2021

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With the United States Supreme Court hearing arguments to repeal the Affordable Care Act, COVID-19 being categorized as a pre-existing condition, and the idea of Medicare for All gaining traction among progressives, health care, specifically who, what, and how coverage is applied, is of the utmost relevance and an immediate concern to millions of Americans. People with pre-existing conditions, whose health care is currently protected by the Affordable Care Act, face an unprecedented risk of losing health care coverage; however, being in this precarious state is typical for people with disabilities, who have been fighting for their rights since before the term pre-existing condition existed. Broadly, this paper will look at the treatment of pre-existing conditions and disabilities in health care. I ask if pre-existing conditions should be considered disabilities and if protecting access to health care for people with pre-existing conditions should be a disability justice issue. Going even further, I will look at this not only as a theoretical question, but I will also consider the practical implications of treating pre-existing conditions as disabilities in health care policy. I will argue that the definition of disability should be expanded to include people with pre-existing conditions because both groups have shared experiences of discrimination in society on top of physical or mental pain, and the United States should adopt a universal health care policy so as to ensure that people with disabilities and pre-existing conditions are no longer discriminated against in health care. This paper will proceed in four parts. In Part I, I will define pre-existing conditions according to the definition given by the health insurance industry and explain the origin of the term. I will also go over the ways the Affordable Care Act and President Trump's executive order regarding health care have attempted to protect pre-existing conditions but have fallen short. In Part II, I will define disability based on the three models of disability as explained by Alison Kafer. I will also discuss how the Rehabilitation Act and the Americans with Disabilities Act are deficient in their protection of people with disabilities against discrimination in health care. In Part III, I will explain why the term disability should be expanded to include people with pre-existing conditions. I will also present and refute arguments against expanding the definition. In Part IV, I will argue that the optimal health care scheme to protect people with disabilities and pre-existing conditions is universal health care. It is optimal because it makes the term "pre-existing condition" irrelevant and will close gaps in coverage and insurance.

I. What is a Pre-Existing Condition?

A. The Origin of the Term

The term "pre-existing condition" is a product of the American health care industry. Because the health care industry, like any other industry in a capitalist country, is driven by profit motive, it logically follows that, "…for most of American history the health insurance industry and its governing laws have preferred an individualized account of fairness that favors 'healthy' people over those with ongoing health-care needs" (Roberts 1980-1981). People deemed healthy are less expensive and complicated to treat and thus insure, so insurance companies want to cover as many healthy people as possible. There are different definitions of a pre-existing condition that are dependent on the insurance company, type of insurance policy, and potentially the legal interpretation by the courts. All of the definitions share the basic notion that "A pre-existing condition is a health condition that predates a person applying for or

enrolling in a new health insurance policy" (*Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* 2). Another slightly more complex and specific definition of a pre-existing condition is "'a condition for which medical treatment or advice was rendered, prescribed or recommended within twelve months (three months for exempt employees) prior to [the] effective date of insurance'" (Polin 391). What both of these definitions have in common is their dependence on the existence of the insurance policy. Without the application for insurance coverage, there is no pre-existing condition because there is no relevant marker of time that delineates what was prior to the application for coverage. Pre-existing conditions are discussed as if they are a legitimate medical condition, but there is nothing medical about the origin of the term. The term exists to ensure that health insurance companies can make money by insuring as many healthy people and as few supposedly unhealthy people as possible.

Before the Affordable Care Act, the United States did not have federal regulations on who the insurance company could deny, so pre-existing conditions were used to deny coverage for a wide variety of reasons. For example, "…if an individual receives treatment for 'signs and symptoms,' which may or may not be related to or caused by an illness later diagnosed, insurance companies can feasibly deny coverage for such an illness" (Williams 381). A simple doctor's visit that much later down the line results in a diagnosis could give an insurance company a perfectly legal reason to either deny or revoke health insurance coverage. Any potential cost that a sick person could impose on an insurance company eats into that company's profits, so the company is incentivized to protect itself from those costs. Creating the idea of a pre-existing condition is the perfect way to do so.

