

January 1994

The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act

Laura J. Schacht

Follow this and additional works at: https://openscholarship.wustl.edu/law_urbanlaw



Part of the [Law Commons](#)

Recommended Citation

Laura J. Schacht, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act*, 45 WASH. U. J. URB. & CONTEMP. L. 303 (1994)

Available at: https://openscholarship.wustl.edu/law_urbanlaw/vol45/iss1/9

This Note is brought to you for free and open access by the Law School at Washington University Open Scholarship. It has been accepted for inclusion in Urban Law Annual ; Journal of Urban and Contemporary Law by an authorized administrator of Washington University Open Scholarship. For more information, please contact digital@wumail.wustl.edu.

THE HEALTH CARE CRISIS: IMPROVING ACCESS FOR EMPLOYEES COVERED BY SELF-INSURED HEALTH PLANS UNDER ERISA AND THE AMERICANS WITH DISABILITIES ACT

The United States faces a health care crisis, leaving nearly forty million people uninsured and twenty million people underinsured.¹

1. Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models for Rationing Care?*, 140 U. PA. L. REV. 1809, 1811 (1992). The number of uninsured is difficult to measure and it changes each month. Most figures place it in the high 30 million range. See Edwin Chen, *Medical Care Reform May be Reaching Turning Point*, L.A. TIMES, July 21, 1991, at A1 [hereinafter *Turning Point*].

The term "underinsured" applies to those who have health care coverage that does not include a full range of needed services. Coverage is generally targeted towards acute care, not chronic or long term care, nor does it often cover prescription drugs and assistive devices. NATIONAL COUNCIL ON DISABILITIES, *SHARING THE RISK AND ENSURING INDEPENDENCE: A DISABILITY PERSPECTIVE ON ACCESS TO HEALTH INSURANCE AND HEALTH-RELATED SERVICES* 5 (1993) [hereinafter *SHARING THE RISK*]. Also included as underinsured are many people who receive government medical help such as Medicare and Medicaid. Because of the low payment schedule, many doctors refuse to treat people receiving Medicaid and Medicare. This in effect reduces the coverage of these people. Hirshfeld, *supra* at 1811 n.6. Medicaid does not cover out-patient prescription costs. *SHARING THE RISK*, *supra* at 23.

There are many reasons for the high number of uninsured people. Some of these causes will be discussed in this Note. Hirshfeld, an Associate General Counsel for the American Medical Association (AMA), lists many of the reasons. Many uninsured hold low-income jobs and their employers do not provide health insurance. However, they are not poor enough to qualify for government programs. Others are unemployed, but are also not poor enough to qualify for government medical programs. Some are not covered by their employer because of their substantive medi-

Employers who offer health benefits look for ways to cut costs without denying all employees health benefits. Bypassing the insurance company eliminates large annual premium increases.² Employers, large and small, increasingly turn inward to self-insurance.³ Under self-insurance, employers pay the health care bills of their employees and do not have to subsidize coverage of those they do not employ. To cut costs further, some employers now eliminate the health benefits for high risk employees or severely restrict the amount they pay for certain catastrophic illnesses.⁴ Most notably, self-insurance health plans cut benefits of persons with AIDS and HIV,⁵ but many

cal problems. Finally, some cannot afford or refuse to pay co-payments required by many health plans. Hirshfeld, *supra* at 1811 n.5.

2. Employers in the 1980s faced annual premium increases from 20-300%. On average, the annual premium increased 21%. Constance Matthiessen, *The Squeeze on Small Businesses: Health Insurance is Hard to Find, Harder to Afford*, WASH. POST, June 11, 1991, at Z10. There is a continuing shift toward employer-financed health care. In 1965, employers paid 17% of the total U.S. health care bill. By 1989, employers paid 29.7% of the U.S. health care bill. *Turning Point*, *supra* note 1. In 1989, health care costs consumed 56% of employers' pretax income, compared to only 8% of pretax income in 1965. Mark A. Rothstein, *Genetic Discrimination in Employment and the Americans with Disabilities Act*, 29 Hous. L. REV. 23, 29 (1992).

3. Throughout this Note, self-insurance refers to an employer who pays for its employees' health benefits without primary aid of an insurance company. As discussed below, many employers purchase some form of stop-loss insurance and use an insurance company as administrator of the plan. *See infra* notes 40-50 and accompanying text. Self-insurance plans are also referred to as self-funded plans. The term "self-insured" is a misnomer because no insurance exists, but this term is frequently used by those practicing in employee benefits.

4. *See, e.g.,* McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) (reducing lifetime coverage for AIDS patients from \$1 million to \$5,000, while keeping coverage for other catastrophic illnesses at \$1 million), *cert. denied*, 113 S. Ct. 482 (1992). One employer, Circle K, attempted to refuse coverage of any claims based on "personal lifestyle decisions." Glenn Huntley, *Firm Suspends Policy Excluding AIDS Claims*, BUS. INS., Aug. 15, 1988, at 2. Circle K would pay for AIDS-related claims by persons contracting AIDS through blood transfusions, but not through homosexual conduct or intravenous drug use. *Id.* Circle K, when it suspended enforcement of the policy, claimed that the policy did not discriminate against homosexuals because they also refuse to pay for injuries resulting from persons driving while intoxicated. *Id.* at 11. Similarly, the Laborers' Health and Welfare Fund of Southern California excludes all AIDS claims unless the victim is under age 13 or contracted AIDS from a blood transfusion. Huntley Collins, *AIDS is Singled Out for Cuts in Coverage, Scared by Costs, Companies Reduce Benefits*, PHIL. INQUIRER, Sept. 20, 1992, at A01.

5. The ACLU has documented at least 25 companies who eliminated or tried to eliminate AIDS from coverage in 1991. Collins, *supra* note 4.

plans also deny health benefits to cancer patients and survivors,⁶ persons with high cholesterol, and persons with disabilities such as high blood pressure.⁷

The self-insurance option has grown in popularity among employers because of flexibility, cost-saving effects, and preemption from strict state insurance and discrimination laws.⁸ Over half of all employers use self-insurance health plans and nearly ninety percent of Fortune 500 companies self-insure their health plans.⁹

The Employee Retirement Income Security Act (ERISA)¹⁰ regulates employee benefit plans, including health-benefit plans.¹¹ Congress and the courts have created a loophole in ERISA that enables self-insured employers to discriminate against those who need coverage most. The ERISA loophole allows employers who self-insure

6. Henry T. Greely, *AIDS and the American Health Care Financing System*, 51 U. PITT. L. REV. 73, 122 (1989). Ninety percent of persons with cancer histories have faced job discrimination. Judith Jean Morrell, *AIDS and Cancer: Critical Employment Discrimination Issues*, 15 J. CORP. L., 849, 851 n.7 (1990). An ever increasing number of cancer survivors has created greater problems for employers. Forty percent of those diagnosed with cancer in 1989 will be alive in five years, which is considered cured. *Id.* at 853. Employers fear higher costs when employing a person with a history of cancer because of high insurance, high absentee rates, and low productivity. *Id.* at 852 n.11. However, studies find that the opposite is true. Employees with cancer often work harder and are absent less because they feel they have something to prove to their employers and themselves. *Id.* at 886. A Metropolitan Life Insurance survey confirms these findings, *id.* at 885, and an AT&T study demonstrates that the cost of cancer is overstated. *Id.* at 889. Because AT&T's insurance rating showed no appreciable rise after participants developed cancer, their health care premiums did not increase. *Id.*

7. See, e.g., Terry A.M. Mumford et al., *Coordinating Employee Benefits with the Americans with Disabilities Act*, in *EMPLOYEE RETIREMENT AND WELFARE PLANS OF TAX EXEMPT AND GOVERNMENTAL EMPLOYERS*, C765 A.L.I.-A.B.A. 5, 10 (1992) (using high blood pressure as an example of being regarded as having a disability).

8. Peggy Stuart, *Self-Insurance Cuts Health Care Costs*, PERSONNEL J., July 1992, at 51, 53 (detailing areas of cost saving including lower administrative and workers' compensation costs, negotiated discounts from local health care providers, and better control of benefits provided). See *infra* note 13 for a partial list of state statutes that mandate benefits.

9. Albert Crenshaw, *States, Companies Fight over Health Care Costs: Firms Fear Loss of Regulation Exemption*, WASH. POST, July 10, 1992, at C11.

10. 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992).

11. See *infra* notes 57-61 and accompanying text for a discussion of the relevant ERISA provisions.

their health plans to ignore state insurance laws.¹² Most states mandate minimum benefits and prohibit termination of health benefits to those with mental and physical disabilities.¹³ ERISA health plans that self-insure do not have to meet these strict requirements.

12. ERISA § 514, 29 U.S.C. § 1144. See *infra* notes 68-70 for a discussion of the ERISA loophole.

13. Many states prohibit termination if an employee becomes ill by means of the following language:

No insurer may cancel, fail to renew or otherwise terminate a long-term care insurance policy solely on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

See ALASKA STAT. § 21.53.020(1) (1991); ARIZ. REV. STAT. ANN. § 20-1691.02(a) (1987); ARK. CODE ANN. § 23-97-208(b)(1) (Michie 1992); CAL. INS. CODE § 10233.2(a) (West Supp. 1993); COLO. REV. STAT. § 10-19-107(1)(a) (West Supp. 1992); DEL. CODE ANN. tit. 18, § 7105(b)(1) (1989); GA. CODE ANN. § 33-42-6(b)(1) (Michie 1990); ILL. REV. STAT. ch. 215, para. 5/351A-4(1) (Smith-Hurd 1993); IND. CODE ANN. § 27-8-12-11(a)(2) (Burns 1992); IOWA CODE § 514G.7(2)(a) (1988); KY. REV. STAT. ANN. § 304.14-615(2)(a) (Baldwin Supp. 1992); LA. REV. STAT. ANN. § 22:1736(B)(1) (West Supp. 1993); MICH. COMP. LAWS ANN. § 500.3907(1) (West Supp. 1993); N.M. STAT. ANN. § 59A-23A-6(c)(1) (Michie 1992); N.C. GEN. STAT. § 58-55-30(b)(1) (1991); N.D. CENT. CODE § 26.1-45-05(1) (1989 & Supp. 1993); OHIO REV. CODE ANN. § 3923.44(B)(1) (Anderson 1989 & Supp. 1992); OKLA. STAT. ANN. tit. 36, § 4426(A)(1) (West 1990); R.I. GEN. LAWS § 27-34.2-6(b)(1) (Supp. 1992); S.D. CODIFIED LAWS ANN. § 58-17B-5(1) (1990); TENN. CODE ANN. § 56-42-105(b)(1) (1989 & Supp. 1992); UTAH CODE ANN. § 31A-22-1405(1) (Supp. 1993); VA. CODE ANN. § 38.2-5203(1) (Michie 1990); W.VA. CODE § 33-15A-6(b)(1) (1992); WYO. STAT. § 26-38-105(b)(2) (1991).

For statutes that require minimum mental health and chemical dependency coverage, see, e.g., CONN. GEN. STAT. ANN. § 38a-514 (West 1992 & Supp. 1993); HAW. REV. STAT. § 431M-2 (Supp. 1992); MASS. ANN. LAWS ch. 175, § 47B (Law. Co-op. 1977 & Supp. 1992); MINN. STAT. § 62D.102(a) (Supp. 1993); MO. REV. STAT. § 376.779 (1985); MONT. CODE ANN. § 33-22-703 (1991); NEB. REV. STAT. § 44-782 (1985 & Supp. 1992); N.D. CENT. CODE § 26.1-36-09 (1989); TENN. CODE ANN. § 56-7-1003 (Supp. 1993); WASH. REV. CODE ANN. § 48.21.240 (West 1987).

For examples of other state minimum benefits requirements, see also CONN. GEN. STAT. § 38a-516 (1990 & Supp. 1993) (newborn coverage); CONN. GEN. STAT. § 38a-518A (1990 & Supp. 1992) (hypodermic needles); N.H. REV. STAT. ANN. § 417-D:2 (1991) (mammography).

At least 18 states prohibit AIDS discrimination in health insurance coverage and eligibility. Eric C. Sohlgrén, 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, 1250 n.7 (1991) (listing Arizona, California, Colorado, Delaware, Florida, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, North Carolina, Oregon, Pennsylvania, South Dakota, Tennessee and Wisconsin). For a further review of state statutes which may prevent HIV and AIDS discrimination, see Ilise L. Feitshans, *Confronting AIDS in the Work Place: Balancing Equal Opportunity and Occupational Health Under Existing Labor Law*, 1989 DET. C.L. REV. 953.

The Americans with Disabilities Act of 1990 (ADA)¹⁴ aims to end discrimination against the disabled in employment practices and public accommodations.¹⁵ At first glance, this new civil rights bill, hailed as the greatest civil rights act since 1964,¹⁶ appears to prohibit discrimination against people with disabilities in all employment-related areas, including health care benefits.¹⁷ However, Congress included section 501(c) to assure insurance companies and employers who self-insure that their usual risk analysis will not be affected.¹⁸

This Note explores the effect of the ADA on employers who self-insure. To meet the public policy goal of providing greater access to health care,¹⁹ this Note proposes changes to the ADA and ERISA which would eliminate discrimination based on illness. Part I contains a brief overview of insurance procedures as they now exist. Parts II and III present the relevant ERISA and ADA provisions and the current interpretations of these provisions. Part IV proposes amendments to ERISA and the ADA which would eliminate the loopholes and create more equitable health care access.

I. INSURANCE PRACTICES

A. General Practices

Traditionally, employers have offered health benefits through group policies purchased from insurance companies.²⁰ To cut pre-

14. 42 U.S.C. §§ 12101-12213 (Supp. IV 1992).

15. See *infra* notes 132-43 and accompanying text discussing the ADA.

16. Dick Thornburgh, *The Americans with Disabilities Act: What it Means to All Americans*, 64 TEMP. L. REV. 375, 377 (1991) (stating that the ADA rectifies this "glaring omission" of the Civil Rights Act of 1964).

17. ADA § 2, 42 U.S.C. § 12101.

18. ADA § 501(c), 42 U.S.C. § 12201(c). See also *infra* notes 20-23 and accompanying text for an overview of traditional underwriting procedures.

19. Edward Hirshfeld claims the health policy in the United States for the last fifty years has been to provide access to needed care, but admits we have failed to meet this goal. Hirshfeld, *supra* note 1, at 1810.

20. Robert A. Padgug & Gerald M. Oppenheimer, *AIDS, Health Insurance, and the Crisis of Community*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 35 (1990). Currently, 81% of health insurance policies are sponsored by employers through group plans. James R. Bruner, Note, *AIDS and ERISA Preemption: The Double Threat*, 41 DUKE L.J. 1115, 1129 (1992). The insurance industry initially used community rating underwriting procedures to set premiums. Padgug & Oppenheimer, *supra* at 38. Community rating bases premiums on the general health of the targeted community. *Id.* Community rating maximizes costs and risk spreading by creating the largest risk pools. Bruner, *supra* at 1120 n.28. When community rating is used

mium costs in response to employers' criticism that the healthy subsidize the unhealthy,²¹ the insurance industry commonly bases premiums on experience rating.²² Insurers and employers target

rather than experience rating, risk is spread over a larger group, which may include higher risk participants, but costs are offset by the larger group which shares the costs. *Id.*

21. The Unfair Trade Practices Act prohibits charging everyone the same premiums because that would foster inequity. 15 U.S.C. § 45 (1988). *See also* Morrell, *supra* note 6, at 861. Additionally, the insurance industry's need to profit makes it difficult to offer insurance on an equitable basis to all in need. Padgug & Oppenheimer, *supra* note 20, at 36.

Genetic screening and blood tests add a new element to the argument that the healthy subsidize the unhealthy. These tests detect non-symptomatic illnesses and conditions. It is easier to target healthy persons by screening out those with genetic or other disorders. Rothstein, *supra* note 2, at 25. HIV provides an excellent example of the use of blood tests to detect an illness. There is also progress on DNA mapping that can predict breast cancer and carriers of diseases which may be passed on to children. *Id.*; *see also* 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, 1032 (1987) (warning of the dangers of genetic screening in health insurance plans).

22. Experience rating is a method of computing premiums based on the insurer's experience with the group insured. Bruner, *supra* note 20, at 1120 n.29. For example, if a risk group has a number of claims for high blood pressure medication, the insurer has the "experience" to know that premiums must be increased to cover costs related to high blood pressure in the future.

