

4-1993

Help! We've Fallen and We Can't Get Up: The Problems Families Face Because of Employment-Based Health Insurance

Jeffrey R. Pettit

Follow this and additional works at: <https://scholarship.law.vanderbilt.edu/vlr>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Jeffrey R. Pettit, Help! We've Fallen and We Can't Get Up: The Problems Families Face Because of Employment-Based Health Insurance, 46 *Vanderbilt Law Review* 779 (1993)
Available at: <https://scholarship.law.vanderbilt.edu/vlr/vol46/iss4/1>

This Symposium is brought to you for free and open access by Scholarship@Vanderbilt Law. It has been accepted for inclusion in Vanderbilt Law Review by an authorized editor of Scholarship@Vanderbilt Law. For more information, please contact mark.j.williams@vanderbilt.edu.

Help! We've Fallen and We Can't Get up: The Problems Families Face Because of Employment-Based Health Insurance

I.	INTRODUCTION	779
II.	THE EVOLUTION OF EMPLOYMENT-BASED INSURANCE	782
III.	FALLING THROUGH THE GAPS: IDENTIFYING THE "AT-RISK" FAMILY	786
	A. <i>Demographics of the Uninsured Family</i>	786
	B. <i>Special Problems Nontraditional Families Face</i> ..	787
	C. <i>Who are the Underinsured?</i>	788
	1. The Use of Ambiguous Terms in Insurance Policies	788
	2. Long-Term Health Care	789
	3. Special Problems Families Under Self-Insured Plans Face	790
IV.	IMPACT ON THE FAMILY	793
V.	UNIQUE PROBLEMS OF EMPLOYMENT-BASED INSURANCE ...	795
	A. <i>Nonportability: Joblock</i>	795
	B. <i>Health Insurance Confusion That Labor Regulations Create</i>	797
VI.	REMEDYING THE PROBLEMS THE EMPLOYMENT-BASED SYSTEM CREATES	799
VII.	CONCLUSION	802

I. INTRODUCTION

Steve Tilghman of Birmingham, Alabama knows first-hand the health insurance problems American families face.¹ Steve's family had adequate health insurance until Steve decided to change careers. After expiration of the eighteen-month extension period COBRA² provides, Steve's family could not afford the one thousand dollar monthly premi-

1. The Health Care Crisis and the American Family: Hearing before the Committee on Labor and Human Resources, 102d Cong., 1st Sess. 15 (1991) (statement of Steve Tilghman).

2. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA), P.L. No. 99-272, 100 Stat. 227, codified at 29 U.S.C. §§ 1161-68. (Supp. 1992), provides employees the opportunity to continue in their employer's group benefits plan for 18 months after ending their employment. Although Congress capped the premiums at 102% of the current group rate, the employee must pay the premiums that the employer previously paid. For a discussion of the shortcomings of the COBRA program, see notes 124-35 and accompanying text.

ums³ necessary to maintain their policy.⁴ Steve's epileptic son further complicated his ability to find adequate health insurance. After having no insurance for two months, Steve ultimately was able to find health insurance for only part of his family. Steve had to acquire a separate, unrated policy for his epileptic son. Steve is uncertain about the value of this policy, fearing that under this plan the insurer will consider the epilepsy to cause any injury to his son, in which case the plan does not cover him.⁵ In short, Steve's family is self-insured. Steve faces tension between protecting his family's financial resources and not compromising his child's health.

The problems Steve's family faced in acquiring health insurance largely are due to the fragmented health care financing system in the United States. The American health care financing system is a hodgepodge of private sources supplemented with public sector coverage.⁶ Theoretically, third-party health insurance is available to all American families: (1) Medicare for the aged and disabled;⁷ (2) Medicaid for the qualified poor or for specified disabilities;⁸ (3) employment-subsidized insurance for workers and their dependents; and (4) privately purchased insurance if ineligible under the previous three categories.⁹ Health care providers, individual patients, and philanthropic groups provide the remainder of health care financing.¹⁰ This frag-

3. Since 1980, health care costs have tripled for American families, rising from \$2500 to \$7500 annually. *Facts for the Presidential Debates* at 5 (Clinton/Gore Campaign, 1992) (citing Health Care Financing Authority, Office of the Actuary).

4. His employer generously offered to allow Steve to keep his current policy for a short period after the COBRA extension had expired.

5. For example, Steve's insurance agent suggested that the policy may regard a normal bicycle injury to be related to his son's epilepsy, stating that the company would assume that a seizure caused the wreck. Hearing before the Committee on Labor and Human Resources at 15 (cited in note 1).

6. See Mary Ann Baily, et al., *Economic Consequences for Medicaid of Human Immunodeficiency Virus Infection*, 11 *Health Care Fin. Rev.* 97 (1990).

7. Medicare is a federal public assistance program that provides health care financing to elderly and certain disabled Americans. See generally *Health Insurance for the Aged Act*, Pub. L. No. 89-97, 79 Stat. 291 (1965), codified as amended at 42 U.S.C. §§ 1395-1395xx (1988 and Supp. 1992).

8. Medicaid is a joint state and federal venture intended to provide access to health care to qualified indigent persons.

9. Families that fall in the last category face significant obstacles in spreading the risk of illness. Administrative costs and risk assessment place private health insurance beyond the reach of most families' resources. Thus, self-acquired insurance "is dependent on having a sufficiently high income and very good health status." Emily Friedman, *The Uninsured*, 265 *J. Am. Med. Assn.* 2491, 2493 (1991).

10. Health care providers and individuals are especially important when the patient is either uninsured or indigent. Health care providers are forced to supplement governmental sources because they are left with unreimbursed costs that exceed set limits on government programs such as Medicaid and Medicare. In addition, hospitals receiving government funds must treat the indigent in order to continue receiving these funds. Insured individuals provide financing through insurance

mented financing system creates inequitable and inefficient results according to the insured's financial status.¹¹

President Clinton has promised to make health care reform a top priority within the first year of his administration.¹² To alleviate the burden on American families, the Clinton Reform Plan will have to address the competing goals of universal access, limited benefits, and the reduction of burgeoning health care costs. Clinton's plan guarantees universal coverage by reducing administrative costs,¹³ preventing drug-price gouging,¹⁴ and establishing a core benefits package.¹⁵ The Clinton Reform Plan, however, continues to place the onus of health care coverage on employers.¹⁶

This Note addresses the problems American families face as a result of employment-based insurance. Part II illustrates the role the American family has played in the evolution of the current, employment-based financing system. Part III identifies which families currently are either uninsured, or at risk of becoming underinsured, in the present fragmented system. Part IV discusses the impact the lack of adequate health insurance has on the family. Part V considers problems unique to employment-based insurance, such as joblock and confusion surrounding beneficial labor regulations. Part VI proposes solutions to ameliorate the impact employment-based insurance has on the American family. This Note concludes that the federal government can ease

premiums and deductibles. For a break down of the amount each source provides, see Chart, *Personal Health Care—Third-Party Payments and Private Consumer Expenditures: Selected Years 1960-1990*, in *The Universal Health Care Almanac*, Table 6.2 (Silver and Cherner, 1990).

11. Senator Kerrey has stated that currently there is a "two-tier system of care; one system for the employed and another for the poor, that guarantees degrading and inadequate care for some and cost shifting, risk skimming, and health care inflation for the rest." 137 Cong. Rec. S9842 (daily ed. July 11, 1991) (statement of Senator Kerrey).

12. "No American family [will] have to go from the doctor's office to the poorhouse." Advance Sheets, *Clinton-Gore on Affordable, Quality Health Care* at 1 (Clinton/Gore Campaign, 1992). Although Clinton has demonstrated his commitment to health care reform by appointing his wife to head the task force, the likelihood of his success remains to be seen. The debate regarding universal health care dates back to Harry Truman's confrontation with Congress concerning Medicare. See generally Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Univ. of Missouri, 1979). Over the years, Congress has considered a variety of diverse proposals to expand health care coverage, ranging from tax incentives, which would preserve competition within the insurance industry, to a noncompetitive "single-payer" system. Robert Pear, *Whose New Health Plan is This Anyway?*, N.Y. Times at D5 (Nov. 15, 1992).

13. Under the present system, each of the 1500 insurance companies process 1500 different claim forms, entangling the American health care system in a bundle of bureaucratic red tape. *Clinton/Gore on Health Care* at 2 (cited in note 12).

