

NOTE

STIGMATIZED SILENCE: THE EXCLUSION OF HIV AND AIDS SUFFERERS FROM THE “OBAMACARE” LEGAL LANDSCAPE

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The continued presence and growing rates of individuals infected with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in the United States has come to reflect an epidemic of significant proportion. Unfortunately, federal legislation has been eerily silent regarding the establishment of protections against health status-based discrimination for asymptomatic HIV and AIDS sufferers. Congress has done little to change this reality, despite the institution of major healthcare system and insurance reform by the Obama Administration in 2010. This Note argues that “Obamacare” and the two laws that define it—the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010—fail to address asymptomatic HIV and AIDS infection as a significant source of health status-based insurance discrimination. As a result, these individuals continue to be ignored, subject to the ambiguities of “disability”-based legislation, and relegated to the status of a legally invisible class.

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INTRODUCTION

American citizens infected with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)¹ hold a tenuous place among the substantively ambiguous concentric circles of the

¹ See generally *Bragdon v. Abbott*, 524 U.S. 624, 633–37 (1998) (discussing the “predictable and . . . unalterable course” of HIV infection). Justice Kennedy, for the majority, outlined the physiological character of HIV:

Once a person is infected with HIV, the virus invades different cells in the blood and in body tissues. Certain white blood cells, known as helper T-lymphocytes or CD4+ cells, are particularly vulnerable to HIV. The virus attaches to the CD4 receptor site of the target cell and fuses its membrane to the cell’s membrane. HIV is a retrovirus, which means it uses an enzyme to convert its own genetic material into a form indistinguishable from the genetic material of the target cell. The virus’ genetic material migrates to the cell’s nucleus and becomes integrated with the cell’s chromosomes. Once integrated, the virus can use the cell’s own genetic machinery to replicate itself. Additional copies of the virus are released into the body and infect other cells in turn. Although the body does produce antibodies to combat HIV infection, the antibodies are not effective in eliminating the virus.

The virus eventually kills the infected host cell. CD4+ cells play a critical role in coordinating the body’s immune response system, and the decline in their number causes corresponding deterioration of the body’s ability to fight infections from

healthcare system, insurance regimes, and the law. Literally and legally, these individuals—despite being engulfed in an epidemiological, and often losing, battle for their lives—have shaky ground, at best, upon which to demand protections under the law throughout the stages of their disease.² Unfortunately for them, the economic rationales for health status-based insurance discrimination and the legislative silence on protection under the Americans with Disabilities Act have resulted in a legal “donut hole,” leaving many asymptomatic³ HIV and AIDS sufferers lost in the legal fray, further stigmatized and uninsured with mounting medical costs and little foreseeable economic relief.

However, now that the Obama Administration has instituted major health care reform, both the health care system and the insurance coverage regime will receive a significant overhaul. This Note argues that, while “Obamacare” reform is no doubt one of the most significant pieces of social legislation of this era, the two laws that define it—the Patient Protection and Affordable Care Act⁴ (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)⁵—are riddled with the same substantive ambiguities that plagued their statutory predecessors,

many sources. Tracking the infected individual’s CD4+ cell count is one of the most accurate measures of the course of the disease.

Id. at 633–34.

² See *Bragdon*, 524 U.S. at 635 (chronicling the stages of HIV: “The initial stage of HIV infection is known as acute or primary HIV infection. In a typical case, this stage lasts three months. The virus concentrates in the blood. The assault on the immune system is immediate. The victim suffers from a sudden and serious decline in the number of white blood cells. There is no latency period. Mononucleosis-like symptoms often emerge between six days and six weeks after infection, at times accompanied by fever, headache, enlargement of the lymph nodes (lymphadenopathy), muscle pain (myalgia), rash, lethargy, gastrointestinal disorders, and neurological disorders. Usually these symptoms abate within 14 to 21 days. HIV antibodies appear in the bloodstream within 3 weeks; circulating HIV can be detected within 10 weeks.”).

³ See *id.* at 635–36 (defining the asymptomatic phase as follows: “After the symptoms associated with the initial stage subside, the disease enters what is referred to sometimes as its asymptomatic phase. The term is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy, dermatological disorders, oral lesions, and bacterial infections. Although it varies with each individual, in most instances this stage lasts for 7 to 11 years. The virus now tends to concentrate in the lymph nodes, though low levels of the virus continue to appear in the blood. It was once thought that the virus became inactive during this period, but it is now known that the relative lack of symptoms is attributable to the virus’ migration from the circulatory system into the lymph nodes. The migration reduces the viral presence in other parts of the body, with a corresponding diminution in physical manifestations of the disease. The virus, however, thrives in the lymph nodes, which, as a vital point of the body’s immune response system, represents an ideal environment for the infection of other CD4+ cells. . . . A person is regarded as having AIDS when his or her CD4+ count drops below 200 cells/mm³ of blood or when CD4+ cells comprise less than 14% of his or her total lymphocytes.”).

⁴ Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered provisions throughout the U.S.C.).

⁵ Pub. L. No. 111-152, 124 Stat. 1029 (2010).

and ultimately leave asymptomatic AIDS and HIV sufferers unprotected from health status-based discrimination.

Part I of this Note examines the historical lineage of the legal duty to treat, tracing that duty from its common law origins to its modern statutory foundations in the Rehabilitation Act of 1973 and up to the more recent Americans with Disabilities Act, passed in 1990. This Part also addresses the most recent Supreme Court case, *Bragdon v. Abbott*,⁶ which directly addresses the ability of healthcare providers to discriminate against HIV-positive individuals in the non-emergency medical care context. Part II provides an overview of the modern American insurance regime, particularly with regard to individuals that the insurance industry commonly perceives as “high risk”—including those with HIV and AIDS. This Part also outlines the federal regulations currently in place to help combat insurance discrimination based on health status. Part III gives a general overview of the pertinent parts of both PPACA and HCERA as they relate to insurance coverage. Finally, the Note concludes by examining whether “Obamacare” might very well bring health status-based discrimination protection to this legally “homeless” class.

