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One Word Can Make All the Difference: An Examination of the Third Circuit's Handling of Health Care Insurance Policy Exclusion Clauses for Pre-Existing Conditions

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ONE WORD CAN MAKE ALL THE DIFFERENCE: AN EXAMINATION OF THE THIRD CIRCUIT’S HANDLING OF HEALTH CARE INSURANCE POLICY EXCLUSION CLAUSES FOR PRE-EXISTING CONDITIONS

I. INTRODUCTION

In recent years, there has been an increase in concern over adequate health care.\(^1\) Insurance companies and consumers alike have become increasingly aware of the rise in the cost of health care.\(^2\) Insurance companies have taken great pains in writing their health care policies, for companies do not want to incur any more expense than is necessary.\(^3\) A particularly problematic situation for insurance companies is how to deal with the pre-existing condition. Most health care insurance policies exclude pre-existing conditions from coverage.\(^4\) Exactly what constitutes a pre-existing condition can be difficult to define.\(^5\) The United States Court of Appeals for the Third Circuit recently joined a growing number of circuit courts in holding that:

[A] health insurance policy, which expressly excludes coverage for a “sickness . . . for which medical advice or treatment was recommended by a physician” within the five years preceding the date of coverage, will not exclude a claim where the insured ex-

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2. See John C. Williams, Annotation, Construction and Application of Provision in Health or Hospitalization Policy Excluding or Postponing Coverage of Illness for Which Medical Care or Treatment Was Received Within Stated Time Preceding or Following Issuance of Policy, 95 A.L.R.3d 1290, 1291 (1979) (noting impact of rising health care costs on both insurance consumer and insurance companies).

3. See id. at 1292 (explaining that insurance companies limit liability with these exclusion clauses in force).

4. See Franco, supra note 1, at 886 (detailing why insurance companies draft exclusion clauses). In general, “[a] pre-existing condition clause is drafted to prohibit, restrict, or postpone coverage for an illness which either predated the insurance contract or developed during a prescribed waiting period after the insurance contract has been executed.” Id.

5. See id. (explaining different ways provision for pre-existing condition can be drafted). There are three different kinds of provisions:

(1) a restriction that remains until a designated period after the date of the insurance policy; (2) a restriction that remains until the insured has not received medical treatment for the condition during a designated period; or (3) a limitation of the amount of coverage provided for insured conditions associated with a pre-existing condition.

Id. at 886-87.
experiences symptoms before, but is not correctly diagnosed until after, the policy goes into effect.  

This Casebrief explains the Third Circuit's treatment of health insurance policy exclusion clauses relating to pre-existing conditions. Part II explains the nature of policy exclusion clauses—provisions of health care policies excluding coverage of an illness for which medical care was received prior to the issuance of the policy. Part III analyzes the Third Circuit's most recent pronouncement on the handling of exclusions for pre-existing conditions. Part IV focuses on other federal courts' treatment of similar or even identical policy language. Part V touches on policy issues and other implications in light of the Third Circuit's ruling in Lawson v. Fortis Insurance Co.  

II. THE MECHANICS OF THE PRE-EXISTING CONDITION

A. Definition of a Pre-existing Condition

What exactly constitutes a pre-existing condition can be difficult to articulate. The National Association of Insurance Commissioners (NAIC) defines a pre-existing condition as:

The existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care, or treatment or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 5-year period preceding the effective date of coverage of the insured person.

6. KMZ Rosenman, Pre-Existing Condition Exclusion Does Not Apply to Misdiagnosed Condition, Litig. Rep. 6 (Dec. 2002), at http://www.kmzr.com/files/tbl_s23Publications/FileUpload117/1875/Litigation%20Reporter%20-%20December%202002.pdf (quoting Lawson v. Fortis Ins. Co., 301 F.3d 159, 162 (3d Cir. 2002) and discussing holding); see Lawson v. Fortis Ins. Co., 301 F.3d 159, 162 (3d Cir. 2002) (reasoning that physician cannot provide treatment "for" condition without knowing what condition is). The court differentiated between "a suspected condition without a confirmatory diagnosis" and "a misdiagnosis or an unsuspected condition manifesting non-specific symptoms." Id. at 166. The court determined that this case resembles "a misdiagnosis or an unsuspected condition manifesting non-specific symptoms." Id. (noting differences in kinds of conditions).  

7. For a further discussion of the mechanics of pre-existing exclusion clauses, see infra notes 11-26 and accompanying text.  

8. For an analysis of the Third Circuit's approach to pre-existing condition policy language, see infra notes 27-78 and accompanying text.  

9. For a discussion of the other federal courts' treatment of pre-existing condition clauses, see infra notes 79-128 and accompanying text.  

10. For a discussion of the policy implications of the Lawson holding for insurance consumers and insurance companies, see infra notes 129-53 and accompanying text.  

11. Franco, supra note 1, at 886 (citing model definition); see 31 Pa. Code § 88.52 (2003) (providing similar definition for pre-existing condition). The Pennsylvania regulations define pre-existing condition as "[a] condition for which medical advice or treatment was recommended by a physician or received by a
There is also a temporal notion to the idea of a pre-existing condition. Courts have introduced various interpretations of when an illness actually begins. Courts have defined manifestation of an illness in three different ways: "(1) at the time of its medical inception; (2) when the condition impaired the normal function of the body; or (3) when a person had actual knowledge of the condition's presence." In the insurance context, a condition exists when an illness manifests itself; however, condition is not always the same as diagnosis. In some policies, a diagnosis is not even a prerequisite for a finding of a pre-existing condition.

B. Nature of the Policy Exclusion

Insurance companies use a policy exclusion provision to eliminate coverage for pre-existing conditions. Insurance companies put exclusion clauses in their policies for a very important reason—to save their other policyholders money. An insurance company operates by having its policyholders pay premiums, and the insurance company uses that money to pay for any losses incurred on the part of its insured individuals. If an insurance company covered already-existing conditions, the physician within a 5-year period preceding the effective date of the coverage of the insured person. See Franco, supra note 1, at 887 (commenting on conflict among courts as to what is considered manifestation).

12. See Franco, supra note 1, at 887 (commenting on conflict among courts as to what is considered manifestation).

13. Id. (quoting Barbara L. Pedersen, Comment, HIV/AIDS and the Pre-existing Health Condition Standard: Teaching an Old Dog New Tricks, 24 J. MARSHALL L. REV. 653, 666 (1990)). Courts differ in their explanations of the temporal beginning of an illness. See id. ("Courts, however, conflict when deciding precisely what constitutes the manifestation of a disease.").


15. See id. (explaining that diagnosis is not dispositive of pre-existing condition). Generally, "unless the policy specifies otherwise, there is no requirement that a diagnosis of a pre-existing condition be made during the specified pre-existing condition period, or that a diagnosis be absolutely definitive, for a pre-existing condition exclusion to apply." Id.; see Cury v. Colonial Life Ins. Co. of Am., 737 F. Supp. 847, 849 (E.D. Pa. 1990) (explaining definition of pre-existing condition).

