

3-2017

Healthism, Intersectionality, and Health Insurance: The Compounded Problems of Healthist Discrimination

Follow this and additional works at: <http://scholarship.law.marquette.edu/benefits>

 Part of the [Disability Law Commons](#), [Elder Law Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Jacqueline R. Fox, *Healthism, Intersectionality, and Health Insurance: The Compounded Problems of Healthist Discrimination*, 18 Marq. Benefits & Soc. Welfare L. Rev. 279 (2017).

This Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Benefits and Social Welfare Law Review by an authorized editor of Marquette Law Scholarly Commons. For more information, please contact megan.obrien@marquette.edu.

HEALTHISM, INTERSECTIONALITY, AND HEALTH INSURANCE: THE COMPOUNDED PROBLEMS OF HEALTHIST DISCRIMINATION

Jacqueline R. Fox*

Healthism can identify situations where a person is subject to a particular form of bigotry based on their individual health status. In health insurance, some forms of healthism are unavoidable due to the very nature of health insurance structures. However, when analyzing health insurance programs, particularly those that are funded through government, it is possible to utilize a healthism framework to, first, recognize and minimize the worst effects of outright bigotry and, second, minimize and potentially ameliorate the worst effects of healthism combined with intersectionality. This Essay analyzes these issue as they relate to health insurance, Medicare, and the potential role of the Independent Payment Advisory Board.

* Jacqueline R. Fox, J.D., LL.M, is an associate professor of health law and bioethics at the University of South Carolina School of Law. Fox received her J.D. and LL.M at Georgetown University Law Center and was post-doctoral Greenwall Fellow in health policy and bioethics and a Yale University Donaghue Visiting Scholar of Research Ethics.

TABLE OF CONTENTS

I. INTRODUCTION	281
II. HEALTH INSURANCE	282
III. THE INDEPENDENT PAYMENT ADVISORY BOARD	288
IV. CONCLUSION	294

I. INTRODUCTION

This Essay takes an initial look at health insurance, and then examines Medicare's Independent Payment Advisory Board by utilizing the framework developed by Jessica L. Roberts and Elizabeth Weeks Leonard in their forthcoming book, *Healthism: Health Status Discrimination & the Law*.¹ The book defines a form of prejudice called "healthism" and lists factors used to determine whether healthism is present in a particular situation. These factors consider whether a behavior or activity is: (1) driven by animus; (2) unfairly stigmatizing; (3) punishment for private conduct; (4) an impediment to accessing health care; (5) a complete barrier to accessing health care; (6) producing worse healthcare outcomes; and (7) maintaining or increasing current disparities.² Currently, health insurance in the United States presents significant problems with a majority of these factors. The Medicare program, enacted to directly address the elderly population's struggle to access health insurance, demonstrates more subtle healthism challenges than the private insurance marketplace, but both models highlight ongoing issues in the very design of a third-party payer system.

During the 2016 election, President Trump and the Congressional majority promised significant changes to the current healthcare system, raising the potential for a large disruption to this system in the near future.³ Given this possibility, the country should consider the healthism factors when discussing the social justice implications of the current system and possible reform efforts.

The ramifications of healthism are significant, but the problem is compounded when healthism is combined with

1. JESSICA ROBERTS & ELIZABETH WEEKS LEONARD, *HEALTHISM: HEALTH STATUS DISCRIMINATION & THE LAW* (Cambridge U. Press, forthcoming 2017).

2. Jessica Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism?*, 50 GA. L. REV. 833, 895 (2016).

3. Alison Kodjak, *Trump Can Kill Obamacare With Or Without Help From Congress*, NPR (Nov. 9, 2016, 7:05 AM), <http://www.npr.org/sections/health-shots/2016/11/09/501203831/trump-can-kill-obamacare-with-or-without-help-from-congress> [<https://perma.cc/4XWG-UW6P>].

intersectionality. First, health insurance healthism can exacerbate disparate treatment due to race, gender, disability status, gender identity, and body norms, which adds a layer of injustice and burden. Second, when healthism is combined with animus, bigotry, or unconscious bias, it can influence insurance plan design, coverage decisions, or the promulgation of governmental regulations in the health care realm, which further exacerbates and entrenches these problems.

