Discrimination Against the Unhealthy in Health Insurance

Mary Crossley*

I. Introduction

What ends do we expect health insurance to serve in our society? This unresolved question, which one scholar aptly terms “the struggle for the soul of health insurance”\(^1\) arises today in many settings. This struggle pits a “social solidarity” vision of health coverage (by which insurance permits the risk of medical costs to be spread broadly across society, so that healthy persons subsidize the care received by unhealthy persons) against an individualistic vision of health coverage (by which insurance enables each person to pay an amount that reflects as closely as possible his own anticipated cost of care). The tension between these two views may emerge, for example, in debates over proposals to require community rating of insurance premiums or to mandate that insurers cover particular services.\(^2\)

This tension is also highlighted by laws that prohibit discrimination in health insurance. These laws – whether they apply directly to insurance issuers or to employers providing health insurance coverage as an employment benefit – seem to embody the social solidarity view that persons with particular traits should neither be denied a place in the insurance pool nor be subjected to inferior coverage. The application of these antidiscrimination laws to health insurance today occupies center stage in controversies over whether employers are required to

---

* Dean and Professor of Law, University of Pittsburgh School of Law.


provide prescription contraceptive coverage for their employees\(^3\) and whether employers can terminate retiree health benefits for Medicare-eligible retirees.\(^4\) Existing laws address discrimination based on a variety of traits, including race, sex, age, disability, genetic makeup, and the need for mental health treatment.

Yet while these antidiscrimination laws at first glance seem to share a common vision of insurance inclusiveness, inconsistencies quickly surface when one examines the particular terms of these laws and courts’ interpretations of them. To date, courts interpreting laws prohibiting health insurance discrimination have failed to articulate any consistent – much less overarching – vision either of the scope of the protection against discrimination or of the justification for that protection. Consequently, in the course of a single opinion, a court may apply one standard for assessing claims of sex discrimination in health insurance and another for claims of disability discrimination.\(^5\) Meanwhile, state legislatures have supplied still another standard in passing laws prohibiting genetic discrimination. So we are left wondering what sense to make of existing legal approaches to health insurance discrimination.

We might also wonder about absences from the foregoing list of traits protected under federal and state antidiscrimination laws. One notable absence is health status. This absence, however, is not the result of legislative oversight or lack of need. 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. These principles are consonant with the individualistic view of health coverage,

\(^3\) See, e.g., Dan Margolies, \textit{Area Women Sue AT&T over Contraceptive Coverage}, KAN. CITY STAR, Jan. 21, 2003.


\(^5\) See Saks v. Franklin Covey Co., 316 F.3d 337 (2d Cir. 2003) (finding that equal access to benefits is the proper inquiry for ADA claims, while Title VII sex discrimination claims require assessment of the relative comprehensiveness of coverage).
where individuals’ costs of coverage should vary with their predicted consumption of medical care. Indeed, some argue that state unfair trade practice laws regulating insurers mandate health status discrimination.

While lawmakers have not recognized “the unhealthy” as a group meriting protection under a civil-rights-informed antidiscrimination law, both state and federal law provide unhealthy people with limited some protection against adverse differential treatment. For example, the handful of states that mandate community rating of health insurance protect persons with health problems from being charged higher premiums than their healthier peers. More broadly, in passing the Health Insurance Portability and Accountability Act (“HIPAA”) in 1996, Congress prohibited group health plans from excluding an individual from a group or charging her higher premiums based on her health status.

Ironically, though, 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. The recent emergence of novel health coverage products is typically attributed to consumer backlash against managed care cost-containment methodologies and managed care’s resulting inability to continue its downward pressure on health care inflation. Also worth noting, however, is that, as employers’ health costs escalated, HIPAA limited their ability either to keep unhealthy and expensive employees out of their groups or to make those employees pay more. As a result, employers have

6 Who are “the unhealthy” to whom this Article frequently refers? The term admittedly suffers from substantial imprecision, but I use it in this Article to refer broadly to those persons whose health status renders them heavy users of (and thus heavy spenders on) health care services. Thus, while people whom we would consider chronically “sick” would certainly fall into this group, so too could individuals who require expensive screening and preventative services on a regular basis to keep them from becoming sick, as could an individual who simply suffers an accident or acute illness requiring hospitalization. A person who has been diagnosed with one or more chronic conditions requiring ongoing medical care and pharmaceutical intervention is the exemplar of a member this group.

increasingly turned to other avenues – from simply increasing enrollees’ copayments to adopting so-called consumer-driven health plans – to constrain their health benefits costs. The common thread uniting recent trends in employer-provided coverage is the shifting of insurance risk (i.e., the risk of incurring medical expenses) away from the insurance company or self-insured employer and onto the shoulders of employees.

Logic and emerging evidence confirm what health insurers have long known: Bearing insurance risk for unhealthy persons costs more than bearing insurance risk for healthy persons. Accordingly, it stands to reason that as employers adopt health coverage vehicles that shift insurance risk from the insurer to individual insureds, the burden falling on unhealthy enrollees generally will be heavier than any burden on healthy enrollees. In this disparity of costs shifted we can discern discrimination against the unhealthy. Although employers adopting these new coverage vehicles in all likelihood treat their employees identically in providing health benefits, the coverage provided imposes a heavier burden on employees with health problems. Adoption of facially neutral policies that disproportionately burden a particular group is, of course, the core definition of disparate impact discrimination.

The observation that increased copayment requirements and consumer-driven vehicles like health savings accounts may disproportionately burden the unhealthy is not novel. Indeed,
concerns about the inequity of this burden have been voiced at least since the policy debates over including a medical savings accounts demonstration project in HIPAA. This Article will review the policy arguments for and against the shifting of insurance risk to individual health care consumers, but will then move beyond partisan debate to examine emerging research on the impacts of this risk shifting. This research suggests that the repercussions do not simply entail imposing heavier financial costs onto unhealthy individuals; instead, they also include effects on health care consumption and, ultimately, health status. In sum, newer forms of coverage may leave unhealthy individuals underinsured and thereby exposed to many of the same harms that uninsured persons face.

In the end, this Article briefly suggests reasons for objecting to and seeking to curb this trend towards the shifting of risk to individual insureds. First, we might find the disproportionate burden visited upon the unhealthy troubling because of a sense that this disparate impact is somehow associated with social inequality and violates their civil rights. Alternatively, we might understand the inequality of burdens as indicating an unjust distribution of consumerism’s benefits and burdens.

This Article proceeds as follows: Part II describes the struggle for the soul of health insurance and suggests how it is implicated in legislation regarding health coverage. Part III reports on the federal and state laws that already prohibit discrimination on a variety of bases and attempts to discern any logic underlying inconsistencies in the coverage of and justifications for these laws. Part IV examines laws that address the legality of health status discrimination in health insurance. The advent of a “consumerist” movement in health coverage is presented in Part V, along with an articulation of the policy perspectives that favor and disfavor the movement. That Part also presents evidence regarding the financial and health
effects of the consumerist movement on unhealthy individuals. Part VI builds on the preceding Parts to sketch rationales for policy responses designed to discourage or redirect the current trends in health coverage.

II. The Struggle for the Soul of Health Insurance: Encapsulating the Debate

The discussion of health insurance discrimination and the unhealthy that follows will be aided by fleshing out the idea of a “struggle for the soul of health insurance.” The phrase comes from the title of Deborah Stone’s insightful and provocative article,10 which examines the competing concepts of solidarity and actuarial fairness in the context of health insurance coverage and pricing decisions. Stone describes the logic of solidarity as understanding health insurance as a form of mutual aid, in which community members pool their risks of incurring medical care expenses and share those expenses when they occur. Under such a system of mutual aid, the majority of members who are fortunate enough to remain healthy subsidize the care of those members who become sick or suffer injuries; the mutual aid system thus explicitly contemplates and accepts redistribution from the healthy to the sick. By contrast, the principle of actuarial fairness, in its purest form,11 cannot abide cross subsidies among insurance purchasers. Instead, the principle of actuarial fairness dictates that each individual should bear financial responsibility for his own risk of incurring medical expenses, so that each person’s

10 Stone, supra note 1.
11 According to Deborah Hellman, in an actuarially fair insurance pricing scheme, “each insured pays a price for coverage that is equivalent to the risk she poses of drawing from the insurance pool, given available information.” Deborah S. Hellman, Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women, 32 HARV. C.R.-C.L. L. REV. 355, 358 (1997). As a practical matter, insurers are unlikely to implement pure actuarial fairness because the costs of predicting each insured’s risk as precisely as possible would outweigh the competitive risk selection benefits that an insurer would reap from such prediction. Consequently, Hellman sees a more moderated approach to actuarial fairness as more plausible. Id. at 398-99. Cf. Stone, supra note 1, at 293 (noting that a perfect implementation of actuarial fairness would be the “antithesis of insurance” because each individual would be better off self-insuring in order to avoid paying an insurer).
insurance premium should reflect that person’s actuarially determined risk – no more and no less. Thus, a health insurance market that follows the principle of actuarial fairness in making coverage and pricing decisions will segment its insureds into ever more finely defined pools, each of which contains policyholders whose risks are as homogeneous as possible. In that way, no one whose health prospects are bright will be called upon to subsidize the medical needs for those with gloomy medical outlooks.\textsuperscript{12}

Stone views this tension between the competing principles of solidarity and actuarial fairness as reflecting more than a simple choice about how to structure and price health insurance. Instead, she asserts that the underlying question posed is “whether medical care will be distributed as a right of citizenship or as a market commodity.”\textsuperscript{13} Thus, the struggle for the soul of health insurance takes on a moral tenor – the combatants invoke political philosophy and neoclassical economics in the struggle.

On the ground, however, it is the extreme skewing of medical spending across the population that makes this struggle unavoidable. While most people are generally healthy and usually do not experience large health care costs in any given year, a relatively small number of people suffer illnesses or accidents that result in massive medical spending.\textsuperscript{14} Because the risk of illness or accidents remains at some level unpredictable, purchasing health insurance is a rational way of seeking to protect against the risk of large medical bills.\textsuperscript{15} The pooling of risk

\begin{itemize}
\item \textsuperscript{12} Stone, \textit{supra} note 1, at 289-293.
\item \textsuperscript{13} \textit{Id.} at 288-289.
\item \textsuperscript{15} Jost, \textit{supra} note 14, at 433.
\end{itemize}
that is a fundamental characteristic of insurance functions as a mechanism for shared savings. 16

The tension between solidarity and actuarial fairness appears full-blown, however, as soon as we recognize that pooling entails the sharing of losses as well as the sharing of risks, for then we immediately ask “Whose losses must I share?” A disciple of actuarial fairness responds that a particular insured should share the losses only of those who share a similar risk profile. A solidarity partisan responds that all members of a community, however defined, 17 should share in the community’s losses. 18

As one might expect, other scholars have also noted this tension between a community solidarity conception of health insurance and an individualistic focus and have used a variety of terms to describe the competing conceptions. 19 Scholars commonly recognize this tension as

---


17 For purposes of discussing private health insurance premiums, the community could be defined broadly as all of an insurer’s subscribers, or it could be defined somewhat more narrowly as those subscribers in a particular geographic area or in a particular industry. The term “community rating” is used to describe a premium pricing scheme in which each insured is charged an identical premium (with perhaps some limited variations). For a description of state laws requiring community rating, see infra Part IV. Of course, under a single-payer health care scheme, the community is defined even more broadly to include all residents of a polity covered by the single payer.

18 Cf. Shearer, supra note 14 (rejecting policy initiatives that would “split the healthy from the sick” and calling for measures “insuring the sick with the healthy”).

19 See, e.g., John V. Jacobi, The Ends of Health Insurance, 30 U.C. DAVIS L. REV. 311, 312 (1997) (contrasting social pooling and individual responsibility visions of health insurance). Rand Rosenblatt contrasts a “modestly egalitarian social contract” model of health law with a market competition model of health law. He notes, however, that proposals by leading academic proponents of a market model of health law include some form of cross-subsidization and guaranteed issue so that high-risk individuals have access to health insurance. Rand Rosenblatt, The Four Ages of Health Law, 14 HEALTH MATRIX 155, 174, 178-81 (2004). Scholars have also noted that other nations display a more consistent commitment to the ideal of social solidarity in health insurance that does the U.S. See Stone, supra note 1, at 289-90 (asserting that American society has only a “weak and wavering commitment to the view that sickness is a condition that triggers mutual aid); Jost, supra note 14, at 434; Jacobi supra, at 313 (attributing America’s “less than firm” commitment to a social solidarity ideal to Americans’ being “imbued with rugged individualism and a preference for voluntary action”). See KENNETH ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY AND PUBLIC POLICY 65 (1986). See also Sharon Hoffman, Unmanaged Care: Towards Moral Fairness in Health Care Coverage, 78 IND. L.J. 659, 662 (2003) (contrasting actuarial fairness with a “moral fairness” standard, which “take[s] into account values of just distribution”); Leah Wortham, Insurance Classification, Too Important to be Left to the Actuaries, 19 U. Mich. J.L. Ref. 349, 360-361
underlying many policy debates regarding health care systems reforms. They also highlight that the tension is based not simply on differing pragmatic assessments of the most effective way of accomplishing a particular goal such as lowering health care costs or increasing the number of people covered by health insurance. Instead, many commentators appreciate that the conflicting visions pose fundamental moral and philosophical questions regarding desert and entitlement, misfortune and injustice.

From the foregoing it might appear that the struggle for the soul of health insurance could accurately be simplified to choosing between “All for one, and one for all” and “Every man for himself” as the slogan governing health insurance policy. A number of scholars, however, have noted that in reality the contrast between social solidarity and individualism is less stark. For even if an individual seeks to obtain health insurance for the purely selfish purpose of protecting herself against the possibility of overwhelming medical costs, by purchasing insurance she enters into a community of risk sharers and thereby produces a public benefit. And while we might assume that proponents of market-based approaches to health insurance policy would align themselves with an actuarial fairness vision, a number of scholars

---

(1985) (contrasting “traditional fair discrimination and antidiscrimination” approaches); Jill Gaulding, Note: Race, Sex, and Genetic Discrimination in Insurance: What’s Fair?, 80 CORNELL L. REV. 1646, 1647 (1995) (contrasting the “efficient discrimination” and “antidiscrimination” perspectives); cf. ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW 136-137 (3d. ed. 2002) (contrasting the “grouping perspective” which would permit the use of gender-based classifications, with the “individual perspective,” which rejects such a classification as unfair and noting the related issue of what type of subsidization in insurance is fair).

20 For the most part, commentators have described policy questions regarding the structure of the health insurance market or regarding health care financing reform more broadly in these terms, see, e.g., Jacobi, supra note 19, but the tension has also been noted in other contexts. See William M. Sage, Judicial Opinions Involving Health Insurance Coverage: Trompe L’Oeil or Window on the World?, 31 IND. L. REV. 49, 51 (1998) (suggesting that tensions about the nature of health insurance are revealed in coverage litigation); cf. Sara Rosenbaum & Brian Kamolie, Managed Care and Public Health: Conflict and Collaboration, 30 J. MED. & ETHICS 191 (2002) (suggesting a similar tension between managed care’s grafting of insurance risk avoidance principles into medical practice and fundamental precepts of public health).

21 See Hellman, supra note 11, at 397-402; Nichols et al., supra note 14 (“opposing views about the ‘optimal’ health insurance market reflect philosophical differences in approach to health system reform”).

22 See Roberta M. Berry, The Human Genome Project and the End of Insurance, 7. U. FLA. J.L. PUB. POL’Y 205, 227-31 (1996); see also Glenn, supra note 16, at 304 (“By tracing out the way that insurance spreads responsibility, we see … [that] insurance builds communities of interest, whether we realize it or not.”).
employing economic theory have pointed out that imperfections in the health insurance market\textsuperscript{23} may create a need for subsidies between low- and high-risk individuals and justify limitations on insurers’ pursuit of actuarial fairness in order to increase market efficiency.\textsuperscript{24} So even many who assert the power of market economies to maximize social welfare have suggested that some regulatory measures consistent with – if not inspired by – a solidarity vision of health insurance may be necessary to improve market efficiency.\textsuperscript{25} Notwithstanding some blurring of the stark contrast the competing visions offer, they continue to point in opposite directions on many questions, including health insurers’ discriminatory risk classification practices, to which we now turn.

III. Laws prohibiting discrimination in health insurance

A. Risk classification as discrimination

Before examining various laws proscribing health insurance discrimination, this section will suggest the diversity of forms that discrimination by health insurers can take. Of course, the most straightforward example is an insurer’s refusal to issue a policy to an individual based on a particular trait. Such a discriminatory refusal to cover is also clearly inconsistent with social solidarity, for it excludes that person from the pooling of risks and losses that insurance

\textsuperscript{23} For an excellent explanation of inefficiencies in the market for health insurance, see Katherine Swartz, Justifying Government as the Backstop in Health Insurance Markets, 2 Yale J. Health Pol’y, L. & Ethics 89 (2001). Swartz asserts that the primary imperfection in the market is information asymmetry that leads to inefficient risk screening practices by insurers seeking to avoid adverse selection. \textit{See also} Thomas L. Greaney, How Many Libertarians Does It Take to Fix the Health Care System?, 96 Mich. L. Rev. 1825, 1836 (1998) (characterizing the health care market as “beset with problems of inadequate information and imperfect agency”).

\textsuperscript{24} See Greaney, supra note 23, at 1846 (stating that “controlling risk segmentation is at the heart of market reform efforts designed to improve efficiency”); Swartz, supra note 23.

\textsuperscript{25} A notable exception is Richard Epstein, who argues in his book, Mortal Peril: Our Inalienable Right to Health Care? (1997), that American society should avoid positive rights to health care, including regulation mandating cross-subsidies. Reviewers of Mortal Peril, however, have criticized Epstein for basing his policy prescription on a commitment to libertarianism and for failing to pay close attention to recognized imperfections in the health care market. See Greaney, supra note 23, at 1826-1828.
coverage provides. But a brief examination of risk classification mechanisms commonly employed by health insurers reveals how discrimination, in the neutral sense of the word, inheres in numerous other insurance practices.\textsuperscript{26}

Private health insurers engage in risk classification practices as part of their competitive strategies for capturing profitable segments of the health insurance market while avoiding unprofitable segments.\textsuperscript{27} Rather than segmenting the market by product and competing based on products’ price and quality, however, health insurers tend to segment the market by customer – competing in their efforts to sell policies to those customers considered likely to be profitable and to avoid customers who can be predicted to be unprofitable.\textsuperscript{28} To this end, health insurers seek to obtain from prospective insureds information that the insurers deem predictive of future health costs and to use that information in a variety of ways to try to avoid, or at least classify risk.

Many risk classification practices employed by insurers fit easily into a rubric of disparate treatment discrimination – where the insurer somehow treats $A$ differently from $B$ based on a trait of $A$, for example, the fact that $A$ is female.\textsuperscript{29} Certainly, if an insurer decides to issue a particular insurance policy to $B$ but not to $A$ because she is female, the insurer has

\textsuperscript{26} Cf. JERRY, supra note 19, at 136 (noting that, from one perspective, “insurance is inherently ‘discriminating’ because the purpose of insurance is to divide a group of potential insureds into smaller categories and price each group according to its risk”).

\textsuperscript{27} For a lucid and accessible description of health insurance markets and how health insurers use risk classification mechanisms to compete, see Swartz, supra note 23, at 95-97. See also Gaulding, supra note 19, at 1651-53 (describing role of adverse selection and competition among insurers in promoting risk classification).

\textsuperscript{28} As Kenneth Abraham notes regarding the insurance industry generally: “Insurers often can capture more protection dollars by classifying because through classification they can offer low-risk individuals lower prices.” ABRAHAM, supra note 19, at 67.

\textsuperscript{29} For a description of risk classification practices, see Gaulding, supra note 19, at 1651-52. cf. Wortham, supra note 19, at 404 (“The selection competition feature probably causes people to most immediately make the analogy of insurance … classifications to civil rights laws.”).
discriminated in underwriting.\textsuperscript{30} Or perhaps the insurer does not flatly turn $A$ away, but instead charges $A$ a higher premium than $B$ for the same policy. In that instance, the insurer has discriminated in its rating, or pricing, practices.\textsuperscript{31} In the alternative, assume that the insurer agrees to cover both $A$ and $B$ for the same price, but decides to exclude certain benefits only from $A$’s coverage or to impose a longer pre-existing condition exclusion on $A$ than on $B$.

Again, the insurer is discriminating against $A$, this time in making coverage decisions. Through these decisions,\textsuperscript{32} the insurer segments its market based on the relative risk that the insurer believes $A$ and $B$ pose. Segmentation occurs when the insurer decides who gets to participate in the pooling of risks, the price that different customers must pay enter the pool, and what risks each customer can transfer to the pool. Health insurers’ use of various types of risk classifications in making underwriting, coverage, and rating decisions has generated significant policy discussion and academic analysis regarding these practices’ legitimacy.

But an insurer’s attempt to limit its exposure to risk may also produce another form of discrimination. In contrast to disparate treatment discrimination, disparate impact discrimination exists not in singling out a person for different treatment based on a protected trait, but in applying a facially neutral practice or policy that disproportionately and adversely

\textsuperscript{30} The insurance industry defines underwriting generally as “the process by which an insurer determines whether or not and on what basis it will accept an application for insurance.” Karen A. Clifford & Russell Inculano, \textit{AIDS and Insurance: The Rationale for AIDS-related Testing}, 100 HARV. L. REV. 1806, 1807-08 (1987).

\textsuperscript{31} “Classification refers to treating an individual as a member of a class based on an individual trait such as gender, residential zip code, driving record, history of cancer, and so forth. … Rating is the process of transforming classifications into prices for insurance.” Wortham, \textit{supra} note 19, at 354 n.19.

\textsuperscript{32} The cases discussed all involve instances of overt, identifiable discrimination. Brian Glenn, in discussing discrimination against certain groups within the insurance industry more generally, points out that disparate treatment discrimination can also take more subtle forms, such as an agent who fails to return certain customers’ phone calls, offers higher prices and weaker policies to members of certain groups, or is slower in handling claims submitted by members of certain groups. Brian J. Glenn, \textit{The Shifting Rhetoric of Insurance Denial}, 34 L. & SOC. REV. 779 (2000).
impacts a group of people sharing the protected characteristic. For example, let us imagine that a health insurer sells the same policy to A and B for the same price, but the policy excludes coverage for breast cancer (while providing coverage for all other cancers). The insurer is treating A and B identically in the coverage provided, but the exclusion of breast cancer undoubtedly would have a disproportionate adverse effect on women. Aside from coverage determinations, insurance marketing strategies or administrative policies may have a disparate impact on a particular group, as may an insurer’s reliance on a non-protected personal trait of an insured. Thus, like its more easily recognized sibling different treatment discrimination, impact discrimination may potentially be found in various health insurer practices.