16. See Kathryn A. Sampson, The Mouse in the Annotated Bibliography: An Insurance Law Primer, 2000 ARK. L. NOTES 85, 92 (summarizing Franco, supra note 1). The reviewer here acknowledges that pre-existing condition exclusions are included in policies "to prevent insurance coverage for illness which existed before the insurer and the insured executed the insurance contract and for illnesses which developed during a waiting period after execution of the insurance contract." Id.

17. See Williams, supra note 2, at 1292 (explaining reason for limitation). Aware of the amount of money that could be spent on already presenting illnesses, insurance companies try to limit their liability with the inclusion of these clauses. See id. (explaining how insuring people already risk-averse will overwhelmingly increase insurance premiums across board).

18. See Franco, supra note 1, at 885-86 (describing how insurance companies function by "pooling" policyholders' premiums).
company would incur significant costs by attracting people with illnesses looking to buy policies with premiums that cost less than the treatment. Therefore, the insurance company would have to pass these additional costs on to its other policyholders, resulting in higher premiums for all those it insures.

Exclusion clauses can be crafted in several different ways. One kind of clause provides for the exclusion of an illness "for which medical care or treatment was received within a stated period of policy coverage," that is, a person requires medical coverage for a condition within the probationary period of the policy. Another kind of clause excludes coverage for an illness that originates before the policy is issued. A final type of exclusion clause is one that precludes coverage for an illness or condition for which medical care or treatment was received before the issuance of the policy. The difference between the last two clauses is that the former excludes illnesses that are known prior to policy issuance while the latter focuses on treatment received for an unknown or misdiagnosed condition.


20. See Franco, supra note 1, at 900-01 (explaining economic need for policy exclusion). Having exclusions "prevent[s] the public from having to pay the cost of applicants who, knowing that they were already suffering from a disease or health condition, purchase coverage hoping to get the insurer to pay for the pre-existing condition." Id. (quoting Ithamar D. Weed, Pre-Existing Disease as a Defense in Accident and Sickness Policies, 15 ASS'N LIFE INS. COUNS. 419, 419 (1960-1961)).

21. See Franco, supra note 1, at 901 (noting that clauses protect public from high insurance costs).

22. Williams, supra note 2, at 1292 (explaining differing constructions of exclusionary clauses). Williams posits that a clause excluding an illness that was treated prior to the effective date of the policy is a more conservative approach for insurance companies than policies that "exclud[e] or postpon[e] coverage of illnesses that originated prior to issuance of the policy or within a stated time." Id. As to the former, Williams explains, "the insurer need not prove that the illness had originated prior to the issuance of the policy or within a stated time, but merely that the insured had received medical care or treatment for the illness." Id. Proving the administration of treatment is far easier than trying to prove that an illness actually existed. See id. (describing requisite proof of "pre-existing" condition).

23. See id. (providing examples of construction); see also Davolt v. Executive Comm. of O'Reilly Auto., 206 F.3d 806, 809-10 (8th Cir. 2000) ("The plan provides that a preexisting condition includes one that is diagnosed or treated within the six month period. The plan does not create an exception for on-going treatment or require that the treatment be an additional form of treatment."); Davey v. N.Y. Life Ins. Co., 528 So.2d 1228, 1228 (Fla. App. 1988) (noting received treatment within six months of time became insured under group policy), review denied by 537 So.2d 568 (Fla. 1988); Zeh v. Nat'l Hosp. Ass'n 377 P.2d 852, 858 (Or. 1963) (holding that treatment received within first six months of effective date constituted pre-existing condition).

24. See Williams, supra note 2, at 1292 (describing different kinds of exclusion provision constructions).

25. See id. (explaining exclusion clause structure).
dition. This latter kind of exclusionary clause will be the focus of this Casebrief.

III. ANALYSIS OF LAWSON v. FORTIS INSURANCE CO.: WHAT IS TREATMENT “FOR” AN ILLNESS?

A. Facts of Lawson v. Fortis Insurance Co.

On October 7, 1998, Joseph Lawson purchased a health insurance policy for himself and his minor child, Elena, to become effective on October 9, 1998. On October 7, Elena’s mother took Elena to the emergency room because Elena was suffering from a hacking cough, a fever, an elevated pulse rate and a swollen right eye. Doctors diagnosed her with an upper respiratory tract infection and prescribed antibiotics. Elena’s symptoms persisted, and on October 14, Elena’s grandmother took her to a pediatrician who ordered more tests and subsequently diagnosed Elena with leukemia. As a result of the diagnosis, Elena underwent chemotherapy that resulted in the remission of the leukemia. Lawson then submitted a claim for benefits to cover the cost of the chemotherapy treatments; however, his insurance carrier, Fortis, denied his claim. Fortis contended that the leukemia was a pre-existing condition within the meaning of the policy. Fortis considered the leukemia a pre-existing condition because the leukemia began and produced the symptoms for which Elena was treated on October 7, 1998—two days before the effective

26. See id. (discussing difference between different kinds of exclusionary provisions for pre-existing conditions).
28. See id. (describing Elena’s presenting symptoms). All of Elena’s symptoms were non-specific and were associated with many different illnesses. See id. (noting further testing needed because symptoms persisted).
29. See id. (discussing diagnosis). In addition to the antibiotics, the doctor also prescribed an anti-allergy medication for Elena. See id. (stating further advised treatment).
30. See id. (noting series of events that led to diagnosis of leukemia). When Elena was first seen in the emergency room, the doctor advised Elena’s mother to take Elena for a follow-up visit to their family physician or back to the emergency room if Elena’s symptoms persisted. See id. (discussing doctor’s prognosis and advice). The Lawsons’ family physician saw Elena on October 13 because her symptoms did not improve. See id. (explaining reason for further visits to doctor). Nonetheless, on October 14, Elena’s grandmother took Elena to a pediatrician who ordered more tests and ultimately diagnosed Elena with leukemia. See id. (stating facts).
31. See id. (discussing subsequent treatment of Elena’s leukemia).
32. See id. (stating that Lawson filed claim for payment of medical bills under Fortis policy).
33. See id. (explaining reason why insurance company denied claim). Fortis’s Medical Director “investigated Elena’s course of treatment and concluded that ‘[w]hile the evaluation [at the Palmerton Emergency Department] failed to diagnose leukemia, advice and treatment for those symptoms were received from a physician.’ This meets the policy definition of a pre-existing condition.” Id.
date of Lawson's policy. 34 Contrary to Fortis's pre-existing-condition conclusion, however, the correct diagnosis of leukemia did not occur until a few days after the insurance policy became effective. 35

B. Procedural History

The Lawsons sued the insurance company for breach of contract and bad faith under the relevant Pennsylvania statute. 36 The Lawsons won a $713,901.12 judgment at the trial court level. 37 The plaintiffs, however, were not successful in their claim of bad faith against the insurance company because they did not meet the necessary burden of proof that the insurance company acted unreasonably. 38 The insurance company ap-

34. See id. (explaining that treatment for condition occurred before effective date). Fortis's Medical Director went on to "determine[,] that Elena had a two-and-a-half week history of fever preceding her diagnosis of leukemia, and he therefore concluded that the symptoms for which she was evaluated and treated on October 7, 1998, were those of leukemia." Id.

