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

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

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

INTRODUCTION

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

1 The title was borrowed from a statement by Lee Smith, chairman of the National Leadership Coalition on AIDS, as quoted in Ron Stodghill II, Managing AIDS: How One Boss Struggled to Cope, BUS. WK., Feb. 1, 1993, at 48 ("I was not trained to manage fear, discrimination, and dying in the workplace.").
Control and Prevention ("CDC"). Additionally, the CDC estimates that approximately one million Americans have been infected by the Human Immunodeficiency Virus ("HIV"). Of this group, some estimates indicate

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


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

As of January 1, 1993, the CDC uses an expanded definition of AIDS. See 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 MORTALITY & MORBIDITY W.K.LY. REP., RECOMMENDATIONS AND RPTS. 1, 6 (1992); AIDS Surveillance Case Definition, 268 JAMA 2634, 2634 (1992). This revised definition, when coupled with HIV infection, increases from twenty-three to twenty-six the total number of opportunistic infections that constitute AIDS. AIDS Surveillance Case Definition, supra, at 6. The three new infections are pulmonary tuberculosis, HIV-related severe immunosuppression and invasive cervical cancer. Id. at 6-7. The CDC's inclusion of persons suffering from HIV-related severe immunosuppression (i.e., those HIV-infected persons with CD4+ T-lymphocyte counts less than 200 cells per cubic milliliter of blood, id. at 6) will significantly increase the number of persons diagnosed with AIDS. See Center for Disease Control and Prevention, Projections of the Number of Persons Diagnosed with AIDS and the Number of Immunosuppressed HIV-Infected Persons—United States, 1992-1994, 269 JAMA 733, 733
that as many as half will develop AIDS within two to ten years of becoming infected.\(^6\) The true horror of these numbers becomes clear with the recognition that virtually all AIDS patients die within five years of diagnosis.\(^7\)

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

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


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

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


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

\(^12\) NATIONAL COMM'N ON AIDS, AMERICA LIVING WITH AIDS 70 (1991).
Insurance companies employ various underwriting tactics\(^\text{13}\) to curtail an HIV-infected person's access to private health insurance.\(^\text{14}\) This, coupled with the prohibitive costs of private health insurance, may explain why "[t]he primary vehicle through which persons with AIDS obtain health insurance is employer-sponsored group health insurance plans."\(^\text{15}\)

The main source of funds, however, continues to be government assistance.\(^\text{16}\) Indeed, commentators refer to this trend as the
"Medicaidization" of AIDS. A five-year study of New York, San Francisco and Los Angeles found that "Medicaid finances a much larger proportion of inpatient care for AIDS than other illnesses, and that during the epidemic years, Medicaid's share increased while that of private insurance declined."

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

As a result of this switch to self-insured benefit plans, the costs associated with insuring health care for HIV-infected persons are shifting
from insurance companies to employers. Consequently, employers are now seeking to avoid these costs. One method of cost avoidance is to place a cap on the total amount of health benefits that an employee may recover as a result of HIV infection or AIDS. This method has survived judicial challenge under the Employee Retirement Income Security Act of 1974 ("ERISA"). Not surprisingly, the capping of insurance benefits has become a viable alternative to employers faced with the rising costs of health care. The current issue is whether, as a matter of policy, employers should be able to cap the health benefits of a group considering the significant stigma already attached to being a member of that group.

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


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

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


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

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

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

I. ERISA'S RESPONSE

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

A. McGann v. H & H Music Co.

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

30 See infra notes 34-117 and accompanying text.
32 See infra notes 118-59 and accompanying text.
33 See infra notes 160-240 and accompanying text.
35 Id. § 1001(a).
36 Id. § 1002(1). This term encompasses "any plan, fund, or program ... maintained by an employer ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise ... medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death." Id. A plan participant includes "any employee or former employee or an employer ... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer." Id. § 1002(7).
38 Id. at 403.
maximum health benefits of $1 million through a group insurance plan purchased from General American Life Insurance Company. 39 Seven months after McGann's diagnosis, H & H Music switched its health insurance plan from a purchased plan to a self-insured plan. Along with this change of insurance plans, H & H reduced the maximum health benefit coverage for persons with AIDS to $5,000. Although the employer made other changes to the plan, no similar benefit limitation was placed on any other catastrophic illness. 40

