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AIDS CAPS, CONTRACEPTIVE COVERAGE, AND THE LAW: AN ANALYSIS OF THE FEDERAL ANTI-DISCRIMINATION STATUTES' APPLICABILITY TO HEALTH INSURANCE

*Sharona Hoffman**

INTRODUCTION

Mutual of Omaha Insurance Company offered its customers insurance policies that limited lifetime benefits for AIDS or AIDS-related conditions ("ARC") to either \$25,000 or \$100,000, while other conditions were covered up to \$1 million over a lifetime.¹ When this discrepancy was challenged by two of its insured as violating the Americans with Disabilities Act ("ADA"),² Mutual of Omaha conceded that AIDS was a disability under the ADA, a federal law that prohibits discrimination against individuals with disabilities.³ The defendant also acknowledged that the AIDS coverage caps were not justified as "consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."⁴ Although the insurer offered no justification for its discriminatory reimbursement limitation, the Seventh Circuit in *Doe v. Mutual of Omaha* ruled that the AIDS cap was not unlawful and could continue to be utilized by the defendant.⁵

The *Doe* decision is typical of opinions issued by many courts that have evaluated and upheld allegedly discriminatory health insurance policies challenged under the ADA. Health insurers typically deny coverage for speech therapy, eyeglasses, hearing

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¹ See *Doe v. Mutual of Omaha*, 179 F.3d 557 (7th Cir. 1999).

² See 42 U.S.C. §§ 12101-213 (1994).

³ See *Doe*, 179 F.3d at 558-59.

⁴ *Id.*

⁵ See *id.* at 557.

aids, most foot care, and treatment for infertility.⁶ Many insurance providers exclude or severely limit coverage for treatment of mental impairment, dental problems,⁷ AIDS, diabetes mellitus, severe obesity, epilepsy, and alcoholism or drug abuse.⁸ Insurance restrictions have generated significant litigation, but have rarely been proscribed by the courts.⁹ While some Americans enjoy full coverage for all their health needs, others who have insurance and suffer from serious or even life-threatening conditions, such as AIDS, must incur the expense of costly treatment or forego it if it is unaffordable.

Allegations of discriminatory insurance coverage are brought not only under the ADA, but also under Title VII of the Civil Rights Act of 1964 ("Title VII"), which prohibits employment discrimination based on gender and other protected classifications.¹⁰ In September of 2000, for example, Jennifer Erickson filed a class action alleging that her employer's prescription drug plan unlawfully discriminated against female employees because it excluded coverage for prescription

⁶ See BERTRAM HARNETT & IRVING I. LESNICK, *THE LAW OF LIFE AND HEALTH INSURANCE* § 6A.11[1] (2000). Not all of the conditions related to these treatments constitute disabilities. See *infra* Part I.B.1.

⁷ See Samuel A. Marcossou, *Who Is "Us" and Who Is "Them"—Common Threads and the Discriminatory Cut-off of Health Care Benefits for AIDS Under ERISA and the Americans with Disabilities Act*, 44 AM. U. L. REV. 361, 416 (1994).

⁸ Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 J. AM. MED. ASS'N (JAMA) 2503, 2504 (1992).

⁹ See, e.g., *McNeil v. Time Ins. Co.*, 205 F.3d 179, 186-89 (5th Cir. 2000) (finding that health insurance plans containing caps for AIDS treatment do not violate the ADA); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999) (finding that a disparity in an employer's insurance benefits for treatment of mental and physical conditions does not violate the ADA); *Bythway v. Principal Health Care of Del. Inc.*, No. Civ. 97-435-GMS, 1999 WL 33220042 (D. Del. Sept. 29, 1999) (holding that a health insurance provision that limited or denied coverage to Hodgkin's disease patients for bone marrow transplants, while allowing it for those suffering from aplastic anemia or acute leukemia, is not unlawfully discriminatory under the ADA); *but see Boots v. Northwestern Mut. Life Ins. Co.*, 77 F.Supp.2d 211, 215-20 (D.N.H. 1999) (holding that a disability plan's limitations on coverage for mental disabilities are potentially discriminatory under the ADA).

¹⁰ See 42 U.S.C. § 2000e-2(a)(1) (1994). The provision reads:

(a) It shall be an unlawful employment practice for an employer-

(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin;

Id. Unlike the ADA, Title VII applies only to employment discrimination and not to discrimination in other contexts such as insurance. Compare *id.*, and 42 U.S.C. §§12101-12213. Thus, benefits that are provided by employers are regulated by the statute, but those purchased directly from an insurance provider are not governed by Title VII. See *id.*

contraceptives while covering other preventive prescriptions.¹¹ On June 12, 2001, a federal district court in the state of Washington granted summary judgment to the plaintiff, finding that the employer-provided benefit plan violated Title VII as amended by the Pregnancy Discrimination Act of 1978 ("PDA").¹² The court reasoned that classifying employees based on their childbearing capacity, regardless of whether they are pregnant, constitutes sex-based discrimination.¹³ Furthermore, when an employer's benefit plan excludes from coverage only a few specific drugs and devices, the employer must ensure that "it provides equally comprehensive coverage for both sexes."¹⁴ Nevertheless, while Jennifer Erickson prevailed in her Title VII claim of discriminatory health insurance benefits, many plaintiffs do not enjoy similar success.¹⁵

This Article will analyze the ADA, Title VII, and other federal anti-discrimination laws and examine the extent to which they govern the terms of health insurance policies.¹⁶ It focuses on exclusions or limitations of coverage in health insurance policies, such as AIDS caps or refusal to reimburse for particular forms of treatment. The Article does not address instances in which a plan administrator denies coverage in an individual case because she determines that a particular procedure was not medically necessary or was experimental.

This Article provides a detailed analysis of the language of the ADA, Title VII, and other statutes, as they apply to health insurance. It also critiques the courts' interpretations of the

¹¹ *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1268 (W.D. Wash. 2001).

¹² *Id.* at 1276-77. The PDA provides in relevant part:

The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work. . . .

¹³ 42 U.S.C. § 2000e(k).

¹⁴ *See Erickson*, 141 F. Supp. 2d at 1271.

¹⁵ *Id.* at 1272.

¹⁶ *See, e.g., Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996) (excluding coverage for fertility treatments is not violative of Title VII); *Saks v. Covey*, 117 F. Supp. 2d 318 (S.D.N.Y. 2000) (failing to cover infertility treatments does not violate Title VII); *Reger v. Espy*, 836 F. Supp. 869 (N.D. Ga. 1993) (denying coverage for high-dose chemotherapy with autologous bone marrow transplant to treat breast cancer found not to violate Title VII).

¹⁶ This Article focuses on health insurance because it has generated extensive litigation, administrative agency guidance, and academic debate. However, the statutory interpretation and many of the concepts developed in this Article can be extended to apply to other forms of insurance and employee benefits. Several of the judicial opinions discussed in the following sections will in fact focus on benefits other than health insurance, such as disability and pension plans.

statutory language in the areas of disability and gender discrimination. This Article argues that in the arena of health insurance, the statutory scheme that purports to protect individuals against disability, gender, and age discrimination is characterized by significant gaps and loopholes. Consequently, while the statutes prohibit some discriminatory insurance practices, their reach is confined, and their effectiveness is limited.

Part I analyzes the ADA at length. The ADA is the first federal anti-discrimination statute to address health insurance in a separate provision,¹⁷ and this provision has generated significant litigation and academic debate. Part II discusses several other federal statutes that regulate health insurance. The Article concludes with a discussion of various means by which the statutory gap could be remedied in order to enhance protection for health insurance beneficiaries.

I. THE ADA AND HEALTH INSURANCE

Analysis of the application of the ADA to health insurance involves attention to a complex series of questions. First, can the ADA be applied to health insurance practices in light of the McCarran-Ferguson Act,¹⁸ which establishes that a federal statute cannot interfere with a state's insurance laws unless the federal statute was specifically enacted to regulate the insurance business? Second, what types of insurance limitations and exclusions are to be deemed disability-based distinctions, governed by the ADA?

Third, two separate sections of the ADA are at issue: Title I, which governs employer conduct,¹⁹ and Title III, which governs the conduct of those who own, lease, or operate "a place of public accommodation."²⁰ Who is covered by each of the two Titles? Does Title III apply to the terms of insurance plans?

Fourth, what is the meaning of the ADA's "safe-harbor

¹⁷ See Americans with Disabilities Act § 501(c), 42 U.S.C. § 12201(c) (1994).

¹⁸ 15 U.S.C. § 1012(b) (1994).

¹⁹ 42 U.S.C. § 12112(a).

²⁰ *Id.* § 12182(a). Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id.* § 12132. Since health insurance companies are not public entities, Title II does not regulate their operations. Furthermore, a public entity that offers employees health insurance as a benefit, can be sued under Title I, which governs employment discrimination. See *id.* § 12112(a). Title II is therefore inapplicable to health insurance controversies. See *Weyer v. Twentieth Cent. Fox Film Corp.*, 198 F.3d 1104, 1114 (9th Cir. 2000).

provision," section 501(c) of the statute,²¹ which creates a defense for insurance providers? Which if any benefit exclusions or limitations are prohibited by the statute? To what extent should insurers have to justify their risk classification practices²² when challenged under the ADA? Each of these questions will be discussed below.

A. *The McCarran-Ferguson Act*

The McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."²³ The McCarran-Ferguson Act is understood to protect not only the validity of state laws, but also states' administrative regimes, and thus it may limit the applicability of a federal law even when a state legislature has not specifically enacted a relevant insurance statute.²⁴ Most states have insurance boards, commissioners, or other officials that are statutorily empowered to regulate the insurance business within the state in order to safeguard the public interest, establish uniform rates, and enforce insurance laws.²⁵ States generally, therefore, have an extensive system of insurance regulation.

Nevertheless, the Supreme Court has interpreted the McCarran-Ferguson Act narrowly. In *Humana v. Forsyth*,²⁶ the Court explained that "[w]hen federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application."²⁷ The Act was designed to protect state regulation from inadvertent federal interference such as might occur if a federal law targets a general activity of which insurance happens to be one component.²⁸ Furthermore, the

²¹ 42 U.S.C. § 12201(c).

²² The practice of classifying risks is the "[c]ategorization on the basis of established criteria for rating risks, establishing premiums and tabulating statistical experience." RICHARD V. RUPP, *RUPP'S INSURANCE & RISK MANAGEMENT GLOSSARY* 76 (1991).

²³ 15 U.S.C. § 1012(b).

²⁴ See *Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999).

²⁵ See LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* 3D § 2:7 (1997).

²⁶ 525 U.S. 299 (1999).

²⁷ *Id.* at 310.

²⁸ See *Barnett Bank of Marion County v. Nelson*, 517 U.S. 25, 39 (1996).

Supreme Court has instructed that the phrase "relates to the business of insurance" is to be interpreted broadly in the preemption context.²⁹ The federal statute at issue need not be predominantly about insurance, but rather, need only make "specific detailed references to the insurance industry."³⁰ For example, the case of *Barnett Bank of Marion County v. Nelson*,³¹ involved a federal statute that established that certain national banks could sell insurance in small towns, while a Florida law precluded such sales.³² The Court found that the federal statute specifically related to insurance and therefore preempted the state law pursuant to the McCarran-Ferguson Act.³³

The question of whether the McCarran-Ferguson Act precludes application of the ADA to insurance practices has generated a split in the circuits. The Third and Seventh Circuits have ruled that the McCarran-Ferguson Act bars plaintiffs' claims regarding allegedly discriminatory health insurance provisions,³⁴ while the Second Circuit has held that application of the ADA to insurance underwriting is not barred by the McCarran-Ferguson Act.³⁵ The logic of the Second Circuit is far more persuasive than that of its counterparts and should be adopted by future courts deciding the issue.

In *Ford v. Schering-Plough Corp.*,³⁶ the Third Circuit concluded that the ADA does not "specifically relate[] to the business of insurance" because the term "insurance" does not appear in the statute's introductory section entitled "Findings and Purposes."³⁷ The court did not elaborate upon its reasoning and provided no further discussion of the question. In *Doe v. Mutual of Omaha Ins. Co.*,³⁸ the Seventh Circuit ruled that the ADA can be construed as preventing insurance companies from refusing to insure disabled individuals.³⁹ However, according to the court, the McCarran-Ferguson Act precludes an interpretation of the ADA that would broaden its scope to govern rate and coverage issues.⁴⁰

²⁹ *Id.* at 38.

³⁰ *Id.* at 41.

³¹ 517 U.S. 25 (1996).

³² *See id.* at 28-29.

³³ *See id.* at 41.

³⁴ *See Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 563-65 (7th Cir. 1999); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 611-12 (3d Cir. 1998).

³⁵ *See Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 33-35 (2d Cir. 1999).

³⁶ 145 F.3d 601 (3d Cir. 1998).

³⁷ *Id.* at 611-12.

³⁸ 179 F.3d 557 (7th Cir. 1999).

³⁹ *See id.* at 564.

⁴⁰ *See id.*

The court explained that states regulate insurance comprehensively and therefore should not be subject to federal intervention.

By contrast, in *Pallozzi v. Allstate Life Ins. Co.*,⁴¹ the Second Circuit held that the ADA “specifically relate[s] to the business of insurance,” and therefore the states are not protected from its intrusion into the realm of insurance underwriting.⁴² Providing an extensive explanation of its decision, the court noted that Title III of the ADA, which prohibits discrimination with respect to the goods and services of a place of public accommodation,⁴³ specifically defines “public accommodation” as including insurance offices.⁴⁴ Moreover, section 501(c), which applies to both Title I and Title III of the ADA, is devoted entirely to insurance and discusses the applicability of the statute to insurance practices.⁴⁵ In fact, the *Pallozzi* court hypothesizes that Section 501(c) was written specifically to address the McCarran-Ferguson Act and to remove any doubt regarding the applicability of the ADA to insurance industry practices, even though these practices are regulated by the states.⁴⁶

The plain language of section 501(c) provides compelling evidence that the ADA extends to risk classification practices.⁴⁷ The text allows insurers to underwrite risks, classify risks, or administer risks so long as the insurers’ decisions are not inconsistent with state law and are not used as a subterfuge to evade the purpose of the ADA.⁴⁸ The statute thus appears to instruct courts to scrutinize risk classification practices to ensure that they are consistent with state law and do not constitute a “subterfuge.” Moreover, if an insurance provider limits or excludes coverage in a manner that cannot be considered to be “underwriting risks, classifying risks, or administering risks,”⁴⁹ it will not be immune from liability for unlawful discrimination.⁵⁰

⁴¹ 198 F.3d 28 (2d Cir. 1999).