35. See id. (contending that Elena had leukemia symptoms all along despite physician's incorrect diagnosis). After the initial denial by the insurance company, Lawson appealed the decision to Fortis's Appeal Review Committee, "which concluded that the definition of a pre-existing condition does not require a correct diagnosis of the condition at the time that it is treated." Id.


37. See Lawson, 301 F.3d at 162 (citing amount district court awarded to plaintiff on breach of contract claim); see also Lawson, 146 F. Supp. 2d at 747 (granting summary judgment on breach of contract claim). The district court then ordered the parties to stipulate to the amount of the medical bills, and on July 27, 2001, entered a judgment for the plaintiffs in the amount of $713,901.12 plus prejudgment interest. See Lawson, 301 F.3d at 162 (discussing procedural history of case).

38. See Lawson, 146 F. Supp. 2d at 746 (holding that plaintiffs did not meet burden of proof). Under 42 PA. CONS. STAT. ANN. § 8371 (West 1998), "in order to recover on a bad faith claim [against an insurer], a plaintiff must show both: (1) that the insurer lacked a reasonable basis for denying benefits; and (2) that the insurer knew or recklessly disregarded its lack of reasonable basis." Lawson, 146 F. Supp. 2d at 746 (citing Klinger v. State Farm Mut. Auto. Ins. Co., 115 F.3d 230, 233 (3d Cir. 1997)). The court found that Fortis's interpretation of the pre-existing clause was reasonable. The court noted that "[w]hile the court rejects the defendant's position [that] the clause can only be read to support its interpretation, other courts have agreed with the defendant that similar clauses are unambiguous." Id. Because the clause is susceptible to many interpretations, the insurance company did not act unreasonably in denying coverage for Elena's condition. See id. at 746-47. (explaining that multiple interpretations of clause rule out finding that Fortis acted unreasonably or recklessly). The court explained that "[m]ere negligence on the part of the insurer is insufficient to sustain a bad faith claim." Id. at 746 (citing Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 751 (3d Cir. 1994)). Plaintiffs' evidence in regard to the bad faith claim did not rise to the level of clear and convincing; therefore, they did not sustain their burden of proof. See id. ("Although the court finds that Fortis erred in denying coverage, Fortis did not act in bad faith in doing so."). On appeal, the court upheld the district court's grant of summary judgment for Fortis on the bad faith claim. See Lawson, 301 F.3d at 161 (discussing holding).
pealed the part of the decision as to the judgment award to the Court of Appeals for the Third Circuit.39

C. Legal Analysis in Lawson

On appeal, the Third Circuit in Lawson affirmed the district court's decision and held that treatment received for an unsuspected or misdiagnosed illness did not constitute a pre-existing condition under the language of the policy.40 The court stated that "the central issue . . . is whether receiving treatment for the symptoms of an unsuspected or misdiagnosed condition prior to the effective date of coverage makes the condition a pre-existing one under the terms of the insurance policy."41 Whether a policyholder could receive treatment for a condition unknown at the time of the alleged treatment concerned the court.42 The Third Circuit began its analysis by looking at the language of the exclusion clause in the Lawsons' insurance policy.43 The district court felt that the language in the clause was ambiguous.44 The court of appeals agreed, explaining that two differing but reasonable interpretations could have been attributed to the policy language.45 The insurance company contended that "the pre-existing condition language . . . does not require accurate diagnosis of the condition, but merely receipt of treatment or advice for the symptoms of it."46 The Lawsons argued that Elena's leukemia was not a pre-existing condition because "one cannot receive treatment 'for' a condition without knowledge of what the condition is."47

39. See Lawson, 301 F.3d at 160 (discussing reason for appeal). Fortis appealed the summary judgment ruling by the district court in favor of the plaintiffs for their claim of benefits. See id. (explaining merits of Fortis's claim on appeal).

40. See id. at 161 (affirming judgment of district court).

41. Id. at 162 (trying to determine what constitutes condition). According to the district court, the insurance policy between the Lawsons and Fortis "was ambiguous as to whether the pre-existing condition exclusion required a diagnosis of the condition." Id.

42. See id. (clarifying issue as "whether it is possible to receive treatment 'for' a condition without knowing what the condition is").

43. See id. (focusing analysis on what constitutes treatment "for" condition).

44. See id. ("The District Court [sic] reasoned that the contract was ambiguous . . . ").

45. See id. at 160 (agreeing that "[p]laintiff's reading of the pre-existing condition language is reasonable").

46. Id. (citing Fortis's argument). Fortis argued that if a person merely receives advice or treatment for symptoms of a later diagnosed condition, the symptoms constitute a pre-existing condition. See id. (breaking down Fortis's contention).

47. Id. (citing Lawsons' argument). The Lawsons argued further that treatment of non-specific symptoms is not enough to rise to the level of a pre-existing condition. See id. at 165 ("Elena received treatment 'for' what were initially diagnosed as symptoms of a respiratory tract infection. Therefore, the treatment she received was not 'for' leukemia, but 'for' a respiratory tract infection.").
court construed the ambiguity in the policy against the insurance company. 48

The ambiguity in the clause turned on the word "for," and, more specifically, the clause did not clarify what constituted "treatment for a condition" under the statute. 49 The court had to determine whether it was possible to receive treatment for a condition without being aware of its existence. 50 The court then set out to determine how other federal and state courts have interpreted similar pre-existing condition language in insurance policies. 51

In its resulting opinion, the Third Circuit relied heavily on the reasoning of the First Circuit in Hughes v. Boston Mutual Life Insurance Co. 52 In Hughes, a man was treated for non-specific symptoms of multiple sclerosis prior to the effective date of his policy, but he was not diagnosed with the illness until after his coverage began. 53 The First Circuit, like the Third, found both the insurance company and the insured's interpretations of the pre-existing clause plausible and, therefore, construed the ambiguity in favor of the insured. 54 Again, central to the ambiguity was the unclear language as to what was considered treatment "for" a condition. 55

48. See id. at 160 (stating holding). The court followed its reasoning from previous cases, stating that "ambiguous terms should be strictly construed against the insurer." Id. at 162 (citing Med. Protective Co. v. Watkins, 198 F.3d 100, 105 (3d Cir. 1999)). The court stated further: "A contract is ambiguous if it: (1) is reasonably susceptible to different constructions, (2) is obscure in meaning through indefiniteness of expression, or (3) has a double meaning." Id. at 163 (quoting Cury v. Colonial Life Ins. Co. of Am., 737 F. Supp. 847, 853 (E.D. Pa. 1990)).

