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# The Americans with Disabilities Act: Implications for Managed Care for Persons with Mental Illness and Addiction Disorders

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*BEHAVIORAL HEALTH ISSUE BRIEF SERIES*

The Americans with Disabilities Act:  
Implications for Managed Care for Persons with Mental  
Illness and Addiction Disorders<sup>a</sup>

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<sup>a</sup> The Department of Health and Human Services has reviewed and approved policy-related information within this document, but has not verified the accuracy of data or analysis presented. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Care Financing Administration (HCFA), or the U.S. Department of Health and Human Services.

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## Executive Summary

This Issue Brief, prepared for the Substance Abuse and Mental Health Services Administration, examines the Americans with Disabilities Act (“the ADA”) and its application to managed care. The ADA provides important protections for persons with disabilities who are members of managed care arrangements, regardless of whether their membership is sponsored by an employer, Medicare, or Medicaid or is purchased privately. The interaction between the ADA and managed care is complex, and different issues can arise under publicly and privately sponsored plans.

### *Overview*

Managed care has its roots in employment-based health insurance. In recent years, however, managed care has become increasingly commonplace as a means of organizing and paying for health care for publicly insured persons with disabilities. This trend is expected to continue as Congress expands Medicare and Medicaid coverage for persons with disabilities who work. Equally as important, attitudes about disability and work have undergone a fundamental shift, and the number of persons with disabilities who work is growing. As the number of workers with disabilities increases, policy makers can be expected to focus greater attention on the issue of how the employment-based health insurance system treats workers with disabilities. Recent legislative reforms such as the Health Insurance Portability and Accountability Act and the Mental Health Parity Act are evidence of Congressional willingness to limit the discretion of insurers to offer – and employers to purchase – managed care products whose design features discriminate against persons with disabilities. Furthermore, in this atmosphere, the number of challenges to discriminatory insurance and managed care practices under the ADA can be expected to grow

### *The Content and structure of the ADA and its application to managed care*

The ADA contains a series of titles, each of which creates its own duties and obligations for entities covered by the title in question.

*Managed care arrangements furnished through employer-sponsored health plans.* Title 1 applies to employers and protects qualified individuals with disabilities from discrimination in the work place. Title 1 reaches employee benefits, including health coverage. Recent judicial interpretations of the provisions of Title 1 establish limitations on who can be considered disabled in an employment discrimination context. These decisions provide that persons whose impairments can be corrected or mitigated through drugs or devices to the point at which they function as would an individual without an impairment cannot be considered disabled under the law. At the same time, these decisions clarify that the mere availability of effective treatment does not eliminate the existence of a disability if in its corrected state the impairment still limits major life activities. While these decisions can be expected to have some impact on the ability of persons with mental illness to bring employment-based ADA claims, the Act would nonetheless cover any individual whose impairment, when treated, continues to limit a major life activity.

In deciding whether employer insurance practices are discriminatory under the ADA, courts and federal agencies tend to distinguish between questions of benefit design (macro-allocation issues) and specific application of benefits to individual cases (micro-allocation). In the case of employee health plan features that exclude or limit care for entire classes of conditions (such as mental illness), courts generally have been unwilling to find discrimination under the ADA and instead continue to permit employers to make across-the-board design decisions that are permissible as long as they apply to everyone. At the same time, limitations and exclusions that single out specific conditions have been considered to violate the Act, as have been individual treatment decisions that result in the denial of coverage on the basis of a disability. Other critical design and structural issues in managed care-style insurance such as network composition and physician incentive plans are only now beginning to receive ADA review in the courts. Federal guidance is extremely limited, and it is unclear whether these practices, if discriminatory, nonetheless would be permissible as a legitimate exercise of employee health plan benefit design. In recent months, federal agencies have shown increased willingness to classify as discriminatory employer health plan practices in the area of mental health that previously might have been considered permissible only a few years ago.

*Managed care plans as public accommodations.* Even where no employment-based claim can be made, an individual member of a managed care plan may nonetheless have a claim against the company under the public accommodations title of the ADA (Title III). With respect to questions of physical access, courts have held that managed care companies constitute places of public accommodation and thus are obligated to make their services accessible to persons with disabilities. With respect to issues related to the content of insurance itself, courts are split over the issue of whether companies can design and market products whose content discriminates against persons with disabilities. As with Title I claims, courts differ over the extent to which the ADA acts as a check on the content of insurance itself. Similar issues might arise under the ADA with respect to other aspects of managed care products such as networks, treatment guidelines, and incentive arrangements. To the extent that these features are viewed as integral to the insurance product, their discriminatory impact might be perceived to be beyond the reach of courts. However, several courts have allowed Title III claims that focus on the structure of insurance, effectively viewing the ADA as a limiting force on what types of products insurers can market.

*Publicly sponsored managed care plans.* Title II of the ADA prohibits discrimination by public entities, including state and local governments. Discrimination is prohibited both directly and indirectly through contract. Thus the ADA applies to publicly purchased managed care products. Despite the lack of federal guidance, a review of the Center for Health Services Research and Policy's contracts data base compiled for *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* reveals that numerous states have attempted to define the types of managed care practices that would constitute a violation of the law. Most states focus on matters involving physical access; several address issues relating to coverage limits, networks, and other features that can have a significant impact on access to treatment.

*The insurance safe harbor.* The ADA extends to the insurance industry a "safe harbor" defense against claims of discrimination. In order to mount a successful defense, an insurer

would have to be able to demonstrate that its product is legal under applicable law and that its practices are actuarially sound are not a subterfuge for discrimination. While the existence of a safe harbor is considered by many to be evidence of the fact that Congress intended to reach issues of insurance content and structure through the ADA, the courts are split over this issue. Thus, the safe harbor defense has rarely been invoked, since courts do not consistently conclude that the ADA reaches insurance content questions. In those cases in which the safe harbor defense has arisen, insurers either have admitted that their limits and design choices have no actuarial basis or else have been unable to offer a defense of actuarial soundness.

### *Conclusion*

Managed care brings into sharp focus the lack of federal guidelines regarding whether the ADA reaches questions of benefit design and what constitutes a benefit design matter. The presence of an insurance safe harbor defense suggests that the ADA was intended to reach not only individual instances of discrimination, but also basic benefit design decisions by purchasers and insurers, regardless of whether they concern specific disabilities or entire classes of conditions. Mental illness presents perhaps the most compelling reason for resolving this issue, whether through agency action or in Congress, since discriminatory limitations related to mental illness are so widespread.

In addition, federal guidelines are needed for publicly purchased products, particularly Medicaid managed care. Because the ADA definition of disability is far broader than that used to determine disability under the Social Security Act, the actual number of beneficiaries with ADA-level disabilities who are enrolled in Medicaid managed care on a mandatory basis could be considerable. The use of mandatory managed care raises important issues regarding the safeguards that should be in place as a means of ensuring that state programs reasonably accommodate the needs of members with disabilities. State agencies have made considerable strides in this area, but guidance is needed regarding enrollment, access, networks, coverage decision-making, physician incentive plans, and quality.

Of special importance is the issue of risk-adjusted premiums. In order to ensure non-discriminatory treatment of enrollees with mental illness, state agencies might need to risk-adjust their premium payments as a reasonable accommodation. The issue of risk-adjusted premiums raises further questions regarding federal Medicaid regulations that place strict upper limits on payments to managed care organizations. To the extent that these regulations prevent Medicaid agencies from making reasonable accommodations in the case of managed care members with disabilities, they need to be carefully reconsidered.

## Introduction

This Issue Brief, prepared for the Substance Abuse and Mental Health Services Administration, examines the Americans with Disabilities Act (ADA) and its relationship to managed care for persons with mental illness and addiction disorders. Part 1 discusses the growing interest in managed care and its relationship to persons with disabilities. Part 2 provides an overview of the ADA and its application to publicly and privately sponsored managed care-style health insurance arrangements. Part 3 presents an overview and analysis of ADA-related performance specifications contained in comprehensive service agreements between state Medicaid agencies and managed care organizations. These specifications are excerpted from *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*,<sup>1</sup> an annual study of Medicaid managed care contracts supported in part by SAMHSA.

The ADA applies to both privately and publicly sponsored managed care-style health insurance arrangements, including arrangements provided through employer-sponsored health plans, other forms of privately purchased coverage, managed care arrangements sponsored by state Medicaid and CHIP agencies, and Medicare-sponsored plans. Furthermore, at least some recent legal rulings suggest that the ADA's protections reach not only the physical access of managed care services, but the actual structure and design of managed care. The ADA thus may act as a limiting force on the amount of discretion the insurance industry has over the design of the products it sells, as well as the discretion that employers have over the structure and content of what they choose to purchase.

The nexus between the ADA and managed care raises particularly important issues for state Medicaid agencies. The ADA definition of disability is far broader than the more narrow definition of disability under the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) programs. Thus, in light of the reduced health status of Medicaid beneficiaries generally (with a particularly disproportionate level of mental illness-related disorders),<sup>2</sup> a significant proportion of all Medicaid managed care enrollees could be considered disabled within the meaning of the ADA. This estimate of a high prevalence of ADA-defined disability among Medicaid managed care enrollees is consistent with other research that shows that AFDC-related Medicaid managed care enrollees have health care costs that are significantly higher than those of their non-Medicaid counterparts.<sup>3</sup> Since enrollment into some form of managed care is compulsory for the majority of non-institutionalized Medicaid beneficiaries, a central question becomes the types of reasonable accommodations that state agencies must ensure are in place before mandating enrollment as a condition of eligibility. The United States Supreme Court's 1999 decision in *Olmstead v L.C.*<sup>4</sup> has served to focus new attention of Medicaid in an ADA context.<sup>5</sup>

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<sup>1</sup> The George Washington University Medical Center, School of Public Health and Health Services, Center for Health Services Research and Policy, Washington, DC (1998).

<sup>2</sup> Studies of the welfare population reveal, for example, that up to 30% can be considered to have an activity-limiting impairment. See, e.g., Pamela Loprest and Gregory Acs, *A Profile of Disability Among Families on AFDC* (Urban Institute, Washington D.C., 1996).

