Applicability of ADA Non-Discrimination Principles to Self-Insured Health Plans: Do "AIDS Caps" Violate the Law?

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APPLICABILITY OF ADA
NON-DISCRIMINATION PRINCIPLES TO SELF-INSURED HEALTH PLANS: DO “AIDS CAPS” VIOLATE THE LAW?

Congress enacted the Americans with Disabilities Act of 1990 (ADA)\(^1\) to establish a comprehensive prohibition of discrimination on the basis of disability.\(^2\) Finding a compelling need and a “clear and comprehensive national mandate for the elimination of discrimination against persons with disabilities,”\(^3\) Congress enacted the ADA to establish “clear, strong, consistent, enforceable standards.”\(^4\) The statutory scheme provides for the federal government to play a “central role” in the enforcement of those standards.\(^5\)

The ADA protects a “qualified individual with a disability”\(^6\) from discrimination in such areas as “employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public serv-

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2. 42 U.S.C. § 12101(b). The ADA is divided into five titles which proscribe discrimination in employment (I), public service (II), public accommodations and services (III), telecommunications services (IV), and miscellaneous provisions (V). Id. §§ 12101-12213. For employers with 25 or more employees, Title I of the ADA took effect on July 26, 1992. It took effect on July 26, 1994 for employers with 15-24 employees. See id. § 12111(5).
3. Id. § 12101(a). An estimated 43 million Americans have physical or mental disabilities. Id.
4. Id. § 12101(b).
5. It has been noted that “[a]lthough all of the 50 states have existing laws that prohibit various types of disability discrimination, those laws have been viewed as being inadequate to address the pervasive problems of discrimination faced by people with disabilities.” Ogletree et al., Americans with Disabilities Act: Employee Rights & Employer Obligations, at 1-40, 1-41 (1992). Further, the disability laws enacted prior to the ADA have been viewed as “highly varied, often uncertain, and inadequately enforced.” Id. at 1-41 (quoting Erf, Potluck Protection for Handicapped Discriminattees: The Need to Amend Title VII to Prohibit Discrimination on the Basis of Disability, 8 Loy. U. Chi. L.J. 814, 844 (1977)).
6. Title I of the ADA defines qualified individual with a disability as “an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires . . . consideration shall be given to the employer’s judgment as to what functions of a job are essential.” 42 U.S.C. § 12111(8).
ices.” With respect to employment discrimination, the ADA prohibits discrimination in compensation “and other terms, conditions, and privileges of employment.” The Equal Employment Opportunity Commission (EEOC) has interpreted “terms, conditions, and privileges of employment” to encompass “[f]ringe benefits available by virtue of employment, whether or not administered by a covered entity.” The EEOC interpretation of the ADA includes employee health benefits.

Employer sponsored health benefit plans and health insurance have received considerable attention largely because the EEOC interpretation of the ADA is not self-evident from the statutory language. Whether the broad anti-discrimination mandates of the ADA will be applied to employer sponsored health plans has led to recent debate and litigation.

7. Id. § 12101(a)(3).
8. Id. § 12112(a).
9. 29 C.F.R. § 1630.4(f) (1993). See infra part II of this text discussing “covered entities.” Additionally, ADA section 102(b)(1), which prohibits “limiting, segregating, or classifying a job applicant or employee in any way that adversely affects the opportunities or status of such an applicant or employee” could be deemed applicable to employer provided health plans. 42 U.S.C. § 12112(b)(1). Not only are job applicants and employees potentially protected against the discriminatory practices of segregation or classification that affect employee benefit participation, the ADA also prohibits “excluding or otherwise denying equal benefits to a qualified non-disabled person because that person has a relationship or association with an individual with a disability.” Id. § 12112(b)(4). For example, this could be read to prohibit an employer from discriminating against an employee or applicant who is the parent of a disabled child.
10. See EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT TO DISABILITY BASED DISTINCTION IN EMPLOYER PROVIDED HEALTH INSURANCE (June 8, 1993) [hereinafter INTERIM ENFORCEMENT GUIDANCE].
11. See infra Part III of this text analyzing the appropriate statutory language of the ADA and EEOC regulations promulgated thereunder.
12. See Alison Grant, Knocking Down Barriers One by One: Disabled See Result of Access Law, Plain Dealer (Cleveland), July 18, 1993, at B1 (discussing the suit brought by the EEOC against a New York company for allegedly violating the ADA by excluding insurance coverage for the treatment of AIDS); Frank Swoboda, Disabilities Law Could Have A Big Impact on Health Care Benefits, Wash. Post, Jan. 3, 1993, at H2 (considering whether the ADA will change the face of health care coverage and whether employers can discriminate against cancer, heart disease, and AIDS patients in providing health care coverage); AIDS Sufferers Suing Under Disabilities Act: Discrimination Claimed in Insurance Cutoffs, Dallas Morning News, June 1, 1993, at 3A (explaining that dozens of cases involving insurance plans have been filed by the EEOC against employers that have eliminated coverage for AIDS patients); Milt Freudenheim, Health Insurance Ruling To Hit Small Employers, N.Y. Times, June 10, 1993, at D2 (asserting that the government crackdown on employers who limit or deny health insurance for employees with AIDS will mainly affect small businesses).
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Compounding and perhaps furthering this debate is the skyrocketing cost of health care. In response to rising health care costs, public officials, private employers, and labor unions have shifted more of the costs of health care to employees. Thus, employers often decrease benefit levels, raise deductibles, require participants to pay more of the premiums, or employers do not provide health insurance at all.

To contain costs, some self-insured health plans have eliminated or capped spending for certain high-cost illnesses or medical procedures. The high-cost illnesses that seem to be singled out most often are Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). Whether the ADA permits either excluding coverage completely or capping coverage for a specific illness such as HIV or AIDS, which are covered disabilities under the ADA, ultimately depends on the circumstances. See Estate of Kadinger v. IBEW Local 110, No. Civ. 3-93-159, 1993 U.S. Dist. LEXIS 18982 (D. Minn. Dec. 21, 1993). In this case the parties entered into a consent decree whereby defendant, IBEW, paid $100,000 to the estate of Mark Kadinger and agreed to eliminate the “AIDS cap” from the terms of the health plan. Id.


16. Id. Despite the great amount of money spent on health care in the United States, “nearly 34 million people, more than half of them working adults or their dependents,” have no health insurance. Id. at 2. In addition, many more are under-insured or fear they may lose their health insurance. Id.

17. See supra notes 12 and 13.

18. Id. The EEOC recently issued regulations in response to the many health insurance plans that were eliminating or capping benefits for AIDS related illnesses. See generally Interim Enforcement Guidance, supra note 10.

19. In November, 1991, the Centers for Disease Control redefined the definition of AIDS to include “all HIV-positive persons with CD4+ lymphocyte counts below 200 cells per cubic millimeter (/mm3) of blood, regardless of whether they have an AIDS defining condition.” Office of Technology Assessment, The CDC’s Case Definition of AIDS: Implications of the Proposed Revisions-Background Paper, at 1, 2 (1990). In addition to this complex case definition, “AIDS defining” conditions are specified. Id.
imately will be determined by the courts' interpretation of ADA section 501(c).21

Because one of the objectives of the ADA is to eliminate discrimination against persons with disabilities in employment benefits and health services,22 the elimination or capping of benefits related to HIV or AIDS is viewed by some as contrary to the purpose of the statute.23 Uncertainty arises, however, for two reasons: first, the broad preemptive provisions contained in the Employee Retirement Income Security Act (ERISA);24 and second, ambiguities in the language of the ADA, particularly section 501(c)(3). Ultimately, the narrow legal issue is whether the ADA's nondiscrimination provisions will apply to self-insured health funds.25

In response to the uncertainty regarding the ADA's applicability to employee health insurance benefit plans, the EEOC, pursuant to its authority under the ADA, issued Interim Enforcement Guidance regulations explaining when and how the ADA applies to "employer provided health insurance."26 Despite these guidance regulations, considerable uncertainty persists. Some self-insured employee health plans maintain that

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1. These definitions may provide a basis for legally defining a person with HIV or AIDS.
21. 42 U.S.C. § 12201(c). The text of 501(c) is mirrored in the EEOC regulations. 29 C.F.R. § 1630.16(f). See also infra part III of this text discussing section 501(c).
22. See supra notes 8-10 and accompanying text.
23. INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 6-11.
25. The United States Supreme Court has determined that ERISA's preemption provision, 29 U.S.C. § 1144(a), is to be interpreted broadly. See Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). This broad preemption precludes states from regulating the contents of self-insured health benefit plans. Id.
26. See INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 1. The regulations were effective upon issuance and are stated to remain in effect "until rescinded or superseded." Id.