Insurance companies protect their profits by limiting or denying coverage for people with pre-existing conditions. The first method that insurance companies use is to limit a person's health insurance coverage by denying coverage for the part of the body that is affected by the pre-existing condition. The second option is to charge people with pre-existing conditions an extremely high rate for insurance compared to healthy people. Lastly, companies can deny coverage entirely to a person with a pre-existing condition via a pre-existing condition exclusion clause in the insurance policy (Williams 375).

People with pre-existing conditions are numerous. As of 2017, it was estimated by the Department of Health and Human Services that "Up to 133 million non-elderly Americans—just over half (51 percent) of the non-elderly population—may have a pre-existing condition. This includes 67 million women and girls and 66 million men and boys" (*Health* 2). Insurance companies have used the term they fabricated to deny an estimated 18% of applications coverage in the individual market, and this number is likely an underestimate because many people who have health conditions chose not to apply for coverage because they were confident they would be denied (Claxton et al. 2).

Insurance companies argue that pre-existing condition exclusion clauses are necessary for their business model. This idea of a pre-existing condition exists because, "In the private sector, health insurers obtain their profits by accurately assessing the risks of their insureds" (Roberts 1970). Knowing whether or not a person who is seeking coverage will be relatively expensive to insure allows an insurance company to avoid taking on costs they deem unnecessary. Pre-existing conditions are a variable in a mathematical risk calculation; there is no consideration of the impact on a person's well-being that results from being labeled as having a pre-existing condition. Because for-profit businesses are risk-averse, "Insurance companies argue that the pre-existing condition clause is necessary to protect them from applicants who fail to disclose

known illnesses when applying for medical insurance" (Williams 376). The insurance industry is doing an excellent job maximizing their profits by avoiding risk, seeing as the top five companies earned approximately $787 billion in profits in 2019 (Herman). Insurance companies do not want to be slapped with unforeseen bills after granting coverage to people who did not know about or share their medical conditions at the time of signing the insurance policy. By creating pre-existing conditions, insurance companies have been able to successfully protect themselves from having to pay for people's health care. The people being denied are the people who have the greatest need for health care coverage because their conditions often demand a high quantity of very expensive medical attention. A system that allows insurance companies to reject people with pre-existing conditions is one that is not serving Americans well.

B. The Government's Attempts to Protect Pre-Existing Conditions

In 2010, during President Obama's administration, Congress passed the Patient Protection and Affordable Care Act (PPACA or ACA), which is a piece of landmark health care reform legislation that, in part, protects health care coverage for people who have pre-existing conditions. One of the "Major provisions of the ACA aimed to reduce high uninsurance rates among specific populations including…people whose preexisting health conditions had made it difficult to obtain affordable, comprehensive private insurance coverage, through prohibitions against denying coverage, charging higher premiums, or limiting coverage for people with such conditions" (Kaye 1015). These measures effectively reduced the uninsurance rate by 22% between 2010 and 2014. In other words, 3.6 million more Americans were insured as a direct result of the ACA's protections for pre-existing conditions (*Health* 2). In order to be sure that insurance companies can and will cover people with pre-existing conditions, there were steps taken such as ensuring a balanced risk pool to keep coverage affordable, providing financial assistance for those in need, and requiring an opt-out fee if people choose to go with private insurance so that revenue can supplement coverage for people with pre-existing conditions (*Health* 4). These steps were necessary in a private insurance market where insurance companies need to be able to make a profit and would experience extreme cuts in profit if they were forced to take on the costs of covering people with pre-existing conditions; the ACA did not challenge the fundamental for-profit business model of the insurance industry. The partial success of the protections for people with pre-existing conditions that were put in place by the ACA resulted in "improved access to health care for the population generally, including for people with disabilities, with across-the-board reductions in uninsurance and delayed or forgone care" (Kaye 1021). People with disabilities benefitted from the ACA because most disabilities are also considered pre-existing conditions, as will be discussed later. As such, the ACA acted as protection for people with pre-existing conditions and for people with disabilities.

