



ARTICLES

The Ends of Health Insurance

John V. Jacobi*

TABLE OF CONTENTS

INTRODUCTION 312

I. GENETIC TESTING IN INSURANCE 319

II. THE ADA AND RISK SELECTION IN
EMPLOYMENT-BASED INSURANCE 345

 A. *The Structure and History of the ADA Demonstrate
 Rejection of McGann* 355

 B. *Examples of Clear Amendatory Language are
 Readily Available* 359

 C. *Enforcement of Fair Discrimination Principles by the
 ADA Will Lead to Social Risk Pooling and Not to
 Increased Risk Segmentation* 363

III. PORTABILITY, GUARANTEED ACCESS AND MSAS 366

IV. NEXT STEPS 385

 A. *The Effects of Adverse Selection* 387

 B. *Risk Adjustment* 393

 C. *It Takes a Budget* 400

CONCLUSION 404

* Associate Professor and Assistant Director, Health Law & Policy Program, Seton Hall University School of Law. I am grateful to Kathleen Boozang, Michael Zimmer and Charles Sullivan for their comments on previous drafts, and to Nicole Huberfeld (Class of 1998) for her invaluable research assistance.

INTRODUCTION

Should competitive commercial health insurers be permitted to deny coverage to a man with heart disease who changes jobs (and therefore insurance coverage) in order to improve his family's standard of living? To a woman who unknowingly carries a genetic marker indicating a high probability of early onset breast cancer? To an asymptomatic man infected with the virus known to cause Acquired Immune Deficiency Syndrome (AIDS)? On the other hand, should the government force a privately insured group to incur higher premiums so that any of these three may obtain coverage? Or deny tax benefits to those who wish to avoid pooled risk by "going it alone," relying for coverage on a Medical Savings Account (MSA)?¹

The answers to these questions depend on what is meant by insurance. Health insurance is premised, in part, on notions of mutual aid and social pooling — the common effort to ameliorate each person's risk of catastrophic medical expense.² But in the United States it has also come to mean "a person's self-centered calculations to protect himself against loss."³ These two discordant visions of American health insurance have come into sharp conflict in Congress twice in recent years. First, the battle over systemic national statutory health reform in 1993 and 1994 pitted (at the extremes) the "pure egalitarians who would like to see health care treated as a social good to be made available to all members of society, on equal terms, regardless of a person's ability to pay for it,"⁴ or regardless of a person's actual or

¹ MSAs are personal funds established by individuals or their employers to pay current out-of-pocket medical costs and to accumulate funds for future medical expenses. See Len M. Nichols et al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, URB. INST. 2 (Apr. 1996) <<http://www.urban.org/pubs/hinsure/winlose.htm>>. MSAs are usually coupled with the purchase of "catastrophic" insurance plans, that provide insurance against extremely costly illnesses. The current interest in MSAs derives from their inclusion in the Health Insurance Portability and Accountability Act of 1996. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2037-53 (discussing tax consequences for MSAs); *infra* text accompanying notes 285-307 (discussing Act's congressional compromise regarding MSAs).

² See WILLIAM A. GLASER, *HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS* 14 (1991).

³ *Id.*

⁴ Uwe E. Reinhardt, *Turning Our Gaze From Bread and Circus Games*, HEALTH AFF.,

predicted health status, against those who regard “[h]ealth care [as] just a commodity,”⁵ and therefore “see nothing wrong with a health system in which the quantity, timeliness, and quality of the health care received by American families varies systematically and positively with household income.”⁶ The latter group prevailed in that legislative battle, “squarely, although perhaps not fairly.”⁷

Congress waged the second, more recent battle over the issues of insurance portability⁸ and MSAs, and ultimately passed the Health Insurance Portability and Accountability Act of 1996.⁹ The legislative battleground was the meaning and social ends of health insurance: social pooling or individual responsibility. The Act’s portability provisions were supported by social poolers as extending coverage to those who would, in an unregulated market, be excluded from the insurance pool for sound actuarial reasons.¹⁰ The provisions granting preferential tax status to MSAs, on the other hand, were alternatively praised for restoring individual control and responsibility to health finance,¹¹ and vilified for enriching the well and well-off at the expense of the poor and ill.¹² The balance this time swung toward a vision

Spring 1995, at 33, 33.

⁵ *Id.* (quoting Rep. Richard K. Arney (R. Texas), WALL ST. J., Nov. 23, 1993, at A4).

⁶ *Id.*

⁷ *Id.* at 34.

⁸ “Portability” in this context refers to the ability of an insurance policy-holder to maintain coverage without disqualification on the basis of current health status upon changing employment status, as provided by the Health Insurance Portability and Accountability Act of 1996. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 102, 110 Stat. 1936, 1955 (providing for increased portability by limiting preexisting condition exclusions); *infra* notes 268-84 and accompanying text (discussing portability).

⁹ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

¹⁰ *See* 142 CONG. REC. S3503-05 (daily ed. Apr. 18, 1996) (statement of Sen. Kassebaum) (indicating general support for non-exclusion of people with preexisting conditions); 142 CONG. REC. H2038-01 (daily ed. Mar. 12, 1996) (statement of Rep. Pallone) (stating that bill addresses preexisting conditions and portability).

¹¹ *See* 142 CONG. REC. H3092 (daily ed. Mar. 28, 1996) (statement of Rep. Ganske) (stating that individuals can control health care spending); 142 CONG. REC. H3100 (daily ed. Mar. 28, 1996) (statement of Rep. Buyer) (stating that MSAs are under individual control).

¹² *See* 142 CONG. REC. H3093 (daily ed. Mar. 28, 1996) (statement of Rep. Pallone) (stating that healthy and wealthy will pay less than others); 142 CONG. REC. H3094 (daily ed. Mar. 28, 1996) (statement of Rep. Brown) (indicating that healthy and wealthy individ-

of health insurance as mutual assistance, and away from individual accountability.¹³

There is a warp and woof to the continuing American discussion about the nature of health insurance. On about a twenty-year cycle during this century, we have considered and rejected joining our industrialized neighbors in treating health care as a public good through national statutory health insurance.¹⁴ Our regular refusal, after acrimonious debate, to enact statutory health insurance may be attributed to America's unique culture of individualism and distrust of government. Alternatively, we may hold responsible the entrenched and powerful institutions that benefit from the lack of national health insurance, and that work assiduously to prevent the passage of national health reform.¹⁵

The alternative perspective on American health financing, and the subject of this article, is the year-to-year development of the law of health insurance, in-between and independent of the dramatic surges of interest in national reform. Health insurance in America is an odd thing. We are imbued with rugged individualism and a preference for voluntary action. In health insurance, this manifests in the peculiar American interest in individual responsibility, an interest that coexists uncomfortably with the underlying goal in insurance law to pool risk. Meanwhile,

uals benefit at others' expense).

¹³ See *infra* Part III (discussing portability, guaranteed access, and MSAs).

¹⁴ See GLASER, *supra* note 2, at 6 (indicating that most U.S. citizens rely on private health insurance or public welfare); MONTE M. POEN, HARRY S. TRUMAN VERSUS THE MEDICAL LOBBY: THE GENESIS OF MEDICARE 3-10 (1979) (surveying early 20th century U.S. efforts to build consensus supporting national health legislation); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237-38 (1982) (comparing U.S. attempts to establish national health care to European attempts during late 19th century); Carol Sakala, *The Development of National Medical Care Programs in the United Kingdom and Canada: Applicability to Current Conditions in the United States*, 15 J. HEALTH POL. POL'Y & L. 709, 709-12 (1990) (discussing various movements toward health care reform in 20th century America).

¹⁵ See THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS 133-72 (1996) (discussing opposition to Clinton Health Plan and stating general objections to government mandates); Lawrence R. Jacobs, *Politics of America's Supply State: Health Reform and Technology*, HEALTH AFF., Summer 1995, at 143, 148-49 (indicating that institutions opposed passage of national health insurance); Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL. POL'Y & L. 329, 330 (1995) (arguing that U.S. lacks comprehensive national health insurance system because structure of American political institutions is incompatible with reform efforts).

most non-elderly Americans obtain health insurance from non-governmental sources, and a substantial percentage have no health insurance at all.¹⁶ In both regards, the United States is unique among highly developed western countries.¹⁷ While many European countries maintain pockets of private insurance or are experimenting with competitive components to a statutory health insurance system,¹⁸ only the United States relies on a competitive private marketplace and voluntary coverage to provide health insurance to the majority of its citizens.¹⁹

The origins of health insurance in both the United States and Europe involved pooling funds and sharing risk. Neighbors, fellow craftspeople, or ethnic communities contributed money to a common fund for the use of their members unfortunate enough to need it.²⁰ The United States missed the wave of

¹⁶ In 1993, 61.1% of non-elderly Americans were covered by employment-based health insurance, and 7.7% were covered by "non-group" (that is, individually purchased) private insurance; 14.4% were covered by Medicaid or another government program, and 16.8% had no insurance. John Holahan et al., *A Shifting Picture of Health Insurance Coverage*, HEALTH AFF., Winter 1995, at 253, 255. See Robert L. Bennefield, *Current Population Reports: Who Loses Coverage and for How Long?*, U.S. CENSUS BUREAU No. P70-54 (May 1996) (indicating that about 66 million people, or 27% of U.S. population, were without health insurance for at least one month during 28 month period between 1992 and 1994); see also R.A. Zaldivar, *20% in U.S. Go Without Health Insurance Annually*, STAR LEDGER, June 24, 1996, at 37 (stating that 27% of Americans went without coverage during 28 month period). Almost all Americans over 65 years of age, of course, are covered by Medicare. See 42 U.S.C. §§ 1395-1395c (1994) (describing Medicare coverage and eligibility).

¹⁷ See GLASER, *supra* note 2, at 21-22.

¹⁸ See Chris Ham & Mats Brommels, *Health Care Reform in the Netherlands, Sweden and the United Kingdom*, HEALTH AFF., Winter 1994, at 106, 110-12 (describing experiments with competition among purchasers and providers in Netherlands, Sweden, and U.S.).

¹⁹ See GLASER, *supra* note 2, at 15 ("The United States alone tries to cover its population by means of a competitive private market."); Reinhard Priester, *A Values Framework for Health System Reform*, HEALTH AFF., Spring 1992, at 84, 86 ("All Western health care systems — except for ours — share a commitment to universal access. Furthermore, all of these systems are undergirded by the belief that nations are obliged to provide a strong network of social benefits to all of their citizens."); Sakala, *supra* note 14, at 712 ("The United States is the only Western industrialized nation that does not guarantee a basic set of medical benefits to all citizens."); see also KAREN DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS AND CONSEQUENCES 1 (1975) (stating that instead of comprehensive national health plan, private institutions provide most coverage to Americans); Leah Wortham, *Insurance Classification: Too Important to be Left to Actuaries*, 19 U. MICH. J.L. REFORM 349, 353 (1986) (stating that while other nations rely on government administered programs, U.S. relies on private insurance).

²⁰ See GLASER, *supra* note 2, at 74 (describing development of mutual assistance funds in U.S.); STARR, *supra* note 14, at 237-43 (comparing development of mutual assistance funds in Europe and U.S.).

rudimentary statutory health coverage programs that swept Europe at the turn of the last century and that steadily developed into the comprehensive systems in place today.²¹ The first large-scale health insurance program in the United States, Blue Cross, arose in the early 1930s.²² The Great Depression devastated the developing hospital industry, which saw its average per-patient income plummet by seventy-five percent, its occupancy rates drop, and its deficits rise.²³ Blue Cross was a non-profit vehicle allowing prepayment of hospital costs at the insured's choice of hospital.²⁴ It prospered through the 1930s and 1940s,²⁵ and set premiums according to "community rating" principles. Through use of these principles, Blue Cross provided coverage "to all members of the community at the same rate, rather than higher rates to high risk groups."²⁶

Beginning in the 1950s, commercial insurers began to challenge the dominance of Blue Cross. The insurers undercut Blue Cross's rates by charging "low-risk" groups according to the actual or expected experience of the group, rather than at the community rate.²⁷ Not surprisingly, commercial insurers prospered. By competing on the basis of accurate risk selection as much as by service and convenience, the commercial insurers came to

²¹ See GLASER, *supra* note 2, at 5-6 (describing, occupation-by-occupation, mandatory insurance statutes in late 19th century Europe, their progress, and how U.S. failed to enact similar scheme); POEN, *supra* note 14, at 3 (describing widespread statutory insurance schemes in early 20th century industrial Europe and how they influenced American labor movement's call for similar protection); STARR, *supra* note 14, at 237-38 (discussing contrast between industrial Europe's adoption of social insurance programs and U.S.'s unwillingness to consider similar legislation).

²² SYLVIA LAW, *BLUE CROSS: WHAT WENT WRONG?* 6-7 (2d Ed. 1976). Small prepayment plans had begun to develop in the 1920s as health care costs began to rise. A frequently described example — a "progenitor" of Blue Cross — was the "Baylor Plan," a prepayment plan initiated in 1929 in Dallas, in which teachers were enrolled, at a cost of \$.50 per day, in a plan that provided 21 days of hospitalization. *Id.* at 7.

²³ See *id.* at 6 (discussing effects of Great Depression on American hospitals); STARR, *supra* note 14, at 295 (discussing decline in hospital receipts and growth in hospital deficits during Great Depression).

²⁴ See LAW, *supra* note 22, at 8 (discussing seven standards of group hospitalization plans under Blue Cross); STARR, *supra* note 14, at 296 (stating that Blue Cross plans would offer free choice of physician and hospital).

²⁵ See RITA RICARDO-CAMPBELL, *THE ECONOMICS AND POLITICS OF HEALTH* 210 (1982) (noting economic growth periods of Blue Cross); STARR, *supra* note 14, at 298 (discussing growth of plan membership through 1940).

²⁶ LAW, *supra* note 22, at 11.

²⁷ See STARR, *supra* note 14, at 328-30 (discussing movement toward experience rating).

dominate the market for health coverage.²⁸ In order to avoid furthering the socialization effects of shared pooling, large employers increasingly avoided formal insurance (and state insurance regulation, preempted by the Employee Retirement Income Security Act of 1974 (ERISA)²⁹) altogether, opting to self-fund their health plans. In the absence of national health insurance, then, Americans largely obtain their coverage from employment-based sources, either insured or self-funded. Americans primarily rely on a “system” of health coverage that is a patchwork of market-driven actors providing “catch as catch can” coverage dependent not on citizenship or residence, but on the apparently unconnected accident of employment status.

The law of health coverage has developed unsteadily. By turns the law has regarded health insurance as a mechanism for enforcing the sharing of risk, regardless of actual or predicted health status, and as a private prepayment mechanism, by which the “fit” between an insured’s health status and premium should — even must — be very close. In the last decade the law governing this dynamic tension has been in turmoil; a turmoil partially obscured by the pyrotechnics of the 1993-94 debate over national health reform. Courts, Congress, and state legislatures have vacillated between principles of individualism and social pooling. The ground has been shifting in the debate as underwriters gain access to increasingly sensitive predictors of future risk. Developing genetic diagnostic techniques allow doctors to identify many latent conditions. This technology provides the scientific basis for screening insurance applicants for genetic predispositions for illness.³⁰ Simultaneously, health insurers and health plans have singled out individuals with expensive medical conditions by imposing extremely low limits on coverage for their expensive conditions. Courts and legislatures, when faced

²⁸ See RICARDO-CAMPBELL, *supra* note 25, at 219-20 (noting increased market share of commercial insurance companies in comparison to Blue Cross); STARR, *supra* note 14, at 332-34 (discussing distribution of individual policies between Blue Cross and commercial insurers).

²⁹ 29 U.S.C. §§ 1001-1461 (1994).

³⁰ See generally Paul H. Silverman, *Commerce and Genetic Diagnostics*, HASTINGS CTR. REP., May-June 1995, at S15, S17 (discussing revolution in genetic testing technology); John R.W. Yates, *Medical Genetics*, 312 BR. MED. J. 1021, 1021-24 (1996) (describing recent advances in genetic analysis).

with these issues, have increasingly nudged the law away from a model of actuarial purity and toward one of shared cost and fuller access to coverage. The congressional debate over the recently adopted Health Insurance Portability and Accountability Act of 1996 is another hesitant step toward enforcing social pooling in American health coverage.

This Article assumes that private, competitive financing of health coverage will continue as a key component of American health care delivery. It will not rehearse the arguments for and against universal statutory health insurance, a topic well covered elsewhere.³¹ It will, rather, examine several strands in the development of the legal structure of health coverage, and conclude that, despite twists and turns, America is moving incrementally but definitely toward a complex model that promotes equity and universality in health coverage.

These twists and turns play out in judicial and legislative interest in efficiency, often manifested as an increasingly accurate relationship between individual risk status and premium, and the counterbalancing interest in fairness as reflected in a tendency to err on the side of providing access to care. Part I of this Article describes a growing consensus among state legislatures that statistically valid genetic indicators of future illness may not be used to deny or set prices for health coverage. Part II examines the interplay between ERISA's broad preemption of anti-risk selecting state laws, and the Americans with Disabilities Act (ADA),³² which, I argue, prohibits broad categories of risk segmentation. Part III explores broader and more explicit movements toward the social pooling principle evidenced by the recent state and federal adoption of insurance reform legislation, including the Health Insurance Portability and Accountability Act of 1996.

³¹ See, e.g., The Health Care Study Group, *Report: Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL. POL'Y & L. 499, 500 (1994) (assessing debate over health care reform with goal of minimizing existing myths and misunderstandings); Candice Hoke, *Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles*, 21 HASTINGS CONST. L.Q. 489, 491-96 (1994) (discussing health reform proposals and implications of public versus private insurance mechanisms); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 115-17 (1995) (discussing proposal for state-led health reform).

³² 42 U.S.C. §§ 12101-12213 (1994).

Finally, Part IV discusses the natural next steps in the slow evolution of American insurance law toward a complex public/private model of universal health coverage. That evolution requires attention to three issues. First, regulation must control for "adverse selection," by which low-risk insureds may attempt to avoid socially-pooled coverage. Second, regulation must protect against the financial interest of plans to "cherry pick" good risks, through market regulation and through risk adjustment. In this way, the hybrid regulated marketplace can protect high-risk individual insureds from high premiums, while suitably rewarding plans that provide broad, equitable coverage. Third, the government cannot forever avoid the cost of moving toward universal coverage. Insurance expansion is not free, and additional political debate must continue to explore the benefits of incurring the attendant social costs. However, taxpayers will be less reluctant to fund coverage for those unable to pay if coverage is provided through familiar institutions, in a cost-efficient environment, and through a reimbursement system regarded as appropriately equitable.

I. GENETIC TESTING IN INSURANCE

Rapid advances in genetic testing will soon enable insurers to determine the genetic component of any applicant's risk of future illness at birth, or before.³³ Should competitive private

³³ See Larry Gostin, *Genetic Discrimination: The Use of Genetically Based Diagnostic and Prognostic Tests by Employers and Insurers*, 17 AM. J.L. & MED. 109, 110 (1991) (forecasting potential misuses of genetic mapping advances); Karen H. Rothenberg, *Genetic Information and Health Insurance: State Legislative Approaches*, 23 J.L. MED. & ETHICS 312 (1995); George P. Smith II, *Accessing Genomic Information or Safeguarding Genetic Privacy*, 9 J.L. & HEALTH 121, 126 (1994-95) (discussing goal of mapping all human genes within 15 years). The Human Genome Project is a "collection of conceptually related, independent, worldwide research efforts with the common goal of analyzing the structure of human DNA and mapping and sequencing the estimated 100,000 human genes." Mark A. Rothstein, *Genetic Discrimination in Employment and the Americans With Disabilities Act*, 29 HOUS. L. REV. 23, 24 (1992). The information produced by this mapping will allow insurers to classify applicants into a number of risk categories, including: current ("expressed") illness; current ("expressed") genetic condition not regarded as illness; latent ("unexpressed") diseases certain to occur; predisposition or increased risk of future illness; and "carrier" of recessive genetic traits that will not manifest in the carrier, but may in offspring (and therefore in a dependent in an insurance policy). See Gostin, *supra*, at 123-27 (defining genetic risk categories and coverage of such categories under ADA); Rothstein, *supra*, at 39-49 (examining impact of ADA on seven defined categories of genetic conditions).

insurers be permitted to obtain and use this information for underwriting purposes?³⁴ At least some genetic information is undeniably relevant to risk assessment. For example, females with a mutation to the gene BRCA1 may have an eighty-five percent chance of developing breast cancer, and a fifty percent chance of developing ovarian cancer.³⁵ A person with the genetic marker for Huntington's chorea is nearly certain to develop the disease, although perhaps not until late in life.³⁶

Insurers could use this information, however, to reject an applicant or place her in a higher-cost premium category even though she has not experienced any illness or obtained any treatment for the identified condition. Actuaries often rely on predictors of future illness to determine insurance status. Aside from behavioral factors such as smoking and occupation, insurers now commonly request, for example, that applicants provide information about infection with the Human Immunodeficiency Virus (HIV), whether or not the applicant has experienced any illness as a result of the infection.³⁷ A system dedicated to permitting and encouraging close correlation between an insured's premium and her risk of illness would therefore be expected to

³⁴ This Article addresses genetic testing as it affects the underwriting, and therefore the health access, aspects of insurance. As part of the process of applying for individual and group coverage, applicants routinely waive their privacy rights to genetic and other medical information. See KENNETH S. ABRAHAM, *DISTRIBUTING RISK* 64-69 (1986) (discussing insurance carriers' classification system); Deborah A. Stone, *The Rhetoric of Insurance Law: The Debate over AIDS Testing*, 15 L. & SOC. INQUIRY 385, 388-91 (1990) (discussing medical underwriting and availability of patient's information to industry). The appropriateness of this coerced disclosure is an important question. See Maxwell J. Mehlman et al., *The Need for Anonymous Genetic Counseling and Testing*, 58 AM. J. HUM. GENETICS 393, 394-95 (1996) (espousing merits of anonymous genetic testing and privacy safeguards); Rothenberg, *supra* note 33, at 316-18. A full development of the privacy issue is beyond the scope of this article.

³⁵ Kathy L. Hudson et al., *Genetic Discrimination and Health Insurance: An Urgent Need for Reform*, 270 SCI. 391, 391 (1995).

³⁶ See Rothstein, *supra* note 33, at 43 (explaining how ADA applies to late-onset diseases such as Huntington's chorea).

³⁷ See ARTHUR S. LEONARD ET AL., *AIDS LAW AND POLICY* 365 (2d ed. 1995) (examining health insurers' policy of excluding HIV-positive applicants during underwriting process); Henry T. Greely, *AIDS and the American Health Care Financing System*, 51 U. PITT. L. REV. 73, 88 (1989) (noting insurance companies' and HMOs' unwillingness to sell policies to those who have AIDS or have tested positive for AIDS); Robert A. Padgug et al., *AIDS and Private Health Insurance: A Crisis of Risk Sharing*, 3 CORNELL J.L. & PUB. POL'Y 55, 57 (1993) (reporting that many self-insured employers administer HIV-antibody tests to remove persons with AIDS or virus that causes AIDS from their insurance plans).

embrace genetic testing. On the other hand, the temporal lag between the identification of a risk factor for insurance underwriting purposes, and the possible manifestation of the illness³⁸ may distinguish genetic conditions from those conditions ordinarily used for underwriting purposes. This factor supports prohibiting health insurers from using genetic testing for underwriting purposes.³⁹

The competitive private insurance market is driven by risk selection. In order to gain a competitive advantage, commercial health insurers honed their ability to predict the future health status (and therefore cost) of prospective insureds.⁴⁰ As described above, this competitive practice of risk identification arose in the years when commercial insurers were attempting to take business away from Blue Cross entities, the dominant health insurers. Blue Cross set premiums by "community rating," which charged all subscribers to an insurance product the same rate regardless of health status or history. To compete for price, the commercial insurers offered lower-cost "experience-rated" premiums to employers with younger, healthier employees.⁴¹

³⁸ See Smith, *supra* note 33, at 125 (noting that carriers of defective genes may never develop symptoms requiring treatment).

