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ETHICAL CHALLENGES OF HIV INFECTION IN THE WORKPLACE

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INTRODUCTION

Infection with the Human Immunodeficiency Virus (HIV) associated with Acquired Immune Deficiency Syndrome (AIDS)[1] poses significant ethical challenges for employers and employees in America's workplaces. As new medications make it physically possible for persons infected by HIV to participate in normal workplace activities for longer periods of time in greater numbers,[2] and as more workers respond to the urgings of public health officials to be tested and submit to prophylactic treatment to prevent the development of physical symptoms,[3] many more known HIV-infected persons[4] than heretofore will

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1. As the AIDS epidemic completes its first observable decade in the United States, it becomes increasingly clear that discussions of law and policy which focus on AIDS as defined by the Centers for Disease Control (CDC) in the first years of the epidemic are misleading and incomplete. CDC clings to a surveillance definition so that comparative statistics will have some meaning, but the reality is HIV infection and its numerous symptomatic manifestations, including CDC-defined Acquired Immune Deficiency Syndrome, AIDS-Related Complex or Conditions, immune deficiency related tuberculosis, lymphatic cancers, and other conditions, all of which have an impact in the workplace. Indeed, "asymptomatic" HIV infection and the mere perception that one is infected with HIV have workplace implications, such that an appropriate discussion of ethical implications must cover all these areas. For that reason, this article will have little mention of AIDS as such, and will normally refer to the phenomenon under discussion as HIV infection.

2. Dr. Ruth Berkelman, Chief of AIDS Surveillance for the U.S. Centers for Disease Control, has speculated that "the introduction of some effective therapies" has delayed the onset of AIDS among infected persons. *See AIDS Cases in U.S. Rose 9% in 1989*, N.Y. Times, Feb. 11, 1990, at 43.

3. In 1990, the Food and Drug Administration responded to research showing the efficacy of AZT as a prophylaxis against the development of symptoms of HIV infection by relabelling the drug for use by asymptomatic persons, thus lending encouragement to increased testing. *See Wider Use of AZT Is Urged for Adults With AIDS Virus*, N.Y. Times, Mar. 3, 1990, at 10.

4. Public health officials have urged persons who may be at risk for AIDS to undergo testing for HIV antibodies. While there is no national count of HIV-infected persons, the U.S. Centers for Disease Control reported that 117,781 cases of AIDS, as tightly defined by the CDC, were counted by the end of 1989. *AIDS Cases in U.S. Rose 9% in 1989*, *supra* note 2.

be asserting their legal rights to continue working. Employment of persons with life-threatening medical conditions will predictably have a significant impact on workplaces, affecting morale and productivity, as well as imposing direct financial burdens both due to claims on employee benefit systems and to necessary accommodations for impaired persons.[5] Employers will have to make decisions that respond to these impacts.

While the issue of legal workplace rights of HIV-infected persons is by no means finally settled,[6] there is an emerging trend in administrative, judicial and legislative forums toward protection of HIV-infected persons from unjustified employment discrimination.[7] However, the slow pace of administrative and judicial processes, the emphasis on monetary settlements of claims by administrative agencies, and the reluctance of HIV-infected people to expose themselves to publicity and stress by asserting their legal rights, combine to make it possible for many employers to eliminate known HIV-infected persons from their workplaces if they are willing to bear the costs involved.[8] Thus, an ethical dilemma is posed for employers, who must decide whether to take the possibly unlawful but

5. It is hard to obtain reliable data on the per patient costs of AIDS treatment, because the nature of available treatments is changing rapidly but careful studies of costs take time. Thus, by the time a careful study is published, its conclusions, to the extent valid, are only valid for an earlier period when different treatment modes and survival rates existed.

6. *Compare* Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988) (ordering reinstatement to classroom of schoolteacher with AIDS) *with* Leckelt v. Board of Commissioners, 714 F. Supp. 1377 (E.D. La. 1989) (refusing to order reinstatement of licensed practical nurse who declined to reveal antibody status after roommate died from AIDS). The Supreme Court has reserved judgment on whether seropositive persons are protected from discrimination by Section 504 of the Rehabilitation Act of 1973, School Bd. v. Arline, 480 U.S. 273, 282 n.7 (1987).

7. A cursory check of state laws compiled in BNA's Individual Employment Rights Manual revealed more than a dozen states with AIDS or HIV-specific laws affecting the workplace, virtually all seeking to protect HIV-infected persons from discrimination or breaches of confidentiality. In addition, several state and federal courts have concluded that discrimination against HIV-infected persons violates laws on handicap or disability discrimination. The federal Office of Personnel Management has issued guidelines forbidding HIV-related discrimination in federal workplaces.

8. In this context, "costs" refers to the lost investment in training and expertise when employees are discharged, the costs of defending discrimination claims when those are asserted, and the costs of settlement in such cases. Although federal law requires most employers to allow discharged employees to continue to participate in group health benefit programs, the former employee can be required to bear the cost of such participation. *See infra* text accompanying notes 58-63.

practical course of termination of employment or forced exclusion from the workplace, or to retain the employee, with the attendant problems that retention will entail, and if the employee is retained, the employer must further decide how to proceed to accommodate the employee.[9]

Neither is the issue of workplace confidentiality settled. While some states have legislated specific confidentiality requirements regarding information about HIV infection to supplement existing provisions in some jurisdictions which generally protect the confidentiality of medical records[10] and some courts have held that government agencies will be constitutionally liable for damages for unjustified disclosure of such information,[11] many persons injured by breaches of confidentiality may decide not to assert claims, and monetary damages will not in most instances suffice to repair the emotional and reputational damage imposed by such breaches. The employer may imagine conflicting imperatives with regard to confidentiality, including concerns about protecting co-workers and customers from danger (whether real or perceived). The infected employee may even present a different confidentiality issue: by not desiring confidentiality, the employee may create circumstances which prove disruptive of normal workplace routine. Thus, both employers and employees face serious ethical issues about confidentiality.

