

# The Struggle for the Soul of Health Insurance

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**Abstract** The politics of American health insurance is a struggle over which vision of distributive justice should govern: the solidarity principle or the logic of actuarial fairness. Actuarial fairness is central to American private health insurance. It is both an antiredistributive ideology and a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups, leading ultimately to the destruction of mutual aid. This fragmentation is accomplished by fostering in people a sense of their differences and their responsibility for themselves, rather than their commonalities and interdependence. Actuarial fairness developed as a business strategy for gaining market share. Medical underwriting, which is far more extensive than commonly known, is the information technology used for implementing actuarial fairness. Despite significant changes in the political context of health insurance which are leading toward restraints on underwriting, the logic of actuarial fairness is so deeply embedded in the structure of competitive markets in insurance and so deeply consonant with social divisions in American society that eradicating it will take more than any current reform proposals contemplate.

In the late 1980s, the trade associations of the health and life insurance industry sponsored an advertising campaign to persuade the reading public that "paying for someone else's risks" is a bad idea. In one of these ads, a photo of a workman in hard hat and tool belt straddling the girders of a steel tower was captioned: "If you don't take risks, why should you pay for someone else's?" Another ad showed a young man and woman playing basketball one-on-one and asked: "Why should men and women pay different rates for their health and life insurance?" The choral refrain at the bottom of each ad in the series went: "The lower your risk, the

lower your premium,” and the small print explained the relevant facts. For example:

Women under 55 normally incur more health care expenses than men of the same age, so they pay more for individual health insurance than men. After age 55, women generally have lower claims costs, so they normally pay less for individual health insurance than men of the same age.

That's why insurers have to group people with similar risks when they calculate premiums. If they didn't, people with low risks would end up subsidizing people with high risks. And that wouldn't be fair.

In late 1991, The Prudential Insurance Company ran a very different sort of ad campaign. In the *New York Times*, *Wall Street Journal*, and many newsweeklies, readers saw a photo of a chest X ray with a large white mass in the lower right quadrant. Though most readers couldn't interpret the X ray, the caption explained its significance: “Because he works for a small company, the prognosis isn't good for his fellow workers either.” The small-print text went on to explain how one employee's serious illness might cause a small company to be charged “excessively high premiums” come renewal time and how the company might even be forced to drop its health insurance coverage. The Prudential, readers were assured, didn't consider this situation fair and was backing legislation to “regulate the guidelines and rating practices of insurers.” Offering a rather different interpretation of fairness from the one in the trade association series a few years back, The Prudential opined, “After all, a small company shouldn't be forced to drop its health plan because an employee was sick enough to need it.”<sup>1</sup>

These advertisements have many layers of meaning. On the surface, the issue is how commercial insurers ought to price their health insurance policies. Just below the surface lurks the struggle over health insurance reform proposals in the states and Congress. But the underlying question is whether medical care will be distributed as a right of citizenship or as a market commodity. If, as “the-lower-your-risk-the-lower-your-premium” series commends, we charge people as closely as possible for the medical care they need and consume, then we are treating medical care like other consumer goods distributed through the market. If, like The Prudential,

we are unwilling to throw sick people and their fellow employees out of the insurance lifeboat, if we think perhaps the healthy should help pay for the care of others, then medical care becomes more like things we distribute as a right of citizenship, such as education. These advertisements symbolize two very different logics of insurance: the actuarial fairness principle and the solidarity principle.

At a deeper level still, these advertisements offer competing visions of community. They suggest how Americans should think about what ties them together and to whom they have ties. Consider hard hats and other workers in dangerous trades who get injuries and diseases doing constructive work for society: no one else, the ads say, should feel an obligation to pay for their risks. Take women of childbearing age, who are daily exhorted to assure the health of their babies, even those not yet conceived: no one else should finance their extra medical care for that purpose, least of all the men with whom they create the next generation (and recreate on the basketball courts). Alternatively, says the Prudential ad, 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.

Many things go into the making of community. Communities share a common culture and a way of perpetuating it. They establish processes for governance, conflict resolution, and self-defense. Above all, the people in a community help each other. Mutual aid among a group of people who see themselves as sharing common interests is the essence of community; a willingness to help each other is the glue that holds people together as a society, whether at the level of a simple peasant community (Scott 1976), an urban ghetto (Stack 1974), or a modern welfare state. What distinguishes mutual aid in the modern welfare state from that in peasant societies is largely a matter of scale: the number of people encompassed in the network of mutual aid, the degree of elaboration or rules and procedures for conducting mutual aid, and the number and variety of goods and services that are mutually provided.

All mutual aid systems are based on a shared definition of the legitimate reasons for redistribution—why, in what circumstances, and to whom people should give up something of their own and offer help. This is not to say there is no conflict over redistribution in a community; the boundaries of legitimate redistribution are constantly under challenge and always being redrawn (Stone 1988). But there is also a core of stable expectations about when people can expect help from one another.

While in most societies sickness is widely accepted as a condition that should trigger mutual aid, the American polity has had a weak and waver-

1. Each advertisement appeared several times in many places. I give here one citation where each may be found: Worker-in-hard-hat ad, *U.S. News and World Report*, 22 June 1987, p. 15; man-and-woman-playing-basketball ad, *USA Today*, 16 February 1987, p. 2A; Prudential chest X-ray ad, *New York Times*, 1 November 1991, p. A29.

ing commitment to that principle. The politics of health insurance can only be understood as a struggle over the meaning of sickness and whether it should be a condition that automatically generates mutual assistance. However, this is more than a cultural conflict or a fight over meanings. The private insurance industry, the first line of defense in the U.S. system of mutual aid for sickness, is organized around a principle profoundly antithetical to the idea of mutual aid, and indeed, the growth and survival of the industry depends on its ability to finance health care by charging the sick and to convince the public that "each person should pay for his own risk."

The central argument of this essay is this: Actuarial fairness—each person paying for his own risk—is more than an idea about distributive justice. It is a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of mutual aid. This fragmentation must be accomplished by fostering in people a sense of their differences, rather than their commonalities, and their responsibility for themselves only, rather than their interdependence. Moreover, insurance necessarily operates on the logic of actuarial fairness when it, in turn, is organized as a competitive market.

The essay begins by explicating the solidarity principle and the actuarial fairness principle as alternative visions of distributive justice. It then describes how actuarial fairness developed as a business strategy for gaining market share and how medical underwriting, the information technology for implementing actuarial fairness, works in practice. Next it describes significant changes in the political context of health insurance that seem to be leading toward restraints on underwriting—not the least of which is The Prudential Company singing the solidarity tune. I argue, however, that the logic of actuarial fairness is so deeply embedded in the structure of competitive markets in insurance and so deeply consonant with social divisions in American society that eradicating it will take more than any current reform proposals contemplate.

### The Solidarity Principle

Both social and commercial health insurance are mechanisms for pooling savings and redistributing funds from healthy premium payers to sick ones. They operate by two fundamentally different logics, however. Social insurance operates by the logic of *solidarity*. Its purpose is to guarantee that certain agreed-upon individual needs will be paid for by a

community or group. This is the logic of mutual aid societies and fraternal associations, as well as the logic of government social insurance programs. Having decided in advance that some need is deserving of social aid, a society undertakes to guarantee that the need is met for all its members. In the health area, the argument for financing medical care via social insurance rests on the prior assumption that medical care should be distributed according to medical need or the ability of the individual to benefit from medical care.

