes the Uniform Distribution of Insurance Benefits

Along with failing to protect the interests of plan holders, the plain meaning analysis fails to promote uniformity and predictability in the distribution of insurance benefits.¹⁰⁵ Unfettered discretion for insurance companies to deny claims inevitably follows from an application of a literal interpretation of exemption clauses.¹⁰⁶ If a plan administrator is in a favorable circuit and the participant has a medical condition that is tangentially relevant to the accident, the insurance company has an increased interest in denying those types of claims.¹⁰⁷ As a result, it is impossible for policyholders and their beneficiaries to predict whether their pre-existing condition will preclude coverage.¹⁰⁸ The

¹⁰³ See Karen Pollitz et al., *Is COVID-19 a Pre-existing Condition? What Could Happen if the ACA Is Overturned*, KAISER FAM. FOUND. (Sept. 30, 2020), <https://www.kff.org/policy-watch/is-covid-19-a-pre-existing-condition-what-could-happen-if-the-aca-is-overturned/> [<https://perma.cc/NL5S-4VZW>] (discussing a CDC study indicating that 20% of younger patients and 35% of older adults had not returned to their baseline health after overcoming initial acute COVID-19 infection). Although most patients appear to make a full recovery after testing positive for COVID-19, preliminary studies looking at the long-term health effects show a number of patients that are experiencing more serious damage to the heart, lungs, and immune system. *Id.*

¹⁰⁴ See Girardeau A. Spann, *A Critical Legal Studies Perspective on Contract Law and Practice*, 1988 ANN. SURV. AM. L. 223, 236 (noting that the judicial enforcement of unintended consequences is inherently in opposition to the basis of contractual obligations). These possible unintended causes may also have a disparate impact on minority groups. See generally Julius Wilder, *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States*, 72 CLINICAL INFECTIOUS DISEASES 707–09 (2021) (discussing the disparate impact the coronavirus has had on underserved groups, especially African American, LatinX, and Indigenous communities).

¹⁰⁵ See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (citing H.R. REP. NO. 93-533, at 12 (1973)) (noting ERISA's legislative history that states that a uniform distribution of benefits provides predictability for benefit plan administrators and beneficiaries).

¹⁰⁶ See Peter A. Myers, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925, 940–41 (2005) (discussing the role of the abuse of discretion standard in allowing insurance companies to put their profits over the interests of their beneficiaries).

¹⁰⁷ See Constance A. Anastopoulou, *Bad Faith: Building a House of Straw, Sticks, or Bricks*, 42 U. MEM. L. REV. 687, 697–98 (2012) (discussing how the unequal bargaining power allows insurance companies to exploit policyholders for financial reasons even though the companies also have a business interest in fulfilling their promises to policyholders in the event of a claim).

¹⁰⁸ See *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (emphasizing the importance of ERISA's interests in predictability and uniformity). Although one of ERISA's competing goals is to promote efficiency to keep administrative costs down, this does not override ERISA's other objectives of protecting the interests of plan participants and the promotion of uniformity. See *id.* (discussing ERISA's competing objectives).

abuse of discretion standard is not simply a stamp of approval.¹⁰⁹ Rather, a court's review under this standard should retain some sort of "bite" in practice to ensure consistency in judicial review.¹¹⁰ After the First Circuit in *Arruda* declined to adopt the substantial factors test, the review of benefit denials for claimants with pre-existing conditions is akin to a mere formality.¹¹¹

Furthermore, due to the circuit split, a court could interpret similar insurance policies in different ways depending on where the policyholder lives.¹¹² This uneven application could even lead to different results with employees that work for the same company who are under the same accident policy operating in different states.¹¹³ Courts should interpret accident policies in the same way in different circuits to maintain consistency and predictability.¹¹⁴ In choosing between the plain meaning approach and the substantial factor test, courts should apply the substantial factor test to promote uniformity.¹¹⁵

¹⁰⁹ See *Torres v. UNUM Life Ins. Co. of Am.*, 405 F.3d 670, 680 (8th Cir. 2005) (noting that although the abuse of discretion test is deferential, it does not amount to automatic approval of a plan administrator's decision). Under the abuse of discretion standard, reviewing courts must weigh conflicts that arise when a plan administrator both makes the benefit determination and pays the money to its beneficiaries out of its own pocket. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Zurich would fall into this category because the company both insured and administered the insurance plan, but the First Circuit did not weigh the conflict of interest factor in their analysis. See *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 25 (1st Cir. 2020) (failing to consider the conflict of interest in their abuse of discretion analysis).

