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Federal Jurisdiction Over Claims by State Attorneys General: The Case for Removal of Pharmaceutical *Parens Patriae* Suits as "Mass Actions" Under the Class Action Fairness Act of 2005

*By: Amy McIntire**

INTRODUCTION

In the world of pharmaceutical litigation, in which verdicts and settlements frequently total hundreds of millions of dollars, the stakes are high for both plaintiffs and pharmaceutical company defendants. Recently, with state attorneys general bringing *parens patriae* suits, or suits on behalf of state citizens, against pharmaceutical companies, state attorneys general have begun to play an increasingly prominent role in the litigation. Results of these *parens patriae* actions have shown that the outcome of pharmaceutical litigation often depends on whether the matter is litigated in state court or is removed to a federal forum. State attorneys general have had more success in state courts, while pharmaceutical company defendants prefer a federal forum. With removal

* Amy McIntire received her J.D. from the University of Notre Dame Law School, where she served as Managing Senior Editor on the Notre Dame Law Review. She currently works as an associate at Chaffe McCall L.L.P. in New Orleans, Louisiana, and she can be reached at mcintire@chaffe.com. The author would like to specially thank Notre Dame Law Professor, Amy Coney Barrett for her guidance and helpful comments.

being such a critical litigation strategy but with no diversity jurisdiction over such suits pursuant to § 1332, pharmaceutical company defendants have argued for removal of these *parens patriae* suits under the Class Action Fairness Act of 2005 ("CAFA").

Under CAFA, federal courts agree that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to the federal class action statute, Federal Rule 23 of Civil Procedure. Likewise, there is no dispute amongst courts that *parens patriae* suits seeking enforcement actions and civil penalties are not removable "mass actions" under CAFA. But, in addressing the critical question of whether *parens patriae* actions seeking money damages are removable pursuant to CAFA's "mass action" provision, a decisive Circuit split has emerged. Although the Supreme Court recently granted a petition for a writ of certiorari and heard oral arguments concerning this issue, a guiding decision remains many months away.[1] With so much at stake in litigation but no clear precedent to rely upon, state attorneys general and pharmaceutical company defendants have turned to the text, structure, and purpose of CAFA in crafting arguments against and in favor of removal.

This Paper examines the application of CAFA to *parens patriae* actions seeking money damages and argues that these actions are removable pursuant to CAFA's "mass action" provision. Part I of this Paper examines the high stakes world of pharmaceutical litigation and the Circuit split, both of which have made the question of removability such a contentious issue. Part II then turns to an exploration of CAFA's text, structure, and purpose and examines the ways in which each of these elements supports (and opposes) the removability of *parens patriae* actions pursuant to CAFA's "mass action" provision. Part II concludes that CAFA's text, structure, and purpose support removal of these actions. Finally, Part III addresses another point of contention between state attorneys general and pharmaceutical company defendants—whether removal of *parens patriae* suits under the "mass action" provision would violate fundamental principles of federalism—and argues that these policy concerns are insufficient to bar the removal of actions that are otherwise removable under the text, structure, and purpose of CAFA. Therefore, CAFA's removable "mass action" provision should apply to *parens patriae* actions seeking money damages, and to hold otherwise would violate the plain language and intent of the statute and would create unsound doctrine of statutory interpretation.

I. THE ROLE OF STATE ATTORNEYS GENERAL IN PHARMACEUTICAL LITIGATION

The stakes for plaintiffs and pharmaceutical company defendants are high since litigation involves pharmaceutical drugs and devices that have large revenues and sizable market shares. Verdicts and settlements frequently total hundreds of millions of dollars and sometimes even billions of dollars.[2] The stakes are generally higher for

[1] See Mississippi *ex rel.* Hood v. AU Optronics Corp., 133 S. Ct. 2736 (2013), *cert. granted*, Mississippi *ex rel.* Hood v. AU Optronics Corp., 701 F.3d 796 (5th Cir. 2012).

[2] *See, e.g.*, Margaret Cronin Fisk, Jef Feeley & David Voreacos, *J&J Said to Agree to $2.2 Billion Drug Marketing Accord*, Bloomberg (June 11, 2012; 3:36 PM), http://www.bloomberg.com/news/2012-06-11/j-j-said-to-pay-2-2-billion-to-end-risperdal-sales-probe.html (reporting that Johnson & Johnson has agreed to pay as much as $2.2 billion to settle U.S. probes of the marketing of its Risperdal antipsychotic drug and other medications . . . "); David Voreacos & Allen Johnson,

the pharmaceutical company defendants than they are for the plaintiffs.[3] While the plaintiffs in pharmaceutical litigation stand to win a lucrative verdict or settlement, the pharmaceutical companies stand to lose that amount of money and also face the risk of incurring unfavorable precedent for additional plaintiffs to capitalize upon.[4] Therefore, both plaintiffs and pharmaceutical company defendants have vested interests in the outcome of pharmaceutical litigation.

Over the last several years, state attorneys general have played an increasingly prominent role in this type of pharmaceutical litigation, and lately, the number of state attorney general lawsuits filed against drug manufacturers has increased.[5] These lawsuits are brought in the form of *parens patriae*[6] actions by state attorneys general, allegedly acting in a representative capacity on behalf of a state's citizens.[7] To bring these *parens patriae* suits, state attorneys general allege that states have either a sovereign interest[8] or a quasi-sovereign interest[9] implicated and, thus, that the action concerns a type of injury

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Merck Paid 3,468 Death Claims to Resolve Vioxx Suits, Bloomberg (July 27, 2010; 4:27 PM), http://www.bloomberg.com/news/2010-07-27/merck-paid-3-468-death-claims-to-resolve-vioxx-suits.html (reporting that Merck paid $4.84 billion in settlement to Vioxx drug users).

[3] Abigail E. Rosen, Note, *Analysis of an FDA Compliance Defense for Pharmaceutical Tort Litigation*, 1 N.Y.U. J. L. & Bus. 241, 266 (2004).

[4] *Id*. ("As a result, the pharmaceutical companies are typically more risk adverse than plaintiffs and are therefore more willing to settle even when the chance of victory is 50% or even higher.").

[5] *See* Miller & Schwartz, *Current Issues in Aggregate Litigation Against Drug and Device Manufacturers: Recent Developments in State AG and TPP Pharmaceutical Litigation*, Drug And Medical Device Seminar, at 257 (May 2012) (explaining that state attorneys general have filed greater numbers of actions against pharmaceutical manufacturers); Alexander Lemann, Note, *Sheep in Wolves' Clothing: Removing Parens Patriae Suits Under the Class Action Fairness Act*, 111 Colum. L. Rev. 121, 122 (2011) (noting that *parens patriae* suits are "an increasingly popular vehicle for state attorneys general to vindicate the rights of their constituents").

[6] *See* Alfred L. Snapp & Son, Inc. v. Puerto Rico, *ex rel.*, Barez, 458 U.S. 592, 600 (1982) (noting that under the doctrine of *parens patriae*, literally meaning "parent of the country," a state may file suit in a representative capacity to protect the interest of its citizens).

[7] Miller & Schwartz, *supra* note 5, at 257.

[8] The Supreme Court has distinguished two types of easily identifiable sovereign interests: (1) the exercise of sovereign power over individuals and entities within the relevant jurisdiction; and (2) the demand for recognition from other sovereigns. *Snapp*, 458 U.S. at 601-02. The exercise of sovereign power over individuals typically involves the power of a state to enforce civil and criminal codes, and the demand for recognition from other sovereigns most frequently involves the maintenance and recognition of states' borders. Richard P. Ieyoub & Theodore Eisenberg, *State Attorney General Actions, the Tobacco Litigation, and the Doctrine of Parens Patriae*, 74 Tul. L. Rev. 1859, 1865 (2000).

[9] The Supreme Court has acknowledged the difficulty of defining what constitutes a quasi-sovereign interest and noted that:

> [Quasi-sovereign interests] are not sovereign interests, proprietary interests, or private interests pursued by the State as a nominal party. They consist of a set of interests that the State has in the well-being of its populace. Formulated so broadly, the concept risks being too vague to survive the standing requirements of Art. III: A quasi-sovereign interest must be sufficiently concrete to create an actual controversy between the State and the defendant. The vagueness of this concept can only be filled in by turning to individual cases.

Snapp, 458 U.S. at 602. Individual cases show that valid quasi-sovereign interests include the health, welfare, and safety of a state's citizens. *See* Georgia v. Pennsylvania Railroad, 324 U.S. 439,

that the states have an interest in protecting citizens from incurring.[10] Many of these lawsuits are premised on theories of economic loss under which a state attorney general claims injury by virtue of state citizens being forced to pay for allegedly defective or falsely marketed pharmaceuticals.[11] For many state attorneys general, these lawsuits have brought prominent and public success, with favorable state-wide publicity and hundreds of millions of dollars in verdicts or settlements.[12] In addition to the motivation of seeking such public and lucrative payouts, state attorneys general have also found lawsuits targeting pharmaceutical companies to be an effective way to alleviate shortfalls in state budgets that may be strained under increasing Medicare costs.[13] Therefore, the act of bringing lawsuits against pharmaceutical companies has become an increasingly popular trend amongst state attorneys general.

With the number of these lawsuits increasing and with verdicts and settlements totaling hundreds of millions of dollars, both state attorneys general and pharmaceutical company defendants seek every available strategic advantage. Recent litigation has shown that the outcome of pharmaceutical litigation often depends on whether the matter is litigated in state court or is removed to a federal forum.[14] State attorneys general have found

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451 (1945) (holding that the economic welfare of a state's citizens constituted a quasi-sovereign interest); Georgia *ex rel.* Hart v. Tennessee Copper Co., 206 U.S. 230, 238 (1907) (holding that the State of Georgia had a quasi-sovereign interest in protecting the State from pollutants emitted by a private company); Missouri v. Illinois, 180 U.S. 208, 241 (1901) (extending quasi-sovereign interests to the protection of citizens' health).

[10] *See Snapp*, 458 U.S. at 602 (noting that states are interested in quasi-sovereign interests on behalf of its citizens).

[11] Miller & Schwartz, *supra* note 5, at 257.

[12] A lawsuit by the Louisiana Attorney General over the drug Risperdal ended in a $257.7 million verdict against Johnson & Johnson, after a jury found 35,542 violations of Louisiana's Medical Assistance Program Integrity Law and penalized the defendant $7,250 for each violation. *Id*. Likewise, a similar suit by the South Carolina Attorney General over the same drug resulted in the imposition of $327 million in penalties. *Id*.

[13] Nina M. Gussack & Elizabeth M. Ray, *The New AG Case: Defending Cases Where There Is an Alliance Between an Attorney General and the Plaintiff' Bar*, Drug And Medical Device Seminar, at 225 (May 2010).

[14] A comparison of state attorneys general actions in federal and state court best highlights the impact a forum may have on the outcome of litigation.

For instance, in the federal case of *In re Zyprexa Products Liability Litigation*, the pharmaceutical company, Eli Lilly was largely successful in defending claims made by the Mississippi Attorney General regarding the drug Zyprexa. *See generally* 671 F. Supp. 2d 397 (E.D.N.Y. 2009). Regarding Medicaid-related allegations of off-label branding, the federal judge applied an "individualized proof rule" which barred one of the State's main theories of causation—that Eli Lilly's conduct caused more Zyprexa to be prescribed to Medicaid beneficiaries. *Id*. at 454. Although the suit was not brought under Rule 23, the judge held that the "individualized proof rule" applied in this type of structural class action. *Id*. at 434. The "individualized proof rule" required plaintiff to prove causation on an individual basis and thus barred aggregate adjudication of claims that include a causation element. *Id*. Because the State Attorney General was not allowed to prove his theory of causation on an aggregate basis, the court granted Eli Lilly summary judgment with respect to any theory of causation that dependent upon individualized showings. *Id*. at 454–55.

In contrast, in a series of state cases regarding the drug Risperdal, pharmaceutical companies have been less successful. For instance, in 2011, a South Carolina judge ordered Johnson & Johnson to pay $327 million in penalties to the State after a jury found the company liable of marketing

more success in state courts for a couple of reasons. First, the state statutes under which state attorneys general bring suit often do not require the state to prove causation of injury.[15] Additionally, the pleading requirements in state courts are often less demanding than the requirements in federal court since the state pleading requirements typically do not require the plaintiff's complaint to include sufficient facts to make it "plausible" that the plaintiff will be able to prove facts to support his or her claims.[16] In contrast, pharmaceutical company defendants have found more success when the matter has been removed to federal court. Unlike the state court actions brought under state statutes which may not require a showing of causation or injury, causation and injury are indispensable elements of tort claims and, thus, must be specifically alleged to satisfy the federal pleading requirements explicated by the Supreme Court in *Ashcroft v. Iqbal*[17] and *Bell Atlantic Corp. v. Twombly*.[18] In order to adequately plead causation in federal court, a plaintiff cannot merely make "conclusory statements," but rather must allege sufficient facts to show that his or her claim is "plausible" on its face to survive a motion to dismiss.[19] Thus, if state attorneys general fail to allege plausible theories of causation or injury, federal courts are free to dismiss pharmaceutical lawsuits at the pleading stage.[20] Furthermore, even if these lawsuits survive the pleadings stage, the individualized nature of the causation and injury elements may render them difficult to prove at trial.[21] Given this trend showing forum as an important determinant in a lawsuit's success, state attorneys general usually want *parens patriae* suits to remain in state court,[22] while pharmaceutical company defendants typically strive to remove them to federal court.

With removal being such a critical strategy but with no diversity jurisdiction over suits by a state pursuant to § 1332, pharmaceutical company defendants have been forced to

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violations. *See* Miller & Schwartz, *supra* note 5, at 265. Likewise, Johnson & Johnson lost a similar case involving Risperdal in Louisiana state court in 2010, and the pharmaceutical company was ordered to pay $257.7 million in penalties and $73.3 million in attorneys' fees and costs. *Id.* In these state court cases, the state attorneys general were not bound by the same federal pleading and "individualized proof" standards.

[15] *See* Miller & Schwartz, *supra* note 5, at 261.

[16] This standard, that a plaintiff's complaint must include sufficient facts to make it plausible that the plaintiff will be able to prove facts to support his or her claims, is the federal pleading standard set forth in *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 546 (2007).

[17] *See* 556 U.S. 662 (2009).

[18] *See Twombly*, 550 U.S. at 544-45.

[19] *Id*. at 555.

[20] *See* Miller & Schwartz, *supra* note 5, at 257 (noting that courts are dismissing pharmaceutical cases for failure to show causation or injury).

[21] *Id*. (*citing In re* Neurotin Mktg. & Sales Practices Litig., 754 F. Supp. 2d 293, 311 (D. Mass. 2010) (holding "that where '[p]laintiffs allege an injury that is caused by physicians relying on [a pharmaceutical company's] misrepresentations,'. . . the injury cannot be shown by generalized proof.").

[22] Even if pharmaceutical company defendants remove claims to federal court, a federal court may still permit the suit to be "remanded" back to state court. *See* Jay Tidmarsh & Roger H. Trangsrud, Complex Litigation And The Adversary System 385 (1998) (explaining that pharmaceutical cases may be remanded to state court for further proceedings).

find less obvious means of removal.[23] As a result, pharmaceutical company defendants have argued for removal of *parens patriae* suits by state attorneys general under the Class Action Fairness Act of 2005 ("CAFA").[24] These arguments for removal have been received with mixed success in federal courts. Federal courts do not disagree that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to the federal class action statute, Rule 23 of the Federal Rules of Civil Procedure.[25] Likewise, there is no dispute amongst federal courts that *parens patriae* suits seeking enforcement actions and civil penalties are not removable as "mass actions" under CAFA.[26] However, in light of the complex drafting of CAFA's "mass action" provision, a decisive split has emerged amongst the Circuits as to whether *parens patriae* suits seeking money damages are removable to federal court as "mass actions" under CAFA.[27]

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[23] Pharmaceutical companies have also begun to explore removal through substantial-federal-question jurisdiction, under *Grable & Sons Metal Products, Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308 (2005), with varied success, but substantial-federal-question jurisdiction is beyond the scope of this Paper.

[24] *See* Pub. L. No. 109-2, 119 Stat. 4 (2005) (codified in relevant part at 28 U.S.C. § 1332(d)).

[25] Regarding this issue, the Fourth, Seventh, Ninth, and Fifth Circuits all agree. In *West Virginia ex rel. McGraw v. CVS Pharmacy, Inc.*, 646 F.3d 169, 172 (4th Cir. 2011), the Fourth Circuit held that the *parens patriae* lawsuit in question was not removable under CAFA as a class action since it was not "similar" to Rule 23 of the Federal Rules of Civil Procedure governing class actions. In affirming the decision to remand the case back to state court, the Fourth Circuit held that "[b]ecause this action was brought by the State under state statutes that are not 'similar' to Federal Rule of Civil Procedure 23, . . . it is not removable under CAFA as a class action." *Id*. Likewise, in *LG Display Co. v. Madigan*, 665 F.3d 768, 172, 174 (7th Cir. 2011), the Seventh Circuit held that a *parens patriae* suit, brought by the Illinois Attorney General against eight manufacturers of LCD panels for violations of the Illinois Antitrust Act, was not a removable class action under CAFA. The Seventh Circuit held the *parens patriae* suit could not be a class action because it was not filed under Rule 23 or the state statute equivalent, 735 ILCS 5/2–801. *Id*. at 771-72. Similarly, in *Washington v. Chimei Innolux Corp*., 659 F.3d 842, 850 (9th Cir. 2011), the Ninth Circuit held that attorney general enforcement actions were not removable as class actions under CAFA. In considering whether *parens patriae* lawsuits were class actions within the meaning of CAFA, the Ninth Circuit looked to the plain language of the statute. *Id*. at 847. The Ninth Circuit concluded that, under CAFA's unambiguous definition of a class action, "a suit commenced in state court is not a class action unless it is brought under a state statute or rule similar to Rule 23 that authorizes an action 'as a class action.'" *Id*. at 848. Finally, in *Louisiana ex rel. Caldwell v. Allstate Ins. Co*., 536 F.3d 418, 422 (5th Cir. 2008), the Fifth Circuit, which has taken the minority view regarding the removability of mass actions under CAFA, did not take an opposing view regarding the removability of class actions under CAFA. Since the Fifth Circuit concluded that the matter in question was properly removed under CAFA's "mass action" provision, the Fifth Circuit did not address whether this lawsuit could, following further proceedings on remand, properly proceed as a removable class action under CAFA. *Id*. at 430. Therefore, there is no disagreement among federal Circuits regarding the removability of class actions under CAFA.

[26] *See, e.g., LG Display Co*., 665 F.3d at 772 (conceding that the state was the real party in interest for the enforcement-related claims); *Allstate Ins. Co*., 536 F.3d at 429-30 (holding the claim for money damages was removable but leaving open the possibility of severing the claim for injunctive relief, in which the State of Louisiana was likely the real party in interest, and remanding that particular claim to state court).

[27] The majority approach, as taken by the Fourth, Seventh, and Ninth Circuits, has excluded the removal of *parens patriae* suits seeking money damages to federal court under CAVA's "mass action" provision. These courts have held that suits brought by state attorneys general, on behalf of

In determining whether *parens patriae* suits seeking money damages qualify as removable "mass actions" under CAFA, federal courts have focused on the "real parties in interest"[28] in the lawsuits. A majority of Circuits—the Fourth, Seventh, and Ninth—have found the states to be the "real parties in interest" in such proceedings and, thus, have held that these *parens patriae* actions were properly labeled lawsuits and were not removable "mass actions" under CAFA.[29] Although the complaints by state attorneys general often include both enforcement-related claims and money damage claims, the majority of Circuits have refused to take a claim-by-claim approach, and instead,

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state citizens, do not qualify as "mass actions" for purposes of CAFA. In contrast, the Fifth Circuit has taken the minority approach and held that *parens patriae* suits seeking money damages do qualify as "mass actions" under CAFA and, thus, are removable.

[28] Rule 17 of the Federal Rules of Civil Procedure provide that "[a]n action must be prosecuted in the name of the real party in interest." Fed. R. Civ. P. 17(a)(1). This instruction to determine the real party in interest is necessary to "protect the defendant against subsequent action by the party actually entitled to recover, and to insure generally that the judgment will have its proper effect as res judicata." Fed. R. Civ. P. 17 advisory committee's notes.

[29] The opinions of the Seventh and Ninth Circuit best illustrate this holding. In *LG Display Co., v. Madigan*, 665 F.3d 768, 772 (7th Cir. 2011), the Seventh Circuit held that a *parens patriae* suit was not a removable "mass action." The defendants argued that this case was a mass action because "monetary relief claims of 100 or more persons [we]re proposed to be tried jointly on the ground that the plaintiffs' claims involve common questions of law or fact." *Id*. at 772. In their argument for removal, the defendants urged the court to consider that the Illinois resident purchasers (and not the State) were the real parties in interest in the controversy. *Id*. The defendants conceded that the State was the real party in interest for the enforcement-related claims, but they argued that the State was not the real party in interest for the damages claims asserted on behalf of Illinois consumers. *Id*. at 772–73. Therefore, in their argument for removal, the defendants urged the court to take a claim-by-claim approach and separately determine the parties in interest in each of the Attorney General's claims. *Id*. at 773. The Seventh Circuit rejected this claim-by-claim approach and looked to the complaint as a whole. *Id*. According to the court, the finding of a state as the real party in interest in a suit "is a question to be determined from the 'essential nature and effect of the proceeding,'" and thus, the State was the singular real party in interest. *Id*. Therefore, the Seventh Circuit affirmed the district court's ruling that this *parens patriae* suit was not a removable "mass action" under CAFA. Likewise, in *Nevada v. Bank of Am. Corp*., 672 F.3d 661, 665 (9th Cir. 2012), the Ninth Circuit held that a *parens patriae* suit filed by the Attorney General was not a removable "mass action" under CAFA. In that case, the Nevada Attorney General sued Bank of America, alleging that the lender misled borrowers about the terms and operation of its home mortgage modification and foreclosure processes, in violation of the Nevada Deceptive Trade Practices Act. *Id*. at 664. The determination of whether this *parens patriae* suit qualified as a "mass action" turned on "whether the State of Nevada or the hundred-plus consumers on whose behalf it [sought] restitution [we]re the real party(ies) in interest." *Id*. at 669. Following the precedent set by the Seventh Circuit in *LG Display Co., Ltd. v. Madigan,* the Ninth Circuit examined the complaint as a whole and concluded that the State of Nevada, as opposed to the individual consumers, was the real party in interest in the lawsuit against Bank of America. *Id*. at 669-70. The court held that Nevada had a sovereign interest in protecting its citizens and economy from deceptive mortgage practices. *Id*. at 671. Specifically, the Ninth Circuit held that foreclosures presented a "widespread and devastating injury not only to those borrowers who were defrauded, but also to other Nevada residents and the Nevada economy as a whole." *Id*. at 670. The court noted that Nevada had "been particularly hard-hit by the current mortgage crisis, and [therefore, had] a specific, concrete interest in eliminating any deceptive practices that may have contributed to its cause." *Id*. Thus, the Ninth Circuit ruled that the injured consumers were not the real parties in interest and that the *parens patriae* lawsuit was not a removable "mass action" under CAFA.

these federal courts have looked at the complaint as a whole to determine the singular "real party in interest."[30] Consequently, when examining the complaint as a whole, the majority of Circuits have found that states have a legitimate sovereign interest in protecting their citizens and economy from deceptive and defective products, such as pharmaceutical drugs,[31] and therefore, the courts have held the states to be the "real parties in interest."[32] In contrast, the Fifth Circuit, standing alone, has found the private consumers, on whose behalf the state attorney general seeks money damages, to be the "real parties in interest" and, thus, has held that *parens patriae* suits seeking money damages are removable "mass actions" under CAFA.[33] As opposed to the majority of Circuits, which view the complaints of state attorneys general in their entirety, the Fifth Circuit has taken a claim-by-claim approach in which "the various claims could be severed so that those claims that were removable under CAFA would remain in federal court but that [state] claims could be remanded to state court."[34] In applying this claim-by-claim approach, the Fifth Circuit held that the insurance policyholders, on whose behalf the state attorney general sought relief, were the real parties in interest,[35] at least in the context of money damages.[36] Therefore, unlike the majority of Circuits, the Fifth

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[30] *See, e.g*., *Bank of Am. Corp*., 672 F.3d at 670 (examining the complaint as a whole and concluding that the State of Nevada, as opposed to the individual consumers, was the real party in interest in the lawsuit against Bank of America); *LG Display Co.*, 665 F.3d at 773 (rejecting the defendants' argument that the court should take a claim-by-claim approach and separately determine the parties of interest in each of the Attorney General's claims).

[31] *See, e.g.*, *Bank of Am. Corp*., 672 F.3d at 671 (holding that Nevada had a sovereign interest in protecting its citizens and economy from deceptive mortgage practices since mortgage foreclosures presented a widespread and devastating injury to all Nevada residents and the Nevada economy); *CVS Pharmacy, Inc*., 646 F.3d at 172 (holding the State was acting in its sovereign and quasi-sovereign capacity as it sought injunctive relief and monetary recovery on behalf of its citizens for violations of West Virginia's generic-drug pricing statute and the West Virginia Consumer Credit and Protection Act).

[32] *See, e.g.*, *Bank of Am. Corp*., 672 F.3d at 670 ("We therefore examine 'the essential nature and effect of the proceeding as it appears from the entire record,' and conclude that Nevada—not the individual consumers—is the real party in interest in this controversy." (citations omitted)); *CVS Pharmacy, Inc.,* 646 F.3d at 172 (holding that the action was a classic *parens patriae* action intended to vindicate the State's quasi-sovereign interests and the individual interests of its citizens); *LG Display Co*., 665 F.3d at 772-73 (holding the action was not a removable "mass action" because the State was the real party in interest for the enforcement-related claims, even if the State was the real party in interest for the damages claims asserted on behalf of Illinois consumers).

[33] Louisiana *ex rel.* Caldwell v. Allstate Ins. Co., 536 F.3d 418, 430 (5th Cir. 2008).

[34] *Id*. (*citing* Louisiana v. AAA Insurance, 524 F.3d 700, 711–12 (5th Cir. 2008)).

[35] *Id*. at 429. The court pointed to the text of the statute under which the Louisiana Attorney General sought relief. Specifically, Section 137 of the Louisiana Monopolies Act authorized the recovery of treble damages and plainly provided that "'any person who is injured in his business or property, under the Monopolies Act 'shall recover [treble] damages.'" *Id*. Therefore, the Fifth Circuit concluded that the plain language of that statute made it clear that individuals had the right to enforce this provision and thus that the private policyholders (and not the State) were the real parties in interest. *Id*.

[36] *Id*. The court left open the possibility of severing the claim for injunctive relief, in which the State of Louisiana was likely the real party in interest, and remanding that particular claim to state court. *Id*. at 430.

Circuit held that a suit brought by a state attorney general for money damages was a removable "mass action" under CAFA.[37]

In spite of the importance of the issue for states and pharmaceutical company defendants and the divisive Circuit split that has emerged, the Supreme Court only recently granted a petition for a writ of certiorari to address this issue.[38] The Supreme Court heard oral arguments on November 6, 2013, and a decision is not due until 2014. Consequently, the question of whether *parens patriae* actions seeking money damages are removable pursuant to CAFA's "mass action" provision remains an open-ended question and, for now, continues to be addressed on a circuit-by-circuit basis. With so much at stake in litigation but no clear precedent to rely upon, state attorneys general and pharmaceutical company defendants have turned to the text, structure, and purpose of CAFA in constructing their arguments.

II. THE CLASS ACTION FAIRNESS ACT OF 2005

On February 18, 2005, the Class Action Fairness Act of 2005 ("CAFA") was signed into law, and its passage marked the most significant change in class action law since the revision of Rule 23 of the Federal Rules of Civil Procedure in 1966.[39] Since there is no dispute amongst the Circuits that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to Rule 23, proponents and opponents of the removal of *parens patriae* actions have focused their arguments on whether these actions qualify as "mass actions" under CAFA. Both sides have wielded the statute as a means to support their respective claims,[40] and both state attorneys general and pharmaceutical company defendants contend that the text, structure, and purpose of CAFA validate their respective arguments.

