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Health Coverage for People with HIV/AIDS

SUMMARY

Three federal laws -- the Americans with Disabilities Act, the Health Insurance Portability and Accountability Act of 1996, and the Employee Retirement Income Security Act -- offer important protections for individuals with AIDS and HIV disease. None of these laws, however, provide comprehensive safeguards against all possible kinds of HIV/AIDS -- specific coverage limits or exclusions in health insurance plans. But collectively the laws ensure that persons with HIV/AIDS are not subjected to the most blatant forms of insurance discrimination.

There is a tension between the principles underlying health insurance and the antidiscrimination mandates of the Americans with Disabilities Act (ADA). Insurance is based on actuarial differentiation between risk classifications; insurers attempt to collect, through premiums, an amount equal to the anticipated expenditures needed to cover benefits for the person(s) covered by the insurance plan. The ADA generally prohibits disability-based distinctions in the provision of employee benefits and private and public health insurance. However, the Act expressly provides a "safe harbor" for insurers' use of most disability-based risk classifications, because Congress understood a "safe harbor" was necessary for the business of insurance.

The "safe harbor," however, does not extend to *all* insurance practices. It covers only the administration of a bona fide plan that contains terms based on or not inconsistent with state law. Moreover, even if a disability-based distinction would otherwise fall within this "safe harbor," the Act prohibits its use if it is a subterfuge to evade the purposes of the Act's antidiscrimination provisions.

People with AIDS, HIV disease, and other disabilities have encountered several hurdles when they attempt to challenge insurers' practices under the ADA. First, there is a split among the federal Courts of Appeals as to whether a former employee receiving health insurance coverage under COBRA or long-term disability benefits has standing to sue under Title I when her employer reduces benefits *after* her term of employment. The Sixth, Seventh, and Eleventh Circuits have ruled that a former employee is not a "qualified individual with a disability" and thus has no standing to sue. The Second Circuit, however, has concluded that a former employee has standing under Title I, a position consistent with the Equal Employment Opportunity Commission's (EEOC's) interpretation of the ADA.

Second, insurers have argued that the public accommodation provisions of Title III apply only to discrimination in access to insurance offices as physical places, and not to the terms and conditions of insurance policies. While the Sixth Circuit has ruled that Title III is limited to physical access, the First Circuit has adopted the Department of Justice's (DOJ's) interpretation of the term "public accommodation" as embracing insurance practices as well as insurers' physical office space.

Where people with HIV/AIDS have succeeded in establishing both jurisdiction and standing, they have been largely successful in challenges to AIDS caps and AIDS/HIV-specific limitations on, or exclusions of coverage. No court, however, has specifically addressed the issue of whether an increase in an employer's premiums as a result of higher HIV/AIDS-related payments constitutes an undue hardship, thereby justifying what would otherwise be a prohibited disability-based distinction.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) represented a landmark, though modest step in federal regulation of health insurance policies. HIPAA ensures that individuals who already are covered by a policy do not lose coverage when they change jobs, and it strictly limits insurers' use of pre-existing condition limitations. Moreover, HIPAA prohibits insurance plans from discriminating in health plan eligibility, premiums, or contributions on the basis of an individual's "health status-related factors." To date, no challenges to health plan practices have been brought under HIPAA, but a General Accounting Office study revealed that some insurers have raised premiums up to 600%.

A few individuals have challenged employers' institution of lifetime AIDS caps under the Employee Retirement Income and Security Act (ERISA). Prior to the enactment of HIPAA, ERISA was the only avenue for challenging self-insured employer-provided insurance. The Fifth Circuit Court of Appeals -- to date, the highest court to hear such a challenge -- ruled that under ERISA, employers enjoy broad discretion to modify the terms of their health insurance plans. The Fifth Circuit found an employer's implementation of a lifetime AIDS cap did not violate ERISA and the U.S. Supreme Court declined to review the case on appeal.



HIV LAW & POLICY STUDY

Health policy and legal protections for persons with HIV

A Project of the Federal Legislation Clinic, Georgetown University Law Center

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HEALTH COVERAGE FOR PEOPLE WITH HIV/AIDS

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Discussion Draft

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HEALTH COVERAGE FOR PEOPLE WITH HIV/AIDS

ANNE M. LEWIS

INTRODUCTION

In the wake of the Clinton Administration's ambitious plan to globally reform how health care is financed and delivered in the United States, there have been significant developments in both public and private health care insurance. These developments are exerting a dramatic effect on health insurance coverage for individuals with AIDS or HIV disease. Concurrently, there has been a parallel revolution in the clinical management of AIDS and HIV disease. The advent of protease inhibitors and other pharmaceutical advances, combined with improved medical management of HIV disease, has transformed the disease – for those who have access to comprehensive health care and who respond to it – from an almost always terminal condition to a potentially chronic, manageable condition.

In the private sector, health care financing and delivery have been in an upheaval – a cataclysm of restructuring that continues to bring wide-spread change for providers, payors, and patients. The socioeconomic forces driving this restructuring are myriad. Foremost among them is a steady increase in the cost of health care services – estimated to be 14 percent of the national gross domestic product in 1995¹ – which has caused a corresponding increase in the cost of health care insurance. Employers have limited choices when deciding how to handle increased health care premium costs. They can continue providing employees the same kind and level of coverage, and absorb the costs in the form of reduced profits or pass the costs onto customers. Alternatively, they can reduce the level of benefits provided, or limit the delivery systems through which employees receive health care coverage – a choice many employers have opted for, by relying on HMOs and other managed care plans. Or employers can drop health care benefits all together.

¹ Linda J. Blumberg & David W. Liska, The Uninsured in the United States: A Status Report 9 (1996).

Health insurers are responding to employers' concerns about the continually rising costs of health care for their employees by demanding less costly, and more cost-effective services from health care providers. Managed care organizations, which are structured on the belief that controlling patients' access to care (especially by costly specialists) will lower the cost of delivering health care, have become the health care delivery system for [a majority] of privately insured Americans. For-profit and nonprofit enterprises alike are riding a wave of integration, mergers, consolidations, and closings aimed at eliminating excess capacity and achieving economies of scale, with the ultimate goal of cutting health care costs.

In the public sector, over the past four years Congress has sought to make fundamental changes in Medicaid and Medicare. Health care measures introduced in the 104th Congress went in the opposite direction from the universal coverage envisioned by the Clinton health care reform plan. The new Republican majority elected to the House of Representatives in late 1994 viewed "reforming" Medicaid and Medicare as a central to achieving their goal of balancing the federal budget and drastically reduce the scope of federal entitlements.

Foremost among the Republican initiatives was the Balanced Budget Act of 1995.² The Republican leadership approved a bill that would reduce federal Medicaid spending by \$168 billion from FY 1996-2002 and replace the current Medicaid program with a new MediGrant program. It would have transformed Medicaid from an open-ended federal entitlement into a state block grant program, with states largely free to decide upon covered populations, benefits, and delivery structure.

The Republican's Medicare proposal would have given beneficiaries incentives to choose Medicare managed care plans over the fee-for-service program, raised beneficiaries' costs, and dramatically reduced

² H.R. 2491 [cite].

payments to providers. The original budget resolution called for \$226 billion less Medicare spending over fiscal years FY 1996-2002. If the proposed reforms did not achieve the annual target level of savings, the legislation included a provision that would automatically reduce payments to providers by the amount necessary to conform with the targets.

When the balanced budget bill reached President Clinton, he vetoed it because it would end the Medicaid entitlement and because the level of spending reductions it would require in Medicare and Medicaid were too great. The federal budget agreement ultimately reached reduced entitlement spending much less than the original Republican numbers initially proposed – to \$72 billion for Medicaid and \$158 billion for Medicare. The agreement did not repeal the Medicaid entitlement and made no major structural changes in the Medicare program.

Not all legislation in the 104th Congress attempted to roll back health insurance coverage. With the 1996 elections approaching, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996,³ which ensures that individuals who already are covered by a health insurance plan do not lose their health care coverage when changing jobs or becoming self-employed and limits insurers' use of pre-existing condition exclusions. The Act does not guarantee coverage will be affordable, but nonetheless was a landmark step toward increased federal regulation of health care.

The 105th Congress reintroduced Medicaid and Medicare reform legislation, but it was far less ambitious in scope than the measures considered in the previous Congress. The Balanced Budget Act of 1997⁴ reduced Medicaid spending, especially for the Medicaid disproportionate share hospital program (which provides

³ Pub. L. No. 104-191, 110 Stat. 1936 (codified at 29 U.S.C. § 1181 *et. seq.* and 42 U.S.C. § 300gg (Supp. 1998)).

⁴ [cite to public law].

supplemental payments to hospitals serving a large number of Medicaid and low income patient), and made relatively modest cuts in the Medicare program. In addition, the legislation eliminated the requirement that states obtain a federal waiver before requiring Medicaid approval before instituting for state-wide Medicaid managed care). The 105th Congress also created the State Child Health Insurance Program (SCHIP), a new federal-state initiative that expands health insurance coverage for children who do not qualify for Medicaid but who cannot afford health insurance coverage. Finally, the budget agreement included the Mental Health Parity Act, an amendment to HIPAA that requires health insurance plans to provide equal coverage for physical and mental disorders.⁵

In sum, the profound changes in public and private health insurance coverage are a mixed bag for people with AIDS and HIV disease. HIPAA offers new protections to individuals who are already insured, and the SCHIP program promises to expand health coverage to thousands of HIV-infected children. But employers, private insurance companies, and state Medicaid programs are all operating under enormous pressure to control health care costs by managing covered individual's utilization of health care services and minimizing expenditures per patient. At the same time, there are promising new therapies for managing HIV disease – therapies that require comprehensive insurance coverage of costly new pharmaceuticals, sophisticated viral load testing, and access to providers experienced in the management of HIV disease. It is more important than ever that individuals with AIDS or HIV disease obtain or maintain health insurance coverage. Thus, AIDS advocates must work for broad interpretations of federal laws that protect health insurance coverage for people with AIDS and HIV disease, in particular the Americans with Disabilities Act (ADA), HIPAA, and the Employee Retirement Income Security Act (ERISA).

⁵ [cite to public law section.]

I. INSURANCE PROTECTIONS UNDER THE AMERICANS WITH DISABILITIES ACT

There is a troubling contradiction within the Americans with Disabilities Act (ADA). Its stated purpose is to ~~redress~~ the many different forms of discrimination that individuals with disabilities face, discrimination that ~~ranges~~ from "outright exclusion" to being relegated to receiving lesser services, benefits, jobs, and other opportunities.⁶ The ADA was intended to reach into all facets of societal life, including (but not limited to) the employment sector, housing, public accommodations and services, education, and health care.⁷ Its goal is broad: "to assure equality of opportunity, full participation, independent living, and economic self-sufficiency" for individuals with disabilities.⁸

But the same statute enacted to eliminate discrimination on the basis of disability also expressly condones virtually all forms of disability-based discrimination in health insurance benefits, including health insurance provided as an employment benefit, government-funded insurance such as Medicaid and Medicare, and health insurance policies purchased by individuals.⁹ Health insurance is a condition precedent to "full participation, independent living, and economic self-sufficiency."¹⁰ Regulation of insurance benefits is, as one of those involved in enacting the ADA succinctly stated, the area in which the ADA is the weakest.¹¹ The contradiction results, as will be explained later, from a political compromise in which Congress agreed

⁶ 42 U.S.C. § 12101(a)(5) (Supp. 1998).

⁷ 42 U.S.C. § 12101(3) (Supp. 1998).

⁸ 42 U.S.C. § 12101(a)(8) (Supp. 1998).

⁹ Institute of Medicine, *Employment and Health Benefits: A Connection at Risk* 28 (1993)

¹⁰ 42 U.S.C. § 12101(a)(8) (Supp. 1998).

¹¹ Don Fersh & Peter W. Thomas, *Complying with the Americans with Disabilities Act: A Guidebook for Management and People with Disabilities* 124 (1993) (quoting Lex Frieden, the former director of the National Council on Disability).

to permit discrimination in insurance underwriting and classification in order to assuage insurance industry lobbyists and self-insured employers. These powerful interests understood the ADA's potential to regulate traditional health insurance practices in unprecedented ways, and were not about to acquiesce in it. Congress "did not want insurance to be a stumbling block to the passage of the ADA."¹² Thus, the ADA includes a broad exemption – or "safe harbor" – for insurance practices that are consistent with state insurance laws.¹³

Because of the "safe harbor," the ADA provides only minimal protections against disability-based discrimination in health insurance. While minimal regulation is the intended result of the "safe harbor," it creates a fundamental and, it will be argued, an unacceptable contradiction with the broad purposes of the ADA. But even this minimal regulation announces an important principle: that health insurance is both a system for the delivery of medical care and an important economic right in this society, a system and a right to which the basic protections of the ADA should extend.

This section will examine the conflict in first principles that led to the ADA's safe harbor for insurance classification in Part A. Part B discusses the specific protections against disability-based discrimination in health insurance benefits that the ADA provides.¹⁴ Part C examines how the courts have dealt with challenges under the ADA to employers' and insurance companies' coverage decisions. Part D illustrates how the insurance exception conflicts with the purposes of the ADA, and why this conflict is especially troubling given the role of employer-provided health insurance benefits in our national health care delivery

¹² *Id.* at 124 (quoting Lex Frieden).

¹³ 42 U.S.C. § 12201(c) (Supp. 1998).

¹⁴ The focus of the Paper is on how Title I of the ADA implicates the ability of employers and their health insurers to design and structure health care benefit plans, and not on how health insurance considerations enter into an employer's decision to hire or discharge an employee because of the health care costs an employee poses. Such discrimination is prohibited by the ADA. 42 U.S.C. § 12112 (Supp. 1994).

system. Part E suggests avenues for mitigating the conflict.

A. A CONFLICT OF FIRST PRINCIPLES AND A COMPROMISE

The Americans with Disabilities Act (ADA) of 1990 is unprecedented civil rights legislation by virtue of its scope and the unique obligations it creates. Most relevant to the current discussion is that the ADA is the first federal civil rights legislation that purports to regulate the substance of health insurance coverage, including employer-provided health insurance benefits under Title I,¹⁵ public health insurance (such as Medicaid [and Medicare]) under Title II,¹⁶ and insurance companies (and insurance offices) as public accommodations under Title III.¹⁷ Heretofore, federal civil rights legislation placed virtually no restrictions on the ability of employers and insurance companies to make disability-based distinctions when deciding which risks to insure, how much to indemnify them, and what premiums to charge for coverage. Thus, in the area of health insurance, the ADA is truly groundbreaking. For the first time employers and their health insurers are encountering at least minimal limitations (though not many more than pre-ADA, as will be demonstrated) on their ability to discriminate among disabilities in the provision of health insurance to employees. The ADA's protections even extend to self-insured¹⁸ health plans, which are exempted from

¹⁵ 42 U.S.C. § 12101 *et. seq.*

¹⁶ 42 U.S.C. § 12131 *et. seq.* For an examination of the impact of Title II on *public* health insurance, particularly Oregon's proposal to ration medical services for the state's Medicaid recipients, *see* James V. Garvey, Note, Health Care Rationing and the Americans with Disabilities Act of 1990: What Protection Should the Disabled Be Afforded?, 68 Notre Dame L. Rev. 581 (1993) (analyzing the legality, under Title II of the ADA, of Oregon's health care rationing plan and concluding that the Oregon plan denies the disabled meaningful access to benefits and services).

¹⁷ 42 U.S.C. § 12181 *et. seq.*

¹⁸ A self-insured health plan is one in which an employer funds its own reserve for paying the health care claims of its employees, and is responsible for bearing all of the costs of employees' health insurance. Alan I. Widiss, To Insure or Not to Insure Persons Infected with the Virus that Causes AIDS, 77 Iowa L. Rev. 1617, 1686 (1992). It is not really insurance, since the employer does not transfer risks to an insurer; the employer instead spreads the risk over its own enterprise. Thus, self-insurance is more aptly called risk retention. Robert E. Keeton & Alan I. Widiss, Insurance Law § 1.3(b), at 13-14 (1988). Some self-insuring employers, however, "reinsure" to protect themselves financially for claims above a certain amount.

state regulation because they are governed by the Employee Retirement Income Security Act (ERISA), which the Supreme Court has held pre-empts all state regulation of self-funded insurance plans.¹⁹

1. The Conflict

There are both philosophical and practical problems in extending the ADA's antidiscrimination provisions to health insurance. The purpose of the ADA is to eliminate discrimination on the basis of disability in all aspects of employment, [government services], and public accommodations. But health insurance underwriting and risk management depends upon making disability-based distinctions and discriminating against those disabilities for which the risks will likely require higher expenditures by insurers.²⁰ The benefits²¹ arrangements that self-insured employers and traditional health insurers regularly use to manage

In contrast, under traditional employer-provided health insurance arrangements the employer pays a premium to an insurance company on behalf of its employees. The premium is the price an employer pays to the insurer to transfer the responsibility for health care costs to the insurer. See generally Keeton & Widiss, *supra*, § 1.3(b), at 11. Premiums are set based on the group's past claims experience ("experience rating") or anticipated future claims experience. The insurance company is then responsible for paying the health claims of the employees. See, e.g., Institute of Medicine, *supra* at 111-13; see also Mark H. Jackson, Health Insurance: the Battle Over Limits on Coverage, in *AIDS Agenda: Emerging Issues in Civil Rights* 147, 148 (Nan D. Hunter & William B. Rubenstein eds. 1992).

¹⁹ See, e.g., *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that ERISA's pre-emption provision was intended to displace all state laws that fall within its sphere, even state laws that are consistent with ERISA's substantive requirements); see also *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (holding that ERISA pre-empts application of a state anti-subrogation law because the law relates to an employee benefit plan governed by ERISA); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987) (holding that common law contract and tort claims were pre-empted by ERISA because the lawsuit raising them related to an employee benefit plan); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding all state laws relating to employee benefit plans are pre-empted by ERISA). Notwithstanding wide-spread criticism of the anomalous regulation of self-insured plans created by the Court's interpretation of ERISA, see *FMC Corp. v. Holliday*, 498 U.S. 52, ___ (1990) (Stevens, J., dissenting) (arguing that if Congress had meant to treat insured and self-funded plans differently, it would have explicitly said so), to date Congress has not amended ERISA. Consequently, many employers have moved to self-insured health plans in order to avoid state regulation, which is more extensive than ERISA's minimal protections. Jackson, *supra* note 17, at 162-63. [However, several bills introduced in the current Congress would amend ERISA to subject self-insured plans to state insurance regulation. Cite to examples.]

²⁰ See, e.g., Jackson, *supra* note ___, at 149.

²¹ Benefits in this context means both how much of each kind of loss per occurrence an insurer will cover, and how much overall financial protection an insurer will provide. Institute of Medicine, *supra* note ___, at 43.

their risks – such as copayments, lifetime benefits caps, charging different premiums to insure individuals or groups with dissimilar risks, and limiting the number and types of treatments or procedures reimbursed²² – have disproportionate effects on individuals with disabilities.²³

Risk classification and management practices have two firm doctrinal foundations. One is insurance law and theory, which posits that insurers must classify risks, based on actuarial data and experience, and consequently discriminate among risks—insuring some but not others, or providing more extensive loss protection for one risk as compared to another.²⁴ Another doctrinal foundation is contract law. An insurance policy is a contract,²⁵ and when structuring group health care coverage for employees or an individual, employers or an individual may contract for whatever level of coverage, limitations, and exclusions they and the insurer can agree upon (or, in the case of self-insured employers, whatever level the employer and employee agree upon, though in reality employees have little input into the contract).²⁶ While state insurance laws typically place some limitations on the ways in which health insurers may discriminate (such as on the basis of sex, race, etc.),²⁷ overall those health insurers which are regulated by state law enjoy great

²² Isbell, *supra* note __, at 26-28 (describing methods employer health plans utilize to manage health care costs and transfer them to employees).

²³ Chai R. Feldblum, Implementation of the ADA: the Employment Sector, *in* The ADA: An Early Look at Implementation __ (Jane West ed.) [manuscript at 46].

²⁴ Institute of Medicine, *supra* note __, at 73; Jackson, *supra* note __, at 155.

²⁵ See, e.g., Keeton & Widiss, *supra* note __, § 1.1(b), at 4 (describing insurance as a contract).

²⁶ Jackson, *supra* note __, at 155; Widiss, *supra* note __, at 1685 n.286.

²⁷ See, e.g., Cal. Insurance Code § 10140(c) (West 1993 & Supp. 1995) (stating that no health insurer can discriminate in its risk classification and premiums on the basis of race, color, religion, national origin, ancestry, or sexual orientation). Notably, California prohibits discrimination on the basis of disability, with the broad proviso that such discrimination is permissible if it "is based on sound actuarial principles or is related to actual or reasonably anticipated experience." Cal. Insurance Code § 10144; Ill. Ann. Stat. ch. 215, para 5/424 (Smith-Hurd 1993 & Supp. 1994) (stating that insurers may not discriminate "between individuals or risks of the same class or of essentially the same hazard and expense [element] because of race, color, religion, or national origin of such insurance risks or applicants"); see also Jackson, *supra* note 17, at 156, 159.

latitude in discriminating among diseases and disabilities.

There are sound reasons that employers and health insurers use these risk management strategies. The underlying rationale draws from the very purpose of risk discrimination. If employers and health insurers cannot control how much of the cost of medical care they will cover, or transfer some of the costs of health care services to employees through copayments, lifetime benefits caps and other cost-sharing devices, then premiums for an entire employer group will be greater (perhaps prohibitively greater) and the level of coverage lower, especially for smaller groups in which there are fewer individuals among whom to spread health care costs.²⁸ In the case of self-insured plans, the costs of fully covering even a few high-cost diseases such as AIDS or cancer could wipe out the fund's financial reserves and threaten the coverage of all employees.²⁹ Higher premiums could mean that some employers, especially smaller employers, simply would not offer health insurance coverage for their employees.³⁰ The result would be more uninsured Americans.³¹ But if employers and insurers are allowed to control how much risk they assume, premiums remain lower and more affordable, and arguably more individuals will receive employer-provided health care benefits or can afford to purchase an individual health insurance policy.³²

²⁸ Jackson, *supra* note __, at 149; Widiss, *supra* note __, at 1627, 1732.

²⁹ Judith K. Barr & Robert A. Padgug, Employers and AIDS: Meeting the Health Care Benefit Needs of People with HIV Disease, 3 Cornell J. L. & Pub. Pol'y 83, 103 (1993).

³⁰ Institute of Medicine, *supra* note __, at 214 (stating that cutting or eliminating health benefits is the "key" cost containment strategy for smaller employers).

³¹ Barr & Padgug, *supra* note __, at 103.

³² For instance, if a Blue Cross plan is able to cap lifetime benefits for all disabilities at \$500,000 instead of \$1 million, it can offer lower premiums because it would be assuming less risk. See George Raine, Blue Cross Causes a Stir with New Offer, San Francisco Examiner, Jan. 28, 1994, at A4 (describing a Blue Cross plan with these features).

Moreover, in the context of employer-provided insurance, there is a strong policy argument for continuing to allow employers broad discretion in discriminating among risks. It is clear beyond cavil that health care costs must be reduced (or their growth limited), and employers are the logical agents to engage in cost control – first, because they have the financial incentive to do so, since they are largely bearing the costs now, and second, because employer-based health insurance covers roughly two-thirds of the population,³³ giving employers extraordinary bargaining power vis a vis health care providers and insurers. It is thus counterproductive to severely restrict employer's ability to economize in their health care benefits spending if the goal is lower aggregate health care costs.³⁴

The conflict between the necessity of risk discrimination in health insurance on the one hand, and the desire not to make disability-based distinctions in the provision of health care insurance (or at least make them more equally) on the other, is exacerbated by the ADA but is by no means new. There has always been an underlying tension between honoring traditional insurance principles and the norm of providing health care to all who need it, a norm based on the common understanding that in many (if not most) cases illness and injury are the result of factors beyond an individual's control, and *ex ante* can happen to anyone.³⁵

2. The Compromise

The broad protections of the ADA could have potentially resolved this tension by forbidding the use of disability-based distinctions in employer-provided health insurance. The general prohibitions in Titles I, II

³³ See *supra* note __ and accompanying text.

³⁴ See generally Clark C. Havighurst, Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?, 140 U. Pa. L. Rev. 1755, 1801-04 (1992).

³⁵ Institute of Medicine, *supra* note __, at 167, 180.

and III, if read literally and given their full effect, could logically and quite easily be interpreted as prohibiting the disability-based distinctions long employed by insurers in their risk classification and management schemes. The insurance industry understood this full well, as did Congress.³⁶ The industry's opposition to the possibility of this unprecedented regulation of health insurance practices threatened the ADA's passage.³⁷ Understanding that they lacked the political support for this application of the ADA, and to appease the insurance industry's lobbyists, disability rights advocates made a political compromise. The result is the "safe harbor" in § 501(c).³⁸

The purpose and effect of § 501(c) (discussed in greater detail below) is to allow employers and health insurers to engage in almost all of the risk underwriting, classification, and management practices post-ADA as they could pre-ADA, subject to some important limits.³⁹ Section 501(c) also clarifies that self-insured plans are still governed by the ERISA pre-emption, and are not subject to state insurance regulation.⁴⁰ This provision was added to § 501(c) shortly before the Senate passed the ADA to alleviate concerns of self-

³⁶ As the House Education and Labor Committee Report notes, "this legislation could arguably find violative of its provisions any action 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." H.R. Rep. No. 485, 101st Cong., 2nd Sess., pt. 2, at 138 (House Education and Labor Committee Report).

³⁷ Feldblum, Implementation of the ADA, *supra* note __, at 48-49.

³⁸ Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327, § 501(c) (codified at 42 U.S.C. § 12201(c) (Supp. 1998)).

³⁹ See Lawrence O. Gostin, Impact of the ADA on the Health Care System, *in* Implementing the Americans with Disabilities Act: Rights and Responsibilities for All Americans 175, 181 (Lawrence O. Gostin & Henry A. Beyer, eds. 1993) (stating that Congress intended to allow insurers and employers the same opportunities to design and administer health insurance plans that they enjoyed before passage of the ADA); see also Institute of Medicine, *supra* note __, at 185; Steven Eisenstat, Capping Health Insurance Benefits for AIDS: An Analysis of Disability-Based Distinctions Under the Americans with Disabilities Act, 10 J. L. & Pol. 1, 10-11 (1993); Eric C. Sohlgren, Note, Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law - ERISA, the Rehabilitation Act and the Americans with Disabilities Act, 24 Loy. L.A. L. Rev. 1247, 1290 (1991).

⁴⁰ "This provision is not intended to disrupt the current regulatory structure for self-insured employers. These employers may establish, sponsor, observe, or administer the terms of a bona fide benefit plan not subject to State laws that regulate insurance." 29 C.F.R. § 1630 app. 416 (1994).

insured employers that language in § 501(c) could be interpreted as applying to *all* employer benefit plans, including self-insured plans, and thus be construed as subjecting them to state regulation.⁴¹

Notwithstanding the "safe harbor," the ADA does offer critical protections against discrimination in employer-provided health insurance benefits – most importantly, protection against blatant and unjustified intentional discrimination, and against singling out one disability for disparate treatment.⁴² Given the broad, general language of the prohibitions in Titles I, II, and III and the "safe harbor," the issue Congress left to be resolved in the courts is what other particular protections can be fairly implied. As the Equal Employment Opportunity Commission (EEOC) noted, in what is surely an understatement, the "interplay between the nondiscrimination principles of the ADA and employer-provided health insurance . . . is both unique and complex."⁴³ It is this issue that is next considered.

B. THE ADA'S PROHIBITIONS ON DISCRIMINATION IN HEALTH INSURANCE BENEFITS

The language of the ADA is broad and ambiguous, and that of the "safe harbor" particularly so. The legislative history, the EEOC's regulations, and the EEOC's Interim Guidance on the application of the ADA to employer-provided health insurance shed additional light on the contours of the ADA's protections. As with most federal civil rights statutes, much of the ADA's precise protections are being fleshed out in the federal courts. But it is appropriate to first turn to the statute itself.

⁴¹ House Education and Labor Committee Report at 137; see also H.R. Rep. No. 485, 101st Cong., 2nd. Sess., pt. 3, at 70-71 (House Judiciary Committee Report).

⁴² See Feldblum, Implementation of the ADA, *supra* note __, at 49.

⁴³ EEOC Interim Enforcement Guidance on the Application of the Americans with Disabilities Act of 1990 to Disability-Based Distinctions in Employer Provided Health Insurance, N-915.002 (June 8, 1993) (hereinafter "EEOC Interim Guidance").

1. Statutory Provisions

Title I. The ADA's Title I protections cannot be invoked unless a plaintiff first establishes that she has a disability (as that term is defined by the ADA), and thus within the statute's purview. The ADA's definition of disability is purposely broad: disability is "a physical or mental impairment that substantially limits one or more" of an individual's "major life activities."⁴⁴ Neither the ADA nor the EEOC regulations list specific disabilities and conditions, out of concern that it would be difficult to be more specific *and* be comprehensive. The trade-off was made in favor of comprehensiveness.⁴⁵ Thus, the ADA's approach to defining disability is a functional one that looks not only to the existence of a physical or mental condition, but also to the impact of that condition on an individual's daily life. The definition is structured to acknowledge that anyone, at any time in their lives, can experience either a temporary or permanent disabling condition.

The provisions relating to employer-provided health insurance benefits are found in Title I of the ADA, which covers discrimination on the basis of disability in employment.⁴⁶ There are three interrelated sources

⁴⁴ 42 U.S.C. § 12102(2) (Supp. 1994). Disability can also mean an individual has a history of a disability (as defined above), 42 U.S.C. § 12102(2)(B), or is perceived by others as being disabled. 42 U.S.C. § 12101(2)(C). The Equal Employment Opportunity Commission's implementation regulations for the ADA further define the key terms in the statute's definition of disability. "Physical impairment" means "[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine . . ." 29 C.F.R. § 1630.2(h)(1) (1994). "Mental impairment" means "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific disabilities." 29 C.F.R. § 1630.2(h)(2). "Major life activities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." 29 C.F.R. § 1630.2(i).

⁴⁵ Chai R. Feldblum, *Antidiscrimination Requirements of the ADA, in Implementing the Americans with Disabilities Act* 35, 38 (Larry O. Gostin & Henry A. Beyer eds. 1993).

⁴⁶ "Employer" is defined under the ADA as "a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and

for the prohibition against discrimination in health care benefits. Taken together, they evidence Congress' intent to bring all health insurance arrangements within the aegis of the ADA, regardless of which of the myriad of different ways employers provide health care coverage for their employees.⁴⁷

The first source is the provision that prohibits employers from discriminating against a qualified individual with a disability because of the individual's disability with regard to, *inter alia*, employee compensation and "other terms, conditions, and privileges of employment."⁴⁸ Both the ADA's legislative history and the EEOC regulations state that the "terms, conditions, and privileges of employment" language encompasses employer-provided benefits,⁴⁹ including health insurance benefits.⁵⁰

The second source is the provision forbidding employers from entering into contractual relationships which have the effect of discriminating against the employer's own employees.⁵¹ The purpose of this provision is

any agent of such person." 42 U.S.C. § 12111(A)(5) (Supp. 1994). "Person" is defined the same as it is in Title VII of the Civil Rights Act of 1964. 42 U.S.C. § 12111(7). That statute defines "person" as "one or more individuals, governments, governmental agencies, political subdivisions, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated organizations, trustees, trustees in bankruptcy, or receivers." 42 U.S.C. § 2000e(a). The federal government is not an employer under the ADA. 42 U.S.C. § 12111(5)(B)(1).

⁴⁷ Ted Storer, Comment, *The Americans with Disabilities Act: Will the Insurance Field Change?*, 20 Ohio N.U. L. Rev. 1031, __ (1994) (noting that insurance was regulated by the ADA because it is "a major category of discrimination faced by people with disabilities"); Widiss, *supra* note __, at 1692.

⁴⁸ 42 U.S.C. § 12112(a).

⁴⁹ 29 C.F.R. § 1630.4(f); House Education and Labor Committee Report at 55. The House Education and Labor Committee Report specifically states that the "anti-discrimination mandate applies in . . . fringe benefits available by virtue of employment, whether or not administered by the [employer] . . ." *Id.*

⁵⁰ In its Interim Guidance, the EEOC specifically states that health insurance is a fringe benefit available by virtue of employment, and subject to ADA prohibitions. EEOC Interim Guidance, *supra* note __, at 2.

⁵¹ The provision states that discrimination includes "participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by [Title I] . . ." 42 U.S.C. § 12112(b)(2); see also 29 C.F.R. § 1630.6; EEOC Interim Guidance, *supra* note __, at 2. See also House Education and Labor Committee Report at 59-60 (stating that the "basic intent of this provision is that [an] entity may not do through a contractual provision what it may not do directly"); House Judiciary Committee Report at 36.

to prohibit an employer from using a contractual arrangement to discriminate in a way that would be prohibited if the employer did it directly. Contractual arrangements with entities providing benefits to employees are specifically included in the prohibition.⁵² Thus, if an employer contracted with a private insurer to provide group health benefits for its employees and the insurer's health plan contained a lifetime benefit cap that applied only to employees with AIDS – which the EEOC has consistently found in consent decrees to be a violation of the ADA – then the employer would be liable for the violation through the contractual relationship.⁵³ If that insurer is found to have violated the ADA, then in accordance with the terms of this provision, the employer could be liable as well.