Costs of employee benefits constitute one of the most significant workplace expenses associated with HIV infection. Drugs now in common use for prophylaxis against development of symptoms are expensive, and hospitalization for serious opportunistic infections is also quite expensive. Most employees rely on job-based group health programs to pay for their health care expenses. HIV-infected persons encounter great difficulty obtaining individual insurance coverage outside

9. Handicap discrimination law applicable to most workplaces requires employers to make "reasonable accommodations" to enable persons with impairments to continue to work. *See infra* text accompanying notes 66-67.

10. *E.g.*, N.Y. PUB. HEALTH LAW § 2781 (McKinney Supp. 1990); CALIF. HEALTH & SAFETY CODE § 199.21 (West Supp. 1990); HAWAII REV. STAT. § 325-101(a) (1989 Supp.); MASS. GEN. LAWS ANN. ch. 111, § 70F (West Supp. 1990); MO. ANN. STAT. § 191.653 (Vernon Supp. 1990); TEX. HEALTH & SAFETY CODE ANN. § 81.103 (Vernon Supp. 1990). *See also* U.S. OFFICE OF PERSONNEL MANAGEMENT, AIDS GUIDELINES, BULLETIN NO. 792-42 (1988).

11. Woods v. White, 689 F. Supp. 874 (W.D. Wis. 1988) (disclosure of prisoner's HIV status to non-medical personnel actionable under 42 U.S.C. § 1983); *accord* Doe v. Borough of Barrington, 729 F. Supp. 376 (D.N.J. 1990). *See also* Zinda v. Louisiana Pac. Corp., 149 Wis. 2d 913, 440 N.W.2d 548 (1989).

of employment-based groups. Existing gaps in federal and state law may make it possible for employers to avoid major costs of covering HIV-related illness while inflicting considerable injury on their affected employees, including a shortened lifespan of inferior quality when lack of insurance coverage results in denial of access to acceptable health care. Once again, the employer is faced with an ethical dilemma, balancing economic and human issues.

In this article, I propose to discuss these ethical issues using principles described by medical ethicists Carol Levine and Ronald Bayer in their analysis of HIV screening policies.[12] They identify four "widely accepted ethical principles . . . derived from secular, religious, and constitutional traditions" which are "commonly applied to medicine, research, and public health":[13]

> 1. the principle of respect for persons (an autonomy principle);
>
> 2. the harm principle (acknowledging that limits may be placed on individual rights when others will be harmed by the exercise of those rights);
>
> 3. the beneficence principle (the requirement that individuals act on behalf of the interests and welfare of others, taking into account a realistic risk/benefit analysis); and
>
> 4. the justice principle (requiring equitable distribution of benefits and burdens and forbidding invidious discrimination).[14]

These principles may come into conflict in considering each of the ethical dilemmas posed above. The justice principle may present the most difficulties, since the negative impact, both psychological and economic, of employing a person with HIV-infection in a society which has refused to take collective responsibility for health care costs may be considerable. I will suggest how I would resolve these conflicts in proposing an ethical solution to the challenges of HIV infection in the workplace.

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12. Carol Levine is Executive Director of the Citizens Commission on AIDS for the New York City Metropolitan Area. Ronald Bayer is a professor at the Columbia University School of Public Health. *See* Levine & Bayer, *The Ethics of Screening for Early Intervention in HIV Disease*, 79 AM. J. PUB. HEALTH 1661 (1989).

13. *Id.* at 1663.

14. *Id.*

I begin with the premise that ethical obligations of individuals and businesses exist independently from minimal legal requirements, but that such requirements are a starting point for analyzing the appropriate response to HIV-related problems, since they are one representation of society's consensus regarding minimally acceptable conduct. Serious inefficiencies in civil rights enforcement enhance the ethical dilemmas, since employers may coldly calculate that violation of the law is justified by cost/benefit analysis. A conscious decision to violate the law based on cost/benefit analysis (rather than, for example, on a sincerely held belief that a law is unconstitutional or otherwise invalid or inapplicable) does not constitute ethical conduct. I will also make some arguments about the ethical obligations of society, transcending those of individual employers or employees.

I. THE STATE OF THE LAW

A. *Discrimination*

Until the Americans With Disabilities Act is enacted and its employment provisions become effective,[15] the legal obligations of most employers with regard to HIV-infected employees and job applicants will differ depending upon the nature and location of their operations. Private and state and local government employers who receive federal financial assistance or who are federal contractors, as well as federal agency employers, are bound by nondiscrimination requirements of the Rehabilitation Act of 1973,[16] which requires that "otherwise qualified handicapped individuals" not suffer invidious

15. The Americans With Disabilities Act [U.S. House of Representitives, 101st Cong., 2nd Sess., H.R. 2273] was awaiting final passage as this article went to press. The Act would eventually cover all employers with fifteen or more employees, but for the first two years following the effective date of the employment title, it would cover only employers with twenty-five or more employees, section 101, and the entire employment title does not take effect until 24 months after enactment, section 107. The Act would forbid discrimination against a "qualified individual with a disability" concerning "job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." *Id.* § 102(a). The employment title of the Act incorporates by reference the "remedies and procedures" of the Civil Rights Act of 1964. *Id.* § 106.

16. 29 U.S.C. §§ 701-796i. The Act exempts certain federal agencies in the national security and defense realms. *See* Doe v. Ball, 725 F. Supp. 1210 (M.D. Fla. 1989) (HIV-infected Navy employee not covered by Rehabilitation Act non-discrimination requirements). This was recently affirmed on appeal *sub nom.* Doe v. Garrett, 903 F.2d 1455 (11th Cir. 1990).

employment discrimination.[17] Under *School Board v. Arline*[18] and subsequent Civil Rights Restoration Act amendments to the Rehabilitation Act,[19] persons whose handicapping condition is contagious are not excluded from protection, provided that their condition does not present a substantial risk of contagion in the workplace.[20] Employers covered by the Rehabilitation Act are required to make "reasonable accommodations" to the handicapping conditions of their employees.[21] State and local laws in many jurisdictions impose similar requirements on employers who may not be covered by the federal law.[22]

Persons suffering gross physical impairments resulting from HIV infection would clearly be "handicapped individuals" under the Act, but those most significantly impaired are least likely to be qualified to work. Less obvious but very real physical impairments, such as a compromised immune system, would also qualify persons for Rehabilitation Act protection, and these individuals are more likely to be found qualified. Most of the caselaw to date has dealt with persons in this latter category,[23] and has concluded that such individuals who are able to work may not be excluded from the workplace solely because of their medical condition.

