CIVIL RIGHTS AS TREATMENT FOR HEALTH INSURANCE DISCRIMINATION

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INTRODUCTION

Section 1557 of the Patient Protection and Affordable Care Act (ACA)[1] broadly prohibits discrimination on the basis of race, color, national origin, gender, age, and disability in healthcare programs or activities receiving federal dollars.[2] The provision should hold interest for civil rights scholars and health policy scholars alike.[3] It's the first civil rights statute to combine four different civil rights statutes into a single provision creating nightmarish ambiguity about the proper standards for cause of action and remedy.[4] Section 1557 also represents the first civil rights statute to broadly tackle discrimination in healthcare, including private health insurance,[5] and to apply sex

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1. Patient Protection and Affordable Care Act § 1557, 42 U.S.C. § 18116 (2012).

2. Section 1557 specifically applies Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973. *Id.* The draft proposed rule for Section 1557 proposes that only entities in receipt of Department of Health and Human Service funds will be regulated. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173 (Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

3. A few notable publications in the law literature include 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 (2015) (exploring Section 1557, gender, and provider conscience); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012) (describing Section 1557's potential to combat racial inequality in healthcare); Sarah G. Steege, Note, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439 (2011) (arguing for the promise of private actions in Section 1557).

4. *See* Steege, *supra* note 3.

5. *See* Watson, *supra* note 3, at 859.

discrimination to healthcare (including discrimination based on gender identity and possibly sexual orientation).[6]

Section 1557 warrants further analysis, but this small article will explore the value added of a civil rights approach to combatting health insurance discrimination when combined with other ACA antidiscrimination efforts. This topic particularly merits attention given that early Section 1557 cases tend to focus on health insurance discrimination.

I. CHARACTERIZING HEALTH INSURANCE DISCRIMINATION

First, it is useful to briefly describe what Section 1557 is up against when it prohibits "discrimination" in the context of health insurance.

Not all insurance discrimination is illegal or even unfair, rather I take the term to only mean difference in treatment between two groups.[7] All insurers place some sort of limit on services that could be discriminatory in that sense. Depending on the type of insurance, insurers might limit expenditures by limiting benefits, excluding those likely to consume a lot of resources, or giving the unhealthy bad insurance terms (higher premiums, lesser benefits, greater cost-sharing), all with an aim towards limiting the payout of the insurer.[8]

To a certain extent, health insurance discrimination is economically motivated. Private insurers seek to promote profits, while public insurers (e.g., Medicare and Medicaid) shield taxpayer money.[9] However, some would argue that discrimination by insurers can be laden with value judgments that reflect society's view of the social worth of a given population.[10]

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6. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,174.

7. Others have noted the difficulty of terminology in this context. *E.g.*, SARA ROSENBAUM, INSURANCE DISCRIMINATION ON THE BASIS OF HEALTH STATUS: AN OVERVIEW OF DISCRIMINATION PRACTICES, FEDERAL LAW, AND FEDERAL REFORM OPTIONS 1 (2009), http://www.rwjf.org/content/dam/farm/reports/reports/2009/rwjf36943.

8. *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, 439–40 (2010) (explaining that conventional insurance inherently relies on underwriting to exclude bad risks and price according to risk profile).

9. Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652 (2008).

10. Elizabeth Pendo, *Shifting the Conversation: Disability, Disparities and Health Care Reform*, 6 FIU L. REV. 87, 92–93 (2010) (describing differences in access

Poor health status, of course, is a central feature of those discriminated against in insurance because health status is so closely related to consumption of healthcare services.[11] Why someone has poor health status, however, is a complex question. Accidents or bad luck may strike even the healthy, or someone may have experienced a lifetime of barriers to the social determinants of health (for example, good education, a living wage, safe housing, and access to affordable medical care).[12] Social determinants can create health disparities that can make whole classes of persons unattractive to insurers, hence why many protected classes (like those protected by Section 1557) have been the subjects of discrimination by insurers in the past.[13]

Discrimination by health insurers not only affects individuals' abilities to achieve their best possible health status,[14] but good health can be seen as necessary to participate meaningfully in civic and social engagements.[15] Not to mention that discrimination is seen as a harm unto itself, for example, if it is based on bias or inaccurate measures of social worth.[16]

From broader societal interests, our health insurance system may be characterized as dysfunctional if health insurance is cost prohibitive or thin in coverage for the very group that needs it, those in poor health. And the system may be unjust if the differentiations in health are the result of social inequality and discrimination. Insurance

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to care for persons with disabilities as partly due to "stereotypes, false beliefs and invisibility.").

11. Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 74 (2005).

12. KAISER FAMILY FOUND., DISPARITIES IN HEALTH AND HEALTH CARE: FIVE KEY QUESTIONS AND ANSWERS (2012), https://kaiserfamilyfoundation.files.wordpress.com/2012/11/8396-disparities-in-health-and-health-care-five-key-questions-and-answers.pdf.

13. *Id.*; Paula Braveman, *Health Disparities and Health Equity: Concepts and Measurement*, 27 ANN. REV. PUB. HEALTH 167 (2006).

14. One study estimates that by "equalizing levels of health coverage, the United States could conceivably address roughly one-third . . . of the reason for disparity." Marsha Lillie-Blanton & Catherine Hoffman, *The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Health Care*, 24 HEALTH AFF. 398, 406 (2005).

15. Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 8 (2001).

16. *See* Larry Alexander, *What Makes Wrongful Discrimination Wrong? Biases, Preferences, Stereotypes, and Proxies*, 141 U. PA. L. REV. 149 (1992). The experience of social discrimination can itself be a driver of bad health. *See, e.g.*, DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015); INST. OF MED., NAT'L ACAD. OF SCIS., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003).

discrimination then evokes questions of distributive justice,[17] as well as economic efficiency.[18]

II. THE ACA'S ANTIDISCRIMINATION AGENDA

Given these issues, many of the ACA's more notable provisions sought to discourage discrimination by health insurers, mainly on the basis of health status.

In addition to requiring group and individual insurers to guarantee the issue[19] and renewability of insurance for anyone wishing to purchase it,[20] these same insurers are longer permitted to exclude enrollees from insurance on the basis of preexisting condition[21] or a host of other factors that might predict healthcare consumption.[22] Insurers are also restricted in using health (or proxies for health) in determining premiums.[23]

The ACA also prohibits discrimination in insurers' coverage of benefits by requiring all insurers to cover at least minimal essential health benefits (EHB) regardless of the health status of the insured.[24] This reduces insurers' ability to compete by avoiding the unhealthy indirectly through leaner benefit packages.[25]

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17. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993) (arguing that actuarial fairness of shifting costs of healthcare onto the unhealthy is a question of distributive justice).

18. Thomas A. LaVeist et al., *Estimating the Economic Burden of Racial Health Inequalities in the United States*, 41 INT'L J. HEALTH SERVICES 231, 234–35 (2011) (Up to 30% of our medical costs for certain minorities—African Americans, Hispanics, and Asians—may be due to health inequities, translating to a loss of $309.3 billion per year in the U.S.).

19. Insurers are allowed to restrict enrollment to specific open enrollment and special enrollment periods. 42 U.S.C. § 300gg-1 (2012).

20. *Id.* § 300gg-2.

21. *Id.* § 300gg-3.

22. *Id.* § 300gg-4 (including health status; physical or mental medical condition; claims history, i.e., the number of claims per patient; medical history; use of health care; genetic information; other evidence of insurability, such as history of domestic abuse; and disability).

23. Premiums may not vary except on the basis of age, geography, tobacco use, and family size. *Id.* § 300gg. Some scholars argue premium differentiation in these categories may contribute to health disparities and is itself counter to ACA's antidiscrimination mission. Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159.

24. 42 U.S.C. § 300gg-6 (2012). The regulations specifically prohibit discrimination in benefit design on the basis of "an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." 45 C.F.R. § 156.125(a) (2015).

25. § 156.125(a).