¹¹⁰ See *McDonough v. Aetna Life Ins. Co.*, 783 F.3d 374, 379 (1st Cir. 2015) (stating that a court is deferential when reviewing a rejected ERISA claim but the review "is not without some bite"). The First Circuit in *Arruda* also acknowledged that the abuse of discretion standard requires "some bite," but then proceeded to ignore its own warning. See 951 F.3d at 23, 25 (deferring to the plan administrator's review of the medical record and not questioning the degree of causation between the pre-existing conditions and *Arruda's* death).

¹¹¹ See *Arruda*, 951 F.3d at 24–25 (declining to adopt the substantial factors test and simply deferring to the insurer's opinion); see also Berkman, *supra* note 9 (interviewing a local ERISA lawyer who called the ruling in *Arruda* an example of extreme deference to the administrator's decision).

¹¹² Compare *Wade v. Minn. Life Ins. Co.*, 29 F. Supp. 3d 891, 895–96 (S.D. Tex. 2014) (finding that the participant's cancer contributed to his death, barring coverage despite evidence that the cause of death was blunt trauma to the head), with *Coleman v. Metro. Life Ins. Co.*, 262 F. Supp. 3d 295, 310–11 (E.D.N.C. 2017) (finding that although the policyholder's cancer may have contributed to his general frailty, the accidental fall was the cause of death and recovery, therefore, was not barred).

¹¹³ See *Tippitt v. Reliance Standard Life Ins. Co.*, 457 F.3d 1227, 1235 (11th Cir. 2006) (noting that one of ERISA's goals was the uniform distribution of insurance benefits).

¹¹⁴ See *id.* (emphasizing the desire for a uniform distribution of benefits); *Weiner v. Wasson*, 900 S.W.2d 316, 332 (Tex. 1995) (Owens, J., dissenting) (stressing the importance of "consistency and predictability" in jurisprudence); see also Kem Thompson Frost, *Predictability in the Law, Prized Yet Not Promoted: A Study in Judicial Priorities*, 67 BAYLOR L. REV. 48, 59 (2015) (discussing judicial preferences and the option to follow another court's precedent to advance stability and regularity across the legal system).

¹¹⁵ See *Tippitt*, 457 F.3d at 1235 (emphasizing ERISA's objective of regularity across states). The substantial factor test conforms with the goals of uniformity and predictability because it grants plan administrators less discretion by requiring that the pre-existing condition substantially contributed to the death rather than that it was simply present at the time of the accident. See, e.g., *Dowdy v. Metro. Life Ins. Co.*, 890 F.3d 802, 808–09 (9th Cir. 2018) (concluding that the policyholder's diabetes did

C. The Plain Meaning Approach Conflicts with the Doctrine of Reasonable Expectations

Finally, the plain meaning approach conflicts with the doctrine of reasonable expectations because a reasonable plan participant would expect to recover from their accident policy even if they have a pre-existing condition.¹¹⁶ Courts use the doctrine of reasonable expectations to guide their interpretation of insurance contracts.¹¹⁷ Under the doctrine of reasonable expectations, courts may reverse a denial of coverage even when the language of the policy appears to preclude it.¹¹⁸ Under the doctrine, the insured's objectively reasonable expectations of the extent of the coverage guides contract interpretation.¹¹⁹ In its strongest usage, it applies regardless of whether the policy language is ambiguous or not.¹²⁰ The doctrine's underlying principles are to avoid unfair results and promote the purposes of insurance, namely, to protect the insured against loss.¹²¹

The plain meaning approach, which the First, Sixth, Seventh, and Tenth Circuits took, conflicts with the doctrine of reasonable expectations because a literal interpretation of exemption clauses for pre-existing conditions often results in a finding of no liability.¹²² This is because exemption clauses generally

not substantially contribute to the amputation of his leg after he suffered a serious injury from a car accident).

¹¹⁶ See *Kievit v. Loyal Protective Life Ins. Co.*, 170 A.2d 22, 26 (N.J. 1961) (noting that policyholders deserve the protection required to meet their reasonable expectations).

¹¹⁷ See Mark C. Rahdert, *Reasonable Expectations Revisited*, 5 CONN. INS. L.J. 107, 108 (1998) (stating that courts use the doctrine to consider policyholders' reasonable expectations of coverage).

¹¹⁸ David J. Seno, *The Doctrine of Reasonable Expectations in Insurance Law: What to Expect in Wisconsin*, 85 MARQ. L. REV. 859, 859 (2002).