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

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

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

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

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

39 Id.
40 Id. The other changes to the insurance coverage included elimination of coverage for chemical dependency treatment, increased individual and family deductibles, adoption of a preferred provider plan, and increased contribution requirements. Id. at 403 n.1.
41 Id. at 403; see 29 U.S.C. § 1140 (1988).
43 McGann, 946 F.2d at 408.
44 Id.
45 Id. at 404.
46 Id. at 408.
47 Id. at 406.
instituted the AIDS-related benefit cap to reduce costs. Such a broad interpretation, however, fails to consider that McGann, in order to withstand a motion for summary judgment, had the burden of providing evidence sufficient to establish the existence of a genuine issue of material fact regarding the employee’s specific intent to discriminate. Hence, on its facts, McGann stands for the proposition that a plaintiff must specifically assert discriminatory intent in order to withstand a motion for summary judgment.

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

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

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

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

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

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

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

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

54 McGann, 946 F.2d at 407.
this respect may stem from some 'prejudice' against AIDS or its victims generally.\(^{55}\)

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

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

\(^{55}\) Id. at 408.

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

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

\(^{58}\) Aronson, 730 F.2d at 16 (emphasis added).

\(^{59}\) McGann, 946 F.2d at 405.

because the plan reserved H & H Music's right to modify the plan, the court concluded that H & H Music did not violate any right to which McGann was entitled.\(^6\) The court justified this conclusion by noting that a contrary result would, in effect, vest welfare benefit plans immediately upon enactment,\(^2\) a result contrary to congressional intent.

\section*{B. Owens v. Storehouse, Inc.\(^6\)}

In April of 1988, Storehouse adopted an employee welfare benefit plan that included lifetime health benefits of $1 million.\(^6\) By November of 1988, five employees of Storehouse had been diagnosed with AIDS. In order to procure stop-loss insurance, Storehouse switched to a self-insured plan and capped its AIDS-related coverage at $25,000.\(^6\) After enacting the benefit limitation, Storehouse continued to pay over $90,000 worth of Owens' claims in excess of the $25,000 cap because the costs of its new plan were running behind its budget. Further, upon notifying Owens that it would begin to adhere to its new policy, Storehouse provided Owens with an additional $7,500 of coverage.\(^6\) Thereafter, Owens brought an action seeking a temporary restraining order to prevent Storehouse from implementing the cap.\(^6\)

Similar to the court in \textit{McGann}, the court in \textit{Owens} upheld the validity of the employer's capping of AIDS-related health insurance benefits. In affirming the district court's opinion, the Eleventh Circuit resolved the case solely on Owens' section 510 claim.\(^6\) The district court's opinion, however, addresses several important ERISA issues that the \textit{McGann} opinion did not address and is, therefore, worthy of discussion.

\subsection*{1. The Employer's Fiduciary Obligations to ERISA Participants}

Owens alleged that Storehouse's capping of AIDS-related insurance benefits constituted a breach of Storehouse's fiduciary duty.\(^6\) Under

\begin{itemize}
\item \textit{McGann}, 946 F.2d at 405.
\item \textit{Id.}
\item 984 F.2d 394 (11th Cir. 1993).
\item \textit{Id.} at 396.
\item \textit{Id.} Storehouse also capped lifetime health benefits for mental illness and substance abuse ($25,000), growth hormone drugs ($10,000), temporomandibular joint dysfunction ($2,500) and nicotine dependence ($500). \textit{Id.} at 397 n.3.
\item \textit{Id.} at 397.
\item \textit{Id.}
\item \textit{Id.} at 397-400.
ERISA, an employer who administers an employee welfare benefit plan acts in a fiduciary capacity towards the plan’s participants. As a fiduciary, the employer is obligated to “discharge his duties with respect to a plan solely in the interest of the participants ... for the exclusive purpose of ... providing benefits to participants.” Thus, this fiduciary duty requires the employer to administer the plan in accordance with the plan’s documents.