The ACA also indirectly discourages discrimination through a variety of provisions that eliminate insurers' incentives to discriminate based on health status.[26]

Despite the various health insurance market reforms of the ACA, some forms of insurance discrimination continue while new ones are evolving to respond to the new market. Drug-tiering is an example. Not explicitly precluded by the ACA, insurers are discouraging enrollment by unhealthy groups (and shifting cost onto them) by placing all or many drugs for certain costly conditions onto higher cost-sharing tiers.[27] This can means thousands of extra dollars for patients and missed treatments.[28] The EHB regulations state that drug-tiering is discriminatory if it puts all drugs for a single disease on the same tier, unless the drugs are actually more expensive.[29] This suggests that the categorization of the person based on disease is the only aspect of tiering that is problematic, and that rational economic insurance discrimination is permissible.[30]

Section 1557 provides another lens to explore the permissibility (and limits) of tiering and other potentially discriminatory market developments and whether economic rationing changes permissibility.

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26. The law sets minimum medical loss ratios such that insurers must spend certain minimum percentages (at least 80%) of the premium dollars they receive to value their enrollees, 45 C.F.R. § 158.210–.211 (2015); it reallocates funds across insurers to compensate those insurers that incurred greater healthcare expenses (thus discouraging cherry-picking of healthy enrollees), 42 U.S.C. § 18061–63 (2012); and it mandates insurance purchase, ensuring that the cost of covering the sick can now be spread across the whole population, an attempt to avoid adverse selection, *id.* § 18091.

27. Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace*, 372 NEW ENG. J. MED. 399, 401 (2015).

28. *Id.*

29. 45 C.F.R. § 156.122 (2015).

30. Besides drug tiering, an example of potentially discriminatory conduct is wellness plans, allowing insurers to vary premiums, to a limited degree, based on health status variations, which some scholars think will simply shift cost from the healthy onto the unhealthy. Jill R. Horwitz et al., *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468 (2013). Another example is network innovations that might exclude specialty practices that treat costly diseases. 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 (2015). Some scholars even argue that provisions of the ACA itself are discriminatory, for example the provisions that allow premium differentiation based on geography or age. *See, e.g.*, Roberts, *supra* note 23.

III. SECTION 1557 AND HEALTH INSURANCE DISCRIMINATION

Section 1557 applies Title IV, Title IX, Age Discrimination Act, and Rehabilitation Act protections to entities that are receiving federal financial assistance.[31] In the context of health insurance this may encompass private insurers offering plans on the exchange and public insurers (e.g., Medicare and Medicaid).[32] Section 1557 also reaches to the federal- and state- facilitated exchanges and their decisions about which plans can be approved for offering on the exchange.[33]

Section 1557's spirit is likely to remain, regardless of the fate of the ACA in the next presidential election, so long as any version of health reform brings federal dollars into the healthcare arena.[34] Section 1557 is driven by the Civil Rights Act of 1964, the mission of which was that "[s]imple justice requires that public funds, to which all taxpayers . . . contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in . . . [protected class] discrimination."[35]

As gaps in the ACA's insurance protections are being identified, advocates and patients are turning to Section 1557 to expand legal protections against discriminatory health insurance. Legal cases and complaints have challenged the following diverse practices: drug tiering that implicates a single disease group (for example, placing all drugs for HIV or MS onto a single high-cost tier),[36] insurance designs that

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31. Patient Protection and Affordable Care Act § 1557, 42 U.S.C. § 18116 (2012).

32. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,173–74 (Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

33. *Id.*; *see, e.g.*, *Cruz v. Zucker*, No. 14-cv-4456 (JSR), 2015 WL 4548162 (S.D.N.Y. July 29, 2015) (plaintiffs suing state Medicaid agency for access to gender-transition benefits).

34. Even proposed repeals of the ACA seem to recommend the use of tax credits, which may well implicate civil rights laws. For example, the Burr-Hatch-Upton proposal uses tax credits for the uninsured and individuals employed by small businesses. THE PATIENT CHOICE, AFFORDABILITY, RESPONSIBILITY, AND EMPOWERMENT ACT 4 (2015), https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf; Press Release, Energy & Commerce Comm., Burr, Hatch, Upton Unveil Obamacare Replacement Plan (Feb. 5, 2015), https://energycommerce.house.gov/news-center/press-releases/burr-hatch-upton-unveil-obamacare-replacement-plan.

35. *Overview of Title VI of the Civil Rights Act of 1964*, U.S. DEP'T JUST., https://www.justice.gov/crt/title-vi-civil-rights-act-1964-42-usc-2000d-et-seq (last updated Jan. 22, 2016) (quoting President John F. Kennedy, 1963).