Having suggested that discrimination of some sort lies at the heart of health insurers’ risk classification practices, I hasten to note that most Americans are not subjected to these practices when they obtain insurance coverage. Most Americans under the age of sixty-five receive health insurance coverage from their employer, and for several reasons insurers do not engage in risk classification practices for large employer groups. The smaller the group for which coverage is purchased, however, the more likely a health insurer is to employ risk

---

33 See Griggs v. Duke Power Co., 401 U.S. 424 (1971). In the employment context, in order to be actionable, the disparate impact from an employer’s practice must not be justified by business necessity.

34 In employment discrimination law, the disparate impact felt is typically that members of a protected group have a higher rate of exclusion from the workplace or a lower rate of advancement within the workplace. In the health insurance setting, the disparate impact felt by a particular group might take the forms of higher levels of uninsurance, higher levels of inadequate coverage, or lower rates of successful claims. For example, an insurer who passes out enrollment applications at a health club may be likely to reach a disproportionately small number of persons with serious health conditions, and applications sent to an insurer who advertises primarily in homemaking magazines may include a disproportionately low number of male applicants. An indemnity insurer that requires that all claim forms be submitted in English may disproportionately affect the ability of subscribers of Mexican origin to receive benefits.

35 See Wortham, supra note 19, at 366 (noting that automobile and property insurers’ use of residential zip code may have a disparate impact on racial minorities).

36 The courts are certainly aware of this point as well. See, e.g., Thompson v. IDS Life Ins. Co., 549 P.2d 510-512 (1976) (en banc) (stating that “insurance, to some extent, always involves discrimination….”).

37 See Swartz, supra note 23, at 96 (explaining why insurers in the large group market are less concerned about adverse selection).
classification devices, so that small employers seeking to purchase coverage are more likely to encounter the use of underwriting, coverage, and pricing mechanisms.38 By all accounts, risk classification practices are *de rigeur* in the market for individual health insurance policies, at least where permitted by law. Thus, health insurers’ discriminatory practices are highly concentrated in the individual market, with some infiltration in the small group market. 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. Moreover, the continuing erosion of employer-sponsored health coverage seems likely to cause the ranks of prospective purchasers in the individual market to swell. Accordingly, the number of purchasers subject to discriminatory practices by insurers will probably increase in the short run.

To this point, I have used “discrimination” in its neutral sense of drawing distinctions and have not focused on the legitimacy or legality of any particular basis for discrimination. The sections that follow undertake the task of cataloging the various bases for health insurance discrimination that the law has proscribed. The treatment of each type of legally regulated discrimination is necessarily circumscribed, for this Part’s remaining purpose is not to provide comprehensive analysis of all such prohibitions, but instead to suggest their number, variety, and inconsistency of approach and rationale. What should emerge from this cataloging is a recognition that society has branded as illegitimate the discrimination embodied in some insurance practices, but not others, without any distinguishable overarching justification for doing so.

38 The small group market is generally defined as groups having 2-50 members. The frequency with which insurers underwrite coverage in the small group market is not entirely clear. See Clifford & Inculano, *supra* note 30, at 1809 n.17 (explaining why insurers may employ risk classification practices with respect to small groups).
B. Laws prohibiting or regulating discrimination in health insurance

In cataloging the various legal proscriptions of health insurance discrimination, identifying several key items will enable comparisons. First, and most salient, what is the individual trait that is placed off limits as a basis for risk classification? Second, what types of discrimination are prohibited? Does the law broadly prohibit both disparate impact and disparate treatment discrimination by health insurers, or does it more narrowly proscribe only the latter? Third, whose actions are constrained? Does the law apply directly to health insurance issuers, to employers providing health insurance coverage, or both? And finally, what rationale justifies the legislative choice to limit insurers’ use of risk classification mechanisms and thus their freedom to pursue profit in the marketplace?

1. Race Discrimination

Race is the trait that receives the strongest protection against being used in health insurance risk classification. Both federal and state laws forbid its use as a mechanism for segregating risk. The strong prohibitions against racial risk classification, however, do not simply reflect a judgment that race is never an actuarially valid predictor of future costs. While commentators have noted that the shorter average life expectancy for black Americans, as compared to white Americans, carries some actuarial significance for both life insurance and annuities, less noted is the possibility that African Americans’ generally lower health status and higher disease burden could justify using race as a risk classifier in health insurance.


See Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Conventions on the Elimination of all Forms of Racial Discrimination*, 14 U. FLA. J. LAW & PUB. POL’Y 45, 51 (2002) (giving several examples of racial disparities in health status and disease incidence, including figure that African Americans have a 70% higher rate of diabetes than white Americans); Lynette Clemetson, *Links between Prison and AIDS Affecting Blacks Inside and Out*, N.Y. TIMES, Aug. 6, 2004, at A1 (reporting that
Notwithstanding its potential actuarial relevance, race is deemed an illegitimate classifier under the insurance regulation laws of most states. Some states achieve this result through laws specifically directed at outlawing race-based classifications; others subsume the use of race within their definitions of insurance unfair trade practices. By their terms, however, state laws apply only to the use of race to treat persons differently; they have not generally been extended to prohibit risk classifications that have a racially disparate impact.

When an individual receives health insurance as a benefit of employment, federal law also prohibits racial classifications. The antidiscrimination mandate of Title VII of the 1964 Civil Rights Act extends to discrimination in employer-sponsored benefit plans such as health insurance coverage. Moreover, Title VII has been interpreted to prohibit not only different treatment based on race, but also disparate impact discrimination. Thus, at least in theory, an insurance risk classifier that has an unjustified disparate impact on a racial group is illegal.

more than half of all new cases of HIV nationwide are among African Americans and that African-American women make up 72% of new cases among women).


See, e.g., Mont. Code Ann. § 33-18-210; see generally Gaulding, supra note 19, at 1659-60.

Some states, however, have effectively proscribed one form of potential disparate impact race discrimination by explicitly prohibiting insurers from using the presence of sickle cell trait – a genetic trait found predominantly among African Americans – as a basis for underwriting or risk rating. See Hellman, supra note 11, at 381-82.

See 42 U.S.C. § 2000e-2(a)(1) (“it shall be an unlawful employment practice for an employer … 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”).

under Title VII. And, beyond the employment context, federal civil rights laws may limit insurers’ use of race as a classifier, even in the absence of state action.

What explains the law’s consistently strong protection against the use of race in underwriting, coverage, and rating decisions? The answer may lie partly in the fact that race is less valuable to insurers in predicting future medical expenses, than are other traits such as sex, age, disability, or medical history – all of which, as we will see, receive more limited protection. Nonetheless, data regarding the greater disease burdens borne by some racial groups might – from the perspective of actuarial fairness – support insurers’ reliance on race in classifying risks. Perhaps we should understand prohibitions on racial classifications less as a judgment of actuarial irrelevance than as a reflection of societal unwillingness to allow a divisive use of race in the context of insurance. In this sense, the social solidarity stance discernible in laws prohibiting racial classifications may be better understood as a particularized manifestation of the more general societal judgment regarding the illegitimacy or repugnance of using race in determining access to societal benefits.

---


Cf. EEOC v. J.C. Penney Co., Inc., 843 F.2d 249 (6th Cir. 1988) (discussing legal uncertainty as to whether disparate impact theory can be used in claim based on section 703(a)(1) of Title VII); Novak v. Nationwide Mutual Ins. Co., 599 N.W.2d 546 (Mich. App. 1999) (noting split of authority on question of whether insurance redlining is prohibited as a form of disparate impact discrimination under the federal Fair Housing Act).

48 See 42 U.S.C. § 1981 (guaranteeing to all citizens a right equal to that enjoyed by white citizens to purchase real and personal property); 42 U.S.C. § 1982 (guaranteeing to all persons a right equal to that enjoyed by white citizens to make and enforce contracts); Wortham, supra note 19, at 362-63 (discussing application of these laws to race or color classification in insurance); cf. Thompson v. Metropolitan Life Ins. Co., 216 F.R.D. 55 (S.D.N.Y. 2003) (approving proposed settlement in class action brought by non-Caucasian policyholders alleging that life insurer violated 42 U.S.C. §§ 1981 and 1982 by selling them policies that cost more and provided fewer benefits than policies sold to Caucasians).

49 See JERRY, supra note 19, at 136 (asserting that notwithstanding black Americans’ shorter life expectancy, “because our society views racial discrimination with repugnance, no one contends that black Americans should pay more for life insurance or receive a premium reduction for annuities”).
2. Sex Discrimination

In contrast to the general consensus that insurers should not use race in classifying risks, controversy has marked attempts to prohibit sex-based classifications50 and protections against sex discrimination in insurance remain more limited. The objections raised to prohibitions on sex-based insurance classifications are not surprising, for sex’s actuarial relevance in evaluating risks of various types is greater than that of race. In a number of settings, sex provides insurers with an inexpensive method of classifying risks;51 in the health insurance setting, relying on sex as a classifier leads to younger women being charged higher premiums than men because of the risk of medical costs associated with pregnancy and childbirth.52 Today, the protection against insurance sex discrimination varies between the state and federal levels and the employment and non-employment contexts.

On the state level, insurance laws largely permit the use of sex as a risk classifier, at least for purposes of rate calculation.53 Despite some proposals to require “unisex” insurance rating,54 most states have declined to eliminate the practice of calculating sex-based premiums. Given the permissiveness of most states’ laws and the actuarial value of sex as a classifier, it is

51 See JERRY, supra note 19, at 133-34 (pointing out relevance to life insurance, annuities, health and disability insurance, and automobile insurance and stating: “[I]n these contexts, gender is a low-cost way to differentiate risks.”).
52 Id. at 134; see also Diane Levick, ConnecticCare Joining Gender Trend: Health Insurer, Following Anthem and UnitedHealth, Plans to Charge More for Most Women, HARTFORD COURANT, Apr. 22 2004.
53 While a number of states restrict the ability of insurers to deny or limit coverage on the basis of sex, see Wortham, supra note 19, at 366, only Montana prohibits all sex-based classifications by insurers. See MONT. CODE ANN. § 49-2-309 (2003).
54 See, e.g., Jerry & Mansfield, supra note 39; cf. Wortham, supra note 19, at 368 (arguing that use of sex should be prohibited in insurance classifications, notwithstanding its statistical association with loss); Anne C. Cicero, Strategies for the Elimination of Sex Discrimination in Private Insurance, 20 HARV. L. REV. 211 (1985).
not surprising that many health insurers discriminate against women by charging them higher
premiums than men.\textsuperscript{55}

This permissiveness evaporates, however, when the setting shifts to employer-
sponsored health insurance coverage, for sex is one of Title VII’s prohibited bases for
discrimination. As with race, therefore, an employer who sponsors group health coverage for
its employees cannot discriminate based on sex in that coverage. In addition, the Pregnancy
 Discrimination Act,\textsuperscript{56} which Congress passed in 1978 to amend Title VII, makes explicit that
discrimination based on “pregnancy, childbirth, or related medical conditions” is a form of sex
discrimination.\textsuperscript{57} Interpreting these laws specifically in the context of employee benefit plans,
the Supreme Court has held that employers cannot provide fringe benefits that discriminate
either by charging members of one sex more for equivalent coverage\textsuperscript{58} or by providing
members of one sex lesser benefits for the same contribution.\textsuperscript{59}

Moreover, in \textit{Newport News Shipbuilding & Dry Dock v. EEOC,}\textsuperscript{60} the Court indicated
that even if an employer provides male and female employees with the same health insurance
plan for the same contribution, the employer discriminates if the coverage provided is less

\textsuperscript{55} See Levick, \textit{supra} note 52. This news article reports that ConnectiCare attributed its decision to switch to
gender rating for small employers in part to the adverse selection that occurred as a result of other companies’
using gender rating: a disproportionate share of employers with more women than men (\textit{i.e.,} high-cost employers)
chose ConnectiCare.

\textsuperscript{56} Pub. L. 95-555, 92 Stat. 2076.

\textsuperscript{57} 42 U.S.C. § 2000e(k).

\textsuperscript{58} Los Angeles Department of Water & Power v. Manhart, 435 U.S. 702 (1978) (holding that requiring female
employees to make bigger contributions than males to employer’s pension plan violated Title VII).

\textsuperscript{59} Arizona Governing Committee v. Norris, 463 U.S. 1073 (1983) (holding that retirement plan that paid men a
higher monthly benefit than women violated Title VII). As Robert Jerry puts it: “Under the logic of [\textit{Manhart and
Norris}], it is a violation of Title VII for an employer to provide its employees any kind of insurance fringe benefit
… unless identical benefits are provided to both men and women and unless contributions, if any are the same for
both genders.” JERRY, \textit{supra} note 19, at 135.

\textsuperscript{60} 462 U.S. 669 (1983).
comprehensive for members of one sex. Implicit in the Court’s reasoning are two points consistent with a strong stance against sex-based inequality in employee benefits. First, the Court accepted the plaintiffs’ invitation to consider the content, or terms, of the coverage provided rather simply examining whether all employees received the same policy for the same price. Second, in establishing relative comprehensiveness as the touchstone for judging policy terms, the Court effectively incorporated an assessment of impacts into its analysis. An inquiry directed to the comprehensiveness of coverage is not confined to asking whether male and female employees receive the same policy with identical terms; it instead compares how thoroughly that policy actually covers male and female enrollees’ medical expenses.

Questions about the sex-relative comprehensiveness of coverage have arisen recently in relation to employers’ exclusion of prescription contraceptive coverage from their health plans. In *Erickson v. Bartell Drug Co.*, a federal court found that such an exclusion violated Title VII because it failed to meet the “special or increased healthcare needs associated with a

61 *Id.* at 676 (“Under the proper test petitioner’s plan is unlawful, because the protection it affords to married male employees is less comprehensive than the protection it affords to married female employees.”). The employer in *Newport News* provided hospitalization and medical-surgical coverage for employees and their spouses. Prior to the passage of the PDA, the plan contained a limitation (not applicable to any other hospital admission) on the coverage of hospitalizations for pregnancy. Presumably in response to the PDA, the employer amended its health plan in 1979 to remove that limitation from the coverage provided to employees; it retained the limitation, however, in the coverage provided to the wives of male employees. *Id.* at 672-73. Accordingly, the plaintiffs in *Newport News* argued that the plan discriminated against married male employees by providing them with a less comprehensive level of spousal coverage than was provided to married female employees. *Id.* at 674.

62 The *Newport News* Court did not explicitly adopt a disparate impact mode of analysis. The opinion can be read as applying a disparate treatment approach to discrimination for it identified the plan’s exclusion of spousal hospital maternity benefits as providing male employees spouses with more limited coverage than female employees’ spouses (who never went to the hospital to have a baby). Because the plan itself contained a distinction based on pregnancy-related benefits, it was not a facially neutral policy in light of the Pregnancy Discrimination Act of 1978. See 462 U.S. at 684 (“The 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions.”). The Court employed a two-step analysis that enabled it to conclude that “discrimination against female spouses in the provision of fringe benefits is also discrimination against male employees.” *Id.*

63 *Cf.* Hoffman, *supra* note 50, at 1350-51 (asserting that Supreme Court cases require a plaintiff to “make a direct comparison between the benefits received by men and women and show that in some respect the insurance coverage available to one gender is inferior to that available to the other sex”).

64 141 F. Supp. 2d 1266 (W.D. Wash. 2001).
woman’s unique sex-based characteristics … to the same extent, and on the same terms, as other healthcare needs.” Erickson expands on the reasoning in Newport News to conclude that an employer offering a health benefit plan is obligated to make certain both that it does not incorporate sex-based distinctions into its terms and that it “provides equally comprehensive coverage for both sexes.” In other words, a policy may violate Title VII by providing less inclusive coverage of women’s health needs, even if its terms make no reference to sex-based characteristics like pregnancy or childbirth.

If one accepts Erickson’s reasoning it becomes evident that Title VII requires an employer offering health insurance coverage to be concerned not only with the equality of treatment of male and female employees, but also (to some degree) with equality of outcome –

65 Id. at 1271.
66 Id. at 1272.
67 The court granted summary judgment to Erickson on her disparate treatment claim because “prescription contraceptives are used only by women,” and as a result found it unnecessary to consider her disparate impact claim. 141 F. Supp. at 1277. Some commentators, however, have suggested that the claim would be better analyzed as a disparate impact claim that looks at the burden imposed disproportionately on women, in terms of both the financial costs of prescription contraceptives and the numerous burdens of unwanted pregnancy. The disparate impact characterization would allow the legal finding of discrimination to survive the eventual introduction of male prescription contraceptives into the market. See Sylvia A. Law, Sex Discrimination and Insurance for Contraception, 73 WASH. L. REV. 363, 374-75 (1998); Lee Korland, Sex Discrimination or a Hard Pill for Employers to Swallow: Examining the Denial of Contraceptive Benefits in the Wake of Erickson v. Bartell Drug Co., 53 CASE W. RES. L. REV. 531, 552-54 (2002).

68 Because the parties to Erickson eventually settled following the district court’s decision, see Bartell Class-Action Settlement on Contraceptive Coverage OK’d, SEATTLE POST-INTELLIGENCER, Mar. 5 2003, at B5, there has been no appellate review of the case. The court’s decision is, however, consistent with the EEOC’s approach to the question. In 2000 the EEOC ruled that an employer’s exclusion of prescription contraceptives from a health plan that otherwise comprehensively covers pharmaceuticals is a violation of Title VII. See EEOC Decision on Coverage of Contraception, available at http://www.eeoc.gov/policy/docs/decision-contraception.html (Dec. 14, 2000). The commentators have been divided in their assessment of Erickson. Compare Korland, supra note 67 (supporting outcome) and Julia Bruzina, Erickson v. Bartell: The “Common Sense” Approach to Employer Based Insurance for Women, 47 ST. LOUIS U. L.J. 463 (2003), with E. Renee Backmeyer, Lack of Insurance Coverage for Prescription Contraception by an Otherwise Comprehensive Plan as a Violation of Title VII as Amended by the Pregnancy Discrimination Act – Stretching the Statute Too Far, 37 IND. L. REV. 437 (2004) (criticizing Erickson) and James A Ryan, Contraceptives and Employer Health Prescription Plans: An Examination of Erickson v. Bartell Drug Co., 11 GEO. MASON L. REV. 215 (2002) (same). Cf. Hoffman, supra note 50 (questioning the soundness of Erickson’s analysis).
as measured by comprehensiveness of coverage. Accordingly, it seems that a woman who receives health insurance coverage from her employer receives strong protection against varied forms of sex discrimination under federal employment law. By contrast, a woman who obtains her own coverage (even if she does so with funds contributed by her employer for that purpose\textsuperscript{69}), receives little or no protection under state insurance law.\textsuperscript{70} The explanation for this inconsistent treatment is not clear, but the inconsistency suggests that as a society we are more concerned about sex-based inequality in employment than we are about pursuing a social solidarity vision of insurance more broadly.

3. Disability Discrimination

At first glance, the Americans with Disabilities Act (“ADA”) appears to be a promising source of protection against health insurance discrimination for people with disabilities. Congress passed the ADA in an effort to eliminate discrimination against persons with disabilities\textsuperscript{71} across a broad swath of American society. Regulatory and judicial interpretations of the ADA, however, permit insurers to use disability as a risk classifier, demanding \textit{at most} consistency with actuarial fairness.

Like Title VII, the ADA extends its prohibition of disability discrimination to employer-provided fringe benefits. The question of what actions should be deemed to be prohibited “discrimination” remains substantially murkier in the context of disability discrimination, than in race or sex discrimination. Without attempting to describe the

\textsuperscript{69} JERRY, supra note 19, at 135.
\textsuperscript{70} See Hellman, supra note 11 (“The individual insurance market, where most underwriting and risk rating takes place, is untouched by [Title VII]”).
\textsuperscript{71} See 42 U.S.C. § 12101(b)(1).
numerous divisions among courts and commentators on this issue,72 I will briefly describe the position that the EEOC’s Compliance Manual73 takes on how the statute applies to employer-provided health insurance. That position represents what is probably the broadest plausible understanding of the ADA’s application, but even it describes substantially circumscribed protection. Moreover, many courts have rejected the EEOC’s positions and construed the ADA even more weakly.

The EEOC asserts that if an employer provides employees with disabilities benefits that are not equal to the benefits received by other employees, the employer may be liable for violating the ADA if any inequality in benefits is based on disability.74 In the Compliance Manual, the EEOC interprets “equality” of benefits broadly and finds unequal benefits if a health plan’s terms contain a disability-based distinction, even if the plan is provided to disabled and non-disabled employees alike. In this sense, the EEOC’s position seems akin to the Supreme Court’s comprehensiveness of coverage test for sex discrimination in health insurance.75 Just as a limitation on maternity benefits constitutes sex discrimination even if all

72 For discussions of the application of the ADA to employer-provided health insurance coverage, see Jacobi, supra note 19: Hoffman, supra note 50; Melissa Cole, Beyond Sex Discrimination: Why Employers Discriminate Against Women with Disabilities when their Employee Health Plans Exclude Contraceptives from Prescription Coverage, 43 ARIZ. L. REV. 501 (2001); H. Miriam Farber, Subterfuge: Do Coverage Limitations and Exclusions in Employer-Provided Health Care Plans Violate the Americans with Disabilities Act?, 69 N.Y.U. L. REV. 850 (1994). The insurance issue most frequently litigated under Title I has involved not health insurance, but the differential in length of benefits provided for physical disabilities and for mental disabilities in employer-provided long-term disability insurance coverage. The current weight of the authority on this question holds that such a distinction in the benefits provided does not violate the ADA, on the reasoning either that the ADA was not intended to protect against discrimination between persons with differing disabilities and/or that the distinction falls within the insurance safe harbor described infra text accompanying note ___. See, e.g., Weyer v. Twentieth Century Fox Film Corp., 198 F.3d. 1104 (9th Cir. 2000); Leonard F. v. Israel Discount Bank of N.Y., 199 F.3d 99 (2d Cir. 1999).
74 See id. at II. “Equal Benefits.”
75 See supra text accompanying note 61. Cf. Jacobi, supra note 19, at 353 n.167 (“Without section 501(c), the ADA would bar employee classifications for purposes of benefits plans on the basis of disability similar to Title VII’s prohibition of classification by sex.”).
employees receive the same policy, a limitation on coverage for HIV/AIDS constitutes
disability discrimination even if all employees receive the same policy.\textsuperscript{76}

The congruity of treatment with sex discrimination ends there, however, on at least two
counts. First, the EEOC takes the position that the ADA, unlike Title VII, does not prohibit
disparate impact discrimination in fringe benefits.\textsuperscript{77} Second, and of more fundamental concern
for this Article, Title V of the ADA includes a safe harbor provision for insurance that, even as
construed by the EEOC, reflects a distinct tilt towards an actuarial fairness approach to
insurance. Section 501(c)\textsuperscript{78} contains the safe harbor, which excludes from ADA coverage
certain actions by insurers and employers sponsoring employee health plans. According to the
EEOC’s interpretation of the notoriously ambiguous section 501(c),\textsuperscript{79} a disability-based
distinction in coverage that produces unequal benefits violates the ADA \textit{unless} the employer
can show that the challenged provision is not a subterfuge to evade the purposes of the ADA.
One of several ways that the EEOC suggests an employer can make this showing is to
demonstrate that “the disability-based disparate treatment is justified by legitimate actuarial
data, or by actual or reasonably anticipated experience, and that conditions with comparable
actuarial data and/or experience are treated the same way.”\textsuperscript{80} In effect, the EEOC reads section
501(c) as creating a safe harbor for insurance classifications based on disability, as long as they

\textsuperscript{76} See COMPLIANCE MANUAL, supra note 73, at II. “Equal Benefits” (giving example of AIDS cap).
\textsuperscript{77} The current version of the Compliance Manual states: “A health-related distinction that is not disability-based,
and that is applied equally to all employees, does not violate the ADA.” See id. at III. “Disability-Based
Distinctions.” In a regulatory precursor to this section of the Compliance Manual, the EEOC dropped a footnote
to an identical sentence and stated explicitly in the footnote that disparate impact theory is not available in the
context of employer-provided health insurance. EEOC’s Interim Enforcement Guidance on the Application of the
See also Hoffman, supra note 50, at 1324-26 (asserting that disparate impact analysis cannot be used in the context
of insurance coverage).
\textsuperscript{78} 42 U.S.C.A. § 12201(c).
\textsuperscript{79} One judge characterized § 501(c) as “totally ambiguous on its face.” See Parker v. Metropolitan Life Ins. Co.,
\textsuperscript{80} See COMPLIANCE MANUAL, supra note 73, at IV. “Justification for Disability-Based Distinctions.”
are actuarially supported. The thinness of this protection stands in marked contrast to the substantial protection provided by Title VII’s prohibition of race- and sex-based distinctions in employer-provided coverage regardless of any actuarial justification. And even the EEOC’s thin protection surpasses that found by the numerous courts that have read the safe harbor effectively to shield any insurance practice that was not adapted for the purpose of evading the ADA.

