

AN OPENING FOR CIVIL RIGHTS IN HEALTH INSURANCE AFTER THE AFFORDABLE CARE ACT

VALARIE K. BLAKE*

Abstract: Section 1557, the civil rights provision of the Affordable Care Act (“ACA”), is unmatched in its reach, widely applying race, gender, disability, and age discrimination protections across all areas of healthcare. This Article will explore the value added of a civil rights approach to combating health insurance discrimination when combined with other ACA anti-discrimination efforts that were designed to regulate the health insurance market. It will emphasize the role that section 1557 can play in combatting healthcare disparities and will explore the utility of disparate impact and disparate treatment claims to those cases. Lastly, the Article will posit that two doctrinal limits weaken a civil rights approach to health insurance equity. First, it is unclear to what extent economic rationality is a permissible defense to insurance discrimination. Second, civil rights doctrine focuses on formal equality, which is of limited use in health insurance, where healthcare distribution must necessarily be unequal. Despite these limitations, section 1557 and civil rights in general will play a critical role in health equity in post-reform healthcare.

“To put it simply, health equity is a civil rights issue.”¹

INTRODUCTION

Section 1557 of the Patient Protection and Affordable Care Act (“ACA”) has potential to broadly remedy discrimination in healthcare. Section 1557 prohibits race, gender, age, and disability discrimination by healthcare entities

© 2016, Valarie K. Blake. All rights reserved.

*Associate Professor of Law, West Virginia University College of Law. The author would like to thank attendees and organizers of the Saint Louis University Center for Health Law Studies and the American Society of Law, Medicine & Ethics 2015 Health Law Scholars Workshop, Professors Mary Crossley, Elizabeth Pendo, Jessica Roberts, Jason Turner, Sidney Watson and Lindsay Wiley, Associate Dean Josh Fershee, and Melanie Stimeling for comments on earlier iterations of this article; Professors Atiba Ellis, Ann Schiavone, Kirsha Weyandt Trychta, and Elaine Wilson for writing support, and Adriana Faycurry and Maggie Powers for research support. The author would also like to thank the West Virginia University College of Law and the Hodges/Bloom Research Fund for research support. All errors and omissions remain my own.

¹ Vivek Murthy, 19th Surgeon Gen. of the U.S., Commissioning and Change of Command Speech (Apr. 22, 2015), available at <http://www.surgeongeneral.gov/swearing-in-murthy.html> [<https://perma.cc/8XBM-W9XD>].

receiving federal financial assistance.² As the first healthcare-specific civil right,³ the first civil right to extend gender protections to healthcare (including protections for gender identity and sexual orientation discrimination),⁴ and the first civil right to broadly capture the private health insurance market,⁵ this provision represents progress for many different groups. With agency rules in development,⁶ advocacy groups are unsurprisingly turning to section 1557 as a basis for arguing for broader rights in healthcare financing and delivery.

Health insurers engage in conduct that may frequently be prohibited under section 1557. For instance, is it a permissible form of discrimination if an insurer fails to cover Sovaldi, the infamous \$84,000 Hepatitis C drug, or if the insurer limits availability to only the sickest Hepatitis patients?⁷ Can insurers pass some of the cost of expensive specialty drugs onto cancer or HIV patients through copays and deductibles?⁸ Can insurers network exclusively with providers who offer better reimbursement rates even if it means that cer-

² See Patient Protection and Affordable Care Act 42 U.S.C. § 18116(a) (2012). Section 1557 specifically applies Title VI of the Civil Rights Act, Pub. L. No. 88-352, 78 Stat. 241 (1964), The Education Amendments of 1972, Pub. L. 92-318, 86 Stat. 235 (1972) (“Title IX”), the Age Discrimination Act, Pub. L. 94-135, 89 Stat. 728 (1975), and the Rehabilitation Act, Pub. L. 93-112, 87 Stat. 355 (1973).

³ See Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 859 (2012).

⁴ See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,216 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92). Department of Health and Human Services (“DHHS”) proposes that sex discrimination cover: “pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity.” *Id.* The agency is also considering sexual orientation, but is taking comments about this prior to their finalization of the rule. *See id.* at 54,176.

⁵ *See id.* at 54,174 (stating that an “issuer participating in any Health Insurance Marketplace is receiving Federal financial assistance when advance payments of premium tax credits and/or cost sharing reductions are provided to any of the issuer’s enrollees”).

⁶ *See id.* at 54,172. The final rule was being finalized as this Article went to print; however, the final rule includes little substantive changes affecting the analysis and issues addressed in this Article.

⁷ *See generally* Soumitri Barua et al., *Restrictions for Medicaid Reimbursement of Sofosbuvir for the Treatment of Hepatitis C Virus Infection in the United States*, 163 ANNALS INTERNAL MED. 215, 215–16, 220 (2015) (discussing different state policies regarding reimbursements for Hepatitis C medication).

⁸ *See generally* Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace*, 372 NEW ENG. J. MED. 399, 400 (2015) (finding that a person with HIV in an adverse tier plan would pay \$3000 more annually); PHRMA, AN ANALYSIS OF EXCHANGE PLAN BENEFITS FOR CERTAIN MEDICINES 6 (June 2014), <http://www.phrma.org/affordable-care-act/coverage-without-access-an-analysis-of-exchange-plan-benefits-for-certain-medicines> (then download report as PDF) [<https://perma.cc/vTQ2-GYDE>] (finding similar tiering for cancer, rheumatoid arthritis, and diabetes).

tain patients do not have adequate access to specialty doctors and hospitals?⁹ Are wellness programs that shift costs from healthy employees onto unhealthy employees permissible?¹⁰ Are ACA provisions that make premiums far more expensive for older smokers permitted?¹¹ Can an insurer limit expensive services such as gender transition therapies?¹² These are all current scenarios where guidance about the limits of permissible insurance discrimination is unclear.

The ACA addressed discrimination in insurance through a number of provisions, mainly targeted at health status discrimination by private insurers.¹³ Despite the ACA's many successes,¹⁴ some forms of health insurance discrimination will persist. Section 1557 is another lens through which to examine the legal boundaries of health insurance discrimination because it extends beyond health status discrimination to protected class discrimination and health disparities. It reaches not just the private market but also public insurance—such as Medicare and Medicaid¹⁵—and many employer-sponsored insurance plans.¹⁶ It creates new remedies and forums for com-

⁹ See Robert Pear, *Lower Health Insurance Premiums to Come at Cost of Fewer Choices*, NY TIMES (Sept. 22, 2013), <http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html> [<http://perma.cc/XS6H-MQQA>].

¹⁰ See Jill R. Horwitz et al., *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468, 468 (2013).

¹¹ See Alex C. Liber et al., *Tobacco Surcharges on 2015 Health Insurance Plans Sold in Federally Facilitated Marketplaces: Variations by Age and Geography and Implications for Health Equity*, 105 AM. J. PUB. HEALTH S696, S696 (2015), <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302694> [<https://perma.cc/8HQY-7GJ6>].

¹² See NAT'L WOMEN'S L. CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 1 (2015), <http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf> [<https://perma.cc/EM4L-7KCT>].

¹³ See generally Patient Protection and Affordable Care Act § 2705, 42 U.S.C. § 300gg-4 (2012) (restricting insurers in discrimination in enrollment); Patient Protection and Affordable Care Act § 2701, 42 U.S.C. § 300gg (restricting insurers regarding discrimination in premiums); Patient Protection and Affordable Care Act § 2706, 42 U.S.C. § 300gg-5 (restricting insurers regarding discrimination in benefits).

¹⁴ See Stephanie Marken, *U.S. Uninsured Rate 11.9% in Fourth Quarter 2015*, GALLUP (Jan. 7, 2016), <http://www.gallup.com/poll/188045/uninsured-rate-fourth-quarter-2015.aspx> [<https://perma.cc/BYT6-P4RH>]. In the fourth quarter of 2015, the rate of uninsured was at 11.9% of the population. *Id.* This is compared with a rate of 16.7% in 2013 prior to the implementation of the major market reforms of the ACA. See *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Oct. 5, 2015), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population> [<https://perma.cc/DDU6-MA2Z>].

¹⁵ See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,171, 54,172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92). Section 1557 extends to all public programs that receive federal healthcare dollars like Medicare and Medicaid, with the exception of Medicare Part B (Medicare coverage for physician care). See *id.* at 54,172, 54,175 n.16 (“A health program or activity also includes all of the operations of a State Medicaid program.”).

¹⁶ See *id.* at 54,189.

plaints.¹⁷ Additionally, section 1557 applies a different framework, exploring health insurance discrimination through civil rights doctrine instead of regulation.

Many of the early section 1557 complaints and lawsuits have focused on ongoing acts of discrimination by health insurers,¹⁸ yet no legal scholarship has addressed section 1557 in this context.¹⁹ This Article is intended to aid courts, litigants, and policymakers who are currently faced with section 1557 challenges. The Article also initiates an academic dialogue about the promise and limitations of a civil rights remedy in health insurance. Though civil rights in health insurance are not altogether new (having applied to some public programs in the past),²⁰ they deserve renewed attention given that section 1557 is more expansive than prior protections (covering gender discrimination and private insurance discrimination). Moreover, these broader protections are the new normal, a response to increased federal subsidies in healthcare that are likely to continue in the future.²¹

The Article will proceed by first giving an overview of health insurance discrimination—why insurers discriminate and who is affected by the discrimination. Part Two will detail the various efforts by the ACA to combat health insurance discrimination, including section 1557 and the ACA provisions that reduce discrimination in premiums, enrollment, and benefits. Part Three will explore what the civil rights framework offers to health insurance discrimination, including how disparate impact and disparate treatment protections can reduce current examples of discriminatory conduct. Lastly, Part Four will describe doctrinal complications that may limit a civil rights ap-

¹⁷ See *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP'T HEALTH & HUMAN SERVS., OFFICE FOR CIVIL RIGHTS, <http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html> [<https://perma.cc/J3JW-YL3Q>].

¹⁸ See, e.g., *Cruz v. Zucker*, 116 F. Supp. 3d 334, 340 (S.D.N.Y. 2015) (challenge brought for access to gender transition therapies); *East v. La. Blue Cross and Blue Shield*, No. 3:14-CV-00115-BAJ, 2014 WL 8332136, at *3 (M.D. La. Feb. 24, 2014) (challenging the exclusion of Ryan White funds as payment for insurance premiums); *Complaint from NHeLP & The AIDS Institute to the Office of Civil Rights*, NHELP (May 29, 2014), <http://www.healthlaw.org/publications/browse-all-publications/HHS-HIV-Complaint#.VyOVeNqrLcs> [<https://perma.cc/J8KL-7BTN>] (arguing that drug-tiering of HIV drugs amounts to disability discrimination).

¹⁹ But see Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L.J. 2470, 2490–2513 (2015) (describing section 1557's effect on provider conscience provisions and gender); Watson, *supra* note 3 (addressing section 1557's role in fighting racial inequality in healthcare); Sarah G. Steege, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Healthcare*, 16 MICH. J. RACE & L. 439, 452–61 (2011) (discussing whether there is a private cause of action for disparate impact cases under section 1557).

²⁰ See *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. at 54,172; see also *infra* Section II.

²¹ The broadening of civil rights law into private markets is a direct effect of these entities receiving federal dollars. Regardless of the fate of the ACA, some form of federal subsidy is present in most models for health reform presented by both political parties.

proach to health insurance discrimination. This Part will address whether economic defenses to discrimination are permitted and whether a civil rights vision of formal equality can appropriately address the unique needs of vulnerable patient populations. The Article will conclude by positing that expanded civil rights in health insurance raise broader normative and theoretical questions that merit further exploration.

I. CHARACTERIZING HEALTH INSURANCE DISCRIMINATION

Section 1557 presents a new opportunity to explore the boundaries between lawful and unlawful health insurance discrimination. First, it is useful to briefly consider what discrimination means in the context of health insurance. Throughout this Article, I use the word *discriminate* to mean only that the conduct on the part of insurers treats one individual or group differently than another each time it makes a decision about limiting a benefit. A failure to decide to cover a new technology harms one group, but favors another whose benefits remain. I do not mean to suggest that all insurers' conduct is necessarily unfair or illegal, or in violation of either the Affordable Care Act ("ACA") antidiscrimination rules or civil rights law.²² A major challenge of discussing health insurance discrimination from a civil rights perspective is that discrimination is endemic in all health insurance: cuts will often be necessary. Indeed, an exercise of this Article will be, in part, to help define when this commonplace and even necessary conduct on the part of the insurer constitutes an illegal versus a permissible form of discrimination under the current legal framework. Whether certain types of health insurance discrimination should or should not be regulated or prohibited, from a *normative* stance, is a question for another article.

This Part will characterize the nature of discrimination in health insurance, exploring why insurers engage in discriminatory practices, who is affected by insurance discrimination, and what the consequences of that discrimination are to individuals and groups. Ultimately, it will provide some context for the competing interests that are at stake when antidiscrimination laws are applied to health insurance.

²² See generally Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism?*, 50 GA. L. REV. (forthcoming 2016) (noting the difficulty of the term "discrimination" as used in regards to health insurance); Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW 1 (2009), <http://www.rwjf.org/content/dam/farm/reports/reports/2009/rwjf36943> [<https://perma.cc/UUN6-RF3R>]; Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 80 (2005).

A. The Framework for Health Insurance Discrimination

Public insurance programs—such as Medicare and Medicaid—and private insurance (employer plans, small group, and individual insurers) both have some interest in limiting services, though to varying degrees and for varying purposes.²³ Public insurance programs aim to conserve taxpayer dollars and to limit the need for premium hikes, whereas private insurers seek to maintain a profit and also to keep premiums low so as to be more competitive with other insurers.²⁴

Limits on health insurance benefits can occur at several levels: enrollment (who is allowed to enroll), rate-setting (how much the covered party pays in premiums and in cost-sharing systems such as copays, deductibles, and coinsurance), the level of benefits (which benefits are covered, for whom, and at what level of cost-sharing), and at the micro-level (decisions about whether to cover an individual claim).²⁵ Limits in any of these categories and in either public or private insurance can be seen as discriminatory even if they are arguably necessary.

Civil rights lawsuits can play a role in both the private and public contexts. It is important to underscore, however, that these two markets are very different in both why and how they place limits on benefits. Public insurers have some interest in limiting healthcare usage.²⁶ Limits in this insurance typically take place on the macro level: whether to cover new benefits or to retain old ones, or whether to reduce the generosity of some aspect of the available benefit because of cost, medical efficacy, budgetary constraints, and other factors.²⁷ Public insurers are typically not able to discriminate based on who gets enrolled or specify the terms because the eligibility is often defined

²³ See Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 652–53 (2008) (comparing a European model of “sickness insurance” that addresses ill health with our U.S. system that covers the healthy and avoids the sick).

²⁴ See generally Jessica L. Roberts, “Healthism”: A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 U. ILL. L. REV. 1159, 1163 (observing that “charging insureds rates based on their relative risk and covering conditions based on their potential costs are exactly what allow health insurers to profit”).

²⁵ See Rosenbaum, *supra* note 22, at 6–7.

²⁶ See generally *Alexander v. Choate*, 469 U.S. 287, 287 (1985) (discussing a state Medicaid agency that sought to reduce coverage for inpatient hospital stays when “[f]aced with Medicaid costs beyond its budget”).

²⁷ See generally Jane E. Allen, *Two Dead Since Arizona Medicaid Program Slashed Transplant Coverage*, ABC NEWS (Jan. 6, 2011), <http://abcnews.go.com/Health/News/arizona-transplant-deaths/story?id=12559369> [<http://perma.cc/2AAN-EAWJ>] (discussing a high-profile instance of Medicaid rationing that occurred when Arizona considered a statewide budget cut for certain types of organ transplants). Though Arizona was facing a deficit and argued that it had selected transplants with poorer health outcomes, public outcry was significant, with the American Medical Association and other groups speaking out against the practice and the state backing down quickly from the policy choice. See *id.*

by statute; for example, all persons over age sixty-five are eligible for Medicare.²⁸

Discrimination in the private market presents larger concerns because profits are at stake and insurers have historically had broader freedom to discriminate (at least prior to enactment of the ACA).²⁹ For example, underwriting has been a primary model in this market.³⁰ Insurers extend or deny insurance and tailor both premiums and cost-sharing based on data about the health status and likely consumption of healthcare services of insured individuals.³¹ The underwriting function is more prominent in the small group and individual insurance markets where there is less ability to spread risk across the group.³² In large groups, insurers still assess the costs of individuals and of the group, but the cost is better predicted because of group size and the ability to spread that cost among the group rather than place it solely on the individual.³³

Both underwriting and limits on services are generally seen as necessary at least to some extent to control for market imperfections that, if left unregulated, could result in rising healthcare costs. One such challenge is adverse selection, a phenomenon whereby sick people are more likely to wait to purchase insurance until they need it, leaving fewer healthy people in the pool to

²⁸ See Rosenbaum, *supra* note 22, at 2. Rosenbaum discusses the continuing role of Medicaid, and notes:

In contrast to insurance markets, Medicaid coverage is available at the very point that serious health need arises. The law contains no eligibility exclusions for pre-existing conditions; many of its numerous eligibility categories are expressly designed to deal with coverage during illness; and states are required to provide for enrollment services in health care settings in order to enable enrollment at the point of health care need.