The third source is the prohibition against employers limiting, segregating, or classifying employees in ways that adversely affect an individual's employment opportunities.⁵⁴ The theory is that health plan limitations may inappropriately limit, segregate or classify employees.⁵⁵

⁵² "[S]uch relationship includes a relationship with an employment or referral agency, labor union, *an organization providing fringe benefits to an employee of the covered entity*, or an organization providing training and apprenticeship programs . . ." 42 U.S.C. § 12112(b)(2) (emphasis added).

⁵³ Some plaintiffs have argued that health insurance plans are themselves employers and subject to Title I liability, on the theory that with regard to this particular function the health insurers are agents of the employer. Courts presented with the question have reached contrary results. Compare Carparts Distribution Center v. Automotive Wholesaler's Ass'n of New England, 37 F.3d 12, 16-18 (1st Cir. 1994) (conceding that a health plan could be an employer under the ADA, but remanding because the record was incomplete to determine whether the health plan in that case was an employer) and Holmes v. City of Aurora, 1995 WL 21606 (N.D. Ill. 1995) (holding that city pension fund should be considered an employer under the ADA in a suit by an insulin-dependent diabetic alleging discriminatory denial of coverage) with Pappas v. Bethesda Hosp. Ass'n, 1994 U.S. Dist. LEXIS 11225 *8-9 (holding with no analysis that a health plan was not an employer under the ADA) and Dodd v. Blue Cross and Blue Shield Ass'n, 835 F. Supp. 888, 891 (E.D. Va. 1993) (holding health insurer was not an employer under the ADA and therefore could not be sued).

⁵⁴ "Discriminates" includes "limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee." 42 U.S.C. § 12112(b)(1) (Supp. 1994).

⁵⁵ EEOC Interim Guidance, *supra* note __, at 3.

Title II. The language of Title II, which prohibits discrimination by public entities, tracks the language of § 504 of the Rehabilitation Act of 1973.⁵⁶ Specifically, Title II provides that:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.⁵⁷

The ADA defines "public entity" to include any state or local government, or any department, agency, or instrumentality of a state or local government.

Most courts that have considered the question have ruled that Title II provides a cause of action for employment discrimination for public employees.⁵⁸ In reaching its conclusion, the Eleventh Circuit Court of Appeals, in Bledsoe v. Palm Beach County Soil and Water Conservation District,⁵⁹ relied on the extensive legislative history addressing this question and the Department of Justice's (DoJ's) regulations. The regulations clearly state that "no qualified individual with a disability shall, on the basis of disability, be subjected to discrimination in employment under any service, program, or activity conducted by a public entity."⁶⁰ Furthermore, the DoJ regulations expressly state that the requirements of Title I govern claims of employment discrimination brought under Title II.⁶¹

Title III. Some plaintiffs have sued insurance companies under Title III of the ADA, which prohibits

⁵⁶ 29 U.S.C. § 704. The Rehabilitation Act prohibits the federal government and any entity receiving federal funding from discriminating against otherwise qualified individuals with disabilities.

⁵⁷ 42 U.S.C. § 12132.

⁵⁸ Doe v. University of Maryland Med. Sys. Corp., 50 F.3d 1261, 1264-65 n.9 (4th Cir. 1995); Rogers v. Department of Health & Env'tl. Control, 985 F. Supp. 635 (D.S.C. 1997).

⁵⁹ 133 F.3d 816 (11th Cir. 1998).

⁶⁰ Id. at 822 (quoting 28 C.F.R. § 35.140(a)).

⁶¹ 28 C.F.R. § 35.140(b).

discrimination in public accommodations,⁶² on the theory that since insurance offices are within the ambit of Title III as places of public accommodation, insurers may therefore not discriminate in the provision of an insurance policy itself. Numerous courts have been presented with this question, including three of the 11 Circuit Courts of Appeals. The majority of courts have concluded that insurance policies themselves, not just insurance offices, are covered by Title III. These decisions are discussed fully in the following section.

Title IV. As discussed above, the potentially broad reach of the above provisions into the realm of health insurance is circumscribed by the "safe harbor" in Title IV.⁶³ The "safe harbor," as explained before, does just that: it excepts established insurance practices from the ADA's prohibitions, subject to important provisos explored later. The "safe harbor" sets out three areas of insurance that the ADA 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
- (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter.⁶⁴

⁶² 42 U.S.C. § 12181 *et. seq.*

⁶³ 42 U.S.C. § 12201 *et. seq.*

⁶⁴ 42 U.S.C. § 12201(c); see also 29 C.F.R. § 1630.16(f) (1994).

2. EEOC Interpretation of the "Safe Harbor"

The language of the "safe harbor" is vague, and the language itself offers little insight into when and how employers and health insurers may permissibly use disability-based distinctions. [The legislative history adds somewhat more depth to the implications of the insurance exception. The EEOC's regulations largely restate the legislative history.] The EEOC's Interim Guidance on the application of the ADA to employer-provided health insurance, however, provides the most substantive agency interpretation of what disability-based distinctions would violate the ADA. It also sets out a framework for analyzing allegations that an employer's health insurance plan violates the ADA.⁶⁵ While the EEOC's interpretation of the insurance exception is the most thorough to date, as internal EEOC guidance that is provided to EEOC investigators, it is not binding on courts.⁶⁶

It is clear that the force and effect of the insurance exception turns on the meaning of subterfuge in the last sentence of the "safe harbor." In the Interim Guidance, the EEOC expressly rejects interpreting

⁶⁵ The framework is as follows:

Whenever it is alleged that a health-related term or provision of an employer provided health insurance plan violates the ADA, the first issue is whether the challenged term or provision is, in fact, a disability-based distinction. If the Commission determines that a challenged health insurance plan term or provision is a disability-based distinction, the [employer] will be required to prove that that disability-based distinction is within the protective ambit of Section § 501(c) of the ADA Consequently . . . the [employer] will be required to prove that: 1) the health insurance plan is either a bona fide insured health insurance plan that is not inconsistent with state law, or a bona fide self-insured health insurance plan, and 2) the challenged disability-based distinction is not being used as a subterfuge.

EEOC Interim Guidance, *supra* note __, at 3-5. "Bona fide" as interpreted by the EEOC is a weak standard. To meet it, an employer need only show that the health insurance plan "exists and pays benefits," and that the plan's terms have been adequately communicated to employees. *Id.* at 10-11.

⁶⁶ *Watson v. Fort Worth Bank & Trust*, 487 U.S. 977, 995 n.3 (1989) (plurality opinion by O'Connor, J.) (describing the EEOC's guidelines for employment selection procedures as "a rule of thumb" for courts, and stressing that courts should take a case-by-case approach).

subterfuge as having the same meaning as under the Age Discrimination in Employment Act (ADEA),⁶⁷ as interpreted by the Court in Ohio Public Employees Retirement System v. Betts.⁶⁸ In Betts, the Court held that subterfuge, as applied to a fringe benefit plan, meant a *specific intent* to discriminate in some non-fringe aspect of the employment relationship.⁶⁹ At least one insurance scholar has implicitly accepted that subterfuge under the ADA requires proving an intent to discriminate.⁷⁰

Instead, the EEOC defines subterfuge as meaning something closer to pretextual discrimination – a disability-based distinction that is without support from actuarial or cost data.⁷¹ The EEOC relied on the ADA's legislative history and on two other factors it found decisive: first, that the ADA expressly prohibits discrimination in fringe benefits, while the ADEA does not; and second, that the ADA expressly prohibits discrimination in fringe benefit plans that existed even before the effective date of the ADA, as well as post-ADA.⁷² In contrast, the ADEA does not.⁷³

Based on this interpretation of subterfuge, and on the legislative history and the EEOC's Interim Guidance,

⁶⁷ 29 U.S.C. § 621 *et. seq.*

⁶⁸ 492 U.S. 158 (1989).

⁶⁹ *Id.* at 181 (emphasis supplied).

⁷⁰ Widiss, *supra* note __, at 1695 n.320.

⁷¹ EEOC Interim Guidance, *supra* note __, at 11-12 & n. 14 (stating that subterfuge means a disability-based distinction that is "not justified by the risks or costs associated with the disability," based on "legitimate" actuarial data or actual or anticipated experience); see also Sohlgren, *supra* note __, at 1291 (reasoning that there would be no finding of subterfuge if risk classifications are based on actuarial principles, or actual or reasonably anticipated costs).

⁷² *Id.* See also Feldblum, Implementation of the ADA, *supra* note __, at 59; Chai R. Feldblum, Workplace Issues: HIV and Discrimination, in *AIDS Agenda: Emerging Issues in Civil Rights* 271, 288 n.98 (Nan D. Hunter & William B. Rubenstein, eds. 1992).

⁷³ EEOC Interim Guidance, *supra* note __, at 9 & n.10.

the parameters of permissible disability-based distinctions from the EEOC's perspective can be described:

Pre-existing condition clauses. Pre-existing condition clauses are policy provisions that deny coverage for a specified time period (usually twelve to twenty-four months) for physical or mental conditions that exist prior to the effective date of coverage under a health insurance plan.⁷⁴ They are permissible so long as they are not used as a subterfuge to evade the purposes of the ADA, even though they may adversely affect individuals with disabilities.⁷⁵

Limits on procedures or treatments. Offering a health insurance policy that limits coverage for the *number* of procedures or treatments, or limits coverage for *types* of procedures or treatments, is probably permissible. But such limits must be universal—that is, they must apply equally to all employees, both those with disabilities and those with no disabilities.⁷⁶ Therefore, limiting the number or types of procedures or treatments covered for a *particular* disability (e.g., denying a hemophiliac coverage for heart surgery when heart surgery for other individuals is covered), as opposed to a permissible across-the-board limit for all employees, would not be permissible.⁷⁷ As another example, if an employer-provided health insurance plan limited the number of blood transfusions per year to five, that limit must apply to all employees, and not just to specific disabilities the treatment of which require a significant

⁷⁴ Institute of Medicine, *supra* note __, at 341.

⁷⁵ EEOC Interim Guidance, *supra* note __, at 7; 29 C.F.R. § 1630 app. 404; House Education and Labor Committee Report at 59; House Judiciary Committee Report at 37-38; see also Feldblum, Workplace Issues, *supra* note __, at 288; Gostin, *supra* note __, at 182.

⁷⁶ EEOC Interim Guidance, *supra* note __, at 7; 29 C.F.R. § 1630 app. 404-05; House Education and Labor Committee Report at 59; House Judiciary Committee Report at 38; see also Feldblum, Implementation of the ADA, *supra* note __, at 57-58; Feldblum, Workplace Issues, *supra* note __, at 288-89.

⁷⁷ House Education and Labor Committee Report at 59; House Judiciary Committee Report at 38; Feldblum, Workplace Issues, *supra* note __, at 289.

number of blood transfusions, such as hemophilia.⁷⁸

Maximum lifetime benefit caps. Universal lifetime caps on benefits for individual employees are permissible.⁷⁹ The EEOC Interim Guidance specifically permits caps,⁸⁰ and gives an example of a \$25,000 lifetime cap on all physical conditions. If applied to an insured with cancer, the EEOC would rule such a cap permissible, even though it is insufficient to cover the costs of treatment for cancer, because the cap applies to all insureds and does not single out a particular disability.⁸¹

Caps or limits on a particular disability or disabilities. Limiting or denying health insurance to an employee *because* of that employee's diagnosis or disability, while continuing to offer coverage for other employees, is in all likelihood a violation of the ADA.⁸² Both the EEOC and courts that have considered challenges to lifetime caps on the treatment of AIDS,⁸³ but not on other diseases or disabilities which cost the same to treat, have found that such caps violate the ADA (see discussion below).⁸⁴ Similarly,

⁷⁸ EEOC Interim Guidance, *supra* note __, at 7.

⁷⁹ The legislative history permits it under the language condoning limits on number and types of treatment that apply equally to all disabilities. House Education and Labor Committee Report at 59; House Judiciary Committee Report at 38. See also 29 C.F.R. § 1630 app. 404-05 (1994).

⁸⁰ EEOC Interim Guidance, *supra* note __, at 7.

⁸¹ *Id.*

⁸² *Id.*; House Education and Labor Committee Report at 59; House Judiciary Committee Report at 38; Feldblum, Workplace Issues, *supra* note __, at 289.

⁸³ The EEOC's ADA regulations, and numerous courts, accept that AIDS and HIV disease is a disability within the terms of the ADA. See, e.g., Carparts Distribution Center v. Automotive Wholesaler's Ass'n of New England, 37 F.3d 12 (1st Cir. 1994) (assuming without explicitly deciding that AIDS was a disability). Recently, however, some courts have begun to question that assumption. See, e.g., Runnebaum v. NationsBank, 123 F.3d 156 (4th Cir. 1995) (en banc), in which a majority of the panel ruled that HIV infection is not per se a disability unless the plaintiff demonstrates that it substantially impairs a major life activity.

⁸⁴ EEOC Interim Guidance, *supra* note __, at 8.

if an employer imposed a pre-existing condition limitation on all blood-related disorders, it would probably violate the ADA unless the employer could demonstrate that the limitation was not a subterfuge to evade the ADA.⁸⁵ The EEOC (with support from the legislative history), however, would permit disability-specific limitations where the limitation is justified by legitimate actuarial data, or actual or anticipated experience, and disabilities with similar actuarial or experiential data are treated similarly.⁸⁶ The EEOC Interim Guidance sets this out as an employer defense to an allegation that a disability-based distinction is a subterfuge.⁸⁷ Thus, if an employer wanted to exclude coverage for AIDS and HIV, which has an estimated lifetime cost per patient of \$119,000,⁸⁸ then the employer must also exclude coverage for all other conditions with estimated lifetime costs per patient of approximately \$119,000 or more. But the employer must come forward with sound actuarial data to support this limitation.⁸⁹

The EEOC would also approve of disability-specific limits on coverage where the limitation is necessary to ensure the financial soundness of the health plan, or to prevent an "unacceptable change" in the health plan (e.g., a drastic increase in premiums, or significant reduction in level and scope of coverage) that would have the effect of "making the health insurance plan effectively unavailable to a significant

⁸⁵ Id.

⁸⁶ Id. at 11-12. The House Education and Labor Committee Report states that a person with a disability may not be subjected to different terms or conditions of insurance *on the basis of disability alone, if the disability does not pose increased risks*. House Education and Labor Committee Report at 136-37 (emphasis added). The corollary is that if a disability *does* pose an increased financial risk to a health insurance plan, then an employer may discriminate against that disability through coverage provisions. See also Feldblum, *Workplace Issues*, *supra* note __, at 288 n. 100; Widiss, *supra* note __, at 1693-96.

⁸⁷ EEOC Interim Guidance, *supra* note __, at 11-12; see also Eisenstat, *supra* note __, at 12; Lizzette Palmer, Comment, ERISA Preemption and its Effects on Capping the Health Benefits of Individuals with AIDS: A Demonstration of Why the United States Health and Insurance Systems Require Substantial Reform, 30 Hous. L. Rev. 1347, 1378-79 (1993).

⁸⁸ Michael T. Isbell, AIDS and Access to Care: Lessons for Health Care Reformers, 3 Cornell J. L. Pub. Pol'y 7, 13 (1993).

⁸⁹ See Eisenstat, *supra* note __, at 36-39 (discussing the cost-based justification under the EEOC's Interim Guidance and how "comparable costs" might be analyzed).

number of other employees, resulting in adverse selection,⁹⁰ or "making the health plan so unattractive that the employer cannot compete in recruiting and maintaining qualified workers due to the superiority of health insurance plans offered by other employers in the community."⁹¹ Again, these are justifications employers can offer for a disability-based distinction in response to allegations of subterfuge.⁹² The legislative history, however, provides no support for the EEOC's "financial necessity" exception.

Universal plan limitations that have a disproportionate effect on a particular disability. It is unclear whether limitations that are universally applied, but have a disproportionate effect on individuals with disabilities, would be permissible. There is authority for both permitting such claims and for rejecting them. This conflicting authority is explored in greater detail below. The EEOC Interim Guidance indicates that the EEOC would probably permit any limits on medical procedures or treatments provided they are applied universally, regardless of any disparate impact they might have on a particular disability.⁹³ The legislative history, however, suggests that it would be subterfuge, or an effective denial of coverage of a disability, where a health plan did not cover any of the procedures and treatments

⁹⁰ EEOC Interim Guidance, *supra* note __, at 12-13 & n.16. A concern commonly voiced when limitations on an employer's use of disability-based distinctions are proposed is that if employers cannot discriminate among risks and are required to treat all employees alike, then a disproportionate number of high utilizers of health care benefits will seek insurance from that particular employer. This phenomena is known as adverse selection. Keeton & Widiss, *supra* note __, § 1.3(c), at 14-15. With regard to the insurance provisions of the ADA, the concern about adverse selection might be overstated, for two reasons. First, any limitations that the ADA places (or could be construed to place) on disability-based distinctions in health insurance will apply to *all* employers and their insurers. Therefore there would be little incentive for high-risk individuals to seek coverage through employment by one employer versus another, because if employer A could not permissibly cap AIDS at \$25,000, neither could employer B. Both would offer approximately the same level of coverage for AIDS as for other actuarially similar diseases, or both would place the same limits on those diseases. Second, if there was indeed any discernible adverse selection problem, an insurer could adjust the employer's premiums. *Id.* The ADA places no restrictions on how premiums are set, provided the minimal requirements of the insurance exception are met.

⁹¹ *Id.* at 12-13; Feldblum, Implementation of the ADA, *supra* note __, at 66-67.

⁹² EEOC Interim Guidance, *supra* note __, at 11; see also Palmer, *supra* note __, at 1378-79.

⁹³ EEOC Interim Guidance, *supra* note __, at 5-8.

associated with treating that disability.⁹⁴ The pertinent language is in the House Judiciary Report, which (obtusely) states that it would not be permissible for an employer "to deny coverage to individuals . . . who are affected by . . . limits on coverage for procedures or treatments, for other procedures or treatments connected with their disability,"⁹⁵ and that "coverage cannot be denied entirely to a person with a disability."⁹⁶ The fair reading of this language is that it would be a subterfuge to effectively deny coverage to an individual with a disability by not covering any procedure and treatments needed for that disability, even though the particular limitations on procedures and treatments are applied to all covered individuals.

C. WHAT'S HAPPENING IN THE COURTS?

1. Procedural Issues

a. Standing Under Title I

Typically, employees who begin receiving coverage for fringe benefits when they are holding an employment position do not challenge the terms and conditions of their benefit policies until they are former employees (e.g., when they retire, or become disabled) and begin to receive benefits under the policies. In many cases involving coverage under long term disability policies, employers and insurance companies have challenged plaintiffs' standing under Title I, arguing that since the plaintiff is no longer able to perform the essential functions of his or her job because of the disability for which they are receiving benefits, the plaintiff is not a qualified individual with a disability. Many courts have upheld this defense, including the

⁹⁴ House Judiciary Committee Report at 38.

⁹⁵ Id.

⁹⁶ Id. at 71.

Sixth Circuit (Parker v. Metropolitan Life Insurance Co.,⁹⁷) , the Seventh Circuit (Equal Employment Opportunity Commission v. CNA Insurance Co.⁹⁸ (hereinafter "EEOC v. CNA"), the Eleventh Circuit (Gonzales v. Garner Food Services,⁹⁹) and numerous U.S. District Courts.¹⁰⁰

In reaching this result, courts have used a highly literal and formalistic interpretation of Title I's requirements. Only a "qualified individual with a disability" may bring a claim of disability-based discrimination under Title I. Title I defines "qualified individual with a disability" as "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds . . ."¹⁰¹ As the Sixth Circuit Court of Appeals reasoned in Parker v. Metropolitan Life Insurance Co.,¹⁰² "at the time [plaintiff] could 'perform the essential functions' of her job, she was not disabled for purposes of her long term disability claim, and therefore was not covered by the [ADA], and at the time her insurance benefits were terminated, she could no longer perform her

⁹⁷ 99 F.3d ____ (6th Cir. 1996), aff'd, 121 F.3d 1006 (6th Cir. 1997), cert. denied, 1997 U.S. LEXIS 607 (hereinafter "Parker I").

⁹⁸ 96 F.3d 1039 (7th Cir. 1996) [check subsequent history].

⁹⁹ 89 F.3d 1523 (11th Cir. 1996).

¹⁰⁰ See, e.g., Erwin v. Northwestern Mut. Life Ins. Co., No. IP 97-0703-C-B/S, LEXIS 4269 *6-11 (S.D. Ind. 1998) (dismissing plaintiff's complaint upon finding he was not a qualified individual with a disability); Fobar v. City of Dearborn Heights, No. 97-CV-71430-DT, 1998 LEXIS 2101 (E.D. Mich. 1998) (granting summary judgment to the defendant on the grounds that the plaintiff was totally disabled and therefore was not a qualified individual with a disability); Bril v. Dean Witter, Discover & Co., 986 F. Supp. 171, 176 (S.D.N.Y. 1997) (holding that the plaintiff, who was totally disabled, was not a qualified individual with a disability; the District Court issued its ruling before the Second Circuit issued a contrary decision in Castellano v. City of New York, No. 96-7920, 96-9004 CON, 96-9257, 96-9289, 96-9601, 96-9237, 1998 WL 91216 (2nd Cir. 1998), discussed below); Esfahani v. Medical College of Penn., 919 F. Supp. 832, 836 (E.D. Pa. 1996) (ruling, on a motion to dismiss plaintiff's claim, that plaintiff had no cause of action under Title I because he was totally disabled and therefore could not perform his employment duties); Hilliard v. BellSouth Medical Assistance Plan, 918 F. Sup. 1016, 1026 (S.D. Miss. 1995) (ruling that plaintiff who retired on disability has standing under Title I to challenge the terms and conditions of his employer's health plan).

¹⁰¹ 42 U.S.C. § 12111(8).

¹⁰² Parker I, 99 F.3d at 186.

job."¹⁰³ (The Sixth Circuit vacated the judgment in Parker. The plaintiff did not seek review of the dismissal of her Title I claim on rehearing. An *en banc* panel affirmed the original appeals court ruling affirming the dismissal of her Title III claim. The *en banc* opinion is discussed *infra*.)

In EEOC v. CNA, the EEOC advanced two arguments in support of standing under Title I for a former employee who challenged the 24 month limit on coverage for mental disorders under her disability insurance policy. The EEOC's primary theory was that the "employment position" a plaintiff in this situation should be considered to hold is that of "disability benefit recipient," a "position" for which there are no essential functions. The Seventh Circuit rejected that argument with little analysis, curtly noting that "an 'employment position' is a job."¹⁰⁴

Alternatively, the EEOC argued that since the ADA dictates that the "powers, remedies, and procedures" available under Title VII of the Civil Rights Act of 1964 apply to ADA claims,¹⁰⁵ former employees have standing to sue under the ADA because they have standing to sue under Title VII.¹⁰⁶ Although it found this argument "more plausibl[e]" than the first theory, the court rejected it as well. It distinguished claims by former employees under Title VII from the claim made by the plaintiff. Former employees brought claims under Title VII in situations where the employer retaliated after the employee was discharged, and the retaliatory conduct provides the necessary nexus to the employment position. In contrast, the ADA plaintiff suffered no discrimination during or after her employment. The employer's decision to provide reduced

¹⁰³ Id.

¹⁰⁴ EEOC v. CNA, 96 F.3d at 1043-44.

¹⁰⁵ 42 U.S.C. § 12117(a).

¹⁰⁶ EEOC v. CNA, 96 F.3d at 1044; see also Erwin v. Northwestern Mut. Life Ins. Co., No. IP 97-0703-C-B/S, LEXIS 4269 *10-11 (S.D. Ind. 1998) (arguing that former employees should be considered a "qualified individual with a disability" under the ADA the same way that a former employee is considered an "employee" under Title VII).

coverage for mental health benefits did not constitute discrimination.¹⁰⁷

Employers and insurers have also challenged the standing of plaintiffs who are claiming discrimination in the terms and conditions of health insurance under Title I. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an individual who is no longer an employee may continue his or her coverage under a former employer's health plan for up to 21 months. In cases where an individual covered through COBRA by a former employer's health plan brought a claim of impermissible insurance discrimination under Title I, courts have ruled that the plaintiffs have no standing because they are not a "qualified individual with a disability." In Gonzales v. Garner Food Services,¹⁰⁸ the Eleventh Circuit denied standing on this ground to the estate of a person with AIDS whose health plan capped coverage for AIDS-related treatment at \$10,000 annually and instituted a lifetime limit of \$40,000 (versus \$1 million for all other employees covered by the health plan).

The Second Circuit is the only Court of Appeals to reject the line of reasoning followed by the Sixth, Seventh, and Eleventh Circuits. In Castellano v. City of New York,¹⁰⁹ a class of city police officers and firefighters who retired on disability challenged the type of retirement benefit they were receiving. The City urged the court to adopt the precedent of the other circuit courts and rule that the plaintiffs could not bring a claim under Title I since they had retired on disability and therefore were not "qualified individuals with a disability."¹¹⁰ The court declined. It first noted that in the context of fringe benefits, the language of Title

¹⁰⁷ Id. at 1045; see also Gonzales v. Garner Food Svcs., Inc., 89 F.3d 1523, 1528 (11th Cir. 1996) (holding that the plain language of Title I limits its scope only to job applicants and current employees who are capable of performing the essential functions of a job).

¹⁰⁸ 89 F.3d 1523 (11th Cir. 1996).

¹⁰⁹ No. 96-7920, 96-9004 CON, 96-9257, 96-9289, 96-9601, 96-9237, 1998 WL 91216 (2nd Cir. 1998).

¹¹⁰ Id. at *6.

I is ambiguous on the question of when an employee has to be a "qualified individual with a disability."¹¹¹ The court examined the purpose of the "essential functions" requirement and concluded that with regard to fringe benefits that are provided post-employment, a plaintiff has standing under Title I if they were qualified when they were employed "and on that basis became entitled" to the benefits.¹¹² In essence, the court evaluated the question of whether a plaintiff was a "qualified individual with a disability" with reference to the time period in which they were employed, rather than at the point in time when they brought their claim:

Because fringe benefits are earned for actual service in employment, it is irrelevant whether former employees, otherwise eligible for fringe benefits, could also perform [the] essential functions at or after termination of their employment . . . [A]n employee's entitlement to post-employment fringe benefits arises . . . during his period of employment . . . [A] former employee with a disability who "with or without reasonable accommodation" could "perform the essential functions of the employment position" for a period sufficient to establish entitlement to an employer-related fringe benefit (i.e., who is otherwise entitled to receive a fringe benefit) is a "qualified individual with a disability" within Title I . . . for the purposes of challenging alleged discrimination in the provision of that fringe benefit."¹¹³

A District Court also declined to follow the Sixth and Seventh Circuit's reasoning on this issue, but relied on a variant of the theory offered by the Second Circuit in Castellano. In the District Court case, Lewis v. Aetna Life Insurance Company,¹¹⁴ in ruling on a motion to dismiss, the court selected a different time frame in which to determine whether the plaintiff was a "qualified individual with a disability." Instead of answering this question by looking at the time the plaintiff was disabled and actually receiving disability benefits, the court focused on the point in time when the plaintiff was offered a disability benefits plan. At that point in time, the court noted, the plaintiff was working and was a "qualified individual with a disability." The discrimination, concluded the court, "occurred when [the plaintiff] was offered a disability benefits plan

¹¹¹ Id.

¹¹² Id. at *8.

¹¹³ Id. at *8-10.

¹¹⁴ 982 F. Supp. 1158 (E.D.Va. 1997).

that provided inferior coverage for disabilities that were mental rather than physical in nature."¹¹⁵

b. Title III Claims

In numerous cases, plaintiffs have brought claims of unlawful discrimination under Title III, which prohibits discrimination in public accommodations. In some cases, plaintiffs alleging discrimination in an employer-provided insurance benefit have sued the employer under Title I and the employer's insurer under Title III. In other cases, plaintiffs have sued an insurance company only under Title III. The issue of whether Title III only prohibits discrimination in access to insurance offices (as physical places) or also prohibits discrimination in the terms and conditions of insurance policies has been one of the most frequently litigated issue in ADA insurance discrimination cases.

The Department of Justice has issued unambiguous interpretations of the scope of Title III's reach. In the preamble to the Title III regulations, DoJ strongly suggests that insurance practices are covered by Title III:

Language in the [ADA's legislative history] indicates that Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified.¹¹⁶

Moreover, in the DOJ Technical Assistant Manual, the Department interprets Title III as extending to the terms and conditions of insurance policies:

Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer. Because of the nature of the insurance business, however, consideration of disability in the sale of insurance contracts does not always constitute "discrimination." An insurer or other public accommodation may underwrite,

¹¹⁵ Id. at 1162-63.

¹¹⁶ 28 C.F.R. pt. 36, app. B, at 612.

classify, or administer risks that are based on or not considered inconsistent with State law, provided that such practices are not used to evade the purposes of the ADA.¹¹⁷

The Sixth Circuit Court of Appeal, as well as many of the District Courts that have addressed the question,¹¹⁸ have held that that insurance benefits are not public accommodations. Therefore, claims of discrimination in the provision of insurance are not actionable under Title III. The Sixth Circuit's *en banc* opinion in Parker v. Metropolitan Life Insurance Company¹¹⁹ is illustrative of the reasoning relied on by courts that have restricted Title III's prohibitions to physical spaces. The panel noted that Title III enumerates 12 categories of entities that are "public accommodations," all of which are physical places. Therefore, Title III only prohibits discrimination in access to physical places.¹²⁰ Because the plaintiff could only obtain the disability insurance benefit plan at issue through her employer and not from an "insurance office," she had no claim under Title III.¹²¹ Given its determination that the meaning of the statutory language was clear, the panel did not review the relevant legislative history.¹²² The panel also rejected the DOJ's interpretation of Title III's applicability to insurance policies in the DOJ Technical Assistance Manual,

¹¹⁷ DOJ Technical Assistant Manual, § III-3.11000.

¹¹⁸ See, e.g., Erwin v. Northwestern Mut. Life Ins. Co., No. IP 97-0703-C-B/S, LEXIS 4269 *11-22 (S.D. Ind. 1998) (holding that a "public accommodation" is a physical place); Brewster v. Colley Assoc./Counseling & Consulting Serv., LTD. No. CIV. 97-0058 M/LFG, 1997 WL 823634 (D.N.M. 1997) (holding an employer benefit plan is not a good offered by a place of public accommodation); Leonard F. v. Israel Discount Bank of New York, 967 F. Supp. 802, 803-06 (S.D.N.Y. 1997) (holding Title III does not apply to employee benefits); Pappas v. Bethesda Hosp. Ass'n. & Benefit Svcs. Agency, Inc., 861 F. Supp. 616, 620 (S.D. Ohio 1994) (holding that Title III applies only to the physical use of a place of public accommodation).

¹¹⁹ 121 F.3d 1006 (6th Cir. 1997), cert. denied, 1998 U.S. LEXIS 607.

¹²⁰ Id. at 1010-11 (citing 42 U.S.C. § 12181(7)).

¹²¹ Id.

¹²² Id. at 1014 note 10.

concluding that it was inconsistent with both the statutory language and DoJ's own Title III regulations.¹²³

The First Circuit, in contrast, ruled in Carparts Distribution Center v. Automotive Wholesaler's Association of New England¹²⁴ that the scope of "public accommodation" is not limited to physical structures. The court found the statutory language of Title III ambiguous on the question, but found nothing in the text of Title III, its implementing regulations, or the ADA's legislative history that limited "public accommodation" to physical structures. The court stopped short of ruling that Title III extends to the substance of insurance policies, instead remanding the case to the district court to give the plaintiff the opportunity to develop facts in support of the broader interpretation of "public accommodation."¹²⁵

In addition, several District Courts in circuits that have not ruled on the scope of Title III have held that "public accommodation" includes the substance of insurance policies.¹²⁶ In Cloutier v. Prudential Insurance Company of America,¹²⁷ for example, the court held that a plaintiff denied life insurance policies because

¹²³ Id. at 1014; see also Pallozzi v. Allstate Life Ins. Co., No. 97-CV-0236 *2-3 (FHS), 1998 WL 139410 (N.D.N.Y.) (holding that Title III does not apply to insurance policies because (1) the "safe harbor" demonstrates that the ADA was never intended to regulate traditional risk classification practices, and (2) Congress did not specifically list "insurance company" in the list of "public accommodation," whereas it did list "insurance office").

¹²⁴ 37 F.3d 12 (1st Cir. 1994).

¹²⁵ Id. at 18-20.

¹²⁶ See, e.g., Doe v. Mutual of Omaha Ins. Co., No. 98 C 0325, 1998 WL 166856 (N.D. Ill. 1998) (ruling that Title III applies to the content of insurance policies); Chabner v. United of Omaha Life Ins. Co., No. C-95-447-MHP, LEXIS 3627 *15-25 (N.D. Cal. 1998) (holding that Title III applies to insurance underwriting); Dunlap v. Association of Bay Area Gov'ts., No. C 97-2224 TEH, LEXIS 2984 (N.D. Cal. 1998) (noting that both parties did not dispute that the defendant HMO was a "public accommodation"); Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1164-65 (E.D. Va. 1997); World Ins. Co. v. Branch, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997) (finding that the scope of Title III extends beyond denial of physical access to places of public accommodation); Doukas v. Metropolitan (cont.)

