ERISA and ADA:
Discrimination Based on Benefits

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I. INTRODUCTION

How are benefits given to employees protected from employer discrimination? To answer this question, one has to consider several federal laws that protect employees from employer discrimination. These include the Employment Retirement Income Security Act (ERISA), the Americans with Disabilities Act (ADA), and the Patient Protection and Affordable Care Act (PPACA).¹

II. ERISA § 510: INTERFERENCE WITH PROTECTED RIGHTS

Section 510 of ERISA protects participants and beneficiaries of employment benefit plans from losing their protected rights created by employment relationships. 29 U.S.C. § 1140. Section 510’s statutory scheme prohibits two types of conduct. First, no person, including employers, can discharge or otherwise discriminate against participants or beneficiaries for exercising their rights under a benefit plan or under ERISA. Id. The second part of Section 510 has a wider application, and prohibits the “interference with the attainment of any right to which the participant may become entitled.” Id. Thus, participants or beneficiaries who are entitled to a present right or who might be entitled to a future right arising from an employment relationship are protected from any person’s interference with those rights. This provision will protect an employee from employer actions that alter the employee’s employment status before the vesting of a claim or a vesting of benefits. It is important to note that Section 510 protects against both vesting and non-vesting rights, including employee welfare benefits that generally do not vest under ERISA. See Inter-Modal Rail Emps. Ass’n v. Topeka and Santa Fe Ry. Co., 520 U.S. 510 (1997). It also protects the accrual of future entitlements to retirement benefits. See, e.g., Majewski v. Automatic Data Processing, Inc., 274 F.3d 1106, 1113 (6th Cir. 2001) (holding that district court improperly dismissed the claim when employee had a right to attain future entitlements to retirement benefits). Although the language of the statute appears to offer broad protection for participants and beneficiaries, Section 510 presents many burdens and challenges.

A. Why bring a Section 510 claim?

While Section 510 claims can be difficult to prove, there are reasons for plaintiffs to bring this claim. First, a Section 510 claim brings an action into federal court. 29 U.S.C. § 1132(f). ERISA subject matter jurisdiction allows for nationwide service of process. 29 U.S.C. § 1132(e)(2). ERISA also provides broad venue choices in any district where the employee benefit plan is administered, where the alleged breach of the plan took place, or where a defendant resides or may be found. Id. Plaintiffs can take advantage of these liberal venue provisions by choosing districts with favorable circuit court law. For instance, circuits can differ on important questions such as the scope of discovery in ERISA cases. Compare Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F. 3d 1151, 1159 (10th Cir. 2010) (Tenth Circuit limiting the ability to obtain discovery outside of administrative records in ERISA cases), with Nolan v. Heald Coll., 551 F.3d 1148, 1155 (9th Cir. 2009) (Ninth Circuit allowing

¹ The PPACA will not be discussed in this paper.
broad discovery outside the administrative record in ERISA cases).

Though ERISA preemption may deter plaintiffs from bringing Section 510 claims, Section 510 claims can still be brought with state law discrimination claims if they are carefully pleaded. Courts have held that Section 510 claims preempt state law claims that are premised on a violation of a right guaranteed by Section 510. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990). For example, a claim that a state law was violated because a defendant interfered with a plaintiff’s attainment of benefits under an ERISA plan will likely be preempted by a Section 510 claim. *Id.* If a state law claim in a complaint is not predicated on a right guaranteed by Section 510, however, the state law claim will likely not be preempted. *Id.*

Another reason to bring a Section 510 claim is the availability of attorneys’ fees. In ERISA cases, courts have discretion to give either party reasonable fees or costs. 29 U.S.C. § 1132(g)(1). The fee claimant does not have to be the prevailing party. *Hardt v. Reliance Std. Life Ins. Co.*, 130 S. Ct. 2149, 2156 (2010). The claimant, however, must at least achieve “some degree of success on the merits.” *Id.* at 2152. *See also Lifecare Mgmt. Servs. LLC v. Ins. Mgmt. Adm’rs Incorp.*, No. 11-10733, 2013 U.S. App. LEXIS 239, at 26.

B. Procedural issues.

1. Who can sue under Section 510?

Section 510 covers both participants and beneficiaries of benefit plans. A participant is any employee or former employee who is or may become entitled to receive a benefit under an employee benefit plan. 29 U.S.C. § 1002(7). A beneficiary is any person designated by a participant who is or may become entitled to receive a benefit under an employee benefit plan. 29 U.S.C. § 1002(8).

One issue regarding standing under Section 510 is under what circumstances can someone outside of an employment relationship (i.e., a job applicant or a former

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2 The five factors are: “(1) the degree of the opposing parties’ culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorneys’ fees; (3) whether an award of attorneys’ fees against the opposing party would deter other persons acting under similar circumstances; (4) whether the parties requesting attorneys’ fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties’ position.” *Lincoln Fin. Co. v. Metro. Life Ins. Co.*, 428 F. App’x 394, 396 (5th Cir. 2011) (citing *Bowen*, 624 F.2d at 1266).
employee) sue? The answer depends on whether the expected rights stem from a previous employment relationship. Some circuits, including the Fifth Circuit, use a “but for” test to determine who can sue. If an individual would have become entitled to benefits under a plan “but for” an adverse employment action, then the individual has standing. See Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1221–23 (5th Cir. 1992) (finding that “but for” the employer’s alleged deceptive inducement of plaintiff to retire, the plaintiff would have been a current employee with an expectation of benefits). Decisions under this test have allowed former employees to sue for rights from a preexisting employment relationship, even though the employment relationship had ended. In this regard, former employees with expected rights from a previous employment relationship will have standing under Section 510, while new job applicants or former employees with only prospective rights from a future employment relationship will not. Independent contractors likely do not have standing because they are neither employees nor former employees.

With regards to beneficiaries, courts have liberally construed the term to include members of an employee’s immediate family. See Stephen Allen Lynn, P.C. Emp. Profit Sharing Plan & Trust v. Stephen Allen Lynn, P.C., 25 F.3d 280, 282–84 (5th Cir. 1994). Accordingly, a member of an employee’s immediate family can sue as a beneficiary of a benefit plan if there was interference with the member’s rights. Id.

