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EMPLOYER HEALTH-CARE PLANS: THE FEASIBILITY OF DISABILITY-BASED DISTINCTIONS UNDER ERISA AND THE AMERICANS WITH DISABILITIES ACT

Susan Nanovic Flannery*

A lot of companies are facing difficult questions about health care costs and they often seek the easiest way out, even if discriminatory. We will need some court decisions to ensure that employers don’t cap coverage for AIDS or other illnesses that are expensive.¹

I. INTRODUCTION

During the past fifty years, employers have borne a significant part of the burden of health care costs while employees, the recipients of such benefits, often fail to appreciate how great a benefit they have been and are receiving. Over the years, these costs have risen while employers often failed to realize to what extent. Because of these burdensome health care costs, many employers have begun to seriously consider their options in this regard. Indeed, employers across the country, faced with rapidly rising costs and fears of competitiveness, are attempting to limit coverage of HIV, AIDS,² and other disabling diseases by self-insuring.³

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2. AIDS stands for Acquired Immunodeficiency Syndrome. Health insurance coverage is especially important to persons with AIDS because the inability of an AIDS sufferer to obtain adequate health insurance coverage can result in financial insolvency and lack of access to medical care. The cost of treating an AIDS case from diagnosis to death ranges from $28,000 to $147,000. Mark Scherzer, Insurance, in AIDS AND THE LAW 185, 189 (Harlon L. Dalton et al. eds., 1987).

3. More than one million Americans, one in 250, are now thought to be infected with HIV. Barbara P. Noble, AIDS Awareness Goes to the Office, N.Y. TIMES, Dec. 6, 1992, at P-25. The majority of those infected are young adults between the ages of 25 and 44, the age category that comprises one-half of the nation’s workforce. Id.

3. A plan is self-insured — sometimes called “self-funded” — when the employer, rather than an insurance company, assumes total financial responsibility and risk for providing

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Until recently, the Employment Retirement Income Security Act of 1974 ("ERISA")⁴ governed this area of the law exclusively. Under ERISA, an employer may, without question, unilaterally modify or eliminate health care benefits for employees⁵ and, in some cases, retirees,⁶ absent a voluntary contractual obligation not to do so.⁷ The Americans With Disabilities Act ("ADA"),⁸ which prohibits discrimination against disabled individuals with respect to compensation and benefits is attempting, however, to usurp ERISA's exclusive jurisdiction in this area. In short, reductions in medical benefits are now being analyzed under the ADA's provisions and no longer exclusively under the provisions of ERISA.⁹

This Article addresses the current trends in analyzing reductions in medical benefits under the ADA while avoiding the wrath of ERISA. The analysis begins with an examination of welfare benefit plans as defined and governed by ERISA. This Article then analyzes the application of the ADA to benefit reductions and the multitude of case law developing under this new legislation. Finally, the Article concludes that, because the state of the law in this area is only beginning to transform itself, employees must take precautionary measures immediately when modifying benefit plans.

benefits. See Eric C. Sohlgren, Note, Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law — ERISA, The Rehabilitation Act and the Americans With Disabilities Act, 24 LOY. L.A. L. REV. 1247, 1251 n.10 (1991). Self-funding employers often “purchase stop-loss insurance, where the employer self-insures its plan expenses up to a certain dollar level for each claim, or up to a specific level of aggregate expenses during the year, but then insures the balance of liabilities over this amount with an independent insurer.” Id.

Self-insuring allows employers flexibility in designing and administering health care plans because ERISA preempts such plans from state-imposed benefit requirements. See infra notes 58, 74-79 and accompanying text. For a discussion on preemption, see infra note 63 and accompanying text. In this way, state laws regulating the insurance industry prohibiting such discrimination cannot reach them.


5. See infra notes 14-73 and accompanying text.


7. See infra note 19 and accompanying text.


9. See infra Section V herein.
II. PREVIOUSLY DETERMINED UNDER ERISA

Under ERISA, an employer has an absolute right to unilaterally create, modify, and terminate the terms and conditions of employee benefits plans without considering the interests of its employees and without creating liability. Indeed, ERISA does not regulate the substantive context of welfare benefit plans and cannot be interpreted to prohibit an employer from changing the terms of a plan even if the change affects some employees more so than others. Any other reading would effectively prevent employers from reacting to changed circumstances and would reduce the flexibility that Congress sought to protect when originally enacting ERISA.

A. OVERVIEW OF WELFARE BENEFIT PLANS UNDER ERISA

Contrary to the vesting requirements imposed on pension plans, ERISA does not require that welfare plan benefits “vest” or

10. ERISA applies to two types of employee benefit plans: employee welfare benefit plans and employee pension benefit plans. 29 U.S.C. § 1002(3) (1988). An “employee welfare benefit plan” means any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section [302(c) of the Labor Management Relations Act, 1947] (other than pensions on retirement or death, and insurance to provide such pensions).


11. See Owens v. Storehouse, Inc. 984 F.2d 394 (11th Cir. 1993) (holding that employer may amend its employee welfare benefit plan to include a cap for AIDS-related claims); Deeming v. American Standard, Inc., 905 F.2d 1124, 1127 (7th Cir. 1990) (holding that employer may not eliminate benefits for past employment); see also Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985) (holding that there is virtually no federal regulation of the terms of benefit plans).


that an employer maintain them at a particular level. Consequently, courts have concluded that welfare benefit plan participants acquire no vested rights in those benefits.

"[T]he policy of allowing employers freedom to amend or eliminate employee benefits is particularly compelling with respect to medical plans." Indeed, "[a]utomatic vesting was rejected [in welfare plans] because the costs of such plans are subject to fluctuating and unpredictable variables."

Even though employee welfare benefit plans are not subject to ERISA's vesting requirements, an employer may create an employee's legally enforceable right to benefits either through a written obligation or by failing to properly reserve the right to amend or change


17. Id; see also Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988) (limiting an employer's right to change medical plans increased the risk of "decreasing protection for future employees and retirees").

18. Moore, 856 F.2d at 492. Vesting is only appropriate for employee pension benefit plans because actuarial decisions concerning fixed annuities are based on fairly stable data. Id. Conversely, "medical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs." Id. For these reasons, limiting an employer's right to change medical plans could increase the risk of decreasing protection for future employees and retirees which ERISA strives to prevent. Id. This risk is especially present when the primary purpose for the change is the financial protection of the plan. Id. To sanction the vesting of welfare benefits "would not only fly in the face of ERISA's plain language but would also decrease protection for future employees and retirees." Id.

19. Generally, a contractual obligation, on the part of the employer, promising benefits is found in the summary plan description ("SPD") which must be furnished to participants and beneficiaries under ERISA. 29 U.S.C. § 1022(a)(1) (1988). Indeed, every ERISA plan must be established and maintained pursuant to a written instrument, "written in a manner calculated to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights . . . under
the benefits. Indeed, an employer may contractually obligate itself to maintain benefits at a certain level in ways that are not mandated by ERISA. However, absent such a contractual assurance, ERISA preserved the right to amend or terminate benefits); at 492 (employer may alter employee welfare benefit plan when summary plan description amendment procedure in the provisions of the employer's plan and then actually amends the plan. Id. (requiring plan to specify amendment procedures). See Moore, 856 F.2d at 492 (employer may alter employee welfare benefit plan when summary plan description disclaimer reserves the right to amend or terminate benefits); see also Schoonejagen v. Curtiss-Wright Corp., Nos. 92-5695, 92-5710, 1994 U.S. App. LEXIS 3701 (3d Cir. 1994) (plan documents must comply with all applicable ERISA disclosure requirements including not only an explicit reservation of rights to modify or terminate a plan, but also identify with particularity those who have authority to change the plan and describe the procedure by which plan amendments may be made).

20. 29 U.S.C. § 1102(b)(3) (1988). While an employer may reserve the right to amend its benefit plan to allow the termination of benefits, it is a violation of ERISA to fail to include an amendment procedure in the provisions of the employer's plan and then actually amend the plan. Id. (requiring plan to specify amendment procedures). See Moore, 856 F.2d at 492 (employer may alter employee welfare benefit plan when summary plan description disclaimer reserves the right to amend or terminate benefits); see also Schoonejagen v. Curtiss-Wright Corp., Nos. 92-5695, 92-5710, 1994 U.S. App. LEXIS 3701 (3d Cir. 1994) (plan documents must comply with all applicable ERISA disclosure requirements including not only an explicit reservation of rights to modify or terminate a plan, but also identify with particularity those who have authority to change the plan and describe the procedure by which plan amendments may be made).

21. Deeming v. American Standard, Inc., 905 F.2d 1124, 1127 (7th Cir. 1990); see also Mark D. DeBofsky, Broken Promises, Lost Benefits — Holding Employers To Their Word, TRIAL 56 (Apr. 1994). Although an employer does not have a fiduciary duty to maintain ERISA plan coverages, it does have a fiduciary duty to provide prompt notice to employees of the termination of plan coverages and to not provide intentionally misleading information regarding ERISA plan coverages. See Rucker v. Pacific FM, Inc., 806 F. Supp. 1453 (N.D. Cal. 1992); but see Vasseur v. Halliburton, 950 F.2d 1002, 1006 (5th Cir. 1992) (holding employee was not entitled to retain the benefit of language in earlier plan version since ERISA does not require that medical plan benefits vest); Ryan v. Chromalloy Am. Corp., 877 F.2d 598, 603 (7th Cir. 1989). As a general rule, unintended representations of coverage will not estop an employer from denying plan coverage. Ryan, 877 F.2d at 603. An exception exists, however, where contractual language is ambiguous and where extrinsic evidence is necessary to determine the parties' intent or where informal communications between an employer and plan participants amount to a showing of fraud. See, e.g., Moore, 856 F.2d at 492 (2d Cir. 1988); see also Alday v. Container Corp., 906 F.2d 660, 666 n.15 (11th Cir. 1990), cert. denied, 498 U.S. 1026 (1991) (plan amended where fiduciary makes promises in informal communications which intentionally deceive employees and contradict otherwise unambiguous summary plan description terms); Armistead v. Vernitron Corp., 944 F.2d 1287 (6th Cir. 1991) (employer may be estopped by oral representations contrary to the terms of the written plan instrument); Sprague v. General Motors Corp., 768 F. Supp. 605 (E.D. Mich. 1991) (employer's representations of coverage might give rise to separate enforceable contract); but see McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985) (disallowing disclaimer in summary plan description proclaiming inconsistencies will be governed by plan document).