In one sense, however, the ADA would seem to provide broader protection against health insurance discrimination than does Title VII, for the ADA applies to health insurers as well as to employers. Title III of the ADA prohibits discrimination by public accommodations, a category that includes insurance offices, but courts have been quite stingy in applying the public accommodations provisions to health insurance discrimination. Most appellate courts that have considered the question have found that Title III’s prohibition does not apply to the contents of insurance policies, so that insurers remain free to use disability in establishing policy limitations, even if they have no actuarial justification for doing so. While a number of courts view Title III as at least potentially constraining an insurer’s decisions regarding whether to issue a policy to a person with a disability and at what price, insurance companies’ use of disability as a risk classifier in underwriting and pricing decisions is largely immunized under

\[81\] For discussions of the scope of § 501(c) that reach this same general conclusion, see Hoffman, supra note 50, at 1341-44; Cole, supra note 72, at 534 (“Section 501(c) represents Congress’ reasoned solution to the problem of prohibiting discrimination on the basis of disability when such a prohibition would make insurance underwriting impossible.”).
\[82\] See supra text accompanying notes ___.
\[83\] 42 U.S.C.A. § 12181(7)(F).
\[84\] For example, in Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999), cert. denied, 528 U.S. 1106 (2000), the Seventh Circuit rejected plaintiff’s claim that Mutual of Omaha’s imposition of a cap on coverage that applied only to the treatment of HIV/AIDS violated the ADA. The court based its rejection on its conclusion that Congress did not intend Title III to apply to the contents of insurance policies. Id. at 560-563. Thus, the court found that plaintiffs’ claim should be dismissed even though Mutual of Omaha conceded that it had no actuarial justification for its AIDS cap. Id. at 558. See also McNeil v. Time Ins. Co., 205 F.3d 179 (5th Cir. 2000).
\[85\] See, e.g., Doe v. Mutual of Omaha, 179 F.3d at 559; Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 33 (2d Cir. 2000) (stating that Title III prohibits a disability-based refusal to sell merchandise by public accommodations).
section 501(c). Some courts have interpreted the statute even more restrictively, finding that Title III demands only physical accessibility of insurance offices.\textsuperscript{86}

Thus, despite the ADA’s self-proclaimed purpose of providing “a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities,”\textsuperscript{87} the statute as interpreted accepts, rather than eliminates, actuarially justified discrimination in health insurance.\textsuperscript{88} Congress’s inclusion of the insurance safe harbor reflected a conscious decision not to disrupt traditional underwriting practices by insurers. Whereas Congress elevated equality concerns over deference to the insurance industry in Title VII, it largely caved to industry concerns regarding federal intrusion into common risk classification practices. As a consequence, people with disabilities are protected from health insurance discrimination only if it is irrational or intentionally discriminatory, and may not receive even that protection if they purchase their health insurance directly from an insurer rather than receiving it as an employment benefit.

4. Age Discrimination

As in the cases of race, sex and disability, the Age Discrimination in Employment Act (ADEA),\textsuperscript{89} announces a federal mandate against discrimination in the terms or conditions of

\textsuperscript{86} Weyer, 198 F.3d 1104; Ford v. Schering-Plough Co., 145 F.3d 601 (3rd Cir. 1998), cert. denied, 525 U.S. 1093 (1999). This position seems particularly difficult to justify. Can a restaurant comply with Title III by making its facility completely accessible, but then refuse to serve meals to persons with disabilities or charge them higher prices for the meals? The position is also unnecessary to the purpose of protecting insurers from having to make major changes to their underwriting practices, for the insurance safe harbor accomplishes that purpose.

\textsuperscript{87} 42 U.S.C. § 12101(b)(1).

\textsuperscript{88} This constricted meaning of discrimination applicable to the health insurance context stands in marked contrast to the expanded definition that the ADA gives to “discrimination” in other contexts. See, e.g., 42 U.S.C. § 12112(b)(5)(A) (stating that in employment context “discrimination” includes a failure to make reasonable accommodations to the limitations of an individual with a disability); Olmstead v. Zimring, 527 U.S. 581 (1999) (recognizing that under the ADA “unjustified institutional isolation of persons with disabilities is a form of discrimination”). By including Section 501(c) in the ADA, Congress singled out insurance as subject to a far more limited understanding of discrimination, albeit an understanding consistent with that used in state unfair trade practice laws. See infra Part III A.

\textsuperscript{89} The ADEA is codified at 29 U.S.C. § 621 et seq.
employment or in employee compensation or privileges. But much as the ADA provides only meager protection against disability-based health insurance discrimination, so too the ADEA’s protection against age discrimination in health benefits is significantly more attenuated than that provided by Title VII. While courts have interpreted Title VII to prohibit treating employees differently based on race or sex and failing to provide equally comprehensive coverage to both sexes, the ADEA explicitly allows employers to provide older workers with lesser benefits than younger workers.

Under an exemption from the ADEA’s antidiscrimination mandate that Congress enacted in 1990, an employer that provides lesser benefits to older workers under the terms of a bona fide benefit plan will not violate the Act if the older workers’ benefits cost the employer as much as the younger workers’ benefits. Courts and commentators have described this exemption as creating an “equal benefit or equal cost” test that applies generally to employee benefit plans. This exemption effectively acknowledges the higher cost of providing health coverage or other insurance for older employees and tolerates employer decisions to scale back accordingly on the coverage provided to older employees – even though an analogous

91 Cf. Hoffman, supra note 50, at 1356 (stating that the ADEA “does not comprehensively regulate the contents of health insurance plans and does not require that individuals in different age categories be offered benefits that are substantively equivalent”).
92 The Older Workers Benefit Protection Act (“OWBPA”), Pub. L. No. 101-433, 104 Stat. 978 (1990), legislatively overruled the Supreme Court’s decision in Public Employees Retirement System of Ohio v. Betts, 492 U.S. 158 (1989), and amended the ADEA to make clear Congress’s intent that the ADEA’s purpose was to “prohibit discrimination against older workers in all employee benefits except when age-based reductions in employee benefit plans are justified by significant cost considerations.” OWPBA § 101.
94 The “equal benefit or equal cost” test does not apply to early retirement incentive programs, which only have to be voluntary and in accord with the ADEA’s relevant purposes. 29 U.S.C. § 623(f)(2)(B)(i).
95 See Auerbach v. Board of Education of the Harborfields Central School Dist. of Greenlawn, 136 F.3d 104, 110 (2d Cir. 1998) (“Realizing that the costs of providing certain employee benefits increases with age, Congress decided that employers need not provide ‘exactly the same benefits’ to older employees as they do for younger ones, when to do so would result in excessive benefit costs that would discourage employers from hiring older workers in the first place.”).
decision to scale back on women’s health benefits in light of their higher cost would certainly be found illegal and intolerable. Thus, the “equal benefit or equal cost” approach to assessing the legality of health coverage under the ADEA can be understood as reflecting a Congressional step away from a social solidarity approach to employer-provided health coverage and a step towards an actuarial fairness approach. Significantly, however, the EEOC has recently signaled its intent to eliminate even the limited protection provided by the “equal cost” prong of the test, at least with respect to employer-provided health coverage for Medicare-eligible retirees.96

A decision by the Third Circuit in 2000 applying the “equal benefit or equal cost” test to an employer’s coordination of retiree health plans with Medicare coverage was the genesis of the EEOC’s eventual regulatory retreat from any sort of protection against discriminatory treatment for this subset of older persons. In *Erie County Retirees Association v. County of Erie*,97 the court held that the test applied not only to benefits provided to active workers, but also to benefits provided to retirees. Under this holding an employer who decides to reduce or eliminate health benefits for retirees once they are eligible for Medicare coverage would violate the ADEA, unless it could show either that it spent as much on benefits for the older, Medicare-eligible retirees or that the older retirees’ benefits were equal to benefits received by younger retirees.98

96 Tying the employee benefits available to an individual’s eligibility for Medicare implicates the ADEA because it is an exact proxy for age, since Medicare eligibility is automatic for persons who turn sixty-five (at least for those who have paid social security taxes for a sufficient period of time). *Cf.* Gutchen v. Bd. of Governors of the Univ. of Rhode Island, 148 F. Supp. 2d 151, 158 (D.R.I. 2001) (noting that Medicare eligibility is “inextricably tied to the retiree’s age”).


98 The court noted that, in assessing the benefits to which the older retirees were entitled, the government-paid coverage (Medicare) and the employer-provided coverage should be considered together. 220 F.3d at 216. Ultimately, the Third Circuit concluded that the plaintiffs had stated a claim of an ADEA violation, reversed the
The EEOC initially responded to the *Erie County* decision by adopting the court’s reasoning as the Commission’s national enforcement policy, but less than a year later an outcry by labor unions, employers, and benefits experts led it to reconsider its position. The concern expressed was that, because employers are not legally required to provide any retiree health benefits, the prospect of ADEA litigation over the adequacy of benefits provided to Medicare-eligible retirees might prompt employers to drop retiree plans altogether.99 In April 2004 the EEOC approved a proposed final rule creating complete exemption from the ADEA’s antidiscrimination rule for the practice of coordinating employer-sponsored with eligibility for Medicare.100 This decision to exempt the benefits provided to Medicare-eligible retirees from any ADEA scrutiny drew immediate fire from retiree advocacy groups and as the 2004 presidential campaign intensified, the EEOC temporarily shelved the regulation.101 Following the election, the Commission renewed its pursuit of the exemption, only to have its proposed rule struck down as a violation of the ADEA in a challenge brought by the AARP.102

This course of events illustrates how a demand for fairness in insurance coverage – even in the weak sense of actuarial fairness – is subject to being overridden by competing political concerns. As noted, Congress’s enactment of the “equal benefit or equal cost” test reflects the adoption of an actuarial fairness approach to older employees’ claims of health insurance benefits.
discrimination. But the EEOC’s proposal to exempt from ADEA coverage employers’ attempts to coordinate a retiree health plan with Medicare coverage signals the agency’s willingness to abandon fairness entirely in hopes of encouraging employers to maintain their retiree plans. Thus, the goal of nondiscrimination or fairness for older persons in employer-sponsored health coverage appears simply as one goal to be balanced against others.

Ironically, the reason that maintaining retiree health plans is so important is that they often provide the only viable coverage option for younger retirees, who – because state laws do not typically proscribe age discrimination by insurers – may be unable to afford individual coverage once they retire and are no longer covered by employee plans. Thus, the question for retirees may be whether they prefer to remain in the frying pan of retiree health plans exempt from ADEA coverage or to jump into the fire of the individual health insurance market.

5. Genetic Discrimination

In contrast to race, sex, disability and age discrimination, where the federal government has played the leading role in addressing health insurance discrimination (albeit indirectly by prohibiting employment discrimination), the states have to date outstripped the federal government in protecting individuals from insurers’ discriminatory use of genetic information. These state laws are of relatively recent advent, prompted by advances in genetic science that permit individual testing to determine the presence of an growing number of genetic markers associated with an elevated risk of developing conditions ranging from breast cancer, to

103 The idea that equality of employer contribution is an acceptable alternative to equality of benefit received is not exactly the same as the vision of actuarial fairness described earlier in this Article, which focused primarily on the insurer’s perception of fairness regarding the amount that insureds should be charged in relation to their actuarially predicted future health costs. Instead, the equal cost prong addresses fairness from the perspective of an employer, in light of insurers’ actuarially based charges for health insurance.
diabetes, to Alzheimer’s disease. These genetic advances, while widely acclaimed for their potential benefit for preventing, detecting, and treating disease in the future, have simultaneously provoked fears that insurers and employers would seek to obtain and use genetic information about individuals.

Beginning in the 1990s, most state legislatures responded to these fears. Legislation broadly regulating health insurers’ use of genetic information for risk classification purposes has been described as evolving from a first wave of laws that barred insurers from considering the results of particular genetic tests, to more recent laws that forbid insurers’ consideration of information about a person’s genetic characteristics, regardless of the information’s source. By prohibiting a variety of risk classification uses and defining broadly the genetic information protected, these newer laws clearly reject an actuarial fairness approach to health insurance – at least with respect to this one particular type of risk-predictive information. As a result, at least some individuals in some states receive strong protection against having their genetic information used against them by health insurers.

---

106 In addition to passing antidiscrimination laws preventing the use of genetic information, some states have passed laws establishing privacy rules in order to protect the confidentiality of genetic information and keep it out of the hands of possible discriminators. See id. at 367.
107 Id. at 374-75.
108 See, e.g., Conn. Stat. Chap. 704 § 38a-816 (defining as an unfair practice an insurer’s use of genetic information to refuse to insure, to limit the amount, extent, or kind of coverage available, or to charge a different rate for the same coverage). As Deborah Hellman points out, however, because so many illnesses are increasingly understood as being influenced by genetics, laws employing these broader definitions of the “genetic information” that insurers cannot use “seemingly prohibit[] almost all forms of discrimination on the basis of health, except perhaps illness or disability caused by accident.” Hellman, supra note 105, at 80.
109 This qualification is necessary for at least two reasons. First, some state genetic discrimination laws apply only to group insurers, not to issuers in the individual market. See Hellman, supra note 105, at 77 n.2. Second,
By contrast, existing federal law provides far less protection against genetic
discrimination in health insurance. Initially, the EEOC and some commentators thought that
the ADA could be read to prohibit discrimination based on an asymptomatic genetic
condition, but subsequent judicial interpretations of the ADA have considerably narrowed
the range of conditions qualifying as disabilities. Accordingly, today it seems highly
unlikely that a court would apply the ADA to a health insurer’s reliance on an individual’s
genetic information. HIPAA, which is discussed in Part III C, provides some protection by
prohibiting group health plans from excluding an individual from a group plan or charging him
higher premiums for coverage based on a “genetic conditions.” Beyond this protection for
group plan members, however, current federal law does not regulate the ability of health
insurers to use genetic information for risk classification purposes.

Whether health insurers should be forbidden to use an individual’s genetic information
in a discriminatory fashion is a question that has generated copious scholarship. Central to
the debate is the justifiability of “genetic exceptionalism.” To wit, what justifies prohibiting

---

genetic discrimination); cf. Paul Steven Miller, *Is There A Pink Slip in My Genes? Genetic Discrimination in the

11. Moreover, as discussed above, even if a unmanifested genetic condition were deemed a disability under the
ADA, that law’s protection against insurance discrimination has been read quite narrowly. See *supra* Part IIIB3.

12. HIPAA also provides that an unexpressed genetic condition cannot be treated as a pre-existing condition by a

13. In October 2003, the Senate unanimously passed the Genetic Information Nondiscrimination Act of 2003,
which would have broadly barred insurance companies from using genetic information about an individual and his
family members to grant or deny health coverage or to adjust premiums, Laurie McGinley, *In 95-0 Vote, Senate
unanimously passed a similar measure. BNA, *Senate Overwhelmingly Passes, Genetic Bias Bill; Rep. Boehner
Promises ‘Another Look,’* HEALTH CARE DAILY REP., Feb. 18, 2005. Notwithstanding broad support in the Senate
for the measure and an expression of support from President George W. Bush, the House has to date refused to
take up the measure. See Julie Rovner, *Johnson Says Genetic Discrimination Measure Unlikely to Move*, CONG.

14. In addition to the sources cited in this section, see the sources listed in Hellman, *supra* note 105, at 78 nn.5-7.
health insurers from considering genetic characteristics, when they are permitted to use other
types of health information in classifying risks? What is it about genetic information that
justifies the exceptional legal protection it receives?\textsuperscript{115}

While some commentators reject genetic exceptionalism as unjustifiable,\textsuperscript{116} others
suggest plausible reasons for the exceptional treatment. Professor Deborah Hellman, for
example, notes that legislation prohibiting insurers’ use of genetic information may be
necessary in order to enable genetic science to make good on its promises of health benefits to
individuals and society more broadly. Individuals who fears genetic discrimination may be less
likely both to seek genetic testing that might offer them some health benefits and to participate
in medical research that entails testing.\textsuperscript{117} Professor John Jacobi, while recognizing that
persons with unfavorable genetic traits may not deserve protection from insurance
discrimination any more than persons with other types of health problems, nonetheless views
genetic discrimination laws as a desirable step towards broader social solidarity reforms of
health insurance.\textsuperscript{118}

These justifications for laws prohibiting genetic discrimination are notably and
essentially instrumental. Rather than invoking the “civil rights” of genetically disadvantaged
persons\textsuperscript{119} or demanding some form of justice for them,\textsuperscript{120} these scholars suggest that genetic

\textsuperscript{115} Id. at 78 (“the question that dominates the current literature is whether genetic discrimination is meaningfully
different from discrimination on the basis of general health status”).

\textsuperscript{116} See Diver & Cohen, supra note 104.

\textsuperscript{117} See Hellman, supra note 105, at 92-94. Hellman emphasizes, however, that the strength of this justification
depends on empirical questions that are as yet unanswered. She also suggests that genetic exceptionalism may be
justified because “the social meaning of treating people differently on the basis of their genetic makeup is different
from the social meaning of discrimination on the basis of health or illness.” Id. at 79. She catalogs and rejects,
however, several other proffered rationalizations for exceptionalism, such as claims that genetic discrimination
should be prohibited because it is irrational, because genes are beyond individuals’ control, or because a small
number of people are especially burdened. Id. at 84-92.

\textsuperscript{118} See Jacobi, supra note 105, at 391, 393.

\textsuperscript{119} Cf. Diver & Cohen, supra note 104, at 1473 (finding the analogy between racial discrimination and genetic
discrimination unconvincing); Pauline Kim, Genetic Discrimination, Genetic Privacy: Rethinking Employee
discrimination laws, with their explicit rejection of an actuarial fairness approach,\textsuperscript{121} may make sense as means to a broader purpose – whether the production of societal health benefits or health insurance reform. In this view, legal prohibitions on discrimination against genetically disadvantaged persons can co-exist with legal permissiveness towards discrimination against otherwise unhealthy (or likely to become unhealthy) persons, not because of any analytically satisfying distinction between the two groups of individuals, but because of other policy concerns.

6. Discrimination against Victims of Domestic Violence

In the same period when state legislatures were passing laws prohibiting health insurers’ discriminatory use of genetic information, insurers’ discrimination against victims of domestic abuse was also prompting legislative responses. Unlike genetic discrimination laws, however, which resulted from public fears of the potential uses of emerging genetic information, laws regulating the use of domestic abuse information reflected public disapproval of evidence of insurers’ actual use of information about an insured’s or applicant’s experience of domestic violence in making underwriting decisions.\textsuperscript{122} From the insurance industry’s perspective, information that an individual has experienced domestic abuse is simply information that – like information about an individual’s medical history, age, occupation, and sex – helps an insurer predict the individual’s likelihood of making future medical claims, so that the insurer can hew

\textit{Protections for a Brave New Workplace}, 96 NW. U. L. REV. 1497, 1550-01 (2002) (arguing that “the analogy between genetic discrimination, and race and sex discrimination, is fundamentally flawed” and that the problem of genetic discrimination in employment should properly be understood as threatening an individual’s privacy rights).

\textsuperscript{120} Indeed, Deborah Hellman makes the point that genetic discrimination laws are arguably unjust because their health-promoting benefits are not applied evenhandedly. \textit{See} Hellman, \textit{supra} note 105, at 99.

\textsuperscript{121} \textit{See} Jacobi, \textit{supra} note 105, at 375 (asserting that state genetic discrimination laws “demonstrate a legislative determination to shift the meaning of non-discrimination from a principle requiring equal treatment \textit{absent} an actuarial showing of difference to one requiring equal treatment \textit{notwithstanding} actuarial difference”).

to the principle of actuarial fairness in deciding whether and at what price to provide the
individual with coverage.123 The industry account, however, was not compelling enough to
persuade the public and legislators that insurers should have free rein in using domestic abuse
information to (as it was sometimes put) victimize an individual a second time, and during the
1990s a majority of states passed laws regulating that use.124

The states’ legislative responses, though, are quite diverse and thus fail to reflect any
consistent understanding as to when or why the use domestic violence information in the
underwriting process is illegitimate. They do, however, usefully illustrate the variety of
legislative views of what fairness in health insurance entails.125 Some state laws merely
instruct insurers not to deny or limit coverage “solely because” of a person’s status as domestic
violence victim. This bare prohibition, however, permits an insurer to consider a person’s
victim status as long as it also relies on other, actuarially relevant information that may be
related to abuse – such as a history of emergency rooms visits or the lingering physical or
mental effects of abuse.126 These laws reject discrimination based purely on a person’s status, but condone application of general underwriting standards to information about conditions or injuries ancillary to that status. Laws that more generally prohibit any underwriting use of an
“abuse victim” classification are only slightly stronger for while they prevent insurers from
singling out victims of abuse for special treatment, they do not protect abuse victims – whether

123 As one commentator wrote on the website of the Competitive Enterprise Institute, “[I]t is extremely
disingenuous to suggest insurers are practicing unfair discrimination when they respond to the higher loss costs
associated with domestic violence by raising rates or denying coverage. That is, after all, how insurers treat all
124 According to a 2002 publication prepared by the Women’s Law Project and the Pennsylvania Coalition
Against Domestic Violence, since 1994 forty-one states had adopted some kind of legislative limits on insurance
discrimination against victims of domestic violence. See FYI: Insurance Discrimination against Victims of
125 Much of the following discussion draws on Hellman, supra note 11, at 404-410.
126 See, e.g., N.Y. INS. LAW. § 2612 (McKinney 2004).
identified as such or not – from the possibility that a history of claims or existing injuries will affect their ability to obtain affordable coverage. In short, both of these types of law effectively prohibit insurers from treating domestic violence victims differently from other persons, while simultaneously embracing a vision of actuarial fairness. Insurers can’t deny coverage or increase premiums because of abuse victim status, but they remain free to engage in underwriting based on health status or medical history.

