"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform

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=abstract

Discussions of health-status discrimination permeated the debate surrounding health-care reform, infusing those conversations with the language of civil rights. Insurance, however, is by its very nature discriminatory. Thus, an antidiscrimination paradigm is not the appropriate normative framework for addressing disparities in health-insurance coverage.

This Article identifies an unresolvable tension between the antidiscrimination approach embraced by health-care reform advocates and the current practices of the private, for-profit health-insurance industry, which the Affordable Care Act (ACA) seeks to preserve. For-profit health insurance has historically disadvantaged individuals based on health status through risk-assessment and cost-sharing mechanisms. Proponents of health-care reform vilified these
accepted business practices as producing untenable discrimination against the sick. Congress, therefore, adopted an antidiscrimination framework in the Affordable Care Act. Specifically, the statute forbids insurers from considering health-related factors in their rating and underwriting decisions. Yet these protections will ultimately fail to eliminate the disparities experienced by the sick in health insurance. As of 2014, individual and small-group insurers may base their rating decisions on criteria including age, geographic location, and tobacco use, and large-group insurers may consider participation in wellness programs. These new rating mechanisms approximate health status, thereby disadvantaging the same populations as the existing system. Thus, while the Affordable Care Act may end health-status discrimination on its face, it will not in its effect. Consequently, this Article proposes an alternate normative framework for addressing the problem of un- and underinsured Americans grounded in a universal right to basic health-insurance coverage. It concludes by teasing out examples of the universal right paradigm within the Affordable Care Act and exploring how those provisions could be improved to ensure that more Americans carry baseline health insurance.
Introduction

On March 23, 2010, President Barack Obama made history by signing the Affordable Care Act (ACA) into law.\(^1\) With between forty-six and fifty million uninsured Americans,\(^2\) and an additional twenty-five million estimated to be underinsured,\(^3\), health-care reform was an essential part of his campaign. During the Democratic National Convention in August 2008, then-Senator Obama vowed to “make certain [insurance] companies stop discriminating against those who are sick and need care the most.”\(^4\) Following his election, President Obama continued to express the hope that reforming health care might eliminate the health-insurance disadvantages traditionally experienced by the sick.\(^5\)

The President was far from alone with this goal. Eliminating the disadvantages experienced by the sick in health insurance served as a major talking point throughout the course of health-care reform.\(^6\) Time and time again, reform advocates recast existing health-insurance practices as intolerable discrimination against those most in need.\(^7\) They argued that restricting health
insurance based on an individual’s health status creates a discriminatory harm contrary to the
U.S. ideals of equality and antidiscrimination. When drafting the legislation, Congress likewise
adopted an antidiscrimination frame, prohibiting various traditional insurance practices that
disadvantage the sick: as of 2014, the legislation bars health insurers from making underwriting
and rating decisions based on health-related factors.

“Discrimination,” however, in the simplest form of the word, has historically been an
essential aspect of private, for-profit insurance. To make money, health insurers must accurately
assess the risks of their prospective insureds, which in turn results in their differentiating on the
basis of health status. Although attacking differential treatment on the basis of health status as
discrimination, the Affordable Care Act seeks to keep the private, for-profit health-insurance
industry in place.

This Article reveals an important and—ultimately unresolvable—tension within the
Affordable Care Act: It simultaneously adopts an antidiscrimination framework and seeks to
preserve traditional private, for-profit insurers as among the primary providers of health
insurance in the United States. Under the new statute, many health insurers can no longer use past or current health conditions in making their determinations. The Affordable Care Act, therefore, calls into question the private, for-profit health-insurance industry’s ability to function absent traditional measures of risk. The new law will test whether the kind of expanded health-insurance coverage envisioned by reformers is possible with the continued reliance private, for-profit insurance. This Article asserts it is not. More broadly, this Article queries whether antidiscrimination provides the correct framework for addressing disparities in the existing health-insurance system or whether the goals of health-care reform warrant a different normative framework, and possibly a different structure of health-insurance delivery. In particular, it examines how antidiscrimination as a framing device shaped the Affordable Care Act’s protections, yet ultimately fails to eliminate the disadvantages experienced by the sick in health insurance. Successfully achieving this end, therefore, requires an alternate normative foundation. This Article suggests that a universal-right model provides a preferable theoretical paradigm to antidiscrimination.
This Article proceeds in three parts. Part I introduces the concept of health-status discrimination or “healthism” and describes how the practices of the private, for-profit health-insurance industry have historically disadvantaged individuals on the basis of health status. Part II explores how antidiscrimination provisions operate in health-insurance legislation through a close reading of the relevant sections of three landmark federal statutes: the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the Affordable Care Act. Part III demonstrates how the Affordable Care Act—despite barring insurers from explicitly considering health status—could replicate existing disadvantages. This Article asserts that the statute’s failure to eliminate disadvantages experienced by the sick in health insurance is a function of the inherent tension between the antidiscrimination paradigm and the traditional practices of the private, for-profit health-insurance industry. It, therefore, proposes an alternate framework based in a universal right to a basic level of health-insurance coverage. This Article concludes by uncovering elements of the universal-right model already present within the Affordable Care Act and suggesting changes
that would allow this alternative theoretical frame to better operate in conjunction with the
changes already enacted by the legislation.

I. Defining “Healthism”: What Is Health-Status Discrimination?

People discriminate every day.\textsuperscript{16} We differentiate on the basis of education, athletic ability, or even attractiveness. Yet for something to qualify as discrimination, in the pejorative sense, that differentiation must constitute a normative wrong.\textsuperscript{17} In short, it must be perceived as being “unfair.” What distinguishes acceptable discrimination from unacceptable discrimination is often the characteristic that forms the basis of that differentiation, especially when differentiating produces an undesirable social result.\textsuperscript{18}

In the past, health insurers have used a person’s health—in the form of preexisting conditions, current health status, family history, or previous claims—to differentiate between insureds in both pricing and coverage.\textsuperscript{19} This differentiation constitutes a key element of the traditional private, for-profit insurance industry: charging insureds rates based on their relative risk and covering conditions based on their potential costs are exactly what allow health insurers
to profit. These practices are so endemic to the industry that one author has called risk-based pricing “the raison d’être of a health-insurance company.”

Taken en masse, however, these policies—either explicitly or implicitly—lead to disadvantage based on an individual’s health status. Advocates of health-care reform, therefore, framed them as producing untenable discrimination against the sick.

This Part outlines the ways in which private health insurance has led to disadvantages for people based on their health status, in both the individual and group markets. Employing an antidiscrimination framework casts these efforts at differentiation from savvy risk-assessment and cost-minimizing strategies to intolerable discrimination against individuals in need of health care. Interestingly, both advocates and opponents of reform adopted the language of antidiscrimination in stating their positions.

A. Health Insurance and Risk Assessment

Defined loosely, insurance is a risk-pooling arrangement designed to indemnify the contracting party against a particular kind of loss. Insurers guarantee their insureds against any
number of possible harms including death (life insurance), property damage (fire insurance, flood insurance, casualty insurance, renter’s insurance), injury (disability insurance), and illness (health insurance). Thus, as part of their services, insurers must set premiums related to their insureds’ probable risks. Failing to assess risk accurately could lead to adverse selection, which can undermine the insurance structure.

Adverse selection describes the tendency of high-risk people to purchase insurance. Thus, the individuals most likely to seek insurance are also the ones most likely to use it. Likewise, low-risk individuals may opt out of insurance, finding it worth the gamble to have limited or even no insurance once premiums reach a certain cost. Because insuring higher-risk individuals is more costly, adverse selection drives up the price of premiums. This process may in turn induce lower-risk individuals to flee the market to save costs. If enough low-risk people leave the insurance pool, rates will again go up, driving those in the remaining group with the lower relative risk to leave the market, and so on, until the market collapses. This phenomenon is known as a “death spiral.”
Adverse selection and death spirals are problems associated with group-based insurance, such as health insurance, as opposed to insurance determined exclusively by experience rating, such as car insurance. Information asymmetries between the insurer and the insured make these difficulties possible, particularly when insureds act based on personal knowledge of their risks while those risks remain unknown to the insurer. If insurers are aware of all potential risks, they can factor those risks into their underwriting and rating decisions to avoid inflating premiums down the line. Accurate risk assessment can, therefore, safeguard insurers from adverse selection and the resulting death spirals.

Profitable insurance thus relies on assessing accurate, calculable risks. By contrast “health” is a fluid and amorphous concept, leaving health insurers with the challenge of evaluating their insureds’ relative “health.” In assessing the health of a particular insured, a health insurer may evaluate the likelihood that that person will require health procedures and services, frequently relying on the opinions and diagnoses of health professionals. As a result, health insurers have
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historically employed medical information, in addition to demographic and behavioral factors like sex, age, and smoking, when determining coverage and setting premiums.\textsuperscript{32}

B. Disadvantage in Traditional Health Insurance

In private, for-profit health insurance, both individual and group health insurers have historically engaged in risk-assessment and other profit-maximizing strategies that systematically disadvantage people with histories of illness and chronic health conditions.\textsuperscript{33} Among these traditional insurance practices are health-status based rating, preexisting condition exclusions, limited coverage, and considerations of claims history. While risk is distributed differently in the individual and group health-insurance markets, both systems have disadvantaged individuals based on their health status.

1. In the Individual Market

The individual health-insurance system has consistently preferred those deemed “healthy” over their riskier counterparts. Consequently, health-insurance companies may reject or offer limited—but expensive—coverage to individuals who appear too dangerous, diseased, or costly
to insure. In the individual market, health insurers have traditionally used health status to
disadvantage existing and potential insureds in at least two contexts: eligibility and rating.

First, insurers may use health information in making eligibility or underwriting decisions.
Underwriting is the process by which insurers evaluate applications for insurance. It involves
assessing the applicant’s potential risk. Once the insurer assesses the relevant risks it may either
assign the applicant to a particular rating class and offer a corresponding policy, or it may
decline to offer a policy altogether. If a potential insured has a condition that puts him or her at a
heightened health risk before applying for coverage, health insurers in the individual market may
simply choose not to cover that particular preexisting conditions. Preexisting conditions
include any number of serious mental and physical health conditions, ranging from breast cancer,
depression, and testing positive for HIV to relatively minor ones, like allergies or acne.

Second, health insurers may also engage in health-status based rating. In the individual
market, health-status based rating involves an assessment of the individual insured’s health risks
based on his or her current and past health conditions. Consequently, when health insurers take
health status into account when setting premiums, those with higher risks pay higher rates. It, therefore, stands to reason that some people pay out of pocket for testing or care that is covered by their health-insurance plan to avoid giving insurers access to health information that could result in a premium increase down the line. It is worth noting that intentionally concealing health information from an insurer creates precisely the type of information asymmetry that leads to adverse selection and its associated problems.

Accordingly, the individual health-insurance market disadvantages people on the basis of their health. Because of these risk-reducing, cost-stabilizing mechanisms, people with severe past or current health problems may have limited or no health insurance and may pay heightened premiums for what little coverage they do have. The result is that those most likely to need medical services are also those least likely to be individually insurable.

2. In the Group Market

Most Americans with health insurance are insured through a group plan. Group health-insurance plans—such as employer-provided health insurance—distribute risk differently than
individual policies. Instead of assessing the relative health risks of individual insureds, group
health insurers look at the relative risk of the group as a whole. As a result, group plans tend to
be more affordable than individual plans because the potential risk is spread over a greater
number of policyholders. Group health-insurance plans come in two varieties: large and small.
The smaller the group, the fewer insureds are available to share risk. Thus, small-group health-
insurance policies feel the impact of individual risk factors, such as health status, more acutely
than large groups. Like individual health-insurance providers, group health insurers
disadvantage their insureds on the basis of health status, albeit less directly.

Group health insurers may use a variety of methods in setting rates and determining
coverage. However, as in the individual market, the goal is the same: to assess risk accurately.
For instance, an insurance company offering group health-insurance coverage might examine
risk at the level of the individual group or at the level of the group’s industry as a whole.
Among the methods for determining group health-insurance premiums are (1) community rating,
(2) community rating by class, (3) prospective experience rating, and (4) retrospective experience rating.45

Community rating involves generating rates per member, per month based on the aggregate claims history of the community (with adjustments for possible future changes in the administration of the plan).46 Similarly, community rating by class examines the community’s aggregate historical claims but in conjunction with certain characteristics of the individual group, such as the age and sex distribution of its members, the kind of industry to which the group belongs, and types of plans available.47 Thus, community rating by class allows the health insurer more specificity in assessing risk by incorporating more factors into its premium determination.48

While community rating looks to group characteristics to assess risk, experience rating examines the actual claims histories of the individual groups.49 Prospective experience rating uses the group’s claims history to calculate future risk.50 Retrospective experience rating also
employs the actual claims experience of the group but includes a retroactive adjustment based on
the claims history for the particular contract period for reconciliation purposes.\textsuperscript{51}

Despite their spreading risk across a larger number of policyholders, group health insurers
also disadvantage individuals based on health status. For instance, insurers in the group market
may reject the group in its entirety.\textsuperscript{52} Group health insurers could also limit the amount and type
of coverage or benefits available to similarly situated members of the group,\textsuperscript{53} thus providing
limited or no coverage for particular health conditions.\textsuperscript{54} Moreover, if a particular insured
develops a costly health condition, that single person’s diagnosis could impact the entire group’s
premium or coverage, particularly in the small-group market. This reality has at times led
employers to ask their employees to leave the group plan\textsuperscript{55} or to fire (or avoid hiring) employees
with expensive conditions.\textsuperscript{56} Group health insurance, however, may also disadvantage insureds
on the basis of health status in more subtle ways, particularly through various cost-sharing
mechanisms.
To start, people with chronic illnesses tend to pay more frequently out of pocket for their health-care expenses. As health-insurance providers attempt to lower costs, they have moved toward more cost-sharing mechanisms designed to redistribute the cost of care between the insurer and the insured. Health insurers have three main strategies for achieving cost sharing: (1) deductibles, (2) coinsurance, and (3) copayments. Deductibles often take the form of flat dollar amounts that the insured must pay before her insurer will begin coverage. With coinsurance, an insured must pay a certain percentage of particular kinds of expenses covered by the insurer. Finally, copayments typically involve an insured paying a relatively small dollar amount toward each designated covered service.

The result is that those with health conditions requiring ongoing care pay significantly more—and more often—than individuals who are not as frequently in need of medical services. In fact, one study indicated that having a single chronic health condition increases an individual’s out-of-pocket expenses by over seventy percent, and having a second condition increases it by three-hundred percent. Thus, many of the mechanisms used to control costs
instead shift those costs to the insureds who are in greatest need of care. In other words, group health-insurance plans also generate disadvantage on the basis of health status.

Existing health-insurance practices—in both the group and individual markets—result in disadvantage on the basis of health status. The very same risk-assessing and cost-minimizing strategies that generate disparate outcomes based on health, however, are also the practices that allow private health insurers to profit.