Id. (citations omitted).

²⁹ See Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS J. HEALTH L. & POL'Y 27, 27–28, 74–75 (2011) (noting that, prior to the implementation of the ACA, states had primary responsibility to regulate insurance, with exceptions for federal programs and for ERISA-regulated employer plans).

³⁰ See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 287 (1993).

³¹ See *id.* at 294–95. See generally Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 441 (2010) (explaining that conventional insurance inherently relies on underwriting to exclude bad risks and price according to risk profile).

³² See Crossley, *supra* note 22, at 84 (arguing that, while most people are covered by employer-sponsored insurance, “[t]he smaller the group for which coverage is purchased, however, the more likely a health insurer is to employ risk-classification devices so that small employers seeking to purchase coverage are more likely to encounter the use of underwriting, coverage, and pricing mechanisms”); Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 380 (2003) (observing the price differences between large group and small group/individual insurance).

³³ See Baker, *supra* note 32, at 380.

adjust for the costs of the sick.³⁴ Moreover, through moral hazard,³⁵ insureds are more likely to seek medical care once they have insurance. Because insureds are paying a monthly premium for insurance, they are no longer bearing the direct costs based on their individual healthcare consumption. Therefore, they are more likely to utilize more healthcare resources.³⁶ Without controlling for these issues, premiums will rise and lower-risk individuals will eventually find that the cost of insurance outweighs its benefits.³⁷ The healthy will leave the market and the sick will have no one to pool their risks with, creating a “death spiral” of ever-increasing premiums until, eventually, no-body can afford the product.³⁸

B. Populations Impacted by Health Insurance Discrimination

The unhealthy and those who face structural discrimination are frequent subjects of health insurance discrimination. These characteristics, while discrete, can often overlap. Health insurance discrimination frequently centers on the health status of the individual, particularly in those insurance markets that engage in underwriting.³⁹ Poorer health status may result in a greater need for healthcare services, which the insurer is incentivized to reduce.⁴⁰

Individuals or groups that are often subject to health insurance discrimination include those with bad health histories or preexisting conditions, those with a current illness (whether chronic or acute), those who may need extensive preventive care to stay well, or those with features that predict an unhealthy future (i.e., based on genetic history).⁴¹ It may also encompass those who desire expensive medical services but do not necessarily qualify or self-identify as having a medical condition, such as those who use infertility services and seek gender reassignment surgeries.⁴² Health status discrimination also includes those with bad luck and no control over their health status, as well as those with certain behaviors that correlate with bad health, such as tobacco use and obesity.⁴³

³⁴ See Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20 KAN. J.L. & PUB. POL'Y 237, 242 (2011).

³⁵ See Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 13 (1999). Moral hazard is an insurance theory that states that insureds consume more healthcare resources, once insured, than they would prior to being insured. See *id.*

³⁶ See *id.*

³⁷ See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 312–19 (1997) (discussing the future of insurance health care coverage).

³⁸ See Roberts, *supra* note 24, at 1165; Jacobi, *supra* note 37, at 317–19.

³⁹ See Crossley, *supra* note 22, at 74.

⁴⁰ See Rosenbaum, *supra* note 22, at 4; Crossley, *supra* note 22, at 76.

⁴¹ See Roberts & Leonard, *supra* note 22, at 14–19; Crossley, *supra* note 22, at 75 n.9.

⁴² See, e.g., Roberts & Leonard, *supra* note 22, at 15.

⁴³ See *id.* at 6.

Arguing against insurance discrimination becomes particularly controversial when discussing populations whose behavioral choices result in bad health.⁴⁴ Some may believe that discrimination is fair if the individual has contributed to or has control over his or her unhealthy conduct, as distinguished from the person with sheer bad luck.⁴⁵ But, it may be virtually impossible to draw a line between personal responsibility for health and a host of uncontrollable factors that might influence personal behavior,⁴⁶ such as genetics or income.⁴⁷

Although individual traits such as genetics and health behavior can impact health status discrimination, they account for only seventy percent of an individual's overall health.⁴⁸ The remaining thirty percent are the result of a combination of healthcare access and social and environmental factors related to health.⁴⁹ Social factors include “the structural determinants and conditions in which people are born, grow, live, work, and age,”⁵⁰ and extend to aspects of one's life that are linked to health, such as an ability to earn a living, consume safe drinking water, live in safe housing, have access to adequate food, and get an education.⁵¹ These factors play a significant role in the health of vulnerable groups. But, social discrimination and integration can also affect health status, as can access to health care—including insurance coverage, provider availability, cultural competency, and healthcare quality.⁵² When social determinants of health are not distributed equally because of structural

⁴⁴ See *id.* at 6–8.

⁴⁵ See *id.* (noting that discrimination law frequently differentiates between behaviors within and outside of the control of the individual). For example, safe drivers do not pay more for the accidents of unsafe drivers in car insurance, so why should this similar notion not also apply to health insurance?

⁴⁶ See *id.* The article states:

[T]here are certain situations in which the law properly should treat individuals differently based on choices that they freely and voluntarily make about their health to create an incentive to make better choices. At the same time, we want to carve out a set of health-related statuses, traits, conditions, or conduct that should be protected from disadvantaging treatment, regardless of their seeming voluntariness.

Id. at 7.

⁴⁷ See generally Youfa Wang & May A. Beydoun, *The Obesity Epidemic in the United States—Gender, Age, Socioeconomic, Race/Ethnic, and Geographic Characteristics: A Systematic Review and Meta-Regression Analysis*, 29 EPIDEMIOLOGIC REVS. 6, 6 (2007) (finding that obesity is tied to eating and exercise habits, which can be influenced by socioeconomics and geography).

⁴⁸ See HARRY J. HEIMAN & SAMANTHA ARTIGA, KAISER FAMILY FOUND., BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 2 (Nov. 2015), <http://files.kff.org/attachment/issue-brief-beyond-health-care> [https://perma.cc/U5UP-3BG7].

⁴⁹ See *id.*

⁵⁰ *Id.* (citing Michael Marmot et al., *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, 372 LANCET 1661, 1661–69 (2008)).

⁵¹ See HEIMAN & ARTIGA, *supra* note 48, at 2.

⁵² See *id.*

discrimination, health and healthcare disparities result.⁵³ For a difference across groups to rise to the level of a disparity, it typically requires a showing that the difference in health status is systemic, able to be altered through regulatory and policy changes, and involves past or present discrimination or marginalization.⁵⁴

Social determinants of health underscore the importance of a civil rights approach to addressing discrimination in health insurance.⁵⁵ Age,⁵⁶ race,⁵⁷ gender,⁵⁸ and disability⁵⁹ have all been linked to health and healthcare disparities,⁶⁰ but disparities are by no means limited to these groups.⁶¹ Socioeco-

⁵³ See Steven H. Woolf & Paula Braveman, *Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse*, 30 HEALTH AFF. 1852, 1857 (2011).

⁵⁴ See Michelle A. Meade et al., *The Intersection of Disability and Healthcare Disparities: A Conceptual Framework*, 37 DISABILITY & REHAB. 1, 3–4 (2014).

⁵⁵ See David R. Williams et al., *Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities*, 14 J. PUB. HEALTH MGMT. PRAC. S8, S8 (2008) (describing impacts of the Civil Rights Movement broadly on reducing health disparities among racial minorities).

⁵⁶ See Joel B. Teitelbaum, *Health Care and Civil Rights: An Introduction*, 15 ETHNICITY & DISEASE 27, 27 (2005) (arguing that patients over sixty-five experience under-treatment, are withheld surgery based on fear of bad outcomes, and are less likely to receive certain diagnoses than young patients). Healthcare can be withheld on the basis of age, because of bias about benefit and quality of life. See *id.* at 29.

⁵⁷ See CTR. FOR DISEASE CONTROL & PREVENTION, CDC HEALTH DISPARITIES AND INEQUALITIES REPORT—UNITED STATES, 2011, at 3 (2011); KAREN SCOTT COLLINS ET AL., COMMONWEALTH FUND, DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS 5 (Mar. 2002), http://www.commonwealthfund.org/usr_doc/collins_diversecommun_523.pdf [<https://perma.cc/BS7B-8QZC>]. Racial minorities are less likely, both adults and children, to have a regular source of medical care like a primary physician, are more likely to use emergency rooms, and are sometimes twice as likely to be hospitalized for preventable conditions. See CTR. FOR DISEASE CONTROL & PREVENTION, *supra*, at 1.

⁵⁸ See RUTH ROBERTSON & SARA R. COLLINS, COMMONWEALTH FUND, WOMEN AT RISK: WHY INCREASING NUMBERS OF WOMEN ARE FAILING TO GET THE HEALTH CARE THEY NEED AND HOW THE AFFORDABLE CARE ACT WILL HELP 1 (May 2011), <http://www.commonwealthfund.org/publications/issue-briefs/2011/may/women-at-risk> (then download report as PDF) [<http://perma.cc/5H7B-SLLR>]. Women generally have greater problems with access on a variety of measures than men. See *id.* at 4 tbl.3.

⁵⁹ See *Disability and Health*, HEALTHY PEOPLE 2020, <http://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health> [<https://perma.cc/V7AX-779U>]; CTR. FOR DISEASE CONTROL & PREVENTION, *supra* note 57, at 3. People with disabilities tend to have a greater chance of delays and difficulties in receiving medical care, higher rates of cigarette smoking, obesity, and high blood pressure, lower rates of appropriate breast cancer screening and PAP testing, lower rates of physical activity, higher rates of psychological stress, lower employment rates, and less social support. See *Disability and Health*, *supra*.

⁶⁰ See Meade et al., *supra* note 54, at 1–2. For the purposes of this article, I define health disparities as differences in health, not necessarily confined to access to care, but influenced by “culture, life style, socioeconomic status, and accessibility of resources.” See *id.* at 1. Healthcare disparities are a “subset of health disparities that reflect differences in access to and quality of

nomics, where one lives, mental health status, and even religious and political affiliations can play a role in one's overall health.⁶² Health disparities put these groups at higher risk for health status discrimination by insurers.⁶³ Though not considered directly by section 1557, health status,⁶⁴ history of domestic violence⁶⁵ and other features have also contributed to health status discrimination.

C. The Consequences of Health Insurance Discrimination

Health insurance discrimination can cause harm in many different ways, the most obvious being the physical and financial effects felt by groups that lack access to health insurance. Discrimination that leads to certain individuals and groups being left uninsured or underinsured, however, can lead to wider negative societal effects. This section discusses the health and social consequences experienced both by discrete groups and by society as a whole, as well as the distributive justice challenges of health insurance discrimination.

healthcare and can be viewed as the inability of the healthcare system to adequately address the needs of specific population groups." *Id.*

⁶¹ See generally Ichiro Kawachi et al., *Health Disparities by Race and Class: Why Both Matter*, 24 HEALTH AFF. 343, 343–44 (2005) (arguing that race plays a role in some disparities); DEP'T OF HEALTH & HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES 1, http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf [https://perma.cc/X2QK-C4KS] (discussing the disparities caused by race and ethnicity).

⁶² See DEP'T OF HEALTH & HUMAN SERVS., *supra* note 61, at 2. Likelihood of premature death in the United States goes down as income increases, while lower education levels correlate directly with income, smoking, and shorter life expectancy. HEIMAN & ARTIGA, *supra* note 48.

⁶³ See generally Crossley, *supra* note 22, at 76 (describing how health status affects insurability).

⁶⁴ See Jon R. Gabel et al., *More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014*, 31 HEALTH AFF. 1 (June 2012); Wendy K. Zellers et al., *Small-Business Health Insurance: Only the Healthy Need Apply*, 11 HEALTH AFF. 174, 175 (1992) (performing an empirical analysis of challenges for obtaining health insurance for small businesses in which preexisting condition was a primary barrier). A study conducted prior to the implementation of ACA market reforms showed that, in 2010, more than half of individual insurance plans would not meet new market regulations in force for 2014. Gabel et al., *supra* at 1. The average family in private plans paid \$4253 out of pocket in "tin" plans (valued at less than sixty percent actuarial value), while the sickest families (the top one percent of consumers of medical resources for that year) in these same plans paid \$15,346. *Id.* at 4. Again in the tin plan, ninety-four percent of people had a deductible with the average amount being \$5376 for single persons. *Id.*

⁶⁵ See Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C. R.-C. L. L. REV. 355, 360–61 (1997) ("Insurers and their defenders claim that because the battered woman is responsible for the increased risk of injury she faces, she justifiably may be denied health insurance coverage."); Ryan Grim, *When Getting Beaten by Your Husband Is a Pre-existing Condition*, HUFFINGTON POST (Nov. 14, 2009), http://www.huffingtonpost.com/2009/09/14/when-getting-beaten-by-yo_n_286029.html [https://perma.cc/TB8Z-72QP].

1. Discrimination as a Harm unto Itself

Some forms of discrimination can be seen as a wrong unto itself, apart from any harm they cause. Prominent constitutional law scholar Larry Alexander and others have committed significant work to the broader topic of what makes certain types of discrimination inherently wrong.⁶⁶ Alexander has argued that discrimination may be inherently wrong if it is based on bias or inaccurate measures of social worth.⁶⁷ He added that discrimination can be viewed as a wrong to the extent it feeds on or supports residual notions of bias against a particular group, or to the extent it systematically disadvantages a whole population rather than an individual.⁶⁸

Using Alexander's framework, discrimination in health insurance, even that which disadvantages the unhealthy, may be viewed as less concerning than other forms of discrimination. Health insurance discrimination can be framed as not being based on bias or inaccuracy, but rather on an accurate depiction of that individual or group's actuarial risk over that of another.⁶⁹ From this perspective, health insurance discrimination can be seen as a mainly economic enterprise—profit-driven in some cases, fund-preserving in others. It can be characterized, particularly in private insurance, as empirics-driven rather than bias-driven.

Some scholars note, however, that discrimination by insurers can reflect the social worth of a given population, similar to discrimination in other contexts.⁷⁰ Insurers' decisions about which benefit to cut or which group to impose higher premiums on are ultimately a tradeoff between helping one group and harming another.⁷¹ For example, an insurer might choose not to cover a new, life-saving cure for Hepatitis C patients, but continue to pay for a high-cost cancer therapy.⁷² These tradeoffs can be laden with value judgments about the quality of life, the social worth, and the deservedness of some groups when compared to others.⁷³ Moreover, to the extent that discrimination is wrong because it disadvantages a whole population, health insurance discrimination is problematic when it underwrites based on the assumptions

⁶⁶ See Larry Alexander, *What Makes Wrongful Discrimination Wrong? Biases, Preferences, Stereotypes, and Proxies*, 141 U. PA. L. REV. 149, 153 (1992).

⁶⁷ See *id.* at 159, 169.

⁶⁸ See *id.* at 159.

⁶⁹ See Stone, *supra* note 23, at 653–54.

⁷⁰ See Elizabeth Pendo, *Shifting the Conversation: Disability, Disparities and Health Care Reform*, 6 FLA. INT'L L. REV. 87, 92–93 (2011) (describing differences in access to care for persons with disabilities as partly due to “stereotypes, false beliefs and invisibility”).

⁷¹ See *id.* at 91–93.

⁷² See *id.*

⁷³ See *id.*

of the health of the group as a whole and not the individual.⁷⁴ In so doing, it may create or sustain health and healthcare disparities.

Health insurance discrimination poses concrete harms in that it may affect an individual's ability to access affordable medical care. But the experience of discrimination itself can also be seen as a harm if it is influenced by stigma, bias, or views of social worth.

2. Distributive Justice and Health Insurance

Regardless of whether any single act of health insurance discrimination is seen as an inherent wrong that is shaped by bias, an economic decision, or both, it nonetheless poses a fundamental distributive justice question. Taking into account the diversity of an insurance community mixed with healthy and sick individuals, the goal must be to allocate healthcare resources in the most just manner. Deborah Stone has famously argued that health insurance is a struggle over two ideologically opposed visions of fairness: actuarial fairness and social solidarity.⁷⁵ The current system has favored actuarial fairness: that it is more fair to discriminate based on the individual's risk.⁷⁶ This way, the healthy do not unfairly have to pay for the costs of the sick.⁷⁷ Social solidarity, as a counterpoint, calls for society to pool the risks of the sick so that everyone shares equally in the burden of disease.⁷⁸ Its broad goal is to allocate medical care according to need, not according to the ability to pay.⁷⁹ The solidarity principle recognizes that medical care will not be "distributed equally, in the sense that everyone gets the same amount."⁸⁰ Instead, people take "their chances that they may never become sick or need expensive care, and that most of their contributions will go to help the members who do need expensive care."⁸¹

Advocates of actuarial fairness argue that it is unfair to put the higher cost of the sick onto the healthy.⁸² This is seen as particularly true when some element of the ill health is considered to be in the control of the individual.⁸³ Opponents of actuarial fairness distinguish healthcare as fundamentally different from other insurance products because of its relationship to health, well-being, and social and civic engagement, and because individuals often

⁷⁴ See *id.*

⁷⁵ See Stone, *supra* note 30, at 287.

⁷⁶ See *id.*

⁷⁷ See *id.* at 293.

⁷⁸ See *id.* at 290–91.

⁷⁹ See *id.* at 291.

⁸⁰ *Id.* at 292; see Crossley, *supra* note 22, at 79.

