Exam ID # _____

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW II MIDTERM EXAM

Professor Pope **Spring 2010**

GENERAL INSTRUCTIONS:

1. **Read Instructions**: You may read these instructions (the first three pages of this exam packet) ***before*** the official time begins.

2. **Honor Code:** While you are taking this exam, you may not discuss it with anyone.

3. **Competence:** Accepting this examination is a certification that you are capable of completing the examination. Once you have accepted the examination, you will be held responsible for completing the examination.

4. **Exam Packet:** This exam consists of **nine pages**, including this cover page. Please make sure that your exam is complete.

5. **Identification:** Write your exam number (last six digits of you SSN) in the space provided in the upper-right hand corner of this page. Write your exam number on the cover of each Bluebook (or your ExamSoft file) that you use for Parts Two and Three. Write your exam number (and fill in the corresponding ovals) on the Scantron form.

6. **Anonymity:** The exams are graded anonymously. Do ***not*** put your name or anything else that may identify you (except for your student number) on the exam.

7 **Timing:** This exam is designed to be completed in one hour and is scored as a one-hour exam. But you have **75 minutes** in which to complete it.

8 **Scoring:** There are 60 points on the exam, approximately one point per minute.

9 **Open Book:** This is an OPEN book exam. You may use ***any*** written materials, including, but not limited to: required and recommended materials, any handouts from class, PowerPoint slides, class notes, and your own personal or group outlines. You may not use a computer other than in its ExamSoft mode.

10 **Format:** The exam consists of three parts which count toward your grade in proportion to the amount of time allocated.

PART ONE comprises 10 multiple choice questions worth two points each, for a ***combined*** total of 20 points. The suggested total completion time is **20 minutes**.

PART TWO comprises one short essay question worth 5 points. The suggested total completion time is **5 minutes**.

PART THREE comprises one long essay question worth 35 points. The suggested completion time is **35 minutes**.

11 **Grading:** All exams will receive a raw score from zero to 60. The raw score is meaningful only relative to the raw score of the other students in the class. The raw score will be converted into a scaled score, based on the class curve. For example, if the highest raw score in the class were 40 of 60, then that student would typically receive an "A." A few days after the exam, I will post the exam itself, an explanatory memo, and/or a model answer to TWEN.

12 **Special Instructions:** Instructions specific to each exam section are printed immediately below.

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Format:** This Part contains 10 multiple choice questions, worth two points each, for a combined total of 20 points. This part has a suggested completion time of 20 minutes. Please note that the questions vary in both length and complexity. You might answer some in 30 seconds and others in three minutes.

2. **Identification:** Write your Student ID ***both*** on the first page of this exam booklet. ***and*** on the Scantron form. Identify the course on the Scantron form. Fill in all the corresponding ovals.

3. **Fill the Ovals on the Scantron:** For each question***, fill in*** the oval on the Scantron corresponding to the best answer choice.

4. **Ambiguity:** If (and only if) you believe the question is ambiguous, such that there is not one obviously best answer, neatly explain why in a separately marked section of your Bluebook or ExamSoft file. Your objection must (i) identify the ambiguity or problem in the question and (ii) reveal what your answer would be for all possible resolutions of the ambiguity. I do ***not*** expect this to be necessary.

SPECIAL INSTRUCTIONS FOR PARTS TWO AND THREE:

1. **Submission:** Write your ***essay*** answers in your Bluebook examination booklets or ExamSoft file. I ***will not*** read any material which appears only on scrap paper.

2. **Legibility:** Write legibly. I will do my best to read your handwriting, but must disregard (and not give you points for) writing that is too small to read or otherwise illegible.

3. **Outlining Your Answer:** I strongly encourage you to use one-fourth of the allotted time per question to outline your answers on scrap paper ***before*** beginning to write in your exam booklet or ExamSoft file. Alternatively, you might draft your outline as a series of headings and sub-headings directly into your ExamSoft file, and then go back to fill-in the analysis with sentences and paragraphs.

