Healthism, Health Care Rights, and the Affordable Care Act

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Jessica L. Roberts, "*H*ealthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 **U. Ill. L. Rev.** 1159 (2012).

Jessica L. Roberts's recently published article, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, offers a provocative, thoughtful rebuttal to the antidiscrimination rhetoric surrounding the Patient Protection and Affordable Care Act ("ACA"). Some of the ACA's most popular reforms, namely, the ban on preexisting condition exclusions, guaranteed issue and renewal, and community rating were touted as eliminating insidious health insurance industry practices that—in then-candidate Obama's words—"discriminat[e] against those who are sick and need care the most."[1] Roberts cites another commentator who characterized the ACA as a "civil bill of rights for the sick."[2] But, as Roberts aptly notes, the practice of "discriminating" against the insured on the basis of health conditions and expected risk is endemic to commercial health insurance underwriting.[3]

For her titular concept, Roberts refashions the term "healthism,"[4] defining it "as discrimination on the basis of health status."[5] She argues that despite the political rhetoric surrounding federal health reform and ACA provisions intended to eliminate "healthism," other provisions of the law in fact operate as proxies for health status discrimination. She notes that previous federal statutes intended to eradicate healthism similarly fell short of this goal.[6] The ACA, on its face, surely does eliminate discrimination, first, by requiring "guaranteed issue" and, second, by requiring "community rating." Guaranteed issue means that health insurers must sell a policy to any individual, regardless of preexisting conditions,[7] and community rating means that the insurer cannot discriminate in the price of the policy based on preexisting conditions or other health status indicators.[8]

But Roberts points to four notable exceptions to those requirements, which she concludes operate as subterfuge for "healthism": the ACA expressly allows insurers to vary premium rates based on (1) age, (2) geographic area, (3) tobacco use, and (4) participation in approved workplace wellness programs. Each exception, she contends, implicitly represents health status. Older people tend to use more health care than younger people. People in congested urban areas (or medically underserved rural areas) tend to have worse health status. Similarly, allowing rate variation based on tobacco use and wellness program participation, she contends, are proxies for health status discrimination.

That sounds right, but the latter two exceptions seem not so much proxies as express congressional endorsement of "healthism." Surely the reason that Congress allowed premium rate variation based on tobacco use and participation in wellness programs was precisely because those behaviors do, in fact, strongly correlate with worse (in the case of smoking) or better (in the case of wellness programs) health status. The ACA's retention of at least those two forms of health status discrimination somewhat undermines Roberts's starting premise that the goal of the ACA was to eliminate healthism. But setting aside my quibble with Roberts's characterization, a more interesting question to me (and the focus of my new project on "individual responsibility rating") is why Congress expressly allowed insurers to continue discriminating based on those particular health-related habits or activities, which seem largely in individuals' voluntary control. One answer, as Roberts notes elsewhere in her illuminating discussion of discrimination, is that lawmakers tend to treat "mutable" and "immutable" conditions differently.

Roberts's convincing bottom line is that the antidiscrimination frame is both descriptively inaccurate of the ACA and normatively unproductive for health reform. Instead, she offers a universal rights frame. More accurately, the goal of the ACA, she suggests, should be seen as "ensuring a minimum level of care for all Americans." Under this frame, she views the ACA's controversial individual mandate,[9] along with the essential health benefits package,[10] as embodying a sort of universal right. It is counterintuitive, yet intriguing, to recast the mandate as some type of affirmative right to health care, especially when it compels private purchase of health insurance, rather than guaranteeing that the government will provide health insurance to all. She acknowledges that this "right" falls well below a cognizable, affirmative claim to health care but at least expresses a moral norm that everyone is "entitled" to a certain basic level of health insurance coverage. While I am not entirely convinced that the ACA embodies this rights framework or that the belief in a right to health care is widely accepted, I do agree with Roberts that the antidiscrimination frame is flawed.

The article concludes by briefly suggesting future directions for health reform, consistent with Roberts' universal rights frame. She points to insurance risk adjustment,[11] nonprofit health insurance,[12] and publicly financed health care as desirable next steps. With those proposals, Roberts just scratches the surface of deep veins of theory and policy, which she may tap in her later work, including fragmentation of the health care system,[13] definition of a universal right to health, and comparative models of social insurance.

In addition to providing rich food-for-thought for other scholars (myself included) and a host of possible further research projects for herself, one of the article's most welcome, useful contributions is Roberts's clear, plain-language description of the health insurance market. She methodically and comprehensively explains the operation of commercial health insurance, defining key concepts, such as risk-pooling, adverse selection, the "death spiral," information asymmetries, community versus experience rating, deductibles, coinsurance, and copayments, providing easy-to-understand examples of each term. This descriptive background portion of the paper, alone, would be a welcome mini-treatise on health insurance for my students, who often struggle to grasp these concepts. All in All, *Healthism*, is an exciting project from a terrific emerging scholar.

1. See Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 **U. Ill. L. Rev.** 1159, at 1161.
2. Roberts, *supra* note 1, at 1187 (citing Robert K. Ross, M.D., President and CEO of The California Endowment).
3. I might go further to note that requiring insurers to cover persons already diagnosed with illnesses defies the very concept of insurance. Black's defines "insurance" as: "A contract whereby one undertakes to indemnify another against loss, damage, or liability arising from an *unknown or contingent event* and is applicable only to some *contingency or act to occur in the future*" (emphasis added). A person who is already sick faces no unknown event and almost certainly needs health care in the present. Because health insurance as it has evolved in the United States operates more as pre-payment for health care than protection against unknown risk, it has been analogized to "insurance for haircuts."
4. Roberts notes that "heathism," along with the term "medicalization," has been used pejoratively to characterize stronger government involvement in prescribing and proscribing healthy activities and imposing healthy lifestyle norms. See generally Robert Crawford, *Healthism and the Medicalization of Everyday Life*, 10 **Int'l J. Health Servs.** 365 (1980).
5. Roberts, at 1171.
6. She discusses the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which eliminates health status discrimination for group health plans, including most employer-based plans, and the Genetic Information Nondiscrimination Act of 2008 (GINA), which prohibits

discrimination in health insurance and employment based on genetic information.
7. ACA § 2705.
8. ACA § 2701. The ACA's community rating requirement is "modified" because it does allow rate variation based on certain factors, discussed next. The ACA also allows plans to charge different premiums for an individual versus a family policy.
9. ACA § 1501.
10. ACA § 1302(b)(1).
11. See generally Mark A. Hall, Risk Adjustment Under the Affordable Care Act: A Guide for Federal and State Regulators, Issue Brief, The Commonwealth Fund, May 2011 (describing the ACA's risk adjustment provisions, designed to protect commercial health insurers that attract a disproportionate share of high risk enrollees).
12. The ACA's medical-loss (MLR) ratio aims, to some degree, to rein in health insurance profits. See ACA § 10101, amending PHSA § 2718. Effective January 1, 2011, health insurers in the individual and small group market are required to spend at least 80% of premium revenues on medical care and quality improvement, and only 20% on overhead, profits, commissions, and other non-claim expenses. In the large group market, the ratio is 85% to 15%.
13. See generally The Fragmentation of U.S. Health Care: Causes and Solutions (Einer Elhauge, ed., 2010).

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