⁴² *Id.* at 33-34.

⁴³ See 42 U.S.C. § 12182(a) (1994).

⁴⁴ *Id.* § 12181(7)(F).

⁴⁵ *Id.* § 12201(c). See *infra* Part I.D. for the text of the provision.

⁴⁶ *Pallozzi*, 198 F.3d at 35.

⁴⁷ See *id.* at 34-35.

⁴⁸ 42 U.S.C. § 12201(c).

⁴⁹ *Id.*

⁵⁰ It should also be noted that the ADA will rarely conflict directly with an insurance law enacted by a state. The states have not enacted laws that specifically allow coverage exclusions or limitations that might be challenged under the ADA. Consequently, the states do not negate the ADA’s anti-discrimination mandate by affirmatively allowing certain forms of discrimination. Rather, when state laws address particular medical conditions, they mandate coverage for those ailments and thus provide patients with

In light of the text of Title III, section 501(c), and relevant Supreme Court precedent, the conclusions of the Third and Seventh Circuits must be rejected. The reasoning of the *Pallozzi* court, on the other hand, is insightful and convincing. Because the ADA specifically relates to the business of insurance, it must be read to regulate insurance classification and underwriting practices, even though insurance is extensively regulated by the states.

B. *Disability-Based Distinctions*

1. The Statutory Definition of "Disability"

While the ADA applies to the business of insurance, its reach is limited. The ADA prohibits only discrimination that is based on disability and does not govern conduct that disadvantages individuals who have medical conditions that are not sufficiently severe to constitute disabilities. The statute defines the term "disability" as follows:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of . . . [an] individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment.⁵¹

An insurance provision that excludes or limits coverage for treatment of a medical condition that does not "substantially limit" a "major life activity"⁵² cannot be successfully challenged under the ADA. Examples would be speech therapy for a slight speech impediment or psychological therapy for a temporary feeling of sadness.

The ADA's statement of "Findings and Purposes"⁵³ begins by

protection against discrimination. See HARNETT & LESNICK, *supra* note 6, at § 13.06[4]. Thus, arguably, the McCarran-Ferguson Act will generally be inapplicable to ADA challenges because the ADA does not explicitly conflict with state laws. However, one might argue that if a state has been silent with respect to a particular insurance term, such as an AIDS coverage cap, it meant to allow its implementation. Therefore, arguably, the prohibition of the practice under the ADA interferes with the state's regulatory scheme, and the McCarran-Ferguson Act must be considered.

⁵¹ 42 U.S.C. § 12102 (2).

⁵² The term "major life activity" is not defined in the statute. However, the Equal Employment Opportunity Commission's ("EEOC") regulations define it as "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(h)(2)(i) (2000).

⁵³ 42 U.S.C. § 12101.

asserting that forty-three million Americans have one or more disabilities and that the number is increasing as our population ages.⁵⁴ The statute therefore contemplates that a significant percentage of Americans will be covered by the ADA. The courts, however, have not been generous to plaintiffs in their interpretation of the ADA's anti-discrimination mandate.

2. The Supreme Court's Interpretation

The Supreme Court has construed the scope of the term "disability" to be quite narrow. The Court has stated that the text's language requires that "a person be presently—not potentially or hypothetically—substantially limited in order to demonstrate a disability."⁵⁵ Consequently, a degenerative condition such as multiple sclerosis is only a disability once it actually substantially limits a major life activity. The Court has also emphasized that in order to have a disability, "an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives."⁵⁶ Furthermore, in *Sutton v. United Air Lines*,⁵⁷ the Supreme Court ruled that an individual whose physical or mental impairment is corrected by medication or other treatments does not have a "disability" and is not entitled to ADA protection.⁵⁸ A person with diabetes or epilepsy whose symptoms are effectively controlled by drug therapy, therefore, will not be considered disabled according to the Supreme Court.

The problem of limited health insurance coverage raises an interesting question in light of the *Sutton* case. In some instances, an individual might have a condition, such as profound hearing loss, that is potentially correctable, but the patient cannot afford the corrective measure because her insurance policy does not provide reimbursement for it.⁵⁹ The Supreme Court did not address the issue of whether a person who does not have access to

⁵⁴ *Id.* § 12101(a)(1).

⁵⁵ *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 482 (1999).

⁵⁶ *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, 122 S.Ct. 681, 693 (2002).

⁵⁷ 527 U.S. 471 (1999).

⁵⁸ *See id.* at 482-83. The case involved severely myopic airplane pilots who were denied employment by United Airlines and subsequently challenged United's minimum vision requirement. The Court ruled that they were not "disabled" under the ADA because their vision was corrected with eyeglasses, and thus they were not entitled to statutory protections. *See id.* at 488.

⁵⁹ Hearing aids are often not covered by insurance policies. *See HARNETT & LESNICK, supra* note 6, § 6A.11[1].

corrective measures for financial reasons can be considered disabled even though effective treatment is available and could potentially mitigate the condition.⁶⁰ Coverage exclusions for hearing aids, for example, pose a difficult problem under the *Sutton* precedent. Do they constitute a disability-based distinction because they prevent severely hearing-impaired individuals from obtaining needed corrective devices or are they not susceptible to challenge under the ADA because hearing impairment is a condition that can be mitigated by use of hearing aids and thus is not a disability?⁶¹ The courts will likely have to grapple with this question in the future.

3. Disparate Impact Analysis

The anti-discrimination laws generally proscribe practices that are facially neutral but have a disparate impact on members of a particular protected class or classes.⁶² Thus, Title I of the ADA provides that employers may not utilize “standards, criteria, or methods of administration . . . that have the effect of discrimination on the basis of disability.”⁶³ Similarly, Title III prohibits individuals and entities from utilizing standards or mechanisms “that have the effect of discriminating on the basis of disability.”⁶⁴ In the context of insurance coverage, however, disparate impact analysis cannot be utilized.⁶⁵

In *Alexander v. Choate*,⁶⁶ the Supreme Court considered a challenge to the State of Tennessee’s decision to reduce from 20 to 14 the number of annual inpatient hospital days for which the state’s Medicaid program would reimburse hospitals.⁶⁷ The

⁶⁰ See Christine Tomko, *Economically Disadvantaged and the ADA: Why Economic Need Should Factor into the Mitigating Measures Disability Analysis*, 52 CASE W. RES. L. REV. (forthcoming 2002).

⁶¹ See *id.* (arguing that individuals who cannot afford mitigating measures should be considered to be individuals with disabilities despite the availability of medication or devices that would alleviate their conditions).

⁶² See *Griggs v. Duke Power Co.*, 401 U.S. 424, 432-36 (1971) (finding that facially neutral educational and testing requirements that were not reasonable measures of job performance and had a disparate impact on the hiring of African Americans violated Title VII).

⁶³ 42 U.S.C. § 12112(b)(3)(A) (1994).

⁶⁴ *Id.* § 12182(b)(1)(D)(i).

⁶⁵ See Bonnie Tucker, *Health Care and the Americans with Disabilities Act: Access to Health Care for Individuals with Hearing Impairments*, 37 HOUS. L. REV. 1101, 1150-51 (2000).

⁶⁶ 469 U.S. 287 (1985).

⁶⁷ See *id.* at 289. The case was brought under section 504 of the Rehabilitation Act of

plaintiffs argued that this reduction was unlawful because it had a disproportionate effect on individuals with disabilities and because any limitation on the number of inpatient hospital days disproportionately disadvantages the disabled.⁶⁸ The Supreme Court disagreed and ruled against the plaintiffs. It reasoned that the fourteen day limitation will provide both those with disabilities and those without them with identical hospital services.⁶⁹ The Court stated that “the reduction, neutral on its face, does not distinguish between those whose coverage will be reduced and those whose coverage will 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.”⁷⁰

The ADA’s legislative history confirms that the *Alexander v. Choate* decision is applicable to the ADA. The House Labor Committee report explains:

[A]s is stated by the U.S. Supreme Court, in *Alexander v. Choate* . . . employee benefit plans should not be found to be in violation of this legislation 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.⁷¹

Likewise, the Equal Employment Opportunity Commission’s (“EEOC”) guidelines provide that health-related distinctions are not disability-based if they are broad distinctions that apply to a variety of dissimilar conditions and affect both persons with disabilities and those without them.⁷² Accordingly, an exclusion or limitation that has an adverse impact on people with a particular disability but also affects people without a disability is not governed by the ADA. The guidelines, therefore, do not support

1973, 29 U.S.C. § 794 (1994). The Rehabilitation Act prohibits disability discrimination by any program receiving Federal funds and thus applies to Medicaid. *See id.* Cases interpreting the Rehabilitation Act are applicable to the ADA, a much newer statute for which a more limited body of interpretive case law exists. The Rehabilitation Act itself states that “[t]he standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under Title I of the Americans with Disabilities Act of 1990.” *Id.* § 791(g) (citation omitted).

⁶⁸ *Choate*, 469 U.S. at 290.

⁶⁹ *See id.* at 302.

⁷⁰ *See id.* One scholar notes that *Alexander v. Choate* may be distinguished from cases brought under the ADA because unlike the ADA, the Rehabilitation Act does not contain an explicit provision prohibiting practices that have a disparate impact on people with disabilities. *See* Chai R. Feldblum, *The Employment Sector*, in IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT 142 n.102 (Jane West ed. 1996).

⁷¹ H.R. REP. NO. 485 (1990), reprinted in 1990 U.S.C.A.N. 420.

⁷² Section 3: *Employee Benefits*, EEOC Compl. Man. (BNA) No. 265, 627:0001, at 627:0022 (Oct. 3, 2000) [hereinafter *Employee Benefits*].

the use of disparate impact analysis in the health insurance context.

Public policy considerations also militate against utilization of the disparate impact theory to challenge health insurance plans under the ADA. If the theory were applicable, essentially all benefits, exclusions, or limitations would be vulnerable to challenge under the ADA since individuals with disabilities are likely to need more medical care than others and to be more disadvantaged by any reimbursement restrictions. For example, limitations on life-time benefits, on coverage for eye care or elective surgery, or on the number of blood transfusions or x-rays for which reimbursement can be obtained, may all have a greater impact on individuals with particular disabilities than on others.⁷³

If disparate impact analysis were applicable to the ADA, insurers who fear repeated court challenges might be reluctant to implement many of the benefit restrictions that have traditionally been used as cost-containment measures.⁷⁴ Premiums would then rise, rendering health insurance unaffordable for an increasing number of individuals.⁷⁵ In the alternative, requiring insurers to tailor their reimbursement restrictions so that they do not adversely impact individuals with disabilities to a greater extent than others would impose a very heavy burden on the industry. Insurers would have to determine on a case-by-case basis which disabilities were adversely affected by each benefit term, which claimants actually had those disabilities, and what amount of additional coverage would eliminate the disparate impact for those

⁷³ See *id.* at 627:0022-0023; see also *EEOC Interim Guidance on Application of ADA to Health Insurance*, EEOC Compl. Man. (BNA) No. 265, N:2303-2304 (Oct. 3, 2000) [hereinafter *EEOC Interim Guidance*].

⁷⁴ When challenged in court, insurers can always defend their benefits terms pursuant to Section 501(c). However, insurers might be concerned that they will be unable to provide sufficient proof of an actuarial or cost-based justification to overcome ADA challenges from sympathetic plaintiffs. See discussion *infra* Part I.D.

⁷⁵ Another concern is adverse selection. Adverse selection refers to a potential shift in the health insurance customer population. If insurers raise premium prices too high, those who perceive themselves as being low-risk will consider the product's price to be higher than its value and will therefore buy little if any health insurance coverage. Those who believe they are high-risk will purchase extensive coverage, unless premium prices rise to the point that it is cheaper for consumers to pay for the full cost of health care out of pocket. If all individuals who have insurance coverage incur high medical costs because of health problems, insurance prices will rise higher and higher, creating a "death spiral" of premiums and leading ever-decreasing numbers of healthy people to buy insurance. As prices continue to rise even high-risk individuals will become unable to afford insurance coverage. Ultimately, adverse selection could destabilize or even bankrupt the insurance industry. See John Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 387-88 (1997).

entitled to ADA protection.⁷⁶ Even if this were possible, it would significantly raise administrative costs that would then be passed on to consumers in the form of higher prices.

4. AIDS Caps and Disparities in Coverage for Treatment of Mental and Physical Conditions

The two insurance practices that have generated litigation most frequently are coverage caps for the treatment of AIDS⁷⁷ and disparities in coverage for treatment of mental and physical ailments.⁷⁸ As discussed below, while the first constitutes a disability-based distinction, the second does not.

In *Bragdon v. Abbott*,⁷⁹ the Supreme Court determined that a woman with asymptomatic human immunodeficiency virus ("HIV") was an individual with a disability because the condition substantially limited her ability to reproduce, which is a major life activity.⁸⁰ The Court declined to decide the question of whether HIV infection always constituted a *per se* disability, as defined by the ADA.⁸¹ Thus, it did not indicate whether an individual who does not wish to reproduce or is unable to do so for reasons other

⁷⁶ See H.R. REP. NO. 485 (1990), reprinted in 1990 U.S.C.C.A.N. 420 (stating that employee benefits plans do not violate the ADA under disparate impact analysis when they do not satisfy the special needs of persons with disabilities by providing them with additional medical coverage).

⁷⁷ See, e.g., *Doe v. Mutual of Omaha Insurance*, 179 F.3d 557 (7th Cir. 1999) (challenging the cap of medical insurance benefits for the treatment of AIDS and AIDS-related conditions); *Gonzales v. Garner Food Services, Inc.*, 89 F.3d 1523 (11th Cir. 1996) (alleging that a health insurance plan's cap for AIDS-related treatment violated the ADA).