By contrast, some states have enacted laws that more broadly limit insurers’ ability to underwrite coverage in ways that have a discriminatory impact on abuse victims, such as predicting future claims based on medical records of repeated emergency room visits for abuse-related injuries. These laws effectively take the stance that, even if it is acceptable generally to consider an individual’s medical history in predicting future claims, it is unacceptable to underwrite based on a history of abuse-related injuries. Such laws therefore tend towards a social solidarity view of health insurance for domestic violence victims.

Of course, as with genetic discrimination laws, legislation that specially protects abuse victims against insurers’ pursuit of actuarial fairness poses the question of how to justify insulating this group from generally applied risk classification practices. In other words, how is the prohibited underwriting classification of “abuse victim” analytically distinguishable from the permissible classification of “person with diabetes”? Justifications advanced for the distinctive treatment of abuse victims are diverse. One justification typically advanced is

127 See Hellman, supra note 11, at 405-06.
128 See id. at 406-407.
129 See, e.g., W. VA. CODE § 33-4-20 (allowing underwriting on the basis of a preexisting condition, provided that “the fact that an individual is, has been, or may be the victim of abuse may not be considered a physical or mental condition”).
130 They do not fully embody a social solidarity view, however, unless they also prohibit an insurer from either refusing to cover an existing abuse-related condition under a pre-existing condition clause or exclusionary waiver or charging the insured a higher premium based on the condition.
Abuse victims should be encouraged to report their abuse and seek medical and other support services, and allowing insurers to use information gathered through reporting and the provision of services to deny coverage for abuse victims will discourage those desired activities.\(^{131}\) Beyond the purely instrumental justification, however, is the argument that domestic violence against women presents a civil rights issue, and therefore insurance discrimination against abuse victims implicates gender equality.\(^{132}\) Finally, Professor Deborah Hellman suggests a moral justification for the distinction:

> The state has a clear and uncontroversial obligation to provide crime protection and to do so on a fair basis …. The suspicion that an illegitimate tolerance toward domestic violence has affected the amount of protection afforded domestic abuse victims, and consequently, the degree of safety they enjoy, means that the state has likely failed to provide the required crime protection fairly. As a result, the community should share the cost the abuse victim faces by virtue of the fact that she is a poor insurance risk.\(^{133}\)

In this view a social solidarity approach is justified for abuse victims because society itself bears some responsibility for their high-risk status.\(^{134}\)

In sum, no single understanding has emerged regarding either when or why insurers’ use of domestic abuse information in classifying risks is illegitimate. Notwithstanding this lack of consensus, the variety of both legislative restrictions on that use and the justifications offered therefor well illustrates the tensions between an actuarial fairness vision of health insurance and

\(^{131}\) See Ellen J. Morrison, Note, Insurance Discrimination Against Battered Women: Proposed Legislative Protections, 72 IND. L.J. 259, 286 (1996) (“Insurance discrimination discourages battered women from seeking necessary medical treatment and legal intervention, deters them from filing insurance claims, and constructs one more economic barrier that prevents victims from leaving abusive environments.”).

\(^{132}\) See id. at 285-86 (relying on Congressional enactment of the Violence Against Women Act of 1994). As Hellman points out, however, a gender equality justification is significantly weakened by the fact that states typically permit health insurers to use sex in rating risks. Hellman, supra note 11, at 383.

\(^{133}\) Hellman, supra note 11, at 410.

\(^{134}\) Id. at 411. Although much of Hellman’s discussion assumes the justifiability of risk rating generally, she also acknowledges that the “strong outcry” against the use of abuse information in underwriting may suggest a more fundamental concern about the fairness of risk classification generally. In that case, she supports legislative prohibitions against the use of abuse information “as an important first step toward a fairer system of health insurance pricing.” Id. at 359.
a social solidarity vision, as well as the challenges in justifying the extension of a social
solidarity approach to some, but not all, members of a community.

7. Discrimination against Persons with Mental Illness

Legislation prohibiting health insurers from limiting coverage for mental health care
services presents yet one more instance in which legislators have intruded on insurers’ freedom,
but this instance has a different look and feel. Unlike the laws discussed previously, mental
health parity legislation does not on its face follow an antidiscrimination model. Instead, rather
than prohibiting health insurers from taking an individual’s mental health condition into
account in deciding whether to issue or how to price a policy, mental health parity laws govern
the benefits that health insurers are required to include in their policies. For example, the
federal Mental Health Parity Act of 1996 provides that employer-sponsored plans governed
by the Act cannot include annual and lifetime limits on coverage of mental health services that
are more restricted than parallel limits on physical health coverage. More aggressively,
some states have enacted parity laws compelling health insurers to cover mental health services
as generously in all regards as physical health services.

In sum, mental health parity legislation focuses on the content and terms of insurers’
generally provided coverage packages rather than focusing on who receives or is denied
coverage. The purpose of the focus on content, however, is to assure persons with mental

135 For a description of state and federal mental health parity legislation, see John V. Jacobi, Parity and
137 Because its obligations are quite limited (most fundamentally, the Act does not require employers to provide
mental health coverage) and subject to separate exemptions for employers with fifty or fewer employees and for
employers whose health costs increase by one percent or more as a result of compliance, commentators have
doubted the legislation’s actual impact on coverage for persons with mental illness. See Patrick J. Kennedy, Why
We Must End Insurance Discrimination against Mental Health Care, 41 HARV. J. LEGIS. 363, 366 (2004)
(characterizing the law’s impact as slight); cf. Jacobi, supra note 135, at 192 (describing the law as “very mild”).
138 See Jacobi, supra note 135, at 190-191 (describing state parity legislation).
illness or disability that health insurance will cover their health needs as fully as it covers the health needs of persons with only physical ailments. In this way parity legislation echoes the Supreme Court’s conclusion in Newport News that insurance policies discriminate based on sex if they fail to cover the medical needs of men and women equally comprehensively.\textsuperscript{139} So understood, mental health parity laws explicitly forbid disparate impact discrimination (or at least specified types of disparate impact discrimination) against persons with mental illness, without addressing disparate treatment discrimination.

What has motivated legislatures to pass mental health parity laws? In part these laws seek to correct traditional imbalances in insurance coverage of mental and physical health treatments – imbalances that today are understood to embody both misconceptions of the nature of mental illness and deep-seated prejudices against persons with mental illness.\textsuperscript{140} In this sense, parity legislation stands in line with state and federal civil rights laws that forbid discrimination against members of historically disadvantaged groups.\textsuperscript{141} This civil rights justification, however, dovetails with government interests in ensuring that persons with mental health needs have access to needed care and thereby avoiding the social and economic costs of untreated mental illness.\textsuperscript{142} Accordingly, these laws seek simultaneously to combat inequality and inadequacy in health insurance coverage.

9. \textbf{What to Make of All These Laws ….}

Undertaking to place all the foregoing laws into some harmonious and analytically coherent framework is likely a futile effort, and one that is certainly beyond the scope of this

\textsuperscript{139} See \textit{supra} text accompanying note 61.
\textsuperscript{141} See Kennedy, \textit{supra} note 137, at 364 (referring to a “civil rights struggle remaining to be fought”); cf. Deborah Stone, \textit{Beyond Moral Hazard: Insurance as Moral Opportunity}, 6 CONN. INS. L.J. 11, 40 (1999) (noting how advocates for improved mental health coverage “successfully invoked equality to improve coverage”).
\textsuperscript{142} See Kennedy, \textit{supra} note 137, at 370-372; Jacobi, \textit{supra} note 135, at 189.
 Nonetheless this Part’s descriptions prompt several observations germane to my project of considering whether government should intervene when health insurance coverage discriminates – in treatment or effect – against unhealthy people. First, the variety of laws prohibiting discrimination in health insurance demonstrates that insurer freedom to pursue actuarial fairness is not sacrosanct. The laws described in this Part confirm lawmakers’ willingness to place an assortment of constraints on insurers’ and employers’ autonomy; they also display a remarkable lack of consistency in how they do so. The various antidiscrimination laws examined supply differing levels and types of protection, depending on the trait at issue. Some protect only against different treatment; others extend to disparate impact discrimination. Demands for actuarial fairness by insurers and employers, as well as political expediency, significantly limit the laws’ protections in some cases (for example, disability and age discrimination), but not in others.

More importantly, no single justification motivates each of the antidiscrimination laws described in this Part. Civil rights and social equality concerns certainly inspire some of the protections, but in other instances (for example, laws forbidding discrimination based on genetic or domestic violence information), instrumental goals regarding the advancement of tangential social concerns appear to play significant roles. Moreover, underlying a number of the laws is the recognition of the vital importance of health insurance to ensuring that individuals who need medical care have adequate access to it. In sum, no single model exists for laws regulating discrimination in health insurance, and therefore an advocate for limiting discrimination against the unhealthy in health insurance may choose among varying rationales for the limits sought. The next Part examines the limited extent to which such protections have already been enacted.
IV. Laws Addressing Health Status Discrimination

The previous Part demonstrates that federal and state lawmakers have encroached on ability of health insurance providers to discriminate on a variety of bases. Notably absent from that Part’s catalog of proscribed bases for discrimination, however, is health status. Admittedly, some forms of prohibited discrimination are closely related to an individual’s current health status – disability discrimination, genetic discrimination, and discrimination against victims of domestic violence certainly fall into this category. And the Mental Health Parity Act, by prohibiting differential coverage limits for physical and mental health care, provides some protection directly to persons with mental illness. Nonetheless, the laws discussed so far do not instruct insurers or employers providing health coverage that they cannot make decisions regarding the issuance, terms, or pricing of insurance coverage based on an individual’s current or past health status. None of these laws forbids an insurance provider from taking into account that an individual has high cholesterol, has received treatment for depression, or has been diagnosed with cancer.143

This Part takes up the task of examining the extent to which existing law constrains the ability of insurance providers to rely on health status information. To put it more bluntly:

---

143 The exception, of course, is if an individual’s health condition rises to the level of a disability so that the protections of the Americans with Disabilities Act apply. A person qualifies as an “individual with a disability” if she can show that she either (1) has a “physical or mental impairment that substantially limits one or more major life activities,” (2) has a “record of” such an impairment, or (3) is “regarded as having such an impairment.” 42 U.S.C. § 12102. While this definition is potentially expansive, the courts – led by the United States Supreme Court – have construed the definition narrowly. See, e.g., Murphy v. United Parcel Service, Inc., 527 U.S. 516 (1999) (finding that employee with high blood pressure was not disabled under the ADA). Consequently, the legal thresholds for an individual to prove either that whatever health impairment she suffers “substantially limits” her performance of a “major life activity” or that she is “regarded as” having such an impairment are today higher than the proponents and drafters of the Act expected them to be. See Chai R. Feldblum, Definition of Disability under Federal Anti-Discrimination Law: What Happened? Why? What Can We Do About It?, 21 BERKELEY J. EMP. & LAB. L. 91 (2000).
Does the law prohibit health insurers from discriminating against the unhealthy? Admittedly, posing this question often provokes an incredulous response: “Isn’t that exactly what health insurers do all the time?” Indeed, when an insurer classifies an individual or small group on the basis of risk, medical information about the prospective insured is typically central to the classification process. One might wonder whether, if an insurer cannot classify risks of future medical expenses based on an applicant’s past or existing health conditions, any valid predictive basis for risk classification exists. While some other bases for predicting future medical expenses might remain, a complete ban on using individuals’ health status information would significantly limit insurers’ capacity for accurate risk prediction.

Rather than debate whether that outcome would represent an advance or setback in health insurance policy, this Part adopts the more discrete and concrete purpose of briefly examining the current legal landscape for limits on this type of discrimination. For starters, neither the states nor Congress has taken up a “no discrimination against the unhealthy” banner, and state laws regulating insurance have even been interpreted as compelling such discrimination. At the same time, though, federal law regulating group health coverage and a number of state laws regulating health insurance premiums function to limit insurance providers’ ability to engage in some forms of health status discrimination.

A. State Laws Prohibiting “Unfair Discrimination” in Health Insurance

Since the states are primarily responsible for regulating insurance, it makes sense to look first to state law for any prohibitions on health status discrimination. As discussed previously, a number of states have laws prohibiting or limiting insurers’ use of particular types of information in classifying risks, and some of this off-limits information – such as genetic information or information about domestic violence – may in fact be linked to an individual’s
health status. Notwithstanding these specific prohibitions, states do not have laws that
generally preclude health insurers from using health status as a risk classifier. Indeed, the most
relevant state laws dealing with health insurance discrimination generally have been interpreted
by some courts as requiring health status discrimination.

All states have passed some form of unfair trade practices legislation applicable to
health insurance, and among the unfair trade practices that health insurers are forbidden to
engage in is “unfair discrimination.” These statutes are based, to varying degrees, on the model
Unfair Trade Practices Act (UTPA)\textsuperscript{144} promulgated by the National Association of Insurance
Commissioners, which bans health insurers from “unfair discrimination between individuals of
the same class and having essentially the same hazard.”\textsuperscript{145} Without further explication this
language simply re-presents the central question at the “struggle for the soul of health
insurance.” To wit, is it “fair” for each insured to pay a premium that reflects as closely as
possible his own predicted costs of medical care (the actuarial fairness view),\textsuperscript{146} or is it “fair”
for risks to be pooled broadly so that persons who are poor risks are not required to carry their
burdens alone (the social solidarity view)?

Although commentators and regulators adopted varying stances on what discrimination
is “unfair” under these state laws, the resolution of the debate in the late 1980s regarding
insurers’ use of HIV-testing results suggests that, at least with respect to health status
classifications,\textsuperscript{147} an actuarial fairness understanding has become dominant. The debate arose

\textsuperscript{144} MODEL UNFAIR TRADE PRACTICES ACT (National Association of Insurance Commissioners 2001).
\textsuperscript{145} Id. § 4(G)(2).
\textsuperscript{146} This view is espoused by Clifford & Inculano, supra note 30, at 1811 (“[U]nder [UTPA] insurers have a
positive duty to separate insureds with identifiable, serious health risks from the pool of insureds without those
risks.”).
\textsuperscript{147} By contrast, as discussed supra note 42 and accompanying text, some states reached the conclusion that the
use of racial classifiers were prohibited as a form of unfair discrimination. Although race may be less strongly
predictive of future losses than health status information, commentators have pointed out that the differing life
in the mid 1980s, when several states passed laws or regulations restricting insurers’ efforts to
determine insurance applicants’ HIV status.\textsuperscript{148} By restricting insurers’ ability to classify risks
based on an individual’s HIV status, the laws functioned to prevent discrimination based on a
particular medical condition. Predictably, the insurance industry argued forcefully that the
HIV-testing laws misapprehended the basic tenets of insurance underwriting and would
unfairly force uninfected persons to shoulder the considerable costs of covering persons with
HIV and AIDS.\textsuperscript{149} In challenges to regulations banning HIV testing, courts accepted these
arguments regarding the meaning of fair discrimination and struck down the regulations as
exceeding the regulators’ statutory authority.\textsuperscript{150} Thus, few today would argue that state unfair
discrimination laws protect unhealthy individuals from risk classification practices that
conform to actuarial fairness

B. State Laws Regulating Health Insurance Premiums

Although state insurance unfair trade practice acts have been interpreted to incorporate
an actuarial fairness standard, the passage of state laws reforming the small group and
individual health insurance markets beginning in the early 1990s significantly infringed upon
insurers’ ability to discriminate against unhealthy persons based on health status.\textsuperscript{151} Legislators

\begin{itemize}
\item See Jerry & Mansfield, supra note 39, at 352.
\item See JERRY, supra note 19, at 145-46 (describing concerns about the potential for breaches of confidentiality
and the potential for covert discrimination against homosexual men as prompting these bans).
\item Clifford & Inculano, supra note 30, at 1811 (suggesting that a failure of insurers to assess the AIDS risk of
prospective insureds would represent “a forced subsidy from the healthy to the less healthy”). These
commentators also argue that laws restricting insurers’ ability to require HIV testing “substantially impede the
insurance industry’s ability to assess risk, thereby undercutting the industry’s financial stability and compromising
its ability to pay future claims.” Id. at 1815.
\item See Life Ins. Ass’n of Mass. v. Commissioner of Ins., 530 N.E.2d 168 (Mass. 1988); Health Ins. Ass’n of
America v. Corcoran, 551 N.Y.S.2d 615 (N.Y. App. 1990), aff’d, 565 N.E.2d 1264 (N.Y. 1990). In addition, on
the legislative front, most of the statutory bans were subsequently repealed.
\item A clarification is called for here. To the extent that small group market reforms implemented community
rating or other reforms for small group policies, these laws cannot be understood as protecting any particular
individual against health status discrimination. Instead, the small group market reforms prohibit certain types of

44
concerned about rising levels of uninsurance and evidence of market failure in the small group and individual insurance markets undertook these reforms in an attempt to make private health insurance more available and affordable. Thus, these reforms can be understood as efforts to “shore up” the weakest aspects of the private health insurance market in order to stave off calls for more comprehensive reform.

One element of these private market reforms were laws passed by a minority of states that required insurers to employ community rating in pricing their policies. Under a system of community rating, insurers charge the same premium to all insureds in a geographic location for a particular benefit package. Although some states enacting community rating reforms allowed insurers to vary premiums based on demographic characteristics such as age or gender, the community rating laws prohibited insurers’ use of health information in setting premiums. In this sense, the states that passed community rating laws against the unhealthy outlawed discrimination against the unhealthy in the pricing of health coverage. These laws favor the insurer discrimination between healthy and unhealthy groups. Although we cannot understand the group reforms as providing protection to any particular individual against health status discrimination, I discuss the small group and individual health insurance market reforms together in this section because both types of reform display a conviction that unhealthy persons (whether group members or those seeking individual coverage) should not be denied access to health insurance or have to bear the expected cost of their predicted poor health. Thus, these laws embody some level of commitment to the social solidarity view that entails a pooling of risk. For a useful compilation of state-level health insurance reforms (including both individual and small group markets) as of August 1, 2001, see a chart compiled by the National Association of Health Underwriters at [link].

See Jacobi, supra note 19, at 369-70; Beth C. Fuchs, Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s, Robert Wood Johnson Foundation, Research Synthesis Report No. 4, June 2004, at [link].


Most states, however, did not include community rating laws in their insurance market reforms and instead passed laws imposing “rating bands” on health insurers. These laws permit insurers to use health status factors as a basis for varying the premiums charged within particular demographic classifications, but limit the range of variation permitted. Hall, supra note 153, at 765. Rating band laws, therefore, permit insurers to continue to engage in health status discrimination in pricing their product, but limit the extent of that discrimination. One
social pooling of risk, explicitly call for good health risks to subsidize the cost of poor health risks, and, from the point of view of the insured, establish a right to pay no more than the community average cost of insurance.\textsuperscript{156}

Of course, as the earlier discussion of the various ways that health insurers discriminate suggests, if state legislation precludes discrimination in pricing, insurers are likely to simply shift their focus to underwriting and coverage decisions as mechanisms for segmenting the market by health status.\textsuperscript{157} Although other elements of the small group and individual market reforms of the 1990s limited insurers’ ability to engage in discriminatory underwriting or coverage practices,\textsuperscript{158} most states failed to enact the full battery of these reforms.\textsuperscript{159} Consequently, one state might include protection from discrimination in pricing, but permit discrimination in underwriting. Ultimately, the state health insurance market reforms of the 1990s were focused on addressing market failures and provided unhealthy persons (and groups) only limited and incomplete protection against health status discrimination.\textsuperscript{160}

might interpret these laws as reflecting the opinion that health status discrimination in pricing health insurance policies is a legitimate practice, but that its impact on insureds should be somehow limited.\textsuperscript{156}  
Jacobi, supra note 19, at 374-75; Korobkin, supra note 154, at 817. Some analysts suggest that the cross-subsidy required by community rating flows from the young to the old. See Health Care Study Group, supra note 16, at 522. Such a subsidy may be objected to as a regressive intergenerational transfer of wealth. Cf. Hall, supra note 153, at 769 (articulating Epstein’s objection). Other commentators, however, suggest that if we adopt a lifespan approach (under which we each expect to be both young and then old), the subsidy is more appropriately understood as a subsidy by the (predicted) healthy of the (predicted) unhealthy. See Korobkin, supra note 154, at 817.\textsuperscript{157}

Swartz, supra note 23, at 98 (“if a state has only one or two of these regulations in place, the carriers can use other mechanisms that are not proscribed to accomplish the same objective”).\textsuperscript{158}  
Laws imposing guaranteed issuance or renewal obligations on insurers can be understood as prohibiting health status discrimination in underwriting decisions, while restrictions on pre-existing condition exclusions and mandated benefits laws can be understood as limiting discrimination in benefits covered.\textsuperscript{159}  
Id. at 98 (asserting that states’ attempts to limit risk segmenting practices “have almost always set up regulations that block the use of only one or two of these mechanisms”).\textsuperscript{160}  
The evidence is also mixed and inconclusive regarding the extent to which the reforms (1) accomplished their goals of increasing the affordability and availability of insurance and thereby increased rates of coverage and (2) avoided the unintended (but predicted) consequence of contributing to adverse selection in the small group and individual market. For a synthesis of the research regarding the effects of the individual market reforms, see Fuchs, supra note 152. For a brief examination of empirical evidence regarding the effects of the small group market reforms, see Hall, supra note 153.
Aside from the failure to address the full range of insurers’ discriminatory practices, state-level insurance market reforms of the 1990s provide only incomplete protection against health status discrimination for another reason. Because ERISA’s preemption provision prevents states from applying insurance laws to self-insured employer health benefit plans, individuals who receive health coverage through their employer’s self-insured plan receive no protection. The states’ inability to control the practices of self-insured employers, along with continuing public fears about the perceived fragility of existing health insurance coverage, contributed to the enactment of a federal response to health insurers’ risk selection practices.

C. The Health Insurance Portability and Accountability Act

In 1996 Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to address the fears of the voting public that they would lose their health insurance when they really needed it. Rather than attempting comprehensive health care reform, HIPAA was focused primarily on addressing the security and portability of health insurance coverage. To deal with these issues, HIPAA includes provisions limiting group plans’ use of pre-existing condition clauses, preventing gaps in coverage when workers change jobs, and imposing guaranteed issue and guaranteed renewal obligations on insurance issuers in the small group market. To further reassure insured Americans, the law also prohibits group health insurers from discriminating against individual participants on the basis of health status in establishing eligibility rules and setting premiums.