C. From Business Savvy to “Healthism”

Both individual and group health insurers—in their efforts to assess risk, limit costs, and maximize profits—base decisions on health status. When examined en masse, these business strategies have a disproportionately negative impact on certain populations, mainly people with health conditions that require ongoing care. Although these practices have been central elements to the traditional private, for-profit health-insurance industry, this systematic disadvantaging of individuals on the basis of health status was framed as “discrimination against the sick” during the recent health-care reform debate. By adopting this frame, reform advocates were
identifying a new kind of discrimination—discrimination on the basis of health status, or “healthism.”

1. “Healthism”: What Is It?

Previously, “healthism” has described the shift in responsibility for health problems from the individual to the state. Conversely, “healthism,” as used here, denotes discrimination on the basis of health status. Both definitions, however, are relevant to the recent changes to the U.S. health-insurance industry. The traditional concept of healthism involves the government’s promotion of coercive health norms, and its attempts to impose lifestyle choices deemed “healthy” on its citizens. Thus, on one hand, health-care reform is “healthist” in its attempt to promote public health. The Affordable Care Act includes such measures as tackling obesity by requiring national restaurant chains to post their nutritional information and embracing employer-provided wellness programs. On the other, health-care reform targets the second kind of “healthism” by including antidiscrimination provisions designed to eradicate
discrimination on the basis of health status in health insurance. While the earlier definition cannot be ignored, this Article focuses on the latter.

2. “Healthism” As “Discrimination”

Discrimination can mean several things. Frequently, it stands for the proposition that individuals should not experience disadvantage on the basis of a particular characteristic. If health status joins the catalogue of forbidden traits, health insurers are undoubtedly discriminators. By using health information to make eligibility, coverage, and pricing decisions, traditional for-profit health insurance has long been “healthist” in both cost and coverage. These business practices became the subject of antidiscrimination rhetoric during the course of health-care reform. In fact, the language of antidiscrimination was so ubiquitous that even opponents of reform framed their position in those terms.

a. The Meaning of “Discrimination”

Yet what does it mean to label a particular practice as “discrimination” in the pejorative sense? As noted, the word “discriminate,” as defined in the dictionary, simply means to
differentiate.\textsuperscript{75} When used derisively, “discrimination” indicates that a normative wrong occurs either in the course of, or as the result of, making that distinction.\textsuperscript{76} But what makes one kind of differentiation acceptable and another morally reprehensible—and perhaps legally actionable—is a complicated question and one that relies heavily on historical and cultural context.\textsuperscript{77} As one scholar has explained, “Discrimination is not one thing, but many.”\textsuperscript{78}

For instance, one could think of discrimination in either group or individual terms.\textsuperscript{79} For instance, sex discrimination can either be understood as discrimination against an \textit{individual} on the basis of “sex” as characteristic, or as discrimination against a particular social \textit{group} that shares a common trait, such as men or women. Take this example: A restaurant has a policy that it will hire only women as waitstaff.\textsuperscript{80} This policy discriminates in the individual sense because the employer considers the applicant’s sex when making a hiring decision. It likewise discriminates in the group sense because the policy disadvantages men, as a group, and advantages women.
Additionally, discrimination can be intended or unintended. Intentional discrimination takes the form of a policy or decision that explicitly considers a particular trait (or membership in a particular group), such as the example above. Alternatively, certain facially neutral practices may lead to unintended discriminatory results. For example, an airline might have a policy that its pilots are at least 5’7” to ensure they can safely operate the plane’s equipment. Women, however, are generally smaller in stature than men. Thus, a height policy that prefers taller individuals will tend to favor male applicants. Although the employer did not intend to discriminate on the basis of sex, the height policy produces that very outcome. Because these unintended discriminatory outcomes perpetuate existing social disadvantages, they are arguably just as problematic as their intentional counterparts.

Often for discrimination to be considered objectionable, the differentiation in question must result in social disadvantage. Conversely, some scholars (and judges) have taken the position that certain traits are so inherently problematic that any intentional consideration of them—positive or negative—rises to the level of discrimination. Consequently, all differential
treatment based on a particular characteristic may at times be referred to as “discrimination,”
even when it produces a neutral or favorable outcome. Although a negative outcome may not
be necessary to construe a practice or policy as discriminatory, members of Congress focused on
disadvantage as the touchstone for “discrimination” in the context of the health-care reform.
Thus, while far from the only acceptable definition, for the purposes of this Article,
discrimination connotes systematic disadvantage related to a protected trait or status.

Despite the numerous ways to construe the meaning of discrimination—group versus
individual, intended versus unintended, positive versus negative—a key determinant of whether
differentiation is acceptable or deplorable relies upon the distinguishing characteristic itself. A
variety of different social categories have been acknowledged as legally inappropriate grounds
for discrimination, including race, national origin, sex, disability, and age. Most
recently, genetic information entered the canon of protected traits in federal antidiscrimination
law.
The idea of “healthism” or health-status discrimination is, therefore, particularly significant because it represents the creation of a new variety of socially recognized discrimination and, consequently, a new antidiscrimination category. Like other such categories, health-status discrimination can be thought of in two ways: discrimination on the basis of a protected trait (“health status”), or alternatively as discrimination against a particular disadvantaged group (“the sick”). While the Affordable Care Act itself is written in terms of the former iteration, members of Congress arguing in favor of reform tended to adopt the latter. Proponents frequently spoke in terms of the disadvantages experienced by chronically ill individuals or those in need of ongoing care.

If health status is in fact a protected category, the traditional private, for-profit health-insurance industry is surely “healthist.” To start, health insurers openly discriminate on the basis of health status when they impose preexisting condition exclusions or engage in health-status based rating. Those practices are healthist on their face. Other policies, however, are healthist in their result, such as the cost-sharing mechanisms now popular within the group market.
Importantly, both result in disadvantage based on an individual’s health status. Both “discriminate.”

b. Adopting Antidiscrimination

Proponents of reform adopted the language of antidiscrimination to describe the ways in which private health insurers have systematically disadvantaged individuals on the basis of health status. In fact, this framing was so powerful that both sides of the debate employed antidiscrimination rhetoric, yet in different ways.

Advocates of health-care reform framed health-insurance practices that disadvantaged people based on health status—not as smart business practices—but as insufferable discrimination. For instance, Representative Louise Slaughter described preexisting condition exclusions as “cruel,” “capricious,” and “done only to enhance the bottom line.”

Representative Edward Perlmutter, in reference to his daughter who was uninsurable at the time because of epilepsy, alleged that excluding her from insurance coverage is not only “wrong” but also “probably unconstitutional under the [Fourteenth] Amendment to the United States
Constitution.”

He went on to explain, “There should not be discrimination in health care. There shouldn’t be denial of coverage because of a preexisting condition. We need to change the system that exists so that there is coverage for all Americans with chronic illness and the like.”

Moreover, some reform proponents described denying health insurance based on health status as akin to race discrimination. On several occasions, Representative Steven Kagen described preexisting condition exclusions as discrimination on the basis not of skin color but of “skin chemistry.” Putting health status on par with race constitutes an important rhetorical move, as race is widely regarded as the most invidious basis for discrimination. Senator Patrick Leahy put things simply: “Insurance companies can and do discriminate against sick people.”

Opponents of health-care reform responded in kind, using their own brand of antidiscrimination rhetoric. Although not directly answering assertions that the existing health-insurance system discriminates against the sick, members of Congress opposing reform instead pointed out that other populations would experience disadvantage should the legislation pass. Thus, in addition to the economically driven arguments that health-care reform would negatively
impact small businesses\textsuperscript{105} and raise premiums,\textsuperscript{106} opponents of reform also asserted that the proposed changes would negatively impact certain groups—mainly the young,\textsuperscript{107} women,\textsuperscript{108} and low-wage workers.\textsuperscript{109} The language of antidiscrimination was, therefore, such a powerful rhetorical tool that both sides chose to employ it.

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Traditional private, for-profit health insurance has historically disadvantaged individuals on the basis of health status. In the past, people with chronic or other kinds of costly conditions in need of ongoing care typically have either had difficulty obtaining health insurance or paid more—both out of pocket and in premiums—for less than comprehensive coverage. The practices that generate these results, such as preexisting condition exclusions, rating based on health status or claims history, and cost-sharing mechanisms, are all ways in which health insurers have attempted to assess risks or otherwise minimize costs. Advocates of health-care reform, however, framed these popular business strategies as unfairly discriminatory on the basis of health status. This observation is not merely an interesting exercise in rhetorical technique.
Characterizing the health-insurance industry as “healthist” is significant because that characterization frames the very problem that health-care reform seeks to address. If health-care reform’s goal is—at least in part—to eliminate *discrimination* on the basis of health status, the appropriate legal framework for addressing the issue becomes antidiscrimination (or “nondiscrimination”) legislation. The following Part explores the antidiscrimination provisions of three federal health-insurance statutes—HIPAA, GINA, and the Affordable Care Act.

II. Combating “Healthism”: Antidiscrimination Provisions in Federal Health-Insurance Legislation

Antidiscrimination often functions as a redistributive—or restitutive—principle. Thus, laws designed to promote antidiscrimination norms seek to dismantle existing disparities tied to their associated, protected characteristics. This redistributive impulse is so strong that some antidiscrimination statutes require covered entities to take affirmative steps to ensure meaningful equality for those covered by the law. More commonly, however, antidiscrimination laws forbid covered entities from making decisions based on protected traits. This kind of
protection is often referred to as adopting a “blindness” perspective: the covered entity must act as though the protected trait is non-existent, or at least imperceptible. The antidiscrimination provisions found in federal health-insurance legislation take this form. They bar health insurers from considering certain enumerated factors in their underwriting and rating decisions.

The Affordable Care Act was not the first time Congress employed an antidiscrimination framework when amending federal health-insurance law. Both HIPAA and GINA included limited antidiscrimination provisions. This Part provides close readings of the antidiscrimination language in each of these three federal health-insurance statutes and examines the efficacy of those provisions in the two pieces of pre-Affordable Care Act legislation.

A. Antidiscrimination in HIPAA

HIPAA represents the first instance in which Congress applied an antidiscrimination approach to health-insurance legislation. Congress passed HIPAA in 1996 both to protect individuals who encountered difficulty in accessing health insurance and to improve health-care delivery generally. Title I governs the availability and range of health-insurance coverage for
group and certain individual plans, and Title II requires national standards for health-care provision, including regulations related to health-information security and privacy.

HIPAA’s supporters cited eliminating health-status discrimination as among one of the legislation’s most significant goals. Representative William Richardson explained that in addition to protecting workers’ health insurance as they change jobs, HIPAA “also prevents discrimination against those individuals with preexisting conditions.” Similarly, Senator Judd Gregg explained that HIPAA “grew out of the recognition that some basic flaws in the regulation of health care caused American families monumental problems,” including the fact that “[i]ndividuals are subject to unfair discrimination in their access to health insurance if they have a medical condition that has required treatment before they joined that health plan.”

HIPAA includes sections designed to limit disadvantage on the basis of health status in private health insurance. Pre-HIPAA, employers and group health insurers could deny or limit coverage due to preexisting medical conditions and individual health status. HIPAA restricted an insurer’s ability to consider preexisting conditions. Thus, post-HIPAA, group plans and
providers of group health insurance could only impose preexisting condition exclusions under
certain specific circumstances. Additionally, HIPAA prohibits group health insurers from
using a number of health-related factors, such as health status and claims history, in making
eligibility determinations. The statute also prevents providers of group health insurance from
requiring an individual in the group to pay higher premiums or make larger contributions than
similarly situated group members on the basis of health-related factors. HIPAA, therefore,
outlaws excluding or medically underwriting individuals in the context of group health
insurance.

Moreover, in conjunction with HIPAA, the Departments of the Treasury, Labor and Health
and Human Services issued final rules for group health-insurance plans that went into effect in
the summer of 2007. These “nondiscrimination rules” were in large part designed to clarify
what constitutes unlawful discrimination with respect to eligibility or premiums in employer-
provided group health insurance.
While HIPAA’s antidiscrimination provisions were extremely popular, they had a limited impact. To start, the protections apply only to group insurers. While only a fraction of Americans hold individual health-insurance policies, they are typically people without access to group health insurance or to public benefits who turn to the individual market out of necessity. Further, once there, they will likely encounter barriers to obtaining and affording coverage. Even after HIPAA, people seeking health insurance via individual plans could still be deemed uninsurable, have their benefits limited, or have their rates increased on the basis of their health status. Moreover, while HIPAA requires group health insurers to provide coverage for preexisting conditions, it does not specify the coverage or benefits insurers must offer or, perhaps more importantly, limit the premiums they may impose. Consequently, even at the time of its passing, it was clear that HIPAA—while making group health insurance more portable and more accessible for certain individuals—might not increase the actual availability of health insurance to a significant degree because of its continued allowance of risk-based rating and its failure to cap premiums.
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Although HIPAA includes certain provisions designed to limit “healthism” in health insurance, the antidiscrimination protections it offers still allow health insurers to make decisions based on health status. While group health insurers could not discriminate against individuals in the group, they could still make group-wide decisions based on health status, such as the kind of benefits or coverage to provide or the amount of a premium to impose. Thus, if one member of a group develops a serious illness, it could affect the health insurance of all group members. 139

This problem became a contentious issue, particularly in the small-group market. 140

Additionally, HIPAA had no impact on the provision of individual health insurance.

Consequently, those people with no access to group health insurance still experienced disadvantage based on their health status. HIPAA, therefore, represents a move toward reducing healthism in health insurance yet continues to allow certain kinds of disadvantage.

B. Antidiscrimination in GINA

Prior to the 2010 health-care reform, the GINA was among the most significant changes to the U.S. health-insurance industry in recent history. 141 In drafting GINA, Congress again used
an antidiscrimination framework. Yet, unlike HIPAA, GINA does not target “healthism”
generally but rather targets discrimination specifically on the basis of an individual’s genetic
information.¹⁴²

GINA outlaws genetic-information discrimination in health insurance¹⁴³ and employment.¹⁴⁴

Pursuant to GINA, a health insurer cannot: (1) use genetic information to determine eligibility,
coverage, or premiums; (2) request or require genetic information or genetic testing; (3) acquire
 genetic information for underwriting purposes; or (4) treat genetic information as a preexisting
condition.¹⁴⁵ Similarly, an employer cannot (1) hire, fire, classify, or otherwise disadvantage
 employees on the basis of genetic information; or (2) request, require, or purchase employees’
genetic information.¹⁴⁶

Given the very personal nature of genetic information, GINA’s supporters frequently
invoked the language of antidiscrimination.¹⁴⁷ Two of GINA’s major supporters in Congress,
Senator Olympia Snowe and Representative Louise Slaughter, argued that basing decisions on an
individual’s genetic information constitutes discrimination. Senator Snowe asserted, “‘Genetic
discrimination is, by its nature, a purposeful act based on an immutable fact—one’s very heredity. . . .” Likewise, Representative Slaughter stated, “No American[s] should have to worry that their genes—which they did not choose, and over which they have no control—will be used against them.” Congress, therefore, drafted GINA as an antidiscrimination statute.