³⁹ That is, it may seem unfair to charge applicants higher premiums, or to refuse them insurance altogether, on the basis of an uncertain prediction about their risk for future illness. See Gostin, *supra* note 33, at 113 ("The results of genetic-based diagnosis and prognosis are uncertain for many reasons.").

⁴⁰ See GLASER, *supra* note 2, at 76 (indicating that in order to compete with Blue Cross/Blue Shield, commercial insurers strictly rated according to age and medical history); LAW, *supra* note 22, at 12 (stating that commercial insurers offered better rates to those groups less likely to fall ill); Robert A. Padgug & Gerald M. Oppenheimer, *AIDS, Health Insurance, and the Crisis of Community*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 35, 38 (1990) (discussing shift from "community rating," which distributes risks over large populations, to "experience rating," which is based on actual utilization); Wortham, *supra* note 19, at 402-07 (describing different forms of competitive forces and consequences on insurance market and customers).

⁴¹ See *supra* text accompanying notes 20-29 (discussing historical trends of health care providers in America and current trend of most individuals obtaining coverage from employers); see also GLASER, *supra* note 2, at 21 (arguing that commercial insurers dominated market by experience rating, thus attracting lower risk patrons); LAW, *supra* note 22, at 12 (explaining that commercial insurers' experience rating forced Blue Cross/Blue Shield to do same in order to compete); STARR, *supra* note 14, at 329 (indicating that commercial insurers attracted more employers with lower rates for healthier populations).

In order to avoid abuses of this competitive process, states⁴² began to pass or apply unfair trade practice acts that prohibited “unfair discrimination” in rate-setting.⁴³ Early unfair trade practice statutes probably⁴⁴ were intended to require “that people be treated the same, not that more and more sophisticated methods be developed so that people could be treated differently.”⁴⁵ As time passed, however, a mechanism intended to preserve risk-spreading principles came to be seen as a requirement that groups of insureds be segmented by risk factors for purposes of setting premiums.⁴⁶

Under these statutes, then, and absent any authority to the contrary, insurers setting health insurance premiums or selecting customers by categorical factors are required to do so only if their risk categorization is actuarially justified.⁴⁷ Under this

⁴² Insurance regulation was specifically abandoned by the federal government in 1948 with the passage of the McCarran-Ferguson Act, codified at 15 U.S.C. §§ 1011-1015 (1994). *See id.* § 1012(b). Substantive regulation of health insurance, then, has become the obligation of the states.

⁴³ *See* Herman T. Bailey et al., *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779, 782 (1976) (discussing interplay between “equitable treatment” and “discrimination” as applied to life insurance pricing); Karen A. Clifford & Russel P. Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806, 1809-10 (1987) (distinguishing between fair and unfair discrimination in compliance with statutory rules); Wortham, *supra* note 19, at 381-86 (discussing states’ unfair discrimination statutes); *see, e.g.*, CAL. INS. CODE § 10291.5 (West 1993 & Supp. 1997) (addressing prevention of fraud, unfair trade practices and sale of economically unsound insurance with respect to disability insurance); GA. CODE ANN. §§ 33-6-4 to -5 (Harrison 1990) (defining and prohibiting unfair methods of competition and unfair deceptive acts or practices associated with insurance business); MD. ANN. CODE, art. 48A § 223 (1957) (prohibiting unfair discrimination with respect to life, health and annuity contracts); N.H. REV. STAT. ANN. § 420-A:23 (1991) (proscribing unfair discrimination laws).

⁴⁴ Wortham explains that the history of these statutes’ enactments are somewhat obscure, as most states maintain little legislative history. Wortham, *supra* note 19, at 383 n.181.

⁴⁵ *Id.* at 383 (footnote omitted).

⁴⁶ *See id.* at 360-61 (discussing validity of traditional fair discrimination perspective in justifying higher premiums for high-risk policy holders).

⁴⁷ The mechanism created to limit segmentation of the market, for fear that the segmentation would be unfair, has arguably evolved into a mechanism *requiring* segmentation, because *failing* to differentiate on the basis of risk would be unfair. One court described this interpretation as the following:

The basic principle underlying statutes governing underwriting practices is that insurers have the right to classify risks and to elect not to insure risks if the discrimination is fair. . . . The intended result of the process is that persons of substantially the same risk will be grouped together, paying the same premiums, and will not be subsidizing insureds who present a significantly greater

view, state unfair trade practice acts required risk selection to proceed, if at all,⁴⁸ with actuarial fidelity. Exceptions to the requirement for actuarial fidelity, then, require specific statutory authority.⁴⁹ But these statutory exceptions exist,⁵⁰ and represent a legislative judgment that the interest in accurate risk segmentation must give way to an interest in cost spreading under some circumstances.⁵¹

hazard.

Life Ins. Ass'n v. Commissioner of Ins., 530 N.E.2d 168, 171 (Mass. 1988) (citations omitted). See Clifford & Iuculano, *supra* note 43, at 1809-10 (describing current view of "fair discrimination").

⁴⁸ The anomaly is the community rating of Blue Cross entities throughout the period when unfair trade practice acts were in effect. The transformation of unfair trade practice acts seems to run in tandem with the transformation of Blue Cross rating practices from community rating to experience rating. Before 1950, when unfair trade practice acts were intended to prevent market segmentation unless justified, about 96% of Blue Cross subscribers were community rated. STARR, *supra* note 14, at 330. By 1980, when most Blue Cross employee groups were experience rated, courts were construing insurance law as requiring risk segmentation. See *Life Ins. Ass'n*, 530 N.E.2d at 170-73 (applying unfair trade practice act to reverse Commissioner's prohibition of AIDS testing); *Blue Cross v. Bell*, 607 P.2d 498, 507-08 (Kan. 1980) (reversing decision of Insurance Commissioner, although by analogy to public utility law and not unfair trade practice act, thereby permitting Blue Cross to abandon community rating); RICARDO-CAMPBELL, *supra* note 25, at 210 (indicating that in 1980 most Blue Cross employee groups were experience rated).

⁴⁹ See *Life Ins. Ass'n*, 530 N.E.2d at 172 (holding that Insurance Commissioner lacked legislative authority to promulgate regulation restricting insurance companies from testing prospective insureds for AIDS); *Health Ins. Ass'n of Am. v. Corcoran*, 551 N.Y.S.2d 615, 618 (App. Div. 1990) (noting that it is legislature's job to deviate from general rule that insurers may select risks they are willing to accept), *aff'd mem.*, 565 N.E.2d 1264 (N.Y. 1990).

⁵⁰ See *Life Ins. Ass'n*, 530 N.E.2d at 172 (noting statutory prohibitions of actuarially valid risk selection under Massachusetts law for various types of insurance — for example, exposure to DES, blindness and mental retardation); *Health Ins. Ass'n*, 551 N.Y.S.2d at 618 (noting similar statutory prohibitions); see also CAL. INS. CODE §§ 10144-10145 (West 1993 & Supp. 1997) (proscribing prohibitions on use of certain categories to increase insurance premiums); 215 ILL. COMP. STAT. ANN. 5/236 (West 1993) (same); ME. REV. STAT. ANN. tit. 24-A, § 2159-A (West 1990) (same); Robert Lowe, *Genetic Testing and Insurance: Apocalypse Now?*, 40 DRAKE L. REV. 507, 529 (1991) (noting statutory limitations on underwriting).

⁵¹ For example, differential rating on the basis of race, particularly in life insurance, is actuarially valid but forbidden. See ABRAHAM, *supra* note 34, at 76 (noting that race is inadmissible underwriting consideration, although it is good predictor for certain kinds of loss experience); Greely, *supra* note 37, at 103 n.74 (indicating that although African Americans have shorter life expectancy than Caucasians, denying coverage on this basis would violate federal and state law); Wortham, *supra* note 19, at 365 (specifying that federal laws and some state laws forbid insurers from classifying based on race).

The most prominent instance in which a legislature overruled the principle of actuarial fidelity concerned gender-specific rating of employment-based retirement annuities and

In only a few recent circumstances prior to the debate over genetic testing did social concerns regarding specific, actuarially significant characteristics overcome the principle of accurate risk segmentation. Legislatures forbade risk segmentation in circumstances that affected groups with a particular history of disparate treatment or groups with conditions of seemingly marginal actuarial significance.⁵² These limits on underwriting were relatively uncontroversial⁵³ and resulted in little judicial review. When the issue of HIV testing for insurance arose in the 1980s, then, there was little to guide administrators or judges in their task of placing this differential treatment within the context of "fair discrimination."

The dispute over HIV testing arose when several states limited the ability of insurers to test for or inquire about the HIV status of applicants.⁵⁴ Insurers responded to these restrictions by

the consequent higher cost or lower benefit for female employees. In *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702, 715-18 (1978), *vacated*, 461 U.S. 951 (1983), and *Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1079-95 (1983), the United States Supreme Court recognized the actuarial validity of the disparate treatment of women in this context, but held that such treatment was nonetheless prohibited by Title VII of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000e to e-17 (1994). See Lea Brilmayer et al., *Sex Discrimination in Employer-Sponsored Insurance Plans: A Legal and Demographic Analysis*, 47 U. CHI. L. REV. 505, 508-39 (1980) (discussing sex discrimination in insurance plans); Wortham, *supra* note 19, at 356-57 (citing academic commentary on gender-based classifications in insurance plans).

⁵² See *supra* note 42 (indicating that federal government abandoned insurance regulation in 1948 and that substantive regulation is now states' responsibility).

⁵³ The exception is gender. See *supra* note 51 (discussing *Manhart* and *Norris*, which hold that disparate treatment of women violates Title VII of Civil Rights Act of 1964). See generally Bailey et al., *supra* note 43, at 786-87 (discussing history of underwriting based on gender).

⁵⁴ See Clifford & Iuculano, *supra* note 43, at 1814-15 (describing laws passed giving those infected with AIDS favored status with underwriting); Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1797 (1987) (discussing how such legislation makes health insurance available to millions of Americans with AIDS or other illnesses); see, e.g., CAL. HEALTH & SAFETY CODE § 199.20-25 (West 1986) (protecting privacy of persons subject to AIDS blood tests) (repealed by 1995 Cal. Stat. c.415 § 19); D.C. Law 6-170 (1986) (barring HIV testing for insurance purposes) (repealed by 36 D.C. Reg. 471 (1988)); ME. REV. STAT. ANN. tit. 5, § 17004 (West 1986) (restricting disclosure of HTLV-III test for AIDS) (repealed by ME. REV. STAT. ANN. tit. 5, § 19202 (West 1989)); MASS. REGS. CODE tit. 211, § 36.00-36.11 (1987) (barring health insurers from using HIV testing) (invalidated by *Life Ins. Ass'n*, 530 N.E.2d at 169); N.Y. COMP. CODES R. & REGS. tit. 11, § 52.27 (1987) (barring health insurers from using HIV test results) (invalidated by *Health Ins. Ass'n*, 551 N.Y.S.2d at 616); R.I. GEN. LAWS § 23-6-24 (1989) (requiring individual's authorization for insurance company to test for HIV); WIS.

arguing that testing for HIV is necessary and appropriate to permit fair risk allocation. They contended that barring such testing would be unfair to non-infected insureds who would either pay increased premiums, or suffer the effects of an insolvent insurer.⁵⁵ Opponents of the testing responded that HIV testing constituted covert discrimination against gay men.⁵⁶ The advocates for testing prevailed. Prohibitions against HIV tests have been overwhelmingly repealed or judicially invalidated.⁵⁷

In retrospect, the controversy became mistakenly focused on two very narrow issues: discrimination against gay men,⁵⁸ and

STAT. ANN. § 631.90-3A (West 1995) (allowing tests for HIV if sufficiently reliable).

⁵⁵ See Clifford & Iuculano, *supra* note 43, at 1822 (stating that banning testing could have grave consequences for health care system).

⁵⁶ See Schatz, *supra* note 54, at 1799 (indicating that most reliable testing would occur if only used on homosexual population).

⁵⁷ See *Life Ins. Ass'n*, 530 N.E.2d at 172 (permitting health insurers to use HIV test results in underwriting process); *Health Ins. Ass'n*, 551 N.Y.S.2d at 622-23 (repealing state laws banning use of HIV testing by insurers).

In petitioners' challenge to the validity of the regulations [barring HIV testing], they assert, essentially, that testing for HIV seropositivity is an actuarially sound means of identifying those persons having a high risk of contracting AIDS and ARC and that the regulation's effect is to mandate health care insurance coverage for this class of persons who are thus highly likely to incur substantial medical bills, persons who are not merely standard actuarial risks.

. . . .
. . . [D]enial of coverage or differential premium rates on the basis of sound underwriting practices accurately assessing risks/future costs are not by nature misleading to the public or prejudicial to policyholders. Indeed, valid underwriting practices promote fairness to the policyholder in not requiring him or her to bear in premiums the costs of insuring others in higher risk categories, and solvency of the insurer, another goal of insurance regulation.

Id. at 617-19 (citations omitted). See also *Mele v. First Colony Life Ins. Co.*, No. 88-3297, 1990 WL 39735, at *2 (D.D.C. Mar. 30, 1990) (describing repeal of ban on HIV testing for insurance in District of Columbia); Mark Scherzer, *Private Insurance, in AIDS LAW TODAY* 404, 419 (Scott Burriss et al. eds., 1993). Scherzer argues that

the [insurance] industry's effort to frame the debate in terms of fairness to the broad mass of insurance policyholders succeeded. . . . [N]o jurisdiction ultimately agreed to ban HIV antibody testing. The few jurisdictions that initially legislated bans or limits of the use of the test — California, Wisconsin, Maine, and Washington D.C. — all scaled back or repealed those limitations within a short time.

Id.

⁵⁸ See Scherzer, *supra* note 57, at 419.

fairness to the pool of *healthy* insureds.⁵⁹ Recent commentators have argued that the debate was mired in the specifics of HIV testing when the more appropriate issue was the central problem of risk segmentation in health insurance.⁶⁰ Advocates of actuarial precision have not missed the similarity between HIV and genetic testing⁶¹ in terms of actual fairness.⁶² Genetic

One might in hindsight criticize those (like this author) who approached antibody testing as a gay rights issue in the mid-1980s. To have insisted upon achieving social equity for gay men in the inherently discriminatory commercial insurance context, when discrimination against them in numerous other realms like employment and housing was still not generally prohibited, may well have been to jump too far too fast.

Id. Perhaps more to the point, discrimination on the basis of sexual orientation is as prevalent in the insurance industry as elsewhere. Insurers certainly were more interested in avoiding applicants infected with HIV than those who were gay. See Jill Gaubing, Note, *Race, Sex and Genetic Discrimination in Insurance: What's Fair?*, 80 CORNELL L. REV. 1646, 1652 n.33 (1995) (citing ROBERT B. HOLTOM, RESTRAINTS ON UNDERWRITING: RISK SELECTION, DISCRIMINATION AND THE LAW 6-7 (1979), who describes loss history, age, sexual preference, occupation, marital status, and attitude as factors upon which insurers traditionally relied). Advocates cast their argument in terms that allowed insurers to assert — with some justification — that they were being asked to give AIDS special status not granted to, e.g., heart disease or cancer. See Clifford & Iuculano, *supra* note 43, at 1814-15 (noting how misunderstanding of insurance principles and desires to prevent discrimination led to passage of laws favoring AIDS-infected individuals); Schatz, *supra* note 54, at 1798 (stating that insurers are really concerned that individuals with other conditions will lobby to be insured as well).

⁵⁹ See Clifford & Iuculano, *supra* note 43, at 1811-12 (“To ignore the risk levels associated with infection and treat a seropositive individual on the same terms as one not similarly infected would constitute unfair discrimination against non-infected insureds . . .”); see also Stone, *supra* note 34, at 392-97 (criticizing narrow focus of industry argument on fairness to those with insurance).

⁶⁰ Stone, *supra* note 34, at 404.

Restricted vantage points contribute to the persuasiveness of a story by giving it coherence. But they also create a certain reductionism in policy analysis. . . . Schatz defines the problem as homosexuals’ access to jobs, health care, and opportunity more generally but not as societal responsibility to all people with AIDS, much less all people with serious illness or risk of illness.

Id.

⁶¹ “Genetic testing” in this context refers to the examination of the chemical components of a person’s chromosomes and deoxyribonucleic acid (DNA). The purpose of genetic testing is to discover whether the tested person carries a genetic indicator of risk of future disease. See U.S. Congress, Office of Technology Assessment, *Genetic Monitoring and Screening in the Workplace*, OTA-BA-455 at 3-6 (1990) [hereinafter *Genetic Monitoring*] (defining genetic testing as consisting of genetic monitoring and genetic screening); NATIONAL CENTER FOR HUMAN GENOME RESEARCH, FACTSHEET: ETHICAL, LEGAL AND SOCIAL IMPLICATIONS OF THE HUMAN GENOME PROJECT (Apr. 1996).

⁶² Ian M. Rolland, Chief Executive Officer of Lincoln National Life Insurance Co. and

testing, like HIV testing, originates from scientific and therapeutic initiatives, and not a desire to sharpen risk selection. But the scientific effort to map and “read” the human genome⁶³ has dramatically accelerated the process of gauging a person’s predisposition for disease by examining his genes.⁶⁴ As the ability to link a person’s genetic makeup with his risk of illness increases, principles of fair discrimination almost compel insurers to include genetic screening in the medical underwriting calculus.

It is clear that the scientific understanding of the genetic component of disease is large and growing.⁶⁵ Whether insurers will use this information depends on several factors.⁶⁶ First, they

chairman of an ACLI task force on genetic testing, Address to American Council of Life Insurance (ACLI) Medical Section meeting (June 11, 1989), *in* Lowe, *supra* note 50, at 510 n.18 (“AIDS focused public attention on risk classification and our need to test. Genetic testing will take over where AIDS leaves off.”).

⁶³ Much of the current effort to map the human genome is now funded and coordinated through the Human Genome Project, but the scientific effort to understand the connection between genetic material and physical disease and disability of course predates that initiative. See NATIONAL CENTER FOR HUMAN GENOME RESEARCH, FACTSHEET: NCHGR (Apr. 1996); see also Jon Beckwith, *Foreword: The Human Genome Initiative: Genetics’ Lightning Rod*, 17 AM. J.L. & MED. 1, 4 (1991) (noting that researchers used chromosome markers to identify disease-related genes long before funding of Human Genome Institute).

⁶⁴ See NATIONAL CENTER FOR HUMAN GENOME RESEARCH, FACTSHEET: POSITIONAL CLONING (Apr. 1996) [hereinafter POSITIONAL CLONING] (identifying 55 “disease genes identified by positional cloning” between 1986 and 1996).

⁶⁵ See *Id.* at 2 (describing how gene maps “being produced by the Human Genome Project, should greatly accelerate the future discovery of disease-linked genes”); Gostin, *supra* note 33, at 110 (indicating that there are 4,000 diseases “known to be caused by single-gene defects,” and many others known to be related to combinations of genetic defects); Hudson et al., *supra* note 35, at 391 (“The accelerated pace of gene discovery and molecular medicine portend a future in which information about a plethora of disease genes can be readily obtained.”).

⁶⁶ The first three of the four factors described *infra* — cost, scientific certainty, actuarial value and legal authority — are a compression of the eight factors attributed to an American insurance company:

- (1) the test must supply information in addition to information otherwise available from other sources (e.g., from a medical history questionnaire),
- (2) the disease of interest must have serious morbidity and/or mortality implications,
- (3) the disease must be common enough to ensure that the test is predictive and that the cost can be justified,
- (4) the test must be predictive of disease (or absence of disease) and reliable,
- (5) the test must be understood, accepted and used by the medical profession,
- (6) laboratories must be able to readily perform the test,
- (7) the test must be affordable and able to provide results quickly, [and]
- (8) the test must be risk-free.

T.H. Cushing, *Should There Be Genetic Testing in Insurance Risk Classification?*, 60 DEF. COUN. J. 249, 252 (1993) (quoting U.S. Congress, Office of Technology Assessment, *Medical Testing*

will not employ the tests unless the tests are cost-effective — either the financial benefit to the risk selection process is greater than the cost of the test, or the insurers can impose the cost on applicants without reducing sales. At present the test costs are high, but will certainly diminish.⁶⁷

Second, insurers will not employ the tests unless the science behind genetic screening progresses sufficiently to permit substantial confidence in the results. At this moment, the confidence in science producing accurate assessments of a broad range of genetic conditions is quite low.⁶⁸ It is broadly anticipated, however, that progress will be rapid, in part due to the substantial financial support of the Human Genome Project.⁶⁹

and Health Insurance, OTA-H-384 at 121 (Washington D.C.: U.S. Gov't Printing Office, 1988)).

⁶⁷ See Gostin, *supra* note 33, at 116 (suggesting costs of \$2,000-\$3,000, but noting likelihood of cost reductions); see also *Genetic Monitoring*, *supra* note 61, at 166 (citing cost of testing for Huntington's Disease in range of \$2,800-\$4,000, including counseling after test).

⁶⁸ See Cushing, *supra* note 66, at 252 (indicating that current genetic testing is largely unusable by insurers because it is, *inter alia*, scientifically uncertain); Lowe, *supra* note 50, at 510-11 (citing literature from ACLI for proposition that "decades of experience and technological refinement" are required before insurers will settle on means to use genetic risk classifications).

⁶⁹ Beckwith, *supra* note 63, at 7-8 (indicating that Human Genome Project will lead to progress in identifying disease genes, and noting projected funding of \$160 million). In attacking HIV testing as a component of insurance underwriting, some commentators and advocates argued that the HIV antibody tests were not sufficiently accurate in identifying those who would progress to AIDS to provide a basis for valid risk selection. See D.C. Law 6-170 (1986) (prohibiting insurers from using HIV test results for underwriting purposes) (repealed by 36 D.C. Reg. 471 (1988)). D.C. Law 6-170 was based on the following premises:

First, there is as yet no test of proven reliability and accuracy for identifying exposure to the probable causative agent of AIDS. And, [s]econd, assuming that a reliable and accurate test will be developed at some point, there is no body of evidence to show its value as a predictor of who will or will not develop AIDS.