36. Jane Perkins & Wayne Turner, *NHeLP and the AIDS Institute Complaint to HHS Re HIV/AIDS Discrimination by Florida Insurers*, NAT'L HEALTH L. PROGRAM (May 29, 2014), http://www.healthlaw.org/publications/browse-all-publications/HHS-HIV-Complaint.

potentially discourage enrollment by vulnerable enrollees,[37] age-based caps on eligibility for benefits,[38] and failure by a state Medicaid agency to cover gender transition benefits.[39] Other, informal claims of Section 1557 violations target plans that exclude dependent enrollees from maternity care, coverage for labor and delivery outside of the service area, and gender-transition care.[40]

Section 1557 uniquely targets protected class discrimination but may reach health status discrimination too because of the relationship between protected class, health disparities, and health status. In this sphere, Section 1557 can supplement the other antidiscrimination laws of the ACA; it does not subtract from them in any way but can take up where the ACA's regulatory framework has left off. First, Section 1557 provides additional remedies. The ACA's other antidiscrimination reforms rely on regulators to update regulations to flag as discriminatory evolving insurance practices and to decertify health plans not in compliance.[41] The draft proposed rule for Section 1557 envisions a more rapid and public forum for civil rights complaints and litigation, while also permitting some individual damages.[42] In many instances, the state or private insurer has changed practices without comment from OCR and without litigation, demonstrating the importance of a public process.[43] Section 1557 complaints and litigation may also serve to put regulators on notice about emerging patterns of discrimination, which can then be addressed through regulatory means.[44]

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37. Complaint, *East v. Blue Cross & Blue Shield of La.*, No. 14-115 (M.D. La. Feb. 20, 2014); *see also East v. Blue Cross Blue Shield of Louisiana*, LAMBDA LEGAL, http://www.lambdalegal.org/in-court/cases/east-v-bcbs (last visited Mar. 6, 2016).

38. Arielle Levin Becker, *State Removes Age Limit for Fertility Treatment Coverage*, HARTFORD COURANT (Aug. 13, 2015, 6:27 PM), http://www.courant.com/business/hc-ctm-fertility-treatment-connecticut-20150813-story.html.

39. *Cruz v. Zucker*, No. 14-cv-4456 (JSR), 2015 WL 4548162 (S.D.N.Y. July 29, 2015).

40. NAT'L WOMEN'S LAW CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 4, 20 (2015), http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf.

41. For example, issuers must comply with the EHB provisions to be certified for offering on the exchange. 45 C.F.R. § 156.125 (2015).

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

43. For example, this happened in response to the NHelp complaint, *see* Perkins & Turner, *supra* note 36, and in the case of the Connecticut state law that imposed an age limit on fertility treatment coverage, *see* Becker, *supra* note 38.

44. For example, the expansion of what is considered discriminatory in EHB regulations. § 156.125.

Moreover, Section 1557 presents new claims beyond the other ACA antidiscrimination laws. It encompasses private and public insurance and state action related to benefit decisions, while most of the other provisions only address private insurance.[45] Section 1557 also goes beyond the ACA's focus on health status discrimination, specifically recognizing protected class discrimination as forbidden in health insurance. For this it has great symbolic meaning and practical effect for health equity.[46] Without Section 1557, protected classes are not directly addressed by the insurance reforms and may only indirectly be benefitted by the health status antidiscrimination provisions in the ACA.[47] Section 1557 also goes beyond the simple regulatory statement that a practice *is* discriminatory, allowing for a discussion informed by civil rights doctrine of *why* the practice is discriminatory.

CONCLUSION

Section 1557 of the ACA substantively builds on the other, better-known provisions that combat health insurance discrimination, while also uniquely protecting vulnerable groups in health insurance. The time is ripe to explore the theoretical and doctrinal limits and strengths of this civil rights approach as part of a wider discussion over what is and what should be seen as discrimination in health insurance.

45. *See, e.g.*, *Cruz v. Zucker*, No. 14-cv-4456 (JSR), 2015 WL 4548162 (S.D.N.Y. July 29, 2015).

46. *See* KAISER FAMILY FOUND., *supra* note 12.

47. *See supra* notes 19–24 and accompanying text. The other ACA antidiscrimination provisions typically only indirectly benefit these groups and may even permit discrimination against these groups.