2. Who can be sued under Section 510?

Because these cases typically involve adverse employment actions taken against employees, the typical defendant will be an employer. Under Section 510’s statutory language, however, it is unlawful for “any person” to discriminate against a participant or a beneficiary for exercising their rights or interfere with a participant or a beneficiary’s protected rights. 29 U.S.C. § 1140. Thus, courts have allowed claims against a wide range of potential defendants, including fellow employees of an injured party and unions. See Rush v. McDonald’s Corp., 760 F. Supp. 1349, 1357–58 (S.D. Ind. 1991) (allowing a Section 510 claim against a former supervisor of plaintiff); Heimann v. Nat’l Elevator Indus. Pension Fund, 187 F.3d 493 (5th Cir. 1999) (allowing a Section 510 suit against a union). It is interesting to note, however, that at least one circuit has limited potential defendants using the theory that Section 510 only extends to an employment relationship. See Deeming v. Am. Standard, Inc., 905 F.2d 1124, 1127 (7th Cir. 1990); Degrave v. Nat’l Automatic Merch. Assoc. Pension Plan, 392 F. Supp. 2d 1032, 1035 (N.D. Ill. 2005).

3. Exhaustion of administrative remedies.

Circuits are split as to whether plaintiffs can be ordered, under a lower court’s discretion, to exhaust administrative remedies before bringing a Section 510 claim. While the Fifth Circuit has expressly held that exhaustion of administrative remedies is not necessary in Section 510 cases, other circuits have required it. Compare Chailland v. Brown & Root, Inc., 45 F.3d 947, 950–51 (5th Cir. 1995) (finding the purpose of administrative claim procedures to be to interpret terms of a plan;
thus they do not apply to a Section 510 claim based on an adverse employer action), *with Lindemann v. Mobil Corp.*, 79 F.3d 647, 649–50 (7th Cir. 1996) (finding Congressional intent giving courts discretion to exhaust administrative remedies before bringing Section 510 claims). Certain courts have held that exhaustion may be required if there is a dispute about the terms of a benefit plan. *See Burds v. Union Pac. Corp.*, 223 F.3d 814, 817–18 (8th Cir. 2000) (“In cases where resolution of the Section 510 issue turns on an interpretation of the ERISA benefits plan at issue, a district court does not abuse its discretion in requiring plaintiffs to exhaust their administrative remedies.”). Thus, this requirement will depend on the court in which the case is brought and the specific dispute at issue.

**C. Evidentiary standards for Section 510 claims.**

In a Section 510 case, plaintiffs can prove the case directly or indirectly. If there is strong enough direct evidence, plaintiffs can prove the case without *prima facie* inferences or presumptions. *Bernal v. Randall Food & Drugs, Inc.*, No. CA-3-96-CV-3464-R, 1998 U.S. Dist. LEXIS 23178, at *45 (N.D. Tex. Mar. 24 1998) (“Evidence is direct when it is sufficient to prove discrimination without inference or presumption. . . . Since [p]laintiff cannot produce direct evidence . . . he must establish a *prima facie* case.”). *See, e.g., Godfrey v. BellSouth Telecos.*, 89 F.3d 755, 759 (11th Cir. 1996) (finding sufficient direct evidence when defendant committed a prohibited conduct with specific intent to prevent plaintiff from benefit eligibility when defendant threatened and disciplined plaintiff for exercising her rights to stay home). While this type of direct evidence is ideal, it is hard to obtain.

Without strong enough direct evidence, plaintiffs have to establish a *prima facie* case and utilize a burden-shifting approach analogous to the *McDonnell Douglas* method of proof to meet evidentiary requirements. *See Bernal*, 1998 U.S. Dist. LEXIS 23178, at *45–46. *See also Stafford v. True Temper Sports*, 123 F.3d 291, 295 (5th Cir. 1997) (Fifth Circuit using the same burden shifting approach as *McDonnell Douglas* under Section 510). If the plaintiff establishes a *prima facie* case, the burden shifts to the defendant to articulate nondiscriminatory reasons for its actions. *Id.* If the defendant is able to articulate valid nondiscriminatory reasons, the burden shifts back to the plaintiff to prove that defendant’s reasons are pretext for discrimination. *Id.*

1. *Prima facie* case.

To establish a *prima facie* case of a Section 510 claim, a plaintiff must demonstrate (a) there was prohibited conduct; (b) it was taken for the purpose of retaliating or interfering (specific discriminatory intent); and (c) it was against the attainment of an individual’s entitled right. *Bodine v. Emplrs. Cas. Co.*, 352 F.3d 245, 250 (5th Cir. 2003); *Chambers v. Ryerson & Son, Inc.*, No. 3:05-CV-1533-D, 2007 U.S. Dist. LEXIS 48338, at *38 (N.D. Tex. July 2, 2007).

a. *Prohibited Conduct.*

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A plaintiff must show that prohibited conduct occurred to prove a Section 510 claim. Thus, a plaintiff must have been “discharge[d], suspend[ed], expel[led], discipline[d], or discriminate[d] against.” 29 U.S.C. § 1140. The Fifth Circuit has held that this requires some “unscrupulous” or “adverse” conduct (such as a discharge or harassment) on the part of the defendant. See Bodine, 352 F.3d at 251 (finding that retaining employees for the purpose of avoiding paying benefits does not qualify as a prohibited conduct under Section 510). The most common action that constitutes interference is the discharging of an employee shortly before the employee would be eligible for a benefit. See Van Zant v. Todd Shipyards Corp., 847 F. Supp. 69, 72 (S.D. Tex. 1994) (“[P]rohibitions were aimed primarily at preventing unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining vested pension rights.”). Courts, however, have found other actionable employer conduct under Section 510, including: (1) the sham transfer of employees to a successor employer to avoid paying benefits;4 (2) inducing an employee to resign to avoid paying benefits;5 (3) writing a bad performance review in order to terminate an employee;6 (4) asking current employees to change to independent contractor status with no benefits;7 (5) constructively discharging an employee by using deceptive conduct to induce retirement;8 and (6) closing a plant allegedly motivated by intent to interfere with employee benefits.9

Under ERISA, employers are generally allowed to reduce or eliminate benefits through plan amendments in accordance with procedures in place as required under ERISA Section 402(b)(3).10 See Inter-Modal Rail Emps. Ass’n, 520 U.S. at 515 (“[An employer] is generally free under ERISA, for any reason at any time, to adopt, modify, or terminate [its] welfare plan. . . . Giving employers this flexibility also encourages them to offer more generous benefits at the outset, since they are free to reduce benefits should economic conditions sour.”); McGann v. H & H Music Co., 946 F.2d 401, 407 (5th Cir. 1991) (finding no Section 510 violation when employer reduced health insurance coverage for AIDS treatments). Such plan amendments, however, must be implemented in accordance with formal procedures outlined in the plan. Inter-Modal Rail Emps. Ass’n, 520 U.S. at 515 (“[Section] 510 helps to make promises credible. . . . An employer

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7 Gitlitz v. Compagnie Nationale Air France, 129 F.3d 554 (11th Cir. 1997); Seaman v. Arvida Realty Sales, 985 F.2d 543 (11th Cir. 1993).

