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Danielle M. Jaffee

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MINDING THE GAP: SEEKING AUTISM COVERAGE IN CLASS ACTIONS WHEN STATE AND FEDERAL LAWS FAIL

DANIELLE M. JAFFEE*

This Note examines the recent trend towards class actions to challenge insurers' denial of autism treatment coverage. The author examines how state and federal laws regarding insurance coverage of autism treatment creates a gap allowing insurers to deny coverage, even in spite of the overwhelming proof of the beneficial nature of autism treatment for autistic individuals. Past individual challenges of insurers' actions gave little guidance to consumers about the legal obligations of insurers for autism treatment and recent collective action has done little to provide more. The author examines the decisions of three courts determining the certification of class challenges to insurers' denials, and proffers how consumers can successfully challenge insurers' practices in class actions moving forward.

I. INTRODUCTION

Currently one in sixty-eight children in the United States is diagnosed with Autism Spectrum Disorder, a number that continues to increase nearly seventeen percent each year.¹ These growing numbers have put increasing pressure on insurance companies to determine what, if any, coverage they provide for individuals living with autism and even more pressure on governments to enact laws ensuring assistance for thousands of citizens.² The pressures and actions of insurers, though plentiful, have left a

* University of Connecticut School of Law, J.D. Candidate 2014; American University, B.A. 2008. I would like to thank Professor Alexandra Lahav for her guidance and insight as I developed this Note. I am also sincerely grateful to my family for their many years of love and support.

¹ *Autism Has High Costs to U.S. Society*, HARVARD SCH. OF PUB. HEALTH (Apr. 25, 2006), <http://archive.sph.harvard.edu/press-releases/2006-releases/press-04252006.html> [hereinafter *High Costs*]; *CDC Estimates 1 in 68 Children has Been Identified with Autism Spectrum Disorder*, CTRS. FOR DISEASE CONTROL AND PREVENTION (March 27, 2014), http://www.cdc.gov/media/releases/2014_p0327-autism-spectrum-disorder.html.

² *See generally Insurance Coverage for Autism*, NAT'L CONFERENCE OF STATE LEGISLATURES (Aug. 2012), <http://www.ncsl.org/issues-research/health/autism->

clear gap of coverage for autism treatment in the self-insured market. With no federal or state laws to fall back on, individuals are often forced to turn to the legal system for assistance. While individual claims for autism treatment have been brought before the courts for over twenty years, a recent trend towards class actions has painted an unclear picture of the rights of the insured to challenge insurers and the ability of courts to allow class challenges in an area generally considered one of individual review by insurance companies.

This Note examines the recent movement toward class action lawsuits against health insurance providers to ensure coverage for autism treatment. Part II reviews what autism is, its growing prevalence in the United States, and its treatment. Part III provides a brief overview of state and federal laws regarding insurance coverage of autism treatment and why it leaves the door open for courtroom battles. Part IV examines past individual legal challenges for coverage that set the stage for current class actions. Part V discusses several recent claims for coverage through class action lawsuits and the vastly different and contradictory rulings district courts issued regarding class certification. Part VI compares the class actions and how the divergent court rulings fail to provide a legal bridge for the autism coverage gap created by federal and state laws. Finally, part VII looks to establish an approach to determine class certification for future class action filings on autism coverage in light of the confusing precedent.

II. AUTISM: WHAT IT IS, HOW TO TREAT IT, AND ITS GROWING PREVALENCE IN AMERICA

Autism is a developmental disease that is being diagnosed at increasing rates in America. It is generally held that early intervention and treatment of autism helps children better develop, however, disputes frequently arise between individuals, health care providers, and insurers as a result of the nature of treatment championed for autistic children.

and-insurance-coverage-state-laws.aspx [hereinafter NCSL]; *Essential Health Benefits*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Feb. 19, 2014); *Preventative Care*, HEALTHCARE.GOV, <http://www.hhs.gov/healthcare/rights/preventive-care/index.html> (last visited Feb. 19, 2014).

A. AUTISM, THE DISEASE

The National Institute of Child Health and Human Development defines autism as a complex developmental disability that results in problems with social interactions and communication.³ Autism manifests itself in individuals differently and thus there are varying diagnoses that require different levels and amounts of therapy.⁴ Combined, “classic” autism, Asperger syndrome, and atypical autism (often diagnosed as Pervasive Developmental Disorder) are part of the Autism Spectrum Disorder⁵ (ASD).⁶

Autism usually emerges in a child before the age of three and is diagnosable under the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV).⁷

Although at one time it was believed that autism was a product of nurture rather than nature, recent research has shown a clear link between autism and genetics. Several studies which examined familial relationships and autism diagnoses show that in families where one child has been diagnosed with autism there is an increased likelihood that a second child in the family will also be diagnosed with autism.⁸ While studies continue to shed light on certain factors that increase the risk of autism, including birth

³ *Autism Spectrum Disorder (ASD): Condition Information*, NAT’L INST. OF CHILD HEALTH & HUMAN DEV. (Dec. 18, 2012), <http://www.nichd.nih.gov/health/topics/autism/conditioninfo/Pages/default.aspx> [hereinafter NICHD].

⁴ *Id.*

⁵ For purposes of this Note, the use of the term autism will encapsulate all Autism Spectrum Disorders.

⁶ NICHD, *supra* note 3.

⁷ *Facts, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 20, 2013), <http://www.cdc.gov/ncbddd/autism/facts.html>; *Diagnostic Criteria, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 26, 2013), <http://www.cdc.gov/ncbddd/autism/hcp-dsm.html>; THE DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS, §299.00 (Am. Psychiatric Ass’n 4th ed.) (1994).

⁸ Two studies have shown that parents who have a child diagnosed with ASD have a 2-18% chance of having a second child diagnosed with ASD; while other studies have shown an increased diagnosis rate of 36-95% in identical twins when one child is diagnosed with ASD. *Research, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 19, 2012), <http://www.cdc.gov/ncbddd/autism/research.html#howmany>.

to older parents⁹ and children with certain genetic or chromosomal conditions,¹⁰ there is still much unknown about what causes autism. Currently, the CDC is conducting a multi-year study to identify additional factors linked to autism diagnoses.¹¹

B. THE GROWING PREVALENCE OF AUTISM

In the last forty years the diagnoses of autism in the United States have increased substantially. In 1975 the prevalence of autism diagnoses per person was 1 in 5,000; in 1985 it increased to 1 in 2,500 and in 1995 it reached 1 in 500.¹² Since 2001 the number has increased from 1 in 250 to 1 in 68 in 2014.¹³ Autism is now more common than Down syndrome or childhood cancer.¹⁴ Autism diagnosis trends also show a bigger impact on males. The current diagnosis rates reflect boys are five times more likely to be diagnosed with autism than girls.¹⁵

Currently, over 1.5 million Americans are diagnosed with autism. While the number is alarming, more alarming is that the rate of individuals diagnosed with autism is growing 10-17% per year, meaning in five years the number of individuals in America diagnosed with autism could be larger than the population of New Hampshire.¹⁶

⁹ Maureen S. Durkin et al., *Advanced Parental Age and the Risk of Autism Spectrum Disorder*, 168 AM. J. EPIDEMIOLOGY 1268, 1268 (2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2638544/pdf/kwn250.pdf>.

¹⁰ *Data and Statistics, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 26, 2013), <http://www.cdc.gov/ncbddd/autism/data.html> [hereinafter *Data and Statistics*].

¹¹ *SEED, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 3, 2014), <http://www.cdc.gov/ncbddd/autism/seed.html>.

¹² *AUTISM SPEAKS, SELF-FUNDED EMPLOYER TOOL KIT 22*, available at http://www.autismspeaks.org/sites/default/files/docs/gr/erisa_tool_kit_9.12_0.pdf [hereinafter *Employer Toolkit*].

¹³ *CDC Estimates 1 in 68 Children has Been Identified with Autism Spectrum Disorder*, CTRS. FOR DISEASE CONTROL & PREVENTION (March 27, 2014), <http://www.cdc.gov/media/releases/2014/p0327-autism-spectrum-disorder.html>.

¹⁴ Geoffrey Cowley, *Understanding Autism*, NEWSWEEK (July 30, 2000, 5:20 PM), <http://www.newsweek.com/understanding-autism-161485>.

¹⁵ Boys are diagnosed at a rate of 1 in 54 while girls are diagnosed at a rate of 1 in 252. *Data and Statistics*, *supra* note 10.

¹⁶ *High Costs*, *supra* note 1; *New Hampshire QuickFacts from the US Census Bureau*, U.S. CENSUS BUREAU (Jan. 16, 2014), <http://quickfacts.census.gov/qfd/states/33000.html>.

C. TREATING AUTISM SPECTRUM DISORDERS

Much of the discussion pertaining to insurance coverage for autism centers on insurance companies covering the treatment expenses that a family incurs as a result of the diagnosis. Because autism is a developmental disorder, the treatment of the disease focuses on not only medication, but additionally, social skills, communication, speech therapy, and sensory integration training.¹⁷ Such therapies are often deemed by insurance companies to be either educational or experimental,¹⁸ thus eliminating their burden to provide coverage because insurance policies exclude “experimental” and “educational” treatments as terms of their contract.¹⁹

The key to treatment for autism comes from research establishing that early intervention can dramatically improve a child’s development and therefore children with autism are encouraged to begin receiving services between birth and three years of age.²⁰ Thus, the bulk of expenses for autism treatment come between the first few years of life when children are undergoing intensive treatment programs to ensure steady development.

