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Fear, Discrimination and Dying in the Workplace: AIDS and the Capping of Employees' Health Insurance Benefits

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NOTES

Fear, Discrimination and Dying in the Workplace:[1] AIDS and the Capping of Employees' Health Insurance Benefits

"Most significantly, there were the first glimmers of awareness that the future would always contain this strange new word. AIDS would become a part of American culture and indelibly change the course of our lives."[2]

INTRODUCTION

The year 1981 saw the first reported case of acquired immunodeficiency syndrome ("AIDS") in the United States.[3] As of September 30, 1992, at least 242,146 cases of AIDS and 160,372 deaths from AIDS had been reported to the United States Center for Disease

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[1] The title was borrowed from a statement by Lee Smith, chairman of the National Leadership Coalition on AIDS, as quoted in Ron Stodghill II, *Managing AIDS: How One Boss Struggled to Cope*, BUS. WK., Feb. 1, 1993, at 48 ("I was not trained to manage fear, discrimination, and dying in the workplace.").

[2] RANDY SHILTS, AND THE BAND PLAYED ON xxi (1987).

[3] Willie L. Brown, Jr., *AIDS: The Public Policy Imperative*, 7 ST. LOUIS U. PUB. L. REV. 11, 11 (1988). There is, however, some evidence that isolated outbreaks of AIDS occurred in the United States prior to 1981. *See* Mary C. Dunlap, *AIDS and Discrimination in the United States: Reflections on the Nature of Prejudice in a Virus*, 34 VILL. L. REV. 909, 910 n.6 (1989) (recounting the story of doctors finding the AIDS virus in blood samples and tissues of a fifteen-year old African American who died in St. Louis, Missouri, in 1969) (citing Crewdson, *AIDS Thought to Be Cause of 1969 Death*, SAN FRANCISCO EXAMINER, Oct. 25, 1987, at A1); Marc J. Sicklick & Ayre Rubinstein, *A Medical Review of AIDS*, 14 HOFSTRA L. REV. 5, 6 (1985) (speculating that the first case in the United States may have occurred in 1977); *id.* at 6 n.12 (noting that the first manifestation of AIDS may have been in 1959 when a Haitian man in Brooklyn developed a pneumocystic carinii pneumonia).

Control and Prevention ("CDC").[4] Additionally, the CDC estimates that approximately one million Americans have been infected by the Human Immunodeficiency Virus ("HIV").[5] Of this group, some estimates indicate

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[4] *See, e.g., Health Officials Discuss Guidelines for Reporting AIDS*, UPI, Jan. 27, 1993, *available in* LEXIS, Nexis Library, Current File (indicating that by 1995 the AIDS death toll will be at least 330,000, while between 515,000 and 635,000 will have been diagnosed as having AIDS); Amanda Husted, *330,000 Americans Will Die from AIDS by 1995*, ATLANTA J. & CONST., Jan. 15, 1993, at D3. These projections take into account the CDC's recently expanded definition of AIDS. *See infra* note 5.

[5] *Update: Public Health Surveillance for HIV Infection–United States, 1989 and 1990*, 39 MORBIDITY & MORTALITY WKLY. REP. 853, 853 (1990). HIV is the virus that ultimately causes AIDS. *See, e.g.*, AIDS COORDINATION COMM., AMERICAN BAR ASSOCIATION, AIDS: THE LEGAL ISSUES 8 (Discussion Draft 1988) [hereinafter ABA AIDS REPORT].

According to current CDC classification schemes, there are four stages of HIV infection. *See id.* at 12. The first stage, which frequently occurs shortly after infection, involves "a short-term febrile illness with symptoms of acute infection." *Id.* The second stage is asymptomatic HIV infection during which the infected person shows no signs of infection. *Id.* The third stage is characterized by a compromising of the immune system; however, the symptoms may vary from no more than persistently swollen lymph glands to diarrhea, night sweats, weight loss, shortness of breath, malaise and persistent fever. *Id.* The final stage is AIDS, which is defined as HIV infection coupled with certain opportunistic infections. *Id. See also* DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR DISEASE CONTROL, *Update: Acquired Immunodeficiency Syndrome–United States, 1981-1988*, 38 MORBIDITY & MORTALITY WKLY. REP. 229, 229 (1989), *reprinted in* REPORTS ON HIV/AIDS: JANUARY-DECEMBER 1989 15, 15 (1990) (defining AIDS). The CDC further categorizes persons within the fourth stage according to the types of symptoms that they presently exhibit. *See* ABA AIDS REPORT, *supra*, at 12. HIV infection is also frequently classified as a three-stage, syndrome–asymptomatic HIV infection, AIDS-related complex and acute AIDS. *See, e.g.*, Joyce N. Hoffman & Elizabeth Z. Kincaid, *AIDS: The Challenge to Life and Health Insurers' Freedom of Contract*, 35 DRAKE L. REV. 709, 713-15 (1987). The only difference in these two classification systems is the latter's absence of short-term febrile illness.

As of January 1, 1993, the CDC uses an expanded definition of AIDS. *See 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MORBIDITY & MORTALITY WKLY. REP.: RECOMMENDATIONS AND RPTS. 1, 6 (1992); *AIDS Surveillance Case Definition*, 268 JAMA 2634, 2634 (1992). This revised definition, when coupled with HIV infection, increases from twenty-three to twenty-six the total number of opportunistic infections that constitute AIDS. *AIDS Surveillance Case Definition*, *supra*, at 6. The three new infections are pulmonary tuberculosis, HIV-related severe immunosuppression and invasive cervical cancer. *Id.* at 6-7. The CDC's inclusion of persons suffering from HIV-related severe immunosuppression (i.e., those HIV-infected persons with CD4+ T-lymphocyte counts less than 200 cells per cubic milliliter of blood, *id.* at 6) will significantly increase the number of persons diagnosed with AIDS. *See* Center for Disease Control and Prevention, *Projections of the Number of Persons Diagnosed with AIDS and the Number of Immunosuppressed HIV-Infected Persons–United States, 1992-1994*, 269 JAMA 733, 733

that as many as half will develop AIDS within two to ten years of becoming infected.[6] The true horror of these numbers becomes clear with the recognition that virtually all AIDS patients die within five years of diagnosis.[7]

In addition to the toll in human lives, AIDS continues to extract a great economic cost. The most devastating cost of AIDS may be health care.[8] The average lifetime health care costs per AIDS victim ranges between $75,000 and $85,000.[9] Moreover, as medical technology increases the life expectancy of HIV-infected persons, the health care costs associated with HIV will also increase.[10] Since the magnitude of these costs would deplete most victims' personal resources,[11] the usual sources for the funds used to cover these costs are private health insurance, employer-provided group health insurance, and government assistance.[12]

(1993) (estimating that the inclusion of HIV-related severe immunosuppression should account for a seventy-five percent increase in the number of AIDS cases reported in 1993). The CD4+ T-lymphocyte count is a white blood cell count that indicates the degree of damage sustained by the immune system. *See* Mike McKee, *A Cloud Within the Silver Lining*, RECORDER, Mar. 4, 1993, at 1. For a more detailed discussion of the epidemiology of AIDS, see ABA AIDS REPORT, *supra*, at 8-12.

[6] *See, e.g.*, Dunlap, *supra* note 3, at 912 n.10 (listing the sources for these estimates).

[7] CENTERS FOR DISEASE CONTROL, DEPARTMENT OF HEALTH & HUMAN SERVICES, *AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update*, 38 MORBIDITY & MORTALITY WKLY. REP. 1, 3 (Supp. 1989).

[8] The estimated cost of AIDS health care for 1991 is between $2.2 billion and $8.5 billion. Cornelis A. Rietmeijer et al., *Cost of Care for Patients with Human Immunodeficiency Virus Infection*, 153 ARCHIVES INTERNAL MED. 219, 219 (1993). The variation depends upon which estimate of the lifetime health care costs of AIDS is used. *See infra* note 9.

[9] *See* Mike McKee, *Was Insurance Cap Illegal?*, LEGAL TIMES, Jan. 4, 1993, at 12. Over the years, there has been significant variance in the estimated lifetime medical costs of AIDS. For instance, in 1986 the estimated lifetime hospital cost of AIDS was reported as $147,340. Rietmeijer et al., *supra* note 8, at 219. This figure has been repeatedly refuted. Instead, the estimated average lifetime health care cost of AIDS is generally between $35,000 to $90,000. *Id.*

[10] *See, e.g.*, Karen Goldberg, *Surviving Despite HIV: As Their Life Expectancy Grows, So Do Needs of AIDS Patients*, WASH. TIMES, Feb. 26, 1993, at A1 (discussing the increased health care costs of AIDS patients).

[11] This depletion of resources may be especially likely now that the demographics of AIDS has "shifted from a generally affluent population of young Caucasian homosexual males . . . to an increasingly inner-city population of poorer black and Hispanic heterosexual[s]." Raymond C. O'Brien, *The Legislative Initiative: The Ryan White Comprehensive AIDS Resources Emergency Act of 1990*, 7 J. CONTEMP. HEALTH L. & POL'Y 183, 183 (1991).

[12] NATIONAL COMM'N ON AIDS, AMERICA LIVING WITH AIDS 70 (1991).

Insurance companies employ various underwriting tactics[13] to curtail an HIV-infected person's access to private health insurance.[14] This, coupled with the prohibitive costs of private health insurance, may explain why "[t]he primary vehicle through which persons with AIDS obtain health insurance is employer-sponsored group health insurance plans."[15]

The main source of funds, however, continues to be government assistance.[16] Indeed, commentators refer to this trend as the

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[13] The term "underwriting" refers to an insurer's determination of the proposed insured's risk of loss to the insurer. If the risk is too great, the insurer will not underwrite; that is, the insurer will deny coverage. *See* Hoffman & Kincaid, *supra* note 5, at 715-17. The risk factors relevant to underwriting health insurance for persons suspected of being infected with HIV fall within two categories: life style factors and the use of HIV antibody testing. *Id.* at 722.

The life style factors considered in underwriting include geographical location of residence, marital status, occupation, and beneficiary selection. *Id.* at 723. For instance, one insurance company developed an "AIDS Profile," which segregated insurance applications of "'single males without dependents that are engaged in occupations that do not require physical exertion.'" Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1787 (1987). Occupations included in the list are "'restaurant employees, antique dealers, interior decorators, consultants, florists, and people in the jewelry or fashion business.'" *Id.* Even attorneys for the insurance industry have admitted that "the use of stereotypical factors . . . may have little reliability as indicators of the applicant's sexual preference." Hoffman & Kincaid, *supra* note 5, at 723.

