WHAT'S WRONG WITH THE ERISA "VACUUM"?: THE CASE AGAINST UNRESTRICTED FREEDOM FOR EMPLOYERS TO TERMINATE EMPLOYEE HEALTH CARE PLANS AND TO DECIDE WHAT COVERAGE IS TO BE PROVIDED WHEN RISK RETENTION PLANS ARE ESTABLISHED FOR HEALTH CARE

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I. INTRODUCTION

Health care was a major issue in the 1992 political campaigns. Candidates repeatedly expressed concern for the thirty to sixty-five million Americans who are not insured or who have inadequate coverage for their health care needs. Ironically, as the fall election campaigns concluded, the United States Supreme Court was deliberating about whether to review *McGann v. H & H Music Co.*,[1] a Fifth Circuit Court of Appeals decision that may ultimately cast more individuals into the ranks of the uninsured or inadequately insured. And just a few days after Americans cast their votes, the Supreme Court—with two justices dissenting—decided not to accept the appeal from the lower court judgments,[2] which allowed an employer to radically reduce health care benefits for one of its employees by instituting a risk retention plan.[3]

Many national associations,[4] as well as members of Congress,[5] had urged the Supreme Court to accept the appeal. The case could be very important, because approximately two-thirds of employers that currently provide employee health care benefits do so by establishing risk retention plans, which are commonly referred to as "self-funded arrangements" or "self-insurance".[6] Employee health care plans may become even more important because they are likely to be a central feature in President Clinton's proposal for health care reform.[7]

This Article briefly reviews what happened in the *McGann* case and examines the reasons why the decision may have a significant impact on health care plans in America. The Article then proposes several legislative actions

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

2. Greenberg v. H & H Music Co., 113 S. Ct. 482 (1992); *see also* Robert Pear, *Justices Leave Intact Ruling That Lets Business Cut Health Benefits*, N.Y. TIMES, Nov. 10, 1992, at A18.

3. *See* Robert Pear, *Bush Faces Hard Choice on Limits on Insurance*, N.Y. TIMES, May 19, 1992, at A12.

4. *See, e.g.*, C.G. Phillips and M.E. Haddad, *Letter to the Hon. Kenneth W. Starr, Solicitor General of the United States*, on behalf of AARP, AHA, AMA, National Commission on AIDS, U.S. Conference of Mayors, and National Governors' Ass'n (Aug. 10, 1992); Letter to the Hon. Kenneth Starr, Solicitor General of the United States from Robert Evans, American Bar Ass'n (July 8, 1992).

5. *House Democrats Ask Justice Department to Reconsider Recommendation in AIDS Case*, 214 DAILY LAB. REP. (BNA) A8 (Nov. 4, 1992).

6. *See* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, MEDICAL TESTING AND HEALTH INSURANCE 114 (1988); *see also* U.S. BUREAU OF THE CENSUS, 1990 STATISTICAL ABSTRACT 413; *cf.* Mark Scherzer, *After* McGann: *Policy Implications of the Decision Authorizing Discriminatory Benefit Caps for Treatment of AIDS*, 7 AIDS & PUB. POL'Y J. 96-98 (1992).

7. See William Clinton, *The Clinton Health Care Plan*, 327 NEW ENG. J. MED. 804, 804-06 (1992).

that would offer greater protection for persons covered by employer-sponsored health care plans.

II. THE *MCGANN* CASE

John W. McGann ("Mr. McGann"), was employed by the H & H Music Company when he learned that he was infected with the human immune virus ("HIV"), which is known to cause AIDS.[8] After Mr. McGann made health insurance claims seeking reimbursement for AIDS-related medical expenses, his employer terminated the company's existing group insurance plan.[9] The plan had provided health care benefits of up to one million dollars for *all* diseases.[10] H & H Music subsequently established a risk retention plan that provided health care benefits of up to one million dollars for all diseases *except* AIDS related claims, which were limited to a lifetime maximum of five thousand dollars.[11] In August 1989, Mr. McGann initiated a suit against the H & H Music Company, the insurer that formerly had provided the group health insurance plan for H & H Music Company, and the administrator of the new plan.[12] Mr. McGann's suit claimed the parties violated section 510 of the Employee Retirement Income Security Act ("ERISA").[13]

Section 510 of ERISA, which is designed to protect employees against discrimination by employers, provides:

> It shall be unlawful for any person to . . . 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 . . . .[14]

McGann's suit raised questions about the effects of the ERISA prohibition by arguing that unlawful discrimination occurs when an existing group health insurance plan is terminated *after* an employee has made claims for benefits as a result of a disease.[15]

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8. McGann v. H & H Music Co., 946 F.2d at 403.
9. *Id.*
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*; *see also* Edward F. Shay, *Discrimination in Health Benefits: ERISA and Beyond*, 7 AIDS & PUB. POL'Y J. 92-95 (1992).
14. Employee Retirement Income Security Act, 29 U.S.C. § 1140 (1988) (emphasis added); *see also* Folz v. Marriott Corp., 594 F. Supp. 1007, 1014 (W.D. Mo. 1984) (noting that Congress enacted § 510 to prevent employers from discharging or harassing employees to defeat vested pension rights).
15. *See* McGann v. H & H Music Co., 946 F.2d at 403.

Mr. McGann alleged that the decision to terminate the group insurance plan was a response to his claims for reimbursement and that the "cap" on treatments for the HIV virus was imposed to deprive him of benefits he otherwise would have been entitled to receive.[16] The defendant's motion for summary judgment conceded the factual allegations of Mr. McGann's complaint.[17] It was also clear that Mr. McGann was the *only* H & H Music employee known to be infected with the HIV virus.[18]

The Fifth Circuit concluded that "even though the employer's decision . . . may stem from some 'prejudice' against AIDS or its victims generally," H & H Music Company's decision to terminate the existing plan did not violate section 510.[19] The decision rested on a well-established proposition: When an employer's group insurance plan clearly provides that it may be amended or terminated, the employer is free to eliminate the entire plan[20] and may do so even though it terminates coverage for employees that are already ill.[21]

The Fifth Circuit also held that establishing a risk retention plan with a five thousand dollar "cap" for AIDS-related claims did not violate section 510 of ERISA.[22] The court reasoned (1) that ERISA is the only regulatory legislation that applies to employer risk retention plans, (2) that ERISA does not establish any requirements for health care plans, (3) that section 510 only requires the employer's plan treat all employees the same, and (4) that H & H Music did not violate section 510 because it reduced health care coverage for AIDS-related claims for every employee.[23]

III. THE ERISA PREEMPTION AND THE ERISA VACUUM

The *McGann* decision rested in large measure on an ERISA provision that was intended to bring about national uniformity in the regulation of employee benefit plans.[24] To attain uniformity, the Act supersedes "*any and*

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16. *Id.* at 403-04. The court noted:

> We assume, for purposes of this appeal that the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses, that this knowledge was obtained either through McGann's filing of claims or his meetings with defendants, and that McGann was the only plan beneficiary then known to have AIDS.