President Donald Trump and the Republican Party have consistently condemned the ACA for being far too costly and for mandating that all people need to have health insurance. The mantra that the president and the Republican Party have adopted is "repeal and replace," i.e., repeal the ACA and replace it with different health care reform. Some Republicans have proposed replacement plans that weaken protections for people with pre-existing conditions, but President Trump had specifically said he intended to preserve these protections. The problem lies in the fact that no policy has been proposed or agreed upon by the Republican Party and President Trump, so there is no way to protect people with pre-existing conditions from either losing coverage or having to pay sky-high premiums if the ACA were to be repealed (Sarlin). President Trump made his desire to protect coverage for people with pre-existing conditions clear via an executive order issued in October of 2020 that "includes a steadfast commitment to

always protecting individuals with pre-existing conditions and ensuring they have access to the high-quality health care they deserve. No American should have to risk going without health insurance based on a health history that he or she cannot change" (United States 62182). This bipartisan support for protections for pre-existing conditions from both President Obama and President Trump's administrations is a victory, but there is no guarantee within this executive order that the protections will actually be maintained. In a private insurance market, requiring that all insurance companies cover people with pre-existing conditions cannot be done without mechanisms to support this kind of costly coverage. People with pre-existing conditions should absolutely be covered, but the private insurance market, absent strong regulations, is not capable of doing so.

C. The Shortcomings of the Government's Attempts to Protect People with Pre-Existing Conditions

While the ACA has made great progress in insuring people with pre-existing conditions, there are still millions of Americans with pre-existing conditions who are not insured or who do not have sufficient insurance. The ACA was fully implemented in 2014, yet "Tens of millions of Americans with pre-existing conditions experience spells of uninsurance. About 23 percent (31 million) experienced at least one month without insurance coverage in 2014" (*Health* 2). Evidently, more reforms are necessary to guarantee that all people with pre-existing conditions have health insurance coverage. The ACA falls short in that people with pre-existing conditions and disabilities experience inconsistent levels of income because their conditions can affect employment. This inconsistency in employment often results in being unable to afford the health care plan for which they were previously able to pay. Another way the ACA does not fully protect people with pre-existing conditions is that these people are often eligible for a variety of programs like Medicaid, expansion coverage, or a marketplace plan, so enrolling in one and then having to switch to another because of job loss or income fluctuation leaves gaps in coverage. These kinds of unpredictable changes can cause serious issues for people with health conditions in that different insurance policies cover different drugs, different doctors, different quantities of treatment, and different out-of-pocket costs and deductibles (Yee 19). People who need elevated health care because of pre-existing conditions are at a great health risk when they are being jockeyed back and forth between different types of coverage, and the ACA does not address these issues sufficiently. Considering pre-existing conditions as disabilities may provide more leverage in the fight for health insurance.

II. What is Disability?

A. The Different Models of Disability

There are three understandings of disability that are helpful in framing a discussion of the relationship between health care and disability. The first is the medical model of disability, which "frames atypical bodies and minds as deviant, pathological, and defective, best understood and addressed in medical terms" (Kafer 5). This model sees disability as a sickness, and sicknesses are meant to be cured. The disability is objectively bad, and, under this model, nobody could desire to have or live with a disability. The medical model creates a framework that makes it acceptable not only to attempt to rid society of disabilities but also of disabled bodies (Kafer 2).

As a result of the medical model's pathologizing of disability, critical disability scholars like Kafer argue society has both subconsciously and consciously set out to eradicate people with disabilities; the health insurance industry is built in a way that perfectly executes this goal. Because health insurance companies seek to cover healthy rather than sick people and have

created pre-existing condition exclusion clauses to carry out this agenda, people with disabilities are denied coverage or charged extremely high premiums that effectively price them out of the market. As such, people with disabilities are denied access to the health care that they may need to live. Society has accepted this state of affairs for a number of reasons, one of which is the common understanding that public health aims to reduce "…the incidence of disease and injury in a given population…Individuals with disabilities often acquire their impairments through disease and injury. Hence, the goal of public health—as it relates to individuals with disabilities—has historically been to prevent them from existing in the first place" (Roberts 1974). The medical model of disability creates a permission structure to either cure or altogether eradicate people with disabilities. It has also been accepted that people with disabilities or medical conditions should be responsible for offsetting the risk they pose to the health insurance companies because these conditions are the responsibility of the individual. This framework allows healthy people to feel no responsibility to support those who are deemed sick.