162 Jacobi, supra note 19, at 376 (characterizing the portability provisions as the “centerpiece” of HIPAA). HIPAA was an omnibus measure that also contained provisions addressing health care fraud and abuse, created a demonstration project for medical savings accounts, and set in motion the creation of privacy regulations.
163 As John Jacobi points out, when combined with the nondiscrimination provisions, the effect of these provisions is to permit “all groups to obtain insurance, and for all members of groups to gain coverage without regard for their actual or expected health status.” Id. at 378.
HIPAA has been characterized as inaugurating the federal regulation of the content of private health insurance, and certainly 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. The statute explicitly forbids a group health insurance provider from relying on any “health status-related factors” of an individual in establishing eligibility rules or setting individual premiums, and the regulations implementing HIPAA make clear that the prohibition on discriminatory eligibility rules extends to rules relating to available benefits. According to the regulations, an issuer that enrolls an individual with a medical condition, but limits the benefits available to her based on the condition, violates HIPAA’s nondiscrimination provision. Thus, HIPAA applies a “disparate treatment” understanding of nondiscrimination to group plans’ use of health status information;


165 The Act defines these “health status-related factors” as including the following:
   (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.


166 The Act also prohibits discrimination based on a health status-related factor of a dependent of an individual within the group. Id.

167 The regulations issued by the Department of Labor (DOL) provide the following illustration:
   Example 5. (i) Facts. A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.
   (ii) Conclusion. In this Example 5, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan’s lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

29 CFR § 2590.702(b)(2)(i)(D).
the Act generally requires that all similarly situated individuals within a group health insurance plan be treated identically with respect to eligibility for enrollment, benefits covered, and premiums charged.

By contrast, HIPAA expressly disavows any attempt to impose a particular benefit package or premium level on employer plans or insurers. As long as the benefits provided under a plan are “uniformly available to all similarly situated individuals,” the plan “is not required to provide coverage for any particular benefit.” Accordingly, a plan may not impose a lower lifetime coverage limit on a person with HIV infection than it imposes on other group members, but it may cap coverage of HIV-related expenses for all group members. Thus, HIPAA clearly rejects any attempt to regulate impact discrimination: As long as all similarly situated group members receive the same benefits at the same individual cost, it is irrelevant that group members with a particular health condition receive a package that fails to cover (or inadequately covers) their actual medical needs.

---

168 The DOL regulations make clear that the determination of which group members are “similarly situated” depends on bona fide employment classifications and not health status: “[A] plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction … is based on a bona fide employment-based classification consistent with the usual business practice.” 29 CFR § 2590.702(d)(1).

169 29 U.S.C.A. § 1182(a)(2). See Rovner, supra note 164, at 201 (“HIPAA permits plans and insurers to select, on a nondiscriminatory basis, the coverage and benefits they wish to offer and the premiums they want to charge.”)


171 Again, the regulations provide a pertinent example:

Example 4. (i) Facts. A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) Conclusion. In this Example 4, the limit does not violate this paragraph (b)(2)(i) because $2000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

29 CFR § 2590.702(b)(2)(i)(D).
HIPAA’s nondiscrimination provisions stand as the sole federal legislation giving individuals any protection against health status discrimination in health insurance, and in some cases, the protection will be significant. For a person with an expensive health condition who obtains a job with an employer offering health benefits, HIPAA’s protection is considerable. That person cannot be excluded from health insurance coverage and cannot be forced to pay more than her co-workers for the same coverage; as long as she is an employee, she is in the pool and her costs are shared across the group consistent with a social solidarity vision of health insurance.

HIPAA’s protective shield, however, is substantially limited in two distinct ways. First, while HIPAA shields an unhealthy group member from paying more for coverage, it does nothing to protect an employer from whatever premium increase an insurer might charge based on the presence of an unhealthy employee in the group. Under HIPAA, 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. Second, while HIPAA defends actual or prospective group members who are unhealthy from exclusion or different treatment, it does little to safeguard the interests of individuals not affiliated with an entity providing group coverage. The statute’s nondiscrimination provision applies only to

172 While the federal Employment Retiree Income Security Act (ERISA), which regulates employee benefit plans, contains a nondiscrimination provision, 29 U.S.C. § 1140, it has been interpreted as not preventing employers from discriminating based on participants’ health conditions when they create or modify benefit plans. See McGann v. H & H Music Co., 946 F.2d 401 (5th Cir 1991).
173 This is true whether the employer purchases health insurance for its employees from a commercial insurance carrier or HMO or self-insures its employee health benefits. The application of HIPAA to both insured and self-insured plans sets it apart from state laws regulating health insurance, because ERISA preempts the application of any state law (even one regulating insurance) to an employee benefit plan itself.
174 Jacobi, supra note 19, at 383-84 (noting that HIPAA’s market reform provisions enforce intraplan, but not interplan, social pooling).
175 Alexandra Marks, Healthcare Costs: Big Woe for Small Firms, CHRISTIAN SCI. MONITOR. Sept. 15, 2004 (reporting that the number of small firms providing coverage has fallen from 68% in 2001 to 63% in 2004).
group plans, not to issuers in the individual market. Although the statute includes a "guaranteed issue" provision granting rights to some would-be purchasers of an individual policy, most persons seeking to purchase coverage in the individual market remain subject to any underwriting and coverage practices that comply with state law. This result is in harmony with HIPAA’s general focus on protecting the health insurance “haves” from loss of coverage, while doing little to help the health insurance “have nots” access coverage.

Ironically, although HIPAA’s nondiscrimination provision shelters unhealthy group members from discrimination in coverage or premiums, the statute may be something of a mixed blessing for those persons, for its constraints may have contributed to the recent trend towards shifting insurance risk onto individual insureds in an employee benefit plan. HIPAA’s nondiscrimination provision limits how an employer can respond to premium hikes attributable (at least in part) to the presence of unhealthy group members. The employer cannot pursue the actuarial fairness principle by making a particular expensive employee pay his own way (either by excluding him from the group or charging him higher premiums), but it can try to moderate its own health insurance cost burden by shifting some of that burden onto employees.

176 The guaranteed issue provision for the individual market limits the ability of issuers in that market to refuse coverage to an applicant who has lost access to group coverage and who satisfies several other conditions. See Swartz, supra note 23, at n.17 (noting that HIPAA does not prevent issuers from engaging in risk selection practices with respect to the “great majority” of persons seeking an individual health insurance policy); cf. Jacobi, supra note 19 (asserting that if a person meets all the statutory conditions, a carrier cannot reject the person or impose pre-existing condition limitations based on her risk of medical expenses).

177 See Edmund L. Andrews, Health Care Heights: Soaring Rates Leave Little Companies in a Bind, N.Y. TIMES, Feb. 24, 2004 (“Because they are rated largely on the age and health experience ratings of their workers, businesses with a slightly older work force or a handful of employees with significant medical bills can see their rates soar 20 or 30 percent.”). While felt particularly in small businesses, employees’ health can also impact the premiums of larger businesses. Andrews reports that an employer with more than 300 employees faced a 24 % premium increase in one year, partly attributable to a handful of employees who required expensive hospital care in the preceding years. Id. Another factor accounting for premium growth is insurers’ attempts to maximize their profits. Kaiser Family Foundation, Employer Health Benefits 2003 Annual Survey, at http://www.kff.org (noting that premiums increased faster than the cost of underlying claims experience).

178 Yet another way to make an expensive employee pay his own way is to terminate his employment so that his inclusion in the employer’s group is no longer assured by HIPAA. Some evidence exists that employers have begun to pursue this strategy, despite the legal risks that it poses. See Joseph Pereira, Parting Shot: To Save on Health-Care Costs, Firms Fire Disabled Workers, WALL ST. J., July 14, 2003, at A1.

51
as a group. As we will see in the next Part, the rise of consumerism in health coverage reflects the choice of many employers to shift the cost of paying for care onto individual insureds.

IV. Discrimination against the Unhealthy in Consumerist Health Care

A. From Managed Care to Consumerism

Significant changes have occurred in the market for health insurance products during the past half decade. Managed care grew to market dominance over the course of the 1990s and succeeded for a period of time in reining in health care cost inflation through a variety of techniques designed to constrain the supply of unnecessary health care services to plan enrollees. By early in the 2000’s, however, it had become clear that managed care’s successes were not to be long lived. Even while one pair of commentators proclaimed managed care’s dominance of U.S. health care, another scholar was describing managed care proponents as being “in full retreat” and suggesting the emergence of a new “consumerism” trend in health care coverage.

Various explanations have been offered for managed care’s inability to sustain its dominance in the health benefits market. Undoubtedly, the “managed care backlash” by

179 See Robinson, supra note 7 (characterizing managed care’s use of network contracting and utilization review as efforts to limit supply).
180 R. Adams Dudley & Harold S. Luft, Managed Care in Transition, 344 NEW ENG. J. MED. 1087 (2001). As the title suggests, however, these authors too recognized that managed care had an uncertain future. Id. at 1091.
182 See David Orentlicher, The Rise and Fall of Managed Care: A Predictable “Tragic Choices” Phenomenon, 47 ST. LOUIS U. L.J. 411, 412 (2003); Clark C. Havighurst, The Backlash against Managed Health Care: Hard Politics Makes Bad Policy, 34 IND. L. REV. 395 (2001). Nonetheless, phrases such as “the death of managed care” are probably overblown, for many structures and elements characteristic of managed care remain part of the health coverage landscape, either on their own or in conjunction with newer product designs. Debra A. Draper & Gary Claxton, Managed Care Redux: Health Plans Shift Responsibilities to Consumers, Issue Brief No. 79 (Center for Studying Health System Change, March 2004), at http://www.hschange.org/content/666?print=1 (noting that in some instances managed care practices are being used in conjunction with newer products). What is remarkable is that the grouping of features known as managed care, which rapidly ascended to dominance in the health benefits marketplace, has in a similarly short period of time lost both the vigor of its cost containment techniques and its
physicians and consumers played a role in defanging managed care’s cost control mechanisms, whether by prompting state legislation regulating managed care or by influencing employers’ purchasing decisions (and consequently plans’ product designs). Coincident with the waning of managed care’s strength, the early 2000s witnessed four consecutive years of double-digit increases in employers’ health care costs and this dramatic escalation left employers scrambling in their search for the next “new thing” to control costs.

Given that a chief objection to managed care was the plans’ sometimes draconian limits on patients’ choice of doctor, hospital, or therapy, it is hardly surprising that the latest trend in health coverage emphasizes expanded choices for consumers of health care. In the early 2000s, reporters, benefits managers, and health insurance industry analysts started using the phrase “consumer-driven health care” to describe the new movement. Lacking a single definition, the phrase has come to refer generally to health plans that give employees both greater responsibility for designing their own benefit packages and choosing their providers (often with the assistance of Web-based information tools), as well as greater financial risk for their health care costs. One version of consumer-driven plans provides employees with some dominance of the marketplace. Cf. Robinson, supra note 181, at 2625 (stating that “once the consumer and physician backlash against managed care began, it quickly swirled into an unstoppable political tornado”).

See Mark A. Hall, The Death of Managed Care: A Regulatory Autopsy (unpublished manuscript on file with author).

See Vanessa Fuhrmans, Employers Expect Increase of 12%, Fifth Year in a Row of Double-Digit Gains, WALL ST. J., Sept. 29, 2003, at A6. Premium rates have increased even faster than average for small companies. See Andrews, supra note 177.


See Jon R. Gabel et al., Consumer-Driven Health Plans: Are They More than Talk Now?, HEALTH AFF. W 395, Nov. 20, 2002; Robinson, supra note 7 (“The contemporary transformation in benefit design centers around this increase in consumer cost-sharing provisions, the multiplication of benefit options offered to each consumer, and the shift from insured toward noninsured, albeit discounted, services.”). Gabel et al. distinguish the term “consumer-driven health plan” from the term “defined contribution plan.” While “consumer driven” refers to health plan design, “defined contribution” refers to “an employer contribution strategy whereby employers set a fixed contribution for health insurance and place the employee at risk for costs beyond that point.” As the authors point out, the two forms are not mutually exclusive, but neither does a consumer-driven health plan necessarily
form of discretionary medical spending account combined with catastrophic health coverage. While promising consumers a broader choice of providers and greater control over their medical decisions, consumer-driven plans promise employers cost savings flowing from the combination of greater efficiency in the purchasing decisions of cost-conscious consumers and a shifting of health care costs to employees. Notwithstanding these promises, commentators quickly recognized consumerism’s potential negative consequences, particularly for persons with chronic conditions.

Accompanying the decline of managed care and the early development of consumer-driven plans was a far more widespread move by employers sponsoring health plans to increase employees’ financial obligations either by raising premium contributions or by increasing cost-sharing obligations. A contemporaneous development was employers’ increasing reliance on “tiered” pharmacy benefits, in which the patient’s cost-sharing obligation varies among different tiers of drugs. While less closely associated with “consumer-driven” health care, these two developments similarly shift financial risk for medical expenses to the enrollee and entail a defined-contribution strategy by the employer. Id. It is true, though, that the emergence of consumer-driven health plans can be seen as consistent with the broader trend in which employers seek to limit their future financial exposure for employee benefits by moving away from defined-benefit plans and towards defined-contribution plans. Cf. Robinson, supra note 181, at 2623 (suggesting that the movement to defined-contribution pension plans, like consumerism in health benefits design, signals a “change from a paternalistic corporate culture to one that defines itself as supporting rather than restricting employee choice”). For an overview of defined contribution approaches to health coverage, see American Academy of Actuaries, Understanding Defined Contribution Health Plans, Issue Brief, June 2002, at www.actuary.org.

Gabel et al. provide an apt contrast between managed care, whose temporary success in constraining employer health costs was “because a third party (or, in some cases, an at-risk physician) was placed in the role of saying no to patients,” and consumer-driven health care, which represents “an effort to put patients in a position to say no to themselves. This can happen only if consumers are aware of the true cost and have a personal stake in it, and if they have enough information and confidence to make treatment decisions.” Gabel et al. supra note 186, at W396.


See Sally Trude, Patient Cost Sharing: How Much is Too Much?, Issue Brief No. 72 (Center for Studying Health System Change, Dec. 2003), at http://www.hschange.org/ contents/630/?print=1 (indicating that employers confronted with the higher premiums that followed the managed care backlash started shifting health costs to workers); Gabel et al., supra note 185, at W4-211 (noting that increased employee cost sharing is occurring in both consumer-driven plans and in traditional plans like preferred provider organizations).
thereby encourage cost-conscious choices. Therefore this Article treats consumer-driven plans, 
tiered benefit plans, and employer cost shifting as close allies in a “consumerist” movement.190
To date, increased cost-sharing and tiered prescription drug benefits have been more widely 
implemented than plans typically designated as consumer-driven products,191 but surveys 
suggest that consumer-driven products will likely gain ground over the next several years, 
particularly with the creation of health savings accounts.192

This Part first will describe these different vehicles by which a consumerist tide is rising in 
health benefits and will summarize some of the debates regarding the trend’s positive and 
negative policy implications. The Part will then proceed to examine some of the still relatively 
limited research into the predicted and actual effects of these changes in health coverage. 
Based on this research, I will argue that the changes are likely to leave persons with chronic 
conditions and those experiencing episodes of acute illness or injury underinsured, and thus 
subject to many of the same health and financial consequences faced by the uninsured. In other

190 Cf. John V. Jacobi, After Managed Care: Gray Boxes, Tiers and Consumerism, 47 St. Louis U. L.J. 397, 
400-01 (2003) (identifying 3 emerging trends as the loosening of controls over patients’ choices, the stratification 
of health insurance offerings into tiers, and employers’ interest in emerging “patient directed” plans).
191 Contrast Gabel et al. supra note 186, at W404 (estimating that about 1.5 million Americans were enrolled in consumer-driven plans in November 2002), with Draper & Claxton, supra note 182 (finding tiered pharmacy arrangements to be in extensive use). Gabel et al. classify consumer-driven plans into “three loosely defined groups.” These include (1) plans that allow employees to specify the benefits and the networks that will be in their package, but impose responsibility on the employee for any amount by which the resulting premium exceeds a fixed employer contribution; (2) “customized package” plans in which employees choose from among preset benefits and network offerings; and (3) “health reimbursement arrangements” (HRAs) in which the employee has a health spending account combined with a high deductible health plan. Gabel et al., supra 186, at W396. As discussed below in Part VB3, the most recent adaptation in the HRAs’ evolutionary chain is the health savings account (HSA). Because of the projected growth in the adoption of HSAs as a result of their creation in the Medicare Modernization Act, this Article will focus on HSAs in its discussions of consumer-driven health plans.
192 See, e.g., Consumer-Directed Health Plan Enrollment Expected to Grow in 2004, BNA Health Care Daily, March 15, 2004 (reporting survey results that 32% of large companies expect to offer a consumer-driven plan next year, as compared to 21% currently offering such coverage); Report See Consumer-Directed Plans Growing into Large Insurance Market Force, BNA Health Care Daily, Aug. 19, 2003 (reporting projection by Forrester Research that by 2010 the number of enrollees in consumer-driven plans will reach 43 million). In addition, Gabel suggests that the results of such surveys may understate the prospects for the growth of consumer-driven plans, because once adopted by large employers, such plans are likely to diffuse to mid-size and smaller firms. See Gabel et al., supra note 185.
words, the adoption of consumerist mechanisms produces an adverse disparate impact on the unhealthy and thus can be understood as discriminatory.

B. Vehicles of the Consumerist Movement

1. Increased Cost-Sharing by Employees

Managed care’s inability to continue controlling health care costs has prompted increasing employer use of cost-sharing devices such as deductibles, copayments, and coinsurance. Historically, health insurers offering indemnity coverage employed deductibles and coinsurance requirements in order to reduce moral hazard by giving patients a financial stake in treatment decisions, but managed care systems minimized cost-sharing and instead controlled the consumption of services through administrative devices or gate-keeping physicians. The new twist in twenty-first century cost-sharing lies both in its acceleration and in employers’ reliance on cost-sharing elements not only to draw employees’ attention to rising health care costs, but also to decrease (or, more precisely, limit the degree of increase in) the employers’ premiums. Because cost-sharing makes employees rather than insurers responsible for some portion of employees’ medical expenses, an increase in cost-sharing represents a decrease in covered benefits. Thus, over the past several years, employers have “bought down” their health insurance premiums by reducing coverage via increased cost-sharing.

193 See infra Part IVB3.
194 See Swartz, supra note 23 n.12 (noting that increasing cost-sharing can reduce moral hazard).
195 See Sally Trude & Joy M. Grossman, Patient Cost-Sharing Innovations: Promises and Pitfalls, Issue Brief No. 75 (Center for Studying Health System Change, Jan. 2004) at http://www.hschange.org/content/643/?topic=topic01 (stating that employers’ enthusiasm for increased cost-sharing stems from “two main desires: to restore patient cost sharing to comparable levels before the advent of managed care or to give workers a greater financial stake in care decisions”).
These increases have involved the full range of cost-sharing mechanisms. Health plans’
average annual deductibles have increased, as have the size of copayment obligations.
Significantly, more plans have begun using coinsurance (in which the consumer bears an
indefinite obligation to pay a percentage of the charges for services received) rather than
copayments (in which the consumer’s obligation is a definite amount). Some employers
have adopted new mechanisms, such as adding separate cost-sharing obligations for inpatient
hospital services. If employers sought to use cost-sharing to make employees feel the pain of
rising health care costs, they have succeeded with a vengeance. In addition to its probable
impact on employees’ accessing needed medical care, employer plans to increase cost-
sharing have been bones of contention in a number of recent labor disputes, and increased
cost-sharing is one reason cited for the growing number of employees choosing not to
participate in employer-sponsored health plans.

Of course, increasing cost-sharing is not the sole way employers could shift health care
costs onto employees; increasing employees’ contributions towards group health insurance
premiums also shifts costs. But while employee premium contributions have also escalated
significantly in the past several years, research indicates employers have primarily relied on


197 Laura Landro, The Informed Patient: When It’s Your Money, You Spend it Differently, WALL ST. J., May 8,
2003 (noting single year jump of $75 in the average annual deductibles in preferred-provider plans).
198 Trude, supra note 189; cf. Trude & Grossman, supra note 195 (noting that a switch from a flat copayment to a
percentage co-insurance approach will “capture patients’ attention quickly”).
199 Kaiser Family Foundation, supra note 177.
200 See infra Part VD2.
201 See Barbara Martinez, Shifting Burden: With Medical Costs Climbing, Workers are Asked to Pay More,
WALL ST. J., June 16, 2003, at A1 (stating that health care cost-shifting prompted strikes at General Electric,
Lockheed Martin and Hershey Foods); Fuhrmans, supra note 196 (citing California grocery workers’ strike).
202 Regopoulos & Trude supra note 196 (suggesting that increases in premium contributions and cost sharing has
probably caused some employees to drop coverage).
203 Trude, supra note 189.
204 Martinez, supra note 201 (citing Kaiser Family Foundation study finding that workers’ average monthly
premium contribution for family coverage more than tripled between 1998 and 2002).
cost-sharing increases to shift costs to employees.205 Although both mechanisms shift health
costs from employers to employees, two differences significant for purposes of this Article bear
noting. First, premium contribution increases shift to employees greater financial responsibility
for purchasing insurance coverage; cost-sharing increases shift to employees greater
responsibility for their own medical expenses. In other words, an employee who pays only an
increased premium contribution has less money in his pocket, but remains as well insured as
before. By contrast, an employee who faces increased cost-sharing becomes partially self-
insured. Cost-sharing mechanisms, by making insureds responsible for a portion of their
medical costs, shift insurance risk to the employee.

A second, related difference lies in how the costs shifted by premium or cost-sharing
increases are distributed among employees. Increases in premium contributions shift higher
costs equally to all employees choosing a particular coverage.206 By contrast, cost-sharing
increases shift costs only to those employees who consume medical services having a cost-
sharing obligation. In other words, a healthy employee who needs no doctors’ services or
prescription drugs bears no additional costs from cost-sharing, but an employee who
experiences health problems and seeks medical treatment does bear additional costs. This
undisputed inequality in how cost-sharing devices shift costs among employees is central to an
understanding of consumerist mechanisms as discriminatory.

205 Trude, supra note 189.
206 Actual premium contributions may vary depending on whether the employee signs up for single, spouse, or
family coverage and, if the employer offers more than one coverage option, on which plan the employee chooses.
But each employee enrolling in a particular type of coverage faces the same contribution.
2. Tiered Plans

Another consumerist mechanism, the tiered benefit plan, combines increased cost-sharing (to shift costs to employees) with differential cost-sharing (to prod subscribers towards the use of particular products). The term “tiered plans” refers generally to health insurance products that group providers or prescription drugs into tiers based on cost (or potentially some other criteria) and encourage subscribers to choose lower-tier products or providers by imposing higher copayment amounts on higher-tier choices. For example, in one tiered pharmacy plan, subscribers pay a $5 copay if they purchase a generic drug, a $20 copay for a brand-name drug on the plan’s “preferred” list, or from $30 to more than $50 for non-preferred brand name drugs on the third tier. The health insurance industry has applied the tiering concept to prescription drugs, hospitals, and physicians, with varying degrees of market penetration. Adopting a tiered plan offers the potential for additional cost savings both by encouraging subscribers to choose lower-cost products and by giving insurers an enticement (inclusion in a lower tier) to offer providers when negotiating for discounted charges.