Id. at 404 n.4; *see also Brief of Amicus Curiae American Association of Retired Persons in Support of Plaintiff-Appellant*, McGann v. H & H Music Company, 946 F.2d 401 (5th Cir. 1991) (No. 90-2672).

17. McGann v. H & H Music Co., 946 F.2d at 403.

18. *Id.* at 408.

19. *Id.*

20. *Id.* at 405, 407; *see also* Aronson v. Servus Rubber Div. of Chromalloy, 730 F.2d 12, 16 (1st Cir. 1984).

21. McGann v. H & H Music Co., 946 F.2d at 407-08.

22. *Id.* at 408.

23. *Id.* at 407.

24. *See* 29 U.S.C. § 1001 (1988).

all State laws insofar as they . . . *relate* to any employee benefit plan described in section 1003(a)."[25] The Supreme Court has held the words "relate to" should be construed expansively,[26] so that the preemption applies to all forms of state action that might affect benefit plans.[27] Consequently, ERISA eliminates almost all state and local regulation of employer established plans.[28]

Two factors that undoubtedly contributed to the decision to create a regulatory exemption for employer risk retention plans were related to financial considerations. First, the costs of employer risk retention plans are subject to fluctuating and unpredictable variables.[29] Second, employer provision of health care plans has been viewed as a voluntary action, and Congress did not want to impose requirements that might either dissuade employers from offering health benefits or cause them to discontinue existing plans.

The significance of the ERISA preemption is underscored by a major exception to preemption: In what is commonly referred to as the "saving clause," ERISA provides that the preemption does not supplant state laws regulating insurance or the business of insurance.[30] Therefore, states may not regulate employee benefits provided by risk retention plans even though they may regulate employee group health insurance plans.[31]

ERISA imposes virtually no regulations or requirements for risk retention plans that provide health care benefits.[32] Furthermore, even though ERISA prohibits discrimination against an employee in the attainment or ex-

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25. *Id.* § 1144(a) (emphasis added). This section provides in full:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b).

Id.; *see also id.* § 1003(a) (defining employee welfare benefit plans); Ingersoll-Rand Company v. McClendon, 111 S.Ct. 478, 483-85 (1990) (holding state cause of action pre-empted by ERISA because it related to an ERISA plan and because it directly conflicted with an ERISA cause of action); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 109 (1983) (holding ERISA pre-empted New York's Human Rights Law only to the extent it prohibited actions permitted under federal law, but ERISA did not pre-empt New York's Disability Benefits Law).

26. *See* Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 8 (1987); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46-48 (1987); Shaw v. Delta Air Lines, 463 U.S. at 96-100.

27. *See* Ingersoll-Rand Co. v. McClendon, 111 S.Ct. at 482-83.

28. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. at 44-46; Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62-63 (1987); Cathey v. Metropolitan Life Ins. Co., 805 S.W.2d 387, 389-90 (Tex. 1991).

29. *See* Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988).

30. 29 U.S.C. § 1144(b)(2)(A) (1988).

31. The distinction between risk retention plans and group insurance plans has been sustained by the Supreme Court. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985).

32. *See* Henry T. Greely, *AIDS and the American Health Care Financing System*, 51 U. PITT. L. REV. 73, 104-11 (1989).

ercise of a right to which the individual is entitled under a benefit plan,[33] it only requires that a plan treat equally all employees that are comparably situated.[34] The lack of federal regulation has, in combination with ERISA's preemption of state regulation, created a regulatory "vacuum."[35]

Thousands of companies have established risk retention plans, thereby avoiding state law requirements that prescribe or mandate benefits health care plans must include.[36] Moreover, many employers view risk retention plans as an attractive alternative to group insurance because no premiums are paid to an insurer, and therefore, the employer incurs no state premiums tax. The portion of employers with risk retention plans has grown to nearly two-thirds of all employers.[37] Even among businesses with one hundred or fewer workers, the portion with risk retention plans increased from nine percent in 1988 to twenty-three percent in 1991.[38]

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33. *See, e.g.*, Folz v. Marriott Corp., 594 F. Supp. 1007, 1015 (W.D. Mo. 1984). In *Folz*, an individual who had been employed for 18 years was discharged two months after he informed his employer that he was suffering from multiple sclerosis. *Id.* at 1010-11. The court concluded that under ERISA the employee was entitled to recover both back pay and future benefits because the purpose behind the discharge was to deny him medical benefits. *Id.* at 1013-17, 1019-20.

34. *Cf.* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983).

35. For a discussion of the regulatory "vacuum" created by ERISA, see Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47 (1988). The authors comment that this result was not carefully considered, but rather the preemption clause was inserted during final negotiations in the conference committee before Congress took final action on ERISA. *Id.* at 48-49.

The House Judiciary Committee appreciated that risk retention plans established by employers were not subject to regulation by the state insurance commission. Its report on the ADA specifically stated:

> [s]elf-insured plans, which are currently governed by the preemption provision of . . . ERISA, are still governed by that preemption provision and are not subject to state insurance laws. . . . [T]hese self-insured plans are subject to state law only to the extent determined by the courts in their [interpretation] of ERISA preemption provision.

H.R. REP. NO. 101-485(III), 101st Cong., 2d Sess. 71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 494.

See also Marcia A. Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, 40 FED'N OF INS. AND CORP. COUNS. Q. 195, 195-242 (1990); Steven L. Brown, Note, *ERISA'S Preemption of Estoppel Claims Relating to Employee Benefit Plans*, 30 B.C. L. REV. 1391, 1416-22 (1989); Jonathan Goldstein, Note, *ERISA'S Deemer Clause and the Question of Self-Insureds: What's a State to Do?*, 67 WASH. U. L.Q. 291, 299-303 (1989).

36. Although ERISA has a crippling effect on the ability of state governments to ensure adequate and fair health care coverage is provided under risk retention plans, it fails to perform either of these functions itself. Moreover, as two commentators have observed, the regulatory vacuum created by ERISA was not a carefully considered goal because the preemption clause was inserted during final conference negotiations in Congress. *See generally* Daniel M. Fox & Daniel C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL., POL'Y & L. 239, 239-60 (1989).

37. See Milt Freudenheim, *Employers Winning Right to Cut Back Medical Insurance*, N. Y. TIMES, Mar. 29, 1992, at 1, 24.

38. *See* R. Corlin, *Statement to the Select Committee on Aging*, Subcommittee on Retirement Income and Employment (July 28, 1992).

