

**LEGAL CHALLENGES TO LIMITS ON  
MENTAL/NERVOUS BENEFITS IN DISABILITY PLANS**

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# LEGAL CHALLENGES TO LIMITS ON MENTAL/NERVOUS BENEFITS IN DISABILITY PLANS

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Limitations on benefits for mental/nervous conditions common in long term disability plans have been frequently subject to challenges in litigation. Both private parties and the Equal Employment Opportunity Commission (“EEOC”) have brought actions contending that these limitations violate the Americans With Disabilities Act (“ADA”), 42 U.S.C. §§ 12101 *et seq.* (2000). In addition, disabled employees and former employees have brought suit under the Employees Retirement Income Security Act (“ERISA”) 29 U.S.C. §§ 1001 *et seq.*, (2000) contending that the application of limitations in particular cases amount to an unlawful denial of employee benefits under that statute. These two principal theories of liability are discussed separately below.

## PART ONE – THE AMERICANS WITH DISABILITIES ACT

The ADA, protects individuals who have “a physical or mental impairment that substantially limits one or more of the major life activities of [the] individual,” or who have “a record of such an impairment,” or are “regarded as having such an impairment.” *Id.* § 12102(2). In an increasing number of cases, employees as well as the Equal Employment Opportunity Commission (“EEOC”) have brought claims for employee benefits, including disability insurance benefits, under that Act. Three titles of the ADA are relevant to these cases.

For employers with at least fifteen employees,<sup>1</sup> Title I of the ADA prohibits discrimination in employment. Title I prohibits discrimination on the basis of disability with respect to an employee’s “terms, conditions, and privileges of employment.” 42 U.S.C. § 12112(a).<sup>2</sup> The EEOC has interpreted this language as

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<sup>1</sup>Most states have their own statutory prohibitions on discrimination based on disability which may apply to companies with fewer than 15 employees. *See, e.g.*, Cal. Gov. Code § 12940 (2000); D.C. Code Ann. § 1-2502 (1999).

<sup>2</sup>In addition, Title I contains a number of more specific provisions that may be applicable to employee benefit plans: (1) § 102(b)(1) prohibiting the limiting or segregating of individuals with disabilities in a manner that adversely affects their opportunities or status; (2) § 102(b)(2) prohibiting participation in contractual

extending to employer-provided health and disability benefit plans, whether or not the plans are administered by the employer. 29 C.F.R. § 1630.4(f).

Title III primarily prohibits discrimination on the basis of disability by places of public accommodation. Section 301 includes “insurance office” among the non-exclusive list of service establishments subject to Title III.<sup>3</sup> Title III does not otherwise mention insurance or employee benefits.

The ADA’s only direct reference to insurance and employee benefits is contained in § 501(c). That section provides the following rule of construction regarding “insurance”:

Subchapters I through III of this chapter and [T]itle IV of this Act shall not be construed to prohibit or restrict--

- (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
- (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
- (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

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

42 U.S.C. § 12201(c) (2000).

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arrangements that have the effect of subjecting individuals with disabilities to discrimination; (3) § 102(b)(3) prohibiting the utilization of standards or criteria that have the effect of discriminating against individuals on the basis of disability; (4) § 102(b)(4) prohibiting discrimination against non-disabled individuals on the basis of their relationship with an individual with a disability; (5) § 102(b)(6) prohibiting the use of criteria that screen out individuals with disabilities unless the criteria are job related and consistent with business necessity; and (6) § 102(d) prohibiting medical exams and inquiries except in very limited circumstances.

<sup>3</sup>42 U.S.C. § 12181(7)(F) (2000).

## I. EEOC INTERPRETATIONS OF TITLE I

Section 1630.16 (f) is the only section of the EEOC's ADA regulations that is specifically directed to employee benefit plans. It provides:

(f) Health insurance, life insurance and other benefit plans

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(1) An insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers benefit plans, or similar organizations may underwrite risks, classify risks, or administer such risks that are based on or not inconsistent with State law.

29 C.F.R. § 1630.16(f). The appendix to the regulations states this provision is “not intended to disrupt the current nature of insurance underwriting, or current insurance industry practices in sales, underwriting, pricing, administrative and other services, claims and similar insurance related activities based on classification of risks as regulated by the States,” nor is it “intended to disrupt the current regulatory structure for self-insured employers.” 29 C.F.R. pt. 1630, App. § 1630.16 (f). The appendix also characterizes the regulations as providing only a “limited exemption . . . to permit the development and administration of benefit plans in accordance with accepted principles of risk assessment.” *Id.*

In June of 1993, the EEOC issued an “Interim Enforcement Guidance on the application of the [ADA] to disability-based distinctions in employer-provided health insurance” (“Interim Guidance” or “Guidance”). Interim Guidance ¶ 1 (June 8, 1993) <<http://www.access.gop.gov/eeoc/doc/health.txt>>. This policy statement was intended to provide guidance to field staff in processing charges raising these issues. The Interim Guidance adopts a narrow definition of “disability-based” distinctions. Limitations that apply to employees both with and without disabilities are not considered disability-based, even though they may disproportionately affect disabled individuals. A distinction is considered to be disability-based only if it “singles out a particular disability (*e.g.*, deafness, AIDS, . . . cancers, muscular dystrophy, kidney diseases), or disability in general (*e.g.*, non-coverage of all conditions that substantially limit a major life activity).” Interim Guidance § III.B.

Based on this definition, the Interim Guidance specifically authorizes the following limitations without further analysis: (1) Different benefit limits for “mental/nervous conditions”; (2) Limitations on “eye care” benefits; (3) Blanket pre-existing condition clauses; (4) Limits or exclusions from coverage of all experimental drugs and/or treatments, or of all “elective surgery”; and (5) “[L]imits on medical procedures that are not exclusively utilized for the treatment of a particular disability” (*e.g.*, limitations on the number of drug transfusions or x-rays covered). *Id.*

For any limitation that comes within the scope of the Interim Guidance's definition of “disability-based,” it would require the employer to prove that the limitation is not a “subterfuge” to evade the purposes of the ADA. The Guidance contains a non-

exclusive list of quite onerous showings the employer may make in order to meet this burden.<sup>4</sup>

The EEOC re-emphasized and expanded on this position in December of 2000 when it issued a new section to its Compliance Manual, entitled “Section 3 - Employee Benefits” (“Section 3”). *EEOC Compliance Manual*, (CCH) ¶¶ 7220-7225 at 5,832 – 5,837 (2000). Section 3 covers discrimination in employee benefits under the ADA, as well as under the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964, and the Equal Pay Act. The ADA portions of Section 3 replaced a 1995 document, entitled “Questions and Answers About Disability and Service Retirement Plans Under the ADA.”

Section 3 adopted the narrow definition of “disability-based” distinctions used in the Interim Guidance, including the list of authorized limitations, as well as the requirement that an employer prove that the benefit plan is “bona fide” and that any such distinctions are not a “subterfuge.” *EEOC Compliance Manual*, ¶¶ 7223 – 7224 at 5,833 – 5,836. In addition, Section 3 also discussed disability-based distinctions in disability retirement and service retirement plans. The EEOC recognized that the provision of disability and/or service retirement plans is not mandatory, but rather left entirely to the discretion of the employer. *Id.* ¶ 7225 at 5,836. The EEOC further recognized that it does not violate the ADA for an employer to offer one type of retirement plan and not the other. However, Section 3 makes clear that if an employer decides to offer either or both types of plans, the plans cannot discriminate against employees with disabilities. *Id.*

As with employee health plans, Section 3 narrowly defines the instances where disability and service retirement plans violate the ADA. Specifically, an employer will violate the ADA if it: (1) excludes employees from participation in a disability or service retirement plan because of their disabilities; (2) requires different lengths of employment for participation in such plans by individuals with disabilities and individuals without disabilities; and (3) sets different levels or types of coverage for individuals with and without disabilities in a service retirement plan. *Id.* However, an employer may offer different levels of benefits in its service retirement plan and disability plan. As long as all employees may participate in a service retirement plan on the same terms, regardless of the existence of a disability, an employer will not violate the ADA if it provides lower levels of benefits in its disability plan. *Id.* at 5,836 – 5,837. In addition, the EEOC specifically states in Section 3 that it does not violate the ADA for

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<sup>4</sup>(1) “[T]hat its health insurance plan actually treats all similarly catastrophic conditions in the same way;” (2) “[T]hat the disparate treatment is justified by legitimate actuarial data, or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated in the same fashion”; (3) [T]hat the disparate treatment is necessary “to ensure that the challenged health insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan”; (4) That the disparate treatment is necessary “to prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged”; or (5) That the treatment for which coverage was denied “does not provide any benefit.” Interim Guidance § III.C.2.a-e (footnote omitted).

an employer to deny service retirement benefits entirely to employees who have previously chosen voluntarily to take disability retirement benefits. *Id.* at 5,837.

As discussed below, the EEOC has advocated more aggressive positions regarding employee benefits in litigation. For example, it has argued, in spite of the terms of § 501(c) that insurers and other benefit providers may be sued directly under Title I.<sup>5</sup> It has also argued that the “qualified individual with a disability” requirement does not prevent a totally disabled individual from maintaining a claim for benefits,<sup>6</sup> and that the principles of the Interim Guidance and Section 3 permitting distinction between mental/nervous conditions and physical conditions do not apply in the case of claims for disability benefits.<sup>7</sup>

## II. APPLICATION TO INSURANCE COMPANIES AND OTHER BENEFIT PROVIDERS

### A. Title I

Title I of the ADA prohibits discrimination by a “covered entity” against a “qualified individual with a disability” with regard to “terms, conditions, and privileges of employment.”<sup>8</sup> The ADA defines a “covered entity” as an “employer, [including an agent of the employer] employment agency, labor organization, or joint labor-management committee.”<sup>9</sup> “Covered entities” are also responsible for any discrimination resulting from any contracts the entities enter into. Thus, on its face, the coverage provision of Title I does not include insurance companies, plan administrators, or health care providers except with respect to their own employees.

The structure of Section 501(c)’s rule of construction regarding “insurance” likewise indicates that insurance companies, plan administrators and health care entities are not covered by the ADA with respect to their involvement in health benefit plans. The language of Section 501(c) distinguishes between an “insurer . . . health maintenance organization, or any agent or entity that administers benefit plans or similar organizations”<sup>10</sup> and “a person or organization covered by this chapter.”<sup>11</sup>

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<sup>5</sup>See discussion *infra* at Section II.A.

<sup>6</sup>See discussion *infra* at Section IV.C.

<sup>7</sup>See discussion *infra* at III.

<sup>8</sup>42 U.S.C. § 12112(a) (2000).

<sup>9</sup>42 U.S.C. § 12111(2) (2000).

<sup>10</sup>42 U.S.C. § 12201(c)(1) (2000).

<sup>11</sup>42 U.S.C. § 12201(c)(2) & (3) (2000).

This interpretation of the statute is supported by the legislative history of Section 501(c). In describing the general objectives of Section 501(c), the House Labor Committee report states, “[t]he Committee does not intend that any provisions of this legislation should affect the way the insurance industry does business in accordance with the State laws and regulations under which it is regulated.”<sup>12</sup> Similarly, the report of the Senate Labor Committee notes that the purpose of adding Section 501(c) was to “make it clear that this legislation will not disrupt the current nature of insurance underwriting or the current regulatory structure for self-insured employers or of the insurance industry in sales, underwriting, pricing, administrative and other services, claims, and similar insurance-related activities based on classification of risks as regulated by the States.”<sup>13</sup>

The federal courts that have considered the question are divided on whether claims under the ADA may be maintained against insurers, plan administrators or health care service providers by individuals who are not their employees. The first court of appeals to consider the issue concluded that employee benefit plan administrators may be liable as “employers” under the ADA. *Carparts Distrib. Ctr. v. Automotive Wholesaler’s Ass’n*, 37 F.3d 12 (1st Cir. 1994). In that case, the First Circuit essentially followed the position advocated by the EEOC as amicus curiae and suggested that a benefit plan and its sponsor could be directly liable under the ADA on any of several alternative theories.

The discussion of ADA issues in *Carparts* may well be considered dicta, however, since the court of appeals began its analysis with the conclusion that the district court decision must be reversed because the lower court had granted summary judgment without sufficient notice to the plaintiff. The opinion’s substantive discussion of the ADA also is questionable for several reasons. Most notably, the First Circuit’s opinion does not address the terms of Section 501(c), which provides a rule of construction applicable to insurance.<sup>14</sup> By its terms, this section must be considered in the interpretation of any other provision of the ADA including the coverage provisions of Title I.

To the contrary, the court in *Carparts* relied principally on cases interpreting the coverage provisions of Title VII, a statute that contains no provision comparable to ADA Section 501(c).<sup>15</sup> First, relying on the Second Circuit’s decision in

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<sup>12</sup>H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. II, at 136 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 419 (“Education and Labor Committee Report”).

<sup>13</sup>S. Rep. No. 116, 101st Cong., 1st Sess. at 84-85 (1989).

<sup>14</sup>The court makes an ambiguous reference to section 501(c) as a “safe harbor of sorts” in its discussion of Title III. *Carparts*, 37 F.3d at 20.