⁸¹ Stone, *supra* note 30, at 292. Crossley has succinctly captured this dichotomy as the battle between "every man for himself" versus "one for all and all for one." Crossley, *supra* note 22, at 80.

⁸² See Stone, *supra* note 30, at 293.

⁸³ See Roberts & Leonard, *supra* note 22, at 22.

lack agency over their health status.⁸⁴ Even where some element of behavior is involved, proponents may argue that individuals have less control over behaviors than society thinks because of socioeconomic conditions.⁸⁵

Stone notes that underwriting, as a practice, emphasizes the differences of individuals in terms of specific risks across discrete, select populations rather than the similarities in that every person is, in some way, fallible and vulnerable to risk.⁸⁶ She sees this separating into different camps of risk as one of the ways in which the focus has ultimately strayed, ideologically, from social solidarity.⁸⁷ Although early health insurance in this country reflected greater notions of mutual aid, this was in more homogenous populations where individuals may have seen their likelihood of risk as equivalent.⁸⁸ Broad health disparities across different groups could feed an unwillingness to pool risks, which could potentially underscore existing disparities for marginalized groups.⁸⁹ As Stone notes, failure to include the unhealthy in the insurance pool is an intentional act on the part of insurers, society, and lawmakers.⁹⁰ Thus, Stone argues that it is imperative to cabin certain forms of discrimination in the health insurance market to greater control fairness of health benefits across the population.⁹¹

Ultimately, Stone is driving at a larger question—not just of health insurance—but of health equity. Health equity requires that every individual have the equal opportunity to “attain their full health potential” while no one is “disadvantaged from achieving this potential because of their social posi-

⁸⁴ See *id.*

⁸⁵ See, e.g., Roberts & Leonard, *supra* note 22, at 42.

⁸⁶ See Stone, *supra* note 30, at 298–99.

⁸⁷ See *id.*

⁸⁸ See *id.* at 299. Early origins of insurance in our country more closely reflected concepts of mutual aid. Early insurance typically involved laborers (or their employers) where each paid an equal premium to be assured a certain amount of access to hospitals and physicians. It may have been supported to a certain extent by the fact that individuals felt equally inclined to the same risks. Even then, however, the model was critiqued for shifting costs of the old onto the young. British “Friendly Societies” were fraternal societies that combined member donations to fund life and health insurance for their members. See Baker, *supra* note 32, at 383. However, young members complained that their funds subsidized older members and that, without proper fund management, there would be no remaining funds left when they aged into requiring them. See *id.* at 384.

⁸⁹ See Stone, *supra* note 30, at 293. In a country where there is a thirty-five year gap between those anticipated to live the longest based on race and county of residence and those expected to live the shortest, it is perhaps unsurprising that there is an unwillingness of some to pool the risks of the others. Christopher J. L. Murray et al., *Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States*, 3 PLOS MED. 1 (Sept. 2006). The difference in life expectancy was so strongly delineated based on race, geography, population density, income, and homicide rate that the authors titled the article “the eight Americas” to express how strongly one’s quality and quantity of life depends on these factors. See *id.*

⁹⁰ See Stone, *supra* note 30, at 293.

⁹¹ See *id.* at 292.

tion or other socially determined circumstance.”⁹² An inequitable system means that individuals’ different health levels are caused by a systematic and unjust distribution of resources that is socially-determined and avoidable.⁹³ To the extent that health insurance discrimination is influenced by *social circumstances* of the group or individual, this discrimination may be said to contribute to greater health inequity, even as it might also be seen as necessary to maintain the function of health insurance.⁹⁴

3. Physical and Financial Harms to Individuals

Some health disparities persist even when people have access to health insurance. Attaining insurance does not guarantee that an individual will make adequate use of the benefits, nor will it eliminate the discrimination that individuals may face in healthcare delivery.⁹⁵ Alternatively, being uninsured does not necessarily mean an individual will be barred from all medical care.⁹⁶ However, health insurance is typically viewed as necessary for regular access to preventive healthcare and treatment, and to shield oneself from medical debt.⁹⁷ Health providers can refuse to treat the uninsured and under-

⁹² LAURA K. BRENNAN RAMIREZ ET AL., CTR. FOR DISEASE CONTROL & PREVENTION, PROMOTING HEALTH EQUITY: A RESOURCE TO HELP COMMUNITIES ADDRESS SOCIAL DETERMINANTS OF HEALTH 6 (2008), <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf> [<https://perma.cc/4UHE-GTAM>]. Paula Braveman has added to this definition, that health equity means no one is denied the prospect of good health because of their belonging to a group that is historically or social disadvantaged. See Paula Braveman, *What Are Health Disparities and Health Equity? We Need to Be Clear*, 129 PUB. HEALTH REPORTS 5, 6 (2014).

⁹³ See KAISER FAMILY FOUND., DISPARITIES IN HEALTH AND HEALTHCARE: FIVE KEY QUESTIONS AND ANSWERS 2 (2012), <http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-healthcare-five-key-questions-and-answers> [<https://perma.cc/5V3T-MFRG>]; RAMIREZ ET AL., *supra* note 92, at 6.

⁹⁴ See RAMIREZ ET AL., *supra* note 92, at 10.

⁹⁵ See Jane Zhu et al., *Massachusetts Health Reform and Disparities in Coverage, Access and Health Status*, 25 J. GEN. INTERNAL MED. 1356 (2010) (discussing health disparities in Massachusetts). Studies of health care disparities in Massachusetts after the 2006 reform suggest that, although insurance rates rose in minority populations, the greater insurance rate appeared to have no effect on health disparities. See *id.* While health insurance generally improves health status, in the Massachusetts context there was no increased access to a personal physician, which may have contributed to the ongoing disparities. See *id.* at 1359. Other studies support the idea that insurance improves access to treatment and prevention for certain chronic diseases but not all diseases. See Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 N. ENG. J. MED. 1713, 1721 (2013).

⁹⁶ See KAISER FAMILY FOUND., *supra* note 14, at 6. They may be able to receive emergency care and may even have some care reimbursed through charity measures. See *id.*

⁹⁷ See RACHEL GARFIELD & KATHERINE YOUNG, THE KAISER FAMILY FOUND., HOW DOES GAINING COVERAGE AFFECT PEOPLE’S LIVES? ACCESS, UTILIZATION, AND FINANCIAL SECURITY AMONG NEWLY INSURED ADULTS 12, 15 (June 2015), <http://kff.org/health-reform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults> [<https://perma.cc/WV4F-DPLL>]. One study showed only twenty-seven percent of the

insured, leaving them only able to seek emergency care at their own expense.⁹⁸ The uninsured are more likely, in turn, to miss diagnoses of serious medical conditions⁹⁹ and to experience unnecessary hospitalizations.¹⁰⁰ As a result, the uninsured have higher rates of mortality than the underinsured.¹⁰¹

Additionally, the uninsured and underinsured are at greater risk of financial insecurity.¹⁰² While nine percent of the uninsured had to declare bankruptcy in 2014, only four percent of the insured had to do so.¹⁰³ Credit rating is affected as well. In 2014, forty-eight percent of the uninsured received a low credit rating, as compared to only twenty-nine percent of the insured.¹⁰⁴ Underinsurance can also be of significant financial consequence.¹⁰⁵

A lack of insurance differentially affects certain protected classes for a combination of reasons, including structural discrimination, income, and other factors.¹⁰⁶ Minorities and lower income people are most likely to be uninsured or underinsured.¹⁰⁷ Moreover, women are less likely to have insurance through their employers,¹⁰⁸ are more likely to have medical debt and to miss

uninsured received preventive care in 2014 when compared with sixty-five percent of insured adults. *See id.* at 12.

⁹⁸ *See* KAISER FAMILY FOUND., *supra* note 14, at 6.

⁹⁹ *See generally* INST. OF MED., HEALTH INSURANCE IS A FAMILY MATTER 8, 96–97 (2002) (explaining the negative experiences that the uninsured have with the health care system).

¹⁰⁰ *See id.*

¹⁰¹ *See* INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 8 (2009).

¹⁰² *See* LIZ HAMEL ET AL., THE KAISER FAMILY FOUND., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY 1 (Jan. 5, 2016), <http://kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors> [<https://perma.cc/EUR2-JWXX>].

¹⁰³ *See* COMMONWEALTH FUND, PROBLEMS OF UNDERINSURANCE (2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/pdf_collins_problem_of_underinsurance_exhibits.pdf [<https://perma.cc/HD62-R9W9>].

¹⁰⁴ *See id.*

¹⁰⁵ *See* Paul D. Jacobs & Gary Claxton, *Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans*, 27 HEALTH AFF. W214, W214 (2008). One study found distinct differences in the amount of assets held by insured versus uninsured households, with many uninsured households not having enough assets to pay for cost-sharing requirements. *Id.* “For households with one uninsured member, less than half had sufficient gross financial assets to meet the minimum HSA-related deductible, only about one-third could meet the average deductible reported for nongroup plans, and less than one-fourth could meet the maximum out-of-pocket limit permitted by law.” *Id.* at W219. Bad health can only heighten the need to consume healthcare, which can further raise costs.

¹⁰⁶ *See, e.g.,* Marsha Lillie-Blanton & Catherine Hoffman, *The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Health Care*, 24 HEALTH AFF. 398, 400 (2005). Related issues include less likelihood of obtaining a job that offers employer-sponsored insurance and inability to obtain insurance because of citizenship status. *See id.* at 400–02.

¹⁰⁷ *See* CTR. FOR DISEASE CONTROL & PREVENTION, *supra* note 57, at 35. In 2004 and 2008, two in five Hispanics and one in five African Americans were uninsured. *See id.*

¹⁰⁸ *See* KAISER FAMILY FOUND., WOMEN'S HEALTH INSURANCE COVERAGE 1 (Dec. 10, 2014), <http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet> [<https://>

necessary care than men,¹⁰⁹ and continue to be likely to pay more for insurance even after ACA reforms.¹¹⁰ The disabled and the elderly may be differentially impacted by health status discrimination and by market innovations that push cost onto the chronically ill.¹¹¹ Ultimately, discrimination by health insurers can further entrench disparities because healthcare becomes costlier and less available for those who most need it.

Some scholars would emphasize unequal treatment in healthcare delivery as a more significant contributor to health disparities.¹¹² They argue that, even if access to health insurance is equal, this may not remove the bias and implicit racism, or even the language barriers, that affect the ability of some individuals to obtain quality medical care.¹¹³ This issue is also ripe for section 1557 lawsuits and future research should tackle these issues.¹¹⁴

4. Social Participation

Unhealthy individuals may be unable to live a full life that enables meaningful social and civic engagement.¹¹⁵ Philosopher Norm Daniels has argued that the value of healthcare is not only an end to itself, but also a means for individuals to engage more in society.¹¹⁶ An ill individual who

perma.cc/ZMX7-QDV7]. They are also more likely to have insurance as a dependent, which may increase instability if they divorce or become widowed. *See id.*

¹⁰⁹ *See* ROBERTSON & COLLINS, *supra* note 58, at 5–8. Women are more likely to report missing necessary care because of cost than men. *See id.* at 2.

¹¹⁰ *See* Robert Pear, *Gender Gap Persists in Cost of Health Insurance*, N.Y. TIMES (Mar. 19, 2012), http://www.nytimes.com/2012/03/19/health/policy/women-still-pay-more-for-health-insurance-data-shows.html?_r=0 [<http://perma.cc/J3L9-EKKL>]. Gender gaps in insurance persist post-ACA, for example a thirty-year old woman pays thirty-one percent more for a health plan than a man in Chicago. *See id.*

¹¹¹ *See, e.g.*, CTR. FOR DISEASE CONTROL & PREVENTION, *COST AS A BARRIER TO CARE FOR PEOPLE WITH DISABILITIES*, http://www.cdc.gov/ncbddd/disabilityandhealth/documents/cost_barrier-tip-sheet--_phpa_1.pdf [<https://perma.cc/5JNQ-XU7K>]. People with disabilities are more likely to report cost as being a barrier to care than people without disabilities in every state in the country. *See id.*

¹¹² *See* William H. Frist, *Overcoming Disparities in U.S. Health Care*, 24 HEALTH AFF. 445, 447–49 (2005) (acknowledging this divide).

¹¹³ *See id.* at 446–47.

¹¹⁴ *See, e.g.*, *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (a female-to-male transgender man alleging discrimination on the basis of gender when providers allegedly subjected him to embarrassing questions, harmful delays in care, disparaging comments about his hormone therapies, and painful genital examinations that continued despite the request of the patient that they stop). A number of complaints about gender discrimination in healthcare delivery have also already been addressed by the Office for Civil Rights. *See OCR Enforcement Under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/civil-rights/for-individuals/section-1557/ocr-enforcement-section-1557-aca-sex-discrimination/index.html> [<https://perma.cc/4NFL-JEHT>].

¹¹⁵ *See* Norman Daniels, *Justice, Health, and HealthCare*, 1 AM. J. BIOETHICS 2, 2 (2001).

¹¹⁶ *See id.* at 3.

does not receive medical care may be confined to his or her home and, as a result, may not be able to obtain employment or to engage in civic life, such as through voting. This is often raised as the primary reason for why universal healthcare ought to be supported in society.¹¹⁷ It is also often seen as the primary purpose for many civil rights laws—to enable members of society who might otherwise be subjugated to be treated as equals through participation. Even civil rights laws that involve accommodation, such as the Americans with Disabilities Act (“ADA”), emphasize enabling the disabled to participate in society.¹¹⁸ For these reasons, physical accommodations (i.e., ramps) have been emphasized over medical benefits (i.e., rehabilitation) to facilitate full social participation.¹¹⁹

5. Costs to the Broader System

Health insurance discrimination may also influence broader economic interests of society. Various types of discrimination by insurers might be seen as a way of keeping insurance costs low through market competition. The ACA adopts the model of managed competition set forth by economist Alain Enthoven’s famous article on the topic.¹²⁰ In essence, Enthoven argues that competition is desirable in healthcare, but that it must be managed or regulated to achieve maximum efficiency.¹²¹ To eliminate discrimination against the unhealthy, Enthoven suggests a variety of weights to rein in the market.¹²² Many of these antidiscrimination techniques were adopted by the ACA. For example, it established a community rating so that the same premium is paid despite health status¹²³ and forbids exclusions based on preexisting conditions.¹²⁴

Healthcare discrimination results in additional costs to the healthcare system. Apart from the toll of human suffering, health disparities and illness can not only directly affect medical expenses, but they can also have indirect costs, such as loss of productivity. One research team suggest that eliminating health disparities for minorities (African Americans, Asians, and Hispanics)

¹¹⁷ *See id.*

¹¹⁸ *See* Americans with Disabilities Act (ADA), 42 U.S.C. § 12202(c) (2012); Ani B. Satz, *Disability, Vulnerability, and the Limits of Antidiscrimination*, 83 WASH. L. REV. 513, 515 (2008) (explaining this distinction as a difference between civil rights laws that emphasize equality of treatment with a welfare model that emphasizes benefits for disabled individuals).

¹¹⁹ *See id.* at 515–16.

¹²⁰ *See generally* Alain Enthoven, *The History and Principles of Managed Competition*, 26 HEALTH AFF. 24, 29 (1993) (describing managed competition).

¹²¹ *See id.* at 30–31.

¹²² *See id.*

¹²³ *See* Patient Protection and Affordable Care Act, § 2701, 42 U.S.C. § 300gg (2012) (prohibiting discriminatory premium rates).

¹²⁴ *See id.* §§ 2702–2705.

through equitable health insurance and other measures would have saved \$229.4 billion in direct medical expenditures over a three-year period.¹²⁵ Direct costs (i.e., illness) and indirect costs (i.e., loss of productivity) of disparities, as well as premature death for individuals in these minority groups, added up to \$1.24 trillion in costs over three years.¹²⁶ Uncompensated care related to the uninsured cost \$84.9 billion in 2013, of which the federal government paid \$53.3 billion and the states paid \$19.8 billion.¹²⁷

Regulating health insurance discrimination is a balancing act. Some amount of freedom by insurers to limit benefits may be seen as necessary in health insurance to control for market imperfections, to control for healthcare costs, and to promote competition.¹²⁸ Through this particular lens, health insurance discrimination may be characterized as economically rational and unbiased to the extent it functions solely in that capacity. Some would argue, however, that health insurance benefit decisions inevitably involve some amount of bias, as the insurer must decide who to favor among a variety of groups. For example, they may consider whether to cover heart therapies but not HIV drugs, or fertility treatment but not gender transition.¹²⁹ Moreover, to the extent benefit decisions equate with problems accessing needed medical care, society may end up footing the bill. And for groups subject to structural discrimination and health disparities, health insurance discrimination may perpetuate these harms and pose foundational health equity issues about just distribution of health benefits.

II. EFFORTS BY THE ACA TO ADDRESS HEALTH INSURANCE DISCRIMINATION: ANTIDISCRIMINATION AND CIVIL RIGHTS

The Affordable Care Act (“ACA”) places restrictions on many of the health insurance practices that result in the inequities and disparities discussed in the prior section. It not only includes many antidiscrimination provisions targeted at health insurance, but it utilizes section 1557 as another tool to examine which practices in health insurance discrimination are or are not legally permitted. A broad inventory of prior efforts to tackle health insurance

¹²⁵ See Thomas A. Laveist et al., *Estimating the Economic Burden of Racial Inequalities in the United States*, 41 INT’L J. HEALTH SERV. 231, 233 (2011).

