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Insurance Risk Classification After McGann: Managing Risk Efficiently in the Shadow of the ADA

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INSURANCE RISK CLASSIFICATIONS AFTER *MCGANN*: MANAGING RISK EFFICIENTLY IN THE SHADOW OF THE ADA*

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TABLE OF CONTENTS

I. INTRODUCTION

A significant part of the health insurance debate which gripped the country during the first two years of President Clinton's administration focused on the critical shortage of employer-sponsored health insurance for disabled, or high risk, employees. Indeed, President Clinton's promise of universal access in connection with the promotion of his health care

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plan[1] is apparently designed to ensure that the increasingly popular employer practice of excluding high risk employees becomes obsolete. In the meantime, while the merits of the Clinton plan and its competitors[2] are

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[1]The stated purpose of the President's proposed plan is "to ensure individual and family security through health care coverage for *all* Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans." H.R. 3600, 103d Cong., 1st Sess. (1993) (emphasis added). In order to be "eligible" for coverage under the plan one must be either (1) "a citizen or national of the United States;" (2) "an alien permanently residing in the United States under color of law;" or (3) "a long-term nonimmigrant." *Id.* § 1001(c). The "comprehensive benefit package" for eligible individuals shall consist of hospital services, services of health professionals, emergency and ambulatory medical and surgical services, clinical preventive services, mental health and substance abuse services, family planning services and services for pregnant women, hospice care, home health care, extended care services, ambulance services, outpatient laboratory, radiology, and diagnostic services, outpatient prescription drugs and biologicals, outpatient rehabilitation services, durable medical equipment and prosthetic and orthotic devices, vision care, dental care, health education classes, and investigational treatments. *Id.* § 1101(a).

The core of the President's plan is the creation of health alliances. *Clinton's Health Plan; A New Framework for Health Care*, N.Y. TIMES, Sept. 23, 1993, at A22.

> Run by the states under Federal scrutiny, these regional purchasing groups would collect and distribute premiums, certify health plans and offer them to consumers, insure that average premiums grow no faster than Federally set limits, collect and publish data on performance of health plans and negotiate with local doctors and hospitals to set fees for service provided outside H.M.O.'s.

Id. These alliances would offer consumers three types of medical plans: "an H.M.O., a fee-for-service plan, or a combination of the two." *Id.* Patients who choose the H.M.O. option would only be able to choose between doctors affiliated with that H.M.O. and would pay $10 for an office visit. *Id.* Under the fee-for-service option "patients can see any doctor they choose, but must pay deductibles" of between $200 and $400 for office visits and hospitalization. *Id.* The regional alliances would be overseen by a National Health Board, consisting of seven members appointed by the President. *Id.*

Most of the cost for health care would be borne by employers. *Id.* "The plan requires them to pay at least 80 percent of the average cost of premiums in their region, and to support family coverage for married workers." *Id.* Employees "[w]ould contribute an average of 20 percent toward their own insurance premiums, plus any required deductibles or co-payments." *Id.*

[2]Health Equity and Access Reform Today Act, S. 1770, 103d Cong., 1st Sess. (1993); Managed Competition Act, H.R. 3222, 103d Cong., 1st Sess. (1993); H.R. 4561, 103d Cong., 2nd Sess. (1994); S. 2109, 103d Cong., 2nd Sess. (1994); H.R. 3918, 103d Cong., 2nd Sess. (1994); H.R. 3955, 103d Cong., 2nd Sess. (1994); S. 1796, 103d Cong., 2nd Sess. (1994); S. 1807, 103d Cong., 2nd Sess. (1994); Health Care Reform Act, S. 2096, 103d Cong., 2nd Sess. (1994); S. 2153, 103d Cong., 2nd Sess. (1994); Action Now Health Care Reform Act, H.R. 101, 103 Cong., 1st Sess. (1993); American Health Security Act, H.R. 1200, 103d Cong., 1st

debated, individuals like John McGann—working and *insured*—continue to discover that like their health, their insurance can disappear at any time.

John McGann's story is a straightforward one. In 1982 he began working for H & H Music Company and was covered by the company's group medical care plan. Pursuant to the plan, in effect from August 1, 1987 to July 31, 1988, all listed coverages were fully insured, up to a lifetime maximum of $1 million. In December 1987 McGann was diagnosed with AIDS. In March 1988 he met with company officials and discussed his illness. Four months later, all employees were notified that the medical care plan was terminated effective August 1, 1988, and that a new group medical/hospitalization plan would become effective and would limit benefits payable for AIDS-related conditions to a lifetime maximum of $5,000. No limitation was placed on any other catastrophic illness. Like many employers hoping to cut health insurance costs, H & H elected to self-insure[3] under the new plan. In an arrangement typical of self-insured firms, H & H entered into an Administrative Services Agreement with a third party which received administrative services fees for the sole purpose of administering the plan and paying claims.

Not surprisingly, McGann exhausted the $5,000 limit for coverage of AIDS by January, 1990. He sued H & H,[4] contending that the limitation for AIDS related conditions violated § 510 of the Employee Retirement

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Sess. (1993); National Health Security Act, H.R. 1691, 103d Cong., 1st Sess. (1993); Consumer Choice Security Act, H.R. 3698, 103d Cong., 1st Sess. (1993); American Health Security Act, H.R. 3960, 103d Cong., 2nd Sess. (1994); Consumer Choice Health Security Act, H.R. 4550, 103d Cong., 2nd Sess. (1994); American Health Security Act, S. 491, 103d Cong., 1st Sess. (1993); Consumer Choice Health Security Act, S. 1743, 103d Cong., 1st Sess. (1993); Health Security Act, S. 1775, 103d Cong., 1st Sess. (1993); Health Security Act, S. 1779, 103d Cong., 1st Sess. (1993).

[3]Whether a policy is self-insured depends on who bore the risk under the plan. "If for example, an ERISA plan only contracted out for someone to 'administer' the plan but the ERISA plan retained all of the risk of loss due to claims made under the plan, such a plan would be a self-funded plan." Longoria v. Cearley, 796 F. Supp. 997, 1002-03 (W.D. Tex. 1992). However, "[i]f a plan paid premiums to some other entity that would bear the risk of the loss, then the plan would not be self-funded and would be insured." *Id.*

Determining whether a plan is self-insured is significant because it will determine whether state or federal law, i.e., ERISA, will apply. "[S]tates are prohibited by ERISA from applying [their own insurance laws] to employee health benefit plans which are self-insured .... As a result, employers have an added incentive to self-insure to avoid the costs of complying with state insurance regulations ...." Kathlynn L. Butler, *Securing Employee Health Benefits Through ERISA and the ADA*, 42 EMORY L.J. 1197, 1203 (1993).

[4]McGann v. H & H Music Co., 946 F.2d 401, 402 (5th Cir. 1991), *cert. denied*, 113 S.Ct. 482 (1992).

Income Security Act (ERISA) which provides:

> [i]t shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a [plan] participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.[5]

The Fifth Circuit affirmed the district court's grant of summary judgment in the employer's favor on the ground that the changes McGann complained of were motivated by a desire to "avoid the expense of paying for AIDS treatment."[6] Because the reduction in AIDS coverage affected *all* employees and because there was no evidence that H & H ever promised that the $1 million cap would be permanent, the court of appeals concluded that McGann could not demonstrate either that he was entitled to the higher cap or that he was the victim of personal retaliation.[7] The Fifth Circuit, in support of its conclusion, noted the following ominous possibility: "If a federal court could prevent an employer from reducing an employee's coverage limits for AIDS treatment once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alteration or termination of ERISA plans would be sorely tested."[8]

Whether the court would have come to the same conclusion in the case of a cancer or heart bypass patient is not certain.[9] We do know, though, that despite McGann's subsequent death and the Supreme Court's refusal to hear his appeal,[10] other employers, perhaps taking their cue from the Fifth Circuit, began to rewrite their health insurance policies in order to

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[5]29 U.S.C. § 1140 (1988), *quoted in McGann*, 946 F.2d at 403.

[6]*McGann*, 946 F.2d at 404.

[7]*Id.* at 404-05.

[8]*Id.* at 408.

[9]Some have argued that it is not mere coincidence that *McGann* and similar cases involve AIDS patients. *See, e.g.*, Michele Zavos, *AIDS and Insurance: No Guarantees*, 20 HUM. RTS. Q. 18 (1993) ("People with AIDS and HIV have been singled out for adverse action because their illness is socially unacceptable, and employers have counted on the fact that other employees would not object to the reduction of benefits for someone with AIDS."); *see also* Bruce Lambert, *AIDS Insurance Coverage Is Increasingly Hard To Get*, N.Y. TIMES, Aug. 7, 1989, at A1.

[10]Greenberg v. H & H Music Co., 113 S.Ct. 482 (1992).

dramatically limit or exclude from coverage altogether AIDS and its related medical conditions. Other employees in situations almost identical to McGann's have enjoyed legal victories,[11] but not because of a more

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[11]See Mason Tenders District Council Welfare Fund v. Donaghey, No. 93 Civ. 1154 (S.D.N.Y. Nov. 19, 1993), in which the Equal Employment Opportunity Commission (EEOC) held that an employer violated the Americans with Disabilities Act (ADA) when it rewrote its plan to exclude payment for AIDS and AIDS-related conditions after an employee, insured under the plan, came down with the virus. The EEOC recently described

> three questions that must be resolved in determining whether an insurance plan violates the ADA. The first is whether there is a disability-based distinction. If such a distinction exists, the second and third questions place the burden on the employer to show that its plan falls within the protection afforded employee benefit plans under the ADA. To do so, an employer must show that it has a bona fide plan and that the challenged disability-based distinction is not being used as a subterfuge.

Lizzette Palmer, *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 (1993) (citing *EEOC Issues Guidance on ADA and Insurance*, Daily Lab. Rep. (BNA) No. 109, at AA-1 (June 9, 1993)).

> The EEOC guidelines indicate that a plan provision is disability-based if it singles out a particular disability, such as AIDS. Under the guidelines, an AIDS cap that sets benefits at a lower level than other physical conditions is a disability-based distinction. Accordingly, if an employer is providing insurance with a disparate cap for AIDS, it will need to prove that it meets the ADA's standards of non-discrimination. First, a self-insurer must show that it maintains a bona fide plan simply by proving that it exists and pays benefits and that it has accurately communicated the terms of the plan to the covered employees. Second, a self-insurer must prove that the challenged distinction is not a subterfuge–that is, a disability-based disparate treatment that is not justified by the risks or costs associated with the disability.

Id. at 1378-79.

"The subterfuge question will most likely be the focus of capping litigation under the ADA because it provides the employer with the opportunity to show a business or insurance justification for the distinction." *Id.* at 1379. An employer may show lack of subterfuge in one of two ways:

> First, an employer may show that there is not a nondisability-based health insurance plan change that could be made without breaching the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan. Second, an employer may prove necessity by showing that there is not a nondisability-based change that could be made without creating an unacceptable change in the coverage or premiums of the plan. An unacceptable change is one that makes the health plan

generous reading of § 510.[12] On the contrary, current § 510 jurisprudence is at an odd juncture: employers may not terminate employees in order to remove them from the insurance pool;[13] they may, however, redraft the

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> effectively unavailable to a significant number of other employees, makes the health insurance plan so unattractive as to result in significant adverse selection, or makes the health insurance 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.