Preventing health insurers from using genetic information in determining eligibility and coverage restricts the kind of information available for underwriting and rate-determination purposes. These restrictions may lead to exactly the kind of information asymmetries that generate adverse selection and lemon problems. Not surprisingly, law and economics scholars have objected to the kinds of limitations posed by GINA. Although restricting access to genetic information may result in negative externalities that undermine the insurer’s interests, Congress still chose to protect genetic information. Hence, GINA demonstrates a shift from using certain health-associated factors in determining health insurance, even when considering that those factors would lead to more accurate risk assessment. This statute represents a move away from a purely economic approach to health insurance to an antidiscrimination model.
Although GINA restricts health insurers’ access to certain kinds of useful information, the statute ultimately reaffirms the preference for the “healthy” over the “unhealthy” in health insurance. Neither GINA’s insurance provisions nor its employment protections safeguard individuals from discrimination on the basis of manifested genetically linked health conditions.

GINA defines “genetic information” as the results of an individual’s genetic tests, the results of an individual’s family members’ genetic tests, and the manifestation of a disease or disorder in an individual’s family member. Despite protecting genetic information, GINA does not cover discrimination on the basis of a manifested genetic condition once it is diagnosable by other means.

For example, GINA’s insurance title explicitly excludes tests directly related to manifested health conditions from its definition of “genetic test.” As a result, a test that detects a manifested condition—even if that condition has a genetic basis—is not a genetic test. Thus, a test that diagnoses Huntington’s disease, a genetically based disorder with a one-hundred percent
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correlation between the associated genetic variant and the development of the condition,\textsuperscript{156} is not a “genetic test” for insurance discrimination purposes.

In addition to the definitions provided in the statute’s text, GINA’s corresponding interpretative regulations further delineate the differences between genetic information and manifested—albeit genetically linked—health conditions. The Departments of Health and Human Services, Labor, and the Treasury drafted the regulations for GINA’s insurance title.\textsuperscript{157} They define “manifestation” or “manifested” as when “an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved.”\textsuperscript{158} While tests for genetic variants—such as those associated with breast or colon cancer—are genetic tests, other kinds of testing—such as tests to diagnose HIV, determine blood count, or measure liver function—are not.\textsuperscript{159}

Congress and GINA’s governing agencies designed the statute primarily to protect \textit{asymptomatic} individuals against discrimination on the basis of genetic information.\textsuperscript{160} As a
result, GINA protects a person with a genetic variant predisposing him or her to a genetic disorder, but once the disease manifests, that diagnosis becomes a preexisting condition subject to limited coverage and increased premiums. For example, if a woman has a genetic variant predisposing her to breast cancer, her health insurer cannot use that information in calculating her rates and coverage; yet once she develops cancer, it can. Perhaps even more bizarrely, the manifestation of a genetically based condition is genetic information under the statute for an individual’s family members, yet not for the individual herself.\textsuperscript{161} Thus, if an insurer covers two siblings and the first sibling develops cancer as the result of a genetic proclivity but the second does not, the insurer may use the first sibling’s diagnosis in determining the terms of her insurance but cannot consider that same diagnosis when calculating the second sibling’s insurance. Thus, while GINA represents Congress’s willingness to limit a health insurer’s access to certain risk assessment criteria in the name of antidiscrimination, GINA reaffirms the preference for the healthy within health insurance by solidly protecting only genetic information that has not yet manifested into a diagnosable medical condition.\textsuperscript{162}
C. Antidiscrimination in the Affordable Care Act

Congress revisited the role of manifested health conditions in health-insurance determinations when drafting the Affordable Care Act. As discussed in Part I, proponents of health-care reform harnessed the rhetoric of antidiscrimination, casting the Affordable Care Act as a “civil rights bill for the sick.” It includes a number of provisions that prohibit discrimination in the delivery of the health-care services. Notably, three of those provisions do away with considerations of medical history and other health-related issues in health-insurance decisions.

The Affordable Care Act amends the Public Health Service Act to eliminate preexisting condition exclusions by both group and individual health-insurance providers. It provides that, “A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.” Thus, as of the legislation’s effective date in 2014, health insurers will no longer be able to deny coverage—even temporarily—based on an individual’s history of illness.
Likewise, the Affordable Care Act also bans health insurers in the individual and small group markets from setting “discriminatory premium rates.” The relevant section limits the information that those health insurers can consider when setting premiums to four criteria: (1) whether the insurance covers an individual or a family, (2) geographic location (or rating area), (3) age, and (4) tobacco use. The ability to consider these factors, however, is not absolute. The Affordable Care Act also sets out guidelines regulating how the states may establish their rating areas and the permissible variations based on age and tobacco use. For example, the legislation requires states to establish at least one rating area and fixes the ratios by which insurers may vary their rates on the basis of age and tobacco use to no more than three-to-one and 1.5-to-one, respectively. Thus, while individual- and small-group insurers may no longer explicitly use past or current health status in determining premiums, they may still vary their rates based on these four factors, which may in fact serve as crude proxies for health status.

Finally, the Affordable Care Act prohibits both group and individual health insurers from discriminating against participants or beneficiaries based on their health status. It provides
that insurers cannot make eligibility decisions based on health status, medical condition (both mental and physical), previous claims, health-care services received, medical history, genetic information, evidence of insurability, disability, or any other health-status-based factors designated. Employer-provided plans, however, can vary health-insurance premiums by up to thirty percent if an employee participates in a wellness program designed to promote health and prevent disease. The statute further authorizes a ten-state Wellness Program Demonstration Project to test the program in the individual insurance market. Thus, while insurers cannot discriminate based on health status, employers can offer insurance benefits for participating in wellness programs that encourage their employees to reduce their health risks.

* * *

The Affordable Care Act was not the only occasion in which Congress applied an antidiscrimination approach to drafting health-insurance law. Both HIPAA and GINA also include provisions designed to eliminate discriminatory treatment. Like the Affordable Care Act, HIPAA targets “healthism” outright by outlawing various kinds of health-status based
determinations. The statute, however, does not completely bar insurers from considering
health information and, as a result, permits certain “healthist” insurance practices to continue.

Similarly, GINA prevents health insurers from making decisions based on genetic information
but not decisions based on manifested genetic conditions. Thus, the law provides limited
protection—prohibiting health insurers from considering a particular type of health-related
information (the results of genetic tests) but permitting them to make decisions based on related
conditions.

Like HIPAA and GINA, the Affordable Care Act’s antidiscrimination provisions may also
ultimately leave the preference for healthy individuals in health insurance in place. The
following Part explores where and how the new legislation’s antidiscrimination approach falls
short and provides another normative framework for expanding health-insurance coverage.

III. Critiquing “Healthism”: Shortcomings of Antidiscrimination and an Alternative Model

The Affordable Care Act adopts an antidiscrimination model for improving health-care
access, while simultaneously attempting to leave the traditional private, for-profit health-
insurance industry intact. As discussed in Part I, the profitability of private health insurance has historically relied upon risk-based differentiation, making the industry inherently discriminatory. Thus, the very nature of the U.S. insurance system does not lend itself to an antidiscrimination model. This Part examines how the antidiscrimination provisions of the Affordable Care Act—while outlawing overt considerations of health-related information—could fail to eliminate disadvantage on the basis of health status in health insurance. It, therefore, proposes that an alternate normative framework may better address the problem of un- and underinsured Americans.

A. How Antidiscrimination Fails

The Affordable Care Act may fail to achieve the goal of ending disadvantage on the basis of health status in health insurance. Like HIPAA and GINA before it, the statute takes a “health-status blind” approach by barring insurers from explicitly considering health status in their underwriting and rating decisions. Although the law is not “healthist” on its face, it could still favor the same individuals who benefited under the preceding system. Within the individual and
small-group markets, the new rating criteria\textsuperscript{185} act as proxies for health and may, therefore, perpetuate existing disparities. Within the large-group market, wellness programs\textsuperscript{186} 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 could thus perpetuate health-status discrimination. Although the law succeeds from an antidifferentiation standpoint,\textsuperscript{187} it fails by producing discriminatory outcomes.

In assessing whether the Affordable Care Act successfully eliminates discrimination on the basis of health status, it is first necessary to define what constitutes success.\textsuperscript{188} In the most technical sense, the legislation achieves its goal: the Affordable Care Act—on its face—limits the ability of health insurers to take health-based information into account when making underwriting and rating decisions.\textsuperscript{189} It eliminates \textit{facial} discrimination. From a functional standpoint, however, the law may in fact fail. Specifically, it does not eradicate discriminatory \textit{outcomes} related to health status.\textsuperscript{190} To borrow language from Title VII doctrine, the new policies will likely have a “disparate impact” on the basis of health-related factors.\textsuperscript{191} Thus, the
same individuals who experienced disadvantage before the reforms may continue to have
difficulty even after 2014.

1. Proxies for Health Status

The Affordable Care Act does away with the consideration of health-related factors in
determining rates in the individual and small-group markets,\textsuperscript{192} replacing those criteria with age,
geographic location (as set by the state-created rating areas) and tobacco use. However, all three
of the new factors function as proxies—albeit inaccurate ones—for health status. Each trait
corresponds to certain kinds of health risks. Consequently, basing premiums on these criteria
may negatively impact many of the same populations disadvantaged when insurers used health-
related factors outright.\textsuperscript{193}

As people age, their need for health-care services tends to increase. Older individuals are at
a higher likelihood of developing degenerative diseases such as age-related hearing and vision
loss.\textsuperscript{194} Similarly, age may also result in compromised immune and other systems, which could
lead to an increased risk for other kinds of health conditions and illnesses.\textsuperscript{195} The inverse is also
true: on average, younger people tend to experience fewer health-related problems. Generally, the older a person becomes, the more likely he or she will be to require health-care services.

Likewise, where a person lives can also approximate her health status. People living in low-income areas—particularly the urban poor and individuals in rural communities—on average tend to experience more health risks combined with less access to health care. Thus, depending on how states draw the boundaries of the rating areas, allowing health insurers to engage in community rating could continue to disadvantage low-income people who live in the inner city, as well as people in rural areas. While the federal government will have review over the rating areas, the law merely provides that the areas are “adequate.” Consequently, the federal government’s definition of adequate will determine whether cordoning off low-income, high-risk populations is an acceptable practice. If adequate means “nondiscriminatory,” higher premiums would be unacceptable. If adequate means “accurate for risk assessment purposes,” however, requiring poorer communities to pay higher health insurance premiums would be permissible. Importantly, under the new system, an income-based subsidy will be available to
help offset the cost of health insurance, yet particular lower-income populations might still experience disadvantage—most notably the “near poor.”

In crafting the Affordable Care Act’s health-insurance system, Congress attempted to anticipate the possible challenges that would be encountered by lower-income individuals. The legislation’s “insurance mandate” requires all Americans—with certain exceptions—to have a minimum amount of health-insurance coverage. Consequently, the Affordable Care Act provides a subsidy for people who meet certain criteria of financial need. The subsidy, implemented as part of the Internal Revenue Code, ultimately manifests as an income-tax benefit. Additionally, the Affordable Care Act also attempts to reduce the amount lower-income individuals pay for out-of-pocket costs. Even with the subsidy program and the effort to limit cost-sharing, however, lower-income individuals may still experience disadvantage. When taken in the entirety with the existing federal income-tax structure, the Affordable Care Act’s attempts to assist lower-income individuals may result in high marginal tax rates. While unintentional, those high rates can have extremely negative taxation effects on low-income
households, with marginal rates sometimes exceeding one-hundred percent. This result will likely be felt most strongly by the “near poor,” those living just above the poverty line. As a result, certain lower-income individuals may still face financial obstacles related to health insurance and health-care access, even after the reform.

Lastly, tobacco use is also a proxy for health status. Smokers face a heightened risk for several health conditions, including various kinds of cancer, cardiovascular and respiratory disease, and loss of bone marrow. Tobacco use thus communicates a higher likelihood of either currently having—or at some point developing—those associated health conditions. Smokers also experience diminished overall health, leading to more time away from work and a heightened consumption of medical services. Thus—as with age and location—tobacco use does not function as a perfect proxy for health, but there are notable parallels. Moreover, tobacco use also correlates with other health disadvantages. Lower-income individuals are statistically more likely to use tobacco. Thus, as with community rating, varying premiums based on tobacco use will likely disadvantage poorer individuals.
To sum up, although Congress eliminated explicit considerations of health status from the rating process, the new factors may negatively affect individuals who already faced disadvantage under the current system. Aging, living in a low-income community, and using tobacco all carry with them well-known and predictable health risks. Thus, age, geographic location, and tobacco use crudely approximate health status, as well as the need for health-related services. Allowing health insurers to take those factors into account will produce a disparate impact on the basis of health status. As a result, the new health-care system may disadvantage the same populations as its predecessor, just through a different, more indirect, process.

2. Wellness Programs

The new rating criteria are not the only features of the Affordable Care Act that could perpetuate existing disparities in health-insurance coverage. As noted, while certain insurers cannot use health status to set rates, employer-provided plans can vary health-insurance premiums up to thirty percent as an incentive to participate in a wellness program. Nevertheless, not everyone is equally capable of participating. In particular, people with
disabilities, older individuals, and low-income workers will likely experience more limited opportunities with regard to wellness programs. Consequently, wellness programs may simply replace negative considerations of health status with positive ones. Like the new rating factors, wellness programs may, therefore, end up disadvantaging some of the same populations as the existing insurance system.

In sum, although the Affordable Care Act prohibits health insurers from explicitly considering health-related factors when making their determinations, the statute allows them to weigh characteristics that closely parallel health status. Older individuals, individuals in low-income areas, and tobacco users all face higher health risks and are, therefore, more likely to be unhealthy. As a result, insurers can still distinguish between individuals who represent good and bad risks. Put simply, the new health-insurance system outlined by the Affordable Care Act may still disadvantage the sick, albeit by proxy.

B. Why Antidiscrimination Fails and an Alternative
Before exploring alternate health-insurance frameworks, it is important to revisit the underlying goals of reform. As explored in Part I, advocates spoke in terms of eliminating the disadvantage experienced by the sick. As Einer Elhauge has noted, people often experience not only “moral discomfort” when those who need care go without but also “a Kantian moral duty to alleviate serious misery suffered by our fellow man.” Health-care reform is, therefore, at its core, largely a moral issue. While antidiscrimination may provide a useful model for civil rights law, however, it does not lend itself to health-insurance law.

Insofar as Congress built discriminatory mechanisms into the new statute, the Affordable Care Act will not eliminate disadvantage based on health status. The new rating factors and the consideration of wellness programs will have a disparate impact on the sick, thereby perpetuating existing disadvantages. This analysis demonstrates how the Affordable Care Act fails. The reason why the Affordable Care Act fails, however, lies in the intrinsic tension between an antidiscrimination framework and the existing practices of the private, for-profit health-insurance
industry. Consequently, Congress should consider an alternate paradigm for addressing the disadvantages individuals experience in private health insurance based on health status.

1. Antidiscrimination and Traditional Health Insurance

Traditional, for-profit health insurance is at odds with an antidiscrimination model. Because of this fundamental discord, protections framed in antidiscrimination terms will never be capable of eliminating health-status discrimination.