<sup>15</sup>At least one district court has recognized this distinction. In *Sampson v. Citibank, F.S.B.*, Civ. No. 98-cv-1272 (D.D.C. Nov. 18, 1998), the court rejected plaintiff’s argument that Aetna Life Insurance Company was an agent of Citibank and therefore was a “covered entity” within the meaning of Title I of the ADA. The Court explained that “[u]nlike Title VII, the ADA contains a provision that expressly prohibits

*Spirt v. Teachers Ins. & Annuity Ass'n*, 691 F.2d 1054 (2d Cir. 1982), *cert. granted and vacated and remanded on other grounds*, 463 U.S. 1223 (1983), *reinstated and modified on other grounds*, 735 F.2d 23 (2d Cir. 1984), *cert. denied*, 469 U.S. 881 (1984), the court held that a plan administrator could constitute an employer if it functioned as an employer with respect to the plaintiff employee's health care coverage; that is, if it "exercised control over an important aspect of [plaintiff's] employment."<sup>16</sup> This was the primary argument advanced by EEOC in its *amicus curiae* brief.<sup>17</sup> The EEOC noted, however, that a finding that the Plan at issue in *Carparts* could be liable under the ADA would not subject traditional insurers to Title I liability because they merely sell a product to employers without exercising control over the level of benefits provided to covered employees.<sup>18</sup>

Alternatively, the *Carparts* court, again relying on *Spirt*, reasoned that a plan administrator could constitute an employer under Title I if it were an agent of a "covered entity."<sup>19</sup> For example, if the administrator "act[ed] on behalf of the entity in the matter of providing and administering employee health benefits," it would be an

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suits by employees against insurance companies and benefit plan administrators (among others) unless such a plan is considered to be a subterfuge." *Id.* at 5 (citing 42 U.S.C. § 12201(c)(2000)). Finding that the plaintiff could not prove "subterfuge," the court concluded that "the ADA was not intended to address claims [against insurance providers] that are more appropriately brought under ERISA." *Id.* at 6.

<sup>16</sup>*Carparts*, 37 F.3d at 17. In *Spirt*, the Second Circuit held that the Teachers Insurance and Annuity Association and College Retirement Equities Fund ("TIAA-CREF") could be considered employers under Title VII because they existed solely to enable their member colleges and universities to delegate their responsibility to provide pension benefits for their employees. 691 F.2d at 1063. Indeed, in *Spirt*, the court found that the TIAA-CREF were "so closely intertwined with those universities" as to require a finding that they too were employers under Title VII. *Carparts*, 37 F.3d at 17.

<sup>17</sup>EEOC Brief at 10. In particular, the EEOC argued that by determining the level of benefits provided to employees, the Plan at issue had assumed a responsibility that is traditionally within the employer/employee relationship, such as the responsibility of setting salaries and vacation time. *Id.*

<sup>18</sup>EEOC Brief at 10 n.7. *See also Rodriguez v. Puerto Rico Marine Management*, 975 F. Supp. 115, 121 n.23 (D.P.R. 1997) (interpreting *Carparts* as holding that "the entity would be deemed an employer if it exists *solely for the purpose of delegating the responsibility* to provide health insurance and *only if it had the authority to determine the level of benefits*." (emphasis added)).

<sup>19</sup>*Carparts*, 37 F.3d at 17-18.

employer under the ADA.<sup>20</sup> Under traditional agency principles, however, insurance companies cannot be considered “agents” of employers to which they sell policies.<sup>21</sup>

However, since the decision, the Second Circuit has rejected the agency theory of *Spirit*. In *Tomka v. Seiler Corp.*, 66 F.3d 1295, 1313-1314 (2d Cir. 1995), the court held that Congress did not intend to hold “agents” of employers to be independently liable under Title VII, and that the inclusion of the term “agent” was only an expression of respondeat superior.<sup>22</sup> Every other court of appeal to address this issue has likewise held that the purpose of defining “employer” under the federal anti-discrimination statutes as including any agent of employer “was merely to import respondeat superior liability.”<sup>23</sup> The view that the term “agent” was included in the ADA and Title VII

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<sup>20</sup>*Id.* at 17. The court noted that title I of the ADA, like Title VII, applies to “any agent” of a “covered employer.” *Id.* at 17 n.7.

<sup>21</sup>In order to be considered an “agent,” there generally must be some manifestation of an agreement to act on behalf of, and at the direction of, the principal. RESTATEMENT (SECOND) of AGENCY §§ 1 & 13 cmt. a (1958). Additionally, the principal must have the right to control the conduct of the agent, and the agent bears a fiduciary obligation to act primarily for the principal’s benefit in connection with the services the agent is requested to perform. *Id.* The typical insurer/customer relationship does not satisfy these criteria of the agency relationship. See, e.g., *Wapensky v. John Hancock Mut. Life Ins. Co.*, 774 F. Supp. 1119, 1130-31 (N.D. Ill. 1991) (rejecting claim that insurance company hired to provide administrative support to trustees of group insurance trust was an agent of the trust); *UNR Indus. v. American Mut. Liab. Ins. Co.*, 92 B.R. 319, 335 (N.D. Ill. 1988) (rejecting argument that fiduciary duties owed to an insured by an insurance broker, as the insured’s agent, should be imputed to a direct writer of insurance).

<sup>22</sup>Based on *Tomka*, district courts in the Second Circuit have gone one step further and held that an individual employee cannot be liable under the ADA. See *Glozman v. Retail, Wholesale & Chain Store Food Employees Union, Local 338*, 204 F. Supp. 2d 615, 627 n. 6 (S.D.N.Y. 2002); *Sacay v. Research Foundation of City Univ. of New York*, 44 F. Supp. 2d 496, 503 (E.D.N.Y. 1999); *Harrison v. Indosuez*, 6 F. Supp. 2d 224, 229 (S.D.N.Y. 1998).

<sup>23</sup>*Smith v. Amedisys, Inc.*, 298 F.3d 434, 448-49 (5th Cir. 2002). See also, *Miller v. Maxwell’s Int’l*, 991 F.2d 583 (9th Cir.), *cert. denied*, 510 U.S. 1109 (1993), *Gary v. Long*, 59 F.3d 1391 (D.C. Cir.), *cert. denied*, 516 U.S. 1011 (1995), *EEOC v. AIC Sec. Investigations, Ltd.*, 55 F.3d 1276 (7th Cir.1995); *Mason v Stallings*, 82 F.3d 1007, 1009 (11th Cir. 1996); *Dici v. Pennsylvania*, 91 F.3d 542, 551-52 (3d Cir. 1996); *Sheridan v. E.I. DuPont de Nemours & Co.*, 100 F.3d 1061, 1078 (3d Cir. 1996); *Wathen v. General Electric Co.*, 115 F.3d 400, 405-06 (6th Cir. 1997); *Spencer v. Ripley County State Bank*, 12 F.3d 690, 692 (8th Cir. 1997); *Lissau v. Southern Food Service, Inc.*, 159 F.3d 177, 180-81 (4th Cir. 1998); *Butler v. City of Prairie Village*, 172 F.3d 736, 744 (10th Cir. 1999). *But see*, *Cross v. Alabama*, 49 F.3d 1490 (11th Cir. 1995) (allowing individual liability) and *Paroline v. Unisys Corp.*, 879 F.2d 100, 104 (1989) (“An individual qualifies as an ‘employer’ under Title VII if he or she serves in a supervisory position and

definitions of employer to confirm the availability of liability on the basis of respondeat superior is supported by the observation of the Supreme Court in *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702 (1978):<sup>24</sup>

Title VII and the Equal Pay Act primarily govern relations between employees and their employer, not between employees and third parties. We do not suggest, of course, that an employer can avoid his responsibilities by delegating discriminatory programs to corporate shells. Title VII applies to “any agent” of a covered employer, 42 U.S.C. § 2000e (b) (1970 ed., Supp. V), and the Equal Pay Act applies to “any person acting directly or indirectly in the interest of an employer in relation to an employee.” 29 U.S.C. § 203(d). In this case, for example, the Department could not deny that the administrative board was its agent after it successfully argued that the two were so inseparable that both shared the city’s immunity from suit under 42 U.S.C. § 1983.<sup>25</sup>

As a final alternative for Title I liability, the *Carparts* court cited the D.C. Circuit’s decision in *Sibley Memorial Hospital v. Wilson*, 488 F.2d 1338, 1341 (D.C. Cir. 1973). There the D.C. Circuit held that Title VII prohibited employment discrimination by a covered “employer” against any “individual” without regard to whether or not the individual was an employee or applicant for employment with that particular employer.<sup>26</sup>

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exercises significant control over the plaintiff’s hiring, firing, or conditions of employment.”), *vacated in part on other grounds*, 900 F.2d 27 (4th Cir. 1990) (person who participates in the discriminatory decision-making process is an “agent.”)

<sup>24</sup>This same passage was quoted in *Carparts*, 37 F.3d at 17 n.7.

<sup>25</sup>435 U.S. at 718 n.33. This reading of Title I is consistent with an explicit ADA provision that holds employers liable for entering into contractual relationships that subject their employees to prohibited discrimination. 42 U.S.C. § 12112(b)(2) (2000). The Interim Guidance states that employers will be held liable for discrimination resulting from health insurance provided by an insurance company, HMO or other third party pursuant to a contract with the employer. Interim Guidance § II.

<sup>26</sup>*Sibley* involved a claim of discrimination by a male private duty nurse against the hospital for refusing to refer him for employment by a female patient. 488 F.2d at 1341. In other circumstances, courts have been reluctant to extend Title VII liability to actions taken by entities outside of the traditional employment relationship. For example, courts have generally rejected the argument that state licensing authorities should be held liable for interference with the employment opportunities of candidates who are rejected through the use of allegedly discriminatory qualification procedures. *See, e.g., Tyler v. Vickery*, 517 F.2d 1089, 1096 (5th Cir. 1975), *cert. denied*, 426 U.S. 940 (1976); *McFarland v. Folsom*, 854 F. Supp. 862 (M.D. Ala. 1994). *See also United States v. Board of Educ. for School Dist.*, 911 F.2d 882, 891 (3d Cir. 1990) (holding that Commonwealth of Pennsylvania was not an “employer” of public school teachers and not

While concluding that it was premature to rule out the application of this precedent under the ADA, the *Carparts* court cautioned that it was not holding that there was automatic coverage whenever an employer of a requisite number of employees takes some action that affects an employee of another entity.<sup>27</sup> 37 F.3d at 18.

Notwithstanding *Carparts*, the majority of courts that have considered the question have found that insurers, as such, are not covered entities under Title I of the ADA and therefore cannot be sued.<sup>28</sup> However, in other contexts the *Carparts* analysis

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covered by Title VII since its control over the teachers' employment was exercised in its regulatory capacity "rather than in the course of a customary employer-employee relationship.").

<sup>27</sup> A later District of Columbia district court decision has cast doubt on the applicability of *Sibley* in this context. In *Johnson v. Greater Southeast Community Hosp. Corp.*, 903 F. Supp. 140, 156 (1995), *order vacated in part on other grounds*, No. Civ.A. 90-1992 RCL, 1996 WL 377147 (D.D.C. June 24, 1996), the court considered a Title VII action by a doctor against a hospital. Although the plaintiff conceded that the hospital had never employed him, relying on *Sibley*, he argued that Title VII also applied "to conduct that interferes with employment relationships like the physician-patient relationship." *Id.* The court rejected this argument, finding that *Sibley* was limited to situations where the defendant has barred the "plaintiff's physical access to his potential employers." The court explained that both *Sibley* and subsequent decisions show that a plaintiff must "prove some link between the defendants' actions and some employment relationship." *Id.* Moreover, it asserted that the extent to which the defendant has a right to control "the 'means and manner'" of the plaintiff's performance is the "most important factor" to consider. *Id.* at 155 (quoting *Spirides v. Reinhardt*, 613 F.2d 826, 831 (D.C. Cir. 1979)).

<sup>28</sup> See *Weyer v. Twentieth Century Fox Films Corp.*, 198 F.3d 1104, 1116, n. 48 (9th Cir. 2000) (affirming grant of summary judgment in favor of administrator of employer's disability plan in Title I ADA claim, and noting "that insurance companies do not even meet the expansive (and questionable) First Circuit approach in *Carparts*."); *EEOC v. Group Health Plan*, 212 F. Supp. 2d 1094, 2002 WL 1762733 (E.D. Mo. Jun. 14, 2002) (administrator of employer's health plan is not a "covered entity" for purposes of the ADA); *Sampson v. Citibank, F.S.B.*, Civ. No. 98-cv-1272 (D.D.C. Nov. 18, 1998) (dismissing Title I ADA count against insurance company because "the ADA was not intended to address such claims"); *Good v. Blue Cross & Blue Shield, Inc.*, 6 AD Cases (BNA) 779, C.A. No. 5-96-2843 (D. Md. 1996) (declining to follow *Carparts* and granting insured's motion to dismiss ADA Title I claim); *Nearhood v. Blue Cross & Blue Shield, Inc.*, 6 AD Cases (BNA) 734, C.A. No. MJG-96-2845 (D. Md. 1997) (declining to follow *Carparts* and granting insurer's motion to dismiss ADA Title I claim); *Pappas v. Bethesda Hosp. Ass'n*, 861 F. Supp. 616, 619 (S.D. Ohio 1994) (granting defendants' motion to dismiss and holding that the administrator of employee benefits for an employer is not an agent of that employer and may not be held liable for benefits that discriminate on the basis of disability); *Dodd v. Blue Cross & Blue Shield Ass'n*, 835 F. Supp. 888, 891 (E.D. Va. 1993) (granting defendant's motion for summary judgment and holding that Blue Cross was not an appropriate defendant under the ADA); *Rodriguez v.*

has been followed,<sup>29</sup> and at least one circuit court recently relied upon *Carparts*' legal theories in determining whether a physician and clinic were "covered entities" under the ADA.<sup>30</sup>

## B. Title III

Title III of the ADA is concerned with regulating places of "public accommodations," ensuring access for individuals with disabilities to premises of covered entities and to the goods and services offered there. It also contains separate obligations for "commercial facilities" and for certain transportation services provided by private entities. It does not otherwise regulate business activities. Neither does Title III address the design of goods or services provided through public accommodations or the innate attractiveness or usefulness of such goods or services to individuals with disabilities.