Id.

[12]There appears to be consensus that § 510 does not afford employees like McGann protection from employer's financially motivated decisions to cap or eliminate specific coverages. In Owens v. Storehouse Inc., 984 F.2d 394 (11th Cir. 1993), the Eleventh Circuit said that "ERISA provides no right to perpetual health insurance with immutable terms." *Id.* at 400. Storehouse had instituted a $25,000 cap for AIDS claims (down from $1 million) after five employees contracted the virus. *Id.* at 396. The court concluded that § 510 "does not prohibit an employer from crafting its medical plan to meet economic imperatives . . . [n]either does it mandate fixed coverage of catastrophic diseases." *Id.* at 400. *See also* Seaman v. Arvida Realty Sales, 985 F.2d 543, 546-47 (11th Cir. 1993), *cert. denied*, 114 S.Ct. 308 (1993) (holding that § 510 is violated when employee is discharged for failing to accept employer's requirement that she become an independent contractor with concurrent loss of health and other employee benefits).

[13]In Folz v. Marriott Corp., 594 F. Supp. 1007 (W.D. Mo. 1984), the district court held that the defendant, Marriott Corporation, had violated the plaintiff's rights under ERISA when Marriott discharged him shortly after it was informed that he suffered from multiple sclerosis. *Id.* at 1010. The court concluded that the evidence showed that the plaintiff was discharged "to avoid the economic consequences that would result due to his continued participation in" the self-funded medical plan offered by Marriott. *Id.* The court drew the "inference of illegal motive" based on three circumstances present in this case. *Id.* First was the timing of the plaintiff's discharge. *Id.* at 1014. Two months after plaintiff informed his employer of his condition he was notified that he was being terminated. *Id.* The firing came despite 18 years on the job and consistent "job performance reviews of 'competent' or better." *Id.* The court was also impressed by the fact that less than one year prior to plaintiff's termination his salary had been raised "over the maximum salary range set by Marriott" for his position. *Id.* *See also* Zimmerman v. Sloss Equip., Inc., 835 F. Supp. 1283, 1288 (D. Kan. 1993) (firing plaintiff while on medical leave and while her health insurance application was pending shows the specific discriminatory intent necessary to establish a prima facie case under ERISA § 510).

Second, the court was persuaded by the fact that "Marriott did not follow its written procedures regarding probation for managers as the plaintiff was not given the opportunity to improve his performance and remain with Marriott." *Folz*, 594 F. Supp. at 1014. Third, defendant's financial incentive for terminating plaintiff, and thereby also terminating its responsibility to provide for his medical care, was substantial. *Id.* Under Marriott's self-funded plan it was responsible for 60% of the plan's total costs. *Id.* at 1015. *See also* Nemeth v. Clark Equip. Co., 677 F. Supp. 899, 904-05 (W.D. Mich. 1987) (holding that where a company chose to close down one of its two plants and evidence showed that pension expenses were

plan so as to exclude specific medical conditions *after* learning that a particular employee suffers from one of those conditions.

While the value of the distinction between employment discrimination and benefits discrimination to a seriously ill employee is debatable,[14] the recent Americans with Disabilities Act[15] clearly is blurring this distinction. As the Fifth Circuit predicted, ADA jurisprudence is generating considerable judicial involvement in the creation, alteration and termination of health insurance plans.[16] This Article examines the insurance practice of risk classification, particularly as it affects the

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considerably more at the closed plant than at the other plant a prima facie violation of ERISA § 510 has been established). After considering these three circumstances the district court concluded that "this is the kind of conduct ERISA was enacted to prevent." *Folz*, 594 F. Supp. at 1015.

McGann's situation was quite different from that of Mr. Folz. McGann's position with his employer was not terminated. Instead, about seven months after informing his employer that he had contracted AIDS, "H & H Music informed [all of] its employees that . . . changes would be made in their medical coverage." *McGann*, 946 F.2d at 403. Clearly, the Fifth Circuit Court of Appeals found a showing of discrimination more difficult in McGann's case than perhaps it would have if McGann had simply been fired in a manner similar to that of Mr. Folz.

[14]In *Seaman*, the Eleventh Circuit recognized that *McGann* creates an apparently "anomalous" result for § 510 jurisprudence: "The combined effect of our holding today and cases such as *McGann* is an interpretation of ERISA that prohibits employers from discharging employees to avoid paying benefits but permits employers to reduce or terminate non-vested benefits simply by changing the terms of a plan." *Seaman*, 985 F.2d at 546.

[15]Americans with Disabilities Act of 1990, 42 U.S.C.A. §§ 12,101-12,213 (West Supp. 1994). The effect of the ADA on employment (as opposed to employee benefit) opportunities for the disabled is as yet unclear. Approximately 12,000 charges of ADA violations were filed in 1993. After one year of ADA enforcement, the percentage of disabled individuals actively employed remained at its pre-ADA level of 29%. Judith Evans, *Federal Disabilities Act No Panacea for Discrimination in the Workplace*, NEWSDAY, July 25, 1993, at 66.

[16]As the First Circuit's opinion in Carparts Distrib. Ctr. v. Automotive Wholesalers Ass'n, Inc., 37 F.3d 12 (1st Cir. 1994) demonstrates, some federal courts believe that altering the coverage terms of a self-insured health plan to limit benefits for AIDS and AIDS-related conditions may violate both Title I (employment) and Title III (public accomodations) of the ADA, even where the entity making the alteration is not an employer. The court noted, "The issue before us is not whether defendants were employers of . . . [the AIDS infected individual] within the common sense of the word, but whether they can be considered 'employers' for purposes of Title I of the ADA and therefore subject to liability for discriminatorily denying employment benefits to [him]." *Id.* at 16. The court then identifies three theories which would support treating the defendants as employers for purposes of Title I. *Id.* at 16-18. With respect to Title III, the First Circuit noted that "public accomodations" are not necessarily limited to "actual physical structures." *Id.* at 19. Although noting that a claim under Title III "may be a less promising vehicle" for AIDS infected plaintiffs, the court concluded that "services" may properly fall within the ambit of public accomodations. *Id.* at 20.

behavior of insureds, and evaluates the various forces which have converged in recent years to create strong incentives for employers like H & H to self-insure, cap, or exclude certain coverages altogether. In particular, it focuses on the misguided regulatory schemes of the various state legislatures as an inadvertent incentive to self-insure, thereby avoiding state content-based insurance regulations. The article argues that the values inherent in risk classification are not compatible with a "discrimination free" environment. *McGann* best represents this inevitable clash between the values associated with risk classification—efficient pricing and fairness to the many over the few (i.e., the creation of loss prevention incentives)— and competing values which may be offended by risk management practices which group individuals by race or sex, or lead to the outright exclusion of those with stigmatizing medical conditions such as AIDS. Section II describes the state of post-*McGann* jurisprudence and continuing efforts by self-insured employers to avoid or control catastrophic health care costs. Section III explores in detail the forces that shape the market for health insurance and examines why small employer groups face higher premium costs and the effects of the trend toward self-insurance. In Section IV, the *Manhart*[17] case is revisited in order to evaluate the meaning of "discrimination" in the insurance context and why risk management practices are not compatible with a "discrimination-free" environment.

II. *MASON TENDERS* AND THE ADA

In *Mason Tenders*,[18] the Equal Employment Opportunity Commission (EEOC) was presented with a set of facts almost identical to those in *McGann*: Donaghey, a union member and construction worker, was diagnosed with AIDS and sued his self-insured,[19] multi-employer labor management-sponsored medical plan when it rewrote its plan and explicitly excluded all payment for AIDS and AIDS-related conditions. Notwithstanding the union's vigorous argument that prudent management of the fund required elimination of coverage for AIDS, the EEOC

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[17]Los Angeles, Dep't of Water & Power v. Manhart, 435 U.S. 702 (1978).

[18]Mason Tenders Dist. Council Welfare Fund v. Donaghey, 25 Daily Lab. Rep. (BNA) p. D-1 (Feb. 9, 1993) (EEOC District Director's Determination in Charge 160-93-0419, Jan. 28, 1993); No. 93 Civ. 1154 (S.D.N.Y. Nov. 19, 1993) (plaintiff's motion for summary judgement denied).

[19]For a discussion of risk retention plans (i.e., self-insurance), see *supra* note 3.

concluded that the union's action violated the Americans with Disabilities Act and that the fund "had no viable defense to the charge of discrimination."[20] The EEOC's theory appears to be that the burden of proof rests with the Fund to show that its disability-based classification is not a subterfuge for evading the ADA. Because the Fund produced no evidence of an actuarial justification for the AIDS exclusion, the EEOC believed that the Fund was discriminating against Donaghey because of his disability and not as a result of actuarial analysis. This result, while lauded by disability rights activists,[21] is by no means uncontroversial,[22] and a non-partisan reading of the statute suggests it may also be incorrect.

The fundamental aim of the ADA is a workplace free from discrimination for the disabled.[23] The Act[24] went into effect on a staggered basis: employers with 25 or more employees in July, 1992, and employers with 15 or more employees in July, 1994. The principal provision of the employment section, Title I, is § 102(a), which states, "[n]o covered entity shall discriminate against a qualified individual with a disability because

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[20]25 Daily Lab. Rep. (BNA) at D-1 (Feb. 9, 1993).

[21]In response to the district director's determination in this matter, Thomas Kendricks, a staff attorney with the Gay Men's Health Crisis, said, "This finding should send a very cold chill down the backs of employers who try to limit coverage of HIV, AIDS and other disabling illnesses by self-insuring. This is a clear signal that the ADA does not allow employers to save money by cutting coverage for the most vulnerable employees out of their benefits packages." *Cutting Benefits Violates ADA, N.Y. EEOC District Director Finds*, Pens. Rep. (BNA) No. 7., at 422 (Feb. 15, 1993). Cary LaCheen, an attorney with New York Lawyers for the Public Interest Inc., responded, "We now have the EEOC saying, for the first time, that this type of exclusionary practice runs afoul of the Americans with Disabilities Act. The law says you can't discriminate on the basis of disability in any terms of employment and that includes the distribution of health benefits." *Id.*

[22]Dissenters with the EEOC's determination in this matter tend to see this issue as a matter of "access to health benefits" versus "a fund's struggle for survival;" a struggle "management must win." AIDS: *N.Y. Welfare Fund Seeks Court Order to Kill EEOC AIDS Bias Ruling Under ADA*, Pens. Rep. (BNA) No. 10, at 563 (March 8, 1993). "If these plans are to survive and continue providing the highest level of benefits to the greatest number of workers and their dependents, then they must have the authority to manage their assets in a rational manner," said Roger Levin, attorney for the Mason Tenders District Council Welfare Fund. *Id.* "The EEOC's finding 'is nothing but an attempt by that federal agency to buffalo the Welfare Fund into providing specified medical benefits not mandated by the plain language of the ADA or is legislative history.'" *Id.*

[23]The preamble to the ADA states, "it is the purpose of this chapter—(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C.A. § 12,101(b) (West Supp. 1994).