American Council of Life Ins. v. District of Columbia, 645 F. Supp. 84, 85 (D.D.C. 1986) (citation omitted). See also *Health Ins. Ass'n of America v. Corcoran*, 551 N.Y.S.2d 615, 617 (App. Div. 1990) (summarizing reasons why use of HIV tests to screen applicants for health insurance is contrary to public health care needs), *aff d mem.*, 565 N.E.2d 1264 (N.Y. 1990). But see Schatz, *supra* note 54, at 1795-96 (finding at least one state that declared HIV antibody tests "medically significant and . . . reliable"). Ultimately, the accuracy of the tests was uniformly agreed to be high. See *American Council*, 645 F. Supp. at 87 (citing overwhelming evidence of accuracy of properly performed, repeated, and confirmed HIV testing); *Health Ins. Ass'n*, 551 N.Y.S.2d at 620 (same). The argument, therefore, fell by the wayside.

Consumers should be protected from classifications premised on immature science. At

Third, insurers should not employ even scientifically established genetic tests if they have little predictive power. For the same reasons insurers will not use scientifically unsupported tests, they should avoid using risk factors that predict only a very low probability of illness.⁷⁰ However, the degree of predictive power required may be very low. Underwriting has not set quantitative limits, as actuaries regard their craft as an art as much as a science.⁷¹ In addition, the only restriction placed on insurers' choice of risk characteristics by unfair trade practice acts is that they "reasonably reflect differences in loss experience and that the data be credible."⁷² Insurers, then, are free to choose among the infinite number of marginally valid relationships between applicants' circumstances and possible health risks, choosing, combining, and rejecting them with or without plan or rationale.⁷³ This is not to say that sensible methods for

best, however, arguments in this vein are time-limited. As was demonstrated in the case of HIV testing, temporarily valid arguments based on the immaturity of the science divert attention from underlying concerns of equity and access to care. Such general concerns will still exist when testing methodologies mature.

Finally, one can argue that insurers' use of inaccurate testing need not be feared because it will fail economically in a stable market. The inaccurate testing will impair the efficiency of the underwriting process itself, subjecting erring insurers to competitive disadvantage. *See, e.g.*, Richard A. Epstein, *The Legal Regulation of Genetic Testing: Old Responses to New Technology*, 74 B.U. L. REV. 1, 18 (1994) (stating that employers are driven by concerns of profit and loss and are responsive to market pressure). *But see* Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L.J. 835, 875 (1986) (stating that substantial market imperfections prevent efficient competition among insurers, masking subjective judgments and biases).

⁷⁰ *See supra* note 69 (discussing differences between Professors Epstein and Wortham in assessing effects of competition on correction of error in risk assessment).

⁷¹ *See* Gaulding, *supra* note 58, at 1652 n.33 (quoting HOLTOM, *supra* note 58, at 5, and stating that underwriting is "art which was passed down from one underwriter to another").

⁷² Wortham, *supra* note 19, at 372 (quoting U.S. GEN. ACCOUNTING OFFICE, ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATION OF THE INSURANCE BUSINESS 127 (1979)).

⁷³ *See id.* at 373-74.

For any insured in any line of insurance, there are a number of possible classifications with a statistical association to risk . . . Insurers choose among possible classifications. State review, if there is any, focuses only on whether the chosen classifiers meet the group average test [for statistical validity]. If other classifiers that are not used would provide different answers about individual risk, one cannot accurately say that subsidy [from one insured to another] in fact has been avoided.

Id. *See also* Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503, 2503 (1992) (describing health insurers' practice of excluding entire industries from

choosing among possible classifiers do not exist.⁷⁴ However, there is no requirement in law that these choices be sensible, and apparently no regulatory reviews of independent analyses have investigated whether the choices are indeed sensible.⁷⁵

The fourth factor controlling insurers' use of genetic information is whether the law will permit it.⁷⁶ The trend in this re-

coverage on basis of marginal differences in risk); Kenneth Vogel, *Discrimination on the Basis of HIV Infection: An Economic Analysis*, 49 OHIO ST. L.J. 965, 988 (1989) (describing how insurance risk pooling can be skewed by irrational selection from among valid risk factors).

⁷⁴ See ABRAHAM, *supra* note 34, at 68-76. "[F]ive features reflect the different aspects of economic efficiency and risk-distributional fairness that are relevant in evaluating risk classification systems." They include: *separation* — "the degree to which insureds in different risk classes have different expected losses"; *reliability* — the extent to which factors can be free from error and fraud, and in particular, the degree to which data can be cheaply and surely verified; *incentive value* — the extent to which factors "create loss prevention incentives on the part of insureds"; *homogeneity* — the extent to which "[l]ike insureds . . . are treated alike," i.e., insureds charged the same premiums have similar expected losses; and *admissibility* — the degree to which social, moral and legal factors preclude the use of factors, e.g., race, which may be a good predictor, but which, for social, moral, or legal reasons, is "almost always an inadmissible consideration." *Id.* See also Wortham, *supra* note 19, at 374 (describing means of choosing among classifiers in terms of significance, stability, and practicality).

⁷⁵ See Wortham, *supra* note 19, at 373 (citing General Accounting Office study finding no systematic state regulatory oversight of statistical bases of risk classification). Commentators have argued that the market is the regulatory mechanism here, as insurers who overvalue risk factors, or choose irrationally from among risk factors, will lose the "overpriced" business to more accurate underwriters. See, e.g., ABRAHAM, *supra* note 34, at 78-79 (stating that insurer lacks incentive to restructure classification system because competing insurers would take advantage of new information without making investment required of innovator). Whether insurance markets actually are efficient enough to prevent the institutionalization of bias and irrationality, or whether, as Wortham argues, it is sufficiently flawed to mask substantial misconception and error in risk classification, is an empirical question that is currently unsettled. See Wortham, *supra* note 19, at 404-05 (indicating that reliance on competition to minimize cost of delivering insurance has not been successful).

In the debate, one must keep in mind the often-repeated criticism of anti-regulation free market enthusiasts: the fair comparison is not between the *theory* of a system of open competition and the *practice* of regulated markets. Rather, apples must be compared to apples, real-world blemishes and all. See Morris L. Barer & Robert G. Evans, *Interpreting Canada: Models, Mind-Sets and Myths*, HEALTH AFF., Spring 1992, at 44, 48 (stating that ground for market theorists' view that competitive system is superior to regulated system "seem[s] only to be that they are able to imagine a hypothetical system they believe would be superior to any presently in existence").

⁷⁶ State unfair trade practice acts will not bar insurers from using statistically valid genetic screening for the same reasons they did not bar the use of valid HIV testing. See *supra* text accompanying notes 54-57 (citing instances where health insurers are barred from using HIV test results). Federal law, specifically Title I of the ADA, generally protects employees from disparate treatment regarding the terms and conditions of their employment. See 42 U.S.C. §§ 12111-12117 (1994). The Equal Employment Opportunity Commis-

gard is clear: state after state is adopting legislation restricting or prohibiting the use of genetic information in insurance underwriting or premium rating decisions.⁷⁷

The evolution of state statutes limiting the extent to which insurers may use genetic information for underwriting and rating purposes can be divided into three periods. In the initial period, the 1970s and 1980s, states prohibited underwriting or rating decisions based on specifically enumerated genetic traits, such as sickle cell trait or Tay-Sachs trait.⁷⁸ The prohibitions somewhat followed the principle of fair discrimination. They targeted conditions that predicted no risk of illness in the applicant, but rather predicted the presence of a trait that could, under some circumstances, be expressed in future generations.⁷⁹

The second stage saw about ten states enact laws broadly barring genetic testing as part of insurance underwriting or rating.⁸⁰ A Wisconsin statute enacted in 1991, for example,

sion, the federal agency charged with enforcement of Title I, has advised that it considers genetic predisposition to a disease a "disability" for purposes of the ADA, and that disparate treatment in employment-based insurance coverage on the basis of genetic testing therefore violates the ADA. See *Definition of the Term "Disability,"* Aff. Action Compl. Man. (BNA) No. 915.002, § 902 (Mar. 15, 1996) (ruling that entities that discriminate on basis of genetic illness, disease, or disorders are covered by ADA). The application of the ADA to employment-based health insurance is addressed *infra* in Part II.

⁷⁷ See Rothenberg, *supra* note 33 (describing status of state laws and pending legislation on genetic testing for health insurance); Jennifer Preston, *Trenton Votes Strict Limits on Use of Gene Tests by Insurers*, N.Y. TIMES, June 18, 1996, at B1 (reporting New Jersey Legislature's passage of bill that would "ban insurance companies from denying access or setting higher rates for individuals who are genetically predisposed to certain diseases").

⁷⁸ See NATIONAL ASS'N OF INS. COMM., COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: STATE POSITIONS ON THE ISSUE OF GENETIC TESTING FOR INSURANCE COVERAGE (May 1996) (listing states' positions on genetic screening); Hudson et al., *supra* note 35, at 392 (stating that first laws addressing genetic discrimination were limited in scope and generally focused on persons with particular trait); Rothenberg, *supra* note 33, at 136; see, e.g., ALA. CODE § 27-5-13 (1982) (prohibiting underwriting decisions based on sickle cell trait); FLA. STAT. ANN. ch. 626.9707 (West 1996) (same); N.C. GEN. STAT. § 58-65-70 (1975) (prohibiting rating or underwriting decisions based on sickle cell or hemoglobin C trait). Much of the discussion of the historical development of genetic testing statutes herein is drawn from Karen H. Rothenberg's comprehensive survey, as supplemented. See Rothenberg, *supra* note 33.

⁷⁹ See, e.g., MD. ANN. CODE art. 48A, § 223(b)(4) (1957 & Supp. 1996) (prohibiting rating decisions based on "sickle cell trait, thalassemia-minor trait, hemoglobin C trait, Tay-Sachs trait, or any genetic trait which is harmless in itself") (emphasis added).

⁸⁰ See, e.g., CAL. INS. CODE § 10140(b) (1994) (barring underwriting or rating use of genetic testing results); COLO. REV. STAT. § 10-3-1104.7 (West Supp. 1996) (same); GA.

prohibits insurers from conditioning insurance coverage, rates, or any other aspect of health care benefits on "whether an individual or a member of an individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were."⁸¹ These second-phase statutes share two features: they are sweeping in the breadth of the genetic conditions encompassed,⁸² and they are uniformly limited in barring the use only of specific laboratory tests for genetic information.⁸³ Notwithstanding this limitation, the second phase of genetic underwriting law establishes that, "for social policy reasons, the general rule giving insurers autonomy in assessing and accepting risks has been deviated from, [and legislatures have] made specific provision therefor by statute."⁸⁴

Both the first and the second periods of restrictions on genetic underwriting were identified by legislatures as prohibiting

CODE ANN. §§ 33-54-1 to -4 (Harrison Supp. 1996) (same); MINN. STAT. § 72A.139 (1995) (same); N.H. REV. STAT. ANN. §§ 141-H:4 to H:5 (1996) (same); OHIO REV. CODE ANN. § 3901.49 (Banks-Baldwin 1994) (same); OR. REV. STAT. § 746.135 (1995) (same); VA. CODE ANN. § 38.2-508.4 (Michie Supp. 1996) (same). Some states have enacted lesser protections, requiring only that the use of genetic information be based on sound actuarial data. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-448 (West 1990 & Supp. 1996) (indicating that genetic information is useful if based on actuarial data); MD. ANN. CODE art. 48A, § 223 (1957 & Supp. 1996) (same); MONT. ANN. CODE § 33-18-206 (1995) (same).

⁸¹ WIS. STAT. ANN. § 631.89(2)(c)-(d) (West 1995).

⁸² *See, e.g.*, COLO. REV. STAT. ANN. § 10-3-1104.7(d) (West Supp. 1996) ("The intent of this statute is to prevent information derived from genetic testing from being used to deny access to health care insurance, group disability insurance, or long-term care insurance coverage."); GA. CODE ANN. § 33-54-1(4) (1994) ("The intent of this chapter is to prevent accident and sickness insurance companies, health maintenance organizations, managed care organizations, and other payers from using information derived from genetic testing to deny access to accident or sickness insurance."); OHIO REV. CODE ANN. § 3901.49(B)(1)-(2) (Banks-Baldwin 1994) (prohibiting insurers from requiring genetic screening or testing, or from considering results of genetic screening or testing, unless such results are voluntarily submitted).

⁸³ *See, e.g.*, CAL. INS. CODE § 10147(b), (e) (West Supp. 1997) (defining genetic characteristic test as "laboratory test" for "scientifically or medically identifiable gene or chromosome, or alteration thereof"); MINN. STAT. ANN. § 72A.139.2(b) (West Supp. 1997) (defining "genetic test" as "a presymptomatic test of a person's genes, gene products or chromosomes"); OR. REV. STAT. § 659.700(4) (1995) (defining "genetic information," barred in underwriting and rating decisions under OR. REV. STAT. § 746.135(3) (1995), as information obtained from "genetic test" or "DNA sample"); *see generally* Rothenberg, *supra* note 33, at 136-38 (discussing statutory definitions of "genetic test").

⁸⁴ Health Ins. Ass'n of America v. Corcoran, 551 N.Y.S.2d 615, 618 (App. Div. 1990), *aff'd mem.*, 565 N.E.2d 1264 (N.Y. 1990).

“discrimination.”⁸⁵ The meaning of the term “discrimination,” however, shifted significantly from *preserving* the predominance of actuarial precision to *rejecting* actuarial precision in favor of maintaining or improving access to health insurance for people with identifiable indications of future risk.

A third phase of regulation of genetic underwriting appears to be under way. Several states have broadened, or are contemplating broadening, their prohibitions of genetic screening beyond laboratory tests to include other indicators of a genetic condition.⁸⁶ A recent New Jersey statute, for example, directs that individual and group health insurers may not underwrite or set rates on the basis of a “genetic characteristic,” defined as “any inherited gene or chromosome, or alteration thereof, that is scientifically or medically believed to predispose an individual to a disease, disorder, or syndrome, or to be associated with statistically increased risk of development of a disease, disorder or syndrome.”⁸⁷ This language is broader than that in previous statutes in terms of what types of genetic information insurers are prohibited from using. The language goes beyond laboratory tests and examinations of DNA to encompass other sources, including medical examinations and genetic histories.⁸⁸

The expansion is made more explicit in a bill pending in the Wisconsin legislature.⁸⁹ That bill would amend Wisconsin’s current statute limiting genetic underwriting and rating⁹⁰ by defining the term “genetic test” as “a test, including a physical examination of an individual or an examination of the family history of an individual, to determine . . . whether an individual has a genetic disease or disorder.”⁹¹ Several other states are

⁸⁵ See Gauding, *supra* note 58, at 1671-73 (showing response of different state legislatures to genetic screening and its discriminatory effects); Wortham, *supra* note 19, at 372-77 (discussing minimal standards required for unfair discrimination and classifiers); see, e.g., CAL. INS. CODE § 10140(b) (West 1993) (indicating that policies distinguishing between people on basis of potential disease-related genetic traits are discriminatory); MINN. STAT. ANN. § 72A.139 (West Supp. 1997) (same); OR. REV. STAT. § 659.705(2)(d) (1995) (same).

⁸⁶ See *infra* notes 87-92 and accompanying text (describing states’ movement toward banning use of certain genetic indicators for insurance purposes).

⁸⁷ S. 695, 207th Leg., 1st Sess. § 14 (N.J. 1996).

⁸⁸ See Preston, *supra* note 77, at B1 (quoting Karen H. Rothenberg on prohibited sources of genetic information under New Jersey statute).

⁸⁹ A.B. 227, 92nd Leg., Reg. Sess. (Wis. 1995).

⁹⁰ WIS. STAT. ANN. § 631.89 (West 1992).

⁹¹ A.B. 227, 92nd Leg., Reg. Sess. § 2 (Wis. 1995).

considering legislation expanding the sources of genetic information that are out of bounds for insurers.⁹²

This third phase of regulation is a logical extension of the second. After all, it is not the performance of DNA tests that troubled legislators who banned their use in underwriting, but the disparate treatment of those with positive tests. Those with positive tests have innate genetic characteristics predictive of health risk. The third phase protects these same people from the same effects — disparate treatment in insurance underwriting or rating due to genetic condition — but does so more directly, by barring insurers from seeking *any* information about these innate characteristics.⁹³ The directness itself, however, is revealing. As the Human Genome Project progresses, and more conditions are strongly linked to heredity, insurers will be barred from asking applicants about family history and about any medical procedures (not limited to genetic tests) undertaken to investigate genetic characteristics. Insurers, therefore, will be barred from asking for family histories for such conditions as Huntington's chorea, early onset breast cancer, or cystic fibrosis,⁹⁴ even if that family history would produce clearly valid predictive information.⁹⁵

⁹² See S. 1740, 1995-96 Reg. Sess. § 2 (Cal. 1995) (defining "genetic characteristics" broadly and without reference to laboratory tests); S. 6599, 219th Gen. Assembly §§ 2-3 (N.Y. 1996) (prohibiting health insurers from considering "unique genetic defect" or "genetic predisposition" in underwriting or rating; both terms defined broadly without reference to laboratory tests); H.R. 5705, 1996 Leg., Feb. Sess. §§ 1, 4 (Conn. 1996) (prohibiting health insurers from underwriting or rating on basis of "genetic information" defined as "the information about genes, gene products or inherited characteristics that may derive from an individual or a family member").

⁹³ Eventually, direct genetic testing will be the "gold standard." The third phase of regulation of genetic underwriting reaches less accurate, but also less expensive and (for the present) more common means of testing. See Michael Landau, *Use of Genetic Testing by Employers and Insurance Companies*, 3 DICK. J. ENVTL. L. & POL'Y 105, 112 (1994) (noting that insurers are currently more likely to obtain genetic information through questionnaires and records on family medical history than through tests).

⁹⁴ See POSITIONAL CLONING, *supra* note 64, at 1 (describing "disease genes").

⁹⁵ See H.R. 5705, 1996 Leg., Feb. Sess. §§ 1 and 4(a) (Conn. 1996) (barring underwriting or rating decisions on basis of "genes, gene products or inherited characteristics that may derive from an individual or family member"). Ambiguity persists in some of the new legislation. For example, the proposed Wisconsin legislation would prohibit inquiry into "a physical examination of an individual or an examination of the family history of an individual to determine . . . whether an individual has a genetic disease or disorder." A.B. 227, 92nd Leg., 1995-96 Sess. § 2 (Wis. 1995). This language, if adopted, would appear to prohibit inquiry into whether an applicant has been *diagnosed* with, e.g., Huntington's chorea

The legislative bans on genetic underwriting and rating, then, substantially modify an insurance system based on fair discrimination, by banning insurers⁹⁶ from considering much information relevant to calculating the expected risk of loss for applicants. The percentage of risk that can be attributed to testable genetic factors, as opposed to environmental factors, is currently unknown and will be difficult to determine with any precision,⁹⁷ but it is certainly substantial.⁹⁸

or early onset breast cancer. The New Jersey statute prohibits underwriting or rating "on the basis of an actual or expected health condition or on the basis of any genetic characteristic." S. 695, 207th Leg., 1st Annual Sess. § 13 (N.J. 1996). This language literally forbids any consideration of existing or predicted medical risk.

⁹⁶ However, this has not held true for applicants. The laws banning genetic underwriting and rating do nothing to limit individuals' access to their own genetic information. To the contrary, the fact that individuals might otherwise be deterred from investigating their own genetic makeup has justified limits on insurers' use of this information. See Paul R. Billings et al., *Discrimination as a Consequence of Genetic Testing*, 50 AM. J. HUM. GENETICS 476, 478 (1992) (noting fear of discrimination from genetic testing causes patients to withhold or give incomplete information on insurance form).

In addition to the real and potentially devastating consequences of being denied health insurance, the fear of discrimination has other undesirable side effects. People may be unwilling to participate in research and to share information about their genetic status with their health care providers or family members because of concern about misuse of this information.

Hudson et al., *supra* note 35, at 391. See Rothenberg, *supra* note 33, at 135 (expressing similar concern).

The imbalance is reflected in the statutes: they prohibit both use of tests by insurers, and inquiry about test results independently obtained by applicants. See MINN. STAT. ANN. § 72A.139 (West Supp. 1997) (prohibiting health plan companies from requiring individual to take genetic test to determine eligibility for coverage); N.H. REV. STAT. ANN. § 141-H:4 (1996) (prohibiting health insurer from requiring individual to undergo genetic testing). This statutorily enforced information imbalance runs contrary to traditional insurance law's interests in avoiding adverse selection. See ABRAHAM, *supra* note 34, at 15 (describing adverse selection as problem for insurers); Wortham, *supra* note 68, at 844 (noting insurers' fear of adverse selection); *supra* text accompanying notes 37-40 (discussing adverse selection).

⁹⁷ See Joseph S. Alper, *Genetic Complexity in Single Gene Diseases: No Simple Link Between Genotype and Phenotype*, 312 BR. MED. J. 196, 196 (1996) (indicating that although it is widely thought that "many diseases . . . are genetically controlled and result from the presence of one, or, at most, a few altered genes[,] [i]t is now becoming evident that this view is inadequate. . . . It may be that there is, in fact, no such thing as a 'simple' genetic disease."); Gostin, *supra* note 33, at 113 (noting that genetic diagnosis is uncertain); Peter S. Harper, *Genetic Testing, Common Diseases, and Health Service Provision*, 386 LANCET 1645, 1646 (1995) ("[M]uch more work needs to be done, both at the research and development level and in terms of basic research, before genetic testing for susceptibility to common diseases is accepted as a valid service.").

⁹⁸ See *supra* note 65 (indicating strong link between genetic makeup and disease discov-

What does this treatment of genetic conditions by insurance law tell us? It is illustrative of a modern resolution of the historical insurance debate between individual responsibility and autonomy on the one hand, and social solidarity on the other. In this case, where a wide (and currently unidentified)⁹⁹ segment of the population would be subject under an individual responsibility model to either exclusion from health insurance or significantly higher premiums on the basis of conditions completely out of their control, legislatures are opting to apply principles of social solidarity. It is inescapable that the genetic underwriting statutes are motivated by an impulse to socialize risk. Whereas improper “discrimination” for purposes of unfair trade practice acts referred to insurers *failing* to differentiate coverage or cost on the basis of anticipated loss, the genetic underwriting statutes use the term to prohibit the differentiation itself — at least for genetic conditions.

There are three closely related explanations for this shift. First, the individual responsibility model is premised on the treatment of health care as a commodity. If health care is

ery); see also Philip J. Boyle, *Shaping Priorities in Genetic Medicine*, HASTINGS CTR. REP., May-June 1995, at S2, S2 (“Thanks to rapid private-sector advances in molecular biology and a \$3 billion federal Human Genome Project that will map and sequence the genetic makeup of humans, a plethora of population screens, diagnostic tests, and therapies will be available — perhaps commonplace — in the next decade.”); Rachel Nowak, *Genetic Testing Set for Takeoff*, 265 SCI. 464, 464 (1994) (indicating that genetic testing for diseases is “medical boom industry”); Benjamin S. Wilfond & Kathleen Nolan, *National Policy Development for the Clinical Application of Genetic Diagnostic Technologies: Lessons from Cystic Fibrosis*, 270 JAMA 2948, 2949 (1993) (describing rapid development of testing methodologies; contrasting with lag in development of bioethics and policy). In what may be a telling factor in assessing whether genetic testing for diseases will become commonplace, commercial interests are now investing heavily in the emerging technology.

The prospect of routine genetic diagnostics for a wide variety of diseases . . . have attracted the attention of commercial testing laboratories and venture capitalists. . . . Major diagnostic companies . . . are developing a variety of technologies by inhouse invention and through alliances and acquisitions. The increase in research and development activity by these firms is designed to position them competitively for what is expected to be a major diagnostic market potential.