8 Christopher v. Mobil Oil Corp., 950 F.2d 1209 (5th Cir. 1992).


10 ERISA Section 402(b)(3) requires that every plan describe a procedure for amending the plan and identify persons with authority to amend the plan.
may, of course, retain the unfettered right to alter its promises, but to do so it must follow the formal procedures set forth in the plan.\(^\text{11}\): *Garratt v. Walker*, 164 F.3d 1249, 1255 (10th Cir. 1998) ("[P]lan may be amended by following the formal procedures in the plan, but the employer may not otherwise act for purposes prohibited by [Section] 510."). Note also that certain types of amendments are closely regulated by other federal laws.\(^\text{11}\)

b. Taken for the purpose of (specific discriminatory intent).

The second element of the *prima facie* case requires a plaintiff to show that the prohibited conduct was taken for the purpose of retaliating or interfering with a protected right (specific discriminatory intent). Thus, the plaintiff has to demonstrate that the defendant had an actual discriminatory intent to either (1) retaliate against the plaintiff for exercising a protected right or (2) prevent or interfere with the plaintiff’s attainment of protected benefits. *Stafford*, 123 F.3d at 295. For instance, if a plaintiff demonstrates that her employer discharged her for the purpose of avoiding long term disability payments, she has shown the required specific discriminatory intent in violation of Section 510. *See Folz v. Marriott Corp.*, 594 F. Supp. 1007, 1013–15 (W.D. Mo. 1984) (finding specific discriminatory intent when plaintiff was discharged by employer to avoid paying benefits shortly after employee was diagnosed with multiple sclerosis). Not surprisingly, this is one of the most contested areas in Section 510 claims.

A plaintiff only needs to show that the discriminatory purpose for interference was a motivating factor, and is not required to show that the discriminatory purpose was the only factor. *Nero v. Indus. Molding Corp.*, 167 F.3d 921, 927–28 (5th Cir. 1999); *Stafford*, 123 F.3d at 295; *Carlos v. White Consol. Indus.*, 934 F. Supp. 227, 232 (W.D. Tex. 1996). *See also Salus v. GTE Directories Serv. Corp.*, 104 F.3d 131, 137–38 (7th Cir. 1997) (plaintiff is not required to show that the interference with protected rights was the only reason for employer’s action, but “only that [employer]’s desire to interfere with his disability benefits contributed to [employer]’s decision to terminate him”) (emphasis in original).

Temporal proximity alone is not sufficient to establish specific intent. *Ryerson & Son, Inc.*, 2007 U.S. Dist. LEXIS 48338, at *42–43 (“[T]he temporal proximity between Chambers’ sick leave and his termination is insufficient, without more, to [establish specific intent].”); *Bernal*, 1998 U.S. Dist. LEXIS 23178, at *52 (“No evidence other than temporal proximity . . . has been placed before the court linking the plaintiff’s employment termination to the exercise of his right to benefits . . . . To infer that [defendant] intended to interfere with Plaintiff’s entitlement to ERISA benefits . . . [would] be speculative [for a *prima facie* case].”); *Kirby v. SBC Servs.*, 391 F. Supp. 2d 445, 456 (N.D. Tex. 2005) (In determining whether plaintiff has established his *prima facie* case, the Court stated “[w]hile proximity of time may be a factor, it is not the determining factor”).

\(^{11}\) For example, pension plan amendments and terminations are closely regulated by Title IV of ERISA. Also, employer plan amendments can violate Title I of the ADA. *See infra* Part III.
The timing of a discharge or other employer conduct, however, can provide proof of causation for specific intent when coupled with other circumstantial evidence. *Nero*, 167 F.3d at 927–28 (citing *Mathews v. Trilogy Commc’ns, Inc.*, 143 F.3d 1160, 1166 (8th Cir. 1998)). The closer the temporal proximity between a prohibited conduct and a protected activity, the stronger the inference of illegal motive when coupled with other circumstantial evidence. *Compare Hamilton v. Starcom Mediavest Grp.*, 522 F.3d 623, 629–30 (6th Cir. 2008) (no inference based on “temporal proximity” for a nine month gap between protected activity and prohibited conduct), with *Montes v. Phelps Dodge Indus.*, 481 F. Supp. 2d 700, 713 (W.D Tex. 2006) (sufficient evidence of specific intent when plaintiff was terminated on same day he tried to accept early retirement benefits and plaintiff offered circumstantial evidence that reason for termination was questionable); *Nero*, 167 F.3d at 927 (sufficient evidence of specific intent when plaintiff was terminated a few days after claiming medical benefits and plaintiff presented evidence that his medical treatments were the most expensive for all employees).

The strength of inference from temporal proximity evidence must also be considered in connection with other factors that might negate the inference. See *Chambers v. Raines Electric, LP*, No. 05-11392, 2006 U.S. App. LEXIS 14960, at *2–3 (5th Cir. June 15, 2006) (“The temporal proximity of the Chambers’ termination to Mr. Chambers’ planned surgery cannot overcome the lack of knowledge on the part of the decision makers that necessarily defeats the Chambers’ prima facie case.”). By way of example, an employer’s lack of knowledge can defeat any inference of specific intent based on temporal proximity. *Bass v. Alegis Grp.*, No. H-04-1652, 2005 U.S. Dist. LEXIS 38813, at *15 (S.D. Tex. Dec. 12, 2005) (defendant’s uncontroverted evidence that defendant did not know the amount of benefits plaintiff will receive and that other employees continued employment after claiming benefits precluded a finding of causation of specific intent based on a timing inference).