If medical care were financed like most market goods, by charging people for exactly the goods and services they consume, the ultimate distribution of medical care would be only partially according to need. Those who are sick and need care would come forward to purchase it, but among the sick, only those who could afford it would actually receive care. In addition, some who are not sick but who have resources might try to purchase care as well. People who could not afford to buy care would not receive any, regardless of their need for it or ability to benefit from it.

Social insurance unties the two essential connections of the market: the linkage between the amount one pays for care and the amount one consumes and the linkage between the amount of care one buys and one's ability to pay. Under a social insurance scheme, individuals are entitled to receive whatever care they need, and the amounts they pay to finance the scheme are totally unrelated to the amount or cost of care they actually use. (If there are coinsurance and deductibles in a social insurance scheme, the amount a person pays is slightly related to the amount one consumes.)

Of course, even social insurance does not guarantee that medical care is distributed exactly according to medical need. Need, after all, is a rather elusive concept, all the more so in the area of medicine.<sup>2</sup> Unlike most consumer goods, the value of medical care depends on its being customized. Whether a person can benefit from a particular medical procedure does not hinge on "tastes and preferences," as classical economic theory would have it, but rather on a correct match between a medical procedure and the person's particular pathology. The degree to which social insurance results in allocation of care according to need is mediated by the professional skill of medical personnel in matching procedures to pathologies. Many other factors influence the distribution of care as well, such as local professional norms about the appropriate use of procedures; the supply of

2. For an exceptionally insightful and nuanced dissection of the concept of unnecessary care, see Blustein and Marmor 1992.

medical facilities, personnel, and equipment; and ownership of diagnostic and therapeutic facilities, such as imaging centers and dialysis clinics (Hillman et al. 1990). All of these factors mean that even under a system of pure social insurance, medical care will not be perfectly distributed according to medical need. But the *ideal* of the solidarity principle is that we should strive to distribute medical care according to medical need and to limit the influence of ability to pay, past consumption of medical care, or expected future consumption.

At the same time, the solidarity principle does not require that medical care be distributed equally, in the sense that everyone gets the same amount. Social insurance is not a fixed shares arrangement, where each contributing member gets an equal slice of the pie. When people “pool their risks” as well as their savings in social insurance, they are taking their chances that they may never become sick or need expensive care, and that most of their contributions will go to help the members who do need expensive care. As in any lottery, they pay into the pot, regardless of whether they ultimately get to draw out of it.

In fact, only some members of a risk pool will get sick enough to need care. Since only those who get seriously sick will receive a payout, the others necessarily pay to help them. Thus, redistribution from the healthy to the sick is built into insurance. Payouts are made on the basis of need (or loss incurred), not on the basis of contributions to the scheme. Health policy analysts and corporate benefits managers frequently discover with great alarm that a small portion of insured people accounts for a huge proportion of claims expenditures, as though this skewing means that something is amiss. But subsidy from the vast majority of policyholders to a small minority is precisely what is supposed to happen in insurance. Such skewing is what people agree to when they join a social insurance risk pool. They accept it because they don't know, when they join, whether they will be on the giving end or the receiving end, and they want to protect themselves in case they are part of the unlucky minority. They accept it, too, because they believe that sickness is one of those contingencies when society should rally around the individual.

### The Principle of Actuarial Fairness

Commercial insurers, that is, private firms selling insurance as a profit-making venture, operate on a deep contradiction. They provide for pooling of risks and mutual aid among policyholders, much as social insurance does, yet they select their policyholders, group them, and price their policies according to market logic. When they speak of equity or distributive

justice, commercial insurers espouse the principle of actuarial fairness. It holds that premium rates should be differentiated so that “each insured [person] will pay in accordance with the quality of his risk” (Bailey et al. 1976: 782, citing Mowbray et al. 1969). By quality of risk, insurers mean the likelihood a person will incur whatever loss he or she is insured against. In life insurance, they are principally interested in factors that might affect life expectancy, while in health insurance, they are interested in factors that affect or predict a person's use of medical care. These include one's occupation, hobbies (since some are very dangerous), family medical history, personal medical history, and any medical information that is prognostic of disease, even if disease hasn't yet occurred.

Insurers assert that actuarial fairness requires them to seek the most complete risk information on applicants. An insurer has the “responsibility to treat all its policyholders fairly by establishing premiums at a level consistent with the risk represented by each individual policyholder” (Clifford and Iuculano 1987: 1806). To accomplish this task, insurers must have the “right . . . to create classifications to recognize the many differences which exist among individuals” (Clifford and Iuculano 1987: 1808). People who have diseases or serious risks to their health are in a sense getting a more valuable insurance policy than those with lesser risks, so they ought to pay more for the extra value. Or, to see the matter another way, if insurers did not identify people with higher risks, separate them from the general pool of policyholders, and charge them more, insurers would be causing a “forced subsidy from the healthy to the less healthy” (Clifford and Iuculano 1987: 1811). “An applicant presenting a low risk of loss to the insurer should not be required to subsidize another applicant who presents a higher degree of risk” (Hoffman and Kincaid 1986–87: 717).

Here is the crux of the conflict: the very redistribution from the healthy to the sick that is the essential purpose of health insurance under the solidarity principle is anathema to commercial insurers. Tellingly, insurers virtually never use the word *subsidy* without a pejorative modifier such as *coerced*, *forced*, or *unfair*. Although all insurance entails a subsidy from the lucky to the unlucky (whether for car accidents, diseases, or fires), commercial insurers eschew subsidy from one “class” of policyholders to another. (*Class*, in insurance jargon, means risk class, or a group of people with similar probabilities of becoming sick or, perhaps more accurately, with similar probabilities of generating costs to a company.) To commercial insurers, subsidy is not what they pursue but the *unwanted result* of their failure or inability to segregate people into homogeneous risk classes.