The most notable form of treatment and the central issue at hand in the pending class actions against insurers is Applied Behavioral Analytics (ABA). ABA is defined as “the science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change.”²¹ ABA therapy is a highly structured one-on-one coaching led by a certified instructor in which a child engages

¹⁷ *Treatment, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION, (Dec. 20, 2013), <http://www.cdc.gov/ncbddd/autism/treatment.html> [hereinafter *Treatment*].

¹⁸ Insurance companies commonly provide themselves a loophole that allows them to deny a request for coverage of experimental treatments, favoring instead that all procedures covered are thoroughly tested and proven effective. *See generally* Jim Williams, *When Insurers Won’t Pay for Experimental Treatments*, ABC NEWS (Feb. 22, 2012), <http://abcnews.go.com/WNT/story?id=131212&page=1>.

¹⁹ Angela Barner, *Unlocking Access to Insurance Coverage for Autism Treatment*, 6 J.L. ECON. & POL’Y 107, 108 (2009).

²⁰ *Treatment*, *supra* note 17.

²¹ Paul Mooney et. al., *Behavior Modification/Traditional Techniques for Students with Emotional and Behavioral Disorders*, in 22 BEHAVIORAL DISORDERS: IDENTIFICATION, ASSESSMENT, AND INSTRUCTION OF STUDENTS WITH EBD 173, 174 (Jeffrey P. Bakken et al. eds., 2012).

in positive reinforcement exercises targeting areas such as language, play, learning, and real-life functioning.²² Studies and advocates strongly encourage the use of ABA treatment in the early stages of life to ensure proper development for children with autism, often stating that if a child receives ABA therapy early there is a strong likelihood that the child will eventually be able to attend regular classes.²³

Behavior analysis treatment for children with autism started in the 1960s when Ivar Lovaas and others at the University of California, Los Angeles, conducted a study amongst forty children diagnosed with autism and subjected them to various amounts of behavior analysis treatment.²⁴ The original study showed a substantial improvement in individuals that underwent forty hours of one-on-one ABA treatment, many of whom were successfully mainstreamed into a regular classroom.²⁵ Further studies have also shown that ABA therapy results in long and short-term gains in intellectual function and educational progress.²⁶

In 1999, the U.S. Department of Health and Human Services issued a report of the Surgeon General on mental health showing substantial support for ABA therapy and its proven efficacy.²⁷ Then again in 2001, the U.S. Surgeon General's report on mental health further corroborated these findings, asserting that ABA therapy minimizes socially unacceptable behavior while increasing socially appropriate behavior, communication skills, and learning abilities for children with autism.²⁸

As a result of years of toting the advantages of ABA therapy, most autistic children participate in the intensive program. Generally, the treatment is administered for thirty to forty hours a week for three to four years, costing families several thousands of dollars.

²² Iver Peterson, *High Rewards and High Costs As States Draw Autistic Pupils*, N.Y. TIMES (May 6, 2000), http://www.nytimes.com/2000/05/06/nyregion/high-rewards-and-high-costs-as-states-draw-autisticpupils.html?page_wanted=all&src=pm.

²³ Barner, *supra* note 19, at 110; Peterson, *supra* note 22.

²⁴ Beth Rosenwasser & Saul Axelrod, *The Contributions of Applied Behavior Analysis to the Education of People with Autism*, 25 BEHAV. MODIFICATION 671, 672 (October 2001), available at <http://bmo.sagepub.com/content/25/5/671>.

²⁵ *Id.* at 672.

²⁶ Barner, *supra* note 19, at 111.

²⁷ U.S. DEP'T OF HEALTH AND HUMAN SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 163-64 (1999), available at <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.

²⁸ Barner, *supra* note 19, at 111.

D. THE COSTS OF TREATMENT: HEAVY BURDENS ON FAMILIES AND STATES BUT POCKET CHANGE FOR INSURERS

In 2006, Harvard released a report by Michael Ganz, MS, PhD that examined the growing costs of autism coverage on individuals, families, and society.²⁹ The report found that it costs society \$35 billion annually to care for individuals with autism and \$3.2 million for an individual to cover their own care over a lifetime.

Further, Ganz and other studies have found, individuals with autism incur twice as many expenses for care as the typical American in their lifetime. Reports have shown that it can total up to \$81,900 for a family to provide adequate treatment to a child with autism, including speech therapy, occupational therapy, and ABA treatment.³⁰ A child with autism will incur 2.5 times more outpatient costs and 2.9 times more inpatient costs in their lifetime than an individual without autism.³¹ These costs only increase if an individual's insurance company fails to cover even some of the treatment.

Ganz's report also examined the cost to society as a whole for autism. These figures considered the effect of autism on both individuals with the disease and their family/caregivers. Considerations included the lower level of employment procured by autistic individuals, including decreased pay and benefits, as well as lower savings value due to increased expenses for medical treatment, therapies, and special programming requirements.³² The study also accounted for the loss or impairment of work time for family members of autistic individuals, including missed work, reduced hours, lower-paying jobs with more flexible requirements, or leaving the workforce entirely to care for their autistic family member.³³

While the numbers for individuals and families coping with autism are often staggering and equivalent to an individual's annual income, the cost for insurers is far less. The Council for Affordable Health Insurance (CAHI) released information in 2009 claiming that an autism mandate,

²⁹ See generally Michael L. Ganz, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, 161 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 343 (2007).

³⁰ Laura C. Hoffman, *Ensuring Access to Health Care for the Autistic Child: More is Needed Than Federal Health Care Reform*, 41 SW. U. L. REV. 435, 437 (2012).

³¹ *Id.*

³² Ganz, *supra* note 29, at 348.

³³ *Id.* at 344.

legislation that requires health insurers to cover autism treatment, only increases the cost of health insurance by about 1%.³⁴ CAHI cautions that the cost could increase if more services are mandated, but they still estimate only a one to three percent increase.³⁵

Further, in the absence of insurance coverage, many families that cannot carry the financial burden of treatment expenses move their children into the Medicaid system, which may cover autism treatment at a higher rate than private insurers. Medicaid coverage is often superior to private insurance because state Medicaid programs offer some level of mental health services coverage and reimbursement,³⁶ while private insurance may not. With nearly 50% of Medicaid beneficiaries suffering from diagnosable mental health disorders in a given year,³⁷ the pressure to keep citizens with access to private health insurance out of the state Medicaid programs is growing. The more individuals with medical conditions that the Medicaid system absorbs, the greater financial burden placed on a state to finance the expanding costs of the program, an even heavier burden with many states struggling from significant state budget deficits.

III. WHAT THE LAWS SAY AND WHY IT IS A BATTLE FOR COVERAGE

Over the last few decades autism coverage proponents have experienced a number of victories in the quest to ensure coverage. However, even in light of moves by both the federal and state governments, efforts have fallen short of reaching millions of Americans, most notably those covered by employer-sponsored health plans.³⁸

³⁴ Victoria C. Bunce, *The Growing Trend Toward Mandating Autism Coverage*, 152 COUNCIL FOR AFFORDABLE HEALTH INS. ISSUES & ANSWERS (Mar. 2009), available at www.cahi.org/cahi_contents/resources/pdf/n152AutismTrend.pdf.

³⁵ *Id.*

³⁶ *Mental Health Services*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Mental-Health-Services-.html> (last visited Mar. 22, 2014).

³⁷ BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH: PREVENTION WORKS, TREATMENT IS EFFECTIVE, PEOPLE RECOVER, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 1, 7, available at http://www.hhs.gov/partnerships/aca_act_and_community/aca_behavioralhealth.pdf.

³⁸ *Employer Toolkit*, *supra* note 12, at 33.

A. FEDERAL

The work on the federal level to guarantee autism coverage has been spotty at best. The federal government has made broad strokes in an attempt to make mental illness and behavioral treatment a staple of health plan coverage. However, while these efforts are admirable, each one falls short of truly providing coverage for such ailments.

At the forefront of autism coverage is the Mental Health Parity Act, originally passed by Congress in 1996 and amended to fix certain loopholes in 2008.³⁹ Together the laws require group health plans to establish financial requirements and treatment limits for mental health and substance abuse services that are no less restrictive than the requirements and limitations imposed on medical and surgical benefits.⁴⁰ Mental Health Parity impacts autism coverage in that the DSM, which serves as the basis for the definition of mental health ailments for both laws and insurers, clearly classifies autism as a mental health disorder. The problem with the act as it is structured is that it does not require mental health benefits coverage; it simply states that if, and only if, a health plan already covers mental health, such benefits shall be no less restrictive. This in turn leaves the option open for health insurers to simply not offer mental health coverage to avoid being subject to such regulations.

Another federal attempt at providing mental health coverage, and specifically autism coverage, to citizens can be found in the Patient Protection and Affordable Care Act (ACA). First, section 1302(b) of the ACA requires all individual and small group plans to provide coverage for “essential benefits.”⁴¹ Originally the Secretary of Health and Human Services was slated to establish a list of required essential benefits that each state must use as their minimum requirements, giving autism advocates hope that treatment would be covered under the mental health and behavioral health treatment category of “essential benefits.”⁴² However, in December 2011, the administration announced the intention that each state would be free to create their own list of “essential benefits” to serve as the

³⁹ 42 U.S.C. § 300gg-26 (2006).