A. The Text of the Statute

At the heart of the statute, CAFA's text expanded federal court jurisdiction through the adoption of a "minimal diversity" standard.[41] In contrast to the Supreme Court's holding

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[37] *Id.*

[38] Mississippi *ex rel.* Hood v. AU Optronics Corp., 701 F.3d 796 (5th Cir. 2012), *cert. granted*, 133 S. Ct. 2736 (2013); *see* West Virginia *ex rel.* McGraw v. CVS Pharmacy, Inc., 646 F.3d 169 (4th Cir. 2011), *cert. denied*, CVS Pharmacy, Inc. v. West Virginia *ex rel.* McGraw, 132 S. Ct. 761 (2011).

[39] *See* Edward F. Sherman, *Class Action Fairness Act and the Federalization of Class Actions*, 238 F.R.D. 504, 504 (2007) (noting the significance); Edward F. Sherman, *Class Actions After the Class Action Fairness Act of 2005*, 80 Tul. L. Rev. 1593, 1593,1615 (2006) (same).

[40] State attorneys general and pharmaceutical company defendants interpret the text and purpose of CAFA to support their respective claims, and since "American courts have no intelligible, generally accepted, and consistently applied theory of statutory interpretation," the parties' differing interpretations of the statute have created a compelling debate. Henry M. Hart, Jr. & Albert M. Sacks, The Legal Process: Basic Problems In The Making And Application Of Law 1169 (William N. Eskridge, Jr. & Philip P. Frickey eds., The Foundation Press 1994); *see also* Antonin Scalia, A Matter Of Interpretation: Federal Courts And The Law 14 (Amy Gutmann ed., Princeton Univ. Press 1997) ("[T]he American bar and American legal education, by and large, are unconcerned with the fact that we have no intelligible theory [of statutory interpretation].").

[41] *See* Class Action Fairness Act of 2005, Pub. L. No. 109-2, 119 Stat. 4 (2005) (amending 28 U.S.C. § 1332 by inserting (d)(1)).

in *Strawbridge v. Curtiss*, which construed the federal diversity jurisdiction statute as requiring "complete diversity,"[42] CAFA required something markedly less than "complete diversity" in order to achieve removal to federal court. Under a "minimal diversity" standard, CAFA expanded federal diversity jurisdiction over class action lawsuits for any case that includes at least 100 plaintiffs and more than a five million dollar amount in controversy,[43] as long as "any member of a class of plaintiffs is a citizen of a State different from any defendant."[44] This expansion of federal diversity jurisdiction under a "minimal diversity" standard has limits. First, a district court must decline to exercise jurisdiction when more the two-thirds of class members and a defendant are citizens of the same forum state.[45] Additionally, a district court may decline to exercise jurisdiction when between one-third and two-thirds of class members and the primary defendant are citizens of the same forum state.[46]

Although CAFA lowers the threshold for removal by establishing a "minimal diversity" standard, a party seeking removal must still prove that the action is either a "class action" or a "mass action." A class action removable under CAFA is "any civil action filed under rule 23 of the Federal Rules of Civil Procedure or similar State statute or rule of judicial procedure authorizing an action to be brought by 1 or more representative persons as a class action."[47] A class action must have 100 or more "members of all proposed plaintiff classes" and an aggregate amount in controversy in excess of five million dollars.[48] The definition of "class action" under CAFA is relatively straightforward, and as discussed in Part I, federal courts do not dispute that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to Rule 23 of the Federal Rules of Civil Procedure.

CAFA's provisions regarding removable "mass actions" have caused substantially more debate. Under CAFA, "mass actions" that qualify as "class actions," removable under §§ 1332(d)(2) through (10), may be removed pursuant to the statute.[49] The text of CAFA proceeds to explicitly define "mass actions."[50] While these provisions governing removable "mass actions" might appear straightforward upon first glance, state attorneys general and pharmaceutical company defendants have advocated for differing interpretations of the text to support their arguments regarding removal.

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[42] *See* 7 U.S. 267, 267 (1806); *see also* Rodney K. Miller, *Article III and Removal Jurisdiction: The Demise of the Complete Diversity Rule and a Proposed Return to Minimal Diversity*, 64 Okla. L. Rev. 269, 275 (2012) ("Congress has also muddied the waters [of complete diversity] by enacting legislation . . . [such as] the Class Action Fairness Act . . . ").

[43] The claims of all of "the individual class members shall be aggregated" to determine the amount in controversy. 28 U.S.C. § 1332(d)(6) (2006). Additionally, any defendant can unilaterally move to remove the lawsuit at any time. § 1453(b).

[44] § 1332(d)(2)(a).

[45] § 1332(d)(4).

[46] § 1332(d)(3).

[47] § 1332(d)(1)(B).

[48] §§§ 1332(d)(2), (d)(5)(B), (d)(6).

[49] § 1332(d)(11)(A).

[50] § 1332(d)(11)(B)(i).

The main point of contention between opponents and proponents of removal stems from CAFA's unusually worded definition of "mass action." The statute explicitly defines removable "mass actions" as:

> [A]ny civil action (except a civil action within the scope of section 1711(2)) in which monetary relief claims of 100 or more *persons* are proposed to be tried jointly on the ground that the plaintiffs' claims involve common questions of law or fact, except that jurisdiction shall exist only over those plaintiffs whose claims in a mass action satisfy the jurisdictional amount requirements under subsection (a).[51]

Opponents of removal of *parens patriae* suits as "mass actions" contend that these suits cannot be removed under CAFA because the state, through its attorney general, is the lone plaintiff in the litigation,[52] which means that the specific choice of the word "persons," as opposed to "plaintiffs," becomes significant. Opponents of removal are eager to read this definition of "mass action" to require a numerosity of 100 or more plaintiffs since such a requirement would prevent *parens patriae* actions from qualifying for removal.

By the plain text of this provision,[53] the removability of a lawsuit as a "mass action" under CAFA depends on whether the lawsuit involves the monetary relief claims of 100 or more persons, and not 100 or more plaintiffs. To read the text of CAFA's definition of removable "mass action" to require "plaintiffs" would violate a fundamental rule of statutory interpretation—when a word is not defined by statute, the word should be construed in accord with its ordinary or plain meaning.[54] Courts and scholars have emphasized the importance of this plain meaning rule as a means to restrict federal

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[51] § 1332(d)(11)(B)(i) (citation omitted) (emphasis added).

[52] *See* Jacob Durling, Note, *Waltzing Through a Loophole: How Parens Patriae Suits Allow Circumvention of the Class Action Fairness Act*, 83 U. Colo. L. Rev. 549, 582 (2012).

[53] A sub-set of the textualist theory of statutory interpretation, the plain meaning approach emphasizes a strong preference for literal or conventional interpretation. This plain meaning approach has several variations, ranging from a conclusive presumption that the plain language always governs to milder approach under which the plain language merely is a starting point. *See* Geoffrey P. Miller, *Pragmatics and the Maxims of Interpretation*, 1990 Wis. L. Rev. 1179, 1199 (1990) ("The plain meaning rule expresses the principle that where the statute is narrowly and tightly drawn, the courts have considerably less interpretive flexibility than when the statute is phrased in vague or general terms."); *id*. at 1222–23 (examining the variations of the plain meaning rule).

But, the plain meaning approach has been the subject of much scholarly criticism. *See, e.g.*, Arthur W. Murphy, *Old Maxims Never Die: The "Plain Meaning Rule" and Statutory Interpretation in the "Modern" Federal Courts*, 75 Colum. L. Rev. 1299, 1317 (1975) (posturing that the plain meaning rule has outlived its usefulness because of its inconsistent application and because the rule does not answer deeper questions regarding the court's role in the legislative process); Richard A. Posner, *Statutory Interpretation—In the Classroom and in the Courtroom*, 50 U. Chi. L. Rev. 800, 807–08 (1983) (arguing that the proposition that courts adhering to the plain meaning rule necessarily begin with the text of the statute is false); *see also* United States v. Ron Pair Enters., Inc., 489 U.S. 235, 249 (1989) (O'Connor, J., dissenting) (questioning the value of facial plain meaning when taken out of context since the "notion that because the words of a statute are plain, its meaning is also plain, is merely pernicious oversimplification.").

[54] Barnett Bank of Marion Cnty., N.A. v. Nelson, 517 U.S. 25, 38 (1996) (holding that courts must apply the plain language of statutes).

courts' impulses to construe statutes to serve policy goals other than the ones Congress articulated within the statute itself.[55] Since the word "person" is not defined anywhere in § 1332(d), it should be understood in accord with its ordinary definition of "a human being."[56] Applying this rule of plain text interpretation to CAFA leads to the conclusion that a removable mass action merely requires the claims of "100 or more persons"[57] and not "100 or more plaintiffs." Therefore, the fact that a state via its attorney general is the only named plaintiff in litigation should not bar the action's removal as a "mass action" under CAFA.

Additionally, opponents and proponents of removal have clashed over the interchangeable use of the broad word "persons" and the more precise term "plaintiffs" in the definition of "mass action." Opponents of removal claim that the broad term "persons" should take its meaning from the narrower term "plaintiffs."[58] The confusion stems from the provision's use of both "persons" and "plaintiffs" in the definition of "mass action:"

> [A]ny civil action (except a civil action within the scope of section 1711(2)) in which monetary relief claims of 100 or more *persons* are proposed to be tried jointly on the ground that the *plaintiffs'* claims involve common questions of law or fact, except that jurisdiction shall exist only over those *plaintiffs* whose claims in a mass action satisfy the jurisdictional amount requirements under subsection (a).[59]

The wording opens the door to the possibility that "plaintiffs" refers back to the broader term "persons" and, thus, that a removable "mass action" requires the claims of 100 or more plaintiffs, which would bar removal of *parens patriae* suits since the state via its attorney general is the lone plaintiff in the litigation. This possibility, however, should be rejected as it would improperly narrow the text of the statute, as chosen specifically by the drafters.

In the context of aggregate litigation, the drafters have labored to find a vocabulary that properly includes all of the persons and parties that have an interest in the proceedings,[60] and in the "mass action" provision of CAFA, the drafters deliberately chose to use the

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[55] Robin Kundis Craig, *The Stevens/Scalia Principle and Why It Matters: Statutory Conversations and a Cultural Critical Critique of the Strict Plain Meaning Approach*, 79 Tul. L. Rev. 955, 972 (2005).

[56] *Person*, Dictionary.com, *available at* http://dictionary.reference.com/browse/person (last visited Nov. 9, 2013).

[57] 28 U.S.C. § 1332(d)(11)(B)(i) (2006).

[58] This claim somewhat resembles the principle of *ejusdem generis* which states that general terms in a list take their meaning from the preceding specific terms. For a more in-depth explanation of the principle of *ejusdem generis, see* Miller, *supra* note 53, at 1999–1200; Cecil L. Smith, *Statutory Interpretation—Ejusdem Generis—Strict Construction of Penal Statutes*, 29 Tex. L. Rev. 120, 120-23 (1950).

[59] § 1332(d)(11)(b)(i) (emphasis added).

[60] Guyon Knight, *The CAFA Mass Action Numerosity Requirement: Three Problems with Counting to 100*, 78 Fordham L. Rev. 1875, 1893 (2010) (commenting on the unusual and vague choice of the word "persons" in the mass action provision).

broad word "persons," rather than the more precise word "plaintiffs."[61] The difference between these two terms, in reference to the required numerosity of monetary relief claims, is meaningful. By choosing to use the broader term "persons," the drafters recognized that persons and parties may join a case in more ways than through formal joinder as plaintiffs, such as through intervention.[62] Especially in the context of complex aggregate litigation in which parties are not always neatly aligned, the use of the word "persons" allows CAFA to reach out and prevent abuses in instances in which the narrow label of "plaintiff" might not formally apply.[63] To relate back and substitute the word "plaintiffs" for the term "persons" would trample over the legislators' deliberate choice of language and would transform the text and meaning of the statute into something that was not passed through the checks and balances system of bicameralism and presentment.[64] Therefore, although the interchange between "persons" and "plaintiffs" does cause some confusion, this choice of wording should not undermine the plain text of the statute which calls for the claims of 100 or more persons, not plaintiffs.

B. The Structure of the Statute

The structure of CAFA, specifically the interplay and overlap between "class actions" and "mass actions," has also caused some confusion. Somewhat perplexingly under CAFA, "mass actions" are both class actions[65] and are not class actions.[66] If a "mass action" meets the provisions of §§ 1332(d)(2) through (10), which detail when a class action is removable under CAFA, then a "mass action" is deemed to be a removable "class action."[67] If a mass action does not meet the aforementioned provisions, then it is not deemed a removable "class action." CAFA explicitly defines "mass actions" as:

> [A]ny civil action (except a civil action within the scope of section 1711(2)) in which monetary relief claims of 100 or more persons are proposed to be tried jointly on the ground that the plaintiffs' claims involve common questions of law or fact, except that jurisdiction shall exist only over those plaintiffs whose claims in a mass action satisfy the jurisdictional amount requirements under subsection (a).[68]

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[61] This contention—that the legislators intentionally chose to use the broader term—is a common defense to the *ejusdem generis* principle. *See* Miller, *supra* note 53, at 1200–01.

[62] *See* Knight, *supra* note 60, at 1893.

[63] *See id*. *See generally* Tidmarsh & Trangsrud, *supra* note 22.

[64] *See* Zedner v. United States, 547 U.S. 489, 509–10 (2006) (Scalia, J., concurring) ("I believe that the only language that constitutes 'a Law' within the meaning of the Bicameralism and Presentment Clause of Article I, §7, and hence the only language adopted in a fashion that entitles it to our attention, is the text of the enacted statute."); *see also* John F. Manning, *Textualism and the Equity of the Statute*, 101 Colum. L. Rev. 1, 70–78 (2001) (explaining the importance of the structure of bicameralism and presentment to originalists and textualists); John F. Manning, *Textualism as a Nondelegation Doctrine*, 97 Colum. L. Rev. 673, 712 (1997) (discussing the risks of circumventing bicameralism and presentment).

[65] 28 U.S.C. § 1332(d)(11)(A) (2006) ("[A] mass action shall be deemed to be a class action removable under paragraphs (2) through (10) if it otherwise meets the provisions of those paragraphs.").

[66] § 1332(d)(11)(B)(i).

[67] § 1332(d)(11)(A).

[68] § 1332(d)(11)(B)(i).

This definition differs from the § 1711(2)'s definition of class actions[69] as it makes no mention of Rule 23 of the Federal Rules of Civil Procedure or an equivalent state rule. Therefore, by its plain language, CAFA's definition of "mass actions" does not include Rule 23 class actions, and by CAFA's text, "mass actions" can be removable "class actions" without being brought under Rule 23 as required by traditional "class actions."

In examining this seeming perplexity of differing definitions of "class actions," courts have labeled mass actions to be "a kind of statutory Janus…[since] under CAFA, a mass action simultaneously is a class action (for CAFA's purposes) and is not a class action (in the traditional sense of Rule 23 and analogous state law provisions)."[70] Therefore, the term "class action," including qualifying "mass actions," as used in CAFA refers to those actions which may be removed with minimal diversity under CAFA, and "class action" under CAFA does not necessarily mean that the action is brought under Rule 23 or a state rule equivalent.

Although there is no dispute among the federal courts that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to Rule 23, the fact that the term "class action" under CAFA has a broader meaning than the term "class action" in the traditional Rule 23 sense lends support to the point that "mass actions," removable as CAFA "class actions," should be construed broadly to include *parens patriae* actions. A substantial overlap between "mass actions" and "class actions" exists in the structure of CAFA's text. Given this structural overlap, a broad interpretation of one term is inextricably intertwined with a broad interpretation of the other term.[71] Furthermore, an expansive construction of the scope of the statute is supported by the purpose of CAFA, which was enacted in order to curb procedural abuses regardless of the labels formally attached to the actions,[72] as well as by the drafters' instructions to construe the scope of CAFA "liberally" and to look beyond "lawsuits that are labeled 'class actions.'"[73]

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[69] § 1711(2) ("The term 'class action' means any civil action filed in a district court of the United States under rule 23 of the Federal Rules of Civil Procedure or any civil action that is removed to a district court of the United States that was originally filed under a State statute or rule of judicial procedure authorizing an action to be brought by 1 or more representatives as a class action.").

[70] Lowery v. Ala. Power Co., 483 F.3d 1184, 1195 n.27 (11th Cir. 2007).

[71] A conventional understanding of the idea of structural inference, as a mean for statutory interpretation, holds that when one part of a text is ambiguous, interpreters can clarify its meaning by considering how it fits within the context of related provisions—or the structure—of the statute in question. John F. Manning, *Separation of Powers as Ordinary Interpretation*, 124 Harv. L. Rev. 1939, 2034 (2011) (examining structural inference); *see also* Bradford R. Clark, *Federal Lawmaking and the Role of Structure in Constitutional Interpretation*, 96 Calif. L. Rev. 699, 720 (2008) (arguing that the context of a constitutional text may include "the structure created by the text"); Henry P. Monaghan, *The Supreme Court, 1974 Term—Foreword: Constitutional Common Law*, 89 Harv. L. Rev. 1, 13 n.72 (1975) (noting that structural considerations of a statute are often simply an embodiment of the actual text).

[72] *See infra* Part II.C.1 (discussing the drafters' choice to include a "mass action" provision in order to allow for removal of abusive actions that may not be formally brought as "class actions").

[73] *See infra* Part II.C.2 (discussing S. Rep. No. 109-14, at 34 (2005), *reprinted in* 2005 U.S.C.C.A.N. 1, 3).

C. The Purpose of the Statute

1. Why CAFA was Enacted

Legislators drafted CAFA in order to address two broad areas of concern: (1) the abuse of class action procedures in state courts and (2) abusive forum shopping by plaintiffs' attorneys. For years prior to its enactment in 2005, CAFA was a hotly debated piece of legislation.

Plaintiff's attorneys and organizations representing consumers, employees, and other types of frequent class litigants vehemently opposed CAFA. Opponents emphasized the importance of class actions as a device that allows for the remedy of wrongs that may be "too trivial to support individual lawsuits"[74] or wrongs that may be too expensive for plaintiffs to litigate individually.[75] Some opponents feared that CAFA would make it more difficult for plaintiffs to have their claims heard if federal judges with heavy dockets refused to grant standing to class action plaintiffs.[76] Additionally, opponents defended the pre-CAFA law as essential to the rights of states to enforce their own law, and from a federalism perspective, opponents expressed concern that CAFA's expansion of federal jurisdiction would wrongfully sweep state law claims brought by state citizens into federal courts.[77] Opponents contended that this expansion of federal jurisdiction was inconsistent with the principles of federalism and would also result in a substantially heavier workload for federal courts across the country.[78]

In contrast, CAFA legislation also had its fair share of ardent supporters. Corporations and organizations representing business interests typically supported the legislation,[79] and these proponents claimed that CAFA was necessary to prevent class action abuse.[80] Proponents claimed that the pre-CAFA law unfairly allowed plaintiff's attorneys to choose any state forum in which to file and litigate nationwide class action claims.[81] Consequently, plaintiff's attorneys often engaged in forum shopping and chose to file suits in "judicial hellholes," state court forums which were historically predisposed to hastily certify nationwide classes, or "magnet jurisdictions," small counties which had acquired reputations for being plaintiff-friendly and thus attracted a high volume of

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[74] *See* Emery G. Lee III & Thomas E. Willging, *The Impact of the Class Action Fairness Act on the Federal Courts*, 156 U. Pa. L. Rev. 1723, 1725 (2008).

[75] *See* John C. Coffee, Jr., *Understanding the Plaintiff's Attorney: The Implications of Economic Theory for Private Enforcement of Law Through Class and Derivative Actions*, 86 Colum. L. Rev. 669, 685 (1986) ("[T]he class action device lowers plaintiffs' litigation costs below the level that would be incurred by bringing individual suits . . . .").

[76] Allan Kanner, *Interpreting the Class Action Fairness Act in a Truly Fair Manner*, 80 Tul. L. Rev. 1645, 1660 (2006).

[77] Lee & Willging, *supra* note 74, at 1725–26.

[78] *Id*. at 1728.

[79] According to one study done by a consumer rights group, from 2000 to 2002, at least 100 large companies and pro-business organizations had at least 475 lobbyists advocating for the passage of CAFA. Kanner, *supra* note 76, at 1659.

[80] Lee & Willging, *supra* note 74, at 1725.

[81] Forum shopping itself is not an illegitimate tactic for lawyers, and CAFA, which provides for removal from state court by a defendant, is actually a method of forum shopping. Rather, CAFA's drafters and proponents were concerned with "abusive" practices of forum shopping.

class actions.[82] Proponents also pointed to the practice of "copy-cat" filings in which plaintiff attorneys would simultaneously file in numerous jurisdictions in order to find the most sympathetic judge.[83] Additionally, proponents of the legislation accused state court judges of being overly lax in applying Rule 23, certifying frivolous class actions as a form "blackmail" to force corporate defendants to pay settlement "ransoms" rather than undertaking expensive litigation costs, and denying corporate defendants their due process rights.[84] In response to opponents' criticism that CAFA violates principles of federalism by sweeping state law claims into federal court, proponents claimed that the litigation of large class action lawsuits in state courts was itself a violation and perversion of federalism and the intent of the framers.[85]

In their effort to curb abusive class action practices, the drafters of CAFA recognized that these practices occurred outside of the narrow context of suits brought under Rule 23, and thus, the drafters specifically included the provision for removable "mass actions." Mass actions originally emerged as a means for plaintiffs, who could not meet the class action requirements of Rule 23(b) of the Federal Rules of Civil Procedure, to aggregate their claims.[86] Mass actions also arose in states that did not have rules permitting class actions, as a way for large numbers of cases to be joined and then treated like class actions.[87] Thus, the history and purpose of mass action lawsuits are intertwined with class actions.[88]

The drafters of CAFA recognized that many of the abuses that occurred in class action lawsuits were also present in mass action lawsuits.[89] In some ways, the drafters concluded that the abuses in mass action lawsuits were more concerning since mass actions allowed plaintiff's attorneys to join unrelated claims arising from different transactions, a practice that could potentially confuse a jury into giving lucrative awards to individual plaintiffs who may not have suffered a real injury.[90] By drafting a separate and distinct "mass action" provision, the drafters astutely recognized that the removal of suits labeled "class actions" was insufficient in order to achieve the broad purposes

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[82] Lee & Willging, *supra* note 74, at 1725; Lemann, *supra* note 5, at 124 ("CAFA itself contains a rebuke of '[a]buses in class actions' by 'State and local courts' that are 'acting in ways that demonstrate bias against out-of-State defendants.'").

[83] Lemann, *supra* note 5, at 125.

[84] *Id*. at 124.

[85] *Id*. at 125.

[86] *See generally* Jack B. Weinstein, Individual Justice In Mass Tort Litigation (1995).

[87] *See* Howard M. Erichson, *Mississippi Class Actions and the Inevitability of Mass Action Litigation*, 24 Miss. C. L. Rev. 285, 286 (2005) (observing that Mississippi, which declined to adopt a state rule on class actions, is a "hotbed" of mass action litigation). *See generally* Francis E. McGovern, *Resolving Mature Mass Tort Litigation*, 69 B.U. L. Rev. 659 (1989).

[88] *See* Charles Silver & Lynn A. Baker, *Mass Lawsuits and the Aggregate Settlement Rule*, 32 Wake Forest L. Rev. 733, 736 (1997) ("Mass actions—lawsuits in which lawyers consensually represent large numbers of signed clients—are natural models for class actions . . . .").

[89] S. Rep. No. 109-14, at 46 (2005).

[90] S. Rep. No. 109-14, at 47 (2005); *see* Silver & Baker, *supra* note 88, at 751 ("The danger of attorney opportunism is predictably greater in mass actions than in conventional lawsuits.").

of CAFA. Therefore, the drafters included the provision regarding removable "mass actions," giving CAFA a broad scope of coverage over interstate class action lawsuits and similarly structured lawsuits that may not be brought formally under Rule 23.[91]

Construing the scope of CAFA broadly is consistent with the purposes behind its enactment.[92] The statute was initially enacted in order to prevent an array of procedural abuses, including the mistreatment of "mass actions" which do not necessarily fit into the narrow definition of "class actions."[93] CAFA's drafters acknowledged that many removable "mass actions" are actually "class actions in disguise."[94] Therefore, when enacting CAFA, the legislators did so with the goal of preventing a broad spectrum of abusive actions. This broad reading of CAFA's purpose is also reflected in the Senate Judiciary Committee's instruction to construe the term "class action" liberally.[95] Additionally, as covered in Part II.B, the fact that the term "class action" under CAFA has a broader meaning than the term "class action" in the traditional Rule 23 sense, combined with the structure of CAFA which creates substantial overlap between "class actions" and "mass actions," lends support to the point that the term "mass actions" should be construed liberally.[96] Therefore, taking into consideration the goal of the legislators who drafted and enacted the statute supports the proposition that CAFA should be construed to have a broad scope.

2. Liberal Interpretation of "Class Action"

Legislative history shows that CAFA's drafters were more concerned with the substance of claims, rather than the labels attached to lawsuits. Proponents of removal use this legislative history to support a broad interpretation of the scope of CAFA,[97] which would allow for the inclusion of *parens patriae* suits as removable "mass actions." In its instruction to interpret the definition of "class action" under CAFA, the Senate Judiciary Committee explicitly noted that:

> [T]he definition of "class action" is to be interpreted liberally. Its application should not be confined solely to lawsuits that are labeled "class actions" by the

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[91] Stephen B. Burbank, *The Class Action Fairness Act of 2005 in Historical Context: A Preliminary View*, 156 U. Pa. L. Rev. 1439, 1449 (2008); Kevin M. Clermont & Theodore Eisenberg, *CAFA Judicata: A Tale of Waste and Politics*, 156 U. Pa. L. Rev. 1553, 1554 (2008).

[92] In addition to valuing the specific intent of the drafters, legal scholars who emphasize the importance of legislative intent as the goal of statutory interpretation have looked to the legislature's general intent—its purpose—in enacting the law. *See, e.g.*, William N. Eskridge, Jr., *The New Textualism*, 37 UCLA L. Rev. 621, 626 (1990) ("[T]he Court views its role as implementing the original intent or purpose of the enacting Congress.").

[93] *See supra* notes 85–87 and accompanying text.

[94] S. Rep. No. 109-14, at 47 (2005).

[95] *See infra* Part II.C.2.

[96] *See supra* Part II.B.

[97] Proponents of legislative history as a tool for statutory interpretation argue that it is relevant to determining the legislative purpose in enacting legislation and also to assist in determining the meaning of specialized terms. *See* Stephen Breyer, *On the Uses of Legislative History in Interpreting Statutes*, 65 S. Cal. L. Rev. 845, 861 (1992); *supra*, notes 90–91.

> named plaintiff or the state rulemaking authority. Generally speaking, lawsuits that resemble a purported class action should be considered class action for the purpose of applying these provisions.[98]

Proponents of removal argue that this instruction to construe the scope of CAFA "liberally" and look beyond "lawsuits that are labeled 'class actions'" shows that the drafters intended the statute to be construed broadly.[99] By providing such an explicit instruction, the legislators expressed their specific intent for a liberal interpretation of removable "class actions." Since removable "mass actions" are "class actions" for the purposes of CAFA,[100] this instruction for liberal construction must include "mass actions." By including such an explicit Senate Judiciary Committee instruction, the legislators expressed their specific intent in favor of liberal interpretation of "class actions" and "mass actions," and any construction of CAFA should take such specific instruction into account.[101] Therefore, after examining the specific intent, as well as the general intent,[102] of the legislators,[103] the drafters' explicit instructions to look beyond the mere labels of lawsuits supports proponents' argument that CAFA should be construed broadly to include the removal of *parens patriae* suits as "mass actions."

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[98] S. Rep. No. 109-14, at 35 (2005), U.S. Code Cong. & Admin. News 2005, p. 3.

[99] *Id*.

[100] *See* 28 U.S.C. § 1332(d)(11)(A) (2006) ("[A] mass action shall be deemed to be a class action removable under paragraphs (2) through (10) if it otherwise meets the provisions of those paragraphs.").