¹²⁶ (cont.) Life Ins. Co., 950 F. Supp. 422, 425-27 (D.N.H. 1996) (following Carparts precedent); Baker v. Hartford Life Ins. Co., No. 94 C 4416, LEXIS 14103 (N.D. Ill. 1995) (holding Title III covers discrimination by a public accommodation that does not occur when the plaintiff is physically present at the place of public accommodation).

his partner was HIV-positive could bring his claim under Title III. Nothing in the statutory language, the court ruled, requires restricting the meaning of "public accommodation" to physical spaces.¹²⁸ In a case with similar facts, Kotev v. First Colony Life Insurance Company,¹²⁹ an HIV-negative man who was twice denied life insurance coverage because his wife was HIV-positive, sued the insurer under Title III. In holding that Title III covered the plaintiff's claim, one of the factors the court found persuasive was the insurer's failure to explain why the insurance "safe harbor" would extend to Title III if (as the insurer contended) insurers could never be liable under Title III.¹³⁰

2. Substantive Issues

a. Cases Challenging AIDS- or HIV-Specific Coverage Limitations

While AIDS has highlighted many of the problems with current health insurance risk classification and management, many of the coverage-related problems that have become salient are not unique to AIDS. They are common to all high-cost diseases and conditions.¹³¹ What is unique about AIDS is that some employers reduced health insurance coverage to draconian levels, often on the basis of naked prejudice.¹³² In the 1980s, many employers and insurers dramatically – and usually without any legitimate actuarial basis

¹²⁷ 964 F. Supp. 299 (N.D. Cal. 1997).

¹²⁸ Id. at 301-02.

¹²⁹ 927 F. Supp. 1316, 1320-23 (C.D. Cal. 1996).

¹³⁰ Id. at 1322.

¹³¹ Widiss, *supra* note __, at 1627.

¹³² See, e.g., Thomas E. Bartrum, Note, Fear, Discrimination and Dying in the Workplace: AIDS and the Capping of Employees' Health Insurance Benefits, 82 Ky. L.J. 249, 271-81 (1994) (observing that many employers reduce or eliminate health insurance benefits for employees with HIV disease or AIDS not because of legitimate cost concerns, but out of fear and prejudice).

– limited or denied coverage for individuals with AIDS or HIV disease.¹³³ Typically, the employer or plan would set a minimal lifetime cap on coverage of expenditures for AIDS or HIV-related treatment – anywhere from \$5,000 to \$75,000 – compared to the standard lifetime cap for other insureds (usually \$1 million to \$2 million). Few of the early challenges to AIDS caps were ever litigated.¹³⁴ In most instances, the cases were settled through a consent decree after a plaintiff filed a charge with the EEOC, with the employer or insurer rescinding the AIDS cap or limitation.¹³⁵

In recent years, courts have been presented with challenges to AIDS caps in individual insurance policies. Courts have expended little effort in finding AIDS caps discriminatory. For example, in World Insurance Company v. Branch,¹³⁶ the District Court ruled that a \$5,000 cap on AIDS treatment in the plaintiff's individual health insurance policy violated the ADA. The court did not feel it necessary to dedicate much analysis to the matter:

[The ADA] requires that underwriting and classification of risks be based on sound actuarial principles or be related to actual or reasonably anticipated experience . . . [T]he court cannot imagine that an insurer could arbitrarily cap the benefits payable with respect to a particular disability without running afoul of this stated purpose . . . [A]s a matter of logic . . . the

¹³³ See, e.g., Jackson, *supra* note __, at 150-55 (detailing instances of AIDS-related discrimination in health insurance).

¹³⁴ [Add footnote from old draft.]

¹³⁵ See, e.g., EEOC v. Mason Tenders Welfare Trust Fund, C.A. No. 93-Civ.-1154-JES (S.D.N.Y. 1996) (consent decree rescinding policy provision that excluded coverage for treatment of AIDS-related opportunistic infections, diseases and neoplasms); EEOC v. Laborers Dist. Council Bldg. & Const. Health & Welfare Fund, C.A. No. 94-3971 (E.D. Pa. 1995) (consent decree eliminating \$10,000 lifetime cap on coverage for AIDS and HIV disease); EEOC v. Monroe Foods, Inc., C.A. No. Y93-2925 (D. Md. 1994) (partial consent decree rescinding policy provision excluding coverage for medical care related to AIDS and HIV-related illnesses); EEOC v. Gage Co., C.A. No. 94-CV-72089DT (E.D. Mich. 1994) (same); EEOC v. International Bhd. Of Elec. Workers, C.A. No. 3-93-159 (D. Minn. 1993) (same); EEOC v. Allied Serv. Div. Welfare Fund, C.A. No. 93-5076-WMB (C.D. Cal. 1993) (same); see also Memorandum from Peggy R. Mastroianni, Associate Legal Counsel, U.S. Equal Employment Opportunity Commission, to the Health Care Financing Administration, U.S. Department of Labor, and the Internal Revenue Service 5 & n.7 (July 7, 1997) (noting that through March, 1997, all cases filed by the EEOC challenging AIDS/HIV caps or exclusions in employer-provided health plans were resolved by settlement; all settlements provided for elimination of the challenged provision).

¹³⁶ 966 F. Supp. 1203 (N.D. Ga. 1997).

underwriting risks associated with treatment of AIDS cannot be so different from the treatment of innumerable other disabilities, which, with the exception of transplant and replacement procedures, are capped under the policy at \$2,000,000 . . . [T]here is a complete absence of evidence demonstrating that [the insurer's] decision to cap its coverage of AIDS was based on sound actuarial principles, reasonably anticipated experience, or bona fide risk classification . . . ¹³⁷

In Anderson v. Gus Mayer Boston Store of Delaware,

¹³⁸ the employer's insurer discovered that one of the defendant's employees had AIDS and increased the employer's premiums by 30 percent.¹³⁹ The employer then switched to a new insurance company that "had the flexibility to deny [coverage] to some members of the group."¹⁴⁰ The plaintiff was the only employee denied coverage by the new insurer. The insurer asserted that the plaintiff was denied coverage because he had been treated for cancer in the past ten years. An insurance company representative asserted in her deposition that the fact that the plaintiff had HIV "never crossed her mind" when she was determining whether to extend coverage to him, despite the fact that the insurer had a directive requiring automatic refusal of coverage for applicants with AIDS.¹⁴¹ Moreover, the representative also revealed that another employee of Gus Meyer had cancer and a second employee had a tumor that was possibly cancerous; the insurer extended coverage to both employees.¹⁴²

The court had little difficulty in concluding that the employer's actions violated the ADA and therefore denied the employer's motion for summary judgment. However, the court also denied the plaintiff's

¹³⁷ Id. at 1208-09.

¹³⁸ 924 F. Supp. 763 (E.D. Tex. 1996).

¹³⁹ Id. at 769.

¹⁴⁰ Id. at 770.

¹⁴¹ Id. at 770 n.7.

¹⁴² Id.

motion for summary judgment on the issue of whether the employer's actions were justified on the grounds of "undue hardship" – that is, Gus Mayer denied any coverage to the plaintiff in order to "prevent an unacceptable change either in the plan's coverage or its premiums, co-payments, or deductibles."¹⁴³ The court noted that the EEOC Interim Guidance provides that an employer may adopt a disability-based distinction in its health insurance benefits if coverage of the disability would be so expensive that the employer's health plan would become insolvent, and there is no other alternative to avoid insolvency.¹⁴⁴ The court concluded that the question of whether providing health insurance coverage to the plaintiff would result in "undue hardship" to Gus Mayer was an issue to be resolved at trial.¹⁴⁵

In a recent Illinois case, Doe v. Mutual of Omaha Ins. Co.,¹⁴⁶ two plaintiffs brought a claim under Title III alleging that an insurance company had discriminated against them on the basis of disability in the terms and conditions of individual health insurance policies the plaintiffs had purchased. The insurance company capped lifetime coverage for AIDS and AIDS-related conditions under the policies at \$100,000 and \$25,000, respectively, but provided a \$1 million lifetime maximum for all other medical conditions. In ruling for the plaintiffs on the insurance company's motion to dismiss, the court held that such a claim could be brought under Title III.¹⁴⁷ (Inexplicably, the District Court, located in the Seventh Circuit, ignored the contrary ruling by the Court of Appeals in EEOC v. CNA, although it later cited the appellate opinion with regard to another issue.) Regarding the allegation of discrimination, the court ruled that the plaintiffs' contention that

¹⁴³ Id. at 779 n.48.

¹⁴⁴ Id. at 781 (quoting EEOC Interim Guidance, supra note __, at ____).

¹⁴⁵ Id.

¹⁴⁶ No. 98 C 0325, 1998 WL 166856 (N.D. Ill. 1998) [check subsequent history].

¹⁴⁷ Id. at *5-6.

the insurance company treated them differently on the basis of AIDS was sufficient to state a claim.¹⁴⁸

b. Cases Challenging Exclusions for Specific Treatments

The Eight Circuit has considered two separate cases challenging a health plan's exclusion of a specific treatment. The plaintiff in Krauel v. Iowa Methodist Medical Center¹⁴⁹ asserted that her health plan's exclusion of treatment for infertility was a disability-based distinction in violation of the ADA. The court rejected her claim. It relied on the EEOC Interim Guidance, which permits disability-based distinctions provided that they apply equally to all covered employees, both those with disabilities and those who are not disabled.¹⁵⁰ The plan's exclusion of infertility treatments applied to all covered individuals. Since no one received treatment for infertility, regardless of the reason for the infertility (e.g., age, a medical condition not recognized as a disability, or ovarian cancer), the exclusion did not discriminate against the plaintiff on the basis of a disability.¹⁵¹

In Henderson v. Bodine Aluminum, Inc.,¹⁵² the Eighth Circuit granted injunctive relief to a plaintiff whose health plan covered high-dose chemotherapy (HDCT) and autologous bone marrow transplants for certain kinds of cancer, but not for breast cancer. The defendant insurance company denied pre-certification of HDCT on the grounds that it was experimental. The District Court denied injunctive relief to the plaintiff, holding that since the employer's health plan did not cover HDCT for most cancers, breast cancer was not

¹⁴⁸ Id. at *8.

¹⁴⁹ 95 F.3d 674 (8th Cir. 1996) [check subsequent history].

¹⁵⁰ Id. at 677-78 (citing EEOC Interim Guidance, supra note ____).

¹⁵¹ Id. at 678.

¹⁵² 70 F.3d 958 (8th Cir. 1995) [check subsequent history].

singled out for disparate treatment.¹⁵³

The Court of Appeals reversed, finding that the plaintiff had demonstrated a sufficient likelihood that she could prevail on the merits of her ADA claim. Specifically, the Court was persuaded by the plaintiff's documentation of a "large and growing body of medical scholarship and testimony showing that HDCT is safe, increasingly widely used, and a significant improvement over standard chemotherapy." The health plan, in contrast, offered no evidence refuting the plaintiff's evidence.¹⁵⁴

Because the Court was reviewing a denial of injunctive relief, which only requires a plaintiff to demonstrate a likelihood that a claim will succeed on its merits and that the plaintiff will suffer irreparable harm if no injunction is granted, the Henderson decision offers minimal value as precedent for challenging health insurance plan exclusions under the ADA. The Court did not undertake an ADA-specific analysis of the plaintiff's claim, focusing instead on the sufficiency of the evidence proffered by the plaintiff.

In a case presenting a similar question, however, a District Court held that a health plan did not violate the ADA by covering autologous bone marrow transplants for some forms of cancer, but not for plaintiff's cancer. The plaintiff in Hilliard v. BellSouth Medical Assistance Plan¹⁵⁵ suffered from multiple myeloma and sought coverage for an autologous bone marrow transplant. The health plan had decided in 1990 that it would cover autologous bone marrow transplants for three kinds of cancer – Hodgkin's disease, leukemia, and non-Hodgkin's lymphoma. Since the plaintiff was not diagnosed with multiple myeloma until 1992, and

¹⁵³ Id. at 960-61.

¹⁵⁴ Id. at 960-62.

¹⁵⁵ 918 F. Sup. 1016 (S.D. Miss. 1995).

he had not presented any evidence demonstrating that multiple myeloma should be treated the same as Hodgkin's disease, leukemia, and non-Hodgkin's lymphoma under the plan, the court held that he was not denied coverage on the basis of his disability.¹⁵⁶

c. Limits on Coverage for Mental Disabilities

The most frequent kind of insurance claim that has been brought under the ADA are challenges to long-term disability insurance policies that limit coverage for mental and emotional disabilities to one or two years, versus continued coverage until age 65 for physical disabilities. Most courts have ruled that lesser coverage for mental disabilities does not violate the ADA. Typically, courts reason that the ADA only prohibits discrimination between disabled and non-disabled individuals, and does not require equal treatment of different disabilities. As long as a policy's limitations apply equally to all individuals, they do not constitute disability-based discrimination.¹⁵⁷

At least once court has disagreed with this reasoning. The court in Lewis v. Aetna Life Insurance

¹⁵⁶ Id. at 1027.

¹⁵⁷ See, e.g., Parker, 121 F.3d at 1015-16; EEOC v. CNA, 96 F.3d at 1044; Brewster v. Colley Assoc./Counseling & Consulting Serv., LTD, No. CIV. 97-0058 M/LFG, 1997 WL 823634 (D.N.M. 1997) (holding that there is no discrimination under Title I where an employer offers all employees the same benefits, even if coverage for disabilities caused by mental disorders differs from coverage for physical disorders); Rogers v. Department of Health & Envtl. Control, 985 F. Supp. 635, ____ (D.S.C. 1997) (following reasoning of Sixth and Seventh Circuits in finding to conclude that the ADA does not prohibit lesser coverage for mental disabilities); Leonard F. v. Israel Discount Bank of New York, 967 F. Supp. 802, 805-06 (S.D.N.Y. 1997) (holding that placing time limits on benefits for mental disorders but not physical disorders is consistent with state insurance law and traditional underwriting practices); Weyer v. Twentieth Century Fox Film Corp., No. C96-1661WD, 1997 LEXIS 21708 (W.D. Wash. 1997) (granting summary judgment to defendant on grounds that the ADA does not prohibit providing a shorter period of coverage for mental disabilities than for physical disabilities); cf. Esfahani v. Medical College of Penn., 919 F. Supp. 832, 836 (E.D. Penn. 1996) (holding, with no analysis, that plaintiff had "adequately alleged" that lower long-term disability coverage for mental conditions was an impermissible "diagnosis-based differentiation").

Company¹⁵⁸ held that an insurer may not provide different levels of coverage for mental and physical disabilities, unless the distinction is based on "sound actuarial principles or other competent factual basis."¹⁵⁹

Whereas most courts treat "mental disabilities" as one disorder, the court in Lewis viewed "mental disabilities" as a heterogeneous group of disabilities, much like "physical disabilities" are viewed individually. The court stated:

Both a decision to deny coverage on the basis of mental disability and to provide inferior coverage for disabilities target the mentally disabled for inferior treatment. In both cases, an insurer has subjected a mentally disabled individual to treatment inferior to that accorded to others solely on the basis of that individual's disability.¹⁶⁰

Courts upholding distinctions in coverage for mental and physical disabilities also find support in the EEOC Interim Guidance, which expressly states that distinctions in insurance coverage between mental and physical disabilities are not disability-based distinctions that violate the ADA.¹⁶¹ The Guidance states:

[A] feature of some employer provided insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the treatment of "mental/nervous" conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions . . . Such broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.¹⁶²

The EEOC, however, no longer supports a distinction in coverage for mental and physical disabilities. In recent cases that the agency has brought or cases in which it has filed amicus briefs, the EEOC has argued

¹⁵⁸ 982 F. Supp. 1158 (E.D. Va. 1997).

¹⁵⁹ Id. at 1168.

¹⁶⁰ Id.

¹⁶¹ See, e.g., Parker, 121 F.3d at 1018;

¹⁶² EEOC Interim Guidance, *supra* note __, at 6.

that such distinctions violate the ADA.¹⁶³

Recent cases upholding lower coverage for disabilities caused by mental disorders have also found support in Congress' enactment of the Mental Health Parity Act of 1997.¹⁶⁴ The Mental Health Parity Act amended the Health Insurance Portability Act of 1996 (discussed in Part II). It mandates that insurers adopt the same coverage limits (e.g., annual or life-time limits) for benefits covering mental disorders as for benefits covering physical disorders.¹⁶⁵ If Congress intended that the ADA require equal coverage of mental and physical disabilities, courts have asserted, it would not have had to enact the Mental Health Parity Act.¹⁶⁶ As for the fact that the Mental Health Parity Act covers only health insurance and not disability insurance, the Parker panel stated (without reference to any supporting legislative history) that Congress did not find the disparities between physical and mental disabilities in disability insurance a "compelling" problem:

While Congress likely realized that equality between the two types of disabilities was not covered by the ADA, it sought to remedy the absence only in the context of health insurance coverage . . . [I]t appears that Congress did not believe the necessity for parity between mental and physical disabilities in long-term disability plans was sufficiently compelling to include them within the purview of the Act.¹⁶⁷

The panel added, however, that "the converse cannot be true: Congress did not need to include long-term disability plans in the Mental Health Parity Act because the ADA required parity in such plans. It simply cannot be the case that the ADA would cover long-term disability plans but not group health insurance

¹⁶³ See Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1168 & n.9 (E.D. Va. 1997).

¹⁶⁴ [add Pub. L. info] (codified at 42 U.S.C. § 300gg-5 (Supp. 1998).

¹⁶⁵ 42 U.S.C. § 300gg-5(1)-(2) (Supp. 1998).

¹⁶⁶ See, e.g., Parker, 121 F.3d at 1018-19; Brewster, 1997 WL 823634 at (following Parker); Rogers, 985 F. Supp. at ___ (D.S.C. 1997) (following Parker and EEOC v. CNA).

¹⁶⁷ Parker, 121 F.3d at 1017-18.

plans."¹⁶⁸ Again, the panel did not offer any reference to the ADA's or the Mental Health Parity Act's legislative history in support of its conclusion.

d. What Constitutes "Subterfuge?"

The EEOC Interim Guidance sets out the following framework for analyzing whether a disability-based distinction is a subterfuge: An employer or insurer would have to prove that (1) the health insurance plan is either a bona fide insured health insurance plan that is not inconsistent with state law, or a bona fide self-insured health insurance plan, and (2) the challenged disability-based distinction is not being used as a subterfuge.¹⁶⁹ "Bona fide" as interpreted by the EEOC is a weak standard. To meet it, an employer need only show that the health insurance plan "exists and pays benefits," and that the plan's terms have been adequately communicated to employees.¹⁷⁰

Courts are divided over what employers and insurance companies must show in order to demonstrate that a plan limitation or restriction does not constitute "subterfuge." As noted above, the EEOC in its Interim Guidance defines subterfuge as a disability-based distinction that is without support from actuarial or cost data.¹⁷¹ Few courts have considered the issue with respect to health insurance. Of those that have, at least

¹⁶⁸ *Id.* at 1018 n.16.

¹⁶⁹ EEOC Interim Guidance, *supra* note __, at 3-5.

¹⁷⁰ *Id.* at 10-11.

¹⁷¹ EEOC Interim Guidance, *supra* note __, at 11-12 & n. 14 (stating that subterfuge means a disability-based distinction that is "not justified by the risks or costs associated with the disability," based on "legitimate" actuarial data or actual or anticipated experience); see also Sohlgren, *supra* note 41, at 1291 (reasoning that there would be no finding of subterfuge if risk classifications are based on actuarial principles, or actual or reasonably anticipated costs).

one District Court has indicated that it would adopt the EEOC's interpretation.¹⁷² Another District Court, however, rejected the EEOC's interpretation of subterfuge in favor of the U.S. Supreme Court's interpretation of subterfuge as requiring a "specific intent" to discriminate in benefits.¹⁷³

Cases alleging that insurers discriminated by refusing to issue life insurance policies, however, have explored the qualitative and quantitative evidence that plaintiffs and defendants must bring forward to demonstrate that an insurer's decision was (or was not) based on credible actuarial data or principles or actual (or reasonably anticipated) experience. In Coultier v. Prudential Insurance Company of America,¹⁷⁴ the insurance company declined to issue a life insurance policy to the plaintiff because his partner was HIV-positive, notwithstanding that the plaintiff-applicant himself was HIV-negative and practiced safe sex with his partner.

Ruling on the insurance company's motion for summary judgment, the court stated that the insurer's decision would be protected under the "safe harbor" if its underwriting decision was based on "either (a) sound actuarial principles, or (b) actual or reasonably anticipated experience."¹⁷⁵ The insurance company offered no actuarial data in support of its underwriting decision, asserting that such data was not needed where its decision "was so obviously supported by 'accepted medical principles' and common knowledge

¹⁷² Doe v. Mutual of Omaha Ins. Co., No. 98 C 0325, WL 166856 *5 (N.D. Ill. 1998) (stating that an insurance company, which had issued individual policies to the plaintiffs that capped lifetime coverage for AIDS and AIDS-related conditions at \$100,000 and \$25,000 but provided a \$1 million lifetime maximum for other medical conditions, could avail itself of the "safe harbor" if the policies were "consistent with sound actuarial principles, reasonably anticipated experience, or bona fide risk classification").

¹⁷³ Conner v. Colony Lake Lure, No. 4:97CV01, LEXIS 15938 (W.D.N.C. 1997); see also Leonard F. v. Israel Discount Bank of New York, 967 F. Supp. 802, 806 (S.D.N.Y. 1997) (adopting Betts definition of subterfuge).

¹⁷⁴ 964 F. Supp. 299 (N.D. Cal. 1997).

¹⁷⁵ Id. at 304 (citing the legislative history of the "safe harbor"); accord, Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 429-32 (D.N.H. 1996).

about AIDS and its mortality risks."¹⁷⁶ In addition, the insurer's underwriters admitted in deposition testimony that they did not seek information outside of their own knowledge of HIV about the risks of HIV transmission.¹⁷⁷ Predictably, the court denied the insurer's summary judgment motion, noting that the insurer had not come forward with anything other than "vague explanations of the risks of HIV infection where the business of insurance requires sound risk assessment practices."¹⁷⁸ To rebut the plaintiff's evidence, the court said, the insurer must present "data, studies, or other information relevant to its risk assessment."¹⁷⁹

Two Circuit Courts, however – the District of Columbia Circuit (Modderno v. King¹⁸⁰) and the Eighth Circuit (Krauel v. Iowa Methodist Medical Center¹⁸¹) – have rejected the EEOC's interpretation in favor of the Betts definition of subterfuge, ruling that "subterfuge" under the ADA means a specific intent to discriminate. The Modderno court based its conclusion in large measure on its assumption that Congress was aware of the Betts decision when it enacted the ADA. Therefore, when it chose to use the term "subterfuge," Congress was "on full alert as to what the Court understood the word to mean and possessed (obviously) a full grasp of the linguistic devices available to avoid that meaning."¹⁸² The Krauel court did

¹⁷⁶ Id. at 304-05.

¹⁷⁷ Id. at 305.

¹⁷⁸ Id. at 307.

¹⁷⁹ Id. at 305; see also Chabner v. United of Omaha Life Insurance Company, No. 98 C 0325, 1998 WL 166856 *30-34 (N.D. Ill. 1998) (ruling that life insurance must produce actuarial data in the form of actuarial tables or clinical studies that estimate mortality rates in order to prove that a rate differential was based on sound actuarial principles).

¹⁸⁰ 82 F.3d 1059, 1064-65 (D.C. Cir. 1996).

¹⁸¹ 95 F.3d 674, 678-79 (8th Cir. 1996).

¹⁸² Modderno, 82 F.3d at 1065.

not undertake its own analysis of the issue, opting instead to adopt the Modderno court's conclusion.¹⁸³

In addition, in the *en banc* Parker decision the Sixth Circuit also indicated that the Betts definition of subterfuge applied to ADA claims.¹⁸⁴ However, the panel addressed the question only in a footnote and gave the issue little analysis. It simply noted that the EEOC's requirement that insurance policies be based on sound actuarial principles in order not to be a subterfuge was inconsistent with the U.S. Supreme Court's holding in Betts. The panel specifically stated that it was leaving the "resolution of the proper definition of subterfuge . . . for another day."¹⁸⁵

D. THE ADA PROTECTION: THE NORM OF EQUALITY IN HEALTH INSURANCE COVERAGE

The preceding overview of what disability-based distinctions are and are not permissible, based on the EEOC's and numerous federal courts' interpretations of the ADA, demonstrate the basic protection in health insurance coverage the ADA affords to individuals with AIDS, HIV, and other disabilities. That basic protection is a guarantee of formal equality, an aspirational objective that "[a]ll people with disabilities must have equal access to the health insurance coverage."¹⁸⁶

This is a new and important protection. It means that employers cannot single out a lone disability and

¹⁸³ Krauel, 95 F.3d at 678-79.

¹⁸⁴ Parker, 121 F.3d at 1014 n.7.

¹⁸⁵ Id.

¹⁸⁶ House Education and Labor Committee Report at 59; House Judiciary Committee Report at 38; 29 C.F.R. § 1630 app. 404 (1994); see also EEOC Interim Guidance, *supra* note 45, at 3; See also Widiss, *supra* note __, at 1694 (reasoning that if the ADA's legislative history and the EEOC's ADA guidelines are followed by the courts, the ADA will only require "that employees with disabilities have access to the same coverage as employees without disabilities"). Professor Widiss' analysis, however, predates the release of the EEOC's Interim Guidance on health insurance, though it is doubtful it would alter his conclusion.

deny coverage for it absent a showing of severe financial necessity, even though an actuarially sound risk classification and management scheme might indicate that an employer or insurer should not, from an actuarial perspective, provide coverage for that disability.¹⁸⁷ There is an assurance that employers will not have a "free hand" to reduce health care costs "on the backs of selected and vulnerable disability groups."¹⁸⁸ But the requirement of similar treatment, however, may have a down side. Instead of singling out one high-cost disability and imposing a \$50,000 lifetime cap, the incentive created by the fairness requirement for employers that want to limit their financial risk is to cap benefits for all diseases or disabilities at \$50,000.

Also, employers and insurers cannot discriminate against a particular disability solely because of prejudice, moral disapprobation, or simple fear. The only disability that has endured this most invidious discrimination is AIDS, and it is difficult to imagine that any other disease would be responded to as egregiously as a few employers have treated employees with AIDS. The ADA prohibits this worst form of discrimination.

More concrete measures to extend equal health insurance coverage to individuals with disabilities, however, are few. As was intended, the insurance exception allows insurers to make disability-based distinctions and discriminate against disabilities where they have an actuarial basis for such discrimination and they treat similar disabilities equally. The only protection, then, is the guarantee of basic equality in access to health insurance benefits, however inadequate the insurance may be. It is a remarkable and unprecedented achievement in civil rights law. But this requirement of formal equality, and nothing more than formal equality, is in tension with both the purpose and structure of the ADA.

¹⁸⁷ See Feldblum, *Workplace Issues*, *supra* note __, at 289 (observing that while it might "make sense, as an actuarial matter, to try to deny coverage completely" for certain diseases, such a limitation "may well be seen as 'subterfuge' for evading the purposes" of the ADA).

¹⁸⁸ *Id.* at 69. See also Samuel A. Marcossan, *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, 431 (1994).

E. THE FUNDAMENTAL CONTRADICTION

1. Exposing the Contradiction

The discussion in Part I.A explains that the "logical conclusion"¹⁸⁹ of the ADA, if it was applied to health insurance in the same way as it is applied to other institutions to which the scope and mandate of the ADA extends, would require drastic changes in the health insurance industry. For instance, pre-existing condition clauses and broad limitations on coverage for procedure and treatments would be prohibited because such practices do indeed discriminate against people with disabilities. But there was no political support for what would have essentially been an overhaul of health insurance practices, and thus the ADA includes a textual limitation – the "safe harbor" – on the extent to which the ADA's basic prohibitions can reach their logical conclusion.¹⁹⁰ But this result creates a deep contradiction in light of the purposes and structure of the ADA.¹⁹¹ As explained above, the ADA's purposes are broad: elimination of discrimination against individuals with disabilities, with the federal government statutorily assigned a central role in achieving that end, and with a specific direction to future Congresses that it use its commerce clause power to "address the major areas of discrimination faced day-to-day by people with disabilities."¹⁹²

To achieve these ends, Congress implemented, through the ADA's structure, an assignment of burdens that

¹⁸⁹ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 49.

¹⁹⁰ Feldblum, Implementation of the ADA, *supra* note __, at 58.

¹⁹¹ See Marcossan, *supra* note __, at 414 (noting that for the insurance exception "to make any sense, it must be interpreted in a way that allows insurers to engage in some conduct that would otherwise constitute discrimination against the disabled").

¹⁹² 42 U.S.C. § 12101(b)(4).

makes the ADA a unique form of antidiscrimination protection. Like other antidiscrimination legislation, such as Title VII of the 1964 Civil Rights Act,¹⁹³ the ADA requires formal equality in that it tells employers what they cannot consider in their employment-related decisions – specifically, an individual's disability to the extent that disability does not prevent an individual from performing the essential functions of a job.¹⁹⁴ But the ADA also requires both a positive form of equality by telling employers what they must consider (to wit, a disability for the purposes of determining whether a reasonable accommodation can be made so that the employee can perform the essential functions of the job¹⁹⁵). Even more importantly, the ADA requires a remedial form of equality – remedial in that the ADA places upon employers some of the costs of eliminating the effects of past discrimination against individuals with disabilities.¹⁹⁶

There are two related premises underlying this positive/remedial requirement of equality. First is the premise that disability must be viewed in a societal context. Societal institutions pose barriers to the full enjoyment of economic rights by individuals with disabilities because society has created institutions against the backdrop of a societal norm in which individuals with disabilities have historically not been included.¹⁹⁷ The second premise is that it is a civil right to be included in the societal norm¹⁹⁸ and to have full equality in one's opportunities to live as valuable and satisfying a life as the rest of the population.¹⁹⁹

¹⁹³ 42 U.S.C. § 2000e *et. seq.*

¹⁹⁴ 42 U.S.C. §§ 12111(8), 12112(a).

¹⁹⁵ 42 U.S.C. § 12112(b)(5).

¹⁹⁶ See, e.g., Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 35-36; Pamela S. Karlan & George Rutherglen, Disability, Discrimination, and Reasonable Accommodation 8 (unpublished manuscript) [update cite with published article].

¹⁹⁷ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 36.

¹⁹⁸ *Id.* at 36-37.

¹⁹⁹ Karlan & Rutherglen, *supra* note 113, at 28.

Proceeding from these premises, the ADA embodies a pragmatic choice that certain institutions – specifically, employers, state and local government, and public accommodations – ought to bear some of the costs of restructuring societal institutions to accommodate individuals with disabilities. This choice is reflected in the duty of institutions under the ADA to reasonably accommodate an individual's disability.²⁰⁰ The amount of costs borne by each institution are regulated according to an institution's financial resources (and, under Title I, the employer's size) via the undue hardship and undue burden provisions.²⁰¹ The choice is economically pragmatic because of the reality that these institutions are better able to financially absorb the costs of achieving the ADA's goals when compared with other parties, namely individuals.²⁰² It is politically pragmatic because the ADA's supporters understood that it was not "politically feasible" to impose the costs on government, via a tax.²⁰³

The choice is also normatively justified, in two ways. First, as Professors Karlan and Rutherglen have suggested in the context of employment, employers bear the costs because if individuals were behind a Rawlsian "veil of ignorance"²⁰⁴ and did not know (1) whether they would be disabled in the future or (2) whether they would be employers or employees, and had to decide from that position how to insure against

²⁰⁰ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note 47, at 37. The ADA provides that it is discrimination if an employer fails to make a reasonable accommodation to an individual's disability unless an employer "can demonstrate that the accommodation would impose an undue hardship on the operation of the business." 42 U.S.C. § 12112(b)(5)(A).

²⁰¹ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 37. "Undue hardship" means "an action requiring significant difficulty or expense, when considered in light of," *inter alia*, the employer's overall financial resources, how many employees the employer has, the effect that the accommodation would have on the employer's operations, and the size of the employer's business. 42 U.S.C. § 12111(10).

²⁰² Karlan & Rutherglen, *supra* note __, at 30-31.

²⁰³ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 49.

²⁰⁴ Karlan & Rutherglen, *supra* note __, at 30 n. 66 (quoting John Rawls, A Theory of Justice 136-47 (1971)).

the cost of disability, individuals would assign the cost to employers – again, because employers can more ably bear it.²⁰⁵ Second, if the cost was not allocated to employers, then violations of the civil right to be included in the societal norm would go unremedied. In enacting the ADA, Congress decided that the costs of unremedied rights violations outweighed the costs imposed on employers. Again, the costs are not boundless. The undue hardship provision, much like the insurance "safe harbor," places a limit on the "logical conclusion" of the ADA's prohibition of disability-based discrimination.²⁰⁶

The undue hardship provision prevents the ADA from *fully* reaching its logical conclusion, but otherwise the ADA comes pretty close to treating disability-based discrimination not as a medical problem, but as a problem of rights discrimination. In all other areas besides health insurance, the ADA has essentially effected this transformation.²⁰⁷ Not so with regard to health insurance. At least as interpreted by the EEOC, the insurance "safe harbor" means that when it comes to health insurance, the ADA stops well short of its logical conclusion.