49. See id. at 165 (observing that key word in exclusion was word "for"). The court thought that "Elena received treatment 'for' what were initially diagnosed as symptoms of a respiratory tract infection." Id.

50. See id. at 162 (deciding whether treatment "for" initially diagnosed condition can be construed as being treated for ultimately diagnosed actual condition).

51. See id. at 163-64 (citing cases on which court relied). The court looked at cases in the First, Fifth, Seventh and Eighth Circuits, and also at the Western District of Wisconsin, the New York Supreme Court's Appellate Division, the Texas Court of Appeals, the Eastern District of Pennsylvania and the Middle District of Pennsylvania. See id. (delineating various federal and state courts addressing similar issue).

52. 26 F.3d 264 (1st Cir. 1994) (holding that both insurer's and insured's interpretations of pre-existing condition clause were reasonable). The court in Hughes concluded that the clause was ambiguous. See id. at 270 (finding pre-existing condition exclusion "susceptible to 'reasonable but differing interpretations'") (quoting Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 586 (1st Cir. 1993)).

53. See Lawson, 301 F.3d at 163 (noting facts of Hughes). Hughes and Lawson have very similar fact patterns insofar as both insureds presented with non-specific symptoms before the effective date of the policy and were subsequently diagnosed with a condition that was then excluded from coverage. See id. (discussing similarity of fact patterns).

54. See id. (explaining holding in Hughes).

55. See id. (discussing problem with construction of clause in Hughes). The way that the clause was structured led to the ambiguity. See id. (indicating ambiguity...
The court noted that the Fifth Circuit, the Seventh Circuit, the Western District of New York, the Wisconsin Court of Appeals and the New York Supreme Court's Appellate Division have also followed the logic used by the First Circuit. These courts have posited that "it is not logical to permit non-specific symptoms, which could be caused by a number of different sicknesses, to be used later as a retroactive trigger for exclusion as a pre-existing condition." These courts require that either the insured or the physician be aware that the insured was receiving treatment for the condition, not a cluster of non-symptoms later determined to be the condition in question.

Other circuits, like the Eighth and the Seventh Circuits, believe that the language in the pre-existing clause does not require a diagnosis of the condition. The rationale behind these decisions is that "the pre-existing condition language is clear and unambiguous that treatment for a condition does not require accurate diagnosis of the condition." Here, the focus is on when the condition actually began in the body, regardless of whether a reasonably accurate diagnosis of the condition could be made. This rationale is based on the biological inception of the illness rather than reasonable diagnostic criteria based on ostensible symptoms.

In the last part of its opinion, the court in Lawson focused on the word "for" in the pre-existing condition clause. Prior to the effective date of the policy, the court believed that Elena received treatment "for" a respiratory infection not "for" leukemia. They believed that the word was due to "lack of clarity regarding what constitutes treatment 'for' a condition".

See id. at 163-65 (citing other courts that followed same logic as First Circuit).

Id. at 164 (stating proposition that if clauses are susceptible to reasonable but different interpretations then clauses are ambiguous).

See id. (discussing true meaning of treatment "for" condition).

See id. at 165 (noting circuits not in concert with holding).

Id. at 164 (explaining that exact diagnosis is not necessary). A cluster of symptoms that could plausibly be attributed to the ultimate diagnosis is enough to be considered a pre-existing condition in these jurisdictions. See id. (reviewing cases holding that discovery and treatment of symptoms trigger pre-existing condition even without definitive diagnosis).


For a discussion on the different definitions of manifestation of an illness, see supra notes 12-14 and accompanying text.

See Lawson, 301 F.3d at 165 (noting "the key word in the pre-existing condition exclusion for our [the court's] purposes is 'for'").

See id. (differentiating between two conditions and their respective symptomologies).
"for" had an "implicit intent requirement." On October 7, before the effective date on the policy, no one—Elena, her parents or her physician—knew that Elena was suffering from leukemia; therefore, no one intended or thought that Elena received treatment "for" leukemia on that day.

Finally, the court discussed two cases decided at the district court level in the Third Circuit that the insurance company attempted to use to bolster its argument. In Cury v. Colonial Life Insurance Co. of America, the District Court for the Eastern District of Pennsylvania held that the insured's multiple sclerosis was not covered because the insured was treated for the symptoms of undiagnosed multiple sclerosis prior to the effective date of the insurance policy. The court also stated that "[t]here is no requirement that a diagnosis, definite or otherwise, of the pre-existing condition must be made during the pre-existing condition period." Similarly, in McWilliams v. Capital Telecommunications Inc., the District Court for the Middle District of Pennsylvania explained that the policy language did not limit pre-existing conditions to those that were diagnosed before the effective date of the plan. In that case, the insured had received an ultrasound for a thyroid lump in the period before the policy became effective and was diagnosed with thyroid cancer shortly after coverage began.

65. See id. (setting out definition of "for"). The court turned to dictionaries for guidance. They found the word "for" defined as follows: Webster's Dictionary states that "for" is 'used as a function word to indicate purpose.' WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 481 (1986). Black's Law Dictionary similarly states that the word 'connotes the end with reference to which anything is, acts, serves, or is done. In consideration of which, in view of which, or with reference to which, anything is done or takes place.' BLACK'S LAW DICTIONARY 579-80 (5th ed. 1979).

66. See id. (stating that insurance company failed to meet intent). No one, including Elena's parents or physician, intended for her to get treatment for leukemia on October 7, 1998. See id. (interpreting word "for" as having implicit intent requirement and applying to facts of case).

67. See id. (distinguishing present decision from other similar holdings).


69. See id. at 849 (discussing holding).

70. Id. at 854 (examining language of clause). The court looked to the plain language of the clause and found that the clause "only requires that the claimant either (a) receive medical treatment or consultation; (b) have medical care or services; (c) have diagnostic tests, [sic] or (d) take prescribed drugs or medicines within 90 days prior to your effective date." Id.


72. See id. at 927 (stating proposition that doctor does not have to define illness)

73. See id. at 922 (discussing facts). Plaintiff had a history of lumps, which either were benign or had disappeared on their own. See id. (describing plaintiff's medical history). Plaintiff was not particularly concerned about this biopsy, for "she thought the lump in her thyroid was just another mass that was either benign or would go away on its own." Id.
The *Lawson* court distinguished its holding from the former two because in *Cury* and *McWilliams*, the insureds went to the physician for a suspected condition.\(^{74}\) It was quite possible that the physician suspected a certain condition, and the "pre-effective date treatment, advice or testing turned out to be 'for' the condition that was ultimately diagnosed."\(^{75}\) Also, the court was not persuaded by the analyses in *Cury* and *McWilliams* because those cases focused "primarily on the absence of a diagnosis requirement,"\(^{76}\) rather than examining the ambiguity in the language of the exclusion clause itself.\(^{77}\) In summary, the court stated:

[I]t is hard to see how a doctor can provide treatment "for" a condition without knowing what that condition is or that it even exists. Thus, in our view, the best reading of the contract language in this case is for coverage of Elena's leukemia treatment. At worst, the language is ambiguous and must therefore be read in favor of the insureds.\(^{78}\)

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74. See *Lawson v. Fortis Ins. Co.*, 301 F.3d 159, 165 (3d Cir. 2002) (noting factual distinctions among cases). In *Cury* and *McWilliams* there were symptoms that were more specific than the symptoms that Elena Lawson had. The court noted that "[i]n these cases, because the claimants suspected a particular condition when they saw their physicians, it might make sense to say that the claimants had received advice or treatment 'for' their respective conditions, although they had not been definitively diagnosed." *Id.*

75. *Id.* at 166 (analyzing differences). The patient already suspected the condition, thus the treatment or advice given was in furtherance of finding out the ultimate diagnosis of the malady. *See id.* (reporting that "pre-effective date treatment, advice, or testing" on these facts triggered pre-existing condition clause).