[101] Many legal scholars emphasize the importance of legislative intent as the goal of statutory interpretation. *See, e.g.,* Eskridge, *supra* note 92, at 641 ("Given our society's commitment to representative democracy, the legislative background of statutes seems like an acceptable source of context."); Earl M. Maltz, *Statutory Interpretation and Legislative Power: The Case for a Modified Intentionalist Approach,* 63 Tul. L. Rev. 1, 9–10 (1988) (arguing that that theories of statutory interpretation which fail to give dispositive weight to legislative intent are inconsistent with the principle of legislative supremacy). *See generally*, Andrei Marmor, Interpretation and Legal Theory (1992) (arguing that the goal of statutory interpretation should be the legislature's intent). Even more narrowly, these subscribers to an intentionalist theory of interpretation argue that the specific intent of the legislators—their actual decision regarding an issue of statutory scope or application—is paramount. *See, e.g.*, Thomas W. Merrill, *The Common Law Powers of Federal Courts*, 52 U. Chi. L. Rev. 1, 24–27 (1985) (contending that concerns regarding separation of powers and electoral accountability limit federal courts to interpreting statutes based on the specific intentions of the enacting body).

[102] *See supra* Part II.C.1.

[103] Many scholars distinguish between legislative intent with respect to a specific controversy and a more general legislative purpose. *See, e.g*., Cass R. Sunstein, After the Rights Revolution 127 (1990) (differentiating between ascertaining "a general legislative aim or purpose" and "how the enacting legislature wanted the [specific] question to be resolved."); William Popkin, *Foreword: Non-Judicial Statutory Interpretation*, 66 Chi.-Kent L. Rev. 301, 307 (1990) (discussing the problem of specific statements in legislative history). For the purposes of this Paper, I contend that legislative intent with respect to a specific controversy and a more general legislative purpose both support an argument for removal.

3. Rejection of the Pryor Amendment

Legislative history also shows that CAFA's drafters considered excluding *parens patriae* suits from the scope of CAFA, but deliberately chose not to adopt this exclusion. When drafting CAFA, Congress specifically considered an amendment that would have disqualified representative actions by state attorneys general from removal to federal courts under CAFA.[104] This provision, named the "Pryor Amendment" after Senator Mark Pryor who sponsored the amendment, was proposed to protect state interests, in light of federalism concerns.[105] Senator Pryor, a former state attorney general, argued that state attorneys general should "be allowed to pursue their individual State's interests as determined by themselves and not by the Federal Government" and advocated that the amendment was necessary to avoid "infringement on State rights . . . ."[106] After much debate, Congress eventually rejected this amendment and, thus, chose not to exclude *parens patriae* suits from CAFA's scope. Congress's choice not to legislate an explicit exclusion of *parens patriae* suits from CAFA's scope has become the topic of much debate between proponents and opponents of removal of *parens patriae* suits.

Opponents of removal of *parens patriae* suits argue that this amendment was rejected because Congress concluded it was unnecessary since these *parens patriae* suits fell outside the scope of CAFA, with or without this specific amendment. Specifically, these opponents point to Senator Chuck Grassley's argument that "because almost all civil suits brought by State attorneys general are *parens patriae* suits, similar representative suits or direct enforcement actions, it is clear they do not fall within this definition [of class actions]."[107] Consequently, Senator Grassley concluded that *parens patriae* suits would remain unaffected by CAFA and that the proposed amendment was unnecessary.[108] Thus, opponents of removal point to this piece of legislative history to support their argument that the drafters never intended for CAFA to remove *parens patriae* suits to federal court.

In contrast to this argument that the amendment was rejected as an unnecessary addition, proponents of removal of *parens patriae* suits argue that the legislative history shows that the amendment was rejected due to concerns over creating a loophole that would allow continued abuse of class and mass actions in state court. Legislative history demonstrates that the drafters of CAFA were concerned that such an amendment would allow state attorneys general to manipulate CAFA to keep class action suits in state court that actually belonged in federal court.[109] Undisputedly, CAFA was drafted for the purpose of curbing these abuses of class action procedures in state court. Senator

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[104] 151 Cong. Rec. S1157 (daily ed. Feb. 9, 2005).

[105] *Id*. at S1158 (daily ed. Feb. 9, 2005) (statement of Sen. Pryor that his amendment would protect "the intent of our Founding Father in recognizing that State sovereignty should not be dismissed by Federal action so easily.").

[106] *Id*. (statement of Sen. Pryor).

[107] *Id*. at S1163 (statement of Sen. Grassley).

[108] *Id*. at S1163 (statement of Sen. Grassley).

[109] *See id*. at S1163-64 (statement of Sen. Hatch).

Orrin Hatch explained the drafters' concern about creating a loophole that would allow continued abuse in state court in his statement:

> At best, [the amendment] is unnecessary. At worst, [the amendment] will create a loophole that some enterprising plaintiffs' lawyers will surely manipulate in order to keep their lucrative class action lawsuits in State court…If this legislation enables State attorneys general to keep all class actions in State court, it will not take long for plaintiffs' lawyers to figure out that all they need to do to avoid the impact of [CAFA] is to persuade a State attorney general to simply lend the name of his or her office to a private class action.[110]

Similarly in his rejection of the proposed amendment as unnecessary, Senator Grassley also acknowledged that the amendment could create "a very serious loophole in [CAFA]."[111] Likewise, Senator Arlen Specter noted that state attorneys general could abuse the proposed amendment by "deputizing" private attorneys into bringing their class actions in state courts.[112] Therefore, in their rejection of the proposed amendment to exclude *parens patriae* suits from CAFA's removal provisions, at least a portion of the drafters expressed concern that such an exclusion would allow for continued abuse and defeat the purpose of CAFA.[113] The rejection of the proposed amendment by this portion of drafters was not solely based on the amendment being deemed "unnecessary." Rather, rejection of the proposed amendment reflected the drafters' concern that a per se exclusion of *parens patriae* suits from CAFA's scope would allow for continued abuse of the very kind that CAFA was enacted to prevent.

With different portions of the debate regarding the rejection of the Pryor Amendment applicable to support arguments by both proponents and opponents of removal, the use of legislative history regarding the Pryor Amendment offers little value to support claims by either state attorneys general or pharmaceutical company defendants. Furthermore, the use of legislative history in statutory interpretation is itself a practice maligned

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[110] *Id*. (statement of Sen. Hatch).

[111] *Id*. at S1163 (statement of Sen. Grassley). Senator Grassley's statement that this amendment was unnecessary since *parens patriae* suits do not "fall within the definition [of class actions]" and his statement that such an amendment could create a "very serious loophole" seem contradictory. *Id*. These statements can be understood and reconciled best if Senator Grassley meant that true *parens patriae* suits in which the state has a genuine sovereign or quasi-sovereign interest do not "fall within the definition [of class action]." *Id*. Implicitly, this means that some *parens patriae* suits are abusively mislabeled and should be removed to federal court.

[112] *Id*. at S1161 (statement of Sen. Specter).

[113] Data on the frequency that state attorneys general actually engage in abuse by lending their name to private plaintiff lawyers is difficult to obtain. But, despite the unavailability of such data, the opportunity for such abuse is great, especially in the context of pharmaceutical litigation. In pharmaceutical litigation, state attorneys general frequently work in conjunction with and/or contract work to private plaintiff attorneys. Gussack & Ray, *supra* note 13, at 225. Instead of working on the litigation with their own staffs, state attorneys general often hire private attorneys to bring the cases on the states' behalf. *Id.* Lately, these alliances have come under increased scrutiny and suspicion. *Id*. Given the frequent co-mingling between state attorneys general and private plaintiff's attorneys in pharmaceutical litigation, the threat of a state attorney general lending his or her name to a private lawsuit is entirely credible.

by many scholars[114] and justices,[115] and in instances such as this where statements of different legislators support conflicting interpretations, an argument for the limited value of legislative history is even more persuasive.[116] Since no portion of the Pryor Amendment was incorporated into the final version of CAFA, nothing in the text of the statute indicates which legislative statements were the more reliable, more accurate indicators of the rationale behind the vote of the whole legislative body. Furthermore, with only the conflicting statements of the legislative debate to rely on, one drafter's statement cannot be construed to carry more weight or be labeled more "correct" than another drafter's statement. Therefore, in light of this direct conflict between the drafters over the Pryor Amendment, legislative history should factor into interpretation of CAFA, if at all, only based on the undisputed instruction by the Senate Judiciary Committee to interpret the definition of class action "liberally" and to look beyond the labels of lawsuits when determining the statute's scope.[117] This limited use of legislative

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[114] *See e.g.*, William R. Bishin, *The Law Finders: An Essay in Statutory Interpretation*, 38 S. Cal. L. Rev. 1, 14, 16–17 (1965) (arguing that legislative history represents the position of "only a very small portion of the lawmaking body" and thus should not be considered when interpreting statutes); Frank H. Easterbrook, *Statutes' Domains*, 50 U. Chi. L. Rev. 533, 547 (1983) ("Because legislatures comprise many members, they do not have 'intents' or 'designs,' hidden yet discoverable."); Max Radin, *Statutory Interpretation*, 43 Harv. L. Rev. 863, 870 (1930) (calling legislative intent an "absurd fiction" that should not be taken into account since the legislature as a whole has "has no intention whatever in connection with words which some two or three men drafted . . .").

[115] During his confirmation hearing, Justice Scalia voiced his displeasure towards using legislative history:

> Once it was clear that the courts were going to use [committee reports] all the time, they certainly became a device not to inform the rest of the body as to what the intent of the bill was, but rather they became avowedly a device to make some legislative history and tell the courts how to hold this way or that. Once that happens, they become less reliable as a real indicator of what the whole body thought it was voting on.

Nomination of Judge Antonin Scalia Before the S. Comm. on the Judiciary, 99th Cong. 106 (1986) (statement of J. Scalia). Most scholars consider Justices Scalia and Thomas to be textualists. *See* Thomas W. Merrill, *Textualism and the Future of the Chevron Doctrine*, 72 Wash. U. L. Q. 351, 351 (1994); Michael P. Van Alstine, *Dynamic Treaty Interpretation*, 146 U. Pa. L. Rev. 687, 717 (1998).

[116] This point is part of a much larger scholarly debate as to the extent in which courts should use legislative history and non-textual sources to interpret statutes. *See* Philip P. Frickey, *From the Big Sleep to the Big Heat: The Revival of Theory in Statutory Interpretation*, 77 Minn. L. Rev. 241, 256 (1992) (examining the Supreme Court's differing views regarding textualism and intentionalism); Patricia M. Wald, *The Sizzling Sleeper: The Use of Legislative History in Construing Statutes in the 1988-89 Term of the United States Supreme Court*, 39 Am. U. L. Rev. 277, 281-82 (1990) (noting the controversy at the Supreme Court over the use of legislative history when construing statutes); Nicholas S. Zeppos, *Legislative History and the Interpretation of Statutes: Toward a Fact-Finding Model of Statutory Interpretation*, 76 Va. L. Rev. 1295, 1314 (1990) ("There are many examples where the textualist has at least arguably reached a result contrary to that which would likely have been reached by the intentionalist."). Textualists advocate for the exclusion of reliance on legislative history, even in cases of ambiguity, on the grounds that such history is unenacted and therefore does not reliably reflect legislative understandings of statutory meaning. *See* Scalia, *supra* note 40, at 29–36; Jonathan T. Molot, *The Rise and Fall of Textualism*, 106 Colum. L. Rev. 1, 38 (2006) ("Textualists tend to exclude one particular piece of evidence: legislative history."). Intentionalists, in contrast, advocate for the use of legislative history in statutory interpretation.

[117] S. Rep. No. 109-14, at 35 (2005), *reprinted in* 2005 U.S.C.C.A.N. 3, 34.

history supports the argument made by proponents of removal that CAFA has a broad scope and that *parens patriae* suits should not be excluded from removal.

III. POLICY IMPLICATIONS

After making arguments for or against removal of *parens patriae* suits based upon the text, structure, and purpose of CAFA, state attorneys general and pharmaceutical company defendants come to one final point of contention—whether removal of *parens patriae* suits under the "mass action" provision would violate fundamental principles of federalism.

Since the inception of the statute, opponents of removal have feared that CAFA's expansion of federal jurisdiction would wrongfully sweep state law claims, brought on behalf of state citizens, into federal courts.[118] Opponents argue that state courts have the most interest in overseeing *parens patriae* suits, since by their very nature these actions concern the rights of state citizens, and opponents to removal contend that an expansion of federal jurisdiction over such state-centric actions violates the fundamental principles of federalism.[119] In response to opponents' criticism that CAFA violates principles of federalism by sweeping state law claims into federal court, proponents of removal claim that the litigation of large class action lawsuits in state courts is itself a perversion of federalism and would violate the framers' intent.[120] Proponents argue that removal would not undermine the fundamental principles of federalism since state courts are not the appropriate forums for large, interstate class actions that may span many states and involve citizens from several states.[121] This rebuttal of opponents' federalism concerns is less persuasive in the context of *parens patriae* suits since those actions, by their very nature, do not involve citizens of many different states. The seriousness of concerns regarding federalism has led several of the Circuits that remain split over removal of *parens patriae* actions to acknowledge and address this policy issue.[122]

Hesitation over sweeping state law claims into federal court is a serious policy concern,[123] and broad removal of all *parens patriae* suits would indeed interfere with

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[118] *See supra* Part II.C.1.

[119] *See supra* Part II.C.1.

[120] *See* Pub. L. No. 109-2, § 2(b)(2), 119 Stat. 4 (2005).

[121] *See supra* Part II.C.1.

[122] The Fourth Circuit also noted that a finding of federal jurisdiction over *parens patriae* actions "would risk trampling on the sovereign dignity of the State and inappropriately transforming what is essentially a West Virginia matter into a federal case." West Virginia *ex rel.* McGraw v. CVS Pharmacy, Inc., 646 F.3d 169, 178 (4th Cir. 2011). The court noted that a federal court should be extremely reluctant to compel this type of removal and should reserve its constitutional supremacy only for when removal serves an overriding federal interest. *Id*.

Although the Fifth Circuit ultimately held that the State of Louisiana had waived its sovereign immunity by joining private parties in the lawsuit and could be involuntarily removed to federal court, the court acknowledged and addressed federalism concerns in a portion of its opinion. Louisiana *ex rel.* Caldwell v. Allstate Ins. Co., 536 F.3d 418, 431-32 (5th Cir. 2008).

[123] *See* Virginia F. Milstead, *State Sovereign Immunity and the Plaintiff State: Does the Eleventh Amendment Bar Removal of Actions Filed in State Court?*, 38 J. Marshall L. Rev. 513, 521–22 (2004) (examining the problem of whether a waiver and consent to suit in one court necessarily translates to waiver and consent in a different court); Heather Scribner, *Protecting Federalism*

state enforcement of state law and hinder the right of states to function independently.[124] But, broad removal of all *parens patriae* actions is not the issue of present concern. Recalling that there is no dispute amongst courts that *parens patriae* suits seeking enforcement actions and civil penalties are not removable under CAFA,[125] federalism concerns are not an issue in civil penalties and enforcement actions, in which the remedy sought is legitimately in the interest of the state and not private citizens. Since civil penalties and enforcement actions are left undisturbed in state court, only suits in which state attorneys general seek money damages on behalf of private citizens implicate these federalism concerns. Since the remedy sought in these *parens patriae* suits is no different from the remedy sought in suits brought by private citizens, it seems odd to hold that federalism concerns require these *parens patriae* suits to stay in state court while actions by private citizens could reach a federal forum through § 1332's diversity jurisdiction, simply because the state attorney general attaches his or her name to the lawsuit. Additionally, in the event that the state attorney general is engaging in jurisdictional gamesmanship by bringing a *parens patriae* suit in order to pursue money damages in a favorable state court, the risk of trampling upon a state's dignity by hauling it unwillingly into federal court seems to be of far less concern than the risk of allowing such an abusive practice by the state attorney general.[126]

Furthermore, hesitation over bringing state law claims into federal court has not created a policy concern that is so serious as to stop scholars and courts from generally agreeing that suits brought by state attorneys general are removable "class actions" as long as they are brought under state statutes that are "similar" to Rule 23.[127] Although federal courts have not had the occasion to hold *parens patriae* suits removable "class actions" under CAFA, since the actions in question have not been brought under statutes "similar" to Rule 23, *parens patriae* actions have been classified as "class actions" outside of a CAFA context.[128] Therefore, it logically follows that, under the appropriate procedural circumstances, *parens patriae* suits may be "class actions" within the context of CAFA.

Interests After the Class Action Fairness Act of 2005, 51 Wayne L. Rev. 1417 *passim* (2005) (arguing that CAFA addressed a "horizontal federalism" problem but created a serious "vertical" one); Georgene M. Vairo, *Judicial v. Congressional Federalism: The Implications of the New Federalism Decisions on Mass Tort Cases and Other Complex Litigation*, 33 Loy. L.A. L. Rev. 1559 *passim* (2000) (examining federalism implications in mass tort litigation).

[124] Lemann, *supra* note 5, at 151.

[125] *See supra* Part I.

[126] Lemann, *supra* note 5, at 151.

[127] *See supra* Part I.

[128] *See* Edward Brunet, *Improving Class Action Efficiency by Expanded Use of Parens Patriae Suits and Intervention*, 74 Tul. L. Rev. 1919, 1922 (2000) ("[I]t is possible for a state to initiate parens patriae suits in a class action format . . . ."); Jack Ratliff, *Parens Patriae: An Overview*, 74 Tul. L. Rev. 1847, 1854 (2000) ("The authority is not particularly robust, but the general approach seems to be that a state attorney general may bring a class action on behalf of a class."); *see also* Alabama v. Chevron U.S.A., Inc., No. CIV.A.78-51-N, 1980 WL 1808, at *1, *2 (M.D. Ala. Jan. 11, 1980) (allowing a class action suit brought by the State on behalf of the State's public entities that had purchased liquid asphalt from the defendants); *In re* Antibiotic Antitrust Actions, 333 F. Supp. 278, 284 (S.D.N.Y. 1971) (approving a class of states bringing *parens patriae* cases on behalf of citizen who had purchased antibiotics); *In re* Sclater, 40 B.R. 594, 599 (Bankr. E.D. Mich. 1984) ("Attorneys general have been held to be proper class representatives.").

This idea is supported by the fact that the otherwise split Circuits agree that such a procedural situation would qualify as a removable "class action" under CAFA, as long as the suit is brought under a statute "similar" to Rule 23.[129] Because courts and scholars have not deemed federalism concerns sufficiently serious to bar the removal of *parens patriae* suits as "class actions," this same hesitation over bringing state law claims into federal court should not bar the removal of *parens patriae* actions seeking money damages as "mass actions" under CAFA. Therefore, although removal of *parens patriae* suits under the "mass action" provision of CAFA implicates some concerns over the violation of principles of federalism, these concerns should not carry the day and prevent removal of actions that are otherwise removable under the text, structure, and purpose of CAFA.

CONCLUSION

The application of CAFA's removable "mass action" provision to *parens patriae* suits seeking money damages is a complex problem, with far reaching and serious implications upon a variety of areas, including pharmaceutical litigation. With federal courts split as to this key question, proponents and opponents of removal are forced to turn to the statute itself. An examination of CAFA's text, structure, and purpose reveal nothing that would prohibit *parens patriae* actions seeking money damages from removal to federal court. Since the plain text of CAFA's "mass action" provision does not bar the removal of *parens patriae* suits and the legislative history of CAFA offers little insight other than an unchallenged instruction to interpret "class actions" broadly, these types of actions should be removable under CAFA's "mass action" provision.

[129] *See supra* Part I.

Waging War on Specialty Pharmaceutical Tiering In Pharmacy Benefit Design

By Chad Brooker[*]

INTRODUCTION

Specialty pharmaceuticals (hereinafter "specialty drugs"), also known as biologics,[1] are an increasingly prevalent and important consideration for health insurers. By the end of 2009, over six hundred specialty drugs were known to be in development.[2] Demonstrating this development trend, the FDA approved twice as many specialty drugs

[*] Chad Brooker received his J.D. from the University of Maryland School of Law in 2013. He is currently the Chief Policy and Legal Analyst for the Connecticut Health Insurance Exchange (d.b.a Access Health CT) and he is a former Exchange Policy expert at the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. He was also previously the lead advisor on Specialty Pharmaceutical and FDA Trend for America's Health Insurance Plans (AHIP) and an Exchange Policy expert at the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

[1] *See FDA 101 Regulating Biologic Products*, Food and Drug Admin. (2008), http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048341.htm (last visited Dec. 4, 2013). A "biologic drug" is one that is made from a living organism. *Id.* "Biotechnology" refers to the application of biological techniques to research and develop new products such as proteins, hormones, vaccines, monoclonal antibodies, and gene therapy. *Id.*

[2] Brian Schilling, *Purchasing High Performance Specialty Drug Costs Poised to Skyrocket but Many Employers Have Yet to Take Note*, The Commonwealth Fund (Apr. 11, 2012), http://www.commonwealthfund.org/Newsletters/Purchasing-High-Performance/2012/April-11-2012/Featured-Articles/Specialty-Drug-Costs-Poised-to-Skyrocket.aspx.

(fourteen) in 2010 as it did traditional pharmaceuticals.[3] That number increased in 2011 when the FDA approved eighteen new specialty drugs.[4] Furthermore, manufacturers are increasingly investing more research and development funds in specialty drugs due to the robust profit margins on specialty drugs.[5] Since specialty drugs typically address chronic illnesses, patients may use these drugs for a long period of time, providing manufactures with a continuous supply of returning customers. Consequently, specialty drugs have "been described as 'jackpot' drugs for manufacturers."[6]

The high cost of specialty pharmaceuticals is the result of the culmination of a number of factors. First, the development costs of producing specialty drugs are high because scientists must rely on molecular and cellular technologies, which are often derived from living organisms or other biological mediums rather than the chemical processes used to make traditional pharmaceuticals.[7] However, this unique development process is also why specialty drugs typically yield significant therapeutic results with fewer side effects.[8] Furthermore, specialty drugs often require complex handling, such as refrigeration and attention to their limited shelf life, and many require complex administration, such as intravenous delivery, which makes them even more expensive.[9] Finally, few specialty drugs have therapeutic or generic equivalents, due to existing patents and the fact that generics are difficult to manufacture given the complexity of their replication and production.[10] This creates very limited or non-existent market competition, allowing pharmaceutical companies to charge exceedingly high rates for specialty drugs while continuing to raise prices year after year.[11]

The trend towards increased reliance on specialty pharmaceuticals would not raise such an important concern if specialty drugs did not represent the most expensive segment of pharmaceuticals not only for insurers, but also for consumers through cost-sharing measures. In 2000, only one specialty drug was on the list of the top ten selling drugs.[12] In 2010, three of the top ten selling drugs were specialty pharmaceutical products.[13] Individuals within the pharmaceutical industry predict that by 2016, seven of the top

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[3] Leah Perry, *2012 Drug Pipeline: Researchers, Industry Experts Remain Optimistic*, Drug Topics (Jan. 15, 2012), http://drugtopics.modernmedicine.com/drugtopics/Modern+Medicine+Now/2012-Drug-Pipeline-Researchers-industry-experts-re/ArticleStandard/Article/detail/756729.

[4] *Id.*

[5] Shilling, *supra* note 2.

[6] *Id*.

[7] *See supra* note 1.

[8] *Id.; see also* Perry, *supra* note 3.

[9] Adam J. Fein, *7 Reasons Why Specialty Drug Dispensing Will Boom*, Specialty Pharmacy Times (May 29, 2012), http://www.specialtypharmacytimes.com/publications/specialty-pharmacy-times/2012/June-2012/7-Reasons-Why-Specialty-Drug-Dispensing-Will-Boom.

[10] *See supra* note 1; *see also* Perry, *supra* note 3.

[11] *Specialty Drug Benefit Report*, Pharmacy Benefit Management Institute (2013), *available at* http://www.specialtydrugbenefitreport.com (last accessed Dec. 4, 2013).

[12] 2000 Drug Trend Report, Express Scripts (2000), *available at* http://www.drugtrendreport.com/docs/DTR-2000.pdf; s*ee also* Schilling, s*upra* note 2.

[13] Fein, *supra* note 9.

ten selling drugs will be classified as specialty pharmaceutical products.[14] According to the Pharmacy Benefit Management Institute's 2012 report, insurance plans report that the average monthly cost of a specialty drug is at least $2,000.[15] Tretinoin, a specialty drug that can help manage some complications of leukemia, costs $6,800 a month.[16] The most expensive cancer specialty treatments can cost upwards of $750,000 per year for a single patient.[17] A 2011 AARP study reported that the average annual cost for a patient who was taking just one specialty drug was $34,550.[18] Specialty drugs do not typically face competition from generics or other drugs, so manufacturers have not hesitated to raise the prices of such drugs annually.[19] As the prevalence and costs of these drug regimens increases (with a seventeen percent increase in average cost in 2011 and a twenty percent average increase in 2012), insurance plans have sought to control their spending on specialty drugs through a number of formulary policies, as well as increased cost-sharing.[20]

Insurers have reacted to the large and increasing costs of pharmaceuticals, attributed in part to the high costs of specialty drugs, by shifting some of the burden of these costs back onto the insurance policy beneficiaries.[21] The most common method of achieving this is through the creation of specialty tiers. Tiering generally refers to a health plan placing a drug on a formulary or preferred drug list, which classifies drugs as generic (tier one), preferred brand (tier two), or non-preferred brand (tier three) pharmaceuticals.[22] The idea of paying differing amounts of money for different types of prescription drugs is not a new concept. Employers and insurers have long used tiers to set the amount that patients pay for generic drugs, brand-name products, and non-preferred brand-name drugs. A large majority of beneficiaries in employer-sponsored

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[14] *Id.*

[15] *Specialty Drug Benefit Report*, *supra* note 11; *see also The Growing Cost of Specialty Pharmacy—Is it Sustainable?*, Am. J. of Managed Care, http://www.ajmc.com/payer-perspectives/0213/The-Growing-Cost-of-Specialty-PharmacyIs-it-Sustainable (last visited Dec. 21, 2013).

[16] *See* Specialty Drug Benefit Report, *supra* note 11.

[17] Schilling, *supra* note 2; *see also* 2012 Drug Trend Report, Express Scripts (2013), http://www.drugtrendreport.com/docs/DTR-FullPDF-1029.pdf.

[18] Susan Dentzer, *Slowing the Impact: The Role of Specialty Pharmacy in Managing Progressive and Chronic Diseases*, United Health Grp. (April 2011), http://www.unitedhealthgroup.com/news/rel2011/Specialty-Pharmacy-WP-Diseases.pdf.

[19] Schilling, *supra* note 2.

[20] *See* Specialty Drug Benefit Report, *supra* note 11; *see also* 2012 Drug Trend Report, *supra* note 17.

[21] Mari Edlin, *Specialty Tier Falls Out of Favor Because of Access Issues*, Formulary J. (Jan 1, 2012), http://formularyjournal.modernmedicine.com/news/specialty-tier-falls-out-favor-because-access-issues ("In Medicare, 100% of Part D enrollees in Medicare Advantage-Prescription Drug Plans (MA-PDPs) and 94% in Medicare stand-alone Prescription Drug Plans (PDPs) are in plans with a specialty tier. The median coinsurance for specialty drugs under PDPs—those costing at least $600 per month—increased from 25% in 2006 to 30%, while MA-PDPs showed a change of 25% to 33%. About half of PDPs charge a 33% coinsurance, while more than three-fourths of MA-PDPs do.").