Proof of financial savings to an employer may also provide evidence of specific intent. See, e.g., *Pennington v. W. Atlas, Inc.*, 202 F.3d 902, 908–09 (6th Cir. 2000) (evidence that employer wanted to save costs and that a spreadsheet was modified to sort out employee by benefit costs were considered in plaintiff’s prima facie case). The plaintiff, however, will have to show that the loss of benefits was more than an incidental loss from the conduct. *Stafford*, 123 F.3d at 295; *Unida*, 986 F.2d at 980; *Clark v. Resistoflex Co.*, 854 F.2d 762, 770 (5th Cir. 1988). See also *Clark v. Coats & Clark, Inc.*, 990 F.2d 1217, 1224 (11th Cir. 1993) (“measures designed to reduce costs in general that also result in an incidental reduction in benefit expenses do not suggest discriminatory intent.”); *Dewitt v. Penn-Del Directory Corp.*, 106 F.3d 514, 522 (3d Cir. 1997) (holding that plaintiffs may introduce evidence that the cost savings for defendant were substantial enough to be viewed as a motivating factor in terminating plaintiffs); *Pennington*, 202 F.3d at 908–10 (holding that even though there were legitimate reasons for the defendant to reduce employees, Section 510 was still violated when plaintiffs provided sufficient evidence that showed an intent to cut benefits by targeting older workers).
In addition, evidence of disparate treatment when compared to other employees may also provide proof of specific intent. See Kirby, 391 F. Supp. 2d at 456 (court considered plaintiff’s disparate treatment evidence in determining whether plaintiff met his prima facie case of specific intent). See also Fitzgerald v. Action, Inc., 521 F.3d 867, 872 (8th Cir. 2008) (reversing summary judgment because employee can show specific intent by producing evidence that employer gave more lenient treatment to other employees who were not protected by Section 510).

c. Entitlement of benefits.

The final element of a plaintiff’s Section 510 prima facie case requires a showing of entitlement to benefits. This requirement is satisfied if the plaintiff has a promised entitlement to benefits. Bodine, 352 F.3d at 251 (“[I]t appears that the [e]mployees neither had nor would have become entitled to any right such that [Section] 510 could come into play in the first place.”). See also McGann, 946 F.2d at 407 (holding that plaintiff was not entitled to benefits because there was no existing, enforceable obligation assumed by the employer to not reduce insurance coverage); Van Zant, 847 F. Supp. at 73 (“The [p]laintiffs’ allegations show no promised benefit, for there is nothing to indicate that the [p]laintiffs were ever promised the [early retirement offer].”). Therefore, if a plaintiff had no current right or a promised expectation of a future right, there is no showing of a prima facie case.

2. Defendant’s burden to articulate nondiscriminatory reasons.

Assuming a plaintiff is able to establish a prima facie case, the burden then shifts to the defendant to articulate nondiscriminatory reasons for the actions—a reason (or reasons) that show the defendant did not have specific intent to discriminate. Bona fide business decisions that result in reorganizations, reductions in force, plant closings, and transferring employees to professional employer organizations (PEO) can serve as legitimate reasons for defendants under Section 510, even if there is a reduction or a loss of employee benefits. See Inter-Modal Rail Emps. Ass’n, 520 U.S. at 515. Thus, for example, the employer in Unida presented evidence that a plant closing was due to legitimate nondiscriminatory reasons because production requirements at the plant decreased significantly and the costs associated with maintaining the plant were higher compared to other plants. 986 F.2d at 980. See also Isbell v. Allstate Ins. Co., 418 F.3d 788, 796 (7th Cir. 2005) (“[Employer] offered legitimate, nondiscriminatory reasons, [including the higher productivity of independent contractors,] for eliminating the employee-agent position and moving to an all-independent contractor agent force.”).

In addition, employers can demonstrate that the adverse employment action was for “good cause” or some other legitimate reason. For instance, the defendant’s reason for discharge in Stafford was that plaintiff intentionally manipulated a machine to make it appear that he was working longer hours. 123 F.3d at 294. Similarly, the defendant’s nondiscriminatory reason in Carlos was that plaintiff engaged in sexual harassment of other employees. 934 F. Supp. at 232. Likewise, in Montes, the defendant’s reason was that plaintiff maliciously deleted files on the company computers. 481 F. Supp. 2d at 714.
3. Plaintiff’s burden to show defendant’s reasons are pretext.

Once the defendant proffers legitimate nondiscriminatory reasons, the burden shifts back to the plaintiff to show that those reasons are pretext. A plaintiff can prove pretext by either “directly persuading the court that a discriminatory reason more likely motivated the employer or indirectly showing that the employer’s proffered explanation is unworthy of credence.” Fitzgerald, 521 F.3d at 872. In determining whether a defendant’s reasons are pretext, courts may consider the “strength of plaintiff’s prima facie case, the probative value of the proof that the employer’s explanation is false, and any other evidence that supports the employer’s case.” Id.

After considering the strength of the plaintiff’s prima facie case and proof that the employer’s explanation was false, for instance, the Western District in Montes found a question of fact as to pretext and denied the defendant’s motion for summary judgment when plaintiff showed that he was terminated in “extreme proximity” from the date of claiming his early retirement benefits and that other employees were merely reprimanded for the same conduct. 481 F. Supp. 2d at 713. Similarly, the Seventh Circuit in Salus found no error in a district court’s finding of pretext when plaintiff was terminated right before his eligibility for disability benefits, termination documents suggested an intent to interfere, and plaintiff provided evidence that showed the employer’s articulated reason that plaintiff failed to call in for work to be false. 104 F.3d at 137–38. Likewise, in finding sufficient evidence that the employer’s explanation for terminating plaintiff was unworthy of credence, the Third Circuit in Kowalski v. L&F Products found a fact issue as to pretext and denied the defendant’s motion for summary judgment when plaintiff provided evidence that showed that the investigator the employer relied upon in discharging plaintiff for working while on disability leave never actually saw plaintiff work. 82 F.3d 1283, 1289–90 (3d Cir. 1996).

Conversely, the Fifth Circuit in Stafford granted the defendant’s motion for summary judgment, finding that the plaintiff had not established a question of fact as to pretext. In Stafford, the plaintiff presented evidence that he was only three weeks away from vesting his pension plan benefits, that the company health plan paid for plaintiff’s daughter’s substantial medical expenses, and that the company health plan paid for plaintiff’s heart surgery two years before plaintiff was fired. 123 F.3d at 294. The defendant’s proffered reason for terminating plaintiff, however, was an issue that had already been litigated and determined in other proceedings. Id. at 295. The Stafford Court found that collateral estoppel prevented the plaintiff from providing evidence to show that defendant’s reason for termination was false and plaintiff’s other evidence was insufficient to show pretext. Id. at 295–96.