It is quite common for insurance companies to use AIDS antibody tests as part of their underwriting process. *See, e.g., id.* at 726-27. Some jurisdictions have enacted bans on using such tests to determine insurability, *id.* at 726 n.84, but "[t]he insurance industry has been remarkably, if not uniformly, successful in its drive to use HIV-antibody testing." Peter Hiam, *Insurers, Consumers, and Testing: The AIDS Experience*, 15 L. MED. & HEALTH CARE 212, 220 (1987).

[14] *See* Eric C. Sohlgren, Note, *Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law–ERISA, the Rehabilitation Act and the Americans with Disabilities Act*, 24 LOY. L.A. L. REV. 1247, 1255 (1991). Insurance companies also engage in various tactics to resist payment of AIDS-related claims. *See* Schatz, *supra* note 13, at 1786. This has been referred to as "postclaim underwriting." *Id.*

[15] Sohlgren, *supra* note 14, at 1254-55. Note, however, that the majority of Americans with health insurance obtain such coverage through participation in group plans. *See* Edward E. Hollowell & James E. Eldridge, *AIDS and the Insurance Industry: The Debate Within the Debate*, 10 J. LEGAL MED. 77, 80 (1989). The prevalence of employer-sponsored health insurance may be a result of the fact that the age of most AIDS victims falls within the prime employment years. *See* Harry R. Adams, *Financial Problems Inherent in the Admission of AIDS Patients into Long Term Care Facilities*, 10 J. LEGAL MED. 89, 100 (1989) (noting that eighty-eight percent of AIDS patients are between the ages of twenty and forty-nine).

[16] *See* Sohlgren, *supra* note 14, at 1255 ("When [AIDS] patients become disabled,

"Medicaidization" of AIDS.[17] A five-year study of New York, San Francisco and Los Angeles found that "Medicaid finances a much larger proportion of inpatient care for AIDS than other illnesses, and that during the epidemic years, Medicaid's share increased while that of private insurance declined."[18]

To circumvent the barriers to obtaining private health insurance, HIV-infected persons have traditionally sought employment with companies offering large group insurance plans,[19] because group insurance plans rarely require individual underwriting in order to obtain coverage.[20] This safe haven, however, is retreating. Instead of providing group insurance, increased numbers of employers provide health insurance coverage through self-funding plans.[21] This allows the employer to maintain control of the plan and reduce administrative costs while circumventing state laws regulating the insurance industry, including state AIDS discrimination laws.[22]

As a result of this switch to self-insured benefit plans, the costs associated with insuring health care for HIV-infected persons are shifting

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they often lose their jobs and insurance. As a result, funds are rapidly depleted and many of them become eligible for public assistance.").

[17] *See* Jesse Green & Peter S. Arno, *The "Medicaidization" of AIDS: Trends in the Financing of HIV-Related Medical Care*, 246 JAMA 1261, 1264 (1990); O'Brien, *supra* note 11, at 184.

[18] Green & Arno, *supra* note 17, at 1264.

[19] *See, e.g.*, Mark Scherzer, *Insurance*, in AIDS PRACTICE MANUAL VIII-2 (2d ed. 1988).

[20] ABA AIDS REPORT, *supra* note 5, at 116. Indeed, one commentator has remarked that "the ideal circumstance for an AIDS victim is to be employed and covered by a company insurance policy when he learns that he has contracted AIDS." Tammie L. Follet, Note, *AIDS: An Insurable Handicap*, 9 HAMLINE J. PUB. L. & POL'Y 117, 123 (1988).

[21] *See Legal Experts Say ADA Will Mean New Areas of AIDS-Related Litigation in the 1990s*, AIDS POL'Y & L., Aug. 8, 1990, at 1, 2 [hereinafter *Legal Experts Say*]. The Employment Retirement Income Security Act of 1974 ("ERISA") covers self-funded insurance plans. 29 U.S.C. §§ 1001-1461 (1988). Self-funding refers to the "employer taking total financial responsibility and risk for providing plan benefits, as opposed to an insurance company assuming all or part of the financial responsibility and risk." Sohlgren, *supra* note 14, at 1251 n.10. However, employers often purchase stop-loss insurance to insure against losses above a specified dollar amount. *Id.*

[22] Scherzer, *supra* note 19, at VIII-2; Wendy K. Mariner, *Problems with Employer-Provided Health Insurance—The Employee Retirement Income Security Act and Health Care Reform*, 327 NEW ENG. J. MED. 1682, 1683 (1992); *Legal Experts Say*, *supra* note 21, at 2. A self-funding employer may avoid state laws because ERISA preempts state law relating to employee benefits. *See* FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990); *see also infra* notes 80-111 and accompanying text (discussing ERISA preemption).

from insurance companies to employers.[23] Consequently, employers are now seeking to avoid these costs.[24] One method of cost avoidance is to place a cap on the total amount of health benefits that an employee may recover as a result of HIV infection or AIDS.[25] This method has survived judicial challenge under the Employee Retirement Income Security Act of 1974 ("ERISA").[26] Not surprisingly, the capping of insurance benefits has become a viable alternative to employers faced with the rising costs of health care.[27] The current issue is whether, as a matter of policy, employers should be able to cap the health benefits of a group considering the significant stigma already attached to being a member of that group.[28]

This Note addresses the validity of limiting the health insurance benefits of persons infected with HIV. First, the Note considers the validity of such benefit capping under ERISA and uses two reported cases[29] as a mechanism

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[23] While addressing the National Leadership Coalition on AIDS, Senator Frank R. Lautenberg (D-NJ) stated that AIDS costs American businesses $50 billion per year. *Impact of AIDS on American Business Called "Fundamental" by Lautenberg*, AIDS POL'Y & L., Nov. 14, 1991, at 7.

[24] *See* James R. Bruner, Note, *AIDS and ERISA Preemption: The Double Threat*, 41 DUKE L.J. 1115, 1128 (1992) ("Employers with self-insured health plans have replaced the commercial insurance industry in this conflict with PWAs [persons with AIDS]. The motivations of the insurance industry in the battle over [AIDS antibody] testing are now the motivations of employers with self-insured group health plans.").

[25] *See, e.g.*, Ron Stodghill II, *Why AIDS Policy Must Be a Special Policy*, BUS. WK., Feb. 1, 1993, at 53, 54 (recounting the story of an Atlanta firm that decreased its lifetime AIDS-related benefits from $1 million to $25,000); Michele Zaros, *AIDS and Insurance: No Guarantees--Self-Insured Companies Can Now Limit Coverage for Catastrophic Illness*, 20 HUM. RTS. 18, 20 (Winter 1993) (reporting that an employer reduced the lifetime AIDS-related benefits for an employee from $1 million to $40,000).

[26] 29 U.S.C. §§ 1001-1461 (1988) [hereinafter ERISA]. The Fifth Circuit recently upheld an employer's capping of lifetime health insurance benefits available to AIDS patients from $1 million to $5,000. McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenburg v. H & H Music Co., 113 S. Ct. 482 (1992). Some practicing attorneys believe that the Supreme Court's denial of certiorari dealt a deathblow to the ERISA issue in capping cases. McKee, *supra* note 5, at 13.

[27] Indeed, one study indicated that at least eighteen employers have reduced or eliminated insurance benefits for persons with AIDS. *See* Mariner, *supra* note 22, at 1683.

[28] *See* Stodghill, *supra* note 25, at 54 (discussing an employer's refusal to allow an AIDS seminar to be conducted because the employer did not want his customers to think he hired "those kind of people").

[29] *See* McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenburg v. H & H Music Co., 113 S. Ct. 482 (1992); Owens v. Storehouse, Inc., 773 F. Supp. 416 (N.D. Ga. 1991). The case Westhoven v. Lincoln Foodservice Products, Inc., 616 N.E.2d 778 (Ind. Ct. App. 1993), also deals with this issue. In *Westhoven*, the Indiana Civil Rights Commission held that Indiana's fair-employment statute prohibited AIDS-related health benefit caps. *Id.* at 780. On appeal to the circuit court, the judge

for examining the specific ERISA issues.[30] Second, the Note determines the effect that the Americans With Disabilities Act of 1990 ("ADA")[31] has on the issue.[32] Finally, the Note explores the policy issues involved in limiting the health benefits of HIV-infected persons and suggests how the current statutory scheme can be altered to provide regulation of self-insured employee health benefit plans.[33]

I. ERISA'S RESPONSE

One of the express purposes of ERISA[34] is to protect "the continued well-being and security of millions of employees and their dependents [who are] directly affected by [employee benefit] plans."[35] To effectuate this purpose, ERISA regulates health benefits, pensions and other fringe benefits of employment. ERISA uses the specific phrase "employee welfare benefit plans" to cover employer-provided group health insurance plans.[36] In order to determine the applicability of ERISA to an employer's capping of the health benefits of employees suffering from AIDS, this Note will examine two reported cases that deal with this issue.

A. McGann v. H & H Music Co.[37]

After working for H & H Music Company ("H & H Music") for five years, John McGann was diagnosed as having AIDS.[38] At the time of McGann's diagnosis, H & H Music was providing its employees with

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found the commission to be without jurisdiction and entered judgment in favor of Lincoln Foodservice. *Id.* at 778. The Indiana Court of Appeals affirmed such a result after holding that ERISA preempted the Indiana civil rights law. *Id.* at 784.

[30] *See infra* notes 34-117 and accompanying text.

[31] 42 U.S.C. §§ 12101-12213 (Supp. III 1991) [hereinafter ADA].

[32] *See infra* notes 118-59 and accompanying text.

[33] *See infra* notes 160-240 and accompanying text.

[34] 29 U.S.C. §§ 1001-1461 (1988).

[35] *Id.* § 1001(a).

[36] *Id.* § 1002(1). This term encompasses "any plan, fund, or program . . . maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death." *Id.* A plan participant includes "any employee or former employee or an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer." *Id.* § 1002(7).

[37] McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenburg v. H & H Music Co., 113 S. Ct. 482 (1992).