The legal requirements with regard to asymptomatic HIV-infected persons are less clear. In *Leckelt v. Board of Commissioners*,[24] a federal trial court concluded that Kevin Leckelt, a hospi-

17. *See* 29 U.S.C. §§ 791, 793, 794. "Handicapped individuals" are defined in section 706(7)(B) to include those with physical or mental impairments, records of such impairments, or who are perceived as having such impairments. A handicapped individual will be considered "otherwise qualified" if the individual is physically and mentally capable of participation in the activity, with reasonable accommodation, despite the handicapping condition. *See* Southeastern Community College v. Davis, 442 U.S. 397 (1979).

18. 480 U.S. 273 (1987).

19. 29 U.S.C. § 706(8)(C), *enacted by* Pub. L. No. 100-259 (1988).

20. *Arline*, 480 U.S. at 287 n.16; 29 U.S.C. § 706(8)(C).

21. *See* 45 C.F.R. § 84.12 (1989); *Arline*, 480 U.S. at 289 n.19; Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 938-39 (1989).

22. Detailed consideration of the current picture under state and local law will not be given here. Those interested are referred to Leonard, *supra* note 21 and sources cited therein. The situation regarding handicap discrimination laws and HIV or AIDS-specific discrimination laws is constantly changing, and those interested in determining the current state of the law are advised to consult looseleaf reporting services, such as BNA's *Fair Employment Practice Manual* and *Individual Employment Rights Manual*.

23. *E.g.*, Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988); Raytheon Co. v. Fair Employment and Hous. Comm'n, 212 Cal. App. 3d 1242, 261 Cal. Rep. 197 (1989).

24. 714 F. Supp. 1377 (E.D. La. 1989).

tal employee discharged after he refused to reveal his HIV antibody status to his employer, was not protected from discrimination by the Rehabilitation Act. Although acknowledging the accumulating authority that "HIV seropositivity is itself an impairment protected" by the Rehabilitation Act,[25] the court found that Leckelt was discharged not for being seropositive or even for being perceived as seropositive, but rather for refusing to comply with the hospital's Infection Control Program by failing to inform the hospital of his antibody status after having obtained confidential HIV testing outside the hospital.[26] The disingenuity of this opinion was exposed in a subsequent letter from the Regional Director of the Office of Civil Rights of the United State Department of Health and Human Services (OCR) to Leckelt's attorney, which concluded that the employer's "overriding concern was not the complainant's insubordination, but his HIV status. There is no suggestion that the type of discipline applied here was the norm for insubordination."[27] OCR also concluded that the hospital's "Infection Control Program" appeared contrived primarily to get rid of Leckelt, whose roommate had died after treatment at the hospital.

Disreputable as it is, the *Leckelt* court opinion is the only published federal court ruling concerning employment discrimination against an *employee* assertedly perceived to be seropositive. Although cases cited by the *Leckelt* court show the widening consensus that HIV seropositive persons are protected from discrimination under the Rehabilitation Act, that proposition cannot be considered fully established with regard to the workplace until a better reasoned decision on the merits issues from another court, or the Fifth Circuit rejects the *Leckelt* view on appeal.[28]

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25. *Id.* at 1385-86 (citing Department of Justice, Office of Legal Counsel, *Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals* (Sept. 27, 1988); Ray v. School District, 666 F. Supp. 1524 (M.D. Fla. 1987); Thomas v. Atascadero Unified School District, 662 F. Supp. 376, 379 (C.D. Cal. 1987); Local 1812, Am. Fed'n of Gov't Employees v. United States Dept. of State, 662 F. Supp. 50, 54 (D.D.C. 1987). The court also referenced in the text Doe v. Centinela Hosp., No. CV 87-2514, 1988 WL 81776 (C.D. Cal. June 30, 1988), a decision holding that an HIV seropositive individual had been unlawfully excluded from a residential alcohol and drug rehabilitation program.

26. 714 F. Supp. at 1386-1389.

27. Letter from Regional Manager Davis A. Sanders to R. James Kellogg, Esq., of New Orleans, attorney for Kevin Leckelt, date (Dec. 1989), *quoted in* 1990 LESBIAN/GAY LAW NOTES 7 (Feb. 1990).

28. A state handicap law decision finding no protection against

B. *Confidentiality*

Legal obligations of confidentiality vary widely. There is no federal law mandating confidentiality about HIV-related information, although the federal Office of Personnel Management has adopted a confidentiality policy for federal executive branch agencies (apart from the military and security agencies) that restricts access to such information on a need-to-know basis and leaves it mostly to the infected individual to determine who knows about his or her condition beyond that small circle.[29]

Many states have enacted laws dealing specifically with HIV or AIDS-related information in the workplace or more generally with confidentiality of such information in the world at large.[30] New York, for example, in Article 27-F added to its Public Health Law in 1988,[31] provides strict rules for access to information about HIV infection, which leave up to the infected individual the decision whom to inform, with enumerated exceptions relating primarily to health care providers.[32]

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discrimination for a seropositive employee is Burgess v. Your House of Raleigh, Inc., 326 N.C. 205, 388 S.E.2d 134 (1990). The case turns on peculiarities of North Carolina law and legislative history, including enactment of a weak AIDS discrimination law invoked by the court as evidence that the legislature believed that HIV infection was not covered by the handicap discrimination law, which had also previously been amended to exclude coverage for contagious conditions.

