

# Journal of Civil Rights and Economic Development

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Volume 10  
Issue 3 *Volume 10, Summer 1995, Issue 3*

Article 9

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# COMBATTING AIDS DISCRIMINATION IN HEALTH INSURANCE

MARC E. ELOVITZ\*

How can we stop health insurance discrimination against people living with HIV? My response to this question focuses on the specific issue of HIV-related limitations on health benefits; but it is important to recognize the broader context. The debate over HIV-related discrimination in health insurance is part of a much larger debate over the need for our health care system to provide better care to a greater number of people.<sup>1</sup> Hopefully, this larger debate will not end despite last year's failure to enact national health care reform legislation.

When we address the issue of AIDS, HIV, and insurance under the Americans with Disabilities Act ("ADA"),<sup>2</sup> we are not generally talking about the challenge of access for everyone. Thus, the question that will be addressed here is not whether every person—or even every person with HIV—will be guaranteed health care.<sup>3</sup> Rather, it is whether people will be afforded equal treatment under the existing systems of coverage.<sup>4</sup>

The problem of HIV-related insurance caps and exclusions has been with us since early in the AIDS epidemic and shows little signs of abating. People living with HIV, as well as their advo-

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<sup>1</sup> See Donna E. Shalala, *Health-Care Reform Must Include Insurance Coverage for AIDS Victims*, PHILA. INQUIRER, Dec. 1, 1993, at A17. Shalala expressed the opinion that *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991), inspired the government to reform the health care system so that people living with HIV and enduring personal crises may maintain the protection of health insurance. *Id.* See also Laurie Garrett, *Clinton Forms AIDS Task Force*, NEWSDAY, Dec. 1, 1993, at 7; *ABA Working Group Submits White Papers on Key Issues to Hillary Rodham Clinton*, HEALTH CARE POL'Y REP. (BNA) No. 24, at D-7 (Aug. 16, 1993).

<sup>2</sup> 42 U.S.C. § 12111 *et seq.* (Supp. V 1993).

<sup>3</sup> See generally Anna M. Rappaport, *Policy Environment for Health Benefits: Implications for Employer Plans*, 43 DEPAUL L. REV. 1107, 1111 (1994).

<sup>4</sup> See Robert E. Stein, *The Rights of Employees with AIDS: The Conflict between the Need for Adequate Insurance Coverage and Individual Privacy in the Workplace*, 10 ST. JOHN'S J. LEGAL COMMENT. 557, 558 (1995).

cates, must pursue aggressive strategies to stop these unjustified and damaging practices. I will focus on the fairly narrow issues of combatting such discrimination under the Employment Retirement Income Security Act of 1974 ("ERISA")<sup>5</sup> and the ADA.

Most of the current analysis of HIV-related health insurance caps and exclusions concerns itself solely with the ADA. But prior to the enactment of the ADA, such caps and exclusions were challenged under ERISA. In two federal circuit Court of Appeals decisions,<sup>6</sup> ERISA was held to provide no remedy for this type of discrimination. Rather than settling the law in this area, as others have either assumed or explicitly argued, ERISA still presents a viable cause of action when a benefit plan is modified to include an HIV-related cap or exclusion. As precedent, the two decisions are binding only on the Fifth and Eleventh Circuits—the Supreme Court has never ruled on this issue. It is my position that these two cases were wrongly decided because the courts failed to refer to basic principles of contract law which, contrary to the assumptions of many commentators and courts, may be referred to when deciding a claim under ERISA.<sup>7</sup>

The theories that I would encourage people to use in the future under ERISA, concomitantly with ADA claims, are contract theories. First, a reliance argument<sup>8</sup> that someone in the position of the plaintiff in, for example, the *McGann*<sup>9</sup> case, had reasonably relied on a term, an amount of insurance coverage, and that by changing that term after the defendant became aware of the AIDS condition caused the plaintiff to suffer a detriment.<sup>10</sup>

The other argument is that changing a policy to incorporate an HIV-related cap or exclusion is unconscionable and therefore un-

<sup>5</sup> 29 U.S.C. § 1001 *et seq.* (Supp. V 1993).

<sup>6</sup> *Owens v. Storehouse*, 984 F.2d 394, 397 (11th Cir. 1993) (holding that ERISA does not forbid company from canceling insurance benefits that are neither vested nor accrued); *McGann v. H & H Music Co.*, 946 F.2d 401, 407 (5th Cir. 1991) (affirming that company could alter terms of medical plan to limit benefits available for AIDS-related claim after it discovered that one of its employees had AIDS), *cert. denied.*, 113 S. Ct. 482 (1992).

<sup>7</sup> See Samuel A. Marcossou, *Who is "Us" and Who is "Them"—Common Threads and the Discriminatory Cut-Off of Health Care Benefits for AIDS Under ERISA and the Americans With Disabilities Act*, 44 AM. U. L. REV. 361, 372 (1994).