[38] *Id.* at 403.

maximum health benefits of $1 million through a group insurance plan purchased from General American Life Insurance Company.[39] Seven months after McGann's diagnosis, H & H Music switched its health insurance plan from a purchased plan to a self-insured plan. Along with this change of insurance plans, H & H reduced the maximum health benefit coverage for persons with AIDS to $5,000. Although the employer made other changes to the plan, no similar benefit limitation was placed on any other catastrophic illness.[40]

McGann brought suit alleging that H & H Music's capping of AIDS-related benefits violated the two prohibitions of section 510 of ERISA.[41] Section 510, in relevant part, provides:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan. . . .[42]

The district court, however, dismissed McGann's action and granted H & H's motion for summary judgment.[43]

The United States Court of Appeals for the Fifth Circuit affirmed the district court's dismissal.[44] Specifically, the Fifth Circuit found that under either section 510 claim McGann had to demonstrate that H & H Music had a specific intent to discriminate.[45] According to the court, McGann failed to provide evidence of discrimination sufficient to survive a motion of summary judgment.[46] This result rested on H & H Music's representation that it had implemented the cap for cost containment purposes.[47]

McGann has been interpreted as holding that an employer can escape ERISA's prohibitions against discrimination by merely alleging that it

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[39] *Id.*

[40] *Id.* The other changes to the insurance coverage included elimination of coverage for chemical dependency treatment, increased individual and family deductibles, adoption of a preferred provider plan, and increased contribution requirements. *Id.* at 403 n.1.

[41] *Id.* at 403; *see* 29 U.S.C. § 1140 (1988).

[42] 29 U.S.C. § 1140 (1988).

[43] *McGann*, 946 F.2d at 408.

[44] *Id.*

[45] *Id.* at 404.

[46] *Id.* at 408.

[47] *Id.* at 406.

instituted the AIDS-related benefit cap to reduce costs.[48] Such a broad interpretation, however, fails to consider that McGann, in order to withstand a motion for summary judgment, had the burden of providing evidence sufficient to establish the existence of a genuine issue of material fact regarding the employee's specific intent to discriminate.[49] Hence, on its facts, *McGann* stands for the proposition that a plaintiff must specifically assert discriminatory intent in order to withstand a motion for summary judgment.

The court's fact-finding represents a more distressing aspect of the *McGann* decision. Despite McGann's being the only employee affected by the new policy and the court's assumption that McGann's diagnosis was the motivating factor for H & H Music's reduction of coverage, the court found that H & H Music had no specific intent to discriminate.[50] Moreover, the court failed to consider evidence of prevalent discrimination against persons diagnosed with AIDS[51] and dismissed the fact that AIDS was the only catastrophic illness for which benefits under the plan were limited.[52]

The court's findings of fact seem predicated on the belief that ERISA leaves employers "free to create, modify and terminate the terms and conditions of employee benefits."[53] For the court, this freedom mandates a narrow interpretation of the term "discrimination."[54] Accordingly, in the court's view, ERISA "does not prohibit an employer from electing not to cover or continue to cover AIDS, while covering or continuing to cover other catastrophic illnesses, even though the employer's decision in

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[48] *See, e.g.*, Alicia Roberts, *High Court Lets Stand Ruling That ERISA Allows Firms to Cut Benefits for Particular Diseases*, MANAGED CARE L. OUTLOOK, Nov. 24, 1992, at 1.

[49] *See* Celotex Corp. v. Catrett, 477 U.S. 317, 321 (1986). This burden is a result of the fact that McGann must prove discrimination at trial. *Id.*

[50] *McGann*, 946 F.2d at 404 & n.4.

[51] *See infra* notes 189-202 and accompanying text (discussing several studies that provide proof of discrimination and its effects).

[52] *McGann*, 946 F.2d at 405. In generalizing McGann's position, the court declared that "[u]nder McGann's theory, any reduction in employee benefits would be impermissibly discriminatory if motivated by a desire to avoid the anticipated costs of continuing to provide coverage for a particular beneficiary." *Id.*

[53] *Id.* at 407. This premise derives from the Supreme Court's statement that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983). The *McGann* court, however, specifically declared that it was not deciding the question of whether an employer has an absolute right to modify its plan absent a contractual limitation on that right. *McGann*, 946 F.2d at 406 n.8.

[54] *McGann*, 946 F.2d at 407.

this respect may stem from some 'prejudice' against AIDS or its victims generally."[55]

Unfortunately, case law supports such a narrow interpretation of discrimination. As a general rule, section 510 prohibits an employer from taking action that would be impermissible under the terms of its plan.[56] Hence, if there exists no cap in the plan, H & H Music could not refuse payment because to do so would constitute discrimination. However, section 510 provides no prohibition against a plan's discriminating between diseases.[57] Thus, the Fifth Circuit "correctly" applied section 510 by holding that McGann must establish more than merely a modification of the plan in order to succeed under section 510. Indeed, precedent holds that a welfare benefit plan modification that "cuts along independently established lines . . . and that has a readily apparent business justification, *demonstrates no invidious intent.*"[58]

Lastly, the *McGann* court declared that section 510's prohibition against an employer's action that interferes with an employee's attainment of any right to which such participant may become entitled only prevents an employer from withholding either benefits capable of vesting or promised benefits.[59] ERISA's vesting requirements do not apply to employee welfare benefit plans; McGann, therefore, had to show that H & H Music had promised permanent coverage.[60] Because McGann failed to allege that H & H Music had promised permanent coverage, and

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[55] *Id.* at 408.

[56] *See* Furnco Constr. Corp. v. Waters, 438 U.S. 567, 577 (1978) (holding that proof of a justification for refusing to hire a job applicant that is reasonably related to the employer's achievement of a legitimate goal does not violate Title VII).

[57] *See* Deeming v. American Standard, Inc., 905 F.2d 1124, 1127-28 (7th Cir. 1990) (holding that "a mere elimination of a 'creep' provision does not support a § 510 claim"); Aronson v. Servus Rubber Div. of Chromalloy, 730 F.2d 12, 16 (1st Cir.) (holding that a termination made for business purposes does not involve invidious intent), *cert. denied*, 469 U.S. 1017 (1984).

[58] *Aronson*, 730 F.2d at 16 (emphasis added).

[59] *McGann*, 946 F.2d at 405.

[60] *See* 29 U.S.C. § 1002(19) (1988); *see also* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) (noting that ERISA's vesting requirements only apply to pension plans). Congress believed that vesting requirements for welfare plans "would seriously complicate the administration and increase the costs of plans whose *primary function is to provide retirement income.*" S. REP. NO. 383, 93d Cong., 1st Sess. 51 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4935; *see also* H.R. REP. NO. 807, 93d Cong., 2d Sess. 60 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4670 (offering a general discussion of the problems associated with vested rights and funds under ERISA). The logic seems to be that the increased costs associated with vesting welfare plans would discourage employers from offering any insurance benefits.

because the plan reserved H & H Music's right to modify the plan, the court concluded that H & H Music did not violate any right to which McGann was entitled.[61] The court justified this conclusion by noting that a contrary result would, in effect, vest welfare benefit plans immediately upon enactment,[62] a result contrary to congressional intent.

B. Owens v. Storehouse, Inc.[63]

In April of 1988, Storehouse adopted an employee welfare benefit plan that included lifetime health benefits of $1 million.[64] By November of 1988, five employees of Storehouse had been diagnosed with AIDS. In order to procure stop-loss insurance, Storehouse switched to a self-insured plan and capped its AIDS-related coverage at $25,000.[65] After enacting the benefit limitation, Storehouse continued to pay over $90,000 worth of Owens' claims in excess of the $25,000 cap because the costs of its new plan were running behind its budget. Further, upon notifying Owens that it would begin to adhere to its new policy, Storehouse provided Owens with an additional $7,500 of coverage.[66] Thereafter, Owens brought an action seeking a temporary restraining order to prevent Storehouse from implementing the cap.[67]

Similar to the court in *McGann*, the court in *Owens* upheld the validity of the employer's capping of AIDS-related health insurance benefits. In affirming the district court's opinion, the Eleventh Circuit resolved the case solely on Owens' section 510 claim.[68] The district court's opinion, however, addresses several important ERISA issues that the *McGann* opinion did not address and is, therefore, worthy of discussion.

1. *The Employer's Fiduciary Obligations to ERISA Participants*

Owens alleged that Storehouse's capping of AIDS-related insurance benefits constituted a breach of Storehouse's fiduciary duty.[69] Under

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[61] *McGann*, 946 F.2d at 405.

[62] *Id.*

[63] 984 F.2d 394 (11th Cir. 1993).

[64] *Id.* at 396.

[65] *Id.* Storehouse also capped lifetime health benefits for mental illness and substance abuse ($25,000), growth hormone drugs ($10,000), temporomandibular joint dysfunction ($2,500) and nicotine dependence ($500). *Id.* at 397 n.3.

[66] *Id.* at 397.

[67] *Id.*

[68] *Id.* at 397-400.

[69] Owens v. Storehouse, Inc., 773 F. Supp. 416, 419 (N.D. Ga. 1991), *aff'd*, 984 F.2d

ERISA, an employer who administers an employee welfare benefit plan acts in a fiduciary capacity towards the plan's participants.[70] As a fiduciary, the employer is obligated to "discharge his duties with respect to a plan solely in the interest of the participants . . . for the exclusive purpose of . . . providing benefits to participants."[71] Thus, this fiduciary duty requires the employer to administer the plan in accordance with the plan's documents.[72]

Normally, an analysis of an employer's alleged violation of ERISA's fiduciary obligation consists of a three-step inquiry. First, is the employer a fiduciary?[73] Second, does the employer's action fall within the scope of her fiduciary obligations?[74] Third, did the employer act as a reasonable person in discharging her fiduciary obligations?[75] Each question must be answered affirmatively before proceeding to the next inquiry. Since the parties in *Owens* appeared to have stipulated that Storehouse was a fiduciary, however, the court resolved this issue by summarily finding that Storehouse's modification of its health benefit plan was not a function of administering its plan.[76] This result is consistent with prior case law holding that an employer acts in his fiduciary capacity when he "decides matters required in plan administration or involving obligations imposed upon the administrator by the plan,"[77] but not when the employer is making business decisions not otherwise regulated by ERISA.[78] The court further recognized that the result would have been different if the benefits had been vested.[79]

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394 (11th Cir. 1993).

[70] Payonk v. HMW Indus., 883 F.2d 221, 225 (3d Cir. 1989).

[71] 29 U.S.C. § 1104(a)(1)(A) (1988).

[72] *Id.* § 1104(a)(1)(D).

[73] Sohlgren, *supra* note 14, at 1281.

[74] *Payonk*, 883 F.2d at 225; *see* Sohlgren, *supra* note 14, at 1281 n.21.

[75] *Payonk*, 883 F.2d at 225; Sohlgren, *supra* note 14, at 1281. The actual standard of care is that of a reasonable person in like circumstances. *See* 29 U.S.C. § 1104(a)(1)(B) (1988).

[76] *Owens*, 773 F. Supp. at 419.

[77] *Payonk*, 883 F.2d at 225.