The regulations provide in part:
The interplay between the nondiscrimination principles of the ADA and employer provided health insurance, which is predicated on the ability to make health-related distinctions, is both unique and complex. This interplay is, undoubtedly, most complex when a health insurance plan contains distinctions that are based on disability. The purpose of this interim guidance is to assist Commission investigators in analyzing ADA charges which allege that disability-based
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the ADA does not cover self-insured health plans and, in particular, that the nondiscrimination provisions and risk classification principles espoused by the EEOC in its guidance regulations do not apply at all to self-insured health plans.

This Comment examines the scope of the ADA and accompanying EEOC regulations and considers whether self-insured health funds may either completely exclude coverage or impose benefit caps for medical expenses incurred in the treatment of AIDS or HIV infection. Part I discusses background issues, including the law prior to the ADA and the unique regulation problems created by self-insured funds. Part II examines the coverage of the ADA. Specific consideration is given to determining whether a self-insured health fund should properly be considered a "covered entity" under the statute. Further consideration is given to AIDS as a covered disability under the ADA. Part III analyzes ADA section 501(c) and considers the complex relationship between the ADA, self-insured benefit plans, insurance industry practices, and the EEOC Interim Enforcement Guidance regulations. Part IV, the conclusion, discusses the likely course of the debate.

I. BACKGROUND

A. Distinguishing Between "Insured" and "Self-Insured" Health Benefit Plans

Over half of all Americans that receive their health care coverage from their employers are covered by self-insured health benefit plans. Generally, an employer sponsored health insurance plan may obtain coverage for its participants in one of two ways. First, an insurance contract may be purchased directly from an insurance company, often referred to as an "insured plan." The EEOC Interim Enforcement Guidance regulations define an insured health plan as a "plan or policy that is purchased from an insurance company or other organization, such as a [Health Maintenance Organization]." In the second method, self-insuring, an employer does not purchase an insurance contract from an insurance company. Rather, an employer or group of employers establishes and

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distinctions in the terms or provisions of an employer provided health insurance plan violates the ADA.

Id.

27. GENERAL ACCOUNTING OFFICE, ACCESS TO HEALTH CARE: STATES RESPOND TO A GROWING CRISIS 2 (1992).
29. INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 4 n.3.
contributes to a qualified trust.\textsuperscript{30} When self-insuring, the “employer directly assumes the liability of an insurer.”\textsuperscript{31} The qualified trust, in turn, pays benefits directly to participants according to the terms of the plan document.\textsuperscript{32} Thus, the major distinction between an insured and self-insured plan is that the latter does not purchase insurance contracts.

\section*{B. ERISA's Preemptive Scope and Self-Insured Health Funds}

The distinction between insured plans and self-insured plans developed primarily through the interpretation of ERISA's broad preemption provision.\textsuperscript{33} The preemption provision provides that ERISA “shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.”\textsuperscript{34} Although ERISA broadly preempts state laws relating to employee benefit plans,\textsuperscript{35} this preemption is qualified by the “insurance savings clause.”\textsuperscript{36} The “savings clause” exempts from federal preemption state laws that regulate insurance\textsuperscript{37} because Congress intended “to reserve to the States the regulation of the ‘business of insurance’” which traditionally has been the subject of state regulation.\textsuperscript{38} Significantly, section 514(b)(2)(B) of ERISA,\textsuperscript{39} the “deemer clause,” provides that a self-insured trust shall not “be deemed to be an insurance

\begin{footnotesize}
\begin{enumerate}
\item Employers and employer groups establish a tax qualified trust to which the contributions are made and from which benefits are paid. The qualified trust is a requirement for tax favored status. \textit{See IRC § 401 (1988).}
\item \textit{Interim Enforcement Guidance, supra note 10, at 4 n.3.}
\item See infra note 57 and accompanying text. A self-insured plan may employ a third party administrator to administer the plan. However, such a role is purely ministerial, and thus the plan sponsor is still the responsible fiduciary. \textit{See generally Mertens v. Hewitt Associates, 113 S. Ct. 2063 (1993).}
\item 29 U.S.C. § 1144(a).
\item \textit{Id. See FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (stating that ERISA’s preemption provision is “conspicuous for its breadth”).}
\item \textit{Id. See Metropolitan Life, 471 U.S. at 733 (explaining that ERISA’s broad preemption is “substantially qualified” by the insurance savings clause); FMC Corp., 498 U.S. at 58 (providing that “[t]he savings clause returns to the States the power to enforce those state laws that ‘regulate insurance’”).}
\item \textit{FMC Corp., 498 U.S. at 58.}
\item 29 U.S.C. § 1144(b)(2)(B).
\end{enumerate}
\end{footnotesize}
company . . . or to be engaged in the business of insurance . . . for [the] purposes of any law of any State." The legal effect of this interaction between the "savings clause" and the "deemer clause" is that states can regulate indirectly the content of insured plans, because states can regulate the terms of an insurance contract that is purchased by an insured plan. However, states cannot regulate directly, or indirectly, the content of self-insured benefit plans. Self-insured plans do not purchase insurance contracts and are not covered by ERISA's "savings clause," because they are "deemed" not to be an insurance company or insurer.

These ERISA provisions are significant because state legislatures have responded to the present health care crisis by passing laws that regulate the substantive content of health insurance policies. For example, a state may require that any health insurance contract sold in the state must contain coverage for outpatient kidney dialysis or for certain birth defects. Moreover, states can mandate that all insurance contracts sold within the state must provide a minimum level of mental health insurance. But because a self-insured fund does not purchase a contract and is not deemed an insurance company, the self-insured fund would not be required to provide insurance for mental illness.

States have taken the lead in developing strategies to expand access to

sult, self-funded ERISA plans are exempt from state regulations insofar as that regulation "relate[s] to" the plan. 
FMC Corp., 498 U.S. at 61.
41. "[S]tatutes regulating the substantive terms of insurance contracts have become common place in all 50 States over the last 30 years." Metropolitan Life, 471 U.S. at 728 (citations omitted).
42. See infra notes 48, 50 and accompanying text.
44. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 728 (1985) (citations omitted). "The substantive terms of group-health insurance contracts . . . have been extensively regulated by the States. For example, the majority of States currently require that coverage for dependents continue beyond any contractually imposed age limitation where the dependent is incapable of self-sustaining employment because of mental or physical handicap." Id.
47. See Metropolitan Life, 471 U.S. at 735 (analyzing whether a Massachusetts statute that requires insurance contracts sold in the state to contain minimum levels of mental health insurance coverage should be extended to plans that self insure).
48. Id. at 735 n.14. The Court recognized that its decision creates a "distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." Id. at 747.
health care, control costs, and provide adequate insurance. However, the restrictions imposed by ERISA's preemption provision have hampered state efforts to reform health care systems because the self-insured funds can operate outside the state scheme.

Recognizing the problem of benefit exclusion, some state legislatures have enacted legislation prohibiting discriminatory exclusion of insurance coverage which is merely based on cost. For example, many states have passed laws that prohibit disparate treatment of HIV or AIDS when an exclusion or cap is not based on specific risk classification principles. Also, virtually all states have enacted laws requiring that insurance coverage and premiums comport with acceptable risk classification principles. Again, owing to ERISA's preemptive scope, self-insured health funds have been immune from these state-mandated risk classification limitations.

Because of the immunity from state regulation, self-insured plans have been able to discriminate against particular disabilities and discontinue

49. See generally General Accounting Office, Access to Health Care: States Respond To Growing Crisis (1992) (explaining that “[s]tates have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs”). Id. at 2. For example, Massachusetts and Oregon have initiated “pay or play” systems whereby employers are required to pay a tax to help finance state insurance. Id. at 3. Minnesota and Vermont have extended coverage to children through insurance and Medicaid expansion. Id. at 50-51.

50. Id. The report identifies ERISA as one of the most significant barriers that states face when considering health care reform because ERISA preempts state authority to regulate certain self-insured employer health plans. Id. It reports that “[s]tates can regulate health insurance companies and their policies but not employer plans, including health benefits provided by employers who self-insure.” Id.