II. HEALTH INSURANCE

By definition, a private marketplace for health insurance has qualities that prejudice people based on their individual health status. Health insurance, in its purest form, is a product that healthy people buy in case they become sick or are injured, much like a homeowner purchasing fire insurance. As with fire insurance, each member pays money into a pool of funds that is used to cover any costs the members have if an insured event occurs. Similarly, the insurance company calculates, in advance, the amount of money that must be in the pool by determining the likelihood of any particular illness or injury occurring in the covered population, and how much it will cost to provide care for that illness or injury. Individuals purchasing insurance, by contributing to this pool, agree to cross-subsidize each other if these events occur. This works because it is impossible to identify who will suffer an illness or injury, but those individuals recognize that a proportion of a given population is likely to suffer from an illness or injury.

Consistent with this concept of insurance, health insurers developed methods to identify and exclude people who did not have a perfect health status because the model, as described above, does not anticipate paying for known and fixed upfront costs. For example, if an insurer knows an applicant's illness will cost \$20,000 to treat, a realistic price for participation in an insurance plan would be \$20,000 plus the risk of generating any additional costs. Any other outcome results in existing plan members subsidizing health care needs that were generated

prior to entering into an agreement to cross-subsidize newly emerging and unpredictable health care needs. Before a health insurance plan is sold, the marketers must determine the likely cost of providing care so the pool has sufficient funds to cover care, and the beneficiaries of the pool are charged the correct amount. To do this, the marketers examine attributes of the population likely to be covered and predict how much it will cost to provide that population with the care that is promised in the insurance contract. Within these calculations, a plan can use a community rating, which assesses the health care costs for a swath of a population, for example, adults in Cincinnati who seek private insurance. A plan could also choose to only offer insurance to individuals whose personal risk of developing an illness is low. This is accomplished through underwriting, a process where an applicant is required to fill out a questionnaire from the insurance company asking for specific information related to their health status. The company then declines to sell that applicant insurance if the risks of future costs presented by their individual health status appear too great. The individual underwriting process allows the plan to set a lower price for each individual who is covered because the members allowed into the pool are healthier to begin with. A plan may also offer insurance to someone, but specifically exclude payments for any health care costs related to an existing condition. Most plans use a combination of these methods to calculate cost and determine whether to cover a new member and whether to include specific exclusions by blending qualities of a community with specific details about the health status of an individual.

In such insurance plans, even if a plan selects new members using strict criteria, new members generally have an introductory time frame where they are covered by a plan but are not covered for pre-existing conditions. For example, new members may not have medical care paid for if it is related to a symptom that predates the plan's start date.

The effect of this system is to identify and exclude people solely based on pre-existing health problems, which is a perfect

example of healthism. The effect of this exclusion of people based on pre-existing conditions, in turn, is to impede, and perhaps entirely foreclose access to, health care (due to prohibitive cost), which produces measurably worse health outcomes.

There are numerous federal and state laws and regulations that seek to alter this marketplace; and due in large part to these changes, current health insurance bears little resemblance to a pure form of insurance. For example, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted in 1986⁴ and requires, in pertinent part, that employers who provide health insurance to their employees must give employees who leave their jobs the option to continue being insured under the company's plan for a specified period of time. This does not fix the problems with gaining access to individual insurance, but delays when the problems occur. This law reduces some effects of healthism by allowing a person with a health issue to have continuous access to health care during the covered time. However, the requirement that the patient pay the cost of the insurance is difficult for people who are sick and unable to work.

The Health Insurance Portability and Accountability Act of 1996⁵ (HIPAA) requires, in pertinent part, private insurance companies to allow new members to use time during which they had health insurance from an immediately prior group insurance plan to avoid a delay in accessing coverage for care in the new plan, eliminating any bar to coverage for pre-existing conditions. This greatly reduces problems related to accessing care, but only benefits employees who participated in an employer-sponsored insurance plan and leaves individuals who do not have access to employer-sponsored insurance unprotected

4. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, title I, § 601, as added Pub. L. 99-272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 227; amended Pub. L. 101-239, title VII, §§ 7862(c)(1)(B), 7891(a)(1), Dec. 19, 1989, 103 Stat. 2432, 2445.