   Outline your answer ***before*** writing because you will be graded not only on the substance of your answer but also on its clarity and conciseness. In other words, organization, precision, and brevity count. If you run out of insightful things to say about the issues raised by the exam question, stop writing until you think of something. Tedious repetition, regurgitations of law unrelated to the facts, or rambling about irrelevant issues ***will*** negatively affect your grade.

4. **Answer Format:** This is important. ***Use headings and subheadings***. Use short single-idea paragraphs (leaving a blank line between paragraphs).

5. **Answer Content:** Address ***all*** relevant issues that arise from the fact pattern and that are responsive to the "call" of the question. Do not just summarize all the facts or all the legal principles relevant to an issue. Instead, ***apply*** the law you see relevant to the facts you see relevant. Take the issues that you identify and organize them into a coherent structure. Then, within that structure, examine issues and argue for a conclusion.

6. **Citing Cases:** You are welcome but not required to cite cases. While it is sometimes helpful to the reader and a way to economize on words, do not cite case names as a substitute for stating the law. For example, do ***not*** write: "Plaintiff should be able to recover under *A v. B.*" Why? What is the rule in that case? What are the facts in the instant case that satisfy that rule?

7. **Cross-Referencing:** You may reference your own previous analysis (*e.g.* B's battery claim against C is identical to A's, above, because __." But be very explicit, clear, and precise what you are referencing. As in contract interpretation, ambiguity is construed against the drafter.

8. **Balanced Argument:** Facts rarely perfectly fit rules of law. So, recognize the key weaknesses in your position and make the argument on the other side.

9. **Additional Facts:** If you think that an exam question fairly raises an issue but cannot be answered without additional facts, state clearly those facts that you believe to be necessary to answer the question. Do not invent facts or issues that are not raised, implied, or suggested by the fact pattern.

STOP !

STOP !

DO NOT TURN THIS PAGE UNTIL THE PROCTOR SIGNALS

PART ONE

10 questions worth two points each = 20 points
Suggested Time = 20 minutes

1. Which of the following is MOST likely a violation of EMTALA:

   A. Hospital performs a faulty screening for patient.
   B. Hospital fails to follow regular screening procedures for patient.
   C. Hospital performs a faulty screening for an indigent and uninsured patient.
   D. Hospital performs a faulty screening that expert testimony confirms fell below the applicable standard of care.

2. Mario's employer has decided that, in the current economic climate, it can no longer provide health insurance benefits. Accordingly, it did not renew any policies for 2009-2010. Mario can probably get relief:

   A. By suing the employer for breach of contract.
   B. By suing the employer under Section 502.
   C. Under COBRA, if he is willing to pay up to 102% of the prior premium.
   D. Both A and C.
   E. Both B and C.
   F. None of the above

3. CMS has assigned a hospital in Cherry Hill, NJ with a standard Medicare reimbursement amount of $6000. A Medicare beneficiary is admitted and treated at this hospital for a condition with a DRG weight of 3.0. She is discharged after 36 hours. Reimbursement from Medicare will be:

   A. Actual costs of the treating the beneficiary.
   B. $18,000, unless the actual costs of treating the beneficiary were less, in which case $18,000 minus the difference.
   C. $18,000, unless the actual costs of treating the beneficiary were a little more, in which case $18,000 plus the additional costs.
   D. $18,000.
   E. $6000.

4. Plaintiff comes to an emergency room and receives an extensive emergency medical examination and treatment for serious injuries that he sustained during an accident. But although the hospital appropriately diagnosed and treated the vast majority of patient's injuries, the hospital failed to take an x-ray of his hip for 25 days. When the x-ray was eventually taken, it reflected that patient had a fractured hip. Because of the delay, plaintiff suffered permanent loss. Plaintiff MOST likely has a valid EMTALA claim:

   A. Because of the hospital's failure to detect his hip fracture.
   B. Because the hospital normally takes such x-rays for similarly-situated patients sooner than it did for this patient.
   C. Because the delay in screening is tantamount to a denial of screening.
   D. Because the hospital failed to stabilize his emergency medical condition and he suffered permanent loss.