IV. WHAT'S WRONG WITH THE ERISA "VACUUM"?

The consequences of the *McGann* decision specifically, and the ERISA "vacuum" generally, conflict with three goals upon which there is a growing national consensus: (1) providing health care coverage for every person in the United States;[39] (2) preventing discrimination against employees,including those who suffer from sexually transmitted diseases; and (3) assuring individuals that their health care benefits will not be terminated if they make claims. The impact of the *McGann* decision on each of these goals could be substantial.

A. *Providing Adequate Health Care Coverage*

Medical care is a matter of great importance to Americans. Each year, approximately twelve percent of the United States' gross national product is spent on health care.[40] Both federal and state governments are focusing attention on health care reform, and are addressin questions about whether government should assure every person access to health care, whether the health care should be rationed or limited, and whether government should attempt to impose significant constraints on the costs of health care and medical expenses insurance plans.[41] Particular attention is being placed on assuring every person in the United States adequate health care.[42]

The ERISA vacuum threatens the health care coverage of some individuals who are currently protected. The precedent established in *McGann*, together with several other judicial decisions,[43] indicates two things. First, there are no legislative constraints on an employer's freedom to cancel existing benefit plans. Second, companies may impose coverage limitations for

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39. *Cf.* Thomas L. Greaney, *No Painless Way to Cut High Costs*, 15 NAT'L L.J. Dec. 21, 1992, at 26 (noting that the 1992 candidates listed health reform as a top priority, but "devoted scant attention to the question of how to control health care costs").

40. *See* Louis W. Sullivan, *The Bush Administration's Health Care Plan*, 327 NEW ENG. J. MED. 801-04 (1992).

41. *See* Eli Ginzberg, *Health Care Reform—Where Are We and Where Should We Be Going?*, 327 NEW ENG. J. MED. 1310-12 (1992).

42. *See, e.g.*, A.C. Enthoven, *Measuring the Candidates on Health Care*, 327 NEW ENG. J. MED. 807-09 (1992); U.E. Reinhardt, *Commentary: Politics and the Health Care System*, 327 NEW ENG. J. MED. 809-811 (1992).

Many proposals for universal health care are being considered by state legislatures, and health care reform is likely to receive high priority from President Clinton and the Congress. *See, e.g.*, Robert J. Blendon et al., *Making the Critical Choices*, 267 J. AM. MED. ASS'N 2509 (1992).

Several states, including Hawaii and Oregon, have already adopted legislative reforms. HAW. REV. STAT. § 323D-1 (Supp. 1992); OR. REV. STAT. § 414.720 (1991).

43. *See, e.g.*, Owens v. Storehouse, 773 F. Supp. 416, 419 (N.D. Ga. 1991).

virtually any type of medical condition or treatment. For example, employers could decide to limit or restrict coverage for cancer treatments, organ transplants, cardiac surgery, neonatal intensive care, psychiatric therapy, and any number of other medical procedures.

In most circumstances, the origin and the nature of a disease or illness that necessitates health care is irrelevant to a sick individual. Furthermore, subject to possible exceptions for conditions that relate to conduct such as drug abuse, there is virtually no reason to permit individual employers to make value judgments about which diseases or illnesses should be covered by, excluded from, or subjected to differential limitations in employee health care plans.

ERISA, in effect, creates a two-tiered system of health care coverage in employer-sponsored plans. Employees covered under traditional health insurance programs increasingly are being protected by state regulations that mandate minimum health coverage, while employees covered under risk retention plans are not. Consequently, ERISA makes it impossible to apply uniform standards for employer-sponsored plans in these states.

Affording employers the opportunity to pick and choose diseases, illnesses, and treatments that will be subject to coverage restrictions clearly conflicts with the growing national consensus that every person in the United States should have access to basic health care.[44] Moreover, allowing employers to eliminate coverage for specific illnesses or forms of treatment is also undesirable because it increases the number of persons who either will be left without any access to care, or whose health care costs will have to be borne by already overburdened publicly supported programs such as Medicaid and Medicare, state or locally operated hospital facilities, and charitable agencies will have to bear.

B. *Preventing Discrimination Against Employees*

Many types of discrimination once routinely practiced by employers in the United States are now prohibited. For example, federal and state laws forbid employers from making hiring, promotion, and termination decisions on the basis of race,[45] ethnicity,[46] age,[47] or disability.[48] Furthermore, illnesses

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44. *Cf.* Scott Shapiro, *Universal Insurance for American Health Care: A Proposal of the American College of Physicians*, 117 ANNALS OF INTERNAL MED., 511, 511-19 (1992).

45. *See, e.g.*, ILL. ANN. STAT. ch. 68, para. 1-102. (Smith-Hurd Supp. 1992); N.Y. EXEC. LAW § 296 (McKinney 1982).

46. *See, e.g.*, ILL. ANN. STAT. ch. 68, para. 1-102. (Smith-Hurd Supp. 1992); N.Y. EXEC. LAW § 296 (McKinney 1982).

47. *See, e.g.*, 29 U.S.C. § 623 (1988); CAL. GOV'T CODE § 12941 (West Supp. 1992); ILL. ANN. STAT. ch. 68 para. 1-102. (Smith-Hurd Supp. 1992); N.Y. EXEC. LAW § 296 (McKinney 1982).

48. *See infra* part V.B.2, which discusses the Americans with Disabilities Act.

increasingly are being treated as the type of disability that employers may not use as a justification for not hiring an individual.[49]

It has been argued that the practices which differentiate the coverage provided by employee health care plans should not be governed by the rules against discrimination that apply to employment decisions.[50] In assessing the persuasiveness of this argument, it is indisputable that the essence of insurance underwriting is the classification—that is, the differentiation—of people so individuals that pose a greater risk can be charged higher premiums, offered coverage subject to specified restrictions, or not insured.[51] It is also essential to recognize that the nation's health care system depends on maintaining the solvency of existing health care benefit plans. Health care plans provided by employers, however, are not merely matters of business decisions.

Employer-sponsored plans are an integral part of the nation's health care system. They are essential to the goals of providing every person coverage and of spreading the risk of the cost entailed in treating serious illnesses. When factors unrelated to health care needs, such as the expenses for treating particular illnesses, are allowed as justifications for restrictions on coverage, access to health care may be seriously compromised.[52] Therefore, if existing federal legislation prohibiting employers from discriminating against disabled individuals does not preclude the imposition of limitations and exclusions for the treatment of specific illnesses or diseases in employer-sponsored health care plans,[53] the regulatory vacuum created by ERISA, in

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49. *See infra* part V.B.2.

