Op-Ed

The Affordable Care Act and Civil Rights: The Challenge of Section 1557 of the Affordable Care Act

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IN MAY 2016, THE OBAMA ADMINISTRATION ISSUED LONG-awaited regulations implementing §1557 of the Affordable Care Act (ACA).¹ Broad in scope, §1557 does what virtually no civil rights law has done before: it extends the principle of nondiscrimination to the content of health insurance, that is, coverage standards themselves. At the same time, however, the challenge of insuring nearly all residents within the world's costliest health care system, coupled with long-standing insurer traditions designed to shield companies, sponsors, and policyholders from excessive costs, underscores the many complexities involved in balancing coverage with equity.

Section 1557 provides that no individual shall be barred from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, any part of which receives federal financial assistance. The concept of federal financial assistance reaches not just grants or public insurance payments but also tax credits, government payment subsidies, and contracts of insurance. The principle of discrimination incorporates the cornerstones of US civil rights law—Title VI of the Civil Rights Act of 1964 (race, color, and national origin), Title IX of the Education Amendments of 1972 (sex), §504 of the Rehabilitation Act of 1973 (disability), and the Age Discrimination Act of 1975 (age).

The reach of existing civil rights laws into health care has been considerable and transformative in its own right. But these laws were generally interpreted as falling short of reaching health insurance coverage itself.² The US Supreme Court ruled that disability antidiscrimination law does not bar state Medicaid programs from imposing across-the-board limits on hospital coverage, even though such limits may leave people with disabilities without access to adequate treatment. Lower courts have similarly ruled in the past that disability nondiscrimination law does

not prohibit private insurers from virtually excluding certain conditions such as HIV from their terms of coverage or from offering lesser coverage for people with mental illness. The Mental Health Parity and Addiction Equity Act of 2008 and the ACA's essential health benefits requirements may, under their own terms, halt some of these practices.

Section 1557 takes the matter of health equity still further. By its terms, §1557 reaches the entire health insurance market.³ Implementing regulations⁴ define its scope to mean insurance policies sold to individuals in the Marketplace where refundable tax credits are available and insurance policies sold to small and large groups by insurers that also participate in public insurance programs such as Medicaid, Medicare, and the Children's Health Insurance Program. Even when such insurers are acting as administrators of self-insured employer-sponsored plans, the final rules treat them as entities that receive federal financial assistance because of their other lines of work. In short, the terms of §1557 mean that landmark federal civil rights laws now permeate the entire US health insurance system.

In broadening the concept of civil rights to reach the content of all forms of coverage, the administration, which took 6 years to issue the rules, has nonetheless been bold, if we consider the extent to which the subject of health insurance was previously excluded from the discussion of civil rights and health care. At the same time, the Administration has moved with caution. Indeed, the final rules are large in scope but short in detail.

As a general matter, the rule bars insurers from denying, canceling, or refusing to issue or renew plans or policies; from limiting coverage of claims; from imposing additional cost sharing or other limitations or restrictions on coverage on the grounds of race, color, national origin, sex, or disability; or from implementing discriminatory marketing practices or "benefit designs." But while the rules are relatively specific where discrimination based on an individual's status as a transgendered person is concerned (prohibiting "categorical" coverage exclusions or limitations for health care related to gender transition), they otherwise set no specific content standards. The preamble accompanying the rules does hint at examples, such as denying medically appropriate surgery to adults with developmental disabilities while covering surgery for adults without such disabilities. But the administration also makes clear that the US Department of Health and Human Services Office for Civil Rights (OCR), which is responsible for administering the rules, will establish

additional broader regulatory standards only as its investigations into specific practices move forward. This will obviously take years, especially given the budget constraints under which OCR has historically operated. But the final rules also suggest broad enforcement, noting that the fact that a separate law appears to sanction a particular practice, such as employer wellness programs that penalize employees for not achieving certain health goals, will not spare the practice from additional civil rights scrutiny. (Ironically, the administration simultaneously issued separate rules that expressly allow wellness programs whose terms were previously considered to violate the Americans with Disabilities Act.)⁵

Health insurance today is a vastly complex enterprise, designed to balance the ACA's most basic requirements—that nearly all Americans have access to affordable coverage regardless of health status, with statutory annual patient cost-sharing limits—against the equally strong budgetary imperatives flowing from the health care system's excessive costs. Insurers must balance access against cost, and, increasingly, they are doing so through coverage terms infused with specific benefit exclusions and limitations, enormous deductibles that make exceptions for selected services, elaborate cost-sharing tiers, and exclusionary provider networks. Furthermore, insurers administer plans using unpublished, discriminatory treatment guidelines that select certain patients and conditions for automatic denial.

The question thus becomes how to overlay civil rights standards onto modern health insurance models. Section 1557 commands a just and equitable approach to coverage. Yet the cost of health care in America, coupled with the selective practices of the insurance industry, has forced plans into designs that are inherently discriminatory, not to mention absurd and incomprehensible. Just how outlandish insurance content can be is frequently shielded from view until a particular challenge reaches the courts, where the legal process can shine a light on what is happening.

How do we begin in this morass? One starting point might be the medical necessity definitions that insurers use in their plan documents. Definitions that effectively tie coverage to conditions from which patients can “recover” by their very terms exclude people with long-term disabilities, as do exclusions that bar coverage unless treatment will “restore” prior functioning. Another point of investigation might be provider incentive plans that sanction or exclude providers that fail to achieve certain population-wide performance benchmarks because the

populations they serve are disproportionately members of racial and ethnic minority groups that carry higher health burdens and are sicker to begin with and thus have a much further road to health to travel.

It will take years to flesh out the meaning of a civil rights framework for health insurance in a nation that has persistently failed to come to grips with the costliest health care on earth and that has essentially embedded commercial insurance norms into the job of allocating health resources across a patient population. But now that §1557 has reached a full implementation stage, we have at least begun the process.

References

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5. 82 Fed Reg 31126 (2016).

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