14. Robert Pear, *Clinton Team Plans to Put a Lid on Prices of Prescription Drugs*, Houston Chron. at A5 (Dec. 15, 1992).

15. *Clinton-Gore on Health Care* at 2 (cited in note 12).

16. This plan would require every employer to provide health care coverage, with tax breaks provided to small businesses to alleviate the burden. Sara Fritz, *Clinton Health Plan Likely to Stir Controversy*, L.A. Times at A24 (Dec. 13, 1992).

families' health care burdens by establishing clear guidelines concerning recent discrimination legislation and by providing refundable tax credits for low income families to purchase insurance.

II. THE EVOLUTION OF EMPLOYMENT-BASED INSURANCE

American families always have played significant roles in health care and health care financing. Prior to the twentieth century, the family filled the primary roles of both health care provider and health care financier, since private health insurance was nonexistent.¹⁷ The frontier society was necessarily self-sufficient, due to the limited existing means of transportation and communication.

During this era, families were able to provide many health care services, since the practice of medicine was much less sophisticated, and people had lower expectations of doctors.¹⁸ If a doctor was needed, the low overhead of rural doctors and the close-knit nature of the community enabled families to afford self-insurance.¹⁹ Rural doctors' offices were modestly equipped; practitioners often could bundle their necessary tools in their proverbial black bags.²⁰ The nonexistence of medical malpractice insurance also lowered medical costs.²¹ Even if the medical expense was more than the family could afford, the compassion of either the doctor or the community ordinarily would alleviate some of the financial burden.²²

17. The first health insurance arose as part of the Baylor Plan. See notes 24-28 and accompanying text.

18. Today, people expect medicine to be able to extend life. See generally *Dr. Wofford's Political Elixir*, *Newsday* 33 (Nov. 17, 1991).

19. Today, families are no longer able to self-insure due to the astronomical rise in health care costs. In 1950, Americans spent the equivalent of \$69.9 billion in 1990 dollars for health care, representing 4.8% of the Net National Product. Patrice Flynn, *Employment-Based Health Insurance: Coverage Under COBRA Continuation Rules*, in U.S. Dep't of Labor, *Health Benefits and the Workforce* 105, 107, Table 1 (1992). By 1990, that figure had risen to \$671 billion, representing 13.7% of the Net National Product. *Id.* For more information concerning the rising costs of health care, see *Selected Sources of Health Insurance by Work Status and Family Income: 1991* in *The Universal Health Care Almanac* at Table 6.7 (cited in note 10).

20. Rashi Fein, *Medical Care, Medical Costs* 2 (Harvard, 1986).

21. Before the twentieth century, medical malpractice insurance was not considered a necessity for health care providers. The existence of the rural doctor standard reduced the likelihood that a patient would succeed in a malpractice suit since the health care provider would be held accountable only to the local community standard. As the rural doctor standard has eroded and society has become more litigious, enormous verdicts have forced health care providers to purchase expensive malpractice insurance, driving up the cost of family health care. Some politicians have targeted tort reform as a means for reducing family health costs. See Sandra Torrey, *Walter Cronkite Video Helps Stir Up Debate Over Tort Reform*, *Washington Post* at F5 (Sept. 14, 1992).

22. Fein, *Medical Care* at 179 (cited in note 20).

Times have changed. The urbanization of America and the assimilation of women into the workforce²³ made a familial or community system of health care inadequate. Baylor University introduced the nation's first health insurance system in response to the increasing health care costs and the large number of delinquent accounts at its hospital.²⁴ Hospital expenditures at that time were only \$5.36 a year per United States resident.²⁵ This figure did not reflect accurately individual burdens, however, since it was an average between those who had spent nothing because they had not been hospitalized and those who had incurred large hospital costs.²⁶

Rather than risk incurring large hospital expenses, Baylor's school teachers opted to "socialize" medical care by paying six dollars a year for treatment at the University Hospital.²⁷ Not knowing whether she would need hospital care, the individual teacher chose to spread the risk by paying a small amount now in case she would indeed need medical care later. These purchasers were not concerned with receiving a dollar for dollar return; most participants hoped that they would not need medical care.²⁸ The individual purchaser chose to subsidize the medical costs of others in order to obtain peace of mind.

Third-party health insurance did not become widespread until World War II.²⁹ Two rationales explain the rapid expansion of third-party health insurance. First, aggregate American family income rose from \$70 billion to \$147 billion during the war, but Americans could

23. Traditionally, women have been the primary providers of health care within the family. See Laura Ramsay, "Sandwiched" Workers Face Costly Success, *Fin. Post* 32 (Jan. 22, 1992).

24. Fein, *Medical Care* at 10-14 (cited in note 20). This plan is the forerunner of the 67 Blue Cross insurance plans that insure over 80 million Americans today. *Id.* at 14. As the nation entered the Great Depression, other companies could not afford to ignore the success of the Blue Cross plans. *Id.* at 13. These companies expanded the concept of risk-spreading from hospital coverage to a full-range of medical services.

25. *Id.* at 10.

26. *Id.* The Baylor Plan originally was limited to the 1250 Dallas school teachers, who paid 50 cents each month in return for 21 days of semi-private care annually at the Baylor hospital. *Id.* at 11. It is unclear whether the plan specifically covered the teachers' families. This distinction, however, may not be relevant because many school teachers of this era were unmarried.

27. *Id.*

28. Studies have indicated that the availability of insurance increases the likelihood that subscribers will seek treatment unnecessarily. See, for example, Leonard E. Burman and Jack Rodgers, *Tax Preferences and Employment-Based Health Insurance*, 45 *Nat'l Tax J.* 331, 337-40 (1992). Some academicians have analogized insurance to strangers agreeing to split the restaurant check before ordering. See Fein, *Medical Care* at 167-70 (cited in note 20). Both strangers may be tempted to order more expensive dishes than they would otherwise, since the increase will be shared by the entire party. *Id.* at 167. Such an analogy is inaccurate, however, because most feel medical treatment is unpleasant and natural limits exist as to how much energy one can spend in seeking out medical care. *Id.* at 170.

29. In 1946, 32 million Americans were covered by health insurance. Fein, *Medical Care* at 23 (cited in note 20). By 1951, this number had risen to 77 million. *Id.*

buy fewer goods because the nation was using its resources for the war effort.³⁰ Families who had suffered economic instability during the Depression now could afford health insurance. Second, millions of veterans who had received free medical care during the war wanted a similar civilian program for their families.³¹ The expansion of third-party health insurance exploded as more families learned of its availability and desirability.³²

Health insurance became employment-based almost by accident. During World War II, concerns of wage stabilization and price control forced the recently created Office of Price Administration to freeze wages.³³ The War Labor Board, however, permitted labor and management to expand fringe benefits. Aided by tax incentives³⁴ and a growing economy,³⁵ collective bargaining was successful in persuading employers to expand health care. As more employers began to provide health insurance, employees began to expect their employers to provide health insurance. By 1949, courts considered an employer's refusal to negotiate over health care benefits an unfair labor practice.³⁶

The evolution of employment-based insurance continues today, as many employers are becoming self-insured.³⁷ Traditionally, only large companies could afford to self-insure due to their ability to spread risk among their large employee pool.³⁸ Today, self-insurance has become an

30. This increase in family income represents a real increase of 50% after accounting for inflation. *Id.* at 21.

31. *Id.* at 23.

32. *Id.*

33. *Id.* at 22.

34. Employers are still allowed to deduct health care costs as "a cost of doing business." See I.R.C. § 162 (1992). During the War, tax rates were as high as 85%. Fein, *Medical Care* at 22 (cited in note 20). The actual expense to employers might have been as little as 15 cents on the dollar if the employer was in the highest tax bracket. *Id.* Although employer-paid health care premiums could be considered "in-kind" compensation, the Internal Revenue Code continues to allow employees to exclude employer-paid health premiums from income. See I.R.C. § 106 (1992). This policy continues to make health care benefits an attractive bargaining chip in collective bargaining agreements. For a discussion of financial inequities this tax scheme creates, see notes 170-75 and accompanying text.

35. The nation's Gross National Product increased from \$91 billion in 1939 to \$211 billion in 1944, nearly a 75% increase in real terms. Fein, *Medical Care* at 21 (cited in note 20).

36. *Id.* at 24.