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

394 (11th Cir. 1993).

70 Payonk v. HMW Indus., 883 F.2d 221, 225 (3d Cir. 1989).
72 Id. § 1104(a)(1)(D).
73 Sohlgren, supra note 14, at 1281.
74 Payonk, 883 F.2d at 225; see Sohlgren, supra note 14, at 1281 n.21.
76 Owens, 773 F. Supp. at 419.
77 Payonk, 883 F.2d at 225.
78 Id.; see also Young v. Standard Oil, 849 F.2d 1039, 1045 (7th Cir.) (holding that an employer does not breach its fiduciary duty by amending its employee welfare benefit plan), cert. denied, 488 U.S. 981 (1988); Witmeyer v. Kilroy, 788 F.2d 1021, 1024-25 (4th Cir. 1986) (holding that trustees do not breach their fiduciary duty when retirement plan amendments that the trustees have adopted meet general ERISA requirements); Sutton v. Weirton Steel Div. of Nat’l Steel Corp., 724 F.2d 406, 410-11 (4th Cir. 1983) (holding that an employer does not violate its fiduciary duty if its plan is not subject to ERISA’s vesting requirements), cert. denied, 467 U.S. 1205 (1984).
79 Owens, 773 F. Supp. at 419. For a discussion of ERISA vesting requirements, see
2. ERISA’s Preemption of State Claims

The court also granted Storehouse’s motion for summary judgment on Owens’ state claims.50 Owens had alleged that the capping of AIDS benefits constituted an unfair employment practice under Georgia law and had sought recovery on a tort theory of intentional infliction of emotional distress.51 To evaluate the court’s holding that ERISA preempted these state claims,52 an examination of the United States Supreme Court’s evolving body of ERISA preemption law is necessary.

ERISA expressly preempts state law.53 Section 514 provides that ERISA “shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan.”54 Preemption was thought necessary to insure a comprehensive and uniform approach to employee pension and welfare benefit plans.55 The Supreme Court has broadly interpreted section 514 to mean that “[a] law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.”56 Hence, section 514 preempts even those state laws that have only an indirect effect on employee benefit plans.57

Section 514’s “saving clause,” which exempts from preemption “any law of any State which regulates insurance, banking, or securities,” creates an exception to the general rule.58 This exception to preemption, however, is limited by the deemer clause. For purposes of state laws regulating insurance, the deemer clause prohibits employee benefit plans

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50 Owens, 773 F. Supp. at 419-20.
51 Id.
52 Id.
53 29 U.S.C. § 1144 (1988). This is only one of three ways in which federal law can preempt state law. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95-100 (1983); English v. General Elec. Co., 496 U.S. 72, 78-79 (1990). Federal law also preempts state law when (1) federal law is so pervasive in the specific regulatory area that it can be said to “occupy the field” and (2) an actual conflict exists between state and federal law. English, 496 U.S. at 79. This is a rather simplified approach to federal preemption. For a more detailed examination, see Susan S. Grover, The Employer’s Fetal Injury Quandary After Johnson Controls, 81 Ky. L.J. 639, 652-56, 659-71 (1992-93).
56 Shaw, 463 U.S. at 96-97.
57 Id.; see, e.g., R.R. Donnelly & Sons Co. v. Prevost, 915 F.2d 787, 788 (2d Cir. 1990) (holding that ERISA preempts state law that requires employers to continue welfare coverage of employees who are eligible for worker’s compensation benefits because ERISA indirectly regulates the employee benefit plan), cert. denied, 111 S. Ct. 1415 (1991).
from being deemed "to be an insurance company or other insurer . . . or to be engaged in the business of insurance." Not surprisingly, courts have experienced difficulty in ascertaining the proper relationship between the deemer clause and the savings clause. 