5. Pub. L. 104-191, August 21, 1996, 110 Stat 1936.

and at risk. Intersectionality is particularly useful in pinpointing flaws in this law. A study conducted in 1997, a year after HIPAA was first passed, found that while 64% of the overall workforce had employer-sponsored health insurance, there were measurable disparities across different races.⁶ For white non-Hispanics, 69% had employer coverage.⁷ For blacks and Hispanics, respectively, the numbers were 52% and 44%,⁸ meaning that the protection offered by HIPAA gave a disproportionate positive effect to whites overall.

The Patient Protection and Affordable Care Act⁹ (ACA), enacted in 2010, has a number of provisions controlling the marketplace. For example, people may only purchase insurance that is subject to the enrollment protections of the ACA during an open enrollment season or due to a delineated life event, such as giving birth.¹⁰ This creates a limited window in which to purchase insurance if an individual becomes sick, thus protecting the functionality of the marketplace as described above. Within the open enrollment time frame, insurance companies may not refuse to issue policies due to the health status of the potential member,¹¹ but they may charge a specific range of higher rates because of a member's age,¹² location of residency,¹³ or tobacco use,¹⁴ all of which can be used as rough

6. Allyson G. Hall, Karen Scott Collins & Sherry Glied, *Employer-Sponsored Health Insurance: Implications for Minority Workers*, THE COMMONWEALTH FUND 1, 2, 5 (1999), http://www.commonwealthfund.org/usr_doc/Hall_employer-sponsored.pdf [<https://perma.cc/D3KS-68DQ>] [hereinafter *2015 Highlights*].

7. *Id.* at 5.

8. *Id.*

9. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2012).

10. Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets. 45 C.F.R. pt. 147 (2014).

11. 45 C.F.R. § 147.104, 147.106, 147.108 (2014).

12. 45 C.F.R. § 147.102(a)(1)(iii) (2014). Insurance companies may charge older adults higher premiums than younger adults, limited to three times what they charge younger adults.

13. 45 C.F.R. § 147.102(b) (2014). Insurance companies are allowed to charge more to those who live in areas where medical costs are high because of the geographic location.

14. 45 C.F.R. § 147.102(a)(1)(iv) (2014). Insurance companies may charge tobacco users up to 1.5 times what they charge those who do not use tobacco products.

estimates of the potential cost to insure. Again, these reforms, while helpful, continue to demonstrate healthism.

First, by limiting enrollment to a specific season, uninsured individuals who become sick or injured outside of the season cannot purchase insurance. Since health care is simply too expensive for most people to self-fund, the enrollment period prevents some individuals from accessing health care when they most need it. Second, allowing insurers to charge higher premiums due to age is a placeholder for the higher health care costs associated with increased age,¹⁵ thus allowing a less direct but still healthist cost burden. Finally, allowing an increased charge for those who use tobacco products both stigmatizes and punishes people who choose to privately consume these legal products. Accordingly, this charge could make it less likely they will purchase insurance due to the increased cost, which then leads to impeded access and worse outcomes for a population that is known to be at a higher risk for poor health.¹⁶

As it is currently defined, health insurance bears little resemblance to classic insurance, not only due to regulations, such as those discussed above, but also due to the massive changes in health care and populations since the middle of the 20th century, when the earlier model of health insurance was prevalent. Today, more money is spent on health care, more can be done to help people, and the types of problems people are living with have changed dramatically.¹⁷ Currently, health care in the United States is extremely expensive, costing roughly

15. *Id.*

16. Alex C. Liber et al., *Tobacco Surcharges on 2015 Health Insurance Plans Sold in Federally Facilitated Marketplaces: Variations by Age and Geography and Implications for Health Equity*, 105 AM. J. OF PUB. HEALTH S696, S696-98 (2015). (“[T]obacco users tend to have lower income and employment, and the current dynamic will ensure that these individuals will be further financially burdened by the tobacco surcharge, even to the point that insurance through the health insurance exchange remains unaffordable even after subsidization. Little systematic evidence has been collected on the effect of tobacco surcharges on consumer behavior or health outcomes.”).