[24]Title I—employment; Title II—public services; Title III—privately operated public accommodations; Title IV—telecommunications; and Title V—miscellaneous issues.

of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions and privileges of employment."[25] The statute defines "disability" broadly[26] and leaves no question that a person with AIDS is disabled for purposes of the statute.[27]

The difficulty, for insurance purposes, is that the Act is remarkably accepting of standard insurance practices. It states, "[Section 501(c)] is . . . not intended to disrupt the current nature of insurance underwriting,"[28] and specifically permits the use of disability-based distinctions for insurance purposes so long as the distinction is based on traditional risk management practices and can be supported by actuarial data.[29] Employers are free to price discriminate (i.e., set price differentials for the same level of coverage) in order to reflect the increased risk (higher expected cost) of covering a person with an expensive-to-treat condition; they may also exclude or cap coverage of specific conditions. This is obviously a disability-based practice, but it is permissible so long as it

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[25]42 U.S.C.A. § 12,112(a) (West Supp. 1994).

[26]"[A] physical or mental impairment that substantially limits one or more of the major life activities of the individual; a record of such an impairment; or being regarded as having such an impairment." 42 U.S.C.A. § 12,102(2) (West Supp. 1994).

[27]H. REP. NO. 485, 101st Cong., 2d Sess. 52 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 334 ("a person infected with the Human Immunodeficiency Virus is covered under . . . the definition of the term 'disability'" in the Americans with Disabilities Act "because of a substantial limitation to procreation and intimate sexual relationships."); S. REP. NO. 116, 101st Cong., 1st Sess. 22 (1989) (a person with HIV is covered under the definition of the term "disability"). The Equal Employment Opportunity Commission has reiterated that coverage is offered by the ADA to a person inflicted with HIV. "In interpreting the ADA, the EEOC has described HIV infection as an impairment that is within the scope of the ADA because it is inherently substantially limiting." Palmer, *supra* note 11, at 1376 (citing 29 C.F.R. § 1630.2(j) (1992)); *see also* Frank C. Morris, Jr., *Americans with Disabilities Act: Overview of the Employment Provisions*, C780 A.L.I. 185, 194 (1993).

[28]29 C.F.R. § 1630.16(f) app. (1993) (Interpretive Guidance on Title I of the Americans with Disabilities Act).

[29]For example,

> 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., 2d Sess. 137 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 420. (emphasis added).

enjoys sound actuarial support.[30] It is this language and history of the ADA which causes one to wonder about the EEOC's conclusion in *Mason Tenders*. There is little doubt that AIDS is an expensive condition to treat[31] and that the capping or outright exclusion of AIDS from coverage would tend to protect the financial integrity of self-insured plans.

If *Mason Tenders* is simply about the failure of the fund to provide actuarial support for its decision to limit benefits, then it represents no more than strict adherence to the anti-subterfuge rule of the ADA. If, on the other hand, the case can only be understood as an attempt to avoid the explicit approval risk management techniques enjoyed under the statute,[32] then it will adversely affect the heretofore unfettered right of ERISA trustees to limit coverages, manage risk, and create incentives for loss prevention.

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[30]It is probably obvious, but worth noting anyway, that any risk management practice which burdens disabled employees is likely to be actuarially sound. If not, it would prove unreliable as a method for classifying risks and competitive forces would likely require an insurer to discard it in favor of something with better predictive ability.

[31]Many experts have estimated the cost of treating a patient with AIDS or HIV. For example,

> [i]t is estimated . . . that the lifetime cost of treating a person with HIV from the time of infection until death is approximately $119,000. The estimated cost of care from HIV infection until the development of AIDS is $50,000, while the estimated cost from AIDS development until death is approximately $69,000.

Fred J. Hellinger, *The Lifetime Cost of Treating a Person With HIV*, JAMA, July 28, 1993, at 474; *see also*, David J. Solomon et al., *Analysis of Michigan Medicaid Costs to Treat HIV Infection*, PUBLIC HEALTH REP., Sept.-Oct., 1989, at 416.

[32]Recently, in a case almost identical to *McGann* and *Mason Tenders*, a union health plan agreed to rescind its $50,000 cap on AIDS benefits in connection with the settlement of a claim that the cap violated the ADA. The participant-decedent's estate and a hospital that provided indigent care sued the health plan, and asserted that the cap amounted to discrimination based upon a physical disability. The plan provided a lifetime maximum benefit of $500,000 for all other conditions. The EEOC intervened in the litigation and likewise alleged ADA violations. Estate of Kadinger v. International Bhd. of Elec. Workers, Local 110, No. 3-93-159, 1993 WL 597548 (D. Minn. Dec. 21, 1993). *But see* Gonzales v. Garner Food Servs., Inc., 855 F. Supp. 371, 374 (N.D. Ga. 1994) (granting employer's motion to dismiss on the ground that terminated plaintiff was no longer an employee of the company when the AIDS cap amendment was adopted); Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n of New England, 826 F. Supp. 583, 587 (D.N.H. 1993) (holding that Title I of ADA does not apply to sponsor of health benefit plan which placed a cap on AIDS related benefits because sponsor was not the employer of plaintiff).

III. THE MARKET FOR SMALL GROUP INSURANCE

Why do we observe employers behaving like H & H Music Co.[33] when making decisions about the health insurance it will offer its employees? Are the EEOC's instincts good when it asserts that the *Mason Tenders* Fund is motivated by discriminatory intent toward people with disabilities (and not by concern for the financial integrity of its self-funded plan)? An understanding of the way that insurers classify risk, set prices, and thereby encourage loss prevention is essential to answering these questions. This section examines the manner in which insurance is priced and the special problems small groups face.

A. *Insurance Markets*

Key to understanding the behavior of employers and insurers[34] is the threshold premise that insurance is a product whose price is a function of supply and demand. Like other products, as the cost of insurance rises, demand for it generally decreases.[35] In a competitive market, the insurer who can develop the most efficient risk classification system—one that classifies and prices risks most accurately—will compete successfully for premium dollars. This is because the insurer can, through classification, offer expected low-cost users lower prices.[36] This does not mean that insurers will go to any lengths to obtain additional information regarding expected losses. Additional information may be expensive and time consuming to collect and may result in a marginal improvement in the efficiency of the classification that is not justified by the expense. What it

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[33]John McGann was one of 152 employees covered by the plan administered by Brooks Mays Corporation as of August 1, 1987, according to Mark A. Huvard, a lawyer for H & H. Huvard says the reason H & H decided to cap coverage for AIDS was that during the previous year, one or two other employees had died of AIDS related illnesses. H & H began to worry about consistently getting "creamed" by more employees coming down with AIDS. Telephone interview with Mark A. Huvard, attorney for H & H Music Company (July 12, 1994). *See also* Milt Freudenheim, *Employers Winning Wide Leeway to Cut Medical Insurance Benefits*, N.Y. TIMES, March 29, 1992, at A1.

[34]Most, but by no means all, health insurance is obtained via the workplace. *See* Richard Kronick, *Health Insurance, 1979-1989: The Frayed Connection Between Employment and Insurance*, 28 INQUIRY 318 (1991); Alan C. Monheit et al., *The Employed Uninsured and the Role of Public Policy*, 22 INQUIRY 348 (1985).

[35]Kenneth S. Abraham, *Efficiency and Fairness In Insurance Risk Classification*, 71 VA. L. REV. 403, 407 (1985).

[36]"The more refined (and accurate) an insurer's risk classifications, the more capable it is of 'skimming' good risks away from insurers whose classifications are less refined." *Id.* at 408.

does suggest is that insurers in a competitive market stand to gain from the creation of an accurate classification system.

The experience of Blue Cross helps to illustrate this point. "When Blue Cross was created in 1933, premiums were assessed on the basis of a community rating standard. That is, premiums were the same for all subscribers without regard to the actual experience of the group."[37] Subsequently, Blue Cross was forced to switch from community rating to experience rating in the face of competition from the for-profit insurance sector which was luring away low-cost subscribers by classifying them separately and charging a lower premium. The effect of community rating, or the failure to classify risks, is the creation of a situation in which high-cost subscribers are subsidized by low-cost subscribers.[38] In a market where subscribers are not forced to purchase coverage and may choose among several competing sources for insurance, the failure to classify risks will be fatal.

Employers with relatively small numbers of employees face special pricing problems when they enter the market and attempt to purchase insurance. Health insurance, for example, is considerably more costly for small groups and individuals than for large employers. This is because small group per-enrollee marketing costs are higher (a large, one-time fee to cover the cost of marketing the plan to an employer must be divided among fewer group members); small groups probably have less ability to bargain for advantageous rates; and the small group risk pool is smaller, which requires higher premium rates.[39] Concerns about possible adverse selection effects are more pronounced in small groups as well. Professors Beam and McFadden have described as "fundamental" the principle that a group proposed for insurance "must have been formed for some other purpose than to obtain insurance for its members."[40] This is to protect the insurer against the effects of adverse selection—the selection by high-risk,

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[37]Maria O'Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 B.Y.U. L. REV. 971, 992-93.

[38]As noted elsewhere, one might defend community rating on equity grounds if the subsidy toward high-cost subscribers was also a subsidy toward low income subscribers. There is evidence, though, that this is not the case. *Id.* at 993.

[39]As Professor Mark Hall has noted, "According to the statistical Law of Large Numbers, the ability to predict accurately the actual loss a group will suffer decreases as the group becomes smaller; therefore, small risk pools require a larger risk premium per equivalent expected loss than do larger groups." Mark A. Hall, *The Role of Insurance Purchasing Cooperatives in Health Care Reform*, 3 KAN. J.L. & PUB. POL'Y 95, 98 (1993-94).

[40]BURTON T. BEAM, JR. & JOHN J. MCFADDEN, EMPLOYEE BENEFITS 70 (3d ed. 1992).

high-cost insureds of insurance options against which they are likely to make significant claims.[41]

Thus, the insurance market firms face is affected by the quality of the classification system that determines price (premium), the probability of a covered event occurring and the expected loss, and the risk aversion of the purchaser. The last factor, risk aversion, assumes that the insurance in question is not mandated and that the purchaser always retains the option of accumulating savings in order to cover any future losses.[42]

B. *Perverse State Mandates and ERISA's "Regulation-Free" Zone*

Numerous commentators have noted the recent growth in self-insurance.[43] This growth is propelled by the twin forces of well

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[41]Given the obvious fact that high-risk persons, e.g., those with high blood pressure, have the greatest need for health and life insurance, the phenomenon of adverse selection is not difficult to understand. A person with high blood pressure may be more likely to seek health insurance than someone in tip-top shape. *See* FRANK J. ANGELL, INSURANCE PRINCIPLES AND PRACTICES 9 (1959). However, insurers and persons of average or low risk have powerful incentives to reduce the effects of adverse selection.