2. Assessing the Contradiction

How troubling one finds this contradiction depends upon how one regards employer-provided health insurance benefits. Underlying the contradiction is another conflict about what employer-provided health insurance benefits are and should be. One perspective is that medical care is a consumer good, and health insurance is simply a fringe benefit. As a fringe benefit, employers should be able to provide health

²⁰⁵ Id. at 30 n. 67 (citing Ronald Dworkin, What is Equality? Part 2; Equality of Resources, 10 Phil. & Pub. Aff. 283 (1987)).

²⁰⁶ Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 49.

²⁰⁷ Deborah A. Stone, The Struggle for the Soul of Health Insurance, 18 J. Health Pol., Pol'y & L. 287, 310 (1993)

insurance benefits (or not) on contractual terms of their own choosing, as with other fringe benefits. Accordingly, there is no equitable reason to impose the costs of ensuring equality in health insurance benefits for individuals with disabilities on employers.²⁰⁸ When employer-provided health insurance is viewed in this way, the insurance exception seems to be a reasonable limitation on the ADA's scope.

Alternatively, one can view medical care as a "merit good"²⁰⁹ or a right of citizenship.²¹⁰ In accordance with this view, employer-provided health insurance is an integral part of the health care delivery system – a form of social insurance, and thus an entitlement that employers should not be able to deny or limit without some kind of governmental oversight. This latter view is the more compelling one – both intuitively, when one considers how critical health insurance is in securing medical care, and also because of the realities of employer-provided health insurance. Health insurance is less a fringe benefit of employment than an entitlement that, because of history²¹¹ and current tax incentives,²¹² is provided through employers for the majority of Americans.²¹³ In short, in the United States, there is a voluntary, employer-based health care financing system,²¹⁴ a system that is likely to remain in place, notwithstanding the wide-spread support for

²⁰⁸ *Id.* at 288.

²⁰⁹ A "merit good" is a good that is generally thought of as something that should be equitably distributed without reference to one's ability to pay for it. Havighurst, *supra* note __, at 1798.

²¹⁰ Stone, *supra* note __, at 289.

²¹¹ See, e.g., Institute of Medicine, *supra* note __, at 47-72 (providing an exhaustive overview of the origins and evolution of employer-provided health benefits).

²¹² The most important is the exclusion of employer-provided health insurance coverage from an employee's gross income. I.R.C. § 106 (1994). See generally Stuart M. Butler, A Tax Reform Strategy to Deal with the Uninsured, J. Am. Med. Ass'n, May 15, 1991, at 2541-44.

²¹³ Approximately 64% of Americans are covered by employer-provided health benefits. Institute of Medicine, *supra* note __, at 28.

²¹⁴ Keeton & Widiss, *supra* note __, § 1.1(a), at 1 (stating that health insurance "is now one of the institutional systems that facilitates the delivery of health care in the United States) (emphasis added).

national single-payer insurance. Further, many Americans continue to believe that this is an acceptable arrangement for financing health insurance.²¹⁵

If one endorse the view that health insurance is something closer to a merit good, the contradictory treatment of health insurance benefits under the ADA becomes all the more troubling given the choice by Congress to place the costs of eliminating disability-based discrimination on employers in all facets of the workplace and the employment relationship.²¹⁶ Why are employer-provided health insurance benefits so broadly exempted from the ADA's mandates when other institutions are not? The answer, as has been shown, was that the ADA was not given its full effect as applied to health insurance benefits because of a political compromise. But by exposing the contradiction, it becomes less philosophically difficult to narrowly read the insurance "safe harbor" and restrict employers' and insurers' use of disability-based distinctions in health insurance. A more expansive reading of the ADA's basic prohibitions, and a more restrictive interpretation of the insurance "safe harbor," would advance the ADA further towards its logical conclusion of prohibiting disability-based discrimination in all societal institutions.²¹⁷ Such a course would undoubtedly prove more expensive for employers, and would restrict the degree to which employers can shift health care costs to employees and government. But the ADA is premised on Congress' choice that institutions, not individuals, are to bear most of the costs of ending discrimination (but not too great a cost, hence the undue hardship provision) on the basis of disability.²¹⁸

²¹⁵ Institute of Medicine, *supra* note __, at 31.

²¹⁶ See Gostin, *supra* note __, at 182 (discussing the difference between regarding insurance as business and insurance as health care policy vis a vis the reach of the ADA, and arguing that the insurance exception becomes worrisome if health insurance is viewed as the latter); see also Stone, *supra* note __, at 291.

²¹⁷ Storer, *supra* note __, at __ (arguing generally that courts should interpret the ADA to limit employer power so that the ADA's goals will not be thwarted).

²¹⁸ But see Eisenstat, *supra* note __, at 46 (suggesting that there be a policy of reinsurance facilitated by public assistance, to help employers with unusually high health care costs).

3. Reasons to Move Toward the Logical Conclusion

Limiting the extent to which employers and insurers can discriminate in health care benefits may have advantages beyond better implementing the ADA's goals. Most importantly, it could help facilitate a wider sharing of risks. In essence, the present *modus operandi* of the health care insurance system is to avoid insuring risks that may lead to high costs, and to pass those costs onto others²¹⁹ – usually employees and government. This strategy requires separating the "potentially healthy" from the "potentially sick" and offering insurance coverage (or more comprehensive coverage) only to the former.²²⁰ There is thus a deep contradiction between how health insurance should operate in principle and how it operates in practice.²²¹ Limiting the ability of employers to discriminate among risks may encourage them to instead find better ways of spreading those risks, rather than passing them on. It might encourage employers with self-funded health care plans (who have smaller pools over which to spread risk)²²² and small employers (who also have small pools over which to spread risk, because they are experience rated) to join together with other self-funded or small employers to form larger risk pools.²²³ Thus, the ADA could actually help achieve better

²¹⁹ See Stone, *supra* note ___, at 290. As Stone states, "The private insurance industry, the first line of defense in the U.S. system of mutual aid for sickness, is organized around a principle profoundly antithetical to the idea of mutual aid, and indeed, the growth and survival of the industry depends on its own ability to finance health care by charging the sick and to convince the public that 'each person should pay for his own risk.'" *Id.*

²²⁰ *Id.* at 294.

²²¹ As Professor Stone points out, "the very redistribution from the healthy to the sick that is the essential purpose of health insurance under the [social insurance] principle is anathema to commercial [health] insurers. . . . Although all insurance entails a subsidy from the lucky to the unlucky (whether for car accidents, diseases, or fires), commercial insurers eschew subsidy from one 'class' of policyholders to another." *Id.*

²²² Robert A. Padgug et. al., AIDS and Private Health Insurance: A Crisis in Risk Sharing, 3 Cornell J. L. & Pub. Pol'y 55, 66-67 (1993).

²²³ This is what reinsurance does, in essence. Reinsurance is a way an insurer can achieve better risk distribution by arranging with another insurer to essentially pool their respective smaller groups into a larger group over which to spread the risk. Keeton & Widiss, *supra* note ___, § 1.3(2), at 13.

risk distribution. Better risk distribution is an idea that is central to health care reform,²²⁴ and accords with the traditional role of insurance.²²⁵ Indeed, it is the very *purpose* of insurance.²²⁶

There are other, more immediate ways as well that a restrictive interpretation of the insurance "safe harbor" can expand health care insurance coverage. It prevents employers from singling out diseases (such as AIDS), or groups of diseases, and not insuring them as extensively as others. Thus, more individuals will be covered for their conditions. Also, the requirement of equality in health care benefits may create new incentives for employers and employees to negotiate new risk sharing arrangements. If the equality requirement forces employers to reduce coverage for not one disease, but many conditions (cancer, heart disease, *and* AIDS, for instance), then employees with many different conditions will directly experience the limits of coverage and will consequently have an impetus to work with their employers to negotiate the balance of health care coverage and cost-saving measures that is acceptable to both parties. Employees could participate with employers in the process of deciding what benefits trade-offs to make in exchange for more affordable premiums, and how much health care costs employees will assume and how much employers will assume.²²⁷ By and large these decisions are now unilaterally made by employers alone.

²²⁴ Padgug, *supra* note 141, at 69, 72; Stone, *supra* note ___, at 311.

²²⁵ It is an elementary principle of insurance that increasing the size of the pool of insureds increases the likelihood that the premiums from low utilizers of health care services (the healthy) will balance out the coverage needs of the high utilizers (the sick). See Keeton & Widiss, *supra* note ___, §1.3(b)(2), at 12; Stone, *supra* note ___, at 292; Widiss, *supra* note 17, at 1732. "Under traditional insurance principles, the costs of catastrophic illnesses are borne by the group as a whole because these costs usually are outside the financial capabilities of most individuals. A policy that permits the exclusion of the expensive, relatively rare illness thus runs contrary to one of the underlying reasons for group insurance." Eisenstat, *supra* note ___, at 36-37. See also Widiss, *supra* note ___, at 1732.

²²⁶ See generally Stone, *supra* note ___, at 292.

²²⁷ Professor Havighurst describes this as prospective self-denial: "private contracts in which consumers accept well-considered, explicit limitations on their future claims." Havighurst, *supra* note ___, at 1764-65. He argues generally that prospective self-denial "can and should be employed more aggressively in the cost-containment effort." *Id.* at 1789-1808. See also Stone, *supra* note ___, at 314 (noting that insurers could offer low-priced policies by excluding coverage for some serious diseases or expensive tests or treatments).

In sum, the ADA can be used to increase the effectiveness and comprehensiveness of a largely employer-based health care financing system. The antidiscrimination provisions of the ADA can police the boundaries of this system, ensuring that more people stay in it instead of being excluded because of their disabilities, and that costs are borne equitably. While requiring employers and insurers to cover more high-risk individuals raises the real concern that their health insurance costs will probably increase, there is the countervailing advantage of expanding the base of insured individuals over which all risks can be spread.²²⁸

F. GIVING FULLER EFFECT TO THE ADA'S PROHIBITIONS

The insurance "safe harbor" provides important protections against disability-based discrimination in employer-provided health insurance, but far less than the ADA mandates in other societal institutions and with fewer costs imposed on employers than are imposed by the ADA's other employment-related provisions. This deficiency argues for considering alternatives that will further extend the ADA's goal of full equality to employer-provided health insurance.

1. Eliminating the Insurance "Safe Harbor"

A logical starting point is the insurance exception itself. The "safe harbor" is a broad exemption for risk discrimination by employers and insurers, and will stand as a serious impediment to any effort to extend the ADA's basic prohibitions into the area of health insurance benefits. One (idealistic) remedy would be to simply repeal the insurance exception.²²⁹

²²⁸ Isbell, *supra* note __, at 16.

²²⁹ See Schmall, *supra* note __, at 789. Professor Schmall argues that the ADA (and ERISA) should "be amended to exclude health insurance from its aegis" – not to allow the ADA to achieve its logical conclusion, but to return health

While this approach has normative appeal, it is politically unrealistic. As discussed in Part I., the insurance exception was a political compromise by disability rights advocates on the ADA's scope in order to ensure that insurance industry opposition did not threaten the passage of the legislation.²³⁰ If an attempt is made to amend the ADA to remove the insurance exception, it is a virtual guarantee that the insurance industry will make sure the effort fails. The role of insurance industry lobbying in the defeat of the Clinton Administration's health care reform proposal in 1994 provides ample evidence for this assessment.²³¹ [Congress does not have the political will to overcome insurance industry opposition, at least not at this time.] Also, amending the ADA to remove the insurance "safe harbor" is analogous to reneging on a deal. The insurance industry supported the ADA on the condition that it would not reach too deeply into traditional insurance industry practices. Amending the ADA would essentially undo the compromise.

2. Expanding the Meaning of Subterfuge

The more appropriate approach is for courts to restrictively apply the insurance "safe harbor" by expansively interpreting the meaning of "subterfuge." This might happen in one of several ways. First, courts could define subterfuge so as to curtail the use of costs as a legitimate reason for employers to discriminate in the provision of health care benefits.²³² In enacting the ADA, Congress made a

insurance to the domain of state regulation. *Id.* Professor Schmall's suggestion presumes that state law will offer more protection against disability-based health care discrimination. While this might be so in some states, it is certainly not true in others. See *supra* note 28. See also Storer, *supra* note __, at __ (suggesting amending the ADA).

²³⁰ In the words of one of ADA's drafters, who also represented the disability rights community in the legislative battle to pass the ADA, "as a practical and a political matter, Congress would not have passed the ADA" if there were not limitations. Feldblum, Antidiscrimination Requirements of the ADA, *supra* note __, at 50.

²³¹ See generally James Fallows, A Triumph of Misinformation, *Atl. Monthly*, Jan. 1995, at 37 (noting the health insurance companies, among other interest groups, had much to lose from health care reform).

²³² But see Marcossion, *supra* note __, at 426 (asserting that the language in the legislative history referencing an actuarial basis for justifying insurance practices "suggests that cost-justification is an integral part of what

determination that nondiscrimination was a more important principle than business costs.²³³ The duty of reasonable accommodation is evidence of this choice. Courts could interpret the insurance "safe harbor" as a narrow exemption from the ADA's broad protections. Consequently, employers would only be allowed to assert cost-based justifications for the use of disability-based discrimination where not using disability-based distinctions would result in costs so burdensome that they would be tantamount to an undue hardship.

In addition, courts could permit disparate impact suits against employers' use of universally applied health plan limitations that effectively deny coverage for a particular disability, on the grounds that such limitations are a form of subterfuge. Although it is not entirely clear that such claims are available under the ADA in health insurance cases, the balance of factors strongly support that they should be. First, as a general matter, disparate impact claims are cognizable under the ADA. The statutory basis is in the Title I provision stating that discrimination includes "utilizing standards, criteria, or methods of administration that have the effect of discrimination on the basis of disability,"²³⁴ and the provision forbidding the use of selection criteria "that tend to screen out an individual with a disability or a class of individuals with disabilities unless the . . . criteria . . . is shown to be job-related."²³⁵ Further, included under the ADA employers' defenses provision is language that mirrors that of the disparate impact provisions of Title VII.²³⁶

Second, allowing disparate impact claims is consistent with the second vision of civil rights embodied in

constitutes subterfuge").

²³³ See Gostin, *Impact of the ADA*, *supra* note __, at 181 (arguing that courts reject costs as an excuse for discrimination because they recognize that antidiscrimination has a higher social value than business interests and cost defenses would "swallow up all the protection currently conferred by disability law").

²³⁴ 42 U.S.C. § 12112(b)(3)(a) (emphasis added).

²³⁵ 42 U.S.C. § 12111(b)(3)(6); *see also* *Harding v. Winn-Dixie Stores, Inc.*, 907 F. Supp. 386, 389 (M.D. Fla. 1995) (stating that disparate treatment and disparate impact are the two theories of recovery under the ADA).

²³⁶ 42 U.S.C. § 2000e-2(k).

the ADA. Disparate impact is designed to remedy discrimination resulting not from invidious animus but from the application of ostensibly neutral practices that have disproportionate effects on specific individuals or groups.²³⁷ The whole ADA framework, especially the reasonable accommodation provisions, is aimed at eliminating not only intentional discrimination, but also the disparate impact that societal barriers have on disabled individuals – the "shameful oversights"²³⁸ that society has erected.

Third, the language in the legislative history stating that "coverage cannot be denied entirely to a person with a disability"²³⁹ (discussed above) suggests that Congress intended to permit disparate impact claims in cases where a universal health plan limitation or limitations disparately impacted upon a particular disability such that coverage for that disability was effectively denied.

But there is also evidence that disparate impact claims challenging universal limitations with disproportionate effects are not to be implied under the ADA. For instance, disparate impact is tolerated in some health insurance arrangements, such as pre-existing condition clauses or permissible limitations on numbers and types of treatment.²⁴⁰ Also, language in the House Education and Labor Committee Report states that health insurance plans should not be found to be in violation of the ADA through a disparate impact analysis "simply because they do not address the special needs of every person with a disability,"

²³⁷ *Griggs v. Duke Power*, 401 U.S. 424 (1971).

²³⁸ *Alexander v. Choate*, 469 U.S. 287, 296 (1985).

²³⁹ House Judiciary Committee Report at 71.

²⁴⁰ "[E]mployers may continue to offer policies that contain pre-existing condition exclusions, even though such exclusions adversely affect people with disabilities, so long as such clauses are not used as a subterfuge to evade the purposes of the act." House Education and Labor Committee Report at 59.

such as medical coverage.²⁴¹ The Report cites Alexander v. Choate,²⁴² a suit under the Rehabilitation Act of 1973. The plaintiffs in Alexander v. Choate alleged that a state's Medicaid coverage limitation had a disproportionate effect on individuals with disabilities. The Court held that the Medicaid limitation did not state a valid disparate impact claim under the Rehabilitation Act (although the Court ruled that disparate impact claims were generally allowed under the Act). The EEOC Interim Guidance cites Alexander v. Choate when it states that "discriminates" means only disparate treatment, and not disparate impact.²⁴³ The EEOC asserts that health insurance distinctions that are not based on disability and are applied equally to all covered employees do not discriminate on the basis of disability and thus do not violate the ADA, and concludes that the disparate impact theory of discrimination is not available "in this context"²⁴⁴ – that is, in situations where insurance provisions are universally applied but adversely limit the coverage of individuals with disabilities.

A closer reading of Alexander v. Choate, however, reveals that the EEOC has correctly read the Court's holding in that case, but has misread the corollary of the Court's holding as well as the Court's disparate impact analysis. Alexander v. Choate involved a challenge under the Rehabilitation Act of 1973 to a state's decision to limit Medicaid benefits.²⁴⁵ In 1980-81, Tennessee undertook a range of cost-saving measures in order to reduced its projected Medicaid costs, including a reduction in the number of inpatient hospital

²⁴¹ House Education and Labor Committee Report at 137.

²⁴² *Id.*

²⁴³ EEOC Interim Guidance, *supra* note __, at 5 & n.7.

²⁴⁴ *Id.*; see also Schmall, *supra* note __, at 836 (arguing that claims alleging discrimination in health care benefits under a disparate impact theory are probably not actionable under the ADA).

²⁴⁵ *Choate* is thus especially relevant to an analysis of disparate impact claims under the ADA because the substantive provisions of Title I of the ADA were largely derived from the Rehabilitation Act of 1973's implementing regulations, as well as judicial interpretation of that Act. Feldblum, Workplace Issues, *supra* note __, at 276.

days covered per fiscal year for each Medicaid recipient from 20 to 14.²⁴⁶ A class of Medicaid recipients challenged the reduction, arguing that this (and any other) reduction in covered inpatient hospital days had a disparate impact on individuals with disabilities, and thus discriminated against individuals with disabilities in violation of the Rehabilitation Act.²⁴⁷ The plaintiffs asserted that if Tennessee wanted to reduce costs, the state had a means open to it that would have less of a disparate impact on individuals with disabilities: it could limit the number of covered inpatient hospital days on a per-stay basis, rather than on a per-insured basis. The state's failure to take this approach, the plaintiffs asserted, was discriminatory.²⁴⁸

The Court held that the Rehabilitation Act should be interpreted to include claims of disparate impact, because such an interpretation would "give effect to the statutory objectives" of the Act,²⁴⁹ which was to proscribe not only disability-based discrimination resulting from "invidious animus" but also discrimination resulting from "thoughtlessness and indifference" and "benign neglect."²⁵⁰ But, in a perplexing side-step, the Court circumscribed the availability of disparate impact claims in cases where universal limits disproportionately affect individuals with disabilities. It stated that some disparate impact showings would state prima facie cases under the Act, but not all would.²⁵¹ It concluded that Tennessee's reduction under Medicaid of covered inpatient hospital days was not discriminatory, despite its disparate impact on the

²⁴⁶ Alexander v. Choate, 469 U.S. 287, 289 (1985).

²⁴⁷ In making out their prima facie case of disparate impact, the plaintiffs presented statistical evidence showing that in the previous year, 27.4% of Medicaid recipients with disabilities required 14 or more days of inpatient hospital care, whereas only 7.8% of non-disabled Medicaid recipients required more than 14 days. *Id.* at 289-90. If 19 days of inpatient care were provided, only 16.9% of disabled Medicaid recipients would not have their inpatient hospitalization needs met, and 4.2% of the non-disabled would not have their needs met. *Id.* at 290 n.3.

²⁴⁸ *Id.* at 291.

²⁴⁹ *Id.* at 299.

²⁵⁰ *Id.* at 296.

²⁵¹ *Id.* at 299.

disabled, because the limitation applied equally to both disabled and non-disabled individuals.²⁵²

Two factors seem to have influenced the Court's conclusion that there was no disparate impact violation in Alexander v. Choate. First, the limitation at issue was a Medicaid limitation, and for purely pragmatic reasons the Court was reluctant to start down the slippery slope of judicially restricting the choices made by state Medicaid officials. The Court understood that many Medicaid provisions would have a disparate impact on individuals with disabilities. The language in Justice Marshall's majority opinion supports this observation. The purpose of the Rehabilitation Act, he wrote, was to assure equal treatment to individuals with disabilities, but it "does not . . . guarantee the handicapped equal results from the provision of state Medicaid."²⁵³ Justice Marshall noted that while Tennessee might have chosen a means of controlling Medicaid costs that had less of a disproportionate effect on individuals with disabilities, the Court found nothing in the Rehabilitation Act that abrogated states' long-standing flexibility under Medicaid to determine the scope and structure of their state Medicaid programs.²⁵⁴

Second, the Court may have been less concerned about this particular disparate impact because it was non-disability specific. In language later reflected in the ADA legislative history, the Court said that the reduction "will leave both handicapped and nonhandicapped Medicaid users with identical and effective hospital services fully available for their use, with both classes of users subject to the same durational limitations."²⁵⁵ Had the Medicaid limitation disproportionately affected only one or two disabilities, the Court might have found it in violation of the Rehabilitation Act.

²⁵² Id. at 302.

²⁵³ Id. at 304.

²⁵⁴ Id. at 307.

²⁵⁵ Id. at 302.

Thus, the EEOC is wrong when it cites Alexander v. Choate for the broad proposition that disparate impact claims in the context of health insurance discrimination are not available under the ADA. To the contrary, the Court expressly said that this kind of claim was cognizable.²⁵⁶ Alexander v. Choate can most fairly be read as supporting the proposition that a non-disability based health plan limitation that applies to all individuals covered under the policy or program and therefore disproportionately affects many disabilities and conditions does not make out a disparate impact violation, even though there is a disparate impact on all (or many) disabilities. The logical corollary (which is consistent with the Court's analysis) is that a health benefit plan provision that disproportionately affected individuals with a specific disability or disabilities could be found in violation of the ADA using disparate impact analysis.²⁵⁷

The EEOC's Interim Guidance also evidences a misunderstanding of disparate impact theory. The EEOC assumes that if a health plan limitation is applied to all insureds, it is not disability-based, and hence does not satisfy the first prong of the EEOC's analytical framework. This is correct if one is using a disparate treatment analysis, as the EEOC does in the Interim Guidance.²⁵⁸ But this is not disparate impact analysis. Disparate impact analysis looks at whether an "artificial, arbitrary and unnecessary" practice, "fair in form," operates when applied to discriminate on the basis of an impermissible factor.²⁵⁹ Thus, if the operation of a health care plan exclusion operates equally on all insureds (as Tennessee's 14-day inpatient hospital limitation arguably did), then under disparate impact analysis the limitation is not discriminatory because there is not a disproportionate impact on a particular disability. But if a universal plan exclusion

²⁵⁶ Id. at 299.

²⁵⁷ Feldblum, Implementation of the ADA, *supra* note __, at 62 n.121.

²⁵⁸ EEOC Interim Guidance, *supra* note __, at 5 n.7.

²⁵⁹ Griggs v. Duke Power, 401 U.S. 424, 429-33 (1971).

disproportionately burdened individuals with particular disabilities, then the exclusion discriminates against individuals with those particular disabilities. If there are other limitations that would achieve the employer's ends without creating the disparate impact, and the employer refuses to adopt the alternative limitations, then under disparate impact theory the limitation is in violation of the ADA. Such a claim might be structured as follows: suppose (simplistically) an employer's health plan eliminated coverage for all prescription drugs and coverage for tests that measured T-cell counts. Suppose further that the only treatments utilized for management of early HIV disease are outpatient prescription drug therapies and viral load monitoring. As a result of these neutral policy limitations, an employee with early HIV disease has effectively been denied any health insurance coverage for his condition; virtually none of the treatments and procedures required to manage his condition are reimbursed. The employee should be able to make a claim of disparate impact. If the employee can demonstrate that a different limitation (one that did not disproportionately deny coverage for his disease, such as a general annual cap on diagnostic tests instead of a blanket exclusion of coverage for viral load tests) is available that can serve the employer's cost management goals, and the employer does not adopt it instead of the discriminatory one, then the employer should be found to have violated the ADA.

In sum, the structure of the ADA, its legislative history, and Alexander v. Choate support disparate impact claims in response to universal exclusions or other terms and conditions in health insurance plans that disproportionately affect a particular disability or disabilities. As a matter of symmetry, the ADA should prohibit both intentional denial of coverage for a disability *and* universal plan limitations that produce the same result: an effective denial of coverage.

II. The Health Insurance Portability and Accountability Act of 1996

[Author's note: subsequent drafts of this paper will include an extensive discussion of HIPAA and its relationship to the ADA and other relevant federal laws. In the interim, readers are referred to the

attached memorandum on HIPAA prepared by the Georgetown Federal Legislation Clinic.]

III. ERISA

[Author's note: subsequent drafts of this paper will also include a fuller discussion of ERISA protections.]

Some plaintiffs have challenged disability-based distinctions in self-insured health plans under ERISA's anti-discrimination provisions. But courts have consistently held that employers have broad discretion to modify their health plans, and that employees have no vested right to a certain level of health care benefits. For instance, in McGann v. H&H Music Co.,²⁶⁰ the Fifth Circuit Court of Appeals held that an employer could reduce its lifetime maximum for AIDS-related claims from \$1 million to \$5,000 because there was no evidence of intentional discrimination against the plaintiff and the continued availability of \$1 million in lifetime coverage was not a right to which the plaintiff may have become entitled.²⁶¹ The court stated that Congress did not intend for ERISA to circumscribe employers' control over the content of their benefits plans, and that it is permissible under ERISA for employers to discriminate among categories of diseases.²⁶²

Because ERISA pre-empts all state insurance regulation of self-insured plans, employers enjoy broad discretion in discriminating among diseases and disabilities. The only antidiscrimination protection under ERISA is found in § 510, which prohibits employer actions taken against an employee who participates in a pension benefit plan when the actions are taken for the "purpose of interfering with the attainment of any

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

²⁶¹ *Id.* at 404-08.

²⁶² *Id.* at 407-08. See also Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993) (holding there was no ERISA violation where an employer modified its self-funded health plan to include \$25,000 lifetime benefit cap for AIDS); Isbell, *supra* note __, at 121-22.

right to which such participant may become entitled under the plan." 29 U.S.C. § __ (1993 & Supp. 1994).



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COMMENTS ON INTERIM RULES IMPLEMENTING
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The following comments address the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA), in light of the nondiscrimination provisions of the Americans with Disabilities Act (ADA). ADA and HIPAA have distinct goals and purposes which shape the manner in which they apply to the provision of health insurance in this country.

The primary goal of the ADA is to prohibit discrimination against persons with disabilities.¹ 42 U.S.C. § 12101(b)(1). In the insurance context, this means that an employer or

¹ The ADA defines "disability" as:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having an impairment.

42 U.S.C. § 12102(2). Courts have found the term disability to include physical or mental impairments as diverse as asymptomatic HIV, *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997); blindness in one eye, *Doane v. City of Omaha*, 115 F.3d 624 (8th Cir. 1997); multiple sclerosis, *Lowe v. Angelo's Italian Foods*, 87 F.3d 1170 (10th Cir. 1996); brain cancer, *Wessel v. AIC Security Investigations*, 55 F.3d 1276 (7th Cir. 1995); obesity, *Cook v. Rhode Island*, 10 F.3d 17 (1st Cir. 1993); chronic lower back injuries, *Colwell v. Suffolk Co. Police Dep't*, -- F. Supp. --, 1997 WL 355257 (E.D.N.Y. 1997); and attention deficit hyperactivity disorder, *Bercovitch v. Baldwin Sch.*, -- F. Supp. --, 1997 WL 256092 (D. P.R. 1997).

insurer may not discriminate against people with one disability as compared to those with another disability, or as compared to those without any disability, *unless* there is an actuarial or experiential justification for the insurer's actions.² In other words, while Congress intended for the ADA to prohibit *discrimination* on the basis of disability in the insurance context, it did not intend for the ADA to achieve universal health care. Under the ADA, an employer or insurer may still make disability-based distinctions if such distinctions are based on sound actuarial principles or actual or reasonably anticipated experience.

In contrast, one of HIPAA's specific goals is to prohibit insurance companies from even considering an individual's health status when determining that individual's eligibility for health insurance. HIPAA represents a decision by Congress that, as a matter of public policy, *all* individuals -- not just healthy individuals -- should have access to adequate health insurance.

I. HIPAA's Prohibitions Against Discrimination in Enrollment

HIPAA prohibits a group health insurance plan from discriminating on the basis of health status-related factors in determining whether an individual is *eligible* to enroll in a plan, and in determining what *premiums or contributions* the individual will be required to pay. Specifically,

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on [any] health status-related factors in relation to the individual or a dependent of the individual. . .

history, genetic information, and disability. *See, e.g.*, 29 U.S.C. § 1182. It is our belief that any person with a “disability” protected under the ADA has a “health status-related factor” under HIPAA. This comment shall use the term “disability” when discussing the nondiscrimination provisions of the ADA and the term “health status-related factor” when discussing the nondiscrimination provisions of HIPAA.

² *See* discussion, *infra* (discussing application of the ADA in the insurance context).

§ 702(a)(1).³ Moreover,

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

§ 702(b)(1).

Thus, as correctly noted in the interim regulations, HIPAA prohibits discrimination on the basis of health status-related factors at the enrollment stage *regardless* of any actuarial or experiential justification that the insurer could assert. Under HIPAA, therefore, a group health plan could not refuse to insure an individual with cancer or refuse to cover pre-existing cancer-related medical needs, nor could it charge a higher premium to that individual as compared to others in the group, regardless of any actuarial or experiential justifications for such actions. Similarly, a plan could not charge higher premiums to individuals who had been hospitalized in the past as compared to those who had not, nor to those who had a genetic predisposition for a particular condition as compared to those who did not. And, a group health plan could not refuse to insure individuals with AIDS, HIV-negative partners of people with AIDS, nor people who contracted AIDS through the commission of illegal acts (e.g., use of intravenous needles, or the practice of sodomy in some states).⁴

³ Since the HIPAA nondiscrimination provisions are substantively the same, *see* 29 U.S.C. § 1182, 42 U.S.C. §300gg-1, and 26 I.R.C. § 9802, this comment shall, for the sake of simplicity, refer only to section 702 (29 U.S.C. § 1182).

⁴ A number of practices discussed in this paragraph would also violate the ADA. Under the ADA, however, an employer or insurer would have the opportunity to attempt to defend these actions on the grounds that they were actuarially justified or based on actual

The latter two examples fall within the definition of the health status-related factor "evidence of insurability." The source of an individual's injury or the *reasons* a person needs medical care do not justify exclusion of an individual from a group health plan. *See* House Conf. Rep. No. 736, 104th Cong., 2nd Sess. at 186 (1996) [hereinafter Conf. Rep.] ("The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in [arguably dangerous] activities . . ."). Similarly, an individual's *association* with a person who has a health condition cannot be the basis for exclusion. *See id.*

The central purpose of HIPAA, then, is to expand plan coverage, not to dictate the benefits that plans provide. This interpretation of the statutory language fits squarely within the stated intent of HIPAA -- to provide greater access to health coverage to those who need it the most. S. Rep. No. 156, 104th Cong., 1st Sess. at 13 (1995) [hereinafter S. Rep.]; *cf.* H.R. Rep. No. 496, 104th Cong., 2nd Sess. at 70 (1996) [hereinafter H.R. Rep.]. It is also plainly supported by the legislative history. Conf. Rep. at 186-187; S. Rep. at 19; H.R. Rep. at 76. The final regulations should include a non-exhaustive list of examples of actions, such as the ones noted above, that would violate HIPAA.

II. HIPAA's Prohibitions Against Discrimination in Benefits

The interim rules implementing HIPAA's nondiscrimination provisions sought comments concerning, *inter alia*, "the extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits" and "application of the prohibitions on

experience or reasonably anticipated experience. *See* discussion, *infra*. In contrast, HIPAA prohibits such practices categorically.

discrimination between groups of similarly situated individuals." 62 Fed. Reg. 16894, 16902 (April 8, 1997). We believe that, except in certain limited instances discussed below, HIPAA (a) permits group health plans to place limitations or restrictions on benefits, and (b) permits these limitations or restrictions to differ as between groups of similarly situated individuals (e.g., faculty members vs. clerical staff) -- even though these limitations may result in the differential treatment of persons with disabilities and other medical conditions. We reach this conclusion on the basis of the statute's plain language, its legislative history, and Congress' stated purpose.