<sup>8</sup> RESTATEMENT (SECOND) OF CONTRACTS § 90 (1983).

A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance of injustice can be avoided only by enforcement of the promise.

*Id.*

<sup>9</sup> *McGann*, 946 F.2d at 403.

<sup>10</sup> See Marcossou, *supra* note 7, at 370-85.

enforceable.<sup>11</sup> The unconscionability principle is about unfair surprise. It is difficult to imagine much more of a surprise than knowing that one has a million dollars in health benefits available, submitting a claim and then having the maximum benefit reduced to five thousand dollars based on the nature of the claim.<sup>12</sup> The unfairness stems from the lack of monetary justification for treating the HIV disease differently from other conditions. HIV disease costs far less to treat than most individuals, employers and insurance companies often assume,<sup>13</sup> and comparatively less than the treatment of other conditions. Thus, the question is not whether it would save an insurance plan money not to treat AIDS, because of course it would, but whether the analysis is done fairly in comparison to the treatment of other conditions. If treating AIDS does not cost more than other conditions, then the surprise of a new AIDS-only coverage limitation is an unfair one and therefore unconscionable.

The failure to consider common law contract principles to identify a source of contractual obligation is outside of established precedent in at least two circuits. The Court of Appeals for both the Sixth Circuit<sup>14</sup> and the Seventh Circuit<sup>15</sup> have decided cases under ERISA relying on common law contract principles, such as

<sup>11</sup> See E. ALLAN FARNSWORTH, *CONTRACTS* §§ 4.27, 4.28 (2d ed. 1990).

<sup>12</sup> See, Marcossou, *supra* note 7, at 388-99.

<sup>13</sup> See, e.g., Judith K. Barr & Robert A. Padgug, *Employers and AIDS: Meeting the Health Benefit Needs of People with HIV Disease*, 3 CORNELL J. L. & PUB. POL'Y 83, 96-97 (1994) (pointing out that cost of treating HIV sufferer from time of infection to death is approximately \$119,000, which is no more costly than many other catastrophic diseases); Randall R. Bovberg, *AIDS and Insurance: How Private Health Care Coverage Relates to HIV/AIDS Infection and to Public Programs*, 27 IOWA L. REV. 1561, 1574 (1992) (reporting that less than 5% of Blue Cross and Blue Shield plans' spending on claims is directed to AIDS-related care); William A. Bradford, Jr. et al., *The AIDS Epidemic and Health Care Reform*, 27 J. MARSHALL L. REV. 279, 300 (1994) (observing that National Commission on AIDS has predicted spending for AIDS will never rise above 2% of total medical spending in United States); Michael T. Isbell, *AIDS and Access to Care: Lessons for Health Care Reformers*, 3 CORNELL J. L. & PUB. POL'Y 7, 13 (1994) (explaining that early fears that AIDS epidemic would bankrupt health care system have proven baseless and noting that as of 1993, medical spending on people with HIV constituted only 1% of U.S. health care spending).

<sup>14</sup> See *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1298-1300 (6th Cir. 1991) (ruling that employer had no right to terminate employee's insurance benefits under collective bargaining agreement). *Accord*, *Vespasian v. Sweeney*, No. 93-4343, 1995 U.S. App. LEXIS, at \*12-14 (6th Cir. Apr. 6, 1995) (recognizing applicability of equitable estoppel doctrine to ERISA claim, but holding that facts did not fulfill threshold requirements to allow recovery).

<sup>15</sup> *Black v. TIC Inv. Corp.*, 900 F.2d 112, 112 (7th Cir. 1990) (holding estoppel principles apply to claims for benefits under unfunded single-employer welfare benefits plans provided for under ERISA).

equitable estoppel. There is no justification for not doing so in cases involving HIV-related caps and exclusions.

Turning to the ADA, the guiding principle is that people cannot be treated differently based on disability.<sup>16</sup> As to health insurance, this prohibits unjustifiably singling out particular disabilities for denial of coverage. A rule of construction, Section 501(c), addresses issues of insurance in detail.<sup>17</sup> The rule of construction explains that the ADA's rules of non-discrimination allow insurers to continue their traditional functions of underwriting, classifying and administering risks, so long as their decisions are based on sound actuarial data.<sup>18</sup> This rule avoids unfair treatment based on false assumptions about the comparative costs of treating AIDS as well as unfair treatment based on antipathy towards people living with AIDS.

The Equal Employment Opportunity Commission ("EEOC") has made a valiant attempt to start addressing the issue of HIV-related caps and exclusions, both in its interim policy guidance<sup>19</sup> and in lawsuits.<sup>20</sup> Few of these cases have reached the stage of a judicial evaluation on the merits because the defendants have been settling for fairly small amounts.<sup>21</sup> My fear is that this is

<sup>16</sup> See 42 U.S.C. § 12112 (Supp. V 1993). Section 12112(a) provides:

No 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.