[22] National Patient Advocate Foundation. *White Paper: Specialty Tiers* (May 2013), http://www.npaf.org/files/5%207%2013%20Specialty%20Tiers%20White%20Paper%20Final_0.pdf.

health care plans have a tiered cost-sharing structure for prescription drug coverage.[23] Given that cost-sharing generally increases with higher tiers, these types of insurance policies have helped increase the use of generic drugs, which are generally cheapest and on which insurers receive the largest discounts.[24]

Under a traditional three-tier prescription drug formulary, a beneficiary is given a choice between more and less expensive equivalent medications for the same disease or health condition. Thus, a beneficiary who is prescribed a tier three drug can decide that he or she does not want to pay the higher copayment and find a chemically equivalent drug at a lower cost on tiers one or two. As such, three-tier plans are said to achieve the following:

> (1) they provide a tool to discourage beneficiaries from making choices that lead to utilization of higher-cost drugs (i.e., discourage moral hazards); (2) they reduce demand for brand-name drugs that was exacerbated by drug company advertising; (3) they move away from undifferentiated drug copayments and help control costs; (4) they offer beneficiaries a choice of medications for a particular disease or condition that vary in cost but not in effectiveness; and (5) because they lower a health insurance company's overall cost to provide insurance, they allow the health insurance company to increase the number of persons who can access insurance benefits and/or lower insurance costs for the individuals already in the insurance pool.[25]

However, unlike the first three tiers, specialty drugs appearing on specialty drug tiers (i.e., tiers four and higher) often do not have generic or lower-cost brand-name equivalents.[26]

Specialty tiers—tiers four and beyond—began to expand in 2006 once the strategy was adopted by Medicare Part D.[27] With Medicare leading the movement, an increasing number of private plans have created a fourth (or higher) tier of drug cost-sharing that is used for specialty or lifestyle drugs.[28] Today, about eighty-five percent of Medicare drug plans include such tiers.[29] As the prevalence of specialty pharmaceutical regimens

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[23] Gary Claxto et al., Employer Health Benefits: 2012 Summary of Findings, The Kaiser Family Foundation & Health Research and Education Fund. 4 (Sept. 11, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf ("Over three-quarters (78%) of covered workers are in plans with three or more tiers of cost-sharing, a figure that has increased tremendously in the past decade.").

[24] Julie Appleby, *Specialty Drugs Offer Hope, But Can Carry Big Price Tags,* USA Today, Aug. 8, 2011, http://usatoday30.usatoday.com/money/industries/health/drugs/story/2011/08/Specialty-drugs-offer-hope-but-can-carry-big-price-tags/50090368/1.

[25] Joseph J. Hylak-Reinholtz & Jay R. Naftzger, *Is It Time to Shed A "Tier" for Four-Tier Prescription Drug Formularies? Specialty Drug Tiers May Violate HIPAA's Anti-Discrimination Provisions and Statutory Goals*, 32 N. Ill. U. L. Rev., 33, 42 (2011).

[26] Bill Walsh, *The Tier 4 Phenomenon: Shifting the High Cost of Drugs to Consumers*, Amer. Assn. of Retired Persons (Mar. 9, 2009), http://assets.aarp.org/rgcenter/health/tierfour.pdf.

[27] Julie Appleby, *Workers Squeezed as Employers Pass Along High Costs of Specialty Drugs*, Kaiser Health News (Aug. 22, 2011), http://www.kaiserhealthnews.org/stories/2011/august/22/workers-squeezed-as-employers-pass-along-high-costs-of-specialty-drugs.aspx.

[28] *Id.*

[29] *Id.*

has grown, the popularity of specialty plans has grown accordingly.[30] Many payors see specialty tiers as an essential element that allows a higher percentage of the drug spending burden to be carried by those who are utilizing higher cost products, allowing beneficiaries who are not using such drugs to maintain lower premiums and cost-sharing.[31] Specialty tiers can either use a coinsurance or a copay cost-sharing scheme. Under a coinsurance scheme, the beneficiary will pay a certain percentage of the costs of the drug and the insurance company will pick up the remainder of the cost. Commonly, coinsurance rates for the specialty tiers range from twenty-eight to fifty percent.[32] As such, coinsurance is a burden for beneficiaries in that the costs of specialty drugs are very expensive and a requirement to pay a sizable percentage of that cost can amount to several hundred or thousands of dollars per month in cost-sharing. Among plans with four or more tiers, in 2012, fifty-five percent of those plans used only a copay—often about $100 per prescription per month—and thirty-six percent of plans used only coinsurance, percentage based cost-sharing—the average percentage was thirty-two percent.[33]

The insurance industry defends the creation of four-tiered plans, but the use of such plans has been met with severe criticism. Patient advocates argue that four-tier plans are unjust because insurance is supposed to spread the risk in an equitable fashion among all insured beneficiaries.[34] However, specialty tiers target those with chronic illness who may have very limited therapeutic options, "forcing many to choose between basic necessities and their medications."[35] On the other hand, insurance industry advocates argue that the use of specialty drugs has risen dramatically and having a tiered system helps to control the costs of premiums for all beneficiaries.[36] Karen Ignagni, the President of America's Health Insurance Plans, noted that "[p]rivate insurers began offering [specialty drug] plans in response to employers who were looking for ways to keep costs down."[37] She further noted, "[w]hen people who need [specialty] drugs pay more for them, other subscribers in the plan pay less for their coverage."[38]

The prevalence of fourth tier plans varies dramatically across health care markets. Four-tier designs are much less prevalent in markets characterized by historically high levels of unionized labor where the corporate benefits structures have been slow to disfavor

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[30] Gary Claxto et al., *supra* note 23, at 149 ("Fourteen percent of covered workers are in a plan that has four or more tiers of cost-sharing for prescription drugs—up from 3% in 2005. For covered workers in plans with three or more cost-sharing tiers, 55% face a copayment for fourth-tier drugs and 36% face coinsurance. The average copayment for a fourth-tier drug is $79 and the average coinsurance is 32%.").

[31] *Id*.

[32] *Id*.

[33] *Id.*

[34] *See* National Patient Advocate Foundation, *supra* note 22.

[35] Kris McFalls, *An Update on Specialty Tier Legislation*, FFF Enters. (Oct. 7, 2011), http://www.fffenterprises.com/News/Article_2011-10-07.aspx.

[36] Gina Kolata, *Co-Payments Soar for Drugs with High Prices*, N.Y. Times, Apr. 14 2008, http://www.nytimes.com/2008/04/14/us/14drug.html?pagewanted=all&_r=0.

[37] *Id.*

[38] *Id.*

valuable fringe benefit schemes.[39] Four-tier penetration also varies greatly by market segment: "the smaller an employer, the greater the price-consciousness and likelihood of adopting a four-tier design. Finally, differences among health plan and employer philosophies and strategies are key in four-tier adoption." [40] There is also a difference among insurance companies in adoption of the four-tier design. For example, Aetna and WellPoint have widely adopted four-tier designs.[41] In contrast, Cigna, does not offer four-tier pharmacy benefits in its fully insured product line; however, upon request from self-insured employers, it can provide these insurance products.[42] More recently, state legislatures have played an important role in affecting the prevalence of four-tiered plans as they seek to alleviate the cost-sharing burden on health insurance beneficiaries.[43]

I. THE COST-SHARING BURDEN OF SPECIALTY TIERS

Specialty drugs have represented the fastest growing segment of health insurance prescription drug spending for much of the last decade.[44] This trend should concern private health insurance payors because specialty pharmaceuticals are very expensive and most are too new, complex, or expensive to produce to experience competition from other branded drugs or generics (biosimilars).[45] While specialty drugs are only used by a small percentage of the population—potentially as low as two percent[46]—specialty drugs accounted for approximately twenty-four percent of total drug expenditures in 2011 and thirty percent of the $325.7 billion in drug expenditures in 2012.[47] Moreover,

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[39] Ha Tu & Divya Samuel, *Limited Options to Manage Specialty Drug Spending*, HSC Research Brief (Apr. 2012), http://www.hschange.com/CONTENT/1286.

[40] *Id.*

[41] *Id.* ("[A]bout half of their small-to-mid-sized group members were covered by such designs as of 2011.").

[42] *Id.* ("[C]iting concerns about affordability and patient adherence . . . .").

[43] New York, California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Mexico, Rhode Island, Vermont, Washington, Illinois, Indiana, Nebraska, Pennsylvania, Virginia, Louisiana, Florida, West Virginia, Alaska, Kansas, Mississippi, Maine, and Wisconsin all have previously introduced legislation regarding the use of specialty tiers in their state. However, only seven states have actually passed laws relating to tiering, and only ten states have active bills. Author research. *See also* Andrew Pollack, *States Seek to Curb Patients Bills for Costly Drugs*, N.Y. Times, A1, Apr. 13, 2012, http://www.nytimes.com/2012/04/13/health/states-seek-to-curb-exorbitant-drug-costs-incurred-by-patients.html?pagewanted=all&_r=0.

[44] *See* Specialty Drug Benefit Report, *supra* note 11.

[45] Biosimilars are generic versions of biologics that must prove that they are "biosimilar" and "interchangeable" with biologic reference products (the branded drugs) in order to be approved for sale in the consumer market. While the Biologics Price Competition and Innovation Act (part of the ACA) will help to create an abbreviated approval process for biosimilars so that they may gain easier and quicker FDA approval as long as they meet the Agency's standards for safety and efficacy. *Biosimilars,* Food and Drug Admin. (July 10, 2012), http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/default.htm.

[46] Ira Studin, *4 Payer Trends to Control Specialty Pharmacy Costs*, Managed Care (May 2012), http://www.managedcaremag.com/archives/1205/1205.sp_trends.html.

[47] *The Growing Cost of Specialty Pharmacy—Is it Sustainable?*, *supra* note 15. In 2010, total national health expenditures were $2.59 trillion dollars with retail prescription drugs accounting for 10% of that amount or $250 billion. Martin A.B. et al., *Growth In US Health Spending Remained*

specialty drugs are anticipated to account for forty-five percent of total drug expenditures by 2017—up from a mere eight percent in 2006.[48] To put this in perspective, with current plan utilization rates, a moderately sized plan of one million members will be approaching one billion dollars in specialty drug spending annually.[49] Of these costs, almost fifty percent of which will be oncology related—cancer biologic costs increased 22.3 percent in 2012 alone.[50] If annual trends of twenty percent growth for spending on specialty drugs continue, that number will again double in less than four years.[51] The damaging potential of this growth has been muted due to the overall downward shift in drug costs in recent years as generic usage has increased; for example, in 2012, traditional drug spending actually decreased while specialty drug spending increased by 18.4 percent.[52] Reacting to this trend, insurance companies have developed prescription drug formularies with four or more tiers (hereinafter "specialty tiers"), in order to control the rising costs associated with expensive specialty drugs by sharing a greater amount of those costs with their patients.[53] While increased specialty drug cost-sharing is certainly warranted, the strain that it places on patients can create negative health and personal externalities.[54] As such, further effort should be exerted to reduce the burden on those patients who depend on these drugs and who often lack alternative treatment options.[55]

The key feature of specialty drug tiers is a drastically increased cost-sharing component, with the consumer paying a larger amount of the cost for expensive drugs. Such cost-sharing can take the form of much higher copayments, where the consumers pay a certain defined price for a drug in that category or coinsurance, where the consumer pays a percentage of the actual cost of the drug. The practice of cost-sharing has been widely criticized by politicians and patients who cite examples of destructive cost-sharing which could force a person to decide between a certain medication and other personal or familial necessities.[56] Because most specialty drugs are used to treat chronic

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Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009, Health Affairs (2012). In 2012, total drug expenditures had risen to $325.7 billion and specialty drug expenditures accounted for $99 billion of that number. Katie Thomas, *U.S. Drug Costs Dropped in 2012, but Rises Loom*, N.Y. Times, Mar. 18, 2013, http://www.nytimes.com/2013/03/19/business/use-of-generics-produces-an-unusual-drop-in-drug-spending.html?pagewanted=all; *Understanding Specialty Pharmacy Management and Cost Control*, Pharmaceutical Strategies Group (June 2010), http://www.psgconsults.com/Understanding_Specialty_Pharmacy_Management_and_Cost_Control_FINAL.pdf.

[48] *The Growing Cost of Specialty Pharmacy—Is it Sustainable?*, *supra* note 15; *see also* 2012 Drug Trend Report, *supra* note 20; Kim, Yoona A., et al, *Retrospective Evaluation of the Impact of Copayment Increases for Specialty Medications on Adherence and Persistence in an Integrated Health Maintenance Organization System* (Nov. 5, 2011).

[49] Artemetrx*, Specialty Drug Trend Across the Medical and Pharmacy Benefit* (2013), http://www.artemetrx.com/docs/ARTEMETRX_Specialty_Trend_Report.pdf

[50] *Id.*; *see also The Growing Cost of Specialty Pharmacy—Is it Sustainable?*, *supra* note 15.

[51] *Id.* According to the Express Scripts, 2012 Drug Trend Report, specialty trend (cost rate change + utilization rate change) rose 18.4% in 2012. 2012 Drug Trend Report, *supra* note 17.

[52] *Id.*; Katie Thomas, *supra* note 47.

[53] *See* Kim, Yoona A., et al, *supra* note 48.

[54] *Id*.

[55] *Id*.

[56] Pollack, *supra* note 43.

diseases such as cancer, rheumatoid arthritis, multiple sclerosis, and inherited disorders, the long-term costs to both the insurers and the patients raises serious concerns.

Spurred by patients and patient advocates, lawmakers in at least twenty states from Maine to Hawaii, have introduced legislation that would either ban specialty tiers or limit aggregate out-of-pocket payments by consumers for expensive specialty tier drugs.[57] New York State passed the first such law, in 2010, prohibiting the use of specialty tiers across the board for beneficiaries of plans offered in the state.[58] Pharmaceutical companies—that would benefit from such legislation because high copayments discourage patients from taking medications sold by pharmaceutical companies—have been helping the state legislatures craft such specialty tier limiting legislation.[59] Some companies, like Pfizer, have even drafted entire bills and have provided them to state legislatures, according to legislators and patient advocates.[60] Insurance companies are pushing back, arguing that reducing payments by users of expensive drugs would raise premiums for everyone else.[61]

State legislators must carefully consider the potential that their attempted protective measures—that ban specialty tiers or limit aggregate out-of-pocket payments by consumers for expensive specialty tier drugs—will be limited in effect by the Employee Retirement Income Security Act of 1974 (ERISA).[62] ERISA preemption applies to nullify state insurance laws that apply to self-insured ERISA plans.[63] As an ode to the traditional areas of state regulation, as evidenced by the McCarran Ferguson Act,[64] state laws directed at the business of insurance are saved from preemption by § 514 of ERISA,[65] also known as the "insurance savings clause." However, self-insured plans, where the employer funds the plan and takes on the risk in the plan, are not "deemed" to be in the business of insurance due to the "Deemer Clause," which is also part of § 514 of ERISA.[66] As such, only insured health benefit plans must comply with state insurance

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[57] *Id*.

[58] *See id*.

[59] *Id*.

[60] *Id.*

[61] *Id*.

[62] Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) (1974).

[63] *Id*. § 514.

[64] McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1976) ("Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States. [§2.] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance."). ERISA carved out an area of federal preemption with respect to such traditional state governance.

[65] ERISA, 29 U.S.C. § 514(b)(2)(A).

[66] ERISA, 29 U.S.C. § 514(b)(2)(B).

mandates, and state laws seeking to limit specialty drug cost-sharing are similarly limited to only insured plans.[67] Considering that more than half of Americans with employer sponsored plans have self-insured plans, such laws alone cannot totally solve the concern of high specialty drug cost-sharing.[68] However, this potential limitation should not discourage state efforts to pass such cost-sharing legislation.

State tier limiting legislation is significantly augmented by the out-of-pocket limits on prescription drug spending that are created by the Affordable Care Act (ACA),[69] which will, as of January 1, 2014, apply to both insured and self-insured plans having plan years stating on or after January 1, 2014.[70] Some insurers have indicated that state laws limiting specialty cost-sharing are unnecessary because of the ACA, however, backers of such legislation argue that the state bills would serve as an important supplement to the federal law. While the ACA serves to alleviate some of the cost-sharing concerns for patients as well as the discrepancies between insured and self-insured plans, the cost-sharing limits may remain burdensome for some families.[71] The ACA reduces the burden on those individuals who are paying the most for their pharmaceuticals, but there will still be a role for states to further assist those who depend on specialty pharmaceuticals from almost assuredly reaching the ACA's maximum cost-sharing limits ($6,350 in 2014 for an individual plan or $12,700 for a family plan) which can be very financially burdensome considering that these payments are in addition to premium costs.[72]

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[67] *See e.g.*, American Medical Security v. Bartlett, 111 F.3d 358 (4th Cir. 1997).

[68] Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, Employee Benefit Research Inst. (Nov. 2012). In 2011, 58.5% of workers with employer-provided health coverage were in self-insured plans. *Id.*

[69] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-48, § 2702, 124 Stat. 119, 318-19 (2010).

[70] *Id*. The ACA applies to both insured and self-insured plans since the legislation made amendments to the Public Health Service Act (PHSA) as well as the Internal Revenue Code sections as they apply to ERISA in order to reach all non-grandfathered plans, whether insured or self-insured. ACA § 1301; ACA § 1201 (adding § 2707(b) (applying cost-sharing limits to "group health plans" which had been defined to encompass self-funded plans) to the PHSA.); and ACA § 1302(c).

[71] *See infra* Section V.

[72] The ACA cost-sharing limits for 2014 were pegged to the High Deductible Health Plan (HDHP) deductible minimums for 2014 which are set year by the Internal Revenue Service (IRS). For 2015 and beyond, the cost-sharing limits will be set through a uniform percentage increase that will be decided by the premium adjustment percentage which is set by CMS in their yearly Benefit and Payment Parameters rulemaking. *See* ACA, Pub. L. No. 111-48, § 1302(c)(1), 124 Stat. 119, 47-48 (2010). It should be noted that there are diminished cost-sharing limits for those who are at or below 250% of the FPL. Limits for those individuals are set at fractions of the OOP limits set for that given year. They are as follows: enrollees with a household modified adjusted gross income (MAGI) between 100% and 150% of the FPL will be eligible for plans with a 2/3 reduction in the maximum annual limitation on OOP cost-sharing; enrollees with household MAGI between 150% and 200% of the FPL will be eligible for a different set of plans at the respective AV level required by the ACA for such subset that also has a 2/3 reduction in the standard maximum annual limitation on OOP cost-sharing; enrollees with household MAGI between 200% and 250% of the FPL will be eligible for a different set of plans at the respective AV level required by the ACA for such subset that also has a 1/2 reduction in the standard maximum annual limitation on OOP cost-sharing. The FPL for 2014 is $11,490 for an individual and requires the addition of $4,020 for each additional person. (i.e., a couple is $15,510). *See* 2014 Notice of Benefit and Payment Parameters, 78 Fed. Reg. 15410 (March 11, 2013).

States should take note, however, that while the ACA has assisted their efforts in protecting citizens from high costs of specialty drugs, the ACA also stated that the state may face increased costs if they seek to limit cost-sharing further than the ACA mandates through state legislation.[73] The ACA requires states that pass laws, after December 31, 2011, that act to strengthen or add to the benefits required to be covered as Essential Health Benefits (EHB) than what appeared in their benchmark plans, as chosen by the state in accordance with the ACA, must defray any additional costs, to the beneficiary or the carrier, in relation to those increased coverage requirements; this has been deemed the "make-whole requirement."[74] While some states have argued that cost-sharing limitations are not an additional benefit but a constraint on plan design—which escapes this "make-whole requirement"—the precarious position of many state budgets could make this risk too much to bear—causing specialty drug related legislative efforts to disappear.[75] Even with this risk in mind, states have continued to legislate to create tighter restrictions on patient cost-sharing (although with diminished success rates), but they have placed language in the bills that would protect the state, by invalidating the law, should they be required to defray the associated costs.[76] However, a careful reading of the rules related to such cost-sharing laws show that state specialty drug out-of-pocket limits reduction laws should escape cost defrayment requirements set forth in the ACA.[77] As such, states should seek to further protect their residents from excessive cost-sharing, with respect to specialty drugs, by passing legislation similar to the legislation that has been enacted in New York, or legislation which sets diminished caps on specialty cost-sharing.

II. STATES REACT TO SPECIALTY TIERS

To protect consumers and address the increasingly expensive cost of specialty pharmaceuticals, legislators from states across the country have introduced or passed

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[73] *See* ACA, Pub. L. 111-48, 24 Stat. 119 (2010); Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70,643, 70,647 (Nov. 26, 2012) ("[T]he Affordable Care Act explicitly permits a state to require QHPs to offer benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional benefits. We propose that state-required benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the state to pay for these state-required benefits."). The final rule, issued on February 25, 2013 maintains these provisions and subjects to the defrayment requirement for at least the 2014 and 2015 plan years. *Id.*; Final Rule, 78 Fed. Reg. 12,834, 12,837-8 (February 25, 2013).

[74] *Id.* ("In this proposed rule, we interpret state-required benefits to be specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements.").

[75] *See id*.

[76] *See e.g.*, Assemb. B. 310, 2011–12 Leg., Reg. Sess. (Cal. 2012) (containing provisions that would make the requirements of the bill inoperative if the Director of the DMHC or the Insurance Commissioner determines that the requirements would result in the "assumption by the state of additional costs pursuant to [the requirements of the ACA]").

[77] *See* ACA, Pub. L. No. 111-48, 124 Stat. 119 (2010); Standards Related to Essential Health Benefits, *supra* note 69, at 70,647.

legislation that seeks to limit the ability of insurers to take advantage of tiering options.[78] While few states have been able to pass such legislation, several active legislative initiatives remain in place today.[79] States have used various mechanisms to protect individual or household finances against cost-sharing mechanisms, the strongest of which is the complete ban of specialty tiers. Even more common are out-of-pocket maximums, which typically take the form of annual limits on the out-of-pocket (OOP) cost-sharing required by individuals or families.[80]

As recognition of the serious problem that specialty drug cost-sharing tiers pose for many of those who depend on those medications, eight states[81] have sought a complete ban on any plan design that contains over a three-tiered pharmacy benefit, effectively forbidding specialty tiers. Currently, New York is the only state to have legislation that places a complete ban on specialty tiers.[82] An additional nine states[83] have sought to impose caps on the OOP expenditures allowed for pharmaceuticals in health insurance plans or to link pharmaceutical OOP payments to the overall plan deductible. These laws have been popular proposals from state legislatures, given that they still allow increased member cost-sharing for high-cost pharmaceuticals, in accord with insurance company interests, while protecting beneficiaries from exceedingly high drug costs.[84] The second largest number of states have approved, or are currently considering legislation that calls for state insurance departments to undertake studies to obtain more information on the prevalence and effect of specialty tiers, seeking to use the findings to craft further limiting legislation.[85] Often accompanying these studies is a moratorium on the

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[78] Standards Related to Essential Health Benefits, *supra* note 69, at 70,653 (proposing that a plan may exceed the annual deductible limit if it cannot reasonably reach a metal tier).

[79] The seven states which have passed laws related to specialty tiering include Alaska, New York, Delaware, Vermont, Florida, Maine, and Louisiana. Author research.

[80] Of the ten states with active bills, six states (Delaware, Nebraska, Pennsylvania, California, Rhode Island, and Massachusetts) have bills that only lower the cost-sharing limits. Author calculation. *See infra* notes 100-106, 119.

[81] New York, Delaware, and Vermont have passed and signed into law bans on specialty tiers for at least certain indications. Only New York has a complete and unlimited ban on specialty tiers. Legislative efforts to enact bans are ongoing in Kansas, Pennsylvania, California, and Massachusetts. Mississippi's legislature considered a complete ban with the same wording as New York in 2012, but it died in committee. Author research.

[82] *See* Pollack, *supra* note 43.

[83] The states and their provisions are as follows: Delaware, bill, total drug OOP limitation to $100 per month; Maine, law, $3,500 per year OOP maximum; Vermont, law, deductible limitation to $2,000 per person per year, $4,000 per family per year; Nebraska, bill, specialty tier cannot exceed 500% of OOP cost of lowest tier; Pennsylvania, bill, deductible limitation of $1,000 per person, $2,000 per family; California, bill, total drug OOP cannot exceed $150 per month and another bill matching federal deductible limits $2,000 per person, $4,000 per family, California, vetoed by gov, oral cancer cost-sharing equal to all other cancer drug delivery methods; Rhode Island, bill, specialty tier cannot exceed 500% of OOP cost of lowest tier and deductible limitation of $1,000 per person, $2,000 per family; Massachusetts, bill, specialty tier cannot exceed 500% of OOP cost of lowest tier; Louisiana, law, oral cancer cost-sharing equal to all other cancer drug delivery methods. Author research. *See infra* notes 101-113, 119.

[84] *See e.g.*, Pollack, *supra* note 43.

[85] S*ee e.g.*, S.B. 137, 146th Gen. Assemb., Reg. Sess. (Del. 2011).

approvals of plans with a four-tiered structure until the results of the study have been analyzed.[86]

The insurance savings clause of § 514(b)(2)(A) of ERISA grants states the ability to make such blanket restrictions and limitations on insurance plans.[87] Section 514 of ERISA states that "[e]xcept as provided in subparagraph (B) [the "Deemer Clause"], nothing in this subchapter will be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."[88] Effectively, this provision grants state insurance departments the freedom to regulate plans that operate and/or are offered in that state as long as the plans are insured plans.[89] Accordingly, the savings clause creates an exception to the general rule that ERISA preempts state laws that relate to employee benefit plans.[90] The purpose of this allowance is to permit states to retain powers over an area of regulation and an industry which they commonly have had purview.[91] The allowance of additive state regulations of health insurance plans is advantageous for beneficiaries in those states which have sought to add increased beneficiary protections. Such regulations, however, can create a patchwork of state regulation that can and do place a burden on compliance measures for insurance companies that must account for this multiplicity of laws given that they operate in multiple states.[92] The avoidance of such a situation was a prime consideration in the enactment of ERISA.[93] Given the popularity of specialty pharmaceuticals by pharmaceutical companies and the

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[86] *Id*.

[87] *See* ERISA, Pub. L. 93–406, 29 U.S.C. § 514 (b)(2)(A) (providing the construction and application of various exemptions found within the subchapter of the statute); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 722, 733–47 (1985) (considering a Massachusetts mental health benefit mandate for group health policies; holding that while the mandate "relate[d] to" employee benefit plans, the law regulated the terms of an insurance contract; and ultimately exempting the law from pre-emption under the savings clause). In this defining case regarding ERISA's "savings clause," the Court, in coming to its conclusion, applied a three-prong test to determine whether an activity or practice constitutes the "business of insurance." *Id*. at 743 (requiring that the activity in question must spread risk, the relationship between insured and insurer must be an integral part of the activity, and it must be limited to entities in the traditional insurance industry (*citing* Union Labor Life Ins. Co. v. Pirineo, 458 U.S. 119, 127–30 (1982))). Under this test, the Court concluded that the Massachusetts mandate and mandated benefits, in general, met all three criteria, and thus ruled that mandated benefit laws are exempt from pre-emption. *Id.* at 743, 759; *see* William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, Emp. Benefit Research Inst. 1, 8 (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf. (distinguishing between plans that are insured and "uninsured," or self-insured, because the Deemer Clause would immunize an uninsured plan from state-mandated benefit laws).

[88] *See* ERISA, Pub. L. 93–406, § 514.

[89] *Id*.; *see also* William Pierron & Paul Fronstin, *supra* note 87.

[90] *Contra American Medical Security v. Bartlett*, 111 F.3d 358 (4th Cir. 1997); s*ee infra* note 119 (explaining the 4th Circuit's decision).

[91] *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1976).

[92] Such was the purpose of ERISA § 514. *See* Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987) (finding Congress's concern with a "patchwork scheme of regulation [that] would introduce considerable inefficiencies in benefit programs . . . ").

[93] *See e.g.*, Siskind v. Sperry Ret. Program, 47 F.3d 498, 503, 505 (2d Cir. 1995) (observing that the purpose of ERISA is to provide regulatory consistency and minimize financial and administrative burdens on employers), *abrogated by* Janese v. Fay, 692 F.3d 221 (2d Cir. 2012).

effectiveness of such drugs, however, state actions may be a critical element of reducing the consumer burdens of healthcare, given that federal legislation that could apply such restrictions to all states, that goes beyond the limitations imposed by the ACA, seems not to be feasible.[94]

A. State Prohibitions of Four-Tiered Plans

It took New York lawmakers over a year and a half, but in 2010, the passage of Senate Bill 5000B[95] marked the first of many state efforts to restrict or limit specialty tier cost-sharing.[96] The New York legislation was a heavily supported bill in that it never received less than a two-to-one yes-to-no vote margin in any of its committee reviews, and it eventually passed the New York Senate by a vote of fifty-five to one, with Senator Thomas O'Mara being the lone nay vote.[97] The wave of nationwide support for a similar ban in other states, however, has not had the success for which many patient advocates had originally hoped.[98] Currently, New York is the only state to have a law that across the board eliminates specialty tiers without constraints or time limitations.[99] Following in the way of New York legislature by placing complete restrictions on the use of tier four and higher cost-sharing by insured health plans when offered in that state under the control of that state's insurance department are Vermont,[100] whose term limited ban expired on July 1, 2013, and, to a lesser extent, Delaware,[101] which only bans four and higher tiered plans as they apply to oral cancer drugs. Both states' plans, however, are limited

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[94] *See e.g.*, Patients' Access to Treatments Act of 2013, H.R. 460, 113th Cong. (Feb. 4, 2013) (GovTrack has the bill as having an eleven percent chance of moving past the House Energy and Commerce Committee and only a three percent chance of passage).