Over the past half decade, tiered pharmacy plans have become a common feature in employer-sponsored benefits packages. Among pharmacy plans, a three-tier design like that

207 Jacobi, supra note 190, at 403.
210 See generally Mays et al, supra note 208. While tiered pharmacy benefits are already widespread, the adoption of tiered hospital and physician networks has to date been far more limited, in part because the developer’s decisions about how to divide providers into tiers is more complicated, and providers may offer greater resistance to the imposition of a tiered structure.
211 Id.
212 Zaneski, supra note 209 (describing an “industrywide wave” of adoptions, with 63% of employees with employer-sponsored drug coverage having tiered copay plans in 2004, up from 27% in 2000); see also Draper & Claxton, supra note 182 (finding that in most of the 12 nationally representative communities visited, tiered
described above is the most common, though the products offered continue to evolve. Tiering
copayment amounts by products provides a somewhat more refined incentive structure than a
uniform increase in copayment obligations, for combining copayments with tiers encourages
the consumer to think about not only whether to take money out of his pocket to consume a
product, but also which product to consume. To the extent that they encourage consumers to
choose which drug to purchase based solely on cost, without consideration of effectiveness,
though, existing standard three-tier products remain a fairly blunt instrument. Further
refinement is possible, however, if insurers can devise incentives to purchase drugs proven to
be the most cost-effective over time.

3. Health Savings Accounts

While market forces generated both the general increase in cost-sharing obligations in
employer-sponsored health plans and the evolution of tiered plans, federal legislation created
the third embodiment of the consumerist movement that this Part examines. The Medicare
Prescription Drug Improvement and Modernization Act of 2003 (MMA) included a
provision creating health savings accounts (HSAs), which are essentially tax-favored savings
accounts that individuals can use for medical expenses. The MMA did not create the HSA out

pharmacy arrangements are in extensive use); Thomas, supra note 209 (calling the use of incentive-based
formularies “standard practice”). Several reasons may have contributed to the rapid uptake of tiered pharmacy
products. First, the escalation in prices for prescription drugs has been the single biggest driver in overall health
care inflation; therefore employers have a particularly strong incentive to try new ways of controlling these costs. See Thomas, supra. Second, because many employers provide prescription drug coverage to employees through a
separate plan, employers can experiment with a tiered pharmacy benefit without signing onto major changes in the
rest of their health coverage. Third, some level of agreement seems to exist among commentators that sorting
prescription drugs into tiers is a more straightforward process than sorting hospitals or physicians.

Cf. Thomas, supra note 209 (noting that savings from tiered plans are accomplished “by both decreasing the
number of medications purchased per member and increasing the proportion of lower-cost brand-name drugs and
generic drugs used”).

See generally Trude & Grossman, supra note 195: Thomas, supra note 209 (noting that employers and
insurers are trying to “fine-tune their tiered formularies to make them ‘value-based,’ with copayments determined
on the basis of the relative cost effectiveness of a drug).


The MMA did so by adding section 223 to the Internal Revenue Code. 26 U.S.C. § 223.
of whole cloth. Rather the HSA is the most recent link on an evolutionary chain of consumer-directed products providing some sort of tax-favored discretionary spending account for individuals; its forebears include the flexible spending account, the health reimbursement account, and the Archer medical savings account.\(^{217}\) Congress’ goal in the MMA was to create a medical spending account that would be more widely available and more attractive to employers and consumers.

While the introduction of health savings accounts raises a number of complex questions about their integration into existing health benefits schemes,\(^{218}\) the HSA’s basic operation is fairly straightforward.\(^{219}\) The MMA enables an “eligible individual” to make contributions to an HSA, which is a tax-exempt account established exclusively for the purpose of paying qualified medical expenses of the individual (and potentially her family). To be an “eligible individual,” a person must be covered by a high-deductible health plan (HDHP), but have no other health coverage.\(^{220}\) To qualify as a HDHP, a policy must have a deductible of at least $1,000 for individual coverage or $2,000 for family coverage,\(^{221}\) and must establish an annual limit on out-of-pocket medical expenses of $5,000 for individual coverage or $10,000 for


\(^{220}\) An individual can obtain his HDHP coverage either by participating in an employer-sponsored plan that offers an HDHP or by purchasing an HDHP in the individual market. A survey of 270 companies reported by Hewitt Associates at the end of March 2004 found that, while six out of ten employers would likely offer HSAs to their employees in the near future, a much smaller number (only one third) currently offered a HDHP. *Most Firms in Survey Plan to Offer HSAs but Fewer Have the Requisite Health Plans*, BNA HEALTH CARE DAILY, Apr. 5, 2004.

\(^{221}\) The law provides, however, that a HDHP is allowed to provide first-dollar coverage for preventive care services. 26 U.S.C. § 223 (c)(2)(C).
family coverage. The individual or her employer can contribute up to $2,600 for an individual or $5,150 for a family annually to the account on a tax-favored basis, but the contribution cannot exceed the HDHP’s deductible. Funds in the HSA can be invested in mutual funds or other investment vehicles, and unspent amounts roll over from year to year. Moreover, the HSA is “portable” – it is the property of the eligible individual and thus follows him upon any change in employment. Once an HSA is established, distributions from the account are not taxed as long as they are used for medical expenses such as covering deductibles or copays, purchasing over-the-counter drugs, or paying for non-covered services.

As commentators have noted (whether to their delight or chagrin), the tax advantages HSA offer are remarkable. The funds an eligible individual contributes to an HSA are not taxed; the funds in an HSA can be invested and grow tax-free; and distributions made from an HSA are not taxed, as long as they are used for qualified medical expenses.

---

222 Such out-of-pocket expenses may include amounts paid to satisfy the deductible and any cost-sharing obligations once the deductible has been satisfied. Not included are the premiums paid to purchase the HDHP.

223 A contribution made by an individual is deductible “above the line,” i.e., it is not included in the individual’s adjusted gross income. A contribution made by an individual’s employer is not taxable income for the employee and is tax deductible by the employer.

224 The maximum annual contribution is scheduled to increase annually, and under a “catch-up” provision, individuals over the age of 55 can contribute more. 26 U.S.C. § 223(b)(3) and (g).

225 Untaxed distributions cannot be used to purchase health insurance, except when the account holder is either purchasing COBRA continuation coverage or is unemployed. Distributions generally can, however, be used to pay the premiums for long-term care insurance, and Medicare-eligible individuals can use distributions to pay either (1) Medicare premiums and out-of-pocket expenses relating to Medicare, or (2) any employee premium needed to maintain retiree coverage under an employer plan. 26 U.S.C. § 223(d)(2).


227 If an individual under the age of 65 uses a distribution from an HSA for purposes other than a qualified medical expense, the distribution is taxed and subject to a 10% penalty. An individual aged 65 or older who so uses a distribution must pay tax on the distribution, but is not subject to the penalty. 26 U.S.C. § 223(f)(A), (C).
exceptionally favorable tax treatment signals the desire of Congressional backers\textsuperscript{228} to provide strong incentives for individuals to establish HSAs. The proponents of HSAs seek to stimulate their widespread establishment in order to dampen health care cost inflation,\textsuperscript{229} but the primary philosophical goal is one of individual empowerment. An analyst from the Heritage Foundation highlights the individualistic focus of consumerism in describing HSAs:

\textit{Health Savings Accounts offer Americans a new coverage option for their health care needs. They give them a new choice in coverage design, greater control of their health care spending, and the ability to own their own health care plans. These are all key features in moving America’s health care system to a consumer-based system.}\textsuperscript{230}

Advocates for HSAs are less likely to focus on the individual risk that accompanies enhanced choice and control. First, it bears emphasis that the HSA is not itself an insurance vehicle; it does not transfer risk to an insurer or spread risk over a group. Instead, it is a mechanism designed to encourage, through tax benefits, individual savings for uninsured medical expenses.\textsuperscript{231} The HSA’s tax benefits are available, however, solely to individuals who have catastrophic health care coverage (the HDHP) and no other coverage. Thus, the necessary result (and intent) of the HSA is that consumers have less comprehensive \textit{insurance} coverage

\textsuperscript{228} In a surprise to many health insurance lobbyists, the language creating HSAs was added as an amendment to the House of Representatives prescription drug bill only when it reached the House floor in the summer of 2003. Although most Democrats opposed the provision regarding HSAs, its inclusion helped rally support from conservative Republicans who were hesitant to approve a new and expensive Medicare benefit. See Jeff Dufour, \textit{Interest in HSAs run Rampant, but Big Sales will Wait Until 2005}, \textsc{The Hill}, Mar. 4, 2004, at \url{http://www.hillnews.com/executive/030404_hsas.aspx}.

\textsuperscript{229} Supporters of HSAs predict that they will “help to re-engage employees with their health care spending while giving employers the ability to make the transition from a defined benefit system, with open-ended costs, to a defined contribution system in which health care spending can be better managed.” Owcharenko, \textit{supra} note 217.

\textsuperscript{230} \textit{Id.}; see also John C. Goodman, \textit{Health Savings Accounts will Revolutionize American Health Care}, Brief Analysis No. 464 (Nat’l Center for Pol’y Analysis, Jan. 15, 2004) (“The concept of HSAs is not conservative or liberal. It’s an empowerment idea.”).

\textsuperscript{231} Accord Robinson, \textit{supra} note 7 (stating that HSAs’ design is “important as representing the evolution from collective insurance toward individual prepayment as the guiding principle of health care coverage”); Brill, \textit{supra} note 226 (asserting that HSAs “are designed to help individuals save for qualified medical and retiree health expenses on a tax-favored basis”). For this reason, the Department of Labor has taken the position that while employer-sponsored HDHPs are group health plans subject to ERISA, HSAs generally will not be deemed ERISA-covered employee benefit plans. See \textit{HSAs Generally Will not Constitute Employee Welfare Benefit Plans}, \textsc{DOL Says}, \textsc{BNA Health Care Daily}, Apr. 15, 2004.
than has typically been provided by employers. The decision to contribute to an HSA requires the consumer to assume the financial risks of medical expenses up to the amount of the deductible. In some case employers may help employees shoulder this increased risk by contributing to employee HSAs, but these contributions are not required.

From this perspective, a common thread shared by the three consumerist mechanisms described in this Part becomes visible. Each shifts to the individual greater financial responsibility for his medical expenses. These are not simply cost-shifting mechanisms (for healthy individuals who consume no medical services will bear no additional costs), but are more properly understood as risk-shifting mechanisms. This shifting of risk leaves the individual less well insured against the costs of poor health or accidents. Admittedly, the HSA offers some individuals a “sweetener” in the form of tax benefits to make the assumption of greater risk more attractive. But all three shift risk to the consumer in hopes that consumers who feel the impact of medical decisions in their own wallets will make wise decisions about what care to consume.

C. Policy Implications of Consumerism in Health Coverage

The accelerating consumerist movement raises several policy concerns that have stimulated public debate. The preceding paragraph hints at two areas of concern directly relevant to consumerism’s potentially discriminatory effects: First, since the trend seeks to endow individuals simultaneously with greater autonomy to make health care decisions and incentives to make those decisions in a cost-conscious fashion, some have questioned

\[232\] The benefit offered to employees whose employer raises cost-sharing obligations or adopts a tiered plan is far less salient, but it may exist in the employer’s ability to moderate health care costs that might otherwise lead it to drop coverage.

\[233\] The debate has been ongoing at least since Congress included a provision authorizing a demonstration project for medical savings accounts (MSAs) in HIPAA. For a description of the debates that preceded this inclusion, see Jacobi, supra note 19, at 379 n.234.
individuals’ ability to make sound, cost-effective decisions regarding medical care. Second, many commentators have suggested the possibility that consumerism may harm, rather than benefit, persons with health problems (and particularly unhealthy persons who are also low-income). A third concern relates less directly to any impact on the unhealthy, but directly implicates the tension between social solidarity and actuarial fairness visions of health coverage. It asks what effect will the consumerism trend – and specifically the development of HSAs – have on the continued viability of employer-sponsored group health coverage. This section will briefly explicate these concerns and sketch the opposing viewpoints on each question.

1. The Effectiveness of Consumer Decision Making

In emphasizing individual authority to make health care decisions, without constraints imposed by third parties, consumerism rides the wave of public sentiment against managed care. Yet proponents of consumer-driven health care do not argue for consumers to have totally unconstrained choices; instead, the consumer’s financial responsibility (at some level) for the choices made is a constraint that simultaneously maximizes consumer autonomy and minimizes the wasteful consumption of health care traditionally encouraged by over-generous insurance coverage.\(^{234}\) The ideal of consumerism thus envisions informed individuals operating as rational consumers of health care services and products and thereby producing an efficient allocation of health care resources. Because of patients’ traditional deference to their physicians’ recommendations and managed care administrators’ more recent assumption of decision-making authority, patients historically have not had enough information to enable

---

\(^{234}\) Cf. id. at 379-380 (noting this arguments supporting tax-favored MSAs); Michael F. Cannon, *Hillary’s Worst Nightmare*, (May 9, 2004), at [http://www.cato.org/cgi-bin/scripts/printtech.cgi/dailys/05-09-04.html](http://www.cato.org/cgi-bin/scripts/printtech.cgi/dailys/05-09-04.html).
competent decision making, but consumerists promote the use of internet-based tools to educate consumers regarding treatment options and to provide information regarding the quality and cost of different providers. Ultimately, a central philosophical tenet of consumerism is the marriage of control and responsibility regarding medical decisions in the hands of the individual.

Others, however, are less sanguine about individuals’ capacity to make cost-effective decisions regarding discrete medical treatment choices. Commonly voiced concerns are that medical decisions are more important and complicated than most consumer decisions, and that accurate consumer-friendly indicators of provider or product quality remain stubbornly in the development stage. Professor Mark Hall points out two additional ways that the distinctive nature of health care renders the efficiency of patient decision-making problematic. First, because typically a person faces momentous medical decisions only infrequently and at a time of crisis, consumers usually do not have the opportunity to accumulate knowledge by

\[\text{\textsuperscript{235}}\text{ Cf. Mark A. Hall, Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms 44 (1997) (noting that consumer ignorance might be viewed as “an artifact of the historical noncompetitiveness of the medical market”).}\]

\[\text{\textsuperscript{236}}\text{ See Jacobi, supra note 190, at 408 (asserting that “[c]ost-conscious consumers are notoriously poor at differentiating between unneeded and therefore dispensable treatments and those necessary to preserve life and health”); Dwight McNeill, Do Consumer-Directed Health Benefits Favor the Young and Healthy? 23 Health Aff. 186 (2004) (asserting that the notion that cost-conscious consumers can make better judgments about their care than could cost-conscious physicians is “not well supported”). It is important to distinguish between market enthusiasts who seek to engage individuals as rational consumers in choosing a health plan or benefit package in a market for health insurance coverage, and those who assert the importance of individuals making consumption choices in a market for health care products and services. In the former scenario, an individual is subject to financial incentives in choosing a level of coverage; in the latter, an individual is subject to financial incentives in choosing what care to receive. Leading academic advocates of a heavier reliance on markets in allocating health care resources have proposed the former scenario. See Rosenblatt, supra note 19, at 178-180 (describing proposals of Alain Enthoven and Clark Havighurst). The forms of consumer-driven health care discussed in this Article embody the latter scenario. Some products also falling under the umbrella of “consumer-driven health plans” emphasize consumer decision-making at the benefit design level, rather than at the service purchase level. See supra note ___ for a description of such products. Consumers’ ability to make sound decisions regarding what level of coverage to purchase is less contested than their ability to make sound decisions regarding what medical care to receive.}\]

\[\text{\textsuperscript{237}}\text{ Cf. McNeill, supra note 236 (noting that humans’ hope for living longer and getting well make the decision process “more emotional than rational”).}\]
repeatedly making a particular medical decision. Second, even as quality information regarding different health care options develops, patients confronted with medical decisions will likely still rely heavily on their personal physician’s advice, which may not produce optimal (from the patient’s perspective) spending decisions. For these reasons, Hall concludes, “it is not feasible to expect a viable consumer-driven market to develop for discrete treatment decisions.” Not surprisingly, proponents of consumerism respond that these concerns insult the public’s intelligence and insist that empowered consumers will rise to the occasion. Regardless of one’s level of optimism regarding patients’ competency to make cost-effective medical decisions, however, this competency is indisputably a central premise of consumerism. Without it, patients’ decisions may be as likely to harm as to promote their health.

2. Consumerism’s Winners and Losers

a. The distribution of consumerism’s costs and burdens

The suggestion that adoption of consumerist mechanisms might harm some patients’ health throws into focus another policy implication of the consumerist trend: How will the benefits and burdens flowing from the shifting of risk from insurers to individuals be distributed? Indeed, criticism leveled at increased cost-sharing and consumer-driven health plans has included impassioned charges that these trends disadvantage persons with chronic health conditions and low-income persons. Although these charges often treat the reason for this disadvantage as self-evident, it is worth briefly unpacking the nature and incidence of the detriment, which on close inspection reveals multiple dimensions.

238 Hall, supra note 235, at 45-46. Other commentators suggest that consumers might be better able to make rational choices about prescription drug purchases than about how to treat a life-threatening illness. Gabel et al., supra note 186, at W406.
239 Cannon, supra note 234. Cannon, who is director of health policy studies at the Cato Institute, anticipates that HSAs will stimulate a “cultural change”: “[H]ealth savings accounts breed the … values of personal responsibility and self-reliance. Where socialized medicine requires a culture of submission, health savings accounts will accustom millions to making their own decisions.” Id.
First, if we focus only on the cost-sharing aspects of consumerist (whether across-the-board cost-sharing obligations, tiered copays, or a high deductible for catastrophic coverage), these devices clearly shift some portion of medical expenses incurred from the insurer to the insured. This result is desirable for an employer seeking to control premiums, and it is philosophically consistent with consumerism’s reliance on informed, cost-bearing consumers as decision makers. The question, however, is not whether employees as a group should therefore be seen as “losers”; instead, I am here concerned with whether some individuals suffer more detriment than others from this shifting.

The answer, of course, is that some individuals are more disadvantaged. Because copayments and deductibles impose costs on an insured person only when care is accessed, those persons who most frequently seek care shoulder the highest financial cost. Thus, a person with a chronic condition who requires regular and ongoing care or a person who experiences a serious injury or acute illness will be disadvantaged financially; he will pay more in copayments or spend his entire deductible, while healthier persons will experience fewer out-of-pocket costs.\(^{240}\) Identifying disproportionate financial costs, however, does not by itself fully capture the nature of the disadvantage at stake. Of perhaps greater importance is the extent to which imposing financial costs burdens the person bearing those costs. A particular absolute level of financial costs may or may not constitute a financial burden – in the sense of affecting a person’s ability to satisfy her other needs – but it is obvious that out-of-pocket

\(^{240}\) See Robinson, supra note 7 (suggesting that “the new benefit designs serve to protect healthy nonusers from chronically ill users because all users pay premiums but the chronically ill users pay much more in deductibles and coinsurance”).

68
medical expenses are far more likely to be burdensome for persons with low incomes.241 Thus, boosting cost-sharing obligations imposes disproportionate financial costs on persons with health problems, and disproportionate financial burdens on persons with lower incomes.

Two final steps in this unpacking process are in order, for the onus imposed by increased cost-sharing is not wholly financial. Instead, it may also entail a health burden. The potential health burden derives from the possibility that an individual who must pay to access care is may choose to delay or forgo even necessary care and may suffer negative health consequences as a result.242 Moreover, this scenario may play out even when the immediate financial cost of accessing care, viewed objectively, may not seem terribly burdensome (e.g., a fifteen dollar copay rather than a five dollar copay for visiting a doctor’s office). Because increased cost-sharing shifts insurance risk to the insured, a person deciding whether to visit her own doctor today cannot foresee whether it is more important to save that fifteen dollars for a copay in case her daughter is sick next month.243 In economic terms, the unpredictability of health care needs hinders a consumer’s ability to make informed, rational decisions about the most valued uses of her money. And it stands to reason that persons with chronic conditions – who recognize themselves as heavy, but not entirely predictable, consumers – may be more likely to forgo care for this reason than persons who are in generally good health. Therefore, following this line of reasoning to its conclusion, it is reasonable to anticipate that augmenting

241 Cf. Jacobi, supra note 190, at 404 (making point that tiered plans “stratify” members by enabling wealthy members “to use their greater disposable incomes to see their providers of choice [while] those of lesser means will increasingly face substantial co-payments and coinsurance that will bar them from some providers”).
242 Cf. Gabel et al. supra note 186, at W406 (characterizing consumer-driven health care as a price-based rationing system that will favor high-income over low-income persons “who are more likely to delay care if they lack the resources to pay for it”).
243 Cf. Jacobi, supra note 190, at 406 (“Those of lesser means may spend reluctantly, attempting to husband their spending accounts against the advent of an emergency, thereby foregoing medically appropriate care.”).
cost-sharing obligations will produce a disproportionate burden of negative health effects for both persons with lower incomes and persons with chronic conditions.

b. The distribution of the benefits of HSAs

The foregoing discussion helps elucidate the concern that consumerist measures entailing increased cost-sharing obligations will disproportionately harm unhealthy persons and persons with low incomes. Standing alone, however, this analysis presents only half of the benefits/burdens calculus, for we have yet to consider the substantial tax advantages that HSAs offer to some people, but not others. These tax advantages accrue disproportionately to persons in the highest tax brackets, on both an annual and long-term basis.

In a single year, the money that an eligible individual contributes to an HSA up to the statutory limit is not included in that person’s taxable income. The tax savings afforded by this deduction are significant for someone in the top tax bracket, but it may produce no savings at all for someone whose income is already so low that she pays no taxes. An additional tax advantage flows to persons who accumulate funds in their HSAs over time, rather than draining the account each year to pay for uninsured medical expenses, for funds invested in an HSA grow tax free. Again, in general terms, this favors high income persons whose investment returns ordinarily would be subjected to the highest rate of taxation, but more precisely it favors

244 An increase in cost-sharing or the adoption of tiered plans seems to offer little if any benefit to insureds, except that these measures may forestall the necessity of an employer’s raising employee premium contributions or dropping coverage altogether.

245 Leonard E. Burman & Linda J. Blumberg, HSAs Won’t Cure Medicare’s Ills (Nov. 21, 2003), at http://www.urban.org/url.cfm?ID=1000578 (calling HSAs “[t]oday’s tax cut for rich people”).