The shift from community rating to experience rating followed a shift to an employment-centered health insurance system. Employers insisted on basing premium rates on actual health care utilization to reduce costs. Padgug & Oppenheimer, *supra* note 20, at 38. This shift created a class of uninsured, beginning with the elderly, unemployed and chronically ill. *Id.* Using smaller risk pools also creates a risk of financial instability for insurers, which is a special concern for self-insured plans. *Id.* at 42. *See infra* notes 47-49 and accompanying text for a discussion on the bankruptcy of health plans.

The Clinton Administration wants to return to community rating underwriting because it spreads risk over a greater population. *Clinton Aide Outlines Health Care Reform Strategy*, BEST'S INS. MGMT. REP., Jan. 11, 1993, at 3. The National Council on Disabilities recommended in a recent report that Congress mandate a return to community rating. SHARING THE RISK, *supra* note 1, at 7.

Twenty-six states offer large risk pooling similar to community rating for individuals who have catastrophic illnesses and who are uninsured. These programs are financed by state taxes on insurance premiums. *See, e.g.*, CONN. GEN. STAT. ANN. §§ 38-371 to -381 (West 1987); ILL. REV. STAT. ch. 73, paras. 1301-14 (1987); IND. CODE ANN. §§ 27-8-10-1 to -8 (Burns 1992 & Supp. 1993); IOWA CODE §§ 514E.1-.11 (1988 & Supp. 1993); MINN. STAT. §§ 62E.01-.55 (1986 & Supp. 1993); MONT. CODE ANN. §§ 33-22-1501 to -1521 (1991); NEB. REV. STAT. §§ 44-4201 to -4235 (1988 & Supp. 1992); N.D. CENT. CODE §§ 26.1-08-01 to -12 (1989 & Supp. 1993); TENN. CODE ANN. §§ 56-39-101 to -122 (Supp. 1993). Commercial insurers support high risk pool plans, but criticize the fact that self-insured plans are not subject to

smaller, healthier risk pools to provide a better fit between costs and risk.²³

The dramatic rise in health care costs over the last decade has created new problems for insurers and employers.²⁴ Health costs have increased annually by more than ten percent,²⁵ while inflation

premium taxes due to the ERISA loophole. Neal St. Anthony, *Federal Officials Criticized on Self-Insurance Plans*, MINNEAPOLIS STAR-TRIB., July 29, 1990, at 01D.

23. Bruner, *supra* note 20, at 1120. One common method of targeting healthier employees is the pre-existing condition clause. If illnesses and medical conditions exist before the individual becomes eligible for participation in the health plan, the plan may refuse to cover either the person or costs related to the particular illness. According to a Blue Cross study, employees are frequently refused insurance based on illnesses. Morrell, *supra* note 6, at 857-58. Ten percent of policies refuse to cover cancer survivors at all, and another ten percent significantly raise group premiums when cancer histories are involved. *Id.* at 88.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) attempts to alleviate some of the hardship these clauses create. COBRA requires former employers to continue coverage for employees who are unable to obtain coverage at their next job. COBRA awards benefits to those who are not eligible for coverage at their new place of employment because of a preexisting condition. Susan G. Curtis & Richard G. Schwartz, *ERISA Coverage: COBRA Continuation Coverage*, in UNDERSTANDING ERISA 1992: AN INTRODUCTION TO BASIC EMPLOYEE RETIREMENT BENEFITS, 439, 450-51 (1992). Under COBRA, the former employee must pay for the coverage. *Id.* COBRA is, however, expensive and limited in its effectiveness. The benefits are available to discharged employees for approximately 18 months. COBRA coverage for former employees is the same as the coverage for other employees. Thus, if an employer changes its benefits package for its employees, the COBRA package changes as well. Leslie Pickering Francis, *Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881, 1911 (1992).

24. Nearly 78% of all labor disputes in the 1980s concerned health benefits as employees and employers began to realize they could not pay for health insurance alone. *Turning Point*, *supra* note 1. One employer reclassified its workers from "employees" to "independent contractors" to avoid paying health benefits. *Seaman v. Arvida Realty Sales*, 985 F.2d 543, 544-45 (11th Cir. 1993).

25. Matthiessen, *supra* note 2. Many factors contribute to the increase in health costs. Ironically, medical advances may be the main culprit. Spencer Rich, *High-Tech Gain in Modern Medicine Wields Hefty Price Tag*, L.A. TIMES, Dec. 18, 1992, at 20B [hereinafter *High-Tech Gain*]. The population lives longer, creating greater use of health care facilities. Kelli D. Back, *Rationing Health Care: Naturally Unjust?*, 12 HAMLINE J. PUB. L. & POL'Y, 245, 245 (1991). New medical technology, such as MRIs, are costly. *Id.* There is an emphasis on preserving life at any cost, without regard to the quality of that life. *Id.* Deregulation has added to the cost, as hospitals and health providers compete for customers through modern technology rather than cost cutting. Cindy Rugeley, *Budget-Buster of Past Revived as Cost Saver: Health Panel Eyes Need Certificate*, HOUSTON CHRON., June 14, 1992, at 1. Litigation also increases health costs because doctors are forced to practice defensive medicine. Stuart, *supra* note 8, at 51. Twenty to thirty percent of services rendered are unnec-

is less than five percent.²⁶ The U.S. Department of Commerce predicted that the United States will spend nearly one trillion dollars on health care in 1993, an increase of twelve percent over 1992.²⁷ To offset these huge annual increases, insurance premiums have increased annually at an average of 21%; while medical costs increased 9.1%, and the U.S. inflation rate was only 4.9%.²⁸

B. *The Rise in Self-Insurance*

Faced with astronomical annual premium increases, even the largest, most financially secure employers have few choices.²⁹ An employer can pay the increase, only to be faced with another increase

essary, perhaps largely due to doctors' fear of malpractice suits. Hirshfeld, *supra* note 1, at 1821-22.

In the past, new additions to hospital equipment had to be approved by a state board. Rugeley, *supra*. Deregulation has allowed hospitals and other health care providers to increase services without concern for access to equipment due to state regulation. For example, San Francisco has as many MRI machines as all of Canada. *New MIRC Publication Spotlights U.S. Healthcare Scenarios for Year 2000*, BUS. WIRE, Feb. 24, 1993, available in LEXIS, Nexis Library, Current File [hereinafter *New MIRC*].

Although many commentators cite AIDS as a drain on health costs, only 1-2% of U.S. health care costs are attributable to AIDS. Padgug & Oppenheimer, *supra* note 20, at 36. Empire Blue Cross, the largest insurer in New York, reports that the total cost of AIDS from 1982-89 was \$35 billion — only 1% of its total expenditures — even though New York is considered one of the epicenters of AIDS. *Cost of Aids Epidemic Only 1% of Empire Blue Cross Total, Insurer Says*, 17 PENS. REP. (BNA) 1165 (July 2, 1990). AIDS does not cost more than most diseases. The estimated cost of AIDS from diagnosis to death ranges from \$23,000 to \$147,000. An average heart attack costs nearly \$67,000. Sohlgren, *supra* note 13, at 1259 n.60. Treatment for cancer of the digestive system costs \$47,500. *Id.*

Hirshfeld argues that health care costs can only be minimally reduced because of the aging population, advances in technology, and structural inflation. Hirshfeld, *supra* note 1, at 1814.

26. Arthur Caplan, *"Managed Competition" in Health Care to Need Disclosure, Mandatory Targets*, ST. PAUL PIONEER PRESS, Jan. 11, 1993, at 4A.

27. *Id.* Costs of health care are dramatically higher in the United States than in countries which provide nationalized health care. U.S. health care costs per person were 85% higher than in France and 158% higher than in Denmark. Stuart, *supra* note 8, at 51. The United States also spends 40% more per capita on health care than Canada. Storer H. Rowley, *Prescription From Canada: Would Universal Health Care Work in this Country?*, CHI. TRIB., May 31, 1992, at 14C.

28. Matthiessen, *supra* note 2.

29. Ninety percent of 384 top executives of the nation's largest companies surveyed asserted that the United States must totally reform its health care system. *Turning Point*, *supra* note 1.

next year; it can drop all health insurance; or it can self-insure its health plan. Increasingly, employers decide to self-insure. Employers who self insure set aside money, often supplemented with employee contributions, to pay the health claims of their employees. No insurance company is involved.³⁰ By 1991, sixty-four percent of all employers self-insured their health plans.³¹ Self-insured health plans now cover over forty percent of the American workforce.³²

The ERISA loophole provides an incentive to self-insure health plans because it preempts such plans from state laws dictating the elements of health plans.³³ Under the loophole, state insurance regulations do not apply to self-insurance plans because they are not considered part of the insurance business.³⁴

30. Some firms employ third party administrators (TPAs) to oversee the plan. Insurance companies often serve as TPAs, but they only process the claims. Aetna now reports that 65% of its business results from service as TPAs. Christine Woolsey, *More Small Firms Self-Fund Benefits*, BUS. INS., Jan. 28, 1991, at 3, 12. An insurance company that has a TPA contract is not considered to be in the business of insurance. *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 412-13 (3d Cir. 1987). See *infra* notes 60-70 and accompanying text for discussion of "business of insurance."

31. Marybeth Burke, *Growth of Self-Funded Plans Sets Hurdles for State Reform Efforts*, HOSPITALS, June 20, 1992, at 34. Use of self-insured plans has dramatically increased in the last few years. In 1990, 59% of U.S. employers self-insured, an increase of 13.5% from 1989. Woolsey, *supra* note 30, at 3. This phenomenon crosses all sizes of firms. In 1990, 37% percent of small firms, those with fewer than 500 employees, self-insured. This represents an increase of 23.3% from 1989. *Id.* Medium size firms, those with 2,500 to 5,000 employees, showed a similar increase of 20.7% so that now 70% of them self-insure. Very small firms, those with fewer than 100 employees, show the most dramatic increase in self-insurance use. In 1988, only 8% of these companies self-insured. Tawn Nhan, *A Healthy Direction: Third Party Health Benefits Administrators Are Thriving as More Mid-size and Small Companies Turn to Self-Insurance to Fight Rising Costs*, ST. PAUL PIONEER PRESS, Dec. 13, 1992, at 8D. Now, 26.7% of very small businesses self-insure — an increase of over 300% in 3 years.

32. Collins, *supra* note 4. Some estimate 56% of employees are covered by self-insured plans. Bruner, *supra* note 20, at 1130.

33. The primary reason for self-insuring is to avoid state regulation. Sohlgrén, *supra* note 13, at 1256-57. Consultants on health care costs now recommend self-insuring as a preferred technique. *Id.* at 1257. Most states require mental health benefits and chemical dependency counseling, and prohibit discrimination against people with disabilities, such as AIDS. Jesus Sanchez, *Ill Feelings Over Self-Insurance*, L.A. TIMES, June 9, 1991, at 1D.

34. See *infra* notes 68-70 and accompanying text discussing preemption and the McCarran-Ferguson Act.

Self-insurance gives employers greater flexibility in their health plans. Employers can eliminate costly coverage for chemical dependency treatment and mental health services.³⁵ Employers reduce costs because they no longer have to pay the profit margin and administrative costs of the insurance companies.³⁶ Employers also recoup money remaining at the end of the year, rather than leaving it to subsidize others.³⁷ Self-insured health plans often negotiate for discounts from local health care providers.³⁸ Employers with self-insured health plans have more control over claims, including workers' compensation claims, by improving access to medical records.³⁹

35. Most states require these benefits be included, but ERISA preempts state law. ERISA § 514, 29 U.S.C. § 1144 (1988 & Supp. IV 1992). See also *supra* note 13 for a list of minimum benefit statutes. Employers may pay the costs of reducing coverage through low employee morale, negative public relations, and less qualified workers at higher salaries. Greely, *supra* note 6, at 119.

36. Profit margins and administrative costs of insurers account for 6-10% of health insurance. Scott Carlson, *When Your Company Self-Insures*, ST. PAUL PIONEER PRESS, May 8, 1990, at 1C. Many employers claim an annual savings of over 25% after switching to self-insured plans. Nhan, *supra* note 31. Costs are further reduced because ERISA preempts state remedies. Federal remedies are limited to medical costs and attorney's fees. *Id.* For a more detailed analysis of the ERISA preemption doctrine, see *infra* notes 57-60 and accompanying text.

37. Nhan, *supra* note 31. By definition, the risk pool is limited to the specific employer and cannot be expanded. Bruner, *supra* note 20, at 1121. But see *infra* note 273 for a discussion of Minnesota self-insured businesses that have banded together to cut costs.

38. Stuart, *supra* note 8, at 52. PPOs and HMOs are also gaining popularity with insurance companies as a means of cutting costs. Under these programs, flat rates are charged, either on a per visit or an estimated use basis. Plan participants are encouraged to use the specified facilities or doctors through lower deductibles and co-payments. See *infra* notes 274-75, which define HMOs and PPOs.

39. Reduction of workers' compensation claims occurs in two ways. First, with access to pre-existing conditions through medical records, fraudulent claims are weeded out. Second, using managed care, fewer claims are brought because the employees feel they are being treated well. Stuart, *supra* note 8, at 53-54.

Employers can also control the commencement and termination of benefits. For example, they can start coverage of new employees after 120 days, rather than insuring them during probationary periods when turnover is the highest. Termination of benefit notices are distributed to former employees faster under self-insured plans, thus reducing the amount of time a person is covered. *Id.* at 53. For an example of the effect of greater access to medical records, see *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984) (involving the discharge of an executive covered by a self-insured health plan after he was diagnosed with a serious illness).

Many self-insured health plans are not entirely self-funded, especially in the case of smaller firms that self-insure.⁴⁰ These plans often purchase stop-loss insurance, a form of reinsurance.⁴¹ Two forms of stop-loss insurance are available. Aggregate stop-loss insurance covers aggregate claims for the employer if claims exceed a specified amount.⁴² Specific stop-loss insurance covers claims in excess of a specified amount during a particular period for a covered individual.⁴³ Many self-insured health plans purchase both forms of stop-loss insurance, especially during the initial period of change from insured to self-insured.⁴⁴ However, these forms of reinsurance can prove costly.⁴⁵ Annual premium increases often top twenty per-

40. Small firms are most likely to purchase reinsurance because of the effect that large claims could have on their cash flow. Woolsey, *supra* note 30, at 12. The lack of "deep pockets" is a problem for small firms self-insuring. One catastrophic illness can jeopardize an entire company that has not prepared for such an event. However, most self-insurance plans are well managed and have a vested interest in remaining well managed to maintain ERISA preemption. Sanchez, *supra* note 33.

41. Stop-loss insurance is a form of reinsurance by which the employer obtains an extra insurance policy for claims which exceed its expectations. If claims exceed a specific dollar value, the reinsurance will cover the excess amount. Up to 73% of plans purchase stop-loss insurance in one form or another. Woolsey, *supra* note 30, at 12.

42. Stuart, *supra* note 8, at 51. Stop-loss insurance usually is triggered when costs exceed 125% of the estimated cost in a given period. Louise Kertesz, *Specific Stop-Loss Costs Zoom*, Bus. Ins., Jan. 29, 1990, at 14.

43. Stuart, *supra* note 8, at 51. For example, if a self-insured plan anticipates \$15,000 coverage per participant during a specified period, but a participant exceeds this amount due to a serious illness, stop-loss insurance covers the excess amount. Some employers find it difficult to purchase stop-loss insurance if their employees have histories of catastrophic illnesses. See, e.g., *Owens v. Storehouse, Inc.*, 773 F. Supp. 416, 418 (N.D. Ga. 1991) (involving denial of reinsurance to an employer because it employed five people with AIDS). Stop-loss insurers now require more information about participants' health status, particularly those participants who are disabled. This enables insurers to adjust premium rates to reflect the estimated cost of coverage for individuals with the relevant health conditions. Kertesz, *supra* note 42, at 14.

44. Stuart, *supra* note 8, at 51-52 (noting that initially a firm may purchase more insurance until it has more reliable claims experience).

45. Specific stop-loss insurance premiums in the 1980s have risen up to 100% per year. Kertesz, *supra* note 42, at 14. To counter the rise in premiums, some employers increase the trigger amount for high risk employees. Thus, an employer may pay more of the health care costs for a high risk employee, but lower its stop-loss insurance premium by setting a high "trigger" for that employee. *Id.*

Courts are split regarding whether stop-loss insurance is exempt from ERISA. One court held that the self-insured plan is not exempt from ERISA; it is subject to state minimum benefits laws through the stop-loss insurance policy. Michigan

cent, making reinsurance prohibitively expensive for many small companies.⁴⁶ While self-insured plans may save money over the long run, a catastrophic illness in one year can eliminate all savings.⁴⁷ A catastrophic illness may bankrupt many health care funds, with or without stop-loss coverage,⁴⁸ but could also lead to bankruptcy of the company that self-insures.⁴⁹ Employers face the tough choice between insuring all employees and risking elimination of health care benefits after a catastrophic illness occurs, or insuring only their healthy employees.⁵⁰

United Food and Commercial v. Baerwaldt, 767 F.2d 308, 313 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986). *But see* Bone v. Associate Management Services, Inc., 632 F. Supp. 493, 494 (S.D. Miss. 1986) (holding stop-loss insurance insures the employer, not the health plan, thus it is not related to ERISA plan and is exempt).