> If the insurer cannot distinguish high- and low-risk individuals he must offer them the same premium. Low risk individuals are worse off and high risk individuals better off compared with the situation in which the insurer knows the risk class of insureds. The insurer has an incentive to identify low-risk individuals since he could increase his expected profits by offering a policy to low risks at a premium below the pooled premium but greater than the low risks' accident probability.

Hugh Gravelle, *Insurance Law and Adverse Selection*, 11 INT'L REV. L & ECON. 23, 25 (1991). Furthermore, in an insurance market in which adverse selection is substantially present, low risk individuals "actually subsidize the insurance purchases of high risks," thereby reducing insurance consumption by "low-risk" insureds. Mark J. Browne & Helen I. Doerpinghaus, *Information Asymmetries and Adverse Selection in the Market for Individual Medical Expense Insurance*, 60 J. OF RISK & INS. 300, 300 (1993). *See also* Mark J. Browne, *Evidence of Adverse Selection in the Individual Health Insurance Market*, 59 J. OF RISK & INS. 13, 13 (1992).

[42]*See generally* PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 159 (3d ed. 1988).

[43]"Self-insurance grew 19.4 percent (from $32 billion to $38.2 billion) while conventional market premium volume rose just 3.8 percent (from $115.6 billion to $120 billion) between 1988 and 1990." L.H. Otis, *Self-Insureds Proliferate in Soft Market*, 95 NAT'L UNDERWRITER, Nov. 25, 1991, at 1, 38. Growth in self-insurance has continued so far through the 1990s. "Self-insurance accounted for 27% of the . . . commercial risk financing market in 1992" and was projected to occupy 30% of the market by the end of 1993. Sara Marley, *Alternative Risk Financing Continues to Gain Strength*, 27 BUS. INS., Jan. 25, 1993, at 3.

intentioned, but ultimately harmful, state regulation and ERISA's content-neutral stance on coverage.[44] Self-insurance (also known as a self-funded or risk-retention plan)[45] is particularly attractive to employers because it frees them from the oversight of state insurance commissioners and the relentless political forces that produce insurance mandates.

1. Mandates and More Mandates

As the noted economists George Stigler[46] and Sam Peltzman[47] have

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It is important to note, however, that while growth in market share continues, it has slowed from its rapid pace of the late-1980s. Between 1991 and 1992 the number of employers opting to self-insure only rose by 2%, down from a rise of 6% between 1990 and 1991. *Id.* Some health care consultants have explained this slowed rate of growth by pointing out that "the majority of employers capable of successfully self-insuring are already doing so." *Id.*

[44]Beginning in 1977 and culminating in the 1985 U.S. Supreme Court decision in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), federal courts have interpreted ERISA's preemption provisions to permit states to regulate and tax the insurance products of commercial insurance companies and Blue Cross/Blue Shield. *Id.* at 746. The Supreme Court pointed out that ERISA generally supersedes "'any and all State laws insofar as they . . . relate to any employee benefit plan.'" *Id.* at 732 (construing 29 U.S.C. § 1144(a)). However, the question before the Court was whether a state statute that required "specified minimum mental-health-care benefits," was an attempt by the state to "regulate insurance," as opposed to an "employee benefit plan," and therefore fell within an exception to ERISA's preemption provision. *Id.* at 727. This exception, known as the "saving clause," states that "nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.'" *Id.* at 733 (construing 29 U.S.C. § 1144(b)(2)(B)) (emphasis added). Noting that ERISA's two preemption provisions seem to contradict one another, the court nonetheless concluded that Congress did not intend to preempt areas of traditional state regulation such as mandated-benefits. *Id.* at 744.

Notwithstanding the Supreme Court's ruling on *insured* plans, employer's self-insured plans have been beyond the reach of state regulators. *See* Daniel M. Fox and Daniel C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL., POL'Y, & L. 239 (1989). Choosing to ignore this distinction, the Supreme Court, in *Metropolitan Life*, pointed out that if this distinction is to be eradicated, change will have to come from Congress and not the courts. *Metropolitan Life Ins. Co.*, 471 U.S. at 747.

[45]For an excellent discussion of the legislative give and take that culminated in permitting the states to regulate insurance companies but not self-insured health plans, see Daniel M. Fox and Daniel C. Schaffer, "Semi-Preemption in ERISA: Legislative Process and Health Policy," 7 AM. J. TAX. POL'Y 47, 48-52 (1988).

[46]Stigler's central thesis has been that "as a rule, regulation is acquired by," as opposed to being thrust upon, a particular "industry and is designed and operated primarily for its benefit." George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. OF ECON. & MGMT. SCI. 3, 3 (1971). Stigler points out that making these regulatory acquisitions is much akin to the purchasing of any consumer good thanks to a political system in which elected representatives

explained, the process by which small interest groups come to dominate a regulatory process is less of a mystery than it may first appear. Basically, the interests of small groups (in this case various health care providers or those with special health care needs) tend to overshadow those of large groups (generally the public at large) because "the costs of using the political process limit not only the size of the dominant group but also their gains."[48] This is not difficult to explain if politics is viewed in terms of a supply and demand economic model "with constituents on the demand side and their political representatives on the supply side."[49] Simply put, because getting the most from the political processes is quite expensive,[50] only a small number of entities can afford to do so.

> Viewed in this way, the market . . . will distribute more of the good to those whose effective demand is highest. For Stigler, the question of which group will have the highest effective demand translates very quickly into a question of

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have the power to "coerce" and private industry has the means and ability to provide these representatives with the campaign contributions necessary to keep them in office. He states,

> If the representative denies ten large industries their special subsidies of money or governmental power, they will dedicate themselves to the election of a more complaisant successor: the stakes are that important. . . . A representative cannot win or keep office with the support of the sum of those who are opposed to: oil import quotas, farm subsidies, airport subsidies, hospital subsidies, unnecessary navy shipyards, an inequitable public housing program, and rural electrification subsidies.

Id. at 11.

[47]*See* Samuel Peltzman, *Toward a More General Theory of Regulation*, 19 J. L. & ECON. 211 (1976).

[48]*Id.* at 213.

[49]*Id.* at 212.

[50]The "expense" of political consumerism is explained by Peltzman in two ways. First, "[T]he size of the dominant group is limited . . . by the absence of something like ordinary-market-dollar voting in politics." *Id.* at 213. In other words, "[T]he voter must spend resources to inform himself about [an issue's] implications for his wealth and which politician is likely to stand on which side of the issue. That information cost will have to offset prospective gains, and a voter with a small per capita stake will not, therefore, incur it." *Id.* Second, a "major limit on effective group size arises from costs of organization. It is not enough for the successful group to recognize its interests; it must organize to translate this interest into support for the politician who will implement it." *Id.* The expense involved in creating an organized effort to effect regulatory change is obviously far more substantial for the average, or even above average, consumer than for the small group.

> numbers. In this view, "producer protection" represents the dominance of a small group with a large per capita stake over the large group (consumers) with more diffused interests.[51]

It is not possible to understand the current movement toward the creation of risk-retention pools[52] without first looking at the regulatory activity of state legislatures with respect to insurers. Clearly, for example, as insurance coverage mandates have increased, the number of covered employees has decreased.[53] All fifty states, to one extent or another, now regulate the terms of group health insurance contracts.[54] Some states demand maternity coverage.[55] Others require benefits for mental health problems,[56] prosthetic devices,[57] and alcohol and drug treatment.[58]

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[51]*Id.* at 212.

[52]Otis, *supra* note 43, at 38; Marley, *supra* note 43, at 3.

[53]As two commentators stated,

> Mandates typically stipulate that certain benefits be included in a group plan, *if one is offered.* By making insurance more expensive, minimum coverage rules may price some firms out of the insurance market. Especially vulnerable are small firms that face much higher premiums to begin with. ERISA grants self-insured benefit plans exemption from all state insurance laws and taxation. Small firms, however, cannot viably self-insure as a means of circumventing mandated benefit requirements. Ironically, it is these very firms where coverage needs to be encouraged if we are to reduce the number of employed uninsured.

Gail A. Jensen & Jon R. Gabel, *State Mandated Benefits and the Small Firm's Decision to Offer Insurance*, 4 J. REG. ECON. 379-404 (1992) (emphasis added).

[54]Professor Rothstein has noted that there are more than 1000 state mandates in existence. Mark A. Rothstein, *Genetic Discrimination in Employment and the Americans with Disabilities Act*, 29 HOUS. L. Rev. 23, 80 (1992).

[55]California: CAL. HEALTH & SAFETY CODE § 231 (West 1994); Colorado: COLO. REV. STAT. ANN. § 10-16-104 (West Supp. 1994); Minnesota: MINN. STAT. ANN. § 62A.041 (West Supp. 1994); New Jersey: N.J. STAT. ANN. § 17B: 26-2.1b (West Supp. 1994); and New York: N.Y. INS. LAW § 3216 (McKinney 1993).

[56]District of Columbia: D.C. CODE ANN. § 35-2302 (1993); Hawaii: HAW. REV. STAT. § 431M-2 (Supp. 1992); Kentucky: KY. REV. STAT. ANN. § 304.17-3185 (Michie/Bobbs-Merrill Supp. 1994); Mississippi: MISS. CODE. ANN. § 83-9-39 (1991); Missouri: MO. ANN. STAT. § 376.381 (Vernon Supp. 1994); Montana: MONT. CODE ANN. § 33-22-703 (1993); New Hampshire: N.H. REV. STAT. ANN. § 415:18-a (1992 and Supp. 1993); Tennessee: TENN. CODE ANN. § 56-7-2601 (1994); Texas: TEX. INS. CODE ANN. art. 3.51-14 (Vernon Supp. 1995).

Why are state legislatures so quick to mandate health care benefits? There are several possible explanations. First, legislators may be attracted to the mandate device because, unlike other decisions to provide constituents with a service, mandates are "free" and do not require an increase in taxes. Thus, a legislature can create the appearance of an expanded "safety net" without the usual accompanying pain of generating additional revenue.[59] Another explanation, the so-called "public interest rationale," is proffered by regulators themselves. It says that there are defects in the market for employer health insurance and that the government must intervene in order to correct them. As Jensen and Gabel have noted, legislators claim that:

> insurers and purchasers may unknowingly undervalue the benefits of some type of care, such as chemical dependency treatment, resulting in a demand for coverage which is "too low" from a societal perspective. . . . [W]ithout mandates, adverse selection might occur which drives up employers' cost of particular coverages. This happens if individuals with chronic conditions tend to enroll in plans offering more extensive coverage . . . and healthier individuals opt for low-benefit plans. . . . [A]dverse selection creates a market shortcoming, which a mandate may be partially able to correct.[60]

A third rationale that may explain the eagerness of legislatures to impose mandates is that they may, in some instances, have the effect of actually reducing state expenditures for treatment costs by shifting these onto the private sector. If, for example, individuals without mental health benefits are treated during periods of crisis at state facilities and at state expense, then the requirement that employers cover this condition relieves the state of the burden of providing free care.

Each of these explanations may partially describe the dynamics which

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[57]California: CAL. INS. CODE § 10123.7 (West 1993); Alaska: ALASKA STAT. § 21.42.375 (1993); Maryland: MD. ANN. CODE, art. 48A, § 354Q (1993).