Section 301 of the ADA sets forth a list of private entities which are considered public accommodations for the purposes of the Act if their operations affect commerce.<sup>31</sup> One of the examples listed is "insurance office," which is grouped with a wide range of other service providers.<sup>32</sup> All of the entities listed in this subsection represent physical locations where services are provided to the public. The Title III

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*City of Aurora*, 887 F. Supp. 162 (N.D. Ill. 1995) (granting defendant's motion to dismiss and holding that the subterfuge exception to § 501(c) does not apply to actions brought under Title II of the ADA); *see also Cramer v. Florida*, 117 F.3d 1258, 1264 n.15 (11<sup>th</sup> Cir. 1997) ("Appellants have not alleged, and could not allege without running afoul of Fed.R.Civ.P. 11, that the employers' insurers and/or insurance servicing agents or the state defendants were covered entities under the ADA); *cf. Bloom v. Bexar County Texas*, 130 F.3d 722, 724-25 (5<sup>th</sup> Cir. 1997) (rejecting analogy to *Carparts* and affirming summary judgment in favor of defendant). *But see Mason Tenders Dist. Council Welfare Fund v. Donaghey*, No. 93-CIV-1154, 1993 U.S. Dist. LEXIS 17,032 (S.D.N.Y. Nov. 22, 1993) (order denying Fund's motion for summary judgment and holding that the Fund is a 'bona fide benefit plan' under § 501(c)(3)).

<sup>29</sup> *See, e.g., Orell v. UMASS Mem. Med. Ctr.*, 203 F. Supp. 2d 52, 62-63 (D. Mass. 2002) (applying *Carparts* to determine whether consulting firm "exercise[d] control over an important aspect of [plaintiff's] employment.").

<sup>30</sup> *Satterfield v. Tenn.*, 295 F.3d 611 (6<sup>th</sup> Cir. 2002) (applying all three tests under *Carparts* in determining that physician and clinic were not covered entities and did not meet the definition of "employer" for purposes of Title I of the ADA).

<sup>31</sup>42 U.S.C. § 12181(7) (2000).

<sup>32</sup>The other service entities listed in this section are: "laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy . . . professional office of a health care provider, hospital, or other service establishment." 42 U.S.C. § 12181(7)(F).

regulations promulgated by the Department of Justice assume a physical location for these types of entities which the regulations characterize as “service establishment[s].”<sup>33</sup>

In its Technical Assistance Manual for Title III, however, the Department of Justice goes far beyond either the language of the ADA or of its own implementing regulations.<sup>34</sup> Section III-3.11000 of the Manual provides: “Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer.”<sup>35</sup> This attempt to reach the terms of insurance contracts not only is without support in the language of the statute, but also is contrary to the general presumption against federal regulations of the business of insurance embodied in the McCarran-Ferguson Act.<sup>36</sup> In suggesting that Title III affects the design of insurance contracts, the Technical Assistance Manual is positing a more intrusive regulation for “insurance offices” than it generally recognizes for public accommodations. The Manual elsewhere states: “As a general rule, a public accommodation is not required to alter its inventory to

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<sup>33</sup>28 C.F.R. § 36.104. The only other mention of insurance in the DOJ regulations is in § 36.212, which repeats § 501(c) of the ADA and adds an additional section prohibiting a public accommodation from refusing service to disabled individuals on the grounds that its insurance coverage requires it to refuse service. 28 C.F.R. § 36.212. This additional provision reflects a comment made in the legislative history. H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. III, at 70 (1990) (“House Judiciary Committee Report”), *reprinted in* 1990 U.S.C.C.A.N. 445, 493. This comment constitutes the only reference to “insurance” in the legislative history of Title III.

<sup>34</sup>*Title III of the Americans with Disabilities Act: Technical Assistance Manual* (Jan. 24, 1992), *reprinted in ADA Manual* 90:0901 (Sept. 1994). While likely reflecting the interpretation the Department will follow in practice under Title III, the Technical Assistance Manual does not constitute a regulation.

<sup>35</sup>DOJ TITLE III TECHNICAL ASSISTANCE MANUAL III-3.11000, *reprinted in ADA Manual* at 90:0917. This section goes on to provide:

Thus, a public accommodation may offer a plan that limits certain kinds of coverage based on classification of risk, but may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

*Id.*

<sup>36</sup>15 U.S.C. §§ 1011-15 (2000). See Robert L. Bergdorf, Jr., *Disability Discrimination in Employment Law*, Bureau of National Affairs 478-79 (1995).

carry accessible or special products that are designed for or easier to use by customers with disabilities.”<sup>37</sup>

The First Circuit’s decision in *Carparts* also contains an inconclusive discussion of the potential for a claim against a plan administrator under the public accommodation provisions of ADA Title III. 37 F.3d at 18-20. The court rejected the lower court’s holding that public accommodations were limited to physical structures that individuals must enter in order to take advantage of the facilities or services offered therein. The court reasoned that, by including “travel service” within the definition of public accommodation, Congress manifested an intent to include all service providers within the reach of Title III whether or not they maintained facilities for their customers to enter. The court noted, however, that there was uncertainty about whether Title III was intended only to provide access to services, or rather whether it was intended to shape and control the services and products that might be offered. In light of this uncertainty, the court cautioned that the record was not sufficiently developed for the court to offer guidance on the applicability of Title III to the plaintiffs’ suit.

In a decision that attracted wide attention, the Sixth Circuit sitting *en banc*, in *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084 (1998), expressly rejected the reasoning in *Carparts*. *Parker* held that Title III does not govern the content of long term disability plans offered by employers. In so holding, the Sixth Circuit determined that a “benefit plan offered by an employer is not a good offered by a place of public accommodation” within the meaning of Title III. *Id.* at 1010. The Sixth Circuit also concluded that a disability plan that offers a longer term of benefits for persons disabled due to physical illness than for persons disabled due to mental illness does not violate either Title I or Title III of the ADA, since it offers the same package of benefits to all individuals without regard to disability. *Id.* at 1012-14.<sup>38</sup>

In *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999), the Third Circuit joined the Sixth Circuit in rejecting the *Carparts* court’s Title III analysis. The court found that under the ADA, disability benefits do not qualify as “public accommodations” because under the “plain meaning of Title III . . . a public accommodation is a place.” *Id.* at 612. The court explained that the “goods, services, facilities, privileges, advantages, or accommodations” to which a disabled person was entitled “are not free standing concepts” but rather refer to what places of “public accommodation provide.” *Id.*

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<sup>37</sup>DOJ TITLE III TECHNICAL ASSISTANCE MANUAL III-4.2500, *reprinted in ADA Manual* at 90:0921. In *Carparts*, 37 F.3d 12, in remanding the case to the district court, the court of appeals left open the possibility that Title III might reach the benefit policies of the health insurance plan at issue but did not decide the question.

<sup>38</sup> See also, *Lenox v. Healthwise of Kentucky*, 149 F.3d 453 (6th Cir. 1998) (affirming summary judgment to employer and finding that ADA does not prohibit health insurance providers from differentiating between persons with different disabilities).

Just as a bookstore must be accessible to the disabled but need not treat the disabled equally in terms of books the store stocks, likewise an insurance office must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled.

*Id.* at 613. Because the plaintiff, Ford, received her disability benefits from her employer “she had no nexus to MetLife’s ‘insurance office’ and thus was not discriminated against in connection with a public accommodation.” *Id.* at 614. In affirming the dismissal of Ford’s complaint the court acknowledged that it was “part[ing] company with” the First Circuit’s *Carparts* decision, explaining that in its view the *Carparts* court had misread the statutory language of the ADA. *Id.*

The Fifth, Seventh, and Ninth Circuits have also recently weighed in on this issue, interpreting Title III to only prohibit insurance companies from denying disabled individuals access to goods and services, as opposed to regulating the content of the insurance policies themselves. See *McNeil v. Time Ins. Co.*, 205 F.3d 179 (5th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 528 U.S. 1106 (2000); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000). Under this construction of Title III, the Fifth Circuit in *McNeil* held that an insurance company did not violate Title III by offering a policy that limited the amount of coverage for AIDS to \$10,000 over the first two years of the policy, because the insurance company offered the policy to the plaintiff on the same terms as it offered the policy to other employees. *McNeil*, 205 F.3d at 188. The court found that the plaintiff was challenging the content of the insurance policy – the AIDS limitation – and that such a claim would not lie under Title III. *Id.* at 189. See also *Doe*, 179 F.3d at 563-65.

Similarly, in *Doe*, the Seventh Circuit recognized that “[t]he common sense of [Title III] is that the content of the goods or services offered by a place of public accommodation is not regulated,” and that, for example, “[a] camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specifically designed for such persons.” *Doe*, 179 F.3d at 560. The Seventh Circuit concluded that Title III “does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance.” *Id.* at 563. The *Doe* court further instructed that, without a clear expression of intent from Congress, Title III should not be construed to “impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts . . . .” *Id.* at 560. Using this analysis, the court held that the two insurance policies at issue, one which limited the amount of coverage for AIDS and AIDS Related Complex to \$25,000, and the other which limited coverage to \$100,000, did not violate Title III, because the insurance companies did not refuse to sell the policies to the plaintiffs. See also *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000) (following *Ford* and *Parker* in holding that administrator of employer’s disability plan did not violate Title III by providing greater benefits for physical disabilities than for mental disabilities, because Title III relates only to the availability of goods and services and not to their content); *Chabner v. United of Omaha Life Ins. Co.*, 225 F.3d 1042, 1047 (9th Cir. 2000) (“we

reiterate our observation, set forth in *Weyer*, that ‘an insurance office must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled.’”).<sup>39</sup>

In contrast, the Second Circuit has read Title III to regulate both content as well as access. In *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, *amended*, 204 F.3d 392 (2d Cir. 2000), the Second Circuit held that Title III of the ADA regulates the “sale of insurance policies in insurance offices” subject to the limitations of § 501(c). Relying on *Carparts*, the court reasoned that the content of goods and services, such as insurance policies, would need to be altered to allow the disabled the opportunity to fully and equally enjoy those goods and services along with the non-disabled. *Pallozzi*, 198 F.3d at 32-33. However, the Second circuit clarified that its decision was not inconsistent with *Parker* and *Ford*, because the *Pallozzi* insurance policy was not provided in the context of employment. *Id.* at 33, n. 3. *See also Leonard F. v. Israel Discount Bank*, 199 F.3d 99, 107 (2d Cir. 1999) (“While we have recently held in *Pallozzi* . . . that an insurance office in its dealings with the public is a ‘place of public accommodation’ and is regulated by Title III, it does not necessarily follow that Title III is implicated when an insurance company issues a disability policy to an employer for the benefit of its employees.”).<sup>40</sup>

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<sup>39</sup> The same result was reached in *Erwin v. Northwestern Mut. Life Ins. Co.*, 999 F. Supp. 1227, 1231-33 (S.D. Ind. 1998) (rejecting *Carparts* and following *Parker* in finding that long term disability plan was not a “good” provided by a “place of public accommodation” under Title III); and *Fennell v. Aetna Life Ins. Co.*, 37 F. Supp. 2d 40 (D.D.C. 1999), (following *Parker* and holding that Title III is limited to places of public accommodation, meaning physical locations, and therefore does not permit suits centered on employee benefits), *affirmed by EEOC v. Aramark Corp. Corp., Inc.*, 208 F.3d 266 (D.C. Cir. 2000). *But see Connors v. Maine Med. Ctr.*, 42 F. Supp. 2d 34, 46 (D. Me. 1999), (holding that the plain language of Title III “would extend to the substance or contents of an insurance policy”).

<sup>40</sup> The impact of *Pallozzi* is further limited by the fact that it did not involve a challenge to any of the terms (*i.e.*, the content) of the insurance policies themselves. Rather, the plaintiffs filed suit against the insurance company for its refusal to issue the plaintiffs a joint life insurance policy based upon their mental disabilities. *Id.* at 29. Moreover, the Fifth Circuit has rejected *Pallozzi* in its entirety. *McNeil*, 205 F.3d at 188, n. 14, 15.