D. Only equitable remedies are available under Section 510.

As discussed above, courts have discretion to give either party reasonable attorneys’ fees or costs, so long as the claimant achieves “some degree of success on the merits.” Hardt, 130 S. Ct. at 2149; Lifecare Mgmt. Servs. LLC, 2013 U.S. App. LEXIS 239, at 25–26.
A plaintiff that proves a Section 510 violation, however, may be precluded from other types of monetary relief because ERISA 502(a)(3) has been held to allow only equitable remedies. In *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) and *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), the United States Supreme Court held that Section 502(a)(3) authorizes only forms of relief that were available in the courts of equity, such as injunction, mandamus, reinstatement, and restitution. See, e.g., *Eichorn*, 484 F.3d at 656 (allowing reinstatement of an employee under Section 510); *McLendon v. Cont'l Can Co.*, 908 F.2d 1171, 1182–83 (3d Cir. 1990) (allowing injunction against implementation of a reduction in force designed to avoid pension liabilities). This does not include compensatory damages, punitive damages, or any monetary legal relief. *Mertens*, 508 U.S. at 255–56. The Great-West Court also found that not all claims for restitution are equitable, and that “the imposition of a constructive trust or equitable lien on particular property” is required for restitution to be equitable. 534 U.S. at 214. In *Sereboff v. Mid-Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the United States Supreme Court further clarified this requirement, and found that only restitution of specific funds that are in the control of defendant is appropriate under Section 502(a)(3). These decisions narrowly construed the remedies available under Section 502(a)(3).

A recent United States Supreme Court decision, however, may have cracked open the door to new forms of monetary relief available under Section 502(a)(3). In *Cigna Corp. v. Amara*, 131 S. Ct. 1866, 1870 (2011), the United States Supreme Court found that reformation of language in an ERISA plan and estoppel are equitable remedies available under Section 502(a)(3). More importantly, the Amara Court found that “surcharge,” which is a “form of monetary ‘compensation’ for loss resulting from a trustee’s breach of duty, or to prevent the trustee’s unjust enrichment,” to be an equitable remedy. *Id.* at 1880. The Court, however, did appear to limit this type of compensatory or “make-whole” relief to only claims against fiduciaries or trustees. *Id.* (“Thus, insofar as an award of make-whole relief is concerned, the fact that the defendant in this case, unlike the defendant in *Mertens*, is analogous to a trustee makes a critical difference.”); *Central States v. Health Special Risk Inc.*, No. 3:11-CV-2910-D, 2012 U.S. Dist. LEXIS 150120, at *8–10 (N.D. Tex. Oct. 18, 2012) (court rejecting plaintiff’s argument for monetary

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12 While ERISA 502(a)(1)(B) allows for recovery of benefits due under the terms of a plan, it is generally only available against defendants who have failed to comply with the terms of a plan (an unlikely scenario for Section 510 claims). *Eichorn v. AT&T Corp.*, 484 F.3d 644, 651–52 (3d Cir. 2007). But see *Madera v. Marsha USA, Inc.*, 426 F.3d 56, 61 (1st Cir. 2005) (a claim that defendant intentionally misclassified a participant’s termination as “for cause” in order to avoid severance payments was properly brought under Section 502(a)(1)(B)).

13 Note that there are courts that look at Amara’s discussion of Section 502(a)(3) as dicta and not binding on lower courts because the lower court in Amara never reached a Section 502(a)(3) discussion. See, e.g., *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, No. 4:09-cv-2556, 2011 U.S. Dist. LEXIS 127526, at *25–26 (S.D. Tex. Nov. 3, 2011) (“The Supreme Court [in Amara] did not need to discuss [Section] 502(a)(3) issue, however, as the lower court declined to reach it. . . . The Court’s analysis is therefore dicta, and not binding on this Court.”) (citing Amara, 131 S. Ct. at 1883–84).
relief under Section 502(a)(3) based on Amara because there was no fiduciary relationship between the parties).

While the impact of Amara remains to be seen, past court opinions based on Mertens, Great-West, and Sereboff have barred compensatory damages and other forms of monetary relief, including back pay, front pay, and other economic and noneconomic damages. See, e.g., Rogers v. Hartford Life & Accident Ins. Co., 167 F.3d 933, 944 (5th Cir. 1999) (“[C]ompensatory damages, whether extra-contractual or not, are not recoverable under ERISA.”); Sorensen v. Fedex Kinko’s Office & Print Servs., Inc., No. SA-06-CA-416-FB, 2006 U.S. Dist. LEXIS 94597, at *4–6 (W.D. Tex. Oct. 19, 2006) (holding that damages for back pay, front pay, emotional distress, physical pain and suffering, and other monetary damages are precluded in a Section 510 case, but reinstatement is an equitable remedy available under Section 510); Millsap v. McDonnell Douglas Corp., 368 F.3d 1246, 1252–54 (10th Cir. 2004) (finding a characterization of back pay as restitution to be wrong or at best only legal restitution under Great West; therefore reversing an Oklahoma district court because back pay is not recoverable under Section 510); Eichorn, 484 F.3d at 656 (back pay is not equitable restitution and therefore not allowed for Section 510 cases). But see Schwartz v. Gregori, 45 F.3d 1022, 1022–23 (6th Cir. 1995) (a pre-Great-West and Sereboff case that allowed back pay because it is restitutionary and allowed front pay in lieu of reinstatement).14

The Amara Court appears to have expanded the appropriate equitable remedies under Section 502(a)(3) and may have provided plaintiffs with new arguments for obtaining monetary relief. One reading of Amara is that monetary relief should be available under Section 502(a)(3) as long as it is a traditional “equitable relief.” Thus, plaintiffs seeking monetary damages under Section 502(a)(3) should seek guidance from equity treatises and argue for relief under which damages had been traditionally categorized as “equitable relief.”

III. AMERICANS WITH DISABILITIES ACT

Title I of the ADA prohibits discrimination against disabled individuals with regard to job application procedures, hiring, advancement, discharge, compensation, job training, and “other terms, conditions, and privileges of employment,” including segregating or classifying employees based on disability. 42 U.S.C. § 12112(a). Entities covered under this section include employers, employment agencies, labor organizations, and joint labor management committees. Id. It is also unlawful for a covered entity to participate in a contractual arrangement or a relationship that subjects a qualified applicant or employee with a disability to discrimination that is prohibited by the “equitable relief.” Back pay is treated as an equitable remedy under Title VII, National Labor Relations Act, the Rehabilitation Act, and the FLSA. Furthermore, there are arguments that back pay should be equitable restitution as defined by Great-West and Sereboff. See Jessica Barclay-Strobel, Shooting the Messenger: How Enforcement of FLSA and ERISA is Thwarted by Courts’ Interpretation of the Statutes’ Antiretaliation and Remedies Provisions, 58 UCLA L. REV. 521 (2010).