⁷⁸ See, e.g., *Ford v. Schering-Plough Corporation*, 145 F.3d 601 (3d Cir. 1998) (challenging the disparity between disability insurance benefits for mental disabilities and disability insurance benefits for physical disabilities); *Wilson v. Globe Specialty Products*, 117 F. Supp. 2d 92 (D. Mass. 2000) (challenging the termination of mental disability coverage under a disability benefit plan); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997) (alleging that a long-term disability plan that provided longer benefits for employees who suffered from physical illness than for those who suffered from mental illness violated the ADA); *Whaley v. United States*, 82 F. Supp. 2d 1060 (D. Neb. 2000) (challenging the validity of a disability insurance policy that limited payments for disabilities relating to nervous or mental disorders); *Bril v. Dean Witter, Discover & Co.*, 986 F. Supp. 171 (S.D.N.Y. 1997) (alleging that a long-term disability plan unlawfully discriminated against the plaintiff by differentiating between psychiatric and physical illnesses). Many of the cases that analyze the ADA's applicability to insurance benefits involve disability insurance rather than health insurance. Disability insurance features the same kinds of limitations and exclusions that are found in health insurance and therefore analysis relating to one type of insurance can be extended to the other.

⁷⁹ 524 U.S. 624 (1998).

⁸⁰ See *id.* at 641.

⁸¹ See *id.* at 642.

than HIV would be entitled to statutory protection.

The Court noted that under *Chevron U.S.A. v. Natural Resource Defense Council*,⁸² guidelines and opinions issued by administrative agencies regarding the definition of "disability" are entitled to deference.⁸³ Both the Department of Justice ("DOJ") and the EEOC have issued statements finding that HIV infection is a disability.⁸⁴ The Court also noted that once HIV has developed into AIDS, many very serious conditions such as pneumocystis carinii, pneumonia, Kaposi's sarcoma, and non-Hodgkins lymphoma often appear.⁸⁵ In addition, many uncomfortable conditions that affect HIV patients, such as fever, weight loss, fatigue, lesions, nausea, and diarrhea, worsen.⁸⁶ A clear inference can be drawn from the Court's statements that even if HIV is not a disability in all cases, AIDS is. Consequently, a limitation of coverage for AIDS treatment that is lower than limitations for other treatments constitutes a disability-based distinction that is vulnerable to challenge under the ADA.⁸⁷

Unlike AIDS caps, unequal coverage for physical and mental conditions is not a disability-based distinction that is governed by the ADA. "Mental conditions" include a broad array of ailments, some of which might be disabilities, such as major depression or multiple personality disorder, and many of which are not, such as low self esteem, temporary grief, and anxiety arising from marital problems.⁸⁸ Because limitations on reimbursement for treatment of mental conditions do not affect only disabilities, they cannot be said to be disability-based distinctions.⁸⁹

The conclusion that the ADA was not designed to prohibit insurance providers from offering beneficiaries less coverage for mental conditions than for physical conditions is bolstered by the fact that Congress passed the Mental Health Parity Act ("MHPA")⁹⁰ in 1996, six years after the passage of the ADA. The

⁸² 467 U.S. 837 (1984). For a discussion of the Chevron principle see *infra* note 147.

⁸³ See *Bragdon*, 524 U.S. at 642.

⁸⁴ See *id.* at 642-47.

⁸⁵ See *id.* at 636.

⁸⁶ See *id.*

⁸⁷ The EEOC, in its guidance, uses the example of an AIDS cap as an illustration of a disability-based distinction. *EEOC Interim Guidance on Application of ADA to Health Insurance*, EEOC Compl. Man. (BNA) No. 176, N:2301, at N:2304 (June 8, 1993). See also, *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997) (stating that "it is clear that, as an individual with AIDS, [the] defendant is disabled under the ADA").

⁸⁸ See *Employee Benefits*, *supra* note 72, at 627:0023.

⁸⁹ See *id.* (concluding that "such distinctions in health insurance plans thus will not generally violate the ADA"). See also discussion of disparate impact analysis, *supra* Part I.B.3.

⁹⁰ 42 U.S.C. § 300gg-5 (1994 & Supp. 2001).

legislation required that certain group health plans that provide both physical and mental health care benefits apply the same aggregate lifetime limits to both.⁹¹ Had Congress believed that the ADA already prohibited such coverage disparities, it is unlikely that it would have passed the subsequent law.⁹² Moreover, the MHPA fell far short of mandating complete parity between benefits for mental health care and benefits for physical health care. The law did not apply to employers with fewer than fifty employees⁹³ or to those who would experience a cost increase of one percent or more as a result of enhancing mental health care coverage.⁹⁴ The statute also had a sunset provision that rendered it inapplicable to “benefits for services furnished on or after September 30, 2001,” and thus it expired five years after its enactment.⁹⁵ It is unreasonable to construe the ADA as requiring absolute parity in light of the fact that Congress later passed a less restrictive statute without explicitly stating that it meant to revise the ADA standard.

The relatively narrow definition of “disability-based distinction” significantly limits the applicability of the ADA’s anti-discrimination mandate to health insurance. This is particularly true in light of the Supreme Court’s mandate that mitigating measures be considered in determining whether an individual has a “disability,” a requirement that precludes many serious conditions from being deemed disabilities. Furthermore, benefit exclusions or limitations that affect both people with disabilities and those without disabilities are not disability-based distinctions. Because the ADA prohibits only disability discrimination and not other types of discrimination, the question of whether a discriminatory insurance term is a disability-based distinction is the threshold question in any ADA inquiry. If the benefits term is

⁹¹ *Id.*

⁹² See ANTONIN SCALIA, A MATTER OF INTERPRETATION 16-17 (1997). Scalia states: Another accepted rule of construction is that ambiguities in a newly enacted statute are to be resolved in such fashion as to make the statute, not only internally consistent, but also compatible with previously enacted laws. We simply assume, for purposes of our search for ‘intent,’ that the enacting legislature was aware of all those other laws.

Id. at 16. Justice Scalia disagrees with this approach, believing that it is based on “fiction.” He argues that it is unrealistic to assume that legislatures debating a particular bill are intimately familiar with all arguably relevant prior legislation. See *id.* at 16-17. In this case, however, it would be unreasonable to think that the authors of the MHPA, which directly addresses disability discrimination, were ignorant of the ADA, a very well-publicized and often cited law that was passed only six years earlier, in 1990.

⁹³ 42 U.S.C. §§ 300gg-5(c)(1), 300gg-91(e)(4).

⁹⁴ *Id.* § 300gg-5(c)(2).

⁹⁵ *Id.* § 300gg-5(f).

not a disability-based distinction, it cannot be challenged under the statute and no further inquiry need be made.

C. *Title I and Title III of the ADA*

1. Title I and Insurance Policies

Title I of the ADA prohibits discrimination in employment and thus forbids employers from discriminating against individuals with disabilities with respect to health insurance benefits.⁹⁶ Likewise, an employer may not engage in a contractual or other relationship that has the effect of subjecting qualified applicants or employees with disabilities to discrimination.⁹⁷ Consequently, an employer may not contract with a third-party insurer to provide its employees with health insurance that is unlawfully discriminatory. This prohibition is significant because approximately sixty-five percent of Americans under the age of sixty-five receive health insurance benefits through employers.⁹⁸ Sixty percent of all small firms offered their employees health insurance benefits in 1999, and virtually all employers with 200 or more employees offer health benefits.⁹⁹

An employer who offers its employees health insurance benefits cannot refuse to provide insurance benefits to a person with a disability even if the cost of insuring such an individual will be high.¹⁰⁰ However, if an insurance plan offered by an employer contains a disability-based distinction, that plan will not automatically violate the ADA, and its legality will be evaluated in light of section 501(c) and other defenses, discussed below.¹⁰¹

⁹⁶ 42 U.S.C. § 12182(a).

⁹⁷ 42 U.S.C. § 12112(b)(2).

⁹⁸ See Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey*, EBRI ISSUE BRIEF, Jan. 2000, at 1, 4.

⁹⁹ See THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS 1999 ANNUAL SURVEY* 25 (1999).

¹⁰⁰ *Anderson v. Gus Mayer Boston Store of Del.*, 924 F. Supp. 763, 780 (E.D. Tex. 1996) (stating that "complete denial [of health insurance benefits] is a *per se* violation of the ADA's mandate that employers provide individuals with disabilities equal access to group health insurance").

¹⁰¹ See *EEOC Interim Guidance*, *supra* note 73. See also discussion *infra* Part I.D.

2. Title III and Insurance Policies

Title III of the ADA reads in relevant part: “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.”¹⁰² A “place of public accommodation” is defined by the ADA as including an insurance office.¹⁰³ A plain reading of the language of this provision reveals that it prohibits discrimination not only with respect to physical access to insurance offices, but also with respect to the goods offered by insurance offices, i.e., insurance policies. The scope of this anti-discrimination prohibition, however, has been vigorously debated in the courts.

First, the courts that have addressed the issue agree that if an individual receives health insurance benefits through her employer, she cannot both sue her employer under Title I and sue the insurance company or administrator of the plan under Title III of the ADA.¹⁰⁴ The courts reason that if an employee obtains insurance through her employer, she has not acquired the benefits from a place of public accommodation and has no direct nexus to the insurance office.¹⁰⁵ In the words of one court, “a benefit plan provided by an employer is not a good offered by a place of public accommodation. As is evident by § 12187(7) [sic], a public accommodation is a physical place. . . .”¹⁰⁶ Consequently, according to the courts, an individual receiving employer-provided health benefits can sue only her employer under Title I and cannot utilize Title III of the ADA.

The reasoning of the courts, however, is unsound. The text of Title III does not limit its applicability only to cases in which the plaintiff obtained goods or services directly from the place of public accommodation. Rather, it prohibits those who own, lease, or operate places of public accommodations, including insurance offices, from subjecting individuals with disabilities to

¹⁰² 42 U.S.C. § 12182(a).

¹⁰³ 42 U.S.C. § 12181(7)(F).

¹⁰⁴ See, e.g., *Leonard v. Israel Disc. Bank of N.Y.*, 199 F.3d 99 (2d Cir. 1999) (noting the issue but deciding the case on other grounds); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-613 (3rd Cir. 1998); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1011-12 (6th Cir. 1997); *Lenox v. Healthwise of Kentucky, Ltd.*, 149 F.3d 453, 456 (6th Cir. 1998); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1114-1115 (9th Cir. 2000).

¹⁰⁵ See cases listed *supra* note 104.

¹⁰⁶ *Parker*, 121 F.3d at 1010.

discrimination with respect to their goods or services. There is no reason why the existence of an intermediary, such as an employer, through whom the plaintiff obtains the merchandise, should render Title III inapplicable. Surely, if a store owner refused to sell his products to the administrators of a rehabilitation center for the disabled because he did not want individuals with disabilities to enjoy his goods, the residents would be able to sue the store owner even though they did not directly attempt to purchase the goods. Likewise, individuals with disabilities who are offered unlawfully discriminatory health insurance through their employers should be able to sue the insurance company that provided the discriminatory policy.¹⁰⁷

A second issue with which the courts have grappled is the scope of Title III's anti-discrimination prohibition. The courts agree that Title III bars insurance companies from refusing to sell insurance policies to persons with disabilities because of their disabilities and consequently requires them to ensure that individuals with disabilities have access to their services.¹⁰⁸ However, the circuit courts that have addressed the issue have held that the ADA does not govern the contents of insurance policies and thus that the courts have no authority to scrutinize benefit exclusions and limitations such as AIDS caps.¹⁰⁹ The

¹⁰⁷ Because Title I is enforced by the EEOC, and Title III is enforced by the DOJ, each agency has issued guidelines regarding the respective Title under its jurisdiction, and neither has addressed the interrelationship between the two. See *Employee Benefits*, *supra* note 72; 29 C.F.R. § 1630.16(f) (2000); 28 C.F.R. § 36.212 (2000). Consequently, no administrative agency guidance exists concerning an individual's right to sue under both Titles.

¹⁰⁸ *Doe v. Mutual of Omaha Insurance*, 179 F.3d 557, 559 (7th Cir. 1999); *Parker*, 121 F.3d at 1012 ("Title III regulates the availability of the goods and services the place of public accommodation offers"); *McNeil v. Time Ins. Co.*, 205 F.3d 179, 186 (5th Cir. 2000) ("Title III prohibits the owner, operator, lessee, or lessor from denying the disabled access to, or interfering with their enjoyment of, the goods and services of a place of public accommodation"); *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 33 (2d Cir. 2000) ("[A]n entity covered by Title III is not only obligated by the statute to provide disabled persons with physical access, but is also prohibited from refusing to sell them its merchandise by reason of discrimination against their disability").

¹⁰⁹ *Doe*, 179 F.3d at 562 (stating that the ADA "regulates only access and not content"); *Weyer*, 198 F.3d at 1115 ("[A]n insurance office must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled"); *Parker*, 121 F.3d at 1012 ("Title III does not govern the content of a long-term disability policy offered by an employer"); *Ford*, 145 F.3d at 608 ("So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities"); *McNeil*, 205 F.3d at 185 ("Title III does not . . . regulate the content of goods and services that are offered").

Some district courts have found to the contrary. See, e.g., *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1208 (N.D. Ga. 1997) (noting that the ADA "requires that underwriting

conclusion of the courts that have interpreted the ADA so narrowly is unfounded. To analyze the decisions, however, one must turn to Section 501(c) of the statute.

D. *The Meaning of Section 501(c)*

Section 501(c) of the ADA states the following:

[T]his Act shall not be construed to prohibit or restrict—

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering 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; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of [the Act].¹¹⁰

Most courts that have interpreted this provision perceive it as an almost complete defense for insurers.¹¹¹

The courts correctly note that the ADA does not require that insurers provide equal benefits for different disabilities.¹¹² As stated above, however, the courts have carried this principle too

and classification of risks be based on sound actuarial principles or be related to actual or reasonably anticipated experience"); *Clouter v. Prudential Ins. Co. of Am.*, 964 F. Supp. 299, 304 (N.D. Cal. 1997) ("[I]nsurers retain their § 501(c) exemption so long as their underwriting decisions are in accord with either (a) sound actuarial principles, or (b) actual or reasonably anticipated experience"); *Lewis v. Aetna Life Ins. Co.* 982 F. Supp. 1158, 1169 ("[T]he Aetna plan's distinction between physical and mental disabilities may survive scrutiny under the ADA only if it is based on actuarial principles or other competent factual information"); *Doukas v. Metro. Life Ins. Co.*, 950 F. Supp. 422, 432 (D. N.H. 1996) ("[W]hile insurers retain the ability to follow practices consistent with insurance risk classification accepted under state law, these methods must still be based on sound actuarial principles or related to actual or reasonably anticipated experience").