If the actuarial fairness principle could be perfectly implemented, if

we had perfect predictive information and precise rating, each person would pay for her- or himself. This, of course, would be the antithesis of insurance. (In fact, in a world of perfect predictive information, there would be no need and no market demand for insurance, because no one would stand to gain by "beating the odds." Since each insurance policy would be priced according to the medical care actually consumed by each policyholder, people would do better to pay for the care directly and avoid paying for the administrative expenses and profit margins of insurance companies. And since the price of insurance would be the same as the price of needed medical care, those who couldn't afford to pay for their own care couldn't afford to pay for insurance either.) Insurers rarely acknowledge that actuarial fairness undermines the solidarity principle of insurance, but the ultimate conclusion of their logic is clear. In the words of Robert Goldstone, vice president and medical director of Pacific Mutual Life Company:

In theory, every individual should have a different rate, based on a multivariate analysis of every possible health condition and risk factor that can be evaluated. (Goldstone 1992: 26)

### Actuarial Fairness as Business Strategy

For all the talk about fairness and equity, tailoring prices to finely differentiated risks is the keystone of insurers' competitive marketing strategy. They seek to gain a larger share of the market for various types of insurance by offering the lowest prices for coverage. A firm can offer lower prices if it can separate the potentially healthy from the potentially sick and offer insurance only to the healthy. Even defenders of the industry acknowledge that market competition and profit seeking drive the pursuit of actuarial fairness:

Although to a large extent the effect [of increasingly sophisticated risk classification] has been equitable . . . , it must be acknowledged that a motivation equally strong is competition between and among insurance companies. The competitive aspects have long been and remain now very compelling, with the insurance industry striving . . . to attract what are considered the best and most desirable insureds by classification devices which can lead to price advantages. (Bailey et al. 1976: 790-91)

Underwriting is the process insurers use to find "the best and most desirable insureds." In a sense, the customers of life and health insurance

companies are not only customers but raw materials. The more durable (long-lived) and well-made (resistant to disease) the policyholders are, the more money the insurance company makes. Underwriting entails gathering information about applicants to determine their risk status and then selecting the better risks to insure. Medical underwriting was first developed in the life insurance business. For most of the nineteenth century, life insurance was sold only to people who could pass a medical examination.<sup>3</sup> People who already had a personal or family history of disease, or for that matter worked in occupations deemed hazardous or unsavory, were refused insurance and labeled by the companies as "uninsurable risks." In the early twentieth century, several companies saw the potential for marketing higher-priced life insurance to people who did not meet the health standards for ordinary (or "standard") insurance, but who still had a very low risk of early death. This market niche was dubbed "substandard" business.

Many life insurance companies saw the substandard market as a way to gain new business. New companies sometimes saw it as a way to attract brokers (who presumably were having trouble placing their high-risk clients elsewhere), and some non-life companies (for example, those selling property or casualty insurance) saw the substandard market as a "way to get their foot in the door" of life insurance (Will 1974: 39-40). As recently as 1985, a British underwriting text said a life insurance company could expect to increase its business by about 5 percent by "accepting substandard lives on a broad basis" (Brackenridge 1985: 45).

To capture the substandard business, life insurers developed a measurement and classification scheme for calculating premium rates for people who normally would not qualify for life insurance. Known as the numerical rating system, it assigns debits and credits to applicants on the basis of their build (height and weight), health history and predictive diagnostic tests, family health history, occupation, and habits. An applicant is assumed to start at 100 percent of the standard risk and so starts with one hundred points. Each disease or abnormal diagnostic finding (such as high blood pressure) is assigned a number of points to be added to the standard risk. If a person has factors that contribute to longevity and health (such as a safe occupation or a good family history), he may receive some credits which will be subtracted from the total. All the points assigned to an applicant are added (or subtracted if they are credits) to

3. Some companies, notably The Prudential and Metropolitan Life, developed what was called "industrial life insurance" for the working class. This insurance was generally available without medical examination or with only a very cursory one, but it was available only for very small amounts.

reach a final numerical rating, which is said to be the person's mortality. For example, an applicant who received twenty-five debits for family history, twenty-five debits for excess drinking, and five credits for being in a safe occupation would get a total score of 145, for a mortality of 145 percent, or an "extra" or "excess" mortality of 45 percent. The actuaries then price a policy for someone deemed to have 45 percent excess mortality. Some diseases are considered so likely to result in early mortality that people with them are deemed uninsurable and refused any offer of a policy.<sup>4</sup>

One consequence of the codification of medical and epidemiological knowledge was that both life and health insurers no longer relied so heavily on staff doctors. Most underwriting decisions are now made by lay personnel, based on information disclosed by the applicant as well as information from applicants' physicians and medical records.<sup>5</sup> The underwriting departments of insurance companies use underwriting guides setting forth a detailed list of diseases and diagnostic tests and explaining how each medical finding is to be treated by that company. Many companies also provide their agents and brokers with a simplified version of this guide, often called a rating manual, and agents usually do a preliminary screening at the time they take an application. They are likely to determine on the spot whether a person or group will be accepted by the company.

The numerical rating system, and the underwriting guides and rating manuals it spawned, have all the trappings of scientific objectivity—medical terminology, elaborate matrices of diseases and point values, and numbers—but they often seem to be based as much on social prejudices and stereotypes as on empirical knowledge. For example, a 1930 pocket manual for agents of the Northwest Union Life Insurance Company (1930) begins a section titled "Uninsurable Risks" with the following statement: "Negroes, Chinese, Japanese, Mexicans and more than one-fourth blood Indians will not be considered" (p. 9). In the same guide, pregnant women are not acceptable until three months after "a normal childbirth," and "a married woman who has not borne at least one normal child is uninsurable until she has been married at least five years" (p. 5). A 1931 underwriting guide for accident and health insurance says that "health insurance should not be encouraged" for menopausal women, because "there are disturbed physical functions of many kinds, nervousness being

particularly common" (Hauschild 1931: 83). The same guide has this (and only this) to say about salpingectomy: "Removal of the tube connecting the ovary to the womb. Consider as due to gonorrhea and underwrite accordingly" (p. 83). The "founding document" of the numerical rating system, published in the *Transactions of the Society of American Actuaries* in 1919, uses the following example to demonstrate the importance of letting personal judgment override the numbers when underwriters use the numerical rating system:

Take, for example, a *clergyman, an occupation which is conducive to longevity*, whose build is most favorable, whose family is very long lived and whose habits are first class. The summation of all of these favorable factors may very well produce a valuation even lower than so favorable a combination would produce in nature. *Undoubtedly the stock from which such a risk springs has expressed its moral and its physical energy in the occupation and the temperate life of this individual.* On the other hand, the rating for a bartender who is known to use alcohol freely or from time to time to excess is not the algebraic summation of the two factors of Occupation and Habits for the reason that *the high mortality incident to the occupation of bartender is in part due of [sic] the fact that substantially all bartenders use alcohol freely.* The valuation of all such cases, especially where factors may be interrelated, must always be tempered by the judgment of the medical expert. (Rogers and Hunter 1919: 71–72; emphasis added)

Occupation was always an important aspect of life and health insurance underwriting (the *New York Times's* alarmed discovery of the phenomenon notwithstanding) (Freudenheim 1990). As the previous quotation illustrates, a great deal of stereotyping went into occupational ratings. Insurers theoretically group occupations into classes with similar average claims costs, but it is striking how the occupational tables of underwriting manuals parallel social class categories. Here are the six occupational categories used in one typical rating system:

- 5A Professional men (such as doctors of medicine, attorneys, certified public accountants, top management personnel from business, or professional people performing primarily office duties).
- 4A Sales managers and management-type salesmen dealing with buyers at the management level. The salesman does not carry demonstration equipment with him and does not travel by private automobile.

4. For descriptions of the numerical rating system, see Rogers and Hunter 1919; Shepherd and Webster 1957; Will 1974; Bailey 1985; and Brackenridge 1985.