We are also guided in this conclusion by the fact that Congress was aware of the fact that the ADA was already in place and already prohibited a range of practices in the benefits area. Indeed, a number of insurance practices that would not violate HIPAA would still violate the ADA.⁵ Thus, the final regulations to HIPAA should clearly state that they are not intended to override or reduce the protections already afforded by the ADA.

A. In general

In enacting HIPAA's general prohibition on discrimination, Congress included a construction clause, section 702(a)(2). This section provides that, to the extent consistent with HIPAA's rules governing pre-existing conditions, HIPAA's non-discrimination provision does not

require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage.

§ 702(a)(2)(A).

⁵ See discussion, *infra*.

The plain meaning of this text is that HIPAA's prohibition against discrimination in section 702(a)(1) does not require group health plans to provide *particular* benefits above and beyond those already provided under the terms of the plan.⁶ For example, section 702(a)(1) would not require a group health plan to pay for substance abuse treatment if the plan did not already cover substance abuse treatment. In other words, HIPAA does not mandate a minimum set of benefits that must be offered by group health plans.

In addition, HIPAA does not

prevent [a group health plan, or group health insurance coverage,] from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

§ 702(a)(2)(B). The plain meaning of this text is that under HIPAA's prohibition, a plan may still establish limitations on the amount, level, extent, or nature of the benefits or coverage provided to similarly situated individuals. Thus, for example, a limit on the number of days per year a plan pays for plan members to be hospitalized would not violate HIPAA, so long as all similarly situated plan members were treated the same.

Finally, as noted above, while HIPAA prohibits group health plans from charging different premiums or contributions to similarly situated individuals, it allows, by implication, group health plans to charge different premiums or contributions to non-similarly situated individuals. § 702(b)(1).

1. “Similarly situated”

⁶ A plan could not, however, change the terms of the plan once an individual with a particular medical condition enrolled in the plan, if the change was implemented in response to that individual's enrollment. See discussion, *infra*.

The key question then, as the interim regulations well noted, is: "what does the term 'similarly situated' mean?" 62 Fed. Reg. at 16902. In particular, does the term "similarly situated" include a consideration of health status-related factors?

After serious reflection, it appears to us that the term "similarly situated" should not be interpreted as including a consideration of health status-related factors. While this is a close question, our conclusion is guided by HIPAA's plain language and legislative history, coupled with the background fact of the ADA's existing prohibitions on discrimination in insurance benefits.

The legislative history accompanying the final version of HIPAA strongly suggests that "similarly situated" refers to *non*-health status-related factors. Examples of groups noted in the legislative history as not being similarly situated include part time vs. full time employees, and individuals residing in different geographic locations. *See* Conf. Rep. at 187. Under this interpretation, section 702(a)(2) would allow a university to provide better benefits to its faculty members than to its clerical staff (e.g., only faculty members get dental benefits) and better coverage (e.g., a \$500,000 cap on benefits for faculty members as compared to a \$100,000 cap for clerical staff). Similarly, section 702(b)(1) would allow the university's group health plan to charge higher monthly premiums to the clerical staff than to the faculty members.⁷ In all these examples, the university is distinguishing only between non-similarly situated individuals; similarly situated individuals are treated the same.⁸

⁷ Again, it would be useful if the final regulations provided examples along these lines.

⁸ For example, clerical staff with a history of heart disease would be charged the same premium as clerical staff without a history of heart disease. Faculty members with AIDS would be entitled to up to \$500,000 worth of medical care, just like faculty members without AIDS.

To pass muster under HIPAA, however, the differential treatment in all these examples would have to be based on *non-health status-related factors*. If, instead, the differential treatment was based *nominally* on non-health status-related factors, but *actually* on health status-related factors such as claims experience or prior receipt of health care (e.g., prior experience showing that clerical staff seek medical care more often than faculty members), this would violate HIPAA. The Conference Statement supports this interpretation. Conf. Rep. at 187.

For example, under HIPAA, an employer could charge lower premiums to employees on the West Coast if the employer was opening new offices in California and in Oregon and needed to induce employees to move out there. But, distinctions based on geographic location that actually were based on presumptions about health status-related factors (e.g., the presumption that people who live on the West Coast live healthier lifestyles than people who live on the East Coast) would violate HIPAA. Similarly, an employer could not rely on geographical distinctions to explain its decision to charge higher premiums on the West Coast when in fact the decision was based on the employer's experience that more people in its California office have AIDS.

Given these examples, the final regulations should make clear that differential treatment based nominally on non-health status-related factors but actually on health status-related factors violates HIPAA. When such distinctions are challenged under HIPAA, the employer or group health insurance plan should bear the burden of establishing that groups of individuals are treated differently on the basis of *non-health status-related factors*, as this evidence is in the possession of the plan, not the individual. *Cf. Cloutier v. Prudential Ins. Co.*, --F. Supp. --, 1997 WL 254197, at *8 (N.D. Ca. 1997). This burden of proof requirement should also be noted in the final regulations.

As noted, the interpretation of the term "similarly situated" is a close question. Thus, for example, the term could mean "similarly situated with respect to health status-related factors" -- i.e., persons who, based on sound actuarial data, actual experience, or reasonably anticipated experience, have a similar morbidity/mortality profile or otherwise pose a similar risk to the insurer. Such an interpretation, however, could undermine the very purpose of HIPAA, as it would allow insurers to affirmatively distinguish between individuals on the basis of their health status related-factors.⁹

If "similarly situated" does not mean "similarly situated with respect to health status-related factors," a group health plan could treat all similarly situated individuals with cancer (e.g., all faculty members with cancer) less well vis-a-vis benefits than those who are healthy (e.g., faculty members with no health problems), or even less well than those with another medical condition, such as epilepsy (e.g., all faculty members with epilepsy), without violating HIPAA. Indeed, this is exactly what the Conference Statement says:

It is the intent of the conferees that a plan cannot knowingly be designed to exclude individuals and their dependents on the basis of health status. However, generally applicable terms of the plan may have a disparate impact on individual enrollees. For example, a plan may exclude all coverage of a specific condition, or may include a lifetime cap on all benefits, or a lifetime cap on specific benefits. Although individuals with the specific condition would be adversely affected by an exclusion of coverage for that condition, and individuals with serious illnesses may be adversely affected by a lifetime cap on all or specific benefits, such plan characteristics would be permitted as long as they are not directed at individual sick employees or dependents. . . .

Conf. Rep. at 186-87.

⁹ See Conf. Rep. at 187 ("[T]his provision is meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums based on their health status and other related factors that could lead to higher health costs.").

Advocates for persons with disabilities would ordinarily be concerned with this significant gap in HIPAA's nondiscrimination mandate. This particular gap, however, was already addressed by Congress when it enacted the ADA in 1990.

2. The ADA overlay

The ADA prohibits discrimination on the basis of disability in employment and in public accommodations. This prohibition extends to disability-based distinctions in the insurance context. *See* 42 U.S.C. § 12112(a) (prohibiting discrimination in the “terms, conditions, and privileges of employment”); 42 U.S.C. §§ 12181(7)(F) & 12182(a) (prohibiting discrimination in the “full and equal enjoyment of the goods [and] services” of public accommodations, including insurance companies).

The ADA’s nondiscrimination mandate is not absolute. The law contains a provision that allows an insurer to underwrite, classify, and administer risks, so long as (a) the plan is a “bona fide” plan that contains terms based on or not inconsistent with state law, and (b) disability-based distinctions are not used as a “subterfuge” to evade the purposes of the ADA. 42 U.S.C. § 12201(c). The legislative history explains the meaning of this provision:

[W]hile a plan which limits certain kinds of coverage based on classification of risks 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.

H.R. Rep. No. 485, 101st Cong., 2nd Sess., pt. II at 136-37 (1990).

In other words, although limits on treatments and procedures applied *uniformly* to all plan members are still allowed, an employer or insurance company is *not* allowed to limit or deny

coverage completely for one disability or to treat that disability differently from others, unless that “refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.” *Id.*¹⁰

Case law concerning applicability of the ADA in the insurance context is still developing. At least one court has held that a “cap” on AIDS-related benefits violates the ADA, and numerous insurance companies with AIDS caps have eliminated their AIDS caps and entered into consent decrees with the EEOC.¹¹ At least one court has found a violation of the ADA where the insurer covered a particular treatment for people with some disabilities but not with

¹⁰ See, e.g., *World Ins. Co. v. Branch*, --- F. Supp. ---, 1997 WL 274732 (N.D. Ga. 1997) (insurance contract capping coverage for AIDS-related treatment at \$5,000 but treatment for all other catastrophic illnesses at \$2,000,000 violates the ADA absent any actuarial evidence distinguishing AIDS from other catastrophic conditions); *Cloutier v. Prudential Ins. Co. of Am.*, --- F. Supp. ---, 1997 WL 254197 (N.D. Cal. 1997) (denying defendant’s motion for summary judgment where no evidence that insurer’s decision to deny coverage to applicant based on partner’s HIV-positive status was based on actuarial principles or reasonably anticipated experience); *Doukas v. Metro. Life Ins. Co.*, 950 F. Supp. 422 (D. N.H. 1996) (denying defendant’s summary judgment motion where question of fact concerning whether insurer’s decision to deny mortgage insurance to woman with bipolar disorder was actuarially justified); *Anderson v. Gus Mayer Boston Store of Del.*, 924 F. Supp. 763 (E.D. Tex. 1996) (denial of insurance altogether can never be actuarially justified). See generally Chai R. Feldblum, *The Employment Sector: Medical Inquiries, Reasonable Accommodations, and Health Insurance, in Implementing the Americans with Disabilities Act* 81 (Jane West, ed. 1996).

¹¹ See *World Ins. Co.*, 1997 WL 274732; see also *EEOC v. Mason Tenders Welfare Trust Fund, et. al.*, C.A. No. 93-Civ.-1154-JES (S.D.N.Y. 1996) (consent decree); *EEOC v. Laborers Dist. Council Bldg. & Const. Health and Welfare Fund*, C.A. No. 94-3971 (E.D. Pa. 1995) (same); *EEOC & Johnson v. Monroe Foods, Inc. et. al.*, C.A. No. Y93-2925 (D. Md. 1994) (same); *EEOC v. The Gage Co.*, C.A. No. 94-CV-72089-DT (E.D. Mich. 1994) (same); *Estate of Mark Kadinger, et. al. & EEOC v. Int’l Bhd. of Elec. Workers, et. al.*, C.A. No. 3-93-159 (D. Minn. 1993) (same); *EEOC v. Allied Serv. Div. Welfare Fund, S. Pac. Lines; Allied Serv. Div.*, C.A. No. 93-5076-WMB, (C.D. Cal.) (same).

others.¹² And a number of courts have held that insurance companies cannot make disability-based distinctions absent sound actuarial or experiential data.¹³

Not all case law, however, has been favorable to persons with disabilities. A majority of courts have held that former employees seeking insurance benefits post-employment do not have standing under Title I as “qualified individuals with disabilities.”¹⁴ And at least one court has suggested that the distinction between coverage for physical and mental benefits may be actuarially justified.¹⁵ Finally, plaintiffs have often found it difficult to challenge insurance companies’ alleged actuarial justifications.

¹² See *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958 (8th Cir. 1995) (granting preliminary injunction requiring insurance company to provide high dose chemotherapy treatment (HDCT) to patient with breast cancer because evidence suggested that HDCT was accepted and effective remedial measure for breast cancer, and plan provided HDCT treatment for other comparable conditions); *but see Hilliard v. Bellsouth Medical Assistance Plan*, 918 F. Supp. 1016 (S.D. Miss. 1995) (fact that insurer offered “alternative” health plan for conditions requiring high cost treatments was sufficient to overcome charge of disability-based distinction, even though the standard plan covered the same high-cost treatment for three other types of cancer).

¹³ See note 10, *supra*.

¹⁴ See *Parker v. Metropolitan Life, Ins. Co.*, 99 F.3d 181 (6th Cir. 1996), *en banc* *hr’g granted*, 107 F.3d 359 (1997) (former employee receiving long-term disability benefits did not have standing under Title I because she could no longer perform essential functions of the job); *Gonzales v. Garner Food Services*, 89 F.3d 1523 (11th Cir. 1996), *cert. denied*, 117 S.Ct. 1822 (1997) (“Since [plaintiff] was neither a job applicant nor a current employee capable of performing essential functions of an available job with [employer] at or subsequent to the time the alleged discriminatory conduct was committed, he was not a [qualified individual with a disability] within the meaning of the ADA.”); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039 (7th Cir. 1997) (employee who was “totally and permanently disabled” could no longer perform essential functions of the job and, therefore, did not have standing under Title I); *but see Graboski v. Giuliani*, 937 F. Supp. 258 (S.D.N.Y. 1996) (retired firefighters had standing to challenge exclusion of disability retirees from the class eligible to receive certain pension benefits).

¹⁵ *Leonard F. v. Israel Discount Bank of N.Y.*, slip op., No. 95 Civ. 6964 (CLB) (S.D.N.Y. June 26, 1997).

Thus, to the extent there are gaps in the ADA's protections, HIPAA has filled them by prohibiting *all* discrimination at the enrollment stage, regardless of any actuarial justification. This extension of the non-discrimination mandate is a welcome addition to the fight against discrimination against persons with disabilities. In many ways, however, the ADA is still broader in coverage than HIPAA, particularly with respect to non-discrimination in benefits. As such, it is imperative that HIPAA's regulations make clear that HIPAA's protections are co-extensive with, rather than overriding or contradicting, the protections afforded persons with disabilities under the ADA.¹⁶

B. As applied to particular individuals

There is at least one area in which HIPAA and the ADA directly overlap, and that is with respect to disability-based distinctions at the benefits level that are targeted at *particular* individuals. Although section 702(a)(2) allows a plan to establish *general* limitations or

¹⁶ See *Morton v. Mancari*, 417 U.S. 535 (1974) (“when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective”). Indeed, if Congress *had* intended to override the ADA, it would have said so clearly. Absent any such statement from Congress, the ADA's protections still stand. See, e.g., *Chisom v. Roemer*, 501 U.S. 380, 396 (1991) (rejecting proposed statutory construction because “if Congress had such an intent, Congress would have made it explicit in the statute, or at least some of the Members would have identified or mentioned it at some point in the unusually extensive legislative history”). Cf. *Harrison v. PPG Industries, Inc.*, 446 U.S. 578, 602 (1980) (Rehnquist, J. dissenting) (“In a case where the construction of legislative language such as this makes so sweeping and so relatively unorthodox a change as that made here, I think judges as well as detectives may take into consideration the fact that a watchdog did not bark in the night.”). In fact, the HIPAA Senate Report specifically states: “[t]he committee does not intend for the language in the [nondiscrimination provisions] to . . . change rights. . . under the Americans with Disabilities Act.” S. Rep. at 19 (emphasis added). Although this language is not included in the Joint Explanatory Statement of the Committee of the Conference, nothing changed in the Conference Report’s nondiscrimination language to indicate a change in intent.

restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals (e.g., it allows faculty members to receive better benefits than clerical staff), we believe this section does *not* allow a plan to establish limitations or restrictions targeted at a *particular individual or individuals* in the plan.

A real life example is illustrative. In *Gonzales v. Garner Food Services*, 89 F.3d 1523 (11th Cir. 1996), *cert. denied*, 117 S.Ct. 1822 (1997), an employer, Garner Food Services (GFS), fired its employee, Timothy Bourgeois, after it learned, as a result of the insurance claims Bourgeois had submitted, that Bourgeois had AIDS. GFS acknowledged that it fired Bourgeois "to avoid paying future health insurance claims" for him. 89 F.3d at 1524. After Bourgeois elected under COBRA to continue his group health insurance benefit coverage, GFS amended its plan. *Id.* The plan originally provided health insurance coverage up to a \$1 million lifetime limit. *Id.* After GFS learned that Bourgeois had AIDS, it placed a cap on AIDS-related treatments up to \$10,000 annually with a lifetime maximum limit of \$40,000. *Id.*

Although the AIDS cap was, ostensibly, a general limitation on the amount and nature of benefits the plan provided, it in fact singled out one particular individual, on the basis of his health status, and provided him lesser benefits than other similarly situated individuals (i.e., those who had worked for GFS, had left GFS' employ either voluntarily or as a result of termination, and had elected to continue their health insurance coverage under COBRA).

GFS' actions clearly would have violated the intent of HIPAA's drafters. As the legislative history notes:

[Lifetime caps on all or specific benefits] would be permitted *as long as they are not directed at individual sick employees*. . . .

It is the intent of the conferees that a plan or coverage *cannot single out an individual based on the health status or health status related factors of that individual for denial of a benefit* otherwise provided other individuals covered under the plan or coverage . . .

[HIPAA] preclude[s] health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether.

Conf. Rep. at 186-87 (emphasis added).

In essence, placing the \$40,000 lifetime cap on AIDS-related treatments excluded Bourgeois from coverage altogether, even though other individuals in the plan were still entitled to benefits (e.g., physician visits, prescription drugs, etc.). Once Bourgeois' medical care exceeded the \$40,000 cap, he was no longer eligible for health insurance, at all. Indeed, before Bourgeois died (10 months after his termination), Bourgeois exhausted the benefits available to him under the AIDS cap limit and was denied payment for claims he submitted in excess of that amount, which totaled approximately \$90,000. 89 F.3d at 1525. Given the legislative history and stated purpose of HIPAA, it appears that Congress intended to prohibit such insurance practices.¹⁷

Under HIPAA, the probative factor in these circumstances would be whether the ostensibly general limitation or restriction was targeted at a particular individual or individuals. For example, a \$1000 yearly cap on pharmaceutical benefits would not, on its face, violate HIPAA. If an employee could demonstrate, however, that the pharmaceutical cap was instituted

¹⁷ The Eleventh Circuit affirmed the lower court's dismissal of the case because it found that Bourgeois was not a "qualified individual with a disability" and thus not entitled to the ADA's protections. 89 F. 3d 1523. The court noted that Bourgeois neither held nor desired to hold a position with GFS at the time of the alleged discriminatory conduct, but rather, participated in the health benefit plan on the basis of his status as a *former* employee. Id. at 1526.

only *after* the insurance company learned the employee had been diagnosed with lupus, the insurance company's actions *would* violate the statute.

III. Conclusion

HIPAA's nondiscrimination provisions are broader, in some ways, and narrower, in others, than those in the ADA. The HIPAA regulations should recognize the complementary relationship between the two statutes, and make clear that HIPAA and its regulations do not negate the protections already afforded persons with disabilities under the ADA.



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Discrimination in the HIV/AIDS Epidemic: A Fifty-State Survey of Anti-Discrimination Laws

SUMMARY

From the beginning of the HIV epidemic, there has been widespread legislative activity on the federal, state, and local levels intended to prohibit discrimination on the basis of HIV infection. The primary federal enactment, the Americans with Disabilities Act (ADA), has generally been viewed as the major legislative response to HIV discrimination. Many states, and some localities, however, have adopted anti-discrimination standards that prohibit HIV discrimination in employment, housing, public accommodations, government services, and other areas. Despite the legislative history of the ADA, federal agency interpretations of that statute, and early court cases that frequently accepted HIV infection as a disability, the Supreme Court's grant of certiorari in *Bragdon v. Abbott* gives cause to examine the extent of coverage for asymptomatic HIV infection under state law as an alternative to federal law.

State statutes can be placed into one or more of four categories: (1) HIV-specific statutes that by their explicit terms prohibit HIV-based discrimination; (2) statutes that prohibit the use of HIV test information or HIV testing to discriminate; (3) statutes that incorporate the 3-pronged "federal disability" definition; and (4) statutes that use a non-specific disability definition, but do not incorporate the federal disability definition. While HIV-specific statutes provide unequivocal coverage, such statutes providing coverage equivalent to other disabilities have been enacted in only five states. Statutes that prohibit the use of HIV information offer protection in some contexts, but in general their coverage is under inclusive, and only three states have adopted broad prohibitions against the discriminatory use of such information. The most widespread disability standard is that of federal law, which has been adopted by 40 states. Given the reliance of many states on this federal definition, there is a significant likelihood that the *Abbott* ruling will resonate, for better or worse, on the state level. Finally, among the minority of states that use a disability definition other than the federal definition, eight states use a disability definition that appears to be broader than that provided under the federal law, while five states and Puerto Rico do not include a specific disability definition or include one that is weaker than federal law.

Given the absence of reliable state data on rates of HIV infection on a national basis, this study used rates of AIDS cases as reported by the CDC as an approximate measure of the demographics of state HIV anti-discrimination protection. Although only one percent of the cases are reported in jurisdictions that significantly limit or have no protection for individuals with HIV, less than one-third (29 percent) of the cases are reported in jurisdictions with clearly established protection for individuals with HIV. Roughly half the cases (47 percent), however, are reported in jurisdictions in which there is substantial uncertainty regarding coverage of HIV infection.



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Discrimination in the HIV/AIDS Epidemic: A Fifty-State Survey of Anti-Discrimination Laws

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Discrimination in the HIV/AIDS Epidemic: A Fifty-State Survey of Anti-Discrimination Laws

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From the earliest moments of the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic there emerged an alliance among public health and community-based organizations emphasizing the importance of effective legislation prohibiting discrimination. Every major government,¹ medical,^{2,3} public health,⁴ legal,^{5,6} and civil liberties⁷ organization to issue a report on the epidemic condemned discrimination.⁸ The Presidential Commission on the Human Immunodeficiency Virus Epidemic, in 1988, was particularly insistent about the transcending importance of federal legislation to safeguard against invidious discrimination:⁹

As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination ... will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone.

Recommendations for anti-discrimination legislation relied on three justifications — discrimination violates basic tenets of individual justice, damages the economic and social fabric of America, and weakens the nation's abilities to prevent and treat HIV/AIDS.

Discrimination based on an infectious condition is just as inequitable as discrimination based on race, gender, or disability. In each case, people are treated inequitably not because they lack inherent ability, but solely because of a status over which they have no control. Complex and often pernicious mythologies develop about the nature, cause, and transmission of disease. As Justice Brennan recognized, "society's accumulated myths and fears about disability and disease are just

Brennan recognized, “society’s accumulated myths and fears about disability and disease are just as handicapping as are the physical limitations that flow from actual impairment. Few aspects of handicap give rise to the same level of public fear and misapprehension as contagiousness.”¹⁰

Persons living with HIV/AIDS have to endure not only archaic attitudes that they present a health threat, but also moral disapproval of their behavior. The fact that HIV/AIDS is associated in the public consciousness with traditionally disfavored groups -- gay men, injection drug users, and commercial sex workers -- only heightens the concern about prejudicial treatment.

Discrimination against persons living with HIV/AIDS is economically and socially detrimental. By rendering talented individuals unemployable or uninsurable, or by impairing their ability to secure housing or receive health care or other services, discrimination tears at the social and economic fabric of the nation.

Finally, discrimination undermines public health efforts to identify infections, prevent transmission, and provide care and treatment for persons living with the HIV disease. The public health strategy is to encourage the population to be tested, to educate the population to avoid risk behaviors such as unprotected sex and the sharing of drug injection equipment, and to provide opportunities for humane care and effective treatment for all persons infected with HIV. From the beginning, it has been clear that if individuals fear the personal, social and economic consequences of being diagnosed with HIV/AIDS, they may forego testing, fail to discuss their health and risk behaviors with counselors or health care professionals, and refrain from entering the health care system for treatment. Consequently, the need for law reform to protect against discrimination emerged as one of the most important public health strategies in the early years of the epidemic.

The social, economic, and public health effects of HIV/AIDS epidemic in the 1980s¹¹ set in

motion a series of events that would lead to enactment of the most significant civil rights legislation since the enactment of the Civil Rights Act of 1964. A coalition of organizations and people committed to the rights of persons with HIV/AIDS and persons with disabilities formed to seek federal legislation designed to proscribe discrimination.^{12,13}

The Americans with Disabilities Act of 1990 (ADA) became the federal anti-discrimination law that had been so widely and earnestly sought. The National Commission on the Acquired Immune Deficiency Syndrome, in 1991, applauded the passage of the ADA: “The landmark Americans with Disabilities Act (ADA) is a significant step toward protecting the rights of all disabled Americans, including people with HIV disease. The passage of the ADA with the inclusion of protections for people with HIV disease is a victory worth celebrating.”¹⁴

That celebration was not long-lived. A consensus emerged initially that the ADA covers persons at all stages of HIV infection, ranging from pure asymptomatic infection to CDC-defined AIDS. The judiciary, however, beginning in the mid-1990s, began to tear down this consensus. Courts began to critically question whether pure asymptomatic HIV infection is automatically to be considered a disability within the meaning of the ADA.^{15,16} Rather, these courts found that the statute’s requirement for “individualized determinations” of a person’s disability to be dispositive. Consequently, according to these courts, each time the case of a person with HIV infection is litigated, the court must make an individualized determination as to whether the infection actually limits, in a substantial way, a major life activity. In its first AIDS case ever, the Supreme Court will decide whether, and to what extent, persons with HIV infection are protected under the ADA.

In *Abbott v. Bragdon*,¹⁷ a dentist refused to fill a dental cavity of an HIV infected patient. The patient then brought suit alleging that the refusal violated the ADA. The dentist conceded that

his professional office was covered by the ADA, but argued that providing services to the infected patient, because of the risk of HIV transmission, would pose a direct threat to his health. Additionally, he argued that the plaintiff, who did not have symptoms of HIV illness, was not an individual with a disability under the ADA. The lower courts rejected the dentist's defenses, concluding that the dentist was unable to show that in 1994, when the case arose, there was evidence that treating an infected patient posed a significant risk. The plaintiff's infection, which she testified resulted in her decision against becoming pregnant, was viewed as substantially limiting the major life activity of reproduction. The Supreme Court agreed to consider three questions presented by the case: (1) whether reproduction is a major life activity; (2) whether asymptomatic HIV infection is a *per se* disability under the ADA; and (3) whether the courts should defer to a health care provider's reasonable professional judgment.

The stakes of the Supreme Court's decision are high. When the ADA was enacted most, if not all, persons infected with HIV were expected to develop symptoms that give rise to disability. Since that time science and medicine have made astonishing advances in the treatment of HIV, and future progress in treatment is virtually assured. The United States has recently entered a therapeutic era for HIV disease allowing many individuals to remain symptom-free, possibly for indefinite periods of time. Rather than a latent infection as previously believed, HIV pathogenesis is now known to produce high rates of viral replication and CD4+ cell death soon after transmission.¹⁸ Recent findings^{19,20,21,22} suggest that a treatment regime of HIV reverse transcriptase inhibitors and protease inhibitors reduces mortality and delays disease progression.¹ Although the long-term

¹ Persons on highly active antiretroviral therapy (HAART) have also demonstrated lower levels of circulating virus, suggesting that treatment benefits not only the individual, but may reduce the risk of transmission as well. Fiscus SA, Adimora AA, Schoenbach VJ, et al. Perinatal

benefits are unknown and much research remains to determine the role of therapy in delaying or preventing clinical manifestations of disease, innovative therapies are already dramatically affecting the population's progression from HIV infection to CDC-defined AIDS.²³ As more and more persons with HIV infection remain asymptomatic, the protection of this group under the ADA becomes critically important.

The *raison d'être* for enactment of the ADA was to help assure equity and justice for persons living with HIV/AIDS, and to promote the public health. Both of these rationales remain as important today as they ever were. For the purposes of a person's claim to be free from discrimination, no morally relevant distinction can be made between a person with asymptomatic HIV infection and a person with symptomatic disease. The public health purposes behind the ADA are even stronger today than they were at the time of the law's enactment. During the early 1990s, medicine had relatively little to offer persons with HIV. Consequently, if a person shied away from the health care system due to a fear of discrimination, arguably, there would be little public health disutility. The dramatic improvements in treatment now make it essential for persons to access the health care system at the very earliest signs of infection. If the Supreme Court were to find that a person with asymptomatic infection is not automatically covered by the ADA, what message would that send? Would persons with infection be dissuaded from being tested, counseled, and treated due to the fear of social risk? The Court's decision, therefore, could have noticeably adverse public health consequences. Even if the Court were to hold that a person with asymptomatic infection *might* qualify as a person with a disability (e.g., because of the reproductive effects of HIV

HIV infection and the effect of zidovudine therapy on transmission in rural and urban counties. JAMA 1996;275:1483-1494.

infection),² this could still deter care-seeking behavior. If persons at risk for HIV understand that, in order to qualify for anti-discrimination protection, they must first litigate the issue, it could serve as a deterrent. In sum, access to testing, counseling, and treatment are now more important than ever, and a decision to limit anti-discrimination protection to asymptomatic individuals would be very harmful to the mission of health care and public health professionals.

If the Supreme Court does limit this protection on the federal level, the question arises whether persons with asymptomatic HIV infection would be covered under state and local anti-discrimination law. The ADA itself envisages that states and localities have provided, and will provide, anti-discrimination protection to persons with disabilities. Congress expressed its will not to interfere with these state statutes and local ordinances, provided they afford as much, or greater, protection against discrimination:²⁴

Nothing in this chapter shall be construed to invalidate or limit the remedies, rights, and procedures of any Federal law or law of any State or political subdivision of any State or jurisdiction that provides greater or equal protection for the rights of individuals with disabilities than are afforded by this chapter.

Two kinds of state and local statute exist throughout the country that potentially could be used to afford this kind of protection. The first, state and local disability laws, may include HIV infection within the definition of “disability” that would not be affected by an adverse Supreme Court ruling. The second, HIV-specific laws (relating, for example, to privacy, anti-discrimination,

² There would be several serious concerns with a Supreme Court decision that focused on reproductive impairments as a basis for a finding of disability. The most obvious problem is that it would exclude from protection persons who have no reproductive impairment: those who are not of reproductive age (the elderly and children); those who were infertile prior to acquiring the infection and, possibly, those who had no intention to reproduce (e.g., some lesbians and gay men). No morally relevant distinction could be made among these groups for the purposes of affording anti-discrimination protection.

and testing) may include express or implicit references to HIV infection that could provide effective redress. In this paper, we provide the results of a fifty-state survey of these two kinds of law. First, we provide a descriptive and analytical discussion of these laws, offering our views as to whether they provide protection independent of federal provisions. Second, we provide a set of tables that summarize the law in each of the fifty states. Finally, in an appendix, we provide a state-by-state summary of the law, with official citations so that readers can review the entire text for themselves. Before offering this state-by-state perspective, we provide a brief discussion of the relevant definitions of “disability” under the ADA, together with an explanation about why that definition has widely been understood to include persons with asymptomatic HIV infection.

The ADA’s Definition of “Disability”

The heart of the ADA is the prohibition, in varying contexts, of discrimination against individuals with a real or perceived disability. Yet the ADA does not identify any specific conditions as disabilities; there is no statutory listing, whether exclusive or inclusive, of disabilities. Instead, in an effort to ensure broad and flexible coverage, the ADA includes a general definition of what constitutes a disability. One necessary task, then, in applying any part of the ADA to HIV infected individuals is to establish that HIV disease meets the statutory criteria.

According to the ADA, a *disability* is a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or a record of such impairment, or being regarded as having such an impairment.²⁵ This definition applies throughout the ADA. Thus, cases concerning the meaning of disability that arise under Title I (employment) are equally applicable to Titles II (public services) and III (public accommodations). Individuals diagnosed with

AIDS, given the extent of disease progression, are clearly individuals with a disability and, hence, fall within the protections of the ADA. In addition, as discussed below, the courts have considered whether asymptomatic HIV infection constitutes a disability in Title I employment cases. The cases (until very recently) established that HIV infection, even if asymptomatic, constitutes a disability. The ADA's legislative history, as covered below, also points to the same conclusion. Thus, it has been widely regarded that individuals with HIV disease who do not have AIDS are entitled to claim the protections of the ADA. Given the statutory structure of the ADA, which contains only a single, over-arching definition of disability, these rulings are applicable to cases involving public services or public accommodations under Titles II or III.

The ADA's coverage also extends to individuals merely regarded as having a disability. Thus, it is unlawful to discriminate against an individual based on the misperception that the person is infected with HIV under the ADA as well as under the laws of many states.²⁶ Persons discriminated against because of their association with a person with HIV infection are also protected,²⁷ as are persons retaliated against because of their opposition to discrimination.²⁸

Pre-Abbott Assumptions that the ADA Covers Persons with Asymptomatic HIV Infection

As the foregoing discussion makes clear, the ADA does not explicitly mention HIV/AIDS. Yet, there existed a sense of complete assurance that strong federal protection was now in force to protect persons at all stages of the disease, ranging from pure asymptomatic HIV infection through to CDC-defined AIDS. This sense of assurance was informed by an understanding of the social and legislative history that gave rise to the ADA, guidance provided by the executive branch, and the interpretation of the statute by the judiciary.