### III. MENTAL/NERVOUS LIMITS UNDER THE ADA

As set forth above, in drafting the ADA, Congress created a rule of construction in § 501(c), 42 U.S.C. § 12201, that Titles I through III of the ADA “shall not be construed to prohibit or restrict” insurance companies or those administering benefits plans from underwriting, classifying, or administering risks in a manner that is not inconsistent with state law. The plain purpose of this rule of construction was to permit insurance companies and those administering benefit plans to draw distinctions between persons or classes of persons otherwise protected by the ADA based on actuarial or other underwriting considerations that are the heart of the insurance business.

The legislative history of the ADA explicitly provides that the Act does not prohibit the issuance of insurance policies that “limit coverage for certain procedures or treatments.” S. Rep. No. 116 at 29. In fact, the Senate Report lists a policy that provides “only a specified amount per year for mental health coverage” as being lawful under the ADA. *Id.* Moreover, the legislative history of the ADA is replete with references to the fact that in enacting the ADA, Congress did “not intend that any provisions of this legislation should affect the way the insurance industry does business in accordance with the State laws and regulations under which it is regulated.” Education and Labor Committee Report at 136, *reprinted in* 1990 U.S.C.C.A.N. at 419; S. Rep. No. 116 at 84. In fact, the Congressional committees specifically “added section 501(c) to make it clear that this legislation will not disrupt the current nature of insurance underwriting or the current regulatory structure for self-insured employers or of the insurance industry in sales, underwriting, pricing, administrative and other services, claims, and similar insurance related activities . . . .” Education and Labor Committee Report at 136, *reprinted in* 1990 U.S.C.C.A.N. at 419; S. Rep. No. 116 at 84-85.<sup>41</sup>

As discussed in Section I above, the EEOC’s Interim Guidance on health insurance specifically approves the use of differential limitations in the case of mental/nervous versus physical conditions with respect to employee health plans. However, in *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039 (7th Cir. 1996), the EEOC took the position that similar distinctions in long term disability programs could violate the ADA. The EEOC argued that the rationale supporting the Interim Guidance on this point is inapplicable in the case of long term disability plans “where, by definition, all individuals

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<sup>41</sup>At the time the ADA was enacted, cases under the Rehabilitation Act, on which ADA was modeled, had long rejected claims challenging differences in benefits provided those with mental/nervous versus physical conditions. *E.g.*, *Doe v. Colautti*, 592 F.2d 704 (3d Cir. 1979); *Doe v. Devine*, 545 F. Supp. 576 (D.D.C. 1982), *aff’d on other grounds*, 703 F.2d 1319 (D.C. Cir. 1983). The courts under that Act embraced the long-accepted standard that the federal discrimination statutes do not require that “any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons.” *Traynor v. Turnage*, 485 U.S. 535, 549 (1988); *Flight v. Gloeckler*, 68 F.3d 61, 63 (2d Cir. 1995) (Rehabilitation Act “does not require all handicapped persons to be provided with identical benefits.”) (quoting *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990)).

qualified for benefits are disabled, in that they are unable to work as a result of their impairments.” The Seventh Circuit rejected the EEOC’s argument, finding insufficient indication in the ADA that Congress meant to mandate mental health parity in disability benefits. *See CNA Ins. Co.*, 96 F.3d at 1044-45.

To date, the appellate case law is contrary to the EEOC’s position. Ten federal courts of appeals have now addressed this issue, and all have held that the ADA does not require equal benefits for different disabilities. In addition to the Seventh Circuit’s *CNA* decision, the *en banc* Sixth Circuit in *Parker*, 121 F.3d at 1006, held that long term disability plans may provide different coverages for mental and physical disabilities. The Third Circuit and D.C. Circuit have also rejected the EEOC’s position. *See Ford*, 145 F.3d at 608 (disparity between mental and physical disability benefits does not violate the ADA); *EEOC v. Aramark Corp.*, 208 F.3d 266 (D.C. Cir. 2000) (long-term disability benefits plan that caps mental disability benefits does not violate the ADA). These circuits have been joined by the Second, Fourth, Ninth, and Tenth Circuits. *See EEOC v. Staten Island*, 207 F.3d 144 (2d Cir. 2000) (we agree “with our sister circuits that ‘[s]o 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.’”); *Rogers v. Dep’t of Health & Envtl. Control*, 174 F.3d 431 (4<sup>th</sup> Cir. 1999) (holding that the ADA does not require a state’s long-term disability plan to provide equal benefits for mental and physical disabilities); *Lewis v. Kmart Corp.*, 180 F.3d 166 (4th Cir. 1999), *cert. denied*, 528 U.S. 1136 (2000) (extending *Rogers* to conclude that the ADA does not require an employer’s long-term disability benefit plan to provide equal benefits for mental and physical disabilities); *Weyer*, 198 F.3d at 1116 (“[T]here is no discrimination under the Act where disabled individuals are given the same opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot be discriminatory.”); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10<sup>th</sup> Cir. 1999) (““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.”) (quoting *Ford*, 145 F.3d at 608-10). In addition, while not addressing the issue directly, the Eighth Circuit has given strong indication that it will follow the vast majority of other circuits and find that a disparity in benefits for mental and physical disabilities does not violate the ADA. *See Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8<sup>th</sup> Cir. 1996) (“Insurance distinctions that apply equally to all insured employees, that is, to individuals with disabilities and to those who are not disabled, do not discriminate on the basis of disability.”)<sup>42</sup>

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<sup>42</sup> The Fifth Circuit has not yet directly addressed a claim for long-term disability benefits where the disability plan provides differing levels of benefits for mental conditions. However, the Fifth Circuit had adopted the reasoning of the Third, Sixth, and Seventh Circuits in an analogous situation involving health insurance benefits, and it is likely that the Fifth Circuit would follow every other circuit to address this issue in the event it is faced with a challenge over disability benefits. *See McNeil v. Time Ins. Co.*, 205 F.3d 179 (5th Cir. 2000) (health insurance plan that caps benefits for AIDS does not violate Title III of the ADA), *cert. denied*, 531 U.S. 1191 (2001). *See also Fermin v. Conseco Direct Life Ins. Co.*, Case No. SA-98-CA-0943 NN, SA-00-CA-1063 NN, 2001 WL 685903 (W.D. Tex. May 1, 2001) (following *McNeil* and other circuit decisions to

While the First Circuit has not yet addressed this issue, several district courts in that Circuit have followed the “plethora” of appellate court rulings on the subject and held that the ADA does not prohibit limitations on mental/nervous benefits in disability policies. See *Pelletier v. Fleet Fin. Group, Inc.*, Nos. 99-245-B, 99-CV-146-PH (D.N.H. Sept. 19, 2000); *Hess v. Allstate Ins. Co.*, No. 99-384-P-C (D. Me. Aug. 2, 2000) (addressing Title I and Title III claims); *Wilson v. Globe Specialty Products, Inc.*, 117 F. Supp. 2d 92 (D. Mass. 2000) (addressing Title III claim). But see *Boots v. Northwestern Mutual Life Ins. Co.*, 77 F.Supp. 2d 211 (D.N.H. 1999) (holding that plaintiff established cause of action under Title III of the ADA by alleging that insurer granted benefits for physical disabilities as long as such disabilities existed but limited mental disability benefits to two years of coverage).

Recognizing the high barriers against ADA challenges on this issue, Plaintiffs are turning to a relatively recent Supreme Court decision, *Olmstead v. L. C. by Zimring*, 527 U.S. 581 (1999), in the hopes of changing the legal landscape in their favor. In *Olmstead*, the Court held that the State of Georgia violated Title II of the ADA by keeping two mentally retarded women institutionalized instead of placing them in community-based homes as recommended by their doctors. *Id.* at 602-03. Specifically, plaintiffs have attempted to hang their hats on a footnote in *Olmstead*, which, in dicta, notes that discrimination may be proven by demonstrating that one member of a particular protected group has been favored over another member of that same group, *Id.* at 598, n. 10, to establish that the ADA prohibits an insurer from treating the physically disabled more favorably than the mentally disabled. This argument has been rejected by almost every court to address it. See *Weyer*, 198 F.3d at 1117-18; *El-Hajj v. Fortis Benefits Ins. Co.*, 156 F. Supp. 2d 27, 30-31 (D. Me. 2001); *Wilson*, 117 F.Supp. 2d at 97; *Witham v. Brigham & Women's Hosp., Inc.*, Civil No. 00-268-M, 2001 U.S. Dist. LEXIS 7027, at \*12 (D.N.H. May 31, 2001); *Pelletier.*, 2000 WL 1513711, at \*3; see also *Staten Island*, 207 F.3d at 151 (mentioning *Olmstead* while holding that disparate insurance coverage between mentally and physically disabled is permissible under the ADA). But see *Boots*, 77 F.Supp. 2d at 218-19 (relying in part on the *Olmstead* footnote to hold that the ADA prohibits insurers from providing lesser benefits to the mentally disabled as opposed to the physically disabled). Moreover, *Olmstead* was based on regulations issued by the Attorney General pursuant to Title II, requiring a public entity to “administer services . . . in the most integrated setting appropriate.” *Olmstead*, 527 U.S. at 592 (quoting 28 C.F.R. § 35.130(d)). In contrast, the EEOC has issued guidance indicating that a different level of benefits for individuals with mental and physical disabilities does not violate Title I. See Interim Guidance § III.B (June 8, 1993).

Based on this virtually unanimous body of caselaw, it would seem that any challenges under the ADA based on differing levels of benefits for mental vs. physical disabilities would fail at the starting gate. However, a recent Eleventh Circuit decision revived this issue at least temporarily. In *Johnson v. Kmart Corp.*, 273 F.3d 1035 (11th Cir. 2001), the plaintiff was a former manager of Kmart stores who stopped working due

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hold that 190-day lifetime limitation on benefits for hospital confinements due to mental illnesses does not violate ADA).

to a mental health condition. *Id.* at 1037. He thereafter applied for and received benefits under Kmart’s long-term disability benefits plan. *Id.* Under the terms of the plan, the plaintiff’s benefits were terminated after two years because he suffered from a mental health-related disability. *Id.* The plan did not contain a similar cap on benefits for individuals with physical disabilities. *Id.* The United States District Court for the Middle District of Florida granted Kmart’s motion to dismiss with prejudice on the grounds that the ADA does not require equal benefits for different disabilities. *Johnson v. Kmart Corp.*, No. 98-02383-CV-T-25E. In so doing, the district court specifically noted its agreement with every other circuit that has rejected such an argument. *Johnson*, 273 F.3d at 1038.

A divided three-judge panel reversed, with Judge Carnes issuing a vigorous dissent.<sup>43</sup> The panel majority, in direct conflict with a prior panel decision, *Gonzales v. Garner Food Servs.*, 89 F.3d 1523 (11th Cir. 1996), *cert. denied*, 520 U.S. 1229 (1997), held that the plaintiff, who was admittedly totally disabled at the time of filing his ADA claim, was a “qualified individual with a disability” under Title I of the ADA. In so holding, the panel majority concluded that the Supreme Court’s decision in *Robinson v. Shell Oil Co.*, 519 U.S. 337 (1997), a Title VII retaliation case, “mandates the conclusion that *Gonzales* is no longer good law and must be deemed overruled.” *Id.* at 1037.

More importantly, the panel majority rejected the reasoning of nine other circuit courts and held that Kmart’s long-term disability plan was discriminatory on its face based on its provision of lesser benefits to persons afflicted with mental disabilities as opposed to physical disabilities. *Id.* at 1056-60. In reaching this unusual holding, the panel majority relied in part on the Supreme Court’s *Olmstead* decision. *Id.* at 1051-54. As discussed above, however, several other courts have rejected the application of *Olmstead* to such claims, and at least three circuit courts post-*Olmstead* have rejected ADA challenges relating to the differences in benefits between mental and physical disabilities. See *Weyer*, 198 F.3d at 1116; *Kimber*, 196 F.3d at 1102; *Staten Island*, 207 F.3d at 148.

The panel majority also relied on the ADA’s legislative history in finding Kmart’s plan violated the ADA. *Johnson*, 273 F.3d at 1055-56 & n. 18. The panel majority read this mandate for “equal access” to require “equal coverage” as well, thereby requiring Kmart to alter the contents of its disability plan.

The *Johnson* decision is no longer effective. The panel decision was authored by a visiting judge from the Eastern District of Pennsylvania, sitting by designation, and joined by only one of the two Eleventh Circuit judges sitting on the panel. The full Eleventh Circuit, on its own motion, ordered rehearing of *Johnson* en banc less than one month after publication of the panel opinion. Pending resolution of

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<sup>43</sup> Judge Carnes’ dissent focused solely on the panel majority’s decision to overrule the prior *Gonzales* decision, and the panel majority’s apparent violation of the “prior precedent rule.” See *Johnson*, 273 F.3d at 1065-1070 (Carnes, J. dissenting). Judge Carnes specifically declined to express a view on the ADA coverage issue.

the en banc rehearing, the panel opinion has been vacated and is thus of no effect. Final resolution of *Johnson* has been delayed by the recent bankruptcy filing by Kmart, which has automatically stayed all litigation, including the en banc rehearing. As a result, the district court's decision granting Kmart's motion to dismiss with prejudice – and following all other circuits in rejecting ADA claims based on the disparity between benefits for mental vs. physical disabilities – still stands and is the law of the case.

