Legal Solutions in Health Reform:
Insurance Discrimination on the Basis of Health Status:

EXECUTIVE SUMMARY

INTRODUCTION:
Actuarial underwriting, or discrimination based on an individual’s health status, is a business feature of the voluntary private insurance market. The term “discrimination” in this paper is not intended to convey the concept of unfair treatment, but rather how the insurance industry differentiates among individuals in designing and administering health insurance and employee health benefit products. Discrimination can occur at the point of enrollment, coverage design, or decisions regarding scope of coverage. Several major federal laws aimed at regulating insurance discrimination based on health status focus at the point of enrollment. However, because of multiple exceptions and loopholes, these laws offer relatively limited protections. This paper provides a brief overview of discrimination practices, the federal law, and federal reform options to manage discriminatory practices in the insurance and employee health benefit markets.

POTENTIAL SOLUTIONS:

Long-Term Solutions
- Establish a nationwide group purchasing mechanism in which all residents could be automatically enrolled with opt-out provisions for those covered through employer-sponsored plans or with coverage through public programs such as Medicaid.
- Require entities that sell health benefits products to meet minimum coverage standards such as a benefit design modeled after the Federal Employee Health Benefit Plan. Allow broader coverage through an exceptions process similar to that used in Medicare Part D in the case of individuals who need benefit different from greater than that specified in the plan design and who can provide medical evidence to support the claim.
- Require payment plans to take into account the higher level of care associated with treating individuals with complex underlying medical conditions and thereby avoid the refusal to treat more complex patients.
- Amend Medicaid to create more explicit standards regarding provider payment levels.
- Revise Medicaid to create coverage for benefits that are necessary to treat and manage serious and chronic health conditions whose treatment requires services and benefits not covered through the nationwide group purchasing pool. In this way, people who receive standard coverage through the pool could still obtain supplemental coverage for serious and chronic conditions through Medicaid.

Interim Solutions

Amend or Expand Existing Federal Laws
- Expand HIPAA’s prohibition on pre-existing condition exclusions to apply to all persons seeking coverage, not just those with requisite “creditable coverage.”
- Enact legislation to subsidize COBRA benefits and enable people to remain in an employer group.
- Expand Medicaid to any child or adult unable to obtain coverage through the individual market.

Expand Protections through Agency Regulations or Interpretation
- Impose limits on the extent to which insurers and plans can impose treatment limits that differentiate between covered physical and mental health conditions.
- Rigorously oversee state compliance with HIPAA’s non-discrimination and guaranteed issue requirements.
RELEVANT LAW:
The following federal laws focus on addressing discrimination based on health status that occurs at the point of enrollment, but only tackle risk management techniques linked to coverage to a limited degree.

- **Title VII of the 1964 Civil Rights Act** prohibits intentional and disparate impact discrimination in the form of lesser benefits based on race; and prohibits both greater charges and provision of lesser-value benefits based on sex.

- **Age Discrimination in Employment Act (ADEA)** permits employers to offer older workers lesser health benefits through the use of an “equal benefit or equal cost” test.

- **Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973** prevent any employer-sponsored plan or public insurance program operating in either the group or individual market from refusing to enroll a qualified person with a disability. Title II of the ADA and Section 504 cover public and federally-assisted programs, but protections are limited to access to any coverage, rather than the quality of coverage. As long as limitations on coverage are applied to all recipients, despite the fact that such limitations have a disproportionate impact on people with disabilities, they are upheld. ADA contains an “insurance safe harbor” that protects risk classification as permissible activity and means that the ADA does not reach the content of insurance.

- **Health Insurance Portability and Accessibility Act (HIPAA)** prohibits application of pre-existing condition exclusions in group health insurance as long as the individual has had at least 18 months of creditable coverage. But coverage design, as long as applied uniformly, can contain specific limitations and exclusions. HIPAA allows employers or insurers to offer premium discounts or modified cost sharing in exchange for participation in a bona fide wellness program.

- **Genetic Information Non-discrimination Act (GINA)** prohibits employee health benefit plans and insurers in both the group and individual markets from using genetic information to determine the level of premiums to be charged.

- **Mental Health Parity and Addiction Equity Act** applies to plans and products that cover mental health or substance abuse disorder benefits and requires parity in financial requirements (deductibles, copayments, and coinsurance) and treatment limitations (limits on number of visits and days of coverage) for mental and physical illness.

- **Newborns and Mothers Protection Act** requires plans that offer hospital stays in connection with childbirth to provide a minimum stay following delivery.

- **Women’s Health and Cancer Rights Act (WHCRA)** applies to group health plans that provide mastectomy benefits and requires plans to cover breast reconstruction, prostheses, and other treatments addressing complications of a mastectomy.

- **Employee Retirement Income Security Act (ERISA)** establishes “full and fair hearing” provisions and standards for timeliness and conduct of internal appeals of health benefit denials.

CONCLUSION:
Congress has limited the use of actuarial techniques that exclude persons from group insurance altogether. However, Congress has only modestly tackled risk management techniques linked to the actual content and administration of coverage. The use of discriminatory practices based on health status to limit coverage is especially apparent in the individual insurance market. If the federal government wishes to move in the direction of sharing health risks more broadly, next steps will include creating larger risk-pooling groups and curbing the ability of insurers to limit adequate coverage based on health status.