50. *See, e.g.*, Karen A. Clifford and Russel P. Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806 (1987).

51. *Cf.* Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L. J. 835, 835-90 (1986).

52. The prevention of discrimination in the provision of health care coverage can be extraordinarily important tc a person's dignity and quality of life. The precedent established in *McGann* indicates there are no constraints on an employer's ability to eliminate coverage for various diseases or types of treatment. Even if not unlawful in the eyes of the judiciary, this practice allows employers to treat employees differently even though they may have equally compelling needs for health care.

Some types of discrimination based on medical conditions may be prohibited by the Americans with Disability Act, which protects individuals handicapped by various types of illness or diseases. *See infra* part V.B.2.; *see also* Lawrence O. Gostin, *The AIDS Litigation Project, A National Review of Court and Human Rights Commission Decisions, Part II: Discrimination*, 263 J. AM. MED. ASS'N 2086, 2087 (1990).

Although group health insurers often do not use individual underwriting classifications when actuarial data shows increased risks, insurers nonetheless employ provisions for conditions to exclude high-risk individuals. *See* Lawrence Bartlett, *Financing Health Care for Persons with AIDS: Balancing Public and Private Responsibilities, in* AIDS AND THE HEALTH CARE SYSTEM 211, 214 (Lawrence O. Gostin ed., 1990).

53. *See infra* part V.B.2.

effect, precludes states from addressing whether such discrimination should be limited or prohibited.

C. *Preventing Termination of Health Care Benefits After Illnesses Begin*

It has long been recognized that insurers may not cancel coverage retroactively to avoid liability for losses that have already occurred.[54] Nevertheless, the employer in *McGann* was allowed to abrogate the group insurance benefits after Mr. McGann's illness began because it had reserved the right to terminate the entire plan.[55] Even though Mr. McGann was relying on his employer's group insurance health care plan to provide coverage, the *McGann* decision, in effect, permitted the employer to eviscerate Mr. McGann's protection.

Allowing employers to avoid liability for health care costs by terminating a plan after a person has become ill could become a devastating practice.[56] Cancelling benefits when they are most needed undermines the very purpose of a health care plan. Moreover, losing coverage after an illness begins is a terrifying prospect for most persons. If an employer is free to eliminate health care plans after an individual's medical problems develop,[57] the individual may be unable to secure any replacement coverage because any new coverage that might be arranged will very likely be subject to pre-existing condition provisions,[58] which foreclose coverage for illnesses that already exist.

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54. *See* ROBERT KEETON & ALAN WIDISS, INSURANCE LAW 113-15 (Practitioner's Ed. 1988).

55. *See* McGann v. H & H Music Co., 946 F.2d at 407-08.

56. Although it seems unlikely employers with a substantial number of insured employees would terminate existing health care plans because of the illnesses of one or two individuals, companies with a relatively small work force might adopt the strategy used by H & H Music Company.

57. *See* Milton Freudenheim, *Insurers Accused of Discrimination in AIDS Coverage*, N.Y. TIMES, June 1, 1993, at A1; *see also* Thomas B. Stoddard, *Now You're Insured, Now You're Not*, N.Y. TIMES, May 23, 1992 at A23. Mr. Stoddard was executive director of Lambda Legal Defense and Education Fund, an organization working on AIDS issues, from 1986 to 1992. *Id.*

58. A preexisting condition provision is designed to exclude, restrict, or postpone coverage for a condition that either existed at the inception of the contract or that occurs during a prescribed period after the coverage becomes effective. 1A JOHN A. APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE §§ 241-255 (1981); *see also* 10 GEORCE COUCH, COUCH ON INSURANCE § 41:13, at 19 (2d ed. 1982).

In many states, an insurer's use of policy provisions to reduce, postpone, or exclude coverage for preexisting conditions is subject to legislative limitations or administrative regulations. *See, e.g.*, CAL. INS. CODE § 10198.7(a)(West Supp. 1993)(effective July 1, 1993, "[n]o health benefit plan . . . shall exclude coverage for any individual on the basis of a preexisting condition for a period greater than six months following the individual's effective date of coverage"); ILL. ANN. STAT. ch. 73, para. 969.3 (Smith-Hurd Supp. 1992) (no misstatements, except fraudulent

V. "FILLING" THE ERISA VACUUM: RECOMMENDATIONS FOR LEGISLATIVE ACTION

Some aspects of the regulatory vacuum created by ERISA's preemption provision should be modified. The federal government could adopt relatively minor changes in existing laws that would afford protection for individuals without radically increasing employers' costs.

A. *Vest Rights in Health Insurance Benefits*

There is an enormous difference in the effect of an employer's decision to cancel a health care plan for individuals that are already ill and for those that are healthy. Healthy persons generally are able to secure new comprehensive health care coverage, while insurers commonly employ pre-existing condition clauses or reject application from seriously ill applicants. Federal law could protect seriously ill individuals that have already initiated claims by vesting the right to continued coverage.

Vesting can be achieved by prohibiting employees from reducing or eliminating health care benefits for those employees that have already claimed benefits or are receiving them under an existing plan. Vesting would apply when conditions have been diagnosed or when the onset of an illness which, though not diagnosed, necessitates medical attention.

The vesting envisioned by this proposal would not foreclose an employer from restructuring or terminating a health care plan. Rather, it would protect individuals that are already ill and suffer from a condition that effectively precludes them from securing an alternative plan that would cover the existing condition. An employer terminating the company's health care plan would be required only to extend the coverage for qualified individuals.[59] The legislative provisions for such vesting could be modeled on the requirements currently imposed on employers by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"),[60] which now requires employ-

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misstatements, may be used to void a policy or deny a claim after policy is in effect two years); IOWA CODE § 514A.3(1)(b)(1991)(same); N.Y. INS. LAW § 3216(d)(1)(B)(i)(McKinney 1985)(same); TEX. INS. CODE ANN. art. 3.70-3A(a), (b) (West Supp. 1993)(same, but no policy may be cancelled if "the insured has been diagnosed as having or has been treated" for HIV or AIDS unless the insured by fraud or misrepresentation obtained coverage by not disclosing an AIDS diagnosis or HIV-related condition).