#### IV. ISSUES FOR DEFENSE

##### A. Burden of Proof Under § 501(c): Role of the *Betts* Decision

As discussed in Section I above, the EEOC considers § 501(c) to be a “limited” exemption, and would place the burden of proof in cases of a disability based distinction in a benefit plan on the employer to show that the limitation is not a “subterfuge” to evade the purposes of the Act. The Interim Guidance also focuses primarily on cost justifications as the requirement for disproving “subterfuge.”

Defendants seeking to avoid any of these EEOC positions have a friend in the Supreme Court's decision in *Public Employees Retirement Sys. v. Betts* (“*Betts*”), 492 U.S. 158 (1989), under the Age Discrimination in Employment Act of 1967 (“ADEA”), as amended.<sup>44</sup> Although Congress expressed its disapproval of the *Betts* decision by enacting the Older Workers Benefit Protection Act,<sup>45</sup> that changed key provisions of the ADEA, this action occurred after the ADA was enacted.

At the time ADA passed, Congress included terms in § 501(c) that had been construed by the *Betts* Court in a very similar context under the pre-amendment version of § 4(f)(2) of ADEA. 29 U.S.C.S. § 623(f)(2)(Supp. 1997). The *Betts* decision reached a number of conclusions that have substantial importance for the interpretation of ADA.

First, § 4(f)(2) of ADEA, while nominally an exemption, was interpreted as limiting the scope of ADEA's prohibitions with respect to employee benefit programs. 492 U.S. at 160. As a result, the Court held that the plaintiff, not the defendant, has the burden of proof with respect to § 4(f)(2). 492 U.S. at 181. The argument should be even stronger under § 501(c) of ADA which is denominated a rule of construction rather than an exemption. See *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 36 (2d Cir. 2000) (following *Betts* and holding that when a plaintiff pleads a claim of discrimination under Title III of the ADA, “the plaintiff has the further obligation to plead (and prove) that the insurance practice complained of is not consistent with state law or is being used as a ‘subterfuge to evade the purposes’ of Title I and III of the Act.”).

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<sup>44</sup>29 U.S.C.S. §§ 621 *et seq.* (1990 & Supp. 1997).

<sup>45</sup>Pub. L. No. 101-433, 104 Stat. 978 (1990).

The *Betts* Court also rejected the EEOC's ADEA guidelines defining "subterfuge" as requiring a cost justification for any age based differences in benefits. Rather it held that for a bona fide benefit plan to be considered a prohibited "subterfuge" the plaintiff must show that it reflected the intent of discriminating on the basis of age in a non-fringe-benefit aspect of employment. 492 U.S. at 181.

Four courts of appeals have now relied on the *Betts* decision in interpreting ADA Section 501(c). In *Ford*, 145 F.3d at 611, the Third Circuit applied the *Betts* definition of "subterfuge" as the meaning Congress intended. To the same effect see *Leonard F. v. Israel Discount Bank*, 199 F.3d 99, 104-05 (2d Cir. 1999); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678-79 (8<sup>th</sup> Cir. 1996); *EEOC v. Aramark Corp.*, 208 F.3d 266 (D.C. Cir. 2000) (relying heavily on *Modderno v. King*, 82 F.3d 1059 (D.C. Cir. 1995), *cert. denied*, 117 S. Ct. 772 (1997)). A number of district courts have also applied *Betts* to ADA cases. For instance, in *Bythway v. Principal Health Care of Delaware*, Nos. Civ. A. 97-435-GMS, CIV. A. 97-600-GMS (D. Del. Sept. 29, 1999), the district court for the district of Delaware, following *Ford* and *Betts*, granted the defendants motion for summary judgment. The court followed the *Betts* definition of "subterfuge," finding that the terms of the health care policy, which limited coverage for bone marrow transplants to only those individuals suffering from certain forms of leukemia were not adopted to evade the purposes of the ADA. The court further refused to interpret the § 501(c) as "ushering in a 'seismic shift in the insurance business [by] requiring insurers to justify their coverage plans in court after a mere allegation by a plaintiff.'" *Id.* at \* 3 (quoting *Ford*, 145 F.3d at 611-12).<sup>46</sup> See also *Whaley v. United States*, 82 F. Supp. 2d 1060, 1063 (D. Neb. 2000) ("It has been held, . . . that the 'subterfuge' qualification to the safe harbor provision does not require an insurance company to justify its policy coverage whenever a plaintiff alleges discrimination.") (citing *Ford* and *Betts*).

## B. Preparing an Affirmative Defense Under § 501(c)

As explained above, the prevailing - though not uniform - view is that the plaintiff should have the burden of establishing "subterfuge" as defined in *Betts* in order to maintain a benefits claim under the ADA. Nevertheless, it may not be apparent until close to the trial of any given case, whether this view of the law will be applied by the court hearing the case. In this section we consider how a defendant should develop an affirmative defense in the event the EEOC/Plaintiff view prevails.

### 1. The Terms of § 501(c)

Section 501(c) provides three separate paragraphs which are applicable to benefit programs provided through insurance, paragraphs (1) and (2), as well as self-insured employee benefit plans, paragraph (3). To qualify under paragraphs (2) and (3), the plan at issue must be "bona fide." This term has been twice defined by the Supreme Court in the context of an employee benefit plan to require only a showing that the plan

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<sup>46</sup> See also *Sampson*, Civ. No. 98-cv-1272, at 5 (adopting *Betts* definition of "subterfuge").

“exists and pays benefits.”<sup>47</sup> In its Interim Guidance on health insurance, EEOC would add an additional requirement of showing that “its terms have been accurately communicated to eligible employees.”<sup>48</sup>

Where the benefit plan at issue is self-insured, proof that the plan is “bona fide” is the only showing the defendant need make. Interim Guidance at III.C.1. Where the plan is provided through insurance, paragraphs (1) and (2) contain the further requirement that the plan be “not inconsistent with State law.” *Id.*

According to the EEOC’s Interim Guidance, this is a question of state law “as interpreted by the appropriate state authorities.”<sup>49</sup> The deference to state interpretation extends to both the issue of which state law is applicable and to the substantive issue of whether the provision at issue is consistent with that law.<sup>50</sup>

Often the insurance contract itself will specify the applicable state law. In the case of multi-state employers, it would be prudent to show conformity with the state law defined as applicable in the plan and the law of the state in which the plaintiff was employed.

There are several ways consistency with state law could be proved. First, existing records of the insurer may establish that the policy provision at issue has been accepted for filing by the state insurance regulator. This would not be the case if the provision was contrary to state law. Second, the opinion of the state insurance regulator could be obtained for purposes of the litigation. Finally, the consistency of the provision with a particular state insurance law could be established through expert opinion.

Defendants can expect that plaintiffs will seek to rely on references in the ADA legislative history to the prohibitions in state insurance law against “unfair discrimination,” as a basis for requiring actuarial justification.<sup>51</sup> Alternatively, they may seek to have the court interpret the relevant provision from the applicable state law as a part of the litigation. As a result it is important to include in the defendant’s proof of consistency with state law evidence that specifically addresses the “unfair discrimination” provision of that law.

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<sup>47</sup> *Betts*, 492 U.S. at 166; *United Air Lines, Inc. v. McMann*, 434 U.S. 192, 194 (1977).

<sup>48</sup> Interim Guidance at § III.C.1.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at n.13. See also *Leonard F.*, 199 F.3d at 107 (the determination of whether an insurance policy is consistent with New York state law is a question of law, not fact).

<sup>51</sup> “Virtually all states prohibit unfair discrimination among people of the same class and equal expectation of life. The ADA adopts this prohibition of discrimination.” H.R.Rep. 101-485,pt.2, at 136, *reprinted in* 1990 U.S.C.C.A.N. at 419.

2. Actuarial Defense

a. Sound actuarial principles defined

Because courts may reject the *Betts* formulation of “subterfuge,” or may read the state law to require actuarial justification, defendants should also be ready to prove that a plan’s provisions are based on sound actuarial principles. The ADA does not define sound actuarial principles and only one reported decision has directly addressed this issue. In *Chabner*, 994 F. Supp. 1185, 1187 (N.D. Cal. 1998), *affirmed on other grounds*, 225 F.3d 1042 (9th Cir. 2000), the district court for the Northern District of California considered a summary judgment motion of the plaintiff, a 35 year-old non-smoking man who had fascioscapulohumeral muscular dystrophy (“FSH MD”). The plaintiff claimed that United of Omaha had discriminated against him by issuing him a life insurance policy costing almost twice as much as one for non-smoking man of his age. Defendant argued it had made the cost differential based on “sound actuarial principles,” namely the recommendation of its underwriter who relied in turn on Chabner’s medical records, industry manuals and experience, and therefore complied with state law. The court rejected this argument, explaining:

While sound actuarial principles may include elements of discretion and judgment based on individual circumstances, *they must also include reference to some sort of actuarial data either in the form of actuarial tables or clinical studies estimating mortality rates.*

*Id.* at 1194 (emphasis added). Because the record was devoid of such actuarial data to support the cost differential, the court granted plaintiff’s motion for summary judgment.

The stringent *Chabner* formulation that sound actuarial principles must include actuary tables and clinical studies, however, is contrary to the standards set forth by the Actuarial Standards Board of the American Academy of Actuaries. In its “Actuarial Standard of Practice No. 12; Concerning Risk Classification” published October 1989, the Board provides a standard intended in part to guide actuaries in complying with state insurance law requirements prohibiting discrimination.<sup>52</sup> The Standard recognizes that in classifying risk, the actuarial professional must rely on estimates, expert opinion, experience and even inference based on experience and judgment when directly applicable data is not available. The standard provides:

*Relevant information from any reliable source, including statistical or other mathematical analysis of available data, may be used. . . . In the absence of actual experience, an actuary may rely on clear actuarial evidence that differences in costs are related to a particular characteristic.*

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<sup>52</sup> See *Actuarial Standard of Practice No. 12*, Actuarial Standard Board (Oct. 1989).

In demonstrating this, the actuary may rely on clinical experience or expert opinion.<sup>53</sup>

The standard recognizes that a statistical demonstration of a cause and effect relationship between risk and classification characteristics is often impossible or impractical, and therefore is not required.<sup>54</sup>

A more flexible view of sound actuarial principles has also been supported by Congress. In the “Statement of Managers”<sup>55</sup> accompanying the Older Workers Benefit Protection Act,<sup>56</sup> which amended the ADEA to require a cost justification for age-related differences in employee benefit plans, Congress addressed this very point. 136 Cong. Rec. S13594-01, S13597 (daily ed. Sept. 24, 1990). Congress explained that employers could base necessary cost data on “generally accepted actuarial provisions” such as:

actuarial extrapolation, smoothing and averaging, and on the use of reasonable related data . . .

*Id.* It further noted that calculations must be based “on the best reasonably available data.”

Notably, at least two circuit courts have recently held that regardless of whether an insurance plan rests on “sound actuarial principles,” § 501(c) r protects any bona fide employee benefit plan adopted prior to the enactment of the ADA. Applying *Betts*, the courts found that § 501(c) could not have been “used as” a subterfuge to evade the purposes of the ADA, if the plan at issue was adopted before the ADA’s enactment. See *Leonard F.*, 199 F.3d at 104; *Aramark*, 208 F.3d at 269-73. See also *Rogers v. Department of Health & Envtl. Control*, 174 F.3d 431, 437 (4th Cir. 1999) (actuarial data not required for application of safe harbor exception).

#### b. Necessary Preparation

To be prepared to prove that plan provisions are based on sound actuarial principles in the face of a potential ADA claim, it is prudent for insurance companies and benefit plan providers to obtain and keep in the files relevant and supportive actuarial reports.<sup>57</sup> Potential sources of relevant actuarial information may include: (1) insurance industry data and survey information; (2) studies and surveys related to analogous

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<sup>53</sup> *Id.* § 5.1 (emphasis added).

<sup>54</sup> *Id.* § 5.2.

<sup>55</sup> A “Statement of Managers” is the highest order of legislative history.

<sup>56</sup> Pub. L. No. 101-433, 104 Stat. 978 (1990).

<sup>57</sup> Recently, the EEOC has begun to routinely seek discovery on this issue as part of its charge processing. Having some actuarial information justifying the provision at issue closely at hand is also beneficial in this context.

coverage, for instance in the Social Security Disability Income (SSDI) program; (3) actuarial opinion expressed in publications and conference materials. For example, updated data concerning mental/nervous disabilities in the form of actuarial tables has recently become available as a result of a Society of Actuaries pilot study aimed at proposing a new Group LTD reserve valuation standard.<sup>58</sup>

In addition to having actuarial reports generally available, once faced with actual litigation,<sup>59</sup> the defendant should be ready to retain at least one actuary as an expert witness to prepare a report containing the actuarial demonstration appropriate for the specific case.

### C. Qualified Individual With A Disability (“QID”)

The ADA provides that a claim under the Act may be brought only by a “qualified individual with a disability” (“QID”). The ADA, in turn defines a “qualified individual” as an “individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.” 42 U.S.C. § 12111(8) (2000). The courts are split as to whether this definition precludes a former employee who is totally disabled from bringing an ADA claim.

