Note

Your Insurance Does Not Cover That: Disability-Based Discrimination Where It Hurts the Most

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*Introduction***

When Brenda Henderson was diagnosed with an aggressive form of breast cancer, her doctor recommended that she undergo a regimen

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** Three days before this Note was set to go to press, Congress passed—and the President signed into law—the Patient Protection and Affordable Care Act ("PPACA" or "Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010). Although this Act addresses many of the concerns raised in this Note—such as limitations on annual and lifetime benefits, coverage exclusions based on health conditions, and premium increases due to medical history—and provides for Secretary review of all premium increases, it does not render the following proposal moot for several reasons. First, unlike the PPACA, this Note's proposal would require that insurers use actuarial data to justify their methods and rates. Using such data would strike a balance between the Act's categorical bar on considering a patient's disability when setting coverage options and the status quo ante, under which the industry was free to set premiums and coverage plans arbitrarily. Further, it would provide the Secretary with a quantifiable method with which to gauge whether premium increases are unreasonable.

In addition, the PPACA appears to include a large loophole that will exempt large portions of the country from its protections. Section 1251 of the law states that many of these protective provisions do not apply to any individual, family, or employer who chooses to retain or renew their current coverage, or for those family members or employees who subsequently join the

of high-dose chemotherapy ("HDCT"), which was the most effective method of treating the disease.[1] Unfortunately, her insurer did not cover HDCT for breast cancer, and Brenda was forced to file a lawsuit in order to obtain this life-saving treatment.[2] The insurer covered HDCT for other types of cancer.[3]

Richard Senter had been with the same health insurer for over ten years.[4] His lifetime policy limit was $1 million.[5] In his fourteenth year with the insurer, Richard discovered that he was suffering from Acquired Immune Deficiency Syndrome ("AIDS").[6] Almost contemporaneously, his insurer decided that it would only cover $25,000 of his medical expenses for his AIDS-related treatment.[7] Coverage for individuals suffering from any other disease remained at $1 million.[8]

These are just two examples of a problem that is often overlooked in the arena of healthcare reform: the problem of private insurance failing "to cover the services people with disabilities most need for independence and health."[9] The policies of private insurers are riddled with coverage exclusions, limitations on treatments, and annual and lifetime caps on coverage, which severely restrict the care that those with disabilities can afford.[10] These restrictions are placed on a variety of conditions, including infertility, obesity, developmental disorders, asthma, cleft pallet, glaucoma, cataracts, pelvic inflammatory disease, and spine or back disorders.[11]

Although passage of the Patient Protection and Affordable Care Act ("PPACA" or "Act")[12] has begun to address the plight of individ-

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existing plan. *Id.* § 1251, 124 Stat. at 161. Accordingly, many individuals who are insured through their employer or who already have insurance coverage will not be protected against discrimination. The proposal of this Note would avoid this problem, as its solution applies equally to all insurers, insurance plans, and insurance holders. Accordingly, as the ramifications and implementation of the PPACA are worked out over the coming months and years, the proposal put forth here may provide an efficient and effective way to accommodate the needs of all stakeholders.

1 Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995).

2 *Id.* at 959–60.

3 *Id.* at 960.

4 Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., 37 F.3d 12, 14 (1st Cir. 1994).

5 *Id.*

6 *Id.*

7 *Id.*

8 *Id.*

9 Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 27 (2004).

10 *Id.* at 28.

11 *Id.* at 28 n.107.

12 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

uals with disabilities who are covered by private health insurance, the reforms' impact and precise form of implementation remain uncertain.[13] In order to give clear direction to the industry and balance protections for persons with disabilities against the needs and realities of the marketplace, Congress should amend a law originally intended to do just that—the Americans with Disabilities Act of 1990("ADA").[14]

Although Congress passed the ADA in order to end discrimination against persons suffering from disabilities,[15] the statute's impact upon discrimination in the insurance market remains unclear and inconsistent. Congress should take action and amend the ADA to make clear that: (1) the ADA covers the content of insurance policies, and (2) insurers will only be exempt from its restrictions if they have independently calculated actuarial proof that a given condition poses the risk of increased costs. This amendment will protect individuals with disabilities from being arbitrarily discriminated[16] against in the terms of their insurance policies, while at the same time allowing insurers to continue to engage in legitimate underwriting practices.

Part I of this Note provides a brief background of the ADA and its relationship to the health insurance industry. Part II discusses the split among the U.S. courts of appeals concerning whether or not the ADA regulates the content of insurance policies. Part III examines the recent passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Wellstone Mental Health Parity Act"),[17] its impact upon discrimination in the insurance industry, and its implications for future congressional action. Part IV sets forth the argument that Congress should take further action and

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13 For example, section 1001 of the Act immediately prohibits lifetime limits on benefits and establishes a coverage option for individuals denied insurance due to a preexisting condition. *See id.* § 1001, 124 Stat. at 130–31. Further, section 1201 of the Act establishes that, beginning in 2014, insurers will be prohibited from, inter alia, imposing preexisting condition exclusions, setting eligibility rules based on medical condition, or varying premiums based on factors other than family size, rating area, age, and tobacco use. *See id.* § 1201, 124 Stat. at 154–55. However, these and other protections afforded to persons with disabilities will not apply to any insurance plan in which an individual, family, or employer was enrolled—or to any subsequently enrolled members of such plan—at the time this Act was passed. *See id.* § 1251, 124 Stat. at 161.

14 Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213 (2006).

15 *Id.* § 12101(b)(1)–(2).

16 Throughout this Note, the term "arbitrary discrimination" will refer to the insurance industry's practice of offering different policies to people with certain disabilities without any statistical evidence to prove that such discrepancies legitimately reflect variations in the amount or cost of treatment needed for an individual's disability.

17 Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765, 3881–93 (to be codified at I.R.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-5).

amend the ADA to clearly cover the conduct of insurance agencies in the sale of policies and to require them to base any discrepancies in coverage upon actuarial data.

I. Background

Congress passed the ADA two decades ago in an effort to eliminate discrimination against persons suffering from disabilities.[18] Unfortunately, ambiguity in the statute has allowed the health insurance industry to sidestep restrictions that apply to almost every other private entity. This Part discusses the terms of the ADA as well as the manner in which the health insurance market has succeeded in avoiding its provisions and in discriminating against individuals based upon their disabilities.

A. The Americans with Disabilities Act of 1990

Congress enacted the ADA on July 26, 1990, "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" and "to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities."[19] Upon signing it into law, President George H.W. Bush heralded that, with its passage, "[e]very man, woman and child with a disability can now pass through once-closed doors into a bright new era of equality, independence, and freedom."[20]

Under the ADA, a disability is classified as "a physical or mental impairment that substantially limits one or more major life activities of such individual."[21] Major life activities include many daily functions, such as "caring for oneself, performing manual tasks, . . . eating, sleeping, walking, . . . learning, reading, concentrating, thinking, communicating, and working."[22] Accordingly, any injury or disease that prohibits an individual from doing any of these or similar tasks constitutes a disability that is protected by the ADA. This is the case even if

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18 42 U.S.C. § 12101(b).

19 *Id.* § 12101(b)(1)–(2).

20 Ann Devroy, *In Emotion-Filled Ceremony, Bush Signs Rights Law for America's Disabled*, WASH. POST, July 27, 1990, at A18; *accord* John W. Mashek, *To Cheers, Bush Signs Rights Law for Disabled*, BOSTON GLOBE, July 27, 1990, at 4 ("We're taking a sledgehammer to another wall . . . which has, for too many generations, separated Americans with disabilities from the freedom they could glimpse but not grasp.").

21 ADA Amendments Act of 2008, Pub. L. No. 110-325, sec. 4, § 3(1)(A), 122 Stat. 3553, 3555.

22 *Id.* § 3(3)(A).

an auxiliary aid or medication may help mitigate the disability's damaging effects or the illness or injury is in remission.[23]

Title III of the ADA addresses discrimination against people with disabilities in the arena of public accommodations, including insurance offices.[24] It provides that these entities are not allowed to discriminate against any individual "in the full and equal enjoyment of . . . goods[or] services" because of a disability.[25] According to the ADA, discrimination occurs when an entity takes note of a person's disability and, therefore, offers him an unequal opportunity to benefit from or enjoy its goods and services.[26] In addition, it is also impermissible to offer a disabled individual an altogether different good or service due to his disability unless the difference is necessary to make the offered good or service an effective option for that individual.[27]

The ADA speaks directly to the insurance industry in Title IV of the Act, in what has become known as the insurance safe harbor provision.[28] In this provision, Congress states that nothing in Title III of the ADA should be interpreted to prohibit an insurer "from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law."[29] Due to this qualification, insurers may continue to group certain risks together and charge different premiums based upon those risks.[30] Title IV also provides, however, that the insurer cannot engage in these practices if it is doing so in an effort to evade the purpose of the ADA, i.e., if it is attempting to discriminate based upon an individual's disability.[31]

Together, Titles III and IV have left the ADA's relationship with the insurance industry anything but clear. Title III provides that insurance offices are public accommodations and therefore not allowed to offer different goods or services to persons with disabilities.[32] How-

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23 *See id.* § 3(5)(C)–(D)(i).