59. A bill currently being considered by the House Retirement Income and Employment Subcommittee provides for this type of vesting coverage. *See* H.R. 6147, 102d Cong., 2d Sess. (1992) (introduced by Reps. William Hughes (D-NJ) and Sherwood Boehlert (R-NY)); *see also* 138 CONG. REC. H3049-50 (daily ed. Oct. 5, 1992) (statement of Rep. Hughes).

ers to continue health care coverage for covered persons under certain conditions.[61]

B. *Broaden the Antidiscrimination Provisions of ERISA and the ADA*

1. *The Antidiscrimination Provision of ERISA*

Section 510 of ERISA, which prohibits discrimination, provides almost no guidance for courts or administrative agencies faced with questions about the appropriateness of actions that eliminate or limit employer-sponsored health care benefits.[62] When individuals have sought protection under section 510, courts have placed the burden on the claimant to prove the employer harbored a specific intent either to retaliate against the employee for exercising rights under the plan,[63] or to interfere with the attainment of any right to which an individual may have become entitled.[64] This creates an almost insurmountable burden for an employee.

McGann provides an example. Even though Mr. McGann's claim resulted in the employer's decisions to terminate the existing group insurance plan and to impose a special "cap" for AIDS-related claims in the new health care plan,[65] the court required a showing that the employer intended to deny the benefit *only* to Mr. McGann.[66] A particularly disturbing result of *McGann* is the latitude it confers upon employers to distinguish among various types of illnesses. Even though the record in that case made clear the employer's group health plan was not adequately funded, only the treatment of AIDS was subject to the five thousand dollar maximum payment limitation.[67] When AIDS is analyzed in terms of its cause, prognosis, prevalence, and lifetime care costs, there is no reason to view it as a medical problem whose

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60. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986).

61. *Id.* § 10002 (codified at 29 U.S.C. § 1161 (1988)); *see also* PAUL M. HAMBURGER, WHAT YOU NEED TO KNOW ABOUT COBRA HEALTH CARE CONTINUATION COVERAGE 45-53 (rev. ed. 1987).

62. *See, e.g.*, McGann v. H & H Music Co., 946 F.2d at 407 ("To interpret 'discrimination' broadly to include defendants' conduct would clearly conflict with Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefits plans without governmental interference.").

63. *See, e.g.*, Kimbro v. Atlantic Richfield Co., 889 F.2d 869, 880-81 (9th Cir. 1989), *cert. denied*, 111 S.Ct. 53 (1990).

64. *See, e.g.*, Dister v. Continental Group, Inc., 859 F.2d 1108, 1111 (2d Cir. 1988).

65. McGann v. H & H Music Co., 946 F.2d at 403-04.

66. *Id.* at 404. The differential impact on Mr. McGann was clear. Although all employees with AIDS were theoretically affected in the same way, McGann was the only employee known to have the disease. *Id.* at 404 n.4.

67. *Id.* at 405.

uniqueness warrants treating it differently from all other costly diseases.[68] Data suggests the cost of treating the HIV virus, which ranges from $50,000 to $125,000,[69] does not exceed the costs of treating major causes of morbidity and mortality that risk retention plans routinely cover.[70] For example, cardiovascular disease and cancer, both of which may require costly surgery or chemotherapy, are responsible for considerably more morbidity and mortality in America.[71]

Section 510 of ERISA should be amended so that a claimant would not be required to prove an employer had a specific intent to single out a particular individual. Coverage limitations or restrictions for specific illnesses, diseases, or treatments would not be permitted in employer-sponsored health care plans unless they actually justified classifying the treatment of a disease or illness differently from other medical conditions. In other words, section 510 of ERISA would forbid an employer from treating an individual or group of individuals differently unless the employer could demonstrate a sound actuarial justification.

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68. Alan I. Widiss, TO INSURE OR NOT TO INSURE PERSONS WITH THE VIRUS THAT CAUSES AIDS, 77 IOWA L. REV. 1617, 1628-40 (1993).

69. *See* E. Gilbert, *ADA Could Bar AIDS Benefits Caps*, in SPECIAL REPORT: EMPLOYEE BENEFITS REVIEW 15 (The National Underwriter Company ed. 1992).

70. *Cf.* Daniel M. Fox and Emily H. Thomas, *The Cost of AIDS: Exaggeration, Entitlement, and Economics*, *in* AIDS AND THE HEALTH CARE SYSTEM, *supra* note 47, at 197, 197-210 (discussing early claims that AIDS patients incurred substantially greater costs than other terminally ill patients, and pointing out the flaws in early methods of accounting those costs).

71. Cancer and heart disease cause prolonged medical care and death for even greater numbers of Americans each year. "During 1989, reported deaths in the United States due to human immunodeficiency virus (HIV) infection accounted for 1% of total deaths," while "[t]he proportion of deaths due to cancer increased to 23.0%." AMERICAN COUNCIL OF LIFE INS., LIFE INSURANCE FACT BOOK 109 (1990). In 1989, 497,220 deaths were caused by cancer, 735,450 deaths were caused by cardiovascular disease, and 147,470 deaths were caused by cerebrovascular disease (including strokes and hypertension). *Id.* It is estimated that during 1989, AIDS-related deaths numbered 24,349. *Id.*

In 1990, 31,196 deaths among persons with AIDS were reported to the Centers for Disease Control by local, state, and territorial health departments. See 40 MORBIDITY AND MORTALITY WEEKLY REP. 41 (1991). THE HIV/AIDS SURVEILLANCE REPORT states that there were 25,386 deaths (adults/adolescents: 24,969; children under the age of 13: 317) in 1990. See Table 8---*AIDS Cases* in Centers for Disease Control, United States Department of Health and Human Services, HIV/AIDS SURVEILLANCE REPORT (December, 1990). Some differences in the data on the number of infections and deaths may be attributable to the definitions employed in connection with the compilation of the statistics.

The CDC reported fewer deaths for 1991. It placed the numbers for AIDS related deaths at 23,999 adults and adolescents, and 249 children under the age of 13. HIV/AIDS SURVEILLANCE REPORT (March, 1992), Table 8.

2. *The Antidiscrimination Provisions of the Americans with Disabilities Act*

The Americans with Disabilities Act of 1990 ("ADA")[72] was designed "to provide a clear and comprehensive national mandate for the elimination of discrimination against [handicapped] individuals" in employment, public accommodations, public services, transportation, and telecommunications.[73] The ADA, which applies to both public and private employers,[74] precludes discrimination against a qualified individual with respect to "job application procedures, the hiring, advancement, or discharge of employees, *employee compensation*, job training, and *other terms, conditions*, and *privileges of employment*."[75]

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72. 42 U.S.C. § 12101 (Supp. II 1990).