The Seventh, First and Eleventh Circuits have adopted a narrow reading of QID, dismissing ADA suits in which former employees have alleged discrimination in their disability benefits. In *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039 (7th Cir. 1996), the court found that a plaintiff receiving long term disability benefits had no cognizable claim under the ADA because she no longer held an “employment position.” The court rejected the EEOC’s argument that the plaintiff’s employment position was “that of ‘disability benefit recipient,’” emphasizing that “[a]n ‘employment position’ is a job” and finding that the claim “raise[d] a different kind of discrimination claim, more grist for the ERISA mill or the national health care debate than for the ADA.” *Id.* at 1043-44; see *Soto-Ocasio v. Federal Express Corp.*, 150 F.3d 14, 18 (1st Cir. 1998) (finding that plaintiff failed to meet her burden of showing that she was a “qualified individual with a disability” under the ADA because she received total disability benefits predicated on her inability to perform her job, and failed to make some type of showing that she was in fact able to perform the essential functions of her job during the time in question.) *Gonzales v. Garner Food Serv., Inc.* 89 F.3d 1523 (11<sup>th</sup> Cir. 1996) (finding that a former employee receiving health care benefits under COBRA did not have standing under the ADA to challenge as discriminatory a limitation on AIDs-related medical benefits).<sup>60</sup>

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<sup>58</sup> The Society of Actuaries website is <http://www.soa.org>.

<sup>59</sup> To assure that the appropriate privilege applies, the insurance company or benefits plan provider should wait until it becomes a defendant in a suit before hiring an expert to prepare a report concerning the specific provision.

<sup>60</sup> See also *Tyndall v. National Educ. Ctrs.*, 31 F.3d 209 (4th Cir. 1994); *Beauford v. Father Flanagan’s Boys’ Home*, 831 F.2d 768, 771-72 (8th Cir. 1987) (interpreting § 504 of the Rehabilitation Act and holding that an employee who cannot perform the

In contrast, the Third Circuit and the Second Circuit have held that Title I of the ADA permits disabled plaintiffs to sue their former employers regarding their disability benefits. Most recently, the Third Circuit in *Ford* explicitly rejected both *CNA* and *Gonzales*, finding that a totally disabled plaintiff could sue her former employer for discrimination concerning her long-term disability coverage. The court reasoned that “the disjunction between the ADA’s definition of “qualified individual with a disability” and the rights that the ADA confers” created an ambiguity in the statute. *Ford*, 145 F.3d at 605. The court then adopted the reasoning of *Robinson v. Shell Oil Co.*, 519 U.S. 337 (1997),<sup>61</sup> a case decided after *CNA* and *Gonzales*, in which the Supreme Court, upon considering a similar ambiguity under Title VII, found that the term “employees” encompassed both present and former employees. *Id.* at 606-07; see *Castellano v. City of New York*, 142 F.3d 58, 69 (2d Cir. 1998) (holding that a former employee with a disability who could perform essential functions of employment for a period sufficient to establish employer-related fringe benefits is a “qualified individual with a disability” under the ADA for the purpose of challenging alleged discriminatory provisions of the fringe benefit), *cert. denied*, 525 U.S. 922 (1998).

In reaching its decision, the *Ford* court distinguished *Nemar v. Disney Store, Inc.*, 91 F.3d 610, 618 (3d Cir. 1996), *cert. denied*, 519 U.S. 1115 (1997), in which an HIV-positive man argued that he was a “qualified individual with a disability” in an ADA suit against his former employer for wrongful termination while at the same time representing to government agencies that he was completely disabled in order to receive disability benefits. The court of appeals in *Nemar* affirmed a district court decision that the plaintiff’s representations to the government estopped him from arguing that he was

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essential functions of the job does not satisfy the prerequisites of the section), *cert. denied*, 485 U.S. 938 (1988); *Venclauskas v. Dep’t of Pub. Safety Div. of State Police*, 921 F. Supp. 78, 81 (D. Conn. 1995) (“In order to be entitled to relief under the ADA, therefore, the plaintiff must plead facts that establish that he is a ‘qualified individual with a disability.’”); *Parker v. Metropolitan Life Ins. Co.*, 875 F. Supp. 1321 (W.D. Tenn. 1995), *aff’d in part and rev’d in part*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084 (1998). A divided panel from the Eleventh Circuit recently held that a totally disabled former employee may be considered a “qualified individual with a disability” for purposes of bringing a claim under Title I of the ADA challenging an employer’s decision to limit benefits for mental disabilities. *Johnson v. Kmart Corp.*, 273 F.3d 1035 (11th Cir. 2001). This opinion has been vacated pending re-hearing en banc, and the resolution of Kmart’s bankruptcy proceedings. See pp. 19-21, *infra*, for a more detailed discussion of *Johnson*.

<sup>61</sup> In *Robinson*, the plaintiff filed an EEOC charge against his employer. While the charge was pending, he applied for another job with a different company. According to the plaintiff, his employer gave a negative reference to his prospective employer in retaliation for his having filed the EEOC charge. After analyzing the relevant statutory provisions, the Court determined that the plaintiff could maintain a retaliation claim under Title VII. In sum, the Court premised its decision on the fact that the term “employee” does not have a temporal qualifier. *Robinson*, 519 U.S. at 846.

“qualified” under the ADA. The *Ford* court explained that despite *Nemar*’s “apparent relevance” it was distinguishable because the facts in that case “did not unearth an internal contradiction in the ADA” as they did in *Ford*. 145 F.3d at 605. Instead the *Nemar* case arose because of the contradictory positions the plaintiff asserted – wrongful discharge, on one hand, and complete disability, on the other. *Id.*

The courts are split with regard to the issue addressed in *Nemar* – whether a party who represented himself as totally disabled to receive disability benefits and then sued his former employer pursuant to the ADA is a qualified individual under the statute. As discussed above, in *Nemar*, the Third Circuit held that in such circumstances the plaintiff was “judicially estopped” from bringing the ADA charge. *See also Garcia-Paz v. Swift Textiles, Inc.*, 873 F. Supp. 547, 555 (D. Kan. 1995) (“Having collected substantial benefits, based on these unaambiguous and seemingly informed representations, plaintiff is estopped from now claiming that she *could* perform the essential functions of her position.”); *Reigel v. Kaiser Found. Health Plan*, 859 F. Supp. 963, 970 (E.D.N.C. 1994) (“Plaintiff . . . cannot speak out of both sides of her mouth with equal vigor and credibility before this court.”); *Reiff v. Interim Personnel, Inc.*, 906 F. Supp. 1280 (D. Minn. 1995) (collecting cases); *Berghuis v. Univ. of Mass. Med. Ctr.*, Case No. 950875B, 1998 WL 1182068, \* 4 (Mass. Super. Apr. 6, 1998) (“It would be inconsistent to hold that [the plaintiff] is totally disabled for the purpose of collecting benefits, yet able to perform essential job functions for the purpose of finding that his termination was discriminatory. Accordingly, [the plaintiff] does not meet the criteria of a ‘qualified’ handicapped or disabled person within the meaning of G.L.C. 151B, § 1(16), or the ADA.”). Other courts, however have held that receipt of disability benefits does not preclude subsequent ADA relief. *See, e.g., Swanks v. Washington Metropolitan Area Transit Authority*, 116 F.3d 582 (D.C. Cir. 1997); *Blanton v. Inco Alloys Int’l Inc.*, 123 F.3d 916 (6<sup>th</sup> Cir. 1997).

The Supreme Court recently addressed this split in *Cleveland v. Policy Management Sys. Corp.*, 526 U.S. 795 (1999). In *Cleveland*, the Supreme Court held that an employee’s pursuit and receipt of Social Security Disability Insurance Benefits would not estop the employee from subsequently pursuing an ADA claim or erect a strong presumption against such a claim. The Court found that an “SSA representation of total disability differs from a purely factual statement in that it often implies a context-related legal conclusion, namely ‘I am disabled for purposes of the Social Security Act.’” *Id.* at 802. The Court found that the doctrine of judicial estoppel was not appropriate because there are many situations where an individual could validly claim to be totally disabled for purposes of the Social Security Act, and yet be capable of performing the essential functions of his or her job. *Id.* at 804. For example, the Court explained that the nature of an individual’s disability may change over time, so that a statement about that disability at the time of an individual’s application for social security benefits may not reflect an individual’s capacities at the time of the relevant employment decision. *Id.* at 805.

However, the Court did not give disabled individuals a free pass; a disabled individual must explain how her claim for Social Security Disability Benefits does not conflict with her claim under the ADA. In order to survive summary judgment, the explanation “must be sufficient to warrant a reasonable juror’s concluding that,

assuming the truth of, or the plaintiff's good faith belief in, the earlier statement, the plaintiff could nonetheless 'perform the essential functions' of her job, with or without 'reasonable accommodation.'" *Id.* at 807.

Since the Supreme Court's ruling in *Cleveland*, the Second, Third, Fourth, Fifth, Seventh, and Eighth Circuits have dismissed ADA claims where the plaintiffs failed to adequately explain a prior representation of total disability for purposes of receiving Social Security Disability or accidental disability pension benefits.<sup>62</sup>

#### D. Defenses to Retaliation Claims

As with all other federal anti-discrimination statutory schemes, the ADA contains a statutory prohibition against retaliation and intimidation. Employees who bring claims of retaliation against insurance companies and plan administrators, however, have met with little success given the courts' interpretation of which entities are covered by the statute.

The ADA's anti-retaliation provision can be found at 42 U.S.C. § 12203. This section provides, in relevant part:

##### (a) Retaliation

No person shall discriminate against any individual because such individual has opposed any act or practice made unlawful by this chapter or because such individual made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this chapter.

##### (b) Interference, coercion, or intimidation

It shall be unlawful to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this chapter.

42 U.S.C. § 122303 (a) & (b) (2000).

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<sup>62</sup> See *Reed v. Petroleum Helicopters, Inc.*, 218 F.3d 477 (5th Cir. 2000); *Motley v. New Jersey State Police*, 196 F.3d 160 (3d Cir. 1999), *cert. denied*, 529 U.S. 1087 (2000); *EEOC v. Stowe-Pharr Mills, Inc.*, 216 F.3d 373 (4th Cir. 2000); *Feldman v. American Memorial Life Ins. Co.*, 196 F.3d 783 (7th Cir. 1999); *Lee v. City of Salem, Indiana*, 259 F.3d 667 (7th Cir. 2001); *Lloyd v. Hardin County*, 207 F.3d 1080 (8th Cir. 2000); *Mitchell v. Washingtonville Central School Dist.*, 190 F.3d 1 (2d Cir. 1999). See also *Jammer v. The School District of Palm Beach County, Florida*, No. 978663CIVHURLEYLYNCH (S.D. Fla. Nov. 19, 1999).

In the employment context, the remedies available for a violation of § 12203 are set forth in § 12117 of the ADA. *See* 42 U.S.C. § 12203(c) (2000). Section 12117, in turn, specifically makes the remedies available under Title VII of the Civil Rights Act of 1964 applicable to actions under the ADA. *See* 42 U.S.C. § 12117(a) (2000). The enforcement provision of Title VII permits actions against an “employer, employment agency, labor organization, or joint labor-management committee.” *See* 42 U.S.C. § 2000e-5(b). Based on this remedial scheme, nearly every court to consider the issue has held that the ADA’s retaliation and coercion provisions do not apply to non-employers.<sup>63</sup> *See, e.g. Baird v. Rose*, 192 F.3d 462, 471-72 (4th Cir. 1999); *Key v. Grayson*, 163 F. Supp. 2d 697 (E.D. Mich. 2001); *Santiago v. City of Vineland*, 107 F. Supp. 2d 512, 551-52 (D.N.J. 2000); *Kautio v. Zurich Ins. Co.*, No. 97-2411-JWL, 1998 WL 164623, at \*2 (D. Kan. Mar. 18, 1998); *Stern v. California State Archives*, 982 F. Supp. 690, 692-93 (E.D. Cal. 1997); *Cable v. Department of Developmental Servs.*, 973 F. Supp. 937, 943 (C.D. Cal. 1997); *cf. Hiler v. Brown*, 177 F.3d 542, 547 (6th Cir. 1999) (holding that “individuals who do not otherwise meet the statutory definition of ‘employer’ cannot be held liable under the Rehabilitation Act’s anti-retaliation provision.”).

For example, in *Stern v. California State Archives*, 982 F. Supp. 690, 692-93 (E.D. Cal. 1997), the plaintiff sued her employer and individual supervisors for violation of the ADA’s retaliation provision. In rejecting the claim against plaintiff’s individual supervisors, the court held that “a careful reading of the relevant provisions in light of the ADA’s overall structure makes it clear that plaintiff cannot maintain an ADA retaliation claim against individual defendants who do not otherwise satisfy the definition of employer.” *Id.* at 692. The *Stern* court reasoned that “[c]onsidering the ADA’s overall framework, it makes sense that the retaliation provision broadly prohibits retaliation by a ‘person,’ but prescribes the available remedies according to the type of retaliation alleged.” *Id.* at 694. “[W]hich remedies a plaintiff is afforded, [if any], depends on whether the alleged retaliation occurred with respect to employment, public services, or public accommodations.” *Id.* at 693. Since the plaintiff complained about retaliation in employment (*i.e.*, a Title I claim), the court looked to Section 12117 to determine what remedy she was afforded.<sup>64</sup> The court concluded that in order for a plaintiff to be afforded a remedy against a defendant under Section 12117, the defendant must meet the definition of “employer.” *Id.* Since the defendants in that case did not meet this definition, the court concluded that they could not be held liable for retaliation in the workplace under the ADA. *Id.*

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<sup>63</sup> The only reported decision finding individual liability under Section 12203 is a 1997 decision in the Eastern District of California. *Ostrach v. Regents of the University of California*, 957 F. Supp. 196 (E.D. Cal. 1997). At least two later district court decisions in the Ninth Circuit, one in the same district, have rejected the reasoning of *Ostrach* and found that the ADA anti-retaliation provision does not apply to non-employers. *See Stern v. California State Archives*, 982 F. Supp. 690, 692-93 (E.D. Cal. 1997), and *Van Hulle v. Pacific Telesis Corp.*, 124 F. Supp. 2d 642 (N.D. Ca. 2000).