5. A detailed description of insurers' sources of information in medical underwriting is in Stone 1992.

- 3A Real estate agents and salesmen of items usually demonstrated (such as typewriters, adding machines, or hardware). Contractors in the construction industry who do not do actual manual labor.
- 2A Self-employed small businessmen, including filling station operators, electricians, and plumbers. Highly skilled technicians and foremen ordinarily employed year-round.
- A Most skilled workers in trades having a relatively light occupational hazard and requiring dexterity rather than strength or lifting ability.
- B All individuals engaged in hazardous occupations, occupations involved in heavy physical work, and substantially all common, unskilled labor. (Closely paraphrased from Will 1974: 122–23)

Insurers use the term *insurability* as though it were a natural property of individuals, rather than a policy decision of a firm.<sup>6</sup> The classic industry textbook on life insurance lists several “reasons why some persons are not insurable.” Each of them is a characteristic of applicants—their imminent death, probable short life span, “poor health of such a nature that a premium cannot be computed because of lack of data relating to the risk involved,” or their dishonesty (Huebner 1935: 514–15). Contemporary insurance texts often state a numerical criterion for insurability: people are uninsurable for life insurance if their mortality is five or more times the standard mortality (see, e.g., Brackenridge 1985: 33). Insurability for health insurance has no single numerical cutoff point; instead, as insurance magazines and texts are quick to point out, insurability depends on the likelihood of need for expensive medical care for a person with any disease.

Insurance is a social endeavor, however, and insurability is a collective decision about membership, not a natural trait of individuals. A person is insurable if a group (fraternal organization, mutual benefit society, insurance company, government program) *decides* it will extend mutual aid to him or her. Commercial insurers’ treatment of insurability as if it were

6. Compare “Applicants for life insurance fall into one of two broad classes, insurable and uninsurable” (Mehr 1983: 458); “Medical insurability is not, however, a phenomenon suffered exclusively by those at risk of developing AIDS. Individuals suffering from developmental disabilities, physical or mental impairments, or chronic health conditions account for a large number of those who are unable to obtain individually purchased health insurance. Estimates place the number of uninsurables in the country today at one million” (Clifford and Iuculano 1987: 1822, footnote omitted).

an individual characteristic, or even a mathematically determined decision based on individuals’ natural traits, masks the way insurers create and control membership organizations through which people will conduct mutual aid. Of course, the mutual aid groups within commercial insurance are anonymous statistical communities of “homogeneous risk classes,” rather than real social or political communities with a common culture or decision-making structure. Still, this creation of exclusive sub-communities of mutual aid is the essence of insurance as a commercial enterprise.

Insurance underwriting, far from being a dry statistical exercise, is a political exercise in drawing the boundaries of community membership. That insurers always understood they were creating communities of privilege is very clear. When, in 1865, the Connecticut General Life Insurance Company petitioned for a charter to form the Connecticut Invalid Life Insurance Company to specialize in substandard risks, the petition noted that

as [the business of life insurance in this state and also the United States] is at present conducted, a large class of community is excluded from its blessing and benefits on account of imperfections of health and constitutional weaknesses. (Buley 1953: 113)

The author of a vanity history of the New York Life Insurance Company, who credits the company with invention of the substandard market, notes: “To most life companies there were only two classes of people in the world: one was entitled to all the privileges and benefits of life insurance; the other was entitled to nothing” (Abbott 1930: 279). The significance of the company’s development of the numerical rating system was best summed up, he says, by the company’s then president, Darwin Kingsley: “This contribution to Life Insurance has taken an innumerable army of men and women out of the Purgatory of the impaired and put them into the Paradise of the insured” (Abbott 1930: 287).

Today’s commercial insurance leaders are perhaps less purple in their prose but no less certain in their minds that membership in private sector insurance schemes is a privilege not all can or should share. In response to public controversy and concern over the implications of new genetic knowledge for access to health and life insurance, Robert Pokorski, a vice president and medical director of Lincoln National Life Insurance Company, directed and coauthored a report for the American Council of Life Insurance (ACLI 1989). The report’s authors agree that fairness, sound insurance principles, and the public interest will require life and health in-

urers to use genetic tests to determine insurability and prices. Discussing the topic of "Public and Private Insurance," Pokorski writes:

Many people believe they are entitled to both private life and private health insurance. . . . The United States has used private means to fulfill certain general social welfare needs such as payment for health care. But private health insurance has never been a completely adequate or universal method of providing access to the health care system, nor has it been a perfect mechanism for covering all diseases. *The poor, disabled, aged or seriously ill cannot always be covered by private means.* (Pokorski 1989: 10–11; emphasis added)

### Actuarial Fairness in Practice: Medical Underwriting in Health Insurance

The numerical rating system originally designed for life insurance became the core of the medical underwriting system in health insurance. Though the core technology was the same, however, the dynamics of health insurance competition were just the opposite of those in life insurance. In life insurance, an aggressive insurer would seek to identify relatively *high-risk* people who were being rejected by other companies and offer them insurance at a slightly higher price. In health insurance, if an insurer were able to identify a relatively healthy group of people, a group whose predicted rates of sickness and medical expense were lower than the standard risks on which premium rates are based, the insurer could profitably offer that group insurance at a lower-than-standard rate. As is now well known, this is the dynamic by which commercial companies plucked customers from Blue Cross/Blue Shield plans and thus gained a foothold in the health insurance market which they at first eschewed (Starr 1982: 295–310; Fein 1985: 10–32).

We have long understood how commercial insurers were able to use experience rating to segment the market into more homogeneous risk classes and thus gain market share. Experience rating is simply retrospective underwriting; insurers base their projections of future medical care consumption on how much medical care a group actually used in the previous year, instead of on less reliable personal questionnaires and epidemiological data. To summarize the story briefly, between 1934 and 1945, thirty-five states passed enabling legislation creating Blue Cross plans as hospital service corporations, granting them status as charitable organizations and exempting them from state insurance laws, reserve re-

quirements, and premium taxes. The main justification for this special treatment was their promise to provide health insurance for all people without regard to ability to pay. The Blue Cross plans (and later the Blue Shield plans covering physicians' services) used community rating. They charged the same premiums to all employee groups in a geographic area or industry, thus pooling the risks of illness broadly in a region.

When commercial insurers entered the market, they used experience rating. This pricing was the key to their strategy for gaining market share. By charging different premiums according to a group's actual use of medical services, insurance companies could offer lower rates to occupations, industries, or firms with healthier-than-average employees. Another variation on this strategy is euphemistically called "durational" rating. An insurer offers a small, healthy group or firm a low premium rate for the first year to lure it from another plan; then, as members of the group get sick and incur medical bills, the insurer raises the rates rapidly. Corporate benefits managers and small business owners would naturally choose to buy insurance from companies that offered them cheaper rates, so they would withdraw from the large Blue Cross/Blue Shield (BCBS) community pool, leaving a slightly less healthy group of people (on average) in the pool. BCBS then had to raise its prices to its remaining members. Eventually, most BCBS plans also gave up community rating.