Congress enacted the ADA several years after ERISA became effective. Although questions have been raised about whether the ADA's protection of handicapped persons affects employee rights regulated by ERISA, it appears clear the House Judiciary Committee did not intend the ADA to alter the effect of ERISA's preemption provisions on risk retention plans. The House Judiciary Committee Report states:

> Section 501(c)(3) of the ADA is designed to clarify that self-insured plans, which are currently governed by the preemption provision of the Employment Retirement Income Security Act (ERISA), are still governed by that preemption provision and are not subject to state insurance laws. Concerns had been raised that Sections 501(c)(1) and (2) could be interpreted as affecting the preemption provision of ERISA. The Committee does not intend such an implication.
>
> Until the preemption provision of ERISA is modified, these self-insured plans are subject to state law only to the extent determined by the courts in their interpretation of ERISA'S preemption provision. Of course, under the ADA, the provisions of these plans must conform with the requirements of ERISA, just as the provisions of other plans must be based on or not inconsistent with state law.
>
> Section 501(c) may not, however, be used as a subterfuge to evade the requirements of this Act pertaining to employment, public services, and public accommodations regardless of the date an insurance or employer benefit plan was adopted.

H.R. REP. NO. 101-485(III), 101st Cong., 2d Sess. 70-71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 493-94.

73. 42 U.S.C. § 12101(b) (Supp. II 1990) provides the purpose of the ADA is:

> (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
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> (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
>
> (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this [Act] on behalf of individuals with disabilities; and
>
> (4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

Id.

74. Initially, the ADA covered employers with 25 or more employees. 42 U.S.C. § 12111(5)(A) (Supp. II 1990). Beginning July 26, 1992, the ADA will apply to all employers with 15 or more employees. *Id.*

75. *Id.* § 12112(a) (Supp. II 1990) (emphasis added).

The ADA defines a disabled individual as (1) a person with a "physical or mental impairment that substantially limits one or more life activities," (2) a person that has "a record of such an impairment," or (3) someone "regarded as having such an impairment."[76] The legislative history of the ADA[77] and the administrative regulations promulgated under it[78] indicate this definition covers a wide range of medical conditions, including infectious diseases such as AIDS and HIV,[79] genetic diseases,[80] as well as chronic illnesses and diseases.[81]

When the estate of John McGann asked the Supreme Court to review the *McGann* decision, the amicus curiae brief filed by the Solicitor General of the United States urged the Court not to accept the case because the ADA, which did not apply when the H & H Music Company terminated its group insurance plan, addresses discrimination under the terms of employee benefit plans.[82] However, despite the stated goal of the ADA and the arguments advanced by the Solicitor General, the Act may do no more than codify the status quo for insurance and risk retention plans.

The ADA preserves for insurers and entities that administer benefit plans the same opportunities to underwrite, classify, and administer risks that existed before it was enacted.[83] Furthermore, employers may establish

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76. *Id.* § 12102(2). Much of the language of the definitional section of the ADA is the same as § 504 of the Rehabilitation Act of 1973. *Compare* 42 U.S.C. § 12102 (Supp. II 1990) *with* 29 U.S.C. § 794 (1988).

77. S. REP. NO. 116, 101st Cong., 1st Sess. 7, 22, 24 (1989).

78. *See* EQUAL EMPLOYMENT OPPORTUNITIES COMM'N, AMERICANS WITH DISABILITIES ACT HANDBOOK, at II-17 to -23 (1991).

79. Severino v. North Fort Myers Fire Control Dist., 935 F.2d 1179, 1182 n.4 (11th Cir. 1991); *see also* 29 C.F.R. 1630.2(j) (1992).

80. *See* Larry Gostin, *Genetic Discrimination: The Use of Genetically Based Diagnostic and Prognostic Tests by Employers and Insurers*, XVII AM. J. L. & MED. 109-44 (1991).

81. *See* Larry Gostin, *The Americans with Disabilities Act and the U.S. Health Care System*, 11 HEALTH AFFAIRS 248-57 (1991).

82. *See In the Supreme Court of the United States, October Term 1992*, No. 91-1283, Greenberg, Executor of Estate of John W. McGann v. H & H Music Co., Brief for the United States as Amicus Curiae, Kenneth W. Starr, Solicitor General; *see also* Robert Pear, *U.S. to Argue Employers Can Cut Health Insurance: White House Backs Move*, NEW YORK TIMES, October 16, 1992, at A1, A18.

83. 42 U.S.C. § 12201(c)(Supp. II 1990) provides:

> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (2) a person or organization covered by this chapter from establishing, 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

and change the terms of a bona fide benefit plan based upon sound actuarial data.[84] Employers may also use pre-existing condition provisions and coverage limitations for certain conditions or treatments, and may require higher co-payments for persons with higher risks.[85] In other words, the ADA appears to provide that employers may continue practices such as pre-existing condition exclusions and coverage limitations—even though such provisions adversely affect persons with disabilities—so long as the employer is not attempting to evade the purposes of the Act.[86] Although employers are permitted to establish coverage limitations or to change plans based upon insurance underwriting principles, they are not allowed to engage in such practices "as a subterfuge to evade the purposes of [the ADA]."[87]

The House Judiciary Committee Report addressed the ADA's subterfuge provision and noted that as long as a plan is based on sound "actuarial principles," the amount, extent, or kind of coverage available to an

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(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to [s]tate laws that regulate insurance.

Id. The Act's legislative history includes many statements that Congress did not intend to affect the way the insurance industry does business. *See* S. REP. NO. 116, 101st Cong., 1st Sess. 84 (1989); *see also* H.R. REP. NO. 101-485(III), 101st Cong., 2d Sess., 71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 494.

84. *See* S. REP. NO. 116, 101st Cong., 1st Sess. 85 (1989).

85. *See id.* at 29; H.R. REP. NO. 101-485(III), 101st Cong., 2d Sess. 71 (1990), *reprinted in* 1990 U.S.C.C.A.N.445, 494.

86. 42 U.S.C. § 12201(c) (Supp. II 1990) provides:

Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict . . . a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with [s]tate law . . . .

Id. In addition, the House Judiciary Committee Report states:

However, employers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments [e.g., a limit on the extent of kidney dialysis or whether dialysis will be covered at all, or a limit on the amount of blood transfusions or whether transfusions will be covered]. It would not be permissible, however, to deny coverage to individuals, such as persons with kidney disease or hemophilia, who are affected by these limits on coverage for procedures or treatments, for other procedures or treatments connected with their disability. It would also not be permissible to deny coverage to such individuals for other conditions not connected with these limitations on coverage, such as treatment for a broken leg or heart surgery. While limitation may be placed on reimbursements for a procedure or the types of drugs or procedures covered, that limitation must apply to all persons, with or without disabilities. Persons with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

H.R. REP. NO. 101-485(III), 101st Cong., 2d Sess. 38 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 460-61.