<sup>3</sup> W. Pete Welch and Martia Wade, "Relative Costs of Medicaid Enrollees and the Commercially Insured in HMOs," *Health Affairs* 14:2 (Summer, 1995) pp. 212-224.

<sup>4</sup> 119 S. Ct. 2176 (1999).

There are currently no express federal standards governing Medicaid managed care in an ADA context, just as there are no managed care-specific ADA standards for employee benefit plans. Despite this fact, our analysis of contracts between state Medicaid agencies and managed care organizations indicates that agencies have made a significant effort to interpret and give meaning to the ADA in a managed care context. At the same time, many unresolved issues in the ADA/managed care relationship remain.

## Part 1. Overview

Enacted in 1990, the Americans with Disabilities Act<sup>6</sup> represents a landmark advance in civil rights law. Building on earlier protections under §504 of the Rehabilitation Act of 1973<sup>7</sup> (which applies to federally funded and conducted activities), the ADA extends anti-discrimination protections well beyond prior law, reaching private employment, all publicly funded services, and public accommodations, including services operated by private entities.

Since its enactment, the ADA has generated extensive efforts to interpret and apply its provisions to a range of situations, including health insurance, whether individually purchased, publicly purchased, or employer-sponsored. However, despite the fact that ADA-based litigation against managed care companies appears to be rapidly increasing, many important issues remain unanswered.

### A growing focus on the relationship between managed care and persons with disabilities

Managed care has its roots in the employment-based health insurance system. The earliest efforts at prepaid health care arrangements were found in health plans created in the early part of the century for teachers, farmers, laborers, and other workers.<sup>8</sup> Consequently, the managed care experience for persons with significant disabilities is relatively recent, spurred on in part by the increasing use of managed care arrangements for Medicare and Medicaid beneficiaries.<sup>9</sup>

For purposes of the ADA, however, perhaps an even more significant managed care-related development has been the sea-change in attitudes and beliefs regarding employment by persons with disabilities. Over the past decade, and in great part because of passage of the ADA, enormous strides have been made in overcoming outmoded beliefs and attitudes regarding disability and employment. This shift led, among other things, to the 1999 enactment of The Ticket to Work and Work Incentives Improvement Act,<sup>10</sup> which offers

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<sup>5</sup> For a review of the *Olmstead* decision, see Sara Rosenbaum, *Olmstead v L.C.: Implications for Persons with Mental Illness and Addiction Disorders*, Center for Health Services Research and Policy (Washington, DC) (1999) available at: [http://www.samhsa.gov/mc/Managed%20Care%20Contracting/Olmstead\\_v\\_LC/olmstead.html](http://www.samhsa.gov/mc/Managed%20Care%20Contracting/Olmstead_v_LC/olmstead.html).

<sup>6</sup> 42 U.S.C. §§12101-12213.

<sup>7</sup> 29 U.S.C. §794.

<sup>8</sup> Paul Starr, *The Social Transformation of American Medicine* (Basic Books, N.Y., 1982).

<sup>9</sup> See, e.g., Marsha Regenstien and Christy Schroder, "Medicaid Managed Care for Persons with Disabilities: State Profiles," Prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC (December, 1998).

<sup>10</sup> Pub. L. 106- .

major new opportunities to ensure that workers with disabilities do not lose Medicare and Medicaid benefits.

These changing attitudes also have caused policy makers to focus on how the design of employment based health plans create access and coverage barriers for workers with disabilities. The Health Insurance Portability and Accountability Act of 1996 (HIPAA),<sup>11</sup> which limits the use of preexisting exclusion clauses, as well as the Mental Health Parity Act of 1996,<sup>12</sup> which seeks to eliminate coverage disparities in the design of employee health benefit plans, are both evidence of policymakers' interest in reducing the potential for discrimination in the design of employee health benefit plans, as well as other forms of health insurance marketed to public and private purchasers.

As managed care has become the principal means by which the working-age population receives health insurance, the proportion of enrollees with disabilities undoubtedly has increased. This is especially true for persons who work at jobs where only one form of health coverage is offered, as well as publicly insured individuals.<sup>13</sup> Furthermore, voluntary enrollment in managed care by persons disabilities also can be expected to be more common because of the tendency (at least until recently) on the part of managed care companies to market enrollment by offering additional benefits.<sup>14</sup> It should come as little surprise, therefore, that there appears to have been a major leap in recent years in the number of ADA-based lawsuits challenging not only individual practices by managed care companies in the area of access to care, but also the very *structure, content, and design* of managed care-style insurance plans.

## **Part 2. The Structure of the Americans with Disabilities Act and its Application to Managed Care Arrangements**

The ADA consists of separate titles, each of which has relevance to the question of managed care, depending on the characteristics of the individual who alleges discrimination, whether the individual's plan membership itself is employer sponsored or made available through other means, and the extent to which the managed care arrangement can be viewed as a public accommodation. Several sets of federal regulations are relevant to an ADA discussion, since different agencies oversee and enforce the law. Each separate title contains different standards for determining who is a qualified individual with a disability, what

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<sup>11</sup> Pub. L. 104-191, amending ERISA, the Public Health Service Act, and the Internal Revenue Code.

<sup>12</sup> Pub. L. 104-204.

<sup>13</sup> Data from employer surveys suggest that many employers now offer a choice of only one plan organized on a managed care basis (i.e., a plan that utilizes a network of participating providers over which the company exerts selection, practice, and utilization controls). Employer sponsored plans tend to be somewhat more loosely organized, using cost-sharing techniques rather than tight management and heavy network restrictions to control access and utilization. See Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, Old Westbury, NY, 1997; 1999-2000 Supplement) at Ch. 2(J).

<sup>14</sup> For example, recent decisions by managed care plans to reduce the extent of their prescribed drug coverage in their Medicare plans led to numerous stories regarding the number of Medicare beneficiaries with disabilities, such as HIV/AIDS, who had selected managed care as a means of gaining access to affordable drug coverage.

actions may constitute discrimination, what types of defenses may be available, and which party bears the burden of proof at different stages of an ADA-related matter.

## A. Managed care arrangements furnished through employer-sponsored health plans

### Key Elements of the Law

In the case of persons whose managed care membership is sponsored by an employer as an employee benefit, Title I of the ADA,<sup>15</sup> relating to employer discrimination, is relevant. Federal regulations implementing Title I make it unlawful for a “covered entity” to

discriminate on the basis of a disability against a qualified individual with a disability in regard to \*\*\*

(c) Rates of pay or any other form of compensation and changes in compensation;

\*\*\*

(f) *fringe benefits available by virtue of employment, whether or not administered by the covered entity.*<sup>16</sup> [Emphasis added]

Federal guidelines issued by the Equal Employment Opportunity Commission (EEOC) clarify that health insurance is a form of fringe benefit covered by Title I.<sup>17</sup>

Under Title I, a “covered entity” means, among other things, an employer<sup>18</sup> with “15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person”.<sup>19</sup> The term “employer” does not include the United States, a corporation wholly owned by the United States government, or an Indian tribe.<sup>20</sup> As a result, federal employees would not be covered by the provisions of Title I, although they are covered by sections 501 and 504 of the Rehabilitation Act.<sup>21</sup>

Under Title I, the term “disability” means

(1) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(2) a record of such an impairment; or

(3) being regarded as having such an impairment.<sup>22</sup>

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<sup>15</sup> 42 U.S.C. §12111 et seq.

<sup>16</sup> 29 C.F.R. §1630.4.

<sup>17</sup> EEOC, Interim Policy Guidance on ADA and Health Insurance (June 8, 1993).

<sup>18</sup> 29 C.F.R. §1630.2(b).

<sup>19</sup> 29 C.F.R. §1630.2(e).

<sup>20</sup> 29 U.S.C. §1630.2(e)(2)(i).

<sup>21</sup> 29 U.S.C. §§791 and 794.

<sup>22</sup> 29 C.F.R. §1630.2(g). The rule also defines physical or mental impairment to include any mental or psychological disorder including mental retardation, organic brain syndrome, emotional or mental illness, and

A “qualified individual with a disability” means

an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position \*\*\* and who, with or without reasonable accommodation, can perform the essential functions of such position.<sup>23</sup>

Pursuant to the statute, the rules specifically exclude from the term “disability” and the term “qualified person with a disability” individuals who are “currently engaging in the illegal use of drugs.” The rules also specify that this exclusion does not apply to persons who “have successfully completed” a supervised drug rehabilitation program and are “no longer engaging in the illegal use of drugs” or who “otherwise [have] been rehabilitated successfully and [are] no longer engaging in the illegal use of drugs.”<sup>24</sup> In addition, the rules specify that an individual shall not be denied health services provided in connection with drug rehabilitation on the basis of the current illegal use of drugs if the individual is otherwise entitled to services.<sup>25</sup> Homosexuality and bisexuality are not considered impairments and as such are not disabilities under the ADA, and the rules exclude for Title I purposes persons who have transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current illegal use of drugs.<sup>26</sup>

In addition to the direct prohibition against discrimination, the rules prohibit covered entities (in this case, employers) from

Participat[ing] in a contractual or other arrangement or relationship that has the effect of subjecting the covered entity’s own qualified \*\*\* employee with a disability to the discrimination prohibited by this part.<sup>27</sup>

The term “contractual arrangement” is defined to include “an organization providing fringe benefits to an employee of the covered entity.”<sup>28</sup> Thus, where an employer contracts with a managed care organization or other insurer either to furnish an insured health plan product or administer a self-insured plan, the employer may not avoid through contract the same obligations that would apply to situations where the employer provides the benefit directly.

The rules also prohibit employers and covered entities from using

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specific learning disabilities. See §1630.2(h) for additional definitions of “major life activities” and “substantially limits”. See 29 C.F.R. §§1630.2(k) and (l) for definitions of having a “record” of an impairment or being “regarded as having” an impairment.