51. See infra note 53 and accompanying text; see supra note 49.

52. See, e.g., Omnibus AIDS Act, Ch. 88-380, 1988 Fla. Laws ch. 1996 (codified in scattered sections of Fla. Stat.)

53. H.R. Rep. No. 485, supra note 20, at 136 (stating “[v]irtually all States prohibit unfair discrimination among persons of the same class and equal expectation of life. The ADA adopts this prohibition of discrimination”). Additionally, most states have adopted the National Association of Insurance Commissioner's Model of Unfair Trade Practices Act. This model Act provides that “availability and pricing of insurance premiums must be the same for all individuals regardless of a physical or mental impairment, except where the refusal, limitation or rare differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.” District of Columbia Bar Task Force Report on the Effect of the Americans with Disabilities Act on Employer-Sponsored Health Plans 52-53 (1993) (hereinafter Bar Task Force Report) (citing NAIC, Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment section 3 (1990)).
coverage for certain illnesses. Self-insured funds must, however, comply with state laws not related to the business of insurance and must comply with federal anti-discrimination laws.

C. Self-Insured Health Plans and Modification of Benefits in Response to AIDS Claims: Pre-ADA Analysis

Because states may not regulate self-insured health plans, and because no federal law, including ERISA, directly regulates the substantive content of self-insured health benefit plans, challenges to a self-insured health plan’s modification of benefit terms relied either on the plan document or the collective bargaining agreement. Generally, employers and plan trustees have broad discretion in determining the terms, coverage, and benefit levels of health benefit plans. Accordingly, the employer or trustees could change the content of the plan’s terms.

Considerable attention was drawn to the issue of benefit modification following the Supreme Court’s denial of certiorari in McGann v. H & H Music Co. In McGann, the United States Court of Appeals for the Fifth Circuit held that an employer had the right to modify its health benefit plan by changing from an insured plan that provided one million dol-

55. The plain language of ERISA provides that preemption applies to “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). Section 514(d), 29 U.S.C. § 1144(b)(4), provides that preemption “shall not apply to any generally applicable criminal laws of a State.” Further, 29 U.S.C. § 1144(b)(4) provides that “[n]othing in this subchapter . . . shall be construed to alter, amend, modify, invalidate or impair or supersede” any federal law, rule or regulation issued under federal law.
56. “ERISA . . . contains almost no federal regulation of the terms of benefits plans.” Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 732 (1985). The one major exception to ERISA’s nonregulation of the content of health benefit plans is the provision requiring plans to continue providing health coverage paid for by the employee at the group rate after certain events that terminate employment. 29 U.S.C. §§ 1161-1168.
57. See Allied & Alkali Workers of America v. Pittsburgh Plate Glass, 404 U.S. 157, 165 (1971) (holding that “under the National Labor Relations Act . . . mandatory subjects of collective bargaining include . . . insurance benefits, . . . and an employers unilateral mid-term modification constitutes an unfair labor practice” and breach of the contract); Hansen v. White Motor Corp., 788 F.2d 1186, 1191 (6th Cir. 1986) (stating that “parties may themselves set out by agreement or private design, as set out in plan documents” the particular terms of the employee health benefits plan).
58. See infra notes 66, 68, 70 and accompanying text.
59. See Seaman v. Arvida Realty Sales, 985 F.2d 543, 546 (11th Cir. 1993) (holding that the effect of its decision and the holding in McGann may cause plan sponsors to “reduce or terminate non-vested health benefits simply by changing the terms of the plan”).
60. 946 F.2d 401 (5th Cir. 1991), cert. denied, 113 S. Ct. 482 (1992).
lars in lifetime medical benefits to a self-insured plan which capped lifetime coverage for AIDS related claims at five thousand dollars.\textsuperscript{61} The health plan continued to provide one million dollars of coverage for all illnesses except AIDS.\textsuperscript{62} McGann, the only plan participant with AIDS, claimed that the employer discriminated against him in violation of ERISA.\textsuperscript{63} Although ERISA does not prescribe any substantive terms or specific benefit level of a health plan, ERISA section 510\textsuperscript{64} prohibits discrimination against a participant or beneficiary for exercising his rights under the provisions of an employee benefit plan.\textsuperscript{65} McGann asserted that the new plan provisions limiting AIDS related coverage constituted an unlawful retaliation by the employer, arguing that the employer’s purpose was to interfere with McGann’s attainment of rights to which he might become entitled.\textsuperscript{66}

The U.S. Court of Appeals for the Fifth Circuit upheld the lower court’s grant of summary judgment in favor of the defendant.\textsuperscript{67} The Fifth Circuit ruled that the plan document gave the employer an absolute right to alter the terms of the plan,\textsuperscript{68} and found that plaintiff had not met his burden of proving the existence of specific discriminatory intent.\textsuperscript{69} The Fifth Circuit, noting that employers are free to “create, modify, and terminate the terms and conditions of [an] employee benefit [welfare] plan

\begin{itemize}
\item \textsuperscript{61} \textit{Id.} at 408.
\item \textsuperscript{62} \textit{Id.} at 403.
\item \textsuperscript{63} \textit{Id.} at 403-04.
\item \textsuperscript{64} 29 U.S.C. § 1140. This section provides that:
\begin{quote}
It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which a participant may become entitled under the plan.
\end{quote}
\textit{Id.} (emphasis added).
\item \textsuperscript{65} \textit{Id.}
\item \textsuperscript{66} McGann v. H & H Music Co., 946 F.2d 401, 405 (5th Cir. 1991), cert. denied, 113 S. Ct. 482 (1992). See Seaman v. Arvida Realty Sales, 985 F.2d 543, 546-47 (11th Cir. 1993) (endorsing the holding in \textit{McGann} that ERISA does not prohibit an employer from changing the terms of a health benefit plan as long as the employer does not discharge an employee to avoid paying benefits).
\item \textsuperscript{67} \textit{McGann}, 946 F.2d at 403, 408.
\item \textsuperscript{68} \textit{See id.} at 405 (stating that in contrast to pension benefits “there is an express statutory exclusion of welfare plans from stringent minimum vesting . . . standards . . . [and] ERISA does not require such vesting of the right to a continued level of the same medical benefits once those are ever included in a welfare plan”).
\item \textsuperscript{69} \textit{Id.} at 404-05.
\end{itemize}
without government interference,"70 held that the participant failed to establish that the benefit changes unlawfully discriminated against him because the changes were to apply "equally to all participants who became afflicted with AIDS."71 Significantly, the court stated that any illness or disease could be singled out for exclusion by an employer even though the employer's decision may stem from some prejudice.72

The dispute in McGann arose prior to the enactment of the ADA.73 As a result, the appellate court's decision was limited to the issue of whether the employer violated ERISA which, as noted, generally provides employers broad discretion in modifying the terms of a welfare benefit plan.74 Thus, because the case was brought prior to the ADA, the question of whether the same conclusion would have been reached if the participant had brought the claim under the ADA was left open.

The answer to this question recently began to unfold. The EEOC has filed determination letters75 and currently is involved in several lawsuits charging that benefit modifications that single out HIV or AIDS (i.e., modifications akin to those found in McGann) are discriminatory and violate the ADA.76 In order to determine whether benefit modifications that single out a particular disability violate the ADA, the scope and applicability of the ADA must be examined.

70. Id. at 408. Further, "ERISA does not broadly prevent an employer from 'discriminating' in the creation, alteration, or termination of employee benefits plans." Id.
71. Id.
72. Id. The court states that section 510 of ERISA does not mandate that if some or even all catastrophic illnesses are covered, that any particular catastrophic illness, including AIDS, must be among them. Id. It states that the provision "does not prohibit an employer from electing not to cover or continue to cover AIDS,...[or] any other disease and its victims." Id.
73. The original lawsuit was brought in the district court in 1989. Because the ADA was not effective until July 26, 1992, the court did not entertain an ADA analysis.
74. See supra notes 66, 68, 70, and accompanying text. See also Shaw v. Delta Airlines, 463 U.S. 85 (1983).
II. The ADA's Scope of Coverage: Is a Self-Insured Health Plan a Covered Entity?

Title I of the Americans with Disabilities Act of 1990 provides that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to . . . employee compensation . . . and other terms, conditions, and privileges of employment." Regulation implemented to enforce this provision explain that a covered entity may not discriminate against a qualified individual with a disability in regard to "[f]ringe benefits available by virtue of employment, whether or not administered by the covered entity."77

First, the term "covered disability" must be understood. Thereafter, the language of the ADA raises two additional issues: first, it must be determined whether AIDS is a disability within the purpose of the Act; second, it must be determined whether self-insured health benefit funds are a "covered entity" subject to both the nondiscrimination requirements of the ADA and the generally accepted risk classification principles espoused by the EEOC.