As discussed, antidiscrimination stands for the proposition that individuals should not experience disadvantage based on a protected characteristic. Antidiscrimination provisions often take a “blindness” approach by simply removing the forbidden trait from the decision-making process. In the context of the Affordable Care Act, the normative value driving the antidiscrimination model is the belief that health insurers should not treat individuals differently on the basis of health status. Specifically, it is the notion that health insurers should not disadvantage the sick. In keeping with this antidiscrimination sentiment, the
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Affordable Care Act bars health insurers from basing their underwriting and rating decisions on health-related information and sets out a new procedure for determining rates.

At the same time, Congress tried its best to preserve the traditional practices of private, for-profit health insurance. As discussed, the health-insurance industry relies on differential treatment to minimize costs and maximize profits. Distinguishing between insureds on the basis of the health status provides a relatively straightforward means of assessing potential risk. The Affordable Care Act, however, does away with those established measures of risk. Thus, to allow for-profit health insurers to continue to operate, the statute provides alternate rating criteria. As discussed, those new criteria have a disparate impact on the basis of health. Yet this result is no accident. For those rating variables to be of use to health insurers—that is for them to allow the health-insurance companies to profit—they must correlate with health risk. Quite simply, any factor that accurately predicts health risk will likewise produce a disparate impact based on health status.
This analysis reveals a conundrum at the heart of the Affordable Care Act. To truly achieve the goal of ending health-status discrimination, health insurers must stop using indicators of health-status, including proxies, as the basis for their decisions. Yet for the private, for-profit health-insurance industry to survive in its present iteration, health insurers must be able to distinguish between the individuals who pose good health risks and those who pose poor health risks. These two interests are ultimately irreconcilable. Hence, an antidiscrimination model can never succeed when paired with traditional for-profit health insurance.

Unrelated reasons also make antidiscrimination an inappropriate paradigm for health-care reform. For example, if differential treatment on the basis of health status is undesirable in health insurance, why is it permissible in other contexts? Why allow healthism to perpetuate in other kinds of insurance, such as life, long-term care, or disability? Why let employers make decisions related to health? Rooting the expansion of health-insurance coverage in the language of antidiscrimination opens the door for antidiscrimination challenges in other areas where they might either be redundant or inappropriate, such as other kinds of insurance or employment.
Moreover, Congress probably did not intend to put health-status discrimination on par with race, sex, or disability discrimination. Characterizing decisions made by health insurers based on health status as “discrimination” may dilute the powerfulness of this language when used in its more traditional contexts. Thus, a normative principle that does not rely on antidiscrimination will better serve the redistributive impulse that fueled health-care reform.

2. Universal Right to Basic Coverage

Yet the failure of the antidiscrimination approach to achieve meaningful equality does not foreclose the opportunity for those disadvantaged to seek redress. Alternate legal paradigms can effectively do the work of antidiscrimination. In particular, claims based in fundamental rights may allow individuals facing disadvantage to challenge discriminatory policies. This doctrinal move has already occurred in the constitutional context. It is likewise applicable to the inequities experienced by the sick in health insurance.

Kenji Yoshino argues that, in the wake of traditional equal protection jurisprudence’s drawing to a close, subordinated groups may still pursue constitutional recourse through “dignity
claims” based in the due process clauses of either the Fifth or Fourteenth Amendments. He explains that a growing “pluralism anxiety” has pushed the Supreme Court to move away from acknowledging equality concerns framed as group-based identity claims and toward those presented in terms of the more expansive doctrines of liberty and universally held fundamental rights. Thus, substantive due process claims—situated in a rights-based frame—may encompass concerns related to inequality and group subordination.

This Article proposes that the symbiosis between equal protection and substantive due process provides a useful analogy for a similar paradigmatic shift within health-insurance legislation. As noted, an antidiscrimination framework—as construed within the Affordable Care Act—seeks to eradicate disadvantage experienced on the basis of health status. Alternatively, a universal right approach to health insurance would maintain that everyone is entitled to a certain basic level of coverage. One model argues that a certain group, unified by a protected characteristic—in this case an unfavorable health status or history—should not experience disadvantage on the basis of that trait. Put differently, the sick should be treated
like the nonsick. The other asserts that there are certain fundamental rights—here, that of basic health-insurance coverage—that all people should enjoy. Both paradigms promote norms of fairness and equality, albeit via different strategies. Instead of disadvantage on the basis of health status, the underlying problem of un- and underinsured Americans becomes the absence of sufficient health-insurance coverage for all people. Thus, reforming the health-care reform could have been framed, not as responding to “discrimination against the sick,” but rather as creating a universal right to a particular variety of coverage.

Given the interconnectedness between the antidiscrimination and universal right frames, it is not surprising that health-care reform advocates employed both when arguing for change. Thus, in addition to language sounding in the register of antidiscrimination, supporters of health-care reform invoked universal rights rhetoric. For example, Senator Ted Kennedy, a long-time supporter of health-care reform, stated “[t]hat every American—north, south, east, west, young, old—will have decent, quality health care as a fundamental right and not a privilege.” Perhaps echoing the late senator, Representative Joe Baca likewise proclaimed that “[a]ccess to health
care is not a privilege” but rather “a human right.” Similarly, Senator Bernard Sanders asserted that most Americans believe in universal coverage and that “nobody should be left out of the system.” While ending discrimination against the sick was a major rallying point for reform advocates, they also spoke in terms of a universal right to basic health-insurance coverage.

There are, of course, shortcomings to the universal right model. Most significantly, providing basic universal coverage requires determining which kinds of conditions, care, and treatment are constitutive of that right and which are not. This query raises the difficult questions of who should make those determinations, how those individuals should be selected, and how often the benefits provided should be revisited to reflect advances in medicine and medical technologies. While less than perfect, a “list-of-services approach” that defines the right to basic coverage in terms of covered medical services avoids some of the administrative complexities associated with delivery structures based on individual inquiries into the cost or necessity of care. Any attempt to institute a health-insurance system based in “fairness”—a
moral undertaking, however, raises various valuation and distributional issues. At present, the states are working their way through similar dilemmas in deciding the basic level of insurance to offer through the Affordable Care Act’s newly created state exchanges. The answers to these questions are never simple. Creating a baseline for health insurance will inevitably exclude certain kinds of coverage, thereby leaving some individuals with less than optimal access to health care.

The universal-right model’s most significant challenge, however, might also be its greatest strength. Pursuant to this paradigm, reformers must decide between the types of coverage to provide, not between which people to insure. In this way, the universal-right model to health insurance parallels substantive due process framework in constitutional law. It avoids creating a new antidiscrimination category. Thus, a universal-right framework also avoids possible spillovers into other areas of legal protections. Litigants will not be tempted to use antidiscrimination language to attack health status-based determination in other contexts.

C. Universal-Right Model and Health-Care Reform
A universal-right model provides a preferable paradigm for health-care reform. Instead of attempting to eradicate disadvantage against the sick, the focus becomes ensuring a minimum level of care for all Americans. Further, reframing the issue of un- and underinsured Americans as the denial of a basic right instead of the result of “healthism” changes the appropriate legal approach for addressing the problem. Barring health insurers from considering health-related factors (and their proxies) is no longer essential. Rather, ensuring access care through providing a minimum level of health-insurance coverage becomes the objective of health-care reform.

Importantly, a right to health has advocates here, as well as abroad. [“Seventy-two percent] of Americans strongly believe that health care should be considered a human right.” A universal right to health—which includes a nested right to access a minimum level of care—enjoys support from a number of international and comparative law sources. Further, as noted, although advocates used antidiscrimination rhetoric, they also championed a universal right to a minimum level of health insurance. It is perhaps then no great surprise that the Affordable Care Act includes elements of a universal-right framework and recognizes the need
for a basic level of health-insurance coverage for all Americans. These themes are perhaps best played out in the statute’s creation of “essential health benefits” and the imposition of the mandate and its accompanying subsidies.

1. Universal Right and the ACA

The Affordable Care Act sets a baseline for certain kinds of health-insurance coverage. It provides that the Department of Health and Human Services will promulgate regulations to establish “essential health benefits.” Those essential benefits must include, at a minimum, several categories of basic coverage, specifically: 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; chronic disease management; and pediatric services, including oral and vision care. Congress, therefore, indicated that a certain degree of foundational coverage should be standard. Moreover, it expressed the desire that all individuals be able to partake in the coverage provided by those
benefits regardless of age, disability, or need for medical care. This provision articulates equality concerns related to health status, thereby demonstrating how a universal-right norm may also serve antidiscrimination ends. Not all health insurers, however, must offer essential health benefits, as defined by the statute.

The Affordable Care Act does not mandate that all health insurers offer essential health benefits to their insureds. Instead, health insurers must provide “essential health benefits packages” to participate in the state insurance exchanges or—in some cases—to avoid tax penalties. An “essential health benefits package” will not only include the essential health benefits, as defined by the Secretary, but also limits on cost-sharing and the availability of four tiers of possible coverage—bronze, silver, gold, and platinum. Although not requiring all health insurers to offer essential health benefits packages, the coverage outlined therein will have a substantial effect on the cost and coverage of health insurance for many people.

Additionally, the mandate, which has been the source of much of the controversy surrounding the Affordable Care Act, can also be read as communicating a universal-right
sentiment. That provision, as of 2014, imposes a tax penalty on individuals without a basic level of health-insurance coverage. To be sure, the mandate has purely practical functions.

Specifically, forcing healthy individuals (who might not otherwise have insurance) to obtain coverage, tempers risks and, thus, costs. Yet beyond those instrumental purposes, it can be read as communicating Congress’s commitment to ensuring that the majority of Americans enjoy some level of health-insurance coverage. In this sense, the mandate stands for the proposition that everyone should be insured.

Although the statute’s inclusion of essential health benefits and a health-insurance mandate evinces Congress’s desire that most Americans carry at least basic health insurance, the Affordable Care Act falls short of bestowing an enforceable right to such coverage. Although the creation of an explicit right seems unlikely in the near future, adjustments to the legislation could have the practical effect of approaching the goal of universal health-insurance coverage.

2. Suggestions for Further Reform
As mentioned several times throughout this Article, the antidiscrimination model conflicts with the traditional, for-profit, private health-insurance industry. Thus, three potential axis of change exist for incorporating a universal right to health care: (1) a shift in industry practices from traditional risk assessment to an alternate strategies, (2) a shift in industry sector from for-profit to nonprofit (or limited profit), and (3) a shift in industry ownership from private to public.

First, prospective reformers could reduce the disadvantage experienced by the sick through changing the current incentive structure of the health-insurance industry. In particular, lawmakers could decrease health insurers’ impulse to carve up the health-insurance market into myriad risk assessment pools, a process Allison Hoffman calls “fragmentation.” One method of addressing fragmentation and its associated problems involves limiting the ability of insurers to profit from enrolling healthier insureds through “risk adjustment of premiums.” In such a system, health insurers would accept contributions either in the form of standardized premiums (either equal or income-based) or taxes but only after a centralized administrative authority had pooled those contributions and calculated the risk profile of the group as a whole. During the
redistribution process, insurers would be compensated more for higher-risk insureds, thus eliminating the preference for the healthy.  When coupled with the mandate, risk adjustment supports the notion of a universal right to basic health insurance. It does not, however, mesh with an antidiscrimination norm that takes a “health-status blind” approach. To the contrary, risk adjustment relies on differentiation but for reallocation purposes. Thus, this suggested reform favors a universal right framework over antidiscrimination.

Second, further reform could alter the for-profit nature of health insurance. As explored at length, the practices that disadvantage the sick are either cost-saving or profit-maximizing devices, making them symptomatic of a for-profit system. Thus, reformers could implement the “sickness fund” structure already popular in Europe, in which private insurers offer mandatory health insurance within a highly regulated market. Unlike the current U.S. system, the private insurers in this model cover everyone and turn either no—or an extremely limited—profit. Even in those sickness fund systems where health insurers can profit, the health-insurance industry is not solely profit driven: regulation ensures that the insurance system serves certain
redistributive social goals. Advocates of improving access to health care have, thus,
frequently proposed restricting or eliminating health insurers’ ability to profit. By requiring
health insurers to offer coverage for all citizens, sickness funds support a universal right
approach, while simultaneously allowing insureds choice in plans and coverage.

Finally, a conversation about a universal right to health insurance would not be complete
without discussing a public option. If health-insurance coverage were truly regarded as a right, it
would be just that—a right guaranteed by the government in the form of publicly provided
insurance. In fact, many wealthy nations already adopt a “social-insurance” approach. In a
public system, the government could either provide the basic level of coverage or could
finance and regulate publicly owned health-care facilities. While this suggestion would
manifest the universal right paradigm to its fullest extent, the notion of expanding public
coverage has been one of health-care reform’s most contentious issues and is, therefore, not
likely to be adopted by Congress anytime soon. Thus, the risk adjustment or market-regulation
strategies are far more likely candidates for future efforts at reform.
In sum, an antidiscrimination model is in tension with certain fundamental elements of traditional private, for-profit insurance. Even when eliminating explicit considerations of health status, maintaining the current system required Congress to give insurers some means to differentiate between good risks and bad risks. Consequently, the Affordable Care Act employs age, geographic location, and tobacco use—all proxies for health status—and participation in wellness programs as permissible rating criteria. Because they approximate health, these rating factors could ultimately create a disparate impact on the same populations already experiencing disadvantage.

Much like the shift from equal protection-based to substantive due process-based claims in constitutional equality jurisprudence, a move from an antidiscrimination to a universal right model could prove useful in the context of health-care reform. Luckily, Congress already built certain universal-right-oriented protections into the Affordable Care Act. Additional steps,
however, could be taken to further reduce the disadvantages experienced by the sick, including risk adjustment of premiums, profit regulation, or public coverage.

Conclusion

In the course of the 2010 health-care debate, advocates of reform often framed the problem of un- and underinsured Americans as the result of “healthist” insurance practices. However, construing this issue as a matter of discrimination on the basis of health status might not lead to the desired result. In particular, preventing health insurers from considering health status—while attempting to keep the traditional private, for-profit health-insurance industry intact—will lead insurers to rely on proxies of health when making rating and underwriting decisions. To eliminate discrimination truly, health insurers must move away from the practices that generated these disparities in the first place.

Importantly, discrimination against the sick may not be the only means of understanding the problem of the un- and underinsured. The inadequate health-insurance coverage experienced by so many Americans can instead be framed as the failure to provide a basic level of health
insurance. This shift in paradigm from antidiscrimination to a universal rights sheds light on where the Affordable Care Act might fail and ways in which Congress could revisit the statute to improve overall health care for more Americans.