<sup>23</sup> 29 C.F.R. §1630.2(m).

<sup>24</sup> 29 C.F.R. §§1630.3(a) and (b). The rules permit covered entities to adopt or administer reasonable policies including drug testing to ensure that individuals continue to meet the exemption to the illegal drug use exclusion. 29 C.F.R. §1630.2(c).

<sup>25</sup> 28 C.F.R. §35.131(b) (Title II) and 28 C.F.R. §36.209(b) (Title III).

<sup>26</sup> 29 C.F.R. §1630.3(d).

<sup>27</sup> 29 C.F.R. §1630.6(a).

<sup>28</sup> 29 C.F.R. §1630.6(b).

criteria or methods of administration, which are not job-related and consistent with business necessity, and (a) that have the effect of discriminating on the basis of disability.<sup>29</sup>

The rules require employers and other covered entities to make “reasonable accommodation” to the

known physical or mental limitations of an otherwise qualified applicant or employee with a disability unless the covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of its business.<sup>30</sup>

The regulations also make it unlawful for an employer to discriminate against a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a family, business, social, or other relationship or association.<sup>31</sup>

The ADA permits employers and covered entities involved in the provision of employment benefits to claim several different types of defenses to charges of discrimination.<sup>32</sup> Many of the defenses allowed under the rules are relevant where the issue involves discrimination in employment itself. For purposes of this analysis, the most relevant defense is raised when an employer or an employer plan is faced with a “disparate treatment” charge; it entails demonstrating that “the challenged action is justified by a legitimate, non-discriminatory reason.” A second relevant defense is the “direct threat” defense, which provides that a qualification standard adopted by an employer may include a requirement that an individual shall not pose a direct threat to the health or safety of the individual or others in the workplace.<sup>33</sup> A third relevant defense, discussed at greater length below, is the “safe harbor” defense. This is an affirmative defense available to insurers against whom a prima facie case of discrimination has been made.

## Application of the ADA to Employer-Sponsored Managed Care Arrangements

Individuals who seek to bring a claim against their employers for violation of Title I in the provision of managed care benefits must be able to prove several basic matters:

- First, that they are disabled within the meaning of the Act;
- Second, that they are “qualified” persons with disabilities;
- Third, that the entity that has allegedly committed the discrimination is a “covered entity”; and
- Fourth, that a form of discrimination prohibited under the Act and implementing regulations has occurred.

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<sup>29</sup> 29 C.F.R. §1630.7.

<sup>30</sup> 29 C.F.R. §1630.9.

<sup>31</sup> 29 C.F.R. §1630.8.

<sup>32</sup> 29 C.F.R. §1630.15.

<sup>33</sup> 29 C.F.R. §1630.15(b)(2).

## Proving the Existence of a Disability

In order to be able to make a claim under the ADA, an individual must be “disabled” within the meaning of the law. In the case of employees, a series of recent Supreme Court decisions creates important new issues that must be considered. During its Spring, 1999 term, the Court issued three rulings regarding the meaning of disability under the ADA. *Sutton v United Airlines*<sup>34</sup> involved two sisters with severe myopia whose condition was correctable with eyeglasses and who sued under the Act when their applications for commercial pilot licenses were rejected on the basis that their uncorrected vision fell below FAA-approved standards. *Murphy v United Parcel Service*<sup>35</sup> involved an individual who was rejected for a job as a driver because of a condition (in this case, hypertension) that when medicated, permitted the plaintiff to carry out all normal daily activities as would a non-disabled person but that when untreated, fell below Department of Transportation (DOT) standards. *Albertsons, Inc. v Kirkingburg*<sup>36</sup> involved a driver whose uncorrected vision similarly disqualified him for his job under DOT standards.

Citing the potential reach of the ADA were disabilities to be measured in their uncorrected state, the Court held that for an impairment to be considered a disability under the Act, it must be evaluated in its corrected state and therefore, that a plaintiff must demonstrate that even when corrected, the impairment substantially limits one or more major life activities.<sup>37</sup> The majority concluded that

A disability exists only where an impairment “substantially limits” a major life activity, not where it “could” or “would” be substantially limiting were mitigating measures not taken. A person whose physical or mental impairment is corrected by medication or other measure does not have an impairment that presently “substantially limits” a major life activity.<sup>38</sup>

The majority also held that:

[t]he use of a corrective device does not, by itself, relieve one’s disability. Rather, one has a disability under [the Act] if notwithstanding the use of a corrective device, that individual is substantially limited in a major life activity. \*\*\* The use or nonuse of a corrective device does not determine whether an individual is disabled; that determination depends on whether the limitations an individual with an impairment *actually* faces are in fact substantially limiting.<sup>39</sup>

The Court further held that a plaintiff may rely on the “regarded as” standard only where the employer *mistakenly* believes either that there is an impairment or that the impairment limits life activities. Nor did the Court believe that the “regarded as” test could be met by the allegation that the opportunity to work in the chosen field (e.g., an airline pilot, a truck driver) was a major life activity, since the plaintiffs could work generally and

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<sup>34</sup> 119 S. Ct. 2139 (1999).

<sup>35</sup> 119 S. Ct. 2133 (1999).

<sup>36</sup> 119 S. Ct. 2162 (1999).

<sup>37</sup> *Sutton*, slip op. at 8.

<sup>38</sup> *Id.* at 9.

<sup>39</sup> *Id.* at 15.

failed to show that their impairments prevented them from engaging in at least a broad class of jobs.<sup>40</sup>

Of additional importance to the Court was the fact that in its preamble, the ADA itself states that some 43 million Americans have a disability. Were the Act held to reach persons with conditions that effectively could be completely corrected, the majority concluded that the number of individuals potentially covered by the Act would swell to approximately 160 million individuals, a result that in the majority's view was not intended by Congress.

These decisions create important limitations on the ability to bring ADA claims. In order to be able to invoke the Act's protections, an individual must be able to demonstrate that despite correction his or her impairment continues to significantly affect a major life activity. Yet the very health care whose availability may be the subject of the litigation may yield sufficient benefit so that the individual is able to function as would a person without the impairment. How these decisions play out in subsequent cases involving claims of discrimination in health benefits by persons with mental illness remains to be seen. To the extent that an individual with either a physical or mental impairment can demonstrate that medication or devices that control or mitigate its effects nonetheless leave her significantly limited in major life activities, proving the existence of a disability will still be possible. Because this type of claim is intensely factual, a significant amount of evidence regarding the effects of treatment for mental illness and addiction disorders on every day functioning and major life activities will be determinative of the viability of a claim under the Act.

### **Proving one's status as a qualified person with a disability**

Beyond proving the existence of a disability, individuals also must demonstrate that they are "qualified individuals with disabilities." Until recently, courts have held that in order to raise an ADA claim based on Title I, an individual must be a current employee.<sup>41</sup> At least one court now has held that former employees may invoke ADA protections. In *Ford v Shering-Plough*,<sup>42</sup> the United States Third Circuit Court of Appeals held that the ADA extends the reach of Title I to former employees. *Shering-Plough*, like many ADA cases, involved limitations on services for persons with mental illness. In this case the facts revolved around a long-term employer-sponsored disability plan that placed a two-year cap on coverage for mental, but not physical, disabilities. The *Shering-Plough* case is important because of its holding that for purposes of Title I, individuals who claim discrimination involving fringe benefits that are designed to be furnished on a *post-employment* basis (e.g., disability benefits and COBRA continuation benefits<sup>43</sup>) are still considered employees for purposes of Title I.

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<sup>40</sup> *Id.* at 17-18.

<sup>41</sup> *Gonzales v Garner Food Services, Inc.*, 89 F. 3d 1523 (11<sup>th</sup> Cir. 1996); *EEOC v CAN Insurance Companies*, 96 F. 3d 1039 (7<sup>th</sup> Cir. 1996).

<sup>42</sup> 145 F. 3d 601(3<sup>rd</sup> Cir. 1998).

<sup>43</sup> Continuation benefits (known as "COBRA" benefits after the name of the federal law that created the right to such coverage) permit certain individuals to continue to obtain health coverage following termination of employment in the case of "qualifying events". 29 U.S.C. §1161 et seq. Common "qualifying events" are illness and disability, termination of employment, divorce, or death of a covered spouse. Only an estimated 20 percent of all persons eligible for COBRA continuation benefits actually elect to participate, since employers covered by COBRA are not obligated to continue to contribute toward the premium. As a result, COBRA-

## Who is a “covered entity”?

Under Title I cases alleging discrimination by a health insurer, the question arises as to whether the insurer is a “covered entity” within the meaning of the ADA. Insurers that provide benefits under employer sponsored plans may insure the benefits; alternatively, they may administer the benefits on behalf of an employer that self-insures. The issue in such cases is whether the entity committing the acts that are the subject of the suit can be viewed as the “agent” of the employer. Federal regulations defining entities would appear to prohibit insurers from escaping liability in these situations, and courts have agreed.<sup>44</sup>

## Types of employee health benefit practices to be challenged: benefit design matters versus individual coverage and treatment decisions

Perhaps the most fundamental question regarding the application of the ADA to health insurance, including managed care, is what types of practices can be challenged. As a general matter, in cases brought against employers for unfair treatment under employee health benefit plans, courts tend to distinguish between *benefit design* matters on the one hand (e.g., what to cover, how much to cover, and other issues that go to the basic design of the benefits extended to employees) and on the other hand, challenges to the *application of the benefits that are offered* in individual cases. Issues of benefit design can be thought of as “macro-allocation” questions; that is, they concern how the employer elects to allocate for *all employees* the resources that it has committed for health care. The second issue is one of “micro-allocation”; it involves individual decisions regarding whether and how benefits that in fact are covered will be furnished to particular individuals. Put another way, macro-allocation issues are those that determine the structure of the benefit plan for all members and affect every member of the group regardless of individual health needs; micro-allocation issues arise when the terms of coverage are applied to individual cases.