[78] *Id.*; *see also* Young v. Standard Oil, 849 F.2d 1039, 1045 (7th Cir.) (holding that an employer does not breach its fiduciary duty by amending its employee welfare benefit plan), *cert. denied*, 488 U.S. 981 (1988); Witmeyer v. Kilroy, 788 F.2d 1021, 1024-25 (4th Cir. 1986) (holding that trustees do not breach their fiduciary duty when retirement plan amendments that the trustees have adopted meet general ERISA requirements); Sutton v. Weirton Steel Div. of Nat'l Steel Corp., 724 F.2d 406, 410-11 (4th Cir. 1983) (holding that an employer does not violate its fiduciary duty if its plan is not subject to ERISA's vesting requirements), *cert. denied*, 467 U.S. 1205 (1984).

[79] *Owens*, 773 F. Supp. at 419. For a discussion of ERISA vesting requirements, see

2. *ERISA's Preemption of State Claims*

The court also granted Storehouse's motion for summary judgment on Owens' state claims.[80] Owens had alleged that the capping of AIDS benefits constituted an unfair employment practice under Georgia law and had sought recovery on a tort theory of intentional infliction of emotional distress.[81] To evaluate the court's holding that ERISA preempted these state claims,[82] an examination of the United States Supreme Court's evolving body of ERISA preemption law is necessary.

ERISA expressly preempts state law.[83] Section 514 provides that ERISA "shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan."[84] Preemption was thought necessary to insure a comprehensive and uniform approach to employee pension and welfare benefit plans.[85] The Supreme Court has broadly interpreted section 514 to mean that "[a] law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan."[86] Hence, section 514 preempts even those state laws that have only an indirect effect on employee benefit plans.[87]

Section 514's "saving clause," which exempts from preemption "any law of any State which regulates insurance, banking, or securities," creates an exception to the general rule.[88] This exception to preemption, however, is limited by the deemer clause. For purposes of state laws regulating insurance, the deemer clause prohibits employee benefit plans

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supra note 60.

[80] *Owens*, 773 F. Supp. at 419-20.

[81] *Id.*

[82] *Id.*

[83] 29 U.S.C. § 1144 (1988). This is only one of three ways in which federal law can preempt state law. *See* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95-100 (1983); English v. General Elec. Co., 496 U.S. 72, 78-79 (1990). Federal law also preempts state law when (1) federal law is so pervasive in the specific regulatory area that it can be said to "occupy the field" and (2) an actual conflict exists between state and federal law. *English*, 496 U.S. at 79. This is a rather simplified approach to federal preemption. For a more detailed examination, see Susan S. Grover, *The Employer's Fetal Injury Quandary After* Johnson Controls, 81 KY. L.J. 639, 652-56, 659-71 (1992-93).

[84] 29 U.S.C. § 1144 (1988).

[85] *See* FMC Corp. v. Holliday, 498 U.S. 52 (1990).

[86] *Shaw*, 463 U.S. at 96-97.

[87] *Id.*; *see, e.g.*, R.R. Donnelly & Sons Co. v. Prevost, 915 F.2d 787, 788 (2d Cir. 1990) (holding that ERISA preempts state law that requires employers to continue welfare coverage of employees who are eligible for worker's compensation benefits because ERISA indirectly regulates the employee benefit plan), *cert. denied*, 111 S. Ct. 1415 (1991).

[88] 29 U.S.C. § 1144(b)(2)(A).

from being deemed "to be an insurance company or other insurer . . . or to be engaged in the business of insurance."[89] Not surprisingly, courts have experienced difficulty in ascertaining the proper relationship between the deemer clause and the savings clause.[90]

Judicial resolution of this issue ultimately depended on distinguishing between insured and self-insured benefit plans.[91] This distinction was first addressed in *Metropolitan Life Insurance Co. v. Massachusetts*.[92] In *Metropolitan Life*, the Court held that the savings clause covered a Massachusetts statute requiring minimum mental health care benefits in group health insurance policies.[93] That is, the Court concluded that the statute regulated insurance and not employee welfare benefits. The effect on employee welfare benefits was merely the indirect result of regulating insurance.[94]

In support of its conclusion the Court noted that had Congress intended to preempt state regulation of insurance contracts, "it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans."[95] In effect, *Metropolitan Life* reconciled the savings and deemer clauses by distinguishing between the situation in which the employer pays for the employees' benefits (self-insured plans) and the situation in which the employer obtains insurance to pay for the employees' benefits (insured plans). Accordingly, insured plans are subject to indirect regulation by the states via direct regulation of the insurance companies, while self-insured plans are free from direct and indirect state regulation.[96]

The Court further clarified this distinction in *FMC Corp. v. Holliday*.[97] In *FMC Corp.*, the employer sought subrogation of an employee's out-of-

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[89] *Id.* § 1144(b)(2)(B).

[90] *See Shaw*, 463 U.S. at 95 (noting disagreement among the lower courts regarding the scope of preemption under ERISA).

[91] For a more exhaustive examination of the judicial treatment of ERISA's preemption provisions, see Bruner, *supra* note 24, at 1133-55; Sohlgren, *supra* note 14, at 1261-71.

[92] 471 U.S. 724 (1985). The *Metropolitan Life* decision is credited with spurring the increased popularity of self-insured employee welfare benefit plans. *See* Bruner, *supra* note 24, at 1130; *see also supra* notes 21-27 and accompanying text (discussing employers' shift to self-insured plans).

[93] *Metropolitan Life*, 471 U.S. at 758.

[94] *Id.* at 743.

[95] *Id.* at 741. According to the Court, two other reasons justified its result: (1) the plain language of the statute supported a finding that benefit laws regulate insurance and not welfare benefit plans, *id.* at 739-40; and (2) under federal statutes, state-mandated benefit laws constitute the "business of insurance." *Id.* at 742-44.

[96] *Id.* at 747.

[97] 498 U.S. 52, 58 (1990).

court settlement for medical costs paid by the employer.[98] The self-insured employee welfare benefit plan provided for this right of subrogation.[99] The employer sought to prevent reimbursement by invoking Pennsylvania's anti-subrogation statute.[100] The Court held that ERISA preempted Pennsylvania's statute and, in so doing, reversed the Third Circuit's decision.[101]

The Court analyzed the Pennsylvania anti-subrogation statute according to ERISA's three-step preemption inquiry.[102] Consistent with the *Shaw* Court's broad interpretation of ERISA preemption,[103] the Court concluded that the Pennsylvania statute fell within the scope of ERISA preemption.[104] The Court then found that the statute regulated insurance and was thus within the scope of the savings clause.[105] Most importantly, the Court reaffirmed *Metropolitan Life* in holding that ERISA, by way of the deemer clause, preempted state regulation of self-insured ERISA plans.[106] The Court explained its application of the savings and deemer clauses to self-insured and insured ERISA plans as follows:

> [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore

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[98] *Id.* at 55.

[99] *Id.* at 54.

[100] *Id.* at 55.

[101] *Id.* at 65.

[102] *See id.* at 57. The steps are as follows: (1) Is the state law related to an employee benefit plan, i.e., does the statute fall within the scope of ERISA's preemption provision? (2) Does the state law regulate insurance, i.e., does the statute fall within the scope of ERISA's savings clause? (3) If so, is the statute brought back into ERISA's preemption provision via the deemer clause? *Id.* at 57-58.

[103] *See supra* notes 86-87 and accompanying text.

[104] *FMC Corp.*, 498 U.S. at 58-60.

[105] *Id.* at 60-61.

[106] *Id.* at 61-65.

> not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.[107]

Because the state statutes involved in *Owens*[108] do not invoke *Metropolitan Life*'s self-insured and insured dichotomy, *Owens* presents an easy case. Considering the Supreme Court's broad construction of ERISA's preemption provision, the issue becomes whether the state statutes relate to an employee benefit plan. In other words, do the statutes have "a connection with or reference to such a plan"?[109] In the *Owens* case, Owens attempted to use Georgia's unfair employment practices provision to limit the employer's right to modify an employee benefit plan. For this reason, the *Owens* court correctly found the state provision to be preempted.[110] Likewise, Owens' intentional infliction of emotional distress claim, which represented an attempt to impose additional duties on the employer with regard to its benefit plan, was also preempted.[111]

C. *Summary*

Although the *McGann* and *Owens* decisions allow employers to engage in outright discrimination against HIV-infected persons, as long as this discrimination is not directed toward a particular individual, ERISA appears to support these decisions. Indeed, ERISA, as drafted, is ill-equipped to attain its lofty purpose[112] as it relates to employer-provided health benefits. In all likelihood this failure of ERISA is a result of the fact that ERISA was originally enacted to remedy the existing laws' deficiencies in protecting employees' pension rights.[113] Consequently, as one commentator remarked, "[h]ealth benefits were placed under ERISA's exclusive governance almost as an afterthought."[114] This may explain why ERISA not only fails to

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[107] *Id.* at 61. One commentator summarized the current status of the ERISA preemption doctrine by stating that ERISA preempts "both: (1) state insurance laws purporting to regulate self-insured employee benefit plans; and (2) state employment discrimination laws relating to employee benefit plans that do not regulate insurance, whether such plans are insured or self-insured." Sohlgren, *supra* note 14, at 1268 (footnotes omitted).

[108] See *supra* notes 80-81 and accompanying text.

[109] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).

[110] Owens v. Storehouse, Inc., 773 F. Supp. 416, 419-20 (N.D. Ga. 1991), *aff'd*, 984 F.2d 394 (11th Cir. 1993).

[111] *Id.*

[112] *See supra* text accompanying note 35.

[113] *See* H.R. REP. NO. 533, 93d Cong., 1st Sess. (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4639.

[114] Mariner, *supra* note 22, at 1684.

require employers to offer health insurance, but also fails to provide any substantive standards for employers who do provide health benefits.[115]

Moreover, the Supreme Court's expansive interpretation of ERISA preemption provisions thwarts states' efforts to provide a substantive standard. Hence, to the extent that state law protects HIV-infected persons' access to health care,[116] *FMC Corp.* allows an employer, with ERISA's blessings, to discriminate against HIV-infected persons.[117]

II. THE ADA'S RESPONSE

A. In General

The Americans with Disabilities Act of 1990[118] extends the protections of Titles II and VII of the Civil Rights Act of 1964[119] to individuals with disabilities. One of the stated purposes of the ADA is "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[120] Specifically, the ADA prohibits discrimination in employment.[121]

1. *Defining Disability Under the ADA*

Coverage under the ADA depends upon whether the individual has a disability. For purposes of the ADA, an individual is disabled if any one of the following circumstances is present:

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[115] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) ("ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits.").

[116] Employment discrimination on the basis of disability or handicap is prohibited by all states and the District of Columbia. *See* Sohlgren, *supra* note 14, at 1248 n.6 (listing each state's specific statutory provision). Likewise, a minority of jurisdictions prohibit AIDS discrimination in health insurance coverage. *See id.* at 1250 n.7.