Both Questions 5 and 6 are based on the following:

A health insurance plan states that "Plan has full discretion and authority to determine the eligibility for benefits and to construe and interpret all terms and provisions of the Policy." The plan also uses, but does not define, terms such as "experimental" and "medically necessary." The plan is both self-insured and self-administered in-house.

5. In a benefits coverage dispute litigated as a breach of contract action, the court will construe ambiguous contract terms:

   A. In favor of the beneficiary/insured.
   B. In favor of the insurer (arbitrary and capricious).
   C. In favor of neither party (de novo).
   D. In favor of the insurer, but with less deference since there is a conflict of interest.

6. In a benefits coverage dispute litigated under Section 502, the court will construe ambiguous contract terms:

   A. In favor of the beneficiary/insured.
   B. In favor of the insurer (arbitrary and capricious).
   C. In favor of neither party (de novo).
   D. In favor of the insurer, but with less deference since there is a conflict of interest.

Both Questions 7 and 8 are based on the following:

Patient has an insurance plan that her employer purchased from Wellpoint. Patient claims that Wellpoint wrongfully denied benefits due under the policy. So, Patient sued Wellpoint under California Insurance Code § 10111.2, which authorizes her to obtain both the denied benefits and 10% prejudgment interest on the value of the denied benefits.

7. Plaintiff's Section 10111.2 claim is:

   A. Preempted by ERISA.
   B. Preempted because of the "deemer clause."
   C. Not preempted because 10111.2 is an insurance law and therefore saved.
   D. Not preempted because 10111.2 does not "relate to" her employee benefit plan.

8. Plaintiff's Section 10111.2 claim is:

   A. Preempted by Section 502.
   B. Preempted by both Section 502 and Section 514.
   C. Not preempted by Section 502, because 502 does not address prejudgment interest.
   D. Not preempted by Section 502, because Section 10111.2 is a law directed primarily at the regulation of insurance and is therefore saved from preemption by the Section 514 "savings clause."
   E. More than one of the above.

9. Garcia works for Best Buy, which has a self-insured plan that is administered by ESIS. If Garcia sued under the same California Insurance Code 10111.2, discussed in Questions 7 and 8, such a claim would be:

   A. Preempted by Section 502.
   B. Preempted by Section 514.
   C. Preempted by both Section 502 and Section 514.
   D. Preempted by neither Section 502 nor Section 514.

10. When a physician treats a Medicaid patient and bills for those services, the physician is paid with:

   A. Federal dollars.
   B. State dollars.
   C. Both federal and state dollars.
   D. Neither federal nor state dollars.

---------- **END OF PART ONE** ----------

PART TWO

1 short essay question worth 5 points

Suggested time = 5 minutes

Mr. N is a self-employed gardener. In 2007, he purchased an individual health insurance policy for himself at a cost of about $1500 per month. In 2010, Mr. N became very ill. His physician explained that Mr. N's only hope was an expensive procedure that was the well-accepted remedy for Mr. N's condition. But Mr. N's insurer refused to pay for the procedure, claiming that it was experimental and not medically necessary, and consequently fell outside the scope of coverage.

1. **Identify and briefly describe** (but do not evaluate) valid claims that Mr. N may bring against his insurer immediately after the coverage denial.

2. **Identify and briefly describe** (but do not evaluate) valid claims that Mr. N's estate may bring against his insurer, if Mr. N dies as a result of not getting the procedure due to lack of coverage.

---------- **END OF PART TWO** ----------

PART THREE

1 long essay question worth 35 points

Suggested time = 35 minutes

Professor Kimble, a former racer of high-speed "drag" boats, has worked for Villanova University (in Villanova, PA) since 1999. Villanova offered Kimble a health insurance policy that it purchased from Blue Cross. Kimble purchased the policy, paying 25% of the premium and Villanova paying 75% of the premium to Blue Cross. Kimble's policy provides, among other things:

> ¶ 30: Benefits are not payable due to an injury arising out of or in the course of employment for compensation or profit.