¹²⁶ See *id.* at 235.

¹²⁷ See TERESA A. COUGHLIN ET AL., THE KAISER FAMILY FOUND., UNCOMPENSATED CARE FOR THE UNINSURED IN 2013: A DETAILED EXAMINATION 3–4 (2014), <http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination> [https://perma.cc/37K8-7BNJ]. Patients themselves paid \$25.8 billion and the private sector paid \$0.7 billion. See *id.* at 1.

¹²⁸ See *supra* Part I.A.

¹²⁹ See Pendo, *supra* note 70, at 92–93.

discrimination is beyond the scope of this article, but civil rights laws,¹³⁰ other federal laws,¹³¹ and state laws¹³² have all made some efforts to protect various populations or to prohibit certain forms of discriminatory conduct in healthcare. No other laws have been as comprehensive in addressing health insurance discrimination as the ACA.¹³³

A. The ACA's Antidiscrimination Provisions

The greater part of ACA antidiscrimination measures address health status discrimination in the small group and individual markets where health insurance discrimination has been the most prevalent. The ACA protections relate to enrollment and cost-shifting, allocation of benefits, and micro-level discrimination.

1. Enrollment and Cost-Shifting

Prior to the enactment of the ACA, insurers were not merely permitted, but incentivized, to avoid covering the healthcare costs of the unhealthy by refusing to enroll them in insurance plans.¹³⁴ The ACA limits this discrimination by requiring both large and small group insurers, as well as individual insurers, to guarantee access to,¹³⁵ and the renewability of, insurance.¹³⁶ As a result, these insurers are no longer permitted to exclude enrollees from their

¹³⁰ See The Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (2008); The Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008); The Pregnancy Discrimination Act of 1978, Pub. L. 95-555, 92 Stat. 2076 (1978); Public Health Service Act, ch. 373, 58 Stat. 682 (1944). Title VI has long been viewed as applying to public insurance programs such as Medicare and Medicaid. See Rosenbaum, *supra* note 22, at 8; Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y L. & ETHICS 215, 215-19 (2003).

¹³¹ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (requiring insurers in the individual and small group to accept any small group and to guarantee issue of insurance to individuals with no more than a sixty-three day gap in coverage).

¹³² See Crossley, *supra* note 22, at 75. Generally, states often forbid considerations of certain features in actuarial calculations, for example race or experience with domestic violence. See *id.* at 85, 103. States typically did not forbid private insurers from categorizing on the basis of sex, age, disability, or health status. See *id.* at 74, 88, 92-93, 98. A minority of states required community rating in insurance policies. See *id.* at 75.

¹³³ See Jost, *supra* note 29, at 27 (arguing that the ACA is the most comprehensive effort to regulate health insurance discrimination).

¹³⁴ See Rosenbaum, *supra* note 22, at 1.

¹³⁵ See Patient Protection and Affordable Care Act, § 2702, 42 U.S.C. § 300gg-1 (2012). Insurers are allowed to restrict enrollment to specific open enrollment and special enrollment periods. See *id.*

¹³⁶ See Patient Protection and Affordable Care Act, § 2703, 42 U.S.C. § 300gg-2 (2012).

insurance plans on the basis of preexisting conditions¹³⁷ or a host of other related factors such as health status, physical or mental condition, claims history (the number of claims per patient), medical history, use of health care, genetic information, disability, or other evidence of, or factors related to, insurability (i.e., history of domestic abuse).¹³⁸ To avoid indirect discrimination, the ACA forbids advertisements by small group and individual health insurers that discourage enrollment of individuals with “significant health needs.”¹³⁹

Insurers also discriminate through cost-sharing or high premiums that discourage enrollment of the unhealthy or shift costs onto them.¹⁴⁰ The ACA limits cost-sharing (copays, deductibles, coinsurance) with caps on out-of-pocket expenses and deductibles,¹⁴¹ and imposes bans on lifetime limits.¹⁴² Furthermore, the ACA prohibits discrimination in premium charges by individual and small group insurers with some exceptions based on age, smoking status, family size, and geographic region.¹⁴³ Group and individual insurers are also allowed to vary premiums based on participation in employer wellness programs with some limits to protect against overt discrimination of the sick.¹⁴⁴ The ACA reduces any incentives for insurers to price-discriminate by limiting the amount of premiums insurers can keep for profit.¹⁴⁵ The ACA also calls for redistribution of profits across insurers, readjusting from those

¹³⁷ See Patient Protection and Affordable Care Act, § 2704, 42 U.S.C. § 1396(a) (2012).

¹³⁸ See Patient Protection and Affordable Care Act, § 2705, 42 U.S.C. § 300gg-4.

¹³⁹ See Patient Protection and Affordable Care Act, § 1311(c)(1)(A), 42 U.S.C. § 18031 (2012).

¹⁴⁰ See Rosenbaum, *supra* note 22, at 3.

¹⁴¹ See *Affordable Care Act Implementation FAQs - Set 12: Limitations on Cost-Sharing Under the Affordable Care Act*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html [<https://perma.cc/3M78-66AN>].

¹⁴² See Patient Protection and Affordable Care Act, § 2711(a), 42 U.S.C. § 1315(a) (2012).

¹⁴³ See CTR. FOR MEDICARE & MEDICAID SERV., OVERVIEW: FINAL RULE FOR HEALTH INSURANCE MARKET REFORMS 1–4 (2013), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf> [<https://perma.cc/56RG-WZW2>]. Age can vary by three to one for adults, meaning that the oldest adult covered cannot be charged more than three times the price of the youngest adult. See *id.* at 1–2. Tobacco users can be charged one and a half times as much as non-users. See *id.* at 2–3. Notably, allowance for variation in premiums in these categories may contribute to health disparities. See Roberts, *supra* note 24, at 1188.

¹⁴⁴ See Patient Protection and Affordable Care Act § 2705j, 42 U.S.C. § 300gg-5 (2012).

¹⁴⁵ See Patient Protection and Affordable Care Act § 2718(b), 42 U.S.C. § 300gg-18 (2012). Medical loss ratios control how much an insurer can keep as profit. The amount varies between fifteen to twenty percent depending on the type of insurance. Thus, insurers should have less incentive to avoid spending premium dollars, as they can only keep a certain percentage anyway. However, insurers do still have an incentive to keep premiums low if they can better compete for business. See Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J. L. SCI. & TECH. 63, 74, 77 (2015).

who better avoided the unhealthy to those who carried greater risk.¹⁴⁶ Finally, because the individual mandate requires everyone to purchase insurance or pay a penalty regardless of how often they access health services, it guarantees that the cost of covering the sick is spread across the entire population.¹⁴⁷

These provisions notably do not eliminate all forms of price discrimination. The statute itself permits some discrimination in premiums.¹⁴⁸ Insurers are also free to design benefits to make full use of the annual out-of-pocket limits, meaning they can shift as much as \$13,700 of a family's medical expenses in a given year back onto the insured.¹⁴⁹ For example, insurers often implement drug copays for expensive prescriptions.¹⁵⁰ Moreover, there is no clear penalty for an insurer who violates any of these provisions, except that, if caught, it may be prohibited from offering insurance plans on the exchange.¹⁵¹ Although insurers have the choice to abstain from selling plans on the exchange, insureds are only eligible for government subsidies if they purchase within the exchange. Therefore, many insurers must rely on the exchange market. Insurers might also avoid these laws by selling only certain types of insurance, such as solely selling large group plans and avoiding small group and individual insurance plans. Ultimately, however, most insurers are not likely to change their business models to avoid civil rights laws.

2. Benefits

Healthcare discrimination also occurs when insurers limit which items they cover. Before the enactment of the ACA, these limits included capping of coverage for certain services associated with diseases that predict high medical consumption (i.e., an AIDS diagnosis) and limits on expensive procedures.¹⁵² The ACA prohibits the previously acceptable use of risk avoidance strategies that evolved with managed care that indirectly evaded certain patients by avoiding their health care providers. This occurred through tactics

¹⁴⁶ See Blake, *supra* note 145, at 75–76 (citing Joseph P. Newhouse et al., *Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges*, 31 HEALTH AFF. 2618, 2618–20 (2012)). Risk adjustment is one measure intended to address risk avoidance. See *id.* at 76. It essentially redistributes money from insurers that successfully dodge risks to those insurers who bear costlier claims. See *id.* However, this author has argued elsewhere that insurers will only stop risk-avoiding to the extent they trust risk adjustment to fairly compensate them for any losses. See *id.*

¹⁴⁷ See Patient Protection and Affordable Care Act § 1501(a)(2), 42 U.S.C. § 18091 (2012).

¹⁴⁸ See Roberts, *supra* note 24, at 1159–60.

¹⁴⁹ See *Out-of-pocket Maximum/limit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit> [<https://perma.cc/6XDW-RDTJ>].

¹⁵⁰ See, e.g., Jacobs & Sommers, *supra* note 8, at 400.

¹⁵¹ Most of the ACA market provisions are monitored for compliance by the state and federal exchange officials and plans can be decertified for noncompliance, or recertified if they come into compliance.

¹⁵² See Rosenbaum, *supra* note 22, at 6–7.

such as utilization review that was meant to avoid providers that proscribed higher amounts and narrow provider networks meant to eliminate high-cost providers.¹⁵³

The ACA provisions limit many of the ways insurers used to discriminate (for example in enrollment), so we may expect insurers to discriminate more in benefits.¹⁵⁴ Protections against benefit discrimination are particularly important not only for this reason, but because, without it, many insureds who finally have been able to purchase and afford insurance may find that the insurance does not result in meaningful coverage.

The Essential Health Benefits (“EHB”) provision of the ACA requires individual and small group insurers to cover a baseline level of medically necessary benefits with limits on cost-sharing.¹⁵⁵ Thus, it creates a homogeneous insurance offering for all insureds that can only be added onto but not subtracted from. Although the U.S. Department of Health and Human Services (“DHHS”) defines the categories of EHBs that must be covered, states define the basic package through selection of a benchmark plan.¹⁵⁶ EHB provisions are applauded in theory, but critiqued in implementation. Scholars argue that state benchmarks may not always be as generous and they risk abrogating the goals of the EHB provision unless the Secretary of DHHS closely reviews plans for compliance.¹⁵⁷

The EHB provision, as with the premium and enrollment reforms, is also concerned with health status discrimination. In establishing the EHBs, the Secretary must not “discriminate against individuals because of their age, disability, or expected length of life.”¹⁵⁸ Additionally, the Secretary must address the health needs of “women, children, persons with disabilities, and

¹⁵³ See *id.* at 7. Prior to the ACA, insurers could also reduce risk by limiting benefits to certain groups or altogether; fewer state or federal laws have addressed benefit discrimination. See *id.*

¹⁵⁴ See *id.*

¹⁵⁵ See Patient Protection and Affordable Care Act § 1302(b)(1), 42 U.S.C. § 18022 (2012). EHBs include the following general categories of items and services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. See *id.*

¹⁵⁶ See generally *State Health Insurance Mandates and the Essential Health Benefits Provision*, NAT’L CONFERENCE OF STATE LEGISLATURES (Dec. 2015), http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx#State_EHB_2013 [<https://perma.cc/738L-4PUG>] (providing an overview of state benchmarks). Benchmarks are model plans selected by the state that represent the minimum level of benefits that an insurer must provide. The National Conference of State Legislatures provides a catalogue of state benchmarks. See *id.*

¹⁵⁷ See Anita Silvers & Leslie Francis, *Human Rights, Civil Rights: Prescribing Disability Discrimination Prevention in Packaging Essential Health Benefits*, 41 J.L. MED. & ETHICS 781, 788–89 (2013).

¹⁵⁸ See Patient Protection and Affordable Care Act § 1302, 42 U.S.C. § 18022(b)(4)(B) (2012).

other groups”¹⁵⁹ and periodically review whether individuals are having difficulty accessing medically necessary services due to coverage or cost issues.¹⁶⁰ If an insurer discriminates against these groups, it fails to provide adequate EHBs.¹⁶¹ Although the groups mentioned by EHB regulations closely resemble those mentioned in premium and enrollment standards, they are not identical—for example, the EHB provision considers expected length of life while other provisions do not—and there is no clear reason why. Further, there is a lack of internal agreement within the EHB standards about which vulnerable groups should be shielded from discrimination.

Federal and state governments must monitor compliance through prospective review when approving an insurer’s plan on the exchange or through retrospective review after a plan has been approved if, for example, an individual files a complaint.¹⁶² Whenever a particular group has its benefits reduced, an inquiry might be made.¹⁶³ Failure to comply with EHB regulations could lead to disqualification from offering on the exchange.¹⁶⁴

Centers for Medicare & Medicaid Services (“CMS”) reviews plans to determine if they are outliers with respect to drug benefits “based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements” impacting a specific category and class.¹⁶⁵ In such outlier analyses, CMS may discover discriminatory practices that are widespread patterns across the whole industry.¹⁶⁶ However, as health policy expert Sara Rosenbaum notes, CMS does not provide standards for how they will review outliers or provide guidelines for determining what are excessive or unusually high authorization steps.¹⁶⁷ Moreover, they have considered, but not imple-

¹⁵⁹ See *id.* § 18022(b)(4)(C).

¹⁶⁰ See *id.* § 18022(b)(4)(G)(i).

¹⁶¹ See 45 C.F.R. § 156.125 (2015) (adding that “[n]othing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques”).

¹⁶² See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,753 (Feb. 27, 2015).

¹⁶³ See *id.* at 10,822–23. CMS will “notify an issuer when we see an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices,” with the review to be triggered any time a plan reduces benefits for a particular group. *Id.* The state or federal government may ask for justification as to why the benefit change is not discriminatory. See *id.* at 18,023.

¹⁶⁴ See *id.*; CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., 2017 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES 7–18 (Feb. 29, 2016), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf> [<https://perma.cc/354Q-GATB>].

¹⁶⁵ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., 2015 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES 40 (Mar. 14, 2014), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf> [<https://perma.cc/6SJZ-B582>].

¹⁶⁶ See Watson, *supra* note 3, at 855–59.

¹⁶⁷ See Sara Rosenbaum, *Update: Final 2015 Letter to Issuers in the Federally-Facilitated Marketplace: Access and Nondiscrimination Considerations*, HEALTH REFORM GPS (Apr. 9, 2014),

mented, additional reviews for outliers with respect to out-of-pocket costs for specific medical conditions such as bipolar disorder, diabetes, HIV, rheumatoid arthritis, and schizophrenia.¹⁶⁸ Review of such outliers for these high cost conditions might better capture efforts by insurers to skimp on benefits or avoid higher cost consumers.

CMS provides common examples of practices it considers to be potentially discriminatory. For example, CMS considers it discriminatory to circumvent coverage for medically necessary benefits by labeling the benefit a “pediatric service” when adults could also benefit from access.¹⁶⁹ Additionally, “refusal to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal” could be discriminatory.¹⁷⁰ Specifically, the single-tablet protection is designed to promote access for the chronically ill who are more likely to use these types of formularies.¹⁷¹ Finally, CMS considers it potentially discriminatory to place “most or all drugs that treat a specific condition on the highest cost tiers.”¹⁷² Such tiering aims to avoid gaps in coverage for patients, but also to prevent insurers from avoiding a whole class of patients with a costly condition.¹⁷³ CMS indicated that drug-tiering would not be discriminatory per se, but that “placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the insurer pays for the drug may often be discriminatory.”¹⁷⁴ Insurers

<http://www.healthreformgps.org/resources/update-final-2015-letter-to-issuers-in-the-federally-facilitated-marketplace-access-and-non-discrimination-considerations> [<https://perma.cc/JZM6-R6HT>].

¹⁶⁸ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., FINAL 2016 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES 38 (Feb. 20, 2015), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf> [<https://perma.cc/3GL3-R6JJ>]. The insurers would be compared against an estimated cost, calculated based on common medically recommended services for the covered conditions. *See id.*

¹⁶⁹ *See id.* at 37. In its proposed rule, CMS clarified that it would be discriminatory based on age to arbitrarily “limit a hearing aid to enrollees who are 6 years of age and younger since there may be some older enrollees for whom a hearing aid is medically necessary.” Patient Protection and Affordable Care Act; Proposed HHS Notice of Benefit and Payment and Payment Parameters for 2016, 79 Fed. Reg. 70,674, 70,723 (Nov. 26, 2014). In other words, a service should not be limited based on age where it is proven clinically effective at all ages. *See id.*

¹⁷⁰ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822 (Feb. 27, 2015).

¹⁷¹ *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 168, at 37 (stating that “such a plan design might effectively discriminate against, or discourage enrollment by, individuals who would benefit from such innovative therapeutic options”).

¹⁷² *Id.*

¹⁷³ *See id.* (“plan design might effectively discriminate against, or discourages enrollment by, individuals who have those chronic conditions”).

¹⁷⁴ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,823.

are expected to base any limitations and exclusions on medical evidence.¹⁷⁵ CMS stopped short of calling any single practice discriminatory, instead stating that each individual case must be weighed within the totality of the circumstances.¹⁷⁶

The EHB provisions are a powerful force against insurance discrimination. But, without further federal efforts, they are unlikely to capture broader endemic patterns of insurance discrimination in the market. Furthermore, they are only as strong as their enforcement and state benchmarks and they do not extend into the large group insurance market.