76. *Id.* (discussing analysis of *Cury* and *McWilliams*). The court in *Lawson* found the analyses in these cases unconvincing because each case focused on only one part of the broader analysis. *See id.* (stating preference for construing language of policy).

77. *See id.* (explaining that ambiguity in language was important element in analysis). The court thought that there was too much focus on the diagnosis requirement in *Cury* and *McWilliams* "without seriously considering whether the language concerning treatment 'for' a particular condition is ambiguous." *Id.* (quoting *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 270 n.5 (1st Cir. 1994)).

78. *Id.* at 165 (stating reasons for holding). In its best reading of the clause, the court felt that Elena was being treated "for" symptoms of a respiratory tract infection in the pre-coverage period, not leukemia; thus, she would be covered for the leukemia since it was diagnosed after the effective date. *See id.* (noting that possibility that "Elena's condition was actually leukemia" never entered Elena's parents' nor Dr. Parika's minds). In its worst reading of the clause, the ambiguity had to be construed against the insurers based on prior precedent. *See id.* at 167 (construing insurance policy strictly against Fortis). For a discussion of the precedent for construing ambiguity in insurance policies, see *supra* note 48.
IV. FEDERAL COURTS' VARIED INTERPRETATIONS OF PRE-EXISTING CONDITION EXCLUSIONS

A. When Does an Illness Begin?

Federal courts differ in how to construe when an illness manifests. Some circuits, like the First and the Fifth, “require some awareness on the part of the insured or the physician that the insured is receiving treatment for the condition itself.” The First Circuit has even gone a bit further and acknowledged the inherent ambiguity in some of these clauses. Other circuits, like the Eighth, however, do not require a diagnosis in order for a condition to exist. One circuit in particular, the Seventh, has handed down conflicting decisions, vacillating between the two constructs. These conflicting interpretations have led to various interpretations of pre-existing condition exclusion language. Each circuit will be looked at in turn.

B. The First Circuit's Approach—Looking at Ambiguity

In *Lawson*, the court centered its discussion on the analysis in *Hughes v. Boston Mutual Life Insurance Co.* In *Hughes*, the court determined “if terms contained in the exclusionary clause are found to be susceptible to more than one reasonable interpretation,” then the exclusion should be found to be ambiguous. The court's approach turned on the interpretation of “treatment ‘for’ a condition,” which the court felt had more than one plausible meaning. Hughes was denied coverage by his insurer for

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79. See *Lawson*, 301 F.3d at 163 (noting that federal courts have interpreted pre-existing language differently).
80. Id. at 164 (explaining how other circuits construe exclusion clauses).
81. For a discussion of the First Circuit’s treatment of pre-existing condition clauses, see infra notes 86-94 and accompanying text.
82. For a discussion on the differences in how the Eighth Circuit deals with pre-existing condition language in health care policies, see infra notes 108-16 and accompanying text.
83. For a discussion of the Seventh Circuit’s incongruent holdings, see infra notes 117-28 and accompanying text.
84. See *Lawson*, 301 F.3d at 163-64 (noting courts’ differing interpretations).
85. For a discussion of each of the circuits, see infra notes 86-128 and accompanying text.
86. For a discussion of the *Lawson* court’s reliance on *Hughes*, see supra notes 52-55 and accompanying text.
87. Franco, supra note 1, at 903 (summarizing holding in *Hughes*). The contra proferentem doctrine dictates that ambiguity is construed against the insurer. See id. (explaining doctrine of contra proferentem). The rationale of contra proferentem centers on what a reasonable policyholder would construe the policy to mean, rather than focusing on what the insurer intended the policy to mean. See id. at 903-04 (noting rationale of doctrine of contra proferentem). This doctrine protects “unsuspecting insureds.” Id. at 903.
being treated for symptoms later determined to be multiple sclerosis. 89 Hughes was not diagnosed with multiple sclerosis until after his insurance policy became effective. 90 The court did acknowledge that an "exclusion does not explicitly require diagnosis;" however, it was disturbing to the court that the clause did not define "what constitutes treatment 'for' a particular condition." 91 The insurance company argued that "treatment 'for' a condition refers to treatment of any symptom which in hindsight appears to be a manifestation of the condition." 92 Hughes argued that the correct interpretation of the clause was the holding in Ross v. Western Fidelity Insurance Co. that either the doctor or the insured must be aware that the insured is in fact receiving treatment for a condition. 93 The court felt that both of these interpretations could reasonably be attributed to the exclusionary clause. Thus, the clause was ambiguous and should be construed in favor of the insured. 94

C. The Fifth Circuit's Approach—Illness Has to Be Apparent

According to the Fifth Circuit in Ross v. Western Fidelity Insurance Co., 95 a sickness has manifested itself when it is "apparent, obvious, or plain." 96 In Ross, the court held that an infant girl's heart defect was not a pre-existing condition and therefore her subsequent heart operation was cov-

89. See id. at 266 (listing presenting symptoms). Hughes complained of "numbness in both lower extremities, loss of balance, and gastrointestinal problems." Id. Hughes's symptoms were "not amenable to any type of clinical diagnosis" before the effective date of his policy. Id. (referring to deposition testimony of several physicians).

90. See id. at 267 (citing date of diagnosis). A physician diagnosed Hughes with multiple sclerosis on March 10, 1988. See id. (specifying date Hughes was diagnosed). This diagnosis was made during the first six months of his probationary period. See id. (indicating probationary period ran from February 1, 1988 to July 1, 1988). Hughes's insurance company would not cover his condition because the company contended that he received treatment for multiple sclerosis "within the 6 months prior to the insured's effective date." Id. at 266.

91. Id. at 269 (holding lack of definition leaves open possibility of more than one interpretation).

92. Id. (citing insurance company's interpretation). The insurance company cited Cury v. Colonial Life Insurance Co. of America, 737 F. Supp. 847, 854-55 (E.D. Pa. 1990). In Cury, the court held that treatment for symptoms of undiagnosed multiple sclerosis before the effective date triggered pre-existing condition exclusion. See Cury, 737 F. Supp. at 854 (opining that there "is no requirement that a diagnosis . . . of the pre-existing condition must be made during the pre-existing condition period").