¹¹⁰ 42 U.S.C. § 12201(c) (1994).

¹¹¹ See e.g., *Doe*, 179 F.3d at 562 ("[S]ection 501(c) is obviously intended for the benefit of insurance companies rather than plaintiffs.").

¹¹² *Parker*, 121 F.3d at 1015; *Weyer*, 198 F.3d at 1116; *Ford*, 145 F.3d at 608; *Wilson*, 117 F. Supp. 2d at 95.

far and have in most cases concluded that “the content of the goods or services offered by a place of public accommodation is not regulated.”¹¹³ Thus, in *Doe v. Mutual of Omaha*,¹¹⁴ the defendant conceded that its AIDS cap was not based on any actuarial principle or economic experience, and yet the court found that the AIDS cap was lawful and consistent with the ADA’s anti-discrimination mandate. The courts have explicitly ruled that the “subterfuge” language of section 501(c) does not require insurers to justify their benefit terms when they are challenged by plaintiffs.¹¹⁵ Courts have also protested that they “are not equipped to become the watchdog of the insurance business”¹¹⁶ by engaging in analysis of actuarial data¹¹⁷ and assert that intrusion by the courts could lead to a destabilizing “seismic shift in the insurance business.”¹¹⁸ By contrast, I argue that section 501(c) imposes an obligation on insurers to provide a cost-based justification for discriminatory benefit limitations or exclusions and provides a defense only for those who can do so.

1. The Plain Text of Section 501(c)

To say that section 501(c) imposes no restrictions upon the benefit terms that can be implemented by insurers and that it leaves them free of the obligation to justify challenged exclusions and limitations is to ignore the provision’s plain language. If the ADA intended to prohibit only an insurer’s refusal to deal with disabled individuals, it would have stated so explicitly. Section 501(c) could have simply directed that insurance providers cannot refuse to provide insurance policies to individuals with disabilities because of their disabilities.

Instead, the statute discusses the permissible activities of underwriting risks, classifying risks, and administering risks, and the impermissible conduct of implementing terms that are contrary to state law or are used as a subterfuge to evade the purposes of the ADA.¹¹⁹ It is therefore ludicrous to conclude that the statute does not instruct the courts to scrutinize insurers’ policy terms to

¹¹³ *Doe*, 179 F.3d at 560. See also cases listed *supra* note 109.

¹¹⁴ 179 F.3d 557 (7th Cir. 1999).

¹¹⁵ See *Ford*, 145 F.3d at 612; *Whaley v. United States*, 82 F. Supp. 2d 1060 (D. Neb. 2000); *Bythway v. Principal Health Care of Del. Inc.*, 1999 WL 33220042 at *3.

¹¹⁶ *Ford*, 145 F.3d at 612.

¹¹⁷ See *Bythway*, 1999 WL 33220042, at *3.

¹¹⁸ *Ford*, 145 F.3d at 612. See also *Bythway*, 1999 WL 33220042, at *3.

¹¹⁹ 42 U.S.C. § 12201(c) (1994).

verify that they are based on permissible practices and do not contain impermissible components. Moreover, the statute generally prohibits disability discrimination with respect to insurance¹²⁰ but qualifies this prohibition by providing an exception for the traditionally valid practices of “underwriting risks, classifying risks, or administering risks.” It follows that if insurers adopt a discriminatory exclusion or limitation that is not based on one of the above mechanisms, the discriminatory benefit term should be deemed unlawful. Again, this determination requires justification of the challenged benefit term by the insurer and judicial scrutiny.

The term “underwriting risks” refers to an insurer’s decision concerning whether, and on what basis, to accept a particular customer.¹²¹ The practice of classifying risks is the “[c]ategorization on the basis of established criteria for rating risks, establishing premiums and tabulating statistical experience.”¹²² The term “administering risks” is not specifically defined in the insurance literature, but it most probably relates simply to the administration of the insurance plan. The commonly accepted principles that underlie risk classification practices are that the system should reflect expected cost differences, should distinguish among risks on the basis of relevant cost factors, and should be applied objectively.¹²³ Moreover, it is commonly accepted that risk classification practices should promote efficiency and fairness, and therefore, equal risks are not to be treated differently and unequal risks are not to be treated the same.¹²⁴

Consequently, in permitting insurers to underwrite and classify risks, the ADA is permitting them to engage in a process of analysis of expected costs and experience involving different risks. The statute cannot reasonably be construed as allowing insurers to exclude or limit benefits for the treatment of disabilities on an arbitrary or irrational basis. If insurers were allowed to do so, the ADA’s reference to the underwriting, classifying, and administration of risks would have no meaning, and the statute’s

¹²⁰ *Id.* §§ 12112(a), 12182(a), 12181(7)(F).

¹²¹ See Karen A. Clifford & Russel P. Inculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806, 1809 (1987). See also Phillip E. Stano, *Underwriting in the Twentieth Century: Grafting Societal Values to the Regulation of Risk*, 19 J. INS. REG. 273, 275 (2000); RUPP, *supra* note 22, at 335.

¹²² RUPP, *supra* note 22, at 76.

¹²³ See AM. ACAD. OF ACTUARIES COMM. ON RISK CLASSIFICATION, RISK CLASSIFICATION STATEMENT OF PRINCIPLES 2 (1980).

¹²⁴ See *id.* at 8; KENNETH S. ABRAHAM, DISTRIBUTING RISK 10-11 (1986); Stano *supra* note 121 at 275-76.

prohibition of discrimination with respect to insurance benefits would have no force.

The courts' concern that judicial intrusion would generate destabilization in the insurance industry is groundless. Requiring insurers to avoid unfair discrimination and to base benefit terms on actuarial analysis is consistent with existing insurance principles. It is, in fact, what insurers are purportedly doing on their own, and thus, the ADA merely formalizes what insurers already understand to be their professional obligation. While insurers have ample incentive to exclude or limit coverage for the treatments that are going to be most costly for the plan, they have a much weaker economic incentive to refuse reimbursement for AIDS treatment or hearing devices if these are expected to be sought rarely and to be less costly than other treatments that are covered.¹²⁵ Exclusion or limitation of coverage for therapies that will generate low expenditures for the health insurance plan will not significantly reduce its expenses or prevent premiums from rising. If the courts are called upon to ensure that challenged insurance terms are based on valid analysis of cost data and are not randomly discriminatory disability-based distinctions, the courts will not in any way cause a "seismic shift"¹²⁶ in the insurance industry. Rather, they will reinforce the industry's integrity and underlying principles.

The courts' objection that they are not equipped to evaluate financial and actuarial data is similarly unconvincing. The ADA explicitly requires courts to engage in complex economic analysis in other contexts. Title I of the ADA requires employers to provide reasonable accommodations for individuals with

¹²⁵ See Herman T. Bailey, *The Regulatory Challenge to Life Insurance Classification*, 25 *DRAKE L. REV. INS. L. ANN.* 779, 824 (1976) ("Insurers are not concerned with stereotyping individuals on the basis of whim, prejudice or surmise, but rather seek to classify them on the basis of factors with statistically demonstrable relationships to the cost of providing coverage."). In some cases insurers will be able to show that an AIDS cap, for example, is based on expected cost-related factors. If many members of a particular group have HIV or AIDS, then treatment for this illness may well be more expensive for the plan than other covered therapies. Nevertheless, many defendants, like Mutual of Omaha Insurance Company, will not be able to provide a cost-based justification for their AIDS cap. The average lifetime health care costs for AIDS-related conditions was estimated in 1999 to be \$155,000. See Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers under the ADA and ERISA*, 35 *TORT & INS. L.J.* 117, 117 (1999). Other procedures and therapies that are routinely covered, such as liver transplants and end-stage renal disease care are more costly for insurers. See *id.* at 132. Moreover, in the aggregate, it is more expensive for insurers to cover treatment for heart and liver disease and for cancer than it is to cover treatment for less frequently occurring diseases such as AIDS. See *id.* at 132-33.

¹²⁶ *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612 (3rd Cir. 1998).

disabilities unless the accommodation would impose an undue hardship upon the employer.¹²⁷ The statute further provides that in order to determine whether an undue hardship would exist, the court must consider the following four factors: (1) the nature and cost of the needed accommodation; (2) the overall financial resources of the facility involved; (3) the overall financial resources of the employer as a whole, including all its facilities; and (4) the employer's general operations.¹²⁸ Similarly, Title III of the ADA provides an undue burden defense for public accommodations that cannot accommodate individuals with disabilities.¹²⁹ Presumably, an employer asserting an undue burden defense in the Title III context would have to offer the court proof that is similar to that required under Title I. If courts can evaluate complex financial data in order to determine the validity of an entity's undue hardship defense, there is no reason why they

¹²⁷ 42 U.S.C. § 12112(b)(5)(A) (1994). The provision reads in relevant part:

(b) . . . the term "discriminate" includes-

...

(5)(A) not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity;

Id.

¹²⁸ 42 U.S.C. § 12111(10)(B). The text provides:

(B) Factors to be considered. - In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include-

(i) the nature and cost of the accommodation needed under this chapter;

(ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;

(iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and

(iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

Id.

¹²⁹ 42 U.S.C. § 12182(b)(2)(A)(iii). The text provides:

(A) . . . discrimination includes-

...

(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;

Id.

should be deemed ill-equipped to evaluate financial data for purposes of a section 501(c) defense.

One problem that might arise is that insurers will offer actuarial data that is out-dated or unreliable, since such data, unfortunately, is often utilized in the risk-classification process.¹³⁰ As is the case generally in litigation, however, it will be up to the plaintiff to convince the court that it should not rely on the defendant's flawed evidence, and the courts will have to be trusted to reach the correct conclusion.

2. The Term "Subterfuge"

Much of the controversy relating to section 501(c) revolves around the meaning of the term "subterfuge." I suggest, however, that the emphasis on that word is misplaced. The "subterfuge" provision adds a further prohibition that will apply in exceptional cases, but it is not central to the meaning of the entirety of section 501(c).

The courts that have interpreted section 501(c) as providing a comprehensive defense for insurers rely on the Supreme Court case of *Public Employee Retirement System of Ohio v. Betts*.¹³¹ The case involved an age discrimination challenge to a plan that disqualified employees from eligibility for disability retirement benefits upon reaching the age of sixty.¹³² At the time, the Age Discrimination in Employment Act ("ADEA")¹³³ contained a provision that is similar to the ADA's section 501(c). Section 4(f)(2) of the ADEA provided an exemption for activities undertaken to observe "the terms of . . . any bona fide employee benefit plan such as a retirement, pension, or insurance plan, which is not a subterfuge to evade the purposes of [the ADEA]."¹³⁴

In the *Betts* case, the Supreme Court reaffirmed its earlier *United Air Lines, Inc. v. McMann*¹³⁵ holding that "'subterfuge' means 'a scheme, plan stratagem, or artifice of evasion,' which, in

¹³⁰ Insurers have been criticized for making risk classification decisions that are not actuarially sound. See, e.g., Donald W. Light, *The Practice and Ethics of Risk-Related Health Insurance*, 267 J. AM. MED. ASS'N 2503, 2505 (1992); John Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 329 (1997); 28 C.F.R. § 36.212 (2000).

¹³¹ 492 U.S. 158 (1989).

¹³² See *id.* at 162.

¹³³ 29 U.S.C. §§ 621-634 (1994 & Supp. 1999). See *infra* in Part II.C, for a more detailed discussion of the ADEA.

¹³⁴ 29 U.S.C. § 623(f)(2). The section was amended in 1990 and no longer contains the "subterfuge" language. For the section's current text, see *infra* note 233.

¹³⁵ 434 U.S. 192 (1977).

the context of § 4(f)(2), connotes a specific 'intent . . . to evade a statutory requirement.'¹³⁶ It rejected EEOC guidelines that construed the subterfuge clause as requiring cost justification for age discrimination in benefit plans.¹³⁷ The Court reasoned that the EEOC guidelines were not due any deference because they were contrary to the plain language of the ADEA.¹³⁸ Consequently, a plan adopted prior to the ADEA's enactment could not constitute a subterfuge because it could not have been conceived with an intent to evade the statutory purpose.¹³⁹ Finally, the *Betts* Court held that in order to prove subterfuge, plaintiffs must prove that the challenged plan provision was intended to discriminate in an aspect of employment that is not itself related to fringe benefits, such as to retaliate against an employee who filed a charge of discrimination or to reduce the net earnings of older employees.¹⁴⁰

The courts that have adopted the *Betts* interpretation in the ADA context have reasoned that Congress must have incorporated the term "subterfuge" into the ADA in 1990 in light of the Supreme Court's *Betts* decision in 1989 and thus intended the term to have identical meanings in the two statutes.¹⁴¹ This interpretation bolsters their conclusion that the ADA does not govern the contents of insurance policies because, under the *Betts* precedent, benefit terms should not be vulnerable to judicial scrutiny unless they were adopted specifically with discriminatory intent.¹⁴² Here too, however, the courts' reasoning is unsound.

Whether the *Betts* interpretation of "subterfuge" was right or wrong, the two provisions at issue are easily distinguishable. First, the ADEA's subterfuge clause was very different from that found

¹³⁶ *Betts*, 492 U.S. at 171 (citing *McMann*, 434 U.S. at 203).

¹³⁷ *Id.* at 170-71. The EEOC regulation provided that "[I]n general, a plan or plan provision which prescribes lower benefits for older employees on account of age is not a 'subterfuge' within the meaning of section 4(f)(2), provided that the lower level of benefits is justified by age-related cost consideration." *Id.* at 170, (quoting 29 C.F.R. § 1625.10(d) (1988)).