87. 42 U.S.C. § 12201(c) (Supp. II 1990) provides that "paragraphs (1), (2), and (3) [of subsection (c)] shall not be used as a subterfuge to evade the purposes of title I and III." *Id.*

individual can be limited.[88] Future litigation is likely to shape clearer contours for the meaning of the term "subterfuge" as it is used in the ADA.[89] In the past, however, the Supreme Court analyzed the term "subterfuge" as it is used in analogous provisions of the Age Discrimination Employment Act of

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88. The House Judiciary Committee Report includes the following examples:

> [Although] a plan [that] 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.*
>
> For example, a blind person [may] not be denied coverage on blindness independent of actuarial classification. Likewise, with respect to group health insurance coverage, an individual with a pre-existing condition may be denied coverage for that condition for the period specified in the policy, but cannot be denied coverage for illness or injuries unrelated to the [pre-]existing condition. And as noted above, while it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, coverage cannot be denied entirely to a person with a disability.

H.R. REP. NO. 485, 101st Cong., 2d Sess., pt.3, at 71 (1990) (emphasis added). Similarly the *Interpretive Appendix* for the *Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act* states:

> "[t]his part is intended to require that employees with disabilities be accorded equal access to whatever health insurance coverage the employer provides to other employees. *This part does not,* however, *affect pre-existing condition clauses included in health insurance policies offered by employers.* Consequently, employers may continue to offer policies that contain such clauses, even if they adversely affect individuals with disabilities, so long as the clauses are not used as a subterfuge to evade the purposes of this part."

Interpretive Appendix for the REGULATIONS TO IMPLEMENT THE EQUAL EMPLOYMENT provisions or the AMERICANS WITH DISABILITIES ACT, *Interpretive Guidance* for § 1630.5 *Limiting, Segregating and Classifying* (emphasis added).

If the view set forth in the House Judiciary Committee Report and in the Equal Employment Opportunity Commission (EEOC) *Title I Interpretive Appendix* is applied by the courts, the effect will be that the ADA only requires that employees with disabilities have access to the same coverage as employees without disabilities. This means insurers providing group coverage for employees or employer risk retention plans are permitted to test new employees to determine the existence of maladies—including HIV infections—that would be subject to "pre-existing conditions" provisions, and also means insurers may continue to impose "caps" for the treatment of specific conditions.

89. Neither the ADA nor EEOC regulations indicate what actions constitute "subterfuge," nor do they comment on the legality of employer decisions to eliminate or reduce the benefits provided by health plans. *See Health Insurance: ADA's Effect on Plans Remains a Puzzle*, 19 PENSION REPORTER 824 (BNA May 18, 1992); *see also* K.A. Ackourey, *Insuring Americans with Disabilities: How Far Can Congress Go to Protect Traditional Practices?*, 40 EMORY L.J. 1183, 1183-1225 (1991).

The Equal Employment Opportunity Commission recently decided that the ADA was violated in a case involving facts somewhat similar to those in *McGann*. *See* Terrence Donaghey, Jr. v. Mason Tenders Dist. Council Trust Fund (Charge No. 160-93-0419, January 27, 1993).

A case has been filed in federal district court in New York seeking a declaratory judgment that the exclusion of coverage for HIV- or AIDS-related illnesses does not violate the ADA. *See Suit Seeks to Exclude AIDS Health Coverage*, NAT'L L. J., Mar. 15, 1993, at 6.

1967 ("ADEA"),[90] and adopted a construction that required an employee prove the employer had a *subjective intent* to discriminate.[91]

Decisions about whether an employer engaged in "subterfuge" require determining whether the employer's actions can be justified by the application of sound actuarial principles. On the basis of the ADA provisions permitting tests *and* authorizing coverage limitations based on sound actuarial principles, it can be persuasively argued that the ADA does not require either group insurance or risk retention plans to provide coverage for conditions related to disabilities that can be identified after an individual has been offered employment. Consequently, there is undoubtedly a possibility courts will hold that the ADA permits defferential coverage when it is justified by sound actuarial data. It is, therefore, probable that an employee benefit plan that provides limited coverage for specific illnesses or has a pre-existing conditions clause will not be found discriminatory as long as the employer provides data showing the coverage limitations were adopted to assure solvency—that is, the employer demonstrates that the limitation or restrictions were adopted to attain or maintain "actuarial soundness."[92]

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90. 29 U.S.C. §§ 621-634 (1988).

91. Public Employees Retirement Sys. v. Betts, 492 U.S. 158, 159 (1989). Justice Marshall filed a dissenting opinion in *Betts*, in which Justice Brennan joined. *Id.* at 182-94 (Marshall, J., dissenting). The ADA may have adopted an approach to questions about "subterfuge"—set forth in the dissent—that requires differences in benefit coverage be based on a cost-related or business justification standard. *See* Myron D. Rumeld & Richard Brook, *ADA May Widen HIV Coverage*, NAT'L L.J., Dec. 21, 1992, at 26-28. Furthermore, although the provisions in the ADA do not specifically address employee benefits, there are several that support this view.

First, the ADA specifically refers to the classification of risks. 42 U.S.C. § 12201(c) provides in part:

> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations *from* underwriting risks, *classifying risks*, or administering such risks that are based on or not inconsistent with [s]tate law; or
>
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, *classifying risks*, or administering such risks that are based on or not inconsistent with [s]tate law; or
>
> (3) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to [s]tate laws that regulate insurance.

42 U.S.C. § 12201(c) (Supp. II 1990) (emphasis added). Second, Congress responded to the decision in *Betts* by amending the ADEA in 1990 to require a cost based justification. See 29 U.S.C. § 623(f)(2)(B)(i) (Supp. II 1990). Third, some of the legislative history of the ADA, as well as EEOC guidelines, reject the majority decision in *Betts*. *See* 136 CONG. REC. H4614, 4623, 4627 (daily ed. July 13, 1990); 29 CFR § 1630.16(f) (1992); EQUAL EMPLOYMENT OPPORTUNITY COMM'N, AMERICANS WITH DISABILITIES ACT HANDBOOK (1991).

92. Proving subterfuge by an employer may be a formidable task. For example, in Public Employees Retirement Sys. v. Betts, 492 U.S. 158 (1989), the Supreme Court discussed the

Because virtually all serious diseases are costly, the critical issue when considering "actuarial soundness" and "subterfuge" should not be whether the employer can prove that covering a particular disease will impose a financial burden on the plan. Rather, when a particular disease or illness is subject to restrictions or exclusions, an employer ought to be required to show why the relative financial burden is greater for the treatment of that condition than for the treatment of other medical conditions. Therefore, the ADA should be amended to define "subterfuge" so that the prohibitions against discrimination would apply unless the employer could show that there would be greater expenses for excluded or restricted treatments than for covered treatments. Requiring such actuarial evidence would make it difficult for employers to base differential coverage on prejudices about either individuals or diseases.