[95] Tier IV Prescription Drugs, 2010 Sess. Law News of N.Y. Ch. 536 (S. 5000-B) (McKinney); (providing that no health care plan or insurance policy that provides prescription drug coverage and for which cost-sharing, deductibles, or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles, or co-insurance obligations for any prescription drug exceeding the dollar amount of cost-sharing deductibles or co-insurance obligations for any other prescription drug provided under such coverage for non-preferred brand drugs or their equivalents).

[96] *See infra* part III(B).

[97] *See* S. 5000-2009, Reg. Sess. (N.Y. 2009) (pertaining to the elimination of cost-sharing, deductibles and co-payments for certain prescription drugs).

[98] *See* National Patient Advocate Foundation, *supra* note 22.

[99] Pollack, *supra* note 43.

[100] *See* S.B. 104, 2011 Leg., Reg. Sess. (Vt. 2011) ("Prior to July 1, 2012, no health insurer or pharmacy benefit manager shall utilize a cost-sharing structure for prescription drugs that imposes on a consumer for any drug a greater co-payment, deductible, coinsurance, or other cost-sharing requirement than that which applies for a nonpreferred brand-name drug.").

[101] *See* The Delaware Cancer Treatment Access Act, H.B. 265, 146th Gen. Assemb. Reg. Sess. (Del. 2011) (providing that individual and group health plans in Delaware that provide major medical and prescription drug coverage will be barred from charging cancer patients higher copayments, coinsurance, or deductibles for oral chemotherapy drugs, which are in the specialty tier, than for intravenous therapies, which are covered under medical benefit which does not have specialty tiers).

in either scope or longevity. Several other states, including Kansas,[102] Massachusetts,[103] California,[104] Pennsylvania,[105] and Mississippi,[106] have pending legislation that seek to place complete restrictions on four or higher tier cost-sharing in plans. Currently, Mississippi is the only state where its legislature passed a complete, unrestricted ban but the Governor vetoed the bill.[107]

Surprisingly, the New York State law was passed even though there was never an issue in New York with specialty tiers.[108] The New York State Insurance Department never authorized a commercial health insurance plan that contained specialty tiers before the introduction of this legislation, although there had never been an official law in New York regarding this practice until New York Senate Bill 5000's introduction.[109] A memorandum in opposition to the legislation, from the law firm of Hinman Straub P.C. written on behalf of Blue Cross and Blue Shield Plans of New York, stated that Senate Bill 5000-B was redundant and unnecessary because no private health insurance plan that contained specialty tiers previously had been approved by the State Insurance Commissioner.[110] Because the New York legislation did not attempt to prevent a practice that was already in place, advocates neither expected nor confronted a forceful opposition

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[102] *See* H.B. 2136, 84th Gen. Assemb., Reg. Sess. (Kan. 2011) ("It shall be an unlawful discriminatory practice . . . [f]or any employer, labor organization, insurer, health maintenance organization or other entity to limit health care coverage such that cost-sharing, deductibles or coinsurance obligations for any prescription medication exceeds the dollar amount of cost-sharing, deductibles or coinsurance obligations for any category of non-preferred brand medication or its equivalent, or brand medication if there is no non-preferred brand medication category.").

[103] *See* S.B. 455, 187th Gen. Assemb., Reg. Sess. (Mass. 2012) (providing that an insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs).

[104] *See* Assemb. B. 310, 2011–12 Leg., Reg. Sess. (Cal. 2012) ("A health insurance policy issued, amended, or renewed on or after January 1, 2012, that covers outpatient prescription drugs shall not require coinsurance as a basis for cost-sharing with the insured for outpatient prescription drugs shall not require coinsurance as a basis for cost-sharing with the insured for outpatient prescription drug benefits.").

[105] *See* H.B. 1609, 2011 Leg., Reg. Sess. (Pa. 2012) ("An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs.").

[106] *See* H.B. 1319, 2012 Leg., Reg. Sess. (Miss. 2012) ("A health care service plan contract issued, amended, or renewed on or after January 1, 2013, that covers prescription medicine shall not create specialty tiers that require payment of a percentage cost of prescription drugs."). This bill has been reintroduced but previously died in committee on March 6, 2012. *Id.*

[107] *See id.* (pertaining to all health care service plans issued, amended, or renewed on or after January 1, 2013).

[108] *See* Haley Gillet et al., *Regulating the Specialty Tier in Georgia*, Ga. Tech. Pub. Pol'y Task Force 2012, 24 (2012), http://www.advocatesforresponsiblecare.org/uploads/GRC_Specialty_Tier_GA_Tech_Final_Report_Regulating_the_Specialty_Tier.pdf.

[109] *See id.* (observing that an important element was that this bill did not incur any costs on New York State; rather, no additional state oversight was necessary to regulate and monitor the elimination of drug formularies containing a specialty tier because they had never been approved by the Insurance Department).

[110] Memorandum from Hinman Straub P.C. Legislative Counsel for the Blue Cross and Blue Shield Plans (Apr. 15, 2010), http://www.nysblues.org/pdf/A8278AS5000A.pdf.

from the insurance industry.[111] The insurance industry was only mildly opposed and did not employ any massive campaign in resistance to the New York legislation.[112]

According to New York Senate Bill 5000, cost-sharing policies in general create negative health outcomes because they decrease the utilization of drugs, which may lead to increased hospitalizations to address the consequences of foregoing treatment.[113] With the degree of cost-sharing in specialty tiers, the legislature found these detrimental effects to be uncontainable.[114] In its legislative findings, Senate Bill 5000-B indicates that "[t]he cost-sharing, deductibles and co-insurance obligations for certain drugs are becoming cost prohibitive for persons trying to overcome serious and often life-threatening diseases and conditions such as cancer, multiple sclerosis, rheumatoid arthritis, hepatitis C, hemophilia and psoriasis."[115] As an attempt to avoid such limitations on patient care, § 3216 of New York State's insurance law was amended by adding paragraph 27, which provides that "[n]o policy delivered or issued for delivery in this state which provides coverage for prescription drugs and for which cost-sharing, deductibles or coinsurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category)."[116] The effect of this amendment is to limit the maximum cost-sharing to the level required for non-preferred brand name drugs, typically referred to as tier three pharmaceuticals.[117]

B. Cost-Sharing Limits Falling Short of Prohibitions

While many states have entertained bills that seek to limit specialty drug cost-sharing, many others have resisted such proposals in order to avoid drawing the ire of insurers in the state, or, for fear that such measures would increase premiums for all beneficiaries—regardless of whether they use drugs covered in the specialty tier.[118] Thirteen states either have passed laws or currently have proposed legislation that would place caps on

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[111] Gillet et al., *supra* note 108, at 26.

[112] *See id*. (reasoning that the legislation would maintain the status quo).

[113] *See e.g*., Kris McFalls, *supra* note 35 (comparing how various states have passed legislation to ban specialty tiers but eventually opining that such legislation will no apply to self-funded plans under ERISA).

[114] *See* Tier IV Prescription Drugs, 2010 Sess. Law News of N.Y. Ch. 536 (S.B. 5000-B) (McKinney) (explaining that such drugs are usually produced in smaller quantities than are other drugs and are unavailable as less expensive generic drugs).

[115] *See id.* (asserting that it is in the public interest to provide assistance to patients to afford necessary prescription drugs and that the "extraordinary disparity in cost-sharing, deductible and co-insurance burdens imposed on patients whose life and health depend on these drugs constitutes serious and unjustified discrimination based on their disease or disability").

[116] *See id.* (intending to provide patients a more affordable access to essential prescription drugs).

[117] *See* Tier IV Prescription Drugs, 2010 Sess. Law News of N.Y. Ch. 536 (S. 5000-B) (McKinney) ("No policy . . . shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent.").

[118] *See supra* notes 100-106 (listing the enacted legislation and active bills).

specialty drug spending,[119] create moratoriums on the creation of new tier four benefit structures,[120] or directed state insurance departments to explore specialty cost-sharing limitations.[121] The most common of these measures is a limitation on the extent of cost-sharing such that the difference between the lowest and the higher cost-sharing amounts among all tiers cannot exceed 500%.[122] This effectively eliminates coinsurance and instead replaces it with a limited copayment feature. Seeing as drugs in the first tier can have OOP amounts as low as five dollars, the ability of insurance companies to attain

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[119] Several states have enacted laws that limit cost-sharing: Maine, Louisiana, and Vermont. *See* Me. Rev. Stat. tit. 24-A, § 4317-A (2012) ("[F]or all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act."); H.B. 693 2012 Leg., Reg. Sess. (La. 2012) (requiring parity for orally administered anti-cancer medications with intravenously administered or injected anti-cancer medications); H.B. 559, Reg. Sess. (Vt. 2012) (establishing an annual out-of-pocket limit for prescription drugs at two thousand dollars per individual and four thousand dollars per family); Del. Gen. Stat. Ch. 33 §3364 (S.B 35, 147th General Assembly) (De. 2013) (indicating that a health plan that provides coverage for prescription drugs shall not have cost-sharing of more than $100 per month for up to a 30-day supply of any single drug, and cannot charge more than $200 per enrollee per month in the aggregate for covered pharmaceuticals).

Various bills that limit cost-sharing exist in other states, too. *See e.g.*, S.B. 455, Reg. Sess. (Mass. 2012) (providing no cost-sharing more than five-hundred percent of the least expensive drug category); Legis. B. 322, 102d Leg. 1st Reg. Sess. (Neb. 2012); S.B. 252, 146th Gen. Assemb., 2d Reg. Sess. (Del. 2011) (stating that any required copayment or coinsurance that applies to covered drugs cannot exceed $100 per month for up to a thirty-day supply of any single drug, whereby such required copayment or coinsurance does not exceed, in the aggregate for all covered drugs, $200 per month per enrollee). "An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs" that cost more than 500% of the lowest price prescription drug. H.B. 1609, 2012 Leg. Reg. Sess. (Pa. 2012) (no plan can create a specialty tier and maximum copay cannot exceed lowest by 500%). *See* Assemb. B. 310 (stating that "health insurance policies . . . shall not require an insured to pay a copayment for outpatient prescription drugs in excess of one hundred fifty dollars ($150) for a one-month supply of a prescription, or its equivalent for a prescription for a longer period, as adjusted for inflation").

A more recently introduced bill, which created a limit on out-of-pocket expenses at the level set by the federal OOP limit, died in the appropriations committee on August 16, 2012. *See* Assemb. B. 1800, 2012 Leg. Gen. Sess. (Cal. 2012); *see also* H.B. 7573, 2012 Leg. Reg. Sess. (R.I. 2012) (providing that no tiers shall be created where the maximum cost-sharing exceeds the lowest in the plan by 500% or more).

[120] Currently, both Florida and Delaware have such laws. *See* H.B. 1003, 115th Leg. 2d Reg. Sess. (Fla. 2013) (creating specialty tier prescription drug moratorium for a year until July 1, 2014, and requiring a report to the Governor and Legislature as to cost-sharing effects.); S.B. 137, 146th Gen. Assemb., Reg. Sess. (Del. 2011) (creating a moratorium on health insurance providers that charge higher cost-sharing for different classification of prescription drugs until the Legislature enacts legislation to limit such higher cost-sharing is not needed, and moreover requiring that by March 15, 2012, the Delaware Healthcare Commission submit to the General Assembly a report that summarizes the impact of specialty cost-sharing).

[121] States who have enacted such requirements include: Florida (*See supra*, note 119), Delaware (*See supra*, note 119), and there is a bill in Illinois to extend the period, by a year, to deliver their previously required report which would be due under the bill on November 30, 2013. 2011 IL H.R. 1310 (NS), 2011 Illinois House Resolution No. 1361, Illinois Ninety-Seventh General Assembly (Jan. 6, 2013).

[122] *See supra*, note 119.

any real assistance in covering the excessive costs of specialty drugs is severely limited. Many other states have targeted or enacted numerical limits as a way to ensure that cost-sharing in the specialty tier cannot rise above a certain set amount.[123] This strategy is much more feasible and yet remains highly effective in that it would allow a cost-sharing amount to be imposed relative to the cost of specialty pharmaceuticals, allowing the beneficiary to share in some, albeit small, amount of the cost of the specialty drugs they use. This structure would not cause as much upward pressure on the cost-sharing for other drug categories, while still limiting the total costs to those beneficiaries who depend on such specialty drugs.

Pharmaceutical companies have been active in lobbying for state legislatures to introduce legislation that limits cost-sharing.[124] For instance, legislators in Maine have reported in-depth discussions with Pfizer, and some pharmaceutical companies have even supplied draft bills that may be introduced by state legislatures.[125] Pharmaceutical companies seek such limits as this creates a wider market for their drugs and helps to insure the patient will actually fill their prescriptions for specialty pharmaceuticals and not be deterred from doing so based on high costs.[126] Noncompliance to a drug regimen is one of the more damaging externalities of high cost-sharing, not only for pharmaceutical companies but also for health care more generally. However, the country's largest health insurance companies have been more active and have effectively ended reform movements in some states.[127] The incentives for insurance companies to oppose such reforms are obvious as the loss of specialty tier cost-sharing greatly affects not only their bottom line but also the risk pool of their health insurance plans.[128]

III. WHY SECTION 514 OF ERISA HAS LIMITING EFFECTS ON STATE EFFORTS

State legislative attempts to limit specialty pharmaceutical cost-sharing are severely limited by ERISA's express preemption of state laws that "relate to" employee benefit plans and which are not saved under the insurance savings clause.[129] Some experts and advocates have argued that the preemption provision in § 514 of ERISA is overly restrictive in that it "prevents state and local governments from regulating employment-based health plans," limiting the potential for comprehensive health insurance reform to start at the state or local level where such legislation is often more easily legislated.[130] For instance, in accordance with ERISA, state specialty tier laws cannot impact self-funded employee health plans which are under the sole purview of ERISA and federal

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[123] *Id.*

[124] Pollack, *supra* note 43.

[125] *Id*.

[126] *See* National Patient Advocate Foundation, *supra* note 22.

[127] *See* Pollack, *supra* note 43.

[128] *See e.g*., 2012 Drug Trend Report, *supra* note 17 (showing the emergence of specialty drugs as the most lucrative of all pharmaceuticals).

[129] *See* ERISA, 29 U.S.C. §§ 514(b)(2)(A), (B).

[130] William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, 8 EBRI Issue Brief no. 314, 38 (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

regulations.[131] This is arguably detrimental considering that over half of all employees with health insurance coverage are enrolled in self-funded employer sponsored plans.[132]

Under the "insurance savings clause" of ERISA, all state laws that govern the business of insurance, such as limitations on cost-sharing, are exempt from ERISA preemption as they apply to insured plans—as established in § 514 of ERISA.[133] All insured employee benefit plans are deemed to be included under the umbrella of the insurance savings clause, and as such, state insurance law mandates apply to these plans—as long as they are additive to ERISA mandates.[134] Conversely, ERISA's "Deemer Clause" declares that self-funded plans[135] are not deemed to be in the business of insurance; and are therefore exclusively under the purview of ERISA, and federal mandates that amend ERISA, such as the ACA.[136] As such, these plans do not have to comply with state mandates that require more than federal minimum coverage and plan design requirements.[137]

The insured/self-insured split is the result of congressional intent that ERISA provide a legal framework for the uniform provision of benefits by employers doing business anywhere in the country.[138] This uniformity allows multistate companies that self-insure to offer consistent benefit packages wherever they happen to be located. The result of which is ease of administration and lower expenses to ensure plan compliance.[139] For self-insured plans, freedom from state benefit mandates also allows plan sponsors to design benefit packages that meet the needs and desires of their employees, as well as to

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[131] *See supra* notes 64–67.

[132] Pierron & Fronstin, *supra* note 130; Carolyn Johnson, *Bill Aims to Stop Specialty Tier Prescription Drug Costs*, ABC News San Francisco, Feb. 9, 2011, http://abclocal.go.com/kgo/story?section=news/health&id=7950299. It is important to note that an increasing number of such self-funded plans do feature stop-loss protections that seek to limit the potential losses of the corporation offering the coverage. As long as the stop-loss is not set at too low a number, such plans will still be considered to be "deemed" saved from state regulation by ERISA preemption. *See* American Medical Security v. Bartlett, 111 F.3d 358 (4th Cir. 1997) (holding that ERISA preempted a Maryland insurance regulation which sought to regulate and require the coverage of certain state mandated benefits if the self-funded health insurance plan had a stop-loss insurance policy with an attachment point below $10,000).

[133] *See* ERISA, at § 514 (stating any state law that governs an area that is also governed by ERISA is preempted and the state law will be invalid to those plans. The Federal coverage requirements had not covered contraceptives or many other female preventative treatments or products until ERISA was amended as part of ACA).

[134] *Id*.

[135] Insured plans involve the employer contracting with an insurance company to cover the risk associated with having a health plan. Self-funded plans are those employee welfare plans where the entity establishing the plan assumes all of the risk associated with paying out and distributing claims as in accordance with the plan. Since they do not involve insurance companies, which are under the purview of states, self-funded plans cannot be regulated by states. *See* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, 514 U.S. 645 (1995).

[136] Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 722, 743, 759 (1985) (one of the factors of the "Deemer Clause" (section 514(B) of ERISA) application is whether the employer has spread the risk of coverage to an insurance company).

[137] *See* ERISA, 29 U.S.C. §§ 524(b)(2)(A), (B).

[138] *See* Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).

[139] Pierron & Fronstin, *supra* note 130, at 7.

effectively promote wellness and control health costs.[140] Such unique needs, as well as the risk that these employers have assumed in their self-insured plans, are some of the primary reasons why they are allowed to largely escape state insurance regulations.[141]

Due to ERISA, state legislation limiting specialty tiering, even if passed in all fifty states, will not apply to self-funded plans.[142] Federal legislation—such as the reform measures enacted in the ACA—is needed to address ERISA-governed plans, particularly to attain a universal application of limits. Given the number of beneficiaries in self-insured employer plans, the federal reform approach would have a much larger influence on the market.[143] Such a federal measure was introduced in the U.S. House of Representatives on February 4, 2013 by Representative David McKinley. The Patients' Access to Treatments Act of 2013,[144] "amend[s] title XXVII of the Public Health Service Act to limit co-payment, coinsurance, or other cost-sharing requirements applicable to prescription drugs in a specialty drug tier to the dollar amount (or its equivalent) of such requirements applicable to prescription drugs in a non-preferred brand drug tier, and for other purposes."[145] This bill is similar to the law enacted in New York in that it effectively bans the usage of specialty tiers by setting the maximum pharmaceutical cost-sharing, which is equal to the rate for non-preferred brand drugs—traditionally the third tier.[146] With eighty-five co-sponsors across both parties (sixty-seven Democrats and eighteen Republicans) there appears to be support for such a bill; however, it will require much more support to transverse the current state of federal politics.[147] While such a measure is assuredly gaining the ire of health insurance advocates, such a measure would prove beneficial to those states that have been wrestling with this issue for a number of years.[148] This bill could essentially solve both the state legislative backlog and the insured/self-insured dichotomy in one legislative act. Since this is a reintroduced bill, however, it is hard to overlook its past failures, especially with all of the recent burdens placed on insurers by the ACA.[149]

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[140] *See generally* Pierron & Fronstin, *supra* note 130.

[141] *Id.*; s*ee also Fort Halifax Packing*, 482 U.S. at 11.

[142] Pierron & Fronstin, *supra* note 130.

[143] *Id.* (indicating that, in 2011, 58.5% of all workers with health insurance coverage were in employer funded self-insured plans).

[144] Patients' Access to Treatments Act of 2013, H.R. 460, 113th Cong. (Feb. 4, 2013). This bill was a re-introduction of H.R. 4209 (112th Cong.) (Mar 19, 2012); *H.R. 460: Patients' Access to Treatments Act of 2013*, GovTrack.us (2013), http://www.govtrack.us/congress/bills/113/hr460 (last visited Dec. 22, 2013).

[145] *H.R. 460: Patients' Access to Treatments Act of 2013*, GovTrack.us (2013), http://www.govtrack.us/congress/bills/113/hr460 (last visited Dec. 22, 2013).

[146] Patients' Access to Treatments Act of 2013, H.R. 460, 113th Cong. (Feb. 4, 2013).

[147] *H.R. 460: Patients' Access to Treatments Act of 2013*, GovTrack.us (2013), http://www.govtrack.us/congress/bills/113/hr460 (last visited Dec. 4, 2013).

[148] *See* Pollack, *supra* note 43; *see also* National Patient Advocate Foundation, *supra* note 22.

[149] *See H.R. 460: Patients' Access to Treatments Act of 2013*, *supra* note 147 (GovTrack lists the bill as having an eleven percent chance of moving past the House Energy and Commerce Committee and only a three percent chance of passage).

IV. WILL THE AFFORDABLE CARE ACT MAKE STATE ACTION ON SPECIALTY TIERS LESS PALATABLE?

While the ACA creates a cost-sharing limit that will apply to all health benefit plans, further state out-of-pocket (OOP) restrictions are necessary because the ACA limits remain prohibitively high for some of the beneficiaries that are most in need.[150] However, some states fear that any increased benefits may trigger an ACA requirement that would require states to defray the extra costs of offering such increased benefits.[151] The cost-sharing limits set forth in the ACA are pegged to the OOP limits for high-deductible health plans (HDHPs).[152] The cost-sharing limits for HDHPs in 2014 are $6,350 for an individual or $12,700 for "family" coverage.[153] This amount is corrected for inflation and generally increases yearly—the 2013 HDHP limit was $6,250 for an individual and $12,500 for "family" coverage.[154] While the restrictions this places on cost-sharing will surely limit the high coinsurance rates that some beneficiaries are required to pay, given their health conditions and the prices for the pharmaceuticals on which they depend, for many Americans these capped amounts can still be extremely burdensome or even cost prohibitive for those on fixed incomes who may not be able to access federal or state health benefits.[155] And the affordability does not appear to be improving for the 2015 benefit year, as Centers for Medicare and Medicaid Services (CMS) on November 26, 2013 issued its proposed 2015 Notice of Benefit and Payment Parameters rule, in which it calls for the OOP limits to be raised by four times the amount the Internal Revenue Service (IRS) raised the HDHP rates for 2014; CMS proposed that the 2015 maximum annual limitation on cost-sharing be $6,750 for self-only coverage and $13,500 for "family" coverage.[156] As such, there may be an even greater need now for states to act to reduce the burden on beneficiaries who depend on specially drugs.

As state legislators consider laws that would prohibit or limit cost-sharing, the ACA has created a wrinkle that may cause budget conscious state governments to think twice about enacting such legislation. It is still unknown if legislation that places limits on

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[150] FAQs About Affordable Care Act Implementation Part XII, United States Department of Labor, (Feb. 20, 2013), http://www.dol.gov/ebsa/faqs/faq-aca12.html. Public Health Service (PHS) Act § 2707(b), as added by the Affordable Care Act, provides that a group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under §§ 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 1302(c)(1) limits out-of-pocket maximums and § 1302(c)(2) limits deductibles for employer-sponsored plans.

[151] *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-48, § 2702, 124 Stat. 119, 318-19 (2010).

[152] *Id.* at § 1302(c)(1); s*ee also supra* note 72 (outlining lower limits applicable to those with incomes under 400% of the Federal Poverty Level).

[153] 2014 HSA/HDHP Limits Announced, Buck Consultants (May 6, 2013), *available at* http://www.buckconsultants.com/portals/0/publications/fyi/2013/FYI-2013-0506-2014-HSA-HDHP-limits-announced.pdf.

[154] *See e.g.*, IRS Announces 2013 HSA Contribution Limits & HDHP Minimum Deductibles & Out-of-Pocket Maximums, CLS Partners (May 7, 2012), http://www.clspartners.com/post.php?id=42.

[155] Kim, Yoona A., *supra* note 48.

[156] HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72321, p. 139 (Nov. 26, 2013), http://www.ofr.gov/OFRUpload/OFRData/2013-28610_PI.pdf.

cost-sharing for prescription drugs would create a new mandate subject to the ACA requirement that for coverage provided through the Exchange, the State is required to pay the full cost of any new mandate exceeding the covered services required in that state's Essential Health Benefits (EHB) Package.[157] Section 1311(d)(3)(B) of the ACA, which is more acutely defined in a November 2012 Department of Health and Human Services (HHS) proposed rule (final rule, issued on February 28, 2013, maintains such provisions but does not speak as directly to its application), allows states to create mandated benefits for exchange plans, above and beyond those required elsewhere in the ACA (EHBs), as long as the state defrays the additional costs.[158] Since coverage for prescription drugs is included as one of the ten required EHBs, state laws related to additional pharmaceutical benefits must comply with this requirement.[159] Within the EHB design template, there is a clearly demarcated area for the inclusion of specialty drug tiers.[160] In addition, the actuarial value calculator, which is used to calculate the coverage level for the plan, known as "metal tiers,"[161] includes the option of adding a specialty drug tier cost-sharing amount that will be used to calculate the average plan cost to the beneficiary.[162]

The November 2012 rule, however, explicitly states that cost-sharing legislation is not a mandate that will trigger the state to defray costs, allowing states to pass such laws without

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[157] ACA, Pub. L. No. 111-48, § 1311 (d)(3)(B), 124 Stat. 119 (2010); *see also* 77 Fed. Reg. 70,643, 70,647 (Nov. 26, 2012). The ACA left states with the requirement that they establish an essential health benefit plan for that state—within certain parameters. Such a plan mirrored a specific existing plan in the state augmented, where required, such that the plan features would be compliant with the ACA. Such existing plans already contained current state mandates that survived ERISA § 514. However, if the state where to add required benefits or plan features above and beyond the ACA requirements after the adoption of an EHB benchmark plan, the state would be required to reimburse the insurance company for the provision of such benefits or plan features where they augmented the EHB or ACA requirements. *Id*.

[158] 77 Fed. Reg. 70,643, 70,647 (Nov. 26, 2012). The defrayment required by the state was suggested in the rule by calculating the additional costs incurred by the plan and spreading that cost across all plan beneficiaries. The state will then pay to the plan on behalf of each beneficiary or to the beneficiary themselves the extra premium costs that the additional benefit(s) creates. *Id.*

[159] *Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage*, Ctr. for Consumer Info. and Ins. Oversight (July 2012), http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html.

[160] *Plans and Benefits Template*, CMS (2012), http://www.serff.com/documents/plan_management_data_templates_plans_benefits_instructions.pdf.

[161] A metal tier is a term that corresponds to four of the five possible levels of health insurance coverage (other level is a catastrophic plan) offered on either the federally-facilitated marketplace or on state marketplaces. Each coverage tier relates to a specific actuarial value (AV) which represents the average amount of coverage provided to an average beneficiary with average medical spend. A bronze plan has an AV of 60% (the insurance company will pay for 60% of the average beneficiaries medical spend in a given year), a silver plan has an AV of 70%, a gold plan has an AV of 80%, and a platinum plan has an AV of 90%. Each plan is granted a 2% deference in order to ensure adequate comparison potential between different plan designs.

[162] *See* ACA, Pub. L. No. 111-48, 124 Stat. 119 (2010); Actuarial Value Calculator Methodology, Dept. of Health and Human Serv. (Feb. 25, 2013), http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf.

the fear of triggering the defrayment requirement of § 1311(d)(3)(B) of the ACA.[163] According to the CMS proposed rule, CMS will, "interpret state-required benefits to be specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements."[164] Legislative studies conducted in California[165] and Maryland[166] suggest that a bill that restricts forms of cost-sharing does not create a mandated covered service; rather, it places restrictions on cost-sharing designs that can be used to craft the levels of cost-sharing within the EHB benchmark plan.[167] In an attempt to reduce the risk of a conflicting interpretation, some states considering going forward with specialty tier limiting legislation have included escape provisions in their legislation.[168] For example, a California specialty tier limiting bill includes language that would make the bill inoperative if it were determined that the requirements would result in the assumption by the state of additional costs pursuant to § 1311(d)(3)(B) of the ACA.[169] The use of such language in other states bills should allow them to pursue specialty tier cost-sharing legislation without the risk that such provisions would activate the ACA requirement that would require states to defray costs.