In Moore, a group of retirees claimed that their former employer kept reducing their health care benefits even though they could point to communications by the employer that described these benefits as "lifetime" and "at no cost." Moore, 856 F.2d at 490. Because the plan unambiguously reserved the employer's right to amend or terminate the benefits, the
simply does not prohibit a company from eliminating previously offered benefits that have neither vested nor accrued.\textsuperscript{22}

\section*{B. THE COURTS TAKE A LOOK}

\subsection*{1. McGann v. H & H Music Co.}

The issue of an employer’s ability to alter a welfare benefit plan received great publicity from the case of \textit{McGann v. H & H Music Co.}\textsuperscript{23} In \textit{McGann}, the plaintiff, an employee of H & H Music, discovered in 1987 that he suffered from AIDS.\textsuperscript{24} He informed the defendant employer that he had been diagnosed with AIDS and submitted claims under his employer’s health care plan for treatment in an amount less than $5,000.\textsuperscript{25} Subsequently, the defendant employer unilaterally changed the group health plan from an insured to a self-funded basis and reduced lifetime benefits for AIDS and AIDS-related illnesses from $1 million to $5,000.\textsuperscript{26}

Shortly thereafter, the plaintiff exhausted the new AIDS lifetime maximum benefit and, because of his condition, could not obtain individual health insurance coverage.\textsuperscript{27} Consequently, he brought suit alleging that H & H Music discriminated against him by reducing coverage for AIDS-related treatment in (1) retaliation against him for exercising his rights under the plan and (2) for the purpose of interfering with his attainment of a right to which he might have become entitled under the plan.\textsuperscript{28} H & H Music moved for summary judgment.\textsuperscript{29} The district court, in granting this motion, held that the employer had an absolute right to alter the terms of medical coverage
available to plan beneficiaries. The court noted that the changes to
the plan were consistent with the paramount purpose of ERISA: to
protect the solvency of employee benefit plans to ensure that valid
claims of employees and their beneficiaries would be paid. Furthermore, ERISA does not mandate particular benefits, so where an em-
ployer retained the right to amend the plan, employees are on notice
that their coverage may change. The Fifth Circuit affirmed the
summary judgment for the employer.

In support of its opinion, the court explained the distinction
between pension and health care benefits and explained that the real
issue was the propriety of such a reduction in light of both clauses
contained in § 510 of ERISA. Under either clause, however, the
court found that the “[plaintiff] failed to adduce evidence of
defendants’ specific intent to engage in conduct proscribed by section
510.”

31. Id. at 394.
32. Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988). Additionally, in
determining that the reduction in benefits did not violate ERISA, the district court in McGann
stated that the plaintiff “was not entitled [under ERISA] to health benefits whose terms never
change.” McGann, 742 F. Supp. at 393-94.
33. McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991). The court held that
(1) there was nothing in the record to suggest that defendant specifically intended to deny
plaintiff particular medical coverage or that defendant’s motivation was other than to avoid
the expense of paying for AIDS treatment for any present or future plan participant and (2)
the defendants did not interfere with the attainment of any of the plaintiff’s rights because of
plan language allowing the employer to amend or terminate the plan. Id. at 404-08. Indeed,
plaintiff had no right to a $1 million lifetime maximum. It should be noted that the court
did not address the issue of whether the AIDS limitation violated the Texas statute that pro-
hibits employment discrimination based on disability. See TEX. REV. CIV. STAT. ANN. art.
5221k, § 5.01 (West 1987).
34. McGann, 946 F.2d at 404-07 (discussing 29 U.S.C. § 1140). These are the discrimi-
nation and interference clauses. Section 510 states:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or
discriminate against a participant or beneficiary for exercising any right to which
he is entitled under the provisions of an employee benefit plan, . . . or for the
purpose of interfering with the attainment of any right to which such participant
may become entitled under the plan . . . .
cause, without it, employers would be able to circumvent the provision of promised benefits.”
35. McGann, 946 F.2d at 408.
a. Discrimination Provision

Specifically, under the discrimination provision in § 510, the plaintiff failed to meet his burden of proving the existence of the defendant employer's specific discriminatory intent as an essential element. Simply, § 510 does not prohibit discrimination between or among categories or diseases in a welfare plan. This is true even if the employer's decision stems from prejudice against AIDS or its victims. In fact, § 510 only prohibits discrimination that is motivated by a desire to retaliate against an employee for exercising his rights under the plan, or to interfere with and deprive an employee of an existing right to which he or she might become entitled.

b. Interference

Similarly, plaintiff failed to state a claim of interference with a right to which he was entitled. The interference clause states that an employer may not discriminate against a participant for exercising

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To make out a prima facie case under § 510, the plaintiff must show: "(1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the [plaintiff] may become entitled." Gavalik, 812 F.2d at 852 (emphasis added). That is, a specific intent to violate ERISA must be shown. Id. Such intent may "be satisfied by the introduction of circumstantial evidence" indicating that the defendant possessed the required scienter. Id.

37. 29 U.S.C. § 1140 (1988). Moreover, in McGann, nothing in the record demonstrated that defendant employer's motive was other than they asserted, i.e., that they wanted to avoid the expense of paying for AIDS treatment. Treatment of AIDS, supra note 23, at A-3. Indeed, the reduction in AIDS benefits applied equally to all employees filing AIDS-related claims. Treatment of AIDS, supra note 23, at A-3.

38. Indeed, "[a] termination that cuts along independently established lines . . . and that has a readily apparent business justification, demonstrates no invidious intent." Aronson, 730 F.2d at 16.

39. McGann, 946 F.2d at 403. The Court also rejected plaintiff's argument that, because AIDS was the only catastrophic illness to which the $5,000 limit applied, and since plaintiff was the only employee known to have suffered from AIDS, the defendant employer retaliated against plaintiff in violation of Section 510. Id. at 405-08. To allow otherwise would mean that any reduction in employee benefits, motivated by a desire to avoid anticipated costs of continued coverage, would be impermissible discrimination. Id. at 408. Indeed, "[i]f a federal court could prevent an employer from reducing an employee's coverage limits for AIDS treatment once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alteration, or termination of ERISA plans would be sorely tested." Id.

40. Id. at 404-07.
any right. The term "right," however, only applies to those rights that an employee becomes entitled to "pursuant to an existing, enforceable obligation assumed by the employer" and not any conceivable right to which an employee may become entitled. Specifically, the employer never promised that the $1,000,000 limit was permanent; nor did he contractually obligate himself to provide such benefit. For these reasons, the employee in McGann failed to show an ERISA violation.

In denying review, the Supreme Court left standing the decision of the Fifth Circuit. It should be noted, however, that the Fifth Circuit's decision probably would have been different if the case had been decided after the enactment of the ADA. It should also be noted that, in McGann, the defendant employer switched to a self-insured plan after learning of its employee's diagnosis of AIDS.

41. See supra note 34.
42. McGann, 946 F.2d at 405.
43. Id. Indeed, in McGann, the employer stated in the summary plan description that the "Plan Sponsor could terminate or amend the Plan or terminate any benefit under the Plan at any time." Id. Thus, the beneficiaries were put on notice that their medical coverage under the plan could change from year to year. See supra notes 19-22 and accompanying text.

But see Vogel v. Independence Fed. Sav. Bank, 728 F. Supp. 1210 (D. Md. 1990) (change in terms and conditions of employee benefits plan violates § 510 because plaintiff and only plaintiff was excluded from coverage). This case may be distinguished from McGann in that, in McGann, the employer specifically reserved the right to amend the plan or terminate any benefit under the plan at any time. Indeed, nothing in ERISA prohibited the employer from adopting an amendment to its health benefits plan that specifically disadvantaged persons with AIDS in order to reduce plan costs.


45. The Supreme Court's denial of review was, however, unexpected. Indeed, this case had generated much interest. Among those submitting amicus curiae briefs were the American Public Health Association, Bay Area Lawyers for Individual Freedom, and Michigan Protection Advocacy. Supreme Court Declines to Review Employer's Reduction of Lifetime Health Benefits Cap for AIDS-Related Claims, Pens. Plan Guide (CCH) ¶ 26,384 (Nov. 13, 1992). The Supreme Court also invited the Solicitor General to file a brief expressing the views of the United States on the issue. Id. Given this interest, many believed that the Supreme Court would want to hear oral argument. Id. Instead, only Justice Blackmun and Justice O'Connor voted to grant the petition. Id.

47. See infra notes 155-71 and accompanying text for further discussion; see also ADA's Role in Benefits Limitation Debated at Bar Section Seminar, Daily Lab. Rep. (BNA) No. 11, at A-19 (Jan. 19, 1993).
48. McGann, 946 F.2d at 403. Although state discrimination laws governing the employ-
2. Litigation Over Benefit Caps Prior to ADA

Although the Fifth Circuit declined in *H & H Music* to address the question of whether an employer has an absolute right to alter the terms of an ERISA plan barring contractual provisions to the contrary, other courts have expressly done so.

a. Application of Federal Law

In *Owens v. Storehouse, Inc.*[^49^] the Eleventh Circuit endorsed an employer’s right to cap benefits for AIDS-related claims.[^50^] In *Owens*, the employer, Storehouse Inc., in an attempt to protect itself from the exorbitant costs accompanying the treatment of AIDS, eventually lowered its cap on AIDS-related claims to $25,000.[^51^] Plaintiff, an AIDS sufferer, filed suit.[^52^]

In its decision, the court observed that “ERISA does not confer a right to particular health benefits.”[^53^] Indeed, Section 510 “does not prohibit an employer from crafting its medical plan to meet economic imperatives. Neither does it mandate fixed coverage of catastrophic diseases.”[^54^]
Indeed, plaintiff attempted to read into § 510 a latent vesting requirement, i.e., that employers may not change the terms of their programs once an employee has contracted a particular illness and has begun submitting claims for it.\textsuperscript{55} Unfortunately, however, Section 510 contains no such requirement.\textsuperscript{56} In support of its holding, the court went on to state that Section 510 must be interpreted both to protect employees’ rights to the terms of the applicable plan and employers’ rights to modify the benefits they offer.\textsuperscript{57}

b. Application of State Law

Because of ERISA’s extensive coverage over the realm of benefits law, the power of states to prohibit unilateral reductions in benefits can never be tested. Indeed, the preemption doctrine prevents state law from barring an employer from reducing health benefits for employees with disabilities.\textsuperscript{58} Such preemption occurs even though the state law may reflect federal policies found in the Rehabilitation Act and the ADA.\textsuperscript{59}
In *Westhoven*, the employer’s self-funded insurance plan provided $1 million in lifetime medical benefits to employees, except for those with AIDS. On these employees, a $50,000 cap was imposed. Plaintiff brought suit. The critical inquiry in *Westhoven* was whether federal law similarly prohibited discrimination on the basis of handicap in the provision of employee welfare plans. If not, ERISA preempts the state law. The court held that Indiana’s law against disability discrimination did not bar the employer from reducing health benefits for its employees with AIDS. Specifically, the state’s attempts to regulate an employer’s provision of health benefits was preempted by ERISA. Indeed, although the state law may reflect federal policies found in the Rehabilitation Act and the ADA, this alone was not enough to save the statute from preemption.