C. *Restore States' Authority to Regulate Coverage Features in Employer Risk Retention Plans*

ERISA was adopted so that employers would be subject to a single body of legislative rules. There is considerable appeal to a regulatory system that applies the same requirements for employers throughout the country. For example, uniform regulation allows corporations with offices in several states to provide the same benefit plan for all employees.

Attaining uniformity is often an elusive goal, however. On one hand, ERISA's preemption provision applies a single and, therefore, at least theoretically a uniform, body of federal law to all employers. On the other hand, the "saving clause" of ERISA permits state regulation of employee group insurance plans even though states are not permitted to regulate employer-

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meaning of "subterfuge" under the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621 (1982 & Supp. V). The Court noted it had previously held the term "subterfuge" "must be given its ordinary meaning as 'a scheme, plan, stratagem, or artifice of evasion.'" *Id.* at 167 (quoting United Air Lines, Inc. v. McMann 434 U.S. 192, 203 (1977)). In other words, there must be an intent to discriminate. The Court also held that in order to challenge a benefit plan provision under the ADEA, an employee must make a prima facie case that the plan was actually designed to discriminate in regard to employment or salary. *Id.* at 181.

In his dissent Justice Marshall noted that the majority opinion:

> immunizes virtually all employee benefit programs from liability under the Age Discrimination Employment Act of 1967 . . . . Henceforth, liability will not attach under the ADEA even if an employer is unable to put forth any justification for denying older workers the benefits younger ones receive, and indeed, even if his only reason for discriminating against older workers in benefits is his abject hostility to, or his unfounded stereotypes, of them. In reaching this surprising result, the majority casts aside the estimable wisdom of all five Court of Appeals to consider the ADEA'S applicability to benefit programs, of the two federal agencies which have administered the Act, and of the Acting Solicitor General on behalf of the Equal Employment Opportunity Commission [EEOC] as amicus curiae, all of whom have concluded that it contravenes the text and history of the Act to immunize discrimination against older workers in benefit plans [that] is not justified by any business purpose.

Id. at 182-83 (Marshall, J., dissenting).

sponsored risk retention plans.[93] Therefore, workers in a given state may still be treated in significantly different ways because many states have enacted regulatory provisions that apply to group insurance plans and require various basic health care benefits be provided to all covered persons.[94] In addition, a number of states have prohibited insurers from excluding or severely limiting health insurance coverage for mental illness, neonatal care, or AIDS.[95]

There are compelling reasons for the federal government to create a national standard that will guarantee basic health care coverage to Americans. So long as the federal government does not require minimum levels of coverage to ensure adequate health care for everyone, however, employees and their families would be well served by an amendment to ERISA that expands the scope of the "saving clause" to include *all* employee health care plans. In other words, in the absence of federal regulations establishing minimum requirements for employee health care plans, federal law remove the obstacles which stand in the way of states that want to ensure decisions affecting health care for all workers are made with due concern for the public interest. Therefore, ERISA should be amended to allow states to mandate the health care benefits employers provide under group insurance plans *and* risk retention plans.

VI. CONCLUSION

Employer-sponsored health care plans presently are, and are likely to continue to be the primary source of financing for health care for most Americans. Individuals covered by employer-sponsored health benefit plans depend upon these arrangements to pay for medical treatments essential to the well being of themselves and their families. Increasingly, employers are using risk retention arrangements for these health care plans.

Congress has, through ERISA's preemption provisions, exempted risk retention plans from state regulation. The Supreme Court essentially has ruled that, even though ERISA does not regulate the coverage risk retention plans offer, state laws designed to ensure specific benefits are provided cannot be applied to these plans. Consequently, ERISA, adopted almost twenty

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93. *See* M.R. GREENE & J.S. TRIESCHMANN, RISK AND INSURANCE 11, 38-43 (5th ed. 1981).

94. *See* G. Scandlen, *The Changing Environment of Mandated Benefits*, EMPLOYMENT BENEFIT NOTES June 1987, at 6-9.

95. *See* Ruth Faden & Nancy E. Kass, *Health Insurance and AIDS: The Status of State Regulatory Activity*, 78 AM. J. PUB. HEALTH 437, 437 (1988); Mark Scherzer, *Insurance and Employee Benefits*, *in* AIDS PRACTICE MANUAL 8-1, 8-10 to -12 (Paul Albert et al. eds., 3d ed. 1991). *But see* Linda Lamel, *State Regulation of the Insurance Industry*, 665 INS. L.J. 336, 336-58 (1978) (arguing earlier state regulations designed to curb sex and race discrimination in the insurance industry were inadequate).

years ago to protect employees, now allows employers to enter what is, in effect, a regulation-free zone.[96] Thousands of employers have decided that the absence of regulation, as well as financial advantages resulting from the elimination of premium taxes, makes the use of risk retention plans very attractive.

In the months since the *McGann* decision, dozens of additional disputes have arisen involving claims that employers wrongfully discriminated by eliminating or limiting the coverage provided by health care plans.[97] Numerous claims are now pending with eithr the United States Equal Employment Opportunity Commission or in the nation's courts. Moreover, the significqance of the judicial precedent established in *McGann* increases as the "shimmering vision of health-care reform . . . seems to be receding into the distance as Administration officials and members of Congress wrestle with . . . taxes and the Federal budget deficit."[98]

The changes proposed in this Article are relatively modest. They would not endanger the financial stability of either health care plans or employers because that depends mostly on sound underwriting practices, prudent management, careful investment of reserves, and increasingly, managed care. Alternatively, employers concerned that the proposed changes would expose them to large individual claims could arrange insurance to cover unexpectedly large costs that might result from a few catastrophic illnesses among those covered by the plan. Furthermore, increased costs could also be equitably distributed to all covered persons through the use of reduced benefits, higher deductibles, higher co-payments, or a shared increase in the fees paid.

Each of the recommended measures would help to ensure that coverage decisions by employers about the coverage to be provided by health care plans are not based upon prejudice, stereotypes, or irrational feats about specific medical conditions. Moreover, the proposal for vesting rights when someone becomes ill would prevent employers from reneging on commitments to provide benefits when the individuals who are covered most need them, and would contribute significantly to making employment-based plans coverage that can be relied on to meet health care needs.

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96. *See* Musto v. American Gen. Corp., 861 F.2d 897, 907 (6th Cir. 1988).

97. *See* Milton Freudenheim, *Insurers Accused of Discrimination in AIDS Coverage*, N.Y. TIMES, June 13, 1993, at A1.

98. *Cf.* Robert Pear, *Clinton's Health-Care Plan: It's Still Big, but It's Farther Away*, N.Y. TIMES, June 13, 1993, at E4.