3. Micro-Level Discrimination

Lastly, the ACA addresses insurer discrimination that might occur at the individual patient level. In these instances, insurers may use utilization reviews and denials to decide whether a particular individual can access a particular service based on medical necessity.¹⁷⁷ For example, the insurer might cover certain experimental cancer therapies, but may choose not to do so in the case of a certain type of patient with a certain type or stage of cancer. Although this type of discrimination is individualized and less likely to reflect broad scale discrimination against populations, it is nonetheless a barrier to accessing necessary medical care. The ACA addresses this by standardizing benefits packages and establishing standards for due process in appeals for insurance denials to address discriminatory or baseless benefit denials.¹⁷⁸

B. Section 1557: The ACA's Civil Rights Provision

Although the ACA antidiscrimination reforms, taken together, relate to a wide swath of discriminatory insurance practices, they are limited in a variety of ways. Some forms of benefit and cost-sharing discrimination can (and do) remain, and many provisions only reach to the individual and small group market. Section 1557 provides another lens to explore the permissibility of other potentially discriminatory market developments through a distinct civil rights framework. Section 1557 represents a new opportunity to examine discriminatory practices in health insurance and to fight discrimination in others areas of healthcare, such as healthcare delivery. DHHS gives section 1557 an aspirational mission to “advance prevention and wellness, reduce health disparities, and improve access to health care services” in order to “ensure equal access to health care.”¹⁷⁹

¹⁷⁵ See *id.*

¹⁷⁶ See *id.*

¹⁷⁷ See Rosenbaum, *supra* note 22, at 7.

¹⁷⁸ See 45 C.F.R. § 147.136 (2015).

¹⁷⁹ U.S. DEP'T HEALTH & HUMAN SERVS., *supra* note 17.

Section 1557 represents a significant expansion of the current civil rights framework that applies to healthcare. Civil rights litigation in healthcare has been fairly minimal when compared to other social programs, such as education. Although civil rights laws are credited with desegregation of hospitals,¹⁸⁰ government reluctance to extend race protections to individual clinicians' offices and to nursing homes,¹⁸¹ and repeated failures by courts to prevent the closures of hospitals that adversely affect minority communities¹⁸² are all seen as failures of the civil rights regime in healthcare. Section 1557 presents an opportunity to reexamine the role of civil rights in healthcare and provides the first civil rights statute to represent a "health-specific" civil right.¹⁸³ It also extends beyond existing civil rights in health insurance both in addressing discrimination by private insurers and discrimination by insurers on the basis of gender—including gender identity and, likely, sexual orientation.¹⁸⁴ Section 1557 of the Affordable Care Act provides that:

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).¹⁸⁵

This has broader remedies than the other ACA antidiscrimination provisions. Lawsuits, including private causes of action, are possible as are individual damages.¹⁸⁶ Complaints may also be sent to the Office for Civil Rights ("OCR")¹⁸⁷ and can be resolved if the entity comes into compliance with sec-

¹⁸⁰ See Sara Rosenbaum et al., *Civil Rights in a Changing Health Care System*, 16 HEALTH AFF. 90, 91 (1997). This occurred when President Lyndon Johnson used Medicare dollars to condition compliance with Title VI. See Watson, *supra* note 3, at 864.

¹⁸¹ See Watson, *supra* note 3, at 865.

¹⁸² See David Barton Smith, *Healthcare's Hidden Civil Rights Legacy*, 48 ST. LOUIS. U. L.J. 37, 45–47 (2003).

¹⁸³ See Watson, *supra* note 2, at 882.

¹⁸⁴ See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,176 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

¹⁸⁵ Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (2012).

¹⁸⁶ See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,192.

¹⁸⁷ See *id.* at 54,182.

tion 1557 or, if not, the agency may suspend, terminate, or refuse to grant federal funds to that entity.¹⁸⁸ Though OCR has been seen as an over-extended agency,¹⁸⁹ the agency has pointed to its responsibility to enforce section 1557 as a reason to expand its funding.¹⁹⁰

The reach of section 1557 with respect to health insurance is also broader than other ACA efforts. A draft proposed rule published in September 2015 clarified that section 1557 reaches all DHHS-funded entities.¹⁹¹ In the context of health insurance, this encompasses small group or individual insurers offering plans on the exchange.¹⁹² Any insurer that participates on the marketplace and receives such funds will be covered by section 1557 for all plans offered on or off the exchange.¹⁹³ Employer plans are regulated by section 1557 if: they are administered by an insurer that also offers plans on the exchange;¹⁹⁴ the employer is in the business of healthcare delivery or insurance; the business receives federal money to fund its employee health benefit plan; or the employer operates a health program or activity.¹⁹⁵ Section 1557 also applies to Medicaid¹⁹⁶ and to Medicare (except Part B).¹⁹⁷ Additionally, it reaches to the federally- and state-facilitated exchanges and their decisions about which plans can be approved for offer on the exchange (and perhaps even their selection of benchmark plans).¹⁹⁸ Thus, Section 1557 reaches virtually all forms of health insurance.

Section 1557's proposed rule prohibits "denying, cancelling, limiting, or refusing to issue or renew a health-related insurance plan or policy or other health-related coverage on the basis of an enrollee's, or prospective enrollee's, race, color, national origin, sex, age, or disability, and the use of market-

¹⁸⁸ *See id.* at 54,220.

¹⁸⁹ *See* Teitelbaum, *supra* note 56, at S2-29.

¹⁹⁰ *See HHS FY 2016 Budget in Brief: Office of the Secretary, Office for Civil Rights (OCR), U.S. DEP'T OF HEALTH & HUMAN SERV.*, <http://www.hhs.gov/about/budget/budget-in-brief/ocr/index.html> [<https://perma.cc/2PB4-P7GR>].

¹⁹¹ *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

¹⁹² *See id.* at 54,174. Specifically, the rule extends to insurers who offer plans on the exchange "when advance payments of premium tax credits and/or cost-sharing reductions are provided to any of the issuer's enrollees," which is likely to encompass all insurers offering plans on the exchange. *Id.*

¹⁹³ *See id.* at 54,189.

¹⁹⁴ *See id.* at 54,174–75.

¹⁹⁵ *See id.*

¹⁹⁶ *See id.* at 54,175 n.16 ("A health program or activity also includes all of the operations of a State Medicaid program.")

¹⁹⁷ *See id.* at 54,172, 54,175 n.16.

¹⁹⁸ *See id.* at 54,174–75. Section 1557 may also reach a host of other healthcare entities that receive federal funds such as pharmacies, drug manufacturers, or healthcare providers, and the implications of this merit further work in the future. *See id.* at 54,185.

ing practices or benefit designs that discriminate on these bases.”¹⁹⁹ Section 1557 does not require an insurer to cover a particular service, but “a covered entity cannot have a coverage policy that operates in a discriminatory manner.”²⁰⁰

Section 1557’s inclusivity may also be a weakness, as it is the “first broad based Federal civil rights statute incorporating the grounds prohibited by four distinct civil rights statutes.”²⁰¹ This leaves uncertainty about how it can be used in court given the different standards, damages, and proofs of the various civil rights statutes it incorporates. The various titles differ, for example, in whether administrative relief must first be exhausted or if one can petition directly to the courts,²⁰² and whether private causes of action are permitted for disparate impact claims.²⁰³ Although other antidiscrimination standards may address some of these claims, section 1557 provides a broader, more public, and potentially more rapid, option that permits a different, but critical, group to receive protections from discriminatory insurance practices.

III. SECTION 1557’S LEGAL PROTECTIONS IN HEALTH INSURANCE

As gaps in the Affordable Care Act’s (“ACA”) insurance protections are identified, advocates are turning to section 1557 to expand the definition of discriminatory conduct in health insurance. This Part will explore the legal framework by which section 1557, as a civil rights tool, will engage questions of health insurance discrimination. It will argue that section 1557 has the potential to reduce health insurance discrimination that affects both protected classes and the unhealthy.

A. Protected Class Discrimination

Other ACA provisions mainly combat health status discrimination in health insurance, with very little attention paid to protected classes. For ex-

¹⁹⁹ *Id.* at 54,189.

²⁰⁰ *Id.* Examples include the following:

A plan that covers inpatient treatment for eating disorders in men but not women would not be in compliance with the prohibition of discrimination based on sex. Similarly, a plan that covers bariatric surgery in adults, but excludes such coverage for adults with particular developmental disabilities would not be in compliance with the prohibition on discrimination based on disability.

Id. Denials that are based on a lack of medical necessity are permitted. *See id.*

²⁰¹ Request for Information Regarding Nondiscrimination in Certain Health Programs and Activities, 78 Fed. Reg. 46,558, 46,559 (Aug. 1, 2013) (codified at 45 C.F.R. Subtitle A).

²⁰² *See* Watson, *supra* note 3, at 878–79. Claims based on age discrimination allow for both private and administrative enforcement but require the exhaustion of administrative remedies before seeking relief from the court. *See id.*

²⁰³ *See* Steege, *supra* note 19, at 448–49.

ample, another provision of the ACA forbids discrimination in enrollment by insurers against the disabled and a variety of categories of health status, but is silent on age, gender, or race.²⁰⁴ Although other provisions of the ACA prohibit varying premiums based on gender, race, or disability, these groups are not specifically listed within section 1557. Instead, gender, race, and age groups are protected through a negative inference because they are not included as part of the few permissible categories in which insurers may discriminate.²⁰⁵ Protected classes were also not addressed in Essential Health Benefits (“EHB”) provisions, except some mentions of age, disability, and women’s health.²⁰⁶

Section 1557 both legally and symbolically recognizes protected class discrimination as its own distinct form of discrimination that mandates protection above and beyond the other antidiscrimination efforts of the ACA. It uniformly makes protected class discrimination an issue across premiums, cost-sharing, and benefits. Furthermore, it provides eight distinct lenses through which to engage the legal limits of health insurance discrimination: race, gender, disability, and age, with a disparate impact and disparate treatment theory for each of these four protected classes. Disparate impact and disparate treatment actions are common factors in civil rights frameworks, and Section 1557’s inclusion of these factors indicates that it will likely follow other civil rights frameworks. Title VI, Title IX, the Age Discrimination Act, and the Rehabilitation Act are all similar in their legal mechanisms, so their inclusion under section 1557 will function in similar ways. Given that there are eight frameworks, it is impractical to focus on each individually, thus this Article will attempt to generalize and demonstrate the broader impact of section 1557 on health insurance discrimination overall.

1. Disparate Treatment and Section 1557

Disparate treatment claims address intentional discrimination; these claims result from similarly situated individuals being treated differently on the basis of membership in a protected class.²⁰⁷ In such a claim, the plaintiffs

²⁰⁴ See Patient Protection and Affordable Care Act § 2705, 42 U.S.C. § 300gg-5 (2012).

²⁰⁵ See Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (2012); Patient Protection and Affordable Care Act § 2701, 42 U.S.C. § 300gg (2012).

²⁰⁶ See Patient Protection and Affordable Care Act § 1302(a)(4), 42 U.S.C. § 18022 (2012).

The EHB provisions contemplated special consideration for age, disability, expected length of life, women, and children. See *id.*

²⁰⁷ See, e.g., AMERICANS WITH DISABILITIES: PRACTICE AND COMPLIANCE MANUAL § 1:238 (West 2016); *Title IX Legal Manual*, U.S. DEP’T OF JUSTICE, <https://www.justice.gov/crt/title-ix> [<https://perma.cc/4DRK-K9AA>] [hereinafter *Title IX Legal Manual*]; U.S. DEP’T OF JUSTICE CIVIL RIGHTS DIV., TITLE VI LEGAL MANUAL 43 (Jan. 11, 2001), <https://www.justice.gov/sites/default/files/crt/legacy/2011/06/23/vimanual.pdf> [<https://perma.cc/3PCH-QXH8>] [hereinafter TITLE VI LEGAL MANUAL].

must show that the defendant knew of the individual's membership in the protected class and treated the plaintiff differently because of it.²⁰⁸ When a case of discrimination has been made, the burden shifts to the defendant to "articulate a legitimate, nondiscriminatory reason for the challenged action."²⁰⁹ The plaintiff can then still argue that the nondiscriminatory reason is a pretext for discrimination, and that the actual purpose is to discriminate based on protected class.²¹⁰ Plaintiffs may also allege that the defendant engaged in a pattern or practice of discriminatory conduct and may prove it by showing that the defendant engaged in classification on the basis of protected class.²¹¹

Though many discriminatory behaviors in the small and individual markets have been addressed by the ACA's other antidiscrimination efforts, some alleged discrimination continues post-reform and is ripe for reexamination under Section 1557. For example, insurers have begun utilizing drug-tiering following the enactment of the ACA. Not explicitly forbidden by the ACA, it is a common practice, often used to discourage consumers from choosing higher cost drugs where generics are available.²¹² Patients with high-cost conditions such as HIV or multiple sclerosis are able to purchase insurance because of the bans on discrimination in enrollment against the unhealthy.²¹³ Yet, in filling their prescriptions for specialty drugs, these individuals face higher co-pays or must purchase coinsurance to obtain their needed drugs.²¹⁴ These drugs may also be subject to higher administrative review based on the type of drug and whether it is generic.²¹⁵ The rise in popularity of drug-tiering since the enactment of the ACA may reflect unfair cost-shifting onto the unhealthy or a way of subversively discouraging enrollment of chronically ill patients.²¹⁶ These patients may pay as much as \$3000 more per year for necessary medications, on top of their other out-of-pocket medical costs and premiums.²¹⁷ The cost could lead individuals to take their medication inter-

²⁰⁸ See TITLE VI LEGAL MANUAL, *supra* note 207, at 43. Proof of bad faith is generally not necessary, though it might implicate whether the plaintiff can receive compensatory damages. *Id.* It can be difficult to obtain evidence of discriminatory intent, thus circumstantial evidence is also permitted. *See id.* Under such cases, plaintiffs can make out a prima facie case of discrimination, showing that 1) the aggrieved is a member of a protected class, 2) the involvement of a program receiving federal funds, 3) rejection of the party, and 4) the program accepted other persons who were not involved in the protected class. *See id.* at 44–45.

²⁰⁹ *Id.* at 45.

²¹⁰ *See id.*

²¹¹ *See id.* at 46.

²¹² *See* Jacobs & Sommers, *supra* note 8, at 400.

²¹³ *See, e.g.,* NHELP, *supra* note 18.

²¹⁴ *See id.*

²¹⁵ *See* Jacobs & Sommers, *supra* note 8, at 400; NHELP, *supra* note 18.

²¹⁶ *See* Jacobs & Sommers, *supra* note 8, at 400.

²¹⁷ *See id.*

mittently, which can lead to drug resistance.²¹⁸ Although out-of-pocket maximums provide some relief, patients with chronic conditions may find themselves hitting their maximum each year, and may face medical debt even with health insurance.

Advocacy groups have begun taking a stand against drug-tiering. In a complaint filed with the Office for Civil Rights (“OCR”), the AIDS Institute and the National Health Law Program (“NHeLP”) challenged drug-tiering against patients with HIV as a violation of section 1557 on the basis of disability.²¹⁹ In that situation, the tiers required copayments, higher coinsurance, and preapprovals for all HIV drugs, regardless of each drug’s price.²²⁰ The National Multiple Sclerosis Society filed a similar complaint about tiering to the Montana Commissioner of Securities and Insurance.²²¹ Relatedly, patient advocacy group I Am (Still) Essential critiqued the EHB provisions for failing to cover important drugs and for allowing the removal of non-EHB drugs at any point in the year.²²²

The EHB regulations suggest that “placing most or all drugs for a certain condition on a high-cost tier without regard to the actual cost the insurer pays for the drug may often be discriminatory.”²²³ Section 1557 provides a platform to engage with this issue by opening discussion about whether this type of discrimination is forbidden even if it is economically justified.²²⁴ Moreover, it allows for a new remedy. In the complaint to the Montana Commissioner of Securities and Insurance, the government interfered to regulate drug tiering rather than leaving it to OCR to handle.²²⁵ The State Commissioner found the pricing to be discriminatory and now requires an exchange to have at least one plan available with a fixed copayment for all drugs.²²⁶ Additionally, section 1557 allows for public complaint, which may put additional pressure on insurers and states to reform practices.²²⁷ Although OCR has not commented on the NHeLP complaint, three of the four insurers

²¹⁸ See NHeLP, *supra* note 18.

²¹⁹ See *id.*

²²⁰ See *id.*

²²¹ See Sally McCarty, *Regulatory Activity in Two States Restricts How Plans Structure Specialty Drug Coverage*, GEO. U. HEALTH POL’Y INST. CTR. ON HEALTH INS. REFORMS (Jan. 21, 2015), <http://chirblog.org/regulatory-activity-in-two-states-restricts-how-plans-structure-specialty-drug-coverage> [<https://perma.cc/799Y-TJSM>].

²²² See Letter from I (Am) Still Essential to Sylvia Matthews Burwell, Sec’y of Health and Human Servs. (July 28, 2014), http://www.theaidsinstitute.org/sites/default/files/attachments/IAMStillEssentialBurwellltr_0.pdf [<https://perma.cc/23RQ-ZGTS>].

²²³ Notice of Benefit and Payment Parameters for 2016, Final Rule, 80 Fed. Reg. 10,750, 10,823 (Feb. 27, 2015).