24 *See* 42 U.S.C. § 12181(7)(F) (including among public accommodations "a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, *insurance office*, professional office of a health care provider, hospital, or other service establishment" (emphasis added)).

25 *Id.* § 12182(a).

26 *Id.* § 12182(b)(1)(A)(ii).

27 *Id.* § 12182(b)(1)(A)(iii).

28 *Id.* § 12201(c).

29 *Id.* § 12201(c)(1).

30 *See* ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 12 (4th ed. 2007).

31 *See* 42 U.S.C. § 12201(c) ("Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter [sic] I and III of this chapter.").

32 *Id*. §§ 12181–82.

ever, Title IV removes the industry from this restriction, allowing it to classify risks—i.e., offer different coverage options for persons with different conditions—as long as it is not doing so in an effort to subvert the purposes of Title III.[33] This back-and-forth makes the ADA's applicability to the insurance industry very ambiguous. As the next Section discusses, the industry has taken advantage of this ambiguity by blatantly discriminating against persons suffering from disabilities in the terms of their health insurance policies.

B. The Practices of the Health Insurance Industry

Despite the attention given to the public health insurance arena, a 2008 report found that 66.7% of Americans are still insured through the private market.[34] The vast majority of this group (58.5%) is insured through employer health plans, while the rest (8.9%) purchase insurance directly.[35] Furthermore, it appears likely that even after the passage of the PPACA, many individuals will remain covered by these same private insurance plans.[36] In order to set premiums and coverage policies, insurers in the private sector often engage in actuarial risk-pooling classifications in which they calculate a given group's likelihood of illness, cost of treatment, length of required care, etc.[37] Moreover, the legislative history suggests that Congress did not intend to abolish such risk classification when it passed the ADA.[38]

However, insurers frequently place disproportionately large costs and restrictions upon groups or individuals who are suffering from certain disabling diseases.[39] They often bar reimbursement for particular conditions, impose lifetime caps on permitted reimbursement, or refuse to cover assistive medical equipment such as hearing aids, pros-

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33 *See id.* § 12201(c).

34 U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 23 (2009), *available at* https://www.census.gov/prod/2009pubs/p60-236.pdf (noting that in 2008 about 1 million fewer Americans were covered by private insurance than in 2007).

35 *Id.*

36 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161 (2010) ("Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.").

37 *See* JERRY & RICHMOND, *supra* note 30, at 11–13.

38 *See* H.R. REP. NO. 101-485, pt. 3, at 70 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 493 ("The Committee added this [safe harbor] provision because it does not intend for the ADA to affect legitimate classification of risks in insurance plans in accordance with the state laws and regulations under which such plans are regulated.").

39 *See* Bagenstos, *supra* note 9, at 27–28.

theses, or wheelchairs.[40] At times, these restrictions are not based on any actuarial data—such as statistical records of the actual health costs associated with a given condition—but only on the insurer's stereotypical perception of the given disease.[41]

Congress ended similar arbitrary distinctions in the arena of mental health with the passage of the Wellstone Mental Health Parity Act in the fall of 2008. This Act requires insurers to provide equal coverage for mental and physical health benefits unless they can prove with actuarial data that such coverage will significantly increase their costs.[42] Further, on March 21, 2010, Congress passed the PPACA, which began to address discrimination against persons with disabilities in the terms of their health insurance plans.[43] Congress should now end all arbitrary discrimination by amending the ADA to clarify and strengthen its relationship with the health insurance industry. This step is necessary because, as the next Part of this Note argues, the courts are anything but clear on what that relationship is under the statute's current formulation.

II. The Circuit Split

The issue of whether the ADA, as currently written, controls the content of insurance policies has been considered by a number of U.S. courts of appeals. The results have been far from consistent. The courts have not only arrived at different conclusions, but have done so based upon several different lines of analysis. These lines include: (1) that an insurance policy is not a public accommodation within the meaning of the ADA;[44] (2) that the ADA only regulates access to insurance policies and not their content;[45] (3) that the insurance industry is exempt from regulation under the safe harbor provision in Title IV;[46] and (4) that the ADA does in fact regulate the content of, as well

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40 *See id.* at 28, 31–32.

41 *See, e.g.*, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 558 (7th Cir. 1999) (noting that insurer had no actuarial data to justify lifetime caps on treatments for AIDS).

42 *See* Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, sec. 512, §§ 712(a)(3)(A), (c)(1)(B)(2)(A)–(B), 122 Stat. 3765, 3881–83. This Act will be discussed in detail in Part III of this Note.

43 *See supra* note 12.

44 *See* Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1014 (6th Cir. 1997) (en banc).

45 *See Doe*, 179 F.3d at 564; *see also* Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., 37 F.3d 12, 20 (1st Cir. 1994) (noting that the substance of insurance policies appeared to be exempted from the ADA's reach).

46 *See* Rachel Schneller Ziegler, *Safe, but Not Sound: Limiting Safe Harbor Immunity for Health and Disability Insurers and Self-Insured Employers Under the Americans with Disabilities Act*, 101 MICH. L. REV. 840, 844 (2002) ("[C]ourts have broadly interpreted Section 501(c) of the

as access to, insurance policies.[47] Because the circuit courts cannot agree on a proper reading of the ADA, health insurers and beneficiaries remain uncertain of their rights and responsibilities[48] and the law continues to allow for discrimination against individuals based upon physical disabilities.

This Part focuses upon the seminal decisions of the First, Sixth, Seventh, and Eighth Circuits. Although all of the cases were decided in the 1990s, they continue to be binding precedent and thus reflect the ambiguity surrounding the ADA's relationship with the health insurance industry today.

A. First Circuit Interpretation: The ADA Demands Equal Access to Insurance Policies but Is Unclear as to Content

The first appellate court to review Title III's meaning of public accommodation was the United States Court of Appeals for the First Circuit in the case of *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England*.[49] In *Carparts*, Richard Senter, a self-insured small-business owner, brought suit against his health insurance administrator for illegal discrimination on the basis of a disability.[50] Mr. Senter claimed that his insurer's decision to cap benefits for persons with AIDS was illegal discrimination pursuant to Title III of the ADA, which prohibits public accommodations from offering different goods and services to persons with disabilities.[51]

ADA—the safe harbor provision—such that health and disability insurers . . . are nearly fully exempt from Titles I and III of the ADA." (footnotes omitted)); *id.* at 856–61 (examining cases that have interpreted the safe harbor provision too broadly).

47 *See* Parker v. Metro. Life Ins. Co., 99 F.3d 181, 187 (6th Cir. 1996), *vacated and reh'g granted*, 107 F.3d 359 (6th Cir. 1997).

48 To see the confusion on this issue within the legal world, one need look no further than the widely divergent advice given by various secondary authorities. *Compare* 1 AMERICANS WITH DISABILITIES: PRACTICE AND COMPLIANCE MANUAL § 4:55 (2004) ("Many courts have rejected the view of the United States Department of Justice . . . that the nondiscrimination mandate of Title III of the [ADA] applies to insurance contracts . . . ." (footnotes omitted)), *with* ANNE MARIE ESTEVEZ & ATHALIA E. LUJO, PUBLIC ACCOMMODATIONS UNDER THE AMERICANS WITH DISABILITIES ACT: COMPLIANCE AND LITIGATION MANUAL § 4:16 (2008–09 ed. 2008) ("Insurance providers may not discriminate on the basis of disability in the sale of insurance contracts or in the conditions and terms of the insurance contracts they offer.").

49 Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., 37 F.3d 12 (1st Cir. 1994). Although the case was filed ten days before the ADA became effective, the plaintiff quickly amended his action to include the federal claim once it became available. *Id.* at 15.

50 *Id.* at 14. The facts of this case are discussed in the Introduction. *See supra* text accompanying notes 4–8.

51 *Carparts*, 37 F.3d at 14–15.