17. See Joseph L. Dieleman et al., *US Spending on Personal Health Care and Public Health, 1996-2013*, 316 JAMA 2627 (2016).

\$10,000 per person per year.¹⁸ Given the numerous recommendations for preventive care,¹⁹ some of these expenses are for care that non-symptomatic people receive to identify and treat previously unknown problems at an early stage before a discovered condition becomes more severe, which means that even if one were to limit insurance purchasing to healthy people, it will still carry the fixed costs of preventive care. Furthermore, a large percentage of Americans have chronic conditions that can be treated and controlled, but not healed.²⁰ Allocating the cost of managing and treating these conditions is a pervasive feature of any current payment system.

In light of preventive care, the high number of people with chronic conditions, and the overwhelming proportion of people who utilize the healthcare system, a model of insurance where a member is healthy at enrollment and presents a limited risk of incurring any covered costs is no longer useful for a system that is meant to cover most Americans. It is likely, and probably preferable, that all members will have health care expenses over time and many of them will have expensive chronic care needs. People become increasingly complex insurance risks over time and, over the course of a lifetime, will most likely find it difficult, if not impossible, to access health care within a traditional insurance marketplace.

The inherent conflict between the historic financial basis for insurance and the current health care needs of the insured

18. This data is as of 2015, see *National Health Expenditures 2015 Highlights*, CTR. FOR MEDICARE & MEDICAID SERV. (2015), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf> [<https://perma.cc/S7C2-LEQ2>].

19. For a list of recommendations made by the United States Preventive Services Task Force, see *Published Recommendations*, U.S. PREVENTATIVE SERV. TASK FORCE (2017), <https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations> [<https://perma.cc/6DBT-M3UQ>]. There are currently ninety-eight separate recommendations. *Id.*

20. According to data collected by the Centers for Disease Control (CDC), roughly half of American adults have a chronic condition. *Chronic Diseases: The Leading Causes of Death and Disability in the United States*, CTR. FOR DISEASE CONTROL & PREVENTION (2016), <https://www.cdc.gov/chronicdisease/overview/> [<https://perma.cc/P3T6-7S73>].

population leads to a system where healthism is present, but increasingly opaque. Third-party payers still have incentives to use people's health status as a reason to treat them differently, but have limited means to do so transparently. It is a poor model for a system if one seeks to provide care without healthism influencing access and treatment.

To understand the risk of a more opaque form of healthism, one must realize that the financial stakes are high and information is asymmetrical. Third-party payers, including private and governmental insurers, pay a significant share of health care expenses, roughly 89% overall.²¹ In this high-stakes atmosphere, insurance consumers are at a disadvantage. The process of pricing health insurance is exceedingly complex, and such complexities of the health needs of the population continue to make it increasingly so. Within that complexity, however, it is relatively simple for actuarial science to predict the costs a specific person is likely to incur for health care in a given year. Even in this current system, with some limitations on insurance company behavior and an understanding that most people present some risk of cost, a sophisticated approach assessing a potential member's health status and dissuading that person from either joining a plan or utilizing care, can have important financial implications. The consumer, not realizing their health status can be assessed and this assessment can change how an insurer relates to them, is thus vulnerable.

III. THE INDEPENDENT PAYMENT ADVISORY BOARD

The ACA creates the Independent Payment Advisory Board²² (IPAB), which acts as a mechanism for controlling costs of the Medicare program. Medicare currently provides insurance to people over the age of 65 and those with disabilities.²³ IPAB

21. *2015 Highlights*, *supra* note 18, at 2.

22. *See* Independent Payment Advisory Board, 42 U.S.C. § 1395kkk (2012).