The combined effect of these holdings is an interpretation of ERISA which prohibits employers from discharging employees to avoid paying benefits, but permits employers to reduce or terminate

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Cir. 1989)). Thus, self-funded insurance plans are not subject to a state’s insurance laws that regulate employee benefit plans. “(I)n order to regulate insurance, a law must not have just an impact on the insurance industry, but must be specifically directed toward that industry.” *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987).

60. *Westhoven*, 616 N.E.2d at 780.
61. Id.
62. Id. at 782.
63. 29 U.S.C. § 1144(a) (1988). The Rehabilitation Act does not displace ERISA’s preemption provision unless the employer is a federal contractor or receives federal funds. See 29 U.S.C. §§ 793-794 (1988). Federal rules impose an affirmative duty to “treat qualified handicapped individuals without discrimination” in all employment practices including “rates of pay or other forms of compensation,” such as employee welfare benefits. 41 C.F.R. § 60-741.4(a) (1990). The ADA was not, however, applied in *Westhoven* because it was not in effect at the time the alleged conduct occurred. *Westhoven*, 616 N.E.2d at 784.
64. *Westhoven*, 616 N.E.2d at 784.
65. Id.
66. Other incidents of an employer limiting AIDS coverage in group health insurance plans did not make it into court. One such incident was in late 1987 in the publicly-reported case of an employer limiting medical coverage for AIDS. Circle K Corporation informed its employees that its self-funded medical plan would no longer cover health care claims resulting from “personal lifestyle decisions” for employees hired after January 1, 1988. *Glenn Huntley, Firm Suspends Policy Excluding AIDS Claims*, BUS. INS., Aug. 15, 1988, at 2. The policy would have excluded AIDS claims by homosexuals and drug users, but not those resulting from blood transfusions. *Id*. Circle K defended its policy as a permissible design to control health care costs, even though the policy did not exclude coverage for all medical claims related to lifestyle choices, such as drug and alcohol rehabilitation. *Id*. at 2, 11. Circle K withdrew its policy in September 1988 before any employees had been denied coverage because of public and employee pressure. *Circle K Drops “Lifestyle” Policy*, BUS. INS., Sept. 26, 1988, at 2. See *Joan Vogel, Containing Medical And Disability Costs by Cutting Unhealthy Employees: Does Section 510 of ERISA Provide a Remedy?*, 62 NOTRE DAME L. REV. 1024 (1987).
nonvested benefits simply by changing the terms of a plan.\textsuperscript{67} Indeed, ERISA's legislative history also supports such an interpretation. The House Report on the act indicated Congress' intent to give employers flexibility in setting the terms of their benefit plans, but at the same time, bind employers by whatever plan they choose to offer.\textsuperscript{68} Further, Congress did not intend that an employer be prohibited from changing the terms of a plan, even if the change affects some employees more than others: "To do so would effectively prevent employers from reacting to changed circumstances and would reduce the flexibility that Congress sought to protect."\textsuperscript{69}

C. EMPLOYERS' INABILITY TO DISCHARGE EMPLOYEE

Accordingly, ERISA bars employers from discharging an employee to avoid paying benefits even if those benefits are not yet vested.\textsuperscript{70} Specifically, the language in § 510 protecting the "attainment" of any right to which employees are entitled supports the finding that employers may not discharge employees to prevent them from taking advantage of future benefits.\textsuperscript{71} The validity of a § 510 claim "does not hinge upon whether the benefits involved are vested, but upon the purpose of the discharge."\textsuperscript{72} A plaintiff "must show that the employer had the specific intent to interfere with the employee's right to benefits" in order to prevail.\textsuperscript{73}

\begin{footnotesize}
\begin{enumerate}
\item[67.] McGann and Owens are distinguishable from Westhoven on one critical point — the former actions were based solely upon § 510 of ERISA. Neither addressed whether state employment anti-discrimination laws prohibited the employers' practices or whether such laws were preempted by ERISA.
\item[69.] Id.
\item[71.] Seaman, 985 F.2d at 545-46.
\item[72.] Id. at 546.
\item[73.] Id.; see also Gavalik v. Continental Can Co., 812 F.2d 834, 851 (3d Cir.) (en banc),
\end{enumerate}
\end{footnotesize}
III. EMPLOYER RESPONSE: SELF-INSURANCE

In response to the recent cases described above, employers across the country have adopted a practice of switching to self-insured plans to avoid AIDS-related or similar health claims. This practice has especially arisen in those states which preclude traditional health insurance plans from excluding one disease from coverage in response to the Americans With Disabilities Act. Indeed, states may regulate

cert. denied, 484 U.S. 979 (1987). On the other hand, ERISA permits any participant or beneficiary to bring an action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B) (1988). Thus, once an employer decides to offer benefits, Congress intended for the employer to be bound by the terms of his plan. "There is a world of difference between administering a welfare plan in accordance with its terms and deciding what those terms are to be." Musto v. American Gen. Corp., 861 F.2d 897, 911 (6th Cir. 1988), cert. denied, 490 U.S. 1020 (1989).

74. See supra notes 3, 67-73 and accompanying text. Self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plan. 29 U.S.C. 1144(b) (1988 & Supp. V 1993). State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. Id. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. Id. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. Indeed, an insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. Id. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan’s insurer. FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990). To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits. Thus, where a "patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation," we have applied the preemption clause to ensure that benefit plans will be governed by only a single set of regulations. FMC Corp., 498 U.S. at 60 (citations omitted) (quoting Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987)).

75. See, e.g., COLO. REV. STAT. §§ 10-3-1104(1)(f)(IV), (VIII), (IX) (1987 & Supp. 1990) (prohibiting insurance classification based on physical disability, except if based on expected risk of loss different from other individuals; prohibiting use of sexual orientation in underwriting; prohibiting adverse underwriting decisions related to seeking AIDS counseling); CONN. GEN. STAT. § 38a-816(12) (1991) (prohibiting refusal or limitation of insurance based on physical disability, except where based on sound actuarial principles or related to actual or reasonably anticipated experience); D.C. CODE ANN. §§ 35-221 to 35-230 (1981 & Supp. 1990) (prohibiting insurance discrimination based on HIV infection or AIDS); FLA. STAT. ANN. § 627.429 (West Supp. 1995) (prohibiting HIV/AIDS coverage limitations in group health insurance policies; limiting use of HIV testing for health insurance eligibility; permitting HIV/AIDS exclusions in first policy year if insurer unable to test); FLA. STAT. ANN. § 627.644 (West 1984) (prohibiting insurance discrimination based on handicap, unless handicap predates application); HAW. REV. STAT. §§ 431:13-103(a)(7)(G)-(H) (Supp. 1990) (prohibiting

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insurance carriers and thereby indirectly regulate health benefit plans, but a state may not directly regulate health benefit plans themselves — that is, those that are self-insured — under the terms of ERISA.\textsuperscript{6} Hence, employers self-insure their plans to avoid both federal and state regulation.\textsuperscript{77} The "loophole" in ERISA allows self-insured health plans to cancel or reduce benefits when most needed. "[T]wo-thirds of the nation's health plans are self-insured, and therefore are exempt from state insurance laws."\textsuperscript{78} Therefore, they are "permitted to cut or eliminate benefits whenever they wish."\textsuperscript{79}
IV. LEGISLATIVE RESPONSE

In response to the Supreme Court's refusal to review McGann, in October 1992 the 102d Congress introduced legislation entitled "The Group Health Plan Nondiscrimination Act of 1992." The bill addressed retroactive reduction in benefits to employees who had relied on benefit coverage promised by their employer, i.e., changes made in the course of medically necessary treatment would be deemed discriminatory under ERISA. It would effectively amend ERISA and vest health plan participants the medically necessary services, for which they filed a claim prior to the time of the plan's amendment, for the duration of their course of treatment. The proposed amendment provided that the employers adoption of any plan change that reduced or eliminated benefits for such treatment would constitute discrimination under Section 510 unless 1) the plan would be unable to pay benefits when due without making the change and without the change would be terminated; or 2) there is no reasonable nondiscriminatory alternative within the employer's control. In the event of a material change, notice would be issued to each participant or beneficiary at least ten days before the change was adopted. Vesting would be waived if, without the change, the plan would be unable to pay benefits and would be terminated, or if no reasonable nondiscriminatory alternative to the plan's change was within the employer's control. From the plan participant's point of view, if the bill was enacted, the health benefit plan would be subject to change only on a fully prospective basis. Troubling aspects confronting the plan

82. Id.
83. Id.
84. In the case of a self-insured group health plan, such notice must: 1) state that the plan is self-insured; 2) state that the plan is not subject to state insurance guarantee fund protection; 3) identify the persons responsible for the claim determinations and processing; and 4) indicate that plan participants or beneficiaries would be responsible for medical expenses if the plan does not pay all benefits for which participants are eligible under the plan. Id. at E3049-50.
85. Id. at E3049. The change could not become effective until sixty days after the issuance of the notice. Id.
86. Id.
87. Michael J. Langan, Should ERISA Vest Health Benefits in Response to McGann v. H
The enactment of the ADA, however, may circumvent the need for such legislation. Indeed, cases currently pending should conclusively determine the issue or, at the very least, clarify the relationship between ERISA and the ADA so that both employers and employees will be better able to anticipate their ramifications.