I. HISTORICAL DUTIES TO TREAT

A. *Common Law Duties*

At common law, contract theory governed the physician-patient relationship. As such, the general rule was that healthcare providers had no duty to treat a patient without the existence of a prior agreement or statutory regulation.⁷ Essentially, “[u]ntil both parties manifest[ed] either an express or implied intent to create a contractual relationship, the physician [had] no duty to treat the patient.”⁸

However, exceptions did and still do exist. If an individual relies on a healthcare provider’s gratuitous undertaking to provide care, the provider’s affirmative step implicitly imposes a duty on the physician to treat the relying individual.⁹ Healthcare providers—often those located in hospitals with emergency facilities—are also required to treat individuals who require emergency care.¹⁰ However, the healthcare provider’s duty to treat only lasts for the duration of the individual’s emergency; once the emergency ends, the duty to treat disappears.¹¹ In addition, while healthcare providers are allowed to take “reasonable precautions to

⁶ 524 U.S. 624 (1998).

⁷ Jill Cohen, *Access to Medical Care for HIV-Infected Individuals Under the Americans with Disabilities Act: A Duty to Treat*, 18 AM. J.L. & MED. 233, 235 (1992).

⁸ *Id.*

⁹ *Id.* at 236.

¹⁰ *Id.*

¹¹ *Id.*

protect themselves during emergencies,” blanket refusals to treat individuals do not fall under such precautionary headings.¹²

Hospitals and physicians who initiate patient care also have a duty to complete treatment; once again, such initiation effectively and implicitly establishes a contractual relationship between the two parties.¹³ Physicians can only terminate these contractual relationships if one of four situations arises: (1) the patient dismisses the physician; (2) the patient and physician mutually consent to terminate the relationship; (3) the patient no longer needs the physician’s services; or (4) the physician withdraws his services and instead provides a suitable medical alternative.¹⁴ All of these common law rules apply to those who have HIV and AIDS.¹⁵

B. *Statutory Duty to Treat*

Today, statutory provisions and administrative regulations have replaced much of the common law regime, and more accurately reflect the current mandate surrounding the duty to treat. Before Congress enacted the Americans with Disabilities Act (ADA) in 1990, Section 504 of the Rehabilitation Act of 1973¹⁶ stood to protect “disabled” individuals against discrimination.

1. Rehabilitation Act of 1973

Under the relevant part of the statute, “[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”¹⁷ To bring a complaint under the Rehabilitation Act, a plaintiff must prove four elements: (1) that the plaintiff fell within the Act’s definition of an “individual with a disability”; (2) that the plaintiff was “otherwise qualified” to benefit from the program or service from which the exclusion occurred; (3) that the plaintiff’s disability was the sole reason for his or her exclusion; and (4) that Section 504 applied to the program or service that excluded the plaintiff.¹⁸ The Act defines as disabled “any person who (1) has a physical or mental impairment which substantially limits one or more of such person’s major life activi-

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.* at 237.

¹⁵ *Id.*

¹⁶ 29 U.S.C. § 794 (2002).

¹⁷ *Id.* § 794(a).

¹⁸ Cohen, *supra* note 7, at 237.

ties; (2) has a record of such impairment; or (3) is regarded as having such impairment.”¹⁹

Courts use a case-by-case analysis to determine whether a plaintiff is disabled; under this analysis, “neither HIV infection nor the existence of full-blown AIDS automatically qualifies an individual as disabled.”²⁰ However, after proceeding through the three-point inquiry described above, many courts have found that HIV and AIDS infection does indeed qualify as a disability.²¹ Expectedly, courts’ analyses tend to be highly fact-specific, and thus their holdings do not establish a *per se* disability rule regarding HIV and AIDS-infected persons.²² Because such analyses do not identify these individuals as “disabled” in the aggregate, asymptomatic HIV and AIDS sufferers lack any guaranteed protections under the statute.

2. Americans with Disabilities Act (ADA)

This Act, passed by Congress in 1990, is the most recent piece of federal legislation that attempts to fill the gap and provide protection to asymptomatic HIV and AIDS sufferers under the definition of a disability.²³ The statute mandates that “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”²⁴

Unfortunately, attempting to construe the statute’s definition of “disability” to include HIV and AIDS sufferers still presents a problem. The ADA defines “disability” in terms that are identical to those found in the Rehabilitation Act of 1973, once again focusing on physical or mental impairments that substantially limit a person’s major life activities, records of such impairments, or whether the individual is regarded as having such impairments.²⁵ In addition, under this statute, “major life

¹⁹ *Id.*

²⁰ *Id.*

²¹ *See, e.g.,* United States v. Happy Time Daycare Ctr., 6 F. Supp. 2d 1073, 1079–80, 1082–84 (1998) (finding sufficient evidence to classify HIV as a disability because defendant’s regarded minor L.W. as having a disability and because HIV-infection had substantially limited L.W.’s major life activity of caring for himself by fighting off common infections); Hamlyn v. Rock Island County Metro Mass Transit Dist., 986 F.Supp. 1126, 1130 (1997) (noting that federal courts have held that the ADA and the Rehabilitation Act “prohibit discrimination against persons with AIDS”); *see also* 28 C.F.R. 36.104(1)(iii) (2010) (classifying “HIV disease (whether symptomatic or asymptomatic) as a physical impairment” under the ADA).

²² *See, e.g.,* Adams v. City of Chicago, 706 F. Supp. 2d 863, 876 (N.D. Ill. 2010) (“Positive HIV status is not a ‘per se disability’ under the ADA, and a person who is HIV positive must present evidence that his status impaired a major life activity.”).

²³ *See* 42 U.S.C. § 12101 (1990).

²⁴ 42 U.S.C. § 12182(a) (1990).