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.* at 867, 869–70. The doctrine allows courts to inject principles of fairness into contract interpretation by giving legal weight to the policyholder's expectations. Laurie Kindel Fett, *The Reasonable Expectations Doctrine: An Alternative to Bending and Stretching Traditional Tools of Contract Interpretation*, 18 WM. MITCHELL L. REV. 1113, 1122 (1992). It is rooted in the fact that insurance contracts are generally contracts of adhesion, which innately reflect an imbalance of bargaining power. See *id.* at 1119 (discussing how insurance contracts are contracts of adhesion, with little to no ability to negotiate the terms); see also *Leafguard of Kentuckiana, Inc. v. Leafguard of Ky., LLC*, 138 F. Supp. 3d 846, 858 (E.D. Ky. 2015) (explaining that a contract of adhesion is a contract that is standardized with boiler plate language that gives the adhering party no opportunity to negotiate). The insurer, who is in the business of protecting its own interests, drafts the policies with the insured often being placed in a binary "take-it-or-leave-it" situation. Fett, *supra*, at 1122. If they want insurance, they are often left with no meaningful choice. *Id.*; see also Peter Nash Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 TORT & INS. L.J. 729, 745 (2000) (describing how insurance agents often espouse reasonable expectations of coverage, while later denying coverage based on unfair limitations and exclusions).

¹²² See *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794, 796 (4th Cir. 1990) (stressing that "an overly literal" interpretation of the pre-existing exemption provision would often result in a finding of no liability).

require that the loss occur due to *only* accidental means.¹²³ As a result of the strict construction, pre-existing conditions, even if merely a remote cause of the accident in question, will obstruct recovery.¹²⁴ Even when the policy language is unambiguous, a reasonable person covered under an accident insurance plan would likely expect to receive benefits if they died from accidental blunt trauma, even if they had a physical condition that increased their risk of heart failure in stressful situations.¹²⁵ Almost one half of Americans are hypertensive, and precluding them from recovering in almost any situation raises the question of why anyone with chronic diseases would opt-in to accident insurance in the first place.¹²⁶ An approach that takes the doctrine of reasonable expectations into consideration would interpret insurance plans as a person of average intelligence and experience would understand them.¹²⁷

On the other hand, the substantial factor test conforms with the doctrine of reasonable expectations because it allows recovery unless the pre-existing condition *substantially contributes* to the accident.¹²⁸ This analysis produces results

¹²³ See, e.g., *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 14 (1st Cir. 2020) (upholding the insurance company's interpretation of an exemption clause that bars coverage for losses that are solely the result of accidental means); *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 794 (10th Cir. 2010) (reviewing an accident policy that distributed benefits only if an accident caused the loss); *Adkins*, 917 F.2d at 795 (considering a benefit denial under an exemption clause in an accident policy that excludes losses caused by something other than an accident).

¹²⁴ Compare *Arruda*, 951 F.3d at 25 (holding that the insurance company rightfully denied accidental death benefits because one out of many pre-existing medical conditions likely contributed to decedent's death after sustaining blunt force trauma in a car crash), with *Goetz v. Life Ins. Co. of Am.*, 272 F. Supp. 3d 1225, 1238–39 (E.D. Wash. 2017) (holding that because the policyholder's pre-existing epilepsy caused him to have an epileptic seizure, which substantially contributed to his drowning accident, his insurer may deny coverage).

¹²⁵ See *Arruda*, 951 F.3d at 25 (upholding a denial of benefits because there was sufficient evidence to conclude that decedent's heart conditions contributed to the death following an auto-accident despite numerous external injuries caused by blunt trauma); *Dixon v. Life Ins. Co. of N. Am.*, 389 F.3d 1179, 1184–85 (11th Cir. 2004) (upholding a denial of benefits because heart failure caused policyholder's death and there was no evidence of external injury or other accidental factors).

¹²⁶ See Holly Gainer, *Nearly Half of U.S. Adults Have High Blood Pressure*, UAB NEWS (Feb. 1, 2019), <https://www.uab.edu/news/health/item/10140-nearly-half-of-u-s-adults-have-high-blood-pressure> [<https://perma.cc/K9W3-RBG7>] (finding that 45.6% of adults in the U.S. were hypertensive, meaning they had high blood pressure, between 2011 and 2014).

¹²⁷ See *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1134 (9th Cir. 1996) (stressing that the court interprets ERISA-governed insurance policies in their ordinary meaning, taking into account the average policyholder's intelligence).

¹²⁸ See *Saltarelli v. Bob Baker Grp. Med. Tr.*, 35 F.3d 382, 387 (9th Cir. 1994) (incorporating the doctrine of reasonable expectations into its ERISA analysis). When a district court in the Ninth Circuit finds the insurance language to be ambiguous, then it will take into consideration the expectations of the policyholder. *Id.* at 386 (refusing to enforce the pre-existing condition exemption because it was buried within the plan and, thus, was not conspicuous enough to the reasonable person). If the policy language is clear, however, the court proceeds with a substantial factor analysis. *Walker Earle v. UN-UM Life Ins. Co. of Am.*, No. CV 19-2903, 2020 WL 4434951, at *11 (C.D. Cal. July 23, 2020). In 1990, in *Adkins v. Reliance Standard Life Insurance Co.*, the Fourth Circuit called this approach a “mid-

more in line with what a reasonable accident policyholder would expect the plan to cover.¹²⁹ It is fair to assume that the reasonable person expects an accident policy to cover injury or loss primarily caused by unexpected accidents.¹³⁰ The substantial factor test reflects this expectation because it requires courts to inquire about the degree to which the pre-existing condition caused the injury or loss.¹³¹