23. Title XVIII of the Social Security Act is administered by the Centers for Medicare and Medicaid Services. Health Insurance for the Aged Act, 42 U.S.C. § 1395-1395ccc (2012). Regulations of the Secretary of Health and Human Services

has two primary responsibilities related to Medicare. First, if Medicare costs per capita are projected to increase a significant amount in the future, IPAB puts together a package of recommendations that will reduce these costs to an acceptable level.²⁴ The content of the package is subject to significant limitations, such as proposals within it cannot reduce “access”²⁵ and cannot cut any care that is already covered by the Medicare program.²⁶ Many commentators originally envisioned IPAB to focus entirely on reducing the payments that Medicare makes to physicians for specific types of care.²⁷ However, access considerations make it unlikely that any significant reductions can occur in this manner because it would reduce the number of physicians who provide services.²⁸ Additionally, because IPAB cannot cut types of care that are currently covered, it must, by necessity, focus its efforts on identifying and limiting coverage for new medical care, drugs, and devices that are not currently covered.²⁹

If IPAB proposes a package and Congress does not respond, it becomes law.³⁰ If Congress opens the package up for debate and alters any aspect of it so that the cost reduction is lessened, Congress must then explicitly fund the increase through the

relating to Title XVIII are contained in 42 C.F.R. pt. 430-485 (2014).

24. See Independent Payment Advisory Board, 42 U.S.C. § 1395kkk (2012) (“... while maintaining or enhancing beneficiary access to quality care under this subchapter.”).

25. *Id.*

26. *Id.*; 42 U.S.C. § 1395kkk(c)(2)(A)(II) (2012) (“The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1395i–2, 1395i–2a, or 1395r of this title, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”).

27. For a full discussion of this statute, see Jacqueline Fox, *Death Panels: A Defense of the Independent Payment Advisory Board*, 66 ADMIN. L. REV. 131, 132 (2014).

28. *Id.*

29. It may be possible for IPAB to consider new uses of previously covered care, drugs, or devices. This would be a fair reading of the statute, but is not specifically expressed.

30. See 42 U.S.C. §§ 1395kkk(e)(1), (3) (2012).

budget.³¹ Once the package is opened, Congress can alter it, as well as Medicare more generally, in any manner.

IPAB has not yet been created, as the Medicare program has not projected increased costs sufficient to trigger it. Once it is created, it must, in addition to creating a package, issue annual reports that recommend methods for reducing costs across the entire health care system in the United States, which is its second major responsibility.³² These reports are not bound by the same limitations the package is subject to and, thus, can presumably cover anything. Of particular interest here, given the package focus is likely to be on future developments in health care and there is a lengthy process by which new developments are studied and receive federal marketing approval, the annual report could include early stage recommendations to those developing new technologies as to how IPAB wishes them to constrain future costs.

Accordingly, there are three distinct areas within the IPAB scheme that have risks regarding healthism. These areas include the package, Congressional action on the package, and the annual reports.

Despite there being three primary risks of healthism within IPAB's structure, concrete measures can be taken to reduce these risks. First, any decision regarding coverage that is based on statistical data will most likely create winners and losers based on health status, given that the data is imperfect. Second, if any type of care is excluded, it will have a disproportionately worse effect on those who already suffer from the social determinants of health, as they will have fewer personal resources to ensure access in a private market. Third, outright animus or unconscious bias can fuel a package of recommendations or a subsequent Congressional debate, as some people may be perceived as being less worthy of protection

31. *See id.* § 1395kkk(d)(3) (2012).

32. *Id.*

or provision of health care, particularly when scarce resources are being allocated.

Program-based cost controls, which are proposals for what exactly will be covered or excluded across the program, rely on data regarding the effectiveness of a particular intervention. This type of decision could have healthist implications. For example, a payer is considering two antibiotics, A and B, for a particular bacterial infection that exhibits specific symptoms, but is not usually diagnosed with a test to identify the specific bacteria strain. Antibiotic A works in 80% of the people and antibiotic B works in 20%. If antibiotic A is covered and antibiotic B is not, or if antibiotic A is the first line of treatment and antibiotic B is the second, some statistical group will likely be harmed by this choice because some people may only respond to antibiotic B and not antibiotic A. At least arguably, those with a bacterial infection who only respond to antibiotic B will suffer harm from this decision due to their health status.

As another example, consider a procedure that costs \$100 to provide and is effective in 50% of patients who receive it. For every 1,000 patients (providing the numbers hold across that population), 500 of them will be cured, costing \$200 per cure. The procedure will directly waste \$50,000 for every 1,000 patients, and 500 of them will be exposed to potential risks from the procedure while receiving no benefit.