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

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

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

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98 Id. § 1144(b)(2)(B).
99 See Shaw, 463 U.S. at 95 (noting disagreement among the lower courts regarding the scope of preemption under ERISA).
91 For a more exhaustive examination of the judicial treatment of ERISA's preemption provisions, see Brumer, supra note 24, at 1133-55; Sohlgren, supra note 14, at 1261-71.
92 471 U.S. 724 (1985). The Metropolitan Life decision is credited with spurring the increased popularity of self-insured employee welfare benefit plans. See Brumer, supra note 24, at 1130; see also supra notes 21-27 and accompanying text (discussing employers' shift to self-insured plans).
93 Metropolitan Life, 471 U.S. at 758.
94 Id. at 743.
95 Id. at 741. According to the Court, two other reasons justified its result: (1) the plain language of the statute supported a finding that benefit laws regulate insurance and not welfare benefit plans, id. at 739-40; and (2) under federal statutes, state-mandated benefit laws constitute the "business of insurance." Id. at 742-44.
96 Id. at 747.
court settlement for medical costs paid by the employer. The self-insured employee welfare benefit plan provided for this right of subrogation. The employer sought to prevent reimbursement by invoking Pennsylvania's anti-subrogation statute. The Court held that ERISA preempted Pennsylvania's statute and, in so doing, reversed the Third Circuit's decision.

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

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

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98 Id. at 55.
99 Id. at 54.
100 Id. at 55.
101 Id. at 65.
102 See id. at 57. The steps are as follows: (1) Is the state law related to an employee benefit plan, i.e., does the statute fall within the scope of ERISA's preemption provision? (2) Does the state law regulate insurance, i.e., does the statute fall within the scope of ERISA's savings clause? (3) If so, is the statute brought back into ERISA's preemption provision via the deemer clause? Id. at 57-58.
103 See supra notes 86-87 and accompanying text.
104 FMC Corp., 498 U.S. at 58-60.
105 Id. at 60-61.
106 Id. at 61-65.
not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.\textsuperscript{7}

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

\textbf{C. Summary}

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

\textsuperscript{7}Id. at 61. One commentator summarized the current status of the ERISA preemption doctrine by stating that ERISA preempts "both: (1) state insurance laws purporting to regulate self-insured employee benefit plans; and (2) state employment discrimination laws relating to employee benefit plans that do not regulate insurance, whether such plans are insured or self-insured." Sohlgren, \textit{supra} note 14, at 1268 (footnotes omitted).

\textsuperscript{108}See \textit{supra} notes 80-81 and accompanying text.


\textsuperscript{111}Id.

\textsuperscript{112}See \textit{supra} text accompanying note 35.


\textsuperscript{114}Mariner, \textit{supra} note 22, at 1684.
require employers to offer health insurance, but also fails to provide any substantive standards for employers who do provide health benefits.\textsuperscript{115}

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

\section*{II. The ADA’s Response}

\subsection*{A. In General}

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

1. \textit{Defining Disability Under the ADA}

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

\begin{itemize}
  \item \textsuperscript{115} Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) ("ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits.").
  \item \textsuperscript{116} Employment discrimination on the basis of disability or handicap is prohibited by all states and the District of Columbia. See Sohlgren, supra note 14, at 1248 n.6 (listing each state’s specific statutory provision). Likewise, a minority of jurisdictions prohibit AIDS discrimination in health insurance coverage. See id. at 1250 n.7.
  \item \textsuperscript{117} Several factors indicate that employers who limit benefits to HIV-infected persons are not solely motivated by cost savings, but also by a discriminatory purpose. See infra notes 208-11 and accompanying text.
  \item \textsuperscript{118} 42 U.S.C. §§ 12101-12213 (Supp. III 1991). The ADA went into effect on July 26, 1992. \textit{Id.} § 12111. Currently, it covers all employers with twenty-five or more full-time employees. \textit{Id.} § 12111(5)(A). On July 26, 1994, however, the scope of the ADA will expand to include all employers with fifteen or more full-time employees. \textit{Id.} At least one case has been filed to determine whether exclusion of health insurance coverage for HIV-related illnesses violates the ADA. See \textit{Suit Seeks to Exclude AIDS Health Coverage}, Nat’l L.J., Mar. 15, 1993, at 6.
  \item \textsuperscript{119} 42 U.S.C. §§ 2000a to a-6, 2000e to e-7 (1988).
  \item \textsuperscript{120} \textit{Id.} § 12101(b)(1) (Supp. III 1991).
  \item \textsuperscript{121} \textit{Id.} § 12112.
The individual has "a physical or mental impairment that substantially limits one or more of the major life activities" of the individual;\(^{22}\)