In employee health benefit law generally, courts have tended to give employers absolute discretion over issues of benefit design. The core question becomes whether or not the ADA limits this discretion. In *McGann v H and H Music Co.*,<sup>45</sup> a seminal employee health benefit discrimination case decided prior to the effective date of the ADA, the United States Court of Appeals for the Fifth Circuit held that an employer did not violate the anti-discrimination provisions of the Employee Retirement and Income Security Act (ERISA) when it elected to modify its benefit plan to furnish far fewer benefits for persons with HIV, AIDS, and AIDS-related conditions. Once the ADA became effective, the obvious question was whether such benefit design limits were still legal.

The resounding answer from federal agencies and the courts has been unwaveringly confusing. Initial rulings by the EEOC suggest that across-the-board benefit limitations that *single out specific conditions and illnesses* for disparate treatment may in fact be unlawful. At the

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covered individuals may be somewhat more likely to be persons who have a significant need for continued coverage and therefore are willing to pay the entire cost of the premium.

<sup>44</sup> See *Carparts Distribution Center, Inc. v Automotive Wholesaler's Assoc. Of New England, Inc.*, 987 F. Supp. 77 (D. Mass., 1997). See also *Lee v California Butchers' Pension Trust Fund*, 1998 U.S. App. LEXIS 21899 (9th Cir. 1998).

<sup>45</sup> 946 F. 2d 401 (5th Cir. 1991); cert. den., 506 U.S. 981 (1992).

same time, however, the EEOC declared that design limitations that apply to entire classes of conditions or treatments are acceptable. In recent months the EEOC appears to have rethought this latter position, but in the meantime, most courts which have reviewed the issue have concluded that the ADA does not limit an employer's discretion to include class-wide, across-the-board benefit limitations. The continuation of this practice has been most evident in the case of mental illness coverage restrictions.

According to the EEOC:

\*\*\* The ADA \*\*\* prohibits employers from indirectly discriminating on the basis of disability in the provision of health insurance. \*\*\*

### III. Disability-Based Distinctions

#### A. Framework of Analysis

Whenever it is alleged that a health-related term or provision of an employer provided health insurance plan violates the ADA, the first issue is whether the challenged provision is, in fact, a disability-based distinction. \*\*\* [If the Commission determines that the challenged term or provision is a disability-based distinction, the employer must provide that (1) the health insurance plan is "bona fide" and (2) that the challenged distinction is not being used as a subterfuge].

#### B. What is a Disability-Based Distinction?

\*\*\*Not all health-related plan distinctions discriminate on the basis of disability. Insurance distinctions that are not based on disability, and that are applied equally to all insured employees, do not discriminate on the basis of disability and so do not violate the ADA.

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

Blanket pre-existing condition clauses that preclude from coverage \*\*\* the treatment of conditions that predate an individual's eligibility for benefits under the plan also are not distinctions based on disability and do not violate the ADA.<sup>46</sup> Universal limits or exclusions from coverage \*\*\* are likewise not insurance distinctions based on disability. Similarly, coverage limits on medical procedures that are not exclusively, or nearly exclusively utilized for the treatment of a particular disability are not distinctions based on a disability. \*\*\*

In contrast, however, health-related insurance distinctions that are based on disability may violate the ADA. A term or provision is "disability based" if it singles out a

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<sup>46</sup> Note that the EEOC guidance was written prior to enactment of the Health Insurance Portability and Accountability Act, P.L. 104-191, which restricts the use of preexisting condition exclusions and waiting periods.

particular disability (e.g., deafness, AIDS, schizophrenia), a discrete groups of disabilities \*\*\* or a disability in general.<sup>47</sup> [Emphasis added]

In reviewing cases involving employment-based health benefit plans, courts generally have followed this distinction between across-the-board exercises of purchasing discretion and disability based distinctions. In construing the obligations of companies administering employee health benefit plans under the ADA's public accommodations theory (discussed below), courts have generally upheld across-the-board limits on coverage of mental illness and other conditions. A recent decision by the United States Court of Appeals in *Kimber v Thiokol Corp.*<sup>48</sup> is emblematic of the direction pursued by courts:

While [Thiokol's disability] plan differentiated between types of disabilities, this is a far cry from a specified disabled employee facing differential treatment due to her disability. Every [Thiokol] employee had the opportunity to join the same plan with the same schedule of coverage, meaning that every [Thiokol] employee received equal treatment. So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities. The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA. *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir.1998), cert. denied, --- U.S. ----, 119 S.Ct. 850, 142 L.Ed.2d 704 (1999). The Fourth, Sixth and Seventh Circuits have also addressed the same issue and arrived at the same conclusion. See *Lewis v. Kmart Corp.*, 180 F.3d 166, 170 (4th Cir.1999) (holding that "the ADA does not require a long-term disability plan that is sponsored by a private employer to provide the same level of benefits for mental and physical disabilities."); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir.1997) (en banc), cert. denied, --- U.S. ----, 118 S.Ct. 871, 139 L.Ed.2d 768 (1998) ("The disparity in benefits provided in the policy at issue is also not prohibited by the ADA because the ADA does not mandate equality between individuals with different disabilities."); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039, 1044 (7th Cir.1996) ("a plan that promised [employees] long-term benefits from the onset of disability until age 65 if their problem was physical, and long-term benefits for two years if the problem was mental or nervous" did not violate the ADA). See also *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir.1996) (noting that excluding one disability from coverage is not a disability-based distinction violating the ADA so long as the exclusion applies equally to all individuals).

The D.C. Circuit also has ruled on this issue in analyzing the Rehabilitation Act and upheld distinctions in benefits based on physical and mental disabilities. *Moddero v. King*, 82 F.3d 1059, 1061 (D.C.Cir.1996), cert. denied, 519 U.S. 1094, 117 S.Ct. 772, 136 L.Ed.2d 717 (1997). Because the language of disability used in the ADA mirrors that in the Rehabilitation Act, we look to cases construing the Rehabilitation Act for guidance when faced with an ADA challenge. See *Bragdon v. Abbot*, 524 U.S. 624, 118 S.Ct. 2196, 2202, 141 L.Ed.2d 540 (1998); see also *Patton v. TIC United Corp.*, 77 F.3d 1235, 1245 (10th Cir.1996).<sup>49</sup>

The logic of this across-the-board versus specific-condition distinction is anything but clear. Both are forms of benefit design limits. Why it is acceptable to limit treatment for an entire class of conditions but not for each enumerated condition has no obvious answer. Indeed, had the plaintiff's policy singled out schizophrenia, it would have been a direct violation of EEOC guidelines. Even the EEOC, as noted in the *Kimber* decision, appears to

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<sup>47</sup> EEOC ADA Guidelines (1993 Daily Lab. Rep.).

<sup>48</sup> 196 F.3d 1092 (10<sup>th</sup> Cir. 1999).

<sup>49</sup> *Id.* at 1101-02.

now recognize the problems with its position, having filed an *amicus* brief on the plaintiff's behalf. It may be that given other recent developments in mental health policy, this is an opportune time for the EEOC to reconsider its earlier positions. However, it is not clear whether doing so through agency action alone would affect the outcome of employment-based cases, given the history of deference to employer decisions regarding benefit design.

Even were one to conclude that the EEOC's initial ruling was erroneous and that discriminating against classes of conditions is in reality no different from discriminating against them one condition at a time, it may be that the benefit design theory is now embedded in ADA as a matter of judicial policy, unless and until Congress alters the Act itself, much as it has begun to take steps to address other discriminatory design practices through such legislation as HIPAA and the Mental Health Parity Act.

The issue of employer discretion over benefit design is not confined to coverage. Managed care raises other potential design issues in addition to those directly related to coverage and treatment. For example, the composition and membership of a health care company's network or its physician incentive plan, can be alternatively thought of as methods of administration or as benefit design matters. What if the incentive plan creates significantly higher incentives to withhold treatment in the case of mental illness? Similarly, what if waiting times for psychiatric care are twice as long as for other forms of treatment? What if the plan places particularly stringent limits on the number of psychiatrists it allows in its networks as a means of slowing resource allocation? Can these actions be challenged as methods of administration that discriminate against persons with disabilities, or are they merely part of the employer's health plan's design and thus insulated from challenge under the ADA? Several courts appear to be willing to label as "design" matters virtually all structural features and characteristics of employer-sponsored health plans, including physician incentive plans and treatment guidelines.<sup>50</sup> Other courts have shown a willingness to consider the effects of such features on the treatment of individuals with disabilities. These other cases have tended to arise in a non-employment-based context, and their relevance to employer-sponsored plans is not clear.

Federal guidelines on the application of the ADA to managed care arrangements are virtually non-existent. As a result, there is no formal policy distinguishing for purposes of employee benefit plans what constitutes permissible coverage and treatment limitations versus unlawful discriminatory conduct. Without further guidance, drawing the line between permissible employer practices and impermissible discrimination will continue on a case-by-case basis.

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<sup>50</sup> For example, in *Herdrich v Pegram*, 154 F. 3d 362 (7<sup>th</sup> Cir. 1998), reh. den. 170 F. 3d 683 (1999), the United States Court of Appeals for the Seventh Circuit held that it is a violation of ERISA to allow physician-owners of health plans to both make coverage decisions and treat patients. The minority found that such conduct is merely part of the plan's design and not reviewable. The case is now pending before the Supreme Court, and a decision is expected by the summer of 2000. In *Jones v Kodak*, 169 F. 3d. 1287 (10<sup>th</sup> Cir. 1999), the United States Court of Appeals for the Tenth Circuit ruled that a plan member who was denied necessary alcohol rehabilitation treatment had no right to make a claim against her plan, because the inappropriate treatment guidelines that were applied in her case were actually part of the terms of coverage themselves and thus were unchallengeable.

While designing plans to exclude or limit coverage for conditions of illnesses appears acceptable, were a health plan administrator to deny medically necessary covered care because of an individual's disability, the denial could be challenged as a micro-allocation decision that violates the disability-based distinction prohibitions set forth by the EEOC. Thus, for example, were a health plan to find that the presence of a mental illness made care for a second physical or mental problem medically unnecessary or inappropriate, such a decision probably be considered violative of the Act.