What is less well understood is how commercial health insurers used *prospective* medical underwriting to attract "desirable risks" and screen out undesirable ones and what the impact of these practices is on access to health insurance and medical care. Insurers generally use the term *medical underwriting* to mean examination of *individuals* (or their records) to determine insurability and price a policy, and they consistently maintain that in this sense there is very little medical underwriting. Since most commercial health insurance is sold to large employee groups, and since (they claim) insurers do not screen individuals in large employee groups, very few people are affected by medical underwriting or put at risk of losing access to health insurance on account of their medical histories and prognoses. Thus, a joint report on genetic testing by the American Council of Life Insurance and the Health Insurance Association of America (ACLI-HIAA 1991: 5) asserts:

Most health insurance is not individually underwritten and so genetic testing would have no effect on the vast majority of health insurance consumers. About 85–90 percent of health insurance is currently purchased through group plans which accept all full-time employees and dependents without evidence of insurability.



This industry assessment of the impact of underwriting is both widely accepted<sup>7</sup> and highly misleading. First, 19 percent of workers who have employer-based coverage work for firms of fewer than ten employees, where individual underwriting virtually always obtains. Another 17 percent work for firms with between ten and twenty-five employees, where individual underwriting is extremely common.<sup>8</sup>

The industry assessment of the extent of medical underwriting is misleading, secondly, because there is a significant amount of individual medical underwriting even in fairly large employee groups. A 1987 survey of health insurer underwriting practices by the Office of Technology Assessment (OTA) (U.S. Congress 1988) found a substantial degree of individual underwriting in groups. Only 44 percent of commercial insurers said they never request a physician statement for some members of large group plans, and only 70 percent said they never use a physical exam for large group plans (i.e., nearly one-third sometimes require physical exams for members of large group plans) (p. 72, Table 2-12). One-third of Blue Cross/Blue Shield plans said they sometimes request an attending physician statement on selected members of large group plans (p. 75). Only 13 percent of commercial insurers said they never use attending physician statements in small group plans (p. 72, Table 2-12). Fully 58 percent of commercial companies and 7 percent of Blue Cross/Blue Shield plans said they were "using or moving towards" screening individuals for high-risk AIDS status in large employee groups (pp. 80-85).<sup>9</sup>

7. See Clifford and Iuculano 1987: 1809: "In contrast to underwriting for individual insurance, insurers underwriting group life and health insurance consider only the relevant characteristics of the *group*, not of the individuals who comprise the group. . . . Although no screening takes place in most group situations, there are at least three exceptions: (1) small groups; (2) late entrants to a group plan; and (3) large amounts of life insurance that are used to supplement basic coverage." See also footnote 9 below.

8. Figures are from the 1987 National Medical Expenditure Survey, cited in HIAA 1991: 7, Fig. 1. It is striking that the HIAA continues to say that no more than 15 percent of workers are subject to underwriting, when the organization obviously knows otherwise.

9. Despite the OTA's findings about the prevalence of individual underwriting in group insurance, the Executive Summary of its report repeats the industry's public relations estimate:

Group applicants for health insurance, who comprise 85 to 90 percent of all persons with health insurance and who obtain their health insurance predominantly through the workplace, seldom if ever, are subjected to individual determinations of their health status. (p. 3)

The general discussion prior to the survey results gives the same impression, suggesting that only very small groups of up to fifteen employees are individually underwritten (p. 44). The discrepancy between the OTA staff's own findings and its summary of its whole investigation in the report suggests the extraordinary power of the industry to influence the perceptions of even a scientific staff agency of Congress. Representatives of the commercial life and health insurers, Blue Cross/Blue Shield, and HMOs were members of the advisory panel for the OTA's study and helped design the survey.

A survey of insurers by the Colorado Division of Insurance found an even greater degree of individual medical underwriting in large group policies than the Office of Technology Assessment, in part because the Colorado survey specifically asked insurers about the group size at which they start to underwrite (Yondorff 1990).<sup>10</sup> According to this survey, 11 percent of all commercial accident and health insurers and nonprofits require individual medical underwriting for *all groups*, regardless of size; 18 percent underwrite groups of up to ninety-nine people; 25 percent underwrite groups of up to seventy-four people; 33 percent underwrite groups of up to forty-nine people; and 40 percent underwrite groups of up to twenty-four people (p. 15, Table 8).

A third reason the industry estimate of the prevalence of underwriting is too low is that it ignores a major device for acquiring medical information about employees in large groups *without* obtaining it directly from the employees. Even when employee groups are large enough to escape traditional individual medical underwriting, insurers often require the employer to submit medical information about individual employees and their dependents. This information is gathered through medical questions on the master application for a group, questions called "risk-finder questions" or "gatekeeping questions" in the industry. Typically, one question asks whether, to the best of the employer's knowledge, any employee or dependent had claims over a certain amount (say \$2,500 or \$7,500) during the previous year or two years. The master application also includes questions about medical problems among employees and their dependents, such as:

Has any employee or dependent had heart disease, cancer, kidney disorder, stroke, or other serious disease?

To the best of your knowledge, during the last 24 months, has any of the employees or dependents to be covered received treatment for cancer,

10. Although this survey covers only insurers operating in the Colorado health insurance market, it is still the best and most important survey on underwriting practices. It asked questions very precisely to elicit clear answers. For example, it asked "What is the smallest group you will cover on a group underwriting basis without individual medical underwriting?" The Office of Technology Assessment survey, by contrast, asked respondents to distinguish their answers to all questions for "individuals" and "individually underwritten groups—i.e., those groups which are too small to qualify for experience rating and whose members must be individually underwritten" (U.S. Congress 1988: Appendix D, p. 184). Thus, the OTA survey was incapable of determining insurer policies about individual underwriting and group size. The Colorado survey also asked many questions about quasi-individual underwriting via "risk fact-finder questions," an important phenomenon discussed below in the essay. Although this was a survey limited to one state, the respondents accounted for 68 percent of the total state insurance market, including nineteen of the top twenty insurers in the state and many large insurers who operate in multiple states.

kidney ailments, diabetes, heart, immune system disorder, psychological, alcohol, or drug disorders?

Are there any employees or dependents with medical conditions that may require hospitalization or surgery within the next 6 months?

Has any of the covered employees/dependents been hospitalized within the last 12 months?

When the answer to any question is yes, the employer is sometimes required to provide the names of employees or dependents and more medical information about them.<sup>11</sup>

Since these group applications request medical information about individual employees and dependents, even though employees do not fill out medical questionnaires, this is really *quasi-individual medical underwriting*, and it is very prevalent. The Colorado survey found that 59 percent of insurers require a risk-finder questionnaire for groups of up to forty-nine people. Nearly half of all insurers (48 percent) require the questionnaire for groups of up to ninety-nine people, and over one-third (36 percent) require it for groups of up to 199 people. Nearly one-third (32 percent) require a risk-finder questionnaire on all groups, regardless of size (Yondorff 1990: 45, Table 15).

In addition to traditional medical underwriting, there is a vast amount of what insurers informally call "underwriting at claims time," after an insurance policy is already in force. When an insured person or the medical provider submits a claim for payment, the insurer must make a decision whether to pay the claim. At this point, individual medical information enters again. The key vehicle here is the *preexisting condition clause*. Preexisting condition clauses exclude payment for any condition the applicant had prior to the insurance contract.<sup>12</sup> They differ from exclusion waivers in two important ways. First, to write an exclusion waiver into a policy, insurers must detect some problem, from either the applicant's medical

11. I am interviewing insurance agents and brokers as part of a larger project. Information about the content and handling of gatekeeper questions comes from these interviews and from health insurance application forms.