(2) The individual has a record of having such an impairment;\(^{23}\)

(3) The individual is regarded as having such an impairment.\(^{24}\)

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

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

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

\(^{122}\) Id. § 12102(2)(A).

\(^{123}\) Id.

\(^{124}\) Id.

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


\(^{128}\) 29 C.F.R. app. § 1630.2(k).


\(^{130}\) 29 C.F.R. app. § 1630.2(l).

\(^{131}\) Fitzpatrick & Benaroya, supra note 129, at 255.
2. Discrimination in Employment

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

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

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

1. The ADA's Applicability to AIDS

The legislative history of the ADA clearly expresses the congressional intent that the ADA cover HIV infection whether it be asymptomatic or fully developed AIDS. Even without this legislative mandate,
however, HIV infection would be embraced in the ADA's definition of disability.\footnote{138} HIV infection substantially limits an infected person's ability to procreate and to engage in intimate sexual relationships. Both of these activities constitute major life activities under the ADA.\footnote{139}

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

The ADA specifically addresses the issue of employer-provided insurance programs.\footnote{140} While the ADA does not prevent an employer or insurer from "establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law . . . or that [are] not subject to State laws that regulate insurance,"\footnote{141} an employer's actions must be consistent with the purposes behind the ADA. That is, an employer can take no action to evade the purposes of ADA.\footnote{142} For instance, the ADA prohibits an employer from "participating in a contractual or other arrangement or relationship that has the effect of subjecting [an employer's] qualified . . . employee with a disability to the discrimination prohibited [and] includes . . . providing fringe benefits to any employee of the [employer]."\footnote{143}

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

> In sum, section 501(c) is intended to afford to insurers and employers the same opportunities they would enjoy in the absence of this legislation to design and administer insurance product and benefit plans in a manner that is consistent with basic principles of insurance risk

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\footnote{138} See supra notes 122-31 and accompanying text.


\footnote{140} 42 U.S.C. § 12201(c).

\footnote{141} Id. § 12201(c)(2)-(3).

\footnote{142} Id. § 12201(c).

\footnote{143} Id. § 12112(b)(2).
classification. This legislation assures that decisions concerning the insurance of persons with disabilities which are not based on bona fide risk classification be made in conformity with non-discrimination requirements. Without such a clarification, this legislation could arguably find violative of its provisions any action taken by an insurer or employer which treats disabled persons differently under an insurance or benefit plan because they represent an increased hazard of death or illness.

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

Against this background, however, one must consider the U.S. Solicitor General’s comments in his brief requesting a denial of certiorari in McGann v. H & H Music146 and arguing that the ADA better addressed McGann’s concerns.147 The Senate Report also provides some hope for HIV-infected persons whose health benefits are limited:

While a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.149

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

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145 Id. at 137.
149 Id. (emphasis added).
150 EEOC Pondering Guidance for Employers on Insurance under Disabilities Act,
these guidelines, the EEOC should define the terms "sound actuarial principles" and "subterfuge."