Silverman, *supra* note 30, at S15. The combination of the force of the technological imperative and the pressure of commercial interests makes it almost inevitable that valid genetic diagnostic tests will be widely employed.

⁹⁹ See JOHN RAWLS, A THEORY OF JUSTICE 12-13 (1971) (describing application of “original position” and “veil of ignorance” in assessing justice of allocative social rules).

“merely” a commodity — a good which society permits to be distributed according to supply and demand — then society would acquiesce in each person being assessed the actual cost of her health coverage, without any social risk pooling. The adoption of genetic underwriting statutes evidences a recognition that health care is more than a commodity. It is, instead, a “primary good,” because it is a “thing[] which it is supposed a rational man wants whatever else he wants.”¹⁰⁰ Without entering the thicket of “rights talk,”¹⁰¹ health care access is very highly valued both because all rational persons value health and therefore value the opportunity to have illness cured and disability avoided,¹⁰² and because society benefits from increased productivity resulting from a healthy populace.¹⁰³ In short, access to health care is a special kind of good. Society does not recognize an absolute obligation to make it available, but statutes are created and interpreted to recognize its social importance. The forced risk pooling, through genetic underwriting statutes, exemplifies the social acceptance of the importance of health coverage and the unacceptability of its denial, even in a private marketplace, on the basis of genetic conditions over which the applicant has no control.

¹⁰⁰ *Id.* at 92.

¹⁰¹ See MARY ANN GLENDON, RIGHTS TALK 109 (1991) (“The American dialect of rights talk disserves public deliberation not only through affirmatively promoting an image of the rights-bearer as a radically autonomous individual, but through its corresponding neglect of social dimensions of human personhood.”); see also Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 47 (1993) (noting that analysis of health care as primary good in ethical sense “often becomes intertwined with the concept of a right to health care”); Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1328-29 (1995) (discussing communitarian arguments for recognizing broad right to health care).

¹⁰² See Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 742 (1986) (discussing connection between health care and opportunity to enjoy life). Health is considered a “primary good” because “one need not know another’s peculiar preferences and goals to know the person will value their health . . . people do not place the same value on health, [but] the connection between health care and the opportunity to enjoy life and pursue one’s other objectives is self-evident.” *Id.*

¹⁰³ See Norman Daniels, *Why Saying No to Patients in the United States is So Hard: Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENG. J. MED. 1380, 1381 (1986) (discussing moral importance of health care which is derived from its effect on opportunities available to healthy society).

The second explanation follows closely from the first. Because health care is considered a primary good, Americans marginally prefer that residents (perhaps only citizens)¹⁰⁴ have some form of health insurance. This is an avowedly modest claim — the impulse obviously stops short of firm support for national statutory coverage, as exists in other developed countries.¹⁰⁵ But we do think of the various health care financing mechanisms as components of a loose system of coverage, and within that system, there is a hierarchy. To the extent possible, people should be covered by privately purchased coverage. Failing that, they might, if they are worthy of public support, be covered by a categorical governmental program.¹⁰⁶ As a last resort, at least for emergency problems, they can find assistance in the ultimate safety net: hospital emergency rooms.¹⁰⁷

This is a “system” of health care which accounts for all Americans.¹⁰⁸ From this perspective, the repeated rejection of at-

¹⁰⁴ The recently enacted Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, sharply limits the eligibility of lawful immigrants to cash benefit programs, and to Medicaid eligibility. See *The Impact of Federal Welfare Reform on Medicaid*, Families U.S.A. (Aug. 1996) <<http://epn.org/families/famwb/html>>. Undocumented aliens are already ineligible for Medicaid. 42 U.S.C. § 1396b(v) (1994).

¹⁰⁵ See *supra* text accompanying notes 20-29 (discussing history relating to U.S. health care system).

¹⁰⁶ The Medicare and Medicaid programs are obvious examples. States create their own programs, however. Some such programs broadly subsidize care for the uninsured. See, e.g., N.J. STAT. ANN. § 26:2H-18.58 (West 1996) (establishing Health Care Subsidy Fund to assist uninsured). Other programs subsidize health care for special populations. See, e.g., N.J. STAT. ANN. § 26:2-148 to -159 (West 1996) (establishing Catastrophic Illness in Children Relief Fund).

¹⁰⁷ See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395d(d) (1994) (imposing treatment requirements on hospitals regardless of patient's eligibility to pay); ARIZ. REV. STAT. ANN. § 36-405 (West 1993) (requiring hospitals to provide emergency treatment); N.J. STAT. ANN. § 26:2H-18.64 (West 1996) (“No hospital shall deny admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payment.”); N.Y. PUB. HEALTH LAW § 2805-b(2) (McKinney 1993) (requiring hospitals to provide emergency care to all persons in need of such care); see also *Thompson v. Sun City Community Hosp., Inc.*, 688 P.2d 605, 609 (Ariz. 1984) (finding hospital had obligation to provide emergency care under state statute).

¹⁰⁸ It is a famously unequal system. The observation that the “system” at least formally covers all Americans is not intended to dispute that fact. We have not valued *equal*, or even *basically adequate* coverage. However, we have, if haphazardly, constructed a system by which at least all citizens have recourse to care for emergent conditions. Additionally, most people have recourse to at least some coverage for non-emergent care.

The stunning inequality and inadequacy of this “system” is beyond the scope of this Article, and has been addressed elsewhere. See Vernellia R. Randall, *Racist Health Care: Re-*

tempts to enact national health insurance can be traced to discomfort, not with the goal of full coverage, but with the chosen means: state control of coverage. Whatever is disputed about the meaning of Americans' repeated rejection of national health coverage, it is undisputed that the innate American distrust of government plays a part in each iteration.¹⁰⁹ As a result, the structural integrity of our "system" depends on the strength of the private insurance market — the overwhelming majority of non-elderly Americans are covered through the voluntary private marketplace.¹¹⁰ The repeated rejection of national statutory coverage suggests a continuing preference for this allocation.

From this perspective, the private insurance system fails to perform its function. It abandons a significant portion of the population, leaving them to filter down to either governmental coverage or uninsured status. We recognize health care as a primary good, yet we repeatedly reject governmental dominance of health care financing. This rejection protects the private insurance sector. With this status comes responsibility: private insurance must be broadly available. An explanation for genetic underwriting laws, then, is that the private market was becoming too selective, thereby impairing its ability to fulfill its social mandate. As a society we are demonstrating that we can separate the social function of private health insurance (broadly providing health access with a minimum of governmental involvement)

forming an Unjust Health Care System to Meet the Needs of African-Americans, 3 HEALTH MATRIX 127, 134-35 (1993) (indicating that current reform measures for health care system are inadequate because they fail to recognize different health care needs of African-Americans); Dorothy E. Roberts, *Irrationality and Sacrifice in the Welfare Reform Consensus*, 81 VA. L. REV. 2607, 2621-22 (1995) (finding that Republican refusal to fund health care aspects in welfare reform disproportionately affects blacks); Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1647-48 (1993) ("[A]n urban Black typically is sicker and in greater need of health care than a suburban white, but is less likely to be able to afford or obtain health care.").

¹⁰⁹ See SKOCPOL, *supra* note 15, at 167 (explaining that individual citizens do not like complying with means tests and burdensome application procedures and that business owners resent regulatory oversight, while state and local officials dislike unfunded mandates); see also Jacobs, *supra* note 15, at 144-46 (commenting on access to health care and supply of health services); Daniel Yankelovich, *The Debate that Wasn't: The Public and the Clinton Plan*, HEALTH AFF., Spring 1995, at 7, 16 (discussing need for public to directly address hard choices regarding health care).

¹¹⁰ See Holahan et al., *supra* note 16, at 256 (stating that in 1993, 68.8% of non-elderly Americans were covered by either employment-based or individually purchased private health insurance).

from the competition-driven means that insurance companies employ to gain market share (accurate segmentation of the population by risk of future claims). When the techniques employed by insurers threaten the social mission, the techniques must yield to social judgment. Or, less abstractly, if insurers' slavish response to a competitive imperative will throw a large number of people from the privately insured ranks into publicly funded programs, or the ranks of the uninsured, the government will step in to curb the competitive urge.¹¹¹

The third explanation¹¹² for the genetic underwriting laws is that, without them, the private health insurance market would

¹¹¹ The argument that protection of the social mission of private insurance should override competitive principles was advanced to no avail in the struggle to limit testing for HIV. See Greely, *supra* note 37, at 126-27 (discussing government financial obligations as opposed to private obligations); Mark H. Jackson, *Health Insurance: The Battle Over the Limits on Coverage*, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 147, 149-50 (Nan D. Hunter & William B. Rubenstein eds., 1992) (discussing health insurance industries' discriminatory treatment of people with HIV); Schatz, *supra* note 54, at 1804 (discussing insurance industry and AIDS-related expenses). The difference between the treatment of genetic testing and testing for HIV may be explained in several ways. First, it may be that the debate over HIV testing was somewhat incoherent because no situation had previously arisen in which potentially millions of people would be shut out of the private insurance market. The opponents of HIV testing were unsuccessful in their argument that broad coverage is more important than actuarial purity. However, they crystallized the issues and promoted national debate and reflection on the nature of insurance. These efforts may be bearing fruit in the genetic testing context. Second, it may be that legislators view genetic preconditions and HIV infection as different. For example, while the former is obviously beyond the applicant's control, the latter is often viewed (often inaccurately) as being within the control of the applicant. (Senator Jesse Helms has been quoted as blaming homosexual men for the AIDS epidemic due to their "incredibly offensive and revolting conduct." He has also accused Congress of "falling all over itself to do what the homosexual lobby is . . . demanding [it] do." Helen Dewar, *Senate Votes to Continue AIDS Program; Helms Fails in Bid to Freeze Funding*, WASH. POST, July 28, 1995, at A10.) Third, it may be that the distinction results from the socially disfavored position occupied by HIV-infected individuals who are overwhelmingly gay, users of illegal drugs, poor, and/or people of color. See LEONARD ET AL., *supra* note 37, at 53-54 (discussing AIDS as political issue); Samuel A. Marcossan, *Who is "Us" and Who is "Them" — Common Threads and the Discriminatory Cut-Off of Health Care Benefits for AIDS Under ERISA and the Americans with Disabilities Act*, 44 AM. U. L. REV. 361, 405 (1994) (stating that homosexuals do not receive full protection of law because of their homosexuality); Maria O'Brien Hylton, *Insurance Risk Classification After McGann: Managing Risk Efficiently in the Shadow of the ADA*, 47 BAYLOR L. REV. 59, 62 n.9 (1995) (quoting Michele Zavos, *AIDS and Insurance: No Guarantees*, 20 HUM. RTS. Q. 18 (1993), and comparing cancer and heart bypass to AIDS for social acceptability).

¹¹² This "explanation" is actually a post hoc justification, as I have found no indication that lawmakers actually considered the issues implicated by this "explanation" in creating genetic underwriting statutes.

be imperiled. Commentators observe that sufficiently perfect genetic mapping of predispositions for disease¹¹³ would squeeze a high proportion of the uncertainty out of expected health claims. Accordingly, risk pooling would be potentially eliminated and converted into a prepayment mechanism. The mechanism would operate like the old-fashioned "Christmas clubs," by which banks induced customers to deposit a set amount each week, in return for a promise of returning the funds (usually without interest) when holiday shopping needs arose. This vision of the "end of insurance"¹¹⁴ is often overstated intentionally to drive home the point that the social mission of health insurance — coverage of people who need care — is disserved by continuing improvements in insurers' actuarial abilities.¹¹⁵ In truth, environmental factors such as accidents and infectious diseases compound the certainly irreducible uncertainty of genetic testing. These factors ensure that perfect predictive knowledge will never exist, and that there will be enough residual uncertainty to create a market for risk pooling.¹¹⁶ But the point is clear: if we wish to continue in our reliance on private, competitive insurance markets to cover the majority of Americans, we must be leery of such actuarial advances as genetic testing.¹¹⁷

¹¹³ This level of detailed technical ability is, of course, unlikely to occur in the near future, if ever. See *supra* text accompanying notes 67-69 (discussing high cost and lack of confidence in current testing).

¹¹⁴ See Light, *supra* note 73, at 2507 n.46 (citing Robert Wright, *The End of Insurance*, NEW REPUBLIC, July 9, 1990, at 26, and discussing problem of genetic testing for insurance purposes).

¹¹⁵ See Gostin, *supra* note 33, at 137 (opining that improvements in genetic testing will thwart social purpose of insurance); Landau, *supra* note 93, at 112-13 (discussing effect of genetic information on insurance rates); see also Greely, *supra* note 37, at 104 (explaining insurance costs in context of HIV); Stone, *supra* note 34, at 405 (defining actuarial rating in context of HIV testing).

¹¹⁶ For example, the presence of a mutation in the BRCA1 gene may establish membership in a genetic classification with a significantly higher likelihood of early onset breast and ovarian cancer, but it does not establish certainty of eventual illness. See Hudson et al., *supra* note 35, at 391. Further, even more certain genetic indicators, such as that for Huntington's chorea, do not identify *when* the illness will manifest. See Rothstein, *supra* note 33, at 43 (discussing discrimination against people with late-onset genetic illnesses).

¹¹⁷ See Thomas H. Murray, *Genetics and the Moral Mission of Health Insurance*, HASTINGS CTR. REP., Nov.-Dec. 1992, at 12, 12 (discussing shift to experience-based system and moral implications of using genetic risk testing as factor).

We may create a catch-22 so that only people who are unlikely to need health insurance can afford it. Genetic testing may permit a much more complete and

However, there is another aspect to this explanation. The above discussion suggests that society will lose due to insurers' expected competitive activity, suggesting that the use of genetic testing, while contrary to the social goal of broad health coverage, is at least in the interest of insurance companies. To the contrary, the unregulated use of highly predictive genetic testing is ultimately destructive to the insurance industry as well. The reason for this is simple: given reasonably available¹¹⁸ genetic testing, insurers will be compelled by competitive forces to use it. The use of the tests, however, is likely to segment the population of customers into (to simplify) three groups. First, there would be a group with a high risk of disease, and therefore a high interest in purchasing insurance, but an actuarial classification that is likely to price them out of the market. Second, a group with a low risk of disease, and therefore a low interest in purchasing insurance would evolve. The third segment would be a group with average risk of disease, and therefore an interest in purchasing insurance, and an actuarial classification likely to make their insurance affordable.

As testing accuracy improves, insurers will discourage a large group of customers by either rating them uninsurable at any price, or by pricing coverage beyond the means of all but the most affluent. Market signals and testing results will simultaneously inform another group of customers that they have a low likelihood of needing coverage. Insurers will therefore be left to divide the small and shrinking middle group comprised of people with both the incentive and the means to purchase health insurance.

refined classification of people into risk categories, and so move us further away from sharing the financial burdens of illness and further in the direction of individualized premiums based on individual risk factors. Genetic risk testing is important because it exposes the logic of a system that provides access to health insurance to those least likely to need it.

Id.

¹¹⁸ "Reasonably available" for these purposes means accurate, affordable, and permitted. See *supra* text accompanying notes 67-72 (discussing insurers' evaluation of cost, accuracy, and predictive power of genetic testing).

The inevitability of this behavior, absent regulation, is explained by Professor Abraham:

When there is . . . competition among insurers for premium dollars, the value of risk classification to insurers becomes [clear]. The more refined (and accurate) an insurer's risk classifications, the more capable an insurer is of skimming good risks away from insurers whose classifications are less refined. If other insurers do not respond, either by refining their own classifications or raising prices and catering mainly to high risks, then their book of risks will contain a higher mixture of poor risks who are still being charged premiums calculated for average risks. Additional poor risks will gravitate toward these insurers whose classifications have not isolated and charged poor risks higher premiums. The resulting adverse selection will further disadvantage these insurers' competitive positions.

This prospect tends to explain the proliferation of risk classifications in insurance markets. . . . [U]p to the point where the cost of refining classifications is not worth the competitive benefit derived, all insurers will classify at roughly the same level of refinement.¹¹⁹

The classification of functionally uninsurables is certain to be large. Health insurance, without consideration of genetic testing, is famously unaffordable to a growing number of Americans.¹²⁰ The increasing number of genetic conditions that are highly predictive of serious illness designate people with these genetic conditions¹²¹ as either uninsurable or insurable only at a rate unaffordable to most Americans.¹²²

¹¹⁹ ABRAHAM, *supra* note 34, at 67-68.

¹²⁰ See, e.g., Holahan et al., *supra* note 16, at 255-56 (arguing that decline in real income coupled with rise in health care costs are shifting many people from employer-sponsored insurance plans into Medicaid).

¹²¹ This is perhaps true even for genetic conditions indicative only of possible disease in offspring. See Mark A. Rothstein, *Discrimination Based on Genetic Information*, 33 JURIMETRICS J. 13, 15 (1992) (indicating that employers, and therefore insurers, will have incentive to disparately treat even carriers of recessive disease genes if coverage includes dependents).

¹²² See Beckwith, *supra* note 63, at 4 (indicating that high proportion of disease will be determined to be genetically based); Gostin, *supra* note 33, at 116 (stating that increase in identification of genetic diseases will lead to increased use of genetic testing by insurance industry); Nowak, *supra* note 98, at 464 (describing increasing practical applications of genetic testing); Yates, *supra* note 30, at 1021 (describing discovery of 60 disease genes in 1995, including genes implicated in conditions such as Alzheimer's disease, diabetes, and several cancers).

Insurers, then, will face a variant of the Prisoners' Dilemma.¹²³ First, they cannot¹²⁴ and probably would not¹²⁵ cooperate in a free market to forego genetic screening. Second, once an insurance company begins to employ accurate genetic testing, its competitors inevitably will follow. Regardless of the choice any competitor makes to use or forego accurate genetic testing, it will be to the marginal benefit of each competitor individually to use such testing. And third, the uniform use of genetic testing will reduce the number of customers for health insurance, thereby reducing the possibility of profit. The *collective* interest of insurers, then, is in foregoing genetic testing, but the best *individual* competitive strategy of each is to use genetic

¹²³ See JOE B. STEVENS, *THE ECONOMICS OF COLLECTIVE CHOICE* 97-99 (1993). "The Prisoners' Dilemma is a classic illustration of a negative-sum game — how two parties acting independently out of self-interest may be destined not to cooperate, much to their mutual detriment." *Id.* at 98 (note and reference omitted). Under the Prisoners' Dilemma, two prisoners detained for a crime they jointly committed are prohibited from consulting with each other and are offered an identical deal: if one confesses and the other does not, the snitch will go free and the other will serve a long sentence; if both confess, they both serve moderate sentences; if both remain silent, they both serve short sentences. ROBERT NOZICK, *THE NATURE OF RATIONALITY* 50 (1993). Assuming that both value their own freedom, each will fare better by confessing, regardless of the other's choice. *Id.* at 51. Both will confess, even though cooperative silence would have been the most beneficial solution. *Id.* See generally DOUGLAS G. BAIRD ET AL., *GAME THEORY AND THE LAW* 33-34 (1994) (discussing Prisoners' Dilemma and game theory); ERIC RASMUSSEN, *GAMES AND INFORMATION: AN INTRODUCTION TO GAME THEORY* 17-19 (2d ed. 1994) (discussing Prisoners' Dilemma); Ian Ayers, *Playing Games with the Law*, 42 *STAN. L. REV.* 1291, 1295-1315 (1990) (discussing use of game theory in model legal problems).

¹²⁴ States have the power to regulate anti-competitive actions of insurance companies under the McCarran-Ferguson Act. See 15 U.S.C. §§ 1011-1015 (1994) (defining ability of states to regulate business of insurance). Federal statutes apply to anti-competitive behavior if states fail to regulate or if insurers engage in a boycott. See *id.* §§ 1012a-1013; see generally Francis Achampong, *The McCarran-Ferguson Act and the Limited Insurance Antitrust Exemption: An Indefensible Aberration?*, 15 *SETON HALL LEGIS. J.* 141, 144-50 (1991) (discussing adoption and scope of Act); Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 *WM. & MARY L. REV.* 81, 89-107 (1983) (discussing scope of insurance industry's exemption from federal antitrust laws); Jay Angoff, *Insurance Against Competition: How the McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Insurance Industry*, 5 *YALE J. ON REG.* 397, 402-06 (1988) (discussing Act's effect on insurance rates); Henry Root Stern, Jr., *The McCarran Act 20 Years After*, 1966 *INS. L.J.* 605, 608-14 (discussing cases interpreting McCarran-Ferguson Act); Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 *DUKE L.J.* 587, 598-621 (interpreting Act as federalist rather than preemptive).

¹²⁵ See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 286 (4th ed. 1992) (describing instability of cartels due to economic interest of participants in "cheating" on collusive scheme).

testing. The industry therefore would suffer for the same reason that participants in the Prisoners' Dilemma spend a lot of time in jail: "individual self-interest leads to actions that are not in the interest of the group as a whole."¹²⁶

State legislatures, then, have rejected the use of genetic testing — an actuarially valid indicator of risk.¹²⁷ Using genetic testing as an underwriting tool starkly questions the fairness of denying access to a primary good (health coverage) on the basis of innate conditions over which the applicant has no control. States have, in this regard, rejected principles of actuarial purity and individual responsibility that support a one-to-one correspondence between insurability and actuarial or predicted health status. This policy choice — adherence to the alternative principle of social pooling — enhances people's access to coverage. It also has the effect, however, of preserving the institution of competitive commercial insurance, which might otherwise impell toward self-destructive efforts to sharply limit insurability on the basis of "clean genes."

II. THE ADA AND RISK SELECTION IN EMPLOYMENT-BASED INSURANCE

The above discussion traces applications of the "fair discrimination" principle in state insurance regulation to its current broad-scale rejection in genetic underwriting statutes. Genetic underwriting potentially affects all applicants for insurance. Its rejection is therefore an important development in settling the tension between social pooling and actuarial precision in American insurance law. To the extent it suggests a trend in the resolution of this tension toward social pooling, its significance is even greater. For a large and growing number of people who obtain their health coverage as an incidence of employment, and whose employers¹²⁸ self-fund the coverage,¹²⁹ however,

¹²⁶ BAIRD ET AL., *supra* note 123, at 313.

¹²⁷ See *supra* notes 33-36 and accompanying text (providing overview of genetic testing for insurance purposes).

¹²⁸ This Article uses the term "employer" in the very broad sense used by courts interpreting benefits disputes under Title VII of the Civil Rights Act of 1964, codified at 42 U.S.C. § 2000e to e-17 (1994), and Title I of the ADA, codified at 42 U.S.C. §§ 12111-12117 (1990). See 42 U.S.C. § 2000e(b) (1994) (defining "employer"); *id.* § 12111(5) (1990)

these state regulations are without effect.¹³⁰ State laws governing discrimination and underwriting practices in self-funded insurance plans are preempted by ERISA, which itself sets no substantive requirements for health coverage.¹³¹ The extent to which the principle of risk pooling was regulated, then, primarily depended on whether an insured happened to receive coverage through a self-funded or insured plan. The passage of

(same). In those contexts, "employer" goes beyond the common meaning of the term to reach any person or entity that "exercised control over" employment-based benefits, or to whom the responsibility to provide those benefits was delegated. See *Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12, 16-17 (1st Cir. 1994) (defining "employer" to include trade association and its administering trust). A employee's health coverage under this rubric comes from his employer so long as the coverage is a benefit of employment, whether the administrator of the coverage is the employer itself, an insurance company, a trust fund maintained by a union or other entity, or a trade association.