14 While the Tenth and Third Circuits have barred back pay as an available remedy under Section 502(a)(3), there are arguments that back pay is an
ADA. 42 U.S.C. § 12112(b)(2). Under EEOC regulations, the phrase “other terms, conditions, and privileges of employment” includes any “[f]ringe benefits available by virtue of employment, whether or not administered by the [employer].” 29 C.F.R. § 1630.4(f); EEOC Interim Guidance, at 2.

By this language, the ADA prohibits employers from discriminating on the basis of disabilities in fringe benefits provided to employees. An employer also cannot discriminate indirectly through a contractual or other relationship what an employer is prohibited from doing directly. Thus, the ADA protects employees from certain disability-based discrimination in employer provided health plans and benefit plans, whether it is provided directly by the employer (“self-insured plans”) or through an insurance company (“fully insured plans”).

A. Clear violations of employer discrimination in health care plans under the ADA.

Two situations are clear violations of the ADA. First, employers are required to afford disabled employees “equal access” to whatever health insurance or other benefits coverage provided to other employees. See Anderson v. Gus Mayer Boston Store, 924 F. Supp. 763, 778 (E.D. Tex. 1996) (“[E]mployees with disabilities must be accorded equal access to whatever health insurance the employer provides to employees without disabilities.”). See also H.R. Rep. No. 101-485 (III), at 38 (1990) (“[I]t is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments [so long as persons with disabilities] have equal access to the . . . insurance coverage that is provided by the employer to all employees.”); EEOC Interim Guidance, at 3 (citing 29 C.F.R. § 1630.16(f)). Thus, the Eastern District of Texas in Anderson found an ADA violation when an employer knowingly excluded the plaintiff from health insurance coverage by switching to a health insurance plan that the employer knew would reject the plaintiff because the plaintiff had HIV and AIDS.15 924 F. Supp. at 778–79.

Second, Section 102(b)(4)16 of the ADA prohibits an employer from “excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association.” 42 U.S.C. § 12112(b)(4). See also EEOC Questions and Answers About the Association Provision of the ADA (“[A]n employer may not deny an employee health care coverage available to others because of the disability of someone with whom the employee has a relationship or association.”); EEOC Interim Guidance, at 3 (“[I]t would violate the ADA for an employer to make an employment decision about any person, whether or not that person has a disability, because of concerns about the impact on the health insurance plan of the disability of someone else with whom that person has a relationship.”) (citing 29 C.F.R. § 1630.8). Courts have found possible violations under this provision.

15 Note that the Anderson Court did hold that the employer could have attempted to defend its actions on the basis that providing coverage would constitute “undue hardship,” which can be a defense only if the employer can show “approaching financial ruin.” Anderson, 924 F. Supp. at 780–81.

16 Section 102(b)(4) of the ADA is codified at 42 U.S.C. § 12112(b)(4).
when employers are alleged to have terminated an employee because of a disability of someone associated with that employee. See *Strate v. Midwest Bankcentre, Inc.*, 398 F.3d 1011, 1021 (8th Cir. 2005) (holding that a fact issue existed as to whether employer violated the ADA by discharging an employee to avoid health care payments to the employee’s daughter, who had Down’s Syndrome); *Jackson v. Serv. Eng’g, Inc.*, 96 F. Supp. 2d 873, 881–82 (S.D. Ind. 2000) (holding sufficient evidence for a fact issue when employer discharged employee due to the increasing health care costs of treating the employee’s wife’s illness). In addition to terminations, the ADA would also prohibit an employer from excluding insurance coverage or otherwise making employment decisions about an employee because of that employee’s association with someone who has a disability.

B. Can health care plans have disability-based distinctions?

While the above situations are clear violations of the ADA, questions arise as to whether health plans can have disability-based distinctions. For instance, can employers implement health plans that exclude some disabilities or treatments from coverage without violating the ADA? Or, can employers implement health plans that have different levels of benefits offered for different types of disabilities? At this time, inconsistent case law makes it difficult to answer these questions. To better understand the problems, however, a discussion of the ADA’s bona fide plan safe harbor is required.

1. ADA’s bona fide plan safe harbor.

Section 501(c) of the ADA expressly creates a “safe harbor” exception for employers, insurers, and plan administrators. This “safe harbor” allows them to establish or observe a bona fide benefit plan with disability-based distinctions whose terms are based on “underwriting risks, classifying risks, or administering such risks” that are not inconsistent with state law, as long as such plans are not used “as a subterfuge to evade the purposes” of the ADA. 42 U.S.C. § 12201(c)(2); EEOC Interim Guidance, at 4. See also *Anderson*, 924 F. Supp. at 779 (“Section 501(c) of the ADA explicitly allows some disability-based distinctions within insurance policies to be drawn by insurers.”).

The EEOC has created a framework for analyzing ADA claims under Section 501(c)’s safe harbor exemption. According to the EEOC Interim Guidance, a determination must first be made as to whether a distinction in a plan is “disability-based.” EEOC Interim Guidance, at 4. A determination must then be made as to whether the plan meets Section 501(c)’s two prong test in that: (1) the plan is either a bona fide insured health plan that is not inconsistent with state law or is a bona fide self-insured health plan; and (2) the disability-based distinction is not a subterfuge. EEOC Interim Guidance, at 5 (citing 29 C.F.R. § 1630.16(f)). Keep in mind that Section 501(c) is only available to health plans with disability-based distinctions that do not totally exclude coverage to a category or categories of disabled individuals. *See Anderson*, 924 F. Supp. at 779–80 (holding that Section 501(c) does not apply to situations where a

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17 Section 501(c) of the ADA is codified at 42 U.S.C. § 12201(c)(2).
disabled individual has been totally excluded from coverage).

a. What is a “disability-based” distinction?

The first issue in determining if a health plan violates the ADA is whether the plan has a disability-based distinction. If there is no disability-based distinction, the plan is valid and does not violate the ADA.