46. Woolsey, *supra* note 30, at 13. See *supra* notes 40 & 45 for a discussion of the aspects of stop-loss insurance.

47. Health claims can fluctuate 50 to 60% in a year. Either stop-loss insurance premiums will rise or the insurance policy will be cancelled the next year because reinsurance is based on experience-rating. Woolsey, *supra* note 30, at 13 (documenting 19.4% rise in stop-loss premiums in 1990); *see also* Kertesz, *supra* note 42, at 14 (noting that specific stop-loss rates are driven by medical care costs).

48. In a three-month period in 1990, three self-insured health plans covering over a total of 7,000 employees went bankrupt in one state. St. Anthony, *supra* note 22. In an effort to prevent health plans from going bankrupt, some members of Congress have tried to amend ERISA to prohibit small firms from self-insuring. Other members of Congress have tried comprehensive plans to provide better and cheaper access for small business to health insurance, including federal and state subsidies. Spencer Rich, *Senate Health Package Focuses on Small Business*, WASH. POST, Mar. 5, 1992, at A07 [hereinafter *Small Business*].

49. *See, e.g., Owens*, 773 F. Supp. at 418 (involving claim by an employer that it would go out of business if it continued to pay all health care costs of its employees with AIDS).

50. It is becoming increasingly difficult to find a "healthy" employee because of better diagnostic and genetic screening. *See generally* Rothstein, *supra* note 2 (discussing effects of Title I of the ADA on genetic screening). Ironically, an employer may have few healthy employees to include in its health plan. Healthy employees are searching for cheaper, individual health insurance policies. The New York State Bar Association lost its coverage from Empire Blue Cross because 2,000 members left the plan after finding less expensive individual coverage. Because they were left with the less healthy members, Empire dropped its contract with the bar association, a move which left 10,000 people uninsured. The bar association as since found another carrier. Francis, *supra* note 23, at 1912. Some employers are finding it nearly impossible to obtain health insurance if their coverage includes a person with a disability. SHARING THE RISK, *supra* note 1, at 3.

II. ERISA PREEMPTION DOCTRINE

The Employee Retirement Income Security Act of 1974 (ERISA)⁵¹ protects employee benefit plans.⁵² As the title indicates, most of the Act concerns retirement benefits.⁵³ Retirement plans have explicit funding and vesting requirements as well as fiduciary duties in an effort to ensure their financial soundness and management.⁵⁴ Employee welfare plans, such as health plans, are subject only to reporting duties and limited fiduciary responsibilities.⁵⁵ Rather than ensuring the financial stability of health and welfare plans through funding and vesting requirements, Congress left such plans virtually unregulated.⁵⁶

51. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992)).

52. There are two categories of employee benefit plans under ERISA:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing . . . through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability . . .

29 U.S.C. § 1002(1).

ERISA also covers pension plans:

(2)(A) . . . the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which . . . is established or maintained by an employer or by an employee organization . . . that by its express terms . . . such plan . . . (i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond.

29 U.S.C. § 1002(2)(A).

53. 29 U.S.C. § 1001.

54. 29 U.S.C. §§ 1021-1031 (reporting and disclosure); 29 U.S.C. §§ 1051-1061 (vesting); 29 U.S.C. §§ 1081-1086 (funding); 29 U.S.C. §§ 1101-1114 (fiduciary duty).

55. 29 U.S.C. §§ 1021, 1102-1113. *See also* Curtis & Schwartz, *supra* note 23, at 441. The Department of Labor, which enforces ERISA, exempts welfare plans with fewer than 100 participants from reporting requirements. *Id.* (citing to Dept. of Labor Reg. §§ 2520.104 to -20).

56. Congress explicitly rejected vesting requirements for health benefits because health insurance must respond to inflation, changes in medical practice and technology, and increases in the cost of insurance over inflation. Too many unstable variables make vesting inappropriate. This treatment of health benefit plans is in contrast to the treatment of pension plans, which are required to vest. Actuarial decisions concerning fixed annuities are based on more stable data. H.R. REP. NO. 807, 93rd Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4726.

A. *Statutory Framework of the ERISA Preemption Doctrine*

To provide national uniformity in pension and welfare benefit plans, Congress specifically preempted all ERISA plans from state regulation.⁵⁷ Section 514 of ERISA preempts any state law that “relate[s] to” an ERISA plan,⁵⁸ including health plans. This makes administration of ERISA plans easier because an employer must only abide by federal laws rather than different laws for each state in which it does business.⁵⁹ The “savings clause” exempts state regulation of “the business of insurance” from federal preemption to maintain the traditional role of the state in regulating the insurance industry.⁶⁰ There is an exception to the savings clause. The “deemer clause” mandates that employee benefit plans, such as self-insured health plans, shall not be deemed insurance companies or insurers, nor be deemed in the business of insurance for purposes of any state laws regulating insurance.⁶¹

57. The Supremacy Clause preempts federal law over state law if the statute expresses such intent, if Congress intends to occupy the field exclusively, or if the state law conflicts with federal law. U.S. CONST. art. IV, § 2. *See also* *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (discussing when federal law preempts state law). The ERISA preemption clause provides: “Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.” ERISA § 514(a), 29 U.S.C. § 1144(a).

State criminal laws are not preempted by ERISA. ERISA § 514(b)(4), 29 U.S.C. § 1144(b)(4). *But see* *Sforza v. Kenco Constructional Contracting, Inc.*, 674 F. Supp. 1493, 1495 (D. Conn. 1986) (holding that § 514(b)(4) of ERISA only refers to laws which are generally applicable, not criminal statutes aimed at the insurance industry).

58. ERISA § 514(a), 29 U.S.C. § 1144(a).

59. 29 U.S.C. § 1001.

60. The savings clause provides: “Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

Until 1944, the business of insurance was left for the states to regulate. In *United States v. Southeastern Underwriters Ass’n*, 322 U.S. 533 (1944), the Supreme Court held that the business of insurance was interstate commerce subject to federal regulation. *Id.* at 553. However, the Court provided that the state still had primary regulatory authority if the matters were fundamentally local and if Congress had not spoken. *Id.* at 548. In 1945, Congress passed the McCarran-Ferguson Act to assure states that they would continue to regulate the business of insurance. 15 U.S.C. §§ 1011-1015 (1988). *See also infra* notes 62-67, which discuss the development of the McCarran-Ferguson Act test.

61. The deemer clause provides:

The McCarran-Ferguson Act⁶² preserves the states' role in regulating insurance.⁶³ Judicial interpretations of the McCarran-Ferguson Act consider three criteria in deciding whether a practice is within the business of insurance.⁶⁴ First, the practice must spread risk.⁶⁵ Second, the practice must be an integral part of the relationship between insured and insurer.⁶⁶ Third, the practice must be aimed solely at entities within the insurance industry.⁶⁷

Self-insured plans do not meet the third McCarran-Ferguson Act criterion⁶⁸ because the ERISA deemer clause prohibits classification of employee benefit plans and insurance contracts as "in the business of insurance" or "insurance subject to state regulation."⁶⁹

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such a plan, *shall be deemed* to be an insurance company or other insurer . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts . . .

ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (emphasis added).

62. 15 U.S.C. §§ 1011-1015.

63. The McCarran-Ferguson Act provides: "Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011.

See *supra* note 60 for a discussion of the traditional role of states in insurance regulation.

64. See *Metropolitan Life Ins., Inc. v. Massachusetts*, 471 U.S. 724, 743 (1985) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

65. *Metropolitan Life*, 471 U.S. at 743.

66. *Id.*

67. *Id.*

68. It is doubtful that self-insurance health plans spread risk, as is required by the first part of the McCarran-Ferguson test. By definition, self-insurance health plans have an unchanging risk pool. The pool is predetermined by the size of the company. However, self-insured plans use traditional underwriting principles, which may be sufficient to meet the first part of the test. *Cf. Bruner, supra* note 20, at 1121. *But see Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (applying McCarran-Ferguson test and finding that self-insured assumes all risk, thus suggesting that self-insureds are not engaged in the insurance business). The second part of the McCarran-Ferguson Act is met because self-insurance is an integral part of the relationship between "insurer" and insured, even though the plan cannot be deemed an insurance company because of the deemer clause.

69. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). See *FMC v. Holliday*, 498 U.S. 52, 62 (1990) (holding that the deemer clause precludes regulation of self-insurance health plans).

More explicitly, a state can regulate the actions of an insurance company, including the terms of its insurance policies, through the traditional delegation of insurance regulation to states. Although states can regulate insurance companies generally, health plans cannot be regulated directly because of the deemer clause. The state indirectly regulates health plans through its control over the insurance company. However, when the health plan is not provided through a company considered to be in the business of insurance,⁷⁰ the state cannot regulate even indirectly the content of the health plan.

B. *Development of the Self-Insured Exemption*

In *Shaw v. Delta Airlines*,⁷¹ the Supreme Court unanimously held that section 514 of ERISA preempts state laws mandating minimum benefits in health insurance plans.⁷² *Shaw* involved New York employment discrimination laws which were broader than the federal law; specifically, Title VII as amended by the Pregnancy Discrimination Act.⁷³ The laws required employers to pay certain benefits to employees unable to work because of injury or illness, including pregnancy.⁷⁴ After determining that the laws “relate[d] to” employee benefits plans, through a broad interpretation of that phrase,⁷⁵ the Court grappled with the relation between Title VII, which depends on state law for enforcement, and the savings exception to preemption.⁷⁶ The Court determined that ERISA preempts state laws which are stricter than Title VII without frustrating Title VII enforcement.⁷⁷

70. See *supra* notes 62-67 and accompanying text for an overview of the “business of insurance” test.

71. 463 U.S. 85 (1983).

72. *Id.* at 98.

73. *Id.* at 88-89.

74. *Id.* at 89-90.

75. 463 U.S. at 96. The Court defined “relates to” in § 514(a) of ERISA as anything having “a connection with or reference to” employee benefit plans. *Id.* at 96-97. The Court found that Congress intended a broad reading of “relates to” rather than a requirement that the state law be specifically designed to affect such plans. *Id.* at 98. To define it otherwise, the Court felt, would read out the rest of § 514 which exempts certain areas from preemption. The Court also rejected limiting preemption to those subjects covered by ERISA, i.e., reporting, disclosure and fiduciary duties. *Id.*

76. 463 U.S. at 102-04.

77. *Id.* at 103. Title VII depends on state law for enforcement, but is silent on employment practices which are legal under federal law and illegal under state law.

Two years later, in *Metropolitan Life Insurance Co. v. Massachusetts*,⁷⁸ the Supreme Court further broadened the scope of the preemption clause. The Court faced a Massachusetts statute mandating minimum mental health benefits for those insured under an employee health plan or under a general insurance policy.⁷⁹ Massachusetts argued that the savings clause exempted the mandated benefits from ERISA preemption because its mandated benefits law regulated insurance.⁸⁰ The Court employed a broad interpretation of "relates to"⁸¹ and easily found that the Massachusetts law related to ERISA welfare plans.⁸² Applying the McCarran-Ferguson Act test,⁸³ the Court found that mandated benefit laws constitute state regulation of the business of insurance.⁸⁴ The Court then carved out a special exemption from state law for self-insured employers.⁸⁵

ERISA requires that its provisions cannot modify or impair federal law. By only partially preempting the state law when it prohibits practices legal under Title VII, federal law is not frustrated. *Id.* at 102-03. The Court recognized the practical difficulty of partial preemption because states will have to determine whether employment practices are illegal under Title VII rather than under a broad state law. The Court felt that state agencies and courts are sufficiently familiar with Title VII to apply it in this manner for ERISA plans. *Id.* at 105-06.

The Court suggested that states could mandate separate disability plans to enforce their anti-discrimination policies. *Id.* at 108. States could allow employers to choose between regulation of disability benefits through two separate plans or one plan which includes state mandated health benefits and health benefits not required by law. *Id.* *But see* California Fed. Savings & Loan Ass'n. v. Guerra, 479 U.S. 272, 292 (1987) (holding that Title VII does not preempt stricter state law on pregnancy disability).

78. 471 U.S. 724 (1985).

79. *Id.* at 727. All states require that certain benefits, such as chemical dependency treatment and mental health coverage, be included in group health plans provided through employers. *Id.* at 728. See also *supra* note 13 for a partial list of these statutes.

80. 471 U.S. at 733.

81. See *supra* note 75 for a discussion of the definition of "relates to."

82. 471 U.S. at 739. The Court found that the statute relates to such plans even if the law was not labeled a benefit plan law. *Id.*

83. See *supra* notes 62-67 and accompanying text for a discussion of the McCarran-Ferguson test.

84. 471 U.S. at 743. The Court found that the statute regulates the spreading of risk based on the explicitly stated purpose of the law. *Id.* Further, such laws directly regulate an integral part of the relationship between insurer and policy holder. *Id.* Finally, the statute has the intent of affecting such relationship. *Id.*

85. The Court exempted "plans that purchase insurance . . ." because they "are directly affected by state laws that regulate the insurance industry." *Id.* at 732. This is in contrast to plans that self-insure. *Id.*

The Court drew a distinction in the application of the deemer clause⁸⁶ by “giv[ing] life” to a congressional distinction between insured and self-insured health plans.⁸⁷ Self-insured plans are not open to indirect regulation.⁸⁸ Because such plans cannot be deemed a product of the business of insurance, the content of the plans cannot be regulated.⁸⁹

ERISA preemption encompasses most state claims, including tort and contract claims.⁹⁰ In *Pilot Life Insurance Co. v. Dedeaux*,⁹¹ Dedeaux brought state actions of tortious breach of contract, breach

86. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). See *supra* note 61 for the text of the clause.

87. 471 U.S. at 747. The Court read the deemer clause to exempt from the savings clause laws regulating insurance contracts that apply directly to benefit plans. *Id.* at 741. Therefore, the only way to regulate the substance of an insurance contract is to regulate the insurance company. Because the deemer clause prohibits “deeming” a plan to be an insurance company, a plan that is not insured through an insurance company cannot be regulated by the state.

88. The Court stated: “We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” 471 U.S. at 747.

89. *Id.* at 741.

90. See, e.g., *Ingersoll-Rand Corp. v. McClendon*, 498 U.S. 133 (1990) (state wrongful discharge claim); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (state law trying to effectuate goals of ERISA); *Anderson v. John Morrell & Co.*, 830 F.2d 872 (8th Cir. 1987) (breach of contract claim for plan modification); *Gilbert v. Burlington Indus., Inc.*, 765 F.2d 320 (2d Cir.) (state claims for severance benefits), *aff'd*, 477 U.S. 901 (1986); *Holland v. National Steel Corp.*, 791 F.2d 1132 (4th Cir. 1986) (state breach of contract claim); *Salomon v. Transamerica Occidental Life Ins. Co.*, 801 F.2d 659 (4th Cir. 1986) (state claims for recovery of benefits); *Children’s Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (state law requiring that mental health benefits be equal to physical health benefits); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985) (state contract and tort claims); *Stone & Webster Eng’g Corp. v. Iilsley*, 690 F.2d 323 (2d Cir. 1982) (state law requiring an employer to provide health insurance coverage to former employee receiving workers’ compensation), *aff’d sub nom. Arcudi v. Stone & Webster Eng’g Corp.*, 463 U.S. 1220 (1983); *Oracare DPO, Inc. v. Merin*, No. 88-4171, 1991 WL 113149 (D.N.J. June 25, 1991) (health plans providing medical services); *Ferrell v. Carroll*, No. Civ.A.89-4328, 1990 WL 63691 (E.D. Pa. May 9, 1990) (breach of contract claims); *Lucas v. Wheeler Mach. Co.*, No. 89-C-0565-5, 1989 WL 226144 (D. Utah Dec. 8, 1989) (state anti-discrimination act and torts claims for negligence and intentional acts); *Self-Insurance Inst. of Am. v. Gallagher*, No. TCA867308 WS, 1989 WL 143288 (N.D. Fla. June 2, 1989) (state law regulating administrators of benefit plans); *Tucker v. Montgomery Ward*, No. 86-C-9734, 1987 WL 14616 (N.D. Ill. July 17, 1987) (right to jury trial); *Johnson v. Montgomery Ward*, No. 85-6542-FR, 1986 WL 10303 (D. Or. July 3, 1986) (state statute prohibiting discrimination in terms of employment); *Brock v. Self*, 632 F. Supp. 1509, 1518 (W.D. La. 1986) (state actions for fraud and breach of contract preempted); *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo.

of fiduciary duties, and fraud against an insurance company that terminated his disability benefits.⁹² The Court found Dedeaux's complaint "relate[d] to" an employee benefit plan.⁹³ Thus, ERISA preempted the complaint. To avoid preemption, the law under which a cause of action is brought must be specific to the business of insurance.⁹⁴ Claims of bad faith can be brought outside the insurance context. Thus, the savings clause did not exempt the complaint from ERISA preemption.⁹⁵

The courts also have determined explicitly which state laws ERISA does not preempt.⁹⁶ *Fort Halifax Packing Co. v. Coyne*⁹⁷

1984) (state tort claims of interference with employee benefit plans, intentional and negligent infliction of emotional distress).