A. AIDS As a Covered Disability Under the ADA

In evaluating whether an individual is within a class protected by the ADA, it must first be determined whether the individual has a disability.79 The term disability under Title I is defined as: "(i) [a] physical or mental impairment that substantially limits one or more of the major life activities of such individual; or (ii) a record of having such an impairment or (iii) being regarded as having such an impairment."80 A person alleging discrimination on the basis of a disability in violation of any ADA provision or regulation can enforce his or her rights under the Act.81

Because Congress did not list all of the conditions and impairments that could form the basis of a disability in the statute,82 it is appropriate to examine the legislative history, regulations, and statutory definitions

77. 42 U.S.C. § 12112(a).
78. 29 C.F.R. § 1630.4(f) (1993).
79. INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 3-4. The charging party must identify and present a statement that alleges discrimination on the basis of disability. See 29 C.F.R. § 1601.12.
80. 42 U.S.C. §§ 12102(1)-(3).
81. Id. § 12117(a). Title I also provides that the powers, remedies and procedures of Title VII of the Civil Rights Act, 42 U.S.C. § 2000(e) (1991), shall apply to enforce claims under Title I of the ADA. Id.
provided under the ADA to determine whether AIDS or HIV ought to be a covered disability. The legislative history of the ADA reveals that Congress provided at least a partial list of conditions and diseases intended to be covered by the ADA. HIV infection was among the list of conditions, diseases, and infections specifically mentioned by Congress. However, because the ADA statutory definition establishes that impairment "must substantially limit one or more major life activities," a question arises whether asymptomatic HIV status qualifies as an impairment. Further, the EEOC Interim Enforcement Guidance provides that a disability-based distinction in a health insurance plan, a distinction that "singles out a particular disability ([such as], deafness, AIDS, [or] schizophrenia)," is a violation of the ADA. In light of the

83. Id.

84. Id. In contrast, Title V of ADA provides a list of conditions expressly excluded from the term impairment, including homosexuality, bisexuality, transsexualism, transvestism, pedophilia, exhibitionism, voyeurism, compulsive gambling, kleptomania and others. 42 U.S.C. § 12111; 29 C.F.R. § 1630.3(d), (e). See also Yvette Ostolaza, Note, Severino v. North Fort Myers Fire Control District; AIDS Discrimination in the Workplace - Will Disclosure Leave HIV-Infected Workers Jobless?, 47 U. MIAMI L. REV. 241 (1992). The ADA was modeled after section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1991), and Title VII, the Civil Rights Act of 1964. One purpose of section 504 of the Rehabilitation Act was to promote handicapped employment by prohibiting discrimination against handicapped persons. Because courts have consistently held that HIV infection is a handicap under section 504, HIV is also a disability under the ADA. Id. at 246-49.

85. 42 U.S.C. § 12102(1) ("No definition of the phrase 'substantially limited' is included in the statutory language of the [ADA].") See OGLETREE ET AL., supra note 5, at 3-19. However, it is indicated that the level of impairment is to be measured by comparison with the average typical person. Id. The definition of "major life activities" includes, caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, standing, lifting and reaching. Id. at 3-18 and 3-19. This list of major life activities is not exhaustive. Id.

86. However, procreation and intimate sexual relations were considered "major life activities" for the purpose of the ADA. H.R. REP. No. 485, supra note 20, at 52, reprinted in 1990 U.S.C.C.A.N. 267, 334. Because HIV limits those activities substantially, even asymptomatic HIV status can qualify as a covered impairment. See Chalk v. District Court, 840 F.2d 701 (9th Cir. 1988) (stating asymptomatic HIV is a handicap under section 504 of the Rehabilitation Act); see also supra note 84 (discussing that the ADA is modeled on the Rehabilitation Act).

87. INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 7-8. However, if the provisions based on disability are not a "subterfuge" to evade the purposes of the ADA, the provisions do not violate the ADA. Id. The INTERIM ENFORCEMENT GUIDANCE provides the following example:

R Company's new self-insured health insurance plan caps benefits for the treatment of all physical conditions, except AIDS, at $100,000 per year. The treatment of AIDS is capped at $5,000 per year. CP, an employee with AIDS enrolled in the health insurance plan, files a charge alleging that the lower AIDS cap violates the ADA. The lower AIDS cap is a disability based distinction. Accordingly if R is
legislative history, regulations, and Interpretive Guidance, one may conclude that HIV and AIDS are covered disabilities for the purposes of the ADA.

B. Are Self-Insured Health Funds "Covered Entities" for the Purpose of the ADA?

The conclusion that AIDS is a covered disability bears significance for self-insured health funds, but only if self-insured health funds are themselves considered "covered entities" under the ADA. If a self-insured health fund is not a covered entity, then federal district courts will lack jurisdiction to adjudicate ADA claims filed against them.\(^8\)

The ADA provides that "[n]o covered entity shall discriminate against a qualified individual with a disability."\(^8\) The Act defines a "covered entity" as "an employer, employment agency, labor organization or a joint labor-management committee."\(^9\) Although these terms are not defined in the ADA itself, the terms' definitions were taken from section 701 of Title VII of the Civil Rights Act of 1964,\(^9\) and incorporated by reference into the ADA through EEOC regulations.\(^9\)

Under the Act, an employer is defined as "a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year, and any agent of such person."\(^9\) For purposes of this analysis, it is beneficial to distinguish self-insured health plans maintained by a single employer\(^4\) from health plans maintained as self-insured, multiple-employer, or multi-employer, Taft-Hartley trusts.\(^9\)

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\(^8\) unable to demonstrate that its health insurance plan is bona fide and that the AIDS cap is not a subterfuge, a violation of the ADA will be found.

\(\text{id. at 8.}\)

\(^8\) See generally Carparts Dist. Ctr. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583 (D.N.H. 1993), vacated and remanded, No. 93-1954, 1994 U.S. App. LEXIS 28319 (1st Cir. Oct. 12, 1994). The district court dismissed the ADA suit against the self-insured health fund because the court determined the fund was not a covered entity. \(\text{id. at 587.}\)

\(^8\) See generally Carparts Dist. Ctr. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583 (D.N.H. 1993), vacated and remanded, No. 93-1954, 1994 U.S. App. LEXIS 28319 (1st Cir. Oct. 12, 1994). The district court dismissed the ADA suit against the self-insured health fund because the court determined the fund was not a covered entity. \(\text{id. at 587.}\)

\(^8\) See generally Carparts Dist. Ctr. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583 (D.N.H. 1993), vacated and remanded, No. 93-1954, 1994 U.S. App. LEXIS 28319 (1st Cir. Oct. 12, 1994). The district court dismissed the ADA suit against the self-insured health fund because the court determined the fund was not a covered entity. \(\text{id. at 587.}\)

\(^8\) See generally Carparts Dist. Ctr. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583 (D.N.H. 1993), vacated and remanded, No. 93-1954, 1994 U.S. App. LEXIS 28319 (1st Cir. Oct. 12, 1994). The district court dismissed the ADA suit against the self-insured health fund because the court determined the fund was not a covered entity. \(\text{id. at 587.}\)

\(^9\) 42 U.S.C. § 12111(2).

\(^9\) 42 U.S.C. § 12111(5). The term employer includes the states but expressly excludes the United States government and its wholly owned subsidiaries, Indian tribes, and bona fide private membership clubs. \(\text{id. § 12111(5)(b).}\)

\(^9\) A "single-employer plan" is defined under ERISA section 3(41) as "an employee benefit plan other than a multi-employer plan." 29 U.S.C. § 1002(41).

\(^9\) \(\text{id. 1002(37). See also infra notes 96-101 and accompanying text.}\)
A multi-employer health plan is a plan to which more than one employer contributes and is maintained pursuant to one or more collective bargaining agreements. The Taft-Hartley Act mandates that employees and employers must be represented equally on the board of trustees that administer such a fund. The employer and employee representatives together are trustees of the fund. Each trust fund has its own legal identity. Thus, even though the trustees of the plan are appointed by a labor union or an employer, they do not represent the interests of the appointing party. Rather, the trustees must administer the trust for the “sole and exclusive benefit” of the beneficiaries of the trust.