²²⁴ See *infra* Section IV.1.

²²⁵ See McCarty, *supra* note 221.

²²⁶ See *id.*

²²⁷ See NHeLP, *supra* note 18 (exemplifying public administrative complaints).

still reduced copays for some HIV medications. NHELP notes, however, that these changes were prompted by settlements with the state's insurance commissioner that only apply to that state for that year, that they did not impact the civil rights charges, and that the insurers did not admit any wrongdoing.²²⁸

Moreover, section 1557 can extend protections beyond the EHB provisions, which only forbid tiering based on disease.²²⁹ Section 1557 can also address tiering that directly discriminates against any of the protected classes, for example, if an insurer charged a higher copay for one gender or for adults versus children. Additionally, it may challenge mid-year removal of a class-based drug that affects a certain disabled population or racial group. Refusals to cover certain procedures for one group when they are available to others may also implicate section 1557. Section 1557's proposed rule provides, as an example: "a plan that covers inpatient treatment for eating disorders in men but not women would not be in compliance with the prohibition of discrimination based on sex."²³⁰ In this situation, section 1557 seeks equality in coverage; if the insurer is offering the benefit to some, then it must offer the benefit to all in order to satisfy the broader goals of disparate treatment claims. This particular aspect of the law has major ramifications for gender and sexuality-based discrimination, particularly discrimination based on sexual orientation or gender identity.

In *Cruz v. Zucker*, New York State's Medicaid agency refused to cover gender reassignment surgeries for individuals below the age of eighteen (or below age twenty-one if the procedure would result in sterility).²³¹ A class of transgender patients alleged discrimination under section 1557 on the basis of gender and disability because "certain services [were] available to non-transgender people but denied to transgender people where medically necessary."²³² The court dismissed this particular claim because plaintiffs failed to allege that other people who were not transgender were actually receiving access to care that transgender persons were not. For example, the plaintiffs were seeking tracheal shaves to remove Adam's apples and breast augmenta-

²²⁸ See Chabeli Herrera, *Coventry Slashes Co-pays on All Oral HIV Drugs*, MIAMI HERALD (Mar. 27, 2015), <http://www.miamiherald.com/news/local/community/miami-dade/article16518374.html> [<https://perma.cc/LZV4-NNSB>]; Letter from NHELP and The AIDS Institute to Jocelyn Samuels, Dir. of the Office for Civil Rights (Jan. 8, 2015), <http://www.healthlaw.org/issues/health-disparities/Letter-to-HHSOfficeofCivilRights#.VvQIRrInU> (then download file as PDF); NHELP, *supra* note 18.

²²⁹ See *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/ccio/resources/data-resources/ehb.html> [<https://perma.cc/R2PJ-Z6KJ>].

²³⁰ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,189 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

²³¹ See *Cruz v. Zucker*, 116 F. Supp. 3d 334, 338 (S.D.N.Y. 2015).

²³² *Id.* at 348 (quoting Plaintiffs' Opposition to Defendant's Motion to Dismiss at 19, *Cruz v. Zucker*, 116 F. Supp. 3d 334, 338 (S.D.N.Y. 2015), ECF No. 34).

tion. These examples demonstrate the challenges that such patients may face under a civil rights framework. Although some non-transgender patients may receive breast augmentation, it is often cosmetic and they would have to show that some individuals are receiving the surgery under Medicaid, perhaps as reconstructive surgery following cancer treatment. A tracheal shave, however, is unlikely to be sought by any patients that are not transgender.²³³

This question of equality in access to benefits can be broadened. For example, if a plan covers hormone treatments for menopause, must it also cover them for transgender patients? If it covers fertility preservation services for cancer patients, must it cover these for gender transition surgeries? The National Women's Law Center ("NWLC") has shown that at least ninety-two insurance plans around the country exclude transition surgery, with some states selecting an EHB benchmark plan that also excludes such services.²³⁴ Section 1557 not only permits challenges to these practices, but its proposed rule also indicates that insurers must cover at least some aspects of transition medicine, whether it be hormone treatments, transition surgery, or others.²³⁵

In the past, it was common practice to deny patients access to medically necessary care based on their gender identity, rather than based on their physiological need.²³⁶ For example, an insurer might fail to cover ovarian cancer treatment for an individual who was born biologically female because he identifies as male legally. The proposed rule of section 1557 prohibits this type of conduct as discriminatory on the basis of gender, and it will be imperative for ensuring access to preventative care for transgender patients.²³⁷ For example, a wellness program in Colorado changed its policies in response to an OCR investigation stemming from allegations that its funding for mammograms and gynecologic exams only extended to individuals who were biologically female.²³⁸ Because a viable claim could be made that this practice violated section 1557 on the basis of gender, the policy was changed to include the provision of services to transgender women who are taking hormones.²³⁹ Similarly, the proposed rule also forbids an insurer from denying services because the requested service does not correlate with the individual's sex as identified at birth.²⁴⁰ The NWLC has also identified a number of other

²³³ *See id.* at 338.

²³⁴ *See* NAT'L WOMEN'S L. CTR., *supra* note 12, at 20.

²³⁵ *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,189.

²³⁶ *See id.*; NAT'L WOMEN'S L. CTR., *supra* note 12, at 20.

²³⁷ *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,189 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

²³⁸ *See* OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 114.

²³⁹ *See* Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,189.

²⁴⁰ *See id.*

insurance practices that can be considered violations of section 1557 based on gender.²⁴¹

Section 1557 provides significant protections for transgender patients who have never enjoyed such protections for access to transgender care or to even some basic preventative care. It is no coincidence that, of roughly four hundred public comments to the U.S. Department of Health and Human Services (“DHHS”) in the initial period for the proposed rule, more than half were submitted by transgender patients describing their personal experiences with discrimination in healthcare,²⁴² and a significant remainder dealt with special issues concerning gay and lesbian individuals.²⁴³

A case in Connecticut demonstrates the potential of utilizing section 1557 with respect to age. The state recently altered a law to prevent it from being seen as facially discriminatory on the basis of age.²⁴⁴ The state had previously mandated that insurers cover diagnosis and treatment of infertility for persons under forty years old.²⁴⁵ The age cap was instituted in response to medical data available at the time of the law’s enactment that suggested that persons over forty years old did not medically benefit from fertility treatment.²⁴⁶ Relying on both section 1557 and the EHB regulations that define medically-unsupported age caps as discriminatory, Connecticut amended this law to remove any age cap and cited new medical data that supports the use of fertility medicine for those over forty years old.²⁴⁷ Challenges may also be made to plans that exclude dependent enrollees from maternity care, coverage for labor and delivery outside of the service area, coverage of breast pumps and BRCA testing, and birth control methods.²⁴⁸

Antidiscrimination provisions in the ACA have been critiqued for sometimes allowing discrimination on the basis of protected class. For example, the rate-setting provisions explicitly allow some ongoing discrimination in premiums based on geography, age, and tobacco use.²⁴⁹ One study suggests that, although these rate differences may not greatly affect prices for young tobacco users, they could pose significant access issues for elderly tobacco

²⁴¹ See NAT’L WOMEN’S L. CTR., *supra* note 12, at 1.

²⁴² See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,172. Of 402 comments, 279 were private testimonials from transgender individuals. *See id.*

²⁴³ *See id.* (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92). One third of all organizational comments dealt with LGBT interests. *See id.*

²⁴⁴ *See* Arielle Levin Becker, *State Removes Age Limit for Fertility Treatment Coverage*, HARTFORD COURANT (Aug. 13 2015), <http://www.courant.com/business/hc-ctm-fertility-treatment-connecticut-20150813-story.html> [<https://perma.cc/L4EB-WMK9>].

²⁴⁵ *See id.*

²⁴⁶ *See id.*

²⁴⁷ *See id.*; 45 C.F.R. § 156.125(a) (2015); CONN. GEN. STAT. § 38a-536 (2015).

²⁴⁸ *See* NAT’L WOMEN’S L. CTR., *supra* note 12, at 22.

²⁴⁹ *See* Roberts, *supra* note 24, at 1159.

users.²⁵⁰ For this reason, section 1557 age discrimination claims could possibly be brought in response to these exclusion exceptions.

Section 1557's strength is in the expansion of protections for new groups never before covered by civil rights laws in health insurance. Particularly to the extent discrimination is a wrong because it involves bias or ongoing subjugation of certain groups, section 1557 asserts an important right in the battle over health insurance discrimination. Many states did not provide protections for gender or age prior to the adoption of the ACA,²⁵¹ and this opens up a plethora of opportunities for protection that never existed before. Disparate treatment claims allow protected classes to challenge discrimination in both premiums and benefits to the extent that they can prove some form of intentional categorization.

2. Disparate Impact and Section 1557

Under a second theory, plaintiffs can claim disparate impact, or discrimination by effect.²⁵² This refers to situations where a defendant "uses a neutral procedure or practice that has a disparate impact on protected individuals, and such practice lacks a substantial legitimate justification."²⁵³ The focus is not on intent, but on outcomes.²⁵⁴ Disparate impact cases can be harder to prove and some scholars argue that the viability of disparate impact claims has been eroding over time.²⁵⁵ As Sidney Watson notes, disparate impact claims are meant to achieve different goals. While disparate treatment theory emphasizes equal treatment of different groups as the way to achieve equality, disparate impact theory emphasizes equal opportunity and "an affirmative duty on defendants to heed the disproportionate consequences of their policies be-

²⁵⁰ See Liber et al., *supra* note 11, at §696.

²⁵¹ See Crossley, *supra* note 22, at 112.

²⁵² See TITLE VI LEGAL MANUAL, *supra* note 207, at 43.

²⁵³ *Id.* at 48.

²⁵⁴ See *id.* Rehabilitation Act cases require additional analysis of whether an individual is otherwise qualified and whether reasonable accommodations may provide meaningful access. See Alexander v. Choate, 469 U.S. 287, 301 (1985); AMERICANS WITH DISABILITIES: PRACTICE AND COMPLIANCE MANUAL § 1:238 (West 2016).

²⁵⁵ See Girardeau Spann, *Disparate Impact*, 98 GEO. L.J. 1133, 1135 (2010) (arguing that the Roberts Court is hostile to disparate impact claims). Spann focuses, in part, on *Ricci v. DeStefano*, where a firefighter department invalidated a promotion test after seventeen white firefighters and one Hispanic performed significantly higher than any African American employees. See *id.* at 1146; *Ricci v. DeStefano*, 557 U.S. at 557, 574. The fire department did not promote the employees, and argued that they had invalidated the test for fear of a discrimination suit. See *Ricci*, 557 U.S. at 557. The Supreme Court held for the firefighters, stating that the employer did not have a strong basis for believing it was at risk of a disparate impact suit. See *id.* at 560.

cause . . . arbitrary or thoughtless policies can be just as harmful as intentional discrimination.”²⁵⁶

Many insurance practices may be better characterized as discriminatory by effect, not by design.²⁵⁷ Insurers can often accomplish the same end—that of avoiding the unhealthy or a protected group—through neutral means that do not categorize based on protected class.²⁵⁸ For example, though insurers may not be able to avoid HIV patients by tiering based on disease status, they may still be able to accomplish the same effect by tiering drugs based on price. This makes disparate impact claims, which examine the effect and not the intent of certain practices, very important in the context of health insurance discrimination.

With a disparate impact claim, a patient could still challenge tiering even if it were based on price and not disability or illness. The claim would require the patient or group of patients to show that the practice of tiering a given drug was not intentionally harmful, but nonetheless had a statistical effect on the protected group. For instance, the practice of placing a certain pain medication in an expensive formulary impacted patients with a multiple sclerosis diagnosis more than those without multiple sclerosis, thus constituting discrimination on the basis of disability. Insurers then could defend this practice by arguing that they had a legitimate justification for placing the drug on that price tier.²⁵⁹

Additionally, wellness plans are a health insurance practice ripe for disparate impact challenge under section 1557. The ACA permits these employer-sponsored health insurance plans to adjust premiums based on health status by as much as thirty percent.²⁶⁰ For instance, a person who performs better than another on a cholesterol measurement may be permitted to pay thirty percent less in premiums.²⁶¹ Some scholars argue that wellness plans may function as stand-ins for discriminating against the unhealthy in healthcare premiums because they essentially shift costs from the employer and healthy

²⁵⁶ Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939, 949 (1990).

²⁵⁷ See Roberts, *supra* note 24, at 1167, 1190 (“[T]he ACA—on its face—limits the ability of health insurers to take health-based information into account when making underwriting and rating decisions. It eliminates facial discrimination.”).

²⁵⁸ See Crossley, *supra* note 22, at 83. Crossley observes that the type of insurance activity will shape whether a disparate treatment or disparate impact claim is more appropriate. See *id.* at 83–84. For example, a refusal to cover a particular class at all could be a clear claim of disparate treatment, whereas a refusal to cover a particular type of therapy is more likely to have a disparate impact. See *id.*

²⁵⁹ For example, insurers could claim that the drug was placed on a specific tier because the drug is, in fact, costlier.

²⁶⁰ See Patient Protection and Affordable Care Act § 2705(j)(3), 42 U.S.C. § 300gg-4 (2012).

²⁶¹ See *id.* Health-contingent wellness plans must not become “a subterfuge for underwriting or reducing benefits based on health status.” 45 C.F.R. § 146 (2015).

employees onto unhealthy employees.²⁶² Claims could be constructed around protected class if, for instance, particular groups are able to argue that it would be harder for them to achieve a certain cholesterol reading than others. In this way, again, section 1557 might challenge a practice as discriminatory that the ACA itself permits. Although other cases have challenged the permissibility of these practices under the Americans with Disabilities Act (“ADA”), they were exempted because the ADA permits discrimination based on valid underwriting.²⁶³ However, section 1557 uses the Rehabilitation Act rather than the ADA. The Rehabilitation Act does not have the same exemption for underwriting, and thus allows for a reexamination of this issue.

Furthermore, narrow provider networks are a common feature in the post-ACA insurance market.²⁶⁴ Insurers compete for better reimbursement rates by limiting their networks to an exclusive group of providers.²⁶⁵ Many have argued that these market innovations can harm the chronically ill, particularly to the extent that they bar access for tertiary and quaternary care.²⁶⁶ These practices will likely not be seen as intentionally discriminatory because they do not overtly prohibit any particular group from enrollment. They can be discriminatory by effect, however, if they discourage enrollment by particular groups or affect the level of care certain groups have access to.²⁶⁷

Many of the other examples discussed in relation to disparate treatment could also be framed as disparate impact cases. The plaintiffs in *Cruz v. Zucker* might not be able to show that other patients will ever receive a Medicaid-covered tracheal shave, but, they may still argue that “regardless of the availability of these treatments to people generally, these coverage exclusions have a disparate impact on transgender people for whom these services are medically necessary.”²⁶⁸ In other words, this treatment is unique to transgender

²⁶² See Horwitz et al., *supra* note 10, at 468; Roberts, *supra* note 24, at 1194–95. As Roberts explains:

Within the large-group market, wellness programs could likewise adversely affect the sick, who may be unable to participate equitably. Because the statute effectively allows insurers to consider information that corresponds to an individual’s health, the statute thus perpetuates health-status discrimination. Although the law succeeds from an anti-differentiation standpoint, it fails by producing discriminatory outcomes.

Roberts, *supra* note 24, at 1190.

²⁶³ See, e.g., *Equal Emp’t Opportunity Comm’n v. Flambeau, Inc.*, No. 14-CV-638-BBC, 2015 WL 9593632, at * 6 (W.D. Wis. Dec. 31, 2015).

²⁶⁴ See Blake, *supra* note 145, at 77.

²⁶⁵ See Pear, *supra* note 9.

²⁶⁶ See Blake, *supra* note 145, at 69; Letter from I (Am) Still Essential to Sylvia Matthews Burwell, *supra* note 222.

²⁶⁷ See Letter from I (Am) Still Essential to Sylvia Matthews Burwell, *supra* note 222.

²⁶⁸ *Cruz v. Zucker*, 116 F. Supp. 3d 334, 348 (S.D.N.Y. 2015) (quoting Plaintiffs’ Opposition to Defendant’s Motion to Dismiss at 19, *Cruz v. Zucker*, 116 F. Supp. 3d 334, 338 (S.D.N.Y. 2015), ECF No. 34).

patients and a failure to cover it leads to disparate harms for only that population.

Disparate impact claims will likely be the lifeblood of successful section 1557 claims. However, there is uncertainty about whether private causes of action for disparate impact are permitted under section 1557.²⁶⁹ All of the civil rights statutes encompassed by section 1557 permit suits that allege disparate impact claims, but Title VI of the Civil Rights Act (Title VI) does not permit private causes of action, meaning that OCR, and not an individual, may bring a disparate impact claim.²⁷⁰

The first district courts to hear section 1557 claims have been split on this issue. In *Rumble v. Fairview Health Services*, the U.S. District Court for the District of Minnesota held that section 1557 was ambiguous “insofar as each of the four statutes utilize different standards for determining liability, causation, and a plaintiff’s burden of proof.”²⁷¹ The court agreed with scholar Sidney Watson that “Congress intended to create a new health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class.”²⁷² The court neglected to name that standard but emphasized that, whatever the standard, it should be tethered to existing civil rights jurisprudence.²⁷³ To not have a single standard, according to the court, would lead to absurd inconsistency and would be particularly challenging in the case of intersectional discrimination, where discrimination is based

²⁶⁹ See Steege, *supra* note 19, at 461.