The policy further provides:

> Blue Cross has full discretion and authority to determine the eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

In 2009, the Yoplait yogurt company retained Kimble to drive its boat in the Schuylkill River Regatta. Yoplait offered Kimble $500 per race. It did not withhold income taxes, pay FICA, or provide workers compensation coverage. Kimble was responsible for supplying her own equipment. Unfortunately, Kimble crashed the boat and was seriously injured. Following the accident, Kimble submitted a claim to Blue Cross for payment of medical expenses incurred for treatment of her injuries. Blue Cross denied coverage on the basis of the ¶ 30 exclusion, explaining that Kimble was injured while driving the boat for pay.

A Pennsylvania statute provides:

> (2) An insurance policy, insurance contract, or plan that is issued in this state that offers health or disability benefits shall not contain a provision purporting to reserve discretion to the insurer, plan administrator, or claim administrator to interpret the terms of the policy, contract, or plan.
>
> (3) An insurance policy, insurance contract, or plan that is issued in this state shall provide that a person who claims health, life, or disability benefits, whose claim has been denied in whole or in part, shall be entitled to have his or her claim reviewed de novo in any court with jurisdiction.

Identify and assess all claims that Kimble can bring against Blue Cross.

---------- END OF PART THREE ----------

MEMORANDUM

TO: Health Law II class (S10)
FROM: Professor Pope
DATE: March 19, 2010
RE: Your Midterm Exam

Attached is the scoring sheet that I used to grade the March 8, 2010 midterm exam. There were a total of 60 earnable points on the exam. The exam scores ranged from 7 to 54. The average score was 34.3.

Per the course syllabus and the exam instructions, I used this scoring sheet only to determine a numeric score. GPA-relevant letter grades are determined only at the **end** of the semester based on the cumulative total of the quizzes, midterm, and final exam. Nevertheless, as soon as I get the necessary information from the registrar, I will correlate rough letter grades for informational purposes only. The J.D., L.L.M., and S.J.D. students (indicated with a *) will be curved together. I am happy to provide you with a copy of your individual exam and exam scoring sheet. And, after you have reviewed these, I am happy to review your exam with you.

ID	MC	SE	LE	T	G
045096	4	0	4	8	
049429	14	1	9	24	
136517	20	4	13	37	
236658	18	1	16	35	
395880	14	3	9	26	
425124	10	3	6	19	
458925	18	4	10	32	
465680	4	0	3	7	
549624	16	5	20	41	
562203	8	0	6	14	
586248	16	4	20	40	
620022	16	4	11	31	
629341	8	1	13	22	
646149	18	4	26	48	

ID	MC	SE	LE	T	G
646169	6	4	4	14	
648194	18	5	30	53	
660798	18	2	34	54	
668313	20	3	17	40	
681445	16	4	19	39	
684035	18	4	25	47	
684798	20	1	19	40	
695758	18	5	27	50	
706142	10	5	27	42	
706922	14	3	32	49	
717950	16	0	17	33	
720577	10	3	19	32	
722239	16	5	20	41	
821142	18	5	26	49	
844483	14	3	12	29	

Multiple Choice

Question	Correct	% students answering correct	Explanation	Points	Earned
1	B	93%		2	
2	F	28%	If there is no plan now in existence, then there is no plan "to which" ERISA or COBRA can help one get access.	2	
3	D	66%		2	
4	B	86%		2	
5	A	76%		2	
6	D	59%		2	
7	A	83%		2	
8	A	59%		2	
9	C	73%		2	
10	C	93%		2	
TOTAL			3 students had 20 points; 9 had 18 points	**20**	

Short Essay

NOTE: This problem was adapted from *Ephram Nehme v. Anthem Blue Cross* (LASC Mar. 15, 2010) (jury verdict). The "call" of the question asked you to "identify and briefly describe (but do not evaluate) valid claims (1) that Mr. N may bring against his insurer immediately after the coverage denial, and (2) that Mr. N's estate may bring against his insurer, if Mr. N dies as a result of not getting the procedure due to lack of coverage.