37. A company that is self-insured allows its employees to assume financial responsibility of potential loss risks among the group rather than purchasing third-party insurance. An increasing number of employers find this arrangement cost effective for insuring employee health care benefits. Many self-insured employers also purchase stop-loss insurance, which allows the employer to assume financial responsibility of employee health plans to a certain dollar amount, but relegates additional risks to independent insurers. See generally, Kenneth Vogel, *Discrimination on the Basis of HIV Infection: An Economic Analysis*, 49 Ohio St. L. J. 965, 986-93 (1989). For a discussion of the unique problems self-insurance creates, see text accompanying notes 80-105.

38. Edward Felsenthal, *Self-Insurance of Health Plans Benefits Firms*, Wall St. J. at B12 (Nov. 11, 1992).

increasingly popular option for many medium-sized and smaller firms. This is because self-insurance enables employers to keep a closer watch on employee health costs and avoid the expenses of state taxes and regulation that third-party insurance premiums encompass.³⁹ Additionally, recent court decisions have enabled self-insured employers to retain complete control of insurance programs without state regulation.⁴⁰

Employment-based insurance is advantageous for several reasons. First, it leads to substantial savings in marketing, processing, and other administrative costs for group purchasers.⁴¹ Second, group insurance enables the insurer to maintain a less restrictive enrollment policy.⁴² Third, group insurance promotes competition among insurers because of employers' increased ability to evaluate potential plans and make informed decisions.⁴³ Fourth, federal tax incentives make health benefits an attractive form of employee compensation.⁴⁴ Last, employers who are able to purchase both worker's compensation and employee health insurance plans from a single insurer may recognize significant savings.

The benefits American families reap from the current employment-based system come at a great cost. America's health care financing system is subject to transformation as societal conditions change. Changes in the system have occurred at crisis points in American society.⁴⁵ A compelling interest must exist, however, to justify a change from the present system. In short, the costs of inaction must outweigh the desire

39. In 1986, only 46% of businesses self-insured their medical plans. In 1991, 65% of companies that offer medical plans were self-insured. While large companies still predominate the number of self-insured companies, small and medium sized companies are rapidly becoming self-insured as well. In 1988, only 8% of smaller firms (firms with fewer than 100 employees) and only 26% of medium-sized firms (firms with 100 to 500 employees) were self-insured. In 1991, these percentages were 22% and 41% respectively. *Id.*

40. See notes 78-102 and accompanying text.

41. Fein, *Medical Care* at 24 (cited in note 20).

42. *Id.* at 24-25. Insurance premiums are normally based on individual risk-assessment, which hinders individuals with substantial illnesses from acquiring insurance. With group policies, insurance premiums are based on the average levels of health and past utilization of the entire group. Group insurance combines the few sick individuals with the many healthy individuals who are also enrolled. This strategy allows a larger number of participants because one high-risk subscriber will have less effect on group risk-assessment.

43. *Id.* at 25. Few employees have the time to decipher the many complex insurance plans on the market. Insurance competitiveness is dependent on purchasers making informed decisions regarding plan benefits and costs. If the group is large enough, employers may have significant leverage with insurance companies to negotiate better health benefits.

44. *Id.* See also note 31 and accompanying text.

45. See generally Fein, *Medical Care* at 10-32 (cited in note 20). Fein argues that the Baylor Plan was implemented to prevent hospitals from going bankrupt due to patients' inability to pay their bills. A second crisis point occurred during World War II, because the War Labor Board instituted a wage freeze, which forced the labor unions to bargain over fringe benefits, such as health care.

to maintain the status quo before a change will occur.⁴⁶ The problems American families face in acquiring adequate health insurance are a result of the present employment-based health insurance system; this crisis stage demands that society take another step along the evolutionary continuum.⁴⁷

III. FALLING THROUGH THE GAPS: IDENTIFYING THE "AT-RISK" FAMILY

Thirty-seven million Americans are uninsured.⁴⁸ Of this number, over seventy-six percent are either employed or nuclear-family dependents of the employed.⁴⁹ Two factors contribute to the existence of the uninsured working family: (1) the employer does not offer health insurance, or (2) if offered, the employee chooses to take higher wages rather than health benefits.⁵⁰

A. *Demographics of the Uninsured Family*

The faces of the uninsured are as diverse as the faces of America; however, common threads do exist among those who are more likely to be uninsured.⁵¹ First, families whose members work for large firms are more likely to acquire employment-based health benefits than families whose members work for small firms.⁵² This may be attributed to the

46. *Id.* at 11.

47. See notes 154-78 and accompanying text.

48. Katherine Swartz, *A Research Note on the Characteristics of Workers Without Employer-Group Health Insurance Based on the March 1988 Current Population Survey*, in U.S. Dep't of Labor, *Health Benefits and the Workforce*, 13, 13 (1992) (based on 1987 statistics). Although the total number of persons estimated to be uninsured declined in 1988, (estimates ranged from 31.1 million to 33.5 million) the number of working Americans without employer-provided group insurance increased (from an estimated 24.2 million in 1987 to an estimated 26.8 million in 1988). *Id.*

49. Friedman, 265 J. Am. Med. Assn. at 2493 (cited in note 9). Over 26.8 million uninsured Americans are members of families in which either the head of the household or the spouse is employed, representing 80.2% of all uninsured. Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* 7, Table 1 (July 1991).

50. Stephen H. Long and M. Susan Marquis, *Gaps in Employment-Based Health Insurance: Lack of Supply or Lack of Demand?*, in U.S. Dep't of Labor, *Health Benefits and the Workforce*, 37, 37-38 (1992). Because only about two percent of employees refuse employer-offered insurance, *id.*, this Note will assume that the uninsured worker is a result of a supply problem rather than a demand problem.

51. Data-based generalities may be misleading, since the working uninsured are a complex population. However, if all American families are to obtain access to adequate health care, health care reformers must attempt to identify which families are at risk of becoming uninsured or underinsured. Although government programs, such as Medicare and Medicaid, leave American families underinsured, the focus of this Note is on families who fall through the gaps of employment-based insurance, since government recipients face unique problems in obtaining adequate health care. See Friedman, 265 J. Am. Med. Assn. at 2492-93 (cited in note 9).

52. Sixty percent of firms that employ fewer than 10 workers do not offer insurance; however, more than 90% of firms with more than 100 employees offer insurance. Long and Marquis, *Gaps in Health Insurance*, in *Health Benefits and the Workforce* at 38 (cited in note 50).

fact that employees in large firms are more likely represented by unions and thus receive higher wages.⁵³ Second, half of all workers whose family incomes are below the poverty level are uninsured; employees earning less than five dollars an hour are ten times more likely to be uninsured than employees earning over fifteen dollars an hour.⁵⁴ Second, families whose members work in service or seasonal industries are less likely to have employer-provided health insurance.⁵⁵ This may be explained by the high turnover in these industries; firms with high turnover are less likely to offer insurance because the high administrative costs associated with turnover diminishes their return on maintaining a healthy workforce.⁵⁶ Third, families whose primary economic providers are young are less likely to have employment-based insurance.⁵⁷ Thus, those families who can least afford to purchase expensive third-party insurance are the families who must do so or risk being uninsured.

B. Special Problems Nontraditional Families Face

Even when employers offer workers health insurance, obtaining coverage for nontraditional family members is difficult. The traditional American family is quickly becoming a relic.⁵⁸ The growing number of American families who do not fit the traditional mold have demanded a change in the legal definition of a family. Some courts have responded by using a functional approach to define "family."⁵⁹ The functional approach acknowledges that some non-nuclear relationships share charac-

53. Id.

54. Burman and Rodgers, 45 Nat'l Tax J. at 332 (cited in note 28).

55. Agriculture, forestry, and fishing industries contain the largest percentage of uninsured workers; over 60% of families whose members work in these industries are uninsured. *A Look at Health Benefits and the Workplace* 8-9 (U.S. Dept. of Labor, 1992). Other industries with a large percentage of uninsured workers include construction (39%) and retailing (36%). Id. at 9. In contrast, transportation, manufacturing, and government employers fail to provide insurance for fewer than 10% of workers in these areas. Long and Marquis, *Gaps in Health Insurance*, in *Health Benefits and the Workforce* at 39 (cited in note 50).

56. Id. at 38.

57. Although 25% of all workers do not have insurance, 40% of those workers between the ages of 18 and 24 are uninsured. *A Look at Health Benefits and the Workplace* at 8 (cited in note 55).