⁴⁰ *Id.*

⁴¹ CENTER FOR CONSUMER AND INSURANCE OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., ESSENTIAL HEALTH BENEFITS BULLETIN 1-2 (2011), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

⁴² See generally AUTISM SPEAKS, COVERAGE OF AUTISM SERVICES UNDER THE AFFORDABLE CARE ACT’S ESSENTIAL HEALTH BENEFITS PACKAGE (Oct. 11, 2011).

benchmark for all small and individual plans sold within the state.⁴³ Resulting from the state flexibility approach, only eleven states deemed autism treatment coverage an essential benefit in their benchmark plans.⁴⁴

Second, section 1001(5) of the ACA requires small group and individual health plans to provide preventative care services at no cost to the insured.⁴⁵ As established by the Department of Health and Human Services, based in part on the recommendation and scoring of the U.S. Preventative Services Task Force, autism screenings for children aged eighteen to twenty-four months are considered a mandatory preventative service.⁴⁶

While the efforts of ACA will undoubtedly help provide coverage to many individuals, it still falls short of reaching the growing number of plans that are just outside of the federal regulations. Large group plans are specifically exempt in the language of the ACA.⁴⁷ Any employer-sponsored plan or individual health plan that was established prior to the passing of the ACA is deemed grandfathered, and thus protected from such requirements so long as they maintain grandfather status, which, for many, will be several years.⁴⁸ Self-funded benefit plans are regulated by the

⁴³ Christine Vestal & Matt McKillop, *Health Law Explained: The States Gain New Flexibility in Setting Policies*, THE PEW CHARITABLE TRUSTS (Jan. 3, 2012), <http://www.pewstates.org/projects/stateline/headlines/health-law-explained-the-states-gain-new-flexibility-in-setting-policies-85899375384>.

⁴⁴ Christine Vestal, *Q&A: How ACA Will Affect People With Autism*, THE PEW CHARITABLE TRUSTS (Aug. 9, 2013), <http://www.pewstates.org/projects/stateline/headlines/qa-how-aca-will-affect-people-with-autism-85899496217>.

⁴⁵ See 42 U.S.C. § 300gg-13 (2012) (codifying § 1001(5) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)).

⁴⁶ *What Are My Preventative Care Benefits?*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3> (last visited Dec. 17, 2013).

⁴⁷ Sarah Barr, *FAQ: Grandfathered Health Plans*, KAISER HEALTH NEWS (Nov. 13, 2013), <http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx>.

⁴⁸ The law is structured to remove grandfathered status once a plan makes “significant” changes that result in increased costs or decreased benefits to participants. This caveat ensures that inevitably most, if not all, plans will comply with the ACA requirements. Current studies state that the number of individuals covered by grandfathered plans has begun to steadily decline and will continue downward in the coming years. Current numbers show that 48% of those covered by their employers are enrolled in grandfathered plans in 2012, down from 54% in 2011. *Id.*

Employee Retirement Income Security Act and exempt from all requirements described above under federal law.

B. STATE

In the absence of comprehensive requirements on the federal level for autism coverage, many states have taken it upon themselves to implement legislation requiring insurers to cover autism. Indiana passed the first meaningful piece of autism coverage legislation in 2001. The law requires individual and group insurance plans to provide coverage for the treatment of pervasive developmental disorders, including autism, that have been prescribed by an individual's treating physician.⁴⁹

It was not until several years later that the movement to require autism coverage took hold and laws began appearing in several states. Currently thirty-seven states and the District of Columbia have laws that address autism coverage, with the bulk of states adopting such legislation in the last four to five years.⁵⁰

The content of autism coverage laws varies from state to state, with thirty-one states specifically requiring insurers to provide for the treatment

⁴⁹ IND. CODE §§ 27-8-14.2-3, 27-8-14.2-4, 27-8-14.2-5 (2013).

⁵⁰ Nine states adopted laws in the 2007-2008 legislative session, eight states in the 2009 legislative session, nine states in the 2010 legislative session, six states in 2011, and three states in 2012. NCSL, *supra* note 2; ALA. CODE § 27-54A-2 (2013); ALASKA STAT. § 21.42.397 (2012); ARIZ. REV. STAT. ANN. §§ 20-826.04, 20-1057.11, 20-1402.03, 20-1404.03 (2007); ARK. CODE ANN. § 23-99-418 (2013); CAL. HEALTH & SAFETY CODE §§ 1374.72, 1374.73 (2013); COLO. REV. STAT. § 10-16-104 (2013); DEL. CODE ANN. tit. 18, § 3366 (2013); FLA. STAT. §§ 627.6686, 641.31098 (2013); 215 ILL. COMP. STAT.5/356Z.14 (2013); IND. CODE §§ 27-8-14.2, 27-13-7-14 (2013); IOWA CODE § 514C.28 (2013); KAN. STATE ANN. § 76-6524 (2013); KY. REV. STAT. §§ 304.17A-142, 143 (2013); LA. REV. STAT. ANN. § 22:1050 (2013); ME. REV. STAT. ANN. tit. 24-A § 2768 (2013); MASS. GEN. LAWS ANN. ch. IV §§ 32A-22, 25 (2013); MICH. COMP. LAWS ANN. § 550.1416e (2013); MO. REV. STAT. § 376.1224 (2013); MONT. CODE ANN. §§ 33-22-515, 33-22-706 (2013); NEV. REV. STAT. § 689A.0435, 689B.0335 (2013); N.H. REV. STAT. ANN. § 417-E:1-2 (2013); N.J. REV. STAT. §§ 17:48-6ii, 17:48-A-7ff, 17B:26-2.1cc, 17B:27-46.iii, 17B:27A-7.16, 17B:27A-19.20 (2013); N.M. STAT. ANN. §§ 59A-22-49, 59A-23-7.9, 59A-46-50, 59A-47-45 (2013); N.Y. INS. LAW §§ 3216, 3221 (2013); R.I. GEN. LAWS § 27.20.11 (2013); S.C. CODE ANN. § 38-71-280 (2013); TEX. INS. CODE ANN. § 1355.015 (2013); VT. STAT. ANN. tit. 8 § 4088i (2013); VA. CODE ANN. § 38.2-3412.1:01 (2013); W. VA. CODE § 5-16B-6e (2013); WIS. STAT. § 632.895(12m) (2013).

of autism.⁵¹ Overall, the laws implemented throughout the country establish varying annual cap limits on how much an insurer is required to pay out, from no limit to \$50,000 a year, and also varying age limits that an insurer is required to cover, such as coverage for life or just for the first two to six years of life.⁵²

While states have made great strides to ensure autism coverage for their citizens, it should be noted that because of the Employee Retirement Income Security Act (ERISA) pre-emption discussed next, self-insured plans⁵³ are exempt from these state level requirements. This means that 29% of children aged 0-18 that are covered by self-insured plans might not have autism coverage.⁵⁴ While several self-insured plans, such as those offered by Microsoft, Eli Lilly, and Home Depot, voluntarily provide autism benefits,⁵⁵ such actions are not mandated by law and therefore there is no guarantee as health care expenses rise that these companies will continue to provide these benefits.

C. ERISA

One of the biggest roadblock to coverage for autism can be found in ERISA. While efforts have been made on the federal level to establish requirements of coverage and equal treatment, and even on the state level to specifically require autism coverage, many plans can still be exempt from such mandates⁵⁶ leaving millions⁵⁷ without a safety net.

ERISA applies to health benefit plans offered in the private industry, but its most notable impact on health insurance laws comes in its protection of self-insured plans – or plans where the employer has taken on

⁵¹ NCSL, *supra* note 2.

⁵² *Employer Toolkit*, *supra* note 12, at 25.

⁵³ The term self-insured plan refers to health benefit plans in which the plan sponsor, an employer, directly funds the health benefits for its enrollees. In contrast, fully-insured plans refer to situations in which an employer purchases group health insurance from an insurer. Michael J. Brien & Constantijn W.A. Panis, *Self-Insured Health Benefit Plans*, U.S. DEP'T OF LABOR 4 (Mar. 23, 2011), <http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport032811.pdf>.

⁵⁴ *Employer Toolkit*, *supra* note 12, at 33.

⁵⁵ *Id.* at 35.

⁵⁶ 29 U.S.C. § 1144 (2006).

⁵⁷ *Employer Health Benefits: 2013 Summary of Findings*, KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TRUST, 1 (Aug. 20, 2013), [available at http://kff.org/private-insurance/report/2013-employer-health-benefits/](http://kff.org/private-insurance/report/2013-employer-health-benefits/).

the financial risk of funding, managing, and administering, its health plan.⁵⁸ Under section 514 of ERISA, self-insured health benefit plans are insulated from many state insurance laws, specifically state insurance mandates. While the first clause, section 514(a), establishes the broad preemption power of ERISA,⁵⁹ specifically, the Supreme Court has held that the key term of section 514(a), “relate to,” should be given its “broad common-sense meaning,” so as to displace all state laws that are in connection with, or making reference, to an employee benefit plan,⁶⁰ section 514(b)(2)(A), the “savings clause,” reserves the right of states to regulate insurance generally.⁶¹ Under this provision even if a state law is preempted under section 514(a) it can still be allowed so long as it regulates insurance, or in other words, if the state law is “specifically directed toward entities engaged in insurance . . . [and] . . . substantially affect[s] the risk pooling arrangement between the insurer and the insured.”⁶²

However, the Deemer clause, section 514(b)(2)(B), establishes the one exception to the right of states to regulate insurance and is the pinpoint clause that exempts self-insured from state mandates.⁶³ The Deemer clause restricts states’ regulation of insurance to only insurance companies and contracts, not plans themselves. Therefore, a self-insured plan is neither an insurance company nor a contract, thus exempt from state regulations and mandates. This loophole created by the ERISA is what allows many plans to be free from autism treatment requirements, thus creating a gap of coverage for millions of Americans.