93. See Hughes, 26 F.3d at 269 (citing Fifth Circuit case). For a further discussion of Ross v. Western Fidelity Insurance Co., 872 F.2d 665 (5th Cir. 1989), see infra notes 95-107 and accompanying text.

94. See Hughes, 26 F.3d at 270 ("Because the exclusion is susceptible to 'reasonable but differing interpretations,' we [the court] find it to be ambiguous.") (quoting Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 586 (1st Cir. 1993)).

95. 872 F.2d 665 (5th Cir. 1989).

96. Id. at 669 (explaining court's definition of manifest).
erated by her parents' insurance policy. 97 The insurance company had two clauses for the definition of pre-existing conditions. 98 One related to when treatment for a condition is administered and the other related to when a sickness first manifests itself. 99 Reading the plain language of the policy, the court rejected both of the insurance company's arguments. 100 As to the meaning of the first clause, the child was diagnosed with pulmonary hypertension rather than the heart defect; thus, the treatment she received "could not have been for that condition." 101 The court reasoned that a doctor could not treat a particular condition that is not known. 102 Upon rehearing, the court did note, however, that while a "diagnosis is [not] always required in order for the underlying condition to be treated, . . . treatment for a specific condition cannot be received unless the specific condition is known." 103 The court also rejected the insurance company's contention that there were symptoms that may have been caused by a heart defect and, therefore, the sickness had manifested itself. 104 Similar to the facts in Hughes, the heart defect was not diagnosed until after the effective date of the policy. 105 The court understood the word "manifest" in its everyday meaning, that is, "apparent, obvious, or

97. See id. (explaining heart condition was not known at time previous to inception of coverage).
98. See id. at 668 (reading two clauses together to determine meaning).
99. See id. at 668-69 (defining two clauses). The court characterized the two clauses in the following way:

The first clause defines "pre-existing condition" in terms of symptoms that would cause an ordinarily prudent person to seek medical attention, while the second clause defines "pre-existing condition" as a condition that did cause the insured to obtain medical attention. Reading the clauses together, we [the court] conclude that the first clause applies to situations in which the insured had symptoms of a condition but failed to seek diagnosis, care or treatment, whereas the second clause applies to situations in which advice or treatment regarding the condition was actually obtained.

Id. (emphasis in original).

100. See id. at 669 (continuing analysis). The court believed that the definitional distinction between the two clauses was intentional, apparent and unambiguous. See id. (explaining reasoning of court).
101. Id. at 669 (emphasis in original) (explaining logic). The pulmonary hypertension was the only diagnosis at that particular time. See id. (detailing facts of case).
102. See id. (stating that underlying condition needs to be capable of being reasonably diagnosed).
103. Ross v. W. Fid. Ins. Co., 881 F.2d 142, 144 (5th Cir. 1989) (emphasis in original) (clarifying holding). Upon rehearing, the court further explained its holding. See id. (detailing implications of holding). Diagnosis is not always required to consider an underlying condition to be treated, but awareness is necessary. See id. (concluding that treatment "for a specific condition" requires knowledge of condition).
104. See Ross, 872 F.2d at 669 (noting that only pulmonary hypertension was present).
105. See id. ("The heart defect here did not manifest itself during the excluded time frame.").
only the symptoms were present; the condition of a heart defect was not.107

D. The Eighth Circuit’s Approach—Manifestation Does Not Equal Knowledge; Diagnosis Is Not Necessary

In interpreting exclusion clauses, the Eighth Circuit looks to the meaning of manifest; it construes manifest in the biological sense.108 Here, manifest is defined less by knowledge and more by the effect of the disease on the body, whether known or not.109 In Kirk v. Provident Life & Accident Insurance Co.,110 the court denied benefits to a man who developed a condition, bacterial endocarditis, before his policy became effective.111 The court subsequently determined that he developed the condition prior to the effective date, even though he was not diagnosed at that time.112 The court focused on the time when the illness actually began, not when a reasonable diagnosis could be made.113 The Eighth Circuit agreed with the district court and found that “although the endocarditis was not diagnosed until after the effective date of the policy, the infection began prior to the effective date.”114 Thus, the start of the infection, though latent, was considered the start of the illness.115 As

106. Id. (explaining that everyday meaning of manifest is applicable in analysis).

107. See id. (noting absence of condition). It did not matter to the court that the symptoms that were present could have been caused by the heart defect because at that time there was no such diagnosis. See id. (finding presence of symptoms irrelevant where heart defect was not diagnosed).

108. See Kirk v. Provident Life and Accident Ins. Co., 942 F.2d 504, 506 (8th Cir. 1991) (noting there were indications that infection was present). The court equates manifest with “became active.” Id.

109. See id. at 505 (explaining “relevant inquiry was when the illness began, not the point of diagnosis”). The dissent had a major disagreement with the majority on this point. See id. (addressing majority’s contentions). The dissenting judge thought the proper question was “when [did] sufficient symptoms exist to allow a reasonably accurate diagnosis of the case.” Id. (Bright, J., dissenting) (citing State Nat’l Life Ins. Co. v. Stamper, 312 S.W.2d 441, 442 (Ark. 1958)).

110. 942 F.2d 504 (8th Cir. 1991).

111. See id. at 506 (noting symptoms of bacterial endocarditis). Kirk had symptoms of intermittent fevers, night sweats, a skin lesion and aches and pains. See id. (discussing facts).

112. See id. (explaining that time period of onset could be determined). A specialist in infectious diseases testified at trial with a reasonable degree of medical certainty that Kirk had the condition for about three months prior to the surgery during the exclusionary period. See id. (discussing facts).

113. See id. (discussing concurrence among doctors about date of onset). The court noted that “[t]he doctors who examined Kirk were in agreement that the symptoms for which Kirk sought treatment in March 1988, [sic] stemmed from bacterial endocarditis; that is, the disease first manifested itself or became active in March.” Id.