## B. Managed Care Plans as Public Accommodations

The preceding section discussed challenges to managed care arrangements involving persons who are qualified disabled individuals, who are employed within the meaning of the Act, and who are challenging the practices of an employer or its agent. However, many managed care enrollees are not employees and the arrangement they are challenging may not be offered by an employer or its agent as an employment benefit. In such situations, Title I of the ADA does not apply. However, the ADA appears to offer a separate basis for challenging the conduct of managed care companies as public accommodations, regardless of whether membership is publicly or privately sponsored.

It is an open question whether a claim that fails because it involves an act committed to the discretion of the *purchaser* nonetheless can succeed if presented as a challenge to the discretion of the *seller* to offer products that discriminate. As with employer cases, the issue may come down to whether the discrimination alleged involves differential treatment for a single condition versus an entire class of benefits.

## Key Elements of Title III

Title III prohibits discrimination by places of public accommodation and commercial facilities. Regulations implementing Title III provide that:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation by any private entity who owns, leases (or leases to), or operates a place of public accommodation.<sup>51</sup>

The “public accommodation theory would appear to apply regardless of whether the plan is employer-sponsored, Medicare-sponsored,<sup>52</sup> Medicaid-sponsored, or individually purchased.<sup>53</sup> Under Title III the definition of disability is the same as that used under Title I and includes both physical and mental impairments.<sup>54</sup> The term “place of public accommodation” specifically includes “a pharmacy, an insurance office, professional office of a health care provider, or other service establishment.”<sup>55</sup> Physicians’ offices and those of

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<sup>51</sup> 28 C.F.R. §36.201(a).

<sup>52</sup> In *Zamora-Quezada v Health Texas Medical Group*, 34 F. Supp. 2d 433 (W.D. Tx. 1998) a federal district court held that a Medicare sponsored plan was covered by the ADA under both a public accommodations theory and as a recipient of federal financial assistance.

<sup>53</sup> *Woolfolk v Duncan*, 872 F. Supp. 1381 (E.D. Pa. 1995).

<sup>54</sup> 28 C.F.R. §36.104. See *supra* notes 22-27 and accompanying text.

<sup>55</sup> *Id.*

managed care network providers generally have been specifically treated as places of public accommodation in cases alleging refusal to treat.<sup>56</sup> Thus, a privately or publicly insured person who is denied care or treated in a discriminatory fashion by a managed care company, either through its provider network or its administrative personnel, would be able to allege discrimination against a “place of public accommodation.”<sup>57</sup> Whether the content of insurance is a public accommodation is another matter.

The types of discrimination prohibited under the public accommodations provisions of the law are enumerated in the regulations, which provide in relevant part as follows:

(a) Denial of participation. A public accommodation shall not subject an individual \*\*\* on the basis of a disability \*\*\* directly or through contractual \*\*\* arrangements to a denial of the opportunity \*\*\* to participate in or benefit from the goods, services, facilities, privileges, advantages or accommodations of a place of public accommodation.

(b) Participation in unequal benefit. A public accommodation shall not afford an individual \*\*\* on the basis of a disability \*\*\* directly, or through contractual \*\*\* arrangements, with the opportunity to participate in or benefit from a good, service, facility, service, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

(c) Separate benefit. A public accommodation shall not provide an individual \*\*\* on the basis of a disability \*\*\* directly, or through contractual \*\*\* arrangements with a good, service, facility, privilege, advantage or accommodation that is different or separate from that provided to other individuals unless such action is necessary to provide the individual \*\*\* with a good, service, facility, or privilege, advantage or accommodation, or other opportunity that is as effective as that provided to others.<sup>58</sup>

In addition, the law requires places of public accommodation to furnish their services in integrated settings:

(a) In general. A public accommodation shall afford \*\*\* services \*\*\* to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

(b) Opportunity to participate. Notwithstanding the existence of separate or different programs or activities provided in accordance with this subpart, a public accommodation shall not deny an individual with a disability to participate in such programs or activities that are not separate or different.<sup>59</sup>

Public accommodations are prohibited from coercing, intimidating, threatening, or interfering with individuals in their enjoyment of their rights. Examples of such prohibited activities are

(1) coercing an individual to deny or limit the benefits, services or advantages to which he or she is entitled \*\*\*; [or]

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<sup>56</sup> *Bragdon v Abbott*, 524 U.S. 624 (1998); *Woolfolk v Duncan*, supra, note 53.

<sup>57</sup> *Zamora-Quezada*, supra note 52.

<sup>58</sup> 28 C.F.R. §36.202.

<sup>59</sup> 28 C.F.R. §36.203.

(2) threatening, intimidating, or interfering with an individual with a disability who is seeking to obtain or use \*\*\* services \*\*\*[.]<sup>60</sup>

Public accommodations also must make “reasonable modifications in policies, practices or procedures when the modifications are necessary to afford goods, [or] services, \*\*\* to individuals,” unless the public accommodation can demonstrate that “making the modification would fundamentally alter the nature of the \*\*\* services.”<sup>61</sup> A public accommodation may refer an individual with a disability to another public accommodation if the individual seeks or requires treatment or services “outside of the public accommodation’s area of specialization” *and* “if, in the normal course of its operations, the referring public accommodation would make a similar referral for an individual without a disability.”<sup>62</sup>

Public accommodation must take “those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently \*\*\* because of the absence of auxiliary aids and services” unless the public accommodation can demonstrate that taking such steps “would fundamentally alter the nature of the \*\*\* services” or would “result in an undue burden, i.e., significant difficulty or expense.”<sup>63</sup>

The rules permit public accommodations to deny services where an individual “poses a direct threat to the health and safety of others”. The term “direct threat” means

(b) \*\*\* a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services.

(c) In determining whether an individual poses a direct threat \*\*\* a public accommodation must make an individualized assessment, based on reasonable judgment, that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature and duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices or procedures will mitigate the risk.<sup>64</sup>

The list of auxiliary services includes “qualified interpreters” as well as a broad list of assistive devices for persons with physical disabilities.

## Application of Public Accommodations Theory to Managed Care

Taken together, the public accommodations provisions create a duty on the part of a public accommodation, which includes insurance offices and health care providers (the service delivery and administrative components of the managed care plan), to make services accessible in an effective and meaningful manner to persons with disabilities. While most publicized conduct by managed care organizations that might constitute segregation or

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<sup>60</sup> 28 C.F.R. §36.206.

<sup>61</sup> 28 C.F.R. §36.302(a).

<sup>62</sup> 28 C.F.R. §36.302(b).

<sup>63</sup> 28 C.F.R. §36.303(a).

<sup>64</sup> 28 C.F.R. §§36.208 (b) and (c).

discrimination tend to focus on physical barriers, the Title III rules would also appear to prohibit more subtle forms of discrimination such as encouraging persons with mental illness not to enroll in a plan, limiting individuals to certain health care providers or settings, disenrolling or seeking to disenroll members whose mental illness or addiction disorders make care more complex and require more experienced primary and specialty care providers, or failing to modify a provider network to include health professionals with experience in managing care of persons with mental disabilities. At least one case has found potentially violative of the Act physician incentive plans that encourage physicians to deny or delay care to persons with disabilities, as well as retaliatory de-selection of physicians who protested benefit denials on disabled patients' behalf.<sup>65</sup>

A vigorous debate is currently under way in the courts regarding whether the *content* of insurance is to be considered a public accommodation under Title III and thus subject to scrutiny, or whether Title III reaches only physical access matters. Much of this debate has arisen in the context of employee health benefits where, after failing for some reason to make a Title I claim, a plaintiff has then tried to reach coverage issues under Title III. Were such a claim to find acceptance, the burden of proof might shift to the insurer to demonstrate that its practices are defensible as an insurer safe harbor. Arguing that the content of insurance is a public accommodation might afford plaintiffs the opportunity to reach not only individual coverage decisions and practices but also issues that in an employment-based context might be seen as beyond the reach of the ADA and within the purview of employers as a design matter.

As noted in the *Kimber* decision, *supra*, one Court of Appeals has recognized the legitimacy of a public accommodations claim involving insurance content; virtually all other appeals courts have rejected this interpretation of the ADA. The case of *Doe v Mutual of Omaha*,<sup>66</sup> decided by the United States Court of Appeals for the Seventh Circuit in 1999, is particularly notable, because on appeal the defendant, Mutual of Omaha, stipulated for purposes of the appeal that its limitations on coverage for HIV/AIDS services had no actuarial basis and was without statistical support. The *Kimber* case offers additional evidence of judicial unwillingness to curb the discretion of either buyers or sellers in the managed care market where design features that limit coverage of health conditions are involved.

In sum, Title III offers an alternative basis for claiming discrimination in managed care. Service delivery-related barriers appear to be clearly covered by the Act, as are matters of physical access. The content of insurance may or may not be covered. Whether in a managed care context limits on the content of care can be successfully distinguished from limits on service delivery, such as controls over access and utilization, is less than clear. If all managed care treatment-related conduct is classified as “design” or “content” (a not inconceivable result given the difficulty in managed care of distinguishing between coverage and treatment decisions), then the use of Title III to challenge managed care practices might be severely curtailed.

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<sup>65</sup> *Zamora-Quezada*, *supra* note 52.

<sup>66</sup> 179 F.3d 557 (1999).

## C. Publicly Sponsored Managed Care Plans: Medicare, Medicaid, and the Children's Health Insurance Program

Nearly all Medicaid and Children's Health Insurance Program (CHIP) agencies purchase managed care products for beneficiaries. In addition, Medicare sponsors managed care for its beneficiaries. The ADA may reach Medicare-sponsored plans under a public accommodations theory.