29. U.S. OFFICE OF PERSONNEL MANAGEMENT, *supra* note 10.

30. The Intergovernmental AIDS Resource Project, a joint effort of a variety of state and municipal governmental associations, reports that: "Between 1983 to 1988, 30 states enacted statutes providing the basic protections of confidentiality for HIV test-related information. Another eight had strengthened confidentiality provisions in existing communicable or sexually transmitted disease laws, which most likely would apply to HIV information." The same source reported that Illinois, Michigan, North Dakota, Wyoming, Ohio, and Florida had enacted new laws affecting confidentiality of HIV test-related information during 1989. 3 Intergovernmental AIDS Reports No. 1, at 3 (George Washington Univ. Jan. 1990). The same source includes a table at pp. 6-7 showing AIDS-related state legislation coverage. In addition, Commerce Clearing House reported that Connecticut enacted a confidentiality law which took effect October 1, 1989. Emp. Prac. Dec. (CCH) ¶ 21,395 (1989).

31. Ch. 584, § 2, L. 1988, *codified as* N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1990).

32. N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1990), provides exceptions to the general prohibition against disclosure without authorization from the seropositive person mainly for purposes of hospital treatment and administration. Some examples are disclosure of HIV antibody status of tissue intended for transplantation, disclosure to public health officials when mandated elsewhere by state or federal law, disclosure to foster care or adoption families when a seropositive infant is to be placed,

An employer who came into possession of such information might be subject to misdemeanor prosecution for passing the information to others without appropriate written consent from the infected individual.[33]

California,[34] Hawaii,[35] Massachusetts,[36] Missouri,[37] New Mexico,[38] and Texas,[39] to take a broad geographical sample, have all passed laws dealing specifically with the confidentiality of HIV-related information, all differing in details from the New York approach but all typically barring dissemination of such information without the consent of the infected individual.[40]

Existing statutory and common law principles governing the confidentiality of medical information in general are also relevant in considering the legal ramifications of HIV confidentiality. Some states specifically provide for the confidentiality of medical records[41] while others have developed constitutional, statutory[42] or common law tort principles[43] concerning personal privacy rights of employees.

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disclosure to third party payors (such as insurance companies) when necessary for processing payments for services rendered, disclosure to corrections, parole or probation officials in the case of prisoners or ex-convicts. The provision permits physicians to disclose the HIV antibody status of patients to public health officials under narrowly circumscribed circumstances where necessary to notify their sexual contacts, but provides that the public health officials may not reveal the name of the seropositive individual to the contact.

33. N.Y. PUB. HEALTH LAW § 2783 (McKinney Supp. 1989); provides civil penalties of up to $5,000 per unauthorized disclosure, and misdemeanor penalties for a willful violation.

34. CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1990).

35. HAW. REV. STAT. §§ 325-101(a) (Supp. 1989).

36. MASS. ANN. LAWS ch. 111, § 70F (Law. Co-op. Supp. 1990).

37. MO. ANN. STAT. § 191.653 (Vernon Supp. 1990).

38. N.M. STAT. ANN. § 24-2B-6 (Supp. 1989).

39. TEX. HEALTH & SAFETY CODE ANN. § 81.103 (Vernon Supp. 1990).

40. This list of state laws does not purport to be complete, since HIV confidentiality is a subject under constant consideration in state legislatures. Consultation of a looseleaf reporting service for up-to-date information is advised.

41. For example, N.Y. PUB. HEALTH LAW § 2803-c(f) (McKinney 1985), specifies the right of patients in health care facilities to confidentiality of their medical records. 10 N.Y. COMP. CODES R. & REGS. § 740.9, makes maintaining the confidentiality of patient medical records a requirement of licensing for medical facilities.

42. *See* Cronan v. New England Tel., 1 Ind. Emp. Rts. Cas. (BNA) 658 (Mass. Super. 1986) (relying on MASS. ANN. LAWS ch. 214, § 1B); Zinda v. Louisiana Pac. Corp., 149 Wis. 2d 913, 440 N.W.2d 548 (1989) (relying on WIS. STAT. § 895.50(2)(c)). *See also* ALASKA CONST. art. I, § 22; CALIF. CONST.

However, confidentiality laws may be characterized more as pious hopes than effective enactments. Direct penalties for their violation are minor,[44] and injunctive relief does not seem a very effective device for addressing breaches of confidentiality after they occur. Legal protections for confidentiality do not appear to have a particularly great deterrent effect, as illustrated by a recent study showing widespread violations of privacy and confidentiality respecting HIV-related information in health care institutions which are technically subject to such laws.[45] Consequently, ethical concerns about confidentiality may loom much larger than legal requirements in discussing the roles of employers and employees with respect to sensitive information about HIV.

C. *Employee Benefits*

HIV infection can present significant expenses for employee benefit plans.[46] As newer drugs go into wider use

art I, § 1; ILL. CONST. art I, § 6; LA. CONST. art I, § 5; R.I. GEN. LAWS § 9-1-28.1 (1985).

43. *E.g.*, Keehr v. Consolidated Freightways, 825 F.2d 133 (7th Cir. 1987); Bodewig v. K-Mart, Inc., 54 Or. App. 480, 635 P.2d 657 (1981); Cordle v. General Hugh Mercer Corp., 325 S.E.2d 111 (W. Va. 1984).

44. In New York, as noted *supra* note 41, confidentiality rules are connected to licensing requirements for health care institutions. Their violation may lead to administratively imposed penalties. In an administrative proceeding pending against a hospital, a pharmacist job applicant was denied employment when a hospital staff member recognized him as a client of the hospital's sexually transmitted disease clinic and revealed the "confidential" record of his HIV antibody test to the personnel making the hiring decision. The State Health Department imposed a $6,000 fine and required the hospital to institute staff training on the confidentiality of medical records. Axelrod v. Westchester County Medical Center (N.Y. State Health Dept. 1988); *see* 1989 LESBIAN/GAY LAW NOTES 5 (Jan. 1989). The likelihood that such confidentiality laws could be the basis of tort suits is being explored in Oklahoma in Miller v. McAlester Regional Health Center (E.D. Okla. filed Feb. 28, 1989) (described in 4 AIDS Pol'y & Law (BNA) No. 6, at 9-10 (Apr. 5, 1989)). Some courts have upheld tort actions in analogous cases where employees alleged violation of privacy rights as a result of unlawful polygraph testing. *See* Perks v. Firestone Tire & Rubber Co., 611 F.2d 1363 (3d Cir. 1979); Molush v. Orkin Exterminating Co., 547 F. Supp. 54 (E.D. Pa. 1982). However, as noted above, only a small percentage of those whose privacy is violated are likely to bring a private action.