[117] Several factors indicate that employers who limit benefits to HIV-infected persons are not solely motivated by cost savings, but also by a discriminatory purpose. *See infra* notes 208-11 and accompanying text.

[118] 42 U.S.C. §§ 12101-12213 (Supp. III 1991). The ADA went into effect on July 26, 1992. *Id.* § 12111. Currently, it covers all employers with twenty-five or more full-time employees. *Id.* § 12111(5)(A). On July 26, 1994, however, the scope of the ADA will expand to include all employers with fifteen or more full-time employees. *Id.* At least one case has been filed to determine whether exclusion of health insurance coverage for HIV-related illnesses violates the ADA. *See Suit Seeks to Exclude AIDS Health Coverage*, NAT'L L.J., Mar. 15, 1993, at 6.

[119] 42 U.S.C. §§ 2000a to a-6, 2000e to e-7 (1988).

[120] *Id.* § 12101(b)(1) (Supp. III 1991).

[121] *Id.* § 12112.

(1) The individual has "a physical or mental impairment that substantially limits one or more of the major life activities" of the individual;[122]

(2) The individual has a record of having such an impairment;[123]

(3) The individual is regarded as having such an impairment.[124]

The Equal Employment Opportunity Commission ("EEOC") has defined physical or mental impairment broadly.[125] Furthermore, a determination of whether a person is disabled should be made without reference to any "mitigating measures" such as medication.[126] In addition to having a physical or mental impairment, the impairment must also substantially limit at least one major life activity to qualify as a disability. Major life activities include functions such as "seeing, hearing, walking, speaking, breathing, learning, performing manual tasks, and caring for oneself."[127]

The "record of such an impairment" provision includes persons who have recovered from impairments or who have been misclassified as having an impairment.[128] It has been suggested that "record" is not limited to medical records, but could also include employment or educational records.[129]

The "regarded as having such an impairment" condition extends the ADA's protection to persons who do not have an impairment.[130] The relevant inquiry is whether the individual is treated as having a disability. A hypothetical situation involving AIDS illustrates this point: "Suppose that an employer had discharged an employee in response to a groundless rumor that the employee was infected with HIV. Although the rumor was unfounded, the employer perceived the person as disabled and discriminated on the basis of perceived disability by discharging the employee."[131]

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[122] *Id.* § 12102(2)(A).

[123] *Id.*

[124] *Id.*

[125] 29 C.F.R. § 1630.2(h) (1992). For instance, the term "physical impairment" includes "any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine." *Id.*

[126] 29 C.F.R. app. § 1630.2(h) (1991).

[127] Rosemary E. Mahoney & Allan Gibofsky, *The Americans with Disabilities Act of 1990: Changes in Existing Protection and Impact on the Private Health Services Provider*, 13 J. LEGAL MED. 51, 57 (1992).

[128] 29 C.F.R. app. § 1630.2(k).

[129] Robert B. Fitzpatrick & E. Anne Benaroya, *Americans with Disabilities Act and AIDS*, 8 LAB. LAW. 249, 255 (1992).

[130] 29 C.F.R. app. § 1630.2(l).

[131] Fitzpatrick & Benaroya, *supra* note 129, at 255.

2. *Discrimination in Employment*

With respect to employment, the ADA prohibits discrimination on the basis of disability against a "qualified individual with a disability . . . in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."[132] A "qualified individual with a disability" is an "individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires."[133]

The essence of an employer's obligation under the ADA is to provide, upon request, reasonable accommodation, unless such accommodation would create an undue hardship for the employer.[134] Failure to provide reasonable accommodation constitutes discrimination by the employer.[135] The term "undue hardship" covers any action requiring "significant difficulty or expense" when considered in light of several relevant factors.[136]

B. Capping Health Benefits of Employees with AIDS Under the ADA

1. *The ADA's Applicability to AIDS*

The legislative history of the ADA clearly expresses the congressional intent that the ADA cover HIV infection whether it be asymptomatic or fully developed AIDS.[137] Even without this legislative mandate,

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[132] 42 U.S.C. § 12112(a) (Supp. III 1991).

[133] *Id.* § 12111(8).

[134] *Id.* § 12112(b)(5)(A).

[135] *Id.*

[136] *Id.* § 12111(10)(A). These factors include the following: the basic nature and cost of the accommodation; the overall size of the business, i.e., the number of employees and the type and location of the facilities; the overall impact that the accommodation would have on the facility needing the reasonable accommodation; and the type of operations of the facility. *Id.* § 12111(10)(B)(i)-(iv). As these factors indicate, whether an accommodation constitutes undue hardship will depend on the specific employer. Fitzpatrick & Benaroya, *supra* note 129, at 261.

[137] HOUSE COMM. ON EDUCATION & LABOR, AMERICANS WITH DISABILITIES ACT OF 1990, H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 2, 1, 52 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 334 [hereinafter H.R. REP. NO. 485]. Likewise, the definition of disability for purposes of the ADA was borrowed from the Rehabilitation Act of 1973. 29 U.S.C. §§ 701-796i(d) (1988). *See AIDS: Covered Indirectly*, CONG. WEEKLY REP., May 13, 1989, at 1123. The ADA applies a similar, if not greater, standard than that of the Rehabilitation Act and its implementing regulations. 42 U.S.C. § 12201(a). HIV

however, HIV infection would be embraced in the ADA's definition of disability.[138] HIV infection substantially limits an infected person's ability to procreate and to engage in intimate sexual relationships. Both of these activities constitute major life activities under the ADA.[139]

2. *The ADA's Applicability to Employer-Provided Insurance Benefits*

The ADA specifically addresses the issue of employer-provided insurance programs.[140] While the ADA does not prevent an employer or insurer 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 that [are] not subject to State laws that regulate insurance,"[141] an employer's actions must be consistent with the purposes behind the ADA. That is, an employer can take no action to evade the purposes of ADA.[142] For instance, the ADA prohibits an employer from "participating in a contractual or other arrangement or relationship that has the effect of subjecting [an employer's] qualified . . . employee with a disability to the discrimination prohibited [and] includes . . . providing fringe benefits to any employee of the [employer]."[143]

The legislative history of section 501 of the ADA appears to provide little hope for the HIV-infected employee whose health benefits are capped. For instance, the House Education and Labor Committee Report concludes:

> In sum, 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 product and benefit plans in a manner that is consistent with basic principles of insurance risk

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infection is widely believed to be a disability under the Rehabilitation Act. *See, e.g.*, Chalk v. United States Dist. Court, 840 F.2d 701, 704-05 (9th Cir. 1988). Indeed, even the Justice Department has agreed that the Rehabilitation Act covers both asymptomatic HIV infection and full-blown AIDS. *Justice Department Memorandum on Application of Rehabilitation Act's Section 504 to HIV-Infected Persons*, Daily Lab. Rep. (BNA) No. 195, at D-1 (Oct. 7, 1988).

[138] *See supra* notes 122-31 and accompanying text.

[139] H.R. REP. No. 485, pt. 2, *supra* note 137, at 52.

[140] 42 U.S.C. § 12201(c).

[141] *Id.* § 12201(c)(2)-(3).

[142] *Id.* § 12201(c).

[143] *Id.* § 12112(b)(2).

> classification. This legislation assures that decisions concerning the insurance of persons with disabilities which are not based on bona fide risk classification be made in conformity with non-discrimination requirements. Without such a clarification, this legislation could arguably find violative of its provisions any action taken by an insurer or employer which treats disabled persons differently under an insurance or benefit plan because they represent an increased hazard of death or illness.[144]

Furthermore, with respect to self-insured group health plans, the Committee stated that "self-insured plans, which are currently governed by the preemption provisions of [ERISA], are still governed by the preemption provision and . . . are subject to state law only to the extent determined by the courts in their interpretation of ERISA's preemption provision."[145]

Against this background, however, one must consider the U.S. Solicitor General's comments in his brief requesting a denial of certiorari in *McGann v. H & H Music*[146] and arguing that the ADA better addressed McGann's concerns.[147] The Senate Report also provides some hope for HIV-infected persons whose health benefits are limited:[148]

> [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.*[149]

These conflicting interpretations of the ADA reflect the need for additional guidance on this issue. The EEOC is planning to issue further guidance that will address the ADA's effect on insurance.[150] Along with

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[144] H.R. REP. NO. 485, pt. 2, *supra* note 137, at 137-38.

[145] *Id.* at 137.

[146] 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenburg v. H & H Music, 113 S. Ct. 482 (1992).

[147] Myron D. Rumeld & Richard Brook, *New Weapons? ADA May Widen HIV Coverage*, NAT'L L.J., Dec. 21, 1992, at 24 (citing Brief for the United States as Amicus Curiae at 17-18).

[148] *See* S. REP. NO. 116, 101st Cong., 1st Sess. 29, 85 (1989).

[149] *Id.* (emphasis added).

[150] *EEOC Pondering Guidance for Employers on Insurance under Disabilities Act*,

these guidelines, the EEOC should define the terms "sound actuarial principles" and "subterfuge."

In addressing these concerns, the EEOC should consider evidence that such benefit-capping is usually done for reasons other than "sound actuarial principles" or that the capping "is related to actual or reasonably anticipated experiences."[151] For instance, AIDS-related benefits are often the only catastrophic illness benefits that are capped.[152] Likewise, the fact that employers cap health insurance benefits for HIV-infected persons while allowing claims for more expensive illnesses suggests that the real basis for such caps is a moral judgment or discriminatory intent.[153] One commentator has suggested that health insurance limits for AIDS patients are likely to be motivated by "prejudice against gay men.... [since] [t]here is still a perception that AIDS is largely a gay male disease."[154]

If, however, the EEOC merely adopts insurance companies' definition of sound actuarial principles, then actual or expected cost increases would almost always justify AIDS coverage restrictions.[155] Likewise, there are a number of other recognized justifications for provisions that disparately impact disabled individuals and would likely be upheld by the ADA, such as "pre-existing conditions limitations, evidence of insurability provisions, and lower coverage of mental or nervous disorders."[156]

As one commentator has suggested, "[t]he precise impact of the ADA on rules capping coverage will depend... on the construction of ambiguous and conflicting provisions of the statute and its underlying legislative history."[157] Possibly the only concrete statement that can be made concerning the ADA's impact on the capping of insurance benefits is that such a limitation cannot be upheld solely on moral justifications.[158] Therefore, the ADA has the

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Daily Lab. Rep. (BNA) No. 207, at A-11 (Oct. 25, 1991).

[151] *See* S. REP. NO. 116, *supra* note 148, at 85.