[58]District of Columbia: D.C. CODE ANN. § 35-2302 (1993); Hawaii: HAW. REV. STAT. § 431M-2 (1993); Minnesota: MINN. STAT. ANN. § 62A.149 (West 1994); Missouri: MO. ANN. STAT. § 376.779 (Vernon 1991); Montana: MONT. CODE ANN. § 33-22-703 (1993); Texas: TEX. INS. CODE ANN. art. 3.51-9 (Vernon Supp. 1994).

[59]*See generally* Peltzman, *supra* note 47.

[60]Jensen & Gabel, *supra* note 53, at 380.

underlie the imposition of mandates. In any event, the number of mandates more than doubled from 1979 to 1989.[61] This growth has not gone unnoticed by small employers, and a recent study suggests that a significant amount of non-coverage is directly attributable to this increased state regulation.[62] Jensen and Gabel found that for 1985 nineteen percent of noncoverage can be explained by state mandates; for 1988 the figure increased to an astonishing forty-three percent.[63]

This is the sense in which state mandates are "perverse." In spite of the professed good intentions of regulators, the mandates are causing employers to exercise one option available to them—to forego offering insurance of any kind. (Another option, of course, is to reduce the number of employees in the face of an expensive mandate.) The mandates, which increase the cost of purchasing insurance (because they require the insurer to cover a larger number of insurable events), result in a reduction in the number of employees to whom any health insurance is available. One is left wondering whether a typical employee would have made the same choice on her own behalf: If forced to choose between minimal or moderate coverage or no coverage at all, would she elect to forego coverage altogether? Probably not.

This raises the same fundamental problem that faced McGann's employer. Should one accommodate the interests of the greatest number of employees at the expense of one person? H & H Music believed that the cost of covering McGann's illness would make it impossible to provide coverage for anyone else. From the company's perspective the very existence of the plan itself, its financial integrity, was at stake.

2. ERISA's "Regulation-Free" Zone

Those employers who do not simply decide to forego offering health insurance to their workers in the face of increasing state mandates, have another attractive option: self-insurance. Employers who elect to self-insure remove themselves from the state regulatory arena and, instead, are governed only by ERISA.[64] ERISA is a particularly attractive option

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[61] *Id.*

[62] *See generally* Jensen & Gabel, *supra* note 53.

[63] *Id.* at 396.

[64] Generally, ERISA preempts state law attempting to regulate any "employee benefit plan." However, a state may still regulate insurance although it may not deem an employee benefit plan to be an insurance company for the purpose of imposing such regulation. 29 U.S.C. § 1144(a)-(b)(2)(B) (1988). As a result of this stipulation, employers choosing to self-insure

because ERISA plans are not subject to state insurance mandates.[65] (Indeed, ERISA has been described as a "regulation-free zone," albeit by those who believe this is a harmful state of affairs.)[66]

Thus, the creation of a risk retention plan enables an employer, regardless of what the otherwise applicable state mandates require, to regain the ability to fashion a health plan which meets the particular needs of her employees[67] at an acceptable price. This need not always involve the desire to avoid covering a known catastrophic condition as in *McGann*. Imagine, for example, an employer who has a largely single, male work force between eighteen and forty years of age. In a state which mandates maternity benefits, infertility treatment, breast reconstruction, and orthodontia coverages, most employees would find themselves with far more extensive (and therefore expensive) coverage than they would have preferred. Some employees might choose to insure against these

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may avoid state mandates. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1985).

[65]29 U.S.C. § 1144(a) states, "[T]he provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." *See generally* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); FMC Corp. v. Holliday, 498 U.S. 52 (1990); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). "ERISA's broad preemption has been successful in protecting employers from inconsistent and conflicting state regulation, allowing them to operate health care plans that are uniform across many states . . . ." Butler, *supra* note 3, at 1239.

[66]*See* Alan I. Widiss and Larry Gostin, *What's Wrong With The ERISA "Vacuum"?: The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage is to be Provided When Risk Retention Plans are Established for Health Care*, 41 DRAKE L. REV. 635, 655 (1992). Others have argued that ERISA's preemption of state regulation has seriously impeded the ability of the state governments to fashion universal access/universal coverage solutions for the millions of uninsured. *See* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990).

[67]I have argued elsewhere that one of the peculiar results of state insurance mandates is that they do not necessarily confer any desirable benefit on any given group of workers who receive them:

> [W]hen the state insists on certain contractual provisions, the parties lose the ability to fashion a flexible contract that meets the needs of the particular individual or group in question. This is of particular concern in the health care arena, where access to coverage is clearly not optimal. Mandated coverage raises the insurer's cost of doing business (and therefore the cost of insurance), *without any necessary corresponding increase in the satisfaction or security of the insured.*

Hylton, *supra* note 37, at 1002 (emphasis added).

contingencies, but many would not. Forcing their employer to provide the coverage has negative consequences for the employees. First, it increases the chances the employer will drop all coverages. Second, it forces employers to pay out a portion of compensation[68] to employees in a form that may be of no value to them.

Given the rush to mandate benefits that has taken place at the state level over the past fifteen or so years, the increase in the number of employers choosing to forego the health insurance benefit is not surprising. In light of the opportunity ERISA creates to regain substantive control of the terms of the insurance contract, the increase in self-insurance is also to be expected. What state legislatures all over the country appear to have forgotten or chosen to ignore is the simple fact that insurance is a product remarkably like most others. One cannot demand that employers offer increasingly expensive versions of the product without, at some point, triggering offsetting (cost-saving) behavior by employers. Total employee compensation is simply one of many costs of doing business. Irrational and burdensome increases in those costs (i.e., increases that in many cases do not translate into enhanced employee welfare), without corresponding increases in productivity are doomed to result in fewer employees, or fewer employees with insurance coverage. Good intentions notwithstanding, state mandates are a superficially attractive, but ultimately shallow approach to the twin problems of insurance discrimination and lack of access. As *McGann* amply demonstrates, the ERISA opt-out option makes state mandates ineffective for those who can self-insure. The question is what, if anything, can be done to help an employee in McGann's catastrophic situation, without jeopardizing benefits for everyone else in the group.

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[68]Employee benefits are properly understood as merely a portion of total compensation. The other components are salary or wages, and other benefits, whether mandated (such as social security, workers compensation or unemployment insurance) or non-mandated (such as vacations, sick leave, disability insurance and so forth). *See* 29 C.F.R. §§ 1620.10 & 1620.11 (1993) ("Under the [Equal Pay Act], the term 'wages' generally includes all payments made to [or on behalf of] an employee as remuneration for employment" and "[f]ringe benefits are deemed to be remuneration for employment." Under the Act, "'[F]ringe benefits' includes, e.g., such terms as medical, hospital, accident, life insurance and retirement benefits; profit sharing and bonus plans; leave; and other such concepts.")

IV. RISK MANAGEMENT IN A "DISCRIMINATION-FREE" ENVIRONMENT

The fundamental dilemma of *McGann*—one person's need for a huge amount of insurance coverage versus other group members' continued need for routine coverage—is one that cannot be resolved without first identifying those values which should inform a group insurance scheme.[69] As some have noted, "attitudes toward insurance always seem to be pulling in two directions—one that highlights the risk assessment or efficiency-promoting features of insurance classification, and the other that stresses insurance's risk-distributional function."[70] This section compares the values of risk classification (efficiency and the creation of loss prevention incentives) discussed above with the risk-distributional functions of insurance, and the values implicit in a so-called "discrimination free" workplace (the goal of the ADA).

A. *The Legal Framework and Identifying Risk Distributional Values*

It should come as no surprise that, from an insurance perspective, the *McGann* conundrum is not new. The tension between efficiency enhancing risk classifications and a competing discomfort with race, sex, or income based classifications did not originate with AIDS and John McGann. On the contrary, in 1978, the U.S. Supreme Court grappled with essentially the same question of the appropriate limits on classifications (this time for pension purposes) by sex. In *City of Los Angeles, Department of Water & Power v. Manhart*,[71] the Court invalidated a pension contribution formula that required female employees to contribute almost fifteen percent more of their paychecks each month to the plan

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[69]I assume here, perhaps naively, that in spite of some indications to the contrary, employers like H & H Music are motivated not by bigotry toward those disabled by AIDS, but by a genuine need to maintain the financial viability of their plans or face the prospect of no coverage for anyone. A case for bigotry, though, might not be terribly hard to make. In Tingle v. Pacific Mutual Ins. Co., 996 F.2d 105 (5th Cir. 1993), plaintiff brought suit against her employer's insurance carrier for treatment of a back injury which cost $71,300. This amount is more than $69,000—the average cost of treating a person with AIDS. *See supra* note 31. And, according to Morton Hunt, *A Common Sense Guide to Health Insurance*, N.Y. TIMES, May 3, 1987, § 6 at 46, 50, 108, "[a] child stricken by leukemia and provided with months of intensive chemotheraphy at a major hospital can run up a total bill of hundreds of thousands of dollars.... [A] two year hospitalization in a specialized facility for treatment of a stroke-induced coma . . . could cost a total of $1 million."

[70]Abraham, *supra* note 35, at 404.

[71]435 U.S. 702 (1978).

because as a group women live longer than men and were expected, therefore, to draw on their defined benefit plan[72] for considerably more years than male employees. No one took issue with the actuarial validity of the city's classification—that is, no one argued that in fact men lived, on average, as long as women. Rather, the plaintiffs (a class of current and former female employees) took the position that Title VII's[73]

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[72]Peter T. Scott explains a defined benefit plan as:

> a retirement plan in which the benefit is expressed as a certain amount to be paid at an employee's retirement. Defined benefit plans generally provide for the monthly payment of a fixed sum, for the life of the retired employee and surviving spouse. The amount of benefit is derived from a plan formula, which often takes into account the employee's years of service with the employer, as well as the employee's average wage or salary.... The formula multiplies these two variables by a percentage, commonly from one to two percent, to arrive at a fixed sum.
>
> Defined benefit plans do not establish individual accounts for each participating employee. Instead, plan assets are pooled in a trust which is funded to meet the aggregate benefit demands of the plan participants. An important feature of defined benefit plans is that the participant is protected against investment risk; if plan assets diminish below appropriate funding levels, it is the plan sponsor's duty to increase pension contributions.

Peter T. Scott, *A National Retirement Income Policy*, 44 TAX NOTES 913, 919-20 (1989), *reprinted in* JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 39 (1990).

In contrast,

> [d]efined contribution plans do not provide specific dollar benefits at retirement. Instead, the benefits payable to participating employees are based on the amount of employer contributions to the plan. In a defined contribution plan, the funds contributed on behalf of each participant are held in a separate account to be paid at retirement.