45. Hilts, *Many Hospitals Found to Ignore Rights of Patients in AIDS Testing*, N.Y. Times, Feb. 17, 1990, at 1. This article discusses a survey conducted by researchers at the University of California at Los Angeles and the Robert Wood Johnson Foundation, which showed that legal restrictions on such information seemed to have little deterrent effect on health care institutions.

46. One study published in the Winter of 1987/1988 concluded that AIDS over several preceding years had become comparable in cost to other

among infected asymptomatic persons, either to retard viral replication or to forestall the development of particular opportunistic infections, the associated expenses may replace hospitalization as the main AIDS expense, because the overwhelming number of HIV-infected persons drawing on employee benefit plans may be asymptomatic. This could lengthen the period of time over which expenses occur, without necessarily reducing the overall expense.

Legal regulation of the substance of employee benefit plans is complicated. The principal federal law, the Employee Retirement Income Security Act (ERISA),[47] does not address substantive issues of benefit coverage. Rather, it provides a general framework within which employers (or employers and unions in collective bargaining situations) determine what actual benefits will be afforded to employees. Most of ERISA deals with the administration of pension plans. Those portions dealing with other benefit plans, such as health and disability benefits, are concerned mainly with broad issues of eligibility for participation, including continued eligibility for participation after termination of employment.[48]

ERISA broadly preempts state laws that "relate to" employee benefit plans, but does not preempt state laws that regulate insurance.[49] Employee benefit plans themselves, even

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major life-threatening health problems, such as end-stage kidney disease, paraplegia from automobile accidents, myocardial infarction in middle-age men, or cancer of the digestive system in middle-age men. *See* Fox & Thomas, *AIDS Cost Analysis and Social Policy*, 15 LAW, MED. & HEALTH CARE 186 (Winter 1986/87). This study identified hospitalization as a major cost component, and predated the widespread use of AZT to retard viral replication and aerosolized pentamidine as a prophylaxis for pneumocystis carinii pneumonia. Preliminary studies seem to indicate improved survival time as these medications have come into wider use. Harris, *Improved Short-term Survival of AIDS Patients Initially Diagnosed With Pneumocystic carinii Pneumonia, 1984 Through 1987*, 263 J. A.M.A. 397 (1990); Lemp, Payne, Neal, Temelso, & Rutherford, *Survival Trends for Patients With AIDS*, 263 J. A.M.A. 402 (1990). Whether this will translate into a larger lifetime expense spread over more years or a reduced lifetime expense due to less need for expensive hospitalization and emergency interventions is open to question.

47. 29 U.S.C. §§ 1001-1461.

48. Part 6 of subchapter 1 of ERISA, as codified in 29 U.S.C. §§ 1161-1168, requires that employers allow employees who are terminated for reasons other than "gross misconduct," 29 U.S.C. § 1163, to continue to participate in a group health plan for up to 18 months. For employees who meet social security disability requirements, this period can extend up to 29 months. *See* Pub. L. No. 101-239, § 6703 (1989). This continued participation would bridge the required waiting periods for participation in the Medicare health insurance program.

49. *See* 29 U.S.C. §§ 1144(a) and (b)(2)(A).

though they may serve an insurance function for employees, are not deemed to be insurance companies for purposes of ERISA preemption.[50] This means that when an employer purchases a health insurance policy to cover his employees as part of an employee benefits plan, that insurance policy will be subject to state insurance laws and regulations,[51] but if an employer provides health benefits directly from his own resources, without purchasing a policy from an insurance company, the employer's health benefits plan will not be subject to state regulation.[52]

ERISA is interpreted *in pari materia* with other federal laws regulating employment, which means that employee benefit plans which discriminate on the basis of sex or race can be challenged under Title VII of the Civil Rights Act of 1964 without raising any problems of ERISA preemption, and employee benefit plans which discriminate on the basis of handicap can be challenged under the Rehabilitation Act if the employer is subject to its jurisdiction.[53] But Rehabilitation Act jurisdiction is limited to government employers and recipients of federal money, leaving large portions of the private sector uncovered. Attempts to apply state or local handicap discrimination laws to challenge discrimination under employee benefits plans will run up against the problem of ERISA preemption, since the Supreme Court has only found preemption avoided where the state law forbids the same conduct as federal law to which the employer is subject.[54]

The proposed Americans With Disabilities Act, although it extends handicap discrimination law into much of the private sector, probably will not ameliorate the problem of ERISA

50. *See* 29 U.S.C. § 1144(b)(2)(B).

51. Metropolitan Life Ins. Co. v. Commissioner, 471 U.S. 724 (1985) (insurance policy purchased for employee benefits plan is subject to minimum standards for health insurance policies specified by state insurance laws and regulations).

52. Shaw v. Delta Air Lines, 463 U.S. 85 (1983) (any direct state law regulation of the substance of an employee benefit plan is preempted by ERISA).

53. One commentator suggests that even under the Rehabilitation Act's prohibition against handicap discrimination, employer caps or exclusions of AIDS coverage may not necessarily constitute unlawful discrimination, since it is not clear that the rehibilitation Act was intended to require employers to provide comprehensive coverage for all medical conditions. *See* Greely, *AIDS and the American Health Care Financing System*, 51 U. Pitt. L. Rev. 73, 113-15 (1989).