²⁵ *Id.* § 12102(1)(A)–(C).

activities” can include “the operation of a major bodily function, including . . . functions of the immune system [and] normal cell growth.”²⁶ However, the problem comes when scholars and commentators—and eventually the courts—attempt to differentiate the statute’s plain language from Congress’s implicit meaning and intent.²⁷ Commentators who champion adherence to the plain meaning of the statute cite Congress’s failure to explicitly list asymptomatic HIV or AIDS infection as a disability,²⁸ particularly because Congress was very well aware of the 1980s AIDS epidemic at the time that it passed the statute.²⁹ On the other hand, commentators who champion a more expansive interpretation of the statute focus on its legislative history, which seems to support the implicit inclusion of HIV and AIDS sufferers under the ADA’s first prong of the disability definition.³⁰ Specifically, commentators often point to statements made by Representative William Dannemeyer, Representative Henry Waxman, and Senator William Armstrong, all of whom classified HIV and AIDS under the ADA definition of a disability.³¹

Despite the statute’s ambiguous scope, an exception exists in which healthcare providers may refuse to offer medical services to individuals who pose a “direct threat” to the health and safety of others.³² The ADA defines a “direct threat” as “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids and services.”³³ Many commentators have used this provision, once again, to argue the existence of Congress’s implicit intent to create a broad duty to treat that covers individuals with HIV and AIDS, suggesting that a presumptive duty to treat exists in all situations outside of the “direct threat” exception.³⁴ However, in order to prove that a “direct threat” exists under the

²⁶ *Id.* § 12102(2)(B).

²⁷ See Lisa Taylor Hudson, *The Duty to Treat Asymptomatic HIV-Positive Patients or Face Disability Discrimination under Abbott v. Bragdon: The Scylla and Charybdis Facing Today’s Dental and Health Care Providers*, 33 U. RICH. L. REV. 665, 671–72 (1999).

²⁸ *Id.* at 673 (referring to “the ADA’s conspicuous silence on the inclusion of AIDS”).

²⁹ *Bragdon*, 524 U.S. at 633.

³⁰ Hudson, *supra* note 27, at 673.

³¹ 136 CONG. REC. H4621 (daily ed. July 12, 1990) (statement of Rep. Dannemeyer) (“The American people have no idea that with the adoption of [the ADA] we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America.”); *id.* at H4626 (statement of Rep. Waxman) (“All such individuals [from asymptomatic HIV infection, to symptomatic HIV infection] are covered under the first prong of the definition of disability in the ADA.”); *id.* at S9694 (July 13, 1990) (statement of Sen. Armstrong) (“the legislative history of this bill makes clear that infection with the AIDS virus—even in the absence of any disabling symptoms—is a covered disability.”); see also Brief for Petitioner at 23 n.17, *Bragdon v. Abbott*, 524 U.S. 624 (1998) (No. 97-156).

³² 42 U.S.C. § 12182(b)(3).

³³ *Id.*

³⁴ Cohen, *supra* note 7, at 242.

statute, healthcare providers—often the defendants in patient discrimination actions—must show that they used reasonable judgment based upon current medical knowledge or the best-available objective evidence to determine that a risk to others actually existed.³⁵ Much of the litigation surrounding this provision turns on the definition of “reasonable judgment,” as well as who should make the determination that the patient posed an actual, significant risk to others.³⁶

C. *Bragdon v. Abbott*

On June 25, 1998, the Supreme Court broke significant ground in favor of HIV-positive and asymptomatic AIDS sufferers. Justice Kennedy, writing for a 5-4 majority, declared that plaintiff-respondent Sidney Abbott’s HIV-positive status was “a physical . . . impairment that substantially limit[ed] one or more of [her] major life activities,” and thereby qualified her asymptomatic HIV infection as a disability under the ADA.³⁷

In a three-step analysis, the majority first concluded that, “in light of the immediacy with which the virus begins to damage the infected person’s white blood cells and the severity of the disease, . . . it is an impairment from the moment of infection.”³⁸ Second, the majority concluded that HIV infection affected a major life activity, namely Abbott’s ability to reproduce and bear children.³⁹ Finally, to satisfy the ADA’s definition of a disability, the majority concluded that the HIV infection did indeed place substantial limitations on her ability to reproduce.⁴⁰ The majority further supported its conclusions by examining agency interpretations issued under the Rehabilitation Act of 1973, administrative guidelines, and regulations issued by the Justice Department, as well as lower court decisions during the pre-ADA era.⁴¹

Dissenting Justices Rehnquist, Scalia, and Thomas argued that determining whether HIV constituted a disability should be an individual-

³⁵ 28 C.F.R. § 36.208(c) (1992).

³⁶ See, e.g., *Bragdon*, 524 U.S. 624, 649–50 (“[*School Bd. of Nassau City v. Arline*], 480 U.S. 273 (1987),] reserved the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied. At most, this statement reserved the possibility that employers could consult with individual physicians as objective third-party experts. It did not suggest that an individual physician’s state of mind could excuse discrimination without regard to the objective reasonableness of his actions. . . . In assessing the reasonableness of [a physician’s] actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority. The views of these organizations are not conclusive, however.”).

³⁷ See *id.* at 631.

³⁸ *Id.* at 637.

³⁹ *Id.*

⁴⁰ *Id.* at 641 (“It cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one’s child does not represent a substantial limitation on reproduction.”).

⁴¹ See *id.* at 642–47.

ized inquiry, and concluded that Abbott failed the third prong of the majority's analysis because she failed to prove that her HIV infection substantially limited any of her major life activities.⁴² Despite the fact that the Kennedy majority concluded otherwise, the Court refused to address the major question of whether HIV infection constituted a *per se* disability under the ADA.⁴³

In the wake of the decision, skeptics continue to argue that the asymptomatic nature of the disease specifically precludes its classification as a physical impairment under the ADA's definition of a disability.⁴⁴ They claim that HIV is not a physical impairment because the disease does not affect the public, economic, or daily aspects of a person's life, which are things Congress intended the definition of a disability to encompass.⁴⁵ Similarly, other skeptics argue that the asymptomatic nature of the disease and the presence of a physical impairment will always be incongruous: in essence, a person with asymptomatic HIV or AIDS will never be physically impaired, and therefore precluded from disability classification, unless physical symptoms exist.⁴⁶ Some critics also attack the classification of HIV as a disability based on the ADA's requirement that an individual must be "regarded as having such an impairment."⁴⁷ However, the Court rebuffed all of these arguments by declaring the use of the term "asymptomatic" to be a misnomer because of the constant presence of the disease immediately upon infection.⁴⁸

While it seems that *Bragdon* represents a giant leap forward for asymptomatic HIV and AIDS patients, and that legislators are more likely to react rationally as public panic decreases and awareness about the disease increases, the "newness and unfamiliarity with the unique nature and scope of AIDS within the context of the law" continues to present obstacles for further legal protections.⁴⁹ To date, the Supreme Court has not yet explicitly addressed the issue of *per se* protection for asymptomatic HIV and AIDS sufferers, which continues to place them in a precarious position of legal ambiguity. Unfortunately, there continues

⁴² *Bragdon*, 524 U.S. at 657–61 (Rehnquist, J., dissenting).