In addressing these concerns, the EEOC should consider evidence that such benefit-capping is usually done for reasons other than "sound actuarial principles" or that the capping "is related to actual or reasonably anticipated experiences." If, however, the EEOC merely adopts insurance companies' definition of sound actuarial principles, then actual or expected cost increases would almost always justify AIDS coverage restrictions. Likewise, there are a number of other recognized justifications for provisions that disparately impact disabled individuals and would likely be upheld by the ADA, such as "pre-existing conditions limitations, evidence of insurability provisions, and lower coverage of mental or nervous disorders." As one commentator has suggested, "[t]he precise impact of the ADA on rules capping coverage will depend... on the construction of ambiguous and conflicting provisions of the statute and its underlying legislative history." Possibly the only concrete statement that can be made concerning the ADA's impact on the capping of insurance benefits is that such a limitation cannot be upheld solely on moral justifications. Therefore, the ADA has the

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153 Sohlgren, supra note 14, at 1259 n.60 (comparing the cost of AIDS health care (between $50,000 and $100,000) with the costs of other illnesses, including autologous bone marrow transplants (between $75,000 and $125,000), heart transplants ($150,000), and liver transplants ($120,000)).
154 Briner, supra note 24, at 1125.
155 Sohlgren, supra note 14, at 1292; see also infra notes 229-40 and accompanying text (noting that society's interest in insurance provides a justification for not leaving actuarial classifications to the discretion of insurance companies).
156 Sohlgren, supra note 14, at 1292.
157 Rumeld & Brook, supra note 147, at 26.
158 Id. at 27.
AIDS IN THE WORKPLACE

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

III. THE POLICY IMPLICATIONS OF HIV BENEFIT CAPS

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

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

A. The Employee's Interest

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

159 S. REP. No. 116, supra note 148, at 29.
160 See, e.g., Brown, supra note 3, at 11-12.
161 Cf. MATTHEW W. FINKIN ET AL., LEGAL PROTECTION FOR THE INDIVIDUAL EMPLOYEE 366 (1989) ("Efforts by some states to protect against [employee health] hazards were undermined by other states that sought to attract by permitting the hazards.").
162 Id.
1. Access to Health Care

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

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

\(^{163}\) See supra notes 8-12 and accompanying text.

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

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

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

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

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

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

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

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

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

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170 Id. at 1891.
171 Id. at 1892-93. Notions of justice, longevity, integrity and consistency with an underlying theory of rights also support giving weight to one's expectations. Id. at 1897.
173 See, e.g., id. (quoting a Blue Cross spokesperson as stating that "[p]reexisting condition clauses 'cause a lot of people to hang onto jobs because they're scared that if they switch they will go uncovered for a period of time for the condition they have'").
174 Francis, supra note 169, at 1888.
These employees may have come to expect the continuation of their employment benefits in roughly the same form as long as their employment continued, although they had no written contractual rights to the continuation. Some employers have used this continued availability of benefits to encourage employee loyalty and longevity of service.\footnote{Id. (footnotes omitted).}

The above arguments support finding the employee’s expectation in continued coverage to be reasonable. It should be noted, however, that this “reasonableness” determination will depend on the circumstances of each case.\footnote{Id. at 1892.} Consequently, as expectations regarding access to health care decrease,\footnote{See, e.g., Don Colburn & Richard Morin, Americans Grade Their Health Care, WASH. POST, Dec. 31, 1991, at 26 (noting presidential election polls indicating that even the affluent worry about continued access to health care).} and public awareness of decisions like McGann\footnote{See supra note 26 and accompanying text.} increase, the reasonableness of an employee’s expectation of continued coverage may become questionable.