⁵⁸ Matt Leming, *More Employers Weigh Self-Funded Health Plans*, SOC’Y FOR HUMAN RES. MGMT. (Aug. 14, 2009), <http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/SelfFunded.aspx..aspx>.

⁵⁹ ERISA shall “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. §1144(a).

⁶⁰ *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98 (1983).

⁶¹ 29 U.S.C. § 1144(b)(2)(A).

⁶² *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

⁶³ This Deemer clause states that no employee benefit plan “shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] contracts.” 29 U.S.C. §1144(b)(2)(B).

IV. THE PAST: PRIOR LEGAL BATTLES FOR AUTISM COVERAGE

The inability of federal and state laws to ensure coverage and the escalating cost of autism treatment has left many struggling for a way to hold insurers liable for treatment. Some individuals have turned to the judicial system as a means to require insurers to provide coverage for treatment. In these individual claims, courts have relied on the insurers' inadequacies to establish individuals' rights to autism treatment coverage, stating that insurers' unsubstantiated rejections of treatment are not enough to uphold a denial of benefits. However, while several individual cases exist, none of the courts have established a precedent that would extend beyond the individuals before them. Each ruling was narrowly tailored to the case at hand, failing to establish a rule or guideline of when, and if, a court would require an insurer to provide specific coverage.

The fight for health insurance coverage of autism is no stranger to the court system. Dating back to the early 1990s, several individual claims against health insurers have been brought seeking coverage for autism treatment. Collectively these individual claims show a deference of the courts to the needs and requirements of individuals over those of health insurers.

The early predecessor to such claims came in 1990 when *Kunin v. Benefit Trust Life Insurance* was heard before the Ninth Circuit.⁶⁴ Kunin was covered by an employer health plan, operated by Benefit Trust that refused to cover his numerous claims. In 1986, Kunin's son was diagnosed with autism and underwent thirty days of treatment, which cost over \$54,000.⁶⁵ The disagreement arose when Benefit Trust stated the policy only allowed for up to \$10,000 for "mental illness or nervous disorders" reimbursement.⁶⁶ The insurer held that autism was classified as a mental illness and therefore Kunin was responsible for costs beyond the reimbursement maximum.⁶⁷

In the opinion, the Court held that the classification of autism as a mental illness was an arbitrary and capricious decision by the insurer because they failed to substantiate the determination. Specifically, the Court stated that the so-called expert the insurers relied on for such a classification had failed to disclose material information, including what

⁶⁴ *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990).

⁶⁵ *Id.* at 535.

⁶⁶ *Id.*

⁶⁷ *Id.*

other doctors he had consulted or his experience or particular expertise concerning autism, to establish a well-founded reasoning behind the determination.⁶⁸ Further, the Court noted that the insurer had failed to make any effort to talk with the boy's own physicians to determine the basis for diagnosis and the recommended treatment before establishing the classification.⁶⁹ In light of these facts and because the policy in question was vaguely worded as to not contain a definition or explanation of mental illness, the Ninth Circuit found that the insurer was obligated to pay the full amount of the claim.⁷⁰ While the case brought the issue of coverage for autism treatment to the forefront, the fact that it turned on the definition of mental illness in the policy language only established a case-specific holding for an insurer's liability.

Following the Ninth Circuit's decision, the district court for the Northern District of Illinois again displayed the proclivity of courts to favor the insured over the insurers in the face of inadequate rationale. In *Wheeler v. Aetna Life Ins. Co.*, the Plaintiff argued that Aetna wrongfully denied coverage of medical treatment for his son who suffered from numerous conditions, including autism.⁷¹ The majority of the argument centered on coverage for speech therapy, physical therapy, ABA therapy, and sensory integration therapy, most of which Aetna refused to cover, citing various reasons, specifically the lack of evidence that such therapies are effective.⁷² Aetna argued that it had the right to reject coverage of certain therapies because the language of the policy granted them discretion to determine "to what extent employees and beneficiaries are entitled to benefits," however the Court rejected this argument, stating that the discretionary decisions of Aetna must still be reasonable and must provide the insured with "every reason for [their] denial of benefits at the time of denial."⁷³

The Court then went on to examine three letters issued by Aetna in which "they utterly fail to consider the actual language of the plan at issue," and thus had failed to provide adequate reasoning for their rejections.⁷⁴ The Court found that the actions of Aetna were, in effect, classifying autism as a developmental disorder which was covered by the

⁶⁸ *Id.* at 537-38.

⁶⁹ *Id.* at 538.

⁷⁰ *Id.* at 541.

⁷¹ *Wheeler v. Aetna Life Ins. Co.*, No. 01 C 6064, 2003 WL 21789029, at *1 (N.D. Ill. July 23, 2003).

⁷² *Id.* at *3-4.

⁷³ *Id.* at *4-7.

⁷⁴ *Id.* at *9.

policy but then subsequently denying all treatment for developmental delays caused by autism.⁷⁵ The Court held these actions by the insurer, if allowed, “[w]ould in effect render the provisions for coverage for autism meaningless.”⁷⁶

Although not a traditional individual claim, the Sixth Circuit issued another judicial opinion showing deference to protecting the rights of individuals to receive coverage of autism treatment in *Parents’ League for Effective Autism Services v. Jones-Kelly*.⁷⁷ The guardians of three Medicaid-eligible children filed for a preliminary injunction against Ohio to prevent the state from implementing amendments that would effectively stop funding autism treatment.⁷⁸ After the Centers for Medicare and Medicaid Services (CMS) issued proposed rules that would limit Medicaid coverage for rehabilitative services, Ohio promulgated amendments to its own Administrative Code, one of which limited coverage by defining rehabilitative services as those that would restore an individual to their prior functioning level.⁷⁹ The new amendments effectively eradicated state funding to programs that provided autism treatment to Medicaid children. The lawsuit claimed such actions violate federal Medicaid law that provides eligible children with such services.⁸⁰ Plaintiffs in the case argued that these rules deny funding to facilities responsible for providing autism treatment to Medicaid-eligible children.⁸¹ The Court did not rule on the merits, but instead granted a temporary restraining order to prevent the state from implementing the amendments.⁸² The decisions, although not conclusive, signaled the judicial system’s hesitance to allow actions that would eliminate adequate coverage for autism treatment in state-run Medicaid programs.

It was not until several years after these cases that a district court would consider the question that currently plagues the class actions for autism treatment: does an insurer’s designation of ABA therapy as “experimental” warrant their refusal to cover such treatment under the terms of their plans? In *McHenry v. PacificSource Health Plans*, the Court

⁷⁵ *Id.* at *13.

⁷⁶ *Id.* at *13.

⁷⁷ *Parents’ League for Effective Autism Servs. v. Jones-Kelley*, 339 Fed. App’x. 542, 542 (6th Cir. 2009).

⁷⁸ *Id.* at 543.

⁷⁹ *Id.* at 545.

⁸⁰ *Id.* at 545-46.

⁸¹ *Id.* at 551-52.

⁸² *Id.* at 543-44, 552.

considered whether an insurance carrier was responsible to an ABA therapist after a child had been diagnosed with autism and his pediatrician prescribed ABA therapy.⁸³ After seeing the therapist for four months, PacificSource denied payment citing its policy that allowed them to deny coverage for experimental or investigational procedures, as well as academic or social skills training.⁸⁴ To support its rejection, PacificSource stated that there was “no ‘gold standard’ for the treatment of autism, and there is much debate in the literature regarding the efficacy of any one approach, including ABA . . . [thus] it [is] clear that ABA [is] not a well-proven or evidence-based standard of medical care.”⁸⁵

The Court rejected both arguments, holding that ABA is supported by decades of research and application, and stated that ABA is an acknowledged autism treatment by several government agencies, including the Department of Health and Human Services and the National Institute of Mental Health, and professional organizations, including the American Psychological Society.⁸⁶ Further, the court stated that although ABA treatment may have incidental benefits related to education and social skills for autistic children, its main focus is modifying behaviors pertinent to every area of the child’s life and thus not solely an academic or social skills program.⁸⁷ In the end, the Court found that ABA therapy was medically necessary for Wheeler’s autism treatment.⁸⁸

While the judicial prerogative has been to favor the insured and coverage for autism treatment, the Court’s failure to rule in a broader context leaves the critical question of all these claims unanswered: will, and should, insurers be required to provide coverage of autism treatment to their insured?

⁸³ *McHenry v. PacificSource Health Plans*, 679 F. Supp. 2d 1226, 1228-29 (D. Or. 2010).

⁸⁴ *Id.* at 1228.

⁸⁵ *Id.* at 1236.

⁸⁶ *Id.* at 1237-38.

⁸⁷ *Id.* at 1240-41.

⁸⁸ *Id.* at 1248. In the end, the Court ruled against a Motion for Summary Judgment, stating that a secondary reason for denial of payments based on the ABA therapists lack of credentialing was enough to support a refusal of PacificSource to reimburse. *Id.* at 1245-46.