58. The percentage of American households consisting of a married couple and their minor children decreased from 44.2% in 1960 to 27% in 1988. Note, *Looking for a Family Resemblance: The Limits of the Functional Approach to the Legal Definition of Family*, 104 Harv. L. Rev. 1640, 1640 n.1 (1991). The number of unmarried, heterosexual couples living in the same household rose from 523,000 in 1970 to 2,764,000 in 1989. Id. at 1640 n.4. Although government population surveys do not include homosexual cohabitants, many sources report that this number is also on the rise. Id.

59. See, for example, *Brashci v. Stahl Assoc., Co.*, 543 N.E.2d 49 (1989) (granting a homosexual male the spousal right to inherit his partner's rent-controlled apartment).

teristics similar to nuclear families, and therefore, should be considered a family unit.⁶⁰ Nevertheless, most health insurers have continued to cling to the traditional definition of family, typically insuring only the legal spouse of the employee and children under the age of nineteen.⁶¹

The problems of obtaining health insurance for family members are especially acute for homosexual couples. Only approximately twenty-five private companies offer health benefits to the homosexual partners of their employees.⁶² Employers may have many reasons for refusing to grant health benefits to homosexual couples, including discrimination and the fear of the high medical costs of AIDS.⁶³ However, these concerns are unfounded, since one study proved that homosexual couples tend to be younger and healthier than their heterosexual counterparts.⁶⁴ Many local governments have responded to this problem by allowing homosexual partners to file a domestic partnership agreement, which gives homosexual and unmarried, heterosexual couples the same status regarding health benefits as married couples.⁶⁵

C. *Who are the Underinsured?*

Although the National Healthcare Expenditure Studies estimated that in 1984 fifty-six million Americans did not have adequate protection against the possibility of excessive medical bills,⁶⁶ recent litigation suggests all American families are at risk of becoming underinsured.⁶⁷ The exact characteristics of the underinsured are difficult to identify because a patient's diagnosis determines the adequacy of her health insurance.⁶⁸ Factors such as: (1) the type of treatment required; (2) the length of treatment; and (3) the type of policy, determine the sufficiency of the family's coverage.⁶⁹

1. The Use of Ambiguous Terms in Insurance Policies

Insurance policies may not meet legitimate expectations of coverage if the insured requires costly treatment. All insurance plans place specific limits on both the monetary value of the policy and the types of covered illnesses in order to allow families to purchase affordable poli-

60. Note, 104 Harv. L. Rev. at 1641 (cited in note 58).

61. William F. Meyer, *Life and Health Insurance Law* § 12:1 at 407-08 (Lawyers, 1971).

62. Rorie Sherman, *Gay No Longer Closeted*, Nat'l L. J. 1, 34 (Oct. 26, 1992).

63. David Tuller and Marc Sandalow, *Next Step for Partners' Benefits*, S. F. Chron. at A1 (May 14, 1991).

64. *Id.*

65. Sherman, Nat'l L.J. at 34 (cited in note 62).

66. Friedman, 265 J. Am. Med. Assn. at 2492 (cited in note 9).

67. See notes 87-102 and accompanying text.

68. Friedman, 265 J. Am. Med. Assn. at 2492.

69. *Id.*

cies. Because insurers are unable to make exhaustive lists of uncovered illnesses, the insurers insert broad terms into the policies describing treatments that are not covered in order to limit their financial exposure.⁷⁰ While generalized terms are necessary to exclude coverage for new and unorthodox procedures, these ambiguous terms may allow insurers to avoid paying for expensive treatment based on cost rather than experimental status.⁷¹ Although courts generally construe ambiguous terms against the drafter,⁷² expensive litigation may delay necessary treatment if the patient must bring an action against the insurer. Thus, many families find that they have purchased a lawsuit in addition to an insurance policy.

2. Long-Term Health Care

When they are confronted with the problem of long-term health care, many families find that they are underinsured. According to a recent Gallup poll, only thirty-seven percent of Americans believe their current insurance is sufficient to pay for long-term care.⁷³ For the one in four families each year who either experiences a serious illness or needs long-term care for one of its members, its fears often are realized if medical costs exceed insurance benefits.⁷⁴ If the illness results in loss of employment, as most catastrophic illnesses eventually will, group health benefits also may be lost.⁷⁵ Although family members provide the majority of long-term care,⁷⁶ nursing home care or other medical assistance may be necessary. A nursing home's high price tag⁷⁷ leaves many American families underinsured, forcing them either to pay substantial medical costs out of the family's assets or to resort to Medicaid.

70. For example, the policy may exclude coverage for treatments labeled "experimental" or "not medically recognized."

71. See generally Jennifer Belk, Comment, *Undefined Experimental Treatment Exclusions in Health Insurance Contracts: A Proposal for Judicial Response*, 66 Wash. L. Rev. 809 (1991).

72. See, for example, *Pirozzi v. Blue Cross-Blue Shield of Va.*, 741 F. Supp. 586, 590 (E.D. Va. 1990) (enjoining insurer from denying coverage for HDCT-ABMT treatment of breast cancer); *Bradley v. Empire Blue Cross & Blue Shield*, 149 Misc. 2d 20 (N.Y. Sup. Ct. 1990) (enjoining the insurer from denying HDCT-ABMT treatment for an AIDS patient).

73. Frank Newport and Jennifer Leonard, *Health Care Anxiety*, S. F. Chronicle at D3 (Aug. 12, 1991).

74. *Id.*

75. Although Congress, in COBRA, allows disabled employees to continue to participate in their group benefit plan for 29 months after their dismissal (11 months beyond the 18 month extension granted to all employees after their employment ends), this extension is not helpful to an unemployed worker who cannot afford the premiums that her employer previously paid. For a further discussion of the mechanics of COBRA, see notes 121-32 and accompanying text.

76. 138 Cong. Rec. S5265 (daily ed. April 9, 1992) (statement of Sen. Rockefeller).

77. The cost may range from \$25,000 to \$60,000 per year. Robert N. Brown, *Long-Term Care: A Primer for Lawyers*, 69 Mich. B. J. 510, 511 (1990).

3. Special Problems Families Under Self-Insured Plans Face

Because the federal Employee Retirement Income Security Act of 1974 (ERISA)⁷⁸ exclusively governs self-insured plans, employers may restrict, at their whim, the health care benefits of about half of American workers and their families.⁷⁹ Congress enacted ERISA with the intent of protecting the financial security of millions of employees and their families.⁸⁰ To accomplish this goal, Congress preempted state regulation of employee benefit plans.⁸¹ However, Congress has not filled the void that federal preemption of state laws creates. Preempted state laws had prevented insurers from arbitrarily modifying coverage of insured families after they filed a claim.⁸²

The Supreme Court has interpreted the scope of the ERISA preemption to apply only to self-insured employee welfare plans. In *Metropolitan Life Insurance Co. v. Massachusetts*,⁸³ the Court acknowledged that its holding, which allowed Massachusetts to require insurance companies to provide minimum health care coverage, created a distinction

78. Employment Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988). ERISA does not govern all self-funded employee plans. For example, governmental employer plans, church plans, and statutorily required plans are not subject to ERISA preemption but are regulated by state insurance laws. See *id.* § 1003(b).

79. Thomas B. Stoddard, *Now You're Insured, Now You're Not*, Washington Post at A23 (May 23, 1992).

80. 29 U.S.C. § 1001(a) (1988). Legislative history indicates that ERISA preemption was intended to curb "abus[ive] and unsound practices which jeopardize[d] the security of the assets and threaten[ed] the availability of funds for employees." Legislative History of the Employee Retirement Income Security Act of 1974, 1 Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., at 204 (remarks of Senator Javits).

81. 29 U.S.C. §§ 514(a), 1144(a) (1988) (saying that ERISA "shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan"). Although Congress preempted the entire field of employee welfare benefit plans, it allowed the states, in the "savings" clause, to continue to regulate insurance, banking, and securities. However, Congress disallowed states to avoid preemption by "deeming" employee benefit plans to be insurance companies or insurance contracts. See *id.* §§ 1144(b)(2)(A) and (b)(2)(B). The complex manner in which Congress preempted state laws has forced the Supreme Court to interpret the breadth of ERISA preemption. See generally *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 857 (1983) (acknowledging ERISA preemption of both direct and indirect state regulations concerning employee welfare plans); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (exempting a Massachusetts statute that required third-party insurers to provide minimum mental health coverage from ERISA preemption); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (acknowledging ERISA preemption of state causes of action of bad faith and breach of contract that impact employee benefit plans); *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990) (acknowledging ERISA preemption of self-insured plans but not third-party insurance plans).