91. 481 U.S. 41 (1987).

92. *Id.* at 43.

93. *Id.* at 47.

94. *Id.* at 51. The Court used the McCarran-Ferguson test to determine whether the practice related to the business of insurance. The Court concluded respondent's claims were not exclusive to the business of insurance regulation. "A common sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Id.* at 50. At best, the Court found an attenuated connection between the law and the insurer-insured relationship. *Id.* at 51.

95. *Id.* at 57.

96. *See, e.g., Mackey v. Lanier Collection Agency & Services, Inc.*, 486 U.S. 825, 831-32 (1988) (general garnishment law which garnished benefit plans); *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (fraudulent inducement); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987) (city ordinance taxing income not preempted as applied to ERISA plan); *Northern Groups Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 95 (6th Cir. 1987) (state regulation requiring health insurance be primary source to pay for medical expenses in auto accident); *Sommers Drug Stores Co. v. Corrigan Enter., Inc.*, 793 F.2d 1456, 1470 (5th Cir. 1986) (breach of fiduciary duty), *cert. denied*, 479 U.S. 1034 (1987); *International Union v. Keystone Consol. Indus.*, 793 F.2d 810, 814 (7th Cir.) (collective bargaining for obligations greater than and separate from ERISA minimum funding requirements for pension funds), *cert. denied*, 479 U.S. 932 (1986); *California Hosp. Ass'n v. Henning*, 770 F.2d 856, 860 (9th Cir. 1985) (traditional vacation benefits), *cert. denied*, 477 U.S. 904 (1986); *Lane v. Goren*, 743 F.2d 1337, 1341 (9th Cir. 1984) (state laws prohibiting employment discrimination); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (state law controlling hospital costs not preempted as long as it did not obstruct self-insured plan from negotiating with hospital for discounts), *cert. denied*, 472 U.S. 1008 (1985); *Bucyrus-Erie Co. v. Wisconsin*, 599 F.2d 205, 213 (7th Cir. 1979) (state employment laws), *cert. denied*, 444 U.S. 1021 (1980); *Upholsterer Int'l Union v. Pontiac Furniture*, 647 F. Supp. 1053, 1056 (C.D. Ill. 1986) (state law imposing criminal sanctions for failure to contribute to established health plan).

97. 482 U.S. 1 (1987).

involved a Maine statute requiring employers to provide a one-time severance payment to their employees in the event of a plant closing.⁹⁸ Fort Halifax challenged the provision, claiming ERISA preempted the state law because it “relate[d] to” benefit plans.⁹⁹ The Court rejected this argument because the preemption clause only concerns benefit plans, not individual benefits.¹⁰⁰ The Court explained that Congress intended to create a statutory scheme allowing uniform administrative policies for benefit plans, rather than having different policies for each state.¹⁰¹ The concern over uniform administrative procedures only arises when the benefits provided require ongoing administrative commitments.¹⁰² A one-time disbursement does not require any ongoing commitment, nor does it require the employer to maintain a plan.¹⁰³

Although *Fort Halifax* appeared to limit the preemption clause by distinguishing between an individual benefit and a benefit plan, the Court returned to a broad interpretation in *FMC Corp. v. Holliday*.¹⁰⁴ FMC ran a self-insured health plan that included a subrogation clause requiring participants to reimburse the plan if the participant recovered in a liability action against a third party.¹⁰⁵ A state law prohibited subrogation when a plan participant recovered in a tort action arising out of an auto accident.¹⁰⁶ The self-insuring employer sought recovery of an award to Holliday, daughter of the plan participant, in a negligence action arising from an auto accident.¹⁰⁷ The Court found that the state anti-subrogation statute “re-

98. *Id.* at 3.

99. *Id.* at 7. ERISA explicitly lists severance pay as a benefit. 29 U.S.C. § 1002(1)(B) (1988 & Supp. IV 1992).

100. *Id.* at 11-12. The Court pointed to the separate use of “benefit” and “plan” throughout ERISA. *Id.* The four dissenting Justices felt that the Maine statute creates a plan controlled by ERISA. *Id.* at 24. Because the state statute creates the plan, it clearly “relates to” the plan, so ERISA preempts the state law. *Id.* at 24 (White, J., dissenting).

101. *Id.* at 9.

102. 482 U.S. at 11.

103. *Id.* at 12. The dissent pointed out that this holding creates a new loophole which premises preemption on the existence of an administrative plan. *Id.* at 23 (White, J., dissenting).

104. 498 U.S. 52 (1990).

105. *Id.* at 54.

106. *Id.* at 55.

107. *Id.* at 55.

late[d] to" an ERISA benefit plan.¹⁰⁸ The savings clause excludes the law from ERISA preemption because the law is aimed at the insurance industry.¹⁰⁹ The development of the exemption for self-insured plans, through the deemer clause, excepts the state law from the savings clause when the health plan is self-insured.¹¹⁰ Thus, Holliday had to reimburse the self-insured health plan.¹¹¹ If the health plan were insured,¹¹² Holliday would have kept the \$50,000 award. The dissent characterized this result as affording Holliday unequal protection of the law.¹¹³

The news headlines demonstrate the impact of the breadth of the preemption clause. *McGann v. H & H Music Co.*¹¹⁴ raised the problem of eliminating health insurance for individuals with AIDS.¹¹⁵ In December 1987, John McGann was diagnosed with AIDS.¹¹⁶ His insurance policy through H & H Music (H & H) had a lifetime cap of \$1 million.¹¹⁷ Under the insured health plan, McGann's health care costs were paid.¹¹⁸ Seven months after McGann was diagnosed and began treatment for AIDS, H & H switched to a self-insured health plan.¹¹⁹ As a cost-saving measure, H & H reduced its lifetime benefits from \$1 million to \$5,000 for participants with AIDS.¹²⁰ All other catastrophic illnesses remained covered up

108. *Id.* at 58. The Court found that it both referred to and had a connection with an ERISA plan. *Id.* at 59 (applying *Shaw* test).

109. *Holliday*, 498 U.S. at 60-61.

110. *Id.* at 61. The Court rejected a new reading of the deemer clause that would only preempt state laws that apply to insurance as a business based on statutory language, e.g., licensure and capitalization provisions. *Id.* at 63.

111. The Court found this result consistent with the idea that the state may regulate the business of insurance as defined by the McCarran-Ferguson Act. *Id.* at 62.

112. This result forms the basis of Justice Stevens' dissent. He saw a "disparate treatment of similarly situated beneficiaries" which results in an irrational outcome. *Id.* at 66 (Stevens, J., dissenting).

113. *Id.*

114. 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992).

115. For other recent cases challenging reduction of benefits, see *Felton v. Unisource Corp.*, 940 F.2d 503 (9th Cir. 1991) (dropping participant with lung cancer); *Owens v. Storehouse, Inc.*, 773 F. Supp. 416, 418 (N.D. Ga. 1991) (reducing coverage for AIDS-related claims).

116. *McGann*, 946 F.2d at 403.

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

to \$1 million.¹²¹ By January 1990, McGann had reached the \$5,000 limit on coverage for AIDS.¹²² McGann claimed H & H discriminated against him for exercising his rights under the medical plan to cover his health care costs.¹²³ He also claimed that the change in the plan interfered with his attainment of rights under the plan.¹²⁴

Though the Fifth Circuit found a connection between the benefit redirection and McGann's health care claims, it accepted as a reasonable justification that H & H discriminated against all AIDS-related claims, not against McGann individually.¹²⁵ The court also found the employer did not promise to continue benefit coverage up to \$1 million.¹²⁶ Health plans do not have vesting requirements under ERISA.¹²⁷ The court refused to see the reduction in benefits as a retaliatory move against McGann for exercising his right to coverage.¹²⁸ To construe the action in this manner would prohibit legitimate changes in benefits to cut costs.¹²⁹ McGann died before his case could reach the Supreme Court.¹³⁰ After his death in 1992, the

121. 946 F.2d at 403. Commentators question the purpose of the reduction of AIDS-related costs, suggesting that the true purpose of the change was discrimination against homosexuals. Sohlgren, *supra* note 13, at 1259.

122. 946 F.2d at 403.

123. *Id.* ERISA prohibits:

the discharge, fine . . . discriminat[ion] against a participant . . . for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with attainment of any rights to which such participant may become entitled under the plan

29 U.S.C. § 1140.

The court stated that the broad reading of discrimination that McGann advocated conflicted with congressional intent to allow employers to create, modify, and terminate ERISA benefits without government interference. ERISA does not require a plan, nor does it require any particular substantive elements in plans that do exist. *McGann*, 946 F.2d at 407.

124. *Id.* at 403.

125. *Id.* at 404.

126. *Id.* at 405. The plan specifically reserved the employer's right to terminate or amend the whole plan or specific benefits at any time. *Id.*

127. *McGann*, 946 F.2d at 405. See also *supra* note 56 for a discussion of reasons Congress rejected vesting requirements for health plans. The purpose of ERISA is to protect the solvency of employee benefit plans so that valid claims of employees will be paid. *McGann v. H & H Music Co.*, 742 F. Supp. 392, 393 (S.D. Tex. 1990), *aff'd*, 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992).

128. *McGann*, 946 F.2d at 405.

129. *Id.*

130. Barbara Presley Noble, *The Legacy of Jack McGann*, N.Y. TIMES, Nov. 15, 1992, at 27.

Supreme Court refused to grant certiorari to review the Fifth Circuit's decision upholding H & H's action under ERISA.¹³¹

III. THE AMERICANS WITH DISABILITIES ACT OF 1990

The Americans with Disabilities Act of 1990 (ADA)¹³² comprehensively addresses the civil rights of persons with disabilities.¹³³ After numerous hearings nationwide,¹³⁴ Congress concluded that

131. The Justice Department seemingly encouraged companies to drop catastrophically ill participants in a brief it filed arguing that the Supreme Court should uphold *McGann*. The Justice Department rationalized its decision by characterizing it as a legal conclusion rather than a policy choice. The brief stated that Congress may amend the ADA to prohibit employers from taking such action in the future. The AMA filed a brief advocating that the Court declare the practice of reducing benefits to the seriously ill illegal. David Savage, *Firms May Cut Ill Workers' Health Benefits*, U.S. ARGUES, L.A. TIMES, Oct. 17, 1992, at A1.

132. 42 U.S.C. §§ 12101-12213 (Supp. IV 1992).

133. Title I prohibits discrimination in employment. 42 U.S.C. §§ 12111-12117. Title II concerns access to transportation and other public services. 42 U.S.C. §§ 12131-12165. Title III guarantees access to public accommodations and services. 42 U.S.C. §§ 12181-12189. Title IV concerns telecommunication access. 47 U.S.C. § 225(d) (amending Communications Act of 1934). Title V combines miscellaneous provisions, including insurance and additional definitions of coverage. 42 U.S.C. §§ 12201-12213 (excluding homosexuals, transvestites, bisexuals and illegal drug users from the definition of disabled person).

Congress declared disabled people a discrete and insular minority, thus opening the door to a Fourteenth Amendment analysis. ADA § 2(a)(7), 42 U.S.C. § 12101(a)(7). This section does not require the courts to declare the disabled a discrete and insular minority, but it does put a great deal of pressure on the courts. The level of scrutiny to be used is difficult to predict. Most likely it will be some form of intermediate scrutiny, similar to the standard used when classification is based on gender. For an analysis of Congress' power to determine which groups constitute discrete and insular minorities, see Matt Pawa, Comment, *When the Supreme Court Restricts Constitutional Rights, Can Congress Save Us? An Examination of Section 5 of the Fourteenth Amendment*, 141 U. PA. L. REV. 1029 (1993). Few courts have had the opportunity to discuss the level of scrutiny applied to disabled persons because they usually sidestep the issue on procedural grounds. See *Heller v. Doe*, 113 S. Ct. 2637 (1993) (declining to address the level of scrutiny applicable because the issue was not argued before lower court); *Trautz v. Weisman*, 819 F. Supp. 282, 294 (S.D.N.Y. 1993) (holding that classification of the disabled as a discrete and insular minority may not provide heightened scrutiny under the Equal Protection Clause, but such classification is relevant to § 1985(c) claims); see also *More v. Farrier*, No. 92-1468, 1993 WL 13505, n.4 (8th Cir. Jan. 27, 1993) (rejecting argument that heightened scrutiny should apply to disabled persons).

134. ADA § 2(a), 42 U.S.C. § 12101(a). Testimony and hearings began in the mid-1980s and included reports from numerous disability councils and polls all finding the same phenomenon: The disabled are poorer, less educated, and have much less social life. S. REP. NO. 116, 101st Cong., 2d Sess. 6, 8 (1990), reprinted in BER-

the forty-three million Americans with disabilities have historically faced discrimination in every facet of their lives.¹³⁵ Title VII of the Civil Rights Act of 1964 (Title VII) and the Rehabilitation Act of 1973, which prohibits employers with government contracts from discriminating against persons with disabilities, were the foundation for the ADA.¹³⁶ Neither of the prior acts confronted discrimination against persons with disabilities in the private sector.¹³⁷ Under the ADA, a person is disabled if she has "a physical or mental impairment that substantially limits one or more of the major life activities;"¹³⁸ "a record of such an impairment;"¹³⁹ or is regarded as

NARD REAMS, JR. ET AL., *DISABILITY LAW IN THE UNITED STATES: A LEGISLATIVE HISTORY OF THE AMERICANS WITH DISABILITIES ACT OF 1990*, PUB. L. 101-336, Doc. No. 2 (no pagination) (1992). "The purpose of the Americans with Disabilities Act is to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities . . ." H.R. REP. No. 485, 101st Cong., 2d Sess., pt. 2, at 22 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 304.

135. Discrimination against persons with disabilities includes denial of benefits and services, especially as related to insurance costs. H.R. REP. No. 485, *supra* note 134, at 29-30. Misperceptions about the disabled as employees, that they increase health costs and have high absentee rates, also lead to discrimination. *Id.* at 33. Congress also cited a continued, irrational fear of cancer as a cause of discriminatory practices. *Id.* at 75. One study shows that disabled men make 36% less than their non-disabled counterparts. *Id.* at 32. The median income of disabled men is \$5,194; for women, it is only \$2,222. Elizabeth R. OuYang, *Women with Disabilities in the Work Force: Outlook for the 1990s*, 13 HARV. WOMEN'S L.J. 13, 16 (1990).

136. Congress incorporated portions of both statutes into the ADA. H.R. REP. No. 485, *supra* note 134, at 23.

137. The Rehabilitation Act only regulates actions of those receiving government funds. 29 U.S.C. § 701. Title VII prohibits discrimination in employment based on gender, ethnicity, race, religion, and national origin. 29 U.S.C. § 2001(e).

138. ADA § 3(2), 42 U.S.C. § 12102(2). Federal Regulations interpreting the ADA define a "physical or mental impairment" as:

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, genito-urinary, hemic and lymphatic, skin, and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

29 C.F.R. § 1630.2(h) (1992).

"Major life activities" have been interpreted to include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." 29 C.F.R. § 1630.2(i) (1992).