Courts have held that health insurance distinctions that are “applied equally to all insured employees [do not discriminate on the basis of disability and so do not violate the ADA].” *McLaughlin v. Gen. Am. Life Ins.*, No. 97-1410, 1998 U.S. Dist. LEXIS 16994, at *6 (E.D. La Oct. 21, 1998) (quoting EEOC Interim Guidance, at 6). Accordingly, a distinction that applies to both employees with disabilities and employees without disabilities does not violate the ADA. See *McLaughlin*, 1998 U.S. Dist. LEXIS 16994, at *6 (holding that a preexisting condition clause that applied to both disabled and nondisabled employees does not violate the ADA); *Templet v. Blue Cross/Blue Shield*, No. 99-1400, 2000 U.S. Dist. Lexis 15605, at *5–10 (E.D. La Oct. 19, 2000) (finding a blanket insurance obesity exclusion that affected the disabled and non-disabled equally did not violate the ADA); *Kraul v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996) (finding a plan’s exclusion of infertility treatments was not disability-based because it applied equally to both the disabled and non-disabled). However, when there is a distinction in a health plan that “singles out a particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney diseases) or disability in general (e.g., non-coverage of all conditions that substantially limit a major life activity),” there is a disability-based distinction that might violate the ADA.18 *McLaughlin*, 1998 U.S. Dist. LEXIS 16994, at *6 (quoting EEOC Interim Guidance, at 8). See also *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997) (finding a cap on expenditures for AIDS treatment in an insurance plan to be disability-based).

b. How do you meet the bona fide plan safe harbor?

If a plan has disability-based distinctions, the EEOC states that the plan must fall under Section 501(c)’s safe harbor to not violate the ADA. Under Section 501(c), a bona fide plan with disability-based distinctions qualifies under the safe harbor exemption only if it is not “a subterfuge to evade the purposes” of the ADA. The EEOC puts the burden of proof on the employer to show that the plan meets the requirements of Section 501(c). EEOC Interim Guidance, at 10.

*Plan has to be “bona fide.”*

To be protected by Section 501(c), the EEOC requires that the plan is either a bona

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18 The EEOC Interim Guidance gave the following example: “R Company’s new self-insured health insurance plan caps benefits for the treatment of all physical conditions, except AIDS, at $100,000 per year. The treatment of AIDS is capped at $5,000 per year. CP, an employee with AIDS enrolled in the health insurance plan, files a charge alleging that the lower AIDS cap violates the ADA. The lower AIDS cap is a disability-based distinction. Accordingly, if R is unable to demonstrate that its health insurance plan is bona fide and that the AIDS cap is not a subterfuge, a violation of the ADA will be found.” EEOC Interim Guidance, at 8–9.
fide health insurance plan that is not inconsistent with state law or a bona fide self-insured health insurance plan. EEOC Interim Guidance, at 11. If the plan is an insured plan, it has to be shown that: (1) “the health insurance plan is bona fide in that it exists and pays benefits, and its terms have been accurately communicated to eligible employees” and (2) “the health insurance plan’s terms are not inconsistent with applicable state law as interpreted by the appropriate state authorities.” EEOC Interim Guidance, at 11. If the plan is a self-insured plan, “the respondent will only be required to prove that the health insurance plan is bona fide in that it exists and pays benefits, and its terms have been accurately communicated to covered employees.” EEOC Interim Guidance, at 12.

**Plan has to not be a “subterfuge.”**

To qualify for the safe harbor, the health insurance plan also cannot be a “subterfuge to evade the purposes” of the ADA. The EEOC defines “subterfuge” as “disability-based disparate treatment that is not justified by the risks or costs associated with the disability.” EEOC Interim Guidance, at 12. For instance, if a lower benefits cap for AIDS treatment was found to be used to deter people with AIDS from accepting employment or enrolling in a plan, or there are studies that demonstrate that the cost of AIDS is comparable to the costs of other covered conditions, then the lower AIDS cap would be a subterfuge as it is not justified by the risks or costs associated.

The EEOC provides a non-exclusive list of potential ways for an employer to prove that the plan is not a “subterfuge.” Under this list, the employer can prove that:

1. It had not engaged in disability-based disparate treatment by showing that the health plan treats all similarly catastrophic conditions in the same way;

2. 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 the same way (proving that the disparate treatment is attributable to legitimate risk classification and underwriting procedures to the increased risks of the disability); 19

3. The disparate treatment is “necessary” (i.e., there is no nondisability-based plan change that could be made) to ensure that the challenged plan satisfies commonly accepted or legally required standards for fiscal soundness; 20

4. The challenged insurance practice is “necessary” (i.e., there is no

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19 But even if an employer shows that the risks and costs of a disability justifies a different treatment, the employer could still be found to have discriminated against that particular disability if evidence shows that the employer treated other conditions that have the same or similar risks and costs differently from the disability challenged. 2 EEOC Compliance Manual §3 (2000).

20 For example, the employer may prove that unlimited coverage for a disability “would have been so expensive as to cause the health insurance plan to become financially insolvent, and there was no nondisability-based [] alteration that would have avoided insolvency.” EEOC Interim Guidance, at 13–14.
nondisability-based plan change that could be made) to prevent the occurrence of an unacceptable change either in the coverage or in the premiums charged for the plan;\textsuperscript{21} and,

(5) If an exclusion of a disability-specific treatment is challenged, that the particular challenged treatment does not provide any benefit. EEOC Interim Guidance, at 12–14.

2. Application of Section 501(c)’s safe harbor.

Courts have inconsistently applied Section 501(c)’s safe harbor exemption to disability-based benefit plans. There are two lines of cases with regards to disability-based distinctions in benefit plans: (1) cases that have not followed the EEOC and have a lenient interpretation of the ADA’s restrictions towards disability-based distinctions in plans and (2) cases that have followed the EEOC’s interpretation of the ADA with regards to disability-based distinctions in plans.

a. Cases lenient on disability-based distinctions in plans.

Some courts have held that there can be differentiations between different disabilities in employee health plans or benefit plans even without the plan falling under Section 501(c)’s safe harbor. See Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1116–18 (9th Cir. 2000) (without even a discussion of Section 501(c)’s safe harbor, finding no Title I violation for a disability-based distinction in an employee health plan that limited benefits for mental disabilities to twenty-four months);\textsuperscript{22} Lenox v. Healthwise of Kentucky, Ltd., 149 F.3d 453, 457–58 (6th Cir. 1998) (without even a discussion of Section 501(c)’s safe harbor, finding no Title I violation when an employee health plan covered some types of transplants, but not heart transplants); Kimber v. Thiokol Corp., 196 F.3d 1092, 1101–02 (10th Cir. 1999) (without cost justifications finding no Title I violation when an employee disability benefit plan provided better benefits for physical disabilities than mental disabilities); EEOC v. Staten Island Sav. Bank, 207 F.3d 144, 149–50 (2d. Cir. 2000) (same) (citing Ford v. Schering-Plough Corp., 145 F.3d 601, 608 (3d. Cir. 1998) (“So long as every employee is offered the same plan regardless of that employee’s contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities. The ADA does not require equal coverage for every type of disability; such a requirement, if it existed would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA.”)).