Social and Legislative History of the ADA

Given the social and political forces that led to the ADA, it is not surprising that there existed a widely held view that the law covered persons living with HIV/AIDS. The AIDS community, as we have suggested, played a powerful role in enactment of the legislation and these groups gave no sign of discontent with the coverage provided in the statute. The same could be said of Congress itself. There was ample discussion, and apparent agreement, in Congress that the ADA applied to persons living with HIV/AIDS. Indeed, the excerpt from the Presidential Commission Report cited above was quoted approvingly by congressional committees endorsing passage of the ADA.²⁹ The same legislative history stated, and took almost as given, that both symptomatic and asymptomatic individuals with HIV were protected.³⁰

Throughout the consideration of the ADA during the 101st Congress, protection from discrimination for persons with HIV infection was a stated objective.³¹ The Senate version of the ADA, S. 933, was referred to the Committee on Labor and Human Resources, which considered the issue of HIV infection as a disability.³² The House version, H.R. 2273, was introduced in four committees, two of which considered the issue of HIV infection as a disability under the ADA: the Committee on Labor and Education³³ and the Committee on the Judiciary.³⁴ All legislative reports that considered the issue concluded that HIV infection is an impairment under the ADA and apparently assumed that the impairment caused by HIV is substantial. Furthermore, most of the congressional consideration of HIV focused on the issue of whether HIV, as an infectious disease, should be treated differently from other disabilities under the ADA. Attempts by critics of the ADA to exclude persons with infectious or communicable diseases from coverage under the ADA were unsuccessful, which again emphasizes congressional intent in extending protections.³⁵ Perhaps even

more significantly, the ADA's disability definition is adopted from the Rehabilitation Act, which at the time of congressional consideration of the ADA was widely viewed as including individuals with HIV infection within its protection. Congress indicated that the ADA is to be read in light of existing standards under the Rehabilitation Act.³⁶ Indeed, both the House³⁷ and Senate³⁸ reports on the ADA approved the Department of Justice's memorandum on the Rehabilitation Act that specified: "a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term *disability* because of a substantial limitation to procreation and intimate sexual relationships."³⁹

Executive Branch Interpretation of the ADA

The administrative agencies charged with enforcing the ADA, the Equal Employment Opportunity Commission (EEOC) and the Department of Justice, both concluded that the statute covered all stages of HIV infection. The EEOC's interpretive guidance, recognizing the unique social history of the disease, sets HIV apart from other disabling conditions. "Some impairments," the EEOC states, "may be disabling for particular individuals but not for other, depending on the stage of the disease or disorder.... Other impairments, however, such as HIV infection, are inherently substantially limiting."⁴⁰ The Department of Justice explicitly includes "HIV disease (symptomatic or asymptomatic)" in its regulations and interpretive guidance. The DOJ notes: "The phrase 'symptomatic or asymptomatic' was inserted in the final rule after 'HIV disease' in response to commenters who suggested the clarification was necessary."⁴¹

Judicial Branch Interpretation of the ADA

Early judicial opinions similarly presumed, virtually without explanation, that disability law covered persons with asymptomatic HIV infection.⁴² Certainly, this appeared to be the case with respect to the federal Rehabilitation Act of 1973, the precursor to the ADA. Parmet and Jackson note: “As an initial matter, every reported decision from the mid-1980s up until the passage of the Americans with Disabilities Act in 1990 determined that both AIDS and, when presented, asymptomatic HIV infection constituted disabilities.... In fact, it took only a few years for an overwhelming judicial consensus to develop that HIV- and AIDS- infected individuals were properly protected by existing disability discrimination statutes.” (p.16-17)⁴³

The broad consensus established in Rehabilitation Act jurisprudence continued after the ADA’s enactment. The early cases continued to see the question of whether asymptomatic HIV infection was a covered disability as a settled matter.⁴⁴

The barely spoken consensus on coverage of persons with asymptomatic HIV infection began to crumble in the mid-1990s, just as the first advancements in the treatment of HIV disease were becoming reality. Emphasizing the ADA’s requirement for “individualized determinations”, a concept thoughtfully endorsed by the Supreme Court in *School Board of Nassau County v. Arline*,⁴⁵ courts began to critically question the premise that asymptomatic HIV infection automatically qualifies as a disability.^{46,47} It is not that these, or other, courts were adverse to the idea of protection for persons with HIV infection. Yet, if the statute was to be construed as it actually was written then the courts would have to make a particularized assessment about whether that individual possessed a substantial limitation in their life activities. No matter how persuasive the policy arguments for automatic inclusion of persons with HIV infection, these courts would read the statute literally and

conservatively. If the Supreme Court were to similarly conclude that HIV infection is not a *per se* disability then, construction of state and local anti-discrimination law becomes vital. There follows a description and analysis of this corpus of legislative provisions — both general disability laws and HIV-specific laws.

Overview of State Law Issues

All states have adopted statutes that prohibit discrimination on the basis of disability. But development of disability nondiscrimination law at the state level has not been uniform or consistent, and although many state statutes share certain characteristics, in the realm of HIV nondiscrimination standards, state-by-state statutory analysis and classification reveals significant variations in coverage of HIV. Historically, some states premised their definition of disability on the notion that a significant and permanent impairment of ambulatory ability or other physical functioning, which could be verified by medical examination, was required.⁴⁸ Many states, however, adopted a definition that is consistent with (if not identical to) the federal statutory definition as set forth in the Rehabilitation Act, which provides a less restrictive definition of impairment in terms of severity and duration, as well as extending protection to individuals discriminated against based on a record of disability or the perception of disability. The enactment of the Americans with Disabilities Act in 1990 provided further impetus for state adoption of the federal statutory standard. This definition is now the most widely used, and at least 40 states have at least one statute that contains this definition in some form. Interpretation of these laws frequently references federal regulations or case law directly interpreting the federal definition of disability. Several states, however, have adopted statutory definitions that are apparently more inclusive than the federal definition, typically by

relaxing the requirement that the impairment must substantially limit a major life activity.⁴⁹ Some state statutes, however, refer to “handicap” or “disability” but do not include any definition of those terms.

In response to the widespread problem of discrimination against individuals with HIV, the lack of clarity regarding coverage under state law, and the Justice Department’s interpretation in 1986 against Rehabilitation Act coverage of HIV infection as an infectious disease,⁵⁰ some states and many local governments adopted HIV-specific statutes. Many states also adopted HIV testing and confidentiality statutes and included restrictions on the discriminatory use of testing or test results in some of these statutes.

Interpretation and analysis of state law to determine the scope of HIV coverage presents several complex challenges. First, the specific statutory language, on its face, may allow more than one reasonable interpretation or application. Although state nondiscrimination enforcement agencies frequently interpret these statutory provisions, the weight to be given such interpretations is not always clear. Such interpretations may be issued informally and may not be adopted subsequently by a reviewing court. A definitive interpretation of state law by the highest appellate court of the state, on the other hand, might settle questions of interpretation, but as noted below, only one such ruling has emerged that currently stands as a valid precedent. Of course, a ruling by the highest court in the state is itself subject to interpretation, clarification, or modification in subsequent cases. Generalization regarding the status of HIV infection under state law is further confounded by the fact that many states have more than one disability nondiscrimination law. The definitions of disability contained in these laws may not be uniform. Clearly then, for many states, statutory interpretation and classification is more an art than a science. Nevertheless, this survey at least offers conclusions

about the general contours of state law on HIV.

Since the enactment of the ADA, advocates and practitioners have often looked to that statute and other federal laws as the primary means of attacking discrimination on the basis of HIV infection.⁵¹ The scope of protection afforded under state law, however, is broader than that of federal law in some contexts, and thus regardless of the outcome in *Bragdon v. Abbott*, state law has an important place in responding to discrimination based on HIV status. In several contexts, state law often reaches conduct not prohibited by federal law. For example, the Maine Human Rights Act -- at issue in *Bragdon*, along with the ADA -- covers all employers in the state of Maine without regard to number of employees.⁵² The ADA, on the other hand, covers only employers with 15 or more employees.⁵³ The laws of many states similarly use a threshold lower than the federal standard to define coverage for employment. Many state housing discrimination laws include the sale or lease of commercial properties, as well as residential, non-commercial housing, within their reach.⁵⁴ The federal Fair Housing Act, however, is limited to residential, non-commercial housing opportunities.⁵⁵ In regard to the state statutes that establish a higher level of protection for HIV than is provided under federal law, federal law has no preemptive effect.⁵⁶

State HIV-Specific Statutes

The issue whether HIV infection⁵⁷ is a protected category for purposes of nondiscrimination statutes is perhaps best answered by inclusion of that term in the statute itself. Only 14 states, however, have enacted statutes that include the term "HIV infection" or equivalent terminology that clearly does not require any disease symptoms. Of these 14 states, only 5 include HIV as a disability with protection equivalent to that of other disabilities as defined by state law.⁵⁸ The other 9 states offer

protection more limited in scope than that accorded other disabilities.⁵⁹ In that regard, HIV is rare among medical conditions to be explicitly by statute. The general trend in state law, as discussed below, has been not to include reference to specific conditions as disabilities. Assuming that a legislature wishes to extend coverage in this area, there is no logical basis for covering individuals with AIDS, but not those with HIV. Narrow legislation, such as that of New Hampshire, which prohibits landlords from evicting tenants “solely on the grounds that the [tenant] has [AIDS] or is regarded to have [AIDS]”⁶⁰ is unique on the state level.

The 5 states in which HIV is defined as equivalent to other disabilities as defined by state law do so by simply incorporating HIV in the definition of “disability” contained in state nondiscrimination laws. Iowa, for example, provides that the definition of disability in its Civil Rights Act, which protects against discrimination in public and private employment, housing, and public accommodations, includes “the condition of a person with a positive human immunodeficiency virus test result, a diagnosis of [AIDS], a diagnosis of [ARC], or any other condition related to [AIDS].”⁶¹ New Jersey and Nebraska take the same approach. New Jersey’s definition of “handicap” includes “AIDS or HIV infection.”⁶² “HIV infection,” in turn, is defined as “infection with the human immunodeficiency virus or any other virus identified as a probable causative agent of AIDS.”⁶³ The Nebraska Individual Rights Act prohibits discrimination in public and private employment, housing, education, and public accommodations on the basis that the individual discriminated against “is suffering or is suspected of suffering from human immunodeficiency virus infection or acquired immunodeficiency syndrome.”⁶⁴ Similarly, Florida provides that “[a]ny person with or perceived as having . . . human immunodeficiency virus shall have every protection made available to handicapped persons.”⁶⁵ This definition is applicable then

to several Florida statutes that provide nondiscrimination standards in public and private employment, housing, and education (including employment by educational facilities). Florida law also specifies two additional contexts in which HIV-based discrimination is unlawful. First, entities receiving state financial assistance may not discriminate against an otherwise qualified individual in housing, public accommodations, or government services on the basis that the individual is "infected with HIV."⁶⁶ Next, Florida courts are prohibited from denying shared parental responsibility, custody, or visitation rights to a parent or grandparent solely because the parent or grandparent "is or is believed to be infected with HIV."⁶⁷

Other states that have adopted HIV-specific standards have not done so as broadly. Hawaii, for example, prohibits discrimination in housing on the basis of HIV,⁶⁸ but does not extend such explicit protection in other categories, such as employment and public accommodations. Kentucky's HIV-specific statute provides that "any person with [AIDS], [ARC], or human immunodeficiency virus shall have every protection made available to individuals with disabilities under [the employment nondiscrimination provisions of Kentucky Revised Statutes §§] and Section 504 [of] the Rehabilitation Act."⁶⁹ Similarly, both Vermont⁷⁰ and Washington⁷¹ limit their HIV protection to public and private employment, and do not include other settings, such as housing or public accommodations. Discrimination in those settings is covered under another statute that does not specify HIV.⁷² Maryland,⁷³ Virginia,⁷⁴ and Wisconsin⁷⁵ require public safety personnel not to discriminate on the basis of HIV status. Montana law provides that a "health care facility may not refuse to admit a person to the facility solely because the person has an HIV-related condition." That law provides that "HIV-related condition" means "any medical condition resulting from an HIV infection, including but not limited to seropositivity for HIV."⁷⁶

North Carolina's HIV-specific statute is unique in that although it specifically references HIV and purports to grant protection from discrimination on that basis, it actually authorizes as lawful as many forms of discrimination as it declares unlawful. The North Carolina Communicable Disease Act (NCCDA) prohibits discrimination in *continued* employment, housing, public services, public accommodations, and public transportation against "any person having AIDS virus or HIV infection on account of that infection."⁷⁷ The NCCDA also prohibits the use or requirement of HIV testing to determine suitability for *continued* employment, housing, public services, public accommodations, and public transportation.⁷⁸ However, the NCCDA allows HIV testing of job applicants, denial of employment to job applicants based on HIV status, and HIV testing as an annual medical examination routinely required of all employees by the employer. Reassignment or termination of employment is allowed if the employee poses a significant risk to himself or others, or if the employee is unable to perform the normally assigned duties of the job. The NCCDA also allows licensed health care providers and facilities to discriminate against patients with HIV infection "to protect the health care provider or employees of the provider or employees of the facility while providing appropriate care" and to refer the patient with HIV to another provider or facility "when such referral is for the purpose of providing more appropriate treatment."⁷⁹ The disingenuous nature of this "protective" enactment is obvious. In sum, of the 14 states with HIV-specific statutes, only 5 provide "across the board" protection; 8 provide coverage equivalent to other disabilities, but limit that coverage to certain contexts or settings of varying scope; and one state allows significantly greater discrimination against individuals with HIV than it or federal law allows against individuals with other disabilities.

In light of questions now raised as to whether HIV infection is or is not a disability under the

general definition used in federal law (as well as in the laws of many states), HIV-specific legislation takes on a new significance. Depending on how such provisions are drafted, however, HIV-specific statutes may be interpreted to mean that HIV is not included in more general definitions of disability. The explicit inclusion of HIV in one provision indicates, it could be argued, that HIV is not covered by a general definition included in some other statute or provision. If it were, there would be no need for the HIV-specific enactment. For example, Hawaii's HIV-specific housing provision may be interpreted to mean that HIV is not covered under the general disability definition applicable to employment discrimination. Additionally, inclusion of HIV infection might be construed as an indication that other infectious diseases were intended to be omitted from coverage. To avoid this statutory construction, the Iowa Civil Rights Act provides that the inclusion positive HIV test results within the definition of disability is "not to preclude" the inclusion of other "conditions resulting from other contagious or infectious diseases" from that definition.⁸⁰

Finally, as described above, some HIV-specific statutes cover HIV-infected individuals, but not those perceived to be infected or those with a positive HIV test result. If read literally, this version of the HIV-specific definition would exclude from coverage individuals who have tested or appear to have tested positive, but who are not in fact infected with HIV. Such individuals would be infants who have their mother's antibodies to HIV, vaccine trial participants, and individuals with false positive test results or medical records erroneously indicating a positive test result.

State Law Limitations on Use of HIV Testing or Test Results⁸¹

After a reliable test for HIV antibodies became widely available in 1985 and the evils resulting from the misuse of such testing became known, many states adopted informed consent for testing and

HIV-related information confidentiality statutes. Because breaches of confidentiality frequently result in discrimination (and in many cases are motivated by an interest in discriminating against an individual with HIV), some states also adopted statutes that prohibit the use of HIV test results to discriminate against any individual who has been tested or has tested positive, or that prohibit HIV testing for purposes, such as employment screening, where testing is not fully voluntary and the results will be used to discriminate. As a result, these “information restrictive” statutes appear to protect from discrimination based on knowledge of test results, not actual HIV status or perceived status.

Twelve states have adopted statutes that impose limitations on the use of HIV testing or HIV test results for discriminatory purposes.⁸² Of the 12 states in this category, only 3 impose broad restrictions on the use of such information in employment, public accommodations, housing, and other areas.⁸³ Six states impose restrictions only in the employment context.⁸⁴ Two states impose limits on HIV testing and the use of results do so in the health care context.⁸⁵ One state, Ohio, prohibits discrimination in by health care providers and public services and publicly-funded services. In the case of some states, such as Florida, it is not clear that the adoption of nondiscrimination standards applicable to HIV information adds or necessarily clarifies nondiscrimination standards, given that the state also has broad nondiscrimination provisions separate from the information restrictive statute. Nevertheless, such enactments may be valuable in enhancing public awareness of the confidentiality provisions applicable to HIV information.

Although these testing and confidentiality statutes may offer protection in many instances, if read literally they provide significantly weaker protection than nondiscrimination enactments that define discriminatory conduct and the protected category more broadly. For example, statutes that

restrict use of HIV test results in the employment context may be interpreted by the courts not to protect the job applicant who is discriminated against because the potential employer, who is not aware of a specific test result, is aware only of rumors that the applicant is HIV infected. In that case, the information relied on is not derived (at least directly) from any HIV test result, and to protect that applicant, it could be argued, would not serve the purpose of enhancing confidentiality for HIV test results and prohibiting their misuse. But under a statute that provides protection based on HIV status, either actual or as perceived, protection from discrimination is significantly strengthened. As another example of the limited scope of these laws, Maryland's HIV informed consent testing statute provides that refusal to undergo HIV testing may not be used "as the sole basis by any institution or laboratory to deny services or treatment."⁸⁶ Such enactments may protect the limited group of individuals who might refuse testing and would not be protected under other nondiscrimination laws, either because they could not successfully claim to have been perceived to be HIV infected or because state law does not protect from discrimination on that basis. On its face, however, the Maryland statute would not reach refusal to treat based on HIV status itself. Some of these information restrictive statutes provide protection from inquiries regarding HIV testing or the results of such testing. There are no reported decisions that interpret these statutes, but in one case in an analogous setting, *Urbaniak v. Newton*,⁸⁷ the California Court of Appeals narrowly interpreted the California confidentiality statute, limiting its application to disclosure of HIV test results by individuals having access to the *record* of such results. In that case, at the conclusion of an examination by a physician retained by the plaintiff's worker compensation insurer, the plaintiff disclosed his HIV status to a nurse so that she would comply with infection control precautions and avoid transmission of HIV to herself or others. The physician, however, disclosed the HIV

information to several third parties, without the plaintiff's knowledge or consent. The Court of Appeals concluded that because the legislature's intent in enacting the statute was to encourage individuals with HIV to seek testing and treatment, the confidentiality statute's application was limited to "persons and institutions that conduct tests for AIDS, assume responsibility for custody or distribution of test results, or use test results in connection with treatment of [sic] affected person."⁸⁸ The physician's disclosure of the plaintiff's HIV status thus did not violate the statute.

State Law Incorporation of Federal Disability Standards

By far the largest category of states incorporates the federal disability standard, as generally set forth in the Americans with Disabilities Act and other federal statutes.⁸⁹ Forty states use this definition in one or more statute, and of these states, 21 states, the District of Columbia, and Guam do not have any specific HIV statutory protection.⁹⁰ In these states, protection for HIV infection, if it exists, is based on these statutes. Additionally, among the 22 states with HIV-specific statutes or statutes that prohibit discriminatory use of HIV testing or test results in specified settings, 9 also use the federal standard to define "disability" for at least some purpose under state law.⁹¹ As a result, the federal disability standard significantly effects the rights of individuals with HIV in at least 30 states.

In some states, the state administrative agencies responsible for enforcement at the administrative level have interpreted the statute as including HIV infection. Whether these interpretations would be accepted by a state court interpreting the statute is open to question. In several cases, the courts have questioned or rejected the interpretation of nondiscrimination statutes as urged by administrative enforcement agencies.⁹² Nevertheless, such agency interpretations at least assure potential complainants that a claim of discrimination based on HIV status will be accepted

by the enforcement agency.

These statutory definitions pose difficulties in interpretation in regard to the impact of federal court decisions. The California Fair Employment and Housing Act (FEHA), for example, prohibits discrimination based on physical or mental "disability" and "medical condition" in public and private employment, housing, and professional licensure, and incorporates the federal definition of disability.⁹³ But no reported California court decision has directly addressed the question of whether asymptomatic HIV infection is a disability under California law, although one trial court has so ruled in an unreported decision.⁹⁴ Decisions involving symptomatic HIV illness or other conditions shed some light on the interpretation of this concept under California law. Thus, the California Supreme Court has ruled that the potential for a medical condition to become disabling in the future is enough to establish it as a current disability.⁹⁵ AIDS itself has been recognized as a disability in part because of the potentially debilitating future effects of the illness,⁹⁶ but other rulings suggest that such a reading of the FEHA may be unjustifiably broad.⁹⁷ Accordingly, the precise meaning of the FEHA may be open to some question until a definitive ruling is issued by the California Supreme Court. Similarly, California's Unruh Civil Rights Act prohibits discrimination based on "disability" in public accommodations or business establishments, as does the Disabled Persons Act,⁹⁸ which incorporates the federal definition of disability. One federal district court has concluded, albeit with little discussion of the issue, that HIV infection is a disability for purposes of the Unruh Act.⁹⁹ The FEHA and Unruh Act take the ADA as establishing at least a minimum non-discrimination standard, and thus a violation of the ADA is deemed a violation of these state laws.¹⁰⁰ A ruling in *Bradgon v. Abbott*, or that of another federal court, that significantly limits the coverage of HIV infection under federal law will very likely generate parallel litigation under state law. As a result, it is currently not

possible to conclude whether HIV infection is or is not a disability in these federal definition states. Even if the Supreme Court rules in favor of a broad definition of HIV as a disability for purposes of the ADA, *Bragdon*-like claims could be litigated in cases under state law, unless the state law, such as that of Kentucky, has provides that it is to be interpreted consistent with federal law or that federal law establishes a minimum standard for nondiscrimination, as does California.

State Statutory Definitions of Disability Not Adopting the Federal Standard

Fourteen states and Puerto Rico employ a definition of disability in at least one nondiscrimination statute that either departs significantly from the federal standard or does not set forth any definition. While these statutes are open to varying interpretation, 8 of these states appear to define “disability” more broadly than does federal law,¹⁰¹ while 1 state, Texas, and Puerto Rico appear to define it more narrowly. The remaining four states do not include any comprehensive statutory definition.¹⁰²

The states that define “disability” more broadly than the federal standard typically do not impose any requirement regarding severity, unlike the federal definition, which includes the requirement that the impairment result in a substantial limitation on major life activity. Instead, these states require that there be a documented impairment. In these states, courts and enforcement agencies may be more likely to regard HIV infection as a disability, and are less likely to find rulings by federal courts persuasive in interpreting state law.

Most notably in this category, the New York Human Rights Law defines “disability” as a “physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques,” or a record such an impairment, or a condition

regarded by others as such an impairment.¹⁰³ Several New York state court decisions indicate that there is no question that HIV is covered under this definition.¹⁰⁴ Nevertheless, other courts have noted that the NYHRL's definition of disability is stricter, not broader, than that of federal law.¹⁰⁵ These decisions appear to ignore the second element of the definition, which includes impairments that are demonstrable by medically accepted clinical or laboratory diagnostic techniques. Similarly, in terms of broader-than-federal protection, the Connecticut Human Rights and Opportunities Act defines "physical disability" as a "chronic physical handicap, infirmity or impairment, whether congenital or . . . from illness" ¹⁰⁶ Because HIV infection is likely to be deemed a chronic physical impairment resulting from illness, such a statute provides a strong case for coverage of HIV infection. Again, the Illinois Human Rights Act prohibits discrimination on the basis of "handicap," which is defined as a "determinable physical or mental characteristic of a person ..., the history of such characteristic, or the perception of such characteristic by the person complained against, which may result from disease" ¹⁰⁷ The Illinois Supreme Court has interpreted the Illinois statute to cover HIV infection.¹⁰⁸ The Indiana Equal Access to Housing for Persons with Disabilities Law defines an individual with a disability as "an individual who, by reason of physical or mental defect or infirmity, whether congenital or acquired by accident, injury, or disease, is or may subsequently be totally or partially prevented from achieving the fullest attainable, physical, social, economic, mental and vocational participation in the normal process of living." ¹⁰⁹ The Maryland Human Rights Act prohibits discrimination in public and private employment, housing, public accommodations, retail services and by persons licensed or regulated by the State Department of Licensing and Regulations on the basis of physical or mental handicap, or perceived handicap, which is defined as "any physical disability . . . which is caused by . . . illness" ¹¹⁰

Texas and Puerto Rico, however, maintain standards that appear to be narrower than federal law. The Texas Rights and Responsibilities of Persons with Disabilities Act defines “disability” as a “mental or physical disability, including mental retardation, hearing impairment, deafness, speech impairment, visual impairment, or any health impairment that requires special ambulatory devices or services.”¹¹¹ Thus, asymptomatic conditions would not be likely to be covered by this definition. Puerto Rico limits its definition of disability to “a temporary or permanent condition of a motor or mental nature which hinders or limits [an individual's] inception or ability to work, study or enjoy life fully.”¹¹² On its face, this statute would not cover asymptomatic HIV, because it would not impair motor or mental functioning.

Judicial Interpretations of State Nondiscrimination Law

Given the considerable ambiguity in state law on the question of coverage of HIV infection, some clarification of standards might be expected from the state courts themselves or from federal courts applying state law. To date, however, the highest courts of appeal in only three states have addressed this issue. Two of those rulings, *Benjamin R. v. Orkin Exterminating Co.*,¹¹³ and *Burgess v. Your House of Raleigh, Inc.*,¹¹⁴ involved state law issues that were affected by subsequent legislation, and thus those rulings are of limited precedential value. But in a third ruling, *Raintree Health Care Center v. Illinois Human Rights Comm’n*,¹¹⁵ the Illinois Supreme Court held that HIV infection is a disability under the Illinois Human Rights Act, given that statute’s definition of disability as “a determinable physical characteristic resulting from a disease.” Because of the specific state statutory language on which that ruling is based, however, it may be of limited precedential value in most states, especially those that have adopted the federal definition.

Several state intermediate appellate and federal courts, applying state law, have addressed the issue of HIV infection as a disability. In *Beaulieu v. Clausen*,¹¹⁶ the Minnesota Court of Appeals has interpreted the Minnesota Human Rights Act (MHRA) to cover asymptomatic HIV infection. The MHRA's definition of "disability" follows that of federal law, and the court concluded that individuals with HIV are materially limited in several major life activities, including social participation (because of emotional or psychological problems such as depression, as well as ostracism by others), sexual and reproductive activities, and employment. In *Robinson v. Henry Ford Health Systems*,¹¹⁷ a federal district court noted, albeit with little discussion, that HIV is a disability under Michigan law, which incorporates the federal definition of disability. Similarly, in *Kotev v. First Colony Life Ins. Co.*,¹¹⁸ a federal district court concluded, without discussion, that HIV infection is a disability under the California's Unruh Act for purposes of establishing a claim of "associational" discrimination. In *Rose City Oil Co. v. Missouri Comm'n on Human Rights*,¹¹⁹ the Missouri Court of Appeals ruled that an individual discriminated against on the basis of perception of HIV infection was not protected under Missouri law. That decision was reversed by legislation.¹²⁰

Several rulings by New York courts have accepted HIV infection as a disability, given New York's broad definition of that term. In one case, *Petri v. Bank of New York Co.*,¹²¹ the Supreme Court for the County of New York ruled that asymptomatic HIV infection, whether perceived or actual, is a disability under New York state law. More recently, in *Cahill v. Rosa*,¹²² the New York Court of Appeals ruled in favor of a patient with HIV infection on the question of whether a dentist's office is a public accommodation. HIV infection has been assumed to be a disability in several other cases reported in the New York Supreme Court, Appellate Division.¹²³⁺¹²⁴

Although there is no question that HIV infection is covered by New Jersey's statutory

definition, in *Poff v. Caro*,¹²⁵ the court held that New Jersey law prohibits housing discrimination based on perception that an individual has AIDS or might be at risk for AIDS, reasoning that there is no logical basis for distinguishing between those with a disability and those so perceived. This reasoning would apply as well in cases of HIV infection.

Finally, in *Abbott v. Bragdon*,¹²⁶ the Court of Appeals for the First Circuit noted that its disposition of issues under the ADA was dispositive of those under Maine law as well, given the co-extensive coverage of the two statutes.

State Law Exclusion of Coverage for Communicable Diseases

Only Georgia and Idaho include explicit exclusions of communicable or infectious disease from their nondiscrimination standards. Most states have abandoned these provisions in favor of "direct threat" provisions that parallel the "direct threat" provision in the ADA. Other states have retained such exclusions in statutes governing specific occupations, such as food service workers. Generally, these statutes are interpreted as inapplicable in the context of HIV, given the well-established view that there is no risk of HIV transmission in the applicable workplaces. Nevertheless, the Supreme Court of North Carolina interpreted the former North Carolina Handicapped Persons Act as not applying to HIV infection because of the statutory exemption of "communicable diseases" from the definition of handicap.¹²⁷ In a more recent case, however, the Supreme Court of Illinois rejected an employer's defense that public health regulations required the dismissal of a food service employee with a "contagious or infectious disease."¹²⁸

The Demographics of State HIV Non-Discrimination Standards

Given the foregoing description of HIV protective legal standards, the jurisdictions included in this survey¹²⁹ can be placed into three categories: first, those with clearly established protection for HIV infection (either from explicit statutory language, judicial precedent, or a combination of both); second, those that provide little or no protection for HIV infection (primarily because of the lack of any disability nondiscrimination law); and, third, those in which coverage of HIV cannot be determined with certainty, given the lack of specific statutory language pertaining to HIV and the lack of judicial precedent on the question. In this third category, some of the states that are included may in practice cover HIV as a disability, and cases involving claims of HIV discrimination may have resulted in successful settlements for plaintiffs with HIV, but without reported judicial opinions addressing the question of HIV as a disability. The important point here, however, is the absence of clear, identifiable legal standards. Without such legal standards, persons or entities that might engage in discrimination on the basis of HIV do not have a clear compliance standard, and, perhaps more importantly, individuals with HIV have no assurance that they have legal protection. Public health strategies, such as HIV case reporting, are frequently premised on the assurance of at least adequate nondiscrimination standards. The absence of that assurance for a significant number of individuals with HIV thus can have profound implications for public health policy.

In order to determine roughly the proportionate extent that the population of individuals with HIV is represented within the jurisdictions as grouped in these 3 categories, comparisons of the proportionate distribution of individuals with AIDS within these categories were calculated.¹³⁰ The states in which protection for individuals can be said to be clearly established as a result of explicit statutory language or court precedent include less than one-third (29 percent) of the reported cases

of AIDS. On the other hand, however, those jurisdictions that significantly limit or have no protection for HIV infection in major areas include only about one percent of the reported cases. Most significantly, however, because of the widespread reliance on the federal definition of disability, roughly half (47 percent) of that population is reported in jurisdictions in which there is substantial uncertainty regarding protection for individuals with HIV.

ENDNOTES

1. Centers for Disease Control. Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS. Washington, DC: US Government Printing Office;1987.
2. Institute of Medicine, National Academy of Sciences. Confronting AIDS: Directions for Public Health Care and Research. Washington, DC: National Academy Press;1986.
3. American Medical Association Board of Trustees. Prevention and control of acquired immunodeficiency syndrome: an interim report. JAMA 1987;258:2097-2103.
4. Association of State and Territorial Health Officials. Guide to Public Health Practice: AIDS Confidentiality and Anti-Discrimination principles: Interim Report. Washington, DC: Association of State and Territorial Health Officials;1987.
5. American Bar Association, AIDS Coordinating Committee. AIDS: The Legal Issues. Washington, DC: American Bar Association;1988.
6. American Bar Association. Policy on AIDS. Chicago, Ill: American Bar Association;1989.
7. ACLU AIDS Project. Epidemic of Fear: A Survey of AIDS Discrimination in the 1980s and Policy Recommendations for the 1990s. New York: American Civil Liberties Union;1990.
8. The concern about discrimination was not limited to the United States. See, e.g., Council of Europe, Comparative Study on Discrimination Against Persons with HIV or AIDS. Strasbourg: Council of Europe;1993.
9. Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 119. Washington, DC: US Government Printing Office;1988.
10. School Board of Nassau County v. Arline, 107 S. Ct.1123 (1987).
11. Berk RA ed. The Social Impact of AIDS in the US. Cambridge, MA: Apt Books;1988.
12. Feldblum C. Medical examinations and inquiries under the Americans with Disabilities Act: a view from the inside. Temple L. Rev. 1991;64:521.
13. Feldblum C. The (r)evolution of physical disability anti-discrimination law: 1976-1996. MPDLR 1996;Sept-Oct: 613.
14. National Commission on Acquired Immune Deficiency Syndrome. America Living with AIDS. Washington, DC: National Commission on Acquired Immune Deficiency Syndrome;1991.
15. Ennis v. National Association of Business and Education Radio, Inc., 53 F.3d 55, 59 (4th Cir. 1995) ("the plain language of the provision requires that a finding of disability be made on an individually/individual basis.").
16. Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997), *aff'g* 912 F. Supp. 580 (D. Me. 1995).