114. Id. at 505 (citing district court analysis).

115. See id. at 506 (acknowledging that test did not show condition was present). During the exclusionary period, blood culture did not produce any bacterial growth. See id. (detailing test procedure).
such, regardless of whether a doctor or the insured has knowledge of an illness, the biological inception date of the condition controls. 116

E. The Seventh Circuit’s Approach—Diagnosis Is Not Necessary or Is It?

The Seventh Circuit has handed down conflicting decisions regarding treatment of pre-existing condition exclusion clauses. 117 In Bullwinkel v. New England Mutual Life Insurance Co., 118 the Seventh Circuit decided that a diagnosis was not necessary in order to exclude a condition from coverage. 119 Conversely, in Pitcher v. Principal Mutual Life Insurance Co., 120 the court held that some awareness on the part of the physician or the insured was necessary in order to exclude a condition from coverage. 121 While seemingly interpreting pre-existing exclusion clauses in different ways, the Seventh Circuit distinguishes between the two cases based on the kind of illness from which the plaintiff suffered. 122 In Bullwinkel, a woman had a lump in her breast checked before her new health insurance began. 123 The doctor did not believe it to be cancerous, but referred her to a surgeon as a precautionary measure. 124 She visited the surgeon two weeks after her insurance was effective, and the surgeon subsequently removed the lump, which turned out to be cancerous. 125 In Pitcher, a woman also had a lump in her breast, but the court deemed that she “did not receive a ‘treatment or service’ for breast cancer... because she was being monitored for the longstanding fibrocystic breast condition and not cancer dur-

116. See id. (explaining reasoning behind analysis). The court noted, “while there was no objective data to confirm a diagnosis of endocarditis until the echocardiogram was done, the flu-like symptoms, high white blood cell count, swelling, and fever, were all indications that the infection was present.” Id.


118. 18 F.3d 429 (7th Cir. 1994).

119. See id. (providing holding).

120. 93 F.3d 407 (7th Cir. 1996).

121. See id. at 412 (citing holding).

122. See id. at 415 (discussing prior precedent). Each plaintiff in these cases was presented as having a lump in her breast, but in Bullwinkel, the plaintiff “suffered from cancer and only cancer” and had “no history of a fibrocystic breast condition.” Id. (emphasis in original); see Lawson v. Fortis Ins. Co., 301 F.3d 159, 164 n.3 (3d Cir. 2002) (noting circuit split).

123. See Bullwinkel, 18 F.3d at 430 (discussing facts of case).

124. See id. at 430 (explaining procedures). Because the doctor sent Bullwinkel to the surgeon for a biopsy, the argument that the doctor treated her “for” cancer gained credence. See id. (noting purpose of surgery).

125. See id. (detailing events leading up to diagnosis). After the doctor removed the lump, Ms. Bullwinkel had additional cancer treatment consisting of surgery, radiation treatment and chemotherapy. See id. (noting further medical treatment).
ing the pre-coverage period."\(^{126}\) The difference, the court noted, was that Ms. Pitcher arranged pre-coverage treatment for cystic fibrosis and not breast cancer, as it later turned out to be.\(^{127}\) On the other hand, Ms. Bullwinkel made her appointment out of concern over a potentially cancerous lump, and, thus, her visit and treatment was related to cancer.\(^{128}\)

**V. IMPLICATIONS OF THE RULING**

**A. Best Interpretation of Pre-existing Condition Clauses**

As discussed, different federal and state courts have attempted to identify the best treatment of policy language dealing with pre-existing conditions.\(^{129}\) Manifestation of illness can be seen as a continuum with the biological inception of the illness at one end and actual knowledge of the illness at the other.\(^{130}\) In a case about whether coverage is due to an insured, an insurance company will argue for limiting coverage based on the biological inception date of an illness, thus manifestation “moves back further in time, excluding more conditions from coverage.”\(^{131}\) Conversely, the insured will argue that manifestation of the disease occurs when the insured has actual knowledge of the condition.\(^{132}\) Having actual knowledge of an illness will generally occur much later in the process than actual biological inception, and, thus, more medical conditions would be included in coverage.\(^{133}\) The Third Circuit, like the First, Fifth and, in

\(^{126}\) *Pitcher*, 93 F.3d at 412 (emphasis in original) (discussing reasoning for holding). The court did not feel that a mammogram constituted treatment, for “it is a purely diagnostic procedure.” *Id.*

\(^{127}\) *See id.* (differentiating between two conditions). The court reasoned, “a fibrocystic breast condition is unrelated to cancer, even though it manifests itself in the *same* area of the body as breast cancer and takes on the form of cysts, masses, and formations of fibrous tissue.” *Id.* (emphasis in original).

\(^{128}\) *See Bullwinkel*, 18 F.3d at 432 (noting that discovery of cancer in September meant Ms. Bullwinkel had cancer in July as well). The court also noted that the discovered lump was “not a trivial or inconclusive symptom.” *Id.* at 433 (citing *Kirk v. Provident Life and Accident Ins. Co.*, 942 F.2d 504, 506 (8th Cir. 1991)).

\(^{129}\) For a discussion of different federal and state courts' treatment of pre-existing condition exclusion clauses, see *supra* notes 79-128 and accompanying text.

\(^{130}\) *See Sampson*, *supra* note 16, at 93 (explaining how manifestation can be structured like continuum).

\(^{131}\) *Id.* Insurance companies will want as large a time frame as possible to increase the chance that the condition will fall within the exclusionary period. *See id.* (discussing insurance companies' stance).

\(^{132}\) *See id.* (noting that insured will argue shortest time frame). Actual knowledge is accomplished through medical examination and/or physician's advice. *See id.* (providing standard for establishing actual knowledge of condition).

\(^{133}\) *See id.* (discussing impact of actual knowledge requirement). Having actual knowledge will mean an increased chance of coverage for a condition. *See id.* (same).
some cases, the Seventh Circuit, has required the latter: there must be some awareness of the condition for which a person is being treated.134

B. Policy Considerations

The court in Lawson acknowledged that it based its decision partly on policy.135 After all, holding against the insured could result in bad public policy.136

1. Knowledge of a Condition Is Necessary

Not imputing knowledge in pre-existing clauses "would invite insurers to search for prior diagnoses for symptoms that were not inconsistent with an ultimate diagnosis in order to deny coverage as a pre-existing condition."137 Thus, an insurance company could deny coverage if the company could find a symptom that was consistent with ultimate diagnosis.138 This symptom could be non-specific—a symptom that could be associated with many illnesses, one of which is the illness in dispute.139 Non-specific symptoms can be caused by any number of conditions.140

The purpose of the pre-existing clause is to "protect innocent premium paying insureds from being deprived of benefits for preexisting con-
ditions of which they have no knowledge."¹⁴¹ There are many illnesses that are latent and do not manifest themselves for many years, and "[t]o deny coverage because of an incipient disease that has not made itself manifest . . . is to set an unconscionable trap for the unwary insured."¹⁴² Insurance policies are supposed to protect people, and it is only right that people know the extent of their coverage.¹⁴³

2. **Inherent Ambiguity in Pre-Existing Clauses Should Be Construed Against the Insurer**

Insurance policies are complex documents and few policyholders can be expected to understand their meaning fully.¹⁴⁴ The court in *Lawson* explained that the clause at issue was subject to two differing but reasonable explanations.¹⁴⁵ If a court finds that an exclusionary clause can lead to conflicting but plausible explanations, as did the *Lawson* court, these courts should find the clause ambiguous.¹⁴⁶ By construing the ambiguities of a policy clause against the insurance company, the policyholder is better protected.