The district court denied Mr. Senter's Title III discrimination claim, interpreting public accommodations to mean only physical places that a plaintiff could actually enter.[52] The First Circuit vacated this holding and remanded for further proceedings.[53] Crucial to the First Circuit's analysis was its interpretation of the plain meaning of the statute's language, which included a "travel service" as a public accommodation.[54] The court found that, because persons often conduct business with travel services over the telephone or by mail, Congress could not have intended public accommodation to mean only a physical structure that must be entered by the individual.[55] The court held, therefore, that "[i]t would be irrational to conclude" that a person is protected by the ADA when conducting business at an agent's office, but not when doing so over the phone or by mail.[56] In the court's opinion, "Congress could not have intended such an absurd result."[57]

The First Circuit also found support in the legislative history of the ADA for its interpretation that public accommodations were not limited to physical structures such as insurance offices.[58] The court relied on legislative reports, which made clear that the purpose of the ADA was "to bring individuals with disabilities into the economic and social mainstream of American life"[59] and to provide individuals with disabilities equal access to all the goods and services that the private sector had to offer.[60] Accordingly, excluding businesses that do not have physical structures frequented by the public from the meaning of public accommodation would "run afoul of the purposes of the ADA and . . . severely frustrate Congress's intent."[61]

Although the First Circuit held that a public accommodation did not need to be a physical structure, it did not decide whether the ADA was intended to control the *content* of the goods and services offered or merely an individual's *access* to them.[62] Because it was not

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52 Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., 826 F. Supp. 583, 586 (D.N.H. 1993), *vacated and remanded*, 37 F.3d 12 (1st Cir. 1994).

53 *Carparts*, 37 F.3d at 21.

54 *Id.* at 19.

55 *Id.*

56 *Id.*

57 *Id.*

58 *See id.*

59 *Id.* (quoting H.R. REP. NO. 101-485, at 99 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 382) (internal quotation marks omitted).

60 *See id.* (citing S. REP. NO. 101-116, at 58 (1989)).

61 *Id.* at 20.

62 *Id.* at 19.

necessary to dispose of the question presented on appeal, the court decided that "at this stage it is unwise to go beyond the *possibility* that the plaintiff may be able to develop some kind of claim under Title III."[63] Therefore, although the First Circuit employed the plain meaning and legislative history of the ADA to make clear that the meaning of public accommodation includes not only physical structures but may also apply to services offered by insurance companies,[64] it refused to address the issue of whether the ADA's protection goes beyond mere access to services or products. As a result, the statute's relevance to individuals with disabilities' health insurance needs remained unclear.

B. Eighth Circuit Interpretation: Access and Content Most Likely Controlled by ADA with Burden of Proof on Insurer

Several years after the First Circuit's decision in *Carparts*, the Eighth Circuit had an opportunity to weigh in on the relevance of the ADA to the health insurance industry in the case of *Henderson v. Bodine Aluminum, Inc.*[65] In *Henderson*, Karen Henderson sought a preliminary injunction against her health insurer after it refused to cover a course of HDCT for her breast cancer.[66] The insurer covered the exact same treatment for many other forms of cancer.[67] Although the district court denied Ms. Henderson's request for an injunction, on expedited review, the Eighth Circuit reversed and directed the district court to issue a preliminary injunction mandating that Ms. Henderson's insurer assure the treating hospital that the HDCT would be covered.[68]

In granting the preliminary injunction, the Eighth Circuit held that Ms. Henderson's claim had a sufficient likelihood of success on the merits because, if she could show that the HDCT was nonexperimental, the insurer's denial of coverage would "arguably" violate the ADA.[69] Although the court did not focus its opinion on whether the denial of coverage would be a violation of the ADA, it did reference the Equal Employment Opportunity Commission's Interim Policy

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63 *Id.* at 20.

64 *See id.* at 19–20.

65 Henderson v. Bodine Aluminum, Inc., 70 F.3d 958 (8th Cir. 1995).

66 *Id.* at 959. The facts of this case are also discussed in the Introduction. *See supra* text accompanying notes 1–3.

67 *Henderson*, 70 F.3d at 959–60.

68 *Id.*

69 *Id.* at 960.

Guidance on ADA and Health Insurance ("EEOC Policy")[70] for the proposition that "if coverage disparities apply to *dissimilar* conditions, they are not disability-based distinctions."[71] The logical inference to be drawn from the court's emphasis on "dissimilar" is that, when coverage disparities apply to similar conditions, they are disability-based and therefore violate the ADA.

This EEOC Policy, relied upon by the Eighth Circuit in finding that Ms. Henderson's insurer may have been in violation of the ADA, establishes that, when a disability-based distinction is made in the terms of an insurance policy, the burden of proof is on the insurer to prove that its distinction falls within the safe harbor provision afforded insurers in section 501(c) of the ADA.[72] To do this, the insurer must show that the coverage plan is a bona fide plan—i.e., that it exists and pays benefits—and that the disability-based distinction in coverage options is not being used as a subterfuge.[73] The EEOC Policy places the burden in this manner because the insurer is the one in control of all the actuarial and claims data used to generate the disability-based distinction.[74] After setting this burden on the insurer, the EEOC Policy provides that the insurer can meet its burden by demonstrating "that the disparate treatment is justified by legitimate actuarial data, or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated in the same fashion."[75] Alternatively, the insurer may prove that the disparate treatment is necessary because the proposed treatment or coverage would be so expensive as to destroy the legally required fiscal soundness of the plan.[76]

Unfortunately, much like the First Circuit in *Carparts*, the Eighth Circuit was not required to decide whether the content of Ms. Henderson's health insurance policy actually violated Title III of the

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70 EQUAL EMPLOYMENT OPPORTUNITY COMM'N, INTERIM POLICY GUIDANCE ON ADA AND HEALTH INSURANCE (1993), *reprinted in* BUREAU OF NAT'L AFFAIRS, INC., AMERICANS WITH DISABILITIES ACT MANUAL 70:1051 (2002) [hereinafter ADA MANUAL].

71 *Henderson*, 70 F.3d at 960. A "disability-based distinction" is one that "singles out a particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney diseases), or disability in general (e.g., noncoverage of all conditions that substantially limit a major life activity)." ADA MANUAL, *supra* note 70, at 70:1053.

72 ADA MANUAL, *supra* note 70, at 70:1053; *see also* 42 U.S.C. § 12201(c) (2006).

73 ADA MANUAL, *supra* note 70, at 70:1054.

74 *See id.* at 70:1053–54.

75 *Id.* at 70:1054 (footnote omitted).

76 *Id.*

ADA.[77] Still, the court's reliance on the EEOC Policy and the finding that Ms. Henderson's argument had a sufficient likelihood of success on the merits[78] suggest that the Eighth Circuit would, in fact, apply Title III of the ADA to the content of health insurance policies. Furthermore, the decision suggests that the court would place the burden of proof on insurers to show that any disability-based distinctions in coverage terms were based on sound actuarial data or other quantifiable bases.[79] Therefore, unlike the First Circuit, which limited its discussion to the fact that the ADA requires equality of *access* to health insurance policies, this decision seems to imply that the Eighth Circuit would also require equality in the *content* of those policies.

C. Sixth Circuit Interpretation: The ADA Regulates Neither Access to nor the Content of Health Insurance Policies

The next circuit to consider the interaction between the ADA and the health insurance industry was the Sixth Circuit in the case of *Parker v. Metropolitan Life Insurance Co*.[80] Unlike the First and Eighth Circuits, however, the Sixth Circuit engaged in a much more insurer-friendly reading of the ADA. In *Parker*, the insurance plan at issue differentiated between long-term physical and mental health disability coverage.[81] Although beneficiaries suffering from a physical disability could receive benefits until they reached the age of sixty-five, those suffering from mental disabilities were only allowed twenty-four months of coverage.[82] Ouida Sue Parker suffered from severe depression and received benefits for the allotted twenty-four months.[83] At the end of this time period, her insurer terminated her payments even though Ms. Parker's doctor wrote to the insurer that her continuing depression was based on "a chemical disorder."[84]

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77 *See* Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995) ("[I]f the evidence shows that . . . the plan provides the treatment for other conditions directly comparable to the one at issue, the denial of that treatment *arguably* violates the ADA." (emphasis added)).

78 *Id.*

79 *See id.* at 961 ("We do not believe it is unfair to expect Bodine and its sophisticated health insurance providers to promptly provide some general evidence that HDCT is not an accepted therapy for breast cancers like Henderson's.").

80 Parker v. Metro. Life Ins. Co., 121 F.3d 1006 (6th Cir. 1997) (en banc).

81 *Id.* at 1008.