17. *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997), *aff'g* 912 F. Supp. 580 (D. Me. 1995), *cert. granted*, ___ S. Ct. ___ (1997).
18. Perelson AS, Newmann AU, Markowitz M, Leonard JM, Ho DD. HIV-1 dynamics in vivo: virion clearance rate, infected cell life-span, and viral generation time. *Science* 1996;271:1582-1586.
19. Hammer SM, Katzenstein D, Huges M, et al. A trial comparing nucleoside monotherapy with combination therapy in HIV-infected adults with CD4 cell counts between 200 and 500 per cubic millimeter. *N Engl J Med* 1996;335:1081-1090.
20. Saravolatz L, Winslow DL, Collins G, et al. Zidovudine alone or in combination with didanosine or zalcitabine in HIV-infected patients with the acquired immunodeficiency syndrome or fewer than 200 CD4 cells per cubic millimeter. *N Engl J Med* 1996;335:1099-1106.
21. Collier AC, Coombs RW, Schoenfeld DA, et al. Treatment of human immunodeficiency virus infection with saquinavir, zidovudine, and zalcitabine. *N Engl J Med* 1996;334:1011-1017.
22. Carpenter CCJ, Fischl MA, Hammer SM, et al. Antiretroviral therapy for HIV infection in 1997: updated recommendations of the international AIDS society panel. *JAMA* 1997;277:1962-1969.
23. See, Gostin LO, Ward JW, Baker AC. National HIV case reporting for the United States: a defining moment in the history of the epidemic. *New Engl. J. Med* 1997; 337:1162-1167.
24. 42 USC § 12201(b).
25. 42 U.S.C. § 12103(2). Department of Justice regulations pursuant to Titles II and III of the ADA specifically note that "HIV disease (whether symptomatic or asymptomatic)" is an impairment. 28 C.F.R. § 35.104 (1996) (definition of disability for purposes of Title II) and 28 C.F.R. § 36.104 (1996) (definition of disability for purposes of Title III).
26. *Sanchez v. Lagoudakis*, 486 N.W.2d 657 (Mich. 1992), *subsequent opinion*, 552 N.W.2d 472 (Mich. Ct. App. 1996).
27. *Finley v. Giacobbe*, 827 F. Supp. 215 (S.D.N.Y. 1993).
28. *Sherer v. Foodmaker, Inc.*, 921 F. Supp. 651 (E.D. Mo. 1996).
29. H.R. Rep. 485, pt. 2, 101st Cong., 2d Sess. 31, *reprinted in*, 1990 U.S.C.C.A.N. 303, 313, 330.
30. *Id.*
31. For a detailed discussion of the legislative history of HIV in regard to the ADA, see David W. Webber, *AIDS and the Law* § 3.6 (3d ed. 1997).
32. Senate Comm. on Labor and Human Resources, Americans with Disabilities Act of 1989, S. Rep. 116, 101st Cong., 2d Sess. 8 (1989); see also statements upon Senate approval, 135 Cong. Rec. S10,789 (Sen. Kennedy); 135 Cong. Rec. S10,794 (Sen. Moynihan); 135 Cong. Rec. S10,800 (daily ed. Sept. 7, 1989) (Sen. Simon).

33. H.R. Rep. No. 485, pt. 2, 101st Cong., 2d Sess. 51 [hereinafter House Labor Report], reprinted in 1990 U.S.C.C.A.N. 303, 333.

34. H.R. Rep. No. 485, pt. 3, 101st Cong., 2d Sess. 28 n.18, reprinted in 1990 U.S.C.C.A.N. 445, 451 n.18 [hereinafter House Judiciary Report] (citing approvingly 1988 Department of Justice memorandum for conclusion that individuals with HIV infection have an impairment that substantially limits a major life activity and thus are disabled).

35. 136 Cong. Rec. H4613 (daily ed. July 12, 1990) (statement of Rep. Dannemeyer in opposition to coverage of persons with communicable diseases); House Judiciary Committee Begins Markup of Bill to Prohibit Bias Against Disabled, 85 Daily Lab. Rep. (BNA) A-10 (May 2, 1990) (House Judiciary Committee rejection of amendment offered by Rep. Dannemeyer to exclude homosexuals infected with HIV from coverage under the ADA). Debate on H.R. 2273 was limited in the House under H. Res. 394, 136 Cong. Rec. 10,839 (1990), and thus the general question of whether individuals with infectious diseases should be covered by nondiscrimination standards was not be debated. See 136 Cong. Rec. 10,851-52 (1990) (statement of Rep. Dannemeyer in opposition to including individuals with communicable diseases within the definition of disability).

36. House Labor Report at 52, reprinted in 1990 U.S.C.C.A.N. 303, 334 (citing approvingly U.S. Department of Justice 1988 opinion that HIV infection is a disability under the Rehabilitation Act because of substantial limitation on procreation and intimate sexual relationships); House Judiciary Report at 28-29, reprinted in 1990 U.S.C.C.A.N. 445, 451 (same).

37. H.R. Rep. No. 101-485, pt. II, at 52 (1990).

38. S. Rep. No. 101-116, at 22 (1990).

39. Memorandum to Arthur B. Culvahouse Jr., Justice Department Memorandum on Application of Rehabilitation Act's Section 504 to HIV Infected Persons (Oct. 7, 1988).

40. Equal Employment Opportunity Commission, ADA Title I Interpretive Guidance, para.1630.2(j).

41. Department of Justice, ADA Title II Interpretive Guidance, para. 35.104.

42. See, e.g., *Martinez v. School Bd.*, 675 F. Supp. 1574, 1583 (M.D. Fla. 1987); *Ray v. School Dist. of DeSoto County*, 666 F. Supp. 1524, 1536 (M.D. Fla. 1987).

43. Parmet WE, Jackson DJ. No longer disabled: the legal impact of the new social construction of HIV. *Am J Law & Med.* 1997;23:7-43.

44. See, e.g., *Robinson v. Henry Ford Health Sys.*, 892 F. Supp. 176, 180 (E.D. Mich. 1994); *Howe v. Hull*, 873 F. Supp. 72, 78 (N.D. Ohio 1994); *T.E.P. v. Leavitt*, 840 F.Supp. 110, 111 (D. Utah 1993).

45. *School Board of Nassau County v. Arline*, 107 S. Ct.1123 (1987).

46. *Ennis v. National Association of Business and Education Radio, Inc.*, 53 F.3d 55, 59 (4th Cir. 1995) ("the plain language of the provision requires that a finding of disability be made on an individually/individual

basis.”).

47. *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997), *aff'g* 912 F. Supp. 580 (D. Me. 1995).

48. The South Carolina Bill of Rights for Handicapped Persons, for example, defines “handicap” as “a substantial physical or mental impairment . . . acquired by . . . disease, where the impairment is verified by medical findings and appears reasonably certain to continue throughout the lifetime of the individual without substantial improvement.” S.C. Code Ann. § 43-33-560 (West supp. 1997).

49. New York, for example, defines “disability” as “physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques,” or a record of such an impairment, or a condition regarded by others as such an impairment. N.Y. Exec. Law § 292(21) (McKinney 1993 & supp. 1998).

50. *Reprinted in AIDS and the Law* 286 (William H.L. Dornette ed., 1st ed., 1987).

51. In some jurisdictions, state or local law may be disfavored in comparison to federal law for several reasons, including statutes of limitation for the filing of complaints that are significantly shorter than those of federal law and the perception that state enforcement agencies lack adequate resources to promptly investigate and resolve complaints.

52. Me. Rev. Stat. Ann. tit. 5, § 4553 (West 1989 & supp. 1997).

53. 42 U.S.C. § 12111(5)(A) (1994).

54. *See, e.g., Seitzman v. Hudson River Assocs.*, 542 N.Y.S.2d 104 (Sup. Ct. N.Y. County 1989) (successful discrimination claim under New York law of physician-tenant whose practice included patients with AIDS).

55. 42 U.S.C. § 3602(b) (1994). In some cases, however, such claims may be brought under Title III of the Americans with Disabilities Act, 42 U.S.C. § 12181(7) (1994).

56. *See* 42 U.S.C. §§ 3615 (FHA), 12201(b) (ADA); *Muncy v. Norfolk & Western Railway*, 650 F. Supp. 641 (S.D. W. Va. 1986) (Rehabilitation Act).

57. Throughout the discussion which follows, all references to “HIV” or “HIV infection” are to asymptomatic infection, unless noted otherwise.

58. Florida, Iowa, Kentucky, Nebraska, and New Jersey. Consult the accompanying Compilation of State Statutes for specific citation to statutory provisions.

59. Hawaii, Maryland, Missouri, Montana, North Carolina, Vermont, Virginia, Washington, and Wisconsin.

60. N.H. Rev. Stat. Ann. § 354-A:10.VI (1995).

61. Iowa Code Ann. § 216.2 (West supp. 1998).

62. N.J. Stat. Ann. §§ 10:5-4.1 and 10:5-5(q) (West 1993 & supp. 1997).

63. *Id.* § 10:5-5(gg).

64. Neb. Rev. Stat. § 20-168 (1995).
65. Fla. Stat. Ann. § 760.50(2) (West 1997).
66. Fla. Stat. Ann. § 760.50 (West 1997).
67. Fla. Stat. Ann. § 61.13(6) (West 1997 & supp. 1998).
68. Haw. Rev. Stat. § 368-1.5(b) (1993).
69. Ky. Rev. Stat. Ann. § 207.135(1) (Michie 1995). Presumably, even if the Rehabilitation Act were interpreted not to cover HIV, individuals with HIV would nevertheless have the same rights as individuals with disabilities under the cross-referenced Kentucky law. Apparently the Kentucky legislature did not anticipate that the Rehabilitation Act could be read not to cover HIV.
70. Vt. Stat. Ann. tit. 21, § 495(a)(6)(7) (1997).
71. Wash. Rev. Code Ann. § 49.60.172 (West 1990 & supp. 1997).
72. Vt. Stat. Ann. tit. 9, § 4501 (1997); Wash. Rev. Code Ann. § 49.60.010 (West supp. 1997).
73. Md. Code Ann., Health-Gen. Code § 18-213(m) (supp. 1997) (fire fighters, emergency medical technicians, rescue squadpersons, law enforcement officers, and correctional officers “may not refuse to treat or transport an individual because the individual is HIV positive”); Md. Code Ann., Health-Gen. Code § 18-213.2(h) (supp. 1997) (correctional officers, first responders, law enforcement officers, medical care facilities, and physicians performing postmortem exams are prohibited from discrimination in regard to the transportation of HIV positive decedents).
74. Va. Code Ann. § 32.1-45.2 (Michie 1997) (public safety agencies include the sheriff’s office, adult or youth correctional, law enforcement, and fire safety organizations, or any governmental agency or department that employs persons who have law enforcement authority).
75. Wis. Stat. Ann. § 252.14 (West supp. 1997) (prohibits discrimination by health care providers, peace officers, fire fighters, correctional officers, state patrol officers, jailers, home health agencies, and inpatient health care facilities).
76. Mont. Code Ann. § 50-5-105(2) (1997).
77. N.C. Gen. Stat. § 130A-148(i) (1997).
78. *Id.*
79. N.C. Gen. Stat. § 130A-148(j) (1997).
80. *Id.*
81. This survey does not include the many state statutes that address the problem of transactions involving “stigmatized” real estate owned or occupied by someone with HIV/AIDS. Although these statutes may limit opportunity for buyers to discriminate against a seller with AIDS, they do not address the issue of discrimination directly. Thus, for example, if a potential buyer of such a property chooses not to bid on a

property because of stigma, or offers a low bid, because of knowledge of the stigma, there is no typically no remedy under such statutes.

82. Arkansas, California, Florida, Hawaii, Kansas, Kentucky, Maine, Maryland, New Mexico, Ohio, Rhode Island, and Texas. These states are identified in the accompanying Table, column B.

83. Hawaii, Kansas, and Rhode Island.

84. California, Florida, Kentucky, Maine, New Mexico, and Texas.

85. Arkansas and Maryland.

86. Md. Code Ann., Health-Gen. Code § 18-336(c) (supp. 1997).

87. 277 Cal. Rptr. 354 (Ct. App. 1991). For a criticism of this ruling as a “cramped reading” of the California statute, see Roger Doughty, Comment, *The Confidentiality of HIV-Related Information: Responding to Aggressive Public Health Interventions in the AIDS Epidemic*, 82 Cal. L. Rev. 111, 143-45 (1994).

88. 277 Cal. Rptr. at 362.

89. For purposes of this discussion and the accompanying Compilation of State Statutes, the “federal disability standard” defines “disability” as an impairment that imposes a substantial limitation on a major life activity, a record of such an impairment, or the perception of such an impairment. While there has apparently never been any dispute that HIV infection is an impairment, “major life activity” is defined by regulation, not statute, and the precise meaning of that term has been disputed. Although some state statutes in this category incorporate the federal regulation definition of “major life activity” (and some incorporate the definition of “impairment”) they stop short of incorporating any of the regulations’ references to HIV as an impairment or a disability. States using this definition are identified in the accompanying Table, column C.

90. Alabama, Alaska, Arizona, Colorado, Delaware, Georgia, Idaho, Indiana, Louisiana, Massachusetts, Minnesota, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, and West Virginia. But note that courts in Minnesota and West Virginia have held that HIV infection is a disability, as discussed below.

91. Florida, Hawaii, Kentucky, Nebraska, and Vermont.

92. See *Runnebaum v. NationsBank of Maryland*, 123 F.3d 156 (4th Cir. 1997) (en banc); *Cortes v. MacDonald’s Corp.*, 955 F. Supp. 541 (E.D.N.C. 1996); *Equal Employment Opportunity Comm’n v. Newport News Shipbuilding & Drydock Co.*, 949 F. Supp. 403 (E.D. Va. 1996).

93. Cal. Gov’t Code §§ 12955.3, 12926(k) (West 1992 & supp. 1998).

94. *California Judge Awards \$729,000 to HIV-Positive Discharged Employee*, 88 Daily Lab. Rptr. (BNA) A5 (May 10, 1994), summarizing *Perrault v. Educational Testing Serv., Inc.*, No. 707306-7, Cal. Super. Ct., Alameda County (May 6, 1994).

95. *American Nat’l Ins. Co. v. Fair Employment & Housing Comm’n*, 651 P.2d 1151 (Cal. 1982) (classifying hypertension as a disability).

96. *Raytheon Co. v. California Fair Employment & Housing Comm'n*, 261 Cal. Rptr. 197, 201 (Ct. App. 1989) (AIDS diagnosis, but noting that condition need not be presently disabling to qualify as a physical handicap).
97. *Cassista v. Community Foods, Inc.*, 856 P.2d 1143 (Cal. 1993) (summarizing legislative history of FEHA disability provisions in regard to federal law, and rejecting a claim that obesity is a disability).
98. Cal. Civ. Code § 54.
99. *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316 (C.D. Cal. 1996) (HIV infection is a disability under the Unruh Act for purposes of establishing a claim of "associational" discrimination).
100. Cal. Civ. Code § 51, 54 (West 1982 & supp. 1998).
101. Connecticut, Delaware, Illinois, Indiana, Maryland, Michigan, Oregon, and New York.
102. Alabama (as to public employment, housing, and public accommodations), Arkansas (as to public accommodations and housing), Mississippi (as to public employment, employment by state-funded employers), and Wyoming (as to public and private employment). Note, however, that the Wyoming Fair Employment Commission Rules of Practice incorporate the federal definition of disability.
103. N.Y. Exec. Law § 292(21) (McKinney 1993 & supp. 1998).
104. *Petri v. Bank of N.Y. Co.*, 582 N.Y.S.2d 608, 611 (Sup. Ct. N.Y. County 1992) (asymptomatic HIV infection, whether actual or perceived, is disability under New York law).
105. *Scott v. Flaghouse, Inc.*, 980 F. Supp. 731 (S.D.N.Y. 1997); *Aquinas v. Federal Express Corp.*, 940 F. Supp. 73 (S.D.N.Y. 1996).
106. Conn. Gen. Stat. Ann. § 46a-51(15) (West 1995).
107. 775 Ill. Comp. Stat. Ann. 5/1-103(I) (West 1993 & supp. 1997).
108. *Raintree Health Care Ctr. v. Illinois Human Rights Comm'n*, 672 N.E.2d 1136, 1141 (Ill. 1996), *aff'g* 655 N.E.2d 944 (Ill. Ct. App. 1995).
109. Ind. Code Ann. § 22-9-6 (West 1997).
110. Md. Ann. Code of 1957, art. 49B, § 15(g) (1994).
111. Tex. Hum. Res. Code Ann. § 121.002(4) (West supp. 1998).
112. P.R. Laws Ann. tit. 1, § 501(d) (supp. 1997).
113. 390 S.E.2d 814 (W. Va. 1990) (subsequent legislation conformed statute in question more closely to federal law, although court's reasoning in concluding that HIV imposes a substantial limitation on major life activities may be persuasive under the subsequent legislation and that of other states).
114. 388 S.E.2d 134 (N.C. 1990) (decided before the adoption of North Carolina's Communicable Disease Act, N.C. Gen. Stat. § 130A-148(i), prohibits discrimination in continuing employment).

115. 672 N.E.2d 1136, 1141 (Ill. 1996), *aff'g* 655 N.E.2d 944 (Ill. Ct. App. 1995).
116. 491 N.W.2d 662 (Minn. Ct. App. 1992).
117. 892 F. Supp. 176, 180 (E.D. Mich. 1994).
118. 927 F. Supp. 1316 (C.D. Cal. 1996).
119. 832 S.W.2d 314 (Mo. Ct. App. 1992).
120. The Missouri HIV and Public Health Act provides that the Missouri Human Rights Act, Mo. Ann. Stat. §§ 213.010-213.137 (West 1996 & supp. 1998), "shall apply to individuals with HIV infection . . ." Mo. Ann. Stat. § 191.665 (West 1996).
121. 582 N.Y.S.2d 608 (Sup. Ct. N.Y. County 1992).
122. 674 N.E.2d 274 (N.Y. 1996).
123. Doe v. Jamaica Hosp., 608 N.Y.S.2d 518 (App. Div. 1994) (mem.).
124. Syracuse Community Health Ctr. v. Wendi A.M., 604 N.Y.S.2d 406 (App. Div. 1993), *aff'd*, 659 N.E.2d 760 (N.Y. 1995).
125. 549 A.2d 900 (N.J. Super. Ct. Law Div. 1987).
126. 107 F.3d 934 (1st Cir. 1997).
127. *Burgess v. Your House of Raleigh, Inc.*, 388 S.E.2d 134 (N.C. 1990). North Carolina law has since been amended, and although its protection is limited, that specific exemption has been deleted.
128. *Raintree Health Care Ctr. v. Illinois Human Rights Comm'n*, 672 N.E.2d 1136, 1141 (Ill. 1996), *aff'g* 655 N.E.2d 944 (Ill. Ct. App. 1995).
129. We do not, however, take into account the impact that local legislation may have in protecting against HIV infection discrimination.
130. Because comparative state-by-state HIV infection data are not available, we use the most recent rates of AIDS cases as published in CDC, *HIV/AIDS Surveillance Report* (mid-year ed., June 1997) (table 1) as a rough estimate of the comparative extent of HIV infection in specific jurisdictions.

HIV Infection as Protected by State Statute in the U.S. (including Guam, Puerto Rico, and the U.S. Virgin Islands)

STATE	A	B	C	D	E	F	G	Comments
Alabama			•	•			→	No disability protection in private employment
Alaska			•					
Arizona			•					
Arkansas		→	•	•				Prohibits health care provider discrimination based on HIV test result
California		→	•					Prohibits employment discrimination based on HIV test result
Colorado			→					Legislature has declared policy of HIV nondiscrimination
Connecticut				→				State definition of disability broader than federal
Delaware			•	→				State definition of disability broader than federal for employment
District of Columbia			•					
Florida	→	•	•					HIV explicitly incorporated in handicap definition
Georgia			•			•	→	No coverage of public accommodations, housing, other areas
Guam			•					
Hawaii	→	•	•					HIV protected in housing discrimination statute
Idaho			•			•		
Illinois				•	→			Ill. Court of Appeals ruled that HIV is a disability
Indiana			•	→				State definition of disability broader than federal for housing
Iowa	→							HIV explicitly incorporated in handicap definition
Kansas		→	•					HIV case reporting data may not be used to discriminate
Kentucky	→	•	•					Prohibits employment discrimination based on HIV status
Louisiana			•					
Maine		•	•		→			1st Cir. Ct. of Appeals ruled HIV is disability under state law & ADA
Maryland	→	•		•				HIV discrimination by public safety personnel prohibited

Key to Table:

A = Statute explicitly includes protection for HIV

B = Statute bars discriminatory use of HIV testing or test information

C = Statute uses "federal disability" standard

D = Statute uses disability definition other than federal standard (or does not define term)

E = Judicial precedent interprets statute as covering HIV infection

F = Statute excludes infectious/communicable diseases from coverage

G = No disability nondiscrimination law in at least one significant category

Arrow symbol (→) indicates column referred to in comment

STATE	A	B	C	D	E	F	G	Comments
Massachusetts			•					
Michigan				•	→			Federal district court ruled that HIV is protected under state law
Minnesota			•		→			Court of Appeals ruled HIV a disability
Mississippi				•			→	No coverage of private employment and other areas
Missouri	→		•					No coverage for "regarded as" HIV infected
Montana	→		•					Health care facilities may not refuse to admit persons with HIV
Nebraska	→		•					Broad protection from discrimination based on HIV
Nevada			•					
New Hampshire			•					
New Jersey	•				→			Superior Ct. ruled persons viewed at risk to develop AIDS covered
New Mexico		→	•					HIV test results may not be used to discriminate in employment
New York				→	•			State definition of disability broader than federal
North Carolina	→						•	Statute offers significantly less protection than federal law
North Dakota			•					
Ohio		→	•					No HIV discrimination in gov't services & gov't-funded services
Oklahoma			•					
Oregon				→				State definition of disability broader than federal
Pennsylvania			•					
Puerto Rico				→				Only condition of "motor or mental nature" covered
Rhode Island		→	•					Discrimination based on "positive AIDS test" prohibited
South Carolina			•					
South Dakota			•					
Tennessee			•					
Texas		→	•	•				HIV testing for employment purposes prohibited
Utah			•					

Key to Table:

A = Statute explicitly includes protection for HIV

B = Statute bars discriminatory use of HIV testing or test information

C = Statute uses "federal disability" standard

D = Statute uses disability definition other than federal standard (or does not define term)

E = Judicial precedent interprets statute as covering HIV infection

F = Statute excludes infectious/communicable diseases from coverage

G = No disability nondiscrimination law in at least one significant category

Arrow symbol (→) indicates column referred to in comment

STATE	A	B	C	D	E	F	G	Comments
Vermont	→		•					HIV discrimination in public and private employment prohibited
Virgin Islands, US							→	No prohibition against HIV discrimination
Virginia	→		•					HIV discrimination by public safety personnel prohibited
Washington	→			•				HIV discrimination in public and private employment prohibited
West Virginia			•		→			W. Va. Supreme Ct. has ruled HIV a disability
Wisconsin	→		•					HIV discrimination by public safety personnel prohibited
Wyoming				→				"Federal disability" definition adopted by state agency

Key to Table:

A = Statute explicitly includes protection for HIV

B = Statute bars discriminatory use of HIV testing or test information

C = Statute uses "federal disability" standard

D = Statute uses disability definition other than federal standard (or does not define term)

E = Judicial precedent interprets statute as covering HIV infection

F = Statute excludes infectious/communicable diseases from coverage

G = No disability nondiscrimination law in at least one significant category

Arrow symbol (→) indicates column referred to in comment

Compilation of State HIV Disability Law (including Guam, Puerto Rico, and the U.S. Virgin Islands)¹

For each state, law summaries are provided in this order: (1) HIV specific state nondiscrimination laws; (2) HIV testing or information laws; (3) general disability laws; (4) administrative or judicial interpretations of significance in regard to coverage of HIV infection. State agency interpretations and local ordinances have been included where available.

ALABAMA

Alabama's disability nondiscrimination law prohibits discrimination against the "physically disabled" in public employment, housing accommodations, and public accommodations. Ala. Code §§ 21-7-2 to 21-7-9 (1997). "Physically disabled" is not defined by statute.

The Alabama Fair Housing Law incorporates the federal definition of disability. Ala. Code § 24-8-3(6) (1992).

Alabama does not have a disability nondiscrimination law applicable to private employers.

ALASKA

The Alaska Human Rights Law prohibits discrimination in public and private employment, housing, credit and financing, based on "disability," and incorporates the federal definition of disability. Alaska Stat. § 18.80.300(9),(12)-(13)(Michie 1996).

ARIZONA

The Arizona Civil Rights Act prohibits discrimination in public and private employment and housing on the basis of "handicap." The definition of handicap incorporates the federal definition of disability. Ariz. Rev. Stat. Ann. § 41-1461.4 (West supp. 1997). The housing nondiscrimination provisions provide that "[h]andicap shall be defined as the term is defined by the Americans with Disabilities Act." *Id.* § 14-1491.8.

The Arizonians with Disabilities Act of 1992, Ariz. Rev. Stat. Ann. § 41-1492.5 (West supp. 1997), prohibits discrimination in public accommodations and commercial facilities on the basis of disability, and incorporates the standards of Title III of the Americans with Disabilities Act, 42 U.S.C. §§ 12181-12184 (1994).

*The authors acknowledge the research assistance of Deborah Reichmann in preparing this compilation. Valuable comments on aspects of various local laws were provided by Ron Boyter, John Davidson, Justin Hayford, and David Schulman.

ARKANSAS

The Arkansas HIV Shield Law provides that "[h]ealth care providers or facilities may not deny appropriate care based upon the results of an HIV test." Ark. Code Ann. § 20-15-905(d) (Michie 1991). The HIV Shield Law does not include any enforcement provisions.

The Arkansas Civil Rights Act prohibits discrimination in public and private employment, public accommodations, property transactions, finance and credit, and voting and participation in the political process on the basis of "any sensory, mental, or physical disability." "Disability" is defined as "a physical or mental impairment that substantially limits a major life function . . ." Ark. Code Ann. § 16-123-102(3) (Michie supp. 1997).

The Arkansas Fair Housing Act prohibits discrimination in housing accommodations and real estate transactions on the basis of "disability." Ark. Code Ann. § 16-123-202 (Michie supp. 1997). No statutory definition of "disability" is provided.

The Arkansas disability discrimination law prohibits discrimination in public services, facilities, employment, public accommodations and housing accommodations on the basis of "physical handicap." Ark. Code Ann. § 20-14-303 (Michie 1991). No statutory definition of "physical handicap" is provided.

CALIFORNIA

California law prohibits the use of HIV test results for determining suitability for employment or insurability. Cal. Health & Safety Code § 120980(f) (West 1996). Similarly, participation in an HIV research study may not be used to determine employability or insurability of a research subject. Cal. Health & Safety Code § 121115 (West 1996).

California's Fair Employment and Housing Act (FEHA) prohibits discrimination based on physical or mental "disability" and "medical condition" in public and private employment, housing, and professional licensure. The FEHA incorporates the federal definition of disability. Cal. Gov't Code §§ 12955.3, 12926(k) (West 1992 & supp. 1998); *see also* Cal. Code Regs. tit. 9, § 7025 (1997).

California's Unruh Civil Rights Act prohibits discrimination based on "disability" in public accommodations or business establishments, as does the Disabled Persons Act, Cal. Civ. Code § 54, which incorporates the federal definition of disability. A violation of the ADA is deemed a violation of these state laws. Cal. Civ. Code § 51, 54 (West 1982 & supp. 1998).

California law prohibits discrimination against individuals with disabilities, as defined by federal law, in programs or activities receiving financial assistance from the state. Cal. Gov't Code § 11135 (West 1992 & supp. 1998).

Los Angeles

Mun. Code §§ 45.80-45.93, *reprinted in part in* Empl. Prac. Guide (CCH) ¶ 20950A.

San Francisco

San Francisco Mun. Code §§ 3801-3816, *reprinted in part in* Empl. Prac. Guide (CCH) ¶ 20950B.

COLORADO

Colorado's Anti-Discrimination Act prohibits discrimination in public and private employment, housing, and public accommodation on the basis of "disability." The definition of "disability" incorporates the federal definition. Colo. Rev. Stat. Ann. § 24-34-301 (West 1997).

The Colorado legislature has issued a legislative declaration that "having . . . HIV infection, being presumed to have the HIV infection, or seeking testing for the presence of such infection should not serve as the basis for discriminatory actions or the prevention of access to services." Colo. Rev. Stat. Ann. § 25-4-1401 (West supp. 1997). No enforcement provisions are included in this provision.

In *Phelps v. Field Real Estate Co.*, 793 F. Supp. 1535, 1544 (D. Colo. 1991), *aff'd* 991 F.2d 645, 650 (10th Cir. 1993), the defendant conceded that HIV infection is a disability under Colorado law.

CONNECTICUT

The Connecticut Human Rights and Opportunities Act prohibits "physical disability" discrimination in public and private employment, housing, public accommodations, and other areas. "Physical disability" is defined as "chronic physical handicap, infirmity or impairment, whether congenital or . . . from illness . . ." Conn. Gen. Stat. Ann. § 46a-51(15) (West 1995).

Conn. Agencies Regs. § 46a-54-57 (1997) (authorizes use of pseudonym for complaints referring to confidential HIV information); *Id.* § 46a-54-41 (standards for the collection, use, maintenance, and release of confidential HIV-related information).

DELAWARE

The Delaware Handicapped Persons Employment Protections Act (DHPEPA) prohibits discrimination in public and private employment and incorporates the federal definition of disability, but defines "substantially limits" to mean that the "impairment so affects a person as to create a likelihood that such person will experience difficulty in securing, retaining or advancing in employment because of a handicap." Del. Code Ann. tit. 19, § 722(4) (1995). The definition of "regarded as having an impairment" includes "a physical or mental impairment that substantially limits major life activities because of the attitudes of others." *Id.* The DHPEPA further provides that the "regarded as" having an impairment provision "is intended to be interpreted in conformity with the federal Rehabilitation Act." *Id.*

The Delaware Fair Housing Act incorporates the federal definition of disability. Del. Code Ann. tit. 6, § 4602(14) (1993).

The Delaware Equal Accommodations Law incorporates the federal definition. Del. Code Ann. tit. 6, § 4502(8) (supp. 1996).

The Delaware Department of Insurance has issued regulations to prevent discrimination against potential insureds by life and health insurers when phrasing questions or requiring tests relating to AIDS. Del. Regs. § 56-1 to 56-5 (1997).

DISTRICT OF COLUMBIA

The District of Columbia Human Rights Act prohibits discrimination in public and private employment, public accommodations, housing, education, real estate transactions, and the sale of motor vehicle insurance on the basis of "disability." "Disability" incorporates the federal definition of disability. D.C. Code Ann. § 1-2502(5A) (1992 & supp. 1997).

Policy Statement, D.C. Office of Human Rights, 8A Lab. Rel. Rep. (BNA) 453:1715 (Oct. 9, 1986).

FLORIDA

The Florida Civil Rights Act provides that "[a]ny person with or perceived as having acquired immune deficiency syndrome, acquired immune deficiency syndrome related complex, or human immunodeficiency virus shall have every protection made available to handicapped persons." Fla. Stat. Ann. § 760.50(2) (West 1997).

The Florida Civil Rights Act, prohibits discrimination in public and private employment the basis of handicap. Fla. Stat. Ann. §§ 760.01-760.11, 509.092 (West 1997 & supp. 1998).

The Florida Fair Housing Act prohibits housing discrimination on the basis of handicap. Fla. Stat. Ann. § 760.20-760.37 (West 1997 & supp. 1998).

The Florida Educational Equity Act, prohibits discrimination against students and employees on the basis of handicap. Fla. Stat. Ann. § 228.2001(2) (West 1989 & supp. 1998).

However, public accommodation, housing accommodations, and public employment nondiscrimination rights are granted to the "physically disabled," the definition of which incorporates the federal standard. Fla. Stat. Ann. § 413.08(6)(a) (West 1998).

Persons or entities receiving state financial assistance may not discriminate against an otherwise qualified individual in housing, public accommodations, or government services on the basis that the individual is "infected with HIV." Fla. Stat. Ann. § 760.50 (West 1997).

Florida prohibits the use of HIV testing as a condition of employment and prohibits discrimination against any individual on the basis of "knowledge or belief that the individual has taken an [HIV] test or the results or perceived results of such test." Fla. Stat. Ann. § 760.50(3)(b) (West 1997).

Florida courts are prohibited from denying shared parental responsibility, custody, or visitation rights to a parent or grandparent solely because the parent or grandparent "is or is believed to be infected with HIV." Fla. Stat. Ann. § 61.13(6) (West 1997 & supp. 1998).

GEORGIA

The Georgia Equal Employment for Persons with Disabilities Code prohibits discrimination in public and private employment on the basis of "disability." "Disability" incorporates the federal definition. Ga. Code Ann. § 34-6A-2 (1992 & supp. 1997). Nondiscrimination provisions do not apply to an applicant for

employment who has "any communicable disease, either carried by or afflicting an applicant." *Id.* § 34-6A-3(b)(2).

Georgia does not have a nondiscrimination statute covering public accommodations, housing, or other areas.

GUAM

The Guam Employment Relations Act prohibits discrimination in public and private employment on the basis of "disability." Disability incorporates the federal definition and includes "physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others as having such an impairment." 22 Guam Code Ann. § 5202(a) (1996).