The ADA, like section 504 of the Rehabilitation Act of 1973, establishes important protections against the provision by public entities of managed care services that discriminate against persons with disabilities.<sup>67</sup>

### Key Elements of the Law

Title II covers "services, programs and activities provided or made available by public entities, which are defined as state and local governments and departments, agencies, special purpose districts or other instrumentalities of state and local governments."<sup>68</sup> Regulations implementing Title II contain a series of prohibitions:<sup>69</sup>

(a) no qualified individual with a disability shall, on the basis of the disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity or be subjected to discrimination by any public entity.

(b) (1) a public entity, in providing any \*\*\* benefit or service, may not, directly or through contractual \*\*\* arrangements on the basis of a disability

(i) deny a qualified individual with a disability an opportunity to participate or benefit from the \*\*\* service;

(ii) afford a qualified individual with a disability with a \*\*\* service that is not equal to that afforded others;

(iii) provide a qualified individual with a disability with [a] \*\*\* service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

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<sup>67</sup> In *Olmstead v L.C. by Zimring*, 119 S. Ct. 2176 (1999), individuals successfully enforced ADA protections against state officials, although the Supreme Court remanded the case to the district court in part for further analysis on the issue of whether to grant injunctive relief against future unlawful conduct. Note that the Supreme Court in *Olmstead* did not address the issue of whether Title II of the ADA is constitutional insofar as it permits the recovery of damages against a state agency. However, it is worth noting that during the 1999 term the Supreme Court handed down several decisions regarding Congress' powers and state sovereign immunity which have been cited as authority for challenging the constitutionality of recovery of damages against a state agency under the ADA. See *Alsbrook v City of Maumelle*, No. 97-1825 (8<sup>th</sup> Cir. 1999). For an excellent analysis of these decisions see Jane Perkins, *Supreme Court Blocks Remedies Against State Actions* (August, 1999), at <http://www.healthlaw.org/pubs/199908federalism>.

<sup>68</sup> 28 C.F.R. §§35.101 and 35.104.

<sup>69</sup> 28 C.F.R. §35.130 et seq. See also *Olmstead*, *supra* note 67 (interpreting the "most integrated setting" requirement).

(iv) provide different or separate \*\*\* services to individuals with disabilities \*\*\* than is provided to others unless such action is necessary to provide qualified individuals with \*\*\* services that are as effective as those provided to others;

(v) aid or perpetuate discrimination \*\*\* by providing significant assistance to an organization, agency or person that discriminates on the basis of disability \*\*\*;

(vii) otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage or opportunity enjoyed by others \*\*\*.

(3) a public entity may not, directly or through contractual \*\*\* arrangements, utilize criteria or methods of administration

(i) that have the effect of subjecting qualified individuals with disabilities to discrimination \*\*\*;

(ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program \*\*\*

(7) a public entity shall make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the accommodation would fundamentally alter the nature of the service, program, or activity.

(8) a public entity shall not impose or apply eligibility criteria that screen out \*\*\* an individual with a disability \*\*\* from fully and equally enjoying any service, program or activity, unless such criteria can be shown to be necessary for the provision of the service, program or activity being offered.

\*\*\*(d) A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Under Title II, the term disability has the same definition as that used under Title I; it also includes the exclusions specified for Titles I and III discussed above.<sup>70</sup> A “qualified person” is one who, with or without reasonable modifications of rules, policies, or practices, meets the “essential eligibility requirements for the receipt of services”.<sup>71</sup> For purposes of Medicaid and CHIP, persons who are eligible for benefits would be considered qualified.<sup>72</sup>

## Issues in the Application of Title II

Consistent with the previous discussion, a Medicaid or CHIP agency, in purchasing managed care services, would be prohibited from contracting with entities that discriminate against persons with disabilities in the provision of either health care or administrative services. For example, in *Anderson v Dept. of Public Welfare*,<sup>73</sup> the court found that the state Medicaid agency could be held accountable under Title II for the lack of auxiliary aids and services provided by private HMOs participating in mandatory managed care programs. Title II also requires “on-going” monitoring in order to ensure that private agencies

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<sup>70</sup> 28 C.F.R. §35.104.

<sup>71</sup> *Id.*

<sup>72</sup> See *Woolfolk v Duncan*, *supra* note 53.

<sup>73</sup> 1 F. Supp. 2d 456 (E.D. Pa., 1998).

operating public programs comply with the nondiscrimination requirements.<sup>74</sup> The rules suggest that agencies would be required to ensure that networks are sufficient to permit equally effective benefits and that network providers do not discriminate. The duty to ensure equally effective benefits and non-discrimination might be considered particularly great in those states in which enrollment in managed care is a mandatory condition of coverage. Moreover, while state agencies can permit persons with disabilities to enroll in managed care on a voluntary basis, it is not clear whether a state agency could prohibit persons with disabilities from belonging to managed care plans.

An interesting question is whether Medicaid or CHIP agencies can draw disability-based distinctions in coverage in contracts with managed care organizations that offer products that contain such distinctions. As is the case with questions of employer health benefit plan design, across-the-board Medicaid service limits that apply to all conditions clearly are permissible under the ADA, in accordance with previously established case law under Section 504, whose legal interpretations are expressly incorporated into the ADA.<sup>75</sup> At some point, however, a benefit limit may amount to a discriminatory method of administration and thus could violate the ADA, although no federal guidelines exist to guide policy makers on where this line might be drawn.

Another interesting issue is the question of reasonable modification. Unlike private managed care, Medicaid-purchased managed care products typically use tightly controlled networks with no point-of-service option for benefits, other than for emergency care. Where a Medicaid product network does not include either primary or specialty providers who are experienced in the care and management of persons with mental illnesses and addiction disorders, an agency may be required to specify that the contractor must modify its network in order to ensure that care is equally effective and non-discriminatory.

In sum, Title II of the ADA is broadly conceived and would reach both Medicaid agencies and their managed care contractors. The law would appear to require agencies to ensure that their managed care plans are designed to ensure equally effective, non-discriminatory care, including modification of networks and administrative operations to ensure that care is equally effective. Similarly, the rules appear to require agencies to ensure that plans modify their operations to ensure that no discrimination in enrollment or disenrollment occurs. Since managed care organizations are also places of public accommodations, these obligations should not place an undue burden on Medicaid agencies,

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<sup>74</sup> See, e.g., *Tugg v Towey*, 864 F. Supp. 1201 (S.D. Fla., 1994).

<sup>75</sup> *Olmstead*, *supra* note 67. In *Alexander v Choate*, 469 U.S. 287 (1985), which involved a challenge under §504 to the legality of across-the-board service limits in Tennessee's state Medicaid plan, the United States Supreme Court ruled that as long as all individuals had equal access to the same services (in this case, 14 days of hospital care annually), no violation of §504 existed. In a recent case, *Rodriguez v City of New York*, 1999 U.S. App. LEXIS 24935 (2<sup>nd</sup> Cir. 1999), the United States Court of Appeals for the Second Circuit held that a similar type of benefit limit (in this case, limits on in-home personal monitoring services for persons receiving home and community services under New York's Medicaid program) was permissible under the ADA because it applied to all individuals regardless of status. Thus, in public programs, as with employee benefits, one can see the concept of benefit design at work. Whether a benefit design limit that singled out certain conditions expressly under Medicaid for dissimilar treatment would be legal is doubtful, just as the legality of such a limit under employee benefit plans is unclear.

since MCOs would need to make these modifications to their operations as a general business matter.

It would appear that agencies could not purchase or permit products that contain disability-based distinctions in coverage, particularly since Medicaid programs are not insurance and thus do not qualify for “safe harbor” protections.

#### D. The Insurance “Safe Harbor”

In applying the ADA to health insurance, whether under a Title I employment context, a Title II public benefit context, or a Title III public accommodations context, the law permits insurers to claim a “safe harbor”, which exempts certain types of insurance practices from claims of discrimination.<sup>76</sup>

Regulations implementing the safe harbor provision in a Title I context provide as follows:

- (1) An insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers a benefit plan or similar organizations, may underwrite risks, classify risks, or administer such risks *that are based on or not inconsistent with State law.*
- (2) A covered entity may establish, sponsor \*\*\* or administer the terms of a *bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law.*
- (3) A covered entity may establish, sponsor, observe or administer *the terms of a bona fide benefit plan that is not subject to state laws that regulate insurance.*
- (4) The activities described in \*\*\* this section are permitted *unless these activities are being used as a subterfuge to evade the purposes of the act.*<sup>77</sup> [Emphasis added]

The insurance “safe harbor” thus represents an affirmative defense available only to insurers (including managed care organizations). In order to come under the safe harbor, the entity must prove three separate elements. First, it must show that that it is operating under a “bona fide” benefit plan, meaning in the employer context that the plan meets the requirements for formal status as an ERISA-sponsored benefit plan.<sup>78</sup> Second, the entity must be able to demonstrate that the terms of the plan are based on underwriting risks, classifying risks, or administering such risks that themselves are either based on or not inconsistent with state law. Third, the entity must show that its activities are not being used as a subterfuge to evade the purposes of the Act.

To trigger the obligation to present a defense under the insurance safe harbor provisions, it is not necessary that a plaintiff prove an intent to discriminate. Instead, where discrimination is shown, the burden shifts to the insurer-defendant to demonstrate that the allegedly discriminatory practice can be justified through actuarial principles. This

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<sup>76</sup> 42 U.S.C. §12201(c).

<sup>77</sup> 29 C.F.R. §1630.16(f).

<sup>78</sup> To be a “bona fide” plan, the plan must “exist[] and pay[] benefits.” See EEOC, Interim Policy Guidance on ADA and Health Insurance (June 8, 1993).

interpretation appears to considerably narrow the ADA “safe harbor” in comparison to other civil rights laws. For example, the Supreme Court has interpreted the term “subterfuge” in the context of the Age Discrimination Act to require a showing of specific intent to discriminate before a subterfuge claim can be supported.<sup>79</sup>

The Equal Employment Opportunity Commission and the Department of Justice have interpreted the “safe harbor” and “subterfuge” provisions to require that any disparities in coverage offered under insurance policies be supported by “sound actuarial” principles.<sup>80</sup> The term “sound actuarial principles” is not defined either under the Act or under its implementing regulations. Indeed, while the term “sound actuarial principles” shows up in numerous federal laws dealing with health insurance, the term remains undefined in all contexts. In *Zamora-Quesada, supra*, a case involving the application of the ADA to Medicare-sponsored managed care plans, the Court provided the following interpretation of the concept of “sound actuarial principles”:

The safe harbor provision protects an insurer engaged in "underwriting" and "classifying risks." Although the [ADA] does not define these terms, underwriting generally refers to the application of the various risk factors or risk classes to a particular individual or group for the purposes of determining whether to provide coverage. \*\*\* Risk classification refers to the identification of risk factors and the groupings of those factors which pose similar risks.