82. The Americans With Disabilities Act (ADA), Pub. L. No. 101-336, 104 Stat. 329, codified at 42 U.S.C. §§ 12101-12213 (Supp. 1992), may finally bring relief to families who receive employment-based health insurance. For a discussion regarding the impact the ADA will have on employment-based insurance, see notes 133-53 and accompanying text.

83. 471 U.S. 724 (1985).

between self-insured and third-party insured employee welfare plans.⁸⁴ Addressing this distinction in *FMC Corp. v. Holliday*,⁸⁵ the Court recognized that while states may regulate insurance companies, these regulations do not affect self-funded employee benefit plans because self-funded benefit plans may not be deemed to be insurance companies for purposes of such state laws.⁸⁶ Therefore, state laws regulating insurance companies indirectly may protect families whose employers purchase third-party insurance, but this protection does not extend to families whose employers self-insure.

Recent cases demonstrate the impact of Congress's failure to provide comparable protections against arbitrary modifications of self-insured plans. As the AIDS virus becomes more widespread in the workplace,⁸⁷ some employers have modified their self-insured plans to avoid paying for expensive AIDS treatment. In *McGann v. H & H Music Co.*,⁸⁸ the Fifth Circuit found that an employer may reduce coverage for AIDS treatment even after the plaintiff had filed AIDS-related claims with his insurer. In *McGann*, although the employer previously had offered third-party insurance to its employees, it became self-insured in order to reduce maximum coverage for AIDS-related claims from one million dollars to five thousand dollars.⁸⁹ The fact that McGann previously had filed AIDS-related claims and was the only current employee known to be infected by the AIDS virus somewhat complicated the employer's decision to limit coverage.⁹⁰ McGann was not successful, however, in proving that his employer's decision specifically was intended to retaliate against his filing of AIDS-related claims, since the restriction also would affect current and future employees.⁹¹ Because ERISA does not require that employers offer any particular insurance benefits,⁹² employers may choose to limit coverage of AIDS

84. Id. at 747. The Court responded that its decision "merely give[s] life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." Id. (citation omitted).

85. 111 S. Ct. 403 (1990). For a sharp criticism of the Court's decision in *FMC Corp. v. Holliday*, see James R. Bruner, Note, *AIDS and ERISA Preemption: The Double Threat*, 41 Duke L. J. 1115 (1992).

86. *FMC Corp.*, 111 S. Ct. at 404.

87. In a 1988 survey of two thousand employers, one in ten employers indicated they presently had one or more employees infected with AIDS. See John P. Furfaro and Maury B. Josephson, *Health Benefits of Employees With AIDS*, N.Y. L.J. at 3 (May 3, 1991). Other surveys indicate the number of workers with AIDS is higher. Id.

88. 946 F.2d 401 (5th Cir. 1991). See also *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991) (allowing company to reduce AIDS benefits of self-insured plans from \$1 million to \$25,000 after worker filed insurance claims).

89. *McGann*, 946 F.2d at 403.

90. Id. at 404.

91. Id.

92. Id. at 406.

while continuing to cover other catastrophic illnesses. This is true even if the decision is based on the employer's prejudice against either AIDS or the employee.⁹³

Although *McGann* involved discrimination against persons infected with AIDS, the Court's decision holds that employers may deny coverage for any disease.⁹⁴ Economic factors, such as the costs of AIDS treatment⁹⁵ coupled with the increasing number of workers infected with AIDS, may have been the driving force behind the employers' decisions. However, fellow employees' prejudices against people with AIDS allowed the employer to limit coverage without severe repercussions.⁹⁶ The employees' silence when employers limit AIDS coverage may haunt them, since *McGann* allows coverage modifications for any disease.⁹⁷

ERISA provides some protection against arbitrary modification of self-insurance plans; employers easily may circumvent these protective measures, however, by carefully drafted employee plans. The Act prevents only a few employers from amending employee plans on account of an existing contractual obligation⁹⁸ or a failure to reserve the right to change benefit plans.⁹⁹ ERISA also forbids employers to reduce employee benefits in retaliation against individual employees who file claims.¹⁰⁰ But, as *McGann* illustrates, employers only must mandate the

93. *Id.* at 408. Other federal legislation, however, may prohibit employment discrimination against particular employees. See generally, Civil Rights Act of 1964, 42 U.S.C. §§ 2000-2000(h) (1988). For a discussion of the ADA on future *McGann*-type cases, see notes 133-53 and accompanying text.

94. *McGann*, 946 F.2d at 408.

95. The government estimates annual AIDS treatment per patient to be \$38,000, with a lifetime cost of \$102,000. Charles Henderson, *Insurers Can't Cut Magic Loose*, AIDS Weekly 9 (Oct. 12, 1992). These costs are expected to rise by as much as 48% by 1995. *Id.*

96. A substantial percentage of AIDS-infected persons are either members of the gay community (47%) or heterosexual drug users (32%). Raymond C. O'Brien, *AIDS: Perspective on the American Family*, 34 Vill. L. Rev. 209, 240 (1989). Racial bias may also have an impact, since 34% of AIDS-infected persons are black and 21% are Hispanic. *Id.*

97. The costs of AIDS treatment is no more expensive than other life-threatening illnesses. Bruner, 41 Duke L. J. at 1125 n.48 (cited in note 85). For example, the lifetime costs of AIDS, ranging from \$50,000 to \$100,000, are comparable to the estimated lifetime costs of heart attack (\$66,837), paraplegia (\$68,700), and digestive cancer (\$47,542). *Id.* For a further comparison of employment discrimination concerning AIDS and cancer, see Judith Jean Morrell, Note, *AIDS and Cancer: Critical Employment Discrimination Issues*, 15 J. Corp. L. 849 (1990).

98. Descriptions or summaries of employee benefit plans may create enforceable obligations against the employer if equity so demands. See Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a)(3)(B) (1988). See *Edwards v. State Farm Mut. Auto Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) (finding that statements in employee benefit summary plans may be binding).

99. See *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) (allowing employer to modify employee benefit plan when summary plan description disclaimer reserves right to amend benefits). But compare *Zittrouer v. UARCO Inc. Group Benefit Plan*, 532 F. Supp. 1471 (N.D. Ga. 1984) (invalidating disclaimers in summary plan description).

100. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1140 (1988). For a further discussion, see Eric C. Sohlgren, Note, *Group Health Benefits Discrimination Against AIDS*

reduction for all employees in order for the courts not to consider the modification a retaliatory measure.¹⁰¹ Therefore, all families who receive employment-based insurance¹⁰² are at risk of joining the ranks of the underinsured due to the ease with which employers may avoid ERISA-provided protections.

IV. IMPACT ON THE FAMILY

For uninsured American families, health care decisions often are based on immediate economic concerns rather than physical need. Many uninsured families forego preventive health care measures due to cost, resorting to hospital emergency rooms for primary care.¹⁰³ At the very least, disregarding preventive health measures creates greater emotional and economic demands on the uninsured family as a medical problem accelerates.¹⁰⁴ At worst, the uninsured are deprived of their family members, whose lives are shortened because they could not afford non-emergency medical care.

The refusal of some private hospitals to treat indigent patients, forcing the uninsured to resort to overcrowded public hospital emergency rooms, also threatens the lives of uninsured families.¹⁰⁵ One study of 467 transferred emergency room patients revealed that the hospital transferred eighty-seven percent because they lacked insurance, resulting in an average delay in treatment of more than five hours.¹⁰⁶ Twenty-four percent of those transferred in this study were listed in unstable condition at the time of their transfer, and the transferred patients had a significantly higher death rate than non-transferred patients.¹⁰⁷ Although state and federal governments have made various attempts to force private hospitals to provide emergency care to the uninsured,¹⁰⁸

Victims: Falling Through the Gaps of Federal Law—ERISA, the Rehabilitation Act and the Americans with Disabilities Act, 24 Loyola L.A. L. Rev. 1247, 1274-80 (1991).

101. *McGann*, 946 F.2d at 408.

102. Although *McGann* only applies to self-insured plans, employers easily may switch from third-party coverage to self-insurance with the intent to restrict coverage.

103. Frank Newport and Jennifer Leonard, *Health Care Anxiety*, S.F. Chronicle at D3 (Aug. 12, 1991).

104. Eric L. Robinson, *The Oregon Basic Health Services Act: A Model for State Reform*, 45 Vand. L. Rev. 977, 983 n.58 (1992).