V. THE PRESENT: BANDING TOGETHER TO CHALLENGE INSURERS FOR AUTISM COVERAGE

After years of individual claims against insurers, a new breed of cases regarding autism coverage began to appear before the courts. In 2010 and 2011, insured individuals, who had been denied insurance coverage for ABA, began banding together to challenge their individual carriers. Three separate claims for class certification were brought before federal courts to directly challenge their insurer's denial of coverage for ABA therapy.⁸⁹ The carriers stated the same reasoning for denial in all cases: ABA is an investigative and experimental treatment. The charges of the insured were the same: the insurance carrier should provide coverage under my policy for ABA treatment for autism.⁹⁰ However, the similarities ended there. In the three cases, often with nearly identical facts, the reasoning of the judges resulted in very different outcomes for class certification.

The first judge reasoned that the presented class failed to establish commonality, or failed to establish that there was a common question of law or fact applicable to the entire class.⁹¹ The court reasoned that a claim for autism treatment would require individualized review of an insured's claim and medical treatment to determine if ABA therapy is actually experimental,⁹² thus a "determination of [the common question's] truth or falsity" would not have resolved the central issue of all claims "in one stroke."⁹³ The second judge found no such failure to establish commonality, and determined that an insurance company's across the board determinations regarding ABA therapy meant a common question of if ABA therapy was a covered benefit existed.⁹⁴ Further, the judge stated that even though the entitlement award for the denied benefit might require individualized review under Federal Rule of Civil Procedure 23(b)(3), such determinations do not predominate over the common question plaguing all class members.⁹⁵ Finally, the third judge found that such classes can easily be certified under common questions as the court is only seeking to

⁸⁹ See generally *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081 (E.D. Tenn. Feb. 19, 2010); *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789 (E.D. Mich. July 14, 2011); *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489 (E.D. Pa. Aug. 12, 2011).

⁹⁰ *Id.*

⁹¹ FED. R. CIV. P. 23(a)(2); *Graddy*, 2010 WL 670081, at *9.

⁹² See *Graddy*, 2010 WL 670081 at *9.

⁹³ *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011).

⁹⁴ See *Potter*, 2011 WL 9378789, at *6.

⁹⁵ See *id.*

determine whether the denial of ABA claims are appropriate.⁹⁶ However, limitations on relief apply in relation to who composes the class.⁹⁷ These rulings create three distinct interpretations of the applicability of class adjudication of autism claims.

A. *GRADDY*, 2010

First, in *Graddy v. Blue Cross BlueShield of Tennessee Inc.*, a group of individuals covered by Blue Cross BlueShield of Tennessee (BCBST) moved for class certification in a claim against the insurer because of their denial of coverage for ABA therapy for autistic individuals.⁹⁸ The Plaintiffs in the case claimed that the actions of BCBST violated ERISA, the Tennessee Autism Equity Act, and the Tennessee Consumer Protection Act. Specifically, the claim stated that BCBST violated its fiduciary duties to the Plaintiffs when it failed to fairly and properly construe and interpret the language of the health plans for the exclusive purpose of providing benefits to the members of the plan.⁹⁹ Further, they alleged that the Tennessee Autism Equity Act required BCBST to provide benefits and coverage for the treatment of autism at the same level it provided for other neurological disorders and that it had failed to do so when it rejected the claims.¹⁰⁰ Finally, the Plaintiffs claimed BCBST had engaged in unfair and deceptive trade practices, violating the Tennessee Consumer Protection Act.¹⁰¹

Under the Federal Rules of Civil Procedure (FRCP) Rule 23(b)(2), the Plaintiffs moved to certify a class of all insured under the BCBST policy who have, or will make, a claim for coverage for ABA therapy and

⁹⁶ See *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *4 (E.D. Pa. Aug. 12, 2011).

⁹⁷ See *id.* at *4–6. In a subsequent amended complaint, Judge Sanchez allowed a second representative to be added to the class to capture all current Cigna members who had submitted ABA claims that were subsequently denied under Cigna's current company-wide policy. However, in the subsequent case Judge Sanchez denied the motion to certify a (b)(2) class because the class in its entirety sought individualized monetary damages, which were not certifiable under (b)(2). *Churchill v. Cigna Corp.*, No. 10-6911, 2012 WL 3590691, at *10 (E.D. Pa. Aug. 21, 2012) [hereinafter *Churchill II*].

⁹⁸ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *3 (E.D. Tenn. Feb. 19, 2010).

⁹⁹ *Id.* at *1-4.

¹⁰⁰ *Id.* at *6.

¹⁰¹ *Id.*

BCBST denied such coverage on the basis that ABA is deemed investigative or experimental.¹⁰² The class argued that BCBST had established “a deliberate company-wide policy to deny all claims for ABA treatment, even though it knows the terms of its Plans provide coverage for the treatment” and further that such denials were made in bad faith and on baseless grounds.¹⁰³

The court rejected class certification on the basis that the class failed to meet the commonality requirement of FRCP 23(a)(2), requiring that “there are questions of law or fact common to the class.”¹⁰⁴ Here, the court reasoned, a claim of breach of fiduciary duty under ERISA requires most questions be answered through individualized review of each class member’s claim, diagnosis, therapy and determination if ABA truly was experimental for their precise condition.¹⁰⁵ Specifically, proving breach of fiduciary duty requires showing a connection between the fiduciaries actions and the harm caused to the individual. The court focused on the varying degrees of autism and how each diagnosis was different. The court reasoned that, “individuals suffering from . . . autism ‘may exhibit the characteristic traits of autism . . . in any combination, and in different degrees of severity,’” and therefore, “the varied behavioral disorders exhibited by patients with ASD, and the question of whether such behavior disorders may or may not be treated by ABA,” means that the class shares no homogeneity that would allow them to operate as a class.¹⁰⁶

The court specifically reserved ruling on the merits of the claim until the complaint could be amended by Graddy to establish an individual claim against BCBST’s decision to deny coverage for ABA treatment.¹⁰⁷ The concluding statements of the court in this opinion showed support for individual claims of autism coverage against insurers that had been stated in prior cases as well as the growing policy support found on the state and federal level for autism coverage, but stopped short of allowing a class action against an insurer.¹⁰⁸

It should be noted that in 2013 the District Court for Oregon addressed a similar class seeking only injunctive relief and, in contrast to

¹⁰² *Id.* at *4.

¹⁰³ *Id.* at *3, *5.

¹⁰⁴ FED. R. CIV. P. 23(a)(2).

¹⁰⁵ *Graddy*, 2010 WL 670081, at *9-10.

¹⁰⁶ *Id.* at *8-10.

¹⁰⁷ *Id.* at *10.

¹⁰⁸ *Id.* at *9-10.

Graddy, was granted certification.¹⁰⁹ In *A.F. v. Providence*, the Plaintiff class included all current members of Providence health plans who had been, or will be up to the time of certification, diagnosed with autism.¹¹⁰ The class sought injunctive relief against Providence to prevent them from uniformly applying a policy exclusion that excludes all coverage for ABA therapy.¹¹¹ After a lengthy discussion of the requirements of a proper class under Rule 23(a), the judge certified the class finding that “injunction would provide specific and meaningful relief to all named class members.”¹¹² Particularly, the judge found that resolving the question raised by the Plaintiffs would provide “complete relief as to the *specific* issue raised by the [class], even if it does not ultimately address every class members’ needs or issues.”¹¹³ While *AF* is the most recent iteration of the autism class action, the opinion issued by the court offers little beyond what has already been expressed in the earlier autism class action court rulings. The vast majority of the *AF* opinion focuses on the checklist requirements of class certification and therefore this author believes it does not warrant further discussion.

B. *POTTER*, 2011

In the second class action claim, the District Court for the Eastern District of Michigan certified a class claim against Blue Cross Blue Shield of Michigan (BCBSM) and its rejection of ABA treatment for autism.¹¹⁴ In *Potter v. Blue Cross Blue Shield of Michigan*, the class brought suit under ERISA claiming first, that BCBSM had improperly denied claims on the basis that ABA is deemed experimental or investigative and second, that BCBSM had denied them the opportunity for a full and fair review of the claim.¹¹⁵

Michael Porter, acting as class representative, made a motion to certify a class containing two subclasses. Subclass A was defined as all insureds under a BCBSM policy who made a claim, or will make a claim,

¹⁰⁹ *A.F. v. Providence Health Plan*, No. 3:13-CV-00776-SI, 2013 WL 6796095 (D. Or. Dec. 24, 2013).

¹¹⁰ *Id.* at *4.

¹¹¹ *Id.* at *1.

¹¹² *Id.* at *10.

¹¹³ *Id.* at *11 (emphasis in original).

¹¹⁴ *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789 (E.D. Mich. July 14, 2011).

¹¹⁵ *Id.* at *2.

for ABA therapy and the claim was, or will be, denied on grounds that such treatment is investigative or experimental.¹¹⁶ Subclass B was defined as all insured under a BCBSM policy who did not make a claim for ABA “in light of Defendant’s policy that such treatment is deemed to be investigative or experimental.”¹¹⁷

The court found that the numerosity standard was easily met, determining that, based on the business size of BCBSM and the number of students diagnosed with autism in Michigan schools, joinder would be impractical, if not impossible.¹¹⁸ Further, the class shared a common question as all of the claims depended on the same contention: there is no reasonable basis for stating that ABA is experimental and not a mainstream medical treatment. Therefore all claims of the class would be addressed when the court determines if the insurer had improperly deemed ABA treatment experimental.¹¹⁹

It was noted that the area of most difficulty on its face was determining the members of the class. While subclass A was easily distinguishable based on the likelihood of BCBSM maintaining records on claims filed, subclass B would be theoretically difficult because of the subjective nature of ascertaining why an individual did not file a claim. However, the court rejected this obstacle, stating that they can assume that if an individual failed to file a claim for ABA treatment, it was a result of them either being told, or somehow learning, that BCBSM deemed all such treatment experimental and excluded from coverage. Therefore, instead of going through the burden of processing an insurance claim only to have it rejected, the individual that received ABA treatment and did not submit the claim did so only because of the BCBSM policy.¹²⁰

The judge here explicitly disagreed with *Graddy*, noting that, although the cases are similar, determining the case would not require answering individualized questions. BCBSM made an across-the-board determination that ABA treatment is experimental and therefore not a covered benefit, thus BCBSM’s determination was not made after considering each individual claim and medical need, but rather based on its uniform determination that ABA is experimental.¹²¹

¹¹⁶ *Id.* at *4.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at *5.