12. These clauses vary in three dimensions: (1) the period of time before the policy takes effect, during which a condition must have appeared or been treated to be considered preexisting; (2) the period of time a person must be "treatment free" after the effective date of the policy before the condition is eligible for coverage in the new policy; and (3) the period of time a person must be covered under the policy before the preexisting condition can be covered, regardless of whether the person has received treatment. This is the waiting period. Typically, for each of these three dimensions, the time period can range from three months to two years, depending on the insurer and the policy.

records or the application, *in advance of issuing the policy*. The policy then specifically names the condition (or body part or system) as excluded. With the preexisting condition clause, insurers do not need any information about the applicant. The clause is like a wild card. It allows the insurer to refuse payment (tantamount to not insuring) for any condition the person had prior to the policy issue date, even when no information about the condition turned up in the medical underwriting process.

Preexisting conditions are generally defined in insurance policies as conditions which "manifested themselves," "existed," or "were treated" before the effective date of the policy. These words leave some leeway for interpretation, especially the "existed" criterion. Insurers have insisted on their right to refuse payment even for treatment of conditions which had not been diagnosed prior to the claim and of which the applicant had no knowledge. Courts have often upheld insurers on this point.<sup>13</sup>

Because of the wild-card property of the preexisting condition clause, it is much more potent than the exclusion waiver and can be applied to many more people. Thus, the second key feature of the clause is that, unlike the exclusion waiver, it can be, and is, widely applied to group policies. According to one survey of two thousand employers, 64 percent of firms with fewer than five hundred employees and 45 percent of firms with more than ten thousand employees used these clauses in their policies (Colton 1991, citing a survey by Foster Higgins). Preexisting condition clauses have the same effect as exclusion waivers—denying coverage for precisely those illnesses people have—without insurers having to do any underwriting at all.

Though we still do not know exactly how many people are affected by medical underwriting, the number must be vastly greater than either the insurance industry or the Office of Technology Assessment report suggests. Consider that about 44 percent of the work force are self-employed or employed in firms of under one hundred employees.<sup>14</sup> Of workers who have employer-based health insurance, 36 percent work in firms of twenty-five or fewer employees, and 60 percent work in firms of one

13. *Dear v. Blue Cross of Louisiana*, 511 So. 2d 73 (La. App. 1987) (insurer entitled to deny payment for a condition that predated the effective date of the policy, even though there had been no diagnosis or treatment but only symptoms); *Hanum v. General Life and Accident Ins. Co.*, 745 W.W. 2d 500 (Tex. App. 1988) (insurer may deny payment under preexisting condition clause for a condition which, though not diagnosed prior to the policy, manifested itself in symptoms from which one learned in medicine could diagnose such a sickness or illness). See also Goldstein 1988.

14. *Citizens Fund* 1991: 22, Table 4 (calculated from Current Population Survey, March 1990; figures are for 1989).

hundred or fewer employees, where, incidentally, self-insurance is not prevalent.<sup>15</sup> From what we know about medical underwriting in groups, the number of people subject to medical underwriting is almost certainly much larger than the 10 to 15 percent of people with commercial health insurance claimed by the insurance industry. A more accurate guess, taking into account all forms of individual medical underwriting, including risk-finder questions and preexisting condition clauses, and taking into account family members' dependence on the insurability of breadwinners, might be that at least half of those with commercial insurance are subject to some form of underwriting.

What happens to people who are subject to medical underwriting? When an individual or group is found to have high risks for disease and so not qualify as a standard risk, insurers might do several things. In the individual market, insurers can reject the applicant altogether as uninsurable; accept the applicant but charge a higher premium ("substandard rates"); accept the applicant but exclude coverage for a disease or organ or body system (called an "exclusion waiver"); or apply *both* an exclusion waiver and substandard rates. In the group market, the options are similar but include treating some members of the employee group differently from others. Thus, an insurer can reject a whole group; accept most of the group but exclude individuals who are deemed high-risk; charge a higher rate for the whole group or, alternatively, increase the rates only for the high-risk individuals in the group; limit the conditions or amounts covered either for the whole group or for certain members of the group; or *both* limit coverage and charge higher rates. (In some states, insurers are required to accept or reject an entire group, and it is in these states that they are likely to reject a group with a few sick or high-risk members, because they cannot control the membership of their insured pool.) All of these responses, of course, directly undermine the purpose of health insurance from the point of view of the solidarity principle or the distribution of medical care according to need; they ensure that the costs of care must be borne by those who need it, and they grant access to medical care (via insurance coverage) to the healthiest people instead of to the sickest. Exclusion waivers, moreover, are a major contributor to underinsurance, since they deny coverage for precisely those medical conditions a person has and is likely to need treatment for.

It is very difficult to know what insurers actually do when faced with high-risk applicants. Since underwriting itself is a chief component of

firms' competitive strategy, insurers are not eager to disclose their practices. An even more important obstacle may be that most insurers do not keep statistics on their underwriting decisions. In the Colorado survey, only 19 percent of respondents said they keep statistics on the number of groups that apply each year and are declined (Yondorff 1990: 20, Table 13).

We can get some indication of the impact of medical underwriting on access to health insurance by looking at the Office of Technology Assessment figures for the individual insurance market in 1987–88, where everyone agrees that individual medical underwriting is universal. The OTA survey found that within the commercial individual insurance market, around 8 percent of applicants are rejected outright for medical reasons. Commercial insurers apply exclusion waivers to another 13 percent, charge higher premiums to 5 percent, and use both exclusion waivers and higher premiums for 2 percent (U.S. Congress 1988: 62). Taking these groups together, fully 28 percent of applicants do not meet the medical criteria to qualify as standard risks. Assuming that people who apply for commercial individual health policies are representative of the population (and they are probably not), we might extrapolate that 23 percent of people would be deemed uninsurable or subject to exclusion waivers if they had to submit to medical underwriting. (Here I have excluded the 5 percent who would have access to insurance if they could afford the higher rates; 23 percent represents the number who would be completely uninsured or underinsured if they had to undergo medical underwriting.) In fact, people who apply for commercial individual health insurance policies are probably wealthier and more educated than average and therefore probably also healthier (if basic epidemiology is right), making the 23 percent estimate *low*.

The Colorado survey asked insurers what actions they took and which action they take most frequently in the group market. Over half the insurers (54 percent) mentioned rejection of the group as the action most frequently taken when underwriting turns up adverse results. Fifteen percent said their most frequent action was to accept the group but exclude the high-risk individuals. Another 15 percent said their most frequent action was to limit coverage of high-risk individuals in the group (Yondorff 1990: 16). Needless to say, each of these actions causes some people to be uninsured or underinsured.