105. Frances Taira and Deborah Taira, *Patient "Dumping" of Poor Families*, 72 Families in Society 409, 409 (1991).

106. *Id.* at 412. The Cook County Hospital in Chicago conducted this study. Its findings were duplicated in similar studies at public hospitals in Dallas, Las Vegas, and Memphis.

107. *Id.* Non-transferred patients had a death rate of 3.8%, while those transferred in the study had a death rate of 9.4%.

108. The Hill-Burton agreements, 42 U.S.C. § 1395x (1988), and the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. §§ 1161-1168 (1988), are the primary pieces of federal legislation that prevent "patient dumping." Hospitals that receive federal funds, such as Medicaid and federal grants, are required to treat all patients regardless of their ability to pay.

commentators estimate that hospitals refuse emergency treatment to 250,000 patients annually because of their inability to pay.¹⁰⁹

Additionally, uninsured families suffer emotional consequences as a result of their health care financing status. These families are "worried sick about getting sick"¹¹⁰ because they do not have the money to pay for a doctor's visit or hospital bill. The uninsured may perceive themselves to be in poorer health than their insured counterparts.¹¹¹ The results of one study show that uninsured families were more likely (1) to report being in poor or fair health; (2) to worry about their health; and (3) to feel limited in their everyday activities.¹¹² Thus, unequal access to health care financing creates unnecessary anxiety for uninsured families.

Families' anxiety levels increase as they attempt to cope with long-term health care needs. In addition to the physical and emotional struggle of combatting a terminal illness, families also face devastating financial struggles. Catastrophically ill workers fall into a precarious health insurance status, since they lose both their job and its accompanying health benefits.¹¹³ These workers are forced to resort to either familial assets or public assistance to finance necessary health care. In order to qualify for Medicaid,¹¹⁴ however, individuals must prove impoverishment.¹¹⁵ To avoid complete depletion of all assets, many families must creatively juggle their financial assets.¹¹⁶ Frequently, families take dras-

Many private hospitals, however, continue to dump patients while still receiving federal funds due to unclear regulations and lax enforcement. Taira and Taira, *72 Families in Society* at 409-10 (cited in note 105).

109. *Id.* at 409.

110. Frank Newport and Jennifer Leonard, *Health Care Anxiety*, S. F. Chronicle at D3 (Aug. 12, 1991).

111. See M. Susan Marquis and Ellen R. Harrison, *Health Status and the Health Care Use of Uninsured Workers*, Health Benefits and the Workforce 21, 24 (1992).

112. *Id.* Marquis and Harrison based their findings on self-reported health status of a control group of families at six different sites in the United States.

113. See notes 73-77 and accompanying text.

114. Medicaid has become a major source of assistance for those in need of long-term care, as Medicare rarely pays for long-term health care. Friedman, 265 J. Am. Med. Assn. at 2492 (cited in note 9). Three-fourths of Medicaid expenses consist of the long-term health care needs of the aged, disabled, and blind. *Id.*

115. Although Medicaid qualifications vary from state to state, all states set very low limits on the value of assets which recipients may own and still qualify for Medicaid. For example, Michigan will allow only up to \$4000 of assets for their Medicaid recipients. George A. Cooney, Jr., *Basic Estate Planning for Long-Term Care*, 69 Mich. B. J. 527, 528 (1990).

116. Because states do not count some assets, such as the homestead, for Medicaid qualification, families are encouraged to shift their assets from countable to noncountable assets. For further suggestions on asset redistribution, see Melinda Beck, *Planning to be Poor*, Newsweek 66 (Nov. 30, 1992). The divestment of these assets does not provide immediate qualification; the federal government allows states a maximum of 30 months after the divestment of countable assets to disqualify an individual for Medicaid. See 42 U.S.C. § 1396p(c)(3) (Supp. 1992).

tic measures, including divorce, for the sole purpose of preventing spousal impoverishment.¹¹⁷ Thus, the impact of long-term care reaches beyond the family purse and actually reshapes family relations.

Families who receive health insurance through self-insured employer plans have additional reasons to be concerned. As *McGann* illustrates, self-insured employers may restrict health care benefits even after a worker has contracted the illness.¹¹⁸ For families battling life-threatening diseases, the increased financial burden resulting from modifications of employment-based plans¹¹⁹ may weaken family relationships. This is especially true for families with one member infected with AIDS, because these family relationships often are already strained due to disputes over "proper" lifestyles.¹²⁰ For families who do not currently have an AIDS-infected member, the *McGann* precedent confirms families' fears that their employment-based insurance may not be available for their families' illnesses.

V. UNIQUE PROBLEMS OF EMPLOYMENT-BASED INSURANCE

A. Nonportability: Joblock

Employers often limit their liability to pay on an insurance plan by excluding preexisting conditions from coverage. Preexisting conditions consist of any medical problem from which the employer can show the employee to have suffered before her employment.¹²¹ Employed workers may be forced to remain in their current jobs because they fear that a new employer will exclude as a preexisting condition an illness or disability which their health insurance currently covers. This situation, known as joblock, stifles the potential of these workers and reduces American productivity.¹²² The twenty million Americans each year who do begin new jobs risk months of noncoverage because of their new employer's preexisting conditions clauses.¹²³ Congress enacted

117. In order to protect one spouse from the debts of the ill spouse, many families have resorted to bankruptcy, divorce, and asset redistribution. James Monroe Smith, *Legal Issues Confronting Families Affected By HIV*, 24 John Marshall L. Rev. 543, 560 (1991).

118. See notes 88-102 and accompanying text.

119. Families can expect little financial assistance from Medicare programs. In 1988, commentators estimated that Medicare only funded health care assistance for 2% of those affected with AIDS, representing only 1% of Medicare's annual budget. Baily, et al., 11 Health Care Fin. Rev. at 99 (cited in note 6).

120. Terry S. Stein and Carol J. Cohen, *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men* at 217 (Plenum, 1986).

121. A Health Insurance Association of America survey found that 68% of employers surveyed have preexisting conditions clauses in their insurance policies. These clauses generally cover any condition that arises within the first nine months of employment. *Employer Concern About Health Care Now Focused on Requirements Under ADA*, 48 BNA C-1, C-3 (March 11, 1992).

122. 137 Cong. Rec. S9840-41 (daily ed. July 11, 1991) (statement of Sen. Kerrey).

123. *Id.* at S9841.

COBRA¹²⁴ to address this problem. COBRA allows workers and their families to continue coverage under their former employer's health plan for a limited period of time.¹²⁵ These employees, however, must pay the premiums that their former employer previously paid.¹²⁶

COBRA has alleviated some of the burdens a change in family or career status creates. A Rand Corporation study estimated that in 1988 over 1.3 million Americans took advantage of the COBRA extension.¹²⁷ Recent data suggests, however, that not all those people COBRA was intended to help have benefited.¹²⁸ A large percentage of those taking advantage of COBRA were either: (1) workers who lost their jobs due to a disability; (2) dependents of workers with employment-based insurance who lost coverage due to a family-related reason; or (3) early retirees using COBRA as a bridge between employment-based insurance and Medicare.¹²⁹ Many employees whose employer terminated them for a reason other than disability or retirement have not taken advantage of the extension periods COBRA provides.¹³⁰ Two possible reasons for their nonparticipation are their ability to gain coverage from a new job or their inability to pay the expensive premiums their employers previously paid.¹³¹ Despite COBRA extensions, those employees with preexisting illnesses who are unable to pay the expensive premiums their employers previously paid are still locked into their jobs if their new employers' insurance policies contain a preexisting conditions clause.¹³²

124. P.L. No. 99-272, 100 Stat. 227, codified at 29 U.S.C. § 1161-1167 et seq. (1988).

125. COBRA regulates employers who employ 20 or more part-time or full-time employees during 50% of the business days in the previous year. COBRA allows former employees who voluntarily leave their job or are terminated to purchase coverage under their former employers' plans for 18 months. Workers or their families who lose coverage for family-related reasons (for example, divorce or death of spouse) are allowed to purchase insurance for 36 months after the event. *Id.* at § 1162(2)(A)(ii). Finally, workers who must leave due to a disability are given 29 months within which to continue coverage. *Id.* at § 1162.

126. COBRA caps the amount of premiums former employees are required to pay at 102% of their former employer's group rate. *Id.* at § 1162(3)(A).

127. Flynn, *Employment-Based Health Insurance*, in U.S. Dep't of Labor, *Health Benefits and the Workforce* at 105 (cited in note 19).