82 *Id.*

83 *Id.*

84 Parker v. Metro. Life Ins. Co., 99 F.3d 181, 184 (6th Cir. 1996), *vacated and reh'g granted*, 107 F.3d 359 (6th Cir. 1997) (internal quotation marks omitted).

After her benefits were terminated, Ms. Parker filed suit in federal court alleging a violation of Title III of the ADA.[85] The district court dismissed Ms. Parker's action, holding that Title III did not cover discrimination in the content of insurance policies—only physical access thereto.[86] Following this decision, the case was appealed to the Sixth Circuit. The initial decision by a Sixth Circuit panel and the subsequent decision of the court en banc were widely divergent, exemplifying how even judges within a single circuit can have varying notions about what exactly the ADA's relationship is to the health insurance industry.

1. The Panel Decision: Access and Content Must Be Regulated by the ADA

Shortly after the district court rendered its decision that the ADA did not reach the content of insurance policies, a Sixth Circuit panel, in an opinion written by Judge Merritt, reversed and held that Title III of the ADA did in fact reach the content of the goods and services provided by public accommodations.[87] The panel relied on a plain-meaning interpretation of the statute to find that the provision of different products and coverage options to people with disabilities was forbidden by the ADA.[88] In addition, it looked to the principle that a statute should be interpreted in a "manner consistent with [its] stated goal," which in the case of the ADA is "to 'provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.'"[89] In the opinion of the panel, an interpretation of the statute that prohibited discrimination in the content of insurance policies, as well as access to those policies, was much more consistent with this goal.[90]

Because the court found that the ADA required equality in both access to and the content of insurance policies, it next had to deal with the insurer's argument that the safe harbor provision of 42 U.S.C. § 12201(c) excludes insurance products from the usual breadth of the ADA's protection.[91] The panel determined that the language of this provision was not clear on its face and therefore looked to the ADA's

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85 *Id.*

86 *Id.*

87 *Id.* at 183.

88 *Id.* at 188.

89 *Id.* (quoting 42 U.S.C. § 12101(b)(1) (2006)).

90 *Id.*

91 *Id.* at 190–91.

legislative history for guidance.[92] In doing so, it cited several provisions of legislative reports, which seemed to imply that the insurer exemption only applied when the insurers had sound actuarial data or actual or reasonably anticipated experience upon which to justify their differential treatment.[93] Based upon these reports, the panel concluded that insurance practices were only protected if they were "consistent with sound actuarial principles, actual reasonably anticipated experience, and bona fide risk classification."[94]

Finally, the panel again looked to the broad legislative purpose in passing the ADA and found that

> [t]o construe the safe harbor provision with the breadth suggested by [Metropolitan Life] would leave the disabled open to arbitrary discrimination in an area which is vital to . . . participation [in mainstream American life]. Medical care in the event of illness is a serious concern to every member of society, disabled or non-disabled. It seems unlikely that Congress would leave the insurance industry virtually untouched by a statute that is designed to address the major areas of discrimination faced day-to-day by people with disabilities. *There could hardly be a good or service more central to the day-to-day life of a seriously disabled person than insurance—for it is often insurance coverage that will determine a*

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92 *Id.*

93 *See id.* For example, one House report states:

> Under the ADA, a person with a disability cannot be . . . subject to different terms or conditions of insurance based on disability alone, if the disability does not impose increased risk.
>
> . . . .
>
> Moreover, while a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure . . . or 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. 101-485, pt. 2, at 136–37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419–20. Another provision states that, "[t]he [safe harbor] provisions recognize that benefit plans . . . need to be able to continue business practices in the way they underwrite, classify, and administer risks, so long as they carry out those functions in accordance with accepted principles of insurance risk classification." *Id.* at 138, 1990 U.S.C.C.A.N. at 421. The relevant Senate committee stated its understanding of the safe harbor provisions in language almost identical to that used by the House. *See* S. REP. NO. 101-116, at 84 (1989) ("Under the ADA, a person with a disability cannot be denied insurance or be subject to different terms or conditions of insurance based on disability alone, if the disability does not pose increased risks.").

94 *Parker*, 99 F.3d at 191 (internal quotation marks omitted).

> *disabled person's ability to prevent the disability from limiting his or her participation in society.*[95]

Based upon these conclusions, the court remanded with instructions to determine whether Metropolitan Life's decision to distinguish between long-term coverage of mental and physical disabilities was based on "sound actuarial principles" or some other permissible basis.[96]

2. *En Banc Review: Insurance Policy Not a "Good" Offered by a Public Accommodation*

The Sixth Circuit, sitting en banc, vacated the panel's decision and affirmed the district court's decision by a vote of eight to five.[97] Although the court agreed that an insurance office was a place of public accommodation, it found that, because Ms. Parker received the plan through her employer rather than directly from the insurer, it was "not a good offered by a place of public accommodation."[98] The court believed that the First Circuit misinterpreted the term "public accommodation" in *Carparts*.[99] The Sixth Circuit found that the "clear connotation" of the list of businesses in Title III was that only physical places qualified as places of public accommodation.[100] Because the court determined that the language was clear on its face that public accommodations are limited to physical places and that Title III only regulates access to such places, not the content of the goods and services they offer, it found it unnecessary to look at any of the legislative history cited in the panel's decision.[101]

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95 *Id.* at 192–93 (emphasis added) (internal quotation marks and citation omitted). The panel also looked to the Technical Assistance Manual authored by the Justice Department to support its conclusion that the ADA only protected insurance agencies from discriminating in the content of their policies when such discrimination was based on sound actuarial principles or was related to actual or reasonably anticipated experience. *Id.* at 193.

96 *Id.*

97 Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1008–09 (6th Cir. 1997) (en banc).

98 *Id.* at 1010.

99 *Id*. at 1014 (applying the canon of construction, *noscitur a sociis*, in which the meaning of a word is limited by the context of surrounding terms to avoid inappropriately expanding the reach of statutes).

100 *Id.* The court also said that terms such as "travel service," "office of an accountant or lawyer," and "insurance office" were not to the contrary. *Id.* ("[I]t is likely that Congress simply had no better term than 'service' to describe an office where travel agents provide travel services . . . . Office of an accountant or lawyer[and] insurance office, . . . in the context of the other terms listed, suggest a physical place where services may be obtained and nothing more.").

101 *Id.* at 1013–14 & n.10. The Third Circuit closely followed this precedent in *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), deciding, inter alia, that insurance policies offered through employers were not places of public accommodation because they were not

In sum, the Sixth Circuit held that the ADA does not reach the content of insurance policies because: (1) those polices are not physical places,[102] and (2) Title III only regulates the availability of offered goods and services, not their content.[103] This holding conflicts not only with the panel's decision but also with the First Circuit's decision in *Carparts*, which held that a public accommodation is not limited to physical structures,[104] and the Eighth Circuit's decision in *Henderson*, which implied that both access to *and* the content of insurance policies were within the purview of the ADA.[105]

D. The Seventh Circuit: The ADA Requires Only Equal Products on Equal Terms

The most recent appellate court to examine the reach of the ADA in the health insurance context was the Seventh Circuit in the seminal case of *Doe v. Mutual of Omaha Insurance Co*.[106] The facts of this case were roughly similar to those in *Carparts*, involving an employment-sponsored health plan, which placed $25,000 or $100,000 caps on coverage for AIDS and AIDS-related conditions, although all other lifetime benefits were capped at $1 million.[107] One important difference in this case was that, unlike the insurer in *Carparts*, the insurer here, Mutual of Omaha, stipulated that it was unable to prove that "its AIDS [c]aps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."[108]

Similar to the panel decision in *Parker*, the United States District Court for the Northern District of Illinois held that "the plain language of Title III, relevant legislative history and the Department of

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physical places. *Id.* at 612–13. Then-Judge Samuel Alito concurred in the judgment, but only upon the grounds that the safe harbor provision in Title IV places the burden of proof on the plaintiff to show that the insurance plan's discrimination was intended as a "subterfuge" and that Ms. Ford failed to meet that burden. *Id.* at 614–15 (Alito, J., concurring). Judge Alito also noted that, because the case could be decided on this ground, he would not decide the issue of whether Title III required more than mere physical access. *Id.* at 615 (stating that the issue "ha[s] divided the circuits, and I would reserve judgment until . . . confronted with a case in which the unique considerations of insurance plans are not at stake").

102 *Parker*, 121 F.3d at 1012.

103 *Id.* at 1013.

104 *See* Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., 37 F.3d 12, 19 (1st Cir. 1994).

105 *See* Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995).

106 Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999).