¹¹⁹ *Id.* at *6.

¹²⁰ *Id.* at *4-5.

¹²¹ *Id.* at *8.

The class was then certified under Rule 23(b)(3) with the presumption that, since the class claim was that ABA claims were improperly rejected by BCBSM because of an experimental classification, no member of this class would have another reason for being rejected by BCBSM and therefore the class would require no individualized determination.¹²² Further, the Court rejected BCBSM's contention and the *Graddy* Court's reasoning, that individual determinations would be needed to decipher how much each class member was entitled to under their claim, explaining that such determinations do not predominate over the common issue that BCBSM improperly denied their ABA claims.¹²³

C. *CHURCHILL*, 2011

The third class action, filed in the Eastern District of Pennsylvania, came to a very different conclusion than the other two courts. In *Churchill v. Cigna Corp.*, the Court differed from *Graddy* by choosing to certify a class action against an insurer for coverage of ABA treatment, but unlike *Potter*, the Court refused to include in the class members of the health insurance plan that had not filed claims for ABA.¹²⁴

The Plaintiffs in *Churchill* charged that Cigna had improperly denied their claim for ABA treatment¹²⁵ of autism in violation of ERISA and thus sought benefits and equitable relief.¹²⁶ The complaint alleges that under Cigna's uniform Medical Coverage Policy, Cigna excluded coverage of ABA on the basis that such treatment is deemed, "experimental, investigational or unproven' for the treatment of [autism]," and therefore

¹²² *Id.*

¹²³ *Id.* On March 30, 2013, the district court issued judgment in favor of the plaintiff class. *Potter v. Blue Cross Blue Shield of Michigan*, 10-CV-14981, 2013 WL 4413310, at *1 (E.D. Mich. Mar. 30, 2013). The Court found that BCBS' denials were arbitrary and capricious and therefore overturned the denial of benefits. *Id.* at *6. The Court remanded the claims for re-administration by BCBS, stating that "the remand is not an opportunity for BCBS to invent new bases for denial of claims that were not previously asserted." *Id.* at *12-13.

¹²⁴ *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *1 (E.D. Penn. Aug. 12, 2011).

¹²⁵ *Id.* The original complaint stated that Cigna rejected both ABA and Early Intensive Behavioral Intervention treatment on the grounds that both treatments were experimental, however, the Court reasoned that Early Intensive Behavioral Intervention was encapsulated by ABA and therefore both treatments will be referred to simply as ABA. *Id.* at *1 n. 2.

¹²⁶ *Id.* at *1.

excluded from coverage.¹²⁷ Kristopher Churchill, acting as the class representative, made a motion to certify two subclasses, similar to those proposed in *Potter*, under Rule 23(b)(2) and (3).¹²⁸ The first group, subclass A, was defined as all insureds enrolled in a plan administered or offered by Cigna who had made a claim, or will make a claim, for ABA therapy which was denied, or will be denied, on the grounds that such treatment is investigative or experimental.¹²⁹ The complaint also moved to have subclass B certified as all insured who were enrolled in a plan administered or offered by Cigna who did not make a claim for ABA therapy in light of Defendant's policy that ABA is "deemed to be investigative or experimental."¹³⁰

The Court established that certification could only be granted to an amended version of subclass A.¹³¹ In its reasoning, the Court found that, although the entire class met the numerosity requirement,¹³² they failed to meet the typicality and adequacy of representation standards of Rule 23.¹³³ Under its determination, the Court found that the entirety of subclass A shared a common question revolving around if Cigna's denial based on a claim that ABA therapy is investigative and experimental was a proper reasoning for denial.¹³⁴ Therefore, answering a single question, common to all members of the class, would address the individual claims.¹³⁵

However, the Court opted to narrow Subclass A in two ways.

¹²⁷ *Id.*

¹²⁸ *Id.* at *1-2. Rule 23 (b)(2) states that "a class action may be maintained . . . if . . . the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." FED. R. CIV. P. 23(b)(2). Rule 23(b)(3) states that "a class action may be maintained . . . if . . . the court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy." FED. R. CIV. P. 23(b)(3).

¹²⁹ *Churchill*, 2011 WL 3563489, at *2.

¹³⁰ *Id.*

¹³¹ *Id.* at *5.

¹³² The Court determined, based on the size of Cigna's business coupled with the growing prevalence of autism diagnoses in America, that even if a small fraction of Cigna members had filed claims for ABA, subclass A would still be too large and too geographically diverse to "render joinder practical." *Id.* at *3.

¹³³ *Id.* at *4-5.

¹³⁴ *Id.* at *4.

¹³⁵ *Id.*

First, because Churchill was no longer a member of a Cigna health plan he could not adequately represent the interests of current members as he lacked any discernible interest in seeking injunctive relief to prohibit Cigna from rejecting ABA claims.¹³⁶ Therefore, the class would have to be limited to only individuals that were former members of Cigna's health insurance plans.¹³⁷

Second, the Court rejected the reasoning that had been upheld in *Potter*, in that the class could not contain individuals who had failed to file a claim for ABA treatment.¹³⁸ The Court found the logic of *Potter* unpersuasive, stating that individuals may have chosen to not file a claim for a variety of reasons, not simply because they knew of Cigna's policy against ABA reimbursement, and in such cases Cigna's policy can therefore not be held to cause harm.¹³⁹

In the end, the Court chose to certify a class of former Cigna members that had submitted claims for ABA treatments that had been rejected by Cigna.¹⁴⁰ In doing so, the Court dismissed Cigna's argument that it had rejected ABA claims for a variety of reasons, often noted on the rejection letters sent to plan members. The Court found that, although Cigna listed a variety of reasons as to why it rejected the claim, including the argument that there might be differences in diagnoses and the type of ABA treatment received, Cigna had still made a class-wide determination that ABA was experimental in all cases and that was the basis for their continuous rejections.¹⁴¹

¹³⁶ *Id.* at *4-5. In a subsequent filing the class was amended to capture current members of the health insurer by adding a second class representative who was currently enrolled in a Cigna health plan. *Churchill II*, No. 10-6911, 2012 WL 3590691, at *1 (E.D. Pa. 2012).

¹³⁷ *Churchill*, 2011 WL 3563489, at *4-5.

¹³⁸ *Id.* at *8.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at *6. On November 26, 2013 a Notice of Class Action Settlement was sent to class members. Notice of Class Action Settlement, *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489 (E.D. Penn. Aug. 12, 2011), available at <http://www.washingtonautismadvocacy.org/updates/wp-content/uploads/Notice-of-ABA-Settlement-Cigna.pdf>. The proposed settlement entitled class members to monetary damages for rejected ABA claims. *Id.* at 2. A fairness hearing was conducted on February 19, 2014. *Id.* at 3. At the time of publication, a final settlement was not yet approved by the court.

VI. CONFLICTING RULINGS HIGHLIGHT THE SUBJECTIVE DETERMINATIONS THAT CREATE THE LEGAL TOOLS AVAILABLE TO CONSUMERS

While the movement to provide coverage for autism treatment has made great strides both in law and in the courtroom, many questions remain. Can you bring a class action against an insurance company to require coverage for ABA treatment? The answer depends on the district. Districts following *Graddy* require individual claims, not class actions, while districts following *Potter* and *Churchill* say certain class actions will work. Can a certified class encapsulate all members of a plan, or only those who have filed a claim that was rejected? A judge could find the presumption that an individual failed to file a claim because they knew of the insurance company's policy applicable, while other judges may believe such a presumption is baseless.

On the face the three class actions look similar. A group of individuals who could not receive health insurance coverage for autism treatment, all filing a claim under ERISA to answer a simple question: is a health insurer's denial of ABA therapy on the grounds that it is "experimental" reasonable? However, the judges in these three cases viewed what was before them in drastically different lights. The contrasting rulings highlight the problems that arise from a class action against an insurance company for denial of benefits. Such cases require a court to rule generally on issues that are very often individual: is this specific claim covered under this specific policy for this specific individual?

A. WHAT'S IN A DEFINITION

The first difference can be seen in the class definitions that were presented for certification. Many may believe that minor differences in class definitions before the court can explain the conflicting rulings, but the differences were slight and easily malleable as demonstrated by the *Churchill* Court's willingness to edit the class definition in its certification.¹⁴²

In *Graddy*, the Court rejected the most basic class definition offered: current and former plan members who had submitted a claim for ABA therapy and were denied because of the company policy deeming

¹⁴² See *Churchill*, 2011 WL 3563489, at *7.