\textsuperscript{21} “Unacceptable change” refers to a drastic increase in premium, co-payments, or deductibles, or a drastic alteration to the scope or benefits provided that would make the plan effectively unavailable to a large number of employees, make the plan so unattractive resulting in significant adverse selection, or make the plan so unattractive that the employer cannot compete in recruiting or maintaining employees. EEOC Interim Guidance, at 14.

\textsuperscript{22} For employers with more than 50 employees, the Mental Health Parity and Addiction Equity Act of 2008 now requires employer self-insured health plans and fully insured health plans that offer treatments for mental illness and substance use disorders to provide benefits in no more restrictive ways than all other medical and surgical procedures covered by the plan.
These cases base their holdings on a number of reasons. Some cases find that the plaintiffs were not treated differently because of a disability, but rather were given the same opportunity as non-disabled persons to join a group policy at a cheaper price. See Weyer, 198 F.3d at 1116; Lenox, 149 F.3d at 457; Kimber, 196 F.3d at 1101; EEOC, 207 F.3d at 149. Other cases find that the legislative history of the ADA supports this conclusion with its statement that “it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments [as long as disabled persons] have equal access to the . . . insurance coverage that is provided by the employer to all employees.” See Weyer, 198 F.3d at 1116–17; EEOC, 207 F.3d at 150. Other courts conclude that the EEOC’s interpretation in its Interim Guidance that the ADA forbids differential insurance coverage in disabilities is entitled to little or no deference. Weyer, 198 F.3d at 1117; EEOC, 207 F.3d at 151–52 (“[T]his court has not yet determined the degree of deference due to an informal publication such as the EEOC Interim Guidance that has not been subject to notice and comment.”). And finally, some courts conclude they lack the specialized knowledge and experience in analyzing actuarial data and risk classification methods; and in general, lack the experience to intervene in the business of the insurance industry. See Ford, 145 F.3d at 612 (“Requiring insurers to justify their coverage plans elevates this court to the position of super-actuary. This court is clearly not equipped to become the watchdog of the insurance business.”).

b. Cases following the EEOC with regards to disability-based distinctions in plans.

Other courts, however, have followed the EEOC interpretations and have found disability-based distinctions in health plans and other benefit plans to violate the ADA unless it falls under the ambit of Section 501(c)’s safe harbor. See Fletcher v. Tufts Univ., 367 F. Supp. 2d 99, 114 (D. Mass. 2005) (following the EEOC approach, finding plan’s limits on mental disability benefits to violate Title I unless employer showed that it was “cost justified”); Iwata v. Intel Corp., 349 F. Supp. 2d 135, 149–50 (D. Mass. 2004) (same); Branch, 966 F. Supp. at 1207–08 (finding AIDS cap in a health plan to violate Title III of the ADA because no evidence was given to show that the cap was based on “actuarial principles, reasonably anticipated experience, or bona fide risk classification”).

c. What about Texas courts?

Few Texas courts have discussed disability-based distinctions in health and benefit plans. Like other courts, the standards and applicability of Section 501(c)’s safe harbor exemption have been inconsistent.

Northern District of Texas.

Two Northern District of Texas cases have discussed disability-based distinctions in insurance plans, with each applying a different standard towards disability-based distinctions. In Attar v. Unum Life Insurance Co. of American, the Northern District of Texas, Dallas division found that a distinction between mental and physical disability in an employer group disability plan has to be justified by “sound actuarial principles, reasonably anticipated experience, and bona fide risk classification.” No. CA 3-96-CV-0367-R,
1997 U.S. Dist. LEXIS 23254, at *42–44 (N.D. Tex. July 19, 1997). The Attar Court expressed its opinion that “it is not the role of the courts to write insurance policies,” but found that this deference still requires disability-based distinctions to be justified by cost data. Id. at 44.

To the contrary, the Northern District of Texas, Fort Worth division in Alexander v. American Airlines followed the Second Circuit’s holding in EEOC v. Staten Island Savings Bank, and held that “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.” No. 4:02-CV-0252-A, 2002 U.S. Dist. LEXIS 7089, at *6 (N.D. Tex. Apr. 22, 2002). Under this, the Court found no ADA violation for an employer provided health plan that excluded coverage for infertility.23 However, in this case the Court did not consider the issue of whether the plan was a subterfuge, and thus did not fully weigh the issue.

The Eastern District of Texas and the Western District of Texas.

In a case not involving a disability-based distinction in a plan, the Eastern District of Texas in Anderson discussed in depth the applicability of Section 501(c)’s safe harbor towards disability-based distinctions in health plans. Following the EEOC’s Interim Guidance interpretations, the Anderson Court stated that disability-based distinctions that are supported by legitimate cost data and other risk classifying devices may be permitted but placed the burden on “those actors classifying risks to show both their rationality and permissibility.” 924 F. Supp. at 780. The Court further stated that “[t]he term subterfuge simply […] denote[s] a means of evading the purposes of the ADA . . . [i]t does not mean that there must be some malicious intent to evade the ADA on the part of the insurance company or other organization . . . .” Id. Similarly, in a case not involving disability-based distinctions in plans, the Western District of Texas in Zamora-Quezada v. Healthtexas Medical Group found that to satisfy Section 501(c)’s safe harbor, “actuarial, statistical, and empirical data” must be provided to show that it was not subterfuge. 34 F. Supp. 2d 433, 444 (W.D. Tex. 1998).

C. Conclusion: When will disability-based distinctions in plans violate the ADA?

To answer this question, a determination must first be made as to which line of cases a court is following. If a court follows the reasoning of the cases that have been lenient on disability-based distinctions in plans, then these distinctions are likely valid. Even if a court follows the EEOC with regards to disability-based distinctions in plans, the plan may still be valid if it can be shown that the distinctions are not a “subterfuge.” This, however, may be a tough burden to overcome. With that said, until the courts standardize the rules, employers should take a conservative approach to matters involving

23 Notably, the Alexander Court also considered the employer’s other grounds for dismissal including the safe harbor defense, and found that the plaintiff had the burden to overcome the defense by showing that the defendant’s plan was a “subterfuge intended to evade the ADA.” 2002 U.S. Dist. LEXIS 7089, at *10. The Court found that the plaintiff had not pleaded subterfuge, and thus did not consider it. Id. This is a departure from most courts, which generally require the defendant to prove the plan is not subterfuge.
employee plans to minimize liability exposure under the ADA.

IV. CONCLUSION

As demonstrated above, there are several federal laws which protect employees from discrimination in the provision of employee benefit. Employers must carefully evaluate decisions relating to the provision or exclusion of such benefits to avoid a charge of unlawful discrimination.