¹³⁸ *See id.* at 171.

¹³⁹ *See id.* at 167-68.

¹⁴⁰ *See id.* at 180-81.

¹⁴¹ *Leonard v. Israel Disc. Bank of N.Y.*, 199 F.3d 99, 104 (2d Cir. 1999) ("[W]hen Congress chose the term 'subterfuge' for the insurance safe-harbor of the ADA, it was on full alert as to what the court understood the word to mean and possessed (obviously) a full grasp of the linguistic devices available to avoid that meaning"); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 611 (3rd Cir. 1998) ("Congress . . . is presumed to have adopted the Supreme Court's interpretation of 'subterfuge' in the ADEA context when Congress enacted the ADA"); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 679 (8th Cir. 1996) ("Had Congress intended to reject the *Betts* interpretation of subterfuge when it enacted the ADA, it could have done so expressly by incorporating language for that purpose into the bill").

¹⁴² *See cases listed supra* note 141.

in the ADA. Unlike section 501(c), the ADEA's provision made no mention of risk classification or underwriting practices. As argued previously, by referring to these mechanisms, the ADA mandates that only legitimate cost analysis will justify an otherwise discriminatory benefit term. Second, in 1990 Congress removed the subterfuge clause from the ADEA, and thus it did not retain two provisions that contain identical words that should be construed as having identical meanings. It cannot, therefore, be argued that section 501(c) excuses all insurer conduct that was not specifically intended to evade the purpose of the statute.

Accordingly, it is incorrect to conclude that plans adopted before the ADA are exempt from the anti-discrimination mandate because they could not have been implemented with an intent to evade the purposes of the ADA.¹⁴³ Rather, benefit terms that discriminate on the basis of disability must be scrutinized by the courts on their own merit to determine whether they comply with statutory requirements.

Nevertheless, I propose that the term "subterfuge" in section 501(c) can be read to mean "with an intent to evade statutory purposes," as it does according to the *Betts* Court, without weakening the argument that the provision as a whole requires cost justification. Because the cost analysis is required by the ADA's reference to "underwriting risks, classifying risks, or administering risks" in the first two paragraphs of the provision, the discussion of subterfuge likely has a different purpose.

Specifically, the subterfuge clause provides that "Paragraphs (1), (2), and (3) [of section 501(c)] shall not be used as a subterfuge to evade the purposes of [the Act]. . . ."¹⁴⁴ This language imposes an additional obligation on insurance providers that goes beyond those addressed in the first three paragraphs. An insurance provider whose disability-based distinction is challenged under the ADA can avoid liability by proving that the distinction is consistent with cost-based risk classification and underwriting principles. However, a defendant who provides a valid justification, will nonetheless be found to have violated the ADA if the plaintiff proves that the discriminatory benefit term was adopted with an intent to discriminate rather than purely to save costs.

For example, an insurer may be able to prove that its AIDS cap is actuarially justified because of very high anticipated costs in the insured pool. However, if the plaintiff produces an internal

¹⁴³ See *Leonard*, 199 F.3d at 105.

¹⁴⁴ 42 U.S.C. § 12201(c) (1994).

memo stating that the AIDS cap was in truth adopted because the insurer believes people with AIDS cause their own illness by engaging in immoral conduct, deserve to be sick, and should not receive medical treatment, the section 501(c) defense will not apply. The coverage limitation was adopted in order to discriminate against individuals with AIDS, and not solely for reasons of cost. Similarly, if an employer is shown to have adopted a policy with an AIDS cap because it wanted an employee with AIDS to resign, the AIDS cap will be deemed a subterfuge, in violation of the ADA, even if the employer can prove an actuarial basis for it.

3. Administrative Guidance

Administrative guidance has been issued by the EEOC regarding the application of the ADA's Title I to health insurance, and by the DOJ, which enforces Title III, and both have provided consistent interpretations of section 501(c).¹⁴⁵ Under *Chevron U.S.A. v. National Resources Defense Council, Inc.*,¹⁴⁶ reasonable agency interpretations of ambiguous statutory provisions are entitled to judicial deference.¹⁴⁷ The circuit courts have generally ignored the agencies' guidance, and one court explicitly rejected it, stating that it is contrary to the plain meaning of the statute.¹⁴⁸ However, as is evident from the courts' repeated struggles to interpret section 501(c), the provision's plain meaning is not free of ambiguity and requires lengthy explication. The administrative

¹⁴⁵ *Employee Benefits*, *supra* note 72; *EEOC Interim Guidance*, *supra* note 73; 29 C.F.R. § 1630.16(f) (2000); 28 C.F.R. § 36.212 (2000).

¹⁴⁶ 467 U.S. 837 (1984).

¹⁴⁷ *See id.* at 842-44. In *Chevron*, the Supreme Court developed a two-step analysis to determine the degree of judicial deference appropriate for administrative interpretations of law. First, the court must determine whether the statute clearly speaks to the question at hand, and if so, the court must implement the plainly expressed intent of Congress. If, however, the statute does not address the pertinent issue or provides ambiguous guidance, courts should accept any reasonable interpretation offered by the enforcing administrative agency. *See id.*

The *Chevron* decision can be explained through several rationales. First, administrative agencies have expertise with respect to the legislation at issue and practical knowledge regarding administration of the statutory scheme. Second, the decision reinforces the separation of powers by assigning policy judgments to the executive branch rather than the courts. Third, according to Justice Scalia, in some cases Congress had no specific intent with respect to the question at issue and meant to leave its resolution to the administrative agency. *Chevron* thus instructs courts to implement Congressional intent by deferring to agency guidance. *See Antonin Scalia, Judicial Deference to Administrative Interpretations of Law*, 1989 DUKE L. J. 511, 514-16 (1989).

¹⁴⁸ *See Leonard v. Israel Disc. Bank of N.Y.*, 199 F.3d 99, 106 n.5 (2d Cir. 1999).

guidelines that have been issued are detailed and thoughtful. Because the EEOC and DOJ have provided reasonable and consistent guidance, their statutory interpretations should receive deference from the courts.

The DOJ's Title III Technical Assistance Manual explains:

[A] public accommodation may offer [an insurance] plan that limits certain kinds of coverage based on classification of risk, but 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.¹⁴⁹

Likewise, in commenting on an employer's obligations with respect to health insurance, the EEOC explains that "[t]he employer may prove that the disability-based disparate treatment is justified by legitimate actuarial data, or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated the same way."¹⁵⁰

¹⁴⁹ DEPT OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT: TITLE III TECHNICAL ASSISTANCE MANUAL III-3.11000 (1993). In addition, the DOJ's interpretive guidance states that "[b]ecause the legislative history of the ADA clarifies that different treatment of individuals with disabilities in insurance may be justified by sound actuarial data, such actuarial data will be critical to any potential litigation on this issue." 28 C.F.R. § 36.212 (2000).

¹⁵⁰ *Employee Benefits*, *supra* note 72, at 627:0024. The guidance continues:

Actuarial data will measure both the likelihood that the employer will incur insurance costs related to the disability and the magnitude of those costs as they arise. Thus, employers must show that the reduction in coverage for the disability or disabilities is required to account for an increased possibility that the benefit will be claimed or that the amounts required for coverage will be higher. Employers may not, however, rely on actuarial data that is outdated or that is based on myths, fears, stereotypes, or assumptions about the disability at issue.

Even where employers can produce actuarial data that demonstrates that the risks and costs of treatment of a condition justify differential treatment of it, employers must also show that they have treated other conditions that pose the same risks and costs the same way. If there is evidence that an employer has treated other conditions differently from the disability at issue, the employer has discriminated by singling out a particular disability for disadvantageous treatment.

Id. The EEOC provides this explanation as an interpretation of the term "subterfuge." As argued above, I believe that the EEOC is correct in stating that section 501(c) requires actuarial justification for disability-based distinctions, but I argue that cost analysis is mandated by the provision's reference to the underwriting and classifying of risks, not by the term "subterfuge."

In addition, the EEOC guidance focuses on section 501(c)'s requirement that an insurance plan be "bona fide." The guidance provides the following explanation concerning the term "bona fide":

Thus, both agencies conclude that the ADA governs the content of insurance policies and that insurance providers must furnish a cost-based justification for challenged disability-based distinctions.

The EEOC offers additional defenses for employers whose insurance plans contain disability-based distinctions. Employers can prove that the different treatment is necessary to maintain the solvency of the benefit plan¹⁵¹ or “to avoid unacceptable changes in the coverage of, or the premiums for, a benefit plan.”¹⁵² Although the EEOC does not explicitly state this, these defenses seem to arise from the general principle that employers are excused from accommodating individuals with disabilities if the accommodation will cause them undue hardship.¹⁵³ While DOJ guidelines do not address the issue, it is reasonable to conclude that insurers could similarly avoid liability under Title III by asserting an “undue burden” defense, because the defense is available not only to employers, but also to public accommodations.¹⁵⁴

EEOC guidance also explicitly rejects application of the *Betts*

Under the first prong of the defense, an employer must demonstrate that its plan is either a *bona fide* insured plan that is not inconsistent with state law, or a *bona fide* self-insured plan. [In a footnote, the EEOC explains that self-insured plans are not subject to state laws that regulate insurance]. To be *bona fide*, a plan must exist and pay benefits; in addition, the terms of the plan must have been accurately communicated to eligible employees.

Id. at 627:0023.

¹⁵¹ *Id.* at 627:0024. The guidance elaborates:

To establish this defense, employers must show:

- that covering the disability or disabilities at issue would require such substantial payments of benefits that it would threaten the fiscal soundness of the plan under commonly accepted or legally required standards, *and*
- that there is no non-disability-based benefit plan change that could be made to limit those fiscal consequences.

Id.

¹⁵² *Id.* The guidance further explains:

An “unacceptable” change is 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:

- increase the cost to other employees so substantially that the benefit plan would be effectively unavailable to a significant number of them;
- make the benefit plan so unattractive as to result in significant adverse selection; or
- make the benefit plan so unattractive that the employer cannot compete in recruiting and maintaining qualified workers due to the superiority of benefit plans offered by other employers in the community.

Id. The guidance also provides a final, rather obvious defense for an employer, which is that it can prove “that a particular treatment that it has excluded from a health insurance plan provides *no* medical benefit.” *Id.*

¹⁵³ See 42 U.S.C. § 12112(b)(5)(A) (1994). See Marcossou, *supra* note 7, at 429-30, for criticism that EEOC guidelines are too lenient and create too many loopholes for employers.

¹⁵⁴ 42 U.S.C. § 12182(b)(2)(A)(iii).

decision to ADA cases.¹⁵⁵ The EEOC asserts that the ADA applies to plans that were adopted prior to the statute's enactment and to insurance terms that are facially discriminatory even if they do not discriminate with respect to non-benefit employment decisions.¹⁵⁶

4. Legislative History

Reliance on legislative history is disfavored by the current Supreme Court.¹⁵⁷ Reportedly, during the 1981 term, the Court utilized legislative history in almost all of its statutory cases,¹⁵⁸ but by 1993, only a small number of cases analyzed legislative history; and no majority opinion cited legislative history as essential to its decision.¹⁵⁹ As demonstrated above, section 501(c) can be interpreted based on its text and in light of the detailed and reasonable administrative guidelines that were developed by the DOJ and EEOC. Nevertheless, as some scholars have argued, legislative history can be valuable in interpreting difficult text,¹⁶⁰

¹⁵⁵ See *Employee Benefits*, *supra* note 72, at 627:0024.

¹⁵⁶ See *id.*

¹⁵⁷ Justice Scalia in particular has argued vigorously against the use of legislative history as an authoritative source for a statute's meaning. See Scalia, *supra* note 145, at 16, 29-36. Scalia believes that legislative intent is not a proper criterion for statutory interpretation since judges must focus on what the legislature said, not what it might have theoretically intended. Furthermore, Scalia notes that floor debates are generally poorly attended and committee reports are rarely read, and thus it is naïve to believe that legislators vote according to what they hear during debates or read in reports. In fact, he believes that in many cases language contained in floor debates or committee reports is prewritten by lawyer-lobbyists who have access to sympathetic legislators and wish to shape the legislative history for purposes of future judicial interpretation. According to Scalia, any significant statute will be accompanied by extensive legislative history that will contain statements that potentially support varied and even contradictory understandings of the text. Thus, it is only the enacted statute itself that represents actual Congressional intent. Scalia concludes that if legislative history is abandoned as an interpretive tool, "[j]udges, lawyers, and clients will be saved an enormous amount of [wasted] time and expense." *Id.* at 36.

¹⁵⁸ See Patricia M. Wald, *Some Observations on the Use of Legislative History in the 1981 Supreme Court Term*, 68 IOWA L. REV. 195, 196-98 (1983).

¹⁵⁹ See Gregory E. Maggs, *Reconciling Textualism and the Chevron Doctrine: In Defense of Justice Scalia*, 28 CONN. L. REV. 393, 398 (1996) (noting that Justice Scalia joined the Court during the 1988 term). See also Stephen Breyer, *The 1991 Justice Lester W. Roth Lecture: On the Uses of Legislative History in Interpreting Statutes*, 65 S. CAL. L. REV. 845, 846 (1992) (noting that in the 1990 term, the Supreme Court decided nineteen out of approximately fifty-five statutory cases without the use of legislative history).

¹⁶⁰ See CASS R. SUNSTEIN, *ONE CASE AT A TIME* 224 (1999) (arguing that when terms are ambiguous or provisions are excessively broad, legislative history should be used as an interpretive mechanism because "[w]ords are hard to understand without some conception of their purpose, and the distinction between purpose and intention . . . is thin"). See also

and thus, the ADA's legislative history merits some attention.