Id. at 40. Often with defined contribution plans employees are permitted or even encouraged to contribute to the plan. Sometimes, as with 401(k) plans, the "employee is given an option of receiving taxable compensation or deferring current income taxation on the portion of salary that is contributed to the defined contribution plan." *Id.* It is also common for an employer to match the amount contributed by the employee to the plan. *Id.*

[73]Civil Rights Act of 1964 § 703(a)(1), 42 U.S.C. § 2000e-2(a)(1) (1988). The section provides in pertinent part:

> (a) Employer practices
> It shall be an unlawful employment practice for an employer . . . to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any

prohibition against discrimination on the basis of sex forbade this practice. The Court agreed, noting that "the basic policy of the statute requires that we focus on fairness to individuals rather than fairness to classes. Practices that classify employees in terms of religion, race or sex tend to preserve traditional assumptions about groups rather than thoughtful scrutiny of individuals."[74]

Much has been written about the wisdom, or lack thereof, of *Manhart*.[75] The central oddity of *Manhart* is the Court's almost nonchalant, yet truly radical suggestion that insurance practices should involve the "thoughtful scrutiny of individuals."[76] This statement suggests a complete abandonment of all risk classifications. Of course, a total inability to classify risks would not lead to the end of insurance, just a change in pricing. Without the ability to classify, an insurer could still charge each individual a price based upon the average expected loss for all insureds. The addition of a fee to cover expenses and profit would enable the insurer to continue to provide coverage to everyone at the same price and without any distinctions. This suggestion is radical in that it sweeps aside, without consideration, the positive effects of risk classification.

Risk classification has several positive effects on the market for insurance. First, it creates a competitive insurance market and promotes efficient pricing practices. Second, and equally important, risk classification creates loss prevention incentives on the part of insureds. This can occur in two ways: behavior/care level effects and activity level

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individual with respect to his compensation, terms, conditions, or privileges or employment, because of such individual's race, color, religion, sex, or national origin.

[74]*Manhart*, 435 U.S. at 709.

[75]*See, e.g.*, George J. Benston, *The Economics of Gender Discrimination in Employee Fringe Benefits:* Manhart *Revisited*, 49 U. CHI. L. REV. 489 (1982); Morton C. Bernstein & Lois G. Williams, *Title VII and the Problem of Sex Classifications in Pension Programs*, 74 COLUM. L. REV. 1203 (1974); Lea Brilmayer et al., *Sex Discrimination in Employer-Sponsored Insurance Plans: A Legal and Demographic Analysis*, 47 U. CHI. L. REV. 505 (1980); David W. Calton, Note, *Sex Discrimination—Pensions—The Court Takes a Stand:* Arizona v. Norris, 30 WAYNE L. REV. 1329 (1984); Anne C. Cicero, *Strategies for the Elimination of Sex Discrimination in Private Insurance*, 20 HARV. C.R.-C.L. L. REV. 211 (1985); Spencer L. Kimball, *Reverse Sex Discrimination:* Manhart, 1979 AM. B. FOUND. RES. J. 83; George Rutherglen, *Sexual Equality in Fringe-Benefit Plans*, 65 VA. L. REV. 199 (1979).

[76]*Manhart*, 435 U.S. at 709.

effects.[77] Behavior/care level effects are manifested when an insured, recognizing that her premiums will rise in the event of an accident, opts to drive with greater care. This incentive to prevent losses only exists so long as insurance premiums are a function of classifications-based experience rating.

In addition, an insured's activity level may be appropriately affected by risk classification if, for example, a driver finds she can no longer afford automobile insurance because her previous risky (expensive) driving has made insurance unaffordable. The dangerous driver will have to cease driving altogether or drive without any coverage. This activity level effect is desirable because those who have been classified as dangerous drivers based on experience (and other factors) will find it most expensive to continue.

Although many are offended by sex-based distinctions, and with good reason,[78] the complete failure to classify means that high cost users have

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[77]For a discussion of care level effects and activity level effects, see Steven Shavell, *Strict Liability Versus Negligence*, 9 J. LEGAL STUD. 1 (1980).

[78]Most gender-based classifications have evolved from a paternalistic desire to protect women. The early 1970s, however, marked a change in the Supreme Court's attitude towards gender-based distinctions. This shift in attitude was born from a realization that paternalistic attitudes did not always protect women but sometimes had quite the opposite effect. Writing for a plurality in 1973, Justice Brennan said, "Traditionally, such discrimination was rationalized by an attitude of 'romantic paternalism' which, in practical effect, put women, not on a pedestal, but in a cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). For the past twenty years, the Court has reviewed laws and policies that create sex-based distinctions with heightened scrutiny. *See, e.g.*, Craig v. Boren, 429 U.S. 190, 197 (1976).

Despite the distance the Court has travelled over the past twenty to twenty-five years, notions of fundamental gender difference remain. When the Court has analyzed the law in question based solely on equal protection principles—whether two groups are being treated differently by the law—the Court more often than not strikes the statute down as violative of the Fourteenth Amendment. *See generally* Kirchberg v. Feenstra, 450 U.S. 455 (1981); Caban v. Mohammed, 441 U.S. 380 (1979); Califano v. Goldfarb, 430 U.S. 199 (1977); Craig v. Boren, 429 U.S. 190 (1976); Stanton v. Stanton, 421 U.S. 7 (1975); Weinberger v. Wiesenfeld, 420 U.S. 636 (1975); Taylor v. Louisiana, 419 U.S. 522 (1975); Stanley v. Illinois, 405 U.S. 645 (1972). *But see* Geduldig v. Aiello, 417 U.S. 484, 496 n.20 (1974) (upholding California's disability insurance program that excluded pregnancy-related disabilities from coverage) ("The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities."). Whenever the Court has focused its legal analysis on physical or societal differences between the sexes, however, it historically has upheld laws differentiating on the basis of gender. *See, e.g.*, Rostker v. Goldberg, 453 U.S. 57 (1981) (upholding Congress' decision to require men, but not women, to register for the draft); Michael M. v. Sonoma County Superior Court, 450 U.S. 464, 469 (1981) (upholding a California statute which made

absolutely no incentive to modify their behavior and take advantage of a premium reduction. For example, a heavy smoker who obtains health insurance under a strict no-classifications regime, has no incentive to discard this notoriously[79] unhealthy habit because she knows that her

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men alone criminally liable for statutory rape) ("[T]his Court has consistently upheld statutes where the gender classification is not invidious, but rather realistically reflects the fact that the sexes are not similarly situated in certain circumstances."); Parham v. Hughes, 441 U.S. 347 (1979) (upholding a Georgia statute permitting the mother but not the father of an illegitimate child to sue for the wrongful death of the child); Califano v. Webster, 430 U.S. 313 (1977) (upholding a provision of the Social Security Act that had the effect of granting to retired female workers higher monthly old-age benefits than those received by similarly situated retired male workers); Kahn v. Shevin, 416 U.S. 351, 353 (1974) (upholding a Florida statute providing a property tax exemption for widows but not widowers). While the Court seems at first to be helping women via paternalism, upon closer examination the dangerous effects of these holdings become apparent. For example, in *Michael M.*, in the process of upholding a statutory rape scheme which applied only to males, the Court failed to consider the different conceptions of appropriate sexuality applied to young men and to young women, and the way in which this has stereotyped and constrained women. As Stephanie Wildman has said:

> The stereotyping of women into dependent roles, the stereotyping of fathers as having minimal involvement with their children, the right of women to control their destiny, the role of pregnant women in the work force, the economic disadvantaging of women in the work force, and discrimination against women in the military, present a litany of real grievances about the role assigned to women in this culture. However, when translated into legal language these claims become a battleground of due process versus equal protection, strict scrutiny versus reasonable basis, penumbras of the Bill of Rights, and a questioning of the very existence of sex discrimination. The abstraction of these very real social problems into this legal vocabulary has diverted attention from the immediate goal of combating sex discrimination.

Stephanie M. Wildman, *The Legitimation of Sex Discrimination: A Critical Response to Supreme Court Jurisprudence*, 63 OR. L. REV. 265, 286-87 (1984) (footnotes omitted).

[79]It has been estimated that cigarette smoking accounts for more than $17 billion in medical care costs annually. Emmet W. Lee & Gilbert E. D'Alonzo, *Cigarette Smoking, Nicotine Addiction, and Its Pharmacologic Treatment*, 153 ARCH. INTERN. MED. 34-35 (1993). This is a conservative figure, however. Other studies have estimated medical care costs alone to be between $22 and $23 billion annually. Kenneth E. Warner, *Health and Economic Implications of a Tobacco-Free Society*, 258 JAMA 2080, 2084 (1987). The economic liability to society caused by smoking is also measured in terms of "indirect costs of productivity losses associated with the premature mortality and excess morbidity of smokers." *Id.* These costs are estimated at between $30 and $43 billion annually. *Id.*

> The estimated lifetime medical expenses and loss of earnings attributable to a two-pack-per-day habit for a smoker younger than 50 years exceed $34,000. This cost to

healthier friends and neighbors will continue to subsidize her premiums regardless of her behavior.

Consider the arguably more serious case of a no-classification auto insurance regime. Under such a system, a reckless driver pays the same premium for auto insurance as a careful, prudent driver. Every time the reckless driver has an accident, his more careful friends and neighbors "encourage" his undesirable behavior in the form of premium supplements. Surely this kind of risk-distributional function is perverse in that it leads to an increase in undesirable behavior by risk-loving individuals and financially penalizes those whose behavior is the least objectionable.

Yet, this is the logic of *Manhart*. At least for those categories explicit in Title VII,[80] risk classifications are not permitted, even where the underlying actuarial assumptions are not at issue. This extreme position on the undesirability of risk classification might suggest that the Court sees no value in the efficiency and loss prevention enhancing attributes of traditional risk management techniques. We know this is not the case. Risk management practices, as recent ERISA decisions demonstrate,[81] are not wholly out of favor, and there is no indication that all risk classifications are forbidden.

The question remains, why forbid classifications based on the categories specified in Title VII and not all that relate to personal, immutable characteristics? The logic of *Manhart* would suggest outlawing classifications based upon sexual orientation, height and weight,

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the individual smoker does not include the cost of the cigarettes and property damage, e.g., to clothing and due to accidental fires, attributable to smoking.

Lee & D'Alonzo, *supra*, at 35-36.

[80]"[R]ace, color, religion, sex [and] national origin." 42 U.S.C. § 2000e-2(a)(1) (1988).

[81]The *McGann* case itself was obviously decided based on traditional risk management practices. Justifying his client's position, Mark A. Huvard, a lawyer for H & H Music, said that "the company had to 'limit its exposure on things that are exotic' or else drop basic health coverage for several hundred other employees." Milt Freudenheim, *Employers Winning Right to Cut Back Medical Insurance*, N.Y. TIMES, March 29, 1992, at A1, 24. Also, in *Owens*, after plaintiff became stricken with AIDS, his employer's insurance provider communicated its "intent to cancel Storehouse's policy because of the high incidence of AIDS in the retail industry generally and among Storehouse's plan members in particular." Owens v. Storehouse, Inc., 984 F.2d 394, 396 (11th Cir. 1993). The federal appeals court affirmed the district court's granting of summary judgement in favor of the defendant ruling that § 510 of ERISA "does not prohibit an employer from crafting its medical plan to meet economic imperatives. Neither does it mandate fixed coverage of catastrophic diseases." *Id.* at 400.

disability, sight and physical reaction time (major factors in auto claims cases), and genetic predisposition to catastrophic illness. The countervailing logic of risk classification would militate in favor of reversing *Manhart* and allowing all of these classifications if an insurer found it economical to develop and use them. For, if the use of sex, race, and other touchy characteristics were truly discriminatory (i.e., actuarially unsound as opposed to simply uncomfortable), there would be a huge profit incentive for a new insurer to enter the market, discard "bigoted" classification practices and, armed with inoffensive classifications, make huge sums of money. That this has not happened suggests that classification practices, even those which draw distinctions that may generate discomfort, are not mere pretexts for irrational, discriminatory acts. On the contrary, these practices are nothing more than attempts to gather and sort information about diverse populations and to insist that those who are more likely to create losses pay more than those who are not.