[152] *See, e.g., Company May Place Cap on AIDS Benefits Without Violating ERISA, Judge Rules*, Daily Lab. Rep. (BNA) No. 140, at A-5 (July 20, 1990) ("'If [the insurance industry's] problem is money, why did they single out AIDS . . . ? Why not say a beneficiary can receive no more than "X" dollars during their lifetime for any illness?'") (quoting Arthur Leonard, Professor of Law at New York Law School).

[153] Sohlgren, *supra* note 14, at 1259 n.60 (comparing the cost of AIDS health care (between $50,000 and $100,000) with the costs of other illnesses, including autologous bone marrow transplants (between $75,000 and $125,000), heart transplants ($150,000), and liver transplants ($120,000)).

[154] Bruner, *supra* note 24, at 1125.

[155] Sohlgren, *supra* note 14, at 1292; *see also infra* notes 229-40 and accompanying text (noting that society's interest in insurance provides a justification for not leaving actuarial classifications to the discretion of insurance companies).

[156] Sohlgren, *supra* note 14, at 1292.

[157] Rumeld & Brook, *supra* note 147, at 26.

[158] *Id.* at 27.

potential to fail to live up to its basic premise that "[a]ll people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees."[159]

III. THE POLICY IMPLICATIONS OF HIV BENEFIT CAPS

The gaps created by the current law may provide an HIV-infected person with little or no legal recourse when confronted with a health benefit cap. Thus, the relevant inquiry shifts to what protections, if any, should be provided.

Although states have been more responsive to the AIDS crisis than the federal government,[160] resolution of the current problems requires assistance from the federal government. Even assuming that states could avoid ERISA's preemption provision, HIV-infected persons cannot rely on the states to adequately protect their interests. In this era of increased competition among the states for revenue, the efforts of one state to protect HIV-infected persons from such caps would likely be undermined by other states seeking to attract industry.[161] Likewise, employees cannot rely on employers to protect their health insurance benefits because "no matter how concerned an employer might be, its efforts would be penalized by its competitive disadvantage against less concerned employers."[162] To effectively resolve the issue, Congress must identify and balance the competing interests of the employer, the employee and society. In other words, Congress must resolve the policy issues behind HIV-related health benefit caps.

A. The Employee's Interest

Employees have significant interests in access to health care and freedom from discrimination. Moreover, the access to health care concern encompasses a myriad of interests, including reliance on the expectation of continued health benefit coverage, access to quality health care, and preservation of financial stability.

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[159] S. REP. NO. 116, *supra* note 148, at 29.

[160] *See, e.g.*, Brown, *supra* note 3, at 11-12.

[161] *Cf.* MATTHEW W. FINKIN ET AL., LEGAL PROTECTION FOR THE INDIVIDUAL EMPLOYEE 366 (1989) ("Efforts by some states to protect against [employee health] hazards were undermined by other states that sought to attract by permitting the hazards.").

[162] *Id.*

1. *Access to Health Care*

One of the primary concerns of an HIV-infected person is the availability of health care.[163] To an HIV-infected person, health care means more than easing pain; it means increasing her life span.[164] Such a person has no right to health care,[165] however, unless she happens to be economically impoverished.[166] Of course, financial impoverishment often is the case since AIDS and other catastrophic illnesses tend to destroy the financial viability of sufferers and their families.[167]

Faced with such a dilemma, the employee is motivated to forego work in order to qualify for public assistance. Yet, a fair assumption seems to be that employees who were initially diagnosed with HIV before their employers instituted a cap did not expect such a result.[168] This

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[163] *See supra* notes 8-12 and accompanying text.

[164] American Public Health Association's Amicus Curiae Brief at 12, Greenburg v. H & H Music, 113 S. Ct. 482 (1992) (No. 91-1283) ("[W]ithout adequate coverage for health care costs, HIV-infected persons cannot take advantage of medical treatments necessary to meaningfully extend their lives.").

[165] Despite the fact that access to health care is not a right, it is often viewed as such. *See, e.g.*, Mike McKee, *Health Law's Cutting Edge*, LEGAL TIMES, Nov. 18, 1991, at 31, 32 (noting that "society is increasingly beginning to view health-care access as a right, not a commodity").

[166] Entitlement to health care only exists if one qualifies for state-controlled Medicaid benefits. *See id.* at 31. However, as President Bush's National Commission on AIDS declared: "'Medicaid coverage varies widely from state to state, often leaving people with HIV disease without effective entitlement to care.'" *Id.* (quoting the National Commission on AIDS). This entitlement, however, depends upon varying state standards. *See* NATIONAL COMMISSION ON AIDS, *supra* note 12, at 73 ("[A]lthough Medicaid is designed to cover low-income people, it falls short of servicing the needs of many poor individuals because of the stringent criteria defining 'low-income' and the prerequisite that assets be below a certain minimum.").

[167] *See, e.g.*, Jay W. Waks, *Disabilities Act May Affect Medical Costs*, NAT'L L.J., June 15, 1992, at 18. A poll conducted in the summer of 1991 indicated that one in four American families had family members afflicted with a catastrophic illness. *Id.* Of this group, only thirty-eight percent had adequate insurance coverage. *Id.*

[168] This discussion assumes that there are categorical differences between an employer capping benefits before a claim is filed and after a claim is filed. *See* 139 CONG. REC. E375 (daily ed. Feb. 18, 1993) (remarks by Rep. Hughes) (introducing an amendment to ERISA that would make it unlawful to eliminate or reduce benefits once a person has become ill). Although an employee may have relied on future coverage in either situation, the employee has not really lost anything until her benefits are curtailed for an illness that she presently has. Therefore, the rest of the discussion assumes that the employer instituted the health benefit cap after the employee's diagnosis of HIV. Note, however, that this distinction may not be valid when considering the employee's interest in being free from discrimination. *See infra* notes 188-202 and accompanying text.

raises the issue of what role the employee's expectations should play in the resolution of this crisis.

Professor Leslie Francis recently noted the importance of the employee's expectations of access to health care.[169] Professor Francis stated:

> On many views of morality, individual autonomy is taken to have moral significance; and expectations are related to autonomy, in the following way. Part of what is involved in treating people autonomously is respecting their ability to make choices and undertake plans. If expectations are ignored altogether, individuals will not have minimally stable contexts in which to plan, or minimal assurance that their plans will be taken seriously. . . . Expectations do not, can not, and should not redefine underlying realities. Nonetheless, if people are to be taken seriously as choosers and planners, it is important at least to open up the question of whether expectations matter morally under some circumstances, and why they do.[170]

According to Francis, an expectation takes on moral significance when the expectation is reasonable and encouraged by the party who will be held to the expectation.[171]

After the employee is diagnosed with an illness, should the employer be forced to recognize the employee's expectation of continued health insurance coverage? In order to answer this question, one must first consider the reasonableness of the expectation. Employers offer benefits as a way to attract and retain the most qualified employees. Indeed, existing health insurance coverage is often stated as a reason why employees remain at a particular place of employment.[172] This is especially true in situations in which the employee has a preexisting illness.[173] The fact that benefit plans are renewed periodically suggests that it may be reasonable to view them as temporal. However, "many employees throughout the 1970s and early 1980s experienced almost automatic renewal or moderate changes in their benefits."[174] As Professor Francis noted:

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[169] *See* Leslie P. Francis, *Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881 (1992).

[170] *Id.* at 1891.

[171] *Id.* at 1892-93. Notions of justice, longevity, integrity and consistency with an underlying theory of rights also support giving weight to one's expectations. *Id.* at 1897.

[172] *See, e.g.*, Paul Cotton, *Preexisting Conditions "Hold Americans Hostage" to Employers and Insurance*, 265 JAMA 2451, 2453 (1991).

[173] *See, e.g., id.* (quoting a Blue Cross spokesperson as stating that "[p]reexisting condition clauses 'cause a lot of people to hang onto jobs because they're scared that if they switch they will go uncovered for a period of time for the condition they have'").

[174] Francis, *supra* note 169, at 1888.

> These employees may have come to expect the continuation of their employment benefits in roughly the same form as long as their employment continued, although they had no written contractual rights to the continuation. Some employers have used this continued availability of benefits to encourage employee loyalty and longevity of service.[175]

The above arguments support finding the employee's expectation in continued coverage to be reasonable. It should be noted, however, that this "reasonableness" determination will depend on the circumstances of each case.[176] Consequently, as expectations regarding access to health care decrease,[177] and public awareness of decisions like *McGann*[178] increase, the reasonableness of an employee's expectation of continued coverage may become questionable.

In considering the issue of what role the employer's encouragement plays in creating expectations, Professor Francis defined the term "encouragement" to include "failures to disabuse someone of beliefs where a disclaimer would ordinarily be expected."[179] Accordingly, encouragement can take a variety of forms. The usual scenario arises when the employer affirmatively encourages an employee to retain her expectations that health coverage will continue. For example, "an employer can encourage an employee to believe that her employment will not be affected by her expensive health needs by reassuring her outright that she 'will always have a job as long as he's in charge.'"[180] A more difficult situation occurs in situations such as the one in *Owens*[181] where the employer is being forced to review employee benefits by its insurer. In this situation, should an employer be required to affirmatively discourage future expectations?[182] Since the employer is the primary source of encouragement regarding the availability of employee benefits, imposing a duty to discourage such expectations may not be an onerous task.[183]

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[175] *Id.* (footnotes omitted).

[176] *Id.* at 1892.

[177] *See, e.g.*, Don Colburn & Richard Morin, *Americans Grade Their Health Care*, WASH. POST, Dec. 31, 1991, at 26 (noting presidential election polls indicating that even the affluent worry about continued access to health care).

[178] See *supra* note 26 and accompanying text.

[179] Francis, *supra* note 169, at 1892.

[180] *Id.*

[181] Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993).

[182] Professor Francis suggests that this, too, constitutes encouragement. *See* Francis, *supra* note 169, at 1892.

[183] *See* 139 CONG. REC. E375, *supra* note 168, at E375 ("Public policy must dictate that plan sponsors should not offer more to their employees than they intend to deliver. . . . Employers must take a realistic look upfront at what level of health benefits

The employee's need for continued health insurance coverage bolsters the desirability of legal protection to prevent health benefit capping. In addition to increasing the HIV-infected employee's expected life span, health care access affects the quality of medical treatment.[184] For instance, an HIV-infected person without health insurance may not be able to benefit from the prophylactic use of AZT.[185]

Another factor to be considered is the HIV-infected employee's lack of access to other sources of private insurance.[186] As previously mentioned, underwriting policies often preclude coverage of HIV-infected persons. Likewise, preexisting condition clauses prevent HIV-infected employees from leaving one employer for another that offers better coverage. Thus, the only option for the HIV-infected employee faced with an HIV-related health benefit cap is to rely upon government-funded health care benefits.[187] Logic dictates against a public policy decision that would encourage persons to forego contributing their work product to society and, instead, to rely upon publicly financed health care.