<sup>64</sup> *See* 42 U.S.C. § 12203(c).

The analysis in *Stern* should apply equally to insurance companies and benefit plans. See *Van Hulle v. Pacific Telesis Corp.*, 124 F. Supp. 2d 642 (N.D. Ca. 2000) (relying heavily on *Stern* and holding that a plan administrator was not a “covered entity” under Title I of the ADA, nor a “place of public accommodation” within the meaning of Title III, and therefore, the employee could not maintain an ADA retaliation action against a plan administrator who was not otherwise subject to the ADA). Moreover, as discussed above, with the exception of the First Circuit’s decision in *Carparts*, the majority of courts have held that insurers and benefit plans are not “employers” for purposes of discrimination claims under Title of the ADA.<sup>65</sup> Given the weight of these decisions, insurance companies should be well able to defend against a retaliation claim brought under the ADA.

#### E. Defenses to Related State Law Claims

Plaintiffs increasingly resort to state or local law as a vehicle for prosecuting employment discrimination claims. This may be done to select a preferred local forum, to avoid the damage caps incorporated in the Civil Rights Act of 1991,<sup>66</sup> or for both reasons. Where claims of disability-based discrimination in benefit plans are brought under state law, new issues for defense become available.

##### 1. Worker’s Compensation Preemption

Worker’s Compensation laws typically provide the exclusive state law remedy for work-related injuries. Depending on the law of the jurisdiction at issue, the preemptive effect of these statutes may provide a defense to state disability discrimination claims. This potential defense deserves consideration with respect to any claim involving disability benefits, as well as in cases where the plaintiff seeks compensatory damages for work-induced emotional injuries.<sup>67</sup>

##### 2. ERISA Preemption

Section 514 (a) of ERISA, 29 U.S.C. § 1144(a), preempts the application of state human rights laws to employee benefit plans to the extent those laws prohibit conduct that is lawful under federal law. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, the state of New York argued that the New York Human Rights Law, which required employers to pay pregnancy leave to employees, was exempted from preemption by § 514(d), which provides that “[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United

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<sup>65</sup> See Section II, *supra*.

<sup>66</sup> See, e.g., *Houck v. Farmers Group, Inc.*, No. 955-2-012249 (Wash. Sup. Ct. King Cty., Sept. 9, 1996), where a jury awarded 2.07 million dollars (including \$1.22 million in compensatory and punitive damages) in a disability case brought under state law as well as the ADA.

<sup>67</sup> See *Jimeno v. Mobil Oil Corp.*, 66 F.3d 1514 (9th Cir. 1995); *Kientzy v. McDonnell Douglas Corp.*, 990 F.2d 1051 (8th Cir. 1993).

States.”<sup>68</sup> This was so, New York argued, because the New York Human Rights Law was a necessary part of Title VII’s overall enforcement scheme, and hence within ERISA’s federal law exemption from preemption. *See* 463 U.S. at 100- 01.

The Court acknowledged that “State laws obviously play a significant role in the enforcement of Title VII,” and that “Title VII requires recourse to available state administrative remedies.” *Id.* at 101. The Court concluded, however, that the practices made unlawful under the New York Human Rights Law – failing to pay benefits for pregnancy leave – were not unlawful under Title VII. Thus, it “fail[ed] to see how federal law would be impaired by pre-emption of a state law prohibiting conduct that federal law permitted.” *Id.* at 103-04. The Court therefore concluded that “pre-emption would not impair Title VII within the meaning of § 514(d).” *Id.* at 103.

*Shaw* has been applied to state prohibitions of disability discrimination that do not contain a provision comparable to § 501(c) of ADA, and mandate a broader regulation of employee benefit plans. Recently, the First Circuit followed *Shaw* and held that a claim of disability discrimination under the Massachusetts discrimination statute was preempted by ERISA. *Tompkins v. United Healthcare of New England, Inc.*, 203 F.3d 90 (1st Cir. 2000). In *Tompkins*, the parents of a sick child sued their employee health plan, alleging that the plan’s denial of benefits for treatment of their child violated both the ADA and the Massachusetts discrimination statute. *Id.* at 92-93. Citing to *Shaw*, the First Circuit determined that the state-law claims were subject to ERISA preemption because the plaintiffs had failed to establish that the denial of benefits also violated the ADA.<sup>69</sup> *Id.* at 97. *See also Muller v. First Unum Life Ins. Co.*, 90 F. Supp. 2d 204 (N.D.N.Y. 2000) (“to the extent that [plaintiff’s New York Human Right’s Law] claim is based upon the disparity in benefits between physical and mental disabilities under the [long-term disability plan], such claim is preempted by ERISA because the ADA does not proscribe such conduct.”); *Fitts v. Fannie Mae*, 44 F. Supp. 2d 317, 328-29 (D.D.C. 1999) (former employee’s claim under D.C. Human Rights Act that sought to “require that [an employer-sponsored, long term disability benefits plan] provide the same level of disability benefits to mentally disabled persons as it does for physically disabled persons . . . [w]ithout a doubt has a connection to and reference to her plan,” and was therefore preempted by ERISA).

It is also possible to argue that ERISA § 514(a), as interpreted in *Shaw*, has the effect of precluding compensatory or punitive damages in excess of those authorized for federal ADA claims.

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<sup>68</sup> 29 U.S.C. § 1144(d).

<sup>69</sup> Both the district court and the First Circuit had previously determined that the plaintiffs had failed to state a claim under the ADA. *Id.* at 93.

## PART TWO – EMPLOYEE RETIREMENT INCOME SECURITY ACT

Given the almost unanimous rulings in the United States Courts of Appeals, it is now extremely difficult for a plaintiff to maintain a claim under the ADA for a limitation on disability benefits for mental or nervous conditions. Moreover, the ability of a plaintiff to maintain a claim under Title I with respect to disability benefits may also depend on whether the plaintiff can simultaneously show “disability” and establish that he is a “qualified individual with a disability.”<sup>70</sup>

Recognizing these difficulties, plaintiffs have begun challenging these mental/nervous distinctions under the Employee Retirement Income Security Act, Act (“ERISA”), 29 U.S.C. §§ 1001 *et seq.* (2000), with some success.

### I. PROCEDURAL BACKGROUND

Plaintiffs seeking relief under ERISA normally assert claims against the benefit plan and/or plan administrator for improper denial of benefits under 29 U.S.C. § 1132(a)(1)(B),<sup>71</sup> and for breach of fiduciary duty based on the improper denial of benefits under either 29 U.S.C. § 1132(a)(2) or 29 U.S.C. § 1132(a)(3).

### II. CLAIMS FOR BREACH OF FIDUCIARY DUTY

Breach of fiduciary duty claims under § 1132(a)(2) based on the refusal to provide benefits to an individual participant normally are dismissed early on in the litigation. The Supreme Court, as well as virtually every circuit court, have limited claims for breach of fiduciary duty to those which inure to the benefit of the plan as a whole, and not to the benefit only of individual plan beneficiaries. *See, e.g., Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140-142 (1985); *Lee v. Burkhardt*, 991 F.2d 1004, 1009 (2d Cir. 1993); *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 992 (7th Cir. 1993); *Reich v. Rowe*, 20 F.3d 25, 30 (1st Cir. 1994); *Farr v. US WEST, Inc.*, 58 F.3d 1361, 1364 (9th Cir. 1995); *Weiner v. Klais & Co.*, 108 F.3d 86, 91-92 (6th Cir. 1997); *Tolson v. Avondale Indus.*, 141 F.3d 604, 610 (5th Cir.

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<sup>70</sup> *See* discussion in Section IV C., *supra*.

<sup>71</sup> Claims for denial of benefits under 29 U.S.C. § 1132(a)(1)(B) may only be brought against the benefit plan as an entity. *See, e.g., Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985); *Jass v. Prudential Health Care Plan*, 88 F.3d 1482, 1490 (7th Cir. 1996); *Lee v. Burkhardt*, 991 F.2d 1004, 1009 (2d Cir. 1993); *Auto Club Ins. Ass’n v. Safeco Life Ins. Co.*, 833 F. Supp. 637, 643 (W.D Mich. 1993); *Riordan v. Commonwealth Edison Co.*, 953 F. Supp. 952, 956 (N.D. Ill. 1996), *aff’d*, 128 F.3d 549 (7<sup>th</sup> Cir. 1997); *Roche v. V.J. Mattson Co.*, No. 93 C 4044, 1995 U.S. Dist. LEXIS 5939, at \*\* 11-13 (N.D. Ill. May 2, 1995), *modified*, 1995 U.S. Dist. LEXIS 13,643 (Sept. 11, 1995), *modified*, 1996 U.S. Dist. LEXIS 10,707 (N.D. Ill. July 25, 1996).

1998); *Conley v. Pitney Bowes*, 176 F.3d 1044, 1047 (8th Cir. 1999), *Griggs v. E.I. DuPont De Nemours & Co.*, 237 F.3d 371, 385, n.7 (4th Cir. 2001). *But see Smith v. Provident Bank*, 170 F.3d 609, 616 (6th Cir. 1999) (plan participants can sue not only on behalf of plan for breach of fiduciary duty, but also for breaches of fiduciary duty that harm them as individuals).

Claims brought under 1132(a)(3) have similarly met with little success. In *Varity Corp. v. Howe*, 516 U.S. 489, 116 S. Ct. 1065 (1996), the Supreme Court determined that § 502(a)(3) could support a cause of action seeking individual relief (as opposed to plan-wide relief) to remedy an ERISA statutory violation, including a breach of ERISA's fiduciary responsibility provisions, but only in the limited situations where adequate relief was *not* available under another provision of ERISA's civil enforcement scheme specifically addressing the harm at issue. Given this limitation, most circuits have refused to permit plaintiffs with a benefit claim under § 502(a)(1)(B) to repackage their benefit dispute into a statutory fiduciary breach claim actionable under § 502(a)(3).<sup>72</sup>

### III. CLAIMS FOR DENIAL OF BENEFITS – 29 U.S.C. § 1132(A)(1)(B)

Claims for denial of benefits under § 1132(a)(1)(B), however, have met with some success. The Supreme Court has held that a claim for denial of benefits under this statutory provision shall be reviewed under a *de novo* standard “unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Where a plan confers power on the administrator to exercise discretion, the appropriate standard of review is the deferential “arbitrary and capricious” standard. *Id.* at 111; *Vlass v. Raytheon Emples. Disability Trust*, 244 F.3d 27, 29-30 (1st Cir. 2001); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379-80 (7th Cir. 1994). In order to determine which standard applies, courts review the terms of the plan on a case-by-case basis, searching for language conferring discretion. There are no magic words. *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7<sup>th</sup> Cir. 2000) (“courts have

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<sup>72</sup> See, e.g., *The May Dept. Stores Co. v. Federal Ins. Co.*, 2002 WL 1895371 (7th Cir. Aug. 19, 2002); *McCall v. Burlington Northern/Santa Fe Co.*, 237 F.3d 506 (5th Cir. 2000), *cert. denied*, 122 S. Ct. 57 (2001); *Estate of Bratton v. National Union Fire Ins. Co.*, 215 F.3d 516 (5th Cir. 2000); *Katz v. Comprehensive Plan of Group Ins.*, 197 F.3d 1084 (11th Cir. 1999); *Rhorer v. Raytheon Engineers & Constructors, Inc. Basic Life, Optional Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 181 F.3d 634 (5th Cir. 1999); *Conley v. Pitney Bowes*, 176 F.3d 1044 (8th Cir. 1999), *cert. denied*, 528 U.S. 1136 (2000); *Wilkins v. Baptist Healthcare Sys.*, 150 F.3d 609 (6th Cir. 1998); *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604 (5th Cir. 1998); *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997), *aff'd*, 525 U.S. 299 (1999); *Coyne & Delany Co. v. Blue Cross & Blue Shield*, 102 F.3d 712 (4th Cir. 1996); *Wald v. Southwestern Bell Corp. Customcare Medical Plan*, 83 F.3d 1002 (8th Cir. 1996). *But see Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001) (permitting individual plaintiffs to assert a claim for breach of fiduciary duty under § 502(a)(3) in addition to a claim for benefits).

consistently held that there are no ‘magic words’ determining the scope of judicial review of decisions to deny benefits”) (internal citations omitted). Moreover, “[d]iscretionary powers may be implied by a plan’s terms even if not granted expressly.” *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991)). See also *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1453 (D.C.Cir. 1992) (“the plan need not use any particular language in conferring discretion”); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 441 (2d Cir. 1995) (the phrase “shall determine conclusively” grants discretion). But see *Cooke v. Lynn Sand & Stone Co.*, 875 F. Supp. 2d 880, 884 (D.Mass. 1994), *aff’d* 70 F.3d 201 (1<sup>st</sup> Cir. 1995) (holding that a provision stating that “the administrator ‘shall make all determinations as to the right of any person to a benefit’” did not “clothe those determinations with final authority” to warrant arbitrary and capricious review); *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789 (11th Cir. 1994) (language conferring discretion must be “express language unambiguous in its design.”).