As the Affordable Care Act faces serious legal and political challenges, Congress may find itself in a position to revisit the issue of health-care reform. Although large-scale changes (such as expanding public programs to cover all Americans) remain unlikely, lawmakers could take implement smaller-scale measures, like risk adjustment and market regulation to provide offset some of the disadvantages that the sick experience.
Assistant Professor of Law, University of Houston Law Center. I would like to thank Seth Chandler, Abbe Gluck, Leslie Griffin, Allison Hoffman, Johanna Kalb, John Lunstroth, Jessica Mantel, Dave Merson-Hess, Chris Robertson and the participants of the University of Houston Law Center Work-in-Progress series and the 2011 American Society of Law, Medicine, & Ethics conference for reading and commenting on drafts. My deepest gratitude goes to Sidney Watson and the University of Saint Louis School of Law for the opportunity to present an early draft of this piece and to my readers, Mary Crossley, Heather Bednarek, Tracy Gunter, Elizabeth Pendo, and Kelly Dineen—as well as the other workshop participants—for their incredibly helpful feedback. Many thanks also go to JB Banzon, Paige Fillingame, and Abigail Go for outstanding research assistance, Emily Lawson for excellent library support, and Elaine Gildea for phenomenal administrative help. I would also like to express my gratitude to the outstanding
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2. In 2008, the year of the presidential election, approximately 46.3 million Americans lacked health insurance. See CARMEN DENAVAS-WALT ET AL., U.S. DEP’T OF COMMERCE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 23 tbl.8 (2010). By 2009, that number had increased to 50.7 million. Id.

3. While harder to measure, a Commonwealth Fund study published in 2008 estimated there to be approximately 25.2 million “underinsured” Americans—individuals who had health insurance but less-than-adequate coverage. See Cathy Schoen et al., How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007, 10 HEALTH AFFS. WEB EXCLUSIVE
w298, w298, w304 exhibit 4 (2008),

http://content.healthaffairs.org/content/early/2008/06/10/hlthaff.27.4w298.full.pdf.


5. President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care (criticizing health insurers for “treat[ing] their customers badly—by cherry-picking the healthiest individuals and trying to drop the sickest, by overcharging small businesses who have no leverage, and by jacking up rates”).


7. For a discussion of the antidiscrimination language used in the health-care reform debate, see infra Part I.C.2. Moreover, eliminating discrimination against the sick has historically been a core objective of health-care reform. See Deborah Stone, Protect the Sick: Health Insurance
Reform in One Easy Lesson, 36 J.L. MED. & ETHICS 652, 652 (2008) ("Covering or not covering sick people is the core issue of health insurance reform, both as a determinant of support and opposition to proposals, and as the proper yardstick for evaluating reform ideas."); see also Michael Lee, Jr., Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act, 29 YALE L. & POL’Y REV. 559, 585 (2011).


9. See infra Part II.C.

10. See infra Part I.A.


12. The Affordable Care Act contains provisions, like the insurance mandate, see infra notes 201–202, designed to keep private insurance intact. See Surowiecki, supra note 11, at 21 (noting
Congress’s “insistence that health-care reform must rely on private insurance companies” does not sit well with its support for community rating and universal access).

13. See infra Part III (analyzing the implications of an antidiscrimination framework and examining an alternative normative basis for improving access to care through expanding health insurance).


16. See ROBERT K. FULLINWIDER, THE REVERSE DISCRIMINATION CONTROVERSY: A MORAL AND LEGAL ANALYSIS 11 (1980) (describing the dictionary meaning of “discrimination” as “morally neutral” and asserting that “we discriminate all the time”).
17. *Id.* ("The dictionary sense of ‘discrimination’ is neutral while the current political use of the term is frequently non-neutral, pejorative. . . . For some, it may be enough that a practice is called discriminatory for them to judge it wrong.").

18. *See infra* notes 90–95.

19. *See infra* Part I.B.

20. *See supra* note 11 and accompanying text.

21. *See* Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 74 (2005) ("Discrimination against unhealthy persons is deeply ingrained in the health insurance industry and traditionally has been generally accepted as a legitimate application of underwriting and risk-classification principles.").


23. An insurance contract has three key elements. It (1) redistributes risk (2) across a large number of individuals (3) by a company that is in the business of professional risk distribution. Thus, health insurance is "[c]overage that provides for the payments of benefits as a result of
sickness or injury. Includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.” Dictionary of Health Insurance and Managed Care 138 (David Edward Macinko & Hope Rachel Hetico eds., 2006) [hereinafter Dictionary].

24. This list includes only first-party insurance, not third-party insurance.

25. For the definition of “adverse selection,” see Dictionary, supra note 23, at 12–13 (“The tendency of people who are less than standard health insurance risks to seek or continue insurance to a greater extent than other individuals. This so-called ‘selection against the insurer,’ or ‘antiselection,’ is a form of stacking the deck and is also found in the tendency of policy owners to take advantage of favorable options in health insurance or managed care contracts. Or, a particular health plan, whether indemnity or managed care, is selected against by the enrollee, and thus an inequitable proportion of enrollees requiring more medical services are found in that plan.”).
26. Adverse selection drives up the cost of insurance. *Id.* For example, “[l]ow enrollee out-
of-pocket costs might lure those individuals requiring more health services into an HMO rather
than an indemnity-plan because the former does not have a deductible. Therefore, the HMO
would have a greater proportion of less-healthy enrollees, thereby driving up costs and increasing
financial risks.” *Id.* at 12. This increase in cost may lead lower risk individuals to leave the
market. *Id.* at 80 (defining a “death spiral” as “[a]n insurance term that refers to a vicious spiral
of high premium rates and adverse selection, generally in a free-choice environment”).

27. For the definition of “death spiral,” see *id.* at 80. This cycle has also been called a lemon
pricing problem. In the used car market, pricing reflects the average used car. Thus, individuals
with “good” used cars cannot get a high enough price and exit the market, leaving behind
“lemons.” See George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the

29. Adverse selection occurs when insurers cannot distinguish “healthy” or good-risk individuals from “unhealthy” or poor-risk individuals. See Akerlof, *supra* note 27, at 492–94.


31. *Id.*


33. See Stone, *supra* note 7, at 652 (“[I]nsurance plans now use premiums, cost-sharing, and other design features in ways that indirectly divide [the population] into the sick and the healthy, to the detriment of the sick.”).
34. Individual insurers can accept an individual but exclude coverage for a certain disease.

MARCINKO, supra note xx, at 226 (defining “preexisting condition” as “[i]n health insurance, an injury, sickness, or physical condition that existed before the policy effective date. Most individual policies will not cover a preexisting condition; most group policies will.”).


36. Stone, supra note 32, at 306 (noting that both individual and group insurers may increase premiums, limit coverage, or do both with respect to high-risk individuals).

37. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82468 (Dec. 28, 2000) (“To protect their privacy and avoid embarrassment, stigma, and discrimination, some people withhold information from their health care providers, provide inaccurate information, doctor-hop to avoid a consolidated medical record, pay out-of-pocket for care that is covered by insurance, and—in some cases—avoid care altogether.”).
38. See supra notes 25–31 and accompanying text.

39. See Stone, supra note 32, at 306 (describing how the current insurance system disadvantages high-risk individuals through medical underwriting).

40. Id. at 308 (“The logic and methods of actuarial fairness mean denying insurance to those who most need medical care. The principle actually distributes medical care in inverse relation to need, and to the large extent that commercial insurers operate on this principle, the American reliance on the private sector as its main provider of health insurances establishes a system that is perfectly and perversely designed to keep sick people away from doctors.”); see also RHODA OLKIN, WHAT PSYCHOTHERAPISTS SHOULD KNOW ABOUT DISABILITY 18 (1999) (“Disability status is associated with certain patterns of health insurance. Persons with disabilities are less likely to be covered by private health insurance than the nondisabled. Those with severe disabilities are more likely to be covered by government (vs. private) insurance than are people with no or mild disabilities, and persons with mild disabilities are the most likely to be uninsured (36%). This latter group might be analogous to those referred to as the working poor—too much
income to qualify for aid and too little income to qualify for aid and too little income to be sufficient for needs, particularly given increased costs of living with a disability.”).

41. Of the privately insured, 87.2 percent hold employer-provided health-insurance policies. See DeNavas-Walt, supra note 2, at 71 tbl.C-1; see also THE KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE, 31 tbl.5 (2010), http://www.kff.org/uninsured/upload/7451-06.pdf (reporting that 58.1 percent of the non-elderly hold employer-based health-insurance policies and that only 5.2 percent of the non-elderly hold private, individual health insurance policies).

42. Small-group health insurers are more likely to operate in a manner akin to the individual market. Because the small-group market encounters many of the same risk-assessment challenges as the individual market, small-group insurers have adopted similar practices. See Mark A. Hall, Public Choice and Private Insurance: The Case of Small Group Market Reforms, 1998 U. ILL. L. REV. 757, 766 (arguing in favor of restoring risk-pooling mechanisms found in
large-group insurance to the small-group market). Thus, small-group health insurers are more likely to engage in the kind of risk assessment and cost-minimizing behaviors associated with individual health insurance. See Karen A. Clifford & Russel P. Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 Harv. L. Rev. 1806, 1809 n.17 (1987) ("Underwriting standards are stricter for small groups . . . because the size of the group is insufficient to spread the risk broadly enough to absorb the effect of adverse selection.").


44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.* at 38.

48. *Id.*

49. *Id.*
50. *Id.* at 38–39.

51. Under retrospective experience rating system, at the end of the contract period, the insured group either (1) pays for claims or (2) receives a dividend from the insurer depending on how the actual claims corresponded with the claims considered in calculating the premiums. *Id.* at 39.

52. While an insurer can chose to reject the entire group, HIPAA prevents group insurers from discriminating against *individuals* on the basis of their health status with regard to eligibility, contributions, or premiums. *See* 29 U.S.C. § 1172(a)(1); *see also* discussion, *infra* Part II(A).

53. *See* 29 C.F.R. § 2590.702(d)(1). The criteria for determining which individuals are similarly situated cannot be health related.

54 Litigants have tried to challenge condition-specific limitations, such as caps on coverage for AIDS-related care, as discriminatory pursuant to the Americans with Disabilities Act and failed. *See, e.g.*, Doe v. Mut. Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999).

55. *See, e.g.*, Sec’y’s Advisory Comm. on Genetics, Health, & Soc’y, U.S. Dep’t of Health & Human Servs., Public Perspectives on Genetic Discrimination 14 (2004), http://oba.od.nih.gov/oba/sacghs/reports/Public_Perspectives_GenDiscrim.pdf (statement of
Tonia Phillips) (explaining how her employer asked her to switch to her husband’s health
insurance while she was seeking preventive treatment for breast cancer after testing positive for a
genetic mutation associated with a heightened chance of developing the disease).

56. Elizabeth Pendo, Working Sick: Lessons of Chronic Illness for Health Care Reform, 9
in employment as the result of chronic illness).

57. See id. at 457 (explaining this reality in the employer-provided health insurance); see also
Crossley, supra note 21, at 131–33; Wenke Hwang et al., Out-of-Pocket Medical Spending for
Care of Chronic Conditions, HEALTH AFFS., Nov.–Dec. 2001, at 267, 275–76; Kathryn Anne
Paez et al., Rising Out-of-Pocket Spending for Chronic Conditions: A Ten-Year Trend, HEALTH

58. See Crossley, supra note 21, at 121–29; see also Pendo, supra note 56, at 457–59.

59. Stone, supra note 7, at 655.

60. Id.
61. Id.

62. Id.


64. See Pendo, supra note 56, at 454 (describing employer-based health-insurance plans).

65. See Crossley, supra note 21, at 76 (“In this disparity of costs shifted we can discern discrimination against the unhealthy.”).

66. See infra Part I.C.2.b


68. While similar to “ableism,” “healthism” is not the exact same concept. Ableism is the social preference for the able-bodied over people with disabilities. Health and disability, while related, are not mutually exclusive categories. See OLKIN, supra note 41, at 10 (“It is possible to
have a disability—for example, [cerebral palsy]—and also to be in excellent health. However, more serious disabilities often compromise an individual’s health. . . . [T]he overlap between disability and illness becomes increasingly important as the conditions on either or both increase in severity. It is probably not possible to come up with a definition of disability that includes only disability and not illness, and vice versa.”). Moreover, disability studies have attempted to demedicalize the notion of disability by redefining it as an experience of social exclusion. Tom Shakespeare, The Social Model of Disability, in THE DISABILITY STUDIES READER 266, 266 (Lennard J. Davis ed., 3d ed. 2010). Conversely, health is predominantly defined and understood in medical terms. Thus, because not all people who are unhealthy meet the legal or social definition of a person with a disability and because disability advocates have attempted to destabilize the relationship between the science of medicine and the experience of disability, I have chosen to distinguish “healthism” from “ableism.” The same individual with cerebral palsy might experience both disability and health-status discrimination in a single event, but “ableism”
would describe the social experience of exclusion while “healthism” would describe disadvantage based solely on the diagnosis.


70. Barry R. Furrow, Health Law: Cases, Materials, and Problems 26 (Health Care Reform Supp. 2010) [articles editor/mech editor: check edition] (“The Act provides subsidies for small employers who wish to establish employee wellness programs, along with technical assistance in the operation and assessment of all employer-based wellness programs. These programs bolster the new provisions that allow employers to give premium discounts to those employees who participate in some kinds of wellness programs. . . . These wellness discounts will also be extended to those in the individual insurance market in up to ten pilot states.”).

71. Id. at 27 (“[The Affordable Care Act] requires chain restaurants (those with more than 20 outlets serving essentially standardized products) to provide nutritional information on those
products by posting calorie information on the menu or the menu board and making additional nutritional information available to customers.”).

72. See infra Part II.C.

73. For a discussion of protected traits, see infra notes 90–95 and accompanying text.

Certainly, “discrimination” does not always demand the presence of disadvantage. See infra notes 86–89. I include disadvantage as an essential element of the definition of discrimination employed in this Article, however, primarily because that is how advocates of health-care reform framed their arguments. See infra notes 86–89.

74. As noted, discrimination also has a neutral meaning. See supra note 16 and accompanying text.

75. See supra note 16 and accompanying text.

76. See supra note 17 and accompanying text.

acceptable discrimination is, in most cases, difficult to locate with precision because it is historically and culturally variable.”).

78. Id.


80. Several restaurants, including the infamous chain Hooters, have women-only hiring policies. See Kimberly A. Yuracko, Private Nurses and Playboy Bunnies: Explaining Permissible Sex Discrimination, 92 CALIF. L. REV. 147, 204–05 (2004) (explaining Hooters’s women-only hiring policy).

81. Id. A policy like Hooters’s does not simply screen for individuals with a particular trait but rather exhibits an outright, facial preference for individuals with that trait.
82. This example of a policy that has a disparate impact on women comes from the Eighth Circuit case, *Boyd v. Ozark Air Lines, Inc.* See 568 F.2d 50, 50 (8th Cir. 1977).

83. *See id.* at 52 n.1.

84. *Id.* at 52 (noting that the trial court found that “the minimum height requirement had a disparate impact on women and Ozark employed no women as pilots”) (footnote omitted).

85. Antidiscrimination scholars have long debated what norm should be at the core of the U.S. antidiscrimination project. One account, often called the “antisubordination principle,” holds that antidiscrimination laws should seek to elevate the social status of subordinated groups by targeting both intentional and unintentional discrimination. *See* Jack M. Balkin & Reva B. Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination?*, 58 U. MIAMI L. REV. 9, 9 (2003) (“Antisubordination theorists contend that guarantees of equal citizenship cannot be realized under conditions of pervasive social stratification and argue that law should reform institutions and practices that enforce the secondary social status of historically oppressed groups.”). To be sure, not everyone shares this perspective. Proponents of
the “anticlassification principle” or “antidifferentiation principle” believe that antidiscrimination
law should seek to eradicate all intentional, differential treatment—positive or negative—but not
facially neutral policies that unintentionally generate discriminatory results. Id. at 10 (“Roughly
speaking, this principle holds that the government may not classify people either overtly or
surreptitiously on the basis of a forbidden category: for example, their race. We add the word
“surreptitiously” because a law that does not explicitly classify by race may nevertheless be
motivated by an invidious purpose to differentiate on the basis of race, and most people think
that this also counts as a violation of the anticlassification or antidifferentiation principle.”).