The social model of disability came about in response to the shortcomings of the medical model through the work of disability activism and critical disability scholarship. Under the medical model, there is no recognition of the hardships placed on disabled bodies by society; "In this framework, the proper approach to disability is to '"treat" the condition and the person with the condition rather than "treating" the social processes and policies that constrict disabled people's lives'" (Kafer 5). In contrast, the social model says that the only things that are disabling about an impairment are the social barriers. To make this argument, the social model invokes a distinction between impairment and disability; "impairment refers to any physical or mental limitation, while disability signals the social exclusions based on, and social meanings attributed to, that impairment. People with impairments are disabled by their environments" (Kafer 7). This shift away from viewing disability as purely a medical condition is extremely valuable, but a purely social model also falls short in accurately understanding disability.

Because of this impairment/disability distinction that is the cornerstone of the social model, there is a lack of recognition of the physical or mental toll a disability takes on a person that is separate from the toll the barriers in society take on people with disabilities. As such, the social model invalidates the physical pain that people with disabilities may experience and their desires to be rid of pain and other symptoms (Kafer 7). In addition, what society recognizes as an impairment can also change, so the idea that an impairment is an objective fact is not true. In reality, "…*both* impairment and disability are social; simply trying to determine what constitutes impairment makes clear that impairment doesn't exist apart from social meanings and understandings" (Kafer 7). Understanding that a person's body can be disabling is important in a discussion of health care. People with disabilities should have access to health care in order to lessen the disabling aspects of their impairments if they so choose. The denial of health care via pre-existing condition exclusion clauses or unaffordable premiums is a social barrier that can be disabling and can also exacerbate the disabling aspects of the impairment itself.

The most accurate framework and the most valuable contribution to the discussion of health insurance as it is related to people with disabilities is Alison Kafer's political/relational model of disability, which is the amalgamation of the medical and social models. In this framework, "the problem of disability no longer resides in the minds or bodies of individuals but in built environments and social patterns that exclude or stigmatize particular kinds of bodies, minds, and ways of being" (Kafer 6). This may not seem like a drastic departure from the social model, but the political/relational model importantly rejects the impairment/disability distinction. There is an acceptance of the desire for medical intervention, and thus a recognition of "…the

possibility of simultaneously desiring to be cured of chronic pain and to be identified and allied with disabled people" (Kafer 6). There is also a need to recognize that disability is inherently political. No decision that a person with disabilities makes is made in a vacuum; there are societal conceptions of what is normal or deviant that inform the decision a person with disabilities may make in terms of seeking treatment (Kafer 6). The idea is to question preconceived notions about disability and to approach disability neither as something to be cured nor as something that can be fully addressed by social reforms.

Another important aspect of the political/relational model is that it is intended to allow people to reimagine disability. The model "makes room for more activist responses, seeing 'disability' as a potential site for collective reimagining" (Kafer 9). How disability is understood through the medical and social models can be reshaped to better serve people with disabilities. Recognizing the need to address the medically disabling aspects of disability as well as the societal barriers that exacerbate disability is possible, especially under a health care scheme that ensures accessibility and affordability. There is also room in this framework to wrestle with who is considered disabled; "…a political/relational framework recognizes the difficulty in determining who is included in the term 'disabled,' refusing any assumption that it refers to a discrete group of particular people with certain similar essential qualities" (Kafer 10). There is an opening to expand the definition of disability, and this new definition can include people who are currently only labeled as having a pre-existing condition.

While disabilities have gone through and are still going through a reframing process that moves from the medical model toward a more widely accepted social and political/relational model, pre-existing conditions are viewed as purely medical. This medical framing of pre-existing conditions is due in large part to the term only being truly meaningful in the context of the health insurance industry. The term suggests that something is innately wrong with a person and gives the insurance industry a reason to deny insurance coverage. People with disabilities experience the same pathologizing of their bodies and exclusions from coverage, but people with disabilities have been able to organize as a group of people who are entitled to civil rights protections. People with pre-existing conditions have been unable to do so because their shared identity exists only on the basis of health insurance, and there has not yet been political mobilization or identity-building around the term; there is no recognition of the social aspect to the term because it is seen as purely medical.