⁴³ *Id.* at 641–42.

⁴⁴ Hudson, *supra* note 27, at 673 (citing Brief for Petitioner at 3, *Bragdon v. Abbott*, 524 U.S. 624 (No. 97-156)).

⁴⁵ *Bragdon*, 524 U.S. at 638.

⁴⁶ See Hudson, *supra* note 27, at 673.

⁴⁷ 42 U.S.C. § 12102(1)(C).

⁴⁸ *Bragdon*, 524 U.S. at 635 ("The term [asymptomatic] is a misnomer, in some respects, for clinical features persist throughout [this phase], including lymphadenopathy, dermatological disorders, oral lesions, and bacterial infections. Although it varies with each individual, in most instances this stage lasts from 7 to 11 years.").

⁴⁹ See Hudson, *supra* note 27, at 671.

to be some judicial hostility in lower federal courts toward ADA coverage of autoimmune disorders that are not yet symptomatic.⁵⁰

II. INSURANCE DISCRIMINATION ON THE BASIS OF HEALTH STATUS

A. *Insurance Regime Overview*

At its core, today's insurance regime attempts to transform so-called unpredictable and unbudgetable events (such as illness and the accompanying need for costly medical care) into predictable and budgetable events by balancing the risks and resources of the insured population.⁵¹ In essence, health insurance allows insured individuals to pay a premium—small amounts of money over a defined period of time—in order to have as-needed access to medical care, regardless of whether the individual actually uses that care.⁵² In return, the insured individuals have guaranteed access to a pool of money in the event that they need medical assistance. As a result, insurers are able to pool large amounts of money from the aggregate of the insured population in order to cover individual policyholders. The underlying logic of the modern insurance regime therefore assumes that health care expenses are more predictable for aggregate *groups of people*, and less so for individuals.⁵³ As such, it is in insurers' economic interest to amass large groups of "predictable," or low-risk, individuals as their insured population in order to spread the costs of medical care among that population's members.⁵⁴

Insurers often go through a process called underwriting to determine whether they should extend insurance coverage to an applicant and, if so, under what terms of coverage.⁵⁵ To determine the appropriate insurance premium, insurers use either the Community Rating Model (CRM), where "risk is divided evenly among the enrollees," or the Experience Rating Model (ERM), where "the insurer uses prior claims experience to predict future risk and charge enrollees accordingly."⁵⁶ Under the ERM,

⁵⁰ See *Bar-Tur v. Arience Capital*, No. 09 Civ. 2653, 2011 U.S. Dist. LEXIS 14114, at *23–*24 (S.D.N.Y. Feb. 9, 2011) ("Bar-Tur has the initial burden of proving that her impairment [of Common Variable Immunodeficiency, a deficiency of the immune system that reduces that amount of antibodies a person produces] rises to the level of a disability under the ADA. . . . Because Bar-Tur has offered insufficient evidence in support of her claim that she has a substantial impairment of a major life activity, [Arience Capital's] summary judgment motion as to her ADA discrimination claim is granted."); see also Nate Raymond, *ADA Doesn't Cover Woman's Immune Deficiency Condition*, N.Y. L.J., Feb. 11, 2011, available at <http://www.law.com/jsp/nlj/PubArticleNLJ.jsp?id=1202481696336> (last visited Mar. 3, 2011).

⁵¹ See LAWRENCE O. GOSTIN & PETER D. JACOBSON, *LAW AND THE HEALTH SYSTEM* 339 (2006).

⁵² *Id.*

⁵³ See *id.*

⁵⁴ See *id.* at 339–40.

⁵⁵ *Id.* at 340.

⁵⁶ See Gostin, *supra* note 51, at 340.

insurers are better able to determine the risks of certain individuals based on prior illnesses or medical history, ultimately allowing the insurer to set different insurance premium rates for “high-risk” and “low-risk” patients on a seemingly case-by-case basis.⁵⁷ In most cases, the individuals that insurers deem to be too “high-risk” may be completely “priced out” of the insurance pool when insurers set high premiums, and therefore individuals who are unable to pay those high premiums may be denied health insurance coverage altogether.⁵⁸

B. *Underlying Policy Rationales: Solidarity vs. Actuarial Fairness*

Two distinct policy perspectives are at odds under the current insurance regime. At one end of the spectrum, citizens and commentators—and even some insurers—espouse the belief that “we should not abandon those who are sick or attached in some way to people who are sick; sick and healthy, we are all one community.”⁵⁹ This is the solidarity principle, and it is often referred to as the mutual aid system.⁶⁰ Most insurers, however, reside at the other end of the policy spectrum and adhere to the actuarial fairness principle.⁶¹ Under this principle, each person must pay for his or her own health risks respectively.⁶² This notion of “distributive justice” attempts to break down the diverse, community-minded mutual aid system into more fragmented and homogeneous groups, and ultimately leads to the destruction of the mutual aid system.⁶³ At the foundation of this rationale, individuals are encouraged to think only of themselves and those under their immediate responsibility, instead of feeling a sense of responsibility for the community at large.⁶⁴

C. *Adverse Selection*

The optimal configuration for insurance providers is for mostly low-risk individuals to purchase health insurance. However, in practice, individuals who are “more likely to get sick and need health care are more likely to purchase health insurance,” while those who believe they are less likely to get sick or need health insurance are less likely to purchase health insurance coverage.⁶⁵ This phenomenon is known as adverse se-

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 287–90 (1993) as reprinted in Gostin, *supra* note 51, at 331 (analyzing a 1991 Prudential Health Insurance advertisement).