V. ENACTMENT OF THE ADA

The ADA prohibits an employer from discriminating on the

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88. Id.

89. Id. at 132-33. The bill, however, was never passed and has not yet been reinstated. Id. at 129.

90. The ADA was designed to "provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(2) (Supp. V 1993). When enacted, the ADA provided a sweeping and broad protection to some 43 million Americans, who Congress concluded were subject to one or more physical or mental disabilities. Id. §§ 12101(a)(1), (b)(1). Its intent was to establish clear and comprehensive prohibitions of discrimination on the basis of disability. Id. § 12101(b)(1). Indeed, it defines the term "disability" broadly to mean, "with respect to an individual, a physical or mental impairment that substantially limits one or more major life activities; a record of such impairment; or even more broadly, being regarded as having such an impairment." Id. § 12102(2).

It went into effect for organizations with twenty-five or more employees on July 26, 1992 and for fifteen or more employees on July 26, 1994. Id. § 12111(5)(A).

91. Through legislation, Congress addressed the absence of a specific antidiscrimination provision in ERISA. Westhoven v. Lincoln Food Serv. Prods., Inc., 616 N.E.2d 778, 783 (Ind. Ct. App. 1993). Instead, ERISA relied upon federal law for assurances that ERISA plans would be administered in a nondiscriminatory fashion. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 104-05 (1983). Such federal laws, however, proved to be inadequate. Thus, the ADA "completes the panoply" of federal civil rights laws by specifically identifying the rights and remedies available to disabled individuals in the private sector with regard to ERISA benefits. See infra notes 93-120 and accompanying text.

92. For purposes of the ADA, an "employer" means a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person, except that, for two years following the effective date of [the ADA], [or until July 26, 1994, the employer must employ 25 or more employees].

42 U.S.C. § 12111(5) (Supp. V 1993). The ADA also prohibits employment agencies, labor organizations, and joint labor management committees from discriminating in employment
basis of disability against a qualified individual with a disability, with regard to "job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." In fact, however, the ADA not only prohibits an employer from directly discriminating on the basis of disability in the provision of health insurance to its employees, but also from indirectly discriminating on the basis of disability. Specifically, employers may not enter into or participate in a contractual or other arrangement or relationship that has the effect of discriminating against qualified applicants or their own employees with disabilities. In short, "[a]n employer or other covered entity may not do through a contractual or other rela-

against qualified individuals with disabilities. Id. § 12111(2).

93. The term "discrimination" encompasses participation in a contractual or other arrangement or relationship, including a relationship with an organization providing fringe benefits to an employee of an entity covered by the ADA that effectively subjects the entity's disabled employees to discrimination prohibited by the ADA. Id. § 12112(b)(2); see 29 C.F.R. § 1630.4 (1994).

94. As defined in the Code of Federal Regulations, the term "Disability means, with respect to an individual —

(1) [a] physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(2) [a] record of such impairment; or

(3) being regarded as having such an impairment.

29 C.F.R. § 1630.2(g) (1994).

95. A "qualified individual with a disability means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." 42 U.S.C. § 12111(8) (Supp. V 1993). The term does "not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use." Id. § 12114(a).

96. Id. § 12112(a). Regulations issued by the Equal Employment Opportunity Commission implementing the employment provisions of the ADA further provide that it is unlawful for an employer to discriminate on the basis of disability against a qualified individual with a disability in regard to "[f]ringe benefits available by virtue of employment, whether or not administered by the [employer]." 29 C.F.R. § 1630.4(f) (1994). Employee benefit plans, including health insurance plans, provided by an employer to its employees, are a fringe benefit available by virtue of employment. Id.

97. See Mason Tenders Dist. Council Welfare Fund v. Donaghey, No. 93 Civ. 1154, slip op. at 3, 19-21 (S.D.N.Y. Nov. 19, 1993); see also infra notes 155-71 and accompanying text.


99. 29 C.F.R. § 1630.6 (1994). An employer is liable for any discrimination resulting from a contract or agreement with an insurance company, health maintenance organization (HMO), third party administrator (TPA), stop-loss carrier, or other organization to provide or administer a health insurance plan on behalf of its employees. 29 C.F.R. app. § 1630.6 (1994).
tionship what it is prohibited from doing directly. 100

A. DISABILITY-BASED DISTINCTIONS 101

Under the ADA, insured 102 health insurance plans may not sub-


Indeed, the appendix to the regulations provides that employees with disabilities be accorded equal access to whatever health insurance coverage the employer provides to other employees. 29 C.F.R. app. § 1630.5 (1994). This provision, however, does not affect pre-existing condition clauses. Id. Therefore, employers may continue to offer policies “even if they adversely affect individuals with disabilities, so long as the clauses are not used as a subterfuge” to erode the ADA. Id. Thus, “it would be permissible for an employer to offer an insurance policy that limits coverage for certain procedures or treatments to a specified number per year.” Id. However, it would not be permissible to limit or deny treatment to a specific group of individuals. See id. “[L]imits also may be placed on reimbursements for certain procedures or on the type of drugs or procedures covered [1], but that limitation must be applied equally to individuals with and without disabilities.” Id. (citing H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 2, at 38, pt. 3, at 29 (1990); S. REP. NO. 116, 101st Cong., 1st Sess. 21 (1989)).

101. On June 8, 1993, the EEOC issued the first formal guidance on the relationship between employer-provided insurance and the ADA. See EEOC Interim Guidance on Application of ADA to Health Insurance, Daily Lab. Rep. (BNA) No. 109, at E-1 (June 9, 1993) [hereinafter Interim Guidance]. The Interim Guidance permits employers to continue making disability-based distinctions for covered employees on the basis of cost or actuarial data in some circumstances as long as the employer establishes that the plan is bona fide and that the distinction is not a subterfuge to evade the purposes of the law. Id. at E-2 to E-3. Indeed, the Interim Guidance applies to virtually all employee health plans, whether provided by commercial insurers or company-administered, and is a major interpretation of the ADA.

In the Interim Guidance, the EEOC expressed support under the ADA for broad discrimination, such as that involving lower levels of benefits for mental disorders or eye care. Id. at E-3. For more limited kinds of discrimination, such as those involving AIDS sufferers, the EEOC has imposed an overwhelming burden on plan sponsors to prove that they were not engaging in subterfuge that such discrimination, regardless of the sponsor's intent, would be in all cases in violation of the ADA. Id. Two reactions from employers regarding the Interim Guidance are that those who do not offer insurance will continue not to do so and those that do, will shift more toward the cafeteria-style benefit plans. Id. Hopefully, the EEOC will be able to tie such guidance to the Clinton Administration's new health care plan.

102. See id. An “insured” health insurance plan is a health insurance plan or policy that is purchased from an insurance company or other organization, such as an HMO. Id. This contrasts with a “self-insured” health plan in which the employer directly assumes the liability of an insurer. See supra note 3 and accompanying text. Insured health insurance plans are regulated by ERISA and state law while self-insured plans are typically subject only to ERISA. See supra note 75 (listing state laws regulating insurance).
ject a person with a disability to different coverage terms or conditions based on disability alone “if the disability does not pose increased risks.”

Despite this provision, however, the ADA permits ERISA plans to continue to underwrite, classify, and administer risks, as long as the functions are carried out according to accepted principles of insurance risk classification. Indeed, Section 501(c) specifically provides that the ADA does not affect pre-existing condition clauses included in insurance policies offered by employers. In fact, employers may continue to use such exclusions, even though they adversely affect persons with disabilities, as long as such clauses are not used as a subterfuge to evade the purposes of the Act. Employers may not, however, deny coverage completely based on a person’s disability alone “if the disability does not pose increased risks.”

103. See 29 C.F.R. § 1630.16(f) (1994). Section 1630.16(f) states:

Health insurance, life insurance and other benefit plans —

(1) An insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers benefit plans, or similar organizations may underwrite risks, classify risks, or administer such risks that are based on or not inconsistent with State law.

(2) A covered entity may establish, sponsor, observe or administer the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law.

(3) A covered entity may establish, sponsor, observe, or administer the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

(4) The activities described in paragraphs (f)(1), (2), and (3) . . . are permitted unless these activities are being used as a subterfuge to evade the purposes of [Title I of the ADA].

Id. Indeed, the fact than an individual disability is not covered by the employer’s current insurance plan or would cause the employer’s insurance premiums or worker’s compensation cost to increase would not be a legitimate nondiscriminatory reason justifying disparate treatment of an individual with a disability. See H.R. REP. No. 485, 101st Cong., 2d Sess., pt. 3, at 70 (1990); see also H.R. REP. No. 485, 101st Cong., 2d Sess., pt. 2, at 136 (1990); S. REP. No. 116, 101st Cong., 1st Sess. 85 (1990).

104. H.R. REP. No. 485, 101st Cong., 2d Sess., pt. 2, at 138 (1990); S. REP. No. 116, 101st Cong., 1st Sess. 86 (1989). Interestingly, the ADA explicitly construes the interplay of its provisions with federal and state antidiscrimination laws and with state laws affecting insurance plans. 42 U.S.C. § 12201(c) (Supp. V 1993). Indeed, section 12201(c) does not displace current underwriting practices or the regulatory structure of the insurance industry. Id. Rather, it reinforces the mandate that state law ensuring the financial integrity, competent administration, and availability of benefit plans must be construed against an antidiscriminatory backdrop. Id. “Admittedly, the line between lawful underwriting, classification, administration and unlawful discrimination may not be readily discernible. Nonetheless, shaping the contours of employee benefit plans to evade the general policies announced in the ADA is clearly unacceptable.” Westhoven v. Lincoln Food Serv. Prods., Inc., 616 N.E.2d 778, 784 n.15 (Ind. Ct. App. 1993) (emphasis in original); see also supra notes 67-74 and accompanying text.