¹²⁹ Briefly stated, health coverage is "self-funded" or "self-insured" when the employer chooses to bear the risk of loss due to claims for care or indemnity itself, even if it contracts with a third party to administer the claims process. In contrast, coverage is "insured" when the employer purchases a product transferring the risk of loss to a third party insurance company. See *FMC Corp. v. Holliday*, 498 U.S. 52, 60-62 (1990) (discussing scope of ERISA with respect to self-funded and insured benefit plans); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743-47 (1985) (differentiating between insured and self-funded plans for ERISA preemption purposes); see also *EEOC Interim Guidance on Application of ADA to Health Insurance*, 20 Pens. & Ben. Rep. (BNA) 1303-04 (June 14, 1993) [hereinafter *EEOC Interim Guidance*] (highlighting ability of insurers to implement disability-based distinctions in self-insured health insurance plans); Hylton, *supra* note 111, at 61 n.3 (discussing difference between self-funded and insured health plans); Alan I. Widiss, *To Insure or Not to Insure Persons Infected with the Virus that Causes AIDS*, 77 IOWA L. REV. 1617, 1686 (1992) (classifying risk retention plans as form of self-insurance).

Employers self-insure not only to avoid the cost of purchasing coverage from an insurance company, but to avoid mandated coverage and nondiscrimination provisions of state law. The trend toward self-insurance is strong, with perhaps two-thirds of plans now self-insuring. Susan Nanovic Flannery, *Employer Health-Care Plans: The Feasibility of Disability-Based Distinctions Under ERISA and the Americans with Disabilities Act*, 12 HOFSTRA LAB. L.J. 211, 225 (1995).

¹³⁰ Members of large employment-based groups typically are not subject to medical underwriting, although medical underwriting becomes more common in smaller groups. See Randall R. Bovbjerg, *AIDS and Insurance: How Private Health Coverage Relates to HIV/AIDS Infection and to Public Programs*, 77 IOWA L. REV. 1561, 1582-83 (1992) (noting that small employment groups, unlike large employment groups, must rely on underwriting due to smaller pools that are less capable of spreading risk); Clifford & Iuculano, *supra* note 43, at 1809 n.17 (stating that small groups apply stricter standards because of inability to spread risk broadly enough to absorb effect of adverse selection); Widiss, *supra* note 129, at 1640-42 (noting that insurers do not equate attributes of small group with those of population generally). The prejudice "seems to be changing," with insurers increasingly screening group applicants for high-risk status. Stone, *supra* note 34, at 390.

¹³¹ See *infra* text accompanying notes 139-46 (discussing ERISA's antidiscrimination and preemption clauses).

the ADA, however, has forced the "fair discrimination" debate into the realm of employment-based coverage.

Ultimately, the ADA forces employment-based coverage toward risk-pooling, and away from risk segmentation.¹³² The path, however, is not as straightforward as with state statutes restricting genetic underwriting. Those statutes simply prohibit insurers from considering actuarially-relevant risk factors.¹³³ As is described below, however, the ADA obtains this result in several steps. First, the ADA subjects employment-based coverage to substantive federal disability-discrimination review for the first time. Second, the ADA does not, like the state genetic underwriting statutes, bar *all* consideration of the affected actuarially-relevant risk factors. Instead, the ADA imposes a standard of *comparative fairness*, requiring that disabling conditions, if considered at all in coverage decisions, be treated the same as all actuarially similar conditions. Finally, it is argued that the counter-intuitive effect of this comparative fairness requirement will be to *increase* social pooling. This effect is achieved because employers will be unwilling or unable, due to employee pressure, to limit coverage for socially sympathetic conditions. Therefore, the employer will also be banned from limiting coverage for socially unsympathetic conditions.

The passage of the ADA provided an opportunity for a reexamination of the principles of risk selection in self-funded health plans. In a blurring of the lines between discrimination and employment,¹³⁴ the Equal Employment Opportunity Commission (EEOC)¹³⁵ and the courts interpret the ADA as imposing for the first time a "fair discrimination" requirement on employment-based health coverage.¹³⁶ Thus, the ADA prohibits

¹³² See *infra* text accompanying notes 220-24 (discussing fair discrimination provisions of ADA).

¹³³ See *supra* text accompanying notes 80-84 (describing state statutory schemes which ban use of certain genetic indicators for insurance purposes).

¹³⁴ See Hylton, *supra* note 111, at 64-65 (noting that, while employers may not terminate employees to remove them from insurance pools, they may redraft plans to exclude specific medical conditions).

¹³⁵ The EEOC is the executive agency charged with the responsibility of, *inter alia*, enforcing the provisions of Title I of the ADA, which regulates employment discrimination. See 42 U.S.C. § 12117 (1994) (mandating that EEOC establish mechanisms to implement ADA).

¹³⁶ See *infra* text accompanying notes 197-202 (discussing state statutory schemes which

limiting coverage for treatment of diseases or conditions without actuarial basis, and without similar treatment of other similarly serious diseases or conditions.¹³⁷ At about the time the courts were struggling with challenges to state regulations forbidding HIV testing by insurance companies,¹³⁸ another issue related to high-risk persons' access to health care arose. The issue concerned another twist on the notion of discrimination: does the "antidiscrimination" provision of ERISA¹³⁹ prohibit employers from denying employees health coverage on the basis of their diagnosis or disability? The seminal case of *McGann v. H & H Music Co.*¹⁴⁰ starkly presented the factual scenario, and answered the question in the negative. Indeed, the court held that nothing in the antidiscrimination provision of ERISA prevents an employer from responding to the health coverage needs of an employee by singling out that employee's condition for non-coverage in an otherwise full health coverage plan.¹⁴¹

In 1987, John McGann was diagnosed with AIDS, and began to submit medical claims to his employer's group medical plan. Shortly thereafter, the employer changed the group medical plan by reducing the lifetime medical benefits coverage for AIDS-related treatment (but no other "catastrophic" illness) from \$1,000,000 to \$5000. The employer simultaneously changed from an insured plan to a self-insured plan.¹⁴² This shift to a self-insured plan was critical; Texas law prohibited insurance companies from writing insurance that "carved out" coverage of

ban use of certain genetic indicators for insurance purposes).

¹³⁷ See *infra* text accompanying notes 159-69 (discussing Title I of ADA and prohibition of discrimination in health coverage).

¹³⁸ See *supra* text accompanying notes 54-57 (noting that state courts have overwhelmingly invalidated prohibitions against HIV testing.).

¹³⁹ Section 510 of ERISA provides:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provision of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan

29 U.S.C. § 1140 (1994).

¹⁴⁰ 946 F.2d 401 (5th Cir. 1991).

¹⁴¹ See *id.* at 408 (stating that ERISA does not prevent employers from discriminating in creation, alteration, or termination of benefit plans).

¹⁴² *Id.* at 403.

specific conditions.¹⁴³ However, because state insurance law is preempted by ERISA in the case of self-insured plans,¹⁴⁴ McGann's remedies were limited to those permitted under ERISA itself.¹⁴⁵ Specifically, McGann's only permissible claim was that the employer's actions violated ERISA's antidiscrimination provision.¹⁴⁶

The court assumed "that the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses, that this knowledge was obtained either through McGann's filing of claims or his meetings with defendants, and that McGann was the only plan beneficiary known to have AIDS."¹⁴⁷ The court nevertheless determined that the employer had not behaved in a discriminatory manner for ERISA purposes.¹⁴⁸ Initially, the court determined that McGann was unable to prove that the employer had the "specific discriminatory intent"¹⁴⁹ to disparately treat him because he had filed AIDS-related claims. Rather, the court found

nothing in the record to suggest that defendants' motivation was other than as they asserted, namely to avoid the expense of paying for AIDS treatment (if not, indeed, also for other

¹⁴³ See Eric C. Sohlgren, *Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law — ERISA, the Rehabilitation Act, and the Americans with Disabilities Act*, 24 LOY. L.A. L. REV. 1247, 1248 n.7 (stating that Texas law prohibits limitation of HIV coverage in group insurance plans); James R. Bruner, Note, *AIDS and ERISA Preemption: the Double Threat*, 41 DUKE L.J. 1115, 1117 n.17 (finding regulations in all 50 states that place limits on discriminating against insureds).

¹⁴⁴ ERISA has a famously broad preemption provision, which holds that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" 29 U.S.C. § 1144(a) (1994). See *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 106-08 (1983) (broadly construing preemption provision). ERISA excepts state laws regulating the business of insurance from its preemptive reach. 29 U.S.C. § 1144(b)(2)(A) (1994). Therefore, state insurance practices laws are enforceable. However, ERISA provides that *self-insured* plans may not be "deemed" insurance for purposes of state law, and any attempt by states to regulate self-insured plans is therefore preempted. *Id.* § 1144(b)(2)(B) (1994).

¹⁴⁵ McGann initially asserted state law claims which were dismissed by the trial court. The dismissal of these state law claims was not appealed. *McGann*, 946 F.2d at 403 n.2.

¹⁴⁶ See *supra* note 139 (quoting ERISA § 510, which describes ERISA's policy of prohibiting discrimination against plan participants who exercise right to obtain benefits).

¹⁴⁷ *McGann*, 946 F.2d at 404 n.4.

¹⁴⁸ See *id.* at 408.

¹⁴⁹ *Id.* at 404.

treatment) no more for McGann than for any other present or future plan beneficiary who might suffer from AIDS.¹⁵⁰

In other words, the record supported the employer's motive as saving money, and not gratuitously harming McGann.

Next, the court found that McGann was able to point to no *right* under the plan of which he was deprived. The plan's coverage provisions and limits were explicitly subject to change, and ERISA was intended to grant employers great flexibility to craft benefits plans.¹⁵¹ Finally, McGann argued that the singling out of AIDS-related benefits, and the temporal proximity of this action to his filing of claims for benefits, demonstrates an intent to disparately treat, if not McGann personally, then a discrete, well-defined group of employees: those with AIDS. The court recognized no such claim under ERISA, finding that a contrary finding would "conflict with Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefits plans without governmental interference."¹⁵²

McGann, then, stands for the proposition that the antidiscrimination provisions of ERISA prohibit only reductions in coverage specifically motivated by the desire to retaliate for an employee's resort to benefits under a plan. The *McGann* court further found that the prohibition extends only to coverage changes that interfere with benefits to which an employee has a vested right under the terms of the plan. The decision goes a long way toward reading the antidiscrimination language out of the statute for coverage changes.¹⁵³ At a minimum it converts the language from a ban on discrimination to a ban on retaliation.¹⁵⁴

¹⁵⁰ *Id.*

¹⁵¹ *See id.* at 405-07.

¹⁵² *Id.* at 407.

¹⁵³ While ERISA has little or no application to changes in health coverage, section 510 applies to prohibit employee *discharges* to avoid paying health benefits. *Seaman v. Arvida Realty Sales*, 985 F.2d 543, 546 (11th Cir. 1993).

¹⁵⁴ Indeed, the court questioned the trial court's determination that "an employer has an absolute right to alter the terms of an employee benefits plan, barring contractual provisions to the contrary." *McGann*, 946 F.2d at 406 n.8. While the court of appeals "[did] not find it necessary to decide this question," neither did it disapprove it. *Id.* One would be hard-pressed to state a claim for relief under the circuit court's interpretation of the antidiscrimination provision that did *not* involve an employer's violation of a contract provision of a plan. Another circuit court opinion reinforced this distinction by observing,

The point here is not whether the court's interpretation of ERISA is correct — it has been universally adopted as the definitive interpretation of the antidiscrimination provision.¹⁵⁵ Rather, *McGann* demonstrates that, prior to the effective date of the ADA, the law governing self-funded group health insurance freely permitted sharp distinctions in coverage, with no enforcement of a fair discrimination principle (the *McGann* court regarded as insignificant the fact that catastrophic illnesses other than AIDS continued to be covered¹⁵⁶) or a principle favoring the pooling of risks over risk segmentation. The question presented by the passage of the ADA is whether the “flexibility” of employers in this regard would be restricted.

Congress enacted the ADA to address the “serious and pervasive problem” of disability discrimination,¹⁵⁷ and “to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities.”¹⁵⁸ Title I of the ADA,¹⁵⁹ which prohibits discrimination in the “terms, conditions, and privileges of employment,”¹⁶⁰ draws broadly from Title VII of the Civil Rights Act of 1964.¹⁶¹ The ADA, at the least, protects against employers' disparate treatment of the disabled. Indeed, in some significant senses it requires more.¹⁶²

“There is a world of difference between administering a welfare plan in accordance with its terms and deciding what those terms are to be.” *Musto v. American Gen. Corp.*, 861 F.2d 897, 911 (6th Cir. 1988).

¹⁵⁵ See *Owens v. Storehouse, Inc.*, 984 F.2d 394, 400 (11th Cir. 1993) (citing *McGann* with approval). The court in *Owens* concluded:

Absent evidence of retaliation or interference with the attainment of an entitled right under the plan, ERISA provides no right to perpetual health insurance with immutable terms. To hold otherwise would impair Congress' express intent that employers be free to fashion medical benefit plans as costs, technology, and the marketplace dictate.

Id. See also *Hylton*, *supra* note 111, at 64 n.12 (“There appears to be a consensus that § 510 does not afford employees like *McGann* protection from employer's [sic] financially motivated decisions to cap or eliminate specific coverages.”).

¹⁵⁶ *McGann*, 946 F.2d at 408.

¹⁵⁷ See 42 U.S.C. § 12101(a)(2) (1994).

¹⁵⁸ *Id.* § 12101(b)(2).

¹⁵⁹ See *id.* §§ 12111-12117.

¹⁶⁰ *Id.* § 12112(a).

¹⁶¹ See *id.* § 2000e to e-17; *id.* § 12117(a) (defining “powers, remedies, and procedures” of enforcement under Title I of the ADA as those “set forth in sections 2000e-4, 2000e-5, 2000e-6, 2000e-8, and 2000e-9” of Title VII); see also *Marcosson*, *supra* note 111, at 406 (describing relationship of two statutes).

¹⁶² For example, it is unlawful discrimination under the ADA to fail to make “reason-

The protection of Title I, extending to the “terms, conditions, and privileges of employment,” has been interpreted by the EEOC as extending to the provision of “[f]ringe benefits available by virtue of employment.”¹⁶³ This prohibition of discrimination in fringe benefits applies whether administered by the employer or by an entity operating under contract for the employer.¹⁶⁴ The protection of fringe benefits, e.g., health coverage, by Title I of the ADA must, however, be considered in conjunction with section 501(c) of the Act.

Section 501(c) of the ADA preserves for insurance companies, employers providing insured health plans, and employers providing self-insured plans, the ability to engage in traditional risk classification, with the caveat that such risk classification cannot be a “subterfuge” for forbidden discrimination.¹⁶⁵ Section

able accommodations” for a disabled person. 42 U.S.C. § 12112(b)(5)(A) (1994). “[R]easonable accommodation[s]’ may include . . . job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.” *Id.* § 12111(9).

This “affirmative action” component of the ADA reflects the view that people with disabilities should be assisted in their efforts to participate fully in society, for their benefit and society’s. See *Statement by President George Bush upon Signing S. 933*, 26 WEEKLY COMP. PRES. DOC. 1165 (July 26, 1990), reprinted in 1990 U.S.C.C.A.N. (104 Stat. 327) 601.

¹⁶³ 29 C.F.R. § 1630.4(f) (1996).

¹⁶⁴ See 42 U.S.C. § 12112(b)(2) (1994); 29 C.F.R. § 1630.4(f) (1996); *id.* § 1630.6(a); see also *EEOC Interim Guidance*, *supra* note 129, at 1303 (stating that ADA prohibits discrimination against qualified applicants, including discrimination in the provision of fringe benefits).

¹⁶⁵ Section 501(c) (codified as amended at 42 U.S.C. § 12201(c) (1994)) provides that the ADA

shall not be construed to prohibit or restrict —

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

501(c), then, presents a puzzle: at what point does risk classification cease being permissible insurance activity, saved from restriction under the ADA, and become an artifice for engaging in prohibited discrimination? For present purposes, the question may be answered by determining whether the ADA overrules *McGann*.¹⁶⁶ Unfortunately, the Baroque structure of the ADA in this regard precludes a definite answer. Had the ADA been drafted without section 501(c), the answer would have been clear: the treatment suffered by McGann constituted disparate treatment, "because of a disability," in the "terms, conditions, and privileges of employment."¹⁶⁷ Therefore, *McGann* would be overruled. Had section 501(c) been included, but without the final clause forbidding its use "as a subterfuge to evade the purposes" of Title I,¹⁶⁸ the result would have been the opposite (*McGann* is upheld), but equally clear. Under these circumstances, section 501(c)(3) would have created a safe harbor for the ERISA-insulated, unreviewable risk segmentation at issue in

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.

42 U.S.C. § 12201(c) (1994).

¹⁶⁶ That is, whether a "carve-out" of treatment of a particular (presumably disfavored) condition is now subject to review against a substantive antidiscrimination standard.

¹⁶⁷ See 42 U.S.C. § 12112(a) (1994). Were the statute drafted without section 501(c), the analysis of disparate treatment of disabled employees for purposes of fringe benefits would mirror the analysis of disparate treatment of women for purposes of annuities under Title VII. Under Title VII, disparate treatment in charging contributions for, or paying on annuities on the basis of gender is unlawful even though "[a]ctuarial studies" establish genuine gender-based class differences, and it is impossible to know which employees will meet and which will defy actuarial prediction. *Los Angeles Dept. of Water & Power v. Manhart*, 435 U.S. 702, 708-09 (1978), *vacated*, 461 U.S. 951 (1983). "Congress decided that classifications based on sex . . . are unlawful," even if that classification is based on a "true generalization" that cannot be further refined by close examination of each employee's individual characteristics. *Id.* See *Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1081 (1983) ("[T]he classification of employees on the basis of sex is no more permissible at the pay-out stage of a retirement plan than at the pay-in stage."). Without section 501(c), the ADA would bar employee classifications for purposes of benefits plans on the basis of disability similar to Title VII's prohibition of classification by sex.

¹⁶⁸ 42 U.S.C. § 12201(c) (1994).

McGann.¹⁶⁹ The inclusion of the final clause in section 501(c), prohibiting “subterfuge,” however, leaves the issue unsettled.

The correct interpretation of “subterfuge” for purposes of section 501(c) has been the subject of extensive analysis by scholarly commentators,¹⁷⁰ courts,¹⁷¹ and the EEOC,¹⁷² and will not be recapitulated here. The more modest task of this section is threefold: first, to demonstrate that the view of the ADA as reversing *McGann* is powerful; second, to observe that

¹⁶⁹ Under these circumstances, subsection 501(c)(1) — permitting risk segmentation in insurance underwriting — and subsection 501(c)(2) — permitting such underwriting in insured group plans — would preserve the status quo. Existing insurance regulations in many states protect individuals from non-renewal due to illness, and, in group insurance, prohibit “carve-outs” of disfavored conditions. See *supra* note 166 (pondering whether “carve-out” is subject to review against substantive antidiscrimination standard).

¹⁷⁰ See Neville M. Bilimoria, *No Relief in Sight: The Impact of the Americans with Disabilities Act on AIDS Discrimination in Employee Medical Plans*, 3 DET. C.L. REV. 1053, 1078-87 (1994) (examining conflicting interpretations of “subterfuge”); Steven Eisenstat, *Capping Health Insurance Benefits for AIDS: An Analysis of Disability-Based Distinctions Under the Americans with Disabilities Act*, 10 J.L. & POL. 1, 11-30 (1993) (discussing alternative forms for “subterfuge” definition); Marcossou, *supra* note 111, at 410-18 (discussing various definitions of “subterfuge” and concluding that term refers to actuarial basis for challenged practice); Lorraine Schmall, *Toward Full Participation and Protection of the Worker with Illness: The Failure of Federal Health Law After McGann v. H & H Music Co.*, 29 WAKE FOREST L. REV. 781, 843 (1994) (examining struggle with meaning of “subterfuge”); Evan J. Spelfogel, *The Interaction of ERISA and the Americans with Disabilities Act*, 68 ST. JOHN’S L. REV. 459, 466-68 (1994) (arguing that congressional intent should control meaning of “subterfuge”); Widiss, *supra* note 129, at 1694-96 (addressing Supreme Court and EEOC approaches to determine meaning of “subterfuge”); Alan I. Widiss & Larry Gostin, *What’s Wrong with the ERISA “Vacuum”? The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage is to be Provided When Risk Retention Plans are Established for Health Care*, 41 DRAKE L. REV. 635, 650-52 (1992) (preferring that term “subterfuge” include sound actuarial principles); Kathlynn L. Butler, Comment, *Securing Employee Health Benefits Through ERISA and the ADA*, 42 EMORY L.J. 1197, 1235-39 (1993) (providing EEOC interpretation of “subterfuge”); H. Miriam Farber, Note, *Subterfuge: Do Coverage Limitations and Exclusions in Employer-Provided Health Care Plans Violate the Americans with Disabilities Act?*, 69 N.Y.U. L. REV. 850, 853-915 (1994) (examining various approaches and offering model synthesis for determining meaning of “subterfuge”); Lizzette Palmer, Comment, *ERISA Preemption and its Effects on Capping the Health Benefits of Individuals with AIDS: A Demonstration of Why the United States Health and Insurance Systems Require Substantial Reform*, 30 HOUS. L. REV. 1347, 1379-81 (1993) (discussing EEOC guidelines for “subterfuge” term).

¹⁷¹ See *Moddero v. King*, 82 F.3d 1059, 1063-65 (D.C. Cir. 1996) (setting forth various interpretations of “subterfuge” term); *Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102, 109-11 (S.D. Iowa 1995) (concluding that “subterfuge” refers to non-fringe benefit of employment relationship); *Piquard v. City of East Peoria*, 887 F. Supp. 1106, 1119-25 (C.D. Ill. 1995) (examining different definitions accorded to “subterfuge”).

¹⁷² See *EEOC Interim Guidance*, *supra* note 129, at 1304 (highlighting disability-based distinctions).

Congress has available to it models of statutory language to *clearly* overrule *McGann*, should the courts interpret the ADA otherwise; and third, to demonstrate that an interpretation of the ADA as overruling *McGann* will, somewhat counterintuitively, lead to more, and not less, risk pooling.

A. *The Structure and History of the ADA
Demonstrate Rejection of McGann*

The EEOC's interpretation of section 501(c) is clear. Unremarkably, it interprets subsections 501(c)(1) and (2) as reaffirming that insurance products and insured plans continue to be subject to state law.¹⁷³ It further interprets section 501(c) as prohibiting any "disability-based disparate treatment that is not justified by the risks or costs associated with the disability" — a requirement applicable to insured and self-insured plans alike.¹⁷⁴ The EEOC set a substantive actuarial standard for establishing a justified risk-cost association, promising to closely examine the underlying validity of such assertions.¹⁷⁵ The agency justifies this interpretation of the subterfuge language by reference to the language of the ADA and its legislative history.¹⁷⁶

The ADA's subterfuge language comes with some baggage, however, as the EEOC recognized.¹⁷⁷ Very similar phrasing has obscured the meaning of the Age Discrimination in Employment

¹⁷³ See *id.* (establishing that state law applies to § 501(c)).