2. *Freedom from Discrimination*

HIV-infected persons suffer from discrimination as a result of their illness.[188] Although fear of AIDS, an illness which is incurable and

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they can afford to offer and then stand by their promises.").

[184] *See, e.g.*, Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 81 (1993) ("Public and nonprofit hospitals have an incentive either not to treat or to under-treat the uninsured, and this incentive has its effects: people without health insurance receive less primary and preventive care than those who are insured.") (footnote omitted). For a detailed discussion of the differences in care that insured and uninsured patients receive, see Jack Hadex, *Comparison of Uninsured and Privately Insured Hospital Patients*, 263 JAMA 374, 377 (1991).

[185] Raymond C. O'Brien, *Discrimination: The Difference with AIDS*, 6 J. CONT. HEALTH L. & POL. 96, 96 n.13 (1990) (describing two studies that indicate that AZT delays progression of AIDS in certain individuals). The preliminary results of a recent study, however, call into question the prophylactic value of early AZT treatment. Naomi Pfeiffer, *Early AZT Efficacy Under Fire*, 34 MED. WORLD NEWS 54, 56 (1993).

[186] *See supra* notes 13-15 and accompanying text.

[187] *See* Schatz, *supra* note 13, at 1804.

[188] *See, e.g.*, Tracy J. Smith, Comment, *AIDS and the Law: Protecting the HIV-Infected Employee From Discrimination*, 57 TENN. L. REV. 539, 540 (1990) ("Despite the overwhelming evidence that HIV is not transmitted through casual contact, however, the public remains fearful. This fear has often developed into panic and has sometimes led to hostility and even violence toward known or suspected HIV carriers."); Madelyn C. Squire, *Arbitration of Health and Safety Issues in the Workplace: Employees Who Refuse Work Assignments Because of Fear of Aids Contagion*, 44 ME. L. REV. 315, 315-17

fatal, may be understandable, our system of law should encourage education, not provide protection for discrimination. Congress recognized as much when it passed the ADA. Indeed, Congress explicitly declared that "[i]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness."[189] Furthermore, a 1988 study by Harvard University researchers noted:

> [T]wenty-nine percent of people surveyed favored tattooing HIV-positive persons, seventeen percent supported banishing people with AIDS to islands to live in colonies like lepers and thirty percent believed people with AIDS should be isolated at work and school. Twenty percent believed that people with AIDS were "getting their rightful due."[190]

Discrimination against HIV-infected persons has taken many forms.[191] For example, HIV-infected persons "have been denied medical care and city services; prohibited from attending school; fired from their jobs; evicted from their homes; abandoned by their families and even denied proper funeral services."[192] The proper role of government should be to provide information and education so as to alleviate the underlying fears motivating such discrimination and prevent the further spread of the disease.[193]

HIV-infected persons also experience discrimination as a result of perceived sexual orientation.[194] This is largely because the majority of

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(1992) (noting the misconceptions regarding HIV and the abuse suffered by its victims despite widespread information regarding the AIDS virus).

[189] 42 U.S.C. § 12101 (Supp. III 1991).

[190] Dunlap, *supra* note 3, at 915 (citing Blendon & Donelan, *Discrimination Against People with AIDS: The Public's Perspective*, 319 NEW ENG. J. MED. 1022, 1026 (1988)). Some of this discrimination results from disapproval of the HIV-infected person's actual or presumed sexual orientation. *See* Joan Vogel, *Containing Medical and Disability Costs by Cutting Unhealthy Employees: Does Section 510 of ERISA Provide a Remedy?*, 62 NOTRE DAME L. REV. 1024, 1030-31 (1987).

[191] *See* Dunlap, *supra* note 3, at 913 ("Fear of people with AIDS has materialized in every public forum and institution in this society, in virtually every context imaginable.").

[192] Smith, *supra* note 188, at 541 (footnotes omitted).

[193] *See* Brown, *supra* note 3, at 19.

[194] *See, e.g.*, High Tech Gays v. Defense Indus. Sec. Clearance Office, 895 F.2d 563, 573 (9th Cir. 1990) (noting that homosexuals have been subjected to a history of discrimination); Schatz, *supra* note 13, at 1786-88. For instance, in post World War II Switzerland, homosexuals "were sometimes given the choice by their employers of

AIDS cases in the United States have involved homosexual or bisexual men.[195] Notwithstanding the fact that most states do not regard either homosexuals or bisexuals as a protected class for equal protection challenges,[196] our legal system should strive to limit sexual orientation discrimination. For as one commentator concluded, sexual orientation discrimination also

> threatens to drive gay and bisexual men back into the closet. Although such a result may be ideologically pleasing to some, its implications are medically disastrous. A climate of homophobia deters frank discussion with physicians and discourages people from seeking out AIDS prevention information that may "implicate" them as gay or bisexual.[197]

Courts have recognized that the law must discourage discrimination against HIV-infected persons.[198] This recognition is apparent in the judicial expansion of the definitions of "disability" and "handicap" to include AIDS when constructing employment discrimination statutes.[199]

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castration or loss of job and pension." Geoffrey J. Giles, *"The Most Unkindest Cut of All": Castration, Homosexuality and Nazi Justice*, 27 J. CONTEMP. HIST. 41, 57 (1992) (footnote omitted).

[195] *See* CENTERS FOR DISEASE CONTROL, DEPARTMENT OF HEALTH & HUMAN SERVICES, HIV/AIDS SURVEILLANCE, U.S. AIDS CASES REPORTED THROUGH MAY 1990, at 8 (June 1990).

[196] *See* Smith, *supra* note 188, at 563. Likewise, many federal courts have relied upon Bowers v. Hardwick, 478 U.S. 186 (1986), "to reject federal equal protection challenges to statutes that discriminate against gays." Shirley A. Wiegand & Sara Farr, *Part of the Moving Stream: State Constitutional Law, Sodomy, and Beyond*, 81 KY. L.J. 449, 463 (1992-93). Courts reach this result despite the fact that *Hardwick* stands for the proposition that homosexual activity is not a fundamental right subject to substantive due process protection. *Id.*

[197] Schatz, *supra* note 13, at 1788. A recent survey of gay and bisexual men that was conducted in Canada has found support for this premise. Ted Myers et al., *Factors Affecting Gay and Bisexual Men's Decisions and Intentions to Seek HIV Testing*, 83 AM. J. PUB. HEALTH 701 (1993). Of the reasons given for not being tested for the HIV antibody, the motivation of 76.8% of the men surveyed was a desire for anonymity. *Id.* at 702. More specifically, most subjects cited a desire to avoid any governmental list of HIV-infected persons and a concern that a positive result could adversely affect their careers and/or insurance. *Id.* at 703 (table 1).

[198] *See, e.g.*, Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988).

[199] *See id.*; Local 1812, American Fed'n of Gov't Employees v. Department of State, 662 F. Supp. 50, 54 (D.D.C. 1987) (holding that an HIV-infected person can be handicapped within the meaning of the Rehabilitation Act, 22 U.S.C. § 3905(e)(4)); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 381 (C.D. Cal. 1987) (holding that a child infected with AIDS was "handicapped"); Raytheon Co. v. California

Likewise, with the passage of the ADA, Congress recognized the need to protect HIV-infected persons from discrimination.[200] Accordingly, "[t]he legal system must be approached with an eye not only to the basic priority that the HIV pandemic must be ended to save lives, but also to its obligation to protect people from mistreatment that the reaction to HIV has so widely mobilized."[201]

Decisions like *McGann*[202] and *Owens*[203] fail to heed this advice. Rather, they lend approbation to beliefs that the discrimination directed at HIV-infected persons is acceptable. It appears that the public's acceptance of discrimination against HIV-infected persons stems from a distaste for homosexual lifestyles. In fact, the question arises whether the result in cases like *McGann* and *Owens* would be the same if the employer limited health care benefits for cancer, a disease that disproportionately affects the African-American population.[204]

B. The Employer's Interests

The costs of HIV and other catastrophic illnesses can be equally devastating to employers who provide health insurance as part of their benefits package.[205] This is especially so in this era of skyrocketing health care costs.[206] There is no doubt that economic viability of the organization is rightfully the primary interest of the employer. Consequently, as long as costs are not employed as a pretext to pass moral judgments on the employee, there is no moral "bad guy" when the employer restricts benefits in order to maintain economic viability.

However, economic realities suggest that employers may be imposing health benefits caps on HIV-infected persons for reasons other than health

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Fair Employment & Hous. Comm'n, 212 Cal. App. 3d 1242, 1248-49 (Ct. App. 1989) ("AIDS thus falls squarely within the physical handicap coverage of the Act."); Cronan v. New England Tel. & Tel. Co., 179 Daily Lab. Rep. (BNA), at D-1 (Aug. 15, 1986) (interpreting Massachusetts' fair employment law).

[200] *See supra* text accompanying note 190.

[201] Dunlap, *supra* note 3, at 930.

[202] See *supra* text accompanying notes 37-62.

[203] See *supra* text accompanying notes 63-117.

[204] Paul Sorlie, *Black-White Mortality Differences by Family Income*, 340 LANCET 346 (1992).

[205] *See, e.g.*, Waks, *supra* note 167, at 18.

[206] *See U.S. Health Costs Expected to Reach $939.9 Billion in 1993*, Daily Rep. for Executives (BNA) 3, at D-5 (Jan. 6, 1993). Health care costs in 1993 are expected to reach $939.9 billion. This would involve a 12.1% increase of 1992 health care expenditures. *Id.*

care costs. For instance, Robert Padgug, director of health care policy for Empire Blue Cross and Blue Shield of New York, notes that AIDS accounted for only three percent of the company's total medical care expenditures.[207] Indeed, the cost of AIDS is not particularly exorbitant when compared to other health care costs.[208] When one considers that the costs associated with one premature baby can be as high as $300,000,[209] the costs associated with AIDS (approximately $85,000) do not seem to be too high.[210]

Likewise, there are more equitable methods to cut costs than to discriminate against persons afflicted by a particular illness. For instance, the employer could put a cap on all health care benefits.[211] This would spread an individual employee's risk of loss across all employees, thus allowing a higher claims cap and reducing the individual employee's possible losses. Likewise, increased employee contributions could be used to offset the employer's costs. Furthermore, the employer could choose to not offer any health care benefits and thereby not encourage an employee's expectations of coverage.[212]

The available nondiscriminatory alternatives, when coupled with the relative costs of AIDS, suggest that employers set HIV-related health benefits caps for reasons other than cost savings.[213] Two possible reasons come to mind: (1) the employer is expressing moral reservations about employees with AIDS[214] or (2) the employer associates AIDS with life style choices and believes that the employee should bear the costs of these choices.[215]

As previously stated, an employer's moral admonition of persons with AIDS by capping AIDS-related benefits amounts to discrimination against

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[207] Mike McKee, *On the Brink*, LEGAL TIMES, Nov. 18, 1991, at 31.