86. This statement holds true for advocates of antisubordination. See id. at 9 (discussing the
antisubordination principle in terms of group disadvantage); see also Robert Post, Prejudicial
(“[L]aw seeks to neutralize widespread forms of prejudice that pervasively disadvantage persons
based upon inaccurate judgments about their worth or capacities.”).

87. See Balkin & Siegel, supra note 85, at 10 (describing the anticlassification principle).
88. This sentiment is at the heart of the anticlassification, or antidifferentiation, principle. *See id.*

89. *See infra* Part I.C.2.b.

90. The Civil Rights Act of 1964 prohibits race discrimination in a variety of contexts, including public accommodations (Title II), federally funded programs (Title VI), and employment (Title VII). *See* Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 2, 28, and 42 U.S.C.).

91. Titles VI and VII of the statute provides similar protections for national origin. *Id.*

92. Title VII of the Civil Rights Act prohibits discrimination on the basis of sex in employment. *See* 42 U.S.C. § 2000e-2(a) (2006) (“It shall be an unlawful employment practice for an employer . . . to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin . . . .”).


96. See infra Part II.C.

97. See infra Part I.C.2.b.

98. See infra Part I.C.2.b.


101. Id.
102. See, e.g., 155 Cong. Rec. H8881 (daily ed. July 28, 2009) (statement of Rep. Steven Kagen) (“Mr. Speaker, I rise today to remind everyone on both sides of the aisle, whether you’re Republican, a Democrat, a Libertarian or an Independent, that hope is on the way. We have some things we can agree upon. Isn’t it a fact that we all agree that it’s time to end discrimination in health care where insurance companies are allowed to discriminate against you because of a preexisting condition? I think it’s time. We secured equal treatment at the lunch counter 50-some years ago; and this year, we’re going to come to some agreement here in the House to end the discrimination in health care and bring equality to the pharmacy counter as well. We can all agree it’s time to end the discrimination in health care due to preexisting conditions, to pass a bill that has a standard plan, an insurance plan that includes all Americans, a standard plan that each and every insurance company must sell to any citizen throughout the land.”); 155 Cong. Rec. H8590 (daily ed. July 23, 2009) (statement of Rep. Steven Kagen) (“You’re going to hear arguments from one side and the other. But we stand on the side of the American people who understand this: There shall be no discrimination to any citizen due to
preexisting medical conditions. After all, we don’t discriminate on the basis of the color of your skin. What about the chemistry of your skin?”); 155 CONG. REC. H3447 (daily ed. March 17, 2009) (statement of Rep. Steven Kagen) (“Mr. Speaker, discrimination is alive and well all across America. You may not have heard about it on the radio or seen it on television, but it’s still alive and well. You won’t see it on television because discrimination today is beneath the skin, beneath the skin of our entire society, as insurance companies, omnipotent as they are, continue to discriminate based on the preexisting condition of a citizen. These insurance companies no longer discriminate on the basis of skin color. Rather, they discriminate against women because of the calcium, or the lack of it, in their bones. They discriminate against people who may have coronary artery disease or any of a number of medical conditions. The lessons of both my profession and my faith have made it clear: We are all really the same beneath our skin. We’re all made of the same clay. And 40 years after the civil rights movement has established that all citizens of any color shall be able to drink from the same water fountain, sit on the same
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bus, and attend the same medical clinic, our Nation still remains divided, not by skin color but by
skin chemistry. Mr. Speaker, it’s time we bring an end to discrimination in health care.”).

103. Race is probably considered the most indefensible basis for discrimination. See
ALEXANDER M. BICKEL, THE MORALITY OF CONSENT 133 (1975) (“[D]iscrimination on the basis
of race is illegal, immoral, unconstitutional, inherently wrong, and destructive of democratic
society.”). For instance, the law permits discrimination on the basis of sex or disability under
certain circumstances, but allows no bona fide occupational qualification (BFOQ) for race. See
(allowing something like a race-based BFOQ in an equal protection case because the challenged
policy was enacted in response to “a truly powerful and worthy concern”).

and Affordable Care Act,’ (Dec. 24, 2009) (available at
http://leahy.senate.gov/press/press_releases/release/?id=065cc6a9-4284-4da6-bc38-
a5aabfdb0a44).

106. See, e.g., id. at S827 (“[U]nder the President’s health insurance plan . . . for millions of Americans in the individual market, premiums would go up because of one-size-fits-all government mandates, because of taxes that are passed on to consumers; but for other reasons as well—by shifting costs.”).

107. See, e.g., 156 Cong. Rec. S828 (daily ed. Mar. 1, 2010) (statement of Sen. Lamar Alexander) (“Costs for young people in the individual market will go up under this plan because if you put in a rule that says my insurance at my age cannot go up more than a certain amount compared with my son’s insurance, then his insurance goes up, and because a scheme like the Democratic plan depends upon requiring everybody to buy insurance. There is a weak provision for that, and I suspect many young people will rather pay the $750 fine rather than buy a $2,500

108. See, e.g., 156 CONG. REC. S39 (daily ed. Jan. 20, 2010) (statement of David M. Pariser, MD, FAAD) ("In an effort to offset the cost of this legislation, [the Affordable Care Act] would impose a cosmetic procedure tax that disproportionately affects women and the middle class."); 155 CONG. REC. S13,815 (daily ed. Dec. 23, 2009) (statement of Sen. Mike Enzi) ("Harvard Professor Kate Baicker reported that an employer mandate, like the one in this bill, will mean
that ‘workers who would lose their jobs are disproportionately likely to be high school dropouts, minority and women.’


110. See generally Sophia Moreau, What Is Discrimination?, 38 Phil. & Pub. Affs. 143 (2010) (arguing that in addition to being redistributive, antidiscrimination can be construed as a restitutive norm).

111. Typically, Congress has drafted antidiscrimination legislation in response to existing systematic disadvantage experienced on the basis of a protected trait. But see Jessica L. Roberts,
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112. Sometimes differential treatment is what leads to meaningful equality. See Christine Jolls, Commentary, Antidiscrimination and Accommodation, 115 Harv. L. Rev. 642 (2001). For example, the Americans with Disabilities Act includes an accommodation mandate. See generally Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12102, 12111–12117, 12131–12134, and 12201–12213 (2006). See, e.g., id. § 12111(9) (defining “reasonable accommodation” under Title I); id. § 12131(2) (explaining that a “qualified individual with a disability” is entitled to “reasonable modifications” under Title II). Further, one of ADA’s definitions of legally actionable discrimination includes the failure to take those steps. Id. § 12112(b)(5)(A) (explaining that under the employment section of the law, discrimination includes “not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such
covered entity can demonstrate that the accommodation would impose an undue hardship on the 
operation of the business of such covered entity”).

113. See Post, supra note 86, at 11 (“American antidiscrimination law typically requires 
employers, except in exceptional and discrete circumstances such as affirmative action, to make 
decisions as if their employees did not exhibit forbidden characteristics, as if, for example, 
employees had no race or sex.”) (footnote omitted).

114. See id. (explaining that the “blindness” approach to employment discrimination law 
requires employers “to make decisions as if their employees did not exhibit forbidden 
characteristics”).

115. While this paper focuses on Congress, the states themselves have also taken action to limit 
“healthism” in both the individual and group health-insurance markets. For example, almost 
every state imposes rating restrictions in the small-group health-insurance market. Nat’l Ass’n 
of Ins. Comm’rs & the Ctr. for Ins. Policy & Research, Health Insurance Rate Regulation 
116. See Crossley, supra note 21, at 114 (“HIPAA has been characterized as inaugurating the federal regulation of the content of private health insurance . . .’’); id. at 115–16 (asserting that pre-GINA and Affordable Care Act “HIPAA’s nondiscrimination provisions [stood out] as the sole federal legislation giving individuals any protection against health-status discrimination in health insurance").


118. Title I covers health-insurance portability and access. See id. § 101 (amending §§ 701–07 of the Employee Retirement Income Security Act (ERISA)); id. § 102 (amending §§ 2701–02, 2711–13, 2721–23, and 2791–92 of the Public Health Service Act (PHSA)); id. § 103 (referencing the implementation through the Internal Revenue Code (IRC)).

119. Title II covers health-care fraud and abuse, creates rules to govern health information privacy and standardize administrative proceedings, and amends the Social Security Act (SSA).

See id. § 201–250; id. § 262; id. § 231 (amending SSA civil monetary penalties).


122. As a result, employees could more readily experience “job lock”—feeling trapped in a current position for fear of losing health insurance or other benefits as a result of changing employers. Kanika Kapur, *The Impact of Health on Job Mobility: A Measure of Job Lock*, 51 Indus. & Lab. Rel. Rev. 282, 282 (1998) (defining “job lock” as “[t]he reduction in job mobility due to the non-portability of employer-provided health insurance”).

coverage (both nongroup and group) guaranteed renewable, and rules requiring insurers to issue coverage to all groups involving from two to fifty employees.”).

124. See 29 U.S.C. § 1181(a)(2006) (stating that insurers may only impose a preexisting condition exclusion when “(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the [six month] period ending on the enrollment date; (2) such exclusion extends for a period of not more than [twelve] months (or [eighteen] months in the case of a late enrollee) after the enrollment date; and (3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage”). All forms of health insurance qualify as credible coverage. See 26 U.S.C. § 9801(c)(1) (2006); U.S.C. § 1181(c)(1); 42 U.S.C. § 300gg(c)(1) (2006). Additionally, HIPAA requires that plans covering dependents must enroll the dependents of covered individuals without preexisting condition exclusions, so long as the dependents are enrolled within thirty days of acquiring their

125. Two relevant provisions provide that:

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

= list

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.
(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.


126. 26 U.S.C. § 9802(b)(1) (“A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in subsection (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.”);

§ 2701) (“A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.”).

127. See Crossley, supra note 21, at 114 (“[C]ertainly the statute’s nondiscrimination provisions take a significant step by protecting an unhealthy member of a group plan from being singled out for exclusion from the plan, lesser coverage, or higher premiums.”).


129. Id.
130. The preexisting condition restrictions were some of HIPAA’s most popular provisions.

*See Furrow, supra* note 70, at 365.

131. Crossley, *supra* note 21, at 116 ("The statute’s nondiscrimination provision applies only to group plans, not to issuers in the individual market.").

132. *See DeNavas-Walt, supra* note 2, at 71 tbl.C-1; *see also The Kaiser Comm’n on Medicaid and the Uninsured, supra* note 42, 31 tbl.5 (reporting that only 5.2 percent of the nonelderly hold private, individual health-insurance policies).

133. *See Crossley, supra* note 21, at 84 ("Although the number of persons who obtain coverage through the individual market is relatively small, the stakes are typically high, for purchasers in the individual market may have no other coverage option.").

134. *See Pendo, supra* note 56, at 465 ("[W]ithout access to group coverage or a public program, many people, including people with chronic illness, are unlikely to secure individual coverage at any price.").
135. For a discussion of how individuals experienced disadvantage on the basis of health status in group health insurance—even post-HIPAA, see supra Part I.B.2.

136. In fact, it does the express opposite. HIPAA makes it clear that the law does not require health insurers to provide particular benefits or coverage, nor does it prevent insurers from imposing restrictions or limitations so long as it does so for all similarly situated individuals. See 29 U.S.C. § 1182(a)(2) (2006); 42 U.S.C. § 300gg-1(a)(2) (2006) (explaining that the Act should not be construed “(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or (B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.”); see also 26 U.S.C. § 9802(a)(2) (2006) (explaining that the Act should not be construed “(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or (B) to prevent such a plan from establishing limitations or
restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly
situated individuals enrolled in the plan or coverage.”).

137. See 29 U.S.C. § 1182(b)(2); 42 U.S.C. § 300gg-1(b)(2) (“Nothing in paragraph (1) shall be
construed—(A) to restrict the amount that an employer may be charged for coverage under a
group health plan; or (B) to prevent a group health plan, and a health insurance issuer offering
group health insurance coverage, from establishing premium discounts or rebates or modifying
otherwise applicable copayments or deductibles in return for adherence to programs of health
promotion and disease prevention.”); see also 26 U.S.C. § 9802(b)(2) (explaining that the Act
should not be construed “(A) to restrict the amount that an employer may be charged for
coverage under a group health plan; or (B) to prevent a group health plan from establishing
premium discounts or rebates or modifying otherwise applicable copayments or deductibles in
return for adherence to programs of health promotion and disease prevention.”).

138. See, e.g., HIPAA Interim Rules, 62 Fed. Reg. at 16,911 (Apr. 8, 1997) (quoting the
Congressional Budget Office finding that “because HIPAA does not impose limits on premiums
issuers may charge, insurance coverage, though available, may be expensive” and thus observing that “the law would ‘make insurance more portable for some people, [but] it would not dramatically increase the availability of insurance in general’” (in original)).

139. See Crossley, supra note 21, at 116 (“Under HIPPA, [in response to a single higher-risk insured] an insurer can still employ risk rating for the entire group, leaving the employer to figure out how to respond to the higher premium price, with one possibility being to cancel coverage altogether.”) (footnote omitted).

140. Because small groups include fewer individuals between whom to pool risk, insurers in the small-group market face many of the difficulties experienced in the individual market. For a discussion of the similarities between individual and small-group insurers, see supra note 43 and accompanying text.

141. Although GINA passed in May 2008, Congress had been considering legislation to safeguard genetic information for almost thirteen years before GINA passed. See Roberts, supra note 111, at 442–51.


144. Title II protects against genetic-information discrimination in employment. Id. §§ 201–213.

145. Pursuant to GINA, group insurers covered under ERISA “may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information” and “shall not request, require, or purchase genetic information for underwriting purposes.” Id. §§ 101(a), 101(b) (amending ERISA § 702(b). Underwriting purposes include determining
eligibility, calculating of premiums or contribution amounts, and applying of any preexisting condition exclusions, and other health insurance or benefit-related activities. *Id.* § 103(d)(10).

Sections 102 and 103 contain identical provisions amending the PHSA and the IRC, respectively. *Id.* § 102(a) (amending PHSA § 2702(b)); *id.* at 103(b) (amending IRC § 9802).

Section 104, which amends the SSA, also protects against the consideration of genetic information when setting premiums. *Id.* § 104(a) (amending SSA § 1882(s)(2). “An issuer of a medicare supplemental policy shall not deny or condition the issuance or effectiveness of the policy (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) and shall not discriminate in the pricing of the policy (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.” *Id.* § 104(a)(E).