Another way to estimate the impact of medical underwriting on access to health insurance is to determine what portion of the citizenry would be ineligible for standard-risk insurance if they were subject to

15. HIAA 1991: 7; citing figures from the 1987 National Medical Expenditures Survey.

individual underwriting. The Citizens Fund of Washington, D.C., used the underwriting manual of a large insurance company to identify medical conditions that would lead to denials, substandard rating, or waivers and then estimated the prevalence of those conditions in the general population from epidemiological surveys. Using this method, the study found that 81 million people under age sixty-five would not qualify for standard insurance if they had to submit to medical underwriting (Citizens Fund 1991: 8). This amounts to about 33 percent of the population, quite a bit higher than the estimate yielded by extrapolating from the OTA survey for the individual insurance market. The Citizens Fund estimate also corresponds rather nicely with a *New York Times* survey on "job lock," in which 30 percent of respondents said they or someone in their family had stayed in a job they wanted to leave mainly because they feared losing health insurance (Eckholm 1991).

#### Where Does It All Lead?

The logic and methods of actuarial fairness mean denying insurance to those who most need medical care. The principle actually distributes medical care in *inverse* relation to need, and to the large extent that commercial insurers operate on this principle, the American reliance on the private sector as its main provider of health insurance establishes a system that is perfectly and perversely designed to keep sick people away from doctors. Many insurance regulators accept this view of insurance as well. A state insurance commissioner defended commercial insurers' use of HIV tests in medical underwriting by saying:

We encourage insurers to test where appropriate because *we don't want insurance companies to issue policies to people who are sick, likely to be sick, or likely to die.*<sup>16</sup>

The commercial industry needs advertisements like "the-lower-your-risk-the-lower-your-premium" series because it is not easy to persuade the public or its elected officials that the task of health insurers and their regulators is to keep sick people away from medical care. These ads were designed to persuade people that actuarial fairness, not solidarity or subsidy, is what insurance is all about. They are another element in the

campaign, so elegantly described by David Rothman in this issue of the *Journal of Health Politics, Policy and Law*, to persuade the middle classes to distinguish themselves from the poor, sick, and unfortunate and to feel morally comfortable about refusing to help others.

Nevertheless, despite the heavy public relations conducted by life and health insurers in the 1980s, the political context of commercial insurance has changed, perhaps unalterably. First, we are in a period of extremely heightened concern about health insurance. As every newspaper reader knows, health insurance was the issue that catapulted Harris Wofford to victory in the 1992 Pennsylvania Democratic primary for the U.S. Senate, after which, health insurance reform became a prominent issue in the 1992 presidential race, and a major plank in President Clinton's agenda.

Second, the AIDS epidemic and the development of blood tests for HIV antibodies pushed insurance underwriting practices into the public spotlight. Insurers defeated bills or regulations in four states and the District of Columbia that would have prohibited the use of HIV tests to screen applicants for life and health insurance,<sup>17</sup> but not without the cost of enormous publicity about and research into medical underwriting more generally. The gay community, through its well-organized support groups and legal rights organizations, was instrumental in investigating and challenging medical underwriting. The Office of Technology Assessment report cited earlier was the direct result of congressional fears that commercial insurers would use medical underwriting to avoid paying for care of people with AIDS, leaving these costs entirely to the public sector.

Third, in the late 1980s and early 1990s, when the battle over insurers' use of HIV tests seemed to have been lost, researchers in the congressionally funded Human Genome Project identified a spate of disease-causing genes—for Huntington's disease, some forms of muscular dystrophy, and cystic fibrosis, among many others—and seemed to be on the verge of finding many more, such as a genetic marker for familial breast cancer. Publicity about these discoveries generated enormous popular media speculation about the impact of gene identification on access to health insurance and jobs.

Finally, the presidential election, the HIV epidemic, and the Human Genome Project all happened after a significant political reconceptualization of disability had occurred in the United States. In political and policy arenas, if not the medical community, disability had come to be understood as a problem of discrimination as much as, or even more

16. Statement made at a meeting (17 February 1987) of the Advisory Panel to the Office of Technology Assessment for its study, *Medical Testing and Health Insurance* (U.S. Congress 1988). I was a member of this panel.

17. In California, the prohibition on HIV tests in health insurance underwriting still stands.

than, a medical problem. People with disabilities and their advocates were already well organized in that set of groups and ideas that constitute the disability rights movement, and civil rights legislation protecting people with disabilities was well established at the federal level (in Section 503 of the Vocational Rehabilitation Act of 1973) and the state level (in a variety of Fair Housing and Employment acts, as well as a few specific state statutes protecting people with particular disabilities from insurance discrimination). In this political context, the identification of new diseases and disease-causing genetic defects creates new categories of people who consider themselves deserving of protection under handicap discrimination principles, and the use of any diagnostic tests or genetic information by insurers will inevitably be interpreted through the lens of civil rights. The disability rights community lobbied hard for protection against medical underwriting in the 1991 Americans with Disabilities Act and probably failed (see Rothstein 1992), but the crystallization of the issue around a major new piece of federal legislation only put the spotlight on underwriting once again.

Insurers have faced numerous challenges to their underwriting practices, and the industry has proven extremely resistant and resilient in the past. As early as the 1880s, several states tried to prohibit life insurance companies from charging higher rates to blacks than whites (James 1947: 338–39). In the late 1960s and 1970s, the property insurance field was plagued by the issue of “redlining,” wherein racial composition of a neighborhood was an explicit factor in determining the availability of mortgages and property insurance. Also in the 1970s, the use of gender as a factor in pricing life and disability insurance, as well as automobile insurance, was highly contested. Disease-based interest groups (notably for those with Tay-Sachs disease and sickle-cell anemia and DES mothers and daughters) challenged the use of “their disease” as an underwriting criterion in life and health insurance and succeeded in winning protections in several states. In the late 1980s, the dominant underwriting issue was life and health insurers’ use of sexual orientation (as a proxy for AIDS risk) and then HIV tests. For the most part, insurers were able to defeat restrictions on their underwriting criteria, either by defeating bills and regulations outright or by inserting narrowing language to permit the use of criteria that are “actuarially sound.”

There are reasons to think, however, that the current challenge to medical underwriting is far more serious and pervasive than any earlier challenges. For the first time, the entire system of medical underwriting and the principle of actuarial fairness is being called into question. Several

states have begun to prohibit some forms of medical underwriting and push insurers back to community rating. Virtually every proposal for national health reform includes some kind of ban on medical underwriting, whether a prohibition of preexisting condition clauses or a requirement for “guaranteed issue” health insurance. (Guaranteed issue does not mean what it sounds like—guaranteed access to health insurance. Far more modest, it requires that *if* an insurer accepts a small group, it *must* insure all employees and may not exclude one or a few for medical reasons.) Even President Bush’s reform plan of 1992<sup>18</sup> would have included guaranteed issue and prohibited denial of health insurance for reasons of health, though the plan would have allowed insurers to base their rates on individual health status. The Health Insurance Association of America, too, abandoned some of its attachment to the actuarial fairness principle, and began calling for guaranteed issue and less medical underwriting in the small business market (HIAA 1991).