A $5,150 HSA contribution, the maximum permitted under the law, would generate a tax reduction of $1,802 per year to a household in the top income tax bracket. The value of the tax benefit would be less than half as much for a moderate-income family. And it would be worth much less than that if the family could not afford to contribute very much into the account.
those who are able to accumulate funds in their account over time. That group is likely to include relatively healthy persons (who have few medical expenses for which they would take HSA distributions) and wealthy persons (who can contribute the maximum allowable to their HSAs, but pay for any medical expenses up to their deductible with non-HSA funds). For this reason, financial planners have already recognized HSAs’ value as tax shelters for wealthy individuals.\(^{247}\) Thus, both the short- and long-term benefits of the tax preferences that HSAs offer disproportionately favor wealthy and healthy individuals.

\[c. \text{Responses by Proponents of Consumerism}\]

Commentators who look upon the consumerist trend with favor offer several responses to these distributional concerns regarding consumerism generally, and HSAs in particular. Rather than emphasizing the burdens that cost-sharing may impose, they view its financial bite as essential to giving Americans incentives to make cost-conscious (and hopefully efficient) health care purchasing decisions and to take greater personal responsibility for the consequences of their health-related behavior.\(^{248}\) The idea is that, if we know we will bear the financial costs of poor health, we may eat better, exercise more, stop smoking, and engage in fewer risky behaviors.

Fans of consumerism also argue that the personal control over health care decisions and the free choice of providers that consumerist health care offers is particularly valuable to and
desired by heavy consumers of health care, such as persons with chronic conditions. In this view, any additional financial costs are offset by the nonfinancial benefits of heightened patient autonomy. Moreover, they note, accurately, that persons who use the most medical care may end up financially better off by establishing an HSA. The MMA requires that HDHPs have a maximum annual limit on out-of-pocket expenses, which may be lower than the limits in some more traditional coverage options. Thus, an HSA combined with an HDHP may provide superior protection against truly catastrophic costs.

Finally, advocates assert that HSAs’ tax preferences are “designed to correct a major flaw in tax law” by “giv[ing] deposits to HSAs the same tax advantages formerly granted only to [employer-paid] health insurance premiums.” They view previous law as unfairly penalizing persons who – rather than participating in an employer’s health plan or seeking to purchase their own individual coverage – simply self-insure by saving to cover their medical expenses. From this perspective, granting tax preferences to HSA contributions is a matter of tax equity between individuals and employers; the regressive effect of the preference is no different from that of other individual tax deductions.

Notwithstanding these responses by consumerist advocates, a strong argument remains that, when predictable distributional effects are considered, healthy and high-income persons

---

249 Gabel et al., supra note 186, at W403 (noting that consumer-driven plan executives “contended that patients with chronic conditions have the potential to gain the most from the increased flexibility offered by their product”).
250 Of course, given the highly skewed character of medical expenditures, this conclusion also throws into question the level of cost savings that consumer-driven plans can offer. As Gabel et al., point out: “… [L]arge deductibles will not tend to reduce utilization for persons who experience expensive episodes of care, or those with chronic diseases, because the annual deductible will be met, and stop-loss insurance coverage will provide for nearly all of the remaining costs.” Id. at W402.
251 See Goodman, supra note 230; see also Cannon, supra note 234.
252 Id. (“The result is a tax law that lavishly subsidizes third-party insurance and severely penalizes individual self-insurance.”). Given the variability and unpredictability of medical expenses, it is questionable whether a rational person would ever choose to forgo insurance coverage altogether in favor of self-insuring. Accordingly, the tax benefits of HSAs are available only to an individual enrolled in a HDHP.
receive a disproportionate share of the advantages flowing from the trend towards consumerism
(and HSAs in particular), while unhealthy persons and low-income persons bear a
disproportionate share of the disadvantages. This skewing of effects on both the benefits and
burdens sides of the ledger shows that consumerist health plans are likely to create real
“winners” and “losers.” In this light, the portrayal of consumerist mechanisms as producing a
discriminatory disparate impact on the unhealthy becomes quite salient, as do the limits of the
protection offered by existing law. While a person with a chronic condition cannot under
HIPAA be excluded from her employer’s health plan or be charged a higher premium to
participate, if her employer adopts consumerist coverage mechanisms, she will likely bear
heavier costs and burdens than will her healthier co-workers.

3. HSAs’ Impact on the Health Insurance Market

Certainly, one might reasonably respond to the foregoing discussion by asking: If
HSAs and other consumerist vehicles are such a bad deal for unhealthy persons, then shouldn’t
they just enroll in more conventional forms of coverage? In the short run, at least, that tactic
may protect unhealthy persons whose employers simply add HSAs or tiered plans as additional
coverage options, but the question raises the third policy concern that exists regarding HSAs.
While less central to consumerism’s discriminatory impact on the unhealthy (and therefore
more briefly examined here), a crux of the debate regarding HSAs’ creation has been their
potential impact on the broader health insurance market, which brings us back to where we
started, with the struggle for the soul of health insurance. 253

253 John Jacobi made this point with respect to tax-favored MSAs, as follows:
The fundamental principled disagreement between proponents and opponents of MSAs concerns
the ends of health insurance. If the purpose of health insurance is to make coverage available
through social pooling of risk, MSAs are anathema, even if they have a limited cost-reducing
Critics of HSAs assert that, even if employers initially maintain other coverage options, the financial benefits that HSAs offer to healthy and wealthy persons will siphon those enrollees from conventional insurance groups, leaving group participants who are on average sicker and poorer. In response, the group insurer will raise its premiums for traditional group coverage, and a cycle of adverse selection proceeds. The fear is that, as premiums for conventional coverage escalate, employers and employees will eventually be unable or unwilling to bear those costs, and employers may simply eliminate conventional coverage. In short, the availability of HSAs – by allowing healthier persons to choose to “go it alone” without facing risks of truly catastrophic costs – may ultimately drive low-deductible coverage out of the market. At that point, insurers offering HDHPs would be free to engage in risk-based underwriting practices that could render even that limited coverage unaffordable or unavailable to high-risk individuals or groups.

In sum, opponents of HSAs forecast that as healthier persons choose to self-insure for non-catastrophic costs, unhealthy persons first will face increased premiums for low-deductible coverage and eventually may lose that coverage option entirely. Thus, from this perspective, the status of HSAs as “just one option among many” is likely to be short lived, so that the

---

effect. On the other hand, if the purpose of health insurance is to accurately assess risk in order to “fairly” charge for coverage, MSAs are appropriate financing vehicles. Jacobi, supra note 19, at 381-382. At the time he wrote, Jacobi viewed MSAs as “outside the stream of the developing insurance system’s structure,” which he viewed as trending towards a social solidarity understanding of health insurance. Today, the tide has reversed, and HSAs are on the leading edge of the current consumerist wave.

Cf. Swartz, supra note 23 (noting that, while adverse selection in the form of a member of a large employer group opting out of employer-sponsored coverage entirely is uncommon, adverse selection is a concern when an employer offers a choice of plans).

See Greenstein & Park, supra note 226; cf. Jacobi, supra note 19, at 380 (articulating this argument with respect to tax-favored MSAs).

Shearer, supra note 14. As Shearer notes, this result could be avoided if some form of risk-adjustment of premiums were required to eliminate any premium advantage that flows solely from the enrollment of healthier than average persons. The MMA, however, contains no mechanism for risk-adjusting HDHP premiums.

See Gabel et al., supra note 186, at W404 (noting that many consumer driven plan executives “admitted to screening out employers that they judged to be high risks”).
distributional effects of HSAs discussed in the previous section will become entrenched and our reliance on health insurance as a mechanism for sharing and distributing risk will be sorely diminished.  

HSA proponents counter that the group insurance sky will not fall simply as a result of HSAs. First, they emphasize the benefits of flexibility and autonomy that HSAs offer to persons with chronic conditions. Because of these benefits, and based on reports by some vendors of health reimbursement accounts (a vehicle similar to HSAs), they suggest that people with health problems may find opening an HSA attractive. If healthy people and unhealthy people open HSAs at the same rate, then the dire predictions of adverse selection will not come to pass. More fundamentally, however, fans of HSAs accept the disproportionate distribution of costs to unhealthy persons as a limited and unobjectionable example of actuarially fair pricing.

D. Research Findings regarding the Effects of Consumerism

As the foregoing description of the policy debates regarding consumerist health care suggests, many of the policy arguments rely on predictions of the real world consequences that will follow the adoption of consumerist approaches to health coverage. But are these

258 James Robinson captures well how the implementation of HSAs represents a significant step away from a social solidarity vision of health insurance:

The principle of collective insurance is that most enrollees will not use the benefits to which they are entitled because they are in good health, thereby leaving their premium payments to help finance the care of unhealthy enrollees with high expenditures. This “use it or lose it” logic contrasts with the “use it or save it” logic underlying the HSA benefit design. Although the HSA product retains insurance principles for catastrophic care (above the high deductible), the savings account itself reflects noninsured prepayment principles, as unspent balances are retained by healthy enrollees rather than diverted to pay for the care of others.

Robinson, supra note 7.

259 See Federal Worker Unions Fight Inclusion of Health Savings Accounts in FEHBP, BNA HEALTH CARE DAILY, Feb. 23, 2004 (quoting the director of the Galen Institute’s Center for Consumer Driven Health Care).  

260 Id.

261 Under the MMA, the combination of an HDHP and an HSA limits the account holder’s maximum out-of-pocket medical expenses. See supra text accompanying note ___.
predictions anything more than partisan “spin” on the relevant questions? Because the rise of consumerist mechanisms is still recent, only limited quantitative or empirical research has been conducted regarding its actual or predictable impact. Nonetheless, several studies have been published of late that bear on the persuasiveness of the foregoing policy arguments.

In an attempt to assess the strength of this Article’s claim that consumerist mechanisms are likely to produce disproportionate adverse effects on unhealthy persons, both in terms of financial costs and burdens and in terms of health burdens resulting from delayed or forgone medical care, this Part will examine the findings of new (and some not so new) research. The first section will describe recent research regarding the distribution of consumerism’s financial costs; the second will describe research relevant to the impact of increased cost-sharing on patients’ access to needed medical care.262

1. Research regarding the distribution of consumerism’s financial costs

Several recent studies have produced findings relevant to consumerism’s distribution of financial costs and burdens. One study by Sally Trude, a scholar at the Center for Studying

262 Because it relates less directly to this Article’s thesis regarding the discriminatory impact of consumerism on unhealthy people, this Part does not examine research regarding the impact of consumerist mechanisms, particularly HSAs or the like, on the health insurance market. A number of analysts have projected these impacts and have predicted that the availability of tax-favored medical spending accounts would result in significantly higher premiums for conventional coverage. See, e.g., Len Nichols et al., Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers (Urban Institute, Apr. 1, 1996), at http://www.urban.org (concluding that the availability of MSAs for healthier individuals would leave those less healthy in traditional plans with much higher premiums and would likely crowd out comprehensive coverage from the market over time); cf. American Academy of Actuaries, The Impact of Consumer-Driven Health Plans on Health Care Costs (Jan. 2004), at http://www.actuary.org/pdf [hereinafter Impact of CDHPs] (stating that “[t]he impact of adverse selection … can potentially worsen over time as high and low users become increasingly segmented and no longer spread costs among both groups”); Shearer, supra note 14 (projecting that if 20% of the healthiest 80% of employees enrolled in an MSA, the average per capita health care costs of those remaining in traditional coverage would increase by 15%). These projections are premised on healthier workers’ disproportionately choosing to open the spending accounts. Advocates for consumer directed plans have relied on reports from purveyors of such plans to challenge that assertion. See Galen Institute Event Dispels Myths about Consumer Choice Care, Press Briefing by Galen Institute, Feb. 18, 2004 (stating that an executive from Definity Health reported that his company was enrolling individuals with significant risk factors), at http://www.galen.org/file_uploads/Feb11_Press.pdf. Ultimately, any reliable data regarding selection effects of HSAs will come only with the passage of time and careful research.
Health Care Change, used actuarial models to estimate the expected out-of-pocket costs for individuals covered by health plans with six different cost-sharing configurations.²⁶³ The study reached the unsurprising finding that as cost-sharing obligations increased, so did enrollees’ average annual out-of-pocket expenditures. Trude emphasized, however, that focusing on average increases “masks the differences between those who use services and those who do not. … Increased patient cost sharing raises out-of-pocket costs more for people with chronic conditions, those in poor health and people with at least one hospitalization.” For example, under a benefit structure with moderate cost-sharing requirements, the average annual out-of-pocket amount was projected to be $236, but persons in poor health would have out-of-pocket costs of $862 on average, and persons with at least one hospitalization would pay $1,066.²⁶⁴

Recognizing that the hardship posed by a particular financial cost depends largely on a person’s income, Trude went on to evaluate how often out-of-pocket spending exceeded ten percent of a person’s income. While only one percent of all persons covered by a plan having no deductible and a $10 physician copayment would experience such high out-of-pocket costs, the figure rose to thirteen percent for all persons whose coverage required a $2500 deductible and a coinsurance rate of thirty percent or higher. Moreover, at this high cost-sharing level, a majority of people in poor health or with at least one hospitalization could be expected to face

²⁶³ Trude, supra note 189.
²⁶⁴ This moderate cost-sharing plan imposed a $20 copay for physician visits, a $150 copay for emergency department visits, and a $250 per day inpatient hospital copay. The health-based out-of-pocket differentials are even larger in benefit structures that more closely resemble HSAs. For example, Trude estimated that the average out-of-pocket costs for all persons covered by an insurance plan with a $1000 deductible and a 20-30% coinsurance rate would be $763, but that the averages for people in poor health and people with at least one hospitalization would be $1883 and $2355, respectively. Under an insurance plan with a $2500 deductible and a 30-50% coinsurance rate, the average payments for all insureds would be $1051, but the expenditures would rise to $2942 and $3768 for persons in poor health and people with at least one hospitalization. Id.
out-of-pocket costs over the ten percent threshold. But for the study’s assumption of a maximum out-of-pocket limit of $1,500 greater than each plan’s deductible, these percentages could well have been higher. Based on her findings, Trude sounds a cautionary note: “As out-of-pocket costs increase… both the financial and medical consequences for seriously ill and low-income people increase.”

In a similar study Dwight McNeill used a simulation and demographic analyses to compare out-of-pocket spending of consumers enrolled in conventional managed care plans with that of enrollees in a consumer-driven plan in order to test the hypothesis that such plans would favor young and healthy persons while disfavoring older and sicker persons. His study divided consumers into four groups – the “healthy,” the “slightly sick,” the “moderately sick,” and the “very sick” – and generated average benefits paid by the insurer and consumer out-of-pocket expenditures for each plan. McNeill found that healthy enrollees saved an average of $584 in out-of-pocket spending by enrolling in the consumer-directed plan, as compared to the conventional plan. By contrast, people in the slightly sick and moderately sick groups lost an average of $250 and $581, respectively. The very sick who enrolled in a consumer-driven plan, however, would save $300 on average. Based on this simulation of gains and losses, together with an analysis of enrollees’ demographic characteristics, McNeill

265 “Under the $2500 deductible scenario, 22 percent of the chronically ill, 53 percent of those in poor health and 66 percent of hospitalized patients would have out-of-pocket costs exceeding 10 percent of income.” Id. Not surprisingly, the percentage of persons bearing oppressive out-of-pocket costs increased as incomes decreased. For example, under the $2500 deductible scenario, only 6 percent of persons whose income exceeded 400% of the poverty level would spend more than 10 percent of their income on health expenses, while 47 percent of persons living in poverty would do so.

266 In other words, according to the design of the study, persons enrolled in the $2500 deductible plan would have their annual out-of-pocket expenditures limited to $4000.

267 Id.

268 McNeill, supra note 236. The consumer-driven health plan used in the study was a $1000 health reimbursement account (HRA) with deductibles of $1,500, $2,500, and $3,500. The maximum out-of-pocket limit for the consumer-driven plan equaled the deductible.

269 McNeill included in his calculation of out-of-pocket expenses the consumer’s premium contribution. Id. at 188.
concluded that his results “support the hypothesis that the healthy, especially young men, are the potential winners with these plans.”

These studies validate worries that cost-sharing increases will have a disproportionate financial impact on unhealthy persons by quantifying the projected level of that impact, and they highlight the costs imposed by high-deductible plans. Because the high-deductible plans that Trude and McNeill used do not exactly match the HDHPs that must accompany HSAs, however, neither study can be read as projecting the precise impact of HSAs. Particularly important is each study’s assumption of a lower annual limit on maximum out-of-pocket expenses than the limit mandated by the MMA. Thus, these studies’ results may underpredict the extent of financial exposure for individuals who establish HSAs. On the other hand, depending on how generously employers subsidize employee coverage via HDHP and HSA contributions, the studies could also overpredict the actual costs borne by employees.

---

270 Id.; see also Nichols et al., supra note 262 (concluding that younger and healthier male workers were more likely to be winners in the switch to tax-favored MSA). In a similar project, the American Academy of Actuaries examined how the adoption of employer-funded health reimbursement accounts coupled with high-deductible health plans, in contrast to an actuarially equivalent PPO, would affect hypothetical health plan participants with low, medium and high health care usage levels. The AAA’s actuarial model found that low users would spend $360 less out of pocket under the CDHP than under the PPO, but that medium and high users would spend $615 and $650 more, respectively. See Impact of CDHPs, supra note 262, at 3-4.

271 As noted above, Trude’s study included a maximum out-of-pocket limit of $1,500 greater than each plan’s deductible, so that the plan with the highest deductible ($2,500) would have a $4,000 maximum. McNeill’s choice of consumer-driven product effectively limited the amount of risk that each consumer bore to the size of the “gap” between exhaustion of the $1000 HRA (funded by the employer) and the deductible. Thus, the most that any enrollee would spend out of pocket for medical care would be $2,500. By contrast, the MMA allows the HDHP to set out-of-pocket limits as high as $5000 for individual coverage (or $10,000 for group coverage). For this reason, McNeill’s result that the very sick actually saved money under a consumer-driven plan may not be replicated under HSAs.

272 For example, if an employer were to purchase HDHP coverage with a deductible of $1,000 and a low out-of-pocket limit for an employee and were also to contribute the maximum amount of $1,000 to that individual’s HSA, the individual would face less financial exposure. Given the current desperation on the part of most employers to minimize their health care costs, it seems improbable that many employers will offer such generous and costly coverage. Cf. Press Release, U.S. Employers See a Role for New Health Savings Accounts in their Benefit Programs, Mercer Human Resources Consulting, Apr. 26, 2004, available at http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1135645 (reporting that in a survey of 991 employers, 39% indicated that, if they were to offer a HDHP with an HSA to employees, they would not contribute any money to the employees’ HSA accounts and 77% said that their contribution amount would be less than the HDHP’s deductible.
Regardless of this imprecision, however, this research bolsters the arguments that consumerist coverage options will tend to hurt unhealthy and poor people while helping healthy and wealthy people.\textsuperscript{273}

Another recent study by Ha Tu used survey data to examine the out-of-pocket cost burdens experienced by people with chronic conditions.\textsuperscript{274} Among all privately insured persons with chronic conditions, Tu found that in 2003 thirteen percent had out-of-pocket costs exceeding five percent of their income. Tu’s findings also confirm the greater incidence of this burden among low-income persons, forty-two percent of whom spent more than five percent of their income on medical expenses. Moreover, the survey’s documentation of dramatic increases between 2001 and 2003 in the percentage of insured persons with chronic conditions experiencing cost burdens suggests the profound impact of employers’ escalation of cost-sharing obligations during that time period.\textsuperscript{275}

2. \textbf{Research regarding Cost-Sharing’s Impact on Access to Needed Care}

Along with the evidence suggesting that the adoption of consumerist mechanisms distributes financial costs disproportionately to unhealthy persons, a body of research demonstrates the impact of high out-of-pocket costs on access to medical care and, by extension, on patients’ health. For example, the survey discussed immediately above also

\textsuperscript{273} See also American Academy of Actuaries, \textit{Medical Savings Accounts: Cost Implications and Design Issues}, Public Policy Monograph (1995), at \url{http://www.actuary.org/pdf/health/msa_cost.pdf} (concluding that if tax-favored MSAs were implemented, the greatest savings would accrue to individuals with only minimal health expenditures and the greatest losses would be experienced by those with substantial health expenditures, primarily pregnant women and older persons).

\textsuperscript{274} Ha T. Tu, \textit{Rising Health Costs, Medical Debt and Chronic Conditions}, Issue Brief. No. 88 (Center for Studying Health System Change, Sept. 2004), at \url{http://www.hschange.org}. The study says that people with chronic conditions are conservatively estimated to include 33\% of the working age population.

\textsuperscript{275} For all privately insured persons with chronic conditions the percentage went from 10\% in 2001 to 13\% in 2004. For low-income (defined as having a family income of less than 200\% of the federal poverty level) privately insured persons with chronic conditions, the percentage went from 28\% in 2001 to 42\% in 2003, an increase of 50\% in just two years. \textit{Id.}
speaks to the question of how high out-of-pocket costs affect access to needed medical care. The survey responses showed that among privately insured persons with chronic conditions, one in six reported that their family experienced difficulties in paying medical bills in the previous year, and the researcher found that the existence of large medical bills had significantly affected access to medical care. Chronically ill insured persons whose families had trouble paying their health-related bills were three to four times as likely as those whose families reported no bill-paying difficulties to delay care, fail to fill a prescription, or simply go without needed care due to cost. These results are consistent with those of another recent survey of households regarding the prevalence of difficulties in paying medical bills and the impact of those difficulties, and these studies suggest that fears of ever-accumulating medical debt may lead even insured people with chronic illnesses to cut back on needed medical care. Moreover, these fears are not idle, in light of recently published research.

276 Among chronically ill insured people with family medical bill-paying problems, 10% went without needed care, 30% delayed care, and 43% failed to fill a prescription, all due to cost. Among chronically ill insured people with no family medical bill-paying problems, the figures were 3%, 8%, and 9% respectively. Id. at 6 and Table 3. This survey’s findings also lend weight to concerns about the impact of large medical bills on access to needed care. Among insured families alone, families reporting medical bill problems were four times as likely as families with no medical bill problems to say that a family member had experienced an unmet medical need in the previous year because of cost, with similar disparities reported regarding delaying care or failing to get needed prescription drugs. Id. at 6 and Table 3.

277 Jessica H. May & Peter J. Cunningham, Tough Trade-Offs: Medical Bills, Family Finances and Access to Care, Issue Brief No. 85 (Center for Studying Health System Change, June 2004), available at http://www.hschange.org. These researchers found that one in seven American families reported problems in paying medical bills in the previous year. Among insured families, more than one in ten reported medical-bill-paying problems, but the rate was significantly higher among families with members having greater health needs: About one in four insured families that had either a member with a hospital stay or an emergency room visit or a member in fair or poor health reported bill-paying difficulties. Id. at 3 and Table 2. But families with high out-of-pocket costs (above $2,000) were the most likely to report bill-paying troubles, with more than one in three having problems, and the researchers noted the role of rising cost-sharing obligations in producing high out-of-pocket costs Id. at 2. This survey’s findings also lend weight to concerns about the impact of large medical bills on access to needed care. Among insured families alone, families reporting medical bill problems were four times as likely as families with no medical bill problems to say that a family member had experienced an unmet medical need in the previous year because of cost, with similar disparities reported regarding delaying care or failing to get needed prescription drugs. Id. at 6 and Table 3.