54. Shaw v. Delta Air Lines, 463 U.S. 85 (1983). In Folz v. Marriott Corp., 594 F. Supp. 1007 (W.D. Mo. 1984), a leading case under ERISA section 510, the court held that pendant state law claims were preempted.

preemtion. During floor consideration in the Senate, a provision was added to the Act apparently intended to preserve the existing effect of ERISA preemption by stating that the Act could not be construed to

> prohibit or restrict . . . a person or organization covered by this Act 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 a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.[55]

Although somewhat obscure, this language appears to preserve the ability of employers to limit coverage of particular medical conditions under self-insurance health plans. Even if the ADA were not emcumbered by this provision, however, it is worth noting that the implementation of the employer chapter is significantly delayed[56] and that employers of fewer than 15 employees will not be covered by the ADA.[57]

The extent of direct protection under ERISA against HIV-related discrimination in employee benefits has not been established in litigation.[58] The most relevant provision, Section 510,[59] forbids discrimination against employees either for exercising their rights under employee benefit plans, or to prevent them from attaining rights to benefits to which they would be

55. *See* H.R. 2273, 101st Cong, 2d Sess., § 501(c)(2), (3) (passed by the House on May 22, 1990). *See also* Greely, *supra* note 53, at 111 n.109.

56. Section 107 provides that the employment chapter will not become effective until 24 months after enactment, and then only with respect to businesses which employ 25 or more employees. After enother two years have passed, those employing 15 or more employees will be covered. H.R. 2273, 101st Cong., 2d Sess., § 107 (1990).

57. *Id.* § 101(4).

58. In at least one jurisdiction, discrimination in benefits against HIV-infected employees has been dealt with as a sex discrimination matter. In a complaint settled by the Oregon Civil Rights Division, the Division initially refused to dismiss the matter using a disparate impact analysis, noting that almost all AIDS cases reported in Oregon were among men, and avoiding ERISA preemption by asserting that the complainants claim would be actionable under Title VII. Beaverton Nissan and M.F. Salta Company, Oregon Civil Rights Division, Bureau of Labor, Case EM-HP-870108-1353 (reported in 3 AIDS Pol'y & Law (BNA) No. 2, at 5 (Feb. 10, 1988); 1989 LESBIAN/GAY LAW NOTES 16 (Mar. 1989)).

59. 29 U.S.C. § 1140.

entitled under such plans.[60] While the main purpose of Section 510 was to prevent employers from strategically discharging employees prior to significant vesting dates under pension plans, it has been used to challenge discharges by employers seeking to avoid benefits claims from ill employees.[61] While Section 510 clearly could be used to challenge a discharge for the purpose of avoiding HIV-related health claims under an employee benefit plan, it is uncertain whether the courts will ultimately sustain the proposition that Section 510, standing alone, forbids discriminatory policies regarding benefits for particular medical conditions. In *Doe v. Cooper Investments*,[62] a federal court temporarily ordered a recalcitrant employer to cover individual health insurance premiums for an employee with AIDS while a Section 510 dispute was being litigated, but the matter was settled before an opinion on the merits could be rendered.

The most significant pending case is probably *McGann v. H & H Music Co.*,[63] in which the employer converted its health plan from a purchase of insurance to a self-insured plan, and in the process placed a $5,000 lifetime cap on HIV-related claims. An employee who had been previously diagnosed with AIDS and who was drawing benefits under the plan filed suit after he was informed that upon the plan conversion he would be subject to the $5,000 lifetime cap, which would be exhausted in his case within one year. The employer moved to dismiss, correctly asserting that ERISA does not explicitly provide for any sort of "vesting" of health benefits and does not expressly restrict employers from converting their plans from purchase of insurance to self-insurance. The employer also contended that it had decided to make the change because of the rising expenses under its prior plan, without regard to the claims history of particular employees. The employee countered that the

60. S. REP. No. 127, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 4838, 4871-72.

61. *E.g.*, Zipf v. American Tel. and Tel. Co., 799 F.2d 889 (3d Cir. 1986); Bradley v. Capital Engineering & Mfg. Co., 678 F. Supp. 1330 (N.D. Ill. 1988); Folz v. Marriott Corporation, 594 F. Supp. 1007 (W.D. Mo. 1984). Courts have imposed a significant burden on plaintiffs in such cases of having to prove that avoidance of liability for benefits was a motivating factor in the discharge.

62. No. 89-B-597 (D. Col. 1989). *See* 4 AIDS Pol'y & Law (BNA) No. 8, at 4 (May 3, 1989); No. 11, at 11 (June 14, 1989). The court's opinion on the motion for temporary relief is not officially published.

63. No. H-89-1995 (S.D. Tex. 1989) (reported in 4 AIDS Pol'y & Law (BNA) No. 20, at 2 (Nov. 1, 1989)). The writer of this article has participated in advising the plaintiffs in this matter.

circumstances of the change gave rise to a strong inference that avoidance of HIV-related expenses was at least a motivating factor for the change, which should at least justify letting the case go through discovery and trial on the question of motivation. Discovery might, among other things, uncover evidence that the employer was subject to the Rehabilitation Act, either as a contractor or funding recipient, which would provide a clearer basis for reaching the issue of discrimination in employee benefits.

II. Ethical Issues

The ethical issues raised by the HIV epidemic and the reality of existing workplace law can be dealt with at several levels. I will first discuss the ethical issues for individual employers, and then briefly consider the broader ethical issues facing society.

Employers confronting the reality or perception of HIV infection can select from an array of responses. The ideal response from the point of view of a person infected with HIV would be for the employer to undertake an objective evaluation of the individual's ability to work, taking into account a realistic assessment of the risk of infection to others; to base employment decisions upon the results of such evaluation, taking into account the expressed desires of the affected employee, without regard to the possible reactions of managers and supervisors, co-workers, customers or members of the public or to costs which might be incurred as a result of employing an HIV-infected person. This response would include a commitment to maintain confidentiality to the extent requested by the employee and consistent with the company's actual needs, a commitment to maintain full employee benefits to the extent consistent with the continued economic viability of the business, and appropriate workplace educational programs to deal with employee fears. This approach would constitute a plausible means of compliance with existing handicap discrimination law and ERISA principles applicable to most workplaces.