	Issue	Points	Earned
There is no ERISA preemption	ERISA only applies where the health insurance is an employee benefit. Here, the fact pattern states: "Mr. N is a self-employed gardener. In 2007, he purchased an individual health insurance policy **for himself** at a cost of about $1500 per month." Therefore, ERISA does not apply; it does not preempt state law remedies. Moreover, it is not even a possible alternative/additional remedy.	--	--
Breach of contract	If Mr. N paid for the procedure himself, then he can get reimbursed. If he does not have the money, then he might be able to obtain injunctive relief.	**2**	
	Some students also mentioned other theories: the implied covenant of good faith and fair dealing, internal dispute resolution mechanisms, and external dispute resolution mechanisms (ala *Rush*). These are valid; but other students mentioned tort claims. Since the question asked you to identify claims that Mr. N could bring "immediately after" the denial, it is unclear that a damages suit is possible.		
	On a breach of contract claim, ambiguous terms are interpreted in favor of Mr. N. Here, given that the procedure is "well-accepted," it is likely not experimental or unnecessary unless those terms are carefully defined in the plan to exclude the procedure.	**1**	
Negligent UR	If the coverage denial was erroneous and was due to negligence in either the review of this claim or in the systems established to review all claims, then Mr. N's estate may have a tort claim ala *Wickline.* (Note: Medical malpractice is not a possible claim because the insurer was not in a treatment relationship with Mr. N.)	**2**	
Total		**5**	

Long Essay

NOTE: This problem was adapted from *Vance v. Pilot Life Insurance Co.*, 831 F.2d 142 (6th Cir. 1987). The "call" of the question asked you to "identify and assess all claims that Kimble can bring against Blue Cross." The only available claim is a claim under ERISA section 502. Consequently, much of this problem involved assessing that claim, particularly the standard of review.

	Issue	Points	Earned
All "coverage" claims are preempted by 502	The health insurance here is an employee benefit. The fact pattern states: "Professor Kimble . . . worked for Villanova . . . . Villanova offered Kimble a health insurance policy . . . ."	**2**	
	Kimble appears to just want coverage/payment: "medical expenses incurred for treatment of her injuries." That is precisely for what 502 provides a remedy. Therefore, per *Davila*, 502 is the exclusive remedy for what Kimble wants.	**5**	
The standard of review without the PA statute	Because the plan language reserves discretion ("full discretion and authority") to Blue Cross, the standard of review would be arbitrary and capricious. But because Villanova is fully insured and Blue Cross is both the administrator and the payer, Blue Cross has a conflict of interest. It reviews claims that it must pay with its own money. Therefore, (putting aside the PA statute) the standard of review will be somewhat less deferential than arbitrary and capricious.	**5**	
Preemption of the PA statute (502)	The discretion-setting provisions of the PA statute are not preempted by 502 because the statute does not provide a remedy. It seeks only to define plan terms (ala the Illinois statute in *Rush*).	**5**	
	Some students read the PA statute (section 3) as also providing a remedy. In that case, 502 (in contrast to 514) preemption would not affect the claim "under" 502. So, one would still have to grapple with the impact of section 2 on the standard of review for the 502 claim.		
Preemption of the PA statute (514)	The PA statute "relates to" the EBP.	**3**	
	The PA statute is directed primarily at the regulation of insurance (e.g. the permissible terms in insurance contracts). Therefore, it is saved from 514 preemption ala *Rush*.	**3**	
	The deemer clause is inapplicable because the plan is fully insured, not self-insured. Villanova "purchased" the plan from Blue Cross and both Kimble and Villanova "pay premiums" to Blue Cross.	**2**	
Effect of PA statute on standard of review	The PA statute mandates a *de novo* standard of review: "shall not contain a provision purporting to reserve discretion" and "claim reviewed de novo in any court." Since the PA statute is not preempted, Blue Cross must comply.	**5**	
Application to the dispute	The standard of review matters because Blue Cross' determination (that the employment exclusion was satisfied) is surely a legitimate reading. The race payment can fairly be construed as "employment." If deference is owed to Blue Cross, then Kimble has little chance of winning. Under a *de novo* standard of review, Kimble has at least a chance.	**5**	
Total		**35**	