⁶⁰ See Stone, *supra* note 59, at 289.

⁶¹ *Id.* at 290 (“[I]nsurance necessarily operates on the logic of actuarial fairness when it, in turn, is organized as a competitive market.”).

⁶² See *id.* as reprinted in Gostin, *supra* note 51, at 332.

⁶³ See *id.*

⁶⁴ See *id.*

⁶⁵ Gostin, *supra* note 51, at 341.

lection. Adverse selection is most likely to occur when policyholders are in a better position than insurers to know whether they pose relatively high or low risks: when insurers charge a uniform premium, high-risk parties buy insurance in greater proportion than their low-risk counterparts.⁶⁶ This process forces insurers to raise the price of coverage, which incentivizes lower-risk parties to either forego insurance or buy less of it, thus increasing the average level of risk among policyholders.⁶⁷ This, in turn, causes a further rise in prices, which restarts the cycle of adverse selection.⁶⁸ The end result of this cycle may be the complete unraveling of the insurer's risk pool.⁶⁹

To combat adverse selection, insurers engage in the strategy of favorable selection or risk shielding, in which they "seek to keep . . . costs down by insuring only the most favorable risks."⁷⁰ Most often, these strategies include insuring large groups—such as *every* employee within a single company—in order to create an economically-favorable mix of high-risk and low-risk individuals that preferably contains more of the latter.⁷¹

Unfortunately, when insurance is not being purchased en masse, individual applicants seeking health insurance are often subjected to more stringent, potentially prohibitive "entrance" requirements.⁷² These requirements may include mandatory physical examinations, extensive and in-depth health history disclosure, and pre-existing condition limitations in which the insurer may delay or refuse insurance coverage for any health condition that was in existence before the date of application.⁷³

Once again, particularly high-risk individuals are often "priced out" of the health insurance application process through the imposition of "lifetime limits on coverage, caps on specific treatments (such as AIDS), refusal to cover preexisting mental and physical conditions, high rates, and [being] designat[ed] as uninsurable."⁷⁴ On the rare occasion that an insurance provider extends coverage to a high-risk individual, the insurer often employs *post*-enrollment risk shielding strategies, including limits on the amount, duration, or scope of coverage; limiting certain treatments; and utilizing administrative procedures in the face of challenges

⁶⁶ KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION* 6 (4th ed. 2005).

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Gostin, *supra* note 51, at 341.

⁷¹ *Id.*

⁷² *See* Gostin, *supra* note 51, at 341.

⁷³ *Id.*

⁷⁴ *Id.*

to coverage denials.⁷⁵ These strategies are interdependent and are often used in various combinations.⁷⁶

D. *Current Federal Efforts to Regulate Health Status Insurance Discrimination*

The current state of federal law reflects a melting pot of regimes aimed at regulating and deterring insurance discrimination based on health status. Currently, federal law draws from civil rights, tax, and labor laws, as well as laws that provide federal funding for state public health activities.⁷⁷ However, many of the current regulatory regimes are inadequate to protect individuals infected with asymptomatic HIV and AIDS from discriminatory insurers.⁷⁸

1. Civil Rights Laws

Many of these regulations and laws are based upon the Civil Rights Act of 1964,⁷⁹ and are only intermittently helpful, if at all, to those infected with HIV and AIDS. Title VII⁸⁰ of the Act prohibits racial discrimination in the context of employment and its fringe benefits, but it is only effective against “intentional discrimination and exclusion, not the disparate effects that stem from the facially neutral use of certain risk classifications.”⁸¹ However, of all the regulatory regime foundations, civil rights laws are perhaps the most effective in prohibiting discriminatory insurance practices that *result* in racially-segregated health care,⁸² simply because discrimination based on race is legally unacceptable.⁸³ Unfortunately, this rationale does not take into account the reality that race usually correlates with poorer health.⁸⁴

The prohibitions against sex- and gender-based risk classifications result in even less certainty. These legal prohibitions vary based on em-

⁷⁵ Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, 37 J.L. MED. & ETHICS 103, 107–08 (2009).

⁷⁶ *See id.* at 108.

⁷⁷ *Id.* at 108.

⁷⁸ *Id.*

⁷⁹ Civil Rights Act of 1964, Pub. L. 88-352, 78 Stat. 241 (codified as amended at 28 U.S.C. § 1447, 42 U.S.C. §§ 1971, 1975a–1975d, 2000a–2000h-6).

⁸⁰ 42 U.S.C. §§ 2000e–2000e-17 (1964).

⁸¹ Rosenbaum, *supra* note 75, at 108.

⁸² *See id.* (citing *Linton v. Carney*, 779 F. Supp. 925, 932 (M.D. Tenn. 1990)).

⁸³ 42 U.S.C §§ 2000d–2000d-7 (1964).

⁸⁴ *See* Francis S. Collins, *What We Do and Don't Know About “Race,” “Ethnicity,” Genetics and Health at the Dawn of the Genome Era*, 36 NATURE GENETICS S13, S14 (2004) (“‘Race’ and ‘ethnicity’ are poorly defined terms that serve as flawed surrogates for multiple environmental and genetic factors in disease causation, including ancestral geographic origins, socioeconomic status, education and access to healthcare.”).

ployment status as well as across state and federal laws.⁸⁵ Prohibitions against age-based risk classifications are even less certain, to the point that the federal government explicitly *authorizes* discriminatory practices based on these classifications. For example, the Age Discrimination in Employment Act of 1967 (ADEA)⁸⁶ explicitly allows employers to give older workers fewer benefits, such as providing fewer benefits to Medicare-age employees.⁸⁷