¹⁷⁴ *Id.* at 1306.

¹⁷⁵ The EEOC Interim Guidance provides:

Actuarial data that is seriously outdated and/or inaccurate is not legitimate actuarial data. The respondent, for example, will not be able to rely on actuarial data about a disability that is based on myths, fears, or stereotypes about the disability. Nor will a respondent be able to rely on actuarial data that is based on false assumptions about disability, or on assumptions that may have once been, but are no longer, true. For example, a respondent would not be able to justify an exclusion of epilepsy from its insurance plan that is based on an erroneous assumption that people with epilepsy are more likely to have serious accidents (and thus file more claims for insurance benefits) than are individuals who do not have epilepsy.

Id. at 1306 n.14.

¹⁷⁶ See *id.* at 1305 n.10.

¹⁷⁷ See *id.*

Act (ADEA)¹⁷⁸ for two decades. The ADEA makes it unlawful to “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s age”¹⁷⁹ Not all age-based disparate treatment is prohibited, however. As originally passed, subsection 4(f)(2) of the ADEA excepts from the Act’s reach “a bona fide seniority system or any bona fide employee benefit plan such as a retirement, pension, or insurance plan, which is not a subterfuge to evade the purposes of this [Act]”¹⁸⁰ In 1977, the Supreme Court decided in *United Air Lines, Inc. v. McMann*¹⁸¹ that the ADEA did not flatly prohibit employers from using plans mandating retirement before age sixty-five.¹⁸² Rather, a mandatory retirement plan would be permitted if it were not a “subterfuge.” The Court then interpreted “subterfuge” according to its ordinary dictionary definition as a “scheme, plan, stratagem, or artifice of evasion.”¹⁸³ It therefore refused to read into subsection 4(f)(2) a “*per se* rule requiring an employer to show an economic or business purpose in order to satisfy the subterfuge language of the Act.”¹⁸⁴ The Court observed that this interpretation of subsection 4(f)(2) required a showing of specific intent to evade the Act’s requirements. Accordingly, the creation of the retirement plan complained of in *McMann*, predating as it did the passage of the ADEA by twenty-six years, could not have been motivated by such intent.¹⁸⁵

Congress acted quickly to reverse *McMann* and amended the ADEA in 1978 to forbid plans requiring retirement on the basis of an employee’s age.¹⁸⁶ The amended statute, however, left intact the exception for plans without mandatory retirement

¹⁷⁸ 29 U.S.C. §§ 621-634 (1994).

¹⁷⁹ *Id.* § 623(a)(1).

¹⁸⁰ *Id.* § 623(f)(2) (1985) (current version at 29 U.S.C. § 623(f)(2) (1994)).

¹⁸¹ 434 U.S. 192 (1977).

¹⁸² *See id.* at 203.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *See id.*

¹⁸⁶ Age Discrimination in Employment Act Amendments of 1978, Pub. L. No. 95-256, § 2(a), 92 Stat. 189 (1978) (codified as amended at 29 U.S.C. § 623(f)(2) (1985)) (stating that “no . . . employee benefit plan shall require or permit the involuntary retirement of any individual . . . because of the age of such individual”).

programs.¹⁸⁷ The Court revisited the now-amended subterfuge language in 1989, in *Public Employee Retirement System of Ohio v. Betts*,¹⁸⁸ a case brought by a sixty-one year-old employee denied access to a disability retirement program due to age. The case turned on the validity of regulations promulgated by the Department of Labor in the wake of the 1978 amendments, which articulated an objective test for subterfuge: “age-based reductions in employee benefits plans” are permissible “where such reductions are justified by significant cost considerations. . . . Where employee benefit plans do meet the criteria in subsection 4(f)(2), benefit levels for older workers may be reduced to the extent necessary to achieve approximate equivalency in cost for older and younger workers.”¹⁸⁹ The Department of Labor regulations interpreted the subterfuge language of subsection 4(f)(2) as not being violated when there is an “age-related cost justification or ‘a substantial business purpose’ for any age-based reduction in benefits.”¹⁹⁰

The Supreme Court limited the effect of the 1978 amendment to its text, finding that the *McMann* interpretation of the subterfuge language as requiring a showing of a subjective intent to violate the law survived.¹⁹¹ The legislative history to the 1978 amendments, relied upon by the court of appeals, was determined to be of no effect, as the “plain statutory language” resolved the matter.¹⁹² Thus, the Court rejected a business purposes test, and returned to a subjective intent-based definition of subterfuge. Finally, Congress clearly resolved the issue in 1990, with the passage of the Older Workers Benefit Protection Act, which removed references to “subterfuge” from subsection

¹⁸⁷ *See id.*

¹⁸⁸ 492 U.S. 158 (1989).

¹⁸⁹ 29 C.F.R. § 1625.10(a)(1) (1996).

¹⁹⁰ *Betts*, 492 U.S. at 164 (quoting *Betts v. Hamilton County Bd. of Mental Retardation*, 848 F.2d 692, 694 (6th Cir. 1988)).

¹⁹¹ *See id.* at 170-71.

¹⁹² *Id.* at 172.

4(f)(2) of the ADEA¹⁹³ and clearly instituted a cost-based, objective test for the validity of age-based benefits distinctions.¹⁹⁴

The subterfuge language of the ADA fits uneasily in this chronology. The ADA was passed — with subterfuge language very similar to that then in the ADEA — after the Supreme Court decided *Betts* and before Congress overruled it. In the Older Workers Benefit Protection Act, Congress rejected the reading of “subterfuge” as requiring a subjective intent to harm a worker on the basis of age. Instead Congress adopted an objective test for permissible age-based disparate treatment in employee benefit plans.¹⁹⁵ Congress had not, however, included a cost-justification test several months earlier in the language of the bills that became the ADA. Rather, legislators included in the legislative history several explanations that Congress intended the “subterfuge” language of the ADA to be governed by an objective, actuarially-based test, and not the *Betts* subjective test. For example, the House Judiciary Committee Report explained that a plan may not limit coverage “based on classification of risk . . . because of physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles, or is related to actual or reasonably anticipated experience.”¹⁹⁶

¹⁹³ Older Workers Benefit Protection Act, Pub. L. No. 101-433, 104 Stat. 978 (1990). *Betts* was decided on June 23, 1989. *Betts*, 492 U.S. at 158. Initial drafting and committee work on the ADA preceded that decision (the bill was introduced in both the House and the Senate on May 9, 1989, and had been presented to different congressional committees since 1987). Cong. Info. Serv. No. 90-PL101-336 (available in cd-rom). The ADA passed in the Senate on September 7, 1989, the House of Representatives on May 17, 1990, and was signed on July 26, 1990. Act of July 26, 1990, Pub. L. No. 101-336, 104 Stat. 378. The Older Workers Benefit Protection Act, overruling *Betts*'s interpretation of the ADEA subterfuge language, was signed on October 16, 1990. Act of Oct. 16, 1990, Pub. L. No. 101-433, 104 Stat. 984.

¹⁹⁴ See Older Workers Benefit Protection Act, Pub. L. No. 101-433, § 103(1) Stat. 978 (1990) (codified at 29 U.S.C. § 623(f)(2) (1996)); Bilimoria, *supra* note 170, at 1079 (stating that Congress intended to create objective discrimination factors rather than subjective, intent-based factors).

¹⁹⁵ See 29 U.S.C. § 623(f)(2)(B)(i). The new language simply requires that “the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker . . .” *Id.* The test could not be clearer or more divorced from subjective intent; it requires only equal effort regardless of age.

¹⁹⁶ H.R. REP. NO. 101-485(III), at 71 (1990), reprinted in 1990 U.S.C.C.A.N. 494. See *Piquard v. City of East Peoria*, 887 F. Supp. 1106, 1123-24 (C.D. Ill. 1995) (citing legislative

Courts should interpret section 501(c), then, under the EEOC's objective test. Under this test, a disability-based difference in treatment for health benefits purposes must be "justified by the risks or costs associated with the disability,"¹⁹⁷ which ordinarily¹⁹⁸ entails "legitimate actuarial data, or by actual or reasonably anticipated experience."¹⁹⁹ Under this interpretation of section 501(c), *McGann* is overruled. In *McGann*, coverage was not limited for any catastrophic illness other than AIDS.²⁰⁰ Self-funded plans can not exclude coverage for AIDS-related treatment unless they can show that "conditions with comparable actuarial data and/or experience are treated in the same fashion."²⁰¹ More generally, the EEOC's interpretation of section 501(c) imposes a "fair discrimination" requirement like that imposed by state unfair trade practice acts,²⁰² requiring that employees' differential treatment on the basis of disability be actuarially justified.

B. Examples of Clear Amendatory Language are Readily Available

While the EEOC's interpretation of section 501(c) has considerable strength, it is open to attack. Congress borrowed the "subterfuge" language from the ADEA after the Supreme Court narrowly construed that language in *Betts*. This may evidence Congress's adoption of that narrow interpretation. Put slightly

statements enunciating an objective test); *see, e.g.*, 136 CONG. REC. S9696-97 (daily ed. July 13, 1990) (statement of Sen. Kennedy) (stating that term "subterfuge" as used in ADA should not be interpreted in manner in which Supreme Court did in *Betts*); 136 CONG. REC. H4614-02 (daily ed. July 12, 1990) (statement of Rep. Edwards) ("The term 'subterfuge' is used in the ADA simply to denote a means of evading the purposes of the ADA. It does not mean that there must be some malicious intent to evade the ADA on the part of the insurance company or other organization . . ."); *see also* Bilimoria, *supra* note 170, at 1079-80 (discussing legislative history).

¹⁹⁷ EEOC Interim Guidance, *supra* note 129, at 1306.

¹⁹⁸ *Id.* The EEOC posits limited situations in which an explanation not tied to actuarial analysis would justify differential treatment. *Id.* For example, when the fiscal soundness of the plan depends on the differential treatment, or a significant number of other employees would lose coverage but for the differential treatment, or the treatment at issue "does not provide any benefit." *Id.* (emphasis in original).

¹⁹⁹ *Id.*

²⁰⁰ *McGann v. H & H Music Co.*, 946 F.2d 401, 403 (5th Cir. 1991).

²⁰¹ EEOC Interim Guidance, *supra* note 129, at 1306.

²⁰² *See supra* notes 47-48 and accompanying text (describing how unfair trade practice acts operate to prevent unjustified segmentation based on insurance risk classifications).

differently, in *Betts*, the Court decided that the subterfuge language common to both the ADEA and the ADA required the application of a subjective test.²⁰³ The language of section 501(c) itself does not evidence a congressional intent to employ a different interpretation of “subterfuge,” and some courts have, under these circumstances, found the legislative history to be either inconclusive²⁰⁴ or irrelevant.²⁰⁵ It may be, then, that in the current era of judicial skepticism of statutory interpretation through legislative history,²⁰⁶ the congressional expressions rejecting *Betts* that were decisive for the EEOC will be unpersuasive to the courts.²⁰⁷

²⁰³ See *Public Employees Retirement Sys. v. Betts*, 492 U.S. 158, 180-82 (1989).

²⁰⁴ See *Piquard v. City of East Peoria*, 887 F. Supp. 1106, 1123-24 (C.D. Ill. 1995) (citing legislative history that evidences intent to reject *Betts* test, but also legislative history that could be interpreted as intending that last clause of § 501(c) prohibit “using paragraphs (1), (2), or (3) to discriminate in a non-fringe benefit aspect of employment”).

²⁰⁵ See *Moddero v. King*, 82 F.3d 1059, 1064-65 (D.C. Cir. 1996) (holding that plain language of § 501(c) requires application of *Betts* test); *Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102, 110-11 (S.D. Iowa 1995) (stating that legislative history is “often unreliable” as guide to congressional intent; enactment of subterfuge language following *Betts* is evidence of adoption of Supreme Court’s interpretation).

Both *Moddero* and *Krauel* are influenced by the modern “textualist” debates, which question the validity of legislative history as a guide to legislative intent. See, e.g., William N. Eskridge, Jr., *The New Textualism*, 37 UCLA L. REV. 621, 690-91 (1990) (arguing that new textualist movement, embodied by Justice Scalia, shifts focus from legislative history to statutory text); John Copeland Nagel, *Newt Gingrich, Dynamic Statutory Interpreter* (essay review), 143 U. PA. L. REV. 2209, 2214-15 (1995) (countering Eskridge’s argument that “originalist approaches are just as indeterminate and no more constraining than dynamic approaches” and Eskridge’s “normative argument for dynamic statutory interpretation”); Richard A. Posner, *Legal Formalism, Legal Realism, and the Interpretation of Statutes and the Constitution*, 37 CASE W. RES. L. REV. 179, 179-80 (1987) (contrasting legal formalism with legal realism asserting that neither applies to statutory interpretation); Cass R. Sunstein, *Interpreting Statutes in the Regulatory State*, 103 HARV. L. REV. 405, 504 (1989) (discussing debate in statutory interpretation and arguing that legislative history is key element).

²⁰⁶ See Nagel, *supra* note 205, at 2227 (citing two exceptions to plain meaning rule, one when evidence exists that Congress intended different results and another when plain language leads to result Congress could not have intended).

²⁰⁷ No doubt the EEOC’s hand would be strengthened if it adopted the Interim Guidance as a formal regulation. Under the *Chevron* doctrine, “if the statute is silent or ambiguous with respect to [a] specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.” *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984). This requirement of deference to agency interpretation has less strength, however, when the agency has spoken through relatively informal means. *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 257 (1991). See also Rebecca Hanner White, *The EEOC, the Courts, and Employment Discrimination Policy: Recognizing the Agency’s Leading Role in Statutory Interpretation*, 1995 UTAH

Old congressional hands responsible for shepherding the ADA into law, such as Senator Kennedy and Representative Edwards, might be forgiven for being insufficiently attentive to the evolution of judicial fashion. No longer is the inclusion of disclaimers in committee reports and floor debate a sufficient response to an erroneous judicial interpretation of congressional intent. Rather, courts increasingly require that the *text* of the legislation clearly evidence a rejection of a judicial interpretation.²⁰⁸ It may have been more difficult in the lumbering process of moving a bill through Congress to change the previously drafted and reviewed language of the ADA than to explain in legislative history that the drafters intended section 501(c) to state an objective test for subterfuge. Judicial norms, however, now demand the effort.²⁰⁹

Should courts reject the legislative history deemed by the EEOC as sufficient expressions of congressional will, two obvious means of amending the ADA are available. First, Congress could explicitly state an objective test for determining the limits of permissible risk differentiation, as it did in amending the ADEA in the Older Workers Benefit Protection Act. There, Congress replaced limiting language, which the Supreme Court

L. REV. 51, 105-06 (discussing courts' interpretations of EEOC regulations as opposed to EEOC's own informal opinions). The EEOC clearly has the authority to adopt such regulations. See 42 U.S.C. § 12116 (1995) (granting EEOC power to issue regulations); White, *supra*, at 69 (noting examples of EEOC's use of its power to issue regulations).

²⁰⁸ See Frederick Schauer, *The Practice and Problems of Plain Meaning: A Response to Alienikoff and Shaw*, 45 VAND. L. REV. 715, 716 (1992) (asserting that trend in Supreme Court jurisprudence has been to increasingly rely on plain meaning, and to give less weight to legislative history); see generally, Nagel, *supra* note 205, at 2227-30 (arguing that Court reads exceptions to plain meaning rule too narrowly).

²⁰⁹ At the risk of stating the obvious, replacing the ambiguous language of section 501(c) with language explicitly stating an objective test would establish more certainty that Congress intended such a test. This, of course, is precisely the point made by at least some current Supreme Court justices in diminishing the value of legislative history in statutory interpretation. See *FDIC v. Meyer*, 510 U.S. 471, 476-77 (1994) (Thomas, J.) (applying plain meaning of term "cognizable" to 28 U.S.C. § 1346(b)); *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475-76 (1992) (Kennedy, J.) (stating that courts "must give effect to clear meaning of statute as written"); *INS v. Cardozo-Fonseca*, 480 U.S. 421, 452 (1987) (Scalia, J., concurring) (stating that statute's plain meaning should be used without regard for legislative history). A more modest point is that long-time members of Congress had come to rely on a convention whereby the expedient of explanation in the legislative history of statutory text was respected by the courts as one permissible means of setting out the perimeters of congressional will.

interpreted as imposing a subjective test,²¹⁰ with a clearly objective test.²¹¹ The ADA could similarly be amended by requiring that self-insured plans engage in "fair discrimination." The amendatory language could be drawn from the congressional report on which the EEOC apparently based its interpretation of section 501(c),²¹² and could read as follows:

[The ADA shall not be construed to prohibit or restrict] a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance *so long as such plan's classification of risk because of physical or mental disability, including refusal, limitation or rate differential, is based on sound actuarial principles, or is related to actual or reasonably anticipated experience.*

This amendment, like the 1990 amendment to the ADEA, would affect only plans that ERISA exempts from the reach of state insurance law.

The second means Congress could choose to amend the ADA to reflect the intent of imposing an objective test would be more far-reaching, and would place the same burden on all forms of health coverage. Section 501(c) now leaves the risk classification of individual insurance and insured group plans to the states, consistent with ERISA.²¹³ All states have adopted some form of the Uniform Unfair Trade Practices Act, and therefore generally require (in the absence of more specific legislation)²¹⁴ that actuarially similar risks be treated similarly.²¹⁵ The modest aim of the ADA in this regard, as evidenced

²¹⁰ See 29 U.S.C. § 623(f)(2) (1982), amended by 29 U.S.C. § 623(f)(2)(B)(i) (Supp. 1996). "It shall not be unlawful for an employer . . . to observe the terms of . . . any bona fide employee benefit plan . . . which is not a subterfuge to evade the purposes of this chapter . . ." *Id.*

²¹¹ See *id.* § 623(f)(2)(B)(i) (Supp. 1996). "It shall not be unlawful for an employer . . . to observe the terms of a bona fide employee benefit plan . . . where, for each benefit or benefit package, the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker . . ." *Id.*

²¹² H.R. REP. NO. 101-485(III), at 71 (1990), reprinted in 1990 U.S.C.C.A.N. 494.

²¹³ Americans With Disabilities Act §501(c)(1)(2), 42 U.S.C. § 12201(c) (1995). See 29 U.S.C. § 1144(b)(2)(A) (1994) (mandating ERISA insurance savings clause).

²¹⁴ See *supra* note 50 and accompanying text (discussing statutory exceptions to actuarial fidelity requirement); *supra* notes 92-93 and accompanying text (discussing exceptions for genetic conditions).

²¹⁵ See *supra* notes 41-49 and accompanying text (discussing states' prohibition of unfair discrimination in rate setting).

by the legislative history cited above, was to impose similar "fair discrimination" requirements on self-funded plans. There is no reason to permit unfair treatment on the basis of disability in private insurance: the ADA prohibits such treatment elsewhere in the marketplace²¹⁶ and was intended to prohibit it specifically in self-funded health plans. Section 501(c) could be amended to require "fair discrimination" in health insurance for plans now governed by state law (thereby simply adopting the requirements of state unfair trade practice acts), as well as self-funded plans. The section, as amended, could read:

[The ADA] shall not be construed to prohibit or restrict a person or organization covered by this chapter, including an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefits plans, or similar organizations, from underwriting risks, classifying risks, or administering such risks, or from establishing, sponsoring, observing, or administering the terms of a bona fide benefits plan, so long as the classification of risk because of physical or mental impairment, including refusal, limitation or rate differential, is based on sound actuarial principles, or is related to actual or reasonably anticipated experience.

The first suggested amendment would merely effect the congressional intent to enforce fair discrimination principles on self-funded plans. The second would extend uniform fair discrimination rules to all health benefits coverage.

C. Enforcement of Fair Discrimination Principles by the ADA Will Lead to Social Risk Pooling and Not to Increased Risk Segmentation

Interpreting the ADA as requiring fair discrimination (with or without the need for congressional amendment), of course, does not bar differential treatment on the basis of disability. Instead, as the EEOC's Interim Guidance recognized, it requires that disability-based differential treatment be supported by "legitimate

²¹⁶ 42 U.S.C. § 12182(a) (1995). Note that Title III of the ADA prohibits disability discrimination in places of public accommodation. *Id.* Notwithstanding section 501(c)'s substantive protection of traditional underwriting principles, the business of insurance is a "public accommodation" along with other "service establishment[s]." 42 U.S.C. § 12181(7)(F) (1995). See *Carparts Distrib. Ctr. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12, 14, 18-20 (1st Cir. 1994) (tentatively finding that trade association's self-funded medical reimbursement plan is subject to Title III of ADA).

actuarial data, or . . . by actual or reasonably anticipated experience.”²¹⁷ The ADA, then, might be seen as increasing risk segmentation at the expense of social pooling.²¹⁸ As described above, insurance companies’ insistence in the 1980s for permission to test for (and exclude from coverage on the basis of) HIV infection increased risk segmentation.²¹⁹ The ADA, however, adds a refinement to the fair discrimination analysis employed in the HIV testing context. The ADA requires *comparative* fairness.²²⁰ Courts supported HIV testing under a fair discrimination rationale on the basis of patently obvious evidence that HIV-infected insureds posed a higher risk than the uninfected.²²¹ Fair discrimination was viewed as requiring the equitable allocation of cost as between high-risk and low-risk insureds. It did not extend to the allocation between different classes of high-risk insureds.²²² The ADA, as interpreted by the EEOC, requires “that conditions with comparable actuarial data and/or experience are treated in the same fashion.”²²³ A disabling

²¹⁷ *EEOC Interim Guidance*, *supra* note 129, at 1306 (citation omitted).

²¹⁸ See *supra* notes 128-29 and accompanying text (discussing ADA’s push towards “fair discrimination” in risk pooling by employment based coverage).

²¹⁹ See *supra* notes 54-59 and accompanying text (discussing insurers’ victory in dispute with states over propriety of HIV testing for risk allocation).

²²⁰ See *supra* notes 197-202 and accompanying text (describing in more detail ADA’s requirement that actuarially similar conditions be treated similarly by insurers).

²²¹ See *Life Ins. Ass’n v. Commissioner of Ins.*, 530 N.E.2d 168, 171 (Mass. 1988) (stating that persons with HIV antibodies have greater risk of illness and shorter life expectancies than people without HIV antibodies); *Health Ins. Ass’n of Am. v. Corcoran*, 551 N.Y.S.2d 615, 619 (App. Div. 1990) (“It can hardly be denied that the present and potential AIDS epidemic represents a formidable financial threat of disastrous proportions to health insurers and the public fisc . . .”), *aff’d mem.*, 565 N.E.2d 1264 (N.Y. 1990).

²²² See *Life Ins. Ass’n*, 530 N.E.2d at 171-72 (discussing policy impacts of ban on use of HIV testing to demonstrate insurability); *Health Ins. Ass’n*, 551 N.Y.S.2d at 620-22 (discussing separate rating classification).