The employer might widen the range of consideration, taking greater account of reactions of others or financial implications. One would be surprised to find an employer making such decisions without considering the wider impact, because an employer has responsibilities to a variety of constituencies. Part of that impact will be psychological: the effect on the workplace of having an employee whose physical and mental condition may deteriorate alarmingly if available medications prove

unable to contain the impairing effects of opportunistic infections, and the impact on co-workers, clients or customers, or other members of the public of knowing that an HIV-infected person will be dealing with them, should such information become known.[64] Such an evaluation would require a realistic assessment of the current level of knowledge in the workplace and the community, and the ability and willingness of the employer to commit resources to increase that level of knowledge. Such an evaluation might also consider the possibility of accommodating the special needs of an HIV-infected person, and how the employer's handling of such issues as confidentiality and employee benefits administration might affect the reactions of others.

Having considered these factors, how might an ethical employer proceed?

One response could be to determine the employer's legal obligations in the situation and to proceed strictly in accordance with those obligations, doing no more and no less than the employer's legal counsel advises is required, but the equation of ethical behavior with mere obedience to law is unsatisfactory in this context, for the law provides at best a floor of minimally acceptable behavior. Furthermore, strict compliance without a more affirmative response is likely to have a negative effect on the employer's business, since some of the negative impact of AIDS on the atmosphere and productivity of a workplace can be avoided through a more active, positive response.

An ethical employer will be concerned with respecting the autonomy of the individual and with preventing harm to the individual and others with whom the individual will come into contact in the workplace. This requires a realistic assessment of workplace transmission risk as well as workplace risk of exposures for the HIV-infected employee with a weakened immune system, especially in a health care institution (where the employee's job could require exposure to contagious con-

64. Such reactions were described in a BNA interview with David M. Herold, Director of Georgia Tech's Center on Work Performance Problems, who had conducted a study on attitudes of workers:

> He said that workers say, "I know, I've read, I understand I can't get it this way" — but there is an infinitesimal probability of getting a horrible disease and they don't want to chance it. Other experts said that, given the certain fatal outcome of the disease, the reaction is understandable, meaning that employers must help employees overcome their fears so they can get on with business. The best way to do this, they agreed, is to educate workers.

Daily Lab. Rep. (BNA) No. 45, at C-2 - C-3 (Mar. 7, 1990).

ditions) or a manufacturing job with heightened exposure to toxic substances. There may seem to be a significant clash between the principle of respect for persons and the principle of beneficence, as the former would dictate letting the HIV-infected employee decide whether to expose himself to workplace risks, given full knowledge of those risks, while the later might justify a more paternalistic approach of the employer deciding to "do what is right" for the HIV-infected employee against the employee's wishes. An employer desiring to pursue the paternalistic course would have a duty to base such a course on knowledge rather than speculation. The ethical employer will want to surmount negative or fearful emotional reactions in accordance with the beneficence principle, which would require a rational response based on a careful weighing of benefits and risks. Finally, an ethical employer will seek a fair distribution of benefits and burdens in line with the justice principle.

How might this play out in a workplace where an ethical approach is affirmatively sought? First, the employer would resolve to make decisions which will not exacerbate the problems the HIV-infected individual confronts, to the extent this can be done without endangering the viability of the business. Second, the employer would resolve to involve the HIV-infected person in the decisionmaking process to the extent this is feasible, since the principle of respect for persons requires that individuals be accorded the right to participate in determinations about their status and opportunities. Effectuating the harm and beneficence principles, the employer would undertake appropriate educational programs in the workplace about HIV infection, employee benefits and personnel policies, so that employees will know their rights and obligations and make decisions in light of such information.[65] Respect for individual autonomy would require the employer to safeguard the confidentiality of HIV-related information, restricting knowledge about an employee's HIV status consistent with the employee's wishes, except to the extent that such knowledge is necessary for others to do their jobs properly. (For example, the reasonable accommodation requirements of disability discrimination law may not be implemented effectively if a supervisor does not know about the need to accommodate and the

65. To date, workplace education programs have proven the most effective way to reduce employee fears and facilitate smooth operation of a workplace where an employee is known to have AIDS. *See More Workplaces Dealing With AIDS as Cases, New Treatments Increase*, Daily Lab. Rep. (BNA) No. 45, at C-1 (Mar. 7, 1990).

reasons for it.) The justice principle will require the ethical employer to undertake a realistic assessment of the costs dictated by the other principles, and to attempt a fair allocation of costs.

The justice principle poses difficult issues. How much expense may an employer fairly be expected to assume to accommodate an HIV-infected employee? The concept of reasonable accommodation found in most handicap discrimination laws has not received extensive caselaw development. In the *Arline* case, the Supreme Court commented that accommodation responsibilities do not include changes in the basic function or mission of the operation, or even job redesign or transfers not normally available under the employer's personnel policies.[66] Regulations suggest that the accommodation duty will vary depending upon the size and scope of the employer's operation.[67] But beyond what the law may require, which may really be quite minimal, what is the right thing for an employer to do? Incurring a major expense to accommodate an employee with symptomatic HIV infection may present undue financial hardship to a small employer, but for many employers the real expenses of accommodation may, upon sober consideration, be over-balanced by the continued productive participation of an individual in whom the employer has a significant training investment. The accommodation requirement under existing disability laws seems to strike an appropriate balance between the beneficence principle, respect for persons, and the justice principle, by recognizing that people with disabilities should be integrated into the workforce, but only to the extent that is consistent with the legitimate interests of employers and fellow employees in the practical ability to get the job done, safety concerns, and the economic health of the business.