The social model of disability is not sufficient for understanding disability because of the inaccurate impairment/disability distinction, and pre-existing conditions defy this distinction in the same way. People with pre-existing conditions may experience physical and mental pain that is exacerbated by social barriers just as people with disabilities do. The social barriers for people with pre-existing conditions can take the form of denial of health care on top of the other social barriers that apply to people with disabilities as well. The social model does, however, effectively illuminate that there are social barriers for people with disabilities and people with pre-existing conditions.

Ultimately, the political/relational model is best suited for justifying expansion of the definition of disability to include people with pre-existing conditions. People with pre-existing conditions, like people with disabilities, may be looking for a medical cure, but they may also be living with their condition. Both groups often have an elevated need for medical care and are excluded from health insurance coverage because of this need. Both groups are treated as a burden to society and are both politicized in the same way.

B. The Government's Attempts to Protect People with Disabilities

Like with pre-existing conditions, the government has attempted to protect people with disabilities against discrimination and has fallen short, especially in the health care system. Adoption of the social model of disability allowed people with disabilities to organize a civil rights effort because of the understanding that people with disabilities are discriminated against by society (Roberts 1982). There were two major pieces of disability rights legislation that passed as a direct result of the organizing that was possible when the disability community came to understand itself as a marginalized group. These were the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. The Rehabilitation Act prohibits discrimination against people with disabilities by programs that are associated with or receive funding from the federal government while the ADA prohibits discrimination against people with disabilities "in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications" (*A Guide to Disability Rights Law*). The ADA defines a person with a disability "as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered" (*A Guide to Disability Rights Law*). This definition leaves a lot of room for legal interpretation, which has proved detrimental to guaranteeing civil rights to a broad range of people with disabilities. Specific to health care, both pieces of legislation would seem to require that people with disabilities not be discriminated against in terms of access to coverage, but this does not hold true.

C. The Shortcomings of the Government's Attempts to Protect People with Disabilities

The government has sought to protect people with disabilities against discrimination, but the legislation that has been passed is not strong enough to stand up to legal challenges or close loopholes in discrimination in health insurance. The ADA's definition of disability, which is based on the definition from the Rehabilitation Act, uses the social model of disability and thus the impairment/disability distinction; "Pursuant to the definition, an impairment only becomes disabling when it leads to some kind of tangible restriction on a person's ability to function in her environment, in the form of a substantial limitation on a major life activity" (Roberts 1987). This definition results in the exclusion of people who identify as disabled and share in the same struggles as other members of the disability community but experience the disabling effects of their impairment independent of societal barriers, i.e. as chronic pain. The courts have interpreted the definition of disability along the lines of the social model as well; "In *Sutton v. United Airlines*, the Supreme Court ruled that individuals with successfully treated medical conditions – persons who are currently functioning well due to mitigating measures such as medications or prosthetic devices – are not protected as 'persons with disabilities' under the ADA" (*Policy Issue Brief*). The court essentially ruled that, if an impairment could be dealt with medically, it would be legal to discriminate against that person with the impairment. The protections against discrimination are only necessary to combat the disabling aspects of society. Again, this implementation of the social model results in the invalidation of the disabling features of an impairment and narrows the definition of disability to the disadvantage of the disability community.

The courts have also detrimentally ruled that health insurance companies are only obligated to offer the same standard of care to all people regardless of disabilities rather than being required to offer sufficient care for people with disabilities. Courts have consistently interpreted civil rights laws in terms of guaranteeing equal treatment rather than equitable treatment. The purpose of the legislation, as determined by the courts, is to make it illegal to treat

certain classes of people differently, and, in health care, this means the content of insurance policies cannot differ between able-bodied people and people with disabilities (Roberts 2005). According to the Seventh Circuit Court of Appeals, "coverage limits embedded in plan design and applicable to all purchasers would not violate the ADA's public accommodations statute" (Rosenbaum et al. 546). The ADA fails to truly protect people with disabilities from being discriminated against in health care because the policy is too passive.