128. See *id.*

129. *Id.*

130. *Id.* at 115.

131. Jacob Alex Klerman and Omar Rahman, *Employment Change and Continuation of Health Insurance Coverage*, *Health Benefits and the Workforce* 93, 98 (1992).

132. See Paul Cotton, *Preexisting Conditions "Hold Americans Hostage" to Employers and Insurance*, 265 *J. Am. Med. Assn.* 2451 (1991).

B. Health Insurance Confusion That Labor Regulations Create

Congress intended the Americans with Disabilities Act (ADA)¹³³ to combat the stereotypical notion that disability equates to lifelong economic dependency. The ADA creates comprehensive and enforceable standards to eliminate discrimination against disabled Americans and their families.¹³⁴ To receive ADA protection, the individual must either suffer from, have a record of, or be perceived to have a disability that substantially limits major life activities.¹³⁵ The ADA prohibits employers with twenty-five or more employees¹³⁶ from discriminating against qualified disabled persons who can meet essential employment qualifications.¹³⁷ Congress exempted both third-party and self-insured employee health benefit plans from complying with ADA requirements, but cautions in the subterfuge clause that employers cannot use these exemptions to undermine the purposes of the ADA.¹³⁸

The subterfuge clause has created significant confusion for employers wishing to modify health benefit plans with respect to specific illnesses.¹³⁹ Employers seek guidance concerning what modifications will constitute subterfuge in order to avoid government fines and third-party lawsuits.¹⁴⁰ The government has given little guidance, however. Congress delegated the authority to create ADA enforcement mechanisms to the Equal Employment Opportunity Commission (EEOC).¹⁴¹

133. Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 329, codified at 42 U.S.C. §§ 12101-12213 (Supp. 1992).

134. Id. § 12101(b). The ADA's purpose was to eliminate the "now almost subconscious assumption that people with disabilities are less than fully human and therefore are not fully eligible for the opportunities, services, and support systems which are available to other people as a matter of right." Rosemary E. Mahoney and Allen Gibofsky, *The Americans with Disabilities Act of 1990: Changes in Existing Protection and Impact on the Private Health Services Provider*, 13 J. Legal Med. 51, 54 (1992) (quoting H.R. Rep. No. 485(II), 101st Cong., 2d Sess. 24 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 313). Prior to the passage of the ADA, disabled persons received limited protection from state laws or through the Rehabilitation Act of 1973, 29 U.S.C. §§ 701-796 (1988). The ADA expands federal protection by regulating a broad range of interests important to disabled persons, including employment relations, access to public and private facilities, and telecommunication services. See Mark S. Joffe, *Americans with Disabilities Act: Red-Flags on Benefit Reductions and Exclusions*, 4 Benefits L. J. 161, 161 (1991).

135. 42 U.S.C. § 12102(2) (Supp. 1992).

136. The ADA regulations became effective for employers of more than 25 employees on July 26, 1992; however, these regulations will not be effective for employers with 15-24 employees until July 26, 1994. Id. § 12111(5)(a). The ADA will not govern employers with fewer than 15 employees. Id.

137. Id. § 12112(a).

138. Id. § 12201(c). The "subterfuge clause" applies to both health plans existing prior to the passage of the ADA and those plans created after the passage of the ADA.

139. Mike McKee, *Courts Will Decide ADA's Impact on Insurance*, *The Recorder at F1* (June 8, 1992).

140. 42 U.S.C. § 12188 (Supp. 1992).

141. Id. § 12116.

Rather than enunciating clear guidelines that employers may follow in modifying employee health benefit plans, the EEOC simply paraphrased the ADA's seemingly contradictory language.¹⁴²

Employers may find limited guidance in case law interpreting the use of the term "subterfuge" in the Age Discrimination in Employment Act of 1967 (ADEA).¹⁴³ In *Public Employees Retirement System of Ohio v. Betts*,¹⁴⁴ a state employee challenged Ohio's retirement system. Ohio provided substantially lower benefits for disabled workers over sixty years of age than for disabled workers under sixty years of age.¹⁴⁵ The state retirement plan provided two levels of compensation: (1) "normal" retirement benefits for employees who are retiring because of age and who have worked at least five years; and (2) enhanced retirement benefits for those employees who are retiring because of a disability and who also have worked at least five years.¹⁴⁶ Ohio forced workers over the age of sixty to accept the normal benefit package of the age retirement plan, regardless of the older workers' qualifications for higher benefits under the disabled package.¹⁴⁷ The Supreme Court applied a malicious intent test and rejected the worker's contention that Ohio's retirement plan was a subterfuge. Thus, for purposes of the ADEA, the Court upheld its earlier definition of subterfuge as a "scheme, plan, stratagem, or artifice of evasion."¹⁴⁸

Because congressional use of the term subterfuge in the ADEA may differ with Congress's intent in enacting the ADA,¹⁴⁹ some employers who are not financially secure may make more extensive modifications to employee benefit plans and still allege that they have complied with the ADA.¹⁵⁰ As *McGann* illustrates,¹⁵¹ some employers desire to restrict coverage of the AIDS virus. These employers might be satisfied only to limit coverage for a particularly expensive drug, such as azidothymidine

142. Compare 29 C.F.R. § 1630.16(f) (1992) with 42 U.S.C. § 12201(c) (Supp. 1992).

143. 29 U.S.C. § 623(f)(2) (1988).

144. 492 U.S. 158 (1989).

145. *Id.*

146. *Id.* at 162.

147. *Id.* at 163.

148. *Id.* at 167 (quoting *United Airlines, Inc. v. McMann*, 434 U.S. 192, 203 (1977)). Congress effectively has overridden the *Betts* decision by passing the Older Workers Benefit Protection Act (OWBPA), Pub. L. No. 101-433, 104 Stat. 978, codified at 29 U.S.C. § 623(f)(2) (Supp. 1992), which eliminated the use of the term subterfuge in age discrimination statutes.

149. For a discussion regarding the inapplicability of the ADEA's definition of subterfuge to the ADA, see Kimberly A. Ackourey, Comment, *Insuring Americans with Disabilities: How Far Can Congress Go to Protect Traditional Practices?*, 40 *Emory L. J.* 1183 (1991).

150. The costs of a catastrophic illness may cripple a self-insured employer, who must pay for all health care costs out of his own financial resources. See generally Jay W. Waks, *Disabilities Act May Affect Medical Costs*, *Nat'l L. J.* 18 (June 15, 1992).

151. See notes 88-102 and accompanying text.

(AZT). Employers who fear that courts would interpret a limitation on coverage for AZT alone as subterfuge for discriminating against persons with AIDS may feel compelled to make overly broad limitations, such as limiting all drug coverage.¹⁵² While the ADA's dual goals of protecting the rights of disabled Americans to work and reducing inaccurate stereotypes in the workplace are noble,¹⁵³ the confusion the ADA's ambiguous language creates and the lack of clarifying regulations places in jeopardy the health benefits of millions of disabled and nondisabled families.

VI. REMEDYING THE PROBLEMS THE EMPLOYMENT-BASED SYSTEM CREATES

To ensure adequate access to health care for all American families, Congress and President Clinton must first address the high costs associated with health care and health care financing. Small businesses are unable to absorb rising insurance premiums that derive from astronomical increases in health care costs, and are forced to limit or to discontinue employee health benefit plans.¹⁵⁴ In 1950, America's national health care expenditures totaled the equivalent of \$69.9 billion in 1990 dollars, representing a \$459 outlay per American.¹⁵⁵ In 1990, health care expenditures had escalated to \$671 billion, representing a \$2,604 share per American.¹⁵⁶ President Clinton has acknowledged this problem by warning drug manufacturers that continued drug price gouging will bring increased federal regulation.¹⁵⁷ Proposals calling for tort reform will provide additional savings.¹⁵⁸ Congress could also avoid costs by establishing uniform policy requirements, which would reduce insurers' administrative costs¹⁵⁹ and avoid the unnecessary litigation costs that ambiguous terms create.¹⁶⁰

152. See Mike McKee, *Courts will Decide ADA's Impact on Insurance*, *The Recorder* 1 (June 8, 1992).

153. For a discussion of the importance of work in American culture, see Morrell, *AIDS and Cancer*, 15 *J. Corp. L.* at 855-56 (cited in note 97).