107 *Id.* at 558.

108 *Id.*

Justice's interpretative guidance" compelled the court to hold that the ADA was meant to regulate both access to and the content of insurance policies.[109] Likewise, the district court held that the safe harbor provision of Title IV only applied if the insurer could show that its policies were consistent with "sound actuarial principles, reasonably anticipated experience, or bona fide risk classification."[110]

The Seventh Circuit, however, reversed the decision of the district court in a decision written by Judge Posner.[111] Judge Posner first agreed that the plain language of Title III meant that a public accommodation could not refuse access to people with disabilities, nor could it refuse to sell goods and services to them on equal terms.[112] Accordingly, "an insurance company [could not] . . . refuse to sell an insurance policy to a person with AIDS."[113] However, Judge Posner also found that once access is granted and an objectively equal product is offered, the ADA does not demand that the goods and services it regulates be equally valuable to all persons.[114] If Congress meant to make such a radical change in the obligations of the retail sector, "it would have made its intention [much] clearer."[115]

The plaintiffs argued that Congress did intend to reach the content of insurance products—thus it included the safe harbor provision of Title IV in the ADA—for if Title III did not reach the content of insurance policies, then Title IV would be entirely meaningless; there is no need to provide an exemption for the content of insurance policies if insurance policies are not regulated.[116] Judge Posner rejected

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109 Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188, 1193 (N.D. Ill. 1998), *rev'd*, 179 F.3d 557 (7th Cir. 1999).

110 *Id.* at 1195 (internal quotation marks omitted).

111 *Doe*, 179 F.3d at 565.

112 *See id.* at 559.

113 *Id.*

114 *See id.* at 560. For example, Judge Posner posited the hypothetical of a camera store. He said that while "[a] camera store may not refuse to sell cameras to a disabled person, . . . it is not required to stock cameras specially designed for such persons." *Id.* Likewise, he opined that it was "apparent" that a bookstore was not required to stock Braille books for the blind, even though they could not prevent blind people from entering the store or from buying other books on the same terms as everybody else. *Id.* at 559.

115 *Id.* at 560.

116 *See id.* at 562. This position was also articulated in several federal district court opinions, including the lower court's decision in *Doe*. *See* Doe v. Mut. of Omaha Ins. Co., 999 F. Supp. 1188, 1195 (N.D. Ill 1998) ("Rather than signaling Congress's intent to broadly exempt insurance companies from the reach of Title III of the ADA, § 501(c)'s safe harbor provision manifests the contrary intent to subject insurance companies to the full scope of the ADA's anti-discrimination prohibitions."); *see also, e.g.*, Chabner v. United of Omaha Life Ins. Co., 994 F. Supp. 1185, 1190–91 (N.D. Cal. 1998) ("If Title III were meant only to prevent insurance companies from denying persons with disabilities equal access to the physical plants of insurance of-

that argument by reasoning that, if such an interpretation were correct, then Title III would regulate the content of goods and services provided by *all* public accommodations, including bookstores and camera shops—a result which he had already found too broad for Congress to have intended.[117] Instead, he suggested that the safe harbor provision may have been included because the insurance industry was concerned that courts would overextend Title III and obtained the safe harbor provision to guarantee that the ADA would not reach the content of insurance policies.[118]

Judge Posner also found that any reading of the safe harbor provision that required federal judges to determine whether an insurer's policies were actuarially sound would be a violation of the McCarran-Ferguson Act,[119] which "forbids construing a federal statute to 'impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.'"[120] Because the plaintiffs' interpretation of the safe harbor provision of Title IV would require federal judicial scrutiny of insurance policies governed by state law—and would therefore "step[ ] on the toes of state insurance commissioners"—Judge Posner found that such an interpretation could not be maintained.[121] As a result, the court held that, although the plaintiffs had no remedy under the ADA, they could file state claims to seek a determination that the AIDS caps were not consistent with state law or sound actuarial principles.[122]

These widely divergent circuit opinions—as well as decisions within each circuit—exemplify the extent to which the current construction of the ADA with respect to insurance coverage is unclear. The First Circuit held that the ADA controls access to, and perhaps the content of, insurance policies;[123] the Eighth Circuit implied that it controls both access and content, and that the burden of proof is on the insurer to explain any discrepancies;[124] the Sixth Circuit held that

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fices, there would have been no need for Congress to include the safe harbor provision dealing with underwriting practices.").

117 *See Doe*, 179 F.3d at 560, 562.

118 *Id.* at 562 (noting that the district court in this case gave "just [that] expansive interpretation" to Title III).

119 McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (2006).

120 *Doe*, 179 F.3d at 563 (quoting 15 U.S.C. § 1012(b)).

121 *Id.* at 564.

122 *Id.* at 564–65.

123 *See* Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., Inc., 37 F.3d 12, 20 (1st Cir. 1994).

124 *See* Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960–61 (8th Cir. 1995).

the ADA has no impact upon employer-provided insurance policies at all;[125] and the Seventh Circuit held that the ADA only requires equal access to products, not that the products be equally beneficial to all individuals.[126]

Although the legislative history,[127] the agency interpretations by the Department of Justice[128] and Equal Employment Opportunity Commission,[129] and the amicus brief that the Justice Department filed in *Doe*[130] all suggest that the legislative and executive branches believe that the ADA regulates both access to and the content of insurance policies, the ambiguous language of the statute has allowed for the current quagmire in the judiciary's interpretation of the ADA's relationship to the health insurance industry. In the fall of 2008, Congress took a first step in clarifying its intentions regarding the regulation of the private health insurance market by enacting the Wellstone Mental Health Parity Act. The Act and its implications are discussed in the following Part.

III. Congress Steps In: The Paul Wellstone and Pete Domenici Mental Health Parity and Equity Addiction Act of 2008

As *Parker v. Metropolitan Life Insurance Co.* suggests, the question of whether the ADA reaches the content of insurance policies is often raised in the context of mental health benefits.[131] Such discrimi-

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125 *See* Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1012–13 (6th Cir. 1997) (en banc).

126 *See Doe*, 179 F.3d at 563.

127 S. REP. NO. 101-116, at 84 (1989); H.R. REP. NO. 101-485, pt. 2, at 136–38 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 420–21.

128 *See* DEP'T OF JUSTICE, TITLE III OF THE AMERICANS WITH DISABILITIES ACT: TECHNICAL ASSISTANCE MANUAL, § III-3.11000, *reprinted in* BUREAU OF NAT'L AFFAIRS, INC., AMERICANS WITH DISABILITIES ACT MANUAL 90:0913 (2002) ("Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer. . . . Thus, a public accommodation may offer a plan that limits certain kinds of coverage based on classification of risk, but may not . . . 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 . . . based on sound actuarial principles or . . . related to actual or reasonably anticipated experience.").

129 *See* ADA MANUAL, *supra* note 70, at 70:1051–53.

130 *See Doe*, 179 F.3d at 563 ("The Department has filed an amicus curiae brief that . . . embraces the plaintiffs' interpretation of the Act.").

131 *See* Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1008 (6th Cir. 1997); *see also* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1117–18 (9th Cir. 2000) (holding that an administrator's decision to classify risks of mental illness differently than physical disabilities fell within the safe harbor provision of the ADA); Lewis v. Kmart Corp., 180 F.3d 166, 170 (4th Cir. 1999) (holding that the ADA did not require employers to provide the same amount of benefits for mental and physical disabilities); Ford v. Schering-Plough Corp., 145 F.3d 601, 614 (3d Cir.

nation frequently takes the form of coverage caps on mental health benefits or significant restrictions on available treatments.[132] On October 2, 2008, Congress passed the Wellstone Mental Health Parity Act, which requires insurers to provide mental health and addiction benefits equal to those for physical disabilities.[133] The Act amends the Employee Retirement Income Security Act ("ERISA"),[134] the Public Health Service Act,[135] and the Internal Revenue Code[136] to require employers to offer their employees benefit packages that include equal coverage in terms of treatment options and overall caps for mental and physical disabilities.[137] There is, however, an exemption if the insurer can prove with actuarial data that such coverage will increase its costs by over two percent in the first plan year or one percent thereafter.[138] These determinations must be made by licensed actuaries.[139]

Accordingly, this legislation forces the insurance industry to end its arbitrary discrimination against persons suffering from mental health disabilities, while at the same time allowing it to continue the standard practice of underwriting risk in conformance with actuarial data. In other words, the industry can still look to statistical records of the costs associated with treating a particular condition in order to properly classify its risk and fit that risk within its plan. An insurer,

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1998) (same); El-Hajj v. Fortis Benefits Ins. Co., 156 F. Supp. 2d 27, 32 (D. Me. 2001) (holding that the ADA does not create a cause of action against insurers who provide different levels of coverage for those who are mentally disabled as opposed to physically disabled).