¹⁴¹ Franco, supra note 1, at 901 (citing Hardester v. Lincoln Nat'l Life Ins. Co., 841 F. Supp. 714, 716 (D. Md. 1994)). One commentator notes, "to consider a disease to exist at a time when the victim is blissfully unaware of the medical 'seeds' visited upon his [or her] body, is to set a trap for the unwary purchaser of health insurance policies." Id. (quoting Hardester, 841 F. Supp. at 716).

¹⁴² *Lawson*, 301 F.3d at 166 (quoting Ranieli v. Mut. Life Ins. Co. of Am., 413 A.2d 396, 401 (Pa. Super. 1979)). The court stated:

> The Pennsylvania Superior Court held that recovery under a pre-existing condition clause was "conditioned on the fact that prior to the stipulated date, the sickness was not manifest, nor could it have been diagnosed with reasonable certainty by one learned in medicine." The [Pennsylvania Superior Court] found such a policy to be "reasonable and salutary."

*Id.* (quoting Ranieli v. Mut. Life Ins. Co. of Am., 413 A.2d 396, 401 (Pa. Super. 1979)). In *Ranieli*, doctors diagnosed a man with a disease in which the vessels within the kidney had been damaged or hardened because of high blood pressure. *See* Ranieli v. Mut. Life Ins. Co. of Am., 413 A.2d 396, 397 (Pa. Super. 1979) (stating facts). His insurance company contended that he suffered from this ailment during the exclusionary period because he had high blood pressure and albumin in his urine. *See id.* (discussing defendant's arguments). While these are symptoms of glomerulonephritis, they can also be symptoms of other ailments. *See id.* (noting underlying science).

¹⁴³ See Franco, supra note 1, at 901 (identifying goal of health insurance). As one commentator aptly states, "[t]he goal of protecting innocent insureds will be distorted if insurers are allowed to deny coverage based on unknown conditions." *Id.*

¹⁴⁴ See id. (noting that most insureds do not even read their insurance policies). Most insurance policies are not written in plain language. *See id.* (providing that laypersons cannot easily understand majority of insurance policies).

¹⁴⁵ See *Lawson*, 301 F.3d at 167 (holding that clause at issue introduced multiple reasonable interpretations).

ties in favor of the insured, the courts maintain coverage for innocent insureds who do not understand the intricacies of the policy language.\textsuperscript{147}

\section*{C. Protection for Insurers}

The primary purpose of the pre-existing condition exclusion is that insurance companies are not saddled with the responsibility of providing coverage for a fraudulent policy applicant.\textsuperscript{148} In light of the \textit{Lawson} decision, it seems that insurance companies have no recourse when it comes to pre-existing condition exclusion clauses.\textsuperscript{149} For example, even if insurance companies structure the language of the exclusion clause exactly as it appears in the Pennsylvania Code, the clause is not necessarily considered unambiguous.\textsuperscript{150} Just as insureds need protection, insurance companies need some safeguard to ensure that the company does not have to carry someone that will cost an inordinate and unfair amount of money.\textsuperscript{151} In other words, companies need protection from “people who only want to pay for insurance when they need it.”\textsuperscript{152} If not, many insurance companies may go out of business, and, with the increasing cost of health care, companies must exist to adequately cover the people who do need insurance.\textsuperscript{153}

\begin{itemize}
\item[--] 147. See Franco, \textit{supra} note 1, at 903-04 (explaining why it is fair to protect insurers). Unsuspecting insureds may find the policy terms misleading. \textit{See id.} (noting complexity of insurance policy agreements).
\item[--] 148. \textit{See id.} at 900 (explaining rationale for exclusion clauses). The objective of the clause is to “act as a safeguard against fraudulent insurance applicants.” \textit{Id.}
\item[--] 149. \textit{See 31 PA. CODE} \textsection 88.52 (2003) (noting definitional constructions of pre-existing condition exclusion clauses).
\item[--] 150. \textit{See id.} (noting that identical construction does not save insurance company). The Code provides, “the fact that State regulations contain a definition of ‘preexisting condition’ that is virtually identical to that contained in an insured’s policy does not conclusively demonstrate that the policy definition is unambiguous.” \textit{Id.; cf.} Lawson v. Fortis Ins. Co., 146 F. Supp. 2d 737, 744 (E.D. Pa. 2001) (noting that other factors might be involved in determining ambiguity).
\item[--] 151. See Franco, \textit{supra} note 1, at 900 (noting that pre-existing clauses are that safeguard). For a discussion of the use of the pre-existing clause as a safeguard for insurance companies, see \textit{supra} notes 16-26 and accompanying text.
\item[--] 152. Franco, \textit{supra} note 1, at 901 (noting that people might try to take advantage of insurance companies).
\item[--] 153. \textit{See id.} at 885-86 (explaining that pooled money that people pay to insurance companies is placed into fund in order for insurance companies to give out benefits to those who truly need it).
\end{itemize}
VI. Conclusion

Pre-existing exclusion clauses are necessary for insurance companies to minimize the skyrocketing costs of health care.\(^{154}\) Equally important, people who need health insurance must receive that coverage.\(^{155}\) Mere semantic constructions of policy language should not leave people who rightly deserve insurance unprotected.\(^{156}\) Further, people should not have to guess about what treatment “for” a condition means. Nor should they be denied coverage without even knowing the condition for which they are receiving treatment.\(^{157}\) Insurance companies should not be allowed to use non-specific symptoms that appeared during the exclusion period along with a physician’s hindsight to deny a person coverage for a condition that manifests itself after the policy’s effective date.\(^{158}\) Litigants in the Third Circuit need to realize that they may be covered for a condition if they fit this criterion. Similarly, insurance companies need to be careful how they write exclusions to keep them free from ambiguity.\(^{159}\) Insurance companies also need to realize that the mere existence of symptoms of a particular condition before the effective date will not preclude them from having to provide coverage for an insured. In the end, though, it is necessary to keep insurance premiums affordable for all consumers of health care by providing insurance fairly and keeping insurance companies in business.

Christina M. Finello

\(^{154}\) See Pearlstein, supra note 19, at A4 (explaining that eliminating pre-existing condition exclusion clause would increase insurance costs for insureds).

\(^{155}\) See Franco, supra note 1, at 885-86 (discussing importance of health care insurance for people to receive adequate health care).

\(^{156}\) See Lawson v. Fortis Ins. Co., 301 F.3d 159, 166 (3d Cir. 2002) (acknowledging impact of decision). The judges on the panel knew that it would be dangerous to condone ambiguity in pre-existing condition exclusion clauses. See id. (providing rationale).

\(^{157}\) See Franco, supra note 1, at 901 (noting that “insurance companies are not required to have applicants examined by physicians in order to rely on the preexisting defense”). While insurance companies do not have to follow stringent practices, insurance applicants have to provide a complete medical history or risk being denied for failure to provide full disclosure. See id. (noting differences in practices).

\(^{158}\) For a discussion of support for this assertion, see supra notes 46-51 and accompanying text.

\(^{159}\) For a discussion of the regulatory language for pre-existing exclusion clauses, see supra notes 11, 149-50 and accompanying text.