A single-employer plan is defined as a plan other than a multi-employer plan. The employer is the plan sponsor. Because the employer is the plan sponsor and directly determines the content and provisions of the plan, a single-employer, self-insured plan is under the direct control of the employer. Thus, when a single employer maintains a self-insured plan, the plan would most likely be considered an “employer,” or at least the agent of the sponsoring employer, within the terms of the ADA.

However, the question of whether a self-insured, multi-employer health fund is a “covered entity” for the purposes of the ADA is not as clear. Because the multi-employer, self-insured fund is governed by the Taft-Hartley Act, it is administered by a board of independent trustees appointed by the employer and labor organization and prohibited from representing the interests of their appointing parties. Thus, the Taft-Hartley trust is an independent entity under the law. Even though an
employer makes contributions to the Taft-Hartley trust pursuant to a written agreement, the fund is not actually the employer of the participant.

It may be argued that the trustees of the Taft-Hartley fund, who were appointed either by the union or the employer, are agents of the employer. Such a contention must survive the scrutiny of NLRB v. Amax Coal Co. Amax made clear that the duty of the appointed trustee of an employee benefit plan, established under Taft-Hartley section 302(c)(5) (a multi-employer plan) "is directly antithetical to that of an agent of the appointing party." Thus, it will likely be held that for the purposes of the ADA the trustees will also not be deemed agents of the appointing party.

In Carparts Distribution Center v. Automotive Wholesalers Association of New England, the United States District Court of New Hampshire determined that a self-insured health plan does not qualify as a covered entity under the ADA. Significantly, the United States Court of Appeals for the First Circuit recently vacated and remanded the district court decision for reconsideration. In Carparts, the plaintiff was the owner and sole shareholder of an automobile parts distributor. The plaintiff's company participated in a health benefit plan sponsored by the Automotive Wholesalers Association of New England, Inc. (AWANE). The plan was self-funded and uninsured. After the plaintiff was diagnosed HIV positive, AWANE and the AWANE health benefit plan

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105. For an employer to make contributions to a qualified health plan, the terms of the plan are required to be in writing. 29 U.S.C. § 186(c)(5).
106. ERISA section 3(5) defines the term "employer" as "any person acting directly as an employer, or indirectly in the interest of the employer." 29 U.S.C. § 1002(5). A self-insured health plan does not directly employ its participants, nor can the trustees represent the employer's interests. See NLRB v. Amax Coal, 453 U.S. 322 (1981).
108. Id. at 331-32.
110. Id. at 585. In response to plaintiffs' allegation that AWANE and the AWANE plan were "covered entities," the court stated that "[n]either AWANE nor the AWANE PLAN qualify as a covered entity as that term is defined in the [ADA] as neither was an employer of [the plaintiff]." Id.
113. Id.
114. Id. at 584.
capped lifetime benefits for AIDS-related illnesses at $25,000. A maximum of one million dollars in benefits would continue to be provided for other than AIDS-related illnesses. The plaintiff filed suit under the ADA alleging discrimination based on the terms of the health insurance coverage modification. The district court found that the trust was not a "covered entity" because it was not the employer of the plaintiff. Because Carparts Distribution Center (Carparts) was wholly owned by the plaintiff, the sole shareholder, Carparts was not named as a defendant. Therefore, the district court never addressed whether the trust was an agent of Carparts. Accordingly, the district court dismissed the action in favor of defendant on a motion for summary judgment. The First Circuit vacated the decision and remanded the case for reconsideration of whether the health benefit plan was the "employer" of the plaintiff. However, before considering whether the health benefit plan may be deemed an "employer," it is appropriate to consider other possibilities under which the health benefit plan may be deemed a covered entity.

Although the plaintiff failed to assert that the AWANE plan fit within any of the other definitions of a "covered entity" under the ADA, such as an employment agency, joint labor-management committee, or labor organization, it is unlikely that plaintiff would have prevailed. First, the AWANE fund is not or would not be deemed an "employment agency" as defined by section 701(c) of Title VII. Employment agency is defined as "any person regularly undertaking with or without compensation to procure employees for an employer or to procure for employees opportunities to work for an employer and includes an agent of such a person." Because it is not the function of the AWANE fund, or the function of any

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115. Id. at 585. Plaintiff was diagnosed HIV positive on May 12, 1986. After the diagnosis, "AWANE and the AWANE [health] plan capped lifetime benefits for AIDS related illnesses." Id.
116. Id.
117. Id.
118. Id.
119. See generally id.
120. Id.
121. Id. at 588.
123. See 42 U.S.C. § 2000e. The terms person, labor organization, and employment agency have the same meaning given to the terms as in section 701 of the Civil Rights Act of 1964. Id. § 12111(7).
124. Id. § 2000e(c).
health plan, to procure employment for its participants, the AWANE plan would not be deemed an employment agency.

A "joint labor-management committee" is defined as a committee "controlling apprenticeship or other training programs, including an on-the-job retraining program, or Federal entity subject to section [717]." Because the AWANE health plan did not engage or control an apprenticeship or job training program, the fund is not a joint labor-management committee.

Arguably, the definition of "labor union" could be deemed to include a Taft-Hartley fund. A labor organization is defined in section 701(d) as:

[A] labor organization engaged in any industry affecting commerce, and any agent of such an organization, and includes any organization of any kind, any agency, or employee representation committee, group, association, or plan so engaged in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours, or other terms or conditions of employment, and any conference, general committee, joint or system board, or joint council so engaged which is subordinate to a national or international labor organization. The definition of labor organization found in section 701(d) establishes that an entity must have as its purpose "in whole or in part" the object of "dealing with employers concerning grievances, labor disputes, wages, rates of pay" and the other subjects of collective bargaining in order to constitute a labor union. In Amax the Supreme Court found that fund trustees "are not representatives for the purpose of collective bargaining or the adjustment of grievances." Because it is clear that a trust and its trustees are not permitted in their role as trustees to be representatives for the purposes of collective bargaining, it is arguable that a trust fund cannot be a labor organization. If correct, this conclusion would remove the last possible basis on which a district court could assert jurisdiction directly over a self-insured, multi-employer health fund.

However, neither Carparts nor any other case to date has addressed whether the AWANE plan or other self-insured, multi or multiple employer trust could be considered a labor-organization and thus a "covered

125. Id. § 2000e(n).
126. Id. § 2000e(d).
127. See id.
129. See supra notes 100, 101, 108 and accompanying text.
Do AIDS Caps Violate the Law?

entity" for the purposes of ADA. Because millions of Americans are insured by self-funded health plans, the outcome of the litigation considering whether the ADA risk classification principles apply to these funds is an important issue with vast implications for health insurers and those who are insured.

Since Carparts, further litigation has focused on whether a self-insured trust will be considered a covered entity. Currently before the United States District Court for the Southern District of New York is Mason Tenders District Council Welfare Fund v. Donaghey. In Mason Tenders, Terrence Donaghey was a participant in the Mason Tenders District Council Trust Fund, a jointly managed, self-insured, labor-management health trust fund. After Donaghey was diagnosed with HIV, the Mason Tenders' health trust fund modified its health coverage and discontinued all coverage for any health expenses incurred for any treatment related to any infections or diseases related to HIV, AIDS, or AIDS-related complex (ARC). Although Donaghey continued to participate in the plan, after July 1, 1991, he was not reimbursed for medical expenses related to HIV or AIDS because of the plan's complete exclusion of treatment related to HIV. Donaghey filed charges with the regional office of the EEOC asserting that the Mason Tenders' health plan violated the ADA because it excluded coverage related to HIV, a covered disability. The EEOC determined that the Mason Tenders' health fund exclusion facially violated the ADA. The current EEOC position is that a self-insured benefit fund is a covered entity within the meaning of the ADA. The determination of whether the Mason Tenders' health fund is a covered entity, however, will ultimately be for the courts to determine.