106. 29 C.F.R. § 1630.16(f) (1994).
diagnosis or disability.\textsuperscript{107} For example, an employer may offer a policy that limits coverage for certain procedures or treatments, but it cannot deny coverage to individuals with certain diseases.\textsuperscript{108} At the same time, it is clear that Section 501(c) also allows insurers and insured ERISA plans to continue to conduct business in the manner in which they did business prior to the enactment of the ADA.\textsuperscript{109}

Clear differences exist, however, between the ADA’s provisions in Section 501(c) regarding self-insured and insured plans.\textsuperscript{110} Indeed, insured plans must base their decisions to limit or exclude coverage for disabling conditions upon the increased actuarial risks posed by those conditions, while no such limitation is expressly imposed upon self-insured plans by the ADA.\textsuperscript{111} Despite this, however, the EEOC has stated that this obligation similarly applies.\textsuperscript{112} Moreover, the rights granted in Section 501(c), whether to self-insured or insured plans, are further limited by the language that the rights “shall not be used as a subterfuge\textsuperscript{113} to evade the purposes” of the ADA.\textsuperscript{114}

\begin{footnotes}
\footnote{107. \textit{Id.}}
\footnote{110. \textit{See 42 U.S.C. § 12201(c) (Supp. V 1993); see also 29 C.F.R. app. § 1630.16(f) (1994) (“self-insured plans which are not subject to state law may provide coverage in a manner that is consistent with basic accepted principles of insurance risk classifications even if this results in limitations in coverage to individuals with disabilities”).}}
\footnote{111. 29 C.F.R. app. § 1630.16(f) (1994).}
\footnote{112. \textit{See Interim Guidance, supra note 101 at E-2; 42 U.S.C. § 12201(c) (Supp. V 1993).}}
\footnote{As the legislative history provides:
\ \[\text{While a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.}\]
\footnote{H.R. REP. No. 485, 2d Sess., pt. 2, at 136-37 (1990); see also S. REP. No. 116, 101st Cong., 1st Sess. 85 (1989). Because the legislative history is sufficiently ambiguous regarding this obligation, it is presently unclear whether the EEOC’s apparent interpretation will control.}
\footnote{113. The term “subterfuge” is not defined in either the ADA or in its legislative history. In a case regarding the ADEA, the Supreme Court gave the term its ordinary meaning, i.e., “scheme, plan, stratagem, or artifice of evasion.” Public Employees Retirement Sys. of Ohio v. Betts, 492 U.S. 158, 167 (1989) (quoting United Air Lines, Inc. v. McMann, 434 U.S. 192, 203 (1977)). There is no reason to think that a different definition would apply as the term is used under the ADA. Because this term clearly requires a showing of intent on the part of the perpetrator of the alleged subterfuge, an intent-based test is appropriate to determine whether an employer, in setting benefit plan limitations or exclusion, is engaging in a subterfuge to evade the purposes of the ADA. Clearly, however, the term does not apply to coverage limitations or exclusions merely because they may have a disparate impact on the
As a result of these statutory provisions, a number of considerations must be taken into account. First, disability-based insurance plan distinctions are permitted only if they are within the protective ambit of Section 501(c) of the ADA. Second, decisions about the employment of an individual with a disability cannot be motivated by concerns about the impact of the individual’s disability on the employer’s health insurance plan. Third, employees with disabilities must be accorded “equal access” to whatever health insurance the employer provides to employees without disabilities. Fourth, because of the ADA’s associate provision, it is violative of the ADA for an employer to make an employment decision about any person, whether or not that person has a disability, because of concerns about the impact on the health insurance plan of the disability of someone else with whom that person has a relationship. All of

114. 29 C.F.R. § 1630.16(f) (1994). Section 1630.16(f) is a limited exemption only applicable to those who establish, sponsor, observe, or administer benefit plans, such as health and life insurance plans. Interpretive Guidance on Title I of the ADA, 29 C.F.R. app. § 1630, at 393 (1994). It does not apply to plans not involving benefits, i.e., liability insurance plans. Id.

The purpose of the section is to permit the development and administration of benefit plans in accordance with accepted principles of risk assessment. Id. It is not intended to disrupt current regulatory structure for self-insured employers. Employers “may establish, sponsor, observe or administer the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.” See 29 C.F.R. § 1630.16(f)(3) (1994). It is not intended to disrupt current nature of insurance underwriting, or current insurance industry practices in sales, underwriting, pricing, administration or other services, claims, similar insurance-related activities based on classification of risks as regulated by the States. See H.R. REP NO. 485, 101st Cong., 2d Sess., pt. 2, at 136 (1990). An employer cannot deny a qualified individual with a disability equal access to insurance or to different terms or conditions of insurance based on disability alone if the disability does not pose increased risks. Id. Part 1630 requires that decisions not based on risk classifications be made in conformity with non-discrimination requirements. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 2, at 71; see also S. REP. NO. 116, 101st Cong., 1st Sess. 84-86 (1989).

115. 42 U.S.C. § 12201(c) (Supp. V 1993). The first two subparagraphs of Section 501(c) apply to insurers and other entities that provide employer coverages to and/or administer insured ERISA plans, and employers that establish or maintain insured ERISA plans. Id. § 12201(c)(1)-(2). The third subparagraph applies to employers that self-insure coverages under their ERISA plans. Id. § 12201(c)(3). See also infra notes 142-44 and accompanying text; Interim Guidance, supra note 101, at E-1 to E-3.


117. See id. § 1630.16(f).


119. See 29 C.F.R. app. § 1630.8 (1994). An employee’s dependents may also be covered by virtue of a health insurance plan provided to the employee because of his employment. Id. Insurance terms, provisions, and conditions concerning dependent coverage are subject to the same ADA standards including application of Section 501(c). Id. The ADA does not pro-
these considerations, discussed more fully below, prevent employers from unilaterally reducing benefits in light of the ADA.\textsuperscript{120}

1. Framework of Analysis\textsuperscript{121}

The question of whether employers sponsoring ERISA plans, the insurers and other entities which provide benefits to these plans may continue the practice of limiting or excluding coverage to identifiable groups of disabled employees, such as AIDS, remains unanswered. Indeed, whether such activity even violates the ADA is not an easy issue to address. To facilitate resolution of the issue, however, a two-part test should be applied.

Under the test, an aggrieved employee must first establish a prima facie showing of a disability-based distinction.\textsuperscript{122} Specifically, she must show that she is a qualified individual with a disability and that the disability is the specific subject of a plan limitation or exclusion.\textsuperscript{123} If established, the employer must then show the following: 1) that the health insurance plan is either a bona fide insured health insurance plan that is not inconsistent with state law, or a bona fide self-insured health insurance plan,\textsuperscript{124} and 2) that the challenged dis-

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\textsuperscript{120} Interim Guidance, supra note 101, at E-3. The Interim Guidance improperly requires self-insured medical benefit plans to treat all catastrophic conditions equally. Interim Guidance, supra note 101, at E-3. Indeed, disparate treatment for various medical conditions of the plan can be shown to prove that similar limitations are in effect for other conditions with comparable actuarial data or experience. Interim Guidance, supra note 101, at E-3. Moreover, there is no common understanding of how to ascertain conditions with comparable actuarial data or experience. Such an analysis could involve consideration of all possible medical conditions and treatment for those conditions, a nearly impossible analysis.

\textsuperscript{121} See Interim Guidance, supra note 101, at E-3. Note that all health-related plan distinctions discriminate on the basis of disability, because, unless an insurance distinction is based upon a disability or does not apply equally to all insured employees, such provisions do not discriminate on the basis of disability and are not violative of the ADA.

\textsuperscript{122} See 42 U.S.C. § 12112 (Supp. V 1993); see also McGann v. H & H Music Co., 946 F.2d 401, 404 (5th Cir. 1991). The test proposed is essentially the one followed in McGann.

\textsuperscript{123} 42 U.S.C. § 12112(a) (Supp. V 1993).

\textsuperscript{124} Interim Guidance, supra note 101, at E-3. If an employer providing a health insurance plan belongs to a multiple employer welfare arrangement (MEWA), pursuant to section 3(40) of ERISA, 29 U.S.C. § 1001(40) (1988), it may be subject to certain state insurance laws even if it is self-insured. Applicable state law is determined with reference to ERISA's Section 514(b)(6)(A). 29 U.S.C. § 1144(b)(6)(A) (1988). The MEWA itself, however, is not subject to the ADA's employment provision. Carparts Distrib. Ctr. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583 (D.N.H. 1993), vacated on other grounds, 37 F.3d 12 (1st Cir. 1994). In Carparts, the plan capped its lifetime benefits for AIDS-related illnesses at $25,000 after plaintiff's diagnosis while other individuals remained entitled to $1 million
ability-based distinction is not being used as a subterfuge. Failure to meet this two-pronged test demonstrates that the disability-based distinction is not within the protective ambit of § 501(c) and, thus, is violative of the ADA.

2. Examples of Disability-Based Distinctions

Broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities are not necessarily distinctions based on disability. For example, the treatment of mental/nervous conditions in lifetime benefits. Id. at 585. Plaintiff was the sole proprietor of the business which participated in a member-funded group health care benefit plan. Id. Plaintiff died and his estate sued, alleging violations of Title I, III, and V of the ADA. Id. The court refused to stretch the ADA’s employment and public accommodation sections to cover the plan. Id. at 587. First, the plan was not a “covered entity” because the plan was not the plaintiff’s employer for purposes of the ADA. Id. In this situation, liability would attach to the employer. Indeed, an employer is prohibited from “participating in a contractual or other arrangement or other relationship.” 42 U.S.C. § 12112(b)(2) (Supp. V 1993). In this situation, such action would be unavailing because the plaintiff was his own employer. Carparts, 826 F. Supp. at 584.

Second, the term “public accommodation” is limited to “actual physical structures with definite physical boundaries which a person physically enters for the purpose of utilizing the facilities or obtaining services therein.” Id. at 586. Although plan limitations had the effect of preventing HIV sufferers from obtaining medical treatment, there was no available remedy to the estate under the ADA. Id. at 589.

The court also refused to apply the ADA’s provisions under Title V requiring changes in insurance coverage to be based on valid actuarial assumptions. Id. at 587. Title V is limited to employers or places of public accommodation and expressly excludes the insurance industry from coverage. Id.

125. See infra Section V(A)(3).

126. The ADA recognizes that benefit plans, insured or not, must be able to continue business practices in the way they underwrite, classify and administer risks as long as they carry out those functions in accordance with accepted principles of insurance risk classification. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 3, at 70-71 (1990). Indeed, the House Committee wished to clarify that, in its view, as is stated by the U.S. Supreme Court in Alexander v. Choate, 469 U.S. 287 (1985), employee benefit plans should not be found to be in violation of the ADA under impact analysis simply because they do not address the special needs of every person with a disability, e.g., additional sick leave or medical coverage. Alexander, 469 U.S. at 289. In Alexander, the reduction in issue did “not distinguish between those whose coverage [would] be reduced and those whose coverage [would] not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having.” Id. at 302.