278 See Tu, supra note 274 (“These results suggest that once families have trouble paying medical bills, concerns about accumulating more bills and further straining family finances may cause many people with chronic conditions to curtail their use of needed medical care.”).
finding that about half of personal bankruptcies have medical causes and that about a third of those filers had health insurance at the time of filing.\textsuperscript{279}

In addition to research into the prevalence and impact of medical debt, several recent studies have focused specifically on how increased copays and tiered pharmacy plans influence prescription drug usage. For example, one study relied on pharmacy claims data to model how doubling the copayment for drugs in eight widely prescribed therapeutic classes affected privately insured consumers’ use of these drugs.\textsuperscript{280} Doubling the copay resulted in substantial spending reductions for all drug classes, but the reduction’s extent varied between different drug classes and different types of patients. Overall, patients with chronic illnesses reduced their usage of medicines prescribed for those conditions somewhat less than the average reduction, but patients with diabetes were as likely as the overall population to decrease their spending. The concern that diabetes patients facing increased copays may suffer ill health effects from cutting back on their medications is at least partially borne out by the findings of a recent study linking cost-related underuse of medications to worse health outcomes among diabetes patients.\textsuperscript{281}

Another study demonstrates that the consumption effects of higher copayments may be particularly pronounced in tiered pharmacy plans.\textsuperscript{282} It found that, while patients’ use of medications for high blood pressure remained stable when copayments increased in a single-tier plan, the overall usage of those drugs declined as copayment amounts increased in multi-


\textsuperscript{280} Dana P. Goldman et al., Pharmacy Benefits and the Use of Drugs by the Chronically Ill, 291 JAMA 2344 (2004).

\textsuperscript{281} See John D. Piette et al., Health Insurance Status, Cost-Related Medication Underuse, and Outcomes Among Diabetes Patients in Three Systems of Care, 42 MED. CARE 102 (2004).

tier plans, and that the consumption of more costly (and more effective) drugs declines as the differential between copayments for generic and brand name drugs increased.\textsuperscript{283} In another study, researchers examined how levels of usage and spending on medications commonly used to treat three chronic conditions changed when two large employer groups implemented two different tiering structures.\textsuperscript{284} These researchers found that employees who faced a more dramatic change in prescription benefits were twice as likely as employees in a comparison group to stop using a particular class of drugs altogether. By contrast, more incremental changes to the other employer’s drug benefit produced only minor effects on the likelihood that a patient would stop using a drug.\textsuperscript{285}

The findings from these studies are admittedly less than conclusive regarding how increasing copayments generally or imposing differential copayments in a tiered benefit plan affects decisions by patients with chronic conditions to purchase prescription drugs. Indeed, the findings suggest that the effects of increased copayments may vary depending on the type of drug, the type of patient, and details of the benefit plan’s structure.\textsuperscript{286} Nonetheless, these

\begin{footnotesize}
\begin{enumerate}
\item[^283] Id. at 231-232. See also Thomas S. Rector et al, \textit{Effect of Tiered Prescription Copayments on the Use of Preferred Brand Medications}, 41 MED. CARE 398 (2003) (finding that tiered copayments were “associated with a significant shift from nonpreferred to preferred brand medications” but noting need for further research regarding clinical effects of these changes).
\item[^284] Haiden A. Huskamp et al., \textit{The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending}, 349 NEW ENG. J. MED. 2224 (2003). One employer made modest changes in its pharmacy benefit, switching from a two-tier plan to a three-tier plan by simply adding a third, higher copay tier without altering the copay in the two existing tiers. The other employer made more dramatic changes by simultaneously moving from a plan with a single copay to a three-tier plan and raising its lowest copay. The study examined the impact on usage of ACE inhibitors which treat hypertension and heart failure; proton pump inhibitors, which treat acid reflux disease; and statins, which are prescribed primarily to reduce cholesterol levels. \textit{Id.}
\item[^285] Id. The comparison group consisted of health plan enrollees not affected by changes in plan design.
\item[^286] Cf. Goldman et al., \textit{supra} note 280 (“Patients do not respond indiscriminately to co-payment increases.”). See also John Hsu et al, \textit{Cost-Sharing: Patient Knowledge and Effects on Seeking Emergency Department Care}, 42 MED. CARE 290 (2004) (finding that patients’ perceptions regarding the size of their insurance copayment for emergency department visits were “strongly associated with avoidance of or delays in emergency care”); Jared T. Lurk et al., \textit{Effects of Changes in patient Cost Sharing and Drug Sample Policies on Prescription Drug Costs and Utilization in a Safety-Net-Provider Setting}, 61 AM. J. HEALTH-SYSTEM PHARMACY 267 (2004) (finding that increases in the copay for prescription drugs were associated with significant decreases in prescription drug utilization).
\end{enumerate}
\end{footnotesize}
studies unquestionably raise a yellow caution flag regarding the likelihood that chronically ill patients may respond to increased copayments by forgoing needed medications. The research teams themselves highlighted this concern:287 One group concluded by stressing the importance of “discourag[ing] the adoption of cost containment systems that encourage poor medication choices in the first place.”288 Unfortunately, while the extant research reaches no definitive conclusions, it does reinforce concerns that significant cost incentives may often lead consumers – even those with life- and disability-threatening conditions – to disregard the venerable proverb: “An ounce of prevention is worth a pound of cure.”

Other research lends further credence to the proposition that consumerism’s cost-sharing burdens create the prospect of harmful health consequences for individuals – consequences that, like the financial costs themselves, are likely to be concentrated among unhealthy persons. In the early 1990s the RAND Corporation conducted a rigorous empirical study into the effect of different levels of health coverage289 on patients’ treatment decisions and health outcomes. Among the study’s numerous findings, a few are particularly relevant to this discussion. First, the researchers found that patients who faced higher cost-sharing obligations did cut back on visits to the doctor or hospital, but not in a way that differentiated

287 See id. ("[S]ignificant reductions in the use of antidiabetic agents or medications to treat dyslipidemia may have short- and long-term clinical consequences."); Huskamp et al., supra note 284 (“The discontinuation of the use of medications such as statins and ACE inhibitors that are needed for the treatment of chronic illnesses raises important questions about potentially harmful effects of formulary changes and the associated changes in copayments"); Kamal-Bahl & Briesacher, supra note 282, at 235 (concluding that their finding suggests “that people with limited personal resources might be forced to do without necessary medications or use less costly (but probably less effective) ones”).

288 Kamal-Bahl & Briesacher, supra note 278, at 235.

289 The levels of coverage ranged from participants enrolled in “free care” plans requiring payment of 5% of the cost of treatment or less, to a catastrophic plan requiring participants to pay 95% of their costs up to an annual maximum of the lesser of $1000 or a percentage of their income. Hall, supra note 235, at 48 (describing RAND Health Insurance Study). Although some HSA account holders may purchase (or receive from their employer) an individual HDHP with a deductible of only $1000, some HDHPs will have higher deductibles, and the law allows them to set their annual out-of-pocket maximum expenditure as high as $5000 (or $10,000 for family coverage). Thus, the catastrophic plan employed in the RAND study is roughly equivalent to the most comprehensive insurance coverage available to HSA holders.
between needed and unnecessary care. Thus, the imposition of cost sharing led to cost-conscious, but not cost-effective, decisions about accessing care. By contrast, once a high-cost-sharing patient consulted a doctor for treatment, that patient received just as much care as a patient without financial incentives. In other words, once care is accessed, decisions about what services to use did not appear to be cost conscious. As Professor Mark Hall summarizes: “These findings confirm that increased cost sharing will lower health care spending, but they cast considerable doubt on whether catastrophic insurance alone will result in improved cost effectiveness. Efficiency entails not just saving money but choosing wisely how to spend it.”

Admittedly, the participants in the RAND study did not have the benefit of internet-based decision support and information tools now becoming available. Thus, that study’s findings may not accurately predict the experience of people enrolled in today’s consumer-driven health plans. Nonetheless, it remains unproven whether these tools enable real patients making real spending choices to make cost-effective decisions. Until that case is made, the apprehension will remain strong that any immediate cost savings generated by consumerism may come at the expense of patients’ health.

Indeed, survey findings confirm that patients’ inability or reluctance to attain needed care may carry adverse health consequences. According to the results of a 2002 survey, among insured Americans who reported postponing medical care that they or their family needed within the previous year, thirty-six percent attributed a temporary disability (including significant pain and suffering) to the delay, while fourteen percent said it caused a long-term

290 Id. at 49.
291 Cf. Robinson, supra note 181 (“The headlong retreat of the public and private sectors from the thankless job of controlling costs is delegating to the consumer a very broad array of tasks for which many are not prepared”).
292 See Hall, supra note 235, at 48 (reporting that RAND study found that “[u]nder some measures of health status, participants were demonstrably worse off as a result of greatly increased cost sharing, although not to a very dramatic extent” and that “these effects where [sic] more pronounce for low-income participants”).
disability. Those with insurance who failed completely to obtain needed care were even more likely to report serious consequences.293

Finally, the large body of research on the health effects of being uninsured also sheds light on how large cost-sharing obligations are likely to affect unhealthy persons. Of course, people who have coverage through consumerist mechanisms are not in fact uninsured. But because of their heightened exposure to insurance risk for their medical needs, some people with consumerist coverage may share important characteristics with the uninsured, notably a reluctance to seek care, difficulty in accessing care, and problems in paying for care. In other words, high cost-sharing obligations may in some cases render people underinsured.

Far less scholarly and political attention has been paid to the challenges faced by the underinsured than to the problems of the uninsured. In general terms, “the underinsured” refers to persons who have some health insurance, but whose coverage is inadequate to protect them against excessive out-of-pocket costs if they experience a catastrophic level of medical need.294 The role that substantial cost-sharing obligations play in rendering insurance coverage inadequate is well recognized.295 As former Secretary of Health and Human Services Donna

294 Cf. id. (“The underinsured have health insurance but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services.”); Rashid Bashshur et al., Defining Underinsurance: A Conceptual Framework for Policy and Empirical Analysis, 50 MED. CARE REV. 199, 206 (218) (asserting that underinsurance exists when out-of-pocket medical costs result in a serious financial burden or coverage limitations hinder the insured’s ability to access needed care). Although no single definition of underinsurance exists, a commonly cited approach finds that people are underinsured if their coverage exposes them to out-of-pocket expenses exceeding ten percent of their family income in the event of a catastrophic illness. See Pamela Farley Short & Jessica S. Banthin, New Estimates of the Underinsured Younger than 65 Years, 274 JAMA 1302 (1995).
295 See, e.g., Kevin T. Stroupe et al., Does Chronic Illness Affect the Adequacy of Health Insurance Coverage?, 25 J. HEALTH POL. POL’Y & L. 309, 314-15 (2000) (classifying lower-income individuals as underinsured based on deductible levels and coinsurance rates); Kaiser Commission on Medicaid and the Uninsured, supra note 293 (noting the potential for uncovered services and cost-sharing to mount up and become onerous); John Dorschner, Underinsured: 29 Million of Us Don’t Have Adequate Coverage, MIAMI HERALD, Oct. 20, 2003 (asserting that the problem of the underinsured will worsen as employers attempt to control costs by continuing to increase
Shalala described the “big crisis” of the underinsured, high cost-sharing obligations mean that the underinsured “can’t afford to use their insurance.”296

Herein lies the affinity between the uninsured and the underinsured: Like the uninsured, persons who have inadequate coverage are more likely to delay obtaining needed care or even forgo it entirely.297 And a substantial body of research demonstrates that receiving too little or delayed medical care harms uninsured persons. In its report, Care Without Coverage: Too Little, Too Late, a committee of the Institute of Medicine reviewed that research and found: “The quality and length of life are distinctly different for insured and uninsured populations, with worse health status and shortened lives among uninsured adults.”298 The committee found specific evidence of harmful effects across a range of health services, including preventive services, cancer care, and care for chronic diseases.299 While confining its focus to the health effects of uninsurance, it acknowledged that being underinsured posed similar, though generally less severe, problems.300 Accordingly, to the extent that consumerism’s elevated cost-sharing obligations leave unhealthy people

deductibles and copays). Other health insurance policy features that may render coverage inadequate include permanent pre-existing condition exclusions, see Stroupe et al., supra at 314, lack of out-of-pocket maximum limits, id., failure to cover prescription drugs, see Claudia L. Schu et al., Lack of Prescription Coverage among the Under 65: A Symptom of Underinsurance, Commonwealth Fund Issue Brief (Feb. 2004), available at http://www.cmwf.org, and failure to cover particular expensive treatments, see Amy Dockser Marcus, Sorry, Only Half of That Surgery is Covered, WALL ST. J., Mar. 12, 2003, at D1.

Dorschner, supra note 295 (quoting Shalala’s remarks).

Cf. id. (quoting researcher from the Kaiser Family Foundation as stating that “[b]asically, it’s the same problem as the uninsured”).

COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 7 (2002).

Id. at 7-13.

Id. at 5; COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE 1 (2001).
underinsured, we have good reason to anticipate that those persons will suffer negative health consequences.301

Taken together, the research described in this Part lends significant force to the argument that consumerist approaches to health coverage can be expected to disproportionately affect unhealthy persons, with the ramifications including burdensome medical debt and avoidable poor health outcomes, including unnecessary hospitalizations, preventable disability, and shortened lives.302 Undoubtedly, the many questions regarding the effects of consumerism justify further careful research; the research to date is by no means definitive. Nonetheless, the existing research strongly suggests that any cost savings that consumerism generates for employers and healthy individuals will come largely at the expense of unhealthy persons. The next Part will briefly examine possible bases for objecting to this discriminatory burden.

VI. Connecting the Dots … and Minding the Gaps

This Article’s fundamental focus has been to consider how the law addresses the phenomenon that, if permitted, health insurers will be least willing to provide health insurance to the people who need it the most – people with health problems. As explained in the previous sections, the justification for avoiding the risk of covering unhealthy people lies in an actuarial fairness vision of health insurance, which permits insurers to screen out or charge more to high-

301 The overlap between the underinsured and people enrolled in the types of benefit plans described in this Article has not been quantified, and its potential size should not be exaggerated. Certainly, without data, we cannot assume that most people enrolled in such plans are underinsured.

302 A recent report relies on case studies to demonstrate how health insurance problems, including high cost-sharing, can lead to severe medical and financial consequences for people with diabetes. See Karen Pollitz et al., Falling through the Cracks: Stories of How Health Insurance can Fail People with Diabetes (Geo. U. Health Policy Inst. & Am. Diabetes Ass’n, Feb. 8, 2005), at http://www.healthinsuranceinfo.net/diabetes_and_health_insurance.pdf. The occurrence of preventable complications has serious societal ramifications as well. In March 2005, a federal agency estimated that the U.S. could save almost $2.5 billion each year by preventing diabetes-related hospitalizations. See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, Economic and Health Costs of Diabetes (March 2005), at http://www.ahrq.gov/data/ hcup/highlight1/high1.htm.
risk individuals. This vision, however, conflicts directly with a social solidarity vision of insurance, which emphasizes the social good that flows from the spreading of risk across the sick and well alike. By examining a broad range of antidiscrimination laws that constrain insurers’ or employers’ ability to classify risks on particular bases, Part III demonstrates that our society swears no absolute allegiance to principles of actuarial fairness. Instead, we are willing to provide groups with varying levels of protection against discrimination, but lack a consistent justification for doing so. In at least some instances, though, the law even protects groups against the discriminatory impact of particular coverage packages.

In the case of health status discrimination, reforms enacted during the 1990s embodied social solidarity goals of increasing the ability of people with health problems to afford and maintain coverage, but these measures remained limited in scope. Moreover, laws prohibiting direct forms of health-status-based risk classification may have helped generate new coverage vehicles that instead discriminate against unhealthy people indirectly, by impact. Part V describes the consumerist trend in health coverage and presents evidence that the shifting of insurance risk that consumerist coverage mechanisms entail can be expected to disproportionately and negatively affect people with health problems. These effects are not limited to forcing unhealthy people pay more money, but are likely to include stranding unhealthy people with even heavier burdens of ill health.

My central goal herein has been twofold: to make the case that consumerist coverage mechanisms can be expected to mete out financial and health disadvantages in a lopsided fashion, with unhealthy people feeling the brunt of the disadvantage, and to demonstrate that lawmakers have in numerous other instances been willing to intervene to protect groups of individuals from discrimination in health insurance. In other words, the Article seeks to show
that a problem (the discriminatory impact of consumerist vehicles on unhealthy people) exists and can be expected to grow, and that our society has been willing to address other, similar problems in the past. I recognize, however, that describing the greater burden imposed on unhealthy people as a problem depends on my own intuitions regarding fairness, and that policy prescriptions need a basis far sturdier than intuition. While it is beyond the scope of this Article to explore fully the analytical foundations for objecting to this unequal burden, I will close by sketching two possible, related approaches.

First, as this Article’s title suggests, we might approach the plight of the unhealthy with respect to health insurance as essentially a problem of discrimination, as that term is commonly used in the context of civil rights legislation prohibiting discrimination in employment and other contexts. Indeed, we have seen that some of the existing laws regulating health insurance discrimination are but pieces of larger efforts to end the unequal treatment of historically disadvantaged groups and extend to discriminatory impacts. On even brief reflection, however, it seems doubtful that a civil rights justification would adequately sustain policy initiatives to limit consumerism’s impact.

First, any civil rights law to advance the health insurance rights of “the unhealthy” would need to define precisely which persons can claim those rights, and this task alone might prove insurmountable. More fundamentally, however, it is unclear to what extent the unhealthy have, as a group, suffered a history of discrimination by virtue of being unhealthy. Indeed, persons with chronic medical conditions (who are likely to constitute a large portion of the unhealthy) are effectively the product of modern medical advances permitting people with

---

303 While this Article has used the term “the unhealthy” as shorthand to describe a large group of people who, for widely varying reasons, can be expected to generate large medical expenses, see supra note 6, legislation providing legal rights to members of this group would require far more definitional rigor.
conditions like diabetes, hypertension, and heart disease to live for long periods with medical assistance. Nor is it clear that the unhealthy suffer substantial discrimination today in contexts other than health coverage. Of course, demonstrating a significant intersection between ill health and racial or ethnic minority status could conceivably bolster regulatory proposals to eliminate or mitigate the discriminatory impact of consumerism, but such proposals would seem to be both under- and over-inclusive. Finally, an effort to limit the disparate impact against the unhealthy that consumerist coverage vehicles produce would have to contend with the assertion that any disparate impact is justified by some sort of “actuarial necessity,” akin to the “business necessity” that justifies a disparate impact in the employment setting. In sum, notwithstanding the rhetorical value of invoking the civil rights heritage, unhealthy people’s current health insurance predicament does not seem at root to be a problem of existing social inequality.

Instead, concerns sparked by the growth of consumerism are more precisely concerns that its skewed allocation of the benefits and burdens will create and aggravate social inequality. The objection is essentially that schemes imposing financial and health burdens on unhealthy persons, while offering financial benefits to healthy and wealthy persons, are inconsistent with leading theories of distributive justice. These schemes appear patently inconsistent with Rawls’ “difference principle,” which calls for a distribution of goods that

304 See Hellman, supra note 105, at 89 (making this point with respect to justifications for genetic discrimination laws). A similar attempt to highlight the overlap between the unhealthy and people with disabilities is likely to be fruitless, both because the Supreme Court’s narrow interpretations of disability have shrunk that overlap and because the lower courts’ narrow application of the ADA to insurance has deflated the law’s significance in that context. See supra Part IIIB3.

305 Cf. Glenn, supra note 16, at 298-99 (noting the ability of insurance to create social and economic inequalities).
maximizes the well-being of the most disadvantaged. Moreover, consumerist vehicles cannot easily be defended against charges of distributive injustice by assertions that the financial and health burdens complained of are simply the results of natural endowments of poor health. Rather, they must be seen as steps away from earlier forms of health coverage – the baseline, so to speak – in which individuals bore relatively little insurance risk for their medical expenses.

Thus, distributive justice arguments appear to provide a more fitting basis for objecting to consumerism’s discriminatory impact on the unhealthy, but a number of issues with this approach remain to be worked out. Most prominently, debates about the contours and persuasiveness of distributive justice arguments remain contentious. For example, although many would agree that good health is morally arbitrary and not somehow deserved, sharp disagreement exists over the extent to which justice entitles the healthy to reap financial benefits from their undeserved good fortune. Furthermore, some would argue that justice permits holding individuals personally responsible for the positive and negative results of their chosen health-influencing behaviors; in other words, some among the unhealthy may deserve their ill health and its consequences. Finally, even if we could reach some level of agreement that the disproportionate financial and health burdens foisted on the unhealthy by consumerism are unjust, lengthy conversations about the proper remedial steps would ensue.

---

306 JOHN RAWLS, A THEORY OF JUSTICE 75-80 (1971). See also NORMAN DANIELS, JUST HEALTH CARE 46 (1985) (noting that justice requires the use of “resources to counter the natural disadvantages induced by disease”); Korobkin, supra note 154 (suggesting how Rawls would evaluate claims to a positive right to health care).
307 Cf. Orentlicher, supra note 182, at 419-420 (noting a societal choice “to allocate medical resources on the basis of wealth rather than medical need of the likelihood of receiving benefit”).
308 See Hellman, supra note 11, at 400-402 (contrasting views of Rawls and Nozick).
309 Cf. Health Care Study Group, supra note 16 (noting this sentiment, as well as the difficulty in applying it fairly and efficiently).
310 The classic debate is whether redistributive goals are better advanced through regulation or by tax-and-transfer schemes. See Hellman, supra note 11 (noting the debate with respect to the use of domestic violence information.
VII. Conclusion

As employers seek to contain their health care costs and politicians create coverage mechanisms to promote individual empowerment, people with health problems increasingly are forced to shoulder the load of their own medical costs. The trend towards consumerism in health coverage shifts not simply costs, but also insurance risk, to individual insureds, and the results may be particularly dire for people in poor health. A growing body of research lends credibility to the contention that unhealthy people will disproportionately pay the price for consumerism, not only in dollars, but in preventable disease and disability. In short, consumerist coverage vehicles discriminate against the unhealthy by impact, and existing laws protecting against health status discrimination do not address impact discrimination. Although some might attempt to justify this impact by invoking the principle of actuarial fairness, a review of the various laws prohibiting discrimination in health insurance reveals our society’s willingness to elevate other social values above actuarial fairness. This Article calls for more careful scrutiny of consumerism’s effects and a sustained dialogue regarding the limits a just society should place on the burdens borne by unhealthy persons.