CONCLUSION

Specialty drugs represent a growing concern for both health insurance issuers and beneficiaries given their exceedingly high cost. They are projected to represent almost half of all drug spending by 2017.[170] Payers have sought to reduce specialty drug spending by sharing more of the cost of these drugs with the beneficiaries who depend on them

[163] ACA, Pub. L. No. 111-48, 124 Stat. 119 (2010); Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70,643, 70,647 (Nov. 26, 2012) (in accord with the final rule which appears at 78 Fed. Reg. 12834, 12837-8, http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

[164] *Id*.

[165] Analysis of Assembly Bill 310: Prescription Drugs, California Health benefits Review Program (Apr. 14, 2011), http://escholarship.ucop.edu/uc/item/8w87h8wq.

[166] 2011 Session Position Paper regarding H.B. 251, Maryland Health Care Commission (2011), http://dls.state.md.us/data/tabs/wha/Issue-Papers—-2012-Legislative-Session-for-web.pdf.

[167] *See supra* note 165. California argues that AB 310 does not require coverage of additional benefits as it specifically states, that "[n]othing in this section shall be construed to require a [health care service plan/health insurance policy] to provide coverage not otherwise required by law for any prescription drug." *Id*. The California report also lists several factors that would be considered by the Department of Insurance in deciding whether there was a mandated benefit that would require the state to defray the extra costs to the plans. *Id.* at 23.

[168] For instance, AB 310 contains provisions that would make the requirements of the bill inoperative if the Director of the DMHC or the Insurance Commissioner determines that the requirements would result in the "assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104(e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law." *id.*

[169] *See* ACA, Pub. L. No. 111-48, § 1311, 124 Stat. 119 (2010).

[170] Schilling, *supra* note 2; s*ee also* 2012 Drug Trend Report, *supra* note 17.

through the creation of specialty drug tiers.[171] This has forced some patients to choose between forgoing other needs to pay for their medications or not take their medications at all. While several states have sought to outlaw the use of specialty drug tiers or limit pharmaceutical OOP cost-sharing, only New York has been successful in passing an unlimited prohibition on specialty tiers.[172] There are, however, currently legislative efforts in a quarter of states that seek to either limit or eliminate cost-sharing requirements for beneficiaries who depend on specialty pharmaceuticals for treatment.[173] While some state legislatures have been concerned that the ACA cost defrayment requirement that applies to new state required benefits that are above and beyond the required benefits in that state's EHB benchmark plan, the November 2012 HHS Essential Health Benefit proposed rule makes it explicit that state laws concerning cost-sharing limitations do not implicate the requirement to defray costs—they merely effect benefit designs, not the number of EHBs.[174] For those states that remained skeptical of this CMS interpretation of the ACA, there is the option of constructing the legislation in such a way that the specialty pharmaceutical cost-sharing limitations would be inoperative should the state be required to defray the costs of such additional benefit features—as has been done in both California and Maryland.[175] Whether such protections are written in, given the CMS interpretation and its appearance in the February EHB final rule, CMS has provided states will an opportunity to limit the burdensome OOP costs that are associated with specialty drugs. Doing so could allow beneficiaries to not have to choose between their medications and basic necessities.[176] While the ACA caps on OOP expenditures go far in reducing the most egregious cases of specialty pharmaceuticals spending, it does not go far enough, and in fact such limits will continue to rise yearly (the limits are slated to rise by $1,000 for families in 2015), providing less and less protection; states must act to further remove or limit the constraints that specialty tier OOP requirements place on beneficiaries who many times have no other treatment options.[177]

[171] *See* Walsh, *supra* note 26.

[172] *See* Pollack, *supra* note 43.

[173] *See supra* Section III(B).

[174] Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg at 70,647, *available at* http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

[175] *See* Analysis of Assembly Bill 310: Prescription Drugs, *supra* note 165.

[176] Kim, Yoona A., *supra* note 48.

[177] *See* HHS Notice of Benefit and Payment Parameters for 2015, *supra* note 156.

Pregnancy on Trial: The Alabama Supreme Court's Erroneous Application of Alabama's Chemical Endangerment Law in *Ex parte Ankrom*

Rachel Suppé*

INTRODUCTION

The National Substance Abuse Index states that methamphetamine is becoming the largest drug pandemic in Alabama.[1] Between 2002 and 2006, there were 1,432

* Rachel Suppé is a third-year law student at American University Washington College of Law. At American University, she is the Senior Content Editor of the Journal of Gender, Social Policy & the Law, and President of the law school's chapter of Law Students for Reproductive Justice. She is interested in gender studies and plans to pursue a legal career advancing women's rights. Her past work experiences include internships at the National Women's Law Center, the American Civil Liberties Union, Servicemembers Legal Defense Network, and the office of U.S. Senator Kirsten Gillibrand. Currently, she is a legal intern at the Center for Reproductive Rights.

[1] *Alabama: Drug Climate*, Nat'l Substance Abuse Index, http://nationalsubstanceabuseindex.org/alabama/index.php (last visited Dec. 3, 2013) [hereinafter *Alabama: Drug Climate*].

methamphetamine lab seizures within the State.[2] Due to a growing concern that Alabama's children were being exposed to the dangerous chemicals used in the production of drugs such as methamphetamine, the State passed what has become known as its "chemical endangerment law" in 2006.[3] The law indicates that a person commits the crime of chemical endangerment when he or she knowingly, recklessly, or intentionally exposes a child to contact with a controlled substance, chemical substance, or other drug paraphernalia.[4] Violation of the statute is a felony.[5]

While the law had admirable aims and sought to protect children forced to grow up in clandestine at-home methamphetamine labs, it was not long before Alabama prosecutors gave the statute new meaning by using it prosecute women who tested positive for drugs during pregnancy. Sixty women in Alabama have been prosecuted under the statute thus far—a number which continues to rise.[6] Medical, pro-choice, and anti-poverty groups have challenged use of the law in this manner, arguing that the law was not intended to criminalize women whose fetuses are exposed to controlled substances in utero. On January 11, 2013, the Alabama Supreme Court rendered a perilous opinion in *Ex parte Ankrom*,[7] holding that the term "child" in the chemical endangerment statute applies to fetuses, and that women who take controlled substances while pregnant can and will be charged with felonies.[8]

Part I of this article discusses the rising use of methamphetamine, and state and federal responses to the growing epidemic. It discusses Alabama's attempt to shield children from methamphetamine labs and state prosecutors' subsequent use of the law to convict pregnant women. Part I also examines the case of two women, Amanda Kimbrough and Hope Ankrom, whose convictions under the chemical endangerment statute reached the Alabama Supreme Court. Part II of this article argues that the Alabama Supreme Court erred in its decision that the term "child" in the statute included fetuses and erred in finding the convictions proper. Part III discusses policy considerations and recommends the use of medical treatment, rather than incarceration, to address drug use. Lastly, Part IV argues that the Alabama State Legislature should clarify that the chemical endangerment law may not be used to prosecute pregnant women, as such a use has dangerous implications for the State's women and families.

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[2] *Alabama: Substance Abuse Statistics*, National Substance Abuse, http://nationalsubstanceabuseindex.org/alabama/stats.php (last visited Dec. 3, 2013).

[3] *See generally* Brief *Amicus Curiae* of Rep. Patricia Todd on Behalf of Petitioner, *Ex parte Ankrom*, No. 1110176, (Ala. Jan. 11, 2013) [hereinafter Todd Brief].

[4] Ala. Code § 26-15-3.2 (2012).

[5] *Id.*

[6] Cameron Steele, *Fetal Argument: County DA to Begin Prosecution of Mothers Who Use Drugs During Pregnancy*, Anniston Star (Sept. 30, 2013), http://www.annistonstar.com/view/full_story/20320041/article-Fetal-Argument—County-DA-to-begin—prosecution-of-mothers-who-use-drugs-during-pregnancy.

[7] No. 1110176, 2013 WL 135748 (Ala. Jan. 11, 2013).

[8] *See id.* at *19.

I. BACKGROUND

A. National and State Level Methamphetamine Statistics

There are currently more than 1.4 million methamphetamine users in the United States, and the number continues to rise.[9] Methamphetamine, or "meth," is a highly addictive stimulant with potent central nervous system stimulant properties.[10] Though methamphetamine is legally available under certain conditions, it is a Schedule II stimulant under the Controlled Substances Act.[11] Methamphetamine produces a brief, intense sensation or rush, and oral ingestion or snorting methamphetamine produces a long-lasting high which lasts up to half a day. [12] Both the rush and the high are believed to result from the release of very high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure.[13] Due to its intense high, highly addictive nature, easy accessibility, and low cost, methamphetamine has become one of the most popular drugs in use in the U.S. today.[14] The largest population of methamphetamine users tends to be the Caucasian rural poor.[15] Within Alabama, the state's overall poverty rate is 17.5 percent with rural areas having a higher poverty level than urban areas.[16] Nearly half of Alabama's methamphetamine users are female and ninety-two percent of Alabama's drug users are white.[17] The National Substance Abuse Index, an independent guide to addiction resources throughout the U.S., reports that "[m]eth is becoming the biggest drug threat in Alabama" and methamphetamine abuse surpasses cocaine abuse statewide.[18]

Distributors of methamphetamine have taken to making the product at home in what have been referred to as "meth labs." Ingredients for methamphetamine can be obtained at any local pharmacy, as the main ingredient used to produce methamphetamine is found in the widely available, non-prescription drug Sudafed, which contains

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[9] *The Reach of Meth*, Frontline (May 16, 2011), http://www.pbs.org/wgbh/pages/frontline/meth/map/.

[10] *Drugs of Abuse 2011*, U.S. Dep't of Justice Drug Enforcement Admin 48 (2011), http://www.justice.gov/dea/docs/drugs_of_abuse_2011.pdf.

[11] *See id.* at 49 (stating that methamphetamine is available only through a prescription that cannot be refilled and that there is only one legal methamphetamine product, Desoxyn, which is currently marketed in 5-milligram tablets and has very limited use in the treatment of obesity and attention deficit hyperactivity disorder (ADHD)).

[12] *Id.* at 48.

[13] *Id.*

[14] *Id.*

[15] Deborah Ahrens, *Methademic: Drug Panic in an Age of Ambivalence*, 37 Fla. St. U. L. Rev. 841, 884-85, 895 (2010).

[16] Alabama Dep't of Mental Health, Office of Prevention, Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama 5 (2011) [hereinafter Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama], http://www.mh.alabama.gov/Downloads/SA/ALStateEPIProfilefinal_2011-11-22.pdf.

[17] *Substance Abuse Treatment Admissions by Primary Substance of Abuse According to Sex, Age Group, Race, and Ethnicity Year = 2010*, Substance Abuse and Mental Health Serv. Admin., Ctr. for Behavioral Health Statistics and Quality, *available at* http://wwwdasis.samhsa.gov/webt/quicklink/AL10.htm (last visited Dec. 3, 2013).

[18] *Alabama: Drug Climate*, *supra* note 1.

pseudoephedrine, the most important ingredient in methamphetamine production.[19] The production process involves the use and release of dangerous toxic chemicals, and the deadly toxic waste left from a methamphetamine lab is often discarded near schools, on roadsides, or at local parks.[20]

According to the Federal Drug Enforcement Agency, there were 11,239 clandestine methamphetamine lab seizures nationwide in 2010.[21] Of those, 666, or approximately seventeen percent, were in Alabama.[22] In 2010, 13,172 drug related arrests were reported in Alabama,[23] and 2,220 of those arrests were for the sale of drugs including barbiturates, amphetamines, and methamphetamine.[24] Within Alabama, methamphetamine labs tend to be located in isolated rural communities: 207 labs were seized in 2002, 280 in 2003, and 297 in 2004.[25] Methamphetamine is such a large problem in Alabama that the Alabama District Attorneys Association has sponsored an anti-methamphetamine awareness and educational campaign called Zero Meth with the goal of "stopping this drug and its life threatening consequences."[26] The campaign's website states that "[m]eth is the number one drug related issue for law enforcement officials in Alabama" and that Zero Meth is Alabama's response to the state's growing epidemic.[27]

B. State Responses to Methamphetamine Production and Use

Because so many methamphetamine labs are in homes, Alabama has become increasingly concerned about the effect that the drug's toxic ingredients can have on the children living in those homes. The Department of Justice Office of Justice Programs (OJP) reports that "[a] child living at a clandestine methamphetamine laboratory is exposed to immediate dangers and to the ongoing effects of chemical contamination. In addition, the child may be subjected to fires and explosions, abuse and neglect, a hazardous lifestyle (including the presence of firearms), social problems, and other risks."[28] OJP's website lists two specific examples which highlight the detrimental effect that at home methamphetamine labs can have on children:

> The five children ranged in age from 1 to 7 years old. The one-bedroom home had no electricity or heat other than a gas stove with the oven door opened. Used hypodermic needles and dog feces littered areas of the residence where

[19] Ahrens, *supra* note 15, at 865.

[20] *ZeroMeth: Facts*, Alabama District Attorneys Ass'n, *available at* http://www.zerometh.com/facts.php (last visited Dec. 3, 2013).

[21] Neal Vickers, *Meth Gets More Emphasis in Alabama*, Examiner.com (Nov. 27, 2011), http://www.examiner.com/article/meth-gets-more-emphasis-alabama.

[22] *Id.*

[23] *See id.* (adding that of those, fifteen percent were for sale of drugs and eighty-five percent were for possession).

[24] *Id.*

[25] *Alabama: Drug Climate*, *supra* note 1.

[26] *Zero Meth: Home*, *supra* note 20.

[27] *Id.*

[28] *Dangers to Children Living at Meth Labs,* Office of Justice Programs, U.S. Dep't of Justice, *available at* http://www.ojp.usdoj.gov/ovc/publications/bulletins/children/pg5.html (last visited Dec. 3, 2013).

> the children were found playing. Because there were no beds for the children, they slept with blankets underneath a small card table in the front room. The bathroom had sewage backed up in the tub, leaving no place for the children to bathe. A subsequent hospital exam revealed that all the children were infected with hepatitis C. The youngest was very ill. His liver was enlarged to the size of an adult's. The children had needle marks on their feet, legs, hands, and arms from accidental contact with syringes.
>
> At another lab site, a 2-year-old child was discovered during a lab seizure. Her parents both abused and manufactured methamphetamine. She was found with open, seeping sores around her eyes and on her forehead that resembled a severe burn. The condition was diagnosed as repeated, untreated cockroach bites.[29]

In response to these dangers, states have undertaken a variety of efforts to protect children exposed to methamphetamine labs. For example, many states have established Drug Endangered Children Programs which coordinate the efforts of law enforcement, medical services, and child welfare workers to ensure that children found in these environments receive appropriate attention and care.[30] Such programs are modeled after the national program created by the Federal Interagency Task Force for Drug Endangered Children.[31] North Carolina, Illinois, Kansas, Nebraska, Arkansas, and California are examples of states which have undertaken efforts, whether though training, policy, education, or research, to address the problem of children being exposed to methamphetamine.[32]

Some states have addressed the crisis legislatively. In Colorado, Indiana, Iowa, Michigan, Montana, South Dakota, Tennessee, and Virginia, child abuse or neglect includes manufacturing a controlled substance in the presence of child or on a premises occupied by a child.[33] In Arizona and New Mexico, allowing a child to be present where there are chemicals or equipment for the manufacture of controlled substances or where controlled substances are used or stored is considered child abuse or neglect.[34] In Florida, Hawaii, Illinois, Minnesota, and Texas, child abuse or neglect includes selling or distributing drugs, as well as, giving drugs or alcohol to a child.[35] In Kentucky, New

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[29] *Id.*

[30] *Methamphetamine Frequently Asked Questions*, Rural Assistance Center, *available at* http://www.raconline.org/topics/substance-abuse/faqs/#meth (last visited Dec. 3, 2013).

[31] *See Drug Endangered Children*, Office of National Drug Control Policy, *available at* http://www.whitehouse.gov/ondcp/dec-info (last visited Dec. 3, 2013).

[32] *Methamphetamine and Child Welfare*, Admin. for Children & Families, U.S. Dep't of Health and Human Servs., *available at* https://www.childwelfare.gov/systemwide/substance/drug_specific/meth.cfm#state (last visited Dec. 3, 2013).

[33] *Feature: Methamphetamine as Child Abuse Laws Gain Ground, But Do They Help or Hurt?*, Drug Reform Coordination Network (July 14, 2006), http://stopthedrugwar.org/chronicle-old/444/drug-child-abuse-laws.shtml.

[34] Child Welfare Information Gateway, *Parental Drug Use as Child Abuse*, Admin. for Children & Families, U.S. Dep't of Health and Human Servs. (July 2012), https://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.pdf.

[35] *Id.* at 3.

York, Rhode Island, and Texas, child abuse and neglect includes use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child.[36] Exposing a child to drugs or drug paraphernalia is a crime in Nebraska, New Hampshire, North Dakota, South Carolina, Utah, Washington, and Wyoming.[37] Lastly, exposing a child to drug sale or distribution or to drug-related activity is a crime in the District of Columbia.[38]

C. Enactment of Alabama's Chemical Endangerment Law

In 2006, Alabama joined the list of states in which it is a crime to expose a child to drugs.[39] That year, the State legislature passed what has become known as Alabama's chemical endangerment law. The law is housed under the title "Child Abuse Generally"[40] and utilizes strict penalties as a means of deterrence.[41] Under the law (hereinafter § 26-15-3.2), a person who knowingly, recklessly, or intentionally causes or permits a child to be exposed to, ingest or inhale, or have contact with a controlled substance, chemical substance, or drug paraphernalia, violates the statute.[42] Causing or permitting a child to be exposed to, ingest or inhale, or have contact with a controlled substance, chemical substance, or drug paraphernalia is a Class C felony, resulting in up to ten years in prison and a fine of up to $15,000.[43] If that exposure, ingestion, inhalation, or contact results in serious physical injury to the child, the crime is a Class B felony, resulting in up to twenty years in prison and a fine of up to $30,000.[44] Finally, if the exposure, ingestion, inhalation, or contact results in the death of the child, the crime is a Class A felony, which results in up to life behind bars and a fine of up to $60,000.[45] In addition to fines and prison time, countless state and federal collateral consequences attach to such felony convictions.[46] Under the Alabama statute, exposure of a child to any controlled substance, chemical substance, or drug paraphernalia, be it cocaine, marijuana, or certain prescription drugs, is a felony. The only exception is that it is not a felony to expose a child to a controlled substance which is lawfully prescribed to that child.[47]

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[36] *Id.*

[37] *Id.* at 4.

[38] *Id.* at 10.

[39] *Id.* at 3; Chemical Endangerment of Exposing a Child to an Environment in which Controlled Substance are Produced or Distributed, Ala. Code § 26-15-3.2 (2006).

[40] Ala. Code § 26-15-3.2 (2012).

[41] H.B. 723, 2008 Sess. (Ala. 2008), Statement of Rep. McLaughlin, http://altaxdollarsatwork.blogspot.com/2008/05/chemical-child-endangerment-debate.html ("My purpose in bringing this bill is to get help for that mother so she doesn't do it again.").

[42] Ala. Code § 26-15-3.2.

[43] *See id.* (laying out the appropriate conviction designations for the violation of the statute); Ala. Code § 13A-5-11(2013) (providing the fines required for each class of felony); Ala. Code § 13A-5-6 (2013) (providing the sentences of imprisonment for each class of felonies).

[44] *Id.*

[45] *Id.*

[46] *See infra* note 190 and accompanying text.

[47] Ala. Code § 26-15-3.2(c).

While the law was intended to punish parents who exposed their children to chemicals during the drug manufacturing process, Alabama began to see a rise in the number of babies testing positive for drugs at birth.[48] Soon, prosecutors took it upon themselves to begin applying the chemical endangerment law in a new manner. Looking to the statute's wording, prosecutors argued that the term "child" in the statute included fetuses as well as born children. Under this theory, they argued, women who expose fetuses to drugs in the womb violate the statute. As a result, in 2007 and 2008, eight women in one Alabama jurisdiction (population 37,000) were prosecuted in an eighteen-month period for drug use during pregnancy.[49] The local prosecutor in the cases referred to the need to protect the "child-to-be" from prenatal drug use.[50]

The debate as to whether the word "child" included fetuses was settled by the Alabama Supreme Court, on January 11, 2013, in the case of *Ex parte Ankrom*.[51] The Alabama Supreme Court opinion involved the consolidated cases of Hope Ankrom and Amanda Kimbrough, two women convicted under § 26-15-3.2. On April 29, 2008, during her twenty-fifth week of pregnancy, Amanda Kimbrough went into labor prematurely and had an emergency C-section at the hospital.[52] Her premature infant died nineteen minutes after birth.[53] A urine sample taken at the hospital tested positive for methamphetamine and Kimbrough later admitted to smoking methamphetamine three days before she went into labor.[54] The Colbert Country Department of Human Resources was informed of the drug test results and Kimbrough's two other children were temporarily removed from her custody.[55] Kimbrough was ultimately sentenced to ten years in prison.[56]

Less than a year later, on January 31, 2009, Hope Ankrom gave birth to a healthy son at a medical center in Enterprise, Alabama.[57] Medical records indicate that Ankrom tested positive for cocaine prior to giving birth and that the infant tested positive for cocaine after birth.[58] Ankrom's doctor also noted that she had tested positive for marijuana and cocaine during her pregnancy.[59] Though she gave birth to a healthy baby, approximately three weeks after the birth, Ankrom was arrested and charged with chemical endangerment of a child.[60] She was indicted by a grand jury and was

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[48] Steele, *supra* note 6.

[49] Krista Stone-Manista, *Protecting Pregnant Women: A Guide to Successfully Challenging Criminal Child Abuse Prosecutions of Pregnant Drug Addicts*, 99 J. Crim. L. & Criminology 823, 825 (2008-2009).

[50] *Id.*

[51] *Ex parte* Ankrom, 2013 WL 135748 (Ala. Jan. 11, 2013).

[52] *Id.* at *23.

[53] *Id.*

[54] *Id.* at *4; *see also* Ala. Code § 20-2-27 (2013) (defining methamphetamine as a Schedule III controlled substance and therefore within the purview of the chemical endangerment law).

[55] *Ex parte Ankrom*, 2013 WL 135748 at *4.

[56] *Id.*

[57] *Id.* at *1.

[58] *Id.*; *see also* Ala. Code § 20-2-25 (2013) (defining cocaine as a Schedule II controlled substance and therefore within the purview of the chemical endangerment law).

[59] *Ex parte Ankrom*, 2013 WL 135748 at *1.

[60] *Id.*

sentenced to three years in prison, though her sentence was suspended and she was placed on probation for a year.[61]

Both women appealed their convictions to the Alabama Court of Criminal Appeals. While the court did not publish its decision in Kimbrough's case,[62] on appeal, Ankrom argued that she could not be guilty under § 26-15-3.2, as it applied to endangerment of a child, not to endangerment of a fetus.[63] The court held that her conviction was proper because the plain meaning of the term "child" includes a viable fetus and the court could only engage in judicial interpretation of the statute's language if the language was ambiguous.[64]

The court found the word "child" unambiguous for three reasons. First, it found that the Alabama Legislature had a policy of protecting "born and unborn life" and that the statute was therefore meant to protect born and unborn life.[65] Second, the court noted that Alabama Supreme Court had previously interpreted the term "minor child" to include viable fetuses for purposes of Alabama's wrongful-death-of-minor statute, and therefore the same interpretation should be applied to § 26-15-3.2.[66] Finally, the court stated that the dictionary defines "child" as "an unborn or recently born person."[67] For these reasons, the court held, a mother who ingested a controlled substance during her pregnancy may be prosecuted for chemical endangerment if she tested positive for drugs during pregnancy or if the child tested positive at birth.[68] Therefore, the guilty verdicts of the two women were sustained.[69]

As a matter of first impression, the Alabama Supreme Court granted certiorari to address whether the term "child" as used in § 26-15-3.2 includes an unborn child.[70] The high court upheld Kimbrough and Ankrom's convictions, finding that the term "child" as used in the statute includes fetuses.[71] The court stated that the term is unambiguous and therefore no judicial interpretation of the statute was required.[72] Because the language of the statute was clear, the women had sufficient notice of their crime and the rule of lenity did not apply.[73] Lastly, the court expanded the statute's scope. While the lower court had held that this statue encompassed only *viable* fetuses,[74] the Alabama Supreme Court held that the statue protected *all* fetuses, regardless of viability.[75]

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[61] *Id.* at *2.

[62] Id.

[63] Ankrom v. State, 2011 WL 3781258 at *1 (Ala. Crim. App. Aug. 26, 2011).

[64] *Id.* at *10-11.

[65] *Id.* at *5.

[66] *Id.*

[67] *Id.*

[68] *Id.* at *11.

[69] *Ex parte Ankrom*, 2013 WL 135748 at *20.

[70] *Id.* at *19.

[71] *Id.* at *20.

[72] *Id.* at *7.

[73] *Id.* at *11.

[74] *Ankrom v. State*, 2011 WL 3781258 at *7.

[75] *Ex parte Ankrom*, 2013 WL 135748 at *18.

The prosecutions of pregnant women and the decision of the Alabama Supreme Court drew the attention of advocates from both the pro-choice[76] and the anti-choice[77] camps, as such laws can have drastic effects on abortion rights. "Fetal abuse" or "fetal neglect" laws afford legal protection to a fetus. Pro-choice advocates fear that such laws are steps towards establishing "fetal personhood," or affording full legal protections to a fetus or embryro from the moment of conception.[78] If a fetus is afforded such legal protection, pro-choice advocates contend, the fetus is legally considered a human being and thus cannot be aborted.[79] Pro-choice groups contend, therefore, that "fetal abuse" and "fetal neglect" laws are used as a tactic to incrementally grant legal rights to a fetus, with the goal of eventually achieving full personhood and criminalizing abortion.[80] Likewise, anti-choice groups readily admit they use such laws as a backdoor tactic aimed at criminalizing abortion.[81]

This Alabama Supreme Court decision makes Alabama only the second state, along with South Carolina,[82] to hold that laws designed to protect children from exposure to drugs can be used to prosecute women for using drugs during their pregnancy. The courts of Texas, Florida, Georgia, Michigan, Kentucky, North Dakota, Missouri, Maryland,

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[76] *See, e.g.*, *ACLU Asks Alabama Court To Protect The Rights Of Pregnant Women*, Am. Civil Liberties Union (July 6, 2010), https://www.aclu.org/reproductive-freedom/aclu-asks-alabama-court-protect-rights-pregnant-women ("The ACLU argues that using the law this way infringes on a woman's fundamental right to continue a pregnancy and singles out pregnant women for discrimination. Similar attempts to punish pregnant women who suffer from addiction have been struck down as unconstitutional, as in a recent case in Kentucky in which the ACLU was also involved.").

[77] *See, e.g.*, Steven Ertelt, *Alabama Court Rules Unborn Children Deserve Legal Protection,* Life News (Jan. 1, 2013), http://www.lifenews.com/2013/01/11/alabama-court-rules-unborn-children-deserve-legal-protection/ (discussing the amicus brief submitted by the anti-choice group Liberty Counsel, which asserted according to "medical science," the unborn are, in fact, human beings and that the Alabama Supreme Court must therefore accord them with the full protection of the law).

[78] Tamar Lewin, *Abuse Laws Cover Fetus, a High Court Rules*, NY Times, Oct. 30, 1997, http://www.nytimes.com/1997/10/30/us/abuse-laws-cover-fetus-a-high-court-rules.html.

[79] *See Personhood In The Womb: A Constitutional Question*, Nat. Pub. Radio (Nov. 21, 2013), http://www.npr.org/2013/11/21/246534132/personhood-in-the-womb-a-constitutional-question (explaining that the "personhood movement" seeks to recognize fertilized eggs, embryos, and fetuses as completely separate constitutional persons under the law in an effort to recriminalize abortion).