Under what legal principles might the Mason Tenders' health trust fund be considered a "labor organization" in light of the holding in Amax and ERISA's fiduciary requirements? The recent decision in Mor-

130. See supra note 96 and accompanying text.
132. See Determination Letter, supra note 75, at 1-2.
133. Id.
134. Id. at 1-2.
135. Id.
136. Id. “The [EEOC's] . . . investigation finds Respondent's medical insurance practices appears, on its face, to violate the American with Disabilities Act of 1990.” Id. at 2.
137. Id.; Determination Letter, supra note 75, at 1-2; INTERIM ENFORCEMENT GUIDANCE, supra note 10, at 7-9.
138. See supra note 101 and accompanying text.
ganbesser v. United States\textsuperscript{139} sheds some light on one possibility. In Morganbesser, the United States Court of Appeals for the Second Circuit held that a local union's pension plan was a labor organization, at least for tax purposes.\textsuperscript{140} The court found that the plan was a labor organization because it was established pursuant to a collective bargaining agreement and a multi-employer plan, administered by a board of trustees comprised equally of employer and union representatives.\textsuperscript{141} The opinion stated that the district court "properly held that the trust meets the requirements of a labor organization and qualifies for an exemption under § 501(c)(5) of the [Internal Revenue] Code."\textsuperscript{142}

Significantly, the same court in 1982 interpreted the term "employer" broadly enough to include any party significantly affecting any person's access to employment opportunities.\textsuperscript{143} In Spirt v. Teachers Insurance & Annuity Association,\textsuperscript{144} the Second Circuit found insurance companies, which were not the employer of those insured, liable under Title VII for benefit plan distinctions based on discriminatory sex-segregated mortality tables.\textsuperscript{145} In Spirt, an insurance company that was not directly the employer of the plaintiff was held to be an "employer" under Title VII because the term is "sufficiently broad to encompass any party who significantly affects access of any individual to employment opportunities, regardless of whether that party may technically be described as an 'employer' of an aggrieved individual."\textsuperscript{146} Thus, the United States Court of Appeals for the Second Circuit agreed that a third party insurance company "which exist[s] solely for the purpose of enabling universities to delegate their responsibility to provide retirement benefits for their employees, [is] so closely intertwined with those universities ... that [it] must be deemed an 'employer' for the purposes of Title VII."\textsuperscript{147} In fact, the recent United States Court of Appeals for the First Circuit decision in Carparts explicitly remanded the case for reconsideration of whether the

\textsuperscript{139} 984 F.2d 560 (2d Cir. 1993).
\textsuperscript{140} Id. at 564 (stating that it is "allowed [for] entities which carry out the function of a labor organization to be jointly administered by employers and employees and still qualify as a labor organization").
\textsuperscript{141} Id.
\textsuperscript{142} Id.
\textsuperscript{143} Id.
\textsuperscript{144} 691 F.2d 1054 (2d Cir. 1982).
\textsuperscript{145} Id. at 1054.
\textsuperscript{146} Id. at 1063 (quoting Vanguard Justice Soc'y, Inc. v. Hughes, 471 F. Supp. 670, 696 (D. Md. 1979)).
\textsuperscript{147} Id.
AWANE health benefit plan functioned as an employer. The First Circuit, relying on Spirt, stated that if "the AWANE and AWANE Plan exist solely for the purpose of enabling entities such as Carparts to delegate their responsibility to provide health insurance for their employees, they are so intertwined with those entities that they must be deemed an 'employer' for the purposes of Title I of the ADA." Given the logic of Morganbesser and Spirt and the First Circuit's opinion in Carparts, it is possible that the Mason Tenders' health benefit fund could be deemed either a "labor organization" under Morganbesser, or alternatively, an "employer" under the theory that the fund, Donaghey's union, and the employer are so closely intertwined that the health trust fund must be deemed an employer for the purposes of the ADA. It follows then that just as the insurance company was a third-party institution managing and setting the terms of an employee benefit, so too is the Mason Tenders' health trust fund a third-party entity responsible for employee benefits of a discrete participant pool. As the court in Spirt pointed out, "the language of the Supreme Court ... would seem to compel a finding that delegation of responsibility for employee benefits cannot insulate a discriminatory plan from attack." The opinion also stated that an employer could not avoid his responsibilities by delegating discriminatory programs to corporate shells.

Of course, it is possible to distinguish Morganbesser and Spirt from the Mason Tenders scenario on several grounds. First, both Morganbesser and Spirt considered pension benefits, whereas Mason Tenders is concerned with health benefits. However, because we are here concerned with the status of each entity as a trust, this distinction is not necessarily dispositive when considering that the pension and health funds are tax qualified and jointly administered by a board of trustees. However, it must be noted that Morganbesser was a tax case. It certainly is possible, therefore, that a court might find a health trust fund to be a labor

149. Id. at *12.
150. See Morganbesser v. United States, 984 F.2d 560 (2d Cir. 1982).
151. See Spirt v. Teachers Ins. & Annuity Ass'n, 691 F.2d 1054, 1063 (2d Cir. 1982).
152. Id.
153. Id.
154. See Morganbesser, 984 F.2d at 561-63 (discussing pension plan benefits); Spirt, 691 F.2d at 1062-64 (considering annuity retirement contracts); Mason Tenders District Council Welfare Fund v. Donaghey, No. 93 Civ. 1154 (S.D.N.Y. filed 1993) (considering payment of health benefits); see generally Determination Letter, supra note 75.
organization for tax purposes, and yet not a labor organization within the definition of the ADA.\textsuperscript{156} \textit{Spirt} is potentially distinguished because it was a Title VII action.\textsuperscript{157} Whereas the definition of "employer" for Title VII purposes was intended to be interpreted broadly,\textsuperscript{158} it could be argued that the definition under the ADA was intended to be interpreted narrowly. However, because the ADA regulations incorporate the Title VII definition of employer, this proposition is unlikely.\textsuperscript{159} It is important to note that the reasoning of \textit{Spirt} is not accepted by all of the Circuit Courts. Although the United States Court of Appeals for the Second Circuit concluded that a third-party insurer could be deemed an employer,\textsuperscript{160} the Sixth Circuit has taken the opposite position, concluding that a third-party insurer has no liability under Title VII.\textsuperscript{161}

Moreover, even if it is determined that the benefit fund is not a covered entity, Donaghey, the Mason Tenders plaintiff, and the EEOC may still be able to sustain their discrimination suit against Donaghey's local union and his employer. They could argue that an "employer" and a "labor organization," both covered entities for the purpose of the ADA,\textsuperscript{162} are prohibited from "participating in a contract or other arrangement or relationship that has the effect of subjecting the covered entity's qualified applicant or employee with a disability to discrimination."\textsuperscript{163} Further, they could point to the EEOC regulations that specifically declare that "[i]t is unlawful for a covered entity to participate in a contractual or other arrangement or relationship that has the effect of subjecting the covered entity's own qualified applicant or employee with a disability to discrimination."\textsuperscript{164}

\begin{footnotesize}
\begin{enumerate}
\item[156.] In \textit{Morganbesser}, the court considered whether the trust fund would lose its tax exempt status. \textit{Id.} Had the court found that the fund was not a "labor organization" the fund would have lost its tax exempt status and would have been liable for significant tax penalties. \textit{Id.} at 566. The court never discussed whether the trust performed any of the traditional functions of a labor organization, such as dealing with employees concerning grievances, labor disputes or wages.
\item[157.] \textit{Spirt v. Teachers Ins. & Annuity Ass'n}, 691 F.2d 1054 1056, 1063 (2d Cir. 1982).
\item[158.] \textit{Id.} at 1063.
\item[159.] \textit{See} 42 C.F.R. § 1601.2.
\item[160.] \textit{Spirt}, 691 F.2d at 1063.
\item[161.] \textit{Peters v. Wayne State Univ.}, 691 F.2d 235 (6th Cir. 1982) (holding that an employer did not retain an insurance company as agents and as such the insurance companies were not liable under Title VII for providing an employer with a benefit program based on a sex-segregated mortality table), \textit{vacated and remanded on other grounds}, 463 U.S. 1223 (1983).
\item[162.] \textit{See} 42 U.S.C. § 12111(5); \textit{see supra} notes 95, 125, 126 and accompanying text.
\item[163.] 42 U.S.C. § 12112(b)(2). Such contractual agreements include a relationship with "an organization providing fringe benefits to an employee of the covered entity." \textit{Id.}
\end{enumerate}
\end{footnotesize}
the discrimination prohibited."164 An organization that provides fringe benefits to an employee of a covered entity is specifically mentioned as one of the types of contractual relationships that is prohibited from discriminating.165 The purpose of this provision is to prevent a covered entity from doing indirectly what the entity could not achieve directly.