The legislative history supports the view that the ADA is intended to govern the content of health insurance policies and to require actuarial or cost-based justification for disability-based distinctions. The issue of insurance is addressed in three committee reports: the Senate Labor and Human Resources Committee report, the House Education and Labor Committee report, and the House Judiciary Committee report.¹⁶¹ Professor Chai Feldblum, one of the authors of the ADA, has stated that the language of the Senate Labor Committee report was "negotiated, line by line, among all parties" including the insurance companies, lawyers for the disability community, and Senate staff.¹⁶² Its value, therefore, cannot be discounted under the theory that it represents the view of only one special interest group that lobbied Congress.¹⁶³

The Senate report states the following:

[W]hile 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.¹⁶⁴

The report further explains that "section 501(c) is intended to afford to insurers and employers the same opportunities they would enjoy in the absence of this legislation to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification."¹⁶⁵ Accordingly, the authors of section 501(c) did not intend it to leave insurers unconstrained in their ability to establish discriminatory benefit exclusions and limitations. Rather, to avoid

Breyer, *supra* note 159, at 848-61 (arguing that reliance upon legislative history is appropriate for five distinct purposes: (1) to avoid absurd interpretive results; (2) to illuminate apparent drafting errors; (3) to elucidate specialized meanings that statutory words may have; (4) to identify the purpose of a law's terminology within the broader statutory context; and (5) to select the most appropriate of several reasonable interpretations of a politically controversial provision.).

¹⁶¹ See Feldblum, *supra* note 70, at 143 n.105.

¹⁶² *Id.* at 113.

¹⁶³ This addresses one of Justice Scalia's primary concerns about legislative history, discussed *supra* note 157.

¹⁶⁴ S. REP. NO. 101-116, at 85 (1989).

¹⁶⁵ *Id.* at 85-86.

violation of the ADA, insurers must utilize accepted actuarial principles or data concerning reasonable cost experience when setting their benefit terms.

Finally, the Senate report explicitly states that the ADA's anti-discrimination mandate applies to insurance plans "regardless of the date an insurance plan or employer benefit plan was adopted."¹⁶⁶ The legislative history, therefore, does not support the view that the *Betts* decision is to apply to the ADA in order to preclude liability with respect to plans adopted before the statute's enactment.

The two House of Representatives reports contain identical language. They provide that any exclusion, limitation, or rate differential in insurance plans must be "based on sound actuarial principles or . . . [be] related to actual or reasonably anticipated experience."¹⁶⁷ They also state that the ADA governs insurance practices regardless of the date of the plan's adoption.¹⁶⁸ Because the legislative history is thoroughly consistent, was co-authored by all interested parties and not by just a single interest group, and clearly explains ambiguous language, it is useful as a tool to interpret section 501(c) and powerfully negates the conclusion of the circuit courts concerning the provision's meaning.

E. Summary

The circuit courts have construed the ADA too narrowly. The plain text of section 501(c), its legislative history, and administrative agency guidance all support the conclusion that the ADA governs the contents of insurance policies and requires insurance providers to justify their disability-based distinctions utilizing valid actuarial principles or cost-related experience.

Nevertheless, the ADA provides only limited protection in the insurance realm to individuals with disabilities. First, the ADA applies only to disability-based distinctions and does not regulate discriminatory terms that affect medical conditions that are not disabilities or that affect a combination of disabilities and non-disabilities.¹⁶⁹ This is a very significant exception because it

¹⁶⁶ *Id.* at 85.

¹⁶⁷ H.R. REP. NO. 101-485, pt. 2, at 137 (1990), *reprinted in* 1990 U.S.C.C.A.N. 420; *id.* pt. 3, at 71, *reprinted in* 1990 U.S.C.C.A.N. 494.

¹⁶⁸ H.R. REP. NO. 101-485, pt. 2, at 136 (1990), *reprinted in* 1990 U.S.C.C.A.N. 419; *id.* pt. 3, at 71, *reprinted in* 1990 U.S.C.C.A.N. 494.

¹⁶⁹ *See Employee Benefits*, *supra* note 72, at 627:0022. *See also* discussion *supra* Part I.B.

eliminates the possibility of successfully challenging many traditional insurance limitations such as those relating to mental health care, eye care, and in-patient hospital days. Second, the ADA does not per se prohibit utilization of disability-based distinctions such as AIDS-caps. Rather, it allows employers to retain discriminatory insurance terms if they can prove a basis for them in sound actuarial principles, past cost experience, or evidence regarding reasonably anticipated benefit claims, so long as there is no evidence that the insurer intended to evade the purposes of the ADA.¹⁷⁰

Finally, employers can avoid all insurance challenges under Title I by not providing employees with health care benefits.¹⁷¹ In the alternative, employers can avoid accusations of discrimination by providing each employee with a set dollar amount to be used towards the purchase of health insurance. This approach is called "defined contribution," and is predicted by some to become increasingly popular in the near future.¹⁷² The ADA may thus

¹⁷⁰ See H.R. REP. NO. 101-485, pt. 2, at 136-37 (1990). See also discussion *supra* Part I.B.

¹⁷¹ See Richard Epstein, *Rationing Access to Medical Care: Some Sober Second Thoughts*, 1 STAN. L. & POL'Y REV. 81, 87 (1991) ("Once employers are told that if they choose to provide any medical care, they must provide a long list of benefits, it may well be that they will choose to provide no one any benefits at all."); see also Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615, 618 (1995) (noting that "employers are not required to provide any health coverage to their workers.").

¹⁷² Julie A. Jacob, *Consumer-Driven Health Plans Could Mean End of Capitation*, AM. MED. NEWS, Aug. 13, 2001, at 15, 18 ("Some sort of consumer-driven, defined-contribution approach is coming."); Lisa Stammer, *Healthcare from a New Perspective: Defined Contribution Plans Will Shift the Focus to Individual Choice and Competition*, HEALTHCARE INFORMATICS, May 2001, at 27. The Stammer article describes different models of defined contributions. Employers could choose to give employees an established dollar amount so that the employee can choose her preferred coverage package and pay any costs that exceed the base amount provided by the employer. Alternatively, employers might identify a variety of health plans and promise employees to pay a base amount directly to the health plan. Employees would be responsible for all costs that exceed that amount or would receive reimbursement if their chosen option costs less than the employer's pledged base amount. Finally, employers can choose to establish medical savings accounts for employees internally, with a financial institution, or with an HMO. See *id.* See also, Linda Havlin & Bill Maloney, *Defining the New Health Care Benefit Models*, EMPLOYEE BENEFIT PLAN REV., Jan. 2001, at 16-18; Paul Fronstin, *Employee-Based Health Benefits: Trends and Outlook*, EBRI ISSUE BRIEF, May 2001, at 20-22; Greg Scandlen, *Everything (and more) You Ever Wanted to Know about Defined Contribution Health Plans, Part II*, HEALTH INS. UNDERWRITER, Jan. 2001, at 48, 54. The Scandlen article notes that defined contributions have several advantages for both employers and employees. Employers can avoid the burdens of choosing and managing health care plans, decrease administrative costs and perhaps increase employee morale by giving workers freedom to choose their own benefit programs. Employees can select from among all options available in the individual market and can customize their benefits according to their needs and preferences. See *id.* at 49-50. Other commentators, however,

create incentives for employers to stop serving as the direct providers of health insurance for the majority of working Americans.¹⁷³

II. TITLE VII AND OTHER ANTI-DISCRIMINATION LAWS

A. Title VII

1. The Statutory Text

Title VII provides, in relevant part, that covered employers may not "discriminate against any individual with respect to . . . compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin."¹⁷⁴ Title VII includes a 1978 amendment known as the Pregnancy Discrimination Act, which prohibits discrimination based on "pregnancy, childbirth, or related medical conditions" and requires that women affected by these conditions receive "benefits under fringe benefit programs" that are equivalent to those given to other employees.¹⁷⁵

Unlike the ADA, Title VII applies only to employment discrimination.¹⁷⁶ Thus, benefits that are provided by employers are regulated by the statute, but those purchased directly from an insurance company are not governed by Title VII.¹⁷⁷ The Supreme Court has stated that because Title VII's anti-discrimination mandate relates only to employment practices and does not directly govern the insurance industry, its application to employer-provided health insurance benefits is not precluded by the

note several disadvantages of defined contributions including (1) the fact that the individual market is more limited and less cost-effective than the group market, (2) that employees may choose to pocket the cash rather than use it to purchase health benefits and thus will join the population of the uninsured, and (3) that employers will lose the tax savings associated with providing insurance benefits to employees. *See id.*

¹⁷³ Approximately 65 percent of Americans under sixty-five receive health insurance benefits through employers. *See Fronstin, supra* note 172, at 4.

¹⁷⁴ 42 U.S.C. § 2000e-2(a)(1) (1994). A covered employer is defined as "a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year." *Id.* § 2000e(b). Several exemptions, however, are established in the provision. *See id.*

¹⁷⁵ *Id.* § 2000e(k). For the full text of the Pregnancy Discrimination Act see *supra* note 12.

¹⁷⁶ 42 U.S.C. § 2000e-2(a)(1).

¹⁷⁷ *See id.*

McCarran-Ferguson Act.¹⁷⁸

Contemporary insurers have eliminated consideration of race, color, religion, and national origin in rate setting and risk classification.¹⁷⁹ Sex-based classifications, however, remain a vigorously disputed practice.¹⁸⁰ Some advocates argue that because sex is an immutable characteristic, gender-based categorization is no less deplorable than race-based classifications and should likewise be abandoned.¹⁸¹ Others contend that actuarial experience reveals cost differentials among males and females, and therefore premium rates and classifications should reflect these economic realities.¹⁸²

While insurers may include consideration of gender in their risk classification practices, employers, under Title VII, are not free to provide unequal benefits to male and female employees. Consequently, gender-based tables may not be used to establish the terms or premium prices of policies that are purchased by employers to effectuate their benefit plans, though they may be used for non-employer-provided policies. The application of Title VII to employer-provided benefits was analyzed by the Supreme Court in three seminal cases.

The case of *Los Angeles Department of Water & Power v. Manhart*¹⁸³ involved an employee group retirement plan that required women to make higher monthly contributions than men in order to receive equivalent monthly pension payments because, according to valid actuarial tables, women generally live longer than men.¹⁸⁴ The Court held that the differential violated Title VII.¹⁸⁵ It reasoned that Title VII prohibited discrimination against individuals and "precludes treatment of individuals as simply components of a racial, religious, sexual, or national class."¹⁸⁶ Thus, although women as a class live longer than men, any particular woman may have a shorter life than the average man's

¹⁷⁸ See *Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1087 n.17 (1983) ("By its own terms, the McCarran-Ferguson Act applies only to the business of insurance and has no application to employment practices."). For a detailed discussion of the McCarran-Ferguson Act, see *supra* Part I.A.

¹⁷⁹ See Leah Wortham, *Insurance Classification: Too Important to Be Left to the Actuaries*, 2 U. MICH. J.L. REFORM 349, 365 (1986); HARNETT & LESNICK, *supra* note 6, § 13.03[1].

¹⁸⁰ See HARNETT & LESNICK, *supra* note 6, § 13.05[6][a].

¹⁸¹ See *id.*

¹⁸² See *id.*

¹⁸³ 435 U.S. 702 (1978).

¹⁸⁴ See *id.* at 704-05.

¹⁸⁵ See *id.* at 717.

¹⁸⁶ *Id.* at 708.

and, consequently, female employees could not be forced to make higher monthly payments solely by virtue of their gender.¹⁸⁷

A similar case, *Arizona Governing Committee v. Norris*,¹⁸⁸ involved Arizona's voluntary pension plan under which all of the companies selected by the state to participate in the plan used sex-based mortality tables and paid women lower monthly retirement benefits than they paid men who had made equivalent contributions.¹⁸⁹ The Court noted that gender was the only consideration used to classify individuals of the same age without regard to other factors affecting longevity, such as smoking, alcohol use, and weight.¹⁹⁰ Citing its *Manhart* decision, the Court declared that the practice was unlawful under Title VII.¹⁹¹

Finally, in *Newport News Shipbuilding and Dry Dock Co. v. EEOC*,¹⁹² the Supreme Court addressed a health insurance term that provided unequal maternity benefits for female employees and the spouses of male employees.¹⁹³ While female employees received hospitalization benefits for pregnancy-related conditions that were equivalent to hospitalization benefits for other medical conditions, the wives of male employees received less extensive coverage.¹⁹⁴ The Court found that the health insurance plan was unlawfully discriminatory because it gave "married male employees a benefit package for their dependents that . . . [was] less inclusive than the dependency coverage provided to married female employees."¹⁹⁵

It follows from these Supreme Court cases that in order to prove a Title VII violation, a plaintiff must make a direct comparison between the benefits received by men and women and show that in some respect the insurance coverage available to one

¹⁸⁷ *See id.*

¹⁸⁸ 463 U.S. 1073 (1983).

¹⁸⁹ *See id.* at 1077. Employees participating in the plan could postpone the receipt of a portion of their earnings until after retirement, thereby delaying the payment of federal income taxes on their wages. Arizona invited private companies to submit bids and describe the investment opportunities they would offer the state employees. It then selected several companies from among them to participate in the program. Employees subsequently chose one of the available companies and decided how much money they wished to defer each month. The state withheld the money from the employees' paychecks, channeled it to the designated companies, and administered the plan. *See id.* at 1076-77.

¹⁹⁰ *See id.* at 1077.

¹⁹¹ *See id.* at 1080-84.

¹⁹² 462 U.S. 669 (1983).

¹⁹³ *See id.* at 672-73.

¹⁹⁴ *See id.*

¹⁹⁵ *Id.* at 684 (referring specifically to the Pregnancy Discrimination Act in reaching its conclusion).

gender is inferior to that available to the other sex. Jennifer Erickson was able to do just that when she challenged her plan's refusal to cover prescription contraceptives.¹⁹⁶ Citing the *Newport News* decision, the court emphasized that "equality under Title VII is measured by evaluating the relative comprehensiveness of coverage offered to the sexes."¹⁹⁷ Accordingly, the court found that a prescription plan's exclusion of reimbursement for medication that can be used only by women constitutes sex discrimination under Title VII.¹⁹⁸ It explained: "the exclusion of prescription contraceptives . . . reduces the comprehensiveness of the coverage offered to female employees while leaving the coverage offered to male employees unchanged."¹⁹⁹

The analytical soundness of the *Erickson* decision, however, is open to criticism. The plaintiff did not make a direct comparison between prescription contraceptives, for which coverage was denied to women, and a comparable medication that was covered for men. In fact, there are no prescription contraceptives for men at the present time. Furthermore, at least arguably, the denial of coverage affects men and women equally, since the woman and her partner must choose an alternate form of birth control or perhaps pay for the pill out of pocket.²⁰⁰ The court's decision revolved around the somewhat tenuous argument that the employer's plan provided complete prescriptive drug coverage for men²⁰¹ and incomplete coverage for women because it denied benefits for one medication that many women choose to utilize. It is not clear, however, that future courts will follow this precedent.