127. Questions arise, however, concerning broad-based distinctions under the ADA. For example, changes for eye refractions, or the purchase of hearing aids or eye glasses are not covered by the ADA, even though poor eyesight is a disability under the ADA. See Interim Guidance, supra note 101, at E-2. According to the Interim Guidance, however, limitations on “eye-care” result from a variety of dissimilar conditions and are a constraint on both those who are and those who are not disabled. Interim Guidance, supra note 101, at E-2. This raises the question of what is a disability-based distinction. Indeed, the difference be-
usually receive a lower level of benefits than is provided for the treatment of physical conditions. Similarly, some health insurance plans provide fewer benefits for “eye care” than for other physical conditions. These distinctions are not based on disability. As a result, even though such distinctions may have a greater impact on certain individuals with disabilities, they do so without intentionally discriminating on the basis of disability and, therefore, are not violative of the ADA.

Similarly, blanket pre-existing condition clauses, as well as universal limits or exclusions from coverage of all experimental drugs or selective surgery, or coverage limited on medical procedures “that are not exclusively or nearly exclusively utilized for the treatment of a particular disability, will not be considered distinctions based on disability,” and, thus, are not violative of the ADA.

Example 1. The R Company health insurance plan limits the benefits provided for the treatment of any physical conditions to a maximum of $25,000 per year. CP, an employee of R, files a charge of discrimination alleging that the $25,000 cap violates the ADA because it is insufficient to cover the cost of treatment for her cancer.
The $25,000 cap does not single out a specific disability, discrete group of disabilities, or disability in general. It is therefore not a disability-based distinction. If it is applied equally to all insured employees, it does not violate the ADA.133

Health-related insurance distinctions based on disability, however, may violate the ADA. Indeed, a term or provision in a health insurance plan “is ‘disability-based’ if it singles out a particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities, (e.g., cancers, muscular dystrophies, kidney diseases), or a disability in general (e.g. non-coverage of all conditions that substantially limit a major life activity).”134 For example, an insurance limitation on substance abuse benefits to $2,000 per year with a $100,000 cap for other ailments may violate the ADA.135 Similarly, a provision excluding psychiatric services after a determination that the condition will not respond to treatment is ambiguous and could be a disability-based distinction requiring justification.136 Moreover, a specific disability singled out by the phrase “psychiatric services” is a disability-based distinction.137

Finally, the *Interim Guidance* allows an exclusion for experimen-

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133. See *Interim Guidance*, supra note 101, at E-2. The *Interim Guidance* will remain in effect until superseded by more comprehensive guidance. 2 AMERICANS WITH DISABILITIES ACT MANUAL (BNA) 38 (1993). Indeed, it is not the final word on the issue. More comprehensive and “fairly narrow” regulations are currently being drafted by the EEOC to be incorporated into the code of federal regulations. See *EEOC Sues New York Benefits Fund Under ADA for Restricting AIDS Coverage*, Daily Lab. Rep. (BNA) No. 110, at A-8 (June 10, 1993).

The effect of the *Interim Guidance* has been difficult to determine. While there have been cases of companies excluding coverage for AIDS and limiting coverage for some diseases and ailments, see *supra* Section II herein, such cases are not common. Additionally, the *Interim Guidance* controls employers, but not insurance underwriters whom critics blame for setting the standard on policy exclusions. Henry J. Reske, *Bias Barred in Company Health Plans*, A.B.A. J., Sept. 1993, at 28. It will be up to the courts to decide how the ADA will be interpreted and ensure that employers do not cap coverage for AIDS or other expensive illnesses.


135. Drug addiction is a disability although a “qualified individual with a disability” does not include a person who is currently using illegal drugs. 42 U.S.C. § 12114 (Supp. V 1993). It does, however, include a person “participating in a supervised drug rehabilitation program and is no longer engaging in such use.” *Id.* Accordingly, this type of disability-based distinction must be justified.


137. *Interim Guidance*, supra note 101, at E-3 (under the *Interim Guidance*, “not responding to treatment” may not be sufficient justification, for if treatment merely maintains “the current health status” of the patient, it requires justification in the form of risk assessment or sound underwriting practices, or of necessity).
tal treatment or experimental drugs and elective surgery because it is broad-based and not based on a particular disability.\textsuperscript{138} This is true, despite the fact that the exclusion may well have a disparate impact on diseases such as AIDS where the best hope often lies in the unknown.

As stated, however, employers may establish and/or observe the terms and provisions of a bona fide benefit plan — including terms or provisions based on disability — without violating the ADA, as long as the terms or provisions are not a "subterfuge to evade the purposes" of the ADA.\textsuperscript{139} Those distinctions that are a subterfuge are violative because they intentionally discriminate on the basis of disability.

Example 2. R Company’s new self-insured health insurance plan caps benefits for the treatment of all physical conditions, except AIDS, at $100,000 per year. The treatment of AIDS is capped at $5,000 per year. CP, an employee with AIDS, enrolled in the health insurance plan, files a charge alleging that the lower AIDS cap violated the ADA. The lower AIDS cap is a disability-based distinction. Accordingly, if R is unable to demonstrate that its health insurance plan is bona fide and that the AIDS cap is not a subterfuge, a violation of the ADA will be found.\textsuperscript{140}

Example 3. R Company has a health insurance plan that excludes from coverage treatment for any pre-existing blood disorders for a period of 18 months, but does not exclude the treatment of any other pre-existing conditions. R’s pre-existing condition clause only excludes treatment for a discrete groups of related disabilities, e.g. hemophilia, leukemia, and is thus a disability-based distinction. CP, an individual with acute leukemia who recently joined R Company and enrolled in its health insurance plan, files a charge of discrimination alleging that the disability-based pre-existing condition clause violated the ADA. If R is unable to demonstrate that its health insurance plan is bona fide and that the disability-specific pre-existing condition clause is not a subterfuge, a violation of the ADA will be found.\textsuperscript{141}

\begin{thebibliography}{9}
\item \textsuperscript{138} See Interim Guidance, supra note 101, at E-2.
\item \textsuperscript{139} 29 C.F.R. § 1630.16(f) (1994).
\item \textsuperscript{140} See Interim Guidance, supra note 101, at E-2; see also Mason Tenders Dist. Council Welfare Fund v. Donaghey, 93 Civ. 1154 (S.D.N.Y. filed Nov. 19, 1993); discussion infra Section VI.
\item \textsuperscript{141} See Interim Guidance, supra note 101, at E-2. The ADA does not provide a “safe
3. Employer's Burden of Proof

Once it is established that a health insurance term or provision constitutes a disability-based distinction, the employer must prove that the plan is either a bona fide insured plan that is not inconsistent with state law or a bona fide self-insured plan and that the challenged distinction is not being used as a subterfuge. In these situations, the employer has the greatest access to the relevant facts. As a general matter, the employer, or in the case of an insured plan, the employer's insurer, controls the risk assessment, actuarial and/or disability-based distinction. Conversely, employees rarely have access to such data and, in general, only have information provided to them in the summary plan description. Accordingly, it is appropriate to place the burden of proof on the employer.

a. Bona Fide Plan or Consistent with State Law

In the case of insured plans, the first requirement is met by showing that: 1) the health insurance is bona fide in that it exists and pays benefits and its terms have been accurately communicated to eligible employees; and 2) the health insurance plan's terms are not inconsistent with applicable state law as interpreted by the appropriate state authorities. In the case of self-insured plans, because they...
are not subject to state law, an employer need only show that the health insurance plan is bona fide in that it exists and pays benefits and that its terms have been accurately communicated to covered employees.

b. Disability-Based Distinction is not a Subterfuge

To fall under the ambit of Section 501(c), an employer must also demonstrate that the challenged disability-based distinction is not a subterfuge to evade the purposes of the ADA. This may be done in one of several ways. Indeed, the Interim Guidance provides a non-exhaustive list of business or insurance justifications as follows:

1) The respondent may prove that it has not engaged in the disability-based disparate treatment alleged. For example, where a charging party contends that a benefit cap for a particular catastrophic disability is discriminatory, the respondent may prove that its plan actually treats all similarly catastrophic conditions that same way.
2) The respondent may prove that the disparate treatment is justified by legitimate actuarial data or by reasonably anticipated experience, and that conditions with comparable actuarial data are treated in the same fashion.

146. See supra note 3 and accompanying text.
147. See Interim Guidance, supra note 101, at E-2 to E-3.
148. Interim Guidance, supra note 101, at E-3. The term “subterfuge” refers to disability-based disparate treatment that is not justified by the risks or costs associated with the disability. Interim Guidance, supra note 101, at E-3. Whether a particular distinction is being used as a subterfuge will be determined on a case by case basis, considering the totality of the circumstances. See supra note 113 (regarding the origin of the term); see also 42 U.S.C. § 12201(c) (Supp. V 1993).
149. See generally Interim Guidance, supra note 101. The courts, however, may have problems with this guidance. Indeed, placing the burden on the employer to show that the plan is non-discriminatory is contrary to the Supreme Court’s recent ruling in Hicks v. St. Mary’s Honor Center, 113 S. Ct. 2742 (1993). In that decision, the court held that the plaintiff retains the burden of showing discriminatory intent. Id. at 2756.
150. Actuarial data that is seriously outdated and/or inaccurate is not legitimate actuarial data. For example, an employer may not rely on data relating to a disability that is based on myths, fears, or stereotypes about the disability. Similarly, an employer may not rely on data that is based on a false assumption about the disability or assumptions which are no longer valid.
151. In short, an employer may prove that the disability-based disparate treatment is attributable to the application of legitimate risk classification and underwriting procedures, thereby increasing the cost to the health insurance plan, and not to the disability itself. In this sense, risk classification refers to the identification of risk factors and their grouping into factors posing similar risks. Underwriting procedures refers to the application of the risk
3) The respondent may prove that the disparate treatment is necessary to ensure that the insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan.\(^5\)

4) The respondent may prove that the challenged insurance practice is necessary to prevent the occurrence of an unacceptable change either in the coverage or in the premiums charged.\(^5\)

5) The respondent may prove that the treatment in question does not provide any benefit or has no medical value.\(^5\)

VI. CONFLICT BETWEEN ERISA AND ADA

As set forth above, a plan sponsor may change the terms of a medical plan or exclude coverage for specific conditions and not violate the ERISA statute. Such rights to exclude coverage for specific conditions, however, may be limited by the ADA. Indeed, the contours of what constitutes disability-based distinctions are being tested in the courts, particularly in the AIDS context.