[208] *See supra* text accompanying notes 9 & 153.

[209] *See* Waks, *supra* note 167, at 18.

[210] One should note, however, that even an $85,000 claim could be devastating to a small, self-insured employer. Larger employers can use various methods to better spread the risk of loss than smaller employers. For instance, an increased employee contribution would go farther to reduce the costs of a large employer than a small employer.

[211] *See supra* note 152.

[212] *See supra* notes 169-83 and accompanying text.

[213] The author realizes that this is a generalization and recognizes that it is possible that an employer may have cut AIDS-related benefits because this was the only catastrophic illness currently seeking coverage.

[214] *See* Brown, *supra* note 3, at 17.

[215] *See* Kenneth E. Labowitz, *The Coming of Conditional Health Insurance*, LEGAL TIMES, Nov. 16, 1992, at 27 (noting that one implication of the *McGann* decision is "that employers can cut health-care costs by conditioning coverage upon employees' personal habits or patterns of behavior, such as diet, smoking, and exercise").

HIV-infected persons.[216] Clearly, the law should discourage this behavior.[217] Indeed, access to health care should be value-neutral.

An employer's conditioning coverage on the employee's supposed life style choice poses a more difficult issue. As one commentator noted, "As there are personal behaviors that, if altered, would significantly reduce health risks and therefore the likelihood of claims . . . [t]here is a simplistic logic in the [premise] . . . that an employer is not obligated to bear blindly the expense of all covered employees for all illnesses and conditions."[218] Indeed, for some time employers have sought to reduce the health care costs associated with smoking.[219] Such measures have generally enjoyed public support.[220] Hence, an employer is beyond reproach for considering an employee's sexual life style, that is, one's sexual orientation, in providing insurance coverage unless such factors can be distinguished from considering the employee's smoking. One may attempt to distinguish sexual life style factors from smoking by arguing that a person's sexual orientation is not a choice.[221] Cigarette smoking is, however, addictive and, therefore, the smoker may not have a choice in the popular sense of the word.[222] Yet, there is a growing body of scientific research indicating that male sexual orientation is a product of genetic inheritance.[223]

Society may distinguish the two cases based on its own legitimate goals. For instance, one aspect of discrimination against persons infected with HIV has been an innocent/guilty dichotomy of victims.[224] "Innocent" victims of HIV include children and persons who contracted

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[216] *See supra* notes 188-202 and accompanying text.

[217] *See supra* notes 197-201 and accompanying text.

[218] Labowitz, *supra* note 216, at 27. One response to such reasoning is that, taken to its logical extreme, almost all illnesses are the "result of our respective lifestyles or that of our parents." Robert R. Gregory, McGann *Ruling Outrageous, Fein View Flawed*, LEGAL TIMES, Dec. 14, 1992, at 34 (letter to the editor).

[219] *See* Vogel, *supra* note 191, at 1036-38.

[220] *See* Mark A. Rothstein, *Refusing to Employ Smokers: Good Public Health or Bad Public Policy?*, 62 NOTRE DAME L. REV. 940, 947 (1987).

[221] *See* Wiegand & Farr, *supra* note 197, at 457 n.49 (relating the expert testimony of Dr. Martin Weinberg, coauthor of the *Kinsey Report on Homosexuals*, asserting that homosexuality is not a choice nor a preference).

[222] *See* Vogel, *supra* note 191, at 1037.

[223] *See, e.g.*, Dean H. Hammer et al., *A Linkage Between DNA Markers on the X Chromosome and Male Sexual Orientation*, 261 SCIENCE 321, 325 (1993). This study of 114 families of homosexual males resulted in a statistical confidence level of more than ninety-nine percent that at least one subtype of male sexual orientation is genetically influenced. *Id.*

[224] *See* Brown, *supra* note 3, at 15.

the virus through a blood transfusion.[225] "Guilty" victims include gays, intravenous drug users and prostitutes.[226] Willie Brown, then Assembly Speaker of the California Legislature, recognized that such characterizations hinder control of the disease by encouraging people not to seek advice regarding the treatment and transmission of HIV.[227] Furthermore, there is something distasteful and particularly "un-American" about allowing employers free reign into the private lives of their employees.

In conclusion, while employers have a strong and legitimate interest in reducing the costs of insurance coverage, there are available alternatives to disease-specific caps that impose less social costs. Widespread discrimination against HIV-infected persons suggests that employers often institute HIV-related benefit caps for reasons unrelated to cost reduction. For this reason, the employer should have the burden of proving that such caps are instituted to control costs. Furthermore, interests in educating the public about HIV and in controlling its spread dictate that sexual orientation life style factors are not legitimate methods of risk classification.

C. The Public's Interest

Courts have long recognized the public's interest in insurance.[228] Indeed, in the early twentieth century, life insurers invoked this interest in support of their argument that they should be exempt from taxation.[229] This interest is further acknowledged by the incentives provided to employers to encourage their providing of insurance coverage for their employees.[230] These considerations led Professor Leah Wortham to conclude the following:

> This combination of necessity and public choice creates an obligation on behalf of society to be concerned about the legitimacy of the classification schemes used by insurers to decide who can buy insurance, how much it will cost, and who will be covered. . . . [This]

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[225] *Id.*

[226] *Id.*

[227] *Id.* at 15-16.

[228] *See, e.g.*, German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 408 (1914) (upholding a state's right to regulate insurance due to its close relation to the public interest).

[229] *See* Leah Wortham, *Insurance Classification: Too Important to Be Left to the Actuaries*, 19 J. L. REFORM 349, 394 (1986).

[230] *See id.* at 397-98.

> leads one . . . to the more important issue of availability of coverage: Can people buy the insurance they need?[231]

As previously discussed, HIV-related insurance caps have the appearance of being motivated by reasons other than cost containment.[232] This suggests that such a classification scheme is not legitimate. Therefore, society has an interest in preventing such classifications. In other words, the gap in insurance availability for HIV-infected persons should be closed.[233]

Economic arguments also support closing this gap. For instance, allowing employers to shift the costs of HIV-related illness to the public adds stress to an already burdened system. As previously mentioned, AIDS has undergone a "Medicaidization."[234] Although Medicaid's financing of HIV-related health benefits has increased from twenty-five percent in 1984-85 to forty-one percent in 1986-87, private insurance funding has decreased from forty-nine percent to forty-three percent over the same period.[235] This shift in the health care cost burden becomes more troublesome when one considers that the total Medicaid budget increased by thirty-three percent from 1988 to 1990.[236] Further, in 1989, employee HIV-related health care claims totaled $455 million[237] and the estimated total cost of caring for persons with HIV was $5.81 billion in 1991.[238] The true aggregate cost-shifting that occurs cannot be accurately and definitively measured because not all cases and costs are reported and these figures are estimates, which are not adjusted for inflation.[239] Yet, these figures illustrate that a mass shifting of AIDS-related costs would increase Medicaid's total AIDS-related costs significantly. Coupled with non-Medicaid budget pressures and increased

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[231] *Id.* at 400.

[232] *See supra* notes 208-16 and accompanying text.

[233] "Gap in availability" is Professor Wortham's language. Wortham, *supra* note 230, at 401.

[234] *See supra* notes 16-18 and accompanying text.

[235] Green & Arno, *supra* note 17, at 1261.

[236] HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 43 (1991).

[237] Fred J. Hellinger, *Forecasting the Medical Care Cost of the HIV Epidemic: 1991-1994*, 28 INQUIRY 213, 223 (1991).

[238] *Id.* Hellinger forecasts that the total health care costs of HIV-related treatment will be $10.389 billion by 1994. *Id.*

[239] Likewise, the 1989 figures are thought to be less than actually expended. *See* Christine Woolsey, *AIDS Claims Hit $1 Billion*, BUS. INS., Oct. 29, 1990, at 4.

public concern about the budget deficit, these figures indicate that the public has an interest in preventing employers from instituting HIV-related health benefit caps.

CONCLUSION

McGann and *Owens* raise serious policy issues. Not only do they highlight that ERISA only provides minimal protection for employee health benefit plans, but they also emphasize the gaps in the ADA through which any employee may fall. Under existing law, any employee's health insurance can be capped.

Americans have certain expectations about their access to medical care. At the very least, it is thought to be more than a mere commodity. As long as these expectations are encouraged by employers as reasonable, our legal system must protect these expectations. This is especially true in a situation in which an employer institutes insurance caps *after* the employee has been stricken by the illness. At the very least, then, Representative Hughes' proposed amendment to ERISA should be passed to provide this protection.[240]

Although employers may have legitimate reasons for limiting disease-specific coverage, doing so raises concerns about discrimination against HIV-infected persons. The legality of such caps only lends credibility to such discrimination. One method of ascertaining the legitimacy of an employer's stated reasons for health insurance caps is to place the burden of persuasion on the employer to show that the cost concerns are not a pretext. Likewise, an employer should be required to institute more equitable cost-saving mechanisms before instituting disease-specific benefit caps.

America is facing a health care crisis. Decisions like *McGann* illustrate that America's health care system is in dire need of repair. Something is fundamentally wrong with an insurance system that fails to provide coverage for those individuals that most need it. This health care crisis affects consumers, insurers, employers, and state and federal governments. Societal interests dictate that employers should not be allowed to shrug off their responsibility so as to increase the government's burden. To do so would undermine any sense of stability workers currently have. Instead, the government must restructure access

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[240] *See supra* note 168.

to health care so as to control costs and spread the burden of providing health care to all interested parties.[241]

*Thomas E. Bartrum**

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[241] In researching this Note, the author often returned to the words of Albert Camus:

> A pestilence isn't a thing made to man's measure; therefore we tell ourselves that pestilence is a mere bogy of the mind, a bad dream that will pass away. But it doesn't always pass away and, from one bad dream to another, it is men who pass away. They went on doing business, arranged for journeys, and formed views. How should they have given a thought to anything like plague, which rules out any future, cancels journeys, silences the exchange of views. They fancied themselves free, and no one will ever be free so long as there are pestilences.

ALBERT CAMUS, THE PLAGUE 36 (Gilbert trans., 1979).

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