132 *See* Soshinsky v. First Unum Life Ins. Co., 105 F. Supp. 2d 10, 12 (N.D.N.Y. 2000) (noting cases that determined that an insurer is not required to treat all disabilities equally).

133 Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765, 3881–93 (to be codified at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-5).

134 Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

135 Public Health Service Act, 42 U.S.C. §§ 201–300ii-4 (2006).

136 26 U.S.C. § 1 *et seq.* (2006).

137 *See* § 512(a)–(c), 122 Stat. at 3881–91.

138 The language amending ERISA reads as follows:

> Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years . . . .

Id. § 512(a)(3)(B)(2)(C), 122 Stat. at 3883. The language amending the other statutes is identical.

139 *Id.*

however, may not simply decide that it will not provide mental health benefits.

The legislation had been under consideration for over ten years, and a great deal of discussion regarding its importance and impact indicates that Congress does not want to allow for discrimination in the context of health insurance.[140] For example, Representative Sheila Jackson Lee from Texas made the following statement when endorsing the Act's passage: "Any of us who represent people know that there are millions who are languishing in the darkness of mental health and mental health disease. *And for once now we are moving a bill that deals with the idea that no one can be discriminated against in any health policy* . . . ."[141] Likewise, former Representative James Ramstad of Minnesota stated, "[I]t is time to end the discrimination against people suffering from mental illness and chemical addiction. *It's time to end the higher co-payments, deductibles, out-of-pocket costs, and limited treatment stays, discriminatory barriers to treatment* that don't exist for any other diseases."[142]

Although these statements were made in reference to discrimination against mental illness, what these members of Congress may not have been aware of was that similar discrimination occurred and continues to occur against persons suffering from a variety of physical disabilities as well.[143] Regardless, the passage of the Wellstone Mental Health Parity Act rejects the outcome of the Sixth Circuit's decision in *Parker*[144] and indicates that Congress did not intend, or at least no longer desires, to allow health insurers to arbitrarily discriminate against persons with disabilities. Congress should take the next step and enact similar legislation amending the ADA to prohibit similar discrimination against persons with certain types of physical diseases without the basis of sound actuarial data.

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140 *See, e.g.*, 154 CONG. REC. S10,292 (daily ed. Oct. 1, 2008) (statement of Sen. Chris Dodd).

141 154 CONG. REC. H1316 (daily ed. Mar. 5, 2008) (statement of Rep. Sheila Jackson Lee) (emphasis added).

142 153 CONG. REC. H16,916 (daily ed. Dec. 19, 2007) (statement of Rep. James Ramstad) (emphasis added).

143 *See supra* notes 10–11 and accompanying text.

144 Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1008 (6th Cir. 1997) (holding that the ADA did not prohibit insurers from giving shorter benefits to mentally disabled individuals).

IV. Proposed Legislation to Clarify the Relationship of the ADA to the Content of Insurance Policies

As evidenced by the circuit split, the ambiguous way that the ADA is written currently allows for a wide variety of judicial interpretations. Although many have criticized the different circuits' interpretations—especially that of the Seventh Circuit[145]—the fact remains that the language of the statute allows for an interpretation that it was not meant to impact the health insurance industry.[146] Congress, therefore, must take steps to ensure that the ADA fulfills its stated purpose of providing an unambiguous, nationally consistent, and effective "mandate for the elimination of discrimination against individuals with disabilities," which "address[es] the major areas of discrimination faced day-to-day by people with disabilities."[147] As currently written, the statute provides anything but "clear, strong, [and] consistent"[148] standards for regulating the arena of health insurance, which is one of the most common areas of hardship and discrimination faced by the disabled on a daily basis.[149]

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145 Bagenstos, *supra* note 9, at 45 (criticizing the access vs. content distinction drawn in *Doe* as based on an inappropriate but not impermissible definition of "content"); Edwin Caspar, Comment, Doe v. Mutual of Omaha*: Do Insurance Policy Caps on AIDS Treatments Violate the Americans with Disabilities Act?*, 75 NOTRE DAME L. REV. 1539, 1549–50 (2000) (arguing that the analysis of the court in *Doe* relied on a flawed analogy in finding that the ADA does not regulate content of insurance policies); Mary Carol Joly, Student Article, Doe and Smith v. Mutual of Omaha Insurance Company*: The Possible Impact of Insurance Caps on HIV-Infected Individuals*, 4 DEPAUL J. HEALTH CARE L. 193, 194 (2000) (arguing that the Seventh Circuit's decision was contrary to the intent and purpose of the ADA); *see also* Jill Alesch, Note, *The Americans with Disabilities Act: An End to Discrimination Against HIV/AIDS Patients or Simply Another Loophole to Bypass?*, 52 DRAKE L. REV. 523, 525 (2004) (arguing that the Supreme Court should reverse the notion among circuit courts that the ADA does not regulate the content of insurance policies).

146 Because the language of the statute is ambiguous, it is possible that the Supreme Court, should it seek to resolve the circuit split, could agree with the reasoning of *Doe*. This is why a legislative correction of the ambiguity is preferable to judicial resolution. *Contra* Alesch, *supra* note 145, at 525.

147 42 U.S.C. § 12101(b)(1), (4) (2006).

148 *Id.* § 12101(b)(2).

149 *See* Parker v. Metro. Life Ins. Co., 99 F.3d 181, 192–93 (6th Cir. 1996), *vacated and reh'g granted*, 107 F.3d 359 (6th Cir. 1997) ("There could hardly be a 'good' or 'service' more central to the day-to-day life of a seriously disabled person than insurance—for it is often insurance coverage that will determine a disabled person's ability to prevent the disability from limiting his or her participation in society.").

A. Precedent for Amending a Statute to Correct Erroneous Judicial Interpretation

This would not be the first time that Congress has acted to correct erroneous statutory interpretations. For example, in 1990, the year it passed the ADA, Congress also passed the Older Workers Benefit Payment Act ("OWBPA")[150] as an amendment to the Age Discrimination in Employment Act of 1967 ("ADEA").[151] Congress passed the OWBPA because, in its view, the Supreme Court in *Public Employees Retirement System of Ohio v. Betts*[152] erred by interpreting the ADEA as permitting age-based employee-benefit reductions for reasons other than age-related cost considerations and by placing the burden of proof for actual discrimination on the plaintiff.[153] In passing the OWBPA, Congress stated "that, as a result of the decision of the Supreme Court in *Public Employees Retirement System of Ohio v. Betts*, [it found] legislative action . . . necessary to restore the original congressional intent in passing and amending the Age Discrimination in Employment Act of 1967 . . . ."[154]

Even more relevant in the ADA context is Congress's recent passage of the ADA Amendments Act of 2008 ("ADAAA").[155] In passing the ADAAA, Congress noted that it "intended that the [ADA] 'provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities,'"[156] but that the Supreme Court and EEOC had since misinterpreted the meaning of the term "disability," thereby "eliminating protection for many individuals whom Congress intended to protect."[157] Therefore, Congress enacted this series of provisions in order to more broadly effectuate the ADA's objectives and reject the various Supreme Court holdings and EEOC rulings to the contrary.[158]

As these amendments demonstrate, it is not uncommon for Congress to step in and clarify the meaning of its previous legislation when the courts have misinterpreted its original intent. Indeed, it is not

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150 Older Workers Benefit Payment Act, Pub. L. No. 101-433, 104 Stat. 978 (1990) (as amended by Pub. L. No. 101-521, 104 Stat. 2287 and codified at 29 U.S.C. §§ 623, 626 (2006)).

151 Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621–634 (2006).

152 Pub. Employees Ret. Sys. of Ohio v. Betts, 492 U.S. 158 (1989).

153 *Id.* at 175, 181.

154 Older Workers Benefit Payment Act, § 101, 104 Stat. at 978 (citations omitted).

155 ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (to be codified in scattered sections of 42 U.S.C.).

156 *Id.* § 2(a)(1).

157 *Id.* § 2(a)(4).

158 *See id.* § 2(a)(8)–(b).

only permissible but imperative that Congress amend statutes to remedy judicial misinterpretation. Although Congress has not yet acted to clarify the ADA's relationship with the insurance industry, the current national health care developments make this a perfect time to do so.