Ethical questions are more starkly drawn in the current economic climate surrounding employee benefits. Premiums for health insurance have been escalating, and conversion to self-insurance will undoubtedly grow as a cost saving measure. Such conversions may provide an escape route from state insurance regulations forbidding caps or benefit limits for particular diseases, but an ethical employer will surely resist the temptation to take advantage of this opportunity to discriminate against HIV-infected employees. Health benefit expenses related to HIV infection are not necessarily greater than those

66. School Bd. v. Arline, 480 U.S. 273, 289 n.19 (1987).
67. 45 C.F.R. § 84.12(a) (1989).

related to other life-threatening illnesses normally covered without question by health plans, so singling out HIV infection but not other conditions for exclusions or caps does not have an objective justification.

Those employers who have justified HIV exclusions as a "self-inflicted problem" because of its association with IV drug use or promiscuous sexual behavior[68] are displaying ignorance about the spectrum of behaviors in which viral transmission may take place, or the state of knowledge of individuals at the time of their infection. It seems likely, given the long period which may elapse between infection and symptoms, that the overwhelming majority of HIV-infected employees became infected when the danger of HIV was unknown to them and information about safer sex practices was unavailable. Also, some portion of HIV-infected employees will have acquired their infection through other behaviors, such as use of tainted medications or receipt of tainted blood transfusions. Even if one were to grant employers the right to allocate health care benefits based on their normative evaluation of the conduct which led to infection, one would question why HIV-related claims should be excluded while illnesses arising from other behaviors, such as smoking, drinking, or poor dietary habits, were not similarly treated. Exclusion of some "lifestyle" claims but not others seems based arbitrarily on employer dislike or disapproval of the people involved, and violates the justice principle by discriminating in compensation, since some employees would be covered for their "lifestyle" illnesses and others would not, regardless of their contribution to workplace productivity.

HIV infection raises ethical issues beyond the individual workplace. The epidemic, together with the phenomenon of rising health insurance premium rates, refusals by insurance companies to sell group policies to employers in particular industries, and the significant number of Americans who are individually considered uninsurable, raises ethical problems for

68. A prime example of this kind of thinking is U.S. Representative William Dannemeyer, a Republican who represents Orange County, California. During consideration of the Americans With Disabilities Act by the House Committee on Energy and Commerce, of which he is a member, Dannemeyer proposed amendments to eliminate protection for people with infectious diseases. Dannemeyer stated that he had no problem with extending protection against discrimination to "innocent acquires" of AIDS but that he would "have trouble extending that protection to the 93 percent who acquire AIDS through homosexual activity or drug abuse." Daily Lab. Rep. (BNA) No. 50, at A-7 (Mar. 14, 1990).

our whole society. Is it consistent with the principles of beneficence and justice for our nation, alone among the great Western democracies, to relegate a large portion of our population to the inferior quality of health care available to the uninsurable? Is it consistent with the principle of respect for persons to tolerate a system in which access to health care turns on the decisions of individual employers about how to allocate their assets, or in which access to health care for uninsurable persons may require them to deplete their assets to qualify for public assistance programs which carry stigmatizing connotations?

The substitution of a system which cuts health care access free from any workplace tie would seem a more appropriate approach for a society which embraces an equitable distribution of benefits and burdens as suggested by the justice principle. Halfway proposals to supplement or perpetuate the current employment-based system do not achieve this equitable distribution, since they still leave a significant portion of the burden on individual employers. A full discussion of the arguments for and against a national health insurance program are beyond the scope of this article, but it is certainly relevant to note that a substantial portion of the ethical issues raised by HIV and the workplace just does not occur in other countries which have chosen to deal with access to health care as primarily a public sector concern.

Another ethical issue for society is raised by our employment at will system, under which employers have no obligation to maintain the employment relationship with employees who are unable to work due to illness or other long-term disabilities. Disability laws only provide protection for those who are able to work. So long as quality health care access is closely tied to employment status, a system which affords no protection to that status once an employee is too disabled to perform falls down on the obligation of beneficence. Without contending that employers should be required to continue compensating employees who can no longer work, our society must address the ethical problem raised by the severance of workplace ties.

The continuation coverage provisions of ERISA are a halfhearted step in this direction, and a further step is the action being taken by some states to authorize their Medicaid systems to help former employees pay the premiums to maintain their health coverage under the ERISA continuation entitlement.[69]

69. New York Governor Mario Cuomo has proposed such an approach for New York State. 4 AIDS Pol'y & Law (BNA) No. 24, at 3 (Jan. 10, 1990).

Because HIV infection has proven to be an unpredictable phenomenon in terms of the long-term outlook for individual physical well-being, the maintenance of some workplace tie might be useful in assisting HIV-infected persons to have gainful employment upon recovery from significant opportunistic infections, and might help provide a psychological lift that would be helpful in the recovery process. In addition, governmental assistance to employers in meeting the expenses of maintaining regular health insurance coverage for temporarily disabled HIV-infected employees might deter unnecessary terminations of employee status.

CONCLUSION

Many American employers have responded ethically to the epidemic of HIV disease with compassion and understanding. Others have placed regard for the bottom line over the ethical principles of respect for persons, beneficence, justice and avoidance of harm, or, with disregard for basic principles of individual autonomy, have made decisions, albeit well-intentioned, without consulting the involved employee.

The developing law of HIV and the workplace suggests minimum standards of an ethical approach, but our society needs to reach beyond the notion of compliance with minimal legal standards if people affected by the epidemic are to be treated in a way consistent with our collective sense of ethical behavior. The ethical approach may also be the most rational approach, since appropriate health education for workforces and compassionate assistance for HIV-infected employees and their family members may result in the least workplace disruption while enabling the employer to continue tapping the skills and experience of infected employees.

More significantly, employers can help form the vanguard of those arguing that our society should radically restructure our health care financing system to more equitably distribute the benefits and burdens of providing quality health care to employees and the unemployed alike. Such a fundamental restructuring could more equitably spread the burdens of a new epidemic while preserving that respect for individual human dignity which lies at the heart of ethical concerns.

Michigan has already adopted such a program. 4 AIDS Pol'y & Law (BNA) No. 21, at 8-9 (Nov. 15, 1989).