HAWAII

The Hawaii Confidentiality of HIV Information Act prohibits the compelled release of HIV test results or disclosure of HIV testing "in order to obtain or maintain housing, employment, or education." Haw. Rev. Stat. § 325-101(c) (1993).

The Hawaii housing nondiscrimination provisions prohibit discrimination on the basis of "HIV (human immunodeficiency virus) infection" and bar inquiries as to whether an individual has been tested for HIV. Haw. Rev. Stat. § 515-3 (1993). The statute also incorporates the federal definition of disability. *Id.* § 515-2.

The Hawaii Civil Rights Act prohibits discrimination in employment, housing, access to state services and public accommodations on the basis of "disability." Disability incorporates the federal definition. Haw. Rev. Stat. § 368-1.5(b) (1993).

IDAHO

The Idaho Commission on Human Rights Act prohibits discrimination in public and private employment, and real estate transactions and financing on the basis of "disability." The statutory definition of "disability" incorporates the federal definition although "substantial limitation" is not specified as being imposed on a major life activity. Idaho Code § 67-5902(15) (1995). Associational discrimination is prohibited in real property transactions. *Id.* § 67-5909 (1995).

ILLINOIS

The Illinois Human Rights Act prohibits discrimination in public and private employment, housing, credit and financing, and public accommodations on the basis of "handicap," which is defined as a "determinable physical or mental characteristic of a person ..., the history of such characteristic, or the perception of such characteristic by the person complained against, which may result from disease" 775 Ill. Comp. Stat. Ann. 5/1-103(I) (West 1993 & supp. 1997). *See also* Illinois Interpretative Rules on Handicap Discrimination in Employment, Ill. Admin. Code tit. 56, § 2500. For purposes of employment, the characteristic must be unrelated to the person's ability to perform the duties of a particular job or position; for purposes of housing, the characteristic must be unrelated to the person's ability to acquire, rent or maintain a housing accommodation; for purposes of credit unrelated to a person's ability to repay; and public accommodations, must be unrelated to the person's ability to utilize and benefit from a place of public accommodation.

In *Raintree Health Care Center v. Illinois Human Rights Comm'n*, 672 N.E.2d 1136, 1141 (Ill. 1996), *aff'g* 655 N.E.2d 944 (Ill. Ct. App. 1995), the Illinois Supreme Court held that HIV infection, because it is "a determinable physical characteristic resulting from a disease," is a handicap with the meaning of the Illinois Human Rights Act.

INDIANA

The Indiana Civil Rights Law prohibits discrimination in public and private employment, housing, public accommodations, and education based on "disability." "Disability" incorporates the federal definition. Ind. Code Ann. § 22-9-1-3(r) (West 1997).

The Indiana Equal Access to Housing for Persons with Disabilities Law defines "individual with a disability" as "an individual who, by reason of physical or mental defect or infirmity, whether congenital or acquired by accident, injury, or disease, is or may subsequently be totally or partially prevented from achieving the fullest attainable, physical, social, economic, mental and vocational participation in the normal process of living." Ind. Code Ann. § 22-9-6 (West 1997).

IOWA

The Iowa Civil Rights Act prohibits discrimination in public and private employment, housing, and public accommodations on the basis of disability, which is defined to include "the condition of a person with a positive human immunodeficiency virus test result, a diagnosis of [AIDS], a diagnosis of [ARC], or any other condition related to [AIDS]." Iowa Code Ann. § 216.2 (West supp. 1998). The inclusion positive HIV test results within the definition of disability is explicitly noted "not to preclude" the inclusion of other "conditions resulting from other contagious or infectious diseases" from that definition. *Id.*

KANSAS

The Kansas Act Against Discrimination prohibits discrimination in public and private employment, public accommodations and services, and housing on the basis of "disability." "Disability" incorporates the federal definition. Kan. Stat. Ann § 44-1002 (1993).

The Kansas HIV reporting statute provides that "[i]nformation regarding . . . HIV infection reported [for epidemiological purposes by physicians and laboratory directors to the state secretary of health] shall not be used in any form or manner which would lead to the discrimination against any individual or group with regard to employment, to provision of medical care or acceptance into facilities or institutions for medical care, housing, education, transportation, or for the provision of any other goods or services." Kan. Stat. Ann. § 65-6004(d) (supp. 1997).

KENTUCKY

The Kentucky Equal Opportunities Act provides that "any person with [AIDS], [ARC], or human immunodeficiency virus shall have every protection made available to individuals with disabilities under [the employment nondiscrimination provisions of Kentucky Revised Statutes §§] 207.130 to 207.240 and Section 504 [of] the Rehabilitation Act. Ky. Rev. Stat. Ann. § 207.135(1) (Michie 1995). HIV testing is prohibited in pre-employment examinations and for current employees, unless HIV status is a bona fide occupational

qualification. Ky. Rev. Stat. Ann. § 207.135(2)(a) (Michie 1995). An employer asserting HIV as a bona fide occupational qualification must prove that the test is "necessary to ascertain whether an employee is currently able to perform in a reasonable manner the duties of the particular job or whether the employee will present a significant risk of transmitting human immunodeficiency virus infection to other persons in the course of normal work activities." Additionally, the employer bears the burden of proving that there exists "no means of reasonable accommodation short of requiring the test." *Id.* § 207.135(2)(b). Employers may make pre-employment inquiries concerning the existence of an applicant's disability and about the extent to which that disability has been overcome by treatment or medication. *Id.* § 207.140(1). Nondiscrimination protections do not apply in the case of applicants for employment or housing who have "any communicable disease."

Discrimination based on HIV infection, or perception of infection, is prohibited in housing, public accommodations, and governmental services. Ky. Rev. Stat. Ann. § 207.135(3)(a)-(b) (Michie 1995). Entities receiving state financial assistance are also prohibited from discriminating on the basis of HIV infection or the perception of HIV infection. *Id.*

Licensed health care professionals who treat patients with HIV are also protected from discrimination. Ky. Rev. Stat. Ann. § 207.135(3)(d) (Michie 1995).

LOUISIANA

The Louisiana Civil Rights Act for Handicapped Persons prohibits discrimination in employment, education, housing and public services on the basis of "handicap." "Handicap" incorporates the federal definition of disability. La. Rev. Stat. Ann. § 46-2253(1) (West 1982).

MAINE

Maine law (Ch. 501, *Medical Conditions*), provides that employees or applicants for employment may not be required to submit to HIV testing or to reveal whether they have been tested for HIV, except when based on a bona fide occupational qualification. This provision is enforced by the Maine Human Rights Commission. Me. Rev. Stat. Ann. tit. 5, § 19204-B (West supp. 1997).

The Maine Human Rights Act prohibits discrimination in public and private employment, housing, public accommodations, financing, and education on the basis of "physical or mental disability." "Disability" incorporates the federal definition of disability. Me. Rev. Stat. Ann. tit. 5, § 4553 (West 1989 & supp. 1997) (definition 7-A).

As noted in *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997), the concept of disability under the Maine Human Rights Act is co-extensive with that of the Americans with Disabilities Act.

MARYLAND

Maryland's HIV informed consent testing statute provides that refusal to undergo HIV testing may not be used "as the sole basis by any institution or laboratory to deny services or treatment." Md. Code Ann., Health-Gen. Code § 18-336(c) (supp. 1997).

Maryland's statute providing for disclosure of HIV information to fire fighters, emergency medical

technicians, rescue squadpersons, law enforcement officers, and correctional officers provides that individuals in those occupations "may not refuse to treat or transport an individual because the individual is HIV positive." Md. Code Ann., Health-Gen. Code § 18-213(m) (supp. 1997). Similarly, the same standard applies to correctional officers, first responders, law enforcement officers, medical care facilities, and physicians performing postmortem exams in regarding the transportation of HIV positive decedents. Md. Code Ann., Health-Gen. Code § 18-213.2(h) (supp. 1997).

The Maryland Human Rights Act prohibits discrimination in public and private employment, housing, public accommodations, retail services and by persons licensed or regulated by the State Department of Licensing and Regulations on the basis of physical or mental handicap, or perceived handicap, which is defined as "any physical disability . . . which is caused by . . . illness" Md. Ann. Code of 1957, art. 49B, § 15(g) (1994).

The Maryland Commission on Human Relations has interpreted the statutory definition as including "infection with Human Immunodeficiency Virus." Md. Regs. Code tit. 14, § 14.03.02.02 (1997). In its interpretation of the Act, the Commission incorporated the federal definition of disability, including the "perceived-as" disabled element. *Id.* § 14.03.02.03.

Discrimination against public school teachers on basis of "handicap" is prohibited. Md. Code Ann., Educ. § 6-104 (1996). "Handicap" is not defined.

Discrimination insurance not allowed for disability unless actuarially justified. Md. Code Ann., Ins. § 27-208 (1997).

MASSACHUSETTS

The Massachusetts Unlawful Discrimination Law prohibits discrimination in public and private employment and real estate transactions on the basis of "handicap." "Handicap" incorporates the federal definition of disability. Mass. Gen. Laws Ann. ch. 151B, § 1 (West 1998).

MICHIGAN

The Michigan Handicappers' Civil Rights Act prohibits discrimination in public and private employment, public accommodations, public services, housing and real estate, educational facilities for handicapped individuals. "Handicap" incorporates the federal definition, but instead of impairment, the statute uses the term "determinable physical or mental characteristic of an individual, which may result from disease, injury, congenital condition of birth, or functional disorder." Mich. Comp. Laws Ann. § 37.1103(e)-(f) (West 1985 & supp. 1998).

In *Robinson v. Henry Ford Health Systems*, 892 F. Supp. 176, 180 (E.D. Mich. 1994), *aff'd without opinion*, 86 F.3d 1156 (6th Cir. 1996), the court noted that persons "who have tested positive for AIDS or the AIDS-related HIV virus are covered as handicapped or disabled individuals under both the Michigan and federal [Rehabilitation] acts."

MINNESOTA

The Minnesota Human Rights Act prohibits discrimination in public and private employment, public accommodations, housing, public services, and education on the basis of "disability." Minn. Stat. Ann. § 363.01 (West 1991). The statutory definition of "disability" incorporates the federal definition, although impairment may be "physical, sensory, or mental" and the limitation on one or more major life activities must be "material." *Id.*

The Minnesota Court of Appeals interpreted this provision to apply to asymptomatic HIV infection in *Beaulieu v. Clausen*, 491 N.W.2d 662 (Minn. Ct. App. 1992), on the basis that individuals with HIV are materially limited in several major life activities, including social participation (because of emotional problems as well as ostracism), sexual activities, child-bearing, access to insurance coverage, and limitations on career choices involving extensive training resulting from limited life expectancy, and limitations on ability to work due to need for medical care.

MISSISSIPPI

Mississippi's employment law prohibits discrimination in public employment and by employers receiving state funding on the basis of "handicap." There is no statutory definition of "handicap." Miss. Code Ann. § 25-9-149 (1991).

Mississippi does not have a nondiscrimination law covering private employment or other areas.

MISSOURI

The Missouri HIV and Public Health Act provides that the Missouri Human Rights Act, Mo. Ann. Stat. §§ 213.010-213.137 (West 1996 & supp. 1998), "shall apply to individuals with HIV infection . . ." Mo. Ann. Stat. § 191.665 (West 1996).

The Missouri Human Rights Act (MHRA) prohibits discrimination in employment, public accommodations, housing and commercial real estate loans on the basis of "handicap." The statutory definition of "handicap" incorporates the federal definition. Mo. Ann. Stat. § 213.010(10) (West 1996). The MHRA also includes "associational" discrimination. Mo. Ann. Stat. § 213.070(4) (West 1996).

MONTANA

The Montana Hospitals and Related Facilities Law provides that a "health care facility may not refuse to admit a person to the facility solely because the person has an HIV-related condition." "HIV-related condition" means "any medical condition resulting from an HIV infection, including but not limited to seropositivity for HIV." Mont. Code Ann. § 50-5-105(2) (1997).

The Montana Human Rights Act prohibits discrimination in public and private employment, public accommodations, education and housing on the basis of "disability." "Disability" incorporates the federal definition. Mont. Code Ann. § 49-2-101 (1997).

NEBRASKA

The Nebraska Individual Rights Act prohibits discrimination in public and private employment, housing, education, and public accommodations on the basis that the individual discriminated against "is suffering or is suspected of suffering from human immunodeficiency virus infection or acquired immunodeficiency syndrome." Neb. Rev. Stat. § 20-168 (1995). Each agency of the state government was required to examine "policies and practices within its jurisdiction that may intentionally or unintentionally result in discrimination against a person who has taken a [HIV] antibody or antigen test or who has been diagnosed as having [AIDS] or [ARC] to ascertain the extent and types of discrimination that may exist," and to report its findings to the state legislature by Dec. 1, 1988. *Id.* § 20-167.

The Nebraska Fair Employment Practice Act prohibits discrimination in public and private employment on the basis of "disability." "Disability" incorporates the federal definition. Neb. Rev. Stat. § 48.1102(9) (1993).

NEVADA

The Nevada Equal Opportunity for Employment Law prohibits discrimination in public and private employment on the basis of "disability." "Disability" incorporates the federal definition. Nev. Rev. Stat. Ann. § 613.310(1) (Michie 1996).

The Nevada Fair Housing Law prohibits discrimination in housing on the basis of "disability." "Disability" incorporates the federal definition. Nev. Rev. Stat. Ann. § 118.045 (Michie 1993).

NEW HAMPSHIRE

The New Hampshire Law Against Discrimination prohibits discrimination in public and private employment, housing and public accommodations on the basis of "physical or mental disability." "Disability" incorporates the federal definition. N.H. Rev. Stat. Ann. § 354-A:2.IV (1995).

Landlords are prohibited from evicting tenants "solely on the grounds that the person has [AIDS] or is regarded to have [AIDS]." N.H. Rev. Stat. Ann. § 354-A:10.VI (1995).

NEW JERSEY

The New Jersey Law Against Discrimination prohibits discrimination in public and private employment, public accommodations and facilities (including public and private schools), public and private housing, real estate transactions on the basis of "handicap," which includes "AIDS or HIV infection." N.J. Stat. Ann. §§ 10:5-4.1 and 10:5-5(q) (West 1993 & supp. 1997). "HIV infection" is defined as "infection with the human immunodeficiency virus or any other virus identified as a probable causative agent of AIDS." *Id.* § 10:5-5(gg).

Announcement, N.J. Div. Civ. Rights, Empl. Prac. Guide (CCH) ¶ 5026 (July 1986) (AIDS discrimination and testing for AIDS prohibited). Associational discrimination is prohibited in housing. N.J. Stat. Ann. § 10:5-4.1 (West 1993).

In *Poff v. Caro*, 549 A.2d 900, 903 (N.J. Super. Ct. Law Div. 1987), the court ruled that New Jersey law prohibits housing discrimination based on the perception that an individual has AIDS or the "potential" to

develop AIDS, noting that there is no rational basis for distinguishing between those with a disability and those so perceived.

NEW MEXICO

New Mexico's Human Immunodeficiency Virus Related Test Limitation Law prohibits employers from requiring disclosure of HIV-related test results for purposes of hiring, promotion, or continued employment. N.M. Stat. Ann. § 28-10A-1 (Michie 1996).

New Mexico's Human Rights Act prohibits discrimination in public and private employment, housing and public accommodations on the basis of "physical or mental handicap" or "serious medical condition." "Handicap" incorporates the federal definition of disability. N.M. Stat. Ann. §§ 28-1-2.M, 28-1-7.A (Michie 1996).

NEW YORK

The New York Human Rights Law prohibits discrimination in public and private employment, public accommodations, housing, financing based on "disability." "Disability" is defined as a "physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques," or a record such an impairment, or a condition regarded by others as such an impairment. N.Y. Exec. Law § 292(21) (McKinney 1993 & supp. 1998). This provision has been interpreted by the New York Division on Human Rights to include HIV infection. Policy Statement, N.Y. Div. Human Rights, 8A Lab. Rel. Rep. (BNA) 455:3081 (Dec. 1985).

Petri v. Bank of N.Y. Co., 582 N.Y.S.2d 608, 611 (Sup. Ct. N.Y. County 1992) (asymptomatic HIV infection, whether actual or perceived, is disability under New York law).

Seitzman v. Hudson River Assocs., 542 N.Y.S.2d 104 (Sup. Ct. N.Y. County 1989) (successful discrimination claim under New York law of physician-tenant whose practice included patients with AIDS).

New York City

119-121 East 97th St. Corp. v. New York City Comm'n on Human Rights, 642 N.Y.S.2d 638 (App. Div. 1996) (successful housing discrimination case involving discrimination on basis of HIV status under New York City law).

NORTH CAROLINA

The North Carolina Communicable Disease Act (NCCDA) prohibits the discrimination in continued employment, housing, public services, public accommodations, and public transportation against "any person having AIDS virus or HIV infection on account of that infection." N.C. Gen. Stat. § 130A-148(i) (1997). The NCCDA also prohibits the use or requirement of HIV testing to determine suitability for continued employment, housing, public services, public accommodations, and public transportation. *Id.* However, the NCCDA allows HIV testing of job applicants, denial of employment to job applicants based on HIV status, and HIV testing as an annual medical examination routinely required of all employees by the employer. Reassignment or termination of employment is allowed if the employee poses a significant risk to the employee or others, or if the employee is unable to perform the normally assigned duties of the job. The

NCCDA also allows licensed health care providers and facilities to discriminate against patients with HIV infection "to protect the health care provider or employees of the provider or employees of the facility while providing appropriate care" and to refer the patient with HIV to another provider or facility "when such referral is for the purpose of providing more appropriate treatment." N.C. Gen. Stat. § 130A-148(j) (1997).

The North Carolina Handicapped Persons Protection Act (NCHPPA) prohibits discrimination in employment, public accommodations, and public services on the basis of handicap. The NCHPPA incorporates the federal definition of disability, N.C. Gen. Stat. § 168A-3(4) (1997), but does not include "working" among the activities identified as major life activities. *Id.*

In *Burgess v. Your House of Raleigh, Inc.*, 388 S.E.2d 134 (N.C. 1990), the Supreme Court of North Carolina interpreted the NCHPPA as not applying to HIV infection because (1) the NCHPPA's exempts "communicable diseases" from the definition of handicap and (2) HIV does not limit a major life activity as defined by the NCHPPA.

The North Carolina Handicapped Persons Act prohibits discrimination in public accommodations and conveyances, and housing on the basis of "handicap." N.C. Gen. Stat. § 168-1 (1997). The Act has been construed to be limited to a present, non-correctable loss of function that substantially limits a person's ability to function normally. *See Pressman v. University of North Carolina*, 337 S.E.2d 644, 649 (N.C. Ct. App. 1985).

NORTH DAKOTA

The North Dakota Human Rights Act prohibits discrimination in public and private employment, housing and public accommodations on the basis of "disability." "Disability" incorporates the federal definition. N.D. Cent. Code § 14-02.4-02 (1997).

OHIO

The Ohio AIDS and HIV Programs Law provides that disclosure of HIV test results to health care providers "may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result . . . in order to refuse to treat the individual." Ohio Rev. Code Ann. § 3701.24.3(B)(2) (Anderson 1997). The Ohio AIDS and HIV Programs Law also provides that no governmental agency or private nonprofit corporation receiving state or local government funds "shall refuse to admit as a patient, or to provide services to, any individual solely because he refuses to consent to an HIV test or to disclose HIV test results." *Id.* § 3701.24.5(A).

The Ohio Civil Rights Commission Act prohibits discrimination in public and private employment, housing, public accommodations, and granting of credit on the basis of "handicap." The statute incorporates the federal definition of disability (setting forth as major life activities the "functions of caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working"). Ohio Rev. Code Ann. § 4112.01(13) (Anderson 1995). "Physical or mental impairment" includes "human immunodeficiency virus infection." *Id.* § 4112.01(16)(a)(iii).

The Ohio Civil Rights Commission has interpreted this law as covering HIV infection. Policy Statement, Ohio Civ. Rights Comm'n, 8A Lab. Rel. Rep. (BNA) 457:275 (Mar. 25, 1987); *see also Lawson v. E.R. Towers Co.*, No. B3112385(13570)-052086 (Ohio Civ. Rights Comm'n, Nov. 14, 1986), *summarized in* 8 Lab. Rel. Rep. (BNA) 421:678.

Ohio Civil Rights Commission regulations include "perceived as" handicapped within the definition. Ohio Admin. Code § 4112-5-02(H) (1997). *See also* Cleveland v. Ohio Civil Rights Comm'n, 648 N.E.2d 516 (Ohio Ct. App. 1994).

OKLAHOMA

The Oklahoma Anti-Discrimination Act prohibits discrimination in public and private employment, public accommodations, and housing on the basis of handicap. Handicap incorporates the federal definition of disability. Okla. Stat. Ann. tit. 25, § 1301 (West 1998).

OREGON

The Oregon Civil Rights of Disabled Persons Act prohibits discrimination in public and private employment, housing and public accommodations on the basis of "disability." "Disability" generally incorporates the federal definition, but defines "major life activity" as including but not limited to "self-care, ambulation, communication, transportation, education, socialization, employment and the ability to acquire, rent or maintain property." Or. Rev. Stat. § 659.400(2)(a) (1996). "Substantially limits" means that the "impairment renders the person unable to perform a major life activity that the average person in the general population can perform . . . or . . . significantly restricts the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the general population can perform the same major life activity." *Id.* § 659.400(2)(d).

PENNSYLVANIA

The Pennsylvania Human Relations Act covers handicap discrimination, including discrimination on basis of perceived handicap, in employment, housing, and public accommodations on the basis of "handicap or disability." Pa. Stat. Ann. tit. 43, §§ 954-955 (1993). "Handicap or disability" incorporates the federal definition of disability.

Pennsylvania Human Relations Commission regulations provide that a handicap or disability which is not job-related but which may worsen and become job related is covered, subject to the defense of undue hardship. Pa. Code tit. 16, § 44.15 (1998).

The Pennsylvania Human Relations Commission has interpreted the Act to cover AIDS/ARC/HIV. Policy Statement, Pa. Hum. Relations Comm'n, Apr. 10, 1986.

Philadelphia

The Philadelphia Fair Practices Act has been interpreted by the Philadelphia City Solicitor to cover HIV infection. Mem. Phila. City Solicitor, 2 Empl. Prac. Guide (CCH) ¶ 5027 (Mar. 4, 1986).

PUERTO RICO

The Puerto Rico Discrimination Against Disabled Persons Act prohibits discrimination in public and private employment, access to the physical facilities of public and private entities, public and private education, and

by Commonwealth-funded private or public institutions on the basis of physical or mental disabilities. P.R. Laws Ann. tit. 1, §§ 502-508 (supp. 1997). Disability is defined as "a temporary or permanent condition of a motor or mental nature which hinders or limits [an individual's] inception or ability to work, study or enjoy life fully." *Id.* § 501(d).

RHODE ISLAND

The Rhode Island Prevention and Suppression of Contagious Disease Act prohibits discrimination in employment, housing, granting of credit, public accommodation, or delivery of services on the basis of "a positive AIDS test result, or perception of same." R.I. Gen. Laws §§ 23-6-22 (1996). The Act also prohibits the requirement of an "AIDS test" as a condition of employment, "except where nondiscrimination can be shown, on the testimony of competent medical authorities, to constitute a clear and present danger of AIDS virus transmission to others." *Id.*

The Rhode Island Civil Rights of People with Disabilities Act prohibits discrimination employment, housing, and public accommodations on the basis of "disability." R.I. Gen. Laws § 42-87-1(b)-(c) (supp. 1997). The Act incorporates the federal definition of disability and cross-references the federal Rehabilitation Act and Americans with Disabilities Act for its definition of prohibited, discriminatory acts or conduct.

The Rhode Island Equal Opportunity and Affirmative Action Act prohibits discrimination in public and private employment on the basis of "disability." "Disability" incorporates the federal definition and provides that the definition "shall include any disability which is provided under the [ADA] and federal regulations pertaining to the [ADA]" citing 28 C.F.R. pt. 35 and 29 C.F.R. pt. 1630. R.I. Gen. Laws § 28-5-6(9) (supp. 1997).

The Rhode Island Equal Opportunity and Affirmative Action Act prohibits discrimination in public employment, services, facilities, and educational programs on the basis of "disability." R.I. Gen. Laws § 28-5.1-1 (1995 & supp. 1997). "Disability" is not defined.

The Rhode Island Fair Housing Practices Act prohibits discrimination in housing on the basis of disability. R.I. Gen. Laws § 34-37-3(5), (9) (supp. 1997).

SOUTH CAROLINA

The South Carolina Human Affairs Law prohibits discrimination in public and private employment on the basis of "disability." "Disability" incorporates the federal definition and provides that the term "must be interpreted in a manner consistent with federal regulations promulgated pursuant to the [ADA]." S.C. Code Ann. § 1-13-30 (West supp. 1997).

The South Carolina Bill of Rights for Handicapped Persons prohibits discrimination in public accommodations, public services, and housing on the basis of "handicap." "Handicap" is defined as "a substantial physical or mental impairment . . . acquired by . . . disease, where the impairment is verified by medical findings and appears reasonably certain to continue throughout the lifetime of the individual without substantial improvement." S.C. Code Ann. § 43-33-560 (West supp. 1997). The definition also excludes individuals who are only regarded as handicapped. The definition of "handicapped person" for purposes of South Carolina law incorporates the federal definition and "any other definition prescribed by federal law or regulation for use by agencies of state government which serve handicapped persons." S.C. Code Ann. § 2-7-35 (1986).

SOUTH DAKOTA

The South Dakota Human Rights Act Law prohibits discrimination in public and private employment, housing, public accommodations and education on the basis of "disability." "Disability" incorporates the federal definition. S.D. Codified Laws § 20-13-1 (Michie 1995).

TENNESSEE

The Tennessee Human Rights Act prohibits discrimination in public and private employment, public accommodations, and housing on the basis of "handicap." "Handicap" incorporates the federal definition of disability. Tenn. Code Ann. § 4-21-102 (1997).

TEXAS

The Texas Communicable Disease Prevention and Control Act prohibits HIV testing for employment purposes, unless the employer can show that HIV status is a bona fide occupational qualification and there is not a less discriminatory means of satisfying the occupational qualification. Tex. Code Health & Safety Ann. § 81.102(a)(4)(a) (West 1992). This provision applies to home collection kits for HIV testing. *Id.* § 85.253(c) (West supp. 1998).

The Texas HIV Service Act provides that the results of HIV testing conducted by a health department voluntary HIV testing program "may not be used for insurance purposes, to screen to determine suitability for employment, or to discharge a person from employment." Tex. Code Health & Safety Ann. § 82.082(c) (West 1992).

The Texas Commission on Human Rights Act prohibits discrimination in public and private employment based on "disability" and incorporates the federal definition of disability. Tex. Lab. Code Ann. § 21.002(6) (West supp. 1998).

The Texas Rights and Responsibilities of Persons with Disabilities Act prohibits discrimination in housing accommodations and public facilities based on "disability." Tex. Hum. Res. Code Ann. § 121.001 to 121.111 (West supp. 1998). "Disability" is defined as a "mental or physical disability, including mental retardation, hearing impairment, deafness, speech impairment, visual impairment, or any health impairment that requires special ambulatory devices or services." *Id.* § 121.002(4).

UTAH

The Utah Anti-Discrimination Act prohibits discrimination in public and private employment on the basis of "handicap." "Handicap" incorporates the federal definition of disability. Utah Code Ann. § 34A-5-102 (1997).

The Utah Fair Housing Act prohibits discrimination in housing on the basis of "disability." "Disability" incorporates the federal definition. Utah Code Ann. § 57-21-1 (1997).

VERMONT

The Vermont Fair Employment Practice Act prohibits discrimination in public and private employment on the basis of "HIV infection." Vt. Stat. Ann. tit. 21, § 495(a)(6)(7) (1997).

The Vermont Discrimination Law prohibits discrimination in public accommodations and housing on the basis of "disability." "Disability" incorporates the federal definition. Vt. Stat. Ann. tit. 9, § 4501 (1997).

VIRGIN ISLANDS, US

The Virgin Islands Civil Rights Act does not include HIV or other disability nondiscrimination provisions. V.I. Code Ann. tit. 10, §§ 1-10, 61-75 (1982 & supp. 1998).

VIRGINIA

The Virginia Disease Prevention and Control Act provides that "[n]o person known or suspected to be positive for infection with . . . human immunodeficiency virus shall be refused services for that reason by any public safety agency personnel." Public safety agencies include the sheriff's office, adult or youth correctional, law enforcement, and fire safety organizations, or any governmental agency or department that employs persons who have law enforcement authority. Va. Code Ann. § 32.1-45.2 (Michie 1997).

The Virginians with Disabilities Act prohibits discrimination in public and private employment, education, public accommodations, and housing on the basis of "disability." "Disability" incorporates the federal definition. Va. Code Ann. § 51.503 (Michie 1997).

The Virginia Human Rights Act (VHRA) prohibits conduct "which violates any Virginia or federal statute or regulation governing discrimination on the basis of . . . disability." Va. Code Ann. § 2.1-714 (Michie supp. 1997). Nothing in the VHRA "shall be deemed to . . . expand upon any of the provisions of any other state or federal law relating to discrimination because of . . . disability." *Id.* § 2.1-717.

WASHINGTON

The Washington Law Against Discrimination prohibits discrimination in public and private employment on the basis of "HIV infection" (actual or perceived), including requiring HIV testing a condition of employment, unless absence of HIV infection is bona fide occupational qualification. Wash. Rev. Code Ann. § 49.60.172 (West 1990 & supp. 1997). Absence of HIV infection as a bona fide occupational qualification exists "when performance of the particular job can be shown to present a significant risk, as defined by the board of health by rule, of transmitting HIV infection to other persons, and there exists no means of eliminating the risk by restructuring the job." *Id.* § 49.60.172(3). Claims of actual or perceived HIV discrimination are to be "evaluated in the same manner" as other claims of disability discrimination. *Id.* § 49.60.174(1).

The Washington Law Against Discrimination prohibits discrimination in public and private employment, public accommodations, housing and real estate transactions, and financing and credit transactions on the basis of "sensory, mental or physical disability." Wash. Rev. Code Ann. § 49.60.010 (West supp. 1997). No definition of disability is provided.

WEST VIRGINIA

The West Virginia Human Rights Act (WVHRA) prohibits discrimination in employment, public accommodations, and housing on the basis of "handicap." "Handicap" incorporates the federal definition of disability. W. Va. Code § 5-11-3(m) (1994).

In *Benjamin R. v. Orkin Exterminating Co.*, 390 S.E.2d 814, 818 (W. Va. 1990), the West Virginia Supreme Court of Appeals ruled that HIV infection is a handicap under the WVHRA on the basis that HIV infection substantially impairs or limits the major life activity of "socialization" because of the psychological impact resulting from knowledge of one's HIV status. (The WVHRA was subsequently amended to conform more precisely to federal law.)

WISCONSIN

The Wisconsin Communicable Disease Control Law prohibits health care providers, peace officers, fire fighters, correctional officers, state patrol officers, jailers, home health agencies, and inpatient health care facilities from discriminating against an individual who has "a positive test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, solely because the individual has HIV infection or an illness or medical condition that is caused by, arises from or is related to HIV infection." Wis. Stat. Ann. § 252.14 (West supp. 1997).

The Wisconsin Fair Employment Act prohibits discrimination in public and private employment on the basis of "handicap." "Handicap" incorporates the federal definition of disability. Wis. Stat. Ann. § 111.31 (West 1997).

WYOMING

The Wyoming Fair Employment Practices Act prohibits discrimination in public and private employment on the basis of "handicap." The statute provides no definition for handicap. Wyo. Stat. § 27-9-105 (1997). The Wyoming Fair Employment Comm'n Rules of Practice incorporate the federal definition of disability.

POSSIBLE OUTCOMES OF THE DISABILITY ISSUE IN BRAGDON v. ABBOTT

(Prepared by Bennett Klein, Gay and Lesbian Advocates and Defenders)

I. AFFIRM

- A. People with HIV are protected by ADA -- legislative history, and nature of HIV as limiting one or more life activities -- either procreation/intimate sexual relations, caring for one's self, or planning for future.
- B. HIV is not in every case a disability, but procreation is a major life activity and Sidney Abbott demonstrated "substantial limitation" because she decided not to have a child.
 - ** Court may not reach whether HIV limits other major life activities, but may give some positive signals that other major life activities remain viable for future litigation.
 - ** Court may also state or imply that individualized showing of limitation is necessary.
- C. Abbott did not demonstrate limitation of a life activity under first prong, but is protected under the "regarded as" prong of the definition of disability because she was excluded from a place of public accommodation because of Bragdon's negative reaction to her impairment/fear of contagion.

II. REVERSE

- A. HIV is not a "per se" disability and HIV does not substantially limit procreation or intimate sexual relations. The Court is not presented with any other issue (although the decision does not preclude litigation of HIV's impact on other major life activities).
- B. Sidney Abbott is not covered under the "regarded as" prong of the definition of disability because Dr. Bragdon did not regard her as being limited in a major life activity.

III. REMAND

- A. Remand for district court to determine whether Abbott is substantially limited in caring for one's self or planning for the future.
- B. Remand for determination of whether Abbott was "regarded as" disabled.