ABA therapy experimental.¹⁴³ Here, the Eastern District of Tennessee rejected the class on the basis that every class member would require an “individualized assessment as to the ultimate propriety of the benefits decision.”¹⁴⁴ The Court reasoned that, although ABA treatment is beneficial to individuals diagnosed with autism, it is not always the preferred and appropriate therapy, nor is the amount required set in stone. Rather, each individual diagnosis requires individual review to determine what therapy is needed, how much, and to what level it should be covered by the health insurance plan.¹⁴⁵

On the other hand, the *Potter* Court found no such individualized assessment is required and went so far as to broaden the class definition. The Court certified a class that contained current and past members of the health plan who received ABA treatment regardless of whether they had or had not submitted a claim to the insurer.¹⁴⁶ The Court directly disagreed with *Graddy*, determining that a company-wide policy deeming ABA therapy experimental had been applied across the board without individual assessment of claims, and therefore individual review of the claims, or not claims, was not necessary. The company policy on its own was at issue, and therefore the issue is capable of remedy without individual assessment.

Finally, *Churchill* was originally presented with the same broad class definition that occurred in *Potter*, a class that consisted of current and former members who had received ABA treatment regardless of if they had filed a claim.¹⁴⁷ Rather than rejecting the class entirely or accepting the class definition, the *Churchill* Court opted to apply judicial discretion and narrow the class definition. In doing so, limited the class to only those individuals who had made claims to their insurer, finding that such a definition was apt for class certification.¹⁴⁸ The *Churchill* Court rejected the reasoning of the *Graddy* Court.¹⁴⁹ Such discretion emphasizes the uncertainty regarding class actions against insurers and the ability to use general determinations against a business that relies on individual appraisals.

¹⁴³ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *4 (E.D. Tenn. Feb. 19, 2010).

¹⁴⁴ *Id.* at *9.

¹⁴⁵ *Id.* at *10.

¹⁴⁶ *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789, at *1, *4 (E.D. Mich. July 14, 2011).

¹⁴⁷ *Churchill*, 2011 WL 3563489, at *2.

¹⁴⁸ *Id.* at *8.

¹⁴⁹ *Id.* at *8, n. 13.

B. HOW MUCH, IF ANY, RELIEF IS APPROPRIATE

The second significant difference between the cases rested with what type of class-wide relief that would be appropriate. In *Graddy*, the Court found that the class could not seek injunctive relief under Rule 23(b)(2) because the class' claim rested on a breach of the fiduciary duty imposed under ERISA which could only be proven by a clear link between the breach of duty and the harm experienced. For the Court, such a link was dependent on the equities of each individual claim, which would in turn require an individual evaluation of each class member, their diagnosis, treatment plan, and specific claim. With a lack of homogeneity within the class, final injunctive relief would not be appropriate for the class as a whole.¹⁵⁰

However, the *Potter* Court found such reasoning inapplicable, and determined that not only could the class of current and former members be extended to include individuals who had not even filed a claim, but also that they could seek both injunctive and monetary relief.¹⁵¹ For the Eastern District of Michigan, a class of individuals denied coverage of a specific treatment, as the result of a company-wide policy are entitled first, to injunctive relief¹⁵² to prevent the company from applying such a policy and second, to monetary relief¹⁵³ that would provide reimbursement for their out-of-pocket expenses.¹⁵⁴ The Court held that although individuals would be entitled to varying amounts depending on their claim, individual entitlement amounts did not predominate over the fact that all members of the health plan had been denied benefits solely on the company policy that deemed ABA therapy "experimental".¹⁵⁵

Finally, in *Churchill*, the Court walked the line between the opposing opinions of the earlier courts when it ruled that a class of individuals who had made a claim for ABA that was denied could not seek injunctive relief, but could receive monetary relief. The Court found that the question of what was owed to the consumers turned on the status of the individuals in the class. Since one subclass contained former members of the Cigna health plans, injunctive relief was inappropriate because former

¹⁵⁰ *Graddy*, 2010 WL 670081 at *8.

¹⁵¹ *Potter*, 2011 WL 9378789 at *9-10.

¹⁵² *Id.* at *9.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at *1.

¹⁵⁵ *Id.* at *9.

members would not be seeking a ruling requiring Cigna to change its company policy for they would receive no benefit from such a change in policy.¹⁵⁶ However, the other class of current members who had filed claims could seek monetary damages rather than injunctive relief.

While all three classes commonly sought at least partial relief under Rule 23(b)(2), the rulings provided three contradictory holdings on whether such relief is applicable. The competing approaches and reasoning leave individuals and lawyers without any clear answers. Is a challenge of an insurance company for an unreasonable denial of benefits available as a class action, and if it is, what relief can be offered?

VII. HOW TO APPROACH AUTISM CLASS ACTIONS IN LIGHT OF AN UNCLEAR PATH FROM THE COURTS

Autism coverage class actions paint a blurry picture at best. The complicated web of federal and state laws striving to provide autism coverage is often sidestepped by ERISA's distinction between insured and self-insured, leaving plans free to reject claims for treatment. Individual challenges to these tactics, while often successful, have proven inefficient. In order to truly clarify answers, the insured have pursued claims collectively, but even collective action has resulted in three different judicial approaches. First, courts have determined that individual questions matter in resolving the reasonableness of an insurer's decision and therefore must be reviewed independently.¹⁵⁷ Others have found that when a company applies an across-the-board determination regarding a benefit, a remedy may also be provided across-the-board.¹⁵⁸ Still other courts have stated that although you may overcome the individualized nature of diagnosis and treatment plans, you cannot bind people who never acted, even if they were harmed by the actions of an insurance company.¹⁵⁹

Even though the picture is complicated and the precedent confusing, moving forward courts can apply a standard that allows for individuals to collectively challenge insurance companies and fill the gap left by federal and state legislation of autism coverage. Taking into

¹⁵⁶ *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *6-7 (E.D. Penn. Aug. 12, 2011).

¹⁵⁷ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *9-10 (E.D. Tenn. Feb. 19, 2010).

¹⁵⁸ *Potter*, 2011 WL 9378789, at *6, *8.

¹⁵⁹ *Churchill*, 2011 WL 3563489, at *7-8.

consideration the requirements and policy basis of Rule 23(a) and (b)(2),¹⁶⁰ allowing class actions against insurers best serves the interest of an efficient judicial system and with proper limitations can strike the balance of providing global peace to all parties while still allowing for individual assessments that insurance companies rely on in business.

Determining if an insurance company's decision to rule ABA therapy as experimental is reasonable does not require an individualized assessment of every claim. Rather, the company-wide policy is in question, not the individual denials; therefore if a court were to determine reasonableness they would determine an answer to a common question to all class members. As the advisory committee notes state, "necessity for a class action is greatest when the courts are called upon to order . . . the alteration of the status quo in circumstances such that a large number of persons are in a position to call on a single person to alter the status quo"¹⁶¹ Applicable here, the courts are being asked to evaluate the company policies regarding ABA therapy, rather than each individual rejection of such a claim. Courts should not be looking at whether every denied claim was appropriate, nor should they conclude that anyone with an autism diagnosis is entitled to ABA therapy. Rather, appropriate analysis of the court should focus on the company policy that hinders millions of Americans' access to benefits they need. If autism coverage class action

¹⁶⁰ Pertinent subsections are as follows:

(a) Prerequisites. One or more members of a class may sue or be sued as representative parties on behalf of all members only if:

- (1) the class is so numerous that joinder of all members is impracticable;
- (2) there are questions of law or fact common to the class;
- (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
- (4) the representative parties will fairly and adequately protect the interests of the class.

(b) Types of Class Actions. A class action may be maintained if Rule 23(a) is satisfied and if . . .

- (2) the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole

FED. R. CIV. P. 23.

¹⁶¹ FED. R. CIV. P. 23(b)(1)(A) advisory committee's note.

claims are accepted by the court as a challenge to insurers' company-wide policies rather than individual claims for benefits, a court can sustain a class certification pursuant to the goals of Rule 23 outlined in the advisory committee notes.

However, while such questions can be answered for the class, two distinct limitations discussed in *Graddy* and *Churchill* must be established to ensure uniformity in application and adherence to the requirements and goals of class actions. First, as the class action jurisprudence stands now, class actions challenging an insurer's policy towards coverage of autism treatment should be limited to injunctive relief. As Rule 23(b)(2) states, "[when] the party opposing the class has acted . . . on grounds that apply generally to the class . . . final injunctive relief . . . is appropriate [for] the class as a whole."¹⁶² Specifically, this has been interpreted to establish two requirements. First, that the party opposing the class, here the insurers have acted, or refused to act, on grounds generally applicable to the class as a whole, and second, any final injunctive relief settling the legality of the behavior is appropriate to the class as a whole.¹⁶³ Applying such interpretation here, an insurance company who makes and enforces a company-wide policy, irrespective of each individual, that deems certain well-accepted procedures as experimental and thus never coverable, has acted on grounds applicable to all plan members who sought or are seeking such treatment and in turn, determination of a court regarding the legality of such a policy applies generally to the class.

As the Supreme Court has stated, "[t]he key to the (b)(2) class is the 'indivisible nature of the injunctive or declaratory remedy warranted — the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them.'"¹⁶⁴ Under this principle, if the policy is deemed unreasonable, injunctive relief that prevents them from applying such policy applies generally for the entire class of effected individuals. A Rule 23(b)(2) class grants members of an insurance plan the opportunity to collectively challenge insurers on the limited question of if a policy is reasonable. This allows individuals to create a stronger driving force based in unity, while still preserving the right of insurers to make individual assessments. Preventing an across-the-board policy opposing a treatment does not strip from insurers the right to review claims for treatment and determine if it fits within the plan language

¹⁶² FED. R. CIV. P. 23(b)(2).