CONCLUSION

As this Comment demonstrates, the First Circuit should have taken the opportunity in 2020, in *Arruda v. Zurich American Insurance Company*, to adopt the Fourth Circuit’s “middle ground” approach to reviewing denials of accidental death and disability benefits. Although an application of the substantial factors test to Mrs. Arruda’s claim may not have resulted in a favorable

dle ground” when determining what a reasonable consumer would expect her insurance to cover. 917 F.2d at 797.

¹²⁹ See *Kievit v. Loyal Protective Life Ins. Co.*, 170 A.2d 22, 26 (N.J. 1961) (holding that the plan participant’s latent Parkinson’s disease did not constitute a cause of the loss based on the reasonable expectations of coverage). Moreover, the Patient Protection and Affordable Care Act (ACA) reinforces the reasonable expectation that pre-existing conditions do not bar insurance coverage. See 42 U.S.C. § 18001. (providing coverage to eligible individuals notwithstanding the presence of a pre-existing condition); *Affordable Care Act (ACA)*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/affordable-care-act/> [<https://perma.cc/7FU3-D2BA>] (describing the ACA and its primary goals); Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C.L. REV. 1, 3, 20 (2016) (discussing changing norms and the shift to more inclusive healthcare). Congress passed the ACA during the Obama Administration in 2010 as a comprehensive health reform bill. See generally Adrianna McIntyre & Zirui Song, *The US Affordable Care Act: Reflections and Directions at the Close of a Decade*, PLOS MED. (Feb 26, 2019), <https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1002752&type=printable> [<https://perma.cc/8PC9-QDRD>] (discussing the ACA’s accomplishments in its first nine years in addition to its various legal and political challenges). One of the pillars of the ACA is that it prohibits health insurers from charging more or refusing coverage altogether due to a pre-existing condition. FURROW ET AL., *supra* note 19, at 458.

¹³⁰ See *Arruda v. Zurich Am. Ins. Co.*, 366 F. Supp. 3d 175, 185 (D. Mass. 2019) (holding that the insurance companies’ determination that Arruda’s cause of death was heart disease was unreasonable because the immediate cause of death was blunt force), *rev’d*, 951 F.3d 349 (1st Cir. 2020); see also *West v. Aetna Life Ins. Co.*, 171 F. Supp. 2d 856, 883 (N.D. Iowa 2001) (emphasizing that when deciding whether an injury was accidental, a court should consider the policyholder’s reasonable expectations of coverage); cf. *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1456 (5th Cir. 1995) (holding that the policyholder’s death was covered and that it was accidental because he did not reasonably expect to die as the result of his autoerotic conduct).

¹³¹ See *Coleman v. Metro. Life Ins. Co.*, 262 F. Supp. 3d 295, 311–12 (E.D.N.C. 2017) (holding that there was nothing in the record to support the finding that the policyholder’s cancer substantially contributed to his death and that at most his cancer resulted in a predisposition to overall frailty that led to his death). Like the ACA, the substantial factor test reflects the fundamental notion that insurance plans should protect their plan participants against risk of loss even if they have common, long-term ailments. Compare *Adkins*, 917 F.2d at 797 (emphasizing the inherent unfairness to anyone that is not in perfect health in applying a strict plain meaning approach), with Elizabeth Guo et al., *Eliminating Discrimination Through Essential Health Benefit’s Anti-discrimination Provisions*, 107 AM. J. PUB. HEALTH L. & ETHICS 253, 253 (2017) (detailing the ACA’s efforts to protect against coverage discrimination).

outcome, it would have certainly offered some protection against prejudice stemming from her husband's long list of physical and mental ailments. The First Circuit's plain meaning interpretation and extreme deference to plan administrators is unreasonable because it stands in opposition with ERISA's two primary policy goals, as well as the doctrine of reasonable expectations. In the era of COVID-19, uncertainty and loss permeate our communities now more than ever. ERISA-regulated plans seek to mitigate risk and provide some iota of certainty for U.S. workers. Yet under the First Circuit's strict interpretation, a pre-existing condition can easily prevent recovery. It is crucial that federal courts keep the policy interests of ERISA in mind when reviewing denials of insurance coverage, especially in a time where a novel virus has increased the risk of long-term health problems, disability, and death.

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