In Mason Tenders, both the labor union, which served as Donaghey’s agent for collective bargaining, and the health trust fund were named parties.166 Because the employer associations and the labor union entered into collective bargaining agreements with a fund that is allegedly discriminating against a covered disability, HIV, the employer and labor union, as covered entities, arguably are violating the ADA because they have entered into a contractual arrangement that subjects a person with a qualified disability to discriminatory practices.167 Accordingly, the labor union and the employer may be found to be liable under the ADA for doing indirectly what they would be prohibited from doing directly.168

Interestingly, the district court in Carparts pointed out that liability under the ADA for the alleged discrimination against plaintiff would lie with Carparts, the employer, because Carparts subjected plaintiff to the alleged discriminatory practices of the AWANE health fund.169 Before concluding that the covered entities are discriminating against a covered disability, such as AIDS, we must first venture through the complex and sometimes confusing maze of section 501(c) of the ADA.170

III. SECTION 501(c); TEMPERING THE BROAD NONDISCRIMINATION PROVISION

It is unlawful for a covered entity to discriminate on the basis of disability in regard to the terms and conditions of employment.171 Moreover, EEOC regulations provide that it is unlawful for a covered entity to dis-

164. 29 C.F.R. § 1630.6(a).
165. Id. § 1630.4(f).
166. See Answer of Defendant Donaghey to Amended Complaint, Affirmative Defenses and Counterclaims at 24, No. 93 Civ. 1154 (S.D.N.Y. filed June 1993).
167. The health benefit fund excluded all coverage for illnesses related to HIV or AIDS. Id. at 23. See Determination Letter, supra note 75, at 1.
168. 42 U.S.C. § 12201(c).
170. 42 U.S.C. § 12201(c). The text of 501(c) is paraphrased in section 1630.16(f) of the EEOC regulations. 29 C.F.R. § 1630.16(f).
171. 42 U.S.C. § 12112(a).
discriminate on the basis of disability against a qualified individual with a
disability with respect to fringe benefits available by virtue of employ-
ment, whether or not administered by the covered entity.\textsuperscript{172} If this broad
prohibition were read literally and out of context, one would have to con-
clude that under no circumstances could a covered entity provide or con-
tract with a health fund that provided disparate treatment for any
covered disability under the ADA. The impact of such a broad prohibi-
tion could prove devastating to the financial integrity of the health insur-
ance industry.\textsuperscript{173}

Congress added section 501(c) of the ADA to alleviate the concerns of
the broad anti-discrimination provisions of the ADA and to temper the
effect of the anti-discrimination provisions with respect to health insur-
ance.\textsuperscript{174} Section 501(c) generally provides that health insurance provi-
ders may continue to rely on traditional risk classification and risk
underwriting principles in administering health plans.\textsuperscript{175} Specifically, sec-
tion 501(c) describes the relationship of the ADA to employee benefit
plans:

\textit{(c) Insurance.—Subchapters I through II of this Chapter and Ti-
tle IV of this Act shall not be construed to prohibit or restrict —}

\textit{(1) an insurer, hospital, or medical service company, health
maintenance organization, or any agent, or entity that ad-
ministers benefit plans, or similar organizations from un-
derwriting risks, classifying risks, or administering such
risks that are based on or not inconsistent with State law; or
(2) a person or organization covered by this chapter from
establishing, sponsoring, observing or administering the
terms of a bona fide benefit plan that are based on under-

\textsuperscript{172} 29 C.F.R. § 1630.4(f).

\textsuperscript{173} One fear of employers is that the EEOC “will severely restrict customary insurance practices aimed at cost containment [and] [e]mployers and insurers will swiftly be ushered to the steps of the bankruptcy court.” Thomasina Rogers et al., \textit{ADA and Benefits Plans: A Civil Rights Law Perspective}, 5 \textit{BENEFITS L.J.} 377, 377 (1992).


In sum, section 501(c) is intended to afford to insurers and employers the same
opportunities they would enjoy in the absence of this legislation to design and
administer insurance products and benefits plans in a manner that is consistent
with basic principles of insurance risk classification. Without such a clarification,
this legislation could arguably find violative of its provisions any action taken by
an insurer or employer which treats disabled persons differently under an insur-
ance or benefit plan because they represent an increased hazard of death or
illness.

\textit{Id.}

\textsuperscript{175} See 42 U.S.C. § 12201(c).
writing risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.176

By implementing section 501(c), the ADA leaves intact the risk and underwriting classifications that were available prior to its passage.177 Thus, "Congress acted in Title V of the ADA expressly to hold harmless insurance practices borne of risk classification and underwriting in the case of employer-purchased insurance."178 Commentators have noted that even by including broad prohibitions against discrimination on the basis of disability, many traditional insurance practices will escape the regulation of the ADA because of the Title V exemption.179 These risk classification principles comprise a traditional insurance practice that insurers have relied upon to manage the cost of their health care plans.180 Section 501(c)(1) and (2) of the ADA permit the use of underwriting and classifying risks.181

A. Traditional Risk Classification

Risk classification is a system of "grouping risks with similar characteristics for the purpose of setting [insurance] prices."182 Health insurers use risk classification principles to determine the cost of a benefit or a plan of benefits.183 Insurers and employers can use insurance claim and cost information to assess risk and in turn use this information in managing their health plans and their costs.184 A result of using risk classification principles is to limit, restrict, or exclude coverage for certain procedures or illnesses.185 Arguably, because the ADA allows risk classification, an insurer could exclude coverage even for a covered disability if the insurer

176. Id. § 12201(c).
177. S. REP. NO. 116, supra note 174, at 85-86.
178. Rogers et al., supra note 173, at 378.
179. Id.
180. See infra notes 182-186 and accompanying text.
181. 42 U.S.C. §§ 12201(c)(1), (2).
183. Id.
184. Id. at 394
185. Id.
followed accepted risk classification principles in reaching its determination.\footnote{186} However, if an insurer does not need to use risk classification principles, the insurer could arguably exclude or cap an illness without having to justify the exclusion or cap.

\textbf{B. Self-Insured Funds and Section 501(c)}

In light of the ambiguous language of section 501(c), and, in particular, 501(c)(3)'s ambiguity, it is uncertain whether self-insured health funds are required to justify a limitation or exclusion for a covered disability by utilizing risk classification principles. Sections 501(c)(1) and (2) explicitly state that a covered entity must underwrite or classify risks “that are based on or not inconsistent with State law.”\footnote{187} In section 501(c)(3) there is no reference to risk underwriting or classification.\footnote{188} Also, whereas 501(c)(1) and (2) invoke state law principles of underwriting and risk classification into their schemes and texts, 501(c)(3) explicitly permits observing and administering “a bona fide benefit plan that is not subject to State laws that regulate insurance.”\footnote{189}

The language implies that section 501(c)(2) refers to “insured” health plans that purchase insurance contracts as these plans are subject to state insurance laws and the risk classification policies of the state. Section 501(c)(3), by referring to benefit plans not subject to state laws, implicates self-insured plans. This implication is a result of the fact that ERISA preemption has traditionally taken self-insured funds out from under the statutory jurisdiction of state insurance law.\footnote{190} Therefore, self-insured plans arguably are not required to justify disability-based distinctions on accepted risk classification principles because of the traditional exemption of self-insured plans from state law and the absence of language in section 501(c)(3) referring to risk classification principles. Consequently, the argument is advanced that when a self-insured fund desires to cap or exclude health insurance for a covered disability, the self-insured fund does not need to apply risk classification principles because section

\footnote{186. \textit{See generally} \textsc{Interim Enforcement Guidance}, \textit{supra} note 10. The EEOC notes that a covered entity charged with discriminating in health care benefits because of “disability-based disparate treatment that is not justified by the risks and costs associated with the disability” may prove that the terms of the plan are not in fact discriminating. \textit{Id.} at 11-13.}

\footnote{187. 42 U.S.C. §§ 12201(c)(1), (2).}

\footnote{188. \textit{Id.} § 12201(c)(3).}

\footnote{189. \textit{Id.}}

\footnote{190. \textit{See supra} notes 33-41 and accompanying text.}
501(c)(3) did not intend to import these practices to self-insured funds.\textsuperscript{191} Instead, the regulation of the funds would simply be governed by ERISA and the body of law that was in place prior to the ADA. The law prior to the ADA was set forth in \textit{McGann v. H & H Music Co.},\textsuperscript{192} which provided that a self-insured health plan had broad authority to modify, exclude or terminate benefits.\textsuperscript{193}

An analysis of section 501(c) does not end with a facial investigation of its text. The ADA legislative history reveals that:

\begin{quote}
[S]ection 501(c)(3) has been added to address one particular concern. There was some concern raised on the part of those who administer self-insurance plans that the language of section 501(c)(2) could be read to affect the preemption doctrine of the Employee Retirement Income Security Act of 1974. Congress does not intend in this bill to affect in any way such preemption doctrine . . . .\textsuperscript{194}
\end{quote}