There needs to be an active guaranteeing of rights to people with disabilities because their needs are different from the needs of able-bodied people. It is the purely civil rights structure of the Rehabilitation Act and the ADA that results in its failure to guarantee the right to sufficient health care for people with disabilities (Roberts 1965). Protecting against discrimination is not enough because "the term 'discrimination' does not convey the concept of invidious treatment of individuals with disabilities; rather, it describes generally how the insurance industry—with society's blessing—has been able to expose certain populations to higher financial risks because of their underlying health conditions" (Rosenbaum et al. 531). Doing away with discrimination as defined in this way does not go far enough because people with disabilities often require a higher quantity of expensive care. Policies made for able-bodied people are not likely to cover what people with disabilities need. For example, "Because people with disabilities often have on-going health-care needs, the focus on acute care means that private health insurance will not cover those required services over the long-term" (Roberts 1996). With the aim of health care being to cure people and discharge them from care, people with disabilities do not fit this framework for care and are not accommodated.

Another flaw in the ADA is a loophole that allows insurance companies to not only fail to provide equitable coverage for people with disabilities but also to discriminate against people with disabilities, specifically in the health insurance industry. This loophole, the so-called safe harbor provision, creates "…a safe harbor for insurance discrimination based on disability, as long as actuarial data supports the differential classifications" (Rosenbaum et al. 544). The idea is that, if an insurance company can demonstrate that a person with disabilities is going to cost more than the coverage they purchase, they can be denied coverage. This denial of coverage is supposed to be founded on a calculation of actuarial risk, but "In practice, insurers often refuse insurance or offer only very expensive and inadequate coverage policies to people with a wide range of various disabilities ranging from developmental disabilities that are present at birth to conditions acquired later in life such as breast cancer or traumatic brain injury" (Yee 17). Paying for people's health care is the original intent of health insurance, so this kind of profit-protection by the insurance companies defies the purpose of their existence. The ADA ultimately fails to protect against this discrimination.

D. Expanding the Definition of Disability

People with pre-existing conditions and disabilities have shared much of the same struggles and would both benefit from an expanded definition of disability that includes people with pre-existing conditions. As it stands, "Having a disability, defined according to limitations in activity or functioning related to a health condition or impairment, is conceptually distinct from having a preexisting condition, which could be anything for which one had previously sought treatment, but there is a substantial overlap between the affected populations" (Kaye 1015). This distinction need not exist under a reimagined definition of disability, and the existing overlap between the two categories presents a jumping off point. Almost every condition that is deemed to be a disability is considered a pre-existing condition (Roberts 1971). Pre-existing conditions that are not considered disabilities are often still impairments that have a disabling

effect on the body and can also be exacerbated by societal barriers. As such, pre-existing conditions fit almost seamlessly into the political/relational model of disability. Accepting that pre-existing conditions fit the political/relational model also means recognizing that pre-existing conditions are political, just as disability is political. Politicizing disability has been the work of critical disability scholarship and the broader disability rights movement, and Kafer is insistent that "Seeing disability as political, and therefore contested and contestable, entails departing from the social model's assumption that 'disabled' and 'nondisabled' are discrete, self-evident categories, choosing instead to explore the creation of such categories and the moments in which they fail to hold" (Kafer 10). Coming up with distinct, narrow legal definitions of disability and pre-existing conditions is harmful to both groups of people who have much to gain by forming a broad coalition.

More important than the legal definition of disability in the fight for rights, specifically the right to sufficient health care, is the building of a broad coalition, as discussed by Patricia Berne et al., Alison Kafer, and Robert McRuer, through expansion of the definition of disability. One of the most important principles of disability justice is a commitment to cross-disability solidarity; this movement for disability justice is "committed to breaking down the ableist/patriarchal/racist/classed isolation between people with physical impairments, people who identify as 'sick' or are chronically ill, 'psych' survivors, and those who identify as 'crazy,' neurodiverse people, people with cognitive impairments, and people who are of a sensory minority…[because] isolation ultimately undermines collective liberation" (Berne et al. 228). Broadening the coalition means that more people with an even wider range of disabilities have stake in advocating for health care. The broader the coalition, the harder it will be to legislate based on a narrow understanding of what disability means and the fewer people who get excluded from the final reforms. People with disabilities and pre-existing conditions have the shared experience of discrimination and lack of access to quality medical care even if their impairments differ drastically, and that discrimination is what can unify them all under the umbrella of disability (Kafer 11).