Like GINA, HIPAA also prohibits group insurers from using genetic information to determine eligibility or to set premiums, albeit on a more limited basis. *See* Jennifer J. Lee, *The First Civil Rights Act of the 21st Century: Genetic Information Nondiscrimination Act of 2008*, 4 J.L. &
Despite prohibiting genetic-information discrimination when setting group premiums and the collection of genetic information, HIPAA does not stop health insurers from requesting or requiring genetic information or testing, or from excluding coverage or limiting benefits based on genetic information. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 101(a), 110 Stat. 1936, 1939 (amending ERISA §§ 701–107); id. § 102(a) (amending PHSA § 2701). Under HIPAA, group health insurers may use genetic information when making decisions regarding accepting groups or setting group premiums. Nancy Lee Jones & Amanda K. Sarata, Cong. Research Serv., The Genetic Information Nondiscrimination Act of 2008 (GINA) 5 (2008). Health insurers could, therefore, choose to reject a group or increase a group premium based on genetic information. Additionally, GINA not only applies to the group plans under ERISA, the PHSA, and the IRC but also individual plans and Medigap covered by the SSA.

Both GINA and HIPAA provide that genetic information is not a preexisting condition. Health Insurance Portability and Accountability Act § 101(a); id. § 102(a).

147. For a more detailed explanation of the antidiscrimination rhetoric used in passing GINA, see generally Roberts, supra note 111. See also and Jessica L. Roberts, The Genetic Information Nondiscrimination Act as an Antidiscrimination Law, 86 NOTRE DAME L. REV. 597 (2011)


150. See Roberts, supra note 111, at 440, 442.
151. See Richard A. Epstein, *The Legal Regulation of Genetic Discrimination: Old Responses to New Technology*, 74 B. U. L. REV. 1, 9–10 (1994) (“A person who knows that he is at risk for Huntington’s disease has a strong incentive to acquire life and health insurance for the condition. This is because the expected payoffs are far greater than the stated premiums, which are based on the life expectancy and health needs of ordinary persons.”); see also Kathleen Taradash, *Note, Preventing a Market for “Lemons”: A Voluntary Disclosure Model as an Alternative to the Prohibition of Genetic Discrimination and the Distortion of Allocative Efficiency*, 34 CONN. L. REV. 1353, 1353 (2002).

152. As early as 1994, Richard Epstein argued that concealing known genetic risk constitutes a moral wrong in both personal and commercial settings. See Epstein, *supra* note 151, at 11–12 (arguing that when an individual is aware of his or her genetic risk factors, “full disclosure should be the norm”). Consequently, Epstein not only favors full disclosure but also advocates giving an employer or insurer the ability to obtain genetic information to ensure informational equality between those entities and their employees and insureds. Epstein explains:
In sum, genetic discrimination raises problems no different from those associated with any other sort of misfortune, and calls for no different response. The greater knowledge that comes from testing increases the informational asymmetries that are always the bane of insurance markets. When testing is possible, dangers from strategic behavior are only enhanced. Accordingly, the case for insisting on standard insurance norms is greater than it was before. Full disclosure of material information in response to direct questions is an indispensable part of that system. If we have reason to suspect that a system of disclosure could prove unreliable, we should allow the employer or insurer to test in order to obtain the knowledge already available to the employee. The person who wants privacy need not apply for the position or the insurance coverage. But he should not be able to have it both ways, and at someone else’s expense.

_Id._ at 13.
153. See Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 101, 122 Stat. 881, 883 (amending ERISA § 702(b)); id. at § 103(a)(2); id. at § 104(b); id. at §§ 201(4)(A)(i)–(iii) (defining “‘genetic information’” as “(i) such individual’s genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual”).

154. Early iterations of GINA did not draw the line at manifestation.

155. § 101(d) (excluding “(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; (ii) or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved” from Title I’s definition of genetic test (emphasis added)).

Whereas GINA’s insurance title limits the definition of “genetic test,” the employment section imposes a restriction on “genetic information.” It clarifies that for employment discrimination purposes genetic information does not include “the use, acquisition, or disclosure of medical
information that is not genetic information about a *manifested* disease, disorder, or pathological condition . . . that has or may have a genetic basis.” *Id.* § 210 (emphasis added). Consequently, even if a manifested impairment has a genetic component, medical information about that manifested impairment is not genetic information within the protection of GINA’s employment provisions.

156. Huntington’s disease is often used as an example because an individual with the variant has a one hundred percent chance of manifesting the disease (if the individual lives long enough to reach the onset age). *See* Henry T. Greely, *Speech, The Revolution in Human Genetics: Implications for Human Societies*, 52 S.C. L. Rev. 377, 382 (2001) (“[Huntington’s disease] is what geneticists call one hundred percent penetrant—one hundred percent of the people with the genotype get the disease.”).

157. These regulations apply to §§ 101–103. *See infra* note 158. Similarly, the Equal Opportunity Employment Commission (EEOC) differentiates between genetic information and manifested impairments in its regulations for GINA’s employment sections. Working with the
National Human Genome Research Institute, it developed the definition for “manifestation” and “manifested” that the interim rules also adopted. Regulations Under the Genetic Information Nondiscrimination Act of 2008, 74 Fed. Reg. 9056, 9059–60 (March 2, 2009) (to be codified at 29 C.F.R. pt. 1635). Notably, in explaining that definition, the EEOC stated that a genetic variation indicating the proclivity for developing a particular impairment is not—in and of itself—sufficient to constitute a diagnosis of the associated condition, regardless of the degree of probability between having the genetic variant and eventually developing the associated condition. \textit{Id.} at 9060 (“The presence of a genetic variant alone does not constitute a diagnosis; other signs or symptoms must be present. . . . Thus, for example, a woman who has group health plan coverage and has the BRCA1 gene variant may not be subject to a preexisting condition exclusion merely because she has the variant.”).

The regulations explicitly provide that when genetic information indicates a one-hundred percent certainty that an impairment will develop at some point in the future—such as in the case of Huntington’s disease—the law still distinguishes between genes that code for a condition and a
diagnosis of the condition itself. *Id.* ("Similarly, Huntington’s disease (HD) is an example of a genetic disease that is not diagnosed solely through use of a genetic test; other signs and symptoms must be present. The presence of the genetic variant virtually guarantees the later development of disease, but the disease does not usually manifest until adulthood. Therefore, even when a genetic variant is 100 percent predictive for development of disease, the presence of the variant does not by itself equal diagnosis of the disease."). GINA, therefore, permits “the use, acquisition, or disclosure of medical information that is not genetic information about a manifested disease, disorder, or pathological condition of an employee or member, even if the disease, disorder, or pathological condition has or may have a genetic basis or component.” *Id.* at 9070 (emphasis added).

Yet while GINA offers no protection, Title I of the ADA and its interpretative regulations do, however, limit “the acquisition, use, and disclosure of medical information that is not genetic information about a manifested disease, disorder, or pathological condition.” *Id.* Thus, genetic information is distinct from manifested conditions even when an exact correlation exists between
the two. GINA, however, may cover information about a manifested condition, so long as it meets the definition of “genetic information.” Id. at 9070–71 (“Notwithstanding paragraph (a) of this section, genetic information about a manifested disease, disorder, or pathological condition is subject to the requirements and prohibitions in sections 202 through 206 of GINA and Sec. 1635.4 through 1635.7 and 1635.9 of this part.”). Yet, insofar as an employer uses medical information outside the definition of genetic information (even when that information includes a genetic component) the ADA—not GINA—applies. Id. at 9070.

158. 26 C.F.R. § 54.9802-3T(a)(6)(i); 29 C.F.R. § 2590.702-1(a)(6)(i); 45 C.F.R. § 146.22(a)(6)(i).

159. The regulations explain:

[A] genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine
whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.


161. For examples of how this distinction operates, see 26 C.F.R. § 54.9802-3T(b)(6)(ii); 29 C.F.R. § 2590.702-1(a)(6)(ii); 45 C.F.R. § 146.22(a)(6)(ii).

162. While GINA may no longer apply, the ADA offers individuals who have manifested genetic conditions some protection. However, it may be incomplete in some cases if an individual has manifested a condition that does not yet substantially limit any of his or her major life activities. See Roberts, supra note 111, at 469–70 nn. 158–62 and accompanying text; see also Maurice Wexler et al., The Law of Employment Discrimination from 1985 to 2010, 25

163. See, e.g., Robert K. Ross, The Health Reform You Haven't Heard About, THE CAL. ENDOWMENT (Mar. 30, 2010, 10:20 AM), http://tcenews.calendow.org/pr/tce/blog-post.aspx?id=3952 (This reform is the civil rights bill for the sick. And make no mistake about it: this is a civil rights issue on par with racism. With the passage of this bill, insurers can no longer discriminate against sick people simply because they are sick. What is being created is a system of health care that is fair for everyone and we leave behind a system that has been patently unfair to too many.).

164. See, e.g., Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1201, 124 Stat. 119, 154 (amending the Public Health Service Act, §§ 2701–08 (prohibiting discrimination based on preexisting condition or health status and prohibiting discrimination against individual participants based on health status).

166. Patient Protecting and Affordable Care Act § 1201 (amending PHSA § 2704(a)).

167. While people currently without any health coverage would be eligible for temporary public insurance, private health insurers could still use health information for underwriting purposes—albeit on a more limited basis until the law goes into full effect in 2014. See J.D. Kleinke, Is it 2013 (or 2014) Yet?, THE HEALTH CARE BLOG,


169. Id. at § 1201 (amending PHSA, § 2701(a)).

170. Id. Section 2701(a)(1) will now read:

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In general—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—
(A) such rate shall vary with respect to the particular

plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with

section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other

factor not described in subparagraph (A).

Id. In addition to the individual and small group markets, this provision also covers insurers in

the large group market that participate in the state exchange program. Id. (amending PHSA §

2701(a)(5)).

171. See, e.g., id. (amending PHSA § 2702(c)).
172. See id. (amending PHSA § 2701(a)(2)(A)–(B) (requiring each state to establish at least one rating area, giving the Secretary of Health and Human Services the ability to review rating areas, and to establish rating areas if the state-created areas are found inadequate)); see also id. (amending PHSA § 2701(a)(1)(A)(iii)) (providing that a rate shall not vary by age by a ratio of more than three to one); id. (amending PHSA § 2701(a)(1)(A)(iv)) (providing that a rate shall not vary by tobacco use by a ratio of more than 1.5 to 1); id. (amending PHSA § 2701(a)(3)) (giving the Secretary and the National Association of Insurance Commissioners the authority to establish the age bans for rating purposes); id. (amending PHSA § 2701(a)(4)) (providing that for family plans variations based on age or tobacco use will be “applied based on the portion of the premium that is attributable to each family member covered under the plan”).

173. See infra Part III.B.2 (discussing how these new factors approximate health status).

174. Patient Protection and Affordable Care Act § 1201 (amending PHSA § 2705).

175. Id. (amending PHSA § 2705(a)(1)–(9)).

176. Id. (amending PHSA § 2705(j)(3)(A)).
177.  *Id.* (amending PHSA § 2705(l)(1)).

178.  *See supra* Part II.A–B.

179.  *See supra* Part II.A.

180.  *See supra* Part II.A.

181.  *See supra* Part II.B.

182.  *See supra* Part II.C.

183.  *See supra* notes 19–22 and accompanying text.

184.  *See supra* Part II.C.

185.  *See supra* notes 169–73 and accompanying text.

186.  *See supra* notes 176–77 and accompanying text.

187.  For a discussion of the antidifferentiation or anticlassification principle, see *supra* notes 85–88. Notably, the Affordable Care Act also eliminates health-status discrimination from the dictionary perspective. *See* notes 16–17 and accompanying text.
188. See Einer Elhauge, Allocating Health Care Morally, 82 Calif. L. Rev. 1449, 1493 (1994) (“[C]laims of discrimination . . . depend on one’s baseline understanding of what constitutes equitable distribution of health care.”).

189. See supra Part II.C (discussing the Affordable Care Act’s elimination of health status from health insurers’ rating and underwriting decisions).

190. Thus, whereas the law succeeds from an anticlassification standpoint, it fails from an antisubordination standpoint. For a discussion of these two principles, see supra notes 85–88.

191. In the Title VII context, “disparate impact” refers to the class of claims that challenges facially neutral policies that produce a discriminatory effect, regardless of the employer’s intent to discriminate. See Griggs v. Duke Power Co., 401 U.S. 424, 424 (1971). More broadly, the phrase “disparate impact” has come to signify any antidiscrimination protections designed to combat unintended discriminatory outcomes. See, e.g., Mary Crossley, Becoming Visible: The ADA’s Impact on Health Care for Persons with Disabilities, 52 Ala. L. Rev. 51, 68 (2000) (“The ADA clearly contemplates reaching at least some forms of disparate impact discrimination..."
by recognizing that physical, social, or economic structures may create barriers or disadvantages for people with disabilities and that a failure to take reasonable steps to remove those barriers or remedy those disadvantages should be deemed to be discrimination.

192. These provisions will also apply to large-group insurers offering plans through the state insurance exchanges. See Patient Protection and Affordable Care Act Pub. L. No. 111-148, § 1201, 124 Stat. 199, 154–56 (2010) § 1201 (amending PHSA § 2701(a)(5)). Offerers in the large-group industry, however, will not be eligible to participate in the exchanges until 2017.

193. Health insurers themselves are likewise skeptical of these new factors. See KAREN SHORE, CHANGES IN HEALTH CARE FINANCING & ORGANIZATION ISSUE BRIEF: CONSIDERATIONS RELATED TO PRICING INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE UNDER HEALTH REFORM (Robert Wood Johnson Foundation ed. 2011) (“Lack of familiarity with a new risk adjustment system could lead to greater uncertainty in the insurance pricing process, potentially adding a ‘risk premium’ to the price of policies.”).
194. See Ian D. Gardner, *The Effect of Aging on Susceptibility to Infection*, 2 REV. INFECTIOUS DISEASES 801, 801 (1980) (identifying three kinds of diseases typically identified with aging: (1) “wearing-out” of organs or systems, (2) autoimmune disorders, and (3) diseases caused by decrease in immune function).

195. *Id.*

196. See David Amsden, *The Young Invincibles*, N.Y. MAG., Apr. 2, 2007, at 29 (describing the young as “naturally resilient and among the least likely to have a serious medical condition”).


199. IMPROVING HEALTH CARE FOR RURAL POPULATIONS: RESEARCH IN ACTION, AGENCY FOR
HEALTHCARE RESEARCH AND QUALITY, available at
http://archive.ahrq.gov/research/rural.htm (citing access to care as an issue facing rural
communities and finding that “[a]lmost one in three adults living in rural America is in poor to
fair health” and that “[r]ural and urban residents are equally likely to lack health insurance”); see
also Sidney D. Watson, Mending the Fabric of Small Town America: Health Reform & Rural
Economies, 113 W. VA. L. REV. 1, 5 (2010) (“Rural people are sicker, they are less likely to have
private health insurance, and rural communities suffer from a shortage of health care
providers.”). Moreover, socio-economic status is also an issue in rural communities. See id. at
11 (explaining that the nature of rural work makes “poverty . . . more widespread in rural
America”).

200. The statute provides:

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The Secretary shall review the rating areas established by each State . . . to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.