In considering the issue of what role the employer’s encouragement plays in creating expectations, Professor Francis defined the term “encouragement” to include “failures to disabuse someone of beliefs where a disclaimer would ordinarily be expected.”\footnote{Francis, supra note 169, at 1892.} Accordingly, encouragement can take a variety of forms. The usual scenario arises when the employer affirmatively encourages an employee to retain her expectations that health coverage will continue. For example, “an employer can encourage an employee to believe that her employment will not be affected by her expensive health needs by reassuring her outright that she ‘will always have a job as long as he’s in charge.’”\footnote{Id.} A more difficult situation occurs in situations such as the one in Owens\footnote{Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993).} where the employer is being forced to review employee benefits by its insurer. In this situation, should an employer be required to affirmatively discourage future expectations?\footnote{Professor Francis suggests that this, too, constitutes encouragement. See Francis, supra note 169, at 1892. Since the employer is the primary source of encouragement regarding the availability of employee benefits, imposing a duty to discourage such expectations may not be an onerous task.\footnote{See 139 CONG. REC. E375, supra note 168, at E375 (“Public policy must dictate that plan sponsors should not offer more to their employees than they intend to deliver. . . . Employers must take a realistic look upfront at what level of health benefits}}
The employee’s need for continued health insurance coverage bolsters the desirability of legal protection to prevent health benefit capping. In addition to increasing the HIV-infected employee’s expected life span, health care access affects the quality of medical treatment. For instance, an HIV-infected person without health insurance may not be able to benefit from the prophylactic use of AZT.

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

2. Freedom from Discrimination

HIV-infected persons suffer from discrimination as a result of their illness. Although fear of AIDS, an illness which is incurable and
fatal, may be understandable, our system of law should encourage education, not provide protection for discrimination. Congress recognized as much when it passed the ADA. Indeed, Congress explicitly declared that “[i]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness.” Furthermore, a 1988 study by Harvard University researchers noted:

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

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

HIV-infected persons also experience discrimination as a result of perceived sexual orientation. This is largely because the majority of
AIDS cases in the United States have involved homosexual or bisexual men. Notwithstanding the fact that most states do not regard either homosexuals or bisexuals as a protected class for equal protection challenges, our legal system should strive to limit sexual orientation discrimination. For as one commentator concluded, sexual orientation discrimination also threatens to drive gay and bisexual men back into the closet. Although such a result may be ideologically pleasing to some, its implications are medically disastrous. A climate of homophobia deters frank discussion with physicians and discourages people from seeking out AIDS prevention information that may “implicate” them as gay or bisexual.

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


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

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

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

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

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

**B. The Employer's Interests**

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

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

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200 See supra text accompanying note 190.
201 See supra note 3, at 930.
202 See supra text accompanying notes 37-62.
203 See supra text accompanying notes 63-117.
205 See, e.g., Waks, supra note 167, at 18.
206 See *U.S. Health Costs Expected to Reach $939.9 Billion in 1993*, Daily Rep. for Executives (BNA) 3, at D-5 (Jan. 6, 1993). Health care costs in 1993 are expected to reach $939.9 billion. This would involve a 12.1% increase of 1992 health care expenditures. *Id.*
care costs. For instance, Robert Padgug, director of health care policy for Empire Blue Cross and Blue Shield of New York, notes that AIDS accounted for only three percent of the company's total medical care expenditures. Indeed, the cost of AIDS is not particularly exorbitant when compared to other health care costs. When one considers that the costs associated with one premature baby can be as high as $300,000, the costs associated with AIDS (approximately $85,000) do not seem to be too high.

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

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

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

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208 See supra text accompanying notes 9 & 153.
209 See Waks, supra note 167, at 18.
210 One should note, however, that even an $85,000 claim could be devastating to a small, self-insured employer. Larger employers can use various methods to better spread the risk of loss than smaller employers. For instance, an increased employee contribution would go farther to reduce the costs of a large employer than a small employer.
211 See supra note 152.
212 See supra notes 169-83 and accompanying text.
213 The author realizes that this is a generalization and recognizes that it is possible that an employer may have cut AIDS-related benefits because this was the only catastrophic illness currently seeking coverage.
214 See Brown, supra note 3, at 17.
215 See Kenneth E. Labowitz, The Coming of Conditional Health Insurance, LEGAL TIMES, Nov. 16, 1992, at 27 (noting that one implication of the McGann decision is "that employers can cut health-care costs by conditioning coverage upon employees' personal habits or patterns of behavior, such as diet, smoking, and exercise").
HIV-infected persons.\textsuperscript{216} Clearly, the law should discourage this behavior.\textsuperscript{217} Indeed, access to health care should be value-neutral.