*Id.*

Section 12112(b)(2) provides:

'[D]iscriminate' includes participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entities qualified applicant or employee with a disability to the discrimination prohibited by this subchapter . . . [including] . . . a relationship with . . . an organization providing fringe benefits to an employee of the covered entity.

*Id.*

<sup>17</sup> 42 U.S.C. § 12201(c) (Supp. V 1993).

<sup>18</sup> 42 U.S.C. § 12201 (Supp. V 1993).

<sup>19</sup> EEOC, EEOC INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993).

<sup>20</sup> *E.g.*, EEOC v. Mason Tenders Welfare Trust Fund, et al., No. 93 Civ. 1154 (S.D.N.Y. Nov. 19, 1993) (challenging health and welfare fund's plan provision denying payment of medical expenses for any illness that is AIDS-related); EEOC v. Lee Data Corp., CV94-3875 (C.D. Cal. June 9, 1994) (challenging lifetime cap of \$100,000 on AIDS-related treatments where other illnesses have lifetime caps of \$1,000,000).

<sup>21</sup> See, *e.g.*, EEOC v. Tarrant Dist., Inc., H-94-3001 (S.D. Tex. Oct. 11, 1994) (requiring defendant to lift AIDS-cap, pay unpaid medical bills of employees subject to cap, and donate \$20,000 to American Foundation for AIDS Research); EEOC v. Conn. Ref. Co., 62 U.S.L.W. 2595, 2595 (Mar. 9, 1994) (settling for \$35,000 in compensatory damages for discriminatory insurance practices). The plan challenged allowed for up to \$1 million in medical coverage for most disabilities, but limited coverage for HIV/AIDS-related sickness to

leading insurance providers to consider the price of settlement to be just another cost of doing business. That is unacceptable. We cannot spend another ten years settling these cases for small amounts while letting businesses deny benefits to people living with HIV until those businesses are dragged into court.

Instead, both the EEOC, and private organizations and private plaintiffs, need to challenge HIV-related caps and exclusions and force either very large settlements, so that defendants learn that this is wrong and they won't get away with it, or bring the cases to trial and set strong precedent both as to the illegality of such policies and as to financial penalties that will result from them.

While the primary focus of this symposium is employment issues, the *Carparts*<sup>22</sup> case highlighted the issue of combatting insurance discrimination under the ADA's public accommodations provision. The United States Court of Appeals for the First Circuit in *Carparts* held that the multi-employer insurance plan was covered under the employment section of the ADA, and in remanding the case noted that the plan might also be covered under the ADA's public accommodations provision. The First Circuit rejected the district court's outright dismissal of the public accommodations claim because it disagreed with the assumption that a public accommodation must be a physical structure.<sup>23</sup> The statute does not refer to buildings, walls, floors or ceilings: "Neither Title III [the public accommodations provision] nor its implementing regulations make any mention of physical boundaries or physical entry."<sup>24</sup> In *Carparts*, the First Circuit correctly noted that:

To exclude this broad category of businesses from the reach of Title III and limit the application of Title III to physical structures which persons must enter to obtain goods and services would run afoul of the purposes of the ADA and would se-

\$10,000. *Id.*; see also, *Kadinger*, No. CIV-3-93-159 (allowing \$50,000 settlement for discriminatory practices which permitted coverage up to \$500,000 for all conditions except AIDS).

<sup>22</sup> *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12, 18-19 (1st Cir. 1994) (rejecting district court interpretation that public accommodation was limited to physical structures with actual boundaries).

<sup>23</sup> *Id.* See 42 U.S.C. § 12182(a) (Supp. V 1993).

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

*Id.* The statute, however, does not clearly define public accommodation. *Id.*

<sup>24</sup> *Carparts*, 37 F.3d at 20.

verely frustrate Congress' intent that individual's with disabilities fully enjoy the goods, services, privileges and advantages available indiscriminately to other members of the general public.<sup>25</sup>

In conclusion, there are important questions of law to be addressed in the fight against HIV-related insurance discrimination, such as whether contractual theories can make ERISA claims viable, whether the EEOC and private litigants will demand higher settlements for ADA claims in order to prevent HIV-related caps and exclusions from becoming an acceptable cost of doing business, and whether other courts will follow the First Circuit's analysis of the coverage of insurance plans under the ADA's public accommodations provision. But, we should also be focusing on why providers are placing caps and exclusions on HIV-related benefits and what justifications they offer. Describing it as exercising their right to put a particular insurance product on the market makes it seem bland and noncontroversial; but offering plans with AIDS-only limitations has no actuarial basis and therefore contravenes any notion of fairness. The federal government, private individuals, and public interest organizations continue to press that issue. But we are left asking when employers, insurance companies, and other entities that provide health insurance benefits will admit there is no justification for these limitations and drop them. How many people living with HIV will needlessly suffer in the meantime?

<sup>25</sup> *Id.*