B. Amending the ADA to Clarify That Its Terms Cover the Content of Insurance Policies

The new amendment should make it clear that the ADA does not tolerate arbitrary discrimination against people with disabilities in the terms of their health insurance policies. Similar language to that used in the ADAAA and OWBPA is appropriate to remedy the circuit court decisions allowing health insurers to discriminate against individuals with disabilities without actuarial justification. The language should read as follows:

> The Congress finds that, as a result of various circuit court decisions interpreting the Americans with Disabilities Act of 1990, legislative action is necessary to restore the original congressional intent in its passage, which was to prohibit discrimination against persons with disabilities by public accommodations, including insurance policies, unless that discrimination was based on sound actuarial principles.[159]

After stating its findings and purpose, Congress must fix two problems with the current judicial construction of the ADA. First, it must make clear that the terms of insurance policies are incorporated as places of public accommodation. This clarification will nullify the decisions of the Third and Sixth Circuits, which held that the clear language of Title III of the ADA did not cover any nonphysical accommodations, such as insurance policies.[160] Congress can achieve this objective by inserting the following text at the beginning of 42 U.S.C. § 12201(c), the safe harbor provision:

> Subchapters I through III of this chapter and title IV of this Act are fully applicable to the content of and access to insurance policies.[161]

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159 This congressional intent can be found in the text of the ADA itself, *see* 42 U.S.C. § 12101(b) (2006), as well as in the legislative history of the ADA, *see* sources cited *supra* note 93.

160 Ford v. Schering-Plough Corp., 145 F.3d 601, 612 (3d Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1010–11 (6th Cir. 1997) (en banc).

161 Except for the additional amendment to the provision's conclusion as proposed in Part IV.C, *infra*, the remainder of the safe harbor provision would remain unchanged.

This language will make it clear that the content of insurance policies is covered by the ADA. It will ensure that courts interpret the ADA as controlling the content of health insurance policies. Accordingly, such language will help make certain that no disabled individual is arbitrarily discriminated against in an area as vital to her day-to-day life as being able to pay her medical bills.

The most significant change that this amendment would accomplish would be to allow the courts to examine any insurance policy that a beneficiary challenged as discriminating based on disability. Thus, in *Parker*, the Sixth Circuit would have actually had to engage in a review of Metropolitan Life's insurance policy limiting mental health benefits to twenty-four months, rather than simply dismissing the claim as not covered by the ADA.[162] Furthermore, this provision would clarify the law and put the health insurance industry on notice that its conduct is within the realm of ADA protection. Accordingly, insurers would have to reevaluate significant coverage discrepancies and limitations in order to make certain that they are not offering benefit packages to individuals with disabilities that are not equal to those offered to the general public unless, as the next Section makes clear, their differences are based on sound actuarial data.

C. Amending the ADA to Place the Burden of Proof on Insurers to Show That Disability-Based Policies Are Based on Actuarial Data

In addition to making clear that the ADA covers the content of insurance policies, Congress must also make clear in the ADA's safe harbor provision that any discrimination in the terms of policies—including limitations on coverage, increases in premiums, and exclusions of treatments—is based on sound actuarial data. Furthermore, it should follow the EEOC Policy's guidance as referenced in the *Henderson* case from the Eighth Circuit and place the burden of proof on the insurer to show that this is the case.[163]

In order to achieve this goal, Congress should replace the current "subterfuge" provision at the conclusion of 42 U.S.C. § 12201(c) with the following, based closely on language from the Wellstone Mental Health Parity Act:

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162 *See Parker*, 121 F.3d at 1008. Furthermore, under the second proposed amendment, the burden of proof would have then been on Metropolitan Life to show that it had sound actuarial reasons for offering less coverage to persons suffering from mental health disabilities. *See infra* Part IV.C.

163 *See* discussion *supra* Part II.B.

> Any decision to create a coverage limit, exclusion, or variance in premiums must be based on sound actuarial data. Determinations as to increases in actual risks and subsequent costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is both independent from the insurer and a member of good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report and all underlying documentation relied upon by the actuary shall be maintained by the insurer.[164]

By placing this requirement on insurers, Congress will continue to allow the insurance industry to underwrite, classify, and administer risks as is necessary for the viability of the insurance plan as a whole, while at the same time ending arbitrary discrimination based upon fears and stereotypes.[165] The basis for this section is also taken from the legislative history of the safe harbor provision, which states that the "ADA requires that underwriting and classification of risks be based on sound actuarial principles or be related to actual or reasonably anticipated experience."[166] Though based on the language of the legislative history, the amendment's language should not include the terms "actual or reasonably anticipated experience" because this phrase is unquantifiable and, therefore, leaves too much ambiguity as to when "reasonably anticipated experience" would justify discriminatory coverage; it would be an exception to the exception that could well swallow the rule.

This amendment would force insurers to engage in actuarial analysis before setting their policies, which would eliminate arbitrary discrimination. Therefore, in cases such as *Doe v. Mutual of Omaha Insurance,* the plaintiff would be able to succeed in showing discrimination when the insurer has no such quantifiable justification for its coverage distinctions. In that case, Doe and Smith would have been

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164 For the basis of this language, see the Wellstone Mental Health Parity Act. Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, § 512(a)(3)(B)(2)(C), 122 Stat. 3765, 3883.

165 *See* Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 558 (7th Cir. 1999) (noting that Mutual of Omaha could not prove that its "AIDS [c]aps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law"); *see also* Adams v. Rice, 531 F.3d 936, 954 (D.C. Cir. 2008) (noting that Congress passed the ADA in order to end differential treatment "based on myths, fears, and stereotypes").

166 H.R. REP. NO. 101-485, pt. 3, at 71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 494; *see also* ADA MANUAL, *supra* note 70, at 70:1052.

victorious in their ADA claim because Mutual of Omaha conceded that it could not show any actuarial justification for the terms of its policies.[167] Likewise, in *Henderson*, the insurer would have had to prove why it did not cover HDCT for breast cancer, making it much easier for Ms. Henderson to get the treatment her disability required.[168]

In addition, this proposed requirement would have the beneficial effect of putting insurers on notice that the law requires firm proof for disability-based coverage distinctions and that they cannot make such distinctions without quantitative justifications. Furthermore, it would clarify that the ADA does in fact protect individuals with disabilities from facing discrimination in the facet of their lives that is arguably most impacted by their disability—their health care.[169]

D. Congress Is the Proper Body to Enact These Changes

Opponents of such an amendment may argue that there are other forums more appropriate than Congress in which to enact these changes. For example, they may argue that the Supreme Court is the appropriate body to handle the change by granting certiorari in a case involving insurance policy discrimination, that the EEOC may best effectuate the changes through its enforcement of the ADA, or that the market has proven itself capable of remedying the problem on its own. None of these entities, however, is able to end discrimination as clearly and as completely as Congress.

1. The Supreme Court Is an Inappropriate Forum

An opponent to congressional reform might argue that the Supreme Court is best equipped to solve the circuit split by granting certiorari in a case involving a question of discrimination in insurance policies.[170] The Supreme Court, however, is not an appropriate forum for three reasons. First, the Supreme Court has already denied certiorari in several of the seminal cases on this issue, including *Doe v. Mutual of Omaha Insurance Co.*[171] and *Parker v. Metropolitan Life Insurance Co.*,[172] which makes it unlikely that the Court would grant

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167 *See Doe,* 179 F.3d at 558.

168 Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995).

169 *See* Parker v. Metro. Life Ins. Co., 99 F.3d 181, 191 (6th Cir. 1996), *vacated and reh'g granted*, 107 F.3d 359 (6th Cir. 1997).

170 *See, e.g.*, Alesch, *supra* note 145, at 525.

171 Doe v. Mut. of Omaha Ins. Co., 528 U.S. 1106 (2000).

172 Parker v. Metro. Life Ins. Co., 522 U.S. 1084 (1998).

review in the future, even though a circuit split exists. Second, the Supreme Court has recently narrowed its interpretation of the ADA's protections,[173] a trend which prompted Congress to pass the ADA Amendments Act of 2008.[174] Unless the Court takes this Congressional rebuke to heart, it is rather unlikely that it would render a decision expanding the scope of the ADA by making it applicable to the health insurance industry.