A third standard of review applies to the review of a denial of benefits in situations where the plan administrator’s own self-interests are in conflict with its fiduciary duties to act in the best interests of the plan and plan participants. In *Firestone*, the Supreme Court stated that “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion.” 489 U.S. at 115, 109 S. Ct. 948 (internal quotation marks omitted). With respect to insurance companies, the most common type of conflict of interest faced by the courts occurs where the insurer operates in the dual role of both the plan administrator and the funding source for the plan. In such cases, courts have found an “inherent conflict of interest” to exist, warranting a slightly more stringent standard of review – a “heightened arbitrary and capricious” standard. See *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir., 1999); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (heightened arbitrary and capricious standard must be used when the plan was administered by an insurance company which paid benefits out of its own assets). This does not end the inquiry however. See *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (fact that insurer is also plan administrator of plan, standing alone, does not establish a conflict of interest). Once an inherent conflict of interest is found to exist, the courts must determine whether the conflict actually impacted the plan administrator’s decision. If not, the arbitrary and capricious standard of review will still apply. See, e.g., *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998) (where plan administrator funds the plan, less-deferential standard of review applies when “(1) a palpable conflict of interest or a serious procedural irregularity exist[s], which (2) cause[s] a serious breach of the plan administrator's fiduciary duty.”); *Morgan v. Contractors*, 287 F.3d 716, 722 (8th Cir. 2002) (same). See also *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000) (setting forth a “sliding scale method, intensifying the degree of scrutiny to match the degree of the conflict.”).<sup>73</sup>

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<sup>73</sup> At least one circuit has held that the risk of a conflict of interest is decreased where the administrator and funder of the plan is the employer, rather than an insurance company, because the employer has “incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits” suggesting that there is at least some counter to the incentive not to pay claims. *Smathers v. Multi-Tool, Inc.*, 298 F.3d 191, 197 (3d Cir. 2002) (quoting *Nazay v. Miller*, 949 F.2d 1323, 1335 (3d Cir. 1991)).

The Eleventh Circuit has promulgated a slightly different version of this test. Under this version, the court must first determine whether the plaintiff “has proposed a ‘reasonable’ interpretation of the plan under which he could be covered.” *Florence Nightingale Nursing Serv., Inc. v. Blue Cross/Blue Shield*, 41 F.3d 1476, 1481 (11th Cir. 1995) (internal quotations omitted). If the plaintiff has advanced such an interpretation, then under the doctrine of *contra preferentem*, which requires ambiguities to be interpreted against the drafter, the plaintiff’s interpretation is taken as correct. *Florence Nightingale*, 41 F.3d at 1481. The burden then shifts to the defendant to prove that its interpretation of the plan was not tainted by self-interest. *Id.*

Upon finding a conflict of interest, the courts typically apply a two-pronged test. First, courts must determine whether the plaintiff has provided “material, probative evidence, beyond the mere fact of the apparent conflict,” which shows that the fiduciary’s self-interest caused the breach of its obligations to the beneficiary. If the plaintiff fails to make such a showing, the traditional arbitrary and capricious standard of review applies. If the plaintiff does make such a showing, a rebuttable presumption is created that the plan breached its fiduciary duties. The plan must then rebut the presumption by presenting evidence to show that the conflict of interest did not affect its decision to terminate or deny benefits. If the plan cannot rebut this presumption, the court applies a *de novo* standard of review to the claim. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 828-29 (9th Cir. 2002); *see also Heaser v. Toro Co.*, 247 F.3d 826, 833 (8th Cir. 2001) (quoting *Layes v. Mead Corp.*, 132 F.3d 1246, 1250 (8th Cir. 1998)) (a “claimant must offer evidence that ‘gives rise to serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator’s whim.’”); *Sullivan v. LTV Aero. & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (upon finding an conflict of interest to exist, court must decide “whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan,” and “whether the evidence shows that the administrator was in fact influenced by such conflict.”).

Against this procedural backdrop, plaintiffs have filed numerous claims challenging limitations on benefits in long-term disability benefits plans based on an express mental/nervous cap. Two recent district court decisions in the beneficiary’s favor are instructive on this issue. *Luton v. Prudential Ins. Co. of Am.*, 88 F. Supp. 2d 1364 (S.D. Fla. 2000); *Fitts v. Fannie Mae*, 191 F. Supp. 2d 67 (D.D.C. 2002).

#### A. *Luton v. Prudential Ins. Co. Of America*

In *Luton*, a participant in a long-term disability benefits policy suffered from various stress-related ailments, including depression. He filed an ERISA action against the plan administrator, alleging that his benefits were improperly terminated based on the plan’s provision that benefits are limited to 36 months if the disability is caused at least in part by a mental condition. *Luton*, 88 F. Supp. 2d at 1368. The *Luton* court first determined that a conflict of interest existed such that the heightened arbitrary and capricious standard of review should apply, because the insurer was both the plan administrator and the funder of the plan. *Id.* at 1370. Applying the Eleventh Circuit’s version of this standard of review, the court first looked at the terms of the plan. At issue

was the definition of the term “mental, psychoneurotic or personality disorder” as stated in the plan. The court first noted that a circuit conflict exists over whether the phrases “mental illness” or “mental disorder” are ambiguous, and that the Eleventh Circuit has not yet directly addressed the issue<sup>74</sup> *Id.* at 1371-72. Basing its decision on this circuit conflict and conflicting expert testimony, the court found that the language of the plan was ambiguous. The court then applied the doctrine of *contra preferentem* and construed the ambiguous provision in favor of the beneficiary.<sup>75</sup> *Id.* at 1373.

Alternatively, the court also held that it would have ruled in favor of the beneficiary even if the deferential arbitrary and capricious standard of review applied. *Id.* at 1374. Specifically, the court found that the plan could not rely on the “caused at least in part by” language in the plan document to terminate benefits because this wording was left out of the Summary Plan Description (“SPD”) provided to the plaintiff. *Id.* In so holding, the court noted that “[t]he conflicting language in the SPD leads to a likelihood of misleading the average plan participant.” *Id.*<sup>76</sup>

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<sup>74</sup> Compare *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604 (5th Cir. 1998); *Lynd v. Reliance Std. Life Ins. Co.*, 94 F.3d 979 (5th Cir. 1996); *Stauch v. Unisys Corp.*, 24 F.3d 1054 (8th Cir. 1994); *Brewer v. Lincoln Nat’l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990) (all holding term to be unambiguous) with *Phillips v. Lincoln Nat’l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992); *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948 (9th Cir. 1993); *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938 (9th Cir. 1995); and *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech.*, 125 F.3d 794, 799 (9th Cir. 1997) (all holding term to be ambiguous).

<sup>75</sup> The court also found that the plan failed to demonstrate that its self interest did not influence its decision to terminate benefits. *Id.* at 1373-74.

<sup>76</sup> Courts are virtually unanimous that, under the principles of estoppel and *contra preferentem*, a participant may be able to recover benefits based solely on a conflict between the language of an SPD and the plan, where the SPD terms are more favorable to the participant. See, e.g., *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 6 E.B.C. (BNA) 1707 (11th Cir. 1985); *Rhorer v. Ratheon Engineers & Constructors, Inc.*, 181 F.3d 634, 640 (5th Cir. 1999); *Barker v. Ceridian Corp.*, 193 F.3d 976, 983 (8th Cir. 1999), *cert. denied*, 529 U.S. 1109 (2000). Some courts, however, have held that where the SPD is silent with respect to the issue in contention, the SPD does not control and the participant may not recover. *Sprague v. GMC*, 133 F.3d 388 (6th Cir. 1998) (*en banc*), *cert. denied*, 524 U.S. 923 (1998); *Mers v. Marriott Int’l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998) *cert. denied*, 525 U.S. 947 (1998); *Martin v. Blue Cross & Blue Shield*, 115 F.3d 1201, 1205 4th Cir. 1997); *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 952 (8th Cir. 1994); *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 838 (5th Cir. 1993). Still others require that the participant demonstrate that he relied on the misleading statements contained within the SPD to his detriment before the participant may recover. See *Aiken v. Policy Management Sys. Corp.*, 13 F.3d 138, 17 E.B.C. (BNA) 2079 (4th Cir. 1993); *Bachelder v. Communications Satellite Corp.*, 837 F.2d 519, 9 E.B.C. (BNA) 1386 (1st Cir. 1988); *Mauser v. Raytheon Co. Pension Plan for Salaried*

B. *Fitts v. Fannie Mae*

Another troublesome decision for insurers and plan sponsors is *Fitts v. Fannie Mae*. In *Fitts*, the United States District Court for the District of Columbia was faced with a former employee who claimed that his employer and long-term disability plan violated ERISA when they determined that her benefits were limited to 24 months under the plan's provision that limited disability payments for any employee who developed a disability that was "due to mental illness." The court completely by-passed consideration of the appropriate standard of review and focused its attention on whether bi-polar disorder, the condition suffered by the plaintiff, was a "mental illness," thereby triggering the 24-month limitation under the plan. *Fitts*, 191 F. Supp. 2d at 69-70. The plaintiff presented expert testimony to support her claim that bi-polar disorder is a physical illness because it is a neurobiological disorder that affects the physical and chemical structure of the brain. *Id.* at 70. In contrast, the defendants presented their own experts to support their argument that bipolar disorder is a mental illness. Specifically, the defendants argued that bi-polar disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ("DSM-IV"), and that bi-polar disorder is typically treated by psychiatrists using psychotherapy and psychotropic drugs. *Id.* at 71.

As in *Luton*, the court began by noting the circuit split over whether the terms "mental illness" or "mental disorder" are ambiguous, and discussing the different approaches courts have taken to resolving the issue *Id.* at 72-74. The court then rejected the defendants arguments in favor of interpreting bi-polar disorder as a "mental illness," and found that more than one reasonable interpretation of the term exists. *Id.* at 76-77. Applying the doctrine of *contra preferentem*, the court then adopted the plaintiff's interpretation and found that her illness was physical in nature. *Id.*

As both *Luton* and *Fitts* demonstrate, claims based on the determination of whether a disability is caused by a mental illness or mental disorder can quickly disintegrate into a war of the experts. Moreover, where applicable, the doctrine of *contra preferentem* militates in favor of the plan participant. If the claim arises in the Fifth or Eighth Circuits, the courts will apply a "laypersons test" and focus on the symptoms, while largely ignoring the expert testimony. *See, e.g., Lynd v. Reliance Std. Life Ins. Co.*, 94 F.3d 979, 983-84 (5th Cir. 1996); *Stauch v. Unisys Corp.*, 24 F.3d 1054, 1056 (8th Cir. 1994). On the other hand, if the claim arises in the Seventh or Ninth Circuits, it appears that the courts will rely on expert testimony and focus on the root cause of the illness to determine whether the disability is mental or physical in nature. *See, e.g., Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013 (1990). If *Luton* and *Fitts* are indicative, insurers and employers will not fare much better in the Eleventh and District of Columbia Circuits.

Where does this leave insurers and plan sponsors? The best defense to these types of claims is better drafting of both SPD's and plan documents, as the *Fitts*

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*Emple.*, 239 F.3d 51 (1<sup>st</sup> Cir. 2001); *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1481 (3d Cir. 1991), *cert. denied*, 501 U.S. 1232, (1991).

court expressly recognized. *See Fitts*, 191 F. Supp. 2d at 76 n. 12. In order to achieve the more favorable “arbitrary and capricious” standard of review, the drafters should be careful to include very strong and clear *Firestone* language, granting the plan administrator discretion to interpret the plan and make benefit determinations. The plans and SPDs should also be written by the same entity, and carefully vetted to ensure that there are no discrepancies or ambiguities between the language of the two documents.

In crafting the definition of a “mental/nervous” limitation, one appealing option is to use an objective standard. For example, a number of policies and plans limit benefits for any disability “caused to any extent” by a condition “listed in the latest version of the DSM.”<sup>77</sup>

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<sup>77</sup> Some more traditional definitions have also been successful. *See e.g., Dames v. Paul Revere Life Ins. Co.*, Case No. CV-98-1397-ST, 2000 WL 236409 \* 4, 12 (D. Or. Feb. 16, 2000) (24 month limit “[f]or any disability which is caused or contributed to by a psychiatric disorder” where “[p]sychiatric [d]isorder means neurosis, psychoneurosis, psychopathy or psychosis” is a precise and unambiguous plan provision interpreted in favor of the plan), *aff’d*, 12 Fed.Appx. 505, 2001 WL 528107 (9th Cir. May 17, 2001).