2. Americans with Disabilities Act (ADA)

Once again, the ADA offers limited protection, precisely because the narrow definition of a disabled person does not always include those infected with asymptomatic HIV and AIDS.⁸⁸ Simply being in poor health does not automatically ensure that an individual will receive disability-based protections.⁸⁹ Moreover, the ADA further discourages applicants by doing little or nothing to regulate the *content* provisions of insurance plans.⁹⁰ Instead, “private health insurers can single out certain conditions (e.g., HIV/AIDS) for complete or near-total coverage exclusion, so long as the exclusion applies to all plan members.”⁹¹

3. Health Insurance Portability and Accountability Act (HIPAA)⁹²

This Act—based in tax law and with regulatory power over certain retirement, health, and welfare benefit plans—establishes certain minimum standards for the employers who chose to provide health insurance en masse to their employees.⁹³ The statute extends protection beyond that of the ADA by focusing “on health status rather than disability.”⁹⁴ However, the statute does not reach far enough to address the content of health insurance plans, which is often where insurers do much of their post-enrollment discriminating.⁹⁵ Instead, HIPAA prohibits insurers from considering health status when assessing an individual’s initial *access* to insurance.⁹⁶ Specifically, the statute prevents those who issue

⁸⁵ See 42 U.S.C. §§ 2000d–2000d-7 (1964).

⁸⁶ 29 U.S.C. §§ 621–634.

⁸⁷ See Rosenbaum, *supra* note 75, at 108.

⁸⁸ *Id.* at 108–09.

⁸⁹ *Id.* at 109 (“Poor health status alone is not enough to trigger disability protections.”).

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 193 (1996) (codified as amended at 42 U.S.C. § 300gg and 29 U.S.C. § 1181 and 42 U.S.C. 1320d).

⁹³ See Rosenbaum, *supra* note 75, at 109.

⁹⁴ *Id.*

⁹⁵ See *id.* at 107–08, 109.

⁹⁶ *Id.* at 110–11.

state-regulated group health insurance from considering health status with regard to “enrollment, date of effective coverage, waiting periods, late and special enrollment rules, eligibility for benefit packages, benefits[,] . . . continued eligibility, and coverage termination.”⁹⁷

Moreover, while there are certain prohibitions that limit insurers from excluding those with pre-existing conditions under HIPAA,⁹⁸ pre-existing physical conditions are defined narrowly as those “for which medical advice was recommended or received within a six month period ending on the enrollment date.”⁹⁹ Even in the attempt to expand the legal prohibitions on health status discrimination, this definition often precludes asymptomatic HIV and AIDS from classification as a pre-existing condition because few of those infected have received medical treatment within six months of their enrollment.¹⁰⁰

E. Proposed Legal Solutions

At this point, one thing is clear: the lackluster framework of the modern health insurance system, as well as the inadequate protections of the legal regime, are in desperate need of change if they are ever to adequately serve the aggregate of the HIV- and AIDS-infected population. Once again, at its core, the underlying risk-averse rationale of the insurance regime seeks to balance the “high-risk” individuals against the “low risk” individuals, in an effort to eliminate large economic expenditures. In a sense, insurers seek to keep their costs down by insuring the largest number of low-risk individuals possible.¹⁰¹

In an attempt to address this legal donut hole, scholars and insurance providers alike have presented a number of insurance reform options in order to balance the low-risk enrollee demand of the insurance industry against the insurance needs of high-risk individuals.

1. Nationwide Group Purchasing

For most high-risk individuals who attempt to purchase insurance on their own, the major problem remains that they are not part of a larger pool—such as a group of employees—to offset their poor health conditions.¹⁰² One way to combat this issue is to mandate a national group purchasing plan—creating a national pool of insured individuals, in

⁹⁷ *Id.* at 110.

⁹⁸ Rosenbaum, *supra* note 75, at 110.

⁹⁹ *Id.*

¹⁰⁰ See generally *id.* at 113 (“[L]aws aimed at ensuring guaranteed entry into coverage arrangements contain numerous limitations and loopholes, such as non-discrimination on the basis of pre-existing conditions that restricts its reach to persons who have not recently been in treatment (within 6 months). . .”).

¹⁰¹ See Gostin, *supra* note 51, at 341.

¹⁰² See Rosenbaum, *supra* note 75, at 113.

which the majority of low-risk individuals throughout the *entire country* offset the minority of high-risk individuals. However, instilling a sense of solidarity in such an amorphous and diverse group—particularly one governed by the actuarial fairness regime for so long—would be difficult to implement in practice. Compulsory enrollment in a national health insurance pool, as well as automatic enrollment with opt-out provisions, would be absolutely necessary in order to ensure the creation of the pool of sufficient size in order to combat the issue of adverse selection that currently pervades the insurance regime.¹⁰³

Responses to such a solution have been mixed.¹⁰⁴ While this solution would provide a sort of “safety net” to employers and individuals alike to ensure that individuals have adequate health coverage no matter what, the institution of a national pool would likely result in the elimination of the individual health insurance market.¹⁰⁵ In theory, this solution would provide a system of health insurance coverage for *every* American,¹⁰⁶ including those infected with HIV and AIDS, who are often actually or constructively denied coverage based on their “high-risk” health status.

2. Minimum Participation and Non-Discrimination Standards

An alternative solution to address the coverage gaps in health insurance would be to require current insurance providers to meet minimum standards, which could be modeled after the standards in nationally-recognized “benchmark” insurance plans such as the Federal Employee Health Benefit Plan.¹⁰⁷ These minimum standards, such as pregnancy non-discrimination, coverage of mothers and newborns, and mental health parity, could apply to every health insurance plan and could be easily regulated.¹⁰⁸

Insurance providers might also be required to institute “exception” systems within the insurance coverage regime. These systems, such as the one found in the Medicare Part D prescription plan,¹⁰⁹ would allow insurance coverage for medical treatments beyond the scope of the basic plan (“extra-contractual treatments”).¹¹⁰ This system would be achieved

¹⁰³ *Id.* at 113–14.

¹⁰⁴ *See id.* at 114.