HIV has been classified as a disability because it impairs the ability to procreate. H.R. REP. No. 485, *supra* note 134, at 52. The Rehabilitation Act was amended by the Civil Rights Restoration Act to include AIDS and HIV as disabilities covered by § 504. 29 U.S.C. § 706(7)(B).

having a disability.¹⁴⁰ Title I prohibits discrimination against persons with disabilities in all “terms and conditions” of employment.¹⁴¹ Section 501(c) of Title V modifies Title I by continuing traditional underwriting procedures in employer-provided and other insurance.¹⁴² Title I applies to all employers with more than twenty-five employees effective July 26, 1992, and to all employers with more than fifteen employees effective July 26, 1994.¹⁴³

A. *Title I: Employment Discrimination*

Section 101 of the ADA¹⁴⁴ prohibits discrimination against qualified disabled persons¹⁴⁵ in all aspects of employment, including

139. ADA § 3(2)(B), 42 U.S.C. § 12102(2)(B). For example, a person with a history of colon cancer has a record of an impairment.

140. ADA § 3(2)(C), 42 U.S.C. § 12102(2)(C). For example, a homosexual person assumed to be HIV positive absent medical proof is considered disabled for purposes of the Act. Homosexuality is not a disability, but if an employer discriminates based on a fear of AIDS, then that employer has regarded the person as disabled. 42 U.S.C. § 12211(a). Some interpret this definition as protecting people with a genetic disposition to a disease. Nancy Lee Jones, *Overview and Essential Requirements of the Americans with Disabilities Act*, 64 TEMP. L. REV. 471, 491 (1991).

141. 42 U.S.C. §§ 12111-12117. “Terms and conditions of employment” is defined as “personnel policies, practices, and matters, whether established by rule, regulations, or otherwise, affecting working conditions . . .” 29 U.S.C. § 7103(a)(14). See also *Fort Stewart Sch. v. Fed. Labor Relations Auth.*, 495 U.S. 641 (1990) (finding health insurance a condition of employment requiring mandatory bargaining); *Newport News Shipbuilding v. EEOC*, 462 U.S. 669, 682 (1983) (holding that health insurance is a part of the “compensation, terms, conditions and privileges of employment” for the purpose of § 703(a) of Title VII). See *infra* note 168 for a discussion of the EEOC’s interpretation of § 501(c) of the ADA.

142. ADA § 501(c), 42 U.S.C. § 12201(c).

143. ADA § 101(5)(A), 42 U.S.C. § 12111(5)(A). The federal government is not an employer subject to the ADA. ADA § 101(5)(B)(i), 42 U.S.C. § 12111(5)(B)(i).

144. ADA § 101, 42 U.S.C. § 12111.

145. A “qualified disabled person” is one who, with or without reasonable accommodation, can perform the essential functions of a job. ADA § 101(8), 42 U.S.C. § 12111(8). Under the Rehabilitation Act, which includes the same language as the ADA in this area, employees must be qualified to perform the job they presently hold, not the job for which they were originally hired to perform. *Taylor v. Garrett*, No. 90-2164, 1993 WL 157722 (E.D. Pa. May 4, 1993). Determination of essential function is left to the discretion of the employer. However, an essential function must be a fundamental rather than a marginal duty of the position. 29 C.F.R. § 1630.2(n) (1992). For example, an employer cannot refuse to hire a blind person because the employer wants the employee to run errands requiring a car if the ability to drive a car is not fundamental to the ability to perform the main job tasks.

hiring, promotion, and "terms, conditions and privileges of employment."¹⁴⁶ Congress found strong evidence of discrimination against the disabled in employment despite state anti-discrimination laws.¹⁴⁷ The scope of Title I is very similar to the scope of Title VII,¹⁴⁸ and the Equal Employment Opportunity Commission (EEOC) enforces

146. The ADA provides: "No covered entity shall discriminate against a qualified individual with a disability because of the 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." ADA § 102(a), 42 U.S.C. § 12112(a).

147. *Hearing on the Discrimination Against Cancer Victims and the Handicapped Before the Subcomm. on Employment Opportunities of the House Comm. on Education and Labor*, 100th Cong., 1st Sess. 3 (1987) [hereinafter *Discrimination Against Cancer*] (stating that only one-third of blind persons, less than half of paraplegics, and less than one-quarter of epileptics are employed).

For state laws prohibiting employment discrimination against the disabled, see, e.g., ALASKA STAT. § 18.80.220 (1986); ARIZ. REV. STAT. ANN. § 41-1463 (1985); CAL. GOV'T. CODE § 12940(a) (West 1992); COLO. REV. STAT. § 24-34-402 (1988); CONN. GEN. STAT. §§ 46a-58, -60(a)(1) (1991); D.C. CODE ANN. § 1-2512 (1991); FLA. STAT. ANN. § 760.10 (West Supp. 1991); GA. CODE ANN. §§ 34-6A-4, 45-19-29 (Michie 1992); HAW. REV. STAT. § 378-2 (Supp. 1992); ILL. ANN. STAT. ch. 68, para. 1-102(A) (Smith-Hurd Supp. 1992); IND. CODE ANN. § 22-9-1-2 (Burns 1988); IOWA CODE ANN. § 216.6 (West Supp. 1993); KAN. STAT. ANN. §§ 44-1001, -1009 (1986); KY. REV. STAT. ANN. § 207.150 (Michie/Bobbs-Merrill Supp. 1990); LA. REV. STAT. ANN. §§ 46:2252, 2254(C) (West 1982); ME. REV. STAT. ANN. tit. 5, §§ 4571, 4572 (West Supp. 1992); MD. ANN. CODE art. 49B, §§ 14, 16 (1986); MASS. GEN. LAWS ANN. ch. 151B, § 4 (16) (West Supp. 1990); MICH. COMP. LAWS ANN. § 37.1102 (West Supp. 1993); MINN. STAT. ANN. §§ 363.03, 363.12 (West 1990 & Supp. 1993); MO. REV. STAT. § 213.055 (1986); MONT. CODE ANN. §§ 49-1-102, 49-2-203 (1989); NEB. REV. STAT. §§ 48-1101, -1104 (1988); NEV. REV. STAT. § 613.330 (1987); N.H. REV. STAT. ANN. §§ 354-A:1, A:2, A:7 (Supp. 1992); N.J. STAT. ANN. § 10.5-4.1 (West Supp. 1990); N.M. STAT. ANN. § 28-1-7 (Michie 1991); N.Y. EXEC. LAW § 296 (Consol. 1983 & Supp. 1991); N.C. GEN. STAT. § 143-422.2, §§ 168A-2, -5 (1987); N.D. CENT. CODE § 14-02.4-03 (Supp. 1993); OHIO REV. CODE ANN. § 4112.02 (Anderson 1991); OKLA. STAT. ANN. tit. 25, § 1302 (West 1987); OR. REV. STAT. § 659.425 (1989); PA. STAT. ANN. tit. 43, § 955 (Supp. 1990); R.I. GEN. LAWS § 28-5-7 (Supp. 1990); S.C. CODE ANN. §§ 43.33-520, -530 (Law. Co-op. 1985); UTAH CODE ANN. § 34-35-6 (Supp. 1990); VT. STAT. ANN. tit. 21, § 495 (Supp. 1992); VA. CODE ANN. § 51.5-41 (Michie 1991); WASH. REV. CODE ANN. §§ 49.60.010, .030 (West 1990); W. VA. CODE §§ 5-11-2, -9 (1990); WIS. STAT. ANN. §§ 111.31, .322 (West 1988 & Supp. 1992); WYO. STAT. § 27-9-105 (1987).

Some states explicitly prohibit HIV testing of job applicants. See, e.g., CAL. HEALTH & SAFETY CODE § 199.22 (West 1990); ME. REV. STAT. ANN. tit. 5, §§ 19201-19206 (1989 & Supp. 1992); MASS. ANN. LAWS ch. 111, § 70F (Law. Co-op. Supp. 1993).

148. Compare 42 U.S.C. § 2000e-2(a) with ADA § 102(a), 42 U.S.C. § 12112(a).

both.¹⁴⁹ Although the scope of Title I parallels that of Title VII, and the remedies available under the two statutes are the same,¹⁵⁰ ADA complaints must be handled differently than Title VII complaints because of the unique difficulties faced by persons with disabilities.¹⁵¹ Each disabled person has a distinct situation. The level of capability within a particular disability varies, while it does not vary by gender, race, ethnicity, or religion.¹⁵²

The ADA prohibits discrimination against the disabled in many areas.¹⁵³ Employers cannot segregate or classify job applicants or employees in a way that affects their opportunities.¹⁵⁴ Employers cannot use standards that perpetuate discrimination or have the effect of discriminating based on disability.¹⁵⁵ Entering into contractual arrangements that negatively affect employees because of their disabilities is also illegal discrimination.¹⁵⁶ Employers cannot deny equal job benefits and opportunities to a qualified employee or applicant based on that person's relationship or association with a

149. Initially, the ADA was considered as an amendment to Title VII. *Discrimination Against Cancer*, *supra* note 147, at 3. Title I of the ADA differs from Title VII because it requires an assessment of how individuals' disabilities affect their abilities. Title VII does not require such individualized assessments. Under Title VII, the burden is on the employer to prove business necessity for testing the person's abilities. Donald R. Livingston & Michael R. Keller, *The ADA Regulations: Facilitating Individualized Justice of the Disabled*, 29 FED. B. NEWS & J. 39, 40 (1992).

150. 42 U.S.C. § 12117(a).

151. Jeffery O. Cooper, *Overcoming Barriers to Employment: The Meaning of Reasonable Accommodation and Undue Hardship in the Americans with Disabilities Act*, 139 U. PA. L. REV. 1423, 1427 (1991).

152. For example, not every person afflicted with cerebral palsy is confined to a wheel chair. EQUAL EMPLOYMENT OPPORTUNITY COMM'N, TECHNICAL ASSISTANCE MANUAL FOR THE AMERICANS WITH DISABILITIES ACT, § 2.1(a)(iii) (1992) [hereinafter MANUAL].

153. ADA § 102(b), 42 U.S.C. § 12112(b).

154. *Id.*

155. ADA § 102(b)(3), 42 U.S.C. § 12112(b)(3).

156. ADA § 102(b)(2), 42 U.S.C. § 12112(b)(2). This includes insurance contracts which use traditional insurance risk assessment. The legislative history discusses this in context. A health plan cannot refuse to cover persons with kidney disease, but can refuse to pay for dialysis. This provides equal access to health coverage. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 3, at 38 (1990), *reprinted in* BERNARD REAMS, JR. ET AL., *DISABILITY LAW IN THE UNITED STATES: A LEGISLATIVE HISTORY OF THE AMERICANS WITH DISABILITIES ACT OF 1990*, Pub. L. 101-336, Doc. No. 5 (no pagination).

third person who has a known disability.¹⁵⁷ Employers must prove an undue hardship or a direct threat as justification for not reasonably accommodating a disabled employee.¹⁵⁸

Perhaps the most significant change for employers will be the prohibition of pre-employment medical screening.¹⁵⁹ To reduce the probability of disabled persons being screened out of jobs,¹⁶⁰ the ADA prohibits medical exams until at least a conditional offer of

157. ADA § 102(b)(4), 42 U.S.C. § 12112(b)(4). Congress included this provision in response to testimony about a dismissal of an employee whose volunteer work brought her in contact with AIDS victims. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 2, 30 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 312. This provision is vitally important to those with disabled spouses and dependents. Nearly 50% of health claims paid by health plans are for dependant coverage. Rothstein, *supra* note 2, at 47.

158. ADA § 102(b)(5)(A), 42 U.S.C. § 12112(b)(5)(A). An employer cannot refuse to hire a disabled person because it would require the employer to make a reasonable accommodation. ADA § 102(b)(5)(B), 42 U.S.C. § 12112(b)(5)(B). Reasonable accommodations may include providing flexible schedules, allowing use of accrued sick leave, granting unpaid leave, hiring readers, reassigning employees to vacant positions, and making break rooms accessible to the disabled. MANUAL, *supra* note 152, §§ 3.1-11. An undue hardship is a high standard of proof. The employer must show a significant difficulty or expense based on their overall financial resources, size of business, and type of operation. ADA § 101(10), 42 U.S.C. § 12111(10). At least one court has held that business necessity supports the ability to cut health benefits as a cost saving measure. See *infra* notes 212-19 and accompanying text for a discussion of *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991). Undue hardship is determined by the size of the covered entity with respect to the number of employees, the budget and number or type of facilities, the type of operation, the overall financial resources, and the nature and cost of actions necessary. Part of the Act requires state subsidies for certain accommodations that employers may be unable to fully fund. H.R. CONF. REP. NO. 558, 101st Cong., 2d Sess. 56 (1990).

The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodations. ADA § 101(3), 42 U.S.C. § 12111(3).

159. ADA § 102(d)(2)(A), 42 U.S.C. § 12112(d)(2)(A). Section 102 prohibits the most frequently used technique to discriminate against persons with cancer, mental illness, heart disease, diabetes, epilepsy, AIDS, and other "hidden" disabilities. Renee L. Cyr, Note, *The Americans with Disabilities Act: Implications for Job Reassignment and the Treatment of Hypersusceptible Employees*, 57 BROOK. L. REV. 1237, 1262 (1992). Over 90% of large employers and 50% of small employers, those with fewer than 500 employees, use pre-employment medical screening. Rothstein, *supra* note 2, at 52.

160. Forty-two percent of employers surveyed reported they had considered an applicant's health insurance risk as a factor in determining employability. Rothstein, *supra* note 2, at 27.

employment has been made.¹⁶¹ Pre-employment inquiries can be made into the ability of an applicant to perform essential job-related functions.¹⁶² Once employed, an employer can conduct voluntary medical exams and require medical histories as a part of an employee health program, and can require tests related to job performance.¹⁶³

B. Section 501(c): Insurance Practices

Despite the ADA's prohibition against discrimination in terms and conditions of employment, Congress included section 501(c)¹⁶⁴ to allow health insurance companies and self-insured health plans to

161. ADA § 102(d)(3), 42 U.S.C. § 12112(d)(3). All applicants must be subject to the exam and all medical records must be kept in a separate, confidential file. Access to medical records is restricted to supervisors and managers, and then only if such information is necessary to accommodate the person's conditions or to facilitate emergency medical treatment. ADA § 102(d)(3)(B), 42 U.S.C. § 12112(d)(3)(B). The conditional exam can include tests unrelated to job performance, though a drug test is not considered a medical exam. ADA § 104(d)(1), 42 U.S.C. § 12114(d)(1). Allowing this wide scope of examination was Congress's compromise with the Bush Administration to ensure passage of the ADA. For a behind-the-scenes account of the formation of the ADA, see Chai Feldblum, *Medical Examinations and Inquiries under the Americans with Disabilities Act: A View from the Inside*, 64 TEMP. L. REV. 521, 543 (1991).

162. ADA § 102(d)(2)(B), 42 U.S.C. § 12112(d)(2)(B).

163. ADA § 102(4)(B), 42 U.S.C. § 12112(4)(B). The voluntariness of these exams is questionable because access to health insurance is premised on complete medical histories. An employee cannot be fired because of possible future health problems. See, e.g., *E.E. Black, Ltd. v. Marshall*, 497 F. Supp. 1088, 1093 (D. Haw. 1988) (holding that if an employee is qualified, an employer cannot refuse to hire him or her based on nonimminent risk of future injury).

164. Section 501(c) provides:

Subchapter I through III . . . and title IV of this Act shall not be construed to prohibit or restrict -

(1) an insurer . . . or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing . . . the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks or administering such risks . . . or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance. Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter.

ADA § 501(c), 42 U.S.C. § 12201(c) (Supp. IV 1992).

continue traditional underwriting procedures.¹⁶⁵ Underwriting procedures discriminate, by their nature, against high risk people. While high risk people may not be disabled, they may fit within the "regarded as having a disability" definition of disabled because they are treated differently.¹⁶⁶ Legislative history of the ADA and the EEOC regulations interpreting the Act indicate that employers must offer equal access to health insurance provided through the employer, but not equal benefits.¹⁶⁷ The EEOC interprets section 501(c) to allow discrimination against disabled persons in health insurance if the disability poses a greater insurance risk.¹⁶⁸ Health

165. For a discussion of the traditional underwriting procedures, see *supra* notes 20-23 and accompanying text. One employee benefits counselor believes that this section does not force employers to add or equalize coverage. *Plan Administration: Disability Act Will Not Require Employers to Change Benefit Plans*, 17 *Pens. Rep. (BNA)* 1274 (1990) (statement of Judith Mazo, Senior Vice President of Martin E. Segal & Co.). Common insurance practices and plan designs that may raise issues under the ADA include: special benefits for chemically dependent persons, managed care programs, pre-existing condition clauses, proof of insurance requirements, limits on lifetime caps for particular diseases, and involuntary wellness programs. Leon E. Irish, *The Impact of the Americans with Disabilities Act of 1990 on Employee Benefit Plans*, in *C796 A.L.I.-A.B.A.* 447, 450 (1993).