201. Id. § 1501 (amending IRC § 5000A(a) to require “applicable individual[s]” to obtain minimum essential coverage).

202. Beginning in 2014, individuals who do not obtain minimum health-insurance coverage are subject to tax penalties. Id. § 1501 (amending I.R.C. § 5000(b)(3)).

203. See id. § 1401 (adding IRC § 36B); see also Seth J. Chandler, The Architecture of Contemporary Healthcare Reform and Effective Marginal Tax Rates, 29 Miss. C. L. Rev. 335, 338 (2010) (describing section 1401 as “a central component of a web of statutory provisions
intended to make it possible for individuals and families of moderate means to acquire health insurance”).


205. See Chandler, supra note 203, at 341 (explaining that economically the subsidy “decomposes into a lump sum payment (the amount the enrollees would have received in a premium tax credit if they were at the low end of the eligibility window) and an income-contingent tax”); see also Watson, supra note 199, at 28 (stating that the “ACA’s most important contribution to making private health insurance premiums affordable for low and moderate income Americans is new refundable federal tax credits”).

206. See Patient Protection and Affordable Care Act § 1402; see also Chandler, supra note 203, at 345 (stating that section 1402 seeks to reduce the amount paid in cost-sharing on the basis of income).

207. See Chandler, supra note 203, at 371 (“[The Affordable Care Act] creates exactly the sort of high marginal rates likely to cause trouble.”).

209. Id. at 1199 (“As a pure matter of arithmetic, the reason marginal tax rates are so steep for low-income households is that current policy treats the poorest families so much more favorably than those who are almost as poor.”).


211. Id. at 4; see also id. at 855-87 (describing the disease impacts of smoking and the health benefits of reducing smoking).

212. Id. at 677 (follow “Chapter 6” link) (“Smokers have a poorer health status, lose more time from work, and use medical care services at a higher rate than their nonsmoking peers.”).

213. For example, while the overall smoking rate in the United States is down, low-income individuals are smoking at the same rate as they were decades ago. See Richard Knox, Program
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214. For a discussion of the correlation between age and health status, see supra notes 194–97 and accompanying text. For a discussion of the correlation between geographic location and health status, see supra notes 198–99 and accompanying text. Thus, these categories merely function as proxies of health status, thereby allowing the same groups to experience disadvantage.

215. Importantly if the described result occurs, it will not be the first time that a prohibition on overt discrimination in health-insurance law. Mary Crossley notes that “[i]ronically . . . HIPAA’s prohibitions of overt discrimination based on health status may have helped stimulate the development of forms of employer-provided coverage that discriminate more subtly against unhealthy persons.” Crossley, supra note 21, at 75 (emphasis added).

216. Supra notes 176–77.
217. *See* United Spinal Association (USA) & National Spinal Cord Injury Association (NSCIA), *Impact of Health Care Reform on People with Disabilities*, April 27, 2010, at 8 (“For example, a person with a disability may be unable to participate in an exercise program or another benchmark of the wellness program.”); *see also* Maegan Martin, *Legal and Practical Impediments to Aggressive Use of Wellness*, at 41 (unpublished manuscript) (on file with author) (“Opponents fear disabled employees will never qualify for wellness rewards because of their inability to participate in wellness programs or meet wellness standards.”).

218. *Id.* at 48 (noting that a wellness program will withstand the ADEA “regardless of its corresponding reward, as long as the obtainment of a wellness reward is not conditioned upon a standard unattainable to employees *because of* their age” (emphasis added)).

participate in wellness programs and that wellness programs allow health status considerations to
creep back into health-insurance rating).

220. See Elhauge, supra note 188, at 1514 (“[A]ny health maximization measure we choose will
be potentially vulnerable to the claim it discriminates against the old or the sick.”) (emphasis in
original); see also USA & NSCIA, supra note xx, at 8 (“If employees who do not participate
received a reduced deductible under the employer-sponsored health plan (or other financial
incentive), the person with the disability who is unable to participate would end up paying a
higher deductible (or would not be eligible for other financial incentives.”).

221. This outcome is not surprising. See Allison K. Hoffman, Oil and Water: Mixing
(“[W]hen certain practices for identifying risk are banned, insurers tend to rely on other
practices—both legal and illegal—to identify higher-risk applicants.”).

222. Allowing risk assessment of any type will continue to disadvantage the sick. See id. at 59
(“To the extent insurers can still engage in risk selection and differential pricing, when healthier
people buy insurance in the individual market, they will pay lower premiums more in line with their own low expected risk, providing few premium dollars to subsidize medical care of others. The converse is that sicker individuals will pay higher premiums (or get less valuable coverage) because of their higher individual risk.”).

223. See supra Part I.B.

224. Elhauge, supra note 188, at 1483.


226. The inconsistent nature of health law arguable results, at least in part from its relying on legal structures and mechanisms imported from other areas of law. See Elhauge, supra note 188, at 1452 (“[I]ntellectually, health care law borrows haphazardly from other fields of law, each of which has its own internally coherent conceptual logic, but which in combination results in an incoherent legal framework and perverse incentive structures.”)
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227. See supra Part II.

228. See Hoffman, supra note 221, at 16 (“[T]he United States is building on a framework of actuarially-rated commercial insurance, whose end goal is profit, rather than on a system of social insurance directed toward the goals of collective benefit and universal access to care.”

Moreover, Congress designed the mandate provision to avoid adverse selection and the resulting insurance death spiral. There is, however, some question whether the preservation of private insurance is superfluous. See Surowiecki, supra note 11, at 21 (“[A]n insurance system with community rating and universal access has no need of private insurers.”).  

229. See supra Part II.B.2.

230. As mentioned, we have protections for age (ADEA) and disability (ADA) in employment. Perhaps “health status” discrimination is more appropriately captured here, than as a separate antidiscrimination category.


While Yoshino provides the most in-depth exploration of this example of “constitutional
displacement,” other scholars have noted the cooperative relationship of these two doctrines. See Lawrence H. Tribe, Essay, Lawrence v. Texas: The “Fundamental Right” That Dare Not Speak Its Name, 117 HARV. L. REV. 1893, 1898 (2004) (describing the doctrine of equal protection and due process as “far from having separate missions and entailing different inquiries, [but] profoundly interlocked in a legal double helix”).

232. See generally Yoshino, supra note 231 (describing the transition from equal protection to substantive due process within constitutional law).

233. See id.; see also Tribe, supra note 231, at 1898 (explaining that the Supreme Court’s decision in Lawrence v. Texas “both presupposed and advanced an explicitly equality-based and relationally situated theory of substantive liberty”).

234. See supra Part I.B.

235. See Elhauge, supra note 188, at 1465 (“A popular moral alternative to absolutism concedes that there are limits on society’s obligation to spend on health care, but asserts that
everyone has a right to a minimum of ‘decent,’ ‘reasonable,’ ‘basic,’ ‘essential,’ or ‘adequate’ health care.”

236. See supra Part I.C.2.a.

237. See Elhauge, supra note 188, at 1465–72.

238. See supra Part I.C.2.b.


242. See Elhauge, supra note 188, at 1454–55 (“[T]he concept of ‘adequate care’ has no coherent affirmative meaning capable of guiding decisions about what to allocate either to health care generally or among different health care needs.”).
243. *Id.* at 1470 (explaining that a list-of-services approach has three major shortcomings: (1) “it assumes, rather than justifies, the relevant moral conclusions: why should these particular services be covered and not others?”; (2) “[s]uch a system funds any health care within the favored categories, even if the potential benefits in the actual case are miniscule, but provides no funding for care outside the favored categories, even if the benefits would be great in the particular case”; and (3) “the approach does not offer an effective means of cost containment”).

244. *See id.* at 1465–72 (exploring a number of alternate ways to implement a universal right model, including reasonable cost, “necessary” health care, restoring “normal species functioning,” list-of-services, and case-by-case determinations).

245. *Id.* at 1459 (explaining that once moral absolutism leaves the picture “[t]he moral question then becomes where, rather than whether, tradeoffs are appropriate”).

246. *See* Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 UCLA L. Rev. 221, 224–27 (2010) (arguing that under the Affordable Care Act’s current structure, political pressures will likely affect the determination of what
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constitutes an essential health benefit and proposing that Congress create an independent commission—free from political influence—to make recommendations on this issue); see also TIMOTHY STOLTZFUS JOST, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT:

EIGHT DIFFICULT ISSUES, THE COMMONWEALTH FUND 29–31 (2010),

http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf (detailing the potential difficulties that could come with standardizing the plans within the exchanges).

247. Despite my position regarding the impropriety of an antidiscrimination model of health insurance, even mentioning the possibility of adding a new “ism” to the canon of antidiscrimination law has generated adverse reactions when I have presented and discussed this project.

248. See supra note 229 and accompanying text (discussing the possibility of antidiscrimination language leading to “healthism” claims in other arenas).

249. See supra note 229 and accompanying text.
250. Friedman & Adashi, supra note 239, at 2639.

251. *See id.* (stating that “the right to health constitutes a concept broader than that represented by the right to health care”). While a right to “health” and a right to “health insurance” are not the same, they are undoubtedly related. *See* Hoffman, supra note 221, at 25 (“While health insurance does not guarantee good medical care, research shows that the inverse is true; the lack of health insurance results in worse care and health outcomes for many, including increased mortality.”).


253. For a discussion of the universal right rhetoric used by reformers, *see* supra notes 238–47 and accompanying text. Thus, while other themes dominated the conversation, the right to health still constituted a major talking point for reformers. *See* Friedman & Adashi, supra note 239, at 2639 (“Even though the right to health was overshadowed during the health care debate
by other narratives, such as insurance reform, cost control, and care delivery, this right remains a central if unheralded narrative of the Affordable Care Act and its legacy.

254. Some authors propose that the Affordable Care Act demonstrates a move toward health as a protected right. See Friedman & Adashi, supra note 239, at 2639 (“In passing the Affordable Care Act, the United States took a giant, if partial, step toward joining other nations wherein the right to health constitutes an inalienable moral and legal right.”).


256. For a discussion of the mandate and its accompanying subsidies, see supra text accompanying notes 201–09.

257. Patient Protection and Affordable Care Act § 1302(b)(1).

258. Id. § 1302(b)(1)(A)–(J). The statute leaves individual insureds free to purchase additional insurance beyond these benefits. See id. at § 1302(b)(5).
259. *Id.* § 1302(b)(4)(D) (“[T]he Secretary shall . . . ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”).

260. *Id.* § 1301(a)(1)(B).

261. Employers of fifty or more individuals will incur tax penalties if they fail to provide their employees with plans that offer the minimum essential benefits and any employee receives federal aid in covering health-care costs. *Id.* § 1513.

262. *Id.* § 1302(a)(1).

263. *Id.* § 1302(a)(2).

264. *Id.* § 1302(a)(3).

265. See Mantel, *supra* note 246, at 223 (“The scope of the essential health benefits will directly or indirectly affect the availability and cost of healthcare for many Americans.”).

267. See Patient Protection Affordable Care Act § 1501 (amending Subtitle D of the IRC by adding “Chapter 48—Maintenance of Minimum Essential Coverage” to require that applicable individuals are “covered under minimum essential coverage” and to impose a penalty for any month in which an individual does not hold such coverage).

268. Both sides have described the mandate as essential to the statute. Compare Florida v. U.S. Dep’t of Health and Human Servs., 780 F. Supp. 2d 1256, 1304 (N.D. Fla. 2011) (invalidating the mandate and consequently the entire law and finding that “this Act has been analogized to a finely crafted watch, and that seems to fit. It has approximately 450 separate pieces, but one essential piece (the individual mandate) is defective and must be removed. It cannot function as
originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions . . . “) with Second Judge Deals Blow, supra note 266, at A18 (“The Obama administration argues that without the insurance mandate consumers might simply wait until they are sick to enroll, undercutting the actuarial soundness of risk pooling and leading to an industry ‘death spiral.’”).

269. See supra text accompanying notes 10–13.

270. Hoffman, supra note 221, at 12 (defining “fragmentation” as “an atomization of the health insurance market into numerous risk pools”).

271. Id. at 62.

272. Id.

273. Id.

274. This system is also known as the “Bismarck” model. REID, supra note 225, at 17 (outlining the structure of the Bismarck model); see also Hoffman, supra note 221, at 14
(explaining the Bismarck system as dependent “upon highly-regulated private entities (for-profit and non-profit) to administer compulsory health insurance; these entities are sometimes called sickness funds and are often organized by profession, region, or religion and funded, through targeted funding often separate from general tax revenue”).

275. Reid, supra note 225, at 17 (“Unlike the U.S. health insurance industry . . . Bismarck-type plans are basically charities: They cover everybody, and they don’t make a profit.”).

276. Hoffman, supra note 221, at 15 (“Although this model of social insurance often incorporates individual choice of provider and sickness funds, it differs from commercial insurance in that it is designed to achieve social ends and, in particular, to be redistributive in nature (across ages, health status, income, and individuals and families).”).

277. See, e.g., Elhauge, supra note 188, at 1453 (suggesting, as part of a larger proposal, a health-care system in which insurers “cannot retain profits from their budget (other than a possible bonus linked to total number of enrollees) but must instead spend it on those enrollees”).
278. In fact, Deborah Stone has argued that the failure to provide more public insurance is what led to the large number of un- and underinsured Americans in the first place. See Stone, supra note 7, at 652–53 (pinpointing the “de facto national decision to rest responsibility for health insurance in the private sector, and to use government only as a last resort for populations the private market did not want to insure, notably, the poor, the elderly, the disabled, and the chronically ill” as the reason why American health insurance evolved into a system in which the sick lack coverage).

279. See Hoffman, supra note 221, at 14 (“Most industrialized countries treat health insurance as social insurance, where people contribute toward financing based on ability to pay, where risk of poor health is pooled broadly, and where access to care is provided on the basis of need.”).

280. This option is the “single-payer” system, in which citizens pay into a national health insurance system that is then responsible for paying private health-care providers. See Reid, supra note, 225, at 18–19. Canada adopts this structure. See id. at 19.
281. In other countries, such as Italy, Spain, and the United Kingdom, the government owns hospitals and clinics. See id. at 17–18.

282. See Hoffman, supra note 221, at 71 (observing that approaches advocating expanding public insurance “have received the most resistance when proposed as part of reform”).

283. See supra Part I.C.2.a (describing health insurers as discriminating against the sick).

284. As discussed, the factors that will replace health status and history as of 2014 for rating purposes all merely approximate health. See supra Part III.A.1.

285. On Wednesday, September 28, 2011, the Obama administration asked the Supreme Court to hear the appeal of a case in which the Eleventh Circuit declared the individual mandate unconstitutional. Adam Liptak, Supreme Court Is Asked to Rule on Health Care, N.Y. TIMES, Sept. 29, 2011, at A1.

286. Less than one year after President Obama signed the Affordable Care Act into law, the House voted 245 to 189 to repeal the legislation. See David M. Herszenhorn & Robert Pear, As Vowed House Votes to Repeal Health Care Law, N.Y. TIMES, Jan. 20, 2011, at A1. The
constitutionality of the mandate, as well as the validity of the Affordable Care Act generally, has already become a hot-button issue for the 2012 presidential election. See Liptak, supra note 284, at A1, A4.