By contrast to the *Erickson* case, in *Kraul v. Iowa Methodist Medical Center*,²⁰² the court found that an employer-provided plan's exclusion of treatment for infertility did not violate Title VII.²⁰³ The court reasoned that when a couple is unable to have a

¹⁹⁶ See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1276-77 (W.D. Wash. 2001).

¹⁹⁷ *Id.* at 1271.

¹⁹⁸ See *id.* at 1271-72.

¹⁹⁹ *Id.* at 1275.

²⁰⁰ See *Kraul v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996) (finding no violation of Title VII with respect to denial of coverage for infertility treatments because it affects men and women equally). While many women who seek oral contraceptives are unmarried and may be solely responsible for their birth control needs, some women seeking fertility treatments will also be unmarried and seeking to start families on their own for a variety of reasons.

²⁰¹ According to both parties, the court acknowledged that the prescription plan did not cover Viagra. However, the court stated only that this exclusion may also violate Title VII and left this determination to other courts that will be faced with the issue. See *Erickson*, 141 F. Supp. 2d at 1275.

²⁰² 95 F.3d 674 (8th Cir. 1996).

²⁰³ See *id.* at 681.

child, they are both affected by the infertility and must bear the cost of treatment, regardless of which one is infertile. It determined that the plaintiff had failed to present statistical evidence demonstrating that “female participants in IMMC’s medical plan and their dependent spouses incurred a disproportionate amount of the cost of infertility treatments as compared with male Plan participants and their dependent spouses.”²⁰⁴

It should be noted that plaintiff’s claim was based on a disparate impact theory, alleging that the exclusion of reimbursement for procedures to treat infertility had a greater adverse effect for women than it did for men.²⁰⁵ Unlike the ADA, Title VII allows plaintiffs to make disparate impact claims relating to health insurance coverage.²⁰⁶ In order to overcome a disparate impact challenge, an employer must show that the insurance term in question is justified by a factor other than sex, such as business necessity²⁰⁷ or generally accepted medical criteria.²⁰⁸

²⁰⁴ *Id.* See also *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318 (S.D.N.Y. 2000) (dismissing plaintiff’s Title VII and PDA claims relating to her plan’s exclusion of coverage for infertility treatments).

²⁰⁵ See *Krauel*, 95 F.3d at 681. For an explanation of the disparate impact theory see *supra* Part I.B.3.

²⁰⁶ See *Wambheim v. J.C. Penney Co.*, 705 F.2d 1492, 1494 (9th Cir. 1983) (concluding that “disparate impact analysis is appropriate” in a Title VII case challenging an employer’s “head of household” policy of allowing employees to obtain coverage for their spouses only if the employee earned more than half of the couple’s combined wages). See also *EEOC v. J.C. Penney Co.*, 843 F.2d 249, 252 (6th Cir. 1988) (using disparate impact analysis to challenge defendant’s “head of household” rule); *Employee Benefits*, *supra* note 72, at 627:0026 (noting that EEOC guidelines allow for the use of the disparate impact theory in Title VII cases).

In ADA cases, the use of the disparate impact theory is inappropriate because insurance terms that are facially neutral and affect both people with disabilities and people without disabilities are not disability-based distinctions and therefore are not covered by the ADA. See discussion *supra* Part I.B.4. ADA analysis is complicated by the threshold questions of whether the plaintiff is an individual with a disability and whether the challenged term is a disability-based distinction. By contrast, Title VII analysis is simpler. All individuals are entitled to statutory protection so long as they have suffered discrimination because of their race, color, religion, sex, or national origin. Consequently, insurance terms that are facially neutral and are applicable to both sexes, but impact one gender to a greater extent than the other, may violate the statute.

²⁰⁷ See *Wambheim*, 705 F.2d at 1495 (finding the “head of household” rule justified by the employer’s policy of keeping insurance costs as low as possible for all employees); *J.C. Penney Co.*, 843 F.2d at 254 (holding that the “head of household” rule is justified because the defendant “wanted the biggest “bang for the buck” with its benefit package, and adopted this plan for that reason.”). A head of household provision allows an employee to choose coverage for a spouse only if the employee earns more than the spouse. *Id.* at 250.

²⁰⁸ See *Employee Benefits*, *supra* note 72, at 627:0026-27 (depicting as an example, an employer that excludes coverage for “experimental treatments” and stating that such an employer may refuse to reimburse a breast cancer patient for a bone marrow transplant if

In *Reger v. Espy*,²⁰⁹ the plaintiff, like Ms. Kraul, failed in her attempt to challenge a plan provision utilizing the disparate impact theory. She alleged that her employer violated Title VII when its insurance plan excluded from coverage high dose chemotherapy and autologous bone marrow transplant (“HDC-ABMT”) to treat breast cancer because the exclusion had a disparate impact on women.²¹⁰ The court found that the plan refused to provide reimbursement for HDC-ABMT for most diagnoses, other than five specific cancers.²¹¹ The exclusion therefore affected both men and women, and the plaintiff failed to prove her disparate impact case.²¹²

2. Legislative History and EEOC Guidelines

The prohibition against discrimination based on gender was added to Title VII on the last day of debates in the House of Representatives,²¹³ and very little legislative history exists concerning the provision.²¹⁴ The legislative history, therefore, is not enlightening with respect to the applicability of Title VII’s original prohibition on sex discrimination to health insurance benefits.

More expansive legislative history exists concerning Title VII’s 1978 amendment, the PDA. The record asserts, for example, that the PDA does not dictate that employers must provide hospital coverage for delivery.²¹⁵ However, if an employer generally offers reimbursement for medical costs, it must provide

it can prove that it used generally accepted medical criteria to conclude that the procedure is experimental).

²⁰⁹ 836 F. Supp. 869 (N.D. Ga. 1993).

²¹⁰ *See id.* at 870, 872.

²¹¹ *See id.* at 872.

²¹² *See id.* Several international clinical trials that were completed a number of years after the decision was issued showed that HDC-ABMT is not effective in prolonging the life of breast cancer patients. *See* Patricia C. Kuszler, *Financing Clinical Research and Experimental Therapies: Payment Due, But From Whom?*, 3 DEPAUL J. HEALTH CARE L. 441, 459-60 (2000).

²¹³ The gender classification was proposed by Representative Smith of Virginia, who voted against the Civil Rights Act. He apparently hoped to “clutter up” Title VII and increase general opposition to it so that it would not be passed. *See* 110 CONG. REC. 2577-84 (1964); *see also* *Bujel v. Borman Food Stores, Inc.*, 384 F. Supp. 141, 144 n.4 (E.D. Mich. 1974).

²¹⁴ *See Meritor Sav. Bank v. Vinson*, 477 U.S. 57, 63-64 (1986); *see also* Marcelo L. Riffaud, *Fetal Protection and UAW v. Johnson Controls, Inc.: Job Openings for Barren Women Only*, 58 FORDHAM L. REV. 843, 845 (1990).

²¹⁵ 123 CONG. REC. 29,642 (1977).

reimbursement on the same basis for expenses related to pregnancy, delivery, and related conditions.²¹⁶ The legislative history asserts that the law requires that “pregnant women be treated the same as other employees on the basis of their ability or inability to work.”²¹⁷

The EEOC has issued guidance concerning the application of Title VII and the PDA to health insurance benefits.²¹⁸ The EEOC guidelines explain that employers cannot provide different coverage to males and females if the underlying condition affects both men and women or if the treatment or diagnostic method is available for both genders.²¹⁹ The guidelines emphasize that disparate impact analysis is available to Title VII plaintiffs and that employers must offer the same terms of coverage for treatment during pregnancy, delivery, and “related medical conditions” as for other treatments.²²⁰

According to its statutory language, caselaw, legislative history, and administrative guidance, Title VII prohibits employer-provided insurance plans from adopting coverage distinctions based on gender and pregnancy-related conditions. A plaintiff who cannot show a direct disparity will not be able to prove a statutory violation. Moreover, since Title VII applies only to employer-provided insurance plans, its effect on the insurance industry as a whole is limited. Finally, employers can avoid accusations of insurance discrimination under Title VII by offering employees no insurance benefits or by providing defined contributions and thus avoiding involvement with the specific terms of the employees’ insurance policies.²²¹

B. *The Equal Pay Act*

The Equal Pay Act (“EPA”)²²² requires, in general terms, that employers pay equal wages to men and women for equal work²²³ and applies to fringe benefits as a component of employees’ compensation packages.²²⁴ EPA claims involve exclusively gender

²¹⁶ See *id.*; see also S. REP. NO. 95-331 (1977).

²¹⁷ S. REP. NO. 95-331 (1977).

²¹⁸ *Employee Benefits*, *supra* note 72, at 627:0025- 28.

²¹⁹ See *id.* at 627:0026.

²²⁰ *Id.* at 627:0026-27.

²²¹ See discussion *supra* Part I.E.

²²² 29 U.S.C. §§ 206-19 (1994 & Supp. 1998).

²²³ *Id.* § 206.

²²⁴ *Employee Benefits*, *supra* note 72, at 627:0025 n.87; *EEOC v. Fremont Christian*

discrimination and are most often brought together with Title VII claims.²²⁵ EPA plaintiffs must show a coverage disparity between the insurance benefits available to men and women in equivalent jobs, and therefore the analysis of EPA claims is very similar to the analysis of cases brought under Title VII.²²⁶ A large number of EPA cases, however, are dismissed because plaintiffs fail to prove that their work was in fact equivalent to that of the members of the opposite gender to which they are comparing themselves.²²⁷ Furthermore, like Title VII, the EPA applies only to employer-provided health insurance and not to the health insurance industry at large.²²⁸ Consequently, it is similarly limited in the extent to which it protects the American public against discrimination in health insurance.

C. *The Age Discrimination in Employment Act*

The Age Discrimination in Employment Act ("ADEA")²²⁹ prohibits employment discrimination based on age²³⁰ and protects individuals who are 40 years old or older.²³¹ The ADEA is similar to Title VII in terms of language, structure, purpose, and analysis.²³² The statute, however, does not require that employers

School, 781 F.2d 1362, 1367 (9th Cir. 1986).

²²⁵ See, e.g., *Fremont Christian School*, 781 F.2d at 1362; *Wambheim v. J.C. Penney Co., Inc.*, 705 F.2d 1492, 1493 (9th Cir. 1983); *Willett v. Emory and Henry College*, 427 F. Supp. 631, 632 (W.D. Va. 1977); *Taylor v. Franklin Drapery Co.*, 441 F. Supp. 279, 281 (W.D. Mo. 1977); *Beavers v. Am. Cast Iron Pipe Co.*, 751 F. Supp. 956, 958 (N.D. Ala. 1990).

²²⁶ See *Employee Benefits*, *supra* note 72, at 627:0025 n.87 (discussing Title VII and stating that "the same basic principles apply to charges of gender discrimination brought under the EPA").

²²⁷ See e.g., *Wolf v. Northwest Indiana Symphony*, 250 F.3d 1136 (7th Cir. 2001) (granting employer's motion for summary judgment in part because the plaintiff conceded that the female employees to whom he compared himself had different job duties than he); *Beavers*, 751 F. Supp. at 966 ("Mr. Beavers has not even attempted to point to a female who performed substantially equal work as did he"); *Jensen v. Kellings Fine Foods*, 1987 U.S. Dist. LEXIS 7221, at *23 (D. Kan. 1987) ("[P]laintiff has failed to meet her burden of showing that work she performed in the beauty aids and housewares department was substantially equal to that of the department heads").

²²⁸ 29 U.S.C. § 206 (1994 & Supp. 1998).

²²⁹ *Id.* §§ 621-34.

²³⁰ *Id.* § 623(a). The provision reads in relevant part:

(a) It shall be unlawful for an employer-

(1) to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age.

Id.

²³¹ *Id.* § 631(a).

²³² See HARNETT & LESNICK, *supra* note 6, § 13.04[2][a]; *Morelock v. NCR Corp.*, 546

offer older employees health insurance benefits that are equivalent to those available to younger workers. Rather, it mandates only that employers spend equal amounts of money or incur equal costs for insurance benefits provided to older and younger members of the workforce.²³³ This provision is based on the fact that the cost of health insurance benefits generally rises as an employee's age advances because people's health deteriorates as they grow older.²³⁴ The ADEA, therefore, does not comprehensively regulate the contents of health insurance plans and does not require that individuals in different age categories be offered benefits that are substantively equivalent. Furthermore, like Title VII and the EPA, it governs only employer-provided health insurance. The ADEA, consequently, provides older Americans with very limited protection against age discrimination in health insurance.

D. *The Health Insurance Portability and Accountability Act*

In 1996, Congress passed the Health Insurance Portability and Accountability Act ("HIPAA").²³⁵ HIPAA requires that all group

F.2d 682, 686 (6th Cir. 1976), *cert. denied*, 441 U.S. 906 (1979) ("The prohibitions of the ADEA are in terms virtually identical to those of Title VII of the Civil Rights Act of 1964, except that 'age' has been substituted for 'race, color, religion, sex or national origin.'") (internal citation omitted). However, some courts have held that disparate impact claims may not be brought under the ADEA. *See, e.g., Adams v. Florida Power Corp.* 255 F.3d 1322, 1324 (11th Cir. 2001) (disallowing a disparate impact claim under the ADEA). The Eleventh Circuit noted that: "The Second, Eighth, and Ninth Circuits allow disparate impact claims under the ADEA. The First, Third, Sixth, Seventh, and Tenth do not." *Id.*

²³³ 29 U.S.C. § 623(f)(2)(B)(i). The provision reads in relevant part:

(f) It shall not be unlawful for an employer, employment agency, or labor organization . . .