[80] *See id.* ("If fetus is a person, everything a pregnant women does is potentially child abuse, abortion is murder . . . . "); *see also Personhood USA Surpasses 1 Million Signatures Against Abortion: Launches Groundbreaking Campaign for 10 Million*, Personhood USA, http://www.personhoodusa.com/press-release/personhood-usa-surpasses-1-million-signatures-against-abortion-launches-groundbreaking/ (explaining that in an effort to protect the unborn, the group is collecting signatures to implement ballot initiatives outlawing abortion).

[81] *See* Jill Filipovic, *The Flaws in Prosecuting Mothers who Suffer from Drug Addiction*, The Guardian (Apr. 26, 2012), http://www.theguardian.com/commentisfree/cifamerica/2012/apr/26/flaws-prosecuting-mothers-drug-addiction.

[82] S*ee* Linda C. Fentiman, *Rethinking Addition: Drugs, Deterrence, and the Neuroscience Revolution*, 14 U. Pa. J. L. & Soc. Change 233, 237-38 (2011) (noting that in every other state which attempted to prosecute a woman in such a way, every state except Alabama and South Carolina has invalidated or overturned the convictions of pregnant drug users). *See generally* Whitner v. State, 492 S.E.2d 777 (S.C. 1997) (upholding the criminal conviction of a woman charged with child neglect for using cocaine during pregnancy).

Hawaii, and Ohio have all struck down prosecutors' attempts to use state drug laws to prosecute women for drug use during pregnancy.[83]

II. ANALYSIS

The Alabama Supreme Court erred in holding that the State's chemical endangerment statute extends to fetuses. Specifically, the court erred by holding that the term "child" was unambiguous and mistakenly found that the legislative intent of the law demonstrated that it was meant to apply to fetuses. The court then incorrectly concluded that the rule of lenity did not apply. The Alabama judiciary has a less than desirable track record concerning women's rights, including abortion rights,[84] and it seems the court offered a contrived opinion in order to arrive at the conclusion it set out to achieve.

A. The Alabama Supreme Court erred in finding that the term "child" as used in § 26-15-3.2 of the Alabama Code was unambiguous and included fetuses.

In a statutory construction case, a court's first step "is to determine whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case."[85] Only if the language is ambiguous, should the court employ other canons of construction.[86] The Alabama Supreme Court thus properly began its analysis by assessing whether or not the statute in question was worded in an ambiguous manner, stating:

> When the language of a statute is plain and unambiguous, as in this case, courts must enforce the statute as written by giving the words of the statute their ordinary plain meaning—they must interpret that language to mean exactly what it says and thus give effect to the apparent intent of the Legislature.[87]

When the language is unambiguous there is no room for judicial construction; the clearly expressed intent of the legislature must be given effect—"it is [the judiciary's job] to say what the law is, not to say what the law should be."[88]

Section 26-15-3.2 states that a person commits the crime of chemical endangerment by exposing a child to an environment in which he or she knowingly, recklessly, or

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[83] Motion for Leave and Brief of Amici Curiae in Support of Petition of Amanda Helaine Kimbrough at 22-27, *Ex parte* Ankrom, 2013 WL 135748 (Ala. Jan. 11, 2013) [hereinafter Motion for Leave] (*citing Ex parte* Perales, 215 S.W.3d 418 (Tex. Crim. App. 2007); Johnson v. State, 602 S.2d 1288, 1296-97 (Fla. 1992); State v. Luster, 419 S.E.2d 32, 35 (Ga. Ct. App. 1992); People v. Hardy, 469 N.W.2d 50, 53 (Mich. App. 1991); Cochran v. Commonwealth, 315 S.W. 3d 325 (Ky. 2010); State v. Geiser, 763 N.W.2d 469, 471-74 (N.D. 2009); State v. Wade, 232 S.W. 3d 663, 666 (Mo. 2007); Kilmon v. State, 905 A.2d 306, 313-14 (Md. 2006); State v. Aiwohi, 123 P.3d 1210, 1214 (Haw. 2005); State v. Gray, 584 N.E.2d 710, 710 (Ohio 1992).

[84] *See Alabama*, NARAL Pro-Choice America, http://www.prochoiceamerica.org/government-and-you/state-governments/state-profiles/alabama.html (last visited Dec. 3, 2013) (assigning Alabama an "F" grade on choice related laws).

[85] Barnhart v. Sigmon Coal Co., 534 U.S. 438, 450 (2002).

[86] *Id.*

[87] *Ex parte* Ankrom, 2013 WL 135748 at *9 (Ala. Jan. 11, 2013) (*citing Ex parte* Pfizer, Inc., 746 So.2d 960, 964 (Ala. 1999)).

[88] *Id.*

intentionally causes or permits a child to be exposed to, ingest or inhale, or have contact with a controlled substance, chemical substance, or drug paraphernalia.[89] The question of whether or not the statute was ambiguous turns on the meaning of the word "child." To determine the meaning of the word "child," the court looked at the two dictionary definitions presented by the State. The State relied on Black's Law Dictionary, which defines "child" as a "baby or fetus" and the Merriam-Webster Dictionary, which defines "child" as "an unborn or recently born person."[90] Relying on only these two definitions, the court held that the word "child" clearly included fetuses and thus ended its analysis of whether or not the term "child" was ambiguous.[91]

The court was incorrect in holding that the term "child" was unambiguous. While looking to a dictionary definition is a customary and well-accepted tool of statutory construction, a court need not limit its use of dictionary definitions to the ones presented by litigants. In countless other cases, the Alabama Supreme Court has furnished its *own* dictionary definitions, outside of the definitions provided by the parties before the court.[92] To develop a thorough and balanced understanding of the word, the court could have and should have done so here. Instead, the court relied on these two dictionary definitions which mention unborn life, and ignored dictionary definitions which do *not* mention unborn life. For example, the Cambridge Dictionary defines "child" as a "boy or girl from the time of birth until he or she is an adult, or a son or daughter of any age,"[93] and the Oxford Dictionary defines "child" as "a young human being below the age of puberty or below the legal age of majority . . . ."[94] Likewise, the American Heritage Dictionary offers a number of definitions of the term, the first of which being "a person between birth and puberty."[95] Therefore, looking to the dictionary definition of "child" does not prove that the term is unambiguous, as some definitions of the term "child" include unborn life and some do not.

Moreover, the Alabama Supreme Court has previously stated that there are times when looking to the dictionary definition of a word will "leave reasonable doubt as to the meaning of" the term in question[96] and will not prove useful in resolving doubts and

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[89] Ala. Code § 26-15-3.2 (2012).

[90] *Ex parte* Ankrom, 2013 WL 135748 at *11 ("As the definitions cited by the State indicate, the plain meaning of the word 'child' is broad enough to encompass all children – born and unborn—including Ankrom's and Kimbrough's unborn children in the cases before us.").

[91] *Id.*

[92] *See, e.g.*, Lambert v. Coregis Ins. Co., Inc., 950 So. 2d 1156, 1163 (Ala. 2006) (rejecting the dictionary definition presented by the petitioner and instead presenting the definitions of a separate dictionary); Board of Zoning Adjustment of City of Trussville v. Tacala, Inc., 2013 WL 149060 at *7 (Ala. Civ. App. April 12, 2013) (providing the dictionary definitions of the terms "extend," "useful," and "life" without the parties before the court having presented any dictionary definitions).

[93] *Child*, Cambridge Dictionary of American English (Cambridge University Press 2013), *available at* http://dictionary.cambridge.org/us/dictionary/american-english/child?q=child.

[94] *Child*, Oxford Dictionary of American English (Oxford University Press 2013), *available at* http://www.oxforddictionaries.com/us/definition/american_english/child.

[95] *Child*, The American Heritage Dictionary of the English Language (Houghton Mifflin Harcourt Publishing Co., 5th Ed. 2013), *available at* http://www.ahdictionary.com/word/search.html?q=child&submit.x=30&submit.y=26.

[96] State Farm Fire & Cas. Co. v. Slade, 747 So. 2d 293, 309 (Ala. 1999).

confusion as to a particular term's scope.[97] In such instances, the court has stated, reliance on those dictionary definitions is inappropriate.[98] Similarly, the U.S. Supreme Court has stated that a dictionary definition of an undefined statutory term is not always dispositive of the term's meaning.[99] Therefore, simple reliance on the dictionary is not always sufficient to determine a statute's meaning. Because the dictionary definitions of the term "child" do not resolve the question of whether the term includes a fetus or not, the dictionary definitions should not have been determinative of the Alabama Supreme Court's decision. For the court to make such a decisive determination based on ambiguous dictionary definitions represented a subjective and one-sided assessment of the term.[100]

In addition to the dictionary definitions, further evidence demonstrates the ambiguity of the term "child" in § 26-15-3.2. After the chemical endangerment law was passed in 2006, Alabama legislators made four attempts to amend the statute's wording to clarify that the statute applies to *both* born children as well as fetuses.[101] These attempted revisions demonstrate that the statute's original wording was not definitive. If the term "child" was unambiguous, such legislators would not have needed to attempt to clarify the statute. Yet, the Alabama Supreme Court still found the term to be unambiguous.

The Alabama Supreme Court was wrong to conclude that "the plain meaning of the word 'child' is broad enough to encompass all children—born and unborn."[102] The mixed dictionary definitions and the attempted amendments to further explain what was meant by "child" demonstrate that the court erred in finding the term unambiguous.

B. The Alabama Supreme Court mistakenly held that the Alabama legislature intended § 26-15-3.2 to apply to drug use during pregnancy.

When a statute's wording is ambiguous, courts are to engage in judicial interpretation of the statute by using various tools of statutory construction, including traditional canons of statutory interpretation, and the statute's legislative history and purpose.[103] Because the court found that the term "child" was unambiguous, the court did not employ

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[97] *See* State Farm Fire & Cas. Co. v. Slade, 747 So. 2d 293, 309 (Ala. 1999); Espey By and Through Espey v. Convenience Marketers, Inc., 578 So. 2d 1221, 1223 n. 1 (Ala. 1991) (finding that although there may be instances when it is necessary to base a judgment on dictionary definitions, this is an unduly narrow approach in some situations).

[98] *State Farm Fire*, 747 So. 2d at 309.

[99] *See e.g.*, United States v. Santos, 553 U.S. 507 (2008); Johnson v. United States, 529 U.S. 694 (2000).

[100] *See* Imani Gandy, *Hope Ankrom and Amanda Kimbrough: Victims of Alabama's Personhood Agenda*, RH Reality Check (Jan. 18, 2013, 10:52 AM), http://rhrealitycheck.org/article/2013/01/18/hope-ankrom-and-amanda-kimbrough-victims-alabama-supreme-courts-zeal-to-protect-u/ (referring to the Alabama Supreme Court's decision in *Ankrom* as "judicial activism" and "the Alabama judiciary's zeal to promote an anti-choice personhood agenda at the expense of pregnant women").

[101] Todd Brief, *supra* note 3 at 10; s*ee infra* Part II(b) for a discussion of the intent and failure of these subsequent amendments.

[102] *Ex parte* Ankrom, 2013 WL 135748 at *11 (Ala. Jan. 11, 2013).

[103] *Id.* at *4 ("Principals of statutory construction instruct this court to interpret the plain language of the statute to mean exactly what it says and to engage in judicial construction only if the language in the statute is ambiguous."); *See* Barnhart v. Sigmon Coal Co., 534 U.S. 438, 450 (2002).

other tools of statutory interpretation.[104] However, when one engages in such judicial construction, it is evident that § 26-15-3.2 was meant to protect children growing up around narcotics, and not fetuses exposed to chemical substances in utero.

In attempting to interpret statutes, courts often look to contemporaneous statements made by legislators during the legislative process.[105] In the instant matter, a number of Alabama legislators spoke out against the use of this law to prosecute women for using drugs during pregnancy. For example, one of the law's original sponsors, former Alabama State Senator Lowell Barron stated that he did not intend for the law to be used against new mothers, saying, "I hate to see a young mother put in prison away from her child . . . maybe we need to revisit the legislation."[106] Alabama Representative Patricia Todd submitted an amicus brief to the Alabama Supreme Court in support of Kimbrough and Ankrom.[107] In her brief, Todd explicitly stated that the legislature had considered making the law applicable to pregnant women who use drugs, but expressly rejected the idea.[108] She added that she was actively involved in the legislature's ultimate refusal to adopt such measures and that the prosecutions were "contrary to the letter of the law and the express will of the Legislature."[109] Representative Jeffery McLaughlin stated that "there can be no prosecution under this bill for a woman who has exposed a child in the womb."[110]

While the petitioners included Senator Barron's statement in their brief, the court dismissed the statement as unpersuasive, noting in a footnote that "[f]ormer Senator Barron's views are irrelevant; this Court will not rely solely on the views of a single legislator in ascertaining the intent of a bill, even when that legislator was a sponsor of the bill."[111] The court went on to provide a long string cite of court opinions from an assortment of jurisdictions indicating that legislator statements regarding the intent of the law should not be afforded too much weight.[112]

The court was incorrect in refusing to acknowledge such legislator statements. An equal number of opinions, including U.S. Supreme Court and Alabama court opinions,

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[104] *Ex parte Ankrom*, 2013 WL 135748 at *7 ("The term 'child' in § 26-15-3.2, Ala. Code 1975, is unambiguous; thus, this Court must interpret the plain language of the statute to mean exactly what it says and not engage in judicial construction of the language in the statute.").

[105] *See, e.g.*, Price Waterhouse v. Hopkins, 490 U.S. 228, 244 n. 9 (1989) (looking to legislator statements to help determine the intent behind a federal employment discrimination law); Arlington Heights v. Metro. Hous. Dev. Corp., 429 U.S. 252, 268 (1977) (stating that a law's purpose can be demonstrated by examining the statements of a decision-making body).

[106] Phillip Rawls, *National Ire Over Ala. Prosecuting Pregnant Moms*, USA Today, Aug. 1, 2008, http://usatoday30.usatoday.com/news/nation/2008-08-01-4274196709_x.htm.

[107] *See generally* Todd Brief, *supra* note 3.

[108] *Id.* at 14.

[109] *Id.* at 18.

[110] H.B. 723, 2008 Sess. (Ala. 2008), Statement of Rep. McLaughlin, http://altaxdollarsatwork.blogspot.com/2008/ 05/chemical-child-endangerment-debate.html ("My purpose in bringing this bill is to get help for that mother so she doesn't do it again.")

[111] *Ex parte* Ankrom, 2013 WL 135748 at *14 n. 8 (Ala. Jan. 11, 2013).

[112] *Id.*

do, rely heavily on legislators' statements.[113] The court should have taken all relevant case law into account in its analysis—even case law that says that a court *may* rely on legislator statements when determining legislative intent.

Similarly, the State argued that § 26-15-3.2 was clearly intended to apply to fetuses because the Alabama legislature "has stated that '[t]he public policy of the State of Alabama is to protect life, born, and unborn.'"[114] While Alabama has stated its policy of protecting unborn life, it has also, on multiple occasions, stated its policy of protecting women, women's health, and pregnant women.[115] Statements regarding the State's policy of protecting women should have been considered by the court alongside statements of policy regarding unborn life, but they were not and the court unquestioningly accepted the State's assertion.

Next, Kimbrough and Ankrom argued that had the legislature intended the law to apply to fetuses, it would have said so in explicit terms, just as the legislature had done in other statutes.[116] The petitioners cited the State's Partial Birth Abortion Act which uses the word "fetus," as well as the State's Women's Right to Know Act, which uses the term "unborn child."[117] In addition, in 2006, the same year that § 26-15-3.2 passed, the legislature amended the State's homicide law to redefine "person" to include a fetus, demonstrating that when the legislature wants to make clear that a law applies to a fetus, it makes a conscious and explicit effort to do so.[118]

In response, the court stated that a review of such statutes "provides no conclusive evidence" as to how the court should interpret the word "child."[119] The court merely wrote that in the aforementioned examples, the legislature chose to use the words "fetus" and "unborn child" because those statues could simply not apply to born children.[120] Had the court delved deeper in its analysis, it may have noted that the legislature purposefully uses the term "child" differently than it uses the term "fetus" or "unborn child," and understood that the term "child" does not encompass the term "fetus."

In addition to the examples proffered by the petitioners, numerous other Alabama statutes differentiate between the terms "child" and "fetus." Alabama's abortion statute uses the term "unborn life."[121] Another Alabama statute reads that the death of a "fetus"

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[113] *See supra* note 105.

[114] *Ex parte Ankrom*, 2013 WL 135748 at *13 (citing the state's abortion law found at Ala. Code § 26-22-1(a) (2012)).

[115] *See, e.g.,* Ala. Code § 22-12D-1 (establishing the Office of Women's Health for the purpose of advocating for women's health and identifying, coordinating, and establishing priorities for programs, services, and resources the state should provide for women's health issues and concerns relating to the reproductive, menopausal, and postmenopausal phases of a woman's life, with an emphasis on postmenopausal health); Rice v. United Ins. Co. of America, 465 So. 2d 1100 (Ala. 1985) (stating that discrimination based on pregnancy violates Title VII of the Civil Rights Act).

[116] *Ex parte Ankrom*, 2013 WL 135748 at *12.

[117] *Id.*

[118] *Id.*

[119] *Id.* at *13.

[120] *Id.*

[121] Ala. Code § 26-22-1 (1997).

must be reported to a particular agency.[122] Alabama's organ donation statute states that the term "decedent" includes a "stillborn infant . . . or fetus."[123] Alabama property law refers to real estate which devises to any other person "born or unborn."[124] The state's drivers' licensing statute offers special rules if the applicant has custody of a "minor or unborn child."[125] It is evident from these statutes that Alabama legislators purposefully differentiate between life inside the womb and life outside the womb when drafting such laws. If the legislature had intended § 26-15-3.2 to apply to both fetuses and born children, the legislature would have written "child or fetus" or a "born or unborn child," rather than just "child."

Courts "must presume that a legislature says in a statute what it means and means in a statute what it says there."[126] The Alabama Supreme Court did not take heed of these instructions from the U.S. Supreme Court. The fact that the Alabama legislature only used the word "child" in the chemical endangerment law strongly indicates the legislature only intended the law to apply to children. For the court to say that the examples of other Alabama statutes offered by the petitioners "provide no conclusive evidence" sweeps very convincing evidence under the rug.

An additional argument advanced by the petitioners was that the legislative attempts to amend the chemical endangerment statute demonstrate that the original law was not meant to apply to fetuses.[127] On four separate occasions, amendments were introduced to reword § 26-15-3.2 to state that for the purposes of this law, the term "child" includes fetuses and children.[128] None of these bills were ever enacted. To these arguments the court replied that "interpreting a statute based on later attempts to amend that statute is problematic" because "several equally tenable inferences may be drawn from such inaction . . . ."[129]

While that conclusion may be true in some circumstances, it is not true here, where it is abundantly clear why these amendments failed. During floor debates on these proposed amendments, Representative Patricia Todd, Representative Jeffery McLaughlin, Representative Pebblin Warren, Representative Dario Melton, and Representative Yusuf Salaam all discussed the implications of expanding the scope of the chemical endangerment law to allow for the prosecution of women who use drugs during pregnancy.[130] Representatives expressed concerns about incarcerating drug users

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[122] Ala. Code § 22-9A-13 (2012).

[123] Ala. Code § 22-19-161 (2008).

[124] Ala. Code § 19-3-170 (1975).

[125] Ala. Code § 16-28-40 (2009).

[126] Connecticut Nat'l Bank v. Germain, 503 U.S. 249, 253-54 (1992).

[127] *Ex parte* Ankrom, 2013 WL 135748 at *13-14 (Ala. Jan. 11, 2013).

[128] *See* Todd Brief, *supra* note 3, at 14 ("The rejection of two proposed amendments to the chemical endangerment law in the 2008 legislative session and two more in 2011 further demonstrates that the law was never intended to apply to a pregnant woman who uses a controlled substance during pregnancy.").

[129] *Ex parte Ankrom*, 2013 WL 135748 at *15.

[130] H.B. 723, 2008 Sess. (Ala. 2008), Statement of Rep. McLaughlin, http://altaxdollarsatwork.blogspot.com/2008/05/chemical-child-endangerment-debate.html ("My purpose in bringing this bill is to get help for that mother so she doesn't do it again.").

rather than offering them treatment, deterring women from seeking prenatal care, and encouraging abortions as a means to avoid criminal prosecution, and more.[131] These concerns were never discussed when the chemical endangerment law was originally debated. That the proposed amendments raised concerns about the effect of the law on pregnant women while the original law did not raise such concerns, strongly supports the conclusion that the original chemical endangerment law was not intended to be used to prosecute a pregnant woman for endangering a fetus.

Moreover, the fact that the debate centered on *expanding* the scope of the law to make it apply to fetuses unequivocally demonstrates that the original bill had a narrower scope and did not apply to fetuses. Even more convincingly, a number of representatives who voted to pass the chemical endangerment law during its original passage in 2006 voted against these amendments, signifying an awareness of the major shift in the implications that the proposed amendments would create.[132] Thus it is clear that in the case of Alabama's chemical endangerment law, there were definite and identifiable reasons why the amendments were rejected. The court was therefore wrong to conclude that "several equally tenable inferences may be drawn from such inaction . . . ."[133]

While the court rejected the petitioner's above-mentioned arguments, further analysis demonstrates that the law as written was not meant to apply to fetuses. First, Alabama enacted the chemical endangerment law on June 1, 2006. Thereafter, the Alabama Department of Human Resources (DHR) was tasked with promulgating rules and regulations to carry out the law.[134] On April 30, 2008, the Department adopted a final rule defining the term "chemical endangerment."[135] The regulation reads as follows:

> Chemical endangerment occurs when children are in a situation/environment where, through direct or indirect exposure, they ingest or inhale a controlled substance (e.g., methamphetamine) or chemical substance (e.g., pseudoephedrine, freon, sulfuric acid, etc.) used in the production of methamphetamine and parents'/primary caregivers' purpose for being in possession of the chemicals is to produce or manufacture crystal meth for personal use or distribution.[136]

No other definition of or commentary on the term "chemical endangerment" appears in Alabama's regulatory code. According to the rule, chemical endangerment only occurs when the child is exposed to chemicals during the production of methamphetamine and when the parent possesses the chemicals to produce or manufacture methamphetamine. Methamphetamine cannot be produced or manufactured in the womb. Therefore the rule demonstrates that the intent of the law was to protect children growing

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[131] *Id.*

[132] Todd Brief, *supra* note 3, at 15.

[133] *Ex parte Ankrom*, 2013 WL 135748 at *15 (*quoting* Pension Benefit Guarantee Corp. v. LTV Corp., 496 U.S. 633, 650 (1990)).

[134] Ala. Admin. Code r. 660-1-3-.01 (1983).

[135] Ala. Admin. Code r. 660-5-34-.02 (2008).

[136] *Id.*

up in methamphetamine labs. Under this regulation, a pregnant woman who uses methamphetamine has not committed chemical endangerment.

When the rule was adopted on August 30, 2008, the DHR was aware of pregnant women being charged under § 26-15-3.2 for use of narcotics during pregnancy. For example, on April 29, 2008, Amanda Kimbrough tested positive for methamphetamine at an Alabama hospital before receiving a C-section.[137] Her test results were delivered to the DHR.[138] A DHR social worker had spoken with her twice before and was aware that she had used methamphetamine.[139] Even earlier than Kimbrough's case, on July 26, 2005, Frieda Baker, Deputy Director of the Family and Children's Services division of the DHR testified before the U.S. Congress about Alabama's growing methamphetamine problem and the drastic effects that the problem has had on the State's children.[140] It is evident that the Department was aware that Alabama mothers were using methamphetamine during pregnancy. Yet, despite this knowledge, the Department still chose to promulgate the rule in a manner which could not logically apply to drug exposure in utero. The DHR administrators, hired for the purpose of developing and carrying out state social services regulations,[141] were tasked with interpreting "chemical endangerment" and consciously did so by limiting the term to refer to exposure of children to chemicals used during methamphetamine production. Courts routinely give deference to agency interpretations of statutory language, and should have done so here.[142]

Second, according to the interpretation of the court in *Ex parte Ankrom*, it is now a felony for pregnant women to take many prescriptions which are lawfully prescribed to them, whether or not that prescription is harmful to the fetus. This interpretation by the court could not have been the intention of the legislature. Many prescription medications are considered "controlled substances" under the chemical endangerment statute:

> Many types of schedule II, III, IV, and V controlled substances are medications, including painkillers, anti-seizure drugs, and stimulants that are routinely, appropriately prescribed for patients—including pregnant women. A recent survey of obstetricians and gynecologists found "that approximately a third

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[137] *Ex parte Ankrom*, 2013 WL 135748 at *3.

[138] *Id.* at *4.

[139] *Id.*

[140] *Fighting Meth in American's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies, Hearing Before the Subcomm.on Criminal Justice, Drug Policy, and Human Resources of the H. Comm. on Government Reform*, 109th Cong. 108 (2006) (statement of Freida Baker, Deputy Director of Family and Children's Services, Alabama Department of Human Resources), *available at* http://www.gpo.gov/fdsys/pkg/CHRG-109hhrg24946/html/CHRG-109hhrg24946.htm.

[141] *See* Ala. Code § 38-2-6 (1975); Ala. Admin. Code r. 660-1-2-.03 (1983).

[142] *See* Barnhart v. Sigmon Coal Co., 534 U.S. 438, 462 (U.S. 2002) ("In the context of an unambiguous statute, [the United States Supreme Court] need not contemplate deferring to the agency's interpretation."). *See generally* Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984).

of their pregnant patients took at least one prescription medication other than prenatal vitamins during pregnancy prior to labor."[143]

The petitioners noted that "many preexisting chronic conditions require continued drug management during pregnancy, and pregnant women may develop diseases or pregnancy-related disorders that require treatment during pregnancy."[144] Pregnant women are routinely issued prescriptions for conditions such as chlamydia, urinary tract infection, depressed mood, generalized anxiety disorder, chronic insomnia, asthma, major depressive disorder, hypertension, frequent/severe headaches, flu, and diabetes.[145]

Importantly, methadone, used for the treatment of opioid addiction—oftentimes during pregnancy—is a controlled substance covered by the chemical endangerment statute.[146] Methadone maintenance treatment is the standard of care for opioid dependence during pregnancy.[147] There are numerous benefits of methadone use during pregnancy, including improved prenatal care, longer gestation, higher birth weight, and increased rates of infants discharged home in the care of their mothers.[148] Alabama's women rely on methadone for the purposes of opiate withdrawal: Alabama ranks seventh in the nation for states with the highest rates of methadone treatment users.[149] The Alabama Supreme Court has thus made it a felony for pregnant women to take crucial medications, forcing them to choose between their health as well as the health of their child and jail time.

Even if a prescription medication taken by a pregnant woman did cause harm to the fetus, it is evident that the legislature would not condone prosecution of such an act. The State's homicide law specifically states that a woman may not be charged with a homicide for causing the death of, or injury to, a fetus by taking medication prescribed to her.[150] This indicates that the legislature wanted to protect women who took lawfully prescribed medications during pregnancy, even if those prescriptions caused death or injury to the fetus. Thus, it is illogical that the legislature would prosecute a woman for harm to a fetus caused by a prescription under § 26-15-3.2, but would not prosecute a woman for that exact same act under the State's homicide law. In *Ex parte Ankrom*, the Alabama Supreme Court stated that it wanted to respect the intentions of the State legislature.[151] Yet the court directly opposed the clear intent of the legislature when it ruled that the chemical endangerment statute could be used to prosecute a woman who takes necessary and often times lifesaving drugs during pregnancy.

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[143] Motion for Leave, *supra* note 83, at 17 (*citing* Maria A. Morgan et al., *Management of Prescription and Nonprescription Drug Use During Pregnancy*, 23 J. Maternal-Fetal & Neonatal Med., 815-17 (2010)).

[144] *Id*.

[145] *Id.*

[146] *Id.* at 20 (*citing* Substance Abuse & Mental Health Servs. Admin., U.S. Dep't of Health & Human Servs., *Methadone Treatment for Pregnant Women*, Pub. No. SMA 06-4124 (2006)).

[147] *Substance Use in Pregnancy*, Soc. of Obstetricians and Gynaecologists of Canada (2011), http://sogc.org/wp-content/uploads/2013/01/gui256CPG1104E.pdf.