²²³ *EEOC Interim Guidance*, *supra* note 129, at 1306. This requirement of comparative equity is fully consistent with the structure of the ADA. Under the ADA, as with other antidiscrimination statutes, adjudication of alleged discriminatory action follows the burden-shifting method developed by the Supreme Court. See *DeLuca v. Winer Indus., Inc.*, 53 F.3d 793, 797 (7th Cir. 1995) (applying Title VII burden shifting in *McDonnell-Douglas Corp. v. Green*, 411 U.S. 792 (1973), to ADA cases). Under this analysis, an employee presents a *prima facie* case of disability discrimination by demonstrating disparate treatment in benefits due to her disabling condition. *Id.* If the employee demonstrates a *prima facie* case, the burden then shifts to the employer to offer a nondiscriminatory reason for the disparate treatment. Following this analysis, the employer may offer the nondiscriminatory reason that the disabling condition creates an actuarial difference between the plaintiff and other employees, and that the disparate treatment was therefore

condition such as HIV infection or a genetic condition, therefore, could be disparately treated in a health benefits plan only if other similarly severe conditions are similarly treated. Under the ADA, then, AIDS treatment could only be excluded or limited from coverage only if care for cancer, heart disease and renal diseases were also excluded.²²⁴

Will, therefore, the ADA have the perverse effect of lessening access to health coverage for those with catastrophic conditions, as some commentators have suggested?²²⁵ That prospect is unlikely. While Americans often view AIDS as “someone else’s problem,”²²⁶ other catastrophic conditions, such as cancer and heart disease are regarded as potential threats to everyone. Accordingly, health coverage that excludes, or dramatically limits, care for such conditions would be considered fundamentally incomplete.²²⁷ Further, the legal treatment of genetic²²⁸ and preexisting conditions²²⁹ demonstrates a trend

based not on the disabling condition, but on the high cost of treatment. The burden then shifts from the employer back to the employee. The employee may then establish that the employer’s explanation was pretextual, by demonstrating that the employer did not treat other conditions resulting in similar actuarial severity in the same manner. *Id.* The EEOC’s language, therefore, is clearly based on the well-accepted notion of pretext in the adjudication of claims under antidiscrimination statutes.

²²⁴ See Marcossan, *supra* note 111, at 391 n.153 (comparing cost of treatment of HIV to cost of other conditions); Padgug et al., *supra* note 37, at 62 (same); Sohlgren, *supra* note 143, at 1259 n.61 (same).

²²⁵ See Bilimoria, *supra* note 170, at 1074-75 (“[E]mployers may simply avoid the EEOC enforcement by reducing coverage for all catastrophic illnesses in the effort to save money on expensive AIDS claims.”); see also Padgug et al., *supra* note 37, at 74 (advocating elimination of employer power to create more favorable risk pools for insurance coverage by reducing benefits for everyone, selected populations, or utilization); Jeffrey Ralph Pettit, Note, *Help! We’ve Fallen and We Can’t Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 798-99 (1993) (stating that employers typically create overly broad limitations on insurance coverage to disguise discrimination against people with AIDS).

²²⁶ See Padgug & Oppenheimer, *supra* note 40, at 42 (noting that some Americans view people with AIDS as separate group); see also Bruner, *supra* note 143, at 1126-27 (noting that many Americans view AIDS as “somebody else’s problem” because they believe that they have no significant risk of contracting AIDS); Marcossan, *supra* note 111, at 430 (stating that many people believe they are at risk for cancer and asserting that this belief explains public’s different perceptions of cancer and AIDS).

²²⁷ See Marcossan, *supra* note 111, at 430 (finding that excluding cancer coverage would be unappealing policy).

²²⁸ See *supra* Part I (describing use of genetic testing by insurance industry).

²²⁹ See *supra* Part II (discussing risk selection in employment-based insurance).

toward the social pooling of risk, excepting the arguably special case of AIDS.

It is unlikely, then, that Americans — or American insurance law — will permit the broad excision from health plans of coverage for catastrophic conditions such as heart disease, renal failure and cancer. If some “favored” catastrophic conditions will be a part of health coverage, the ADA requires that actuarially similar “disfavored” diseases, such as AIDS, be covered as well. Therefore, although in theory the requirement of equal treatment of favored and disfavored catastrophic diseases could lead to either a reduction or increase in the breadth of coverage, in the real world only the latter is likely. When pressed, employers and insurers would rather cover disfavored diseases than omit coverage of favored diseases. The marketplace and legislatures will not permit otherwise.

III. PORTABILITY, GUARANTEED ACCESS AND MSAS

President Clinton signed the Health Insurance Portability and Accountability Act of 1996 into law on August 21, 1996 (“the 1996 Act”).²³⁰ The 1996 Act is a far cry from that proposed by President Clinton as the Health Security Act of 1993, which was designed to “ensure individual and family security through health care coverage for all Americans . . . and to ensure and protect the health care of all Americans.”²³¹ The 1996 Act’s less stirring design aims to discretely modify the competitive marketplace for health insurance.²³² From the perspective of

²³⁰ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

²³¹ The Health Security Act, H.R. 3600, 103d Cong. Preface (1993).

²³² See Health Insurance Portability and Accountability Act, preface. It was intended as:

[a]n Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

Id. In his signing statement, President Clinton sounded a subdued note, calling the bill “a modest but important step . . . to improve Americans’ access to health care coverage.” President William Clinton, *The White House: Office of the Press Secretary* (visited Aug. 21, 1996) <<http://docs.whitehouse.gov/white-health-insurance-portability-act.text>>. After describing

the architectonic comprehensiveness of the Health Security Act, the reforms of the 1996 Act seem modest. But from a slightly longer perspective, the 1996 Act is significant. It represents a thoughtful, if limited, injection of regulation into the world of insurance underwriting.

The 1996 Act clearly takes sides on the question of whether private insurance markets should be structured to foster social pooling or to maximize individual responsibility and advantage: it requires the private insurance market to protect the interests of "poor risks," even when rational actuarial judgment would reject their membership in insurance pools.²³³ State legislatures and Congress were making similar choices in their treatment of genetic conditions and HIV infection in insurance underwriting. Even assuming legislators in those contexts were reacting to isolated, emotionally compelling situations rather than making a policy choice between social pooling and individualism, the 1996 Act's enforcement of limitations on underwriting leaves no such doubt. The 1996 Act, and the state legislation (much of it more comprehensive in scope) that came before it, reflect a judgment that insurance markets must be structured to enhance the broad availability of coverage.

The debate that led to the passage of the 1996 Act revealed a struggle between those who advocated the social-sharing ethic previously manifested in the limitations on genetic and disability-based limitations, and those who extolled the practical benefits of personal responsibility and increased segmentation of the insurance market through the fostering of Medical Savings Accounts (MSAs).²³⁴ Both the substantial market regulation

the "several key reforms" included in the bill, the President acknowledged that the bill "includes compromises that are less than perfect," including the favorable tax treatment given a limited number of Medical Savings Accounts (MSAs) and the failure of the bill to include provisions establishing "parity" of coverage for physical and mental health services. *Id.*

²³³ Health Insurance Portability and Accountability Act § 2702.

²³⁴ In Congress, the debate largely supported the portability provisions. *See* 142 CONG. REC. S3503 (daily ed. Apr. 18, 1996) (statement of Sen. Kassebaum) (supporting portability provisions as extending availability of coverage to those currently unable to obtain coverage); 142 CONG. REC. S3513 (daily ed. Apr. 18, 1996) (statement of Sen. Kennedy) (same); 142 CONG. REC. H2038 (daily ed. Mar. 12, 1996) (statement of Rep. Pallone) (same). The congressional debate between social pooling and individual responsibility arose in the contest over the addition of tax benefits for MSAs to the proposed legislation. Some members of Congress favored MSAs to increase individual responsibility in the health care system. *See*

142 CONG. REC. H3045-02 (daily ed. Mar. 28, 1996) (statement of Rep. Ganske) (stating that MSAs "return control over health care spending to consumers, save money, and lower health care overutilization"); 142 CONG. REC. H3100 (daily ed. Mar. 28, 1996) (statement of Rep. Buyer) (stating that "MSAs are true portability. The account belongs to the individual and is under the individual's control. This is a creative solution to provide more affordable insurance coverage and greater choice."). Others opposed MSAs as destroying the fabric of shared risk. See 142 CONG. REC. H3093 (daily ed. Mar. 28, 1996) (statement of Rep. Pallone) (stating that addition of MSAs "breaks the insurance risk pool. Essentially what it does is to encourage healthy people and wealthy people to opt out and buy catastrophic coverage and get a tax break to put their money aside and leave everyone else in this risk pool so that they have to pay higher premiums . . ."); 142 CONG. REC. H3094 (daily ed. Mar. 28, 1996) (statement of Rep. Brown) (stating that MSAs "will enrich a select group of high-end catastrophic providers, skim the well-off and healthy out of the insurance pool, and increase costs for everyone left behind"); 142 CONG. REC. S3513 (daily ed. Mar. 28, 1996) (statement of Sen. Kennedy) (stating that "by pulling the healthiest individuals out of the conventional insurance market, [MSAs] will raise premiums for everyone else, including those who need coverage the most").

Outside of Congress, the debate was wider-ranging. Some business and political journals derided the market-regulating aspects of the Kassebaum-Kennedy bill both on the grounds that they were contrary to small government, antiregulatory principles, and that they would be ineffective in expanding access to health insurance. See Steve Forbes, *Hillary Clinton's Triumph*, FORBES, May 20, 1996, at 25 (stating that Kassenbaum-Kennedy Bill is "socialized monstrosity"); *No Thanks, Nancy*, THE ECONOMIST, Apr. 27, 1996, at 29 (arguing that Kassenbaum-Kennedy Bill would result in increased bureaucracy, loss of coverage to high-risk individuals, increased cost to everyone and loss of cost control); *Rx: Obstruction*, NAT'L REV., Apr. 22, 1996, at 17 (predicting that bill would result in high costs and high rate of uninsurance). MSAs were alternatively supported as "maximiz[ing] consumer choice and establish[ing] a bulwark against Government regulation of the health care market." Robert Pear, *Deal in Congress Gives Health Bill a New Momentum*, N.Y. TIMES, July 26, 1996, at A1, A16. However, some critics attacked MSAs as "bad health policy" because it would strip healthy, wealthy consumers from insurance pools, leaving "sick people and those with chronic health problems," thereby increasing the cost of coverage for those who need it most. Robert Pear, *G.O.P. Plan Would Profit Insurer with Ties to Party*, N.Y. TIMES, Apr. 14, 1996, at A16.

On the other hand, voices from other quarters argued that serving the interest of social pooling posed little or no threat to the integrity of the private insurance system. See Jacob Alex Klerman, *New Estimates of the Effect of Kassenbaum-Kennedy's Group-to-Individual Conversion Provision on Premiums for Individual Health Insurance*, RAND, 1996, at 3 (countering arguments presented by insurance industry groups and concluding that the reforms would increase insurance premiums no more than 5.7%, and perhaps less than 1%). In addition, it was argued that MSAs would provide little social benefit, but could endanger the continued availability of coverage for the most needy. See Marilyn Moon et al., *Medical Savings Accounts: A Policy Analysis*, Urb. Inst., (visited Nov. 13, 1996) <<http://www.urban.org/pubs/hinsure/msa.htm>> (utilizing statistics to examine effect on individuals if they switched from current health plan to alternatives).

In the end, a bill was passed that included substantial market regulation, although it also contained a demonstration project of favorable tax treatment of MSAs. See *infra* notes 256-300 and accompanying text (examining components of 1996 Act). Perhaps inevitably, both parties struggled to be identified as having been in favor of the market regulation provisions. See Todd S. Purdum, *Clinton Signs Bill to Give Portability in Insurance*, N.Y. TIMES,

components and the tightly controlled MSA provisions of the 1996 Act, however, demonstrate an embrace of the social ethic of collective responsibility. The market reforms cut significantly into the ability of insurers and employers to limit coverage of those most in need of coverage. The MSA provisions are limited in scope and are targeted to individual and small group insurance markets — markets historically underserved by the insurance industry.²³⁵

In the years prior to the 1993-94 debate over comprehensive national health coverage, the states recognized the failure of the insurance marketplace to make health coverage available for many residents. High rates of uninsurance were traceable to many causes, but two causes drew much attention during this period. First, states recognized that details of the commercial insurance market's structure are simply irrelevant to the poor, who are without the means to choose to participate. For this population, states explored programs to expand Medicaid, to subsidize insurance for the poor, and to fund hospitals for services provided to the poor and uninsured. These state programs are largely beyond the scope of this article.²³⁶

The second cause is "market failure": the perceived inability of market forces, without government intervention, to expand the percentage of the population covered by health insurance. While the primary barrier to expanded employment-based

Aug. 22, 1996, at B12 (quoting bipartisan support for bill); Stewart Ugelow, *Clinton Signs Bill to Secure Health Benefits*, WALL ST. J., Aug. 22, 1996, at A16 (same).

²³⁵ The uninsured are overwhelmingly connected to the work force. About 84% of the uninsured are workers or dependents of workers. Diane Rowland et al., *A Profile of the Uninsured in America*, HEALTH AFF., Spring 1994, at 283, 284-85. Most employees of large firms are covered by health insurance. It is the employees of small firms and the self-employed who go without insurance. While "95 percent of firms with 100 or more workers offer health benefits," more than two-thirds of firms with fewer than 25 employees offer benefits, and "[t]he self-employed and employees of firms with fewer than 100 workers make up over half (53 percent) of the uninsured population." *Id.* at 285. While ability to pay explains a part of this disparity, market conditions are also at fault. "Small firms tend to have less ability to negotiate favorable group rates, in part because they have a small pool of employees over which to spread the risk." *Id.*

²³⁶ See Trish Riley, *State Health Reform and the Role of 1115 Waivers*, HEALTH CARE FIN. REV., Spring 1995, at 139, 139-44 (discussing problems states have experienced in implementing programs to provide health coverage to poor); see also Lawrence D. Brown, *The Medically Uninsured: Problems, Policies and Politics*, 15 J. HEALTH POL. POL'Y & L. 413, 419-22 (1990) (same); Kenneth E. Thorpe et al., *Including the Poor: The Fiscal Impacts of Medicaid Expansion*, 261 JAMA 1003, 1003 (1989) (same).

coverage is economic — health coverage is expensive²³⁷ — states concluded that significant non-economic barriers to health coverage were within the reach of state legislative remedies. Although several states considered, and even enacted, major systemic versions of near-universal coverage not unlike that proposed for the nation in the 1993 Health Security Act, political reaction to “big government” or to the preemptive effect of ERISA led to the rejection, repeal, or scaling back of those programs.²³⁸ States have, however, moved forward in large numbers with small group and individual insurance market reform statutes.

By 1993, insurance reform measures had been adopted by forty-three states,²³⁹ and by 1996 all but three states had adopted such reforms.²⁴⁰ The measures impose structural changes in the market for small group and individual insurance.²⁴¹ The

²³⁷ See Michael A. Morrissey et al., *Small Employers and the Health Insurance Market*, HEALTH AFF., Winter 1994, at 149, 153-55 (stating that high price of health coverage is major *expressed* reason for small employers' failure to offer health coverage).

²³⁸ See Michael S. Sparer, *Great Expectations: The Limits of State Health Care Reform*, HEALTH AFF., Winter 1995, at 191, 192 (stating that Minnesota, Colorado and Washington have scaled back their plans for comprehensive reform); see also *Oregon Health Plan Faces Nearly \$17 Million in Cuts*, STATE HEALTH WATCH 11 (Apr. 1996) (reporting expected retrenching in Oregon's planned health reforms); *Washington Repeals 1993 Health Services Act*, STATE INITIATIVES IN HEALTH CARE REFORM, No. 13, 10 (July/Aug. 1995) (reporting that ERISA problems and political reaction to comprehensive changes led to repeal of plan that would have mandated that employers provide coverage for employees, capped insurance premiums, and set uniform benefits packages).

²³⁹ See Colleen M. Grogan, *Hope in Federalism? What Can the States Do and What Are They Likely to Do?*, 20 J. HEALTH POL. POL'Y & L. 477, 481 (1995).

²⁴⁰ See BLUE CROSS & BLUE SHIELD ASS'N, STATE INDIVIDUAL INSURANCE REFORM LAWS (Dec. 1995) [hereinafter BLUE CROSS REPORT] (reporting that all but three states — Michigan, Pennsylvania and Alabama — had enacted small group insurance reform statutes); NATIONAL ASS'N OF INS. COMM'RS, NAIC'S COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS HE-12-1 to HE-12-10 (1996) [hereinafter NAIC REPORT] (same). This Article excludes Hawaii from discussion because Hawaii's unique ERISA waiver and long-standing comprehensive health coverage system exceed the level of consumer protection offered by the market reforms adopted by other states. See Deane Neubauer, *State Model: Hawaii, a Pioneer in Health System Reform*, HEALTH AFF., Summer 1993, at 31, 31-33.

²⁴¹ Because states have recognized that the uninsurance problem is concentrated on those individually insured and employees of small firms (or their dependents), the statutes are limited to the small group and individual market. See Rowland, *supra* note 235, at 285 (finding that approximately only one third of employers with less than 25 workers offer health insurance). The definition of “small” for these purposes varies from state to state. Many states regulate groups up to 50. See, e.g., COLO. REV. STAT. § 10-16-102(40) (1990 & Supp. 1996) (defining “small employer” as one having no more than 50 eligible employ-

structural changes leave the system intact but incrementally improve the breadth of the market's coverage by tinkering with the details of underwriting practice.²⁴² In designing these reforms, states have attempted to walk a fine line between expanding insurance availability and destabilizing the private market for insurance. Specifically, the reforms seek to minimize moral hazard (the tendency of people to avoid purchasing insurance until care is needed),²⁴³ and adverse selection (the tendency of

ees); DEL. CODE ANN. tit. 18, § 7202(29) (1974 & Supp. 1994) (defining "small employer" as one employing, during at least 50% of working days in previous calendar quarter, no more than 50 employees); MD. ANN. CODE, art. 48A, § 698(q)(1)(i) (1957 & Supp. 1996) (defining "small employer" as one employing, during at least 50% of the working days in previous calendar quarter, more than one employee and no more than 50 employees); N.J. STAT. ANN. § 17B:27A-17 (West Supp. 1996) (defining "small employer" as one employing, during at least 50% of working days in previous calendar quarter, more than one employee and less than 50 employees); OKLA. STAT. ANN. tit. 36, § 6512(28) (West Supp. 1997) (defining "small employer" as one employing, during at least 50% of working days in previous calendar quarter, at most 50 employees); S.C. CODE ANN. § 38-71-920(1) (Law Co-op. Supp. 1995) (defining "small employer" as one employing, during at least 50% of working days in previous year, no more than 50 eligible employees). Many other states set the limit at 25 employees. *See, e.g.*, IOWA CODE § 513B.31.5 (1996) (defining "group" as single employer with no more than 25 full-time employees and their dependents); ME. REV. STAT. ANN. tit. 24A, § 2808-B.1.D (West Supp. 1996) (defining "eligible group" as employer which, during previous calendar quarter, employed less than 25 employees on at least 50% of working days). *See generally* NAIC REPORT, *supra* note 240, at HE-12-1 to HE-12-10 (listing state provisions for small group health insurance and specifying number of employees required for groups); BLUE CROSS REPORT, *supra* note 240.

²⁴² In Professor Diver's terms, these statutes are "incrementalist" and do not constitute an attempt by the states to comprehensively reconfigure the health care delivery system. *See* Colin S. Diver, *Policymaking Paradigms in Administrative Law*, 95 HARV. L. REV. 393, 396-401 (1981) (differentiating between policy implementation based on broad systemic vision ("comprehensive rationality") versus "piecemeal and tightly restricted" modifications to status quo ("incrementalism")).

²⁴³ *See* ABRAHAM, *supra* note 34, at 14. "Insureds . . . are handicapped by having less-than-perfect information. One handicap in particular has significant effects on the allocation of resources between insurance and loss prevention. This is the problem of moral hazard [I]nsureds to some extent control the probability that losses will occur." *Id.* In this context, the concern is that "reforms" could allow individuals to avoid purchasing insurance up until expensive services become necessary. Were this permitted to occur, the insurance function would be subverted, as no shared pool of funds, collected against future risk, would exist, and the only people paying "premiums" would be the people on their way to the hospital. The premiums of well-insureds would no longer be available to support the costs of ill-insureds. *See* Moon et al., *supra* note 234, at 8 (evaluating arguments for and against MSAs and possible effects on insurance industry).

inaccurate pricing to lead to a skewing of enrollment toward high-risk people).²⁴⁴

The state reforms have many common elements. Most states have adopted a "guaranteed issue" provision, which requires all health carriers to offer a health plan to any small employer seeking coverage.²⁴⁵ Some require that carriers guarantee issue for all of their plans.²⁴⁶ Others require carriers to guarantee issue for two plans,²⁴⁷ or require the offer of only one plan.²⁴⁸ Most states have further mandated "guaranteed renewal," limiting the circumstances in which renewal of a small employer's policy may be denied for good cause, such as fraud or nonpayment of premium, but prohibiting nonrenewal on the basis of claims history or member health status.²⁴⁹ Most states also limit the duration of preexisting condition provisions.²⁵⁰ States set two limits in this regard. First, they limit the "look back" period — the time during which treatment or diagnosis was or should have been sought in order for the condition to

²⁴⁴ See ABRAHAM, *supra* note 34, at 15 (describing adverse selection as problem for insurers).

²⁴⁵ See U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE REGULATION: VARIATIONS IN RECENT STATE SMALL EMPLOYER HEALTH INSURANCE REFORMS 9, 18 (June 1995) [hereinafter GAO REPORT] (stating that most states include guaranteed issue provision); see also BLUE CROSS REPORT, *supra* note 240; NAIC REPORT, *supra* note 240, HE-12-1 to HE-12-10 (listing some states' provisions for small employer health plans).

²⁴⁶ See, e.g., CAL. INS. CODE § 10705.1 (West Supp. 1997) (entitling "guaranteed associations" with less than one thousand members to purchase small employer health coverage and treating them as if there were one thousand or more members); ME. REV. STAT. ANN. tit. 24-A, § 2808-B (West Supp. 1996) (requiring small group insurance carrier to guarantee coverage to all eligible groups meeting carrier's minimum requirements); N.Y. INS. LAW § 4317 (McKinney 1992) (guaranteeing coverage to all groups of individuals at all times).

²⁴⁷ See, e.g., DEL. CODE ANN. tit. 18, § 7207 (Supp. 1994) (requiring small employer insurance carriers to provide two health benefit plans for small employers); N.C. ADMIN. CODE tit. 11, § 12.1304 (1994) (permitting HMO's to provide two different plans of comparable value).

²⁴⁸ See, e.g., ARIZ. REV. STAT. ANN. § 20-2304 (West Supp. 1996) (requiring that basic health plan be offered); WIS. STAT. § 635.09 (1991) (mandating that insurance carrier may not deny coverage to small employers based on occupation or type of business).

²⁴⁹ BLUE CROSS REPORT, *supra* note 240; GAO REPORT, *supra* note 245, at 19; NAIC REPORT, *supra* note 240.