The Senate Labor Committee explained its understanding of section 501(c):

\begin{quote}
Since there is some uncertainty over the possible interpretations of the language contained in [ADA] Titles I, II and III as it applies to insurance, the Committee added section 501(c) to make it clear that this legislation will not disrupt the current nature of insurance underwriting or the current regulatory structure for self-insured employers or of the insurance industry in sales, underwriting, pricing, administrative and other services, claims, and similar insurance related activities based on classification of risks as regulated by the States.\textsuperscript{195}
\end{quote}

Reading the Senate Labor Committee Report in conjunction with Senator Harkin's statement implies that Congress intended that self-insured plans would continue to be exempt from state insurance law under the ADA. The Senate Labor Committee Report also may be read to preserve the pre-ADA regulatory structure for self-insured health plans. However, the Senate Labor Report goes on to state that "the [ADA] is intended to apply nondiscrimination standards equally to self-insured plans as well as to third-party payer . . . plans with respect to persons with

\textsuperscript{191} The argument that the risk classification principles espoused in sections 501(c)(1) and (2) should apply to section 501(c)(3) must overcome the structural framework of 501(c) which implies that each subsection is to be read discretely.

\textsuperscript{192} 946 F.2d 401 (5th Cir.), \textit{cert. denied}, 113 S. Ct. 482 (1992).

\textsuperscript{193} See \textit{supra} notes 66-70 and accompanying text.


\textsuperscript{195} S. REP. NO. 116, \textit{supra} note 174, at 84 (emphasis added).
Despite the fact that risk classification principles are absent in section 501(c)(3), the EEOC has taken the position that limitations and exclusions of coverage in self-insured plans must be justified by risk classification principles. The EEOC's Determination Letter in *Mason Tenders* states:

The Commission's investigation reveals Respondent [The Mason Tenders Health Plan] did not follow any accepted risk classification for excluding HIV/AIDS coverage from its health insurance plan. ... Respondent also admits it had no actuarial study recommending exclusion of HIV/AIDS coverage or that it would be in financial difficulty if it continued the coverage.

... Significantly, Respondent admits it continues to pay benefits for other high cost medical conditions such as cancer, heart disease, and kidney disease. Moreover, the Commission's investigation and evidence of record reveals no actuarial justification for exclusion of HIV/AIDS coverage.

Based on Respondent's admissions, the Commission finds in this particular case, there is no valid rationale to the exclusion of HIV/AIDS coverage. ... Respondent has violated the ADA.

Although states have adopted risk classification principles, self-insured funds are not within the province of state law. Thus, the EEOC's position that risk classification principles must be applied to all insurance plans, whether self-insured or not, may create uncertainty as to what risk classification principles should be applied to self-insured funds. The EEOC could alleviate this uncertainty by drawing risk classification principles from state law, by adopting model insurance regulations, or by promulgating risk classification principles through regulation.

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196. *Id.* at 86.
197. See *Interim Enforcement Guidance*, *supra* note 10, at 6-12.
199. See *supra* notes 38-43 and accompanying text.
200. See generally *Interim Enforcement Guidance*, *supra* note 10. See also *Determination Letter II*, *supra* note 198, at 1-3.
201. For example, the EEOC could adopt the risk classification principles of the state of the district court that is hearing the action. However, this may create a lack of uniformity in the application of risk classification. For the sake of uniformity the EEOC may wish to promulgate risk classification principles through regulation.
In response to the uncertainty about the scope of health insurance the EEOC, on June 8, 1993, issued Interim Enforcement Guidance regulations which consider the applicability of the ADA to disability-based distinctions in employer-provided health insurance plans. The regulations provide that whenever an individual charges a term or provision contained in an employee health benefit plan violates the ADA, the first question that must be answered is whether the term or provision is in fact a disability-based distinction. The regulations explain the term disability-based distinction by explaining what is not a disability-based distinction. "Insurance distinctions that are not based on disability, and that are applied equally to all insured employees, do not discriminate on the basis of disability and so do not violate the ADA." Therefore, benefit plans that provide a lower level of benefits for mental and nervous conditions than for other medical conditions are not disability based distinctions. Similarly, blanket pre-existing condition clauses are not disability based distinctions. However, health-related insurance distinctions that are based on a disability may violate the ADA. For example, a term or provision in a health plan is disability based if it singles out a particular disability, such as, deafness, AIDS, and schizophrenia, or a term is disability based if a discrete group of disabilities, such as cancer, muscular dystrophy, or kidney disease, is singled out.

Yet even if the term or provision in a self-insured benefit plan is a disability based distinction, the plan may avoid liability under the ADA if two conditions are met. First, the plan must be proven to be a "bona fide" employee benefit plan. For self-insured funds this requirement is satisfied by proof that it exists as a plan, pays benefits, and accurately communicates the terms of the plan to covered participants.

Once it is shown that the plan is "bona fide," it must prove that the "disability-based distinction" is not a subterfuge designed to avoid the purposes of the ADA. The EEOC Interim Enforcement Guidance de-

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203. Id. at 3-4.
204. Id. at 5.
205. Id. at 1.
206. Id. at 7.
207. See id. at 6-10.
208. Id. at 7.
209. Id.
210. Id. at 10-11.
211. Id. at 11.
212. Id. The term "subterfuge" is not defined in the ADA.
fines subterfuge as a “disability based disparate treatment that is not justified by the risks or costs associated with the disability.” The regulations provide five justifications to explain how it can be proven that a plan is not a subterfuge to avoid the purposes of the ADA:

a. The respondent may prove that it has not engaged in the disability-based disparate treatment alleged.

b. The respondent may prove that the disparate treatment is justified by legitimate actuarial data, or by actual or reasonably anticipated experience.

c. The respondent may prove that the disparate treatment is necessary (i.e. that there is no disability-based health insurance plan change that could be made) to ensure that the challenged health insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan.

d. The respondent may prove that the challenged insurance practice or activity is necessary (i.e. that there is no disability based change that could be made) to prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged for the health insurance plan.

e. Where the charging party is challenging the respondent’s denial of coverage for a disability-specific treatment, the respondent may prove that this treatment does not provide any benefit.

Thus the EEOC’s position is that in order to exclude or cap a covered disability, a health plan must justify the exclusion based on risk classification. However, it is uncertain whether or not the courts will sustain such a position in light of section 501(c), which does not include specific language requiring risk classification. It could be argued that Congress chose not to include within section 501(c)(3) language mandating the use

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213. *Id.* Interestingly, the Age Discrimination in Employment Act (ADEA) has a “subterfuge proviso” that is worded analogously to the ADA’s proviso. See 29 U.S.C. § 623(f)(2) (1988 & Supp. IV 1992); see also Kimberly A. Ackourey, Comment, *Insuring Americans with Disabilities: How Far Can Congress Go To Protect Traditional Practices?*, 40 *Emory L.J.* 1183 (1991) (comparing the ADA with the ADEA subterfuge proviso and concluding that the ADA will adopt the ADEA’s case law interpreting that proviso). However, courts interpreting the ADEA have defined subterfuge as a “scheme, plan, stratagem or artifice of evasion.” *Id.* at 1192. The ADA, on the other hand, has declared that for the purposes of the ADA “subterfuge refers to disability based disparate treatment that is not justified by the risks or costs associated with the disability.” *Interim Enforcement Guidance, supra* note 10, at 11.

214. *Id.* at 11-13.
of risk classification, and that the EEOC, through its regulations is trying to federalize standards of risk management without congressional authorization.

IV. Conclusion

Self-insured health plans likely will be deemed covered entities,\textsuperscript{215} or at least federal courts could assert jurisdiction over an employer or labor organization that contracts with a self-insured health plan.\textsuperscript{216} However, even if the self-insured health plan is determined to be a covered entity, neither the plan itself nor parties contracting with the plan will violate the ADA if they cap or exclude coverage without relying on risk classification principles. The EEOC's regulations declaring that self-insured health plans must comply with risk classification will be deemed invalid because the EEOC has ventured beyond the statutory mandate of ADA section 501(c).

Patrick J. Morgan

\textsuperscript{215} See supra Part III.B of this text. The courts likely will adopt the analysis in Spirt v. Teachers Ins. & Annuity Ass'n, 691 F.2d 1054 (2d Cir. 1982).

\textsuperscript{216} See supra notes 162-68 and accompanying text.