Both of these examples demonstrate that it is imperative, from a healthism perspective, to consistently generate reliable data about effectiveness and make increasingly accurate assessments about the best care for individuals. Population-based assessments make sense when allocating scarce resources, and this argument is not meant to challenge that approach. Rather, an acknowledgment of the healthist effects of such a decision require that it be implemented with an eye towards continual refinement to alleviate future harms that spring from health status. Furthermore, given that one can statistically pinpoint an area of waste, as in the second example, and waste in one area causes resources to be unavailable for the treatment

of other patients, a healthism framework advocates for a system that continually searches for a better and more accurate patient population for any procedure.

When a particular form of care is beneficial and still excluded from coverage, the burden of providing that care is shifted to the patient. By applying an intersectionality analysis, this burden, based initially on health status, may become significantly more burdensome to those who are members of an otherwise marginalized group.

Medicare and other third-party payers continually struggle with the level of illness that a patient must suffer to justify covering an admission to a hospital or continuing to keep a patient in the hospital. In theory, many sick people can be cared for at home. Doing otherwise wastes scarce resources, such as money and hospital beds, and perhaps, unnecessarily disrupts patients' lives. However, for those who have insufficient resources for home care, a decision to not admit or discharge them heightens the risk of many factors of healthism. People who do not have a home simply cannot receive home-based care. Medical instructions requiring a caretaker are burdensome for those who do not have a person to help them throughout the time frame when they need assistance. It may be difficult or impossible to purchase the medical aids, special foods, or medicines that are required for those of limited means. Additionally, those with limited literacy or cognitive disabilities may have difficulty understanding and following complex directions. Accordingly, admission criteria may lead to reduced access to care and worse health outcomes, while compounding existing disparities.³³ Concrete evidence of this problem can be seen in readmission statistics, which consistently show that

33. In a study that sought to understand why patients living in poverty had worse outcomes after discharge than patients who had greater financial means, one patient explained, "I knew I couldn't do the things they were asking me to do. So, I just sort of gave up. I knew I would end up back in the hospital." Susannah M. Bernhein & Joseph S. Ross, *Hospital Discharge and the Transition Home for Poor Patients: "I Knew I Couldn't Do What They Were Asking Me"*, 29 J. GEN. INTERN. MED. 269, 270 (2013).

patients of lower economic status consistently have higher readmission rates than those who have more resources.³⁴

A focus on healthism and intersectionality reveals that a more holistic approach to broad coverage decisions is necessary to provide more just and effective treatment, as well as minimizing waste. Third-party payer decisions that seem facially neutral, such as what severity of illness justifies hospitalization, must consider the disparate effect of these decisions on those who are more vulnerable. A policy is certainly flawed when it worsens the effect of these background conditions, and perhaps is flawed unless it ameliorates them. For example, for those who do not have sufficient resources, the Medicare plan could be changed to provide coverage for a residential stay in an institution that can provide the proper level of care.

A final example is animus and bias for those with specific health conditions and those who have both a health condition and a particular trait that can be the focus of bias or outright bigotry. When making scarce resource allocations with regards to providing health care, some people will lose based on their health status, as the very decisions themselves concern which health problems are addressed and by what means. These decisions will be a challenge both when IPAB creates a package and when Congress chooses to alter the package's contents. However, these decisions can be made in a way that is honest and respectful, acknowledging trade-offs and minimizing the effect of animus and bias.

Congressional debates regarding the opening of a package is a particular area of concern. A debate over the allocation of scarce resources could inspire political catering to those with higher standing in the political system and distort the outcome in favor of those people, while worsening existing inequalities that led to others having lesser political power in the first place. It should be possible to minimize injustice in such a procedure.

34. *Id.* at 269.

Accordingly, defining healthism and being aware of the pernicious effect of healthism combined with intersectionality concerns is a significant first step. It seems, though, that more could be done. Given that these concerns are reasonable, it seems equally justifiable to require auditing of proposals prior to debate so that some effort is made to identify the negative effects of any proposal and the populations who stand to suffer from them, as well as the beneficial effects and those who will receive them.

IV. CONCLUSION

Some degree of healthism is possibly unavoidable in insurance markets and government-sponsored insurance programs. However, an awareness of healthism in its most pernicious form, particularly when combined with other forms of bigotry, can serve to help these programs become more just and ethically defensible.