¹⁶³ 2 ALBA CONTE & HERBERT B. NEWBERG, NEWBERG ON CLASS ACTIONS § 4:11 (4th ed. 2002).

¹⁶⁴ Wal-Mart Stores, Inc. v. Dukes, 131 S. Ct. 2541, 2557 (2011).

and is appropriate. Rather, review of a company-wide policy and its application prevents an insurer from establishing a policy that unfairly hurts and impedes the rights of consumers without consideration for the actual claim, plan language, or any other information relied on by insurers typically when reviewing a benefit claim.

While our current jurisprudence lays a clear and straightforward path towards injunctive relief, an area worthy of further exploration is the potential for success as a (b)(3) class seeking reimbursement. Although some lower courts have begun to explore reasoning that would support a (b)(3) class against insurers for claim denials, the success is limited and Supreme Court jurisprudence signals a pushback. Courts that have supported (b)(3) classes against insurers first find predominance in the form of the overriding legal issue of the class, rather than focusing on the individualized damages that would arise. For example, in *Bauer v. Kraft Foods Global, Inc.*, a local union and retired employees sued an employer under ERISA and their collective bargaining agreement because of the elimination of a health plan and increased cost of prescription drugs.¹⁶⁵ The district court reasoned that the “overriding legal issue” presented was whether the employer’s plan amendments violated the class members rights generally.¹⁶⁶ Since that question predominated and the only subsequent issue would be damages, certification under (b)(3) was applicable.¹⁶⁷ Applied to autism class actions, the overriding legal issue, whether the insurer’s denial of coverage for autism treatment is reasonable, would predominate over any other issue presented.

Although such an argument could be made, in order to certify an autism class action as a (b)(3) class, courts must be willing to view individualized damages as secondary to the overriding legal issue, thus maintaining predominance. As such, in order for a (b)(3) class to prevail a court must accept the argument that while the amount of individual damages may vary, the formula used to calculate them is consistent across the board. The Fourth Circuit accepted a similar proposition in *Ward v. Dixie National Life Insurance Co.*, a class action against insurers claiming that supplemental cancer insurance policies require payment to the insured at the rate of the actual charged treatment, rather than the lesser amount medical providers received from insurers.¹⁶⁸ This reasoning is easily transferable to autism class actions in that the requested monetary damages

¹⁶⁵ *Bauer v. Kraft Foods Global, Inc.*, 277 F.R.D. 558, 558 (W.D. Wis. 2012).

¹⁶⁶ *Id.* at 563.

¹⁶⁷ *Id.* at 563-564.

¹⁶⁸ *Ward v. Dixie Nat’l Life Ins. Co.*, 595 F.3d 164, 180 (4th Cir. 2010).

of the class are simply the cost of treatment not covered by the insurer, a simple and standard equation for all members of the class.

Despite the fact that the argument may be made in favor of a (b)(3) class action against insurers, a recent decision of the Supreme Court in *Comcast Corp. v. Behrend* raises concerns about the acceptance of such a “one formula for all” argument.¹⁶⁹ While the Plaintiffs in *Comcast* developed a formula for damages that incorporated four theories of antitrust impact, it failed to distinguish which specific theory applied.¹⁷⁰ Thus, one segment of the class could have damages based on the theory that Comcast overcharged because of the elimination of provider competition, while another segment is entitled to damages because of Comcast’s increased bargaining power.¹⁷¹ Justice Scalia made clear that, while a uniform damages equation may exist, one must first ensure that there is a “translation of the legal theory of the harmful event into an analysis of the economic impact of that event.”¹⁷² Under this principle, concerns about a universal formula for an autism class action may be raised. Although an insurer has a company-wide policy of denial for ABA therapy, perhaps even absent such a policy, a claim may still be denied. For instance, an insured might receive ABA therapy from a non-covered provider, thus subject to a different reimbursement rate, or conceivably, although the child is on the autism spectrum, ABA therapy is not the recommended treatment and thus not covered. Directly contrasted to the holding in *Comcast*, while uniform damages may apply, the harmful event of a company-wide policy does not directly translate to the economic impact; other factors may also contribute. Under the *Comcast* precedent and the shaky ground on which a (b)(3) class for denied insurance claims rests, this author would hesitate without a clearer showing by the courts to pursue such a class.

Further, there is concern and caution for a class action seeking monetary damages for a denial of benefits inherent in the insurance world. Insurance companies, as part of their business model for assuming risk, maintain the ability to review claims individually and determine in each case what is allowed. If a class action were allowed to seek monetary damages, the individual question of how much each plan member was entitled to would be answered universally, removing from the insurer the business right to review the claim. Normally, for an insurer, monetary

¹⁶⁹ *Comcast Corp. v. Behrend*, 133 S. Ct. 1426 (2013).

¹⁷⁰ *Id.* at 1430-31.

¹⁷¹ *Id.* at 1433-34.

¹⁷² *Id.* at 1435.

relief would involve a close examination by the insurer of the claim, the policy, the diagnosis, and the treatment plan. A class action would remove such independent review applied by insurers in all other claims. Therefore, in allowing the insured to challenge insurance companies as a class action, they should be limited in injunctive or declaratory relief, which addresses these concerns and controls the reach of the class action.

Second, in allowing a class action for injunctive relief, the court must limit the class definition to capture only individuals who are currently part of the plan regardless of if they have filed a claim or not. As discussed above, class actions for autism treatment should be limited to seeking injunctive relief, which sets the foundation for limiting class members to those currently enrolled in the plan. The claims at issue in these class actions are similar to issues arising in employment class actions when a class includes present and former employees. Under such circumstances, courts have reasoned that only current, and not former, employees would be affected, meaning the class would no longer fall within the perimeters of Rule 23(b)(2).¹⁷³ Past members of an insurance plan cannot share the same interest as current members in seeking injunctive relief, for past members would receive no benefit from a ruling that prevents insurers from issuing uniform rejections of ABA therapy.¹⁷⁴ Therefore, if only injunctive relief class actions are to be certified in regards to autism treatment claims, class members must be limited to those that would receive actual relief via an injunction, not open to all those who have been wronged in the past.

Finally, contrary to the rationale applied by *Churchill* to reject a broad class encompassing those who submitted claims and those who did not, the restriction to only injunctive relief claims requires no such separation. As a result of being restricted to 23(b)(2) classes, any class action brought before a court would be considered a mandatory class and therefore, regardless of a claim's status, all members of the plan and the

¹⁷³ 2 WILLIAM B. RUBENSTEIN, NEWBERG ON CLASS ACTIONS § 4:32 (5th ed. 2011); see *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2559-60 (2011); *Chen-Oster v. Goldman, Sachs & Co.*, 877 F. Supp. 2d 113, 121 (S.D.N.Y. 2012) (interpreting the Supreme Court's decision in *Dukes* to reason that former employees "have no material stake in whether their former employer is or is not enjoined . . . since they are no longer there.").

¹⁷⁴ See *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *4 (E.D. Penn. Aug. 12, 2011), where the Court notes why it cannot certify a class encompassing current and past plan members that is represented solely by a past plan participant. The former plan participant has an "incentive . . . to seek only the highest amount of monetary relief possible, not injunctive relief from which he could not benefit." *Id.* at *5.

class would receive the same relief. A ruling that prevents an insurer from applying a company-wide policy prohibiting coverage of ABA therapy because of experimental status would have the same benefit for all insured. Whether they filed a claim or not, the insurer would no longer be allowed to enforce the policy that prevented coverage and all individuals would be free to submit claims as they see fit.

Churchill's final paragraphs sufficiently outline why a broad class approach is unpersuasive, stating a presumption that *all* insured failed to submit a claim based on the insurance providers company policy to deny ABA coverage is impractical.¹⁷⁵ As the *Churchill* Court found, there are a “multitude of reasons why a beneficiary might fail to file a claim,” and depending on the situation, the insurer’s policy designating ABA therapy experimental would not be the actual cause of harm to the individual.¹⁷⁶ By limiting remedies in these class actions a court removes the need to determine the motivations of each class member. While there still remains a “multitude of reasons why a beneficiary might fail to file a claim,” such considerations no longer warrant examination by the courts to determine appropriate remedies.¹⁷⁷

Although judicial precedent has done little to pave a clear path for autism treatment class actions against insurers, future class certification and class action claims can be better analyzed. Consideration can be given to the three recent holdings of *Graddy*, *Potter*, and *Churchill*, but the approach that will best serve individuals and insurers finds its base in no single case. Individuals should be empowered to unify in challenges against their insurers when denied autism treatment coverage but within limits that respect and preserve insurers’ autonomy to maintain individualized review.

VIII. CONCLUSION

With state laws unable to reach self-insured plans and federal laws failing to address the gap of required coverage that results from ERISA preemption provisions, it is unlikely we will see a decrease in courtroom battles for treatment coverage. While individual claims will undoubtedly continue, the recent showing of three class actions focused on the same

¹⁷⁵ *Id.* at *7-8.

¹⁷⁶ *Id.* at *8.

¹⁷⁷ *Id.* The Court also states that the Third Circuit precedent requiring ERISA plaintiffs to file a claim for benefits before a request for judicial interference would prohibit them from following such a presumption. *Id.*

question, presents the court system with a new challenge: establishing an understanding of the extent to which class actions can be brought to challenge insurers' practices. With a complicated web of state laws, federal regulations, and unclear judicial precedent, the court system must seriously examine its approach to complicated class action lawsuits. In doing so, one must look no further than the most recent class certification rulings, which, although contradictory, can serve as a patchwork for future court decisions.