B. *Empirical Evidence About Gendered Pension Classifications*

Enough time has elapsed since *Manhart* to have enabled empirical evaluations of the effects of the no gender classifications rule on both pension coverage[82] and participation rates.[83] Since *Manhart* was decided, several changes have taken place in pension coverage. First, overall labor force pension coverage declined during the 1980s, especially among younger male workers.[84] This is, in part, because employment patterns

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[82]Pension coverage refers to the number of employees whose employers offer access to a pension plan, whether defined contribution, defined benefit, 401(k) or 403(b). LANGBEIN & WOLK, *supra* note 72, at 24. Section 403(b) plans, also known as tax-sheltered annuities,

> often operate as "salary reduction" arrangements, under which the employee and the employer agree that the employee's salary will be reduced in the future and the reduction is contributed to the 403(b) plan. These salary reduction arrangements function much like 401(k) plans, in that the voluntary deferral (within limits similar to 401(k) plans) is not included in the employee's income.

Id. at 123.

[83]Pension participation rates refers to the number of employees who chose to participate in non-mandatory plans. Mandatory plans are those minimum pension programs that must be offered by employers. *Id.* at 35.

[84]Between 1979 and 1988 coverage fell by 14 points among workers aged 25-34;

shifted toward jobs with lower rates of pension coverage. At the same time, fewer eligible employees were electing to participate in employer-sponsored pension plans.[85]

Reductions in pension plan coverage and participation are important concerns because they affect the likelihood that an individual will reach retirement with only a public pension[86] for support. In addition, pension

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> among high-school dropouts aged 25-64, it fell by 17 points; and for the intersection of these groups, men aged 25-34 with less than 12 years of schooling, pension coverage fell by a stunning 26 percentage points. By contrast, pension coverage among male college graduates aged 35-64 . . . fell by only 5 percentage points . . . .

David E. Bloom & Richard B. Freeman, *The Fall in Private Pension Coverage in the United States*, AM. ECON. ASS'N PAPERS & PROC. 539, 540 (1992) (published in 82 AM. ECON. REV.). The decline in pension coverage during the 1980's has been attributed to two general causes. The first is structural changes in the labor market. William E. Even & David A. Macpherson, *Why Did Male Pension Coverage Decline in the 1980s?*, 47 INDUS. & LAB. REL. REV. 439, 440 (1994) ("[T]he fraction of the work force that was unionized, in manufacturing, and at large employers declined during the 1980s. Since these job characteristics have been associated with higher pension coverage, these shifts may account for some of the decline."). Second,

> Structural changes in the pension market may also have played a role in the decline in coverage during the 1980s. For example, the changing regulatory environment during the 1980s may have caused coverage to decline. Hay-Huggins (1990) provided evidence that regulatory changes substantially increased both pension start-up costs and continuing administrative costs associated with pension systems during the 1980s. These greater costs could lead firms to drop coverage, and may impede new firms from adopting a plan.

Id. For a thorough discussion of employee demand for pensions, see Alan L. Gustman et al., *The Role of Pensions in the Labor Market: A Survey of the Literature*, 47 INDUS. & LAB. REL. REV. 417 (1994).

[85]As Even and MacPherson state:

> Among the young [aged 21-35], the percentage of workers offered a pension plan fell by 2.6 [percentage] points [from 1979 to 1988], whereas the percentage that participated (among those who were offered a plan) fell by 6.9 points. Among the mature [aged 36-55], the offer rate actually rose 0.8 points, while the participation rate fell 3.2 points.

Even & Macpherson, *supra* note 84, at 452.

[86]It is not likely that the employee who relies solely on social security to supply retirement income will be able to maintain preretirement income levels. According to statistics compiled by Munnell "a worker aged sixty-five earning $13,783 (average wage) in 1981 receive[d] a benefit in early 1982 equal to 47 percent of preretirement earnings; to maintain his preretirement standard of living, he would need approximately 68 percent of prior earnings."

savings are part of the national savings rate, and reductions in the already low U.S. savings rate could lead to reduced opportunities for growth and investment.[87]

With the importance of pension savings in mind, it is startling to discover that one effect of *Manhart* appears to be an *increase* in discrimination in pension compensation. A recent study prepared by researchers at the U.S. Department of Labor[88] demonstrates that the unisex pension policy required by *Manhart* "transfers wealth among single life annuitants without reducing discrimination in pension compensation, [therefore] it is properly evaluated as a transfer program. . . . The largest costs are borne by men in plans predominantly comprising women; the largest gains are received by women in plans predominantly comprising men."[89]

What this means is that while the Court was correct in determining that

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ALICIA H. MUNNELL, THE ECONOMICS OF PRIVATE PENSIONS 23 (1982). Although "[r]etirees require considerably less than 100 percent of their preretirement income to maintain their standard of living," *id.*, according to the above figures the 65 year old average wage earner would have to come up with 21 percent of preretirement earnings through savings of one kind or another in order to maintain a preretirement standard of living. It is important to note, however, that the replacement of earnings provided by social security tends to increase as preretirement wage earnings decrease if the retiree is married. *Id.* at 26.

[87]Beginning in the 1980s, when "the baby boomers were spending heavily at the start of their careers for such items as housing and furnishings," the savings rate in the United States took a nose dive. Gene Koretz, *A Low Savings Rate Hurts—But So Would A High One*, BUS. WK., Nov. 19, 1990, at 37. "Instead of rising, the personal savings rate, which averaged 8% in the 1970s, fell like a stone during the expansion—hitting a postwar low of 2.9% of disposable income in 1987 as households took on a record amount of debt to maintain or improve their living standards." *Id.* By 1993 the savings rate in the U.S. rose to a still meager 5%. Louis S. Richman, *How Americans Can Save More*, 128 FORTUNE, Nov. 15, 1993, at 97. Meanwhile, personal savings rates in other industrialized countries make the United States look like "a grasshopper in a world of ants." Al Sommers, *Is the United States A Rotten Saver?*, 31 ACROSS THE BOARD, Apr. 1994, at 15-16. For example, "[t]he Japanese save about 17% of their income." *Nation's Low Savings Rate Causes Concern (Congress Considers Restoring IRA Deduction Advantages)*, 110 SAVINGS INSTITUTIONS, Dec. 8, 1989, at 8. The effects of Americans' inability to save has staggered growth and perpetuated this country's disadvantage in the world market by pushing "real interest rates to record highs." *Id.* "This has caused 'U.S. capital costs to soar above those abroad, which is limiting investment and productivity.'" *Id.* The bottom line is that unless Americans change their spend and save patterns, this country's "economic future is far from certain." *Economists Bemoan Low Savings Rate (But Aging Baby Boomers Could Be The Key)*, SAVINGS INSTITUTIONS, April 1990, at 39.

[88]David D. McCarthy & John A. Turner, *Risk Classification and Sex Discrimination in Pension Plans*, 60 J. RISK & INS. 85 (1993).

[89]*Id.* at 100.

sex discrimination occurs against high mortality risk women when they participate in pension plans using sex-based mortality tables, it erred in concluding that such discrimination "is necessarily sex discrimination in compensation."[90] A sex-based classification can minimize the kind of individual discrimination the Court was concerned with in *Manhart* because:

> [w]hen all types of annuities are considered, it is unclear that unisex pension policy furthers the goal of reducing economic disparity [between men and women]. . . . [M]en received more net gain than women from unisex pensions. This unexpected result occurred because the benefits of retired men receiving joint and survivor benefits were increased since the benefit reduction for providing survivors' benefits to their wives was lessened.[91]

None of this suggests that the value judgment implicit in *Manhart*—the avoidance of classifications to protect groups which have suffered historical discrimination—was wrong. It does, however, raise questions about the efficacy of prohibiting classifications as a mechanism for equalizing compensation.

C. *Selecting From Among Values Affected By Classification*

How then can one choose between the attractions of classification—efficiency and the creation of loss prevention incentives—and the sympathetic desire of the Court to avoid practices which further reinforce patterns of compensation which are a function of discrimination? In work far afield from this paper, Mari Matsuda argued for approaches which "give special credence to the perspective of the subordinated" and for a "first principle of anti-subordination."[92] Assuming it is unnecessary to

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[90]*Id.* at 101.

[91]*Id.*

[92]Mari J. Matsuda, *Pragmatism Modified and the False Consciousness Problem*, 63 S. CAL. L. REV. 1763, 1764 (1990); *see also* Alex M. Johnson, Jr., *The New Voice of Color*, 100 YALE L.J. 2007, 2015-16 (1991) (asserting that scholars of color are able to speak from a unique perspective unavailable to white scholars). Professor Johnson carefully points out, however, that the "voice of color" does not always exist whenever a scholar of color speaks. Instead, "The scholar of color must draw on her experiences and general insight gained as a person of color before the voice of color is articulated." *And see* Margaret J. Radin, *The Pragmatist and the Feminist*, 63 S. CAL. L. REV. 1699, 1707 (1990) (arguing that pragmatism and feminism are

make the case for the pervasive subordination of disabled individuals in our society, including those with gainful employment like McGann, what is lost by forbidding insurers from singling out particular catastrophic conditions? First, and most obvious, is the cost to other members of the insured group. Is the anti-subordination principle so valuable that it ought to outweigh all other competing economic concerns? Suppose that application of the anti-subordination principle results in no insurance coverage for anyone, or insurance offered at a price which no employee can afford. It is hard to see how any employee, even one who is disabled, benefits by this result.

When the Fifth Circuit in *McGann* suggested that the central issue was the continued financial integrity of the plan,[93] this was merely another way of stating that the interests of one individual must give way when they are so at odds with the very existence of all the needs of the larger group. (If group insurance has its own first principle it is probably protection of the

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alike in that they "both arrive at an embodied perspectivist view of knowledge"). Radin states that pragmatism and feminism largely share the commitment to finding knowledge in the particulars of experience. "It is a commitment against abstract idealism, transcendence, foundationalism, and atemporal universality; and in favor of immanence, historicity, concreteness, situatedness, contextuality, embeddedness, narrativity of meaning."); Martha Minow & Elizabeth V. Spelman, *In Context*, 63 S. CAL. L. REV. 1597, 1601 (1990) (explaining the importance of seeing things in the context in which they are presented). The authors

> emphasize "context" in order to expose how apparently neutral and universal rules in effect burden or exclude anyone who does not share the characteristics of privileged, white, Christian, able-bodied, heterosexual, adult men for whom those rules were actually written. It is the particular particularities associated with legacies of power and oppression [the authors] mean to highlight by the interest in context.