154. See Friedman, 265 *J. Am. Med. Assn.* at 2493 (cited in note 9).

155. Flynn, *Employment-Based Health Insurance*, in *Health Benefits in the Workplace* at 107 (cited in note 19).

156. *Id.*

157. Janice Castro, *Paging Dr. Clinton*, *Time* 24, 26 (Jan. 18, 1993).

158. *Id.*

159. In 1990, administration costs were \$30.7 billion for private insurers (14.2% of total costs). *Key Health Insurance Statistics: 1985-1990*, in *The Universal Health Care Almanac* Table 6.9, (cited in note 10). Self-insured plans may face even greater administrative costs, since each employer must generate individual forms and become an expert on insurance issues.

160. See notes 70-72 and accompanying text.

Congress should not obhigate employers to provide mandatory health insurance benefits to their workers.¹⁶¹ A mandated health insurance plan would leave employers with only a few options to cope with increased employment costs: (1) pass the increase to the consumer through higher prices; (2) reduce workers' wages and other fringe benefits; or (3) eliminate the number of jobs available.¹⁶² Most employers would pass on the increased costs through reduced wages or layoffs in order to maintain competitive pricing in a global market.¹⁶³ Employees working at or near minimum wage are at risk of losing their jobs, since employers may not reduce wages below minimum levels to compensate for their increasing insurance expenditures and these workers usually have few fringe benefits.¹⁶⁴ Although the majority of the uninsured are either employed or dependents of the employed,¹⁶⁵ mandated health coverage would leave many currently uninsured families both uninsured and unemployed, because the majority of these uninsured are also low wage earners.¹⁶⁶

Additionally, Congress should eliminate confusion and inequities that existing ambiguous federal regulations have created.¹⁶⁷ First, Congress should invalidate decisions such as *McGann* by "grandfathering" employers' health care policies so that any subsequent modifications do not apply to an employee who previously had contracted a disease. Although the employer must be able to control the amount of health insurance provided to its workers in order for it to remain competitive, the employer should not be able to revoke relied upon coverage for a worker after that worker has become ill. Such a result shifts the costs of health care from employer-provided sources to government sources.¹⁶⁸

161. Early recommendations from President Clinton's chief health care advisor, Judith Feder, would require every employer to provide health care coverage for their workers. Sara Fritz, *Clinton Health Plan Likely to Stir Controversy*, L.A. Times at A24 (Dec. 13, 1992).

162. See Jacob Alex Klerman, *Employment Effect of Mandated Health Benefits*, in U.S. Dep't of Labor, *Health Benefits and the Workforce* 145 (1992). Proposals calling for mandated health insurance estimate the annual premiums would range from \$700 to \$1200 for individual policies and \$1800 to \$3000 for family policies. *Id.* at 145.

163. The accuracy of this conclusion may be questionable for service and retail industries, which employ a high percentage of the uninsured. See note 54 and accompanying text. Assuming all employers in these industries uniformly incorporated the increased costs in their service prices, customers would have little choice to purchase these services from American markets if higher customs were placed on retail products purchased in foreign countries.

164. See generally Klerman, *Mandated Health Benefits*, in *Health Benefits and the Workforce* at 146-52.

165. Swartz, *Research Note*, in *Health Benefits and the Workforce* at 13 (cited in note 48).

166. For a discussion of the characteristics of the uninsured, see notes 51-57 and accompanying text.

167. See notes 133-53 and accompanying text.

168. Henry T. Greely, *AIDS and the American Health Care Financing System*, 51 U. Pitt. L. Rev. 73, 126-32 (1989).

Congress also can avoid wary employers' overly broad health modifications by requiring the EEOC to establish clear guidance concerning the ADA's provisions.¹⁶⁹

Finally, Congress should remove some of the financial burdens that bar access to adequate health care by revising the tax code to provide refundable tax credits based on income and health care needs for qualified uninsured families.¹⁷⁰ The government could fund these tax credits through revenue derived from revisions of the federal tax code's treatment of employer-provided health benefits.¹⁷¹ The value of employer-provided health insurance currently is excluded from a worker's taxable income,¹⁷² creating an inequitable distribution of government benefits¹⁷³ and the overconsumption of health care.¹⁷⁴ Congress should provide the working poor who purchase health insurance through tax credits with part of the \$65 billion in revenue derived from such a revision.¹⁷⁵ It should use the remainder to fund government programs for both high-risk persons who cannot purchase third-party health insurance because of poor health, and those who do not purchase health insurance for reasons such as inadvertence or lack of knowledge of the credit program.

The public currently subsidizes the uninsured's health care through expensive hospital costs and high insurance premiums.¹⁷⁶ A tax credit program is more efficient and effective than the current system at providing accessible health care to Americans who cannot afford to purchase third-party health insurance.¹⁷⁷ The tax credit program would

169. See notes 149-53 and accompanying text.

170. For a more detailed analysis of such a program, see Stuart M. Butler, *A Tax Reform Strategy to Deal With the Uninsured*, 265 J. Am. Med. Assn. 2541 (1991).

171. Although President Clinton is considering similar tax proposals, public pressures against tax increases make this an unlikely option. Judi Hasson, *Taxing Benefits is Health Care Option*, USA Today at 4A (Dec. 17, 1992). In order to avoid increasing the tax burden on middle class taxpayers, Congress could allow a set deduction for both employment-provided and individually-purchased health insurance to replace the current exclusion. This deduction should be phased-out as incomes reach higher levels.

172. See I.R.C. § 106 (1992). Individuals who do not have employment-based insurance are able only to deduct health insurance premiums if their total medical expenses (health insurance premiums can be considered as medical expenses) exceed a 7.5% floor. See *id.* § 213(a).

173. The inequity the present tax treatment creates is a result of three factors. First, low wage earners are less likely to benefit from the exclusion than higher compensated workers because the majority of the working uninsured are low wage earners. See notes 53-54 and accompanying text. Second, high wage earners are more likely to receive generous health insurance plans than low wage earners. Third, the progressive nature of the tax system makes this exclusion more valuable to workers in the highest tax bracket than workers in the lower tax brackets. See Butler, 265 J. Am. Med. Assn. at 2541 (cited in note 170).

174. See Burman and Rodgers, 45 Nat'l Tax J. at 337-40 (cited in note 28).

175. *Id.* at 331.

176. See Friedman, 265 J. Am. Med. Assn. at 2494 (cited in note 9).

177. Congress might soften public pressures against "giveaway" programs by reminders that government previously had subsidized even wealthy workers who received employment-based

maintain incentives for employers to provide health insurance for its workers through continued favorable tax treatment¹⁷⁸ and help maintain employee morale. It would also enhance competition among private insurers by the influx of new purchasers into the insurance market. In short, a tax credit program would create a more efficient distribution of health care subsidies to the uninsured while retaining competition among third-party insurers.

VII. CONCLUSION

The fissures the American health care system creates run deep, leaving many American families on the brink of falling into the gap. Middle-class families have lost faith in a system that forces them to pay escalating insurance premiums while the rising cost of health care surpasses their insurance benefits. Small businesses are limiting or discontinuing employee health benefit plans, because they are not able to absorb the rising insurance premiums resulting from astronomical increases in health care costs. Consequently, families delay doctor visits, increasing the cost of medical care when they resort to emergency rooms for primary care. The problems with the American health care system feed on one another, threatening the emotional and financial stability of the American family.

The federal government may not be able to find a cure for the illnesses from which families suffer, but it can alleviate the emotional and financial burdens families face as a result of their inability to acquire health insurance. Current proposals that require employers to provide mandatory health insurance will leave many low-income employees and their families uninsured and unemployed. Congress can make health care accessible to these families by reducing the cost of health care and by subsidizing the purchase of private health insurance for low income families through refundable tax credits.

The solutions herein proposed are not intended to be an exhaustive list; much more can and should be done to remedy the problems created by the fragmented health insurance system. Until Congress chooses to act, however, some families' health care needs for their chil-

health insurance through tax exemptions for employment-based insurance. See notes 172 and accompanying text.

178. The suggested revisions would continue to allow employers to deduct health benefits provided to employees as an ordinary and necessary business expenditure. See I.R.C. § 162 (1992).

dren will remain dependent on the sympathy invoked in convenience store customers by the child's picture on a coin jar.

*Jeffrey Ralph Pettit**

* The author wishes to thank Rick McMurtry, Rebecca Simpson, Elizabeth Bowles, and Professor Ellen Wright Clayton for their valuable contributions to this Note. In addition, the author would like to thank his family for their continued support and love.