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152. Thus, the employer may prove that its limited coverage for the treatment of a discrete group of disabilities was enacted because continued unlimited coverage would have been so expensive as to cause that health insurance plan to become financially insolvent, and there was no nondisability-based health insurance plan alternative that would have avoided insolvency. See, e.g., Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988). Under this exception, however, an administrator could, in theory, violate its fiduciary duty under ERISA by failing to take remedial action to prevent financial insolvency just to prove their case to the EEOC.

153. Interim Guidance, supra note 101, at E-3 (an “unacceptable” change would be a drastic increase in premium payments (or in co-payments or deductibles), or a drastic alteration to the scope of coverage or level of benefits provided, that would 1) make the health insurance plan effectively unavailable to a significant number of other employees, 2) make the health insurance plan so unattractive as to result in significant adverse selection, or 3) make the health insurance plan so unattractive that the employer cannot compete in recruiting and maintaining qualified workers due to the superiority of health insurance plans offered by other employers in the community).

154. See Interim Guidance, supra note 101, at E-3. For example, the employer could show “that the disability-specific treatment does not cure the condition, slow the degeneration/deterioration or harm . . . , alleviate the symptoms of the condition, or maintain the current health status of individuals with the disability who receive the treatment.” Interim Guidance, supra note 101, at E-3. Of course, the employer could not provide coverage for other conditions which are similarly of no medical value.
A. EEOC FINDS EXCLUSION OF AIDS COVERAGE VIOLATES ADA

The tables regarding exclusion of AIDS coverage have turned with two recent pronouncements on the issue.155

In Mason Tenders District Council Trust Fund v. Donaghey, the EEOC's New York District Director, Spencer H. Lewis, Jr., ruled that a construction union wrongfully denied health benefits to a member with the AIDS virus.156 Although this is the first ruling of its kind, and it is limited to the facts at hand, its implications are likely to become much broader.157

In Donaghey, the Fund changed its health insurance plan on July 1, 1991 to "explicitly exclude payment for expenses arising from HIV infections, AIDS, and/or AIDS related complexes ("ARCs")."158 On November 11, 1992, Terrence Donaghey, an HIV-positive construction worker, filed a charge with the EEOC alleging that the Fund discriminated against him by maintaining a medical insurance plan which excluded payment for medical expenses resulting from HIV-related

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156. See EEOC Sues New York Benefits Fund Under ADA for Restricting AIDS Coverage, Daily Lab. Rep. (BNA) No. 110, at A-8 (June 10, 1993). The decision in Donaghey preceded the EEOC's issuance of formal guidance on the matter. However, in making this determination, the EEOC sent out a message that it will not permit the ADA to allow employers to save money by slashing coverage for the most vulnerable employees out of their benefit packages. Clearly, the EEOC is ready to pursue the matter vigorously and aggressively.

In an affidavit supporting its motion for summary judgment, the Fund later attacked the EEOC's Interim Guidance. Fund Defends Elimination of AIDS Coverage; Assails EEOC Guidance on ADA and Insurance, Daily Lab. Rep. (BNA) No. 161, at C-3 (Aug. 23, 1993) [hereinafter Elimination of AIDS Coverage]. It argued that, because the Interim Guidance was not subject to public notice and commentary, it would be fundamentally unfair to apply it to plan changes in place two years ago. "It strains credulity to assert that Congress intended to effect wholesale changes in the administration of self-insured, jointly-administered, multi-employer, labor management trust funds, which are already extensively regulated by ERISA." Id.


158. Text of EEOC District Director's Determination in Charge No. 160-93-0419, Jan. 28, 1993, Daily Lab. Rep. (BNA) No. 25, at D-1 (Feb. 9, 1993) [hereinafter EEOC Charge No. 160-93-0419]. It should also be noted that, at the time of reducing coverage for AIDS, the Fund also cut back in 22 other areas. For example, the plan eliminated treatment for alcoholism. See Elimination of AIDS Coverage, supra note 156, at C-4.
infections, AIDS and/or ARCs. The Fund argued that the decision to change the coverage of the health plan was motivated by excessive losses experienced by the health fund and not by any intent to discriminate against particular individuals with AIDS-related illnesses. The EEOC District Director found that the Union “ha[d] no viable defense to the charge of discrimination” and that the Fund’s medical insurance, on its face, violated the ADA. This case, however, is far from over.162

159. EEOC Charge No. 160-93-0419, supra note 158, at D-1. In a statement issued by the Gay Men’s Health Crisis Center, Donaghey stated: “[d]enying me this coverage is equal to denying me a chance to live.” Cutting Insurance Benefits For AIDS Violates Disabilities Act, EEOC District Director Says, Daily Lab. Rep. (BNA) No. 25, at AA-1 (Feb. 9, 1993) [hereinafter Cutting Insurance Benefits].

160. EEOC Charge No. 160-93-0419, supra note 158, at D-1. The three fund trustees were also named in the suit, i.e., Mason Tenders District Council of Greater New York, Mason Tenders Union Local 23, the Association of Brick Mason Contractors of Greater New York, Inc. and the Building Contractors Association, Inc. Cutting Insurance Benefits, supra note 159, at AA-1.


162. The District Director’s determination prompted the Fund to sue the EEOC in federal court on March 31, 1993, seeking invalidation of the district office’s determination. EEOC Sues New York Benefits Fund Under ADA for Restricting AIDS Coverage, Daily Lab. Rep. (BNA) No. 110, at A-8 (June 10, 1993) [hereinafter Restricting AIDS Coverage]. The Fund argued that it was not covered by the ADA because the individual who could potentially bring an ADA action against it is not a Fund employee. Id. Even if it was, the modifications to the plan were to reduce costs in order to insure its economic survival and operations, and not for any discriminatory intent. Id. The case is pending before Judge John E. Sprizzo of the United States District Court for the Southern District of New York. Id.

Additionally, pursuing the district office’s determination, the EEOC sued Mason Tenders in the United States District Court for the Southern District of New York on June 9, 1993 for allegedly violating the ADA by excluding HIV-related conditions from its health insurance coverage. EEOC v. Mason Tenders Dist. Council Welfare Fund, No. 93-3865 (S.D.N.Y. filed June 9, 1993). The complaint charged the Fund and co-defendants with intentionally engaging in unlawful employment practices by denying AIDS coverage. Id. Indeed, the EEOC alleged that the defendants “acted with malice or reckless indifference to the federally protected rights” of Donaghey. See ADA MANUAL, (BNA) COMPLAINT 60:0535. The EEOC seeks compensatory damages for past and future pecuniary losses as well as for “physical and emotional pain and suffering, mental anguish, and loss of enjoyment of life,” punitive damages to “malicious and/or reckless conduct,” and injunctive relief against discrimination on the basis of disability in the health plan as well as an order instructing the defendants to “carry out policies, practices, and programs” for equal employment opportunity that “eradicate the effects” of past and present discrimination. See Restricting AIDS Coverage, supra, at A-9.

Defending the Fund’s actions, its attorney, Roger M. Levin, stated that the EEOC’s action “is nothing more than an attempt to raid the treasury of the welfare fund in order to provide specific medical benefits to only a few, while destroying the fund’s ability to provide the greatest level of benefits to the largest number of participants.” Restricting AIDS Coverage, supra, at A-10. “By filing its own suit rather than awaiting resolutions of the fund’s suit, Levin said, EEOC ‘has evinced its intention to severely undermine ERISA-governed
This decision seriously questions the practice of employers who try to limit the coverage of HIV, AIDS, and other disabling illnesses by self-insuring, and has drawn nationwide attention because it raises difficult issues regarding whether, in light of the ADA, employers or other entities may decrease health insurance costs for chronic, debilitating conditions.

In Laborers District Council Building and Construction Health and Welfare Fund, the EEOC determined that a union health and welfare fund that insures Philadelphia construction workers violated the ADA when it capped lifetime medical benefits for HIV-related illnesses at $10,000. In its determination letter, EEOC District Director Johnny J. Butler wrote that the Fund adopted a limit in April 1992 on payments for AIDS-related claims based on fear rather than on any “actuarial or other objective information about benefit costs.” For this reason, the policy constituted a “subterfuge” because it was adopted only two months after learning that one of its participants, John Doe, a participant since 1980, was HIV-infected. The Fund argued that it needed to cap HIV-related benefits “because of its precarious financial state, caused by a decline in hours medical benefit funds by imposing ADA standards through the back door.” Restricting AIDS Coverage, supra, at A-10. Indeed, because only one of the ADA’s five titles “could conceivably apply to self-insured ERISA funds,” it could not have been Congress’ intention to effectuate wholesale changes in those funds. Restricting AIDS Coverage, supra, at A-10.

In July 1993, Mason Tenders sought summary judgment in the declaratory judgment action. See Elimination of AIDS Coverage, supra note 156, at C-1. The Fund argued that its modifications were governed by ERISA, not the ADA. Elimination of AIDS Coverage, supra, note 156, at C-1. The Fund also argued that it was not covered by Title I of the ADA. Elimination of AIDS Coverage, supra, note 156, at C-1. The court denied the motion and ruled that the Fund is a “bona fide benefit plan” for purposes of the ADA. Elimination of AIDS Coverage, supra, note 156, at C-1. The Fund must now show that it acted lawfully when it cut benefits for AIDS and AIDS-related illnesses. Elimination of AIDS Coverage, supra, note 156, at C-1.