¹⁰⁵ *Id.* at 114.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *See id.*

¹⁰⁹ *See, e.g.*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE PRESCRIPTION DRUG COVERAGE: HOW TO REQUEST A COVERAGE DETERMINATION, FILE AN APPEAL, OR FILE A COMPLAINT 2–3 (2009), <http://www.medicare.gov/publications/pubs/pdf/11112.pdf> (giving an overview of the exception process for a recipient to appeal Medicare’s refusal to cover non-formulary drugs).

¹¹⁰ Rosenbaum, *supra* note 75, at 115.

by instituting a neutral Board, likely composed of specially appointed healthcare professionals, to determine whether an “extra-contractual” or “high-risk” treatment is indeed necessary for the individual patient.¹¹¹ The underlying rationale for such a system has also shown up in Congress’s so-called “patients’ bill of rights” legislation.¹¹² In keeping with this approach, other measures of reform have included the institution of risk-adjusted payment methodologies, in which insurance provider payouts would increase or decrease based on the level of care or treatment needed by individual policyholders.¹¹³

III. “OBAMACARE” EXAMINED

At this point, the Obama Administration has achieved one of its major goals of passing healthcare reform legislation.¹¹⁴ On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law,¹¹⁵ followed closely by the passage of the Health Care and Education Reconciliation Act (HCERA) on March 30, 2010 to amend certain provisions in the PPACA.¹¹⁶ However, in the shadow of these laws, the question remains: where do asymptomatic HIV and AIDS sufferers fit in?

A. *Amending the Existing Public Health Service Act*

A scattered series of provisions throughout the PPACA make several amendments to the Public Health Service Act,¹¹⁷ enacted by Congress in 1944 to consolidate and revise all existing legislation related to the nation’s Public Health Service. The PPACA makes the multiple changes to the Public Health Service Act, including the elimination of lifetime or annual coverage limits, establishing a prohibition on rescissions, the establishment of an appeals process, and a provision that eliminates discrimination based on health status.

¹¹¹ See *id.* at 114.

¹¹² See, e.g., Bipartisan Patient Protection Act, S. 1052, 107th Cong. § 1(a), 103–04 (2001).

¹¹³ Rosenbaum, *supra* note 75, at 115.

¹¹⁴ E.g., Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 23, 2010, at A19 (as corrected on March 25, 2010), available at <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

¹¹⁵ *Id.*

¹¹⁶ Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029.

¹¹⁷ 42 U.S.C. § 300gg et seq. (2010).

1. Elimination of Lifetime or Annual Coverage Limits¹¹⁸

The PPACA prohibits insurance companies from establishing dollar limits on the total lifetime amount that an insurance company will pay for covered benefits to the insured or to the insured's beneficiaries.¹¹⁹ In addition, the PPACA precludes insurers from setting "unreasonable" annual limits on covered benefits,¹²⁰ and precludes insurers from setting unreasonable deductible amounts.¹²¹ The unreasonableness of the deductible is specifically defined by the Internal Revenue Code which establishes a deductible range of \$1,000 to \$5,000 for individual self-coverage and \$2,000 to \$10,000 for families.¹²²

2. Prohibition on Rescissions¹²³

The PPACA seeks to ensure the guaranteed renewability of individual and group health insurance coverage.¹²⁴ Once individuals are insured, insurers can only rescind that coverage when there is clear and convincing evidence of insurance fraud on the part of the insured.¹²⁵

3. Establishment of an Appeals Process¹²⁶

The PPACA requires every insurer to implement a process whereby individuals can dispute coverage determinations and claims.¹²⁷ As part of the process, insured individuals must have culturally- and linguistically-appropriate notice that the appeals process exists, the ability to review their file, and the option of an external review process that ensures adequate consumer protections.¹²⁸

4. Prevent Discrimination Based on Health Status

The PPACA inserts a section into the Public Health Service Act that precludes insurance companies from implementing coverage restrictions or establishing excessive premiums on individuals.¹²⁹ As a result, an insurance provider cannot exclude an individual or restrict insurance coverage based on certain delineated factors, including health status,

¹¹⁸ Patient Protection and Affordable Care Act, 42 U.S.C. § 1001 (2010) (amending the Public Health Service Act, 42 U.S.C. § 2711).

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ 42 U.S.C. § 18022(c)(1).

¹²² 26 U.S.C. § 223(c)(2)(A)(ii) (2010).

¹²³ 42 U.S.C. § 300gg-12 (2010).

¹²⁴ 42 U.S.C. § 300gg-12 (2010).

¹²⁵ 42 U.S.C. § 300gg-12 (2010).

¹²⁶ 42 U.S.C. § 300gg-19 (2010).

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ 42 U.S.C. § 300gg (2010).

physical and mental medical conditions, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, and any other health-status related factor determined appropriate by the Secretary of Health to determine insurance eligibility.¹³⁰ However, like its statutory predecessors, the law does not clearly define the term “disability.”

B. Expanding Health Insurance Coverage

Beyond amendments to the existing Public Health Service Act, the bulk of the PPACA takes on the arduous task of expanding the previously existing health insurance coverage regime.¹³¹ Provisions of the PPACA that have the potential to apply to asymptomatic HIV and AIDS sufferers include the creation of a national high risk pool program, the prohibition of exclusion based on preexisting conditions, and the establishment of an essential benefits package.

1. National High Risk Pool Program

No later than ninety days after the PPACA’s enactment, the Secretary of Health must establish a temporary high-risk pool insurance program that will provide insurance coverage to eligible individuals until January 1, 2014, when many of the permanent provisions of the Health Care Exchange take effect.¹³² The Secretary can establish this temporary insurance pool by contracting independently and directly with eligible insurance providers.¹³³ The program is only open to (1) citizens and those who are lawfully present in the United States, (2) individuals not covered under creditable coverage, and (3) individuals who have a preexisting condition.¹³⁴

2. Prevent Exclusion Based on Preexisting Conditions

While there are independent criteria that insurers must meet in order to qualify to enter into a contract with the Secretary, there are other requirements for the acceptability of the temporary high-risk insurance pool—including preclusion against preexisting condition restrictions.¹³⁵ Once again, one criterion for individuals to be eligible for the temporary pool is the presence of a preexisting condition, as determined “in a manner consistent with guidance issued by” the Secretary of Health.¹³⁶

¹³⁰ 42 U.S.C. § 300gg-4 (2010).