²⁷⁰ See *id.* at 442–43. A disparate impact claim has been found in Title VI. See *Guardians Ass’n v. Civil Serv. Comm’n of City of New York*, 463 U.S. 582, 585 (1983). A disparate impact claim has also been found to be not available for private causes of action. See *Alexander v. Sandoval*, 532 U.S. 275, 294 (2001) (holding that “[n]either as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action” in a disparate impact claim). The ADA, the Rehabilitation Act, and Title IX all allow for disparate impact claims, though these appear to enforce private right of actions. See, e.g., *Alexander v. Choate*, 469 U.S. 287, 287 (1985) (“Assuming that § 504 or its implementing regulations reach some claims of disparate-impact discrimination . . .”); *Sharif ex rel. Salahuddin v. N.Y. State Educ. Dep’t*, 709 F. Supp. 345, 345, 360 (S.D.N.Y. 1989) (holding that plaintiffs did not have to prove intentional discrimination but could prevail on the basis of disparate impact). Sara Rosenbaum, Joel Teitelbaum, and Alexandra Stewart offer a critique of the limitation on private actions in disparate impact claims. See Sara Rosenbaum et al., *Olmstead v. L.C.: Implications for Medicaid and Other Publicly Health Services*, 12 HEALTH MATRIX 93, 137–38 (2002) (arguing that if the effort to reduce widespread discrimination in a given industry must fall on the federal government, it is inappropriate to place this responsibility on OCR when the majority of funding decisions in healthcare come from other federal agencies). Sarah Steege offers an argument for permitting all private causes of action in section 1557. See Steege, *supra* note 19, at 452–60.

²⁷¹ See *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2015 WL 1197415, at *19 (D. Minn. Mar. 16, 2015).

²⁷² *Id.* at *21–22 (citing Watson, *supra* note 3, at 870). The court cites Watson, who argues that section 1557 is a health specific civil right requiring regulations and applications that are sensitive to health law issues and not just civil rights generally. See Watson, *supra* note 3, at 870.

²⁷³ See *Rumble*, 2015 WL 1197415, at *22–23.

on the interaction of multiple classes.²⁷⁴ The U.S. District Court for the Eastern District of Pennsylvania disagreed in *Southeastern Pennsylvania Transportation Authority v. Gilead Sciences*, holding that, although Congress intended a private right of action under section 1557, the standards and burdens of proof will vary within section 1557 for whichever protected class is being claimed.²⁷⁵ Thus, although the plaintiffs argued that they experienced disparate impact on the basis of race, the court would not consider the argument because Title VI typically does not allow a private cause of action for disparate impact.²⁷⁶ The proposed rule for section 1557 suggests that private causes of action and damages should be allowed where the original civil rights law allows it.²⁷⁷ Moreover, private rights of action are available against Title I ACA entities, such as the state or federal marketplaces.²⁷⁸

A resolution of the legal question of which legal standards apply to section 1557 cases is necessary for the sake of both courts and litigants. The question of whether to allow disparate impact cases, in particular, poses basic questions of fairness that need to be resolved for this law and for other future civil rights statutes that might incorporate multiple existing civil rights statutes.²⁷⁹ If section 1557 truly focuses on broad discrimination in healthcare, it seems unfair that some groups have more legal actions available to them than others. Is it not more equitable to suggest that, in crafting section 1557, Congress recognized that discrimination in public funds in healthcare was an expansive issue and, for this reason, intended to provide all four groups an equal shot at litigating disparate impact claims? Undoubtedly, with an overtaken OCR, there is some real risk that racial inequities will not be as easily resolved without permitting private causes of action in these cases.

B. Characterizing Health Status Discrimination as a Section 1557 Violation

Although section 1557 addresses protected class discrimination in health insurance, at times this cannot be entirely distinguished from distinct but overlapping questions of health status discrimination. This is because protected classes often represent the groups of unhealthy individuals that insurers seek to avoid. Is an insurer's failure to cover a certain chronic pain drug dis-

²⁷⁴ See *id.* at *23.

²⁷⁵ See *Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 698–99 (S.D.N.Y. 2015).

²⁷⁶ See *id.* at 701. The court states that the plaintiffs' claim is not successful because, while they might show that minorities are disproportionately impacted by Hepatitis C (and thus its prices), they did not show that "Gilead is intentionally pricing out any members of any protected class on the basis of their protected status." *Id.* at 702.

²⁷⁷ See *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. 54,172, 54,192 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

²⁷⁸ See *id.*

²⁷⁹ See Steege, *supra* note 19, at 441.

crimination against those with chronic disease, against those who are disabled, or even against women who experience this affliction higher than men? The other ACA antidiscrimination measures do not reach all forms of potentially discriminatory conduct, and section 1557 can play a distinct but augmentative role to that end.

Not all of those who an insurer may consider to be “unhealthy” could also be considered a member of a protected class. Yet, protected classes have historically been part of the group discriminated against by insurers,²⁸⁰ possibly because of health and healthcare disparities that result from broader discrimination and structural inequality.²⁸¹ Consequently, individuals in a protected class and those categorized as unhealthy may be intersectional.²⁸² Critical race scholar Kimberlé Crenshaw and others have theorized on the topic of intersectionality in civil rights.²⁸³ Their work embodies the idea that, although the protected class model of civil rights law tends to treat groups as “mutually exclusive categories of experience and analysis,” some groups will embody multiple protected class identities at once.²⁸⁴ For example, African American women are both women and a racial minority.²⁸⁵ Crenshaw argues that the civil rights approach of singular protected classes fails to capture the compounded discrimination that occurs when an individual occupies multiple disenfranchised identities.²⁸⁶ The courts may only recognize an individual as an African American or as a woman, but not acknowledge the unique hardships of a black woman.²⁸⁷ As a result, protected classes can frequently subsume the intersectional identity, meaning, for example, that an African American woman must either be identified as a woman or as an African American. If she is disparately impacted, she only has recourse if all women are statistically affected, or all black persons.²⁸⁸ Yet, because she is intersectional, she is seen as too unique compared with a protected class to represent all women or all African Americans.²⁸⁹

²⁸⁰ See Crossley, *supra* note 22, at 112.

²⁸¹ See Meade et al., *supra* note 54, at 2; Kawachi et al., *supra* note 61, at 344.

²⁸² See Crossley, *supra* note 22, at 151. See generally Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL. F. 139, 149 (1989) (discussing the intersectionality of discrimination for black females).

²⁸³ See Chery I. Harris, *Whiteness as Property*, 106 HARV. L. REV. 1709, 1791 (1993); Judy Scales Trent, *Women of Color and Health: Issues of Gender, Community, and Power*, 43 STAN. L. REV. 1357, 1363, 1365 (1991); Crenshaw, *supra* note 282, at 149.

²⁸⁴ Crenshaw, *supra* note 282, at 139.

²⁸⁵ See *id.* at 149.

²⁸⁶ See *id.* at 149–50.

²⁸⁷ See *id.*

²⁸⁸ See *id.*

²⁸⁹ See Trent, *supra* note 283, at 1365. The experience of being multiple protected classes can be unique and can sometimes compound discrimination. The particular experience of black

The interplay between protected class and the unhealthy in the ACA is similar. An African American woman might be discriminated against by an insurer because of her race and her gender, but also because of her perceived unhealthy status which may be driven by genetic or social factors related to her gender or race or neither. The ACA regulations will protect her from discrimination on the basis of health, while the civil rights remedies may protect her from discrimination based on gender and race. Because the unhealthy can occupy several classes at once, and because different aspects of the ACA target different aspects of discrimination, it is critical that civil rights laws and other antidiscrimination laws be viewed collectively to determine whether they sufficiently confront all types of health insurance discrimination.

The extent to which section 1557 is meant to combat health status discrimination broadly remains unclear. Though section 1557 was never part of the broader legislative history of the ACA, scholars note that the general tone throughout the debates indicated the purpose to implement strong antidiscrimination measures regarding healthcare.²⁹⁰ The ACA antidiscrimination provisions themselves never reference section 1557's protections, apart from the EHB regulations which indicate that an EHB violation is not a per se section 1557 violation.²⁹¹ Although Congress may ultimately have intended to confine section 1557 to protected class issues, its function may have broader application in health insurance.

Designed not only to fight protected class discrimination, but also to contribute to the broader battle of health status discrimination, section 1557 has some unique attributes compared with other ACA antidiscrimination protections. Section 1557 provides a civil rights lens to better inform the regulatory process with respect to what is or is not discriminatory in the ACA. Although the EHB regulation states that it is discriminatory to tier drugs on the

women in dominant cultural ideology encompasses intertwined relationships with race and gender. *See id.* Trent emphasizes this point in the context of healthcare:

Take, for example, the case of a Latina who is pregnant. Her relative ability or inability to get good prenatal care may well be influenced by her status as an undocumented worker or by her lack of fluency with English. It is at the confluence of these two problems—difficulties because she is a woman, difficulties because she is part of the Latino community, that one finds a woman of color issue.

Id.

²⁹⁰ *See* Deutsch, *supra* note 19, at 2496 (noting that this silence by Congress “does not necessarily suggest it did not mean Section 1557 to significantly alter patients’ rights,” but “[r]ather, the lack of history may indicate that the provision made its way quietly into the ACA in order to avoid attention and conflict”); Steege, *supra* note 19, at 455. The House version intended to create a broader civil right that barred discrimination on any basis apart from the “need for medical care.” Watson, *supra* note 3, at 872.

²⁹¹ *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822 (Feb. 27, 2015) (codified in scattered sections of 45 C.F.R.).

basis of disease without justification based on the price of the drug, it provides no doctrine for why such an action is discriminatory.²⁹² Section 1557 can go beyond a regulatory statement that a practice *is* discriminatory and supply a doctrinally-informed discussion of *why* the practice is discriminatory. Section 1557 complaints and lawsuits may also be a public way of bringing regulators' attention to ongoing instances of discrimination that they can then address through regulation.

A regulatory approach, however, may not have the flexibility to respond to new discriminatory innovations in the market in the way that section 1557 claims can. Regulatory changes can be slow and, perhaps, politically impossible. Likewise, as Reva Siegel warns in other civil rights contexts, discriminatory practices "evolve as they are contested," leading to a transformation of class treatment but not an abolishment of discrimination.²⁹³ One scholarly article has characterized the efforts to regulate evolving discrimination as a form of "whack-a-mole."²⁹⁴ While insurers find new innovative ways to discriminate, regulators slowly catch up and regulate, leading these insurers to find other unregulated avenues for discrimination. Section 1557 provides the potential threat of a lawsuit or a public complaint to OCR, which may be enough to change insurers' conduct.²⁹⁵ Additionally, clear and unambiguous civil rights guidance from OCR can inform this process and reduce the need for lawsuits or civil rights complaints.²⁹⁶ Courts may also grant injunctions to stop discriminatory conduct before it gains traction.²⁹⁷

Section 1557 may be able to monitor and contest age-old discriminatory insurance practices that have not been eradicated by the ACA. EHB regulations only offer outlier analysis in that they will review for whether an insur-

²⁹² See *id.*

²⁹³ Reva Siegel, *Why Equal Protection No Longer Protects: The Evolving Forms of Status-Enforcing State Action*, 49 STAN. L. REV. 1111, 1114 (1997).

²⁹⁴ Douglas Jacobs & Robert Restuccia, *Ensuring a Discrimination-Free Health Insurance System*, HEALTH AFFAIRS BLOG (June 11, 2015), <http://healthaffairs.org/blog/2015/06/11/ensuring-a-discrimination-free-health-insurance-system> [<https://perma.cc/3KRY-YDYD>].

²⁹⁵ See generally Watson, *supra* note 3, at 859.

²⁹⁶ See *id.* at 882.

²⁹⁷ See, e.g., *East v. Blue Cross & Blue Shield of La.*, No. 3:14-CV-00115-BAJ, 2014 WL 8332136, at *1 (M.D. La. Feb. 24, 2014). The class represented by John East successfully received an injunction against Louisiana insurers who threatened to refuse to accept Ryan White payments (federal dollars to cover HIV patients' premiums). See *id.* at *2. The court ordered a temporary injunction against this conduct on the basis that failure to accept these types of premiums could be a potential violation of section 1557 on the basis of disability. See *id.* at *1. The court's reasoning was short, but the court did highlight some of the harms to the parties if the insurer were permitted to refuse funds. See *id.* at *2. The injunction serves "public interest because it ensures that insureds in East's position maintain their current health care coverage, thereby avoiding, among other things, additional costs resulting from lost health care coverage, such as emergency room treatment in lieu of regularly scheduled doctor appointments and medications." *Id.* at *2 n.1.

er's practices have been going against the grain.²⁹⁸ But, this may be ineffective as "insurance discrimination is often based on long-standing and pervasive benefit-design customs" and relying only on outliers could miss "endemic patterns of discrimination."²⁹⁹ Section 1557 may reach broader and more entrenched practices of health status and protected class discrimination.

IV. DOCTRINAL ISSUES RAISED BY SECTION 1557 IN HEALTH INSURANCE ANTIDISCRIMINATION

Civil rights claims may play a critical role in eliminating discriminatory health insurance practices, both with respect to protected classes and health status discrimination. As a legal approach, however, civil rights actions present inherent doctrinal features that are limiting in the context of health insurance and broader health equity concerns.

There are two critical doctrinal questions regarding section 1557's utility in health insurance discrimination. First, civil rights laws have tended to permit economic rationality as a defense to a claim of discrimination. This Part briefly discusses the extent to which this should be viewed as a permissible defense following the enactment of the Affordable Care Act ("ACA"). Second, civil rights emphasize a formal vision of equality that may achieve much in eradicating health insurance discrimination. But, this vision of equality may, at times, miss the point when it comes to health insurance discrimination.

A. Economic Rationality

A major uncertainty regarding section 1557 claims is the extent to which insurers are permitted to argue actuarial fairness as a defense to a civil rights claim following the ACA, particularly for private insurers. Most civil rights statutes allow some form of defense based on rational economic conduct on the part of the defendant.³⁰⁰ In response to claims brought under Title VI, Title IX, and the Age Discrimination Act, the defense would be framed as a "substantial legitimate justification."³⁰¹ Similarly, in regards to the Rehabilitation Act, a defense can be raised if coverage of the benefit would amount to a fundamental alteration of the program.³⁰²

²⁹⁸ See *CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS.*, *supra* note 168, at 37–38.

²⁹⁹ *NHELP*, *supra* note 18.

³⁰⁰ See, e.g., *Title IX Manual*, *supra* note 207; *TITLE VI LEGAL MANUAL*, *supra* note 207, at 51.

³⁰¹ See, e.g., *Title IX Manual*, *supra* note 207; *TITLE VI LEGAL MANUAL*, *supra* note 207, at 51.

³⁰² See *Satz*, *supra* note 118, at 556.

Historically, the public has accepted the practice of private insurers charging based on actuarial fairness, rather than social solidarity.³⁰³ Yet, acceptance of actuarial fairness is ambiguous in the ACA. The rate-setting provisions seek to pool premiums primarily without respect to individual risk, though they do allow actuarially-relevant considerations around age, tobacco use, and geography.³⁰⁴ Conversely, the enrollment provisions and the mandate to purchase insurance seem to signal commitment to social solidarity by allowing everyone to have the opportunity to purchase health insurance equally.³⁰⁵ The incorporation of the Rehabilitation Act instead of the Americans with Disabilities Act (“ADA”) in section 1557 may also signal a move away from actuarial fairness because the latter specifically exempts acts of discrimination based on actuarial calculations unless they are a subterfuge to avoid the broader purpose of the law.³⁰⁶

Although Essential Health Benefits (“EHB”) regulations agree that tiering of all drugs for a particular condition might be discriminatory, they include a major caveat: that this practice is not discriminatory if it is justified by actuarial fairness because drugs on a particular tier actually do cost more.³⁰⁷ Moreover, it is unclear to what extent the ACA’s maintenance of the for-profit private insurance industry signals a retention of at least some aspects of actuarial fairness.³⁰⁸ Notably, the proposed rule did not address this tension of economic discrimination. Timothy Jost states that the proposed rule fails to directly address the major discrimination question of “whether insurers can impose high cost-sharing or otherwise limit access to expensive drugs needed by certain disabled populations, like persons with AIDS.”³⁰⁹

Because the private health insurance market has never been fully regulated by civil rights laws, and because this market has been re-shaped by the other ACA antidiscrimination provisions, it is impossible to predict how the courts and agencies will consider the topic of permissibility of actuarial fair-

³⁰³ See Stone, *supra* note 30, at 292–93.

³⁰⁴ See CTR. FOR MEDICARE & MEDICAID SERV., *supra* note 143.

³⁰⁵ See Stone, *supra* note 30, at 290–92.

³⁰⁶ The ADA has a specific provision that exempts insurers from antidiscrimination law if their actions are actuarially justified, while the Rehabilitation Act does not. Under the ADA, Title V, a plan must be “bona fide” and “underwriting risks, classifying risks, or administering such risks” may not be “used as a subterfuge” to discriminate. 42 U.S.C. § 12201(c) (2012). Thus the inclusion of the Rehabilitation Act may mean that a number of insurance practices cannot occur even if they are actuarially justified. Or it may simply reflect the reality that the Rehabilitation Act governs programs accepting federal money, and not state action.