166. 29 C.F.R. § 1630.2(l)(1) (1992). One way that people are regarded as having impairments is if they have a physical or mental impairment that does not substantially limit major life activities, but are treated as having such limitations. *Id.*

167. H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 2, at 59 (1990), *reprinted in* 1990 U.S.C.A.N. 267, 341. "[E]mployers may continue to offer policies that contain [pre-existing condition] clauses, even if they adversely affect individuals with disabilities . . ." 29 C.F.R. § 1630.5 app. (1993). Pre-existing condition clauses are expressly allowed, but coverage must still be given for other illnesses and conditions. S. REP. NO. 116, 101st Cong., 2d Sess. 6, 85 (1990). It is illegal to refuse to hire a person because the health plan does not cover their disability. *MANUAL, supra* note 152, § 7.9.

168. *MANUAL, supra* note 152, § 7.9. The EEOC issued new interim regulations in June 1993. EEOC, No. N-915.002, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INS., (June 8, 1993) [hereinafter INTERIM GUIDANCE]. The EEOC established a three-prong test for determining whether a benefit exclusion is prohibited by the ADA. First, the provision must be reviewed to determine if it is a disability-based distinction. For example, if a benefit exclusion singles out a particular disability or group of disabilities, such as cancer or kidney diseases, then it is a disability-based distinction. *Id.* at 7. If an exclusion is broad based, such as all experimental drugs, the exclusion is not a disability-based distinction. *Id.* Second, if a disability-based distinction exists, the employer must prove that the plan is bona fide. *Id.* at 10. Self-insured plans prove this by showing that the plan exists and pays benefits, and that its terms have been accurately communicated to covered employees. *Id.* at 11. Finally, the employer must prove the exclusion is not a subterfuge to evade the purposes of the ADA. Subter-

plans, such as self-insured plans, can limit coverage of procedures and treatments.¹⁶⁹ For example, a health plan can refuse to cover experimental drugs, which adversely affects high risk employees such as HIV and cancer patients who often rely on experimental drugs, but the plan cannot refuse to pay for that same employee's broken leg.¹⁷⁰

State anti-discrimination laws are still very important in protecting health benefits.¹⁷¹ Employers who do not self-insure their health plans must adhere to state laws if they are stricter than the ADA.¹⁷² States still bind insured plans to their anti-discrimination laws.¹⁷³ Employers who self-insure can continue to use classifications that adversely affect the disabled, as long as employers base their classifications on sound actuarial evidence¹⁷⁴ and reasonable expectations and do not use the classifications as a subterfuge¹⁷⁵ to discriminate against persons with disabilities.¹⁷⁶ For example, an employer who self-insures cannot refuse to hire a person because

fuge refers to disparate treatment that is not justified by the actuarial risks and costs associated with the disability. *Id.*

169. MANUAL, *supra* note 152, § 7.9.

170. 29 C.F.R. § 1630.5 app.

171. The ADA sidesteps the problems with health insurance and employment by maintaining the burden on states to regulate insurance practices. John W. Parry, *Mental Disabilities Under the ADA; A Difficult Path to Follow*, 17 MENTAL & PHYSICAL DISABILITY L. REP. 100 (1993).

172. ADA § 501(b), 42 U.S.C. § 12201(b). "Nothing in this chapter shall be construed to invalidate or limit the remedies, rights and procedures . . . of any state or jurisdiction that provides greater or equal protection for the rights of individuals with disabilities that are afforded by this chapter." *Id.*

173. 29 C.F.R. § 1630.1(c)(2).

174. The EEOC requires the actuarial date to be current and accurate. INTERIM GUIDANCE, *supra* note 168, at 11 n.14.

175. The EEOC defines "subterfuge" as disparate treatment that is not justified by the risks or costs associated with the disability. See *supra* note 168 for a discussion of the EEOC's interpretation of subterfuge. Subterfuge has been interpreted under the Rehabilitation Act to include schemes, plans, strategies, or artifices of evasion. Kimberly A. Ackourey, Comment, *Insuring Americans with Disabilities: How Far Can Congress Go to Protect Traditional Practices?*, 4 EMORY L.J. 1183, 1190 (1991) (citing *United Airlines, Inc. v. McMann*, 434 U.S. 192, 203 (1977)).

176. H.R. REP. NO. 485, at 137. "Insured" plans are not as free to eliminate coverage for high risk participants using these methods because state laws restrict the ability to refuse coverage to disabled. See *supra* note 13 for a list of state laws restricting the ability to terminate coverage. Administering a bona fide plan without subterfuge is the only standard a self-insured health plan must meet. Irish, *supra* note 165, at 5.

she has a history of breast cancer, but can refuse to cover costs associated with cancer under the pre-existing condition clause or by proving the plan is bona fide and is not a subterfuge for evading the purposes of the ADA.¹⁷⁷ A plan can also limit an employee to three blood transfusions per year, although this has a disparate impact on hemophiliacs.¹⁷⁸ The EEOC guidelines indicate that a health plan cannot discriminate based on disability, but can discriminate in impact against the disabled by refusing to cover certain costly procedures and treatments.¹⁷⁹

C. *Impact of the ADA on Health Benefits*

While many hail the ADA as an end to discrimination against people with disabilities, such assertions are unwarranted. The definition of discrimination in Title I conflicts with the language and meaning of section 501(c). If Title I were interpreted strictly, most health insurance underwriting would be illegal.¹⁸⁰ Application of Title I to a self-insured health plan illustrates the reason Congress limited the scope of Title I by adopting section 501(c). If an employer operating a self-insured health plan classifies an employee in a way that denies her benefits, her employment opportunities are necessarily affected.¹⁸¹ Medicaid and Social Security Disability benefits substantially limit the amount a person can earn without losing eligibility.¹⁸² Absent health coverage for a disability, a disabled person must choose between a job with inadequate health coverage and

177. See *supra* note 168 detailing the interim EEOC guidelines. Under Title VII, health plans cannot deny coverage to employees with breast cancer because of the disparate impact that would have on women. See, e.g., *Brady v. Cut Cement Products Co.*, 11 Mass. Discrimination L. Rep. 1053 (1988), discussed in *OuYang*, *supra* note 135, at 24.

178. See *Alexander v. Choate*, 469 U.S. 287, 302 (1985) (upholding reduction of benefits which disparately impacted disabled persons).

179. *MANUAL*, *supra* note 152, § 7.9. See also 29 C.F.R. § 1630.5 app.; *INTERIM GUIDANCE*, *supra* note 168 (detailing the burden of proof on an employer to justify a health plan which has a disparate impact on disabled persons).

180. The legislative history recognizes this conflict. To alleviate the strict reading of Title I, Congress included § 501(c). S. REP. NO. 116, at 86. Congress explicitly rejected reading § 501(c) to require impact analysis. H.R. REP. NO. 485, at 137.

181. ADA § 102(b)(1), 42 U.S.C. § 12112(b)(1) (Supp. III 1993). The National Council on Disabilities noted that “[a]ccess to health insurance fundamentally affects the lives of Americans with disabilities, influencing their decisions on occupation, employment and living arrangements.” *SHARING THE RISK*, *supra* note 1, at 1.

182. See, e.g., 42 U.S.C. §§ 1302, 1396 (1988); 42 C.F.R. § 435.1007 (1992).

unemployment with arguably adequate government health coverage.¹⁸³ Risk assessment is a concept that effectively discriminates on the basis of disability, which is prohibited under Title I.¹⁸⁴ A strict application of Title I, without section 501(c), would prohibit an employer from contracting with an insurer who uses risk assessment because of its inherent discrimination against the disabled.¹⁸⁵ Title I, strictly interpreted, should make it impossible for the insurance industry to use traditional cost-cutting methods such as risk assessment and pre-existing condition clauses.

Because few cases have been brought alleging a violation of Title I or section 501(c), it is unclear how these sections will be interpreted together.¹⁸⁶ However, Congress closely modeled the ADA after the Rehabilitation Act,¹⁸⁷ which prohibits employers who contract with the federal government from discriminating against persons with disabilities.¹⁸⁸ Section 501(a) of the ADA explicitly adopts the standards of the Rehabilitation Act.¹⁸⁹ Additional provi-

183. A Louis Harris poll found that a majority of the unemployed disabled depend on government benefits and insurance payments for support. Eighty-two percent said they would give up their government benefits for a full time job. S. REP. No. 116, at 9.

184. ADA § 102(b)(3)(A), 42 U.S.C. § 12112(b)(3)(A).

185. ADA § 102(b)(2), 42 U.S.C. § 12112(b)(2).

186. The EEOC recently held that a New York union violated the ADA by refusing to cover AIDS-related costs. Robin Schatz, *EEOC: Union's Health Plan Violates Law*, NEWSDAY, Feb. 16, 1993, at 16. This case is interesting because the Fifth Circuit in *McGann v. H & H Music Co.* reached the opposite conclusion based on ERISA. See *supra* notes 114-31 for a discussion of *McGann*. H & H ran a self-insured health plan, and the union did not. Schatz *supra*. See also *Kinney v. Yerusalim*, 812 F. Supp. 547 (E.D. Pa. 1993) (concerning public access); *EEOC v. AIC Sec. Investigations, Ltd.*, 823 F. Supp. 571 (N.D. Ill. 1993) (finding AIC liable for discharging its executive director after he was diagnosed with brain cancer); *D'Amico v. New York State Bd. of Law Examiners*, 813 F. Supp. 217 (W.D.N.Y. 1993) (requiring new bar exam with reasonable accommodations for visually impaired person); *Cuff v. IBM*, No. 92-0936, 1992 WL 129610, at *3 (E.D. Pa. June 10, 1992) (dismissing Title I ADA complaint because action took place before effective date of the ADA); *Gersman v. Group Health Ass'n. Inc.*, 975 F.2d 886 (D.C. Cir. 1992) (dismissing § 109 claim because the ADA not effective yet).

187. 29 U.S.C. §§ 701-796(i) (1988).

188. 29 U.S.C. § 701.

189. "Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under Title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 *et seq.*) or the regulations issued by the Federal agencies pursuant to such title." ADA § 501(a), 42 U.S.C. § 12201(a).

sions and language were borrowed from Title VII.¹⁹⁰ Taken together, Title VII and the Rehabilitation Act indicate how section 501(c) will be interpreted.

In *Alexander v. Choate*,¹⁹¹ the Supreme Court held that modifications in health benefits that have a disparate impact on the disabled are legal under section 504 of the Rehabilitation Act.¹⁹² Section 504 prohibits discrimination against the disabled in benefit programs receiving federal funds.¹⁹³ Tennessee, faced with an enormous budget shortfall, reduced the number of hospital days covered by its Medicaid program.¹⁹⁴ Respondents, a class of disabled Medicaid recipients, argued that the annual limitation on hospitalization had a disproportionate effect on the disabled¹⁹⁵ and should be eliminated.¹⁹⁶ Although the Court held that a section 504 violation does not require an intent to discriminate,¹⁹⁷ it refused to hold that a program that has a disparate impact on disabled persons violated section 504 when disabled persons still have meaningful access to the benefits.¹⁹⁸ Reducing the number of days covered did not deny meaningful access to health care.¹⁹⁹ The change was facially neutral and provided the disabled and non-disabled with equal access to

190. 42 U.S.C. § 12112(a) adopts the scope and language of Title VII of the Civil Rights Act of 1964.

191. 469 U.S. 287 (1985).

192. *Id.* The defendant reduced hospital coverage from 20 to 14 days.

193. Section 504 provides in part:

(a) No otherwise qualified individual with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency . . .

29 U.S.C. § 794(a).

194. 469 U.S. at 289.

195. *Id.* at 290. In 1979-80, 27.4% of all disabled individuals who were hospitalized and receiving Medicaid in Tennessee required more than 14 days of care, while only 7.8% of non-disabled Medicaid recipients required more than 14 days of hospitalization. *Id.*

196. 469 U.S. at 291. Respondents suggested a limit on per visit coverage, rather than per year coverage.

197. Congress abandoned the intent requirement because discrimination against persons with disabilities is most often a product of ignorance and thoughtlessness. *Id.* at 295.

198. *Id.* at 302.

199. *Id.* The disabled can still go to the hospital and receive care.

benefits.²⁰⁰ The Rehabilitation Act only assures equal opportunity, not equal results.²⁰¹ The Court lauded Tennessee's choice to provide broad-based benefits rather than to devise a costly system that would provide equal results to the disabled.²⁰²

In *School Board of Nassau County v. Arline*,²⁰³ the Supreme Court held that a contagious disease can be a disability under Section 504 of the Rehabilitation Act.²⁰⁴ In the late 1950s, Arline had been hospitalized with tuberculosis.²⁰⁵ Arline, a teacher, was discharged in 1979 after her third relapse of tuberculosis in two years.²⁰⁶ The Court held that Arline fit the definition of disabled because her hospitalization for tuberculosis²⁰⁷ in the 1950s established a record of impairment.²⁰⁸ The Court held that the school board must determine whether Arline was otherwise qualified, despite the contagious nature of her disease.²⁰⁹ If she was otherwise qualified and did not pose a direct threat to others, the school board was required to make reasonable accommodations.²¹⁰

At least one court has accepted the elimination of health benefits for high risk or seriously ill participants as a business necessity defense.²¹¹ In *Owens v. Storehouse, Inc.*,²¹² Owens, an employee of

200. *Id.*

201. 469 U.S. at 304 n.5. For example, an HIV-positive pneumonia patient may require more care than an HIV-negative pneumonia patient to reach the same level of health.

202. The Court worried that if equal results were required, the state would have to break down its program by disability. The Court held that this was not a reasonable accommodation. *Id.* at 308.

203. 480 U.S. 273 (1987).

204. Section 504 of the Rehabilitation Act formed the basis of § 102 of the Americans with Disabilities Act. See *supra* note 193 for the text of the Rehabilitation Act § 504.

205. *Id.*

206. 480 U.S. at 276. Tuberculosis is a physical disorder affecting the respiratory system.

207. The Court deferred to the opinion of public health officials regarding the contagious nature of respondent's condition. 480 U.S. at 288. See Morrell, *supra* note 6, at 874 (discussing the importance of this decision for those with HIV and AIDS).

208. *Id.* at 281. Section 3 of the ADA also includes individuals with a record of impairment in the definition of disabled.

209. 480 U.S. at 282.

210. *Id.* at 287.

211. The EEOC also allows this as an excuse for excluding the disabled from a health plan. An employer can show that the disparate treatment is necessary be-

Storehouse, challenged the elimination of his coverage for AIDS-related claims.²¹³ Storehouse had a self-insured health plan which reduced benefits for AIDS-related costs from \$1 million to \$25,000.²¹⁴ Storehouse claimed that its self-insured plan could no longer afford to pay more than \$25,000 in benefits for each of the five employees with AIDS.²¹⁵ According to Storehouse, continuing coverage up to \$1 million would financially ruin it and subject all of its employees to unemployment.²¹⁶ Storehouse could not get stop-loss insurance for the five employees with AIDS.²¹⁷ The court rejected Owens' ERISA harassment claim because the termination of benefits did not alter the employment relationship.²¹⁸ The court also refused to find a breach of fiduciary duty because such duty does not exist if a plan modifies or eliminates a benefit plan that does not vest.²¹⁹

There are many ways to legally circumvent the purpose of the ADA. The disparate impact test in section 102(b)(3) does not apply to section 501(c).²²⁰ Congress explicitly allowed risk assessment policies that discriminate against persons with disabilities,²²¹ although theoretically discrimination against disabled persons is prohibited. For example, a health plan may refuse to pay for dialy-

cause continued unlimited coverage would be prohibitively expensive and would result in either insolvency or drastic increases in premiums. The employer must also show that no non-disability-based health insurance change exists as an alternative to not providing benefits. INTERIM GUIDANCE, *supra* note 168, at 12.

212. 773 F. Supp. 416 (N.D. Ga. 1991).

213. *Id.* at 418.

214. *Id.*

215. *Id.* The health plan paid \$90,000 of plaintiffs' claims because the plan's other claims in 1990 were lower than anticipated.

216. *Id.*

217. 773 F. Supp. at 418. AIDS is having a great impact on the reinsurance market, although AIDS only represents about 1.2% of reinsurance premiums. Kertesz, *supra* note 42, at 16.

218. 773 F. Supp. at 419.

219. *Id.* at 419. See *supra* note 56 for a discussion of the exemption from vesting requirements for welfare benefit plans.

220. 29 C.F.R. § 1630.5 app.