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

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

\textsuperscript{216} See supra notes 188-202 and accompanying text.
\textsuperscript{217} See supra notes 197-201 and accompanying text.
\textsuperscript{218} Labowitz, supra note 216, at 27. One response to such reasoning is that, taken to its logical extreme, almost all illnesses are the "result of our respective lifestyles or that of our parents." Robert R. Gregory, McGann Ruling Outrageous, Fein View Flawed, LEGAL TIMES, Dec. 14, 1992, at 34 (letter to the editor).
\textsuperscript{219} See Vogel, supra note 191, at 1036-38.
\textsuperscript{220} See Mark A. Rothstein, Refusing to Employ Smokers: Good Public Health or Bad Public Policy?, 62 NOTRE DAME L. REV. 940, 947 (1987).
\textsuperscript{221} See Wiegand & Farr, supra note 197, at 457 n.49 (relating the expert testimony of Dr. Martin Weinberg, coauthor of the Kinsey Report on Homosexuals, asserting that homosexuality is not a choice nor a preference).
\textsuperscript{222} See Vogel, supra note 191, at 1037.
\textsuperscript{223} See, e.g., Dean H. Hammer et al., A Linkage Between DNA Markers on the X Chromosome and Male Sexual Orientation, 261 SCIENCE 321, 325 (1993). This study of 114 families of homosexual males resulted in a statistical confidence level of more than ninety-nine percent that at least one subtype of male sexual orientation is genetically influenced. Id.
\textsuperscript{224} See Brown, supra note 3, at 15.
the virus through a blood transfusion. 225 "Guilty" victims include gays, intravenous drug users and prostitutes. 226 Willie Brown, then Assembly Speaker of the California Legislature, recognized that such characterizations hinder control of the disease by encouraging people not to seek advice regarding the treatment and transmission of HIV. 227 Furthermore, there is something distasteful and particularly "un-American" about allowing employers free reign into the private lives of their employees.

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

C. The Public's Interest

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

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

225 Id.
226 Id.
227 Id. at 15-16.
228 See, e.g., German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 408 (1914) (upholding a state's right to regulate insurance due to its close relation to the public interest).
230 See id. at 397-98.
leads one...to the more important issue of availability of coverage: Can people buy the insurance they need? 231

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

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

231 Id. at 400.
232 See supra notes 208-16 and accompanying text.
233 "Gap in availability" is Professor Wortham's language. Wortham, supra note 230, at 401.
234 See supra notes 16-18 and accompanying text.
235 Green & Amo, supra note 17, at 1261.
238 Id. Hellinger forecasts that the total health care costs of HIV-related treatment will be $10.389 billion by 1994. Id.
239 Likewise, the 1989 figures are thought to be less than actually expended. See Christine Woolsey, AIDS Claims Hit $1 Billion, BUS. INS., Oct. 29, 1990, at 4.
public concern about the budget deficit, these figures indicate that the public has an interest in preventing employers from instituting HIV-related health benefit caps.

**CONCLUSION**

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

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

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

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

²⁴⁰ See supra note 168.
to health care so as to control costs and spread the burden of providing health care to all interested parties.\textsuperscript{241}

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\textsuperscript{241} In researching this Note, the author often returned to the words of Albert Camus: A pestilence isn't a thing made to man's measure; therefore we tell ourselves that pestilence is a mere bogy of the mind, a bad dream that will pass away. But it doesn't always pass away and, from one bad dream to another, it is men who pass away. They went on doing business, arranged for journeys, and formed views. How should they have given a thought to anything like plague, which rules out any future, cancels journeys, silences the exchange of views. They fancied themselves free, and no one will ever be free so long as there are pestilences.

\textsc{Albert Camus, The Plague} 36 (Gilbert trans., 1979).

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