(B) to observe the terms of a bona fide employee benefit plan-

(i) where, for each benefit or benefit package, the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker.

Id.

It should also be noted that under Medicare law, an employer must offer its Medicare-eligible employees the same health benefits that it offers similarly situated employees under the age of 65. *See* 42 U.S.C. § 1395y(b)(1)(A)(i) (Supp. 2001). Thus, an employer may not take the availability of Medicare into account when establishing an employee's health benefits. *See also Erie County Retirees Ass'n. v. County of Erie, Pa.*, 220 F.3d 193, 197-98, 216 (3d Cir. 2000) (finding that a defendant who offered Medicare-eligible retirees health insurance benefits that were inferior to those provided to retirees who were not eligible for Medicare was not entitled to summary judgment unless the defendant could show that it could meet the equal benefit or equal cost standard).

²³⁴ *Employee Benefits*, *supra* note 72, at 627:0006.

²³⁵ 42 U.S.C. §§ 300gg-300gg-92 (1994 & Supp. 2001).

health plans limit to no more than twelve months their period of excluded coverage for preexisting conditions; that is, conditions for which medical advice, diagnosis, care, or treatment was recommended or received in the prior six months.²³⁶ HIPAA's portability provisions guarantee that individuals covered by group insurance at one employer for eighteen continuous months will be granted access to any group policy offered by a new employer.²³⁷

Furthermore, HIPAA requires insurers operating in the small-group market²³⁸ to guarantee issue of all the products they offer in the small-group market to all small groups, and, in any group, all eligible members of the group must be offered enrollment, regardless of their health status.²³⁹ In addition, a group health plan may not require any member of a group to pay a higher premium than other members of the group because of a healthstatus-related factor.²⁴⁰ The statute requires all group carriers, in both large and small group markets, to guarantee renewal of their products.²⁴¹

HIPAA also reaches individual health insurance policies. It guarantees the portability of group insurance to individual insurance for certain individuals²⁴² and requires that all individual policy coverage be guaranteed renewable.²⁴³ The statute does not restrict the amount of premium that an insurer may charge a

²³⁶ *Id.* § 300gg(a). In the case of a late enrollee, the period of excluded coverage may be extended to 18 months. *Id.* In addition, group insurers must generally credit enrollees for any time during which they were previously excluded from coverage because of a preexisting condition exclusion that was applied to them by a previous insurer. *Id.* §§ 300gg(a), (c).

²³⁷ *Id.* § 300gg-11. This portability requirement is designed to alleviate the concerns of employees who were reluctant to leave current jobs for fear that they will be denied health insurance by future employers due to preexisting conditions. See Len M. Nichols & Linda J. Blumberg, *A Different Kind of 'New Federalism'? The Health Insurance Portability and Accountability Act of 1996*, 17 HEALTH AFFAIRS 25, 27 (1998).

²³⁸ A small-group market is defined as consisting of two to fifty employees. 42 U.S.C. § 300gg-91(e)(4), (5).

²³⁹ *Id.* § 300gg-11. More specifically, HIPAA provides that insurers offering group insurance may not base rules of eligibility for enrollment on any of the following factors: health status, physical or mental illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. *Id.* § 300gg-1(a).

²⁴⁰ *Id.* § 300gg-1(b).

²⁴¹ *Id.* § 300gg-12.

²⁴² *Id.* § 300gg-41. Individuals are eligible under the following conditions: 1) they have had eighteen months of continuous prior coverage with no coverage gap lasting longer than sixty-two days and have most recently had group coverage; 2) they have exhausted any COBRA benefits available to them and have no current access to group insurance or a public program; and 3) they are eligible for some type of guaranteed issue coverage in the individual market. *Id.* § 300gg-41(b).

²⁴³ *Id.* § 300gg-42.

person purchasing an individual policy.²⁴⁴ The absence of regulation in this area is significant. A recent study found a vast range of annual premiums in the individual market extending from \$408 to \$30,000, with an average of \$2,998 per year for healthy single people and \$3,996 for those with medical problems.²⁴⁵

HIPAA enhanced protection for health insurance beneficiaries by reducing health insurers' ability to select risks. However, it still allows them considerable discretion to engage in risk classification. Insurers may charge different groups different premiums in the group market, and individuals purchasing policies in the individual market may also be charged vastly different rates. In addition, the statute does not address limitations and exclusions of coverage for particular treatments. The statute, therefore, does not provide comprehensive protection to health insurance consumers and allows insurers to exercise discretion in many areas.

III. CONCLUSION

Numerous federal anti-discrimination laws address the issue of health insurance coverage. One would therefore assume that they provide extensive and thorough protection against disability, gender, and age discrimination in insurance practices. This, however, is not the case. Several of the laws apply only to employer-provided insurance benefits.²⁴⁶ Some create significant defenses for insurers, which allow them to justify discriminatory benefit terms.²⁴⁷ Thus, insurers can establish AIDS caps, can refuse to cover hearing aids, can often drastically limit or exclude coverage for mental health care,²⁴⁸ and can offer older employees far less insurance coverage than that available to younger workers. Moreover, none of the civil rights laws protect people on the basis of economic status, which is often the most significant determinant of the level of insurance obtainable by individuals. Consequently, we have in the United States 42.6 million uninsured people who

²⁴⁴ *Id.* § 300gg-41(g)(1).

²⁴⁵ See Geri Aston, *Individual Market Tough for Many Insurance Buyers*, AM. MED. NEWS, July 9, 2001, at 14.

²⁴⁶ These laws include Title VII, the EPA, and the ADEA. See discussion *supra* Part II.

²⁴⁷ See, e.g., American with Disabilities Act § 501(c), 42 U.S.C. § 12201(c) (1994); *id.* § 4(f), 29 U.S.C. § 623(f)(2)(B)(i) (1994 & Supp. 1999).

²⁴⁸ See discussion of Mental Health Parity Act, *supra* Part I.B.3. The Act expired on September 30, 2001. 42 U.S.C. § 300gg-5(f).

are not eligible for Medicaid or Medicare coverage.²⁴⁹ The federal statutory scheme that is designed to combat discrimination is fraught with large and troubling gaps in the arena of health insurance.

Several approaches can be utilized to enhance protection for insurance beneficiaries. First, additional federal statutes could be passed to prohibit discriminatory insurance practices. Federal regulation that requires increasingly extensive coverage while leaving the private insurance system otherwise unchanged, however, could ultimately harm rather than help the American public. With additional coverage requirements, insurance companies would likely continue to raise premiums in order to maintain profitability, making insurance unaffordable for many individuals. Furthermore, ever-increasing insurance costs could induce employers to stop providing health insurance to their employees, because employers are not required by law to provide insurance benefits.²⁵⁰

Federal law is also often ambiguous with respect to its applicability to health insurance. The statutes have generated considerable litigation, which is costly for plaintiffs, defendants, and taxpayers.²⁵¹ Inconsistent decisions issued by different courts also may cause confusion for insurers seeking judicial guidance concerning insurance terms. Federal anti-discrimination laws are the product of extensive lobbying and political compromise. Consequently, they often contain equivocal and imprecise language, which is open to varying interpretations.²⁵²

Finally, because legislation is often a response to public pressure and political concern, it does not necessarily assist all those in need.²⁵³ Groups with strong lobbyists or prominent

²⁴⁹ See Aston, *supra*, note 245, at 14; see also Randall R. Bovbjerg & Frank C. Ullman, *Health Insurance and Health Access*, 22 J. LEG. MED. 247, 247 (2001). Other estimates range from 42.1 million uninsured (in 1999) to 44 million uninsured (in 2000). See Steven A. Schroeder, *Prospects for Expanding Health Insurance Coverage*, 344 NEW ENG. J. MED. 847, 847 (2001); see also Stephen Blakely, *The Economic Costs of the Uninsured*, EBRI NOTES, Aug. 2000, at 1. Over 80% of the uninsured are from families in which at least one member is employed, and almost two thirds are under the age of 35. More than half are in families whose incomes fall below 200% of the federal poverty level, that is, less than \$34,100 for a family of four. See Schroeder, *supra*, at 847.

²⁵⁰ See Lenhart, *supra* note 171, at 618 (“[E]mployers are not required to provide any health coverage to their workers”); see also Blakely, *supra* note 249, at 1 (“Employers are not legally required to provide coverage to their workers, and individuals are not legally required to maintain coverage”).

²⁵¹ See cases discussed *supra* Parts I-II.

²⁵² See SCALIA, *supra* note 92, at 34 (discussing the involvement of lobbyists in Congressional floor debates).

²⁵³ See *id.*

representatives might succeed in promulgating legislation that benefits their special interest, while equally deserving groups may fail because of much weaker lobbying abilities and less prominence.²⁵⁴

In the alternative, additional regulation of health insurance coverage could be left to the states. Many states have in fact tried to address specific problems of discrimination by mandating coverage for particular treatments. Almost 1000 different state mandates concerning health insurance coverage have been issued by state legislatures.²⁵⁵ State mandates, however, also provide only a very partial solution.

First, state mandates will not protect patients enrolled in self-funded employee benefit plans²⁵⁶ because under a federal law called the Employee Retirement Income Security Act ("ERISA"),²⁵⁷ state laws regulating insurance are preempted with respect to self-funded plans and cannot be enforced.²⁵⁸ This exception is quite consequential because a growing number of employers are self-insured.²⁵⁹ In addition, state legislation, like federal legislation, can lead to the problems of rising insurance

²⁵⁴ In 1998, for example, Congress enacted the Women's Health and Cancer Rights Act of 1998. 29 U.S.C. § 1185(b) (Supp. 2001). The Act requires all group health plans and health insurance issuers offering coverage for mastectomies to provide reimbursement for reconstructive surgery that is associated with a mastectomy. Patients suffering from other cancers, however, have not achieved the passage of legislation that addresses their specific coverage issues. *See id.*

²⁵⁵ *See* United States General Accounting Office Report to the Honorable James M. Jeffords, U.S. Senate, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance* GAO/HEHS-96-161 (1996), at 9 (noting that "[o]n average, states have enacted laws mandating about 18 specific benefits"); *New Study Shows 992 Mandated Benefits in the States*, MED. BENEFITS, Sept. 30, 1991, at 6; Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 2 (1999) (citing Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, HEALTH AFF. Nov.-Dec. 1997, at 26, 30).

²⁵⁶ Employers who choose self-funded plans pay their employees' medical claims on their own rather than contracting with a commercial insurer that collects premiums and serves as a third party payer. Every medical claim translates into an out-of-pocket expense for these employers. They are therefore known as self-insured employers. *See* Mark A. Rothstein, *The Law of Medical and Genetic Privacy in the Workplace*, in GENETIC SECRETS: PROTECTING PRIVACY AND CONFIDENTIALITY IN THE GENETIC ERA 281, 293 (Mark A. Rothstein ed., 1997).

²⁵⁷ 29 U.S.C. §§ 1001-461.

²⁵⁸ *See* Sharona Hoffman, *A Proposal for Federal Legislation to Address Health Insurance Coverage for Experimental and Investigational Treatments*, 78 OR. L. REV. 203, 41-243 (1999); *see also* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) ("We read the . . . [statute] to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance.'").

²⁵⁹ *See* Rothstein, *supra* note 256, at 293. In 1993, 93 percent of employers with more than 40,000 employees were self-insured, as were 85 percent of employers with 5,000-40,000 employees, and 37 percent of those with 50-199 employees. *See id.*

costs, litigation due to ambiguous drafting, and piecemeal responses to lobbying from powerful interest groups or to high profile cases.²⁶⁰

A third approach is governmental intervention in the form of a centralized, publicly accountable agency that would establish an extensive, nationally binding health care coverage mandate. Many other industries are already regulated by powerful administrative agencies. For example, the Federal Aviation Administration ("FAA") regulates the aviation industry,²⁶¹ the Environmental Protection Agency ("EPA") regulates activities that affect the environment,²⁶² and the Food and Drug Administration ("FDA") regulates food and drug products.²⁶³ There is no reason why the health insurance industry should not be subject to similar governmental oversight.

Construction of a detailed model for such an agency is beyond the scope of this paper.²⁶⁴ However, it is important to emphasize that the regulatory entity should make its decisions in light of current scientific research, medical outcome data, and patient preferences, with input from patients, physicians, researchers, research sponsors, and insurers. Moreover, it should focus on the global cost of the coverage requirements it designs in order to create a benefits package that is responsive to both patient needs and the reality of finite economic resources.

²⁶⁰ The point is illustrated clearly by an Assembly Insurance Committee Statement regarding a New Jersey law that mandates reimbursement for the treatment of Wilm's tumor by high dose chemotherapy and an autologous bone marrow transplant. N.J. STAT. ANN. § 17:48-6f note (West 1996) (Assembly Insurance Committee Statement). It states in relevant part: This bill has been referred to as the "Tishna Rollo Bill." Tishna Rollo is an eight-year-old Glen Ridge girl who is battling Wilm's tumor, a rare form of cancer which generally affects the kidneys before spreading to other parts of the body. Recently, Tishna's case has received much attention because her doctors have concluded that the transplants are the one chance they have to cure her disease, yet her family's health insurer initially refused to provide coverage for the treatment because it asserted that such treatment was not covered in her health insurance contract as it is considered "experimental" or "investigational." Court action on this issue is pending. This bill will eliminate the controversy surrounding the treatment and, in effect, absolve health insurers, and ultimately the courts, of the responsibility of making any determination regarding this issue. *Id.*

²⁶¹ See 49 U.S.C. § 106 (1994 & Supp. 1997).

²⁶² See 42 U.S.C. § 4321 (1994) (Reorganization plans, Section 1).

²⁶³ See 21 U.S.C. § 393 (1994 & Supp. 1999).

²⁶⁴ For further discussion see Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage* (submitted for publication in the spring of 2002).

Additional piecemeal federal and state legislation will not effectively solve the problem of discrimination in health insurance coverage. Without a national benefits package, we will continue to have hearing impaired individuals who cannot afford hearing aids and people with AIDS who cannot obtain needed treatment. It is only with oversight and regulation by a centralized, publicly accountable governmental agency that we can begin to tackle the challenge of enhancing protection for health insurance beneficiaries.