163. See Leo Uzych, Commentary, ERISA ERECTS HEALTH CARE REFORM BARRIERS, 16 PENN. L.J. 2, 16 (June 14, 1993).
165. EEOC FINDS UNION HEALTH FUND VIOLATED ADA BY CAPPING HIV-RELATED BENEFITS at $10,000, Daily Lab. Rep. (BNA) No. 186, at A-6 (Sept. 28, 1993) [hereinafter Capping HIV-Related Benefits]. Plan participants were eligible for lifetime benefits of up to $100,000 for any disease or condition unrelated to HIV infection. Id. On behalf of Doe, the AIDS Law Project of Pennsylvania filed charges against the Union (Laborers International Union of North America). Id. According to the complaint, the benefit cap forced Doe to severely limit his medical treatments, compromising their efficacy and causing him “extreme mental anguish, inconvenience, and emotional pain and suffering.” Id.
166. Id.
167. Id.
worked by union members and rising health care costs in recent years. The Fund also cited the lifestyles of its members, whom it claims are at greater risk for HIV infection because of greater-than-average drug use and other factors. Indeed, "trustees feared that several members might develop full-blown AIDS within a short time, causing the Fund to incur high medical costs" which could lead to bankruptcy. The EEOC observed, however, that the Fund "admit[ted] that it had no data on which it based its concern as to how many members could become HIV-infected or how many would begin to incur high medical claims."

B. DISTRICT COURT APPROVES SETTLEMENT

A federal judge in Minnesota approved a consent decree settling a lawsuit alleging that a union health insurance plan's limit on AIDS benefits violated the ADA. In addition to paying $100,000 to the worker's estate, the settlement also removed the benefit plan's cap on AIDS benefits retroactively to July 26, 1992.

In Kadinger, both the estate and a Minnesota hospital sued the union and its health benefits plan alleging that the plan's cap on benefits for AIDS violated the ADA. The plan provided only $50,000 in lifetime benefits for AIDS while insuring other catastrophic conditions up to $500,000. The plan's trustees argued that they established the cap at a time when the "cost of treating AIDS

168. See id. at A-7.
169. Id.
170. Id.
171. Id. Presently, the EEOC is trying to reach a settlement with the welfare fund on behalf of a claimant who is seeking removal of the limit on HIV-related health benefits and damages. See id. at A-6.
173. Electrical Workers Health Plan Will Pay $100,000 in Minnesota AIDS Bias Settlement, Daily Lab. Rep. (BNA) No. 244, at D-11 (Dec. 22, 1993) [hereinafter AIDS Bias Settlement]. In addition, for the next three years, the plan was required to report to the EEOC "all of the amendments to its terms that contain[ed] a disability-based distinction in coverage or benefits. The plan must also justify any distinctions." Id. Further, the IBEW and National Electric Contractors Association "[had] to provide the EEOC with similar reports regarding any amendments to their collective bargaining agreements." Id. Further, "[t]he plan must also provide educational seminars on the ADA and its obligations under the law to all persons who acted as its trustees." Id. See Kadinger, 1993 U.S. Dist. LEXIS 18982, at *8.
174. The hospital brought suit in an attempt to recover the cost of treating Kadinger. See AIDS Bias Settlement, supra note 173, at D-11.
176. Id.
was projected as being extremely high. They believed the cap was necessary to maintain the plan's viability. Because the cap took effect before Kadinger became HIV positive, the trustees did not believe it was intentionally discriminatory. The EEOC maintained that the cap's effective date did not matter. "What mattered was that the cap was in place and not actuarially supportable when the ADA took effect in 1992..." As stated, however, this case never made it into the court room and thus the conflict between ERISA and the ADA was never actually analyzed. It is clear, however, that the ADA's provisions were significant in fashioning the consent decree.

C. THE REAL ISSUE

Despite an employer's apparent right to increase or reduce benefits, employees will continue to argue that their own case is distinctive because the employer altered the benefits plan specifically to prejudice that claimant. They will further argue that such action threatens access to health care for the most vulnerable set of insured Americans who are already facing a crisis in medical coverage. Employers will respond with an equally compelling argument and it is their argument which should win. Indeed, employers are permitted to respond to actuarial experiences when attempting to avoid exorbitant medical costs in order to protect the future of the plan itself. Although claimants would be helped by a decision in their favor, at present, such a ruling would fly in the face of ERISA's plain language and decrease protection for future employees and retirees.

Even though uncertainty currently clouds this realm of the law, it appears that, even if caps on benefit payments for certain health conditions are scrutinized under the ADA, they will pass scrutiny. In short, as long as an employer is motivated to adopt changes to ensure the financial security of a plan, the ADA will not be violated. Accordingly, when insurers and plan administrators observe the terms of a bona fide health insurance plan which reduces medical benefits and

which does not appear to include a disability-based distinction as a subterfuge to evade the ADA, the loophole which exists is seemingly under check.

In conclusion, an employer may unilaterally alter its medical benefits plan if: it is not contractually obligated to adhere to the terms of its medical benefits plan, does not act in a discriminating manner toward an employee in its modification of the plan, and presents a reason which is not a subterfuge to evade the ADA. 183 There are steps, however, which an employer should immediately take to protect its actions and prevent a possible lawsuit.

VII. EMPLOYER PRECAUTIONS

There are certain precautions an employer should take to avoid liability under the ADA based upon discriminatory reductions in its welfare benefit plan.

A. THE TERMS OF THE PLAN ITSELF

First, any potential plan limitations or exclusions that might impact upon a disabled employee should not be made on the basis of the employer's personal, social, ethical, or moral views. Instead, any such limitation or exclusion should be based solely on sound underwriting principles, and steps should be taken to assure such principles if later questioned. For example, practitioners should be warned "to avoid plan limitations on [certain] kinds of medical treatment (e.g., hearing aid purchases, transplants, infertility procedures) because they may run afoul of the [ADA]." 184 Moreover, "[b]enefit exclusions or limitations should be 'broadly characterized' to avoid the appearance that employers are targeting any particular group, such as employees with AIDS . . . ." 185

Next, an employer should be sure that the limitation or exclusion is in fact consistent with underwriting principles. This may be done simply by providing benefits through the purchase of insurance. In

this way, an employer may rely on the insurer to provide proper coverage. In the absence of such coverage, or in the case of a self-insured plan, the employer may want to obtain advice from benefit or actuarial consultants to verify that the exclusion or limitation which the employer seeks to impose is based solely upon sound underwriting principles. Either way, documentation must exist for the limitation or exclusion. Absent such documentation, an employer may be opening itself up to liability. Indeed, an employer may not rely only on costs and “legitimate actuarial data” for making a disability-based distinction, but also may have to provide evidence to support its decision and show that other alternatives were not available.

Additionally, it is imperative that an employer put a statement in the summary plan description unambiguously reserving the right of the plan sponsor to terminate or amend the plan, or to terminate any benefit under the plan at any time. In this way, if an employer finds that it must alter the terms of the plan, it will be permitted to do so without risk of violating either ERISA or the ADA.

Finally, once the limitation or exclusion has been implemented, notice should be given to the employees specifying the reasons for it. This will not only satisfy ERISA requirements that employers provide complete and comprehensive notice to employees of their right under ERISA plans, but it will also help the employer avoid any accusations that it acted underhandedly in failing to notify employees fully and candidly of implemented plan changes.

Accordingly, all employers should review their existing health plan and look for all restrictions relating to disabilities. These restrictions should be uniform. If they are not, the employer should be prepared to present actuarial justification for the non-uniformity. With

186. This documentation might consist of such items as inter-office memoranda, corporate minutes, or correspondence with insurance or actuarial consultants. It should specify the reasons for the limitation or exclusion and document the propriety of the employer's view that the limitation or exclusion is based upon sound underwriting principles.
187. The decision, and documentation of the decision, should occur prior to implementation of the exclusion or limitation.
188. See supra notes 19-22 and accompanying text.
189. See supra notes 50-69 and accompanying text.
190. See supra notes 19-22 and accompanying text.
191. Employers should also keep a “paper trail” of any benefit changes they make and the reasons for the changes. See 1 AMERICANS WITH DISABILITIES ACT MANUAL (BNA) 34 (1992); EEOC WILL DEVELOP GUIDANCE ON HEALTH INSURANCE UNDER ADA, Daily Lab. Rep. (BNA) No. 194, at A-13 (Oct. 6, 1992); Interim Guidance, supra note 99, at E-3 (no subterfuge if distinction justified by “legitimate actuarial data”).
respect to future amendments to the plan, document the reasons for such changes, including actuarial cost justifications.

B. EDUCATION

To protect themselves, among the things companies also must do is to give employees time to obtain medical care or develop options for helping employees who need sick leave or who want to work but cannot work full-time in the office. Indeed, "[l]itigation . . . is not the way to resolve workplace disputes involving AIDS." Instead, education is important. AIDS education especially needs to be repeated and updated. Employers should let people know how to avoid the contraction and spread of AIDS; provide general transmissions information; and develop a company policy that includes opportunities for assistance, offers guidance, discusses how to deal with an infected co-worker or customer, and the applicable legal rules. It is not enough to have a policy against discrimination; the policy has to be explained, enforced, and monitored.

VIII. CONCLUSION

Benefit reductions in employer health insurance plans evidence the existence of runaway health care costs in the United States and are a last resort for many employers. Indeed, at present, other plausible options appear nonexistent. Legislation requiring that some employees and their dependents may be “grandfathered” in their current level of health benefit coverage, when a health plan is modified, is an approach that appears to address the symptoms, but not the underlying illness, and may only accelerate the pace of the health care crisis in this country. Perhaps ERISA should exclusively govern. This might allow employers the authority to manage their assets in a rational manner and enable the plan to survive and continue providing the highest level of benefits to the greatest number of workers and their dependents.

Present ERISA preemption principles, however, influence employers in favor of self-insured plans allowing employers to avoid


193. Id. (quoting Robert Stein, an attorney with the firm Blicker Futterman & Stein in Washington, D.C., as a panelist for the human resources committee of the ABA’s Urban State & Local Government Law Section on August 9, 1993).
state regulation. Thus, in a sense, ERISA hinders state efforts to build and implement health care reform. Perhaps the balance struck, in favor of the ability of multistate employers to adopt uniform benefits of self-insured, at the expense of the state’s ability to regulate is no longer sound. Additionally the social desirability of permitting a greater degree of state latitude in health care reform counsels in favor of revisiting and modifying the scope of ERISA preemption as applied to mandated benefit law. Despite all of this, however, the fact remains that the ADA has been enacted and employers have no choice but to adhere to its terms as best they can while complying with ERISA.