Finally, and most importantly, Judge Posner may have been correct in his decision in *Doe* that a judicial construction of the ADA that required federal judges to examine the content of insurance policies would violate the McCarran-Ferguson Act, which forbids such judicial action without direct congressional approval.[175] Therefore, in order to find that the ADA does regulate the insurance industry, the Court would have to find that the purpose of the ADA is to regulate insurance, which would be a difficult argument to make in light of the ADA's current language. A congressional amendment would avoid this problem, however, because where Congress speaks directly to an issue regarding insurance, as it would in the proposed amendments, the McCarran-Ferguson Act does not apply.[176]

2. *The EEOC Is Not the Appropriate Body to Effectuate a Change in the Law*

Others may argue that the EEOC is the proper body to handle this problem by prosecuting insurers who engage in discriminatory practices. However, this response would also be inadequate to solve the current problems faced by individuals with disabilities in the realm of health insurance. Although the EEOC can act, its decisions do not embody the law of the land.[177] For example, the EEOC issued an interim letter in 2001 stating that it did not approve of arbitrary discrimination against persons suffering from catastrophic conditions such as HIV/AIDS.[178] Unfortunately, however, this position does not have the force of law.

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173 *See* Toyota Motor Mfg., Ky., Inc. v. Williams, 534 U.S. 184, 187 (2002); *see also* Sutton v. United Air Lines, Inc., 527 U.S. 471, 475 (1999).

174 *See* ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(a)(4)–(5), 122 Stat. 3553, 3553 (explicitly referencing *Toyota Motor* and *Sutton*).

175 *See* Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 563–64 (7th Cir. 1999).

176 *See* 15 U.S.C. § 1012(b) (2006).

177 *See, e.g.*, Kremer v. Chem. Constr. Corp., 456 U.S. 461, 477 (1982) ("[T]he EEOC cannot adjudicate claims or impose sanctions; that responsibility, the final responsibility for enforcement, must rest in federal court." (internal quotation marks omitted)).

178 *See* Office of Legal Counsel, U.S. Equal Employment Opportunity Comm'n, Letter Re-

Even when the EEOC goes after insurance companies to force settlements,[179] it remains merely an enforcement mechanism, unable to overrule the circuit court opinions holding that the ADA does not apply to the health insurance industry. Congressional action would clarify the law once and for all, allowing individuals to know their rights and ensuring that future discrimination does not occur.

3. Market Forces Are Not Sufficient to Correct the Problem

An additional argument may be that the market is the proper solution, as it has already solved a large part of the problem. For example, many insurers no longer discriminate against persons with HIV/AIDS by arbitrarily capping their coverage.[180] Nevertheless, that the law is unsettled leaves many questioning what insurers can and cannot do with regard to how they handle treatments and coverage for persons with different disabilities. Without congressional clarification, insurers might still be free to arbitrarily discriminate against any new disease that may arise and that involves increased costs and social disapproval. Furthermore, it is not likely that these groups will be able to quickly achieve the requisite level of organization and funding (such as that accumulated by individuals suffering from AIDS) to have substantial force within the market.[181] Congress needs to ensure that Americans such as these do not lack adequate coverage merely because they do not have the bargaining power to obtain it.[182]

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garding Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market (Apr. 4, 2001), *available at* http://www.eeoc.gov/eeoc/foia/letters/2001/titlevii_ada_insurance_benefits.html (last visited Dec. 1, 2009).

179 *See* Nancy Montwieler, *Puerto Rico Blue Cross Ends AIDS Limitation; Pays $200,000 to Subscriber in EEOC Accord*, 27 BNA PENSION & BENEFITS REP. 3045, 3045 (Dec. 12, 2000) ("La Cruz Azul (Blue Cross) of Puerto Rico has agreed to eliminate a restriction on AIDS coverage in its insurance policies and to pay $200,000 to one of its subscribers, under a consent decree reached with the Equal Employment Opportunity Commission . . . .").

180 *See Mutual of Omaha Insurance to Lift Discriminatory Caps on AIDS Coverage*, LAMBDA LEGAL (Apr. 12, 2000), http://www.lambdalegal.org/news/pr/new-york-tuesday-april-11.html (last visited Dec. 3, 2009) (noting that Mutual of Omaha's practice was not followed by most insurance companies).

181 *Cf.* Mary K. Olson, *Managing Delegation in the FDA: Reducing Delay in New-Drug Review*, J. HEALTH POL. POL'Y & L. 397, 401 (2004) (noting that well-organized AIDS advocates were able to accelerate the Food and Drug Administration's process for approving AIDS drugs, but that that acceleration did not "spill over" into other drug approvals).

182 Because the disabled are a small part of the overall population, they may not have the bargaining power to ensure that the insurance market treats them fairly. *See, e.g.*, Adrienne Asch, *Disability Equality and Prenatal Testing: Contradictory or Compatible?*, 30 FLA. ST. U. L. REV. 315, 331 (2003) ("Despite the symbolic and tangible changes attributable to laws like the Americans with Disabilities Act, the nation's disabled population is still less educated, less em-

4. No Further Action Is Necessary to Correct This Problem

Finally, some may argue that the ADA as currently written does not need to be amended because Congress has already taken care of this problem by passing the PPACA. This argument, however, is erroneous for several reasons. First, although the Act does a great deal to alleviate discrimination against persons with disabilities in terms of their health care,[183] it is both under- and overinclusive. At the outset, the Act is underinclusive because it apparently fails to protect two significant subsets of the American public. First, its ban on arbitrary insurance decisions does not apply to those who choose to retain their current coverage.[184] Second, the Act similarly omits from its protection those who do or will receive health insurance through an employer-based plan that existed before the Act was adopted.[185] As the majority of individuals currently receive their health insurance through the employment-based market,[186] these exemptions may allow the industry to continue arbitrarily discriminating against many Americans suffering from disabilities. By amending the ADA as this Note proposes, however, Congress would make clear that health insurers cannot arbitrarily discriminate against *any* person suffering from a disability, regardless of when or through whom he purchased his insurance.

Further, the PPACA is overinclusive in that it makes categorical prohibitions that will likely put undue pressure upon the health insurance market. For example, plans included under the Act are required, inter alia, to accept all applicants,[187] abolish any caps on benefits,[188] and vary premiums based only on age, tobacco use, rating area, and

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ployed, less involved in civic life, [and] less represented in the political process . . . than their numbers warrant.").

183 *See supra* note 12.

184 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251(a), 124 Stat. 119, 161 (2010) (allowing an individual to choose to retain their current insurance coverage and stipulating that "this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment").

185 *Id.* § 1251(c), 124 Stat. at 161 ("A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).").

186 As previously discussed, in 2008, 58.5% of Americans received health care through their employer. *See supra* note 34 and accompanying text.

187 § 1201, 124 Stat. at 155.

188 *Id.* § 1001, 124 Stat. at 131.

family size.[189] This ignores the unfortunate reality that some individuals pose greater risks than others to insurers, and, thus, to the sustainability of plans as a whole. The amendments proposed in this Note, on the other hand, take this reality into account by allowing insurers to continue to classify, underwrite, and administer risk, so long as those classifications are based upon quantifiable actuarial data and not stereotypes such as the ones made by Mutual of Omaha in *Doe*.[190] Because the implementation of the PPACA will take time, Congress should pass the proposed amendments in order to achieve an effective and efficient solution for all interested stakeholders.

In addition to the problems that remain in the health insurance arena, the fact that a circuit split exists regarding the interpretation of the ADA shows that the statute, as currently formulated, has failed "to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities."[191] The proposed amendment would end this disagreement among circuits, clarify the ADA's relationship to the health insurance industry, and ensure that the goals of the ADA have been achieved.

Conclusion

The current inconsistency and ambiguity in the ADA with regard to discrimination in health insurance policies has negatively impacted those with disabilities and society at large. The proper steps to alleviate this burden have already begun with the passage of the Wellstone Mental Health Parity Act and the new PPACA. However, Congress must be careful to maintain the appropriate balance between forbidding discrimination and sustaining the insurance market. By amending the ADA to mimic the language of the OWBPA, the Wellstone Mental Health Parity Act, and the legislative history of the ADA, and by requiring insurers to grant equal coverage for all disabilities absent actuarial proof that such coverage greatly enhances its costs (and thus that it is not using risk classification as a subterfuge), Congress will both clarify a very unsettled area of insurance discrimination law and fill in the gaps left by the PPACA. Such a clarification will protect *all* insured individuals from discriminatory policies. At the same time, it will permit the industry to engage in the legitimate risk-classification practices that are necessary to ensure the fairness and sustainability of the market as a whole. By amending the ADA to make clear that

189 *Id.* § 1201, 124 Stat. at 155.

190 *See* Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 558 (7th Cir. 1999).

191 42 U.S.C. § 12101(b)(2) (2006).

health insurers cannot discriminate absent actuarial data, Congress can effectively and efficiently complete the steps it has already taken and ensure that no man, woman, or child suffering from a disability will be discriminated against where it hurts the most—their health insurance.