¹³¹ See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹³² 42 U.S.C. § 18001(a).

¹³³ 42 U.S.C. § 18001(b)(1).

¹³⁴ 42 U.S.C. § 18001(d)(1)–(3).

¹³⁵ 42 U.S.C. § 18001(c)(2)(A).

¹³⁶ See 42 U.S.C. § 18001(d)(3).

The Secretary of Health must also take on a policing and oversight¹³⁷ role by establishing criteria to determine if “insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual’s health status.”¹³⁸ If an insurer engages in such prohibited risk-dumping activity, that insurer must reimburse the program for the medical expenses of the individual who was encouraged to disenroll in the insurance plan.¹³⁹

3. Establishment of Essential Benefits

Finally, the PPACA makes significant strides toward the protection of asymptomatic HIV and AIDS sufferers by requiring the Secretary to define the minimum level of care that insurance companies must provide for their insured members.¹⁴⁰ The law refers to such standards as the “essential benefits package,” and at a minimum explicitly includes ambulatory patient services, emergency services, hospitalization benefits and maternity and newborn care, as well as mental health and substance abuse disorder services, prescription drug services, rehabilitative services, laboratory services, specific preventative services, and oral and vision pediatric services.¹⁴¹

When determining the scope of the “essential benefits,” the Secretary must ensure the essential health benefits are equal to the benefits provided under a typical employer plan.¹⁴² In making this determination, the Secretary may not make any “coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals based on their age, disability, or expected length of life.”¹⁴³

The PPACA also establishes various levels of insurance that will be available to Americans, ranging from Bronze (the lowest coverage level) to Platinum (the highest coverage level).¹⁴⁴ The Bronze, Silver, Gold, and Platinum coverage levels provide 60, 70, 80, and 90% of the actuarial value of benefits, respectively.¹⁴⁵

¹³⁷ See 42 U.S.C. § 18001(f).

¹³⁸ 42 U.S.C. § 18001(e)(1).

¹³⁹ See 42 U.S.C. § 18001(e)(2).

¹⁴⁰ See 42 U.S.C. § 18022 (2010).

¹⁴¹ See 42 U.S.C. § 18022(b)(1)(A)–(J).

¹⁴² See 42 U.S.C. § 18022(b)(2)(A).

¹⁴³ 42 U.S.C. § 18022(b)(4)(B).

¹⁴⁴ See 42 U.S.C. § 18022(d)(1).

¹⁴⁵ See 42 U.S.C. § 18022(d)(1)(A)–(D).

CONCLUSION

While the “Obamacare” plan is, no doubt, one of the most significant pieces of social legislation since the Social Security Act,¹⁴⁶ PPACA has the same substantive ambiguities that plague its statutory predecessors. To be fair, the statutory language goes to pain-staking lengths to prohibit health status-based insurance discrimination and exclusion based on preexisting conditions.¹⁴⁷ However, the law once again fails to address asymptomatic HIV and AIDS infection as a significant source of insurance discrimination. Even if asymptomatic HIV and AIDS infection represents a minute subset of the “health status” category that is more likely to be addressed in the later regulations accompanying the law, lawmakers still had an opportunity to include HIV and AIDS as a part of the reform discussion, and they failed to take advantage of it.

Currently, any legal protections for asymptomatic HIV and AIDS sufferers that might arise out of PPACA hang in a precarious balance, based solely on the discretion of the Secretary of Health and Human Services. As a result, much of the responsibility to fill the substantive void and statutory ambiguity will fall on the Secretary’s shoulders. Extensive regulations and exhaustingly comprehensive definitional sections will be essential in this effort, and in ensuring that the law covers all of the groups—including asymptomatic HIV and AIDS sufferers—that have consistently been “priced out” and excluded from health insurance coverage.

Based on the text of the statute, the two crucial areas where the Secretary can make the greatest strides for individuals with asymptomatic HIV and AIDS are in (1) the amendments to the Public Health Act that prohibit discrimination based on health status (as defined by the Secretary)¹⁴⁸ and (2) the process to define the benefits that make up the essential benefits package.¹⁴⁹ In the battle against health insurance discrimination, “health status” seems like the term that will be easiest to construe as inclusive of asymptomatic HIV and AIDS. However, in promulgating regulatory guidelines or definitions, the Secretary will need to refer explicitly to HIV/AIDS infection as a qualifying health status factor or a preexisting condition in order to avoid the same litigation battles that have plagued the debate between plain meaning and Congressional intent. Unfortunately, the fact that Congress did not address or discuss the issue during the legislative process makes it more difficult to

¹⁴⁶ See Alan Silverleib, *Senate Approves Health Care Reform Bill*, CNN, (Dec. 24, 2009, 1:01 PM), <http://www.cnn.com/2009/POLITICS/12/24/health.care/index.html>.

¹⁴⁷ See 42 U.S.C. § 18001(c)(2)(A).

¹⁴⁸ See 42 U.S.C. § 300gg-4.

¹⁴⁹ See 42 U.S.C. § 18022.

advance the argument that Congress intended HIV/AIDS to be a pre-existing condition, much less a disability.

To its credit, PPACA incorporates all of the insurance reform suggestions championed by commentators.¹⁵⁰ The law refers to a single risk pool that insurance companies must consider when extending coverage to applicants. PPACA also incorporates benchmark insurance plans on which to model the new insurance coverage regime, and the statute creates the essential health benefits package that outlines the minimum standard of coverage that insurance providers must meet. Overall, however, the incorporation of these elements has done little to champion the cause of asymptomatic HIV and AIDS sufferers. “Obamacare,” despite the overall healthcare significance of its reformative effort, continues to foster the same legislative ambiguity and silence that has left HIV and AIDS sufferers as a legally invisible class.

¹⁵⁰ See discussion *supra* Part II.E. .