[148] *Id.*

[149] Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama, *supra* note 16, at 62.

[150] Ala. Code § 13A-6-4(b) (1988).

[151] *Ex parte* Ankrom, 2013 WL 135748 at *9, *18, *19 (Ala. Jan. 11, 2013).

C. Because the petitioners had no notice of their alleged crime, the Alabama Supreme Court was incorrect in concluding that the rule of lenity did not apply.

Criminal statutes are to be strictly construed against the state[152] and due process requires that parties before the court have notice that their alleged conduct was proscribed by law.[153] The notice given must provide ordinary persons with clear notice of what is prohibited.[154] When no such notice exists, the rule of lenity applies and criminal statutes are to be construed in favor of the accused.[155] Kimbrough and Ankrom argued that there was no notice that their conduct was illegal under § 26-15-3.2.[156] Without much discussion, the Alabama Supreme Court determined that because the term "child" unambiguously includes fetuses, the rule of lenity did not apply.[157]

As demonstrated in Parts II(a) and II(b), the term "child" was ambiguous in its use. Section 26-15-3.2 states that a person commits the crime of "chemical endangerment" by exposing a child to an environment in which the child comes into contact with a controlled substance, chemical substance, or drug paraphernalia.[158] To satisfy due process, "notice of a crime must provide ordinary persons with clear notice of what is prohibited."[159] This statute does not provide clear notice to ordinary persons. This case raised the question of whether the term "child" did or did not include fetuses. The question was debated by politicians, attorneys, judges, and others trained in legal scholarship throughout Alabama and the Nation. Once the question reached the Alabama Supreme Court, the decision still was not unanimous, as two judges dissented. When those trained in legal scholarship are unable to conclusively decipher the meaning of a term, an ordinary person without legal training cannot be expected to do so. As stated in the dissents of Chief Justice Malone and Justice Murdock, because the petitioners had no notice of their crime, the rule of lenity applied, and the court should have overturned their convictions.[160]

III. POLICY CONSIDERATIONS AND RECOMMENDATIONS

In addition to the aforementioned legal concerns raised by § 26-15-3.2, the statute has a number of dangerous policy implications for Alabama's women and families. While a few cases such as Hope Ankrom's and Amanda Kimbrough's have been sensationalized in the media, these stories represent just a few of the hundreds of women and families who are put in danger by the statute.[161] The statute puts a vulnerable population (pregnant, usually low-income, substance-abusing women) at higher risk physically,

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[152] *See id.* at *4 (*citing* Castillo v. United States, 530 U.S. 120, 131 (2000)).

[153] *Id.* at *25 (Malone, C.J., dissenting).

[154] *Id.* at *26 (Murdock, J., dissenting) (*citing* United States v. Sepulveda, 115 F.3d 882, 887 n. 12 (11th Cir. 1997)).

[155] *Id.* at *9 (*quoting Ex parte* Bertram, 884 So. 2d 889, 891 (Ala. 2003)).

[156] *Id.* at *1-2.

[157] *Id.* at *6-7.

[158] Ala. Code § 26-15-3.2 (2012).

[159] *See* Skilling v. United States, 130 S. Ct. 2896, 2927-28 (2010).

[160] *Ex parte Ankrom*, 2013 WL 135748 at *24-26 (Malone, C., J. and Murdock, J., dissenting).

[161] Ahrens, *supra* note 15, at 883-84 (referencing similar cases in Hawaii, Wyoming, and Oklahoma).

emotionally, and financially. While this article does not endorse the use of narcotics, this article does warn that granting legal rights to a fetus is dangerous for women and that drug use should be treated with appropriate medical care rather than incarceration.

A. Personhood and Abortion Rights

While Alabama's chemical endangerment law has many tangible and specific consequences, the overarching danger of this law is that it creates legal rights for a fetus. When legal rights are given to a fetus, the legal rights of the pregnant woman carrying that fetus are automatically compromised. Granting legal rights to fetuses may snowball: if one legal right is given to a fetus, as is the case with the chemical endangerment laws, the door opens for granting additional rights, if not full, legal protections, to a fetus. Granting full legal rights to a fetus would create fetal personhood, and grant the fetus the same legal rights and protections as a human being. If fetuses are considered human beings for legal purposes, abortion becomes murder, and thus, illegal.

Moreover, recognition of a fetus as a person would be inconsistent with existing Alabama law. Like every other state in the U.S., Alabama does not legally recognize fetal personhood. Though attempts have been made in Alabama to pass such legislation, time and time again, the State legislature has actively chosen not to give legal rights to fetuses.[162] Despite the State's decision not to create such rights for the unborn, the Alabama Supreme Court opinion usurps this decision. The opinion, hailed as "sett[ing] the stage for [a] personhood amendment,"[163] stands in stark contrast to the will of the legislature and dangerously compromises the legal rights of Alabama's women.

B. Punishing Pregnancy

Section 26-15-3.2's current use is problematic because it punishes women in a way that men cannot be punished. While possession or sale of illegal narcotics is a crime, use of narcotics is not. Generally speaking, because only women can become pregnant and because the Alabama Supreme Court has held that § 26-15-3.2 applies to narcotics use during pregnancy, § 26-15-3.2 punishes women, but not men, who use illegal narcotics. In addition to illegal narcotics, § 26-15-3.2 punishes women, but not men, who take medications lawfully prescribed to them by a health care provider—a punishment that,

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[162] *See* S.B. 205, 2013 Reg. Sess. (Ala. 2013), S.B. 5, 2012 Reg. Sess. (Ala. 2012), H.B. 405, 2011 Reg. Sess. (Ala. 2011), S.B. 301, 2010 Reg. Sess. (Ala. 2010), S.B. 225, 2009 Reg. Sess. (Ala. 2009), H.B. 348, 2008 Reg. Sess. (Ala. 2008), H.B. 128, 2007 Reg. Sess. (Ala. 2007); *see also Historic Personhood Bills and Amendments Introduced in Alabama Legislature*, Personhood USA, *available at* http://www.personhoodusa.com/press-release/historic-pro-life-personhood-bills-and-amendments-introduced-alabama-legislature/ (last visited Dec. 3, 2013) (highlighting Alabama's personhood movement and referring to it as "an effort to provide equal protection to unborn children by defining them as persons under the laws of Alabama").

[163] *The Alabama Supreme Court Opinion Sets the Stage for Personhood Amendment*, Right Remedy: A Ministry of Dr. Patrick Johnston and Family, *available at* http://rightremedy.org/articles/399 (last visited Dec. 3, 2013).

if convicted, can result in a felony conviction and up to life behind bars,[164] making the statute's gender disparity of grave severity.[165]

When women are punished for "deviant" behavior during pregnancy, it is not unlikely that the state will go on to punish women for other acts during pregnancy. Under the veil of fetal protection, that state could allow for the prosecution of pregnant women who drink alcohol, smoke cigarettes, eat unhealthily, fail to seek prenatal care, drive recklessly, work at a location that exposes them to toxic fumes, attempt suicide, or stay in a physically abusive relationship. While such punishments may seem absurd, many of them have been proposed in states across the U.S., including Alabama.[166] The chemical endangerment law begs the question—where does one draw the line? Punishing women solely due to their pregnancy status is a dangerous step towards future erosion of women's rights.

C. Dangerous for the Health of the Women, Fetuses, and Families

The interpretation of § 26-15-3.2 adopted by the court guarantees the opposite effect that prosecutors intended. Alabama State prosecutors urge that such prosecutions are necessary to protect unborn life.[167] For three reasons, the interpretation of the law actually harms unborn life. First, healthcare in Alabama prisons ranks among the lowest in the nation:

> In Alabama, medical care in prison is appalling. Alabama received an "F" rating for the delivery of prenatal care to pregnant inmates. Alabama is last in the nation in terms of per inmate medical spending. The Julia Tutwiler Prison for Women is overcrowded and has a history of failing to provide basic medical care, adequate hygiene, beds, ventilation, and nutrition. County jails in Alabama are similarly ill equipped to provide healthy environments to

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[164] Ala. Code § 26-15-3.2 (2013); Ala. Code § 13A-5-11(2013) (providing the fines required for each class of felony); Ala. Code § 13A-5-6 (2013) (providing the sentences of imprisonment for each class of felonies).

[165] *See* Meghan Horn*, Mothers Versus Babies: Constitutional and Policy Problems with Prosecutions for Prenatal Maternal Substance Abuse*, 14 Wm. & Mary J. Women & L. 635, 648 (2008) ("If prosecutors persist in seeking to hold women criminally responsible for fetal injuries as a result of parental substance abuse, they should apply the same statutes to new fathers with substance abuse problems.").

[166] *See, e.g.*, Bei Bei Shuai v. State, 966 N.E.2d 619, 628 (Ind. Ct. App. 2012) (charging the defendant with murder and attempted feticide for attempting to commit suicide while pregnant); *Smoking While Pregnant May be Illegal,* Associated Press (June 13, 2006, 4:51 PM), http://www.fox16.com/news/story/Smoking-While-Pregnant-May-be-Illegal/P8kkEclKmE-5hB4mHZ-_Iw.cspx (discussing former Arkansas Governor Mike Huckabee's proposal to ban pregnant women from smoking cigarettes); *Punishing Women for Their Behavior During Pregnancy An Approach That Undermines Women's Health and Children's Interests*, Ctr. for Reprod. Rights 2 (2000) [hereinafter Punishing Women], http://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf (providing examples of criminal prosecutions against pregnant women who drank alcohol, failed to heed a doctor's recommendation to remain on bed rest, and failed to heed a doctor's recommendation to refrain from engaging in sexual intercourse).

[167] *See* Steele, *supra* note 6.

pregnant women. Such conditions are antithetical to the health and well-being of pregnant women and their fetuses.[168]

If a state is concerned about fetal life, it should not place pregnant women in prison, where the jails are among the most decrepit in the Nation and where healthcare and prenatal healthcare is nothing short of abominable.[169]

Second, overwhelming empirical research demonstrates that when women are threatened with punishment for illegal acts during pregnancy, those women will not seek vital prenatal medical care due to concern that their doctors will report them to the authorities.[170] The American Medical Association and the American College of Obstetricians and Gynecologist, among others, have spoken out on this issue and submitted amicus curiae briefs to the Alabama Supreme Court, stating that women will avoid prenatal care when they believe doctors are gathering evidence for law enforcement.[171] While medical care is crucial for any pregnant woman and the fetus, it is even more crucial when that woman is using illegal narcotics.[172] Quitting drugs cold turkey can be medically unsafe for both the mother and the fetus. It is therefore paramount that pregnant drug users and

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[168] Motion for Leave, *supra* note 83, at 15-16.

[169] *See* Statement of Patricia Todd (audio recording), *available at* http://altaxdollarsatwork.blogspot.com/2008/05/chemical-child-endangerment-debate.html (discussing the deplorable healthcare of Alabama's prisons and how dangerous it is for a pregnant women to be forced to live in such conditions in relation to H.B. 723, 2008 Sess. (Ala. 2008)).

[170] *See* Steele, *supra* note 6 ("By effect, some gynecologists say, prosecuting mothers harms infants more than helps them: Prenatal attention 'can greatly reduce the negative effects of substance abuse during pregnancy,' according to Dr. David Garry, a New York obstetrician and member of the American Congress of Obstetricians and Gynecologists. When women aren't getting it, that risk goes up.").

[171] *See* Motion for Leave, *supra* note 83, at 4 (written by National Advocates for Pregnant Women and the Southern Poverty Law Center and signed onto by the American Academy of Addiction Psychiatry, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Medical Women's Association, American Nurses Association, The Alabama Women's Resource Network, American Society of Addiction Medicine, Black Women's Health Imperative, Child Welfare Organizing Project, Global Lawyers and Physicians, Harm Reduction Coalition, Institute for Health and Recovery, International Center for Advancement of Addiction Treatment of the Beth Israel Medical Center Baron Edmond de Rothschild Chemical Dependency Institute, International Centre for Science in Drug Policy, International Doctors for Healthy Drug Policies, International Mental Disability Law Reform Project, Legal Action Center, National Asian Pacific American Women's Forum, National Association of Nurse Practitioners in Women's Health, National Association of Social Workers, Alabama Chapter, National Council on Alcoholism and Drug Dependence, Inc., National Institute for Reproductive Health, National Latina Institute for Reproductive Health, National Organization for Women – Alabama, National Perinatal Association, National Women's Health Network, National Women's Law Center, Our Bodies Ourselves, Southern Center for Human Rights, Pippa Abston, MD, PhD, FAAP, Sheila Blume, MD, Susan C. Boyd, PhD, Wendy Chavkin, MPH, MD, Nancy Day, MPH, PhD, Gabriele Fischer, MD, Deborah A. Frank, MD, Leslie Hartley Gise, MD, Stephen R. Kandall, MD, Howard Minkoff, MD, Daniel R. Neuspiel, MD, MPH, Robert G. Newman, MD, MPH, Linda Worley, MD, Trecia Wouldes, PhD, and Tricia E. Wright, MD, MS).

[172] Steele, *supra* note 6 (stating that the nurse manager for the obstetrics (OB) department acknowledged that pregnant women who are struggling with drug problems already are scared of getting help for their addictions or prenatal care because they do not want DHR to take away their babies).

their doctors develop safe and trusting relationships, as well as attainable medical plans during pregnancies.

In addition, critics of the law suggest that women may choose to leave the State during labor to deliver their child outside of Alabama to avoid prosecution.[173] Such a journey may create delay in receipt of medical attention and poses significant health risks for both mother and child. If Alabama prosecutors are truly concerned about the welfare of the State's unborn, they should encourage women to seek prenatal care and immediate access to medical care when experiencing symptoms of labor, rather than deter them from doing so with the threat of incarceration.

Third, while the State prosecutors urge that this law will protect unborn life, such a policy will likely encourage abortion.[174] A woman convicted under the chemical endangerment law could face up to life behind bars and a fine of up to $60,000.[175] The law forces women to choose between an abortion and jail time. National Advocates for Pregnant Women state that the law will actually increase instances of abortion in Alabama:

> Although it is difficult to know how frequently abortions result from fear of prosecution, one study reported that "two-thirds of the women [surveyed] who reported using [c]ocaine during their pregnancies…considered having an abortion." In at least one well-documented case, a woman did obtain an abortion to win her release from jail and prevent prosecution. In State v. Greywind, a pregnant woman accused of child endangerment, based on alleged harm to her fetus from drugs she had taken, obtained an abortion. The prosecutor then dropped the charge.[176]

State prosecutors claiming to protect future life are, in actuality, incentivizing women to end their pregnancies rather than carry them to term.

Additionally, women convicted under § 26-15-3.2 are likely to be living below the poverty line. The largest population of methamphetamine users tends to be the Caucasian rural poor.[177] Within Alabama, the State's overall poverty rate is 17.5 percent with rural areas having a higher poverty level than urban areas.[178] Nearly half of Alabama's methamphetamine users are female and ninety-two percent of Alabama's drug users are white.[179] Abortion can be incredibly expensive and even cost prohibitive to a woman

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[173] *Cf. id*.

[174] *Ex parte* Ankrom, 2013 WL 135748 at *25 (Ala. Jan. 11, 2013) (Malone, J., dissenting) ("[T]he chemical-endangerment statute will now supply women who have, either intentionally or not, run afoul of the proscriptions of the statute a strong incentive to terminate their pregnancy.").

[175] § 26-15-3.2; § 13A-5-11; § 13A-5-6.

[176] Motion for Leave, *supra* note 83, at 11-12.

[177] *See* Ahrens, *supra* note 15, at 884-85, 895.

[178] Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama, *supra* note 16, at 5.

[179] *Substance Abuse Treatment Admissions by Primary Substance of Abuse According to Sex, Age Group, Race, and Ethnicity Year = 2010*, Substance Abuse and Mental Health Serv. Admin., Ctr. for Behavioral Health Statistics and Quality, http://wwwdasis.samhsa.gov/webt/quicklink/AL10.htm (last visited Dec. 3, 2013).

lacking in financial resources. Thus, a woman facing conviction under § 26-15-3.2 who can afford an abortion can bypass a felony conviction by obtaining one, while a woman facing conviction under § 26-15-3.2 who cannot afford an abortion would have no choice but to accept a felony conviction. Therefore, the law may disproportionately affect the poor because the poor are less likely to be able to afford the one escape from prosecution under § 26-15-3.2: an abortion.

Not only does § 26-15-3.2 harm women and fetuses, but it also harms Alabama's families as well. The law hurts the spouses, significant others, the dependents, including other children that are left behind when women convicted under § 26-15-3.2 are put in prison.[180] Such economic consequences have a particularly devastating effect on low-income families.[181] Currently, Alabama prosecutes pregnant women who use harder drugs, specifically cocaine, methamphetamine, and other opiates—drugs which tend to be used more in poor communities.[182] These already financially devastated communities become even more entrenched in poverty when incarceration is used as a tool for punishing drug use.[183] Conviction under § 26-15-3.2 results in heavy jail time and exorbitant monetary fees.[184] In addition, such families must gather the money for lawyers' fees and bails often set at $500,000.[185] Moreover, such a conviction could carry severe collateral consequences at a state and federal level. Depending on the type of conviction, a woman guilty of violating the chemical endangerment law can

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[180] *See* Motion for Leave, *supra* note 83, at 3-4 ("[A]mici contend that the relevant medical and scientific research does not support the prosecution of women who use a controlled substance and continue to term for the crime of 'chemical endangerment' and that such prosecutions undermine maternal and fetal health. Amici recognize a strong societal interest in protecting the health of women, children, and families. In the view of amici, however, such interests are undermined, not advanced, by the judicial expansion of the chemical endangerment law to apply to pregnant women who seek to continue their pregnancies to term despite a drug problem.").

[181] *See, e.g.*, Marcos Ortiz, *Meth Bust Sends Family into Poverty*, ABC News, May 5, 2013, http://www.abc4.com/content/news/top_stories/story/Meth-bust-sends-family intopoverty/2l_4Dj5l00S7pqlCVaP9aA.cspx (last visited Dec. 3, 2013).

[182] *See* Filipovic, *supra* note 81 ("So they focus on the most vulnerable, least sympathetic pregnant women first and establish the rights of fetuses there. They can't go right for the prescription-drug-using upper-middle-class white women, in part because those women are considered at least marginally important in society, and in part because the people doing the prosecuting come from the same backgrounds and social classes as upper-middle-class white women and are therefore less likely to easily tag those women as criminals and unfit mothers. So women of colour, poor women and rural women are the targets, and they're having a wide pro-life strategy built on their backs.").

[183] Sasha Abramsky, *Toxic Persons: New Research Shows Precisely How the Prison-to-Poverty Cycle Does its Damage*, Slate (Oct. 8, 2010), http://www.slate.com/articles/news_and_politics/jurisprudence/2010/10/toxic_persons.single.html (reporting that children of prisoners are more likely to live in poverty, to end up on welfare, and to suffer the sorts of serious emotional problems that tend to make holding down jobs more difficult).

[184] *See* Ala. Code §§ 26-15-3.2, 13A-5-11, 13A-5-6 (2013); s*ee also* Ala. Code § 26-15-3.2 (2013) (noting that judges may choose to apply another provision of the law only if it provides a harsher penalty than this section).

[185] Ada Calhoun, *The Criminalization of Bad Mothers*, NY Times, Apr. 25, 2012, http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html?pagewanted=all&_r=0.

be denied public assistance and food stamps for the rest of her life,[186] can be denied public housing,[187] can be asked during a job interview about her past convictions and denied employment on the basis of those convictions,[188] can lose her license to practice a regulated profession,[189] can be denied federal welfare benefits,[190] can be denied social security benefits while imprisoned,[191] and more.

In addition, conviction under § 26-15-3.2 takes a heavy toll on the family's children. Ankrom, for instance, has three young children. Her prosecution under § 26-15-3.2 means that those children have to cope with the stress and turmoil of their mother being taken to prison and their mother carrying a felony conviction for the rest of their lives. Like Kimbrough, mothers convicted under such chemical endangerment laws may have their children taken away from them and even placed into the foster care system. In Alabama, the DHR performed 2,432 child removals from a home due to alcohol and/or drug abuse in fiscal year 2010.[192] Most of these removals were due to drug abuse by a parent.[193] For a law which prosecutors say is meant to protect the child-to-be, its application seems to forget about the best interests of the child that already is.

Lastly, there are enormous economic costs resulting from conviction under § 26-15-3.2 which can have an extremely devastating impact on Alabama's families. Once released from prison, a woman charged under § 26-15-3.2 must overcome the stigma associated with her conviction and the felony conviction on her record, making it difficult, if not impossible, for her to find employment. Ankrom, for example, was studying to be a physical-therapy assistant. Due to her conviction, it has become impossible for her to find work.[194] She now stays home with the children full time.[195]

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[186] *See After Prison: Roadblocks to Reentry,* Legal Action Ctr, http://lac.org/roadblocks-to-reentry/main.php?view=profile&subaction1=AL (last visited Dec. 3, 2013) (explaining Alabama's collateral consequences); *see also A Report on State Legal Barriers Facing People with Criminal Records*, Legal Action Ctr., *available at* http://www.lac.org/roadblocks-to-reentry/upload/reportcards/5_Image_Alabama%20final.pdf (last visited Dec. 3, 2013).

[187] *Id.*

[188] *Id.*

[189] David McKnight, *Criminal Law and Civil Death: The Collateral Consequences in Alabama*, Reentry Net (2012), http://www.reentry.net/library/item.411672-Criminal_Law_and_Civil_Death_The_Collateral_Consequences_in_Alabama (*citing* Ala. Code § 38-13-2(31) (1975)).

[190] *Consequences for People with Criminal Records: 2011-2012 Legislative Round-Up*, Am. Civil Liberties Union, et al. 12 (2012), http://www.sentencingproject.org/doc/State%20Collateral%20Consequences%20Legislative%20Roundup%20Sept%202012%20(1).pdf

[191] McKnight, *supra* note 189 (*citing* 20 C.F.R. § 404.468 (2013) (stating that "no monthly benefits will be paid to any individual for any month . . . the individual is confined . . . for conviction of a felony").

[192] Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama, *supra* note 16, at 90.

[193] *Id.*

[194] Calhoun, *supra* note 185.

[195] *Id.*

D. Recommendations

Both the World Health Organization and the American Psychiatric Association classify substance abuse as a disease, and the American Medical Association explains that "addiction is not simply the product of a failure of individual willpower."[196] As the National Association for Perinatal Addiction Research and Education explains, "[t]hese women are addicts who become pregnant, not pregnant women who decide to use drugs."[197] As such, drug use should be treated with health care, not incarceration.[198]

While some drug treatment programs are specifically tailored for pregnant and parenting women to help them overcome their addictions and improve birth outcomes, such programs are extremely rare and overburdened.[199] A number of factors contribute to this shortage of programs and willingness of pregnant women to utilize them. First, numerous barriers exist to treatment for pregnant women including stigma, lack of financial resources, lack of child care, fear of losing custody of children, and fear of prosecution.[200] Second, the private insurance industry does not support coverage for alcohol and drug treatment,[201] making rehab cost-prohibitive for many pregnant women struggling with addiction. Third, many rehab programs are unable or unwilling to provide pregnant women with both addiction treatment and prenatal medical care.[202] These programs often report fear of program liability, inability to care for infants, lack of services for other children while mothers are in treatment, lack of financial resources, and limited staff training and knowledge about pregnancy and substance use.[203]

The circumstances are no different in Alabama. The State's lack of resources for pregnant, drug-addicted mothers is one of the biggest problems contributing to the rise in infants born with drug withdrawal symptoms.[204] Many of the State's drug rehabilitation programs will not take pregnant women due to the added health care responsibilities associated with treating drug-addicted women who are pregnant.[205]

As discussed, punishing pregnant women through felony conviction is damaging to the women, to the fetuses, and to the families involved. Alabama lawmakers should correct the dangerous decision rendered by the Alabama Supreme Court in *Ex parte Ankrom* by

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196 Punishing Women, *supra* note 166, at 7.

197 *Id.*

198 *See* Motion for Leave, *supra* note 83, at 7 (citing the recommendations of the American College of Obstetricians and Gynecologists regarding substance use and/or abuse during pregnancy).

199 *Id.* (citing a 1991 report by the Federal General Accounting Office that found that the most critical barrier to women's treatment "is the lack of adequate treatment capacity and appropriate services among programs that will treat pregnant women and mothers with young children").

200 *Facts About Drug Treatment*, Nat'l Advocates for Pregnant Women, http://www.advocatesforpregnantwomen.org/issues/crackfacts.htm (last visited Dec. 3, 2013).

201 *Id.*

202 Substance Abuse Treatment: Addressing the Specific Needs of Women, Substance Abuse and Mental Health Serv. Admin. (2009), *available at* http://www.ncbi.nlm.nih.gov/books/NBK83238/.

203 *Id.*

204 *See* Steele, *supra* note 6.

205 *See id.*

clarifying that the law may not be used to prosecute women for the exposure of a fetus to controlled substances or chemical substances in utero.

CONCLUSION

The Supreme Court of Alabama engaged in judicial activism when it incorrectly upheld Hope Ankrom and Amanda Kimbrough's convictions. The court erred when it held the term "child" to be unambiguous and ignored the unequivocal evidence provided by the legislative history. The court also erred in not applying the rule of lenity. Importantly, the court ignored the over forty health care professionals, medical, social, and legal groups, including the American Medical Association, American College of Obstetricians and Gynecologists, and American Psychiatric Association, which appeared as amici in *Ex parte Ankrom*, warning the court of the dangerous implications of criminalizing drug use during pregnancy.[206]

"A court must not rewrite a statute to make it consistent with the court's idea of orderliness and public policy."[207] Rather than acting as neutral arbiters, the judges acted as advocates, legislating from the bench and refusing to engage in a deep analysis and true consideration of the law's intent. When a court ignores both precedent and congressional intent, it embarks upon a dangerous path, where parties before the court come to fear its unpredictability, rather than seek refuge in its commitment to justice. As a result of *Ex parte Ankrom*, Alabama's women have been pushed to the peripheral and left in an extremely precarious position, forced to grapple with the rewritten and damaging policy of the Alabama Supreme Court.

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[206] *See* Motion of the American Medical Association and Medical Association of Alabama to Appear as Amici Curiae and Adopt, in part, the Briefs of Amici Curiae Filed by the American Academy of Addiction Psychiatry, et al., in Support of the Petitioners, *Ex parte* Ankrom, 2013 WL 135748 (Ala. Jan. 11, 2013); *see also* Motion for Leave, *supra* note 83, at 4 (written by National Advocates for Pregnant Women and the Southern Poverty Law Center and signed onto by the American Academy of Addiction Psychiatry, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Medical Women's Association, American Nurses Association, The Alabama Women's Resource Network, American Society of Addiction Medicine, Black Women's Health Imperative, Child Welfare Organizing Project, Global Lawyers and Physicians, Harm Reduction Coalition, Institute for Health and Recovery, International Center for Advancement of Addiction Treatment of the Beth Israel Medical Center Baron Edmond de Rothschild Chemical Dependency Institute, International Centre for Science in Drug Policy, International Doctors for Healthy Drug Policies, International Mental Disability Law Reform Project, Legal Action Center, National Asian Pacific American Women's Forum, National Association of Nurse Practitioners in Women's Health, National Association of Social Workers and National Association of Social Workers, Alabama Chapter, National Council on Alcoholism and Drug Dependence, Inc., National Institute for Reproductive Health, National Latina Institute for Reproductive Health, National Organization for Women – Alabama, National Perinatal Association, National Women's Health Network, National Women's Law Center, Our Bodies Ourselves, Southern Center for Human Rights, Pippa Abston, MD, PhD, FAAP, Sheila Blume, MD, Susan C. Boyd, PhD, Wendy Chavkin, MPH, MD, Nancy Day, MPH, PhD, Gabriele Fischer, MD, Deborah A. Frank, MD, Leslie Hartley Gise, MD, Stephen R. Kandall, MD, Howard Minkoff, MD, Daniel R. Neuspiel, MD, MPH, Robert G. Newman, MD, MPH, Linda Worley, MD, Trecia Wouldes, PhD, and Tricia E. Wright, MD, MS).

[207] People v. Freed, 766 N.E.2d 253, 262 (4th Dist. 2002).

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