³⁰⁷ See 45 C.F.R. § 156.298 (2015).

³⁰⁸ See Enthoven, *supra* note 120, at 29 (describing managed competition).

³⁰⁹ Timothy Jost, *Implementing Health Reform: HHS Proposes Rule Implementing Anti-Discrimination ACA Provisions (Contraceptive Coverage Litigation Update)*, HEALTH AFFAIRS BLOG (Sept. 4, 2015), <http://healthaffairs.org/blog/2015/09/04/implementing-health-reform-hhs-proposes-rule-implementing-anti-discrimination-aca-provisions> [<https://perma.cc/BKS3-DQMJ>].

ness as a defense in these types of cases. The courts could emphasize the private business aspect of private insurance akin to other private industries and attempt to balance free markets concerned with profits on one hand, and discrimination on the other.³¹⁰ Other private industries have utilized this balance, for example regulation by civil rights in employment laws.³¹¹ Many of the forms of discrimination mentioned in this Article have business purposes beyond that of discriminating against a protected group. Cost-sharing has been linked to differential harm to poor persons and the chronically ill, but it can also be justified because it reduces moral hazard and wasteful healthcare spending.³¹² The civil rights encompassed in section 1557, however, all prevent discrimination through the use of federal dollars, plain and simple, without respect to the issue of free markets.³¹³ Despite the status these insurers hold as private entities, section 1557 aims to ensure that federal dollars must not permit discrimination.

Perhaps there is an argument to be made that price discrimination is not the type of discrimination that these civil rights laws forbid because the law is more worried about protecting classes of persons. This is not so simple, however, when you consider that protected class membership and health status can be so closely intertwined in health insurance, and that price discrimination can be discrimination against a protected class. Moreover, the harms to the insurance market resulting from the prohibition of discrimination based on price have been alleviated by medical loss ratios and risk adjustment, reinsurance, and risk corridors.³¹⁴ With this in mind, should it still be considered rational and justified for an insurer to discriminate based on price?

Ultimately, the question of price discrimination raises a fundamental inner tension within the ACA. Although section 1557 might significantly restrain discrimination in private insurance as a method of competition, the ACA ultimately retained private markets as a vehicle for financing healthcare,

³¹⁰ See, e.g., *Tex. Dep't of Hous. & Cmty. Affairs vs. Inclusive Cmty. Project, Inc.*, 135 S. Ct. 2507, 2511, 2518 (2015) (framing the substantial interest as a business necessity, balancing the interests of nondiscrimination against the ability of businesses "to make the practical business choices and profit-related decisions that sustain a vibrant and dynamic free-enterprise system").

³¹¹ See *id.*

³¹² A famous insurance study conducted by RAND in the 1970s showed that although cost-sharing can curb moral hazard for certain groups, persons cutting back on services did not differentiate between cost-effective and non-cost-effective care. See THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH REFORM DEBATE, RAND CORPORATION 4-5 (2006), http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf [<https://perma.cc/B4PY-GS7G>]. In other words, they sometimes avoided medically necessary cost-effective care, as much as frivolous and unnecessary care. See *id.* The seriously ill and those with lower incomes were most motivated to reduce care, which can ultimately harm their overall health. See *id.*

³¹³ See *Title VI of the Civil Rights Act of 1964* 42 U.S.C. § 2000D *et seq.*, DEP'T OF JUSTICE, <http://www.justice.gov/crt/about/cor/coord/titlevi.php> [<https://perma.cc/VA6M-NTU7>].

³¹⁴ See Rosenbaum, *supra* note 22.

likely with an idea of keeping insurance costs low through market competition.³¹⁵ An overly heavy-handed approach by the courts in response may be unlikely, as they have historically shied away from what they perceive as health policy matters regarding the rationing of healthcare benefits.³¹⁶ Courts may be unwilling to strike a balance between the free market and antidiscrimination, particularly given that the matter has not been clearly addressed in the law or the accompanying rules.

B. Formal vs. Substantive Equality in Health Benefits

The role of formal equality resonates throughout civil rights laws and, therefore, presents a significant challenge to section 1557 claims.³¹⁷ Formal equality emphasizes sameness of treatment such that all similarly situated persons should be treated equally and all groups must have an opportunity to access a given benefit.³¹⁸ But, if unprotected classes do not have access to a benefit, then a vision of formal equality does not require the protected classes to have access either.³¹⁹ Conversely, substantive equality recognizes that sameness of treatment might not address inequality and that some difference in treatment might be necessary to allow for a level playing field.³²⁰ Samuel Bagenstos has framed this standard in the context of disability and health insurance as a difference between access and content.³²¹ When disabled parties seek to *access* the same benefits and treatments that non-disabled persons can enjoy, they have successfully stated a claim under both the Rehabilitation Act and the ADA.³²² Yet, when they argue that the *content* of the benefits needs to change to accommodate a disabled group, they fail because the court is unwilling to require a “fundamental alteration” to an insurance plan.³²³ Simply,

³¹⁵ See Enthoven, *supra* note 120, at 29.

³¹⁶ See Leslie Francis & Anita Silvers, *Debilitating Alexander v. Choate: ‘Meaningful Access’ to Health Care for People with Disabilities*, 35 *FORDHAM URB. L.J.* 447, 466 (2014); Mary Crossley, *Becoming Visible: The ADA’s Impact on Health Care for Persons with Disabilities*, 52 *ALA. L. REV.* 51, at 74–77 (2000).

³¹⁷ See Catherine Barnard & Bob Hepple, *Substantive Equality*, 59 *CAMBRIDGE L.J.* 562, 562 (2000) (explaining formal equality).

³¹⁸ See *id.*

³¹⁹ See *id.*

³²⁰ See *id.* at 563.

³²¹ See SAMUEL R. BAGENSTOS, *LAW & THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT* 70–74 (2009).

³²² See *id.*

³²³ See *id.* (framing this as an access vs. benefits standard). Mary Crossley has linked this concept to another framing by Sara Rosenbaum. Rosenbaum says the “fundamental alteration” limit is in re-designing the insurance product. See Rosenbaum et al., *supra* note 270, at 105. That is, insurers will not be expected to re-design their insurance products to accommodate the protected class. See *id.* She argues that this defense is expansive because almost any aspect of the plan can be seen as going to the heart of the insurance design—cost-sharing, provider compensation, eligibility for coverage, etc. See *id.* See generally Mary Crossley, *Giving Meaning to “Meaningful*

civil rights laws (or at least disability laws) only permit an examination of whether there is discrimination within the benefits already offered, but do not allow for arguments that additional benefits should be offered to better address certain individuals' special needs.

Section 1557 does not require an insurer to cover a particular service, rather it states that "a covered entity cannot have a coverage policy that operates in a discriminatory manner."³²⁴ Thus, section 1557 is not likely to engage the question of whether protected classes receive levels of care necessary for their well-being, but only that insurers must not discriminate on the basis of protected class in the coverage provided. Section 1557's rule provides examples: a plan that covers bariatric surgery for adults cannot exclude those adults with developmental disabilities, or a plan that covers treatment for eating disorders cannot cover inpatient care for men but not women.³²⁵ Yet, the plan is not required to cover the bariatric surgery or eating disorder treatment at all unless the EHB requires it.

Additionally, the draft proposed rule for 1557 states that insurers cannot forbid all coverage for gender transition, as this would be discriminatory on the basis of gender.³²⁶ But, insurers could certainly respond by covering only low-cost procedures, such as hormones, while excluding high-cost procedures, such as transition surgery. Likewise, in determining whether a transgender person has been discriminated against in access to benefits, the Office for Civil Rights ("OCR") will first look to "whether and to what extent coverage is available when the same service is not related to gender transition."³²⁷ For example, if a particular plan denies coverage for a hysterectomy that a patient's provider describes as medically necessary for the treatment of gender dysphoria, OCR will evaluate and compare the plan's coverage of hysterectomies in circumstances not related to gender dysphoria.³²⁸ As a result, this limits the reach of disparate impact claims brought forth by section 1557 to claims of discrimination in already-covered benefits.

Formal equality may pose a distinct challenge to plaintiffs seeking more comprehensive health insurance benefits, particularly those with complex

Access" in *Medicaid Managed Care*, 102 KY. L.J. 255, 263 (2014). Justice Ginsburg has underscored this point in the past: "We do not in this opinion hold . . . that the ADA requires States to 'provide a certain level of benefits to individuals with disabilities.' We do hold, however, that States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 603 n.14 (1999) (quoting *id.* at 624 (Thomas, J., dissenting)).

³²⁴ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,189 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

³²⁵ *See id.*

³²⁶ *See id.* at 54,189–90.

³²⁷ *Id.* at 54,190.

³²⁸ *See id.*

health needs. It is flawed because it fails to recognize that, in the financing of healthcare particularly, division of goods must necessarily be unequal.³²⁹ People's healthcare needs vary over their life cycle, some communities require more healthcare than others, and very few individuals will likely always consume a large majority of healthcare resources.³³⁰ Further, some vulnerable patients inevitably need services that no other comparator group will need. Transgender patients in *Cruz* argued that failure to cover certain hormone therapies was discriminatory.³³¹ Under a formal equality framework, however, they only win if they can show that other patients who are not transgender receive those same therapies.³³²

It also remains unclear as to how civil rights will apply when rationing leads to disadvantages for only some in a protected class, rather than the group as a whole. For example, many insurers are placing limits on, or failing to cover, the Hepatitis C drug Sovaldi, which costs \$84,000 for a course of treatment.³³³ There may not be a disparate treatment case if the insurer opts not to cover the drug at all because nobody has access—whether in a protected class or not.³³⁴ If the insurer provides access to some, for example based on how serious one's liver damage is, there may not be a viable disparate treatment suit because the question would be whether Hepatitis C patients are being treated differently from non-Hepatitis patients and it may be hard to prove a statistical harm.³³⁵

³²⁹ See THE CONCENTRATION OF HEALTHCARE SPENDING, NAT'L INST. FOR HEALTHCARE MGMT. (July 2012), <http://www.nihcm.org/pdf/DataBrief3%20Final.pdf> [<https://perma.cc/XA4M-TVCN>] (explaining that spending on health care services is concentrated among a small portion of the population with high use).

³³⁰ The trouble with equal treatment in the healthcare context is nicely summarized by David Orentlicher:

[T]he requirement of equal access to health care benefits does not simply mean that different persons must receive exactly the same benefits. If we treat people in exactly the same way, there will be greater hardship on some persons than on others. As the Supreme Court has observed, “[s]ometimes the greatest discrimination can lie in treating things that are different as though they were exactly the same.”

David Orentlicher, *Deconstructing Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 31, 77 (1996) (citing *Jenness v. Fortson*, 403 U.S. 431, 442 (1971)).

³³¹ See *Cruz v. Zucker*, 116 F. Supp. 3d 334, 338 (S.D.N.Y. 2015).

³³² See *id.*; Barnard & Hepple, *supra* note 317, at 562.

³³³ See Barua et al., *supra* note 7, at 215.

³³⁴ For example, in a current suit against the makers of the drug under section 1557, the United States District Court for the Eastern District of Pennsylvania has found the pricing not to be discrimination because “[t]here are no allegations that Gilead changes the prices of its drugs depending upon whether the potential consumer has Hepatitis C.” *Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 700 (S.D.N.Y. 2015).

³³⁵ See *id.*

Some aspects of the ACA point more towards a vision of substantive equality, which may inspire a court to follow suit. For example, EHB regulations require that single or extended release tablets be covered when they are medically appropriate.³³⁶ Mandating coverage of these drugs (and calling a failure to not cover it discrimination) is favorable to chronically ill patients, and may even reflect a recognition of HIV patients in particular that often take single tablet antiretrovirals. Though not every patient will need access to such drugs, the regulation recognizes a substantive fairness issue. Moreover, although section 1557's proposed rule does not state that all transgender services ought to be covered, it suggests that categorical bans of all types of services for a protected group may be discriminatory.³³⁷ This may be another example of the regulations contradicting the formal equality model by allowing for a claim to a positive right to a benefit regardless of how or if it is made available to the non-protected group.³³⁸

Although a formal equality framework enhances equality in health insurance benefits, it does not go as far as substantive equality. To the extent that lawsuits under section 1557 continuously fail because of this issue, regulatory efforts may be more important. Section 1557 or EHB regulations may be able to address some visions of substantive equality by simply mandating coverage of a certain benefit for a certain group. For example, the section 1557 proposed rules simply declare that it is discriminatory not to cover some

³³⁶ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 168, at 37.

³³⁷ Specifically, § 92.207 states that a "categorical (or automatic) exclusion of all health services related to gender transition is unlawful on its face . . . [because it] systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex." Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,190 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

³³⁸ One significant exception is the cases invoking section 1557 and disability discrimination. A discussion of this topic is beyond the scope of this article, but suffice it to say that the proposed rule requires covered entities to reasonably accommodate disabilities in accordance with *Alexander v. Choate*, 469 U.S. 287 (1985). See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,204 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92). In *Choate*, patients sued the state Medicaid agency after it reduced inpatient hospital coverage from twenty days to fourteen days, arguing that the cut violated Section 504 of the Rehabilitation Act by disparately impacting the disabled who require greater access to hospitals than their non-disabled peers. See *Choate*, 469 U.S. at 287. The drop in covered inpatient stays did not exclude the disabled from the Medicaid services or deny them meaningful access because Medicaid patients were offered the same benefits as the nondisabled and could equally enjoy the fourteen covered days. See *id.* The Court refused to ask whether these patients had *enough* hospital days or whether they needed more, suggesting that at least in the case a more formal vision of equality was not far from their minds. In extrapolating to section 1557 cases, the accommodation would need to be "reasonable" and to supply the disabled person with meaningful access, but it should not rise to the level of "fundamental" or "substantial" alteration to the program. See *id.* at 300. While in *Choate* the Court was somewhat reluctant to impose too great of an accommodation onto the defendants, as a state Medicaid agency with a budget deficit, courts might view this differently if private, for-profit insurance was involved. See *id.* at 309.

aspect of gender transition care.³³⁹ Without a requirement in the regulations that insurers cover certain types of benefits, insurers may choose simply not to cover a benefit rather than have to provide it to all groups equally.

Section 1557 can do much to fight both protected class and health status discrimination in health benefits, but it is not a panacea. A number of the doctrinal limitations inherent in civil rights may prevent section 1557 from realizing universal access to all necessary benefits. Rather, section 1557 is best read as one of several antidiscrimination provisions of the ACA that can work in concert to tackle health insurance discrimination.

CONCLUSION

Section 1557 or a similar provision is likely to remain in health insurance, regardless of the future of health reform. The original intent behind the Civil Rights Act of 1964, which became the model for future civil rights laws incorporated into section 1557, was that “simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination.”³⁴⁰ The idea of simple justice in government funds is consonant with Deborah Stone’s social solidarity model presented previously.³⁴¹ That is, simple justice requires that the common fund paid in by all insureds through premiums not be used in a way that further entrenches disparities, whether health status-based or health disparities-based. As long as any version of health reform brings federal dollars into the healthcare arena there will be an opportunity to apply these broad civil rights protections.³⁴²

Section 1557 substantively builds on the other, better-known provisions of the ACA that combat health insurance discrimination while also uniquely protecting vulnerable groups in health insurance. It can play a significant role in eliminating health disparities related to health insurance discrimination and can contribute to broader health equity. However, civil rights laws will not be the cure-all for every aspect of health insurance discrimination because they include a number of doctrinal limitations. Fundamentally, section 1557 can bring healthcare closer to social solidarity by pushing society to examine

³³⁹ See *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. 54,172, 54,190 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

³⁴⁰ DEP’T OF JUSTICE, *supra* note 313 (quoting President John F. Kennedy).

³⁴¹ See Stone, *supra* note 30, at 287.

³⁴² Even proposed repeals of the ACA seem to recommend the use of tax credits, which may well implicate civil rights laws. The Burr, Hatch, Upton proposal uses tax credits for the uninsured and individuals employed by small businesses. See, e.g., THE PATIENT CHOICE, AFFORDABILITY, RESPONSIBILITY, AND EMPOWERMENT ACT 4, <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf> [https://perma.cc/8M42-RKRR].

whether benefits are being equally offered across groups and determining to what extent courts can permit economic discrimination in the face of harms to protected classes. Section 1557, like the ACA, however, is not a form of universal coverage. As a civil rights provision, section 1557 may not engage well with questions of universal access and substantive equality, or of whether an insurer must cover a given benefit in order to make the system more equitable.

Inevitably, section 1557 and the wider antidiscrimination agenda of the ACA in addressing the issue of freedom from discrimination in insurance come close to reaching broader issues of a right to healthcare. They also raise a fundamental, broader question about the purpose of civil rights protections and antidiscrimination protections in health insurance: should we worry about health status discrimination because it may further entrench already disadvantaged groups, or do we worry about it as an issue in and of itself?³⁴³ To that end, what are the best remedies and which forms of discrimination should we inhibit? The role that civil rights doctrine can and will play in these broader questions of health equity is ripe for further legal and theoretical study.

³⁴³ See Roberts & Leonard, *supra* note 22, at 6–7, 33–35; Roberts, *supra* note 24, at 1166–70.