Thus, the court in *Zamora-Quesada* applied the concept of “sound actuarial principles” to the threshold decision made by insurers regarding whether to provide coverage at all. Whether the insurance safe harbor extends to medical underwriting once coverage actually has begun is not clear.

In an actuarial context, the American Academy of Insurance Actuaries, to which 80 percent of all actuaries currently practicing in the U.S. belong,<sup>81</sup> maintains Actuarial Standards of Practice (ASOP). According to the Actuarial Standards Board (ASB), which issues the standards, a health insurance plan is actuarially sound if projected premiums suffice to cover expected costs and administrative expenses and return a profit.<sup>82</sup> Under this definition, the concept of actuarial soundness would appear to extend not only to initial coverage, but also to subsequent decisions that are designed to keep actual utilization in line with initial projections.

Although the ADA requires actuarial soundness by insurers, the preceding discussion makes clear that this defense becomes necessary only if the particular insurance practice is reachable under the ADA to begin with. If the content of coverage is insulated from judicial review, either because it is a matter of employer discretion or because the public accommodations concept reaches only questions of physical access, then insurers would not have to defend their benefit structures as actuarially sound. The admission of no actuarial soundness by Mutual of Omaha in the *Doe* case, cited above, is striking. But even the most

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<sup>79</sup> *Ohio Public Employees Retirement System v Betts*, 492 U.S. 158 (1989).

<sup>80</sup> 28 C.F.R. §36.212; DOJ Technical Assistance Manual §III-3.11000; EEOC, Interim Policy Guidance on ADA and Health Insurance (June 8, 1993).

<sup>81</sup> Telephone Interview with Dwight K. Bartlett III, Senior Health Fellow, the American Academy of Actuaries (Aug. 5, 1999).

<sup>82</sup> See Richard Sieger, What is an Actuary, <http://www.casact.org/career/what.htm> (site visited Aug. 5, 1999).

actuarially unsound insurance design choices are perfectly permissible if the authority to make such discriminatory choices falls within the discretion of the company selling the product or the entity purchasing the product (i.e., an employer, a Medicaid agency, the Medicare program, or some other purchaser).

### **Part 3. Medicaid Managed Care Contracts and the ADA**

As noted, there are no federal regulations or guidelines that specifically interpret the provisions of the ADA in a managed care context. Therefore, state managed care contracts are of interest, because they are evidence of how states interpret the requirements of the ADA in their managed care operations.

Tables 1 and 2 at the end of this Issue Brief summarize the scope of state contract specifications related to the ADA. The tables indicate two things: First, states have generally taken a broad approach to articulating the notion that discrimination based on disability in a managed care context is prohibited under the ADA; second, states have done a poorer job in articulating the specific affirmative obligations managed care organizations must undertake (e.g., to make “reasonable accommodations” to persons with disabilities). As of this time it does not appear that any managed care entity has challenged its duties under the law on the ground that the state’s expectation of “reasonable accommodation” creates a fundamental alteration in the nature of the program or an undue burden on the entity. To the extent that state enforcement actions or private challenges to barriers in managed care increase, such challenges may develop.

#### **Anti-discrimination specifications**

##### **General provisions**

Table 1 indicates that most, but not all, states include in their specifications a general prohibition incorporating the provisions of the Act against discrimination against persons with disabilities. State specifications vary considerably in scope. Pennsylvania, Maine, Missouri, and Minnesota offer examples of broad provisions that incorporate the prohibitions of the federal law. The Missouri contract incorporates both non-discrimination and “reasonable accommodation” provisions into a single broad specification that provides in relevant part:

2.11 To ensure mainstreaming of program members the health plan shall take affirmative action so that members are provided covered services without regard to \*\*\* physical or mental handicap except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

2.11.1 Denying or not providing to a member any covered service or availability of a facility.

2.11.2 Providing to a member any covered service which is different, or is provided in a different manner or at a different time from that

provided to other members, other public or private patients, or the public at large.

2.11.3 Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.

2.11.4 The assignment of times or places for the provision of services on the basis of \*\*\* physical or mental handicap of the participants to be served.

2.11.5 If the health plan knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than this contract), the health plan will be in default of its contract. In addition, if the health plan becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) days, it will be in default of its contract.

Missouri RFP, pp. 13-14 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 2, Table 3.10].

The Missouri provision clarifies that the contractor's duties extend to its subcontractors and that the contractor has an affirmative duty to correct known instances of discrimination. In addition, the provision clarifies that the prohibitions and affirmative action provisions extend not only to the manner and setting of care, but also to coverage.

Kansas includes in its contract a general specification that is qualitatively significantly different from that found in the Missouri, Pennsylvania, and Maine contracts, as well as other contracts that contain broad prohibitions and affirmative duty obligations. The Kansas Medicaid program appears to interpret the ADA to permit some differentiation in treatment of Medicaid patients, including patients with disabilities, as long as services are "sufficient." The contract does not indicate what is meant by "sufficient," who determines sufficiency, or how it will be measured. The contract appears to give contractors considerable discretion to set the amount and level of differentiation and in effect permits the separation of Medicaid members including disabled members, as long as the results are "sufficient", as the following language illustrates:

Provide contract services to Medicaid members under this contract in the same manner as those services are provided to other members of the HMO, although delivery sites, covered services and provider payment levels may vary. The HMO must guarantee that the locations of facilities and practitioners providing health care to members are sufficient in terms of \*\*\* handicapped accessibility.

Kansas Contract, p. 14 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 2, Table 3-10].

## Specific applications

*Enrollment and service obligations:* The majority of contracts specify prohibitions against discrimination in enrollment. In most cases, the prohibition against denial of enrollment is absolute. This of course raises at least the inference that contractors have an absolute duty to serve members equally regardless of their disability status, since otherwise the enrollment of such patients could result in sham care arrangements.

Minnesota makes this absolute duty to serve all enrollees explicit through the following specification:

The Health Plan must offer appropriate services for the following special needs groups when required or requested.  
\*\*\* Services must be available within the Health Plan *or through contractual arrangements with providers.*

- a. seriously and persistently mentally ill \*\*\*;
- c. Abused children and adults, abusive individuals; \*\*\*
- f. Dual MI/DD or MI/CD clients \*\*\*;

Minnesota Contract, Appendix 1, pp. 6-7 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 2, Table 3-10 (emphasis added)].

Oklahoma interprets the Act to permit contractors to use their discretion in enrolling and disenrolling persons with mental handicaps under certain circumstances:

Contractor may not refuse an assignment or seek to disenroll a member or otherwise discriminate against a member on the basis of \*\*\* mental handicap \*\*\* except when that condition can be better treated by another provider type subject to [certain limitations related to state authorization of the conduct].

Oklahoma Contract, p. 14 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 2, Table 3-10].

Presumably, the state views its approval authority as a check on the potential for plans to disenroll complex and high need patients or patients whom no provider wishes to serve. Because a central aspect of managed care is the relationship between members and their health care providers the issue of enrollment and service is central.

*Disenrollment:* Among states that address the issue of disenrollment, there is considerable variation in the showing that a contractor will be required to make to disenroll a

member, particularly where the member is alleged to be abusive, threatening, or non-compliant.

Massachusetts offers an example of a specification that places the burden on the plan to make explicit showings to the state before a request for the disenrollment of a member will be considered:

The Contractor may submit a written request to the Division to terminate the enrollment of any Enrollee only if: \*\*\*

b. after reasonable efforts, documented by the Contractor, at least three plan physicians are unable to establish a satisfactory physician/patient relationship with such enrollee; \*\*\*

c. the enrollee has used or attempted to use services delivered at an emergency room at least five times for purposes which do not meet the definition of emergency services \*\*\*, and the Contractor has made at least five substantive documented attempts to educate the enrollee regarding appropriate emergency room use and alternatives to emergency room services, and the enrollee continues to seek services in an emergency room in non-emergency situations \*\*\*;

d. the enrollee has committed, or attempted to commit, at least three documented acts of physical abuse which pose a direct threat to individuals responsible for the provision of service under this contract or other enrollees. Such acts must be unrelated to the enrollee's physical or mental condition.

Massachusetts Contract, pp. 15-16 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 1, Table 1-7].

New Mexico, on the other hand, offers an example of a contract that appears to delegate the decision entirely to the contractor with no minimum standards set by the agency:

Provide your policies and procedures and/or criteria for applying for member disenrollment. Provide your definition of non-compliance.

New Mexico RFP, p. 51 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 1, Table 1.7].

*Coverage:* The states that address the issue of coverage do so as part of a broader provision that identifies coverage as an area in which contractors are prohibited from discriminating. The contracts do not offer more specific applications of coverage situations that would be considered discriminatory. The actuarial reasonableness defense discussed above would presumably come into play where the conduct at issue involves a managed care contractor whose product is bought by a Medicaid agency.

As noted, the question of discrimination in coverage and service is a complex one, particularly where, as in managed care, coverage and delivery tend to be merged into a single event. Clearly, providing less coverage for persons because of their mental illness would be a violation of the ADA, just as would be the practice of providing the same level of coverage but segregating persons with mental illness into separate provider settings. But where coverage differentials are justified by medical considerations, or where certain network providers are particularly competent to furnish care, one would assume that this type of medical justification, if supported by objective facts and evidence, would justify separate treatment.