There are, however, valid concerns with the call for an expansion of the definition of disability. Because the severity of certain pre-existing conditions may be lesser than that of certain disabilities, there is the potential for the fight for rights and health care for severely disabled people to be watered down to accommodate only the more manageable of pre-existing conditions. People with pre-existing conditions who identify as disabled may have "able-bodied privileges" that cause much differentiation within the label of disabled (McRuer 36). To claim to be disabled despite maintaining able-bodied privileges requires a commitment to work to disavow these privileges. People with pre-existing conditions who have able-bodied privileges are still incentivized to work to achieve equitable and accessible health care because people with pre-existing conditions and disabilities experience the same kind of discrimination in health care, whether it is through exclusions or high premiums. The severity of the impairment may have an impact on to what extent a person is discriminated against, but, nonetheless, both groups of people have an interest in health care reform.

Another point of concern in expanding the definition of disability is the possibility of appropriation. It is true that "…[nondisabled people] risk appropriation, since the space for 'tolerance' for people with disabilities that compulsory able-bodiedness and neoliberalism have generated can make nondisabled claims to be crip look like appropriation (and, indeed, nondisabled claims to be crip could quite easily function as appropriation)" (McRuer 37). People who do not traditionally fall into the category of or identify themselves as disabled may be

appropriating disability by claiming this identity without being discriminated against or facing societal barriers the way that people who are traditionally considered disabled do, and this potential for appropriation cannot be entirely prevented. If nondisabled people start to identify as disabled, though, that may be a promising sign that people with disabilities are gaining rights and equitable treatment. People generally will not claim an identity if people with that identity are worse off in society, so there may be rights and privileges to gain if people are appropriating disability. While problematic, that appropriation may be a sign of progress. Questions like, "Can claiming crip be a method of imagining multiple futures, positioning 'crip' as a desired and desirable location regardless of one's own embodiment or mental/psychological processes?" indicate that, if more people are claiming to be disabled, society may be gaining a new understanding of what it means to have a disability (Kafer 13). Nonetheless, it is important to be wary of appropriation and the potential harms it can cause to the disabled community.

E. Universal Health care: The Health care Policy Most Suited to Protect People with Pre-Existing Conditions and Disabilities

Ultimately, implementing a universal health care system is the optimal reform to ensure that all people, but specifically people with pre-existing conditions and disabilities, are able to obtain sufficient and affordable health care. Universal health care will, importantly, not require that there be clear definitions and divisions between able-bodied people, people with disabilities, and people with pre-existing conditions because people who need a little or a lot of care will have all of their care covered. Universal health care also remedies the issue of uninsurance or gaps in insurance coverage for people who have pre-existing conditions or disabilities because there is no switching back and forth between plans, inability to pay, or denial of coverage.

The term "pre-existing condition" also becomes effectively irrelevant under universal health care because there is no longer a need to evaluate whether or not a person's medical condition will cut into the profit margins of an insurance company. Because everyone in the United States would be fully covered, there is no time when a condition would predate coverage and prevent someone from getting and maintaining coverage. People with pre-existing conditions would be able to identify as disabled based on societal barriers outside of denial of health care and how their pre-existing conditions can be debilitating to their bodies.

Universal health care will also function as civil rights legislation, despite being health care reform legislation. As seen with the ACA beginning to move toward reforms that protect people with pre-existing conditions and thus people with disabilities, "…non-civil rights statutes can affect civil rights outcomes" (Roberts 1966). Universal health care would accomplish the goals of civil rights legislation even more effectively than the Rehabilitation Act or the ADA were able to because universal health care guarantees the right to health care for people with pre-existing conditions and disabilities rather than just guaranteeing equal coverage, which is not sufficient. The fact of the matter is that "…universal health care serves the greater good, not just those with a heightened need for care, everyone stands to gain from access to expansive and affordable health care" (Roberts 2013). People with pre-existing conditions and disabilities all stand to gain from universal health care, but so does the rest of the country.

In sum, the definition of disability should be expanded to include people with pre-existing conditions because people with disabilities and people with pre-existing conditions have shared experiences of the disabling effects of their conditions as well as discrimination in society. To adequately address discrimination in health care, a universal health care policy must be adopted to guarantee that people with disabilities and pre-existing conditions are sufficiently covered.

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