221. The EEOC interprets § 501(c) to prohibit barring disabled persons from benefits. However, the EEOC counsels employers that they can refuse to cover certain procedures and treatments that may adversely affect the disabled. MANUAL, *supra* note 152, at § 7.9. The EEOC draws a distinction between adversely impacting the disabled and disparate treatment of the disabled, with the former being legal and the latter being illegal. See INTERIM GUIDANCE, *supra* note 168, at 5 n.7.

sis, but cannot refuse to cover a person with kidney disease. Equal access to health benefits means coverage which is the same for all, not coverage which provides equal results. Pre-existing condition clauses, which discriminate against persons with disabilities, do not constitute discrimination under the Rehabilitation Act, and thus probably the ADA, because the exclusions apply to all participants though they have a disparate impact on the disabled.²²² Additionally, ERISA plans generally include a provision reserving the right of an insurer or employer to change the terms of the policy at any time.²²³ This provision allows an employer to terminate benefits at any time during an employee's illness.²²⁴

IV. PROPOSAL FOR INSURANCE REFORM IN ERISA & THE ADA

Tackling the problems of the health care crisis involves changing the structure of the way we view access to health care. No single effort will solve the problem. Cost containment, better access to health care, and emphasis on preventive medicine will begin to alleviate some of the problems.²²⁵ A full discussion of the options is beyond the scope of this Note. This Note proposes amendments to ERISA and the ADA consistent with the purpose of the ADA: to

222. Sohlgren, *supra* note 13, at 1286 (citing *Alexander v. Choate*, 469 U.S. 287, 302 (1985)).

223. The reservation allows employers to change a policy at any time, arguably frustrating enforcement. Sohlgren, *supra* note 13, at 1272. With no vesting requirement for health plans, a participant or beneficiary does not have an undeniable claim to benefits in the plans. *Id.* at 1273. Sohlgren suggests that failure to pay benefits may be a breach of fiduciary duty by the employer. The fiduciary is supposed to protect the beneficiary; a change in plan terms appears to derogate this duty. However, as Sohlgren points out, the duty only extends to the terms of the plan as amended. *Id.* at 1280-82.

224. See, e.g., *McGann v. H & H Music Co.*, 946 F.2d. 401 (5th Cir. 1991). A change in a health benefit plan that has a disparate impact on disabled persons is legal as long as the change applies to all plan participants. See *Alexander v. Choate*, 469 U.S. 287 (1985) (reducing the number of hospital days Medicaid will pay for a participant); see also *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991) (accepting a defense of legitimate business necessity by self-funded plan terminating benefits for persons with AIDS).

225. In his State of the Union Address on February 17, 1993, President Clinton recognized these goals as important in the battle to control health care costs. Clinton's plan calls for immunization for all children and caps on Medicare payments. *The State of the Union: President Clinton's Address*, WASH. POST, Feb. 18, 1993, at A24. The National Council on Disabilities criticizes the current insurance scheme as lacking emphasis on wellness, prevention of disabilities, and promotion of independence. SHARING THE RISK, *supra* note 1, at 21.

protect the disabled from discrimination. These changes would ensure that covered employees continue to be covered and would increase the number of employees initially eligible for coverage. Absent other cost-saving reforms, health insurance may be too costly for many employers. These proposals fulfill an asserted public policy of providing better access to health care through private insurance reform, with minimal government involvement.²²⁶

A. Amendment to ERISA Section 514

In the twenty years since the enactment of ERISA, only one of the dozens of amendments offered has passed.²²⁷ Most recent amendments propose exemptions from ERISA for states trying to address the problems of health care access.²²⁸ If adopted, these

226. Despite cries for universal health care, or socialized medicine, it appears very unlikely that such a system will be implemented soon. President Clinton appointed Hillary Rodham Clinton to head the Health Care Commission proposing comprehensive health care reform. Edwin Chen, *Hillary Clinton to Lead Health Panel*, L.A. TIMES, Jan. 26, 1993, at A1, col.5 [hereinafter *Health Panel*]. Most commentators agree some form of managed competition and managed care will be proposed. Edwin Chen, *Medical Status Quo "Will Kill Us", First Lady Says*, L.A. TIMES, Feb. 23, 1993, at A12, col. 1 [hereinafter *Status Quo*]. See also Frank Swoboda, *Employers' Health Cost Rise Slows, Workers Paid Bigger Share, Had Fewer Choices in 1992*, WASH. POST, Mar. 2, 1993, at D1. At publication time, legislation for the Clinton health plan had not been introduced.

Many large businesses, the AMA, and the middle class have recently asked for more government involvement due to the enormity of the problem. *Turning Point*, *supra* note 1, at A1. See *infra* notes 276-77 for definitions of managed care and managed competition. The AMA's position is a change from its position in the 1980s. Common Cause, a public interest research group, calls the AMA the "Leader of the PACs." In the 1980s, the AMA and its state affiliates contributed nearly \$12 million to members of Congress to prohibit or influence health care reform. *Medical-Industry PACs Gave \$60 Million to Congressional Candidates During a Decade When Health Care Costs More Than Doubled*, COMMON CAUSE NEWS (Common Cause, Washington D.C.), Oct. 16, 1991, at 5.

227. The one amendment that passed exempted Hawaii from ERISA. Congress exempted Hawaii because it had a comprehensive health plan in place before ERISA was passed. ERISA § 514(5)(A), 29 U.S.C. § 1144(5)(A). Hawaii requires employers to provide health insurance for its employees. For those remaining uninsured, the state offers a subsidized program which provides care on a sliding scale pay rate. Hawaii spends only 9% of the state's gross product on health care. Access alone has proven to be a powerful cost container. Susan FitzGerald, *On Health Care Issue, States Take Initiative with no Federal Action, They are Starting Their Own Reforms*, PHILA. INQUIRER, July 26, 1992, at F01.

228. 138 CONG. REC. E3059 (daily ed. Oct. 5, 1992) (statement of Rep. Wyden). State efforts to reform health care have taken many forms. All have run up against ERISA, and now the ADA, preventing them from fully implementing the programs.

amendments would circumvent ERISA's goal of uniform regulation.²²⁹ The federal government's refusal to address the health care crisis has forced many states to attempt various methods of improving access to health care.²³⁰ ERISA has proven to be an unmovable roadblock in health care reform.²³¹ The insurance industry, especially the Self-Insurance Industry of America (SIIA), business, and labor all lobby strongly against waivers and reform of the preemption doctrine.²³²

Steve Dornfeld, *Feds Balk at Treating Health Care System, Then Stop States From Trying Own Cures*, ST. PAUL PIONEER PRESS, Sept. 14, 1992, at 4A (reporting governors' appearances before Senate finance committee asking for ERISA reform). See *infra* note 230 for a discussion of some state reform programs.

229. 29 U.S.C. § 1001.

230. Oregon's plan, which provides health care for enumerated conditions, was denied a waiver by the Bush Administration and Congress because it may discriminate against the disabled. In March 1993, the Clinton Administration granted Oregon its needed waivers. Spencer Rich, *U.S. Approves Oregon Plan for Health Care Rationing*, WASH. POST, Mar. 20, 1993, at A1. The Oregon plan would purportedly reach 450,000 uninsured. 138 CONG. REC. E3059 (daily ed. Oct. 5, 1992) (statement of Rep. Wyden).

Florida has guaranteed basic health coverage to all uninsured by 1995. As part of this guarantee, Florida law requires all employers to provide health insurance to its employees by 1995. ERISA has proven to be a strong obstacle in implementing this plan. 1992 GAO REPORT, *reprinted in* 138 CONG. REC. E3060-61 (daily ed. Oct. 5, 1992).

The Minnesota plan controls costs by implementing regional health planning, monitoring quality of health care, developing practice parameters and conducting consumer education and wellness programs. MINN. STAT. ANN. § 62D.04(3) (West Supp. 1993). It provides private insurers access to larger risk pools so long as they adhere to certain requirements. MINN. STAT. ANN. § 43A.317(1) (West Supp. 1993). This program goes beyond the risk pool that only pays for the uninsurable. Minnesota taxes insurance premiums and hospital income to fund health insurance for the uninsured. MINN. STAT. ANN. §§ 60A.15(1), 62C.01(3), 295.52 (West Supp. 1993).

Vermont has reformed the methods by which insurance companies offer policies. Beginning in July 1993, insurance companies selling individual policies must accept anyone who applies and cannot set discriminating rates based on medical conditions. Fitzgerald, *supra* note 227. Similar requirements went into affect for small group insurance policies in July 1992. *Id.* ERISA precludes the state from requiring such restrictions for self-insured health plans. *Id.*

Massachusetts has passed a "pay or play" system. By 1995, all employers are required to (1) offer a level of benefits greater than or equal to Massachusetts requirements or (2) pay into a state insurance fund. Burke, *supra* note 31, at 36.

231. 138 CONG. REC. E3053 (daily ed. Oct. 5, 1992) (statement of Rep. Wyden).

232. Self-Insurance Industry of America (SIIA) obviously is protecting its own interests in self-insurance. Business wants government to continue the ERISA exemption for self-insurance. The AFL-CIO is fighting reform for two reasons: it is self-insured and it wants comprehensive health care reform. 138 CONG. REC.

Some commentators call for an overhaul of ERISA so that all requirements for pension plans apply equally to welfare benefit plans.²³³ The reasons Congress did not do this originally are still valid today.²³⁴ The health care market is very different from the annuities that fund pension plans.²³⁵ A vesting requirement in employee welfare plans, such as self-insured health plans, prohibits the flexibility necessary for the plan to respond to changing technologies and increasing costs.²³⁶ Some funding requirements should be implemented to ensure payment of available benefits²³⁷ and to prevent health plans from suffering financially, especially self-insured health plans.²³⁸ A health plan should be required to set aside an amount to pay for medical costs, determined by experience rating, in a separate fund.²³⁹ This set-aside would ensure the availability of money, and would still allow employers to recoup money remaining at the end of the year.

\$15,601 (daily ed. Sept. 29, 1992). The AFL-CIO feels that reforming the pre-emption doctrine only complicates the battle. *Id.*

Lobbying to prevent comprehensive health care reform is a multimillion dollar business. Common Cause estimates that over \$60 million in PAC contributions were made in congressional campaigns and to members of Congress by the insurance industry, medical industry PACs, and the AMA during the 1980s. Vicki Kemper & Vireca Novac, *A Plague on Both Their Houses, The Medical Industry Complex and its PAC Contributions to Congressional Candidates*, COMMON CAUSE NEWS (Common Cause, Washington D.C.), Oct. 16, 1991, at 2. Nearly every member of Congress, 519 of 534 members in 1991, received money from these PACs.

233. Crenshaw, *supra* note 9, at C11 (questioning ERISA's protection of employees).

234. See *supra* note 56 and accompanying text for a discussion of reasons for limited regulation of welfare plans.

235. H.R. REP. NO. 807, 93rd Cong., 2d Sess. 60 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4726.

236. Marjorie M. Kress, *Benefit Vesting in Employee Health Plans*, 24 TORT AND INS. L.J. 88, 104 (1988).

237. 29 U.S.C. §§ 1081-1086. Pension funding has received much recent attention. The GAO reports that the Pension Benefit Guaranty Corp. (PBGC), which is similar to the Federal Savings & Loan Insurance Corp., may have to pick up \$17.9 billion in bankrupt pension funds by the end of the century. Some pension plans are significantly underfunded in comparison to the benefits promised. David Hess, *Time Bomb May Blow Up U.S. Deficit*, HOUS. CHRON., Jan. 8, 1993, at A13.

238. See *supra* note 40 and notes 47-49 and accompanying text for a discussion of the financial problems for self-insured plans.

239. Because there are no regulations for funding, the employees are left with the bills if a firm that self-insures goes out of business. Carlson, *supra* note 36, at 1C.

More importantly, section 514 should be amended to prohibit health plans from denying benefits to disabled employees which are available to similarly situated insured employees.²⁴⁰ Section 514²⁴¹ should be amended to read:

(2)(C): Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title, nor any trust established under such a plan, shall be construed to be exempt from state laws which regulate benefits.

The proposed amendment maintains many of the attractive features of self-insurance, and does not create two classes of employees with respect to benefit packages.²⁴² Self-insured health plans are still exempt from state laws concerning the business aspect of insurance, such as licensing and capitalization.²⁴³ Under the amendment, self-insured health plans are also still exempt from state taxes on premiums paid to finance state health care reform. To some this is a major drawback.²⁴⁴ States rely on this income to fund their own Medicaid and health reform programs.²⁴⁵ However, broad waivers for state plans contravene the purpose of ERISA — to provide uniform administration of retirement and welfare plans.²⁴⁶ The proposed amendment would require additional administration, but only in the basic health package by requiring self-insured health plans to include state-mandated benefits. Many state statutes have similar, if not identical, mandated benefits which decrease the state-by-state

240. A similar amendment was proposed in 1979. The bill was reported to the Senate, but died without debate. *Metropolitan Life*, 471 U.S. at 740 n.16.

241. See *supra* notes 57, 60-61 for the text of ERISA § 514.

242. For an illustration of the "similarly situated" problem, see *supra* notes 104-13 and accompanying text, which discuss *FMC v. Holliday*, 498 U.S. 52 (1990).

243. Lobbyists for the self-insurance industry caution that many employers may drop health benefits if they are subject to different regulations in each state. Collins, *supra* note 4.

244. There are current efforts in Congress to create waivers so that states with health care reform acts can properly fund them. See, e.g., *State Health Care Financing Equity Act of 1992*, reprinted in 138 CONG. REC. S13,267-69 (daily ed. Sept. 10, 1992).

245. See Crenshaw, *supra* note 9, at C11.

246. See H.R. REP. NO. 533, 93rd Cong., 1st Sess. 1 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4640; see also *supra* notes 89-92 and accompanying text for a discussion of *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987). But see Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 323 (1990) (advocating ERISA waivers).

administration.²⁴⁷ As amended, ERISA section 514 focuses on the administration of the benefit plan, rather than particular benefits.²⁴⁸

B. *Amendment to the ADA Section 501(c)*

Under Title VII, it is illegal to use actuarial data to discriminate against women and minorities.²⁴⁹ Now that disabled persons have been raised to the status of a discrete and insular minority,²⁵⁰ such discrimination against them should also be illegal. Title I prohibits discrimination in terms and conditions of employment.²⁵¹ However, section 501(c) exempts health insurance plans from a strict application of Title I, and it is unclear how the courts will interpret this contradiction.²⁵² Some commentators might find the contradiction between Title I and section 501(c) necessary until comprehensive reform of access to health care occurs.²⁵³ All limitations on coverage adversely affect someone,²⁵⁴ thus, employer-provided health insurance underwriting would be illegal under Title I because it inherently discriminates in the terms and conditions of employment against persons with disabilities.²⁵⁵ To alleviate uncertainty, section 501(c) must be amended.

247. See *supra* note 13 for a list of state minimum benefits laws.

248. See *supra* notes 104-13 and accompanying text for a discussion of *FMC v. Holliday*, 498 U.S. 52 (1990), which drew a distinction between administration of a benefit plan and the benefits themselves under ERISA.

249. Lawrence Z. Lorber & Kenneth J. Raphael, *Insurance Provisions under the ADA: How Will it Impact Employee Benefits?*, 39 *FED. B. NEWS & J.* 87, 88 (1992). For example, it is illegal to pay fewer benefits to women than men on the actuarial premise that women live longer. *Los Angeles Dept. of Water and Power v. Manhart*, 435 U.S. 702, 711 (1978).

250. ADA § 2(7), 42 U.S.C. § 12101(7) (Supp. IV 1992). See also *supra* note 133 regarding the use of "discrete and insular minority" with respect to the ADA.

251. 5 U.S.C. § 7103(a)(14) (1988) defines "terms and conditions of employment" to include sick leave and health benefits.

252. Lorber & Raphael, *supra* note 249, at 88. Interpretation is further complicated for purposes of this Note by the recent effective date of the Americans with Disabilities Act, leaving little time for claims to be brought.

253. Actuarial data is necessary to set premiums that will keep a plan from going bankrupt. Certain illnesses do cost more and criticism of the healthy subsidizing the unhealthy or disabled are valid. See *supra* note 21 for a discussion of this criticism.

254. Greely, *supra* note 6, at 113.

255. For instance, failure to pay for a broken leg, a temporary disability, is not the type of discrimination against the disabled that the ADA was intended to prohibit. *MANUAL*, *supra* note 152, § 2.1(a)(iii).