Several contracts (Missouri, Pennsylvania, and Maine) note that distinctions in coverage are acceptable if based on medical necessity. This is an area that has not yet been addressed in either federal regulations or ADA case law.

As Table 1 indicates, outside of enrollment, few states have even general provisions relating to non-discrimination in administration of the health plan, particularly in the area of grievances and appeals. A number of states do, however, specify a prohibition against discrimination in the employment of persons with disabilities.

## Reasonable Modification of MCO Practices

As indicated earlier, far fewer states have addressed the issue of what constitutes a reasonable modification of enrollment, coverage, access, and provider services. The concept of reasonable accommodation applies to all public services covered by Title II. As a result, state Medicaid programs would appear to have a duty to ensure that the managed care systems in which they enroll beneficiaries can affirmatively meet their needs. This is particularly true in Medicaid where enrollment is typically mandatory as a condition of coverage.

The disenrollment provisions reviewed previously can be viewed as states' attempts to not only avoid direct threat situations, but also to provide a reasonable accommodation for persons with disabilities for whom managed care may not work well. The Wisconsin contract offers another example of how a state has attempted to make a "reasonable accommodation" by allowing certain individuals to elect to remain in the fee-for-service system and effectively opt out of mandatory enrollment:<sup>83</sup>

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<sup>83</sup>This opt-out provision raises an important Medicaid policy question regarding the modifications that would be required in the case of persons with disabilities. According to state Medicaid officials in at least one U.S. Department of Health and Human Services region, Health Care Financing Administration officials have taken the position that states operating mandatory managed care waiver programs under §1915 may not allow certain beneficiaries to opt out, even if they cannot be adequately served within a managed care setting. Whether this HCFA position in fact places a state in violation of the "reasonable accommodation" provisions of the ADA is unclear. According to state Medicaid officials, HCFA's justification for this position (which arose in the case of persons with mental illness) was that without total enrollment, the actuarial basis for the state demonstration would be skewed toward healthy enrollees and thereby violate HCFA policy regarding federal financial participation in mandatory managed care programs. It would appear that requiring an expansion of a pre-existing provider network to allow for the use of experienced providers might be an alternative to requiring

For Medicaid recipients who are eligible for HMO enrollment under \*\*\* this contract, and who are thought to meet one or more of the criteria [for exemptions], the AFDC case head shall be given the option of enrolling the recipient \*\*\* in the HMO or applying to have the affected person remain in the Medicaid fee-for-service system. \*\*\* The HMO shall not counsel or otherwise influence an enrollee or potential enrollee in such a way as to encourage exemption from enrollment or continuing enrollment.

Wisconsin Contract, pp. 83-84 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 1, Table 1-4].

*Providers:* The Minnesota contract excerpted above provides an example of a state that imposes a duty on contractors to get adequate care to members, even if they must go to non-network providers to do so. The state of Texas also maintains in its contract an affirmative obligation on contractors to ensure that care is appropriate for persons with disabilities. The Texas contract specifies that contractors

shall develop and maintain a system for identifying members who have disabilities or chronic or complex medical conditions and for providing medically necessary services to meet their preventive, primary acute and specialty health care needs \*\*\*.

HMO shall provide an adequate primary care and specialty care provider network \*\*\* HMO must also ensure an adequate number of specialty physicians who are willing to be PCPs and provide medical homes to members with disabilities or chronic illness.

Texas Contract, p. 17 [reprinted in *Negotiating the New Health System*, Vol 2, Part 2, Table 3.1].

*Quality measurement:* An important question is whether health plans furnish care that is of good quality in the case of persons whose underlying disabilities make normal approaches to coverage and care insufficient. The obligation to measure the clinical quality of care for persons with disabilities does not appear to be a feature of any state contract at this point, presumably because the entire area of quality measurement and improvement for persons with co-morbidities has scarcely begun to develop. The Illinois contract does require companies to include in their clinical studies

medical management for a limited number of medically complicated conditions as agreed to by the Contractor and the Department.

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persons with disabilities to remain in plans that cannot adequately serve them, a requirement that would appear to place a state in violation of the ADA.

Illinois Contract, Appendix A, pp. 2-3 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 3, Table 5.1].

Oklahoma also provides an illustration of an effort to reach the very difficult question of quality management in the case of persons with disabilities (interestingly, the provision does not address the topic of mental disability, however):

**Adults with complex/chronic illnesses and physical and developmental disabilities**

Contractor must have in place all of the following to meet the needs of its adult members with complex/chronic illnesses and physical or developmental disabilities \*\*\*:

Satisfactory methods/guidelines for identifying persons at risk of or having chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, home health services, etc. \*\*\*

Medical protocols for the diagnosis and treatment of conditions common to the Aged, Blind and Disabled population \*\*\*.

**Children with special health care needs**

Children with special health care needs include those who have or are suspected of having a serious or chronic physical or developmental condition and who require health and related developmental services of a type or amount beyond that required by children generally. Contractor will be responsible for performing all of the same activities for this population as for adults. In addition Contractor must have in place for these children \*\*\* medical protocols for diagnosis and treatment of conditions common to the disabled child population \*\*\*.

Oklahoma Contract, pp. 37-38 [reprinted in *Negotiating the New Health System*, Vol. 2, Part 3, Table 5.1].

## Conclusion

This Issue Brief underscores the complexity of the ADA in a managed care context. The ADA is relevant whether membership in a managed care plan is a function of employee provided health benefits, individually purchased coverage, or public assistance. If the ADA is understood to reach issues of insurance design and benefit structure, the law would reach practices by buyers and sellers that limit coverage for classes of disease and illness. The existence of the safe harbor provision of the law would appear to suggest that Congress contemplated that benefit design matters would be covered by the Act, although most courts have dismissed this argument in public accommodations cases challenging across-the-board content limits. Indeed, a review of the federal guidelines in this area underscores an interpretation that would favor the application of the ADA to questions of broad benefit design.<sup>84</sup>

Early federal agency guidance appears to suggest that benefit structures that limit coverage for entire classes of illness (in particular, mental illness) may be permissible, although discrimination against specific conditions would not be. This distinction is neither rational nor workable, as the jumble of ADA cases suggests. Indeed, in recent years both Congress and the federal agencies have attempted to remove barriers emanating from “across-the-board” benefit design choices through legislation such as HIPAA and the Mental Health Parity Act.

The fundamental question that now confronts policy makers is whether employers and insurers should be able to design products that single out entire classes of health conditions for differential treatment, even when there is no actuarial basis for such actions. This issue will increasingly confront policy makers in the coming years, as persons with physical and mental disabilities go to work in ever greater numbers. While Congress may continue to slowly redesign Medicare and Medicaid to afford greater coverage for workers with disabilities, it is inevitable that at some point lawmakers will be faced with the basic question of whether the ADA should apply to the benefit design choices made by insurers and purchasers, particularly where no actuarial data to justify the choice is forthcoming. Furthermore, to the extent that courts increasingly attribute benefit design status to numerous types of insurance practices, such as network composition and physician incentive plans, this theory of “immunity through design” threatens to swallow all efforts to establish individual protections against discriminatory insurance practices.

Similarly, complex issues await resolution in the area of Medicaid managed care and the ADA. Increasingly, persons with disabilities as defined under the ADA are mandated to enroll in managed care as a condition of Medicaid eligibility. This trend raises a question regarding the types of minimum safeguards that must be in place before mandatory enrollment can proceed. How should enrollees with disabilities be informed of their options, counseled, and enrolled? What disenrollment protections apply? What types of networks by specialty must be in place, and what types of controls over access to non-network providers can agencies permit contractors to use? Can a Medicaid agency mandate enrollment if the contractor’s network fails to make reasonable accommodation for such

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<sup>84</sup> *Law and the American Health Care System*, *supra* note 13, at Ch. 2(F).

individuals, and how would such reasonable accommodation be measured? Can the entity use treatment guidelines that are calibrated to normative managed care patients and practices rather than to a special needs population? Can the entity use physician incentive arrangements that reward the reduction in unnecessary services in the absence of risk-adjusted payments and utilization controls?

This last question is of particular importance. Were an agency to attempt to risk-adjust its premium payments in order to permit its contractors to make reasonable accommodations to disability-related concerns, how would such enhanced payments fare under federal Medicaid regulations that establish strict upper payment limits on Medicaid managed care premiums?<sup>85</sup> Federal regulations provide that under risk contracts, Medicaid payments may not exceed “the cost to the agency of providing those same services on a fee-for-service basis to an actuarially equivalent group.” Whether this rule is sufficient to permit the level of payment that is necessary to achieve reasonable accommodation in the case of persons with disabilities is doubtful, since in the fee-for-service context the term “provides” means merely to “pay for”. Simple payment for services may be considerably less costly than the amount that would be required to ensure that reasonable accommodations are in place to ensure that covered managed care services are actually available to persons with disabilities. Clearly, adapting managed care to meet the needs of persons with disabilities may result in initial outlays that from an actuarial point of view are considerably higher than those that would have been needed under a fee for service system, where the agency’s duty was merely to pay for, rather than provide, care. To the extent that federal Medicaid upper payment limit rules work to prohibit the risk-adjustment of premiums in order to ensure reasonable accommodations, such rules may create additional concerns under the ADA.

Finally, if a Medicaid managed care contractor were to be sued under the ADA, could it raise the safe harbor defense? As noted, this question has been answered in the negative by at least one court in a Medicare context, since Medicare prohibits medical underwriting by health plans. A further question is whether a Medicaid managed care product can be considered insurance at all, particularly since many states exempt these products from state insurance law. Medicaid is not an insurance program; instead, it operates in accordance with a series of third-party financing policies that in virtually every respect fundamentally differ from insurance. While Medicaid agencies are permitted to use federal funds to buy managed care products, any coverage which agencies extend either directly or through their contractors must be consistent with federal coverage and access requirements. Thus, the concept of an insurance safe harbor in a Medicaid claim may simply not be relevant.

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<sup>85</sup> 42 C.F.R. § 447.361.