The election of Bill Clinton shifted the political center of gravity in health insurance reform to the federal level, another major political change. In the past, health insurance (like all insurance) has been mostly a matter of state jurisdiction, and major insurers were able to use this fragmentation to their advantage. Challenges to underwriting practices would necessarily arise in state legislatures or sometimes in insurance departments, which could be picked off one by one. Detail teams from the Health Insurance Association of America and the American Council of Life Insurance could overwhelm local legislators with their technical expertise, and insurance PAC money could buy state votes. Moreover, when regulation of underwriting practices is a state matter, insurers have the potent weapon of the exit threat. (When the District of Columbia tried to stop insurers from using HIV tests, the large companies simply said they would stop writing business in the district. Congress caved shortly thereafter.) Now that underwriting is up for discussion in Congress, the White House, and the Department of Health and Human Services, insurers have a more formidable opponent.

The political actors and alliances participating in the insurance issue have also changed dramatically. Up until recently, commercial insurers were a potent and usually united force, whenever there were public policy challenges to their underwriting practices in the form of proposed regulatory or statutory constraints. The commercial industry is no longer the

18. The President’s Comprehensive Health Reform Program, 6 February 1992, Washington,

political behemoth it once was (Carlson 1992; Garland 1992; Kirk 1992; Kosterlitz 1991, 1992a, 1992b). Several of the largest commercial insurers—CIGNA, Aetna, and Metropolitan Life—have withdrawn from the Health Insurance Association of America, taking millions of dollars in dues and fees with them. They are positioning themselves to be players in any nationally mandated health insurance scheme. Small firms and large brokerage firms oppose many of the small-group market reforms advocated by the larger firms. Insurers are regrouping into new coalitions with other health care interest groups and small businesses. Many firms have ceased writing health insurance, so that there are fewer firms in any coalition to stop health insurance reform. The commercial industry finds itself in competition with some of its old allies—the large corporations who used to be major customers but who now self-insure and, incidentally, are not subject to the state insurance regulation that governs the commercial sector. Indeed, many in the commercial industry promote regulation of the self-insured sector by rewriting some of the ERISA exemptions, a position which creates a deep split between commercial insurers and other big business.

By now, most of the large insurers, as well as the Health Insurance Association of America and other industry trade groups, have acknowledged that underwriting and “cream skimming” are problems to be addressed. The Prudential Company’s X-ray advertisement testifies to this rush to the side of the angels. With the fragmentation of the health insurance industry, hastened by the withdrawal of most large employers from commercial markets as they self-insured, and with the simultaneous rise of the health insurance issue to the presidential agenda, imposing public policy goals on private insurers is no longer politically unthinkable. But is it doable? Can a state—or even federal—ban on preexisting clauses or on denials for medical reasons really change the way health insurance operates? Can a few regulations change the balance of human raw materials—middle-class and poor, healthy and not-so-healthy, young and old—between the private sector and the public fisc?

Big change will not come easily. Piecemeal restrictions on underwriting that ban the use of specific medical tests or diseases (such as HIV tests or genetic tests) are clearly not going to be very effective. Though insurers might not be able to ask directly about specific tests or diseases, their network of information sources on any individual is so extensive that they are likely to acquire the information by other means (Stone 1992). They are also likely to resort to cruder, more exclusive proxy measures when they are legally forbidden from using information they believe they need.

(When California banned the use of HIV antibody tests in health and life insurance underwriting in 1985, insurers tested applicants with the T-cell test instead [Battista 1989: 26]; many continued using sexual orientation as a proxy measure for AIDS risk and using occupation, zip code, and beneficiary designations as proxies for sexual orientation.)

Medical underwriting and the belief in the principle of actuarial fairness are so deeply embedded in the structure of business and the mentality of insurance employees that they will be hard to eradicate. Public policy has, for over a century, both permitted and exhorted insurers to compete in the market, on the theory that competition would breed innovation, efficiency, and ultimately public welfare. Insurers quickly discovered that, in health insurance, the most effective competitive strategy was risk segregation and selection. To restrain this kind of behavior while the rest of the competitive economic environment does not change is a tall order. Billions of dollars, millions of jobs, and innumerable organizations depend on the underwriting function. Some examples: The National Association of the Self-Employed, with 165,000 members, probably wouldn’t exist but for the fact that it offers health insurance to members. The Council of Smaller Enterprises in Cleveland, a leading opponent of small-group market and national reforms, brokers health insurance coverage for about 8,500 small businesses (Carlson 1992). For small insurance agencies, a substantial part of their business is simply *re-placing* small businesses with new insurers, and these companies would not be looking to move were it not for the competitive underwriting that gives them an incentive to shop.

Even if there were a comprehensive statutory ban on medical underwriting in health insurance, the infrastructure of medical underwriting will remain in place because it will continue to be used for life insurance. Insurers will still have medical underwriting departments and the concomitant capacity to gather medical data. Likewise, the Medical Information Bureau, the industry’s central data bank for medical information on insurance applicants and policyholders, will continue to operate for and be financed by life insurers (see Stone 1992).

What risk classification and segregation insurers cannot accomplish through direct medical underwriting they can often accomplish through targeted marketing and through pricing. In 1900, Frederick Hoffman, then chief statistician of The Prudential Company, wrote that many states had passed laws “compelling Industrial [life insurance] companies to accept Negro risks at the same rates as those charged the white population. “Fortunately,” he observed, “the companies cannot be compelled to

solicit this class of risks, and very little business of this class is now written by Industrial companies, practically none by the Prudential" (p. 153). It is no accident that HMOs and other managed care plans feature their maternity and fitness club benefits when they market their plans to large employee groups: they are appealing to the young and the health-conscious. Through targeting of their sales efforts and tailoring of their benefit packages, insurers can accomplish a great deal of sifting.

Without requiring any medical information or performing any medical underwriting, insurers could offer low-priced policies excluding coverage for various serious diseases, or even excluding only expensive tests and treatments for certain diseases. In the competitive market, customers would shop around for the best deals to suit their budgets and their risk preferences. Those who know (or think) they have a low risk for particular diseases would buy just the policies tailored to their own risk profiles. Through self-selection and pursuit of the almighty bargain, individuals would sort themselves into homogeneous risk classes, albeit perhaps not as refined as the classes achieved through underwriting. The market could accomplish for insurers what government forbids them to do for themselves. Indeed, a great deal of exactly this kind of sorting is already happening within large groups, as insurers and self-insured employers offer employees "freedom of choice" among plans ranging from low-cost, no-frills plans to richer, more comprehensive benefit packages (Kramon 1992).

If risk classification is central to the economic organization of commercial insurance, it is perhaps even more central to the social and political organization of American life. The underwriting criteria that insurers have found so necessary to preserve the fiscal soundness and actuarial fairness of their business dovetail precisely with those identities that have formed our major social cleavages: race, ethnicity, class, and more recently sexual orientation and disability. Underwriting makes and perpetuates a series of internal social divisions, so that, in a far broader sense than insurers usually mean, "likes share their risks with likes." Just as social insurance is a mechanism for implementing mutual aid and a means of defining a diverse and integrated community, the principle of actuarial fairness in all its institutional forms is a marvellously invisible way of creating and perpetuating a segregated society. It explains misfortune as the result of unalterable natural characteristics of individuals, for which the only possible solution is a division of society into the Purgatory of the unfortunate and the Paradise of the blessed.

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