But see Richard Delgado, *When a Story Is Just a Story: Does Voice Really Matter?*, 76 VA. L. REV. 95, 99-100 (1990) (arguing that Critical Race Theorists like Professor Matsuda

> are urging nothing more unusual than that persons who have grown up in the minority community may have information not easily accessible to others and a special stake in disseminating it. Encouraging them to do so seems no stranger than holding that university professors should determine academic policy or that the patient in the dentist's chair is the one who knows when it hurts.);

Randall L. Kennedy, *Racial Critiques of Legal Academia*, 102 HARV. L. REV. 1745, 1749 (1989) (denying that historically oppressed persons, those of color in particular, speak with any singular voice and that they have any unusual insights into issues concerning race).

[93]McGann v. H & H Music Co., 946 F.2d 401, 404 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992).

group's continued existence.) Of course, under a universal payer system, which some advocate,[94] McGann's employer would not have been faced with the difficult decision of passing along enormous premium increases to employees or dropping coverage altogether in order to pay for McGann's AIDS treatment. In a real sense though, the price controls such a system would require would simply spread the cost of McGann's treatment over the entire tax-paying population.[95] At some point, even that larger group would find its ability to cover itself at a reasonable cost threatened if it continued to pay for every conceivable condition and treatment regardless of circumstances.[96] Under those conditions, the large group's instinct for self-preservation would undoubtedly triumph. Just as the group in *McGann* did, society would and should opt for some caps and exclusions.

Possibly the most troubling aspect of *McGann*, however, is the *ex post* nature of the decision to exclude AIDS. It was only after H & H Music

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[94]A bill proposing a universal, single-payer system was sponsored in Congress by Representative Jim McDermott (D-Wash), H.R. 1200, 103d Cong., 2d Sess. (1994), (H.R. 1200) and Senator Paul Wellstone (D-Minn.), S. 491 103d Cong., 2d Sess. (1994) (S. 491). *See also* Adam Clymer, *House Bill Asks 8.4% Payroll Tax For Canadian-Style Health Plan*, N.Y. TIMES, January 28, 1994, at A19. This approach was "co-sponsored by 92 House Democrats and one independent." *Id.*

The single-payer plan appears more efficient:

> The single-payer plan would create a universal public system of health insurance coverage with comprehensive benefits financed by income and payroll taxes instead of premiums. All Americans would be covered, in much the same way the elderly are now covered by Medicare. Employer-based coverage, private insurance, Medicare and Medicaid would be replaced by a single plan. Costs would be controlled through administrative simplification and by a national budget with Government-regulated payment rates for doctors and hospitals.

Navigating the Health Swamp: A Primer, N.Y. TIMES, June 12, 1994, at 4A, 3.

[95]For an entertaining discussion of price controls in the context of the current health care reform proposals, see Simon Rottenberg & David J. Therous, *Rationing Health Care: The New Threat of Price Controls*, THE INDEPENDENT INST., 1994 (copy on file at DePaul College of Law).

[96]In order to reduce cost burdens under the Canadian system, at least one province, Ontario, which insures 10 million people or nearly 40% of Canada's population, is ending certain kinds of health coverage. Clyde Farnsworth, *Now Patients Are Paying Amid Canadian Cutbacks; Spending Outstrips the Government's Resources*, N.Y. TIMES, March 7, 1993, at 1, 18. It has decided to end "coverage of electrolysis, used for the removal of unwanted hair," and is "reviewing coverage of 40 other items including psychoanalysis, vasectomies, newborn circumcision, in vitro fertilization and chiropractic, podiatric and osteopathic services." *Id.*

was informed of his condition that they decided to drastically cap coverage. The central issue in *McGann* is not the usefulness of risk classifications, which is beyond doubt, but the timing of the employer's decision to cap coverage. Permitting H & H Music to cap coverage after McGann contracted AIDS effectively sanctions a miscalculation on the employer's part and does so at precisely the point in time when McGann cannot shop around for an alternative insurance source.[97]

For years McGann paid his premiums, under the (mistaken) impression that the $1 million cap could not and would not be taken away. It is one thing for an employer to decide, without knowing whether any group member has a catastrophic condition, to limit coverage. This is always a

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[97]There is precedent for an *ex post* withdrawal of benefits, however. In Flemming v. Nestor, 363 U.S. 603, 610 (1960), the Supreme Court concluded that social security benefits were not "an accrued property right" and could be terminated because the putative recipient was deported for being a member of the Communist Party. In his dissent, Justice Black argued that the Due Process Clause of the Fifth Amendment was violated by this *ex post facto* taking. He noted:

> People who pay premiums for insurance usually think they are paying for insurance, not for "flexibility and boldness." I cannot believe that any private insurance company in America would be permitted to repudiate its matured contracts with its policyholders who have regularly paid all their premiums in reliance upon the good faith of the company.... [Congress] ... could repeal the [Social Security] Act.... This means that it could stop covering new people, and even stop increasing its obligations to its old contributors. But that is quite different from disappointing the just expectations of the contributors to the fund which the Government has compelled them and their employers to pay its Treasury.

Id. at 624-25 (Black, J., dissenting).

Some members of Congress, however, have recently responded to this apparent injustice:

> Realizing that ERISA no longer provides protection for employees such as McGann, on February 8, 1993, Representative William Hughes and fifteen other members of the House of Representatives introduced a bill designed to "reaffirm the safeguards the drafters incorporated into ERISA." Under this legislation, called the Group Health Plan Nondiscrimination Act of 1993, § 510 would be modified so that changes made to eliminate or reduce benefits while an employee is being treated for a disease or medical condition previously covered by the plan would establish an employer's intent of discriminate. This modification effectively prohibits the retroactive reduction or elimination of benefits related to one or more particular diseases or medical conditions.

Butler, *supra* note 3, at 1231.

legitimate financial exercise. It is another matter entirely to make *ex post* actuarial reevaluations.[98] The latter always brings with it the possibility of personal retaliation (which McGann alleged), and smacks of "bait and switch."[99] The former, when premised upon actuarially sound

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[98]Clearly, banning *ex post* reevaluations as I suggest here will have the effect of penalizing employers who, from whatever source, have in their possession information regarding a particular employee's ill health. This may create a perverse incentive not to learn about (or acknowledge) the presence of a catastrophic illness in the work place. On the other hand, it creates a strong incentive for an employee who may wish to avoid McGann's problems to promptly inform her employer of her condition and thereby protect against subsequent caps or exclusions.

[99]"Bait advertising" is defined by the Code of Federal Regulations as "an alluring but insincere offer to sell a product or service which the advertiser in truth does not intend or want to sell." 16 C.F.R. § 238.0 (1994). The "switch after sale" includes, *inter alia*, "[f]ailure to make delivery of the advertised product within a reasonable time or to make a refund." 16 C.F.R. § 238.4 (1994). A number of states have also outlawed "bait and switch" tactics in their consumer protection laws. For example, in People *ex rel.* Dunbar v. Gym of Am., Inc., 493 P.2d 660 (Colo. 1972), the Supreme Court of Colorado held that the term "bait and switch" used in the Colorado Consumer Protection Act was not unconstitutionally vague. The court ruled as it did for two reasons. First, the statute:

> specifically define[d] "bait and switch" advertising as advertising which "consists of an attractive but insincere offer to sell a product or service which the seller in truth does not intend or desire to sell." Second, "bait and switch" advertising and selling techniques have long been recognized in the legal literature and have long been subject to equitable sanctions.

Id. See also ALA. CODE § 13A-9-43 (1994) which states,

> (a) A person commits the crime of bait advertising if in any manner, including advertising or other means of communication to the public or to a substantial number of persons, he offers to sell property or services with the intent, plan or purpose not to sell or provide the advertised property or services:
> (1) At the price at which he offered them; or
> (2) In a quantity sufficient to meet the reasonably expected public demand, unless the advertisement discloses a limitation of quantity; or
> (3) At all.

and ARK. CODE ANN. § 4-88-107 (Michie Supp. 1993) which defines "deceptive and unconscionable trade practices" as, *inter alia*,

> (5) The employment of bait-and-switch advertising, consisting of an attractive but insincere offer to sell a product or service which the seller in truth does not intend or desire to sell, evidenced by a refusal to show or disparagement of the advertised product, the requirement of a tie-in sale or other undisclosed conditions precedent to

classifications, is a legitimate, non-personal attempt to control costs in an effort to protect the continued viability of the insured group.

The spirit of *Manhart* suggests that the creation of any classification which relies on categories made up of historically subjugated persons ought to be unlawful. This may have some superficial appeal, but in the face of new evidence raising questions about the anti-discriminatory effect of unisex pension tables, caution is advisable. Risk classification encourages efficient behavior by persons both inside and outside of any particular category. It also assigns costs fairly in that those who are high risk (e.g., smokers, reckless drivers, etc.) pay for their dangerous behavior, and those who behave "better" (at least from an insurance standpoint) are rewarded for doing so.

The tendency to encourage loss prevention is lost if risk classification falls into disfavor. The fundamental unfairness of *McGann* is mainly a function of the timing (and therefore the retaliatory nature) of the employer's decision to cap coverage. Legislation could remedy this result by limiting employer coverage changes to *ex ante* situations, cases where the change is made without knowledge of the particular health needs of any one group member.

V. CONCLUSION

All employers, and small firms in particular, are under pressure to control health insurance expenditures as part of their normal efforts to restrain the growth of total labor costs. Insurance is a typical consumer good, and as its price rises, demand for it (by employers and covered group members) diminishes. Recent employer efforts to avoid state mandates by forming risk-retention pools are consistent with these forces.

Supporters of risk management practices,specifically classification, reveal preferences for efficiency and loss prevention incentives as the operative values in the insurance market. These values are not universally shared and frequently clash with competing concerns about avoiding the grouping of individuals based on sex, race, etc. In cases such as *Manhart*, and more recently *McGann* and *Mason Tenders*, this clash is clearly evident. There is no obvious mechanism to resolve the risk classification / risk-distributional function debate. Implicit in *Manhart* is the belief that efficiency concerns must be subordinated because certain classifications

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the purchase, demonstrating a defective product, or other acts demonstrating an intent not to sell the advertised product or services.

promote discrimination and deflect attention from the unique qualities of each individual in the group. This reasoning has always been shaky, but new empirical evidence which calls into question whether women have benefited from a unisex pension classification system suggests that insurance classifications are probably the wrong place to look for culprits in the war against sex discrimination.

What offends us most about *McGann* and similar cases is the *ex post* nature of the employer's decision to amend the insurance contract. Permitting employers to cap or eliminate coverages after learning that a group member needs a specific type of care is both unfair and, especially in AIDS cases, reeks of personal retaliation and hostility. ERISA should be amended to permit only *ex ante* actuarial reevaluations for existing employees. Such a rule would be consistent with the spirit of both the ADA and with the anti-discrimination provisions of ERISA.