One suggestion has been to amend section 501(c) to define "subterfuge" as any use of actuarial data to exclude coverage of a catastrophic or chronic illness to the extent that such coverage is less than another catastrophic illness covered by the plan.²⁵⁶ This suggestion prevents the exclusion of persons with specific illnesses, such as AIDS or cancer,²⁵⁷ but does not prevent disparate impact on the disabled. Employers can avoid a complaint under the proposed subterfuge amendment by refusing to pay for certain treatments and procedures, an act which disparately impacts the disabled.²⁵⁸ Employers could also refuse to pay for "lifestyle choices"-related illnesses.²⁵⁹ Thus, persons developing lung cancer from smoking or contracting AIDS from sexual contact or drug use would be impacted disparately.

In addition to a subterfuge definition,²⁶⁰ the ADA must specify that a disparate impact test is applicable.²⁶¹ To end discrimination against disabled employees in insurance, as has been done under Title VII for women and minorities, section 501(c) should be amended to read:

Subchapters I through III of this chapter and Title IV of this Act shall not be construed to prohibit or restrict —

(1) an insurer, hospital, medical service company, health maintenance organization, or any agent or entity that administers benefit plans or similar organization from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law or *Section 102(b)(3)*; or

(2) a person or organization covered by this chapter from establishing, sponsoring, overseeing, or administering the terms of a bona fide benefit plan that are based on underwriting risks,

256. Sohlgren, *supra* note 13, at 1298.

257. Even if a person with a history of cancer has health benefits, those benefits are always subject to reduction and cancellation. Individual health insurance is difficult to buy until five to ten years after the last treatment, and even then the terms of coverage usually exclude payments for cancer. Morrell, *supra* note 6, at 859.

258. The EEOC already recognizes this as a valid exercise of risk assessment and administration of health plans. 29 C.F.R. § 1630.5 app.

259. See Huntley, *supra* note 4, at 2 (discussing Circle K's attempt to refuse coverage for AIDS when the virus was contracted by means other than blood transfusion).

260. See *supra* note 168 for a discussion of the EEOC's interpretation of subterfuge.

261. Ackourey, *supra* note 175, at 1208 (interpreting the ADA under Title VII analysis).

classifying risks, or administering such risks that are based on or not inconsistent with state law or *Section 102(b)(3)*; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan *subject to Section 102(b)(3)*, but that is not subject to state law that regulates insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter. *Section 102(b)(3) shall not include, for the purpose of insurance underwriting, pre-existing condition clauses for the length of their term, not to exceed 180 days, nor employee co-payments.*²⁶²

The section 501(c) amendments require fundamental change in the insurance industry.²⁶³ Coverage no longer could be denied for certain conditions and treatments unique to disabled persons.²⁶⁴ Risk assessment would be limited: Insurers would project costs to adjust both premiums and the amount of funds set aside for the next period. Because disabled persons each have a different set of conditions which must be taken into account, the final provision of the amendment allows employers and insurers to pass some of the additional cost to the employee.²⁶⁵

262. This Note criticizes the use of pre-existing condition clauses because they discriminate against the disabled, but they are apparently here to stay. Realistically, Congress lacks the will to pass a bill barring pre-existing condition clauses. By limiting pre-existing condition clause terms to 180 days, this proposal aims to alleviate some of the hardship caused by such clauses without being unrealistic as to the power of the insurance lobby. However, pre-existing clauses face increased scrutiny. The Health Care Commission, headed by Hillary Rodham Clinton, is considering the prohibition of pre-existing condition clauses. *Status Quo*, *supra* note 226, at A12. See also Mumford, *supra* note 7, at 31 (recommending practitioners monitor litigation on pre-existing condition clauses). The National Council on Disabilities also urges the elimination, through Congressional action, of preexisting condition clauses. SHARING THE RISK, *supra* note 1, at 7.

COBRA provides protection for those who are denied coverage under a new health plan, including persons excluded from the new plan by a pre-existing condition clause. See *supra* note 23. However, COBRA is costly and does not cover those who had no prior insurance. Pre-existing condition clauses, according to the National Council on Disabilities, limit the availability of jobs for persons with disabilities because they cannot afford to live without health coverage for up to one year. SHARING THE RISK, *supra* note 1, at 3.

263. One commentator argued that a broad interpretation of the ADA to include health plans would have a billion dollar effect and would totally disrupt the current system. Irish, *supra* note 165, at 461.

264. 29 C.F.R. § 1630.5 app.

265. Employee co-payments do not necessarily discriminate against the disabled. Many non-disabled people frequent the doctor's office for their own or their chil-

C. *Analysis of the Proposed Amendments*

The amendments to ERISA and the ADA would end egregious discrimination against employees covered by self-insured health plans, especially disabled employees. The proposal provides incentives for employers to rely on other forms of cost-cutting, such as managed care and managed competition. The proposal also maintains the best features of self-insurance without creating two classes of similarly situated employees with respect to benefit packages. Taken together, the modifications to ERISA and the ADA supply an impetus to change and encourage equal access to health care.

Employers cannot deny insurance to disabled employees if insurance is offered to other employees.²⁶⁶ Not only does a health plan have to include benefits it may not have offered before,²⁶⁷ but the plan must also offer equal coverage. Because the health plan no longer can circumvent state minimum benefits laws by self-insuring,²⁶⁸ the plan cannot refuse to cover treatments or procedures when such refusal has a disparate impact on the disabled.²⁶⁹ If a plan covers one disability, it must cover all disabilities. Excluding coverage of a disability or treatment discriminates on the basis of disability. However, tax incentives to offer benefit plans to employees counter some of the increased costs.²⁷⁰ Employee co-payment schedules also offset cost increases. Small, per-visit deductibles encourage a result where those who utilize their health coverage most

dren's minor aches and pains, and would face similar out-of-pocket expenses as the disabled.

266. 29 C.F.R. § 1630.5.

267. See *supra* note 13, which details the benefits frequently eliminated in self-insured health plans.

268. The plan would still be exempt from taxing, licensing, and capitalization requirements.

269. Costs of reform are often grossly overstated. The typical accommodation for a disabled person under Title I will be less than \$500. Over 51% of the necessary accommodations will cost nothing. Cooper, *supra* note 151, at 1448-49.

270. Employers may take a deduction for payments to health insurance plans as an "ordinary and necessary expense incurred . . . in carrying on any trade of business." 26 U.S.C. §§ 101-106. Dave Durenberger, the senior U.S. Senator from Minnesota, noted that the deductions for contributions to health insurance plans amount to a \$66 billion subsidy to business. Dave Durenberger, *Choices for the Clinton Era, Time for Fairness on Health Premiums*, N.Y. TIMES, Feb. 28, 1993, at 25. At least two bills are currently pending in Congress to reform this subsidy. The bills would cap tax subsidies and impose an excise tax on expenses exceeding the plan amount. *Id.*

pay the most. These deductibles have a disparate impact on the disabled, who may require frequent medical visits, but it also impacts non-disabled employees²⁷¹ who visit doctors frequently for minor treatment.²⁷²

These amendments force greater innovation and reform in cost-cutting measures.²⁷³ Medical providers will receive more pressure to reduce costs. HMOs,²⁷⁴ PPOs,²⁷⁵ managed care,²⁷⁶ and managed

271. A disabled person under the ADA must be substantially impaired in a major life activity or regarded as having such an impairment. ADA § 102, 42 U.S.C. § 12112 (Supp. III 1991).

272. See, e.g., *infra* note 273, which discusses Minnesota consortiums that require small per visit co-payments.

273. In the summer of 1992, two interesting programs emerged from Minnesota self-insured health plans by use of managed competition. Two coalitions were formed by self-insured employers to pool access to health care. The first coalition consists of 363 small- and medium-sized companies, of which approximately one-third are self-insured. Gordon Slovut, *363 Small-, Medium-Sized Businesses Forming Health Plan with Prudential*, MINNEAPOLIS STAR-TRIB., June 5, 1992, at 01D. The individual firms remain self-insured and maintain separate health funds. The second coalition, the Business Health Care Action Group (BHCAG), consists of 14 of the largest employers in Minnesota, including Pillsbury, IDS, Norwest Corp., Honeywell, General Mills and Dayton Hudson. The BHCAG plan covers 125,000 employees and dependents. Business Health Care Action Group, *Business Health Care Action Group Press Release* (July 15, 1992) (on file with the *Washington University Journal of Urban and Contemporary Law*) [hereinafter *Press Release*]. Both coalitions used their economic leverage to develop practice parameters and outcome-based quality standards through the consortium of health care providers. BHCAG has contracted with a consortium of health care providers, including the Mayo Clinic. *Id.* In June 1993, 3M joined the BHCAG. Walter Parker, *3M Joins Big Health Care Action Group*, ST. PAUL PIONEER PRESS, June 2, 1993, at 6C.

Quality will no longer be measured only through provider credentials. Rather, both coalitions emphasize limitation of health care to only medically necessary care, preventative and early intervention care, and adherence to predefined medical practice standards. Slovut, *supra*; *Press Release, supra*. Use of participant co-payments and wellness incentives, such as preventative care, promote "appropriate use of health care resources." *Press Release, supra*.

The BHCAG's provider consortium was picked through a bidding process. Bidders had to show not only reduction in costs, but a commitment to improving quality of care. Co-payments range from \$10-\$100 depending on the service. Higher co-payments for use of providers outside the consortium provide incentives for use of consortium providers, but also give employees a choice in where they receive care. *Id.*

274. Health Maintenance Organizations (HMOs) are one form of managed care. HMOs control costs by designating clinics where participants must receive care. Swoboda, *supra* note 226, at D1. HMOs are governed by national legislation. See 42 U.S.C. § 300(e) (1988).

competition²⁷⁷ will become more prevalent because they are already proven cost-saving measures.²⁷⁸ Use of managed care is already on the rise.²⁷⁹ Managed care programs assign case workers to each participant to determine the best and least costly method of treatment, thereby reducing costs dramatically.²⁸⁰ Use of managed care by persons with disabilities allows them to receive the necessary care, even though it may mean more care for disabled persons than for non-disabled persons.

Administration of the amendments may be the largest obstacle to their adoption. The insurer or employer must determine equal coverage under a disparate impact analysis. The amount and type of treatment differ by person. A disabled person may need more transfusions or dialysis than a non-disabled person. However, the burden on employers to determine appropriate coverage is minimal: Employers already must confer with disabled persons to determine reasonable accommodations on the job under the ADA.²⁸¹ Managed care inherently analyzes the needs of the participant and provides the best health care at the lowest cost.²⁸² Reasonable accommodations can be made, subject to an undue hardship analy-

275. Preferred Provider Organizations (PPOs) are a type of managed care. A health plan that includes a PPO contracts with specified doctors to provide services at set costs. Swoboda, *supra* note 226, at D1.

276. Managed care uses peer review, patient data monitoring, practice parameters, and other quality standards to control costs. Generally, managed care is available through HMOs and PPOs. For a history of managed care, see Frank J. Rief III, *The Evolution of Managed Care, MANAGED HEALTH CARE: DOES IT OFFER A CURE FOR THE NATION'S HEALTH CARE ILLS?*, C653 A.L.I.-A.B.A. 1 (1991).

277. Managed competition organizes consumers into large pools to shop among health care providers for lower prices and higher quality. *Status Quo*, *supra* note 226, at A12. See *supra* note 273 for an example of managed competition in practice.

278. The Minnesota coalitions expect a 10-20% reduction in costs over and above normal cost-saving achieved through self-insurance. Slovit, *supra* note 273; see also *Press Release*, *supra* note 273.

279. *Employers See Health Costs as Continuing Threat to Bottom Line*, 17 Pens. Rep. (BNA) 1166 (1990). Nearly 77% of employers offer at least one type of managed care. Swoboda, *supra* note 226, at D1.

280. Managed care can reduce health costs by up to 75%. Morrell, *supra* note 6, at 890.

281. ADA § 501(d), 42 U.S.C. § 12201(d); 29 C.F.R. § 16302(0).

282. See *supra* note 276 for a definition of managed care.

sis.²⁸³ Thus, if flexible work schedules can accommodate the need for medical attention, they must be implemented.²⁸⁴ The undue hardship test is a difficult test to meet²⁸⁵ because the proposed accommodation must pose a substantial financial burden.²⁸⁶ Federal government grants and state aid, already available, will combine with managed care to offset some of the increases.²⁸⁷

V. CONCLUSION

The proposed modifications to ERISA and the ADA are not likely to be successful absent fundamental change in the present health care system. The health care crisis is crippling the U.S. economy.²⁸⁸ Until a national effort deals comprehensively with the multifaceted problem, the states and employers are left to attempt reform.²⁸⁹ Because our society is based on private industry, nationalized health care or health insurance, as implemented in Canada, is unlikely in the near future.²⁹⁰

283. See *supra* note 158 and accompanying text for a discussion of the ADA's undue hardship and reasonable accommodation provisions. See generally Cooper, *supra* note 151.

284. Regulation of the ADA already requires this type of accommodation. 29 C.F.R. § 1630.2(0)(2).

285. ADA § 101(10)(B), 42 U.S.C. § 12111(10)(B) (listing factors to be considered in determining undue hardship). The accommodation must require *significant* difficulty or expense. ADA § 101(10)(A), 42 U.S.C. § 12111(10)(A) (emphasis added).

286. ADA § 101 (10), 42 U.S.C. § 12111(10).

287. Cf. I.R.C. §§ 44, 190 (1993). For a list of agencies providing guidance, see EQUAL EMPLOYMENT OPPORTUNITY COMM'N, THE RESOURCE DIRECTORY FOR THE AMERICANS WITH DISABILITIES ACT (1992).

288. We currently spend 14% of the GNP on health care. Left untouched, health care will consume 20% of the GNP by the year 2000. *New MIRC*, *supra* note 26.

289. 138 CONG. REC. E3059 (daily ed. Oct. 5, 1992) (statement of Rep. Wyden).

290. The Canadian system is a single-payer system: everyone is insured by the government. Rowley, *supra* note 27, at 14C.

States are proving to be the laboratories of reform.²⁹¹ Twenty-six states have risk pools to cover the uninsurable.²⁹² Some states are altering Medicaid coverage to provide insurance to those who earn too much to qualify for traditional Medicaid.²⁹³ Employers have overwhelmingly decided that the easiest cost-cutting method is to eliminate people from coverage.²⁹⁴ The easiest way to do this is to self-insure. A health plan that self-insures is exempt from state laws mandating certain health benefits and prohibiting plans from dropping participants based on their health condition.

The amendment to ERISA that requires all health plans to meet certain minimum benefits does not alter the essential purpose of ERISA: to provide uniformity. Broad waivers presently circumvent the purpose of ERISA. The proposed amendment would impose alterations in the benefit plan package, but would not affect the administration or taxation of the plan.

The amendment to the ADA ensures that the true purpose of the Act is met. A disabled person does not have a viable choice if they must choose between unemployment and a job with no meaningful health benefits. The amendment encourages cost-saving reforms such as managed care and managed competition, which will allow disabled persons to work and maintain effective health coverage.

The amendments to ERISA and the ADA are mere precursors to fundamental change in the U.S. health care system. To a great extent, the modifications encourage reform. Nationally-mandated

291. In Washington D.C., there is an increasing awareness of the need for national reform. Bills are pending to grant ERISA waivers to state reform packages. *See, e.g.*, S. 3180, 103rd Cong., 1st Sess. (1993) (removing barriers to state reform); S. 2843, 103rd Cong., 1st Sess. (1993) (expanding regulation of self-insured plans). Additionally, some bills call for nationally-mandated minimum benefits and require all employers to offer health insurance. *See, e.g.*, H.R. 212, 102d Cong., 1st Sess. (1991), reported in 137 CONG. REC. E1483-84 (1991) (statement of Rep. Stark) (requiring all insurers to offer a health plan of basic benefits to employers); S. 3267, 101st Cong., 2d Sess. (1990) (requiring nationalized minimum benefits through ERISA). Many proposals included small business incentives to offer insurance. *See, e.g.*, S. 3165, 102d Cong., 2nd Sess. (1992) (providing incentives to small business to offer insurance). These bills would prohibit the use of pre-existing condition clauses unless the employee had been without insurance in the previous six months. *Small Business*, *supra* note 48, at A07.

292. *See supra* note 13 for a listing of risk pool statutes.

293. *See supra* note 230 for a description of state reform plans.

294. *See supra* note 273 for a discussion of the Minnesota plan by self-insured employer coalition.

minimum benefit packages consistent with Title VII and the ADA would alleviate ERISA preemption problems. The cost of health care reform is great, but the cost of refusing to reform health care access is even greater. Nearly every American recognizes the need for health care reform. No longer can the health care system provide care only for the wealthy and the insured. Meaningful health care access must be available to all.

*Laura J. Schacht**

* J.D. 1994, Washington University.

COMMENTS