²⁵⁰ See Jennifer M. Franco, Note, *Undermining the Protection of Health Insurance: The Preexisting Condition Clause*, 30 NEW ENG. L. REV. 883, 885-87 (1996); Widiss, *supra* note 129, at 1715. Preexisting illness provisions typically permit an applicant to obtain health coverage, but exclude or limit coverage for any illness or condition that arose prior to coverage. See Franco, *supra*, at 885-87; Widiss, *supra* note 129, at 1715.

count as “preexisting” for underwriting purposes. Second, they limit the time following the new coverage for which treatment for the preexisting condition may be excluded.²⁵¹ Many states limit both the look-back and exclusion period to six months,²⁵² while many others limit both periods to twelve months.²⁵³

As of June 1995, thirty-eight states had adopted “portability” limitations.²⁵⁴ These statutes address a particular preexisting illness concern: employees covered by insurance and receiving treatment for a condition could lose their coverage for that condition if they change jobs to a new workplace with a preexisting illness provision. This concern inhibits employees from seeking other employment — they suffer from “job lock.” States attempt to alleviate “job lock” by requiring carriers to waive their usual preexisting conditions provision for employees who were covered continuously by health insurance prior to the date of the new coverage.²⁵⁵ These portability statutes allow employees, whose new workplace has insurance covered by the portability statute, to change jobs without losing coverage for their existing illnesses.

Finally, most states have adopted some form of restrictions on the setting of premium rates.²⁵⁶ Many modeled their premium

²⁵¹ GAO REPORT, *supra* note 245, at 19.

²⁵² *See, e.g.*, COLO. REV. STAT. § 10-16-214(3)(a)(V) (Supp. 1996) (limiting look-back and exclusion period to six months); KY. REV. STAT. ANN. § 304.17A-110 (Banks-Baldwin Supp. 1994) (limiting exclusion period to six months); N.M. STAT. ANN. § 59A-56-14 (Michie 1994) (allowing six month exclusion period).

²⁵³ *See, e.g.*, 215 ILL. COMP. STAT. § 95/10 (West Supp. 1996) (allowing 12-month period for exclusion of preexisting condition); LA. REV. STAT. ANN. § 22:215.12 (West 1995) (limiting look-back and exclusion period to 12 months); S.C. CODE ANN. § 38-71-730 (Law Co-op. 1989) (limiting exclusion of preexisting conditions to 12-month period); *see generally* BLUE CROSS REPORT, *supra* note 240; GAO REPORT, *supra* note 245, at 24-25.

²⁵⁴ GAO REPORT, *supra* note 245, at 20.

²⁵⁵ *Id.* Most provisions do not literally require *continuous* coverage. *See, e.g.*, IDAHO CODE § 41-4708 (Supp. 1996) (allowing 30-day break in coverage); MASS. GEN. LAWS ch. 176J, § 5 (Supp. 1996) (allowing break in coverage). Some states permit a 60-day break in coverage. *See, e.g.*, N.C. GEN. STAT. § 58-50-130 (Supp. 1995) (permitting 60-day break in coverage); TEX. CODE ANN. § 26.49 (Supp. 1997) (same). Other states permit 90 days. *See, e.g.*, NEB. REV. STAT. § 44-5260 (Supp. 1995) (allowing 90-day break in coverage). However, some states require continuous coverage, permitting no break. *See, e.g.*, OKLA. STAT. tit. 36, § 6519 (Supp. 1997) (failing to allow any break in coverage); VT. STAT. ANN. tit. 8, § 4080a (Supp. 1996) (requiring continuous coverage).

²⁵⁶ The GAO reports that at least 44 states adopted “premium rate restrictions as part of reforms passed between 1990 and 1994.” GAO REPORT, *supra* note 245, at 20. One concern with the portability provisions included in the 1996 Act is the lack of premium restrictions.

provisions on the National Association of Insurance Commissioner's Small Employer Health Insurance Availability Model Act No. 118, which uses "rating bands." These rating bands place small groups in a limited number of premium categories, within and between which premium variation is tightly controlled. The balance of the states use a variation of community rating.²⁵⁷ In either case, these forty-four states enforce broad risk pooling in the small group market. Significantly, they limit or even bar the use of health status or claims experience in setting premiums, and limit other risk selection criteria to "demographic" factors such as "age, gender, industry, geographic area, family composition, and group size."²⁵⁸ In many states, the extent to which even these limited factors may be used to differentiate groups by risk for rating purposes diminishes over time.²⁵⁹ Some states are scheduled to implement pure community rating in the small group market in the future.²⁶⁰

The effect of these state statutes is to restrict insurers' ability to segment risk based on actual or predicted health or claims experience and to force the social pooling of risk. The states have moved toward this goal without doing violence to the competitive structure of the insurance market: insurers may continue to compete for market share on the basis of service and quality, but are discouraged from competing on the basis of their actuarial skill in identifying and denying coverage to those most in need of health care. And states have accomplished these changes while acknowledging the importance of the phenomena of moral hazard and adverse selection. While preexisting limitation clauses are limited, they are not prohibited, thereby encouraging

See infra note 285 and accompanying text (arguing that consumers may forego necessary health care services if premiums increase substantially).

²⁵⁷ GAO REPORT, *supra* note 245, at 21-22 (reporting that 28 states use some variation of NAIC's premium restrictions, while 16 states use another approach to restrict rates — generally some form of adjusted community rates).

²⁵⁸ *Id.* at 10.

²⁵⁹ *See* CAL. INS. CODE § 10715 (West Supp. 1997) (establishing standard employee risk rates); CONN. GEN. STAT. § 38a-569 (1993) (same); LA. REV. STAT. ANN. § 22:228.6(B)(2)(a) (West 1993) (placing limitations on premium ratings); MD. ANN. CODE art. 48A, §702 (1957 & supp. 1993) (establishing rating methodology); MINN. STAT. § 62L.03 (1993) (same); *see generally* GAO REPORT, *supra* note 245, at 27-29.

²⁶⁰ *See* Colo. Reg. 4-2-12 (1995) (establishing small group rating); ME. REV. STAT. ANN. tit. 24-A, § 2808-B (West 1992) (creating rating plan for small group policy carriers).

people to obtain insurance (and begin contributing to the pool of funds available to pay for care) *prior* to their need for coverage. In addition, states have offered reinsurance mechanisms²⁶¹ — or mandated them²⁶² — allowing participating carriers that underwrite a higher risk population in the regulated market to look to carriers with lower risk populations for compensation. This reconciliation process permits carriers the assurance that they will not suffer significant competitive disadvantage by being denied the use of historically important risk segmentation tools.²⁶³

The state statutes, then, explicitly favor social pooling over risk segmentation, and do so in a more comprehensive fashion than the state statutes banning genetic underwriting²⁶⁴ or the ADA's prohibition of capping benefits for "dread diseases."²⁶⁵ For an entire market, and for all conditions, the state statutes prohibit insurers from using information that would predict the "true cost" of coverage and instead require that all or most of that "true cost" be spread among a pool of insureds. States thereby require that groups of relatively well persons subsidize the cost of coverage for relatively unwell persons. The insurance carriers' historic goal of accuracy in the attribution of cost to insureds is subordinated to the goal of increasing access to insurance. Access is favored by reducing the price of entry for those with actual or predicted high cost, forcing that cost to approach the average cost of coverage for the population

²⁶¹ Some states have created voluntary systems for inter-plan sharing of underwriting risk, giving insurers the option to reinsure against unfavorable risk selection. *See, e.g.*, DEL. CODE ANN. tit. 18, § 7210 (1994) (permitting insurers to reinsure against unfavorable risk selection); N.J. STAT. ANN. § 17B:18-66 (West 1985) (permitting reinsurance through pooling arrangements with other insurers); TEX. CODE ANN. § 26.58 (West 1996) (permitting insurance carriers to obtain reinsurance).

²⁶² Some states have *required* that carriers participate in reinsurance plans that limit any carrier's exposure to unfavorable risk selection in a market that limits carriers' ability to select against risk. *See, e.g.*, CONN. GEN. STAT. § 38a-569 (Supp. 1996) (requiring insurance carrier participation in reinsurance plan); MO. REV. STAT. § 379.942 (1992) (same); N.D. CENT. CODE § 26.1-36.3-07 (1995) (same).

²⁶³ *See infra* notes 300-02 and accompanying text (addressing effect of reinsurance mechanisms, along with premium effect of move toward social pooling).

²⁶⁴ *See supra* Part I (discussing consensus against using valid genetic indicators of future illness to deny health insurance or set coverage prices).

²⁶⁵ *See supra* Part II (arguing that interplay between preemption of anti-risk selecting state laws and ADA prohibit broad categories of risk segmentation).

affected by the statutes. The 1996 Act represents a federal endorsement of that policy choice.

The 1996 Act selects from among the market reforms advanced by various state statutes. In some senses it is more far-reaching than even the most comprehensive of the state statutes because it reaches self-insured plans.²⁶⁶ ERISA preemption limits the reach of all state reform statutes affecting employment-based coverage to the regulation of “the business of insurance.”²⁶⁷ State statutes, then, left untouched those businesses that provided coverage without purchasing insurance. In other important senses, however, the federal measure lacks the systemic sweep of many state statutes, and, by creating a demonstration project for MSAs, it seems to cut against its underlying function of fostering increased social pooling in health coverage. On balance, however, it advances a configuration of the health coverage market that assists those most in need of care in gaining access to coverage.

The centerpiece of the 1996 Act is its advancement of “portability” in health coverage. In this regard, it limits, by amending ERISA and the Public Health Service Act, the imposition of preexisting condition requirements in any group health plan or group health insurance. It limits the “look back” period²⁶⁸ to six months, and limits the period of exclusion to twelve months (eighteen months for “late enrollees”²⁶⁹) for preexisting conditions.²⁷⁰ Health coverage becomes “portable” by virtue of the Act’s provision that allows employees to obtain “credit” for continuous coverage.²⁷¹ The credit provision permits any employee

²⁶⁶ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 101(a), 110 Stat. 1936, 1939 (1996) (amending ERISA to place limits on imposing preexisting condition exclusions for all group health plans).

²⁶⁷ 29 U.S.C. § 1144(b)(2)(A) (1985).

²⁶⁸ See *supra* notes 251-53 and accompanying text (explaining limitation of look-back period).

²⁶⁹ A “late enrollee” is a person who forgoes the opportunity to enroll in a health plan at the expected time (i.e., upon first becoming eligible, or upon losing other coverage). Health Insurance Portability and Accountability Act § 101(a).

²⁷⁰ See *id.* (amending ERISA); *id.* § 102(a) (amending Public Health Service Act). Both provisions exclude pregnancy as a preexisting condition, and prohibit the application of preexisting condition limitations (under certain conditions) to newborns and adopted children.

²⁷¹ See *id.* §§ 101(a), 102(a).

without a “break in coverage” of more than sixty-three days²⁷² to count any previous months of coverage by a previous employer or carrier toward the twelve months of exclusion. Once the employee has been covered for twelve months, she has fulfilled her “lifetime limit” of preexisting condition exclusion, and cannot suffer any exclusion — absent a break in coverage — by a subsequent employer or carrier.²⁷³ The period of exclusion, then, need be served only once, and an employee may choose to change employment without concern for losing coverage for an existing condition.

The 1996 Act has two versions of “guaranteed issue”/“guaranteed renewal” provisions. First, the Act contains a provision barring carriers from refusing to issue coverage to an employer with from two to fifty employees.²⁷⁴ Guaranteed renewal under the Act extends to both small and large groups.²⁷⁵ Second, the Act provides for a species of guaranteed issue/guaranteed renewal *within* the plan itself. For any size group, neither the plan nor a health carrier insuring the group may

establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (A) Health status.
- (B) Medical Condition (including both physical and mental illnesses).
- (C) Claims experience.
- (D) Receipt of health care.
- (F) Genetic information.

²⁷² *Id.*

²⁷³ *See id.*; see also Kassebaum-Kennedy Health Insurance Bill Clears Congress: Medical Savings Accounts Limited to Demonstration Program, FAMILIES USA (Aug. 1996) <<http://epn.org/families/fakeka.html>> (stating that 12-month exclusion is lifetime limit).

²⁷⁴ *See* Health Insurance Portability and Accountability Act § 102(a). Large groups are not similarly protected, but rather would be subject to a series of studies and reports to Congress. *See id.* This different treatment is consistent with the substantially higher rate of insurance among employees of large employers, and the consequent supposition that little in the way of market reform is necessary to facilitate insurance availability for this population. *See supra* notes 241-42 and accompanying text (describing relationship of employer size to likelihood of insurance).

²⁷⁵ *See* Health Insurance Portability and Accountability Act § 102(a).

- (G) Evidence of insurability (including conditions arising out of acts of domestic violence).
- (H) Disability.²⁷⁶

This protection of "high cost" individuals within plans runs not just to eligibility and renewal, but to the cost of participation as well. No individual in a group plan may be required

to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled in the plan as a dependent of the individual.²⁷⁷

The combination of these provisions allow all groups to obtain insurance,²⁷⁸ and for all members of groups to gain coverage without regard for their actual or expected health status. These provisions apply to all groups, whether self-funded or insured, and in all states, although state laws with provisions *more* protective of employees are not preempted.²⁷⁹ It therefore sets a new floor for portability and guaranteed issue/guaranteed renewal for group insurance, but not a ceiling.²⁸⁰

Finally, the Act provides guaranteed access to the insurance market for individuals leaving group insurance. If a person maintains group coverage for eighteen months, and has exhausted all available COBRA coverage,²⁸¹ all health carriers in the state must offer and subsequently renew her individual health coverage.²⁸² The carrier must²⁸³ offer a selection of insurance

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ Small groups obtain insurance by force of law, while large groups, presumably, obtain it through the market.

²⁷⁹ Health Insurance Portability and Accountability Act § 101(a).

²⁸⁰ The 1996 Act explicitly disavows any effect on the issues raised in *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991). See *supra* notes 140-56 and accompanying text (explaining that *McGann* was disavowed by 1996 Act). The Act includes as a "rule of construction" the provision that "[n]othing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage." Health Insurance Portability and Accountability Act § 101(a).

²⁸¹ Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision, employers with 20 or more workers are required under most circumstances to make available to departing employees continuing coverage under the employer's group plan, at the employee's expense, for a period of 18 to 36 months. 29 U.S.C. §§ 1161-68 (1996).

²⁸² See Health Insurance Portability and Accountability Act § 102(a).

²⁸³ The state may have obtained a waiver on the strength of an approved insurance

products, and may not reject the person on the basis of actual or predicted health conditions, or impose preexisting conditions limitations.²⁸⁴ This individual insurance protection assures employees who leave or lose their employment that they will find health insurance coverage in the individual insurance market.

While these market reform provisions of the Act found a high degree of consensus in both houses of Congress,²⁸⁵ the debate over other provisions was contentious and long.²⁸⁶ Congress was overwhelmingly willing to implement terms limiting actuarial selection, thereby requiring insurance pools to accept members who might in a free marketplace be uninsurable or insurable only at a prohibitive price. The question of whether potential members of insurance pools could opt out of the pool, taking their own path with a tax-favored MSA, however, split Congress sharply. The House of Representatives passed a version of the Act that categorically gave favorable tax treatment to MSAs.²⁸⁷ The Senate, on the other hand, passed a version that ignored MSAs altogether.²⁸⁸ The debate in and out of Congress was both pragmatic and philosophical. From a pragmatic perspective, there was sharp disagreement over the effect of MSAs on the rate of medical inflation. Philosophically, the legislators' underlying views on the nature of insurance as either social pooling or individual risk planning led them in opposite directions in the MSA debate.

Arguments for tax-favored treatment of MSAs center on their predicted tendency to engage consumers in cost containment by providing direct incentives for prudent purchasing. Instead of regarding health care as essentially free because paid for by remote third-party payers, consumers with MSAs would have personal control over the funds from which payments are made, and would therefore make careful cost-benefit calculations. The asserted effect of this heightened scrutiny of personal health

expansion demonstration project, and therefore, would not have to meet this requirement.
See id.

²⁸⁴ *See id.*

²⁸⁵ *See supra* note 232 and accompanying text (detailing legislative history).

²⁸⁶ *See supra* note 234 and accompanying text (discussing MSA debate in Congress).

²⁸⁷ *See* H.R. CONF. REP. NO. 104-736, at 3 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, 1996.

²⁸⁸ *See id.*

care purchasing would be to moderate the rate of health spending overall.²⁸⁹ Any possible harmful effects on the risk level of the residual insurance pools — sure to be peopled by those with the highest health risks²⁹⁰ — are accepted as either a “natural tendency of competitive insurance markets,”²⁹¹ or as reflective of the innate fairness of attributing the cost of an individual’s health risk to the individual himself.²⁹²

Opponents of MSAs counter with two assertions. From a philosophical perspective, opponents have argued that MSAs would draw the well and the wealthy out of insurance pools, as only those for whom price pressure is minimal or who believed themselves to be at low risk for illness would give up the security of full insurance coverage. Those remaining in insurance pools would therefore be those most in need of coverage but least able to withstand upward price pressure. The exit of low-risk members, however, would arguably drive premiums up, reducing access for this vulnerable population.²⁹³ From a prag-

²⁸⁹ The leading scholarly advocate of MSAs has been the economist Mark Pauly. *See* MARK V. PAULY, AN ANALYSIS OF MEDICAL SAVINGS ACCOUNTS: DO TWO WRONGS MAKE A RIGHT? 1 (1994) (stating that purpose of MSAs is to encourage efficient use of medical services without waste); Mark V. Pauly, *Killing with Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Competitive Managed Care*, in HEALTH POLICY REFORM: COMPETITION AND CONTROLS 149, 172 (Robert B. Helms, ed., 1993) (proposing use of fallback or publicly designated insurer as means to control medical costs); Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, HEALTH AFF., Spring 1995, at 126, 127 (proposing tax credits for purchase of catastrophic coverage and MSAs); *see also* AMERICAN ACADEMY OF ACTUARIES, MEDICAL SAVINGS ACCOUNTS: COST IMPLICATIONS AND DESIGN ISSUES ii (May 1995) [hereinafter ACTUARIES] (describing mixed forecast for effect of MSAs, but arguing that with “careful design of the law enabling the establishment of MSA[s],” savings from prudent purchasing could result); Emmett B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 JAMA 1666, 1666 (1996) (stating that although cost savings would be relatively modest, “waste from the excessive use of generously insured care could be reduced, and MSAs would be attractive to both sick and healthy people”).

²⁹⁰ *See* Pauly & Goodman, *supra* note 289, at 136 (discussing burden of risk-reflected premiums on high-risk insureds); *see also* ACTUARIES, *supra* note 289, at 18 (asserting that higher-cost individuals will quickly exceed their deductibles, thus reducing their incentive to control MSA utilization).

²⁹¹ Pauly & Goodman, *supra* note 289, at 136.

²⁹² *See* 142 CONG. REC. H3092 (daily ed. Mar. 28, 1996) (statement of Rep. Ganske) (supporting MSAs because they return control of health expenditures to consumer); 142 CONG. REC. H3100 (daily ed. Mar. 28, 1996) (statement of Rep. Buyer) (supporting incentives that would allow more individuals to obtain affordable insurance).

²⁹³ *See* Len M. Nichols, *Medical Savings Accounts and Risk Segmentation*, HEALTH AFF., Summer 1995, at 275, 276 [hereinafter Nichols, *Medical Savings Accounts*] (discussing prob-

matic perspective, it was argued that MSAs would not improve health expenditure efficiency because personal control of health expenditures is inconsistent with the structure of cost containment through managed care, where systemic utilization review channels spending choices.²⁹⁴ Further, to the extent cost pressures lead consumers to select fewer services, their selections may be *unwise*. Lay consumers, particularly low-income consumers, may forego *necessary* services and not merely the superfluous, when faced with immediate cost pressures connected with treatment decisions.²⁹⁵

The fundamental principled disagreement between proponents and opponents of MSAs concerns the ends of health insurance. If the purpose of health insurance is to make coverage available through social pooling of risk, MSAs are anathema, even if they have a limited cost-reducing effect.²⁹⁶ On the other hand, if the purpose of health insurance is to accurately assess risk in order to “fairly” charge for coverage,²⁹⁷ MSAs are

lem occurring when risk segmentation results in higher prices for high-risk people); Iris J. Lav, Center on Budget and Policy Priorities, *MSA Provision in Health Care Reform Bill Creates Tax Shelter and Casts Doubt on Expansion of Insurance Coverage* (Mar. 27, 1996) <<http://epn.org/cbpp/cbmsas.html>> (explaining that healthier people would have lower health care costs); Moon et al., *supra* note 234 (explaining that higher risk member would pay greater health care costs); Nichols et al., *supra* note 1 (stating that studies demonstrate that healthier members of MSA risk pool would save money under MSA plan).

²⁹⁴ See Moon et al., *supra* note 234, at 5 (“[H]igh priced procedures and techniques may actually face less market discipline if we move to an open-ended fee-for-service policy that fully protects families above the deductible as compared with pressures on technology in the managed care context.”); see also William C. Hsiao, *Medical Savings Accounts: Lessons from Singapore*, HEALTH AFF., Summer 1995, at 260, 264 (suggesting that leaving health choice to consumers may have failed to limit health care cost escalation in Singapore).

²⁹⁵ JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 339-40 (1993); Deborah Chollet, *Why the Pauly/Goodman Proposal Won't Work*, HEALTH AFF., Summer 1995, at 273, 273.

²⁹⁶ See Nichols, *Medical Savings Accounts*, *supra* note 293, at 275.

To many supporters of MSAs, increasing risk segmentation is good, since they believe that all should pay their expected costs, and the very sick and poor should receive subsidies commensurate with society's taste for explicit redistribution. But to those who think we all might be sick someday, and who fear that the social preference for explicit redistribution can be severely understated at times, increasing the already considerable degree of risk segmentation is not a constructive, incremental health care reform.

Id.

²⁹⁷ See Clifford & Iuculano, *supra* note 43, at 1808, 1812 (addressing actuarial accuracy in terms of fairness).

appropriate financing devices.²⁹⁸ The thesis of this Article — that by pushing incrementally in the direction of social pooling, health insurance law and policy are marginalizing risk selection — places MSAs outside the stream of the developing insurance system's structure. The real world is messy, however, and in the end, Congress reached a compromise. The House and Senate sponsors considered various middle grounds between the House's full endorsement of MSAs and their rejection by the Senate. Advocates of MSAs proposed limiting them to small businesses — suggesting a market for MSAs of about 6.1 million potential participants.²⁹⁹ A counterproposal of “a small MSA demonstration in a few states” was made.³⁰⁰ Ultimately, the compromise permitted a nation-wide demonstration limited to 750,000 employees of small businesses.³⁰¹ The compromise sunsets the demonstration no later than the year 2000,³⁰² and while those who elect participation in MSAs before the program's sunset will be allowed to continue to receive favorable tax treatment for their MSA contributions, no new participation is permitted absent further legislation.³⁰³

Under the compromise that became part of the Act, the tax deductibility of the MSA contributions is contingent on the contributors' participation in a “high deductible health plan,” defined as having an annual deductible of between \$1500 and \$2250 per year for individual coverage, and between \$3000 and \$4500 for family coverage.³⁰⁴ Total “annual out-of-pocket expenses required to be paid under the plan (other than premiums) for covered benefits” may not exceed \$3000 for individual, and \$5500 for family coverage.³⁰⁵ If these conditions are met,

²⁹⁸ See Pauly & Goodman, *supra* note 289, at 136-37 (stating that purpose of insurance market is efficient allocation of risk; and that government should intervene with subsidies if fairness concerns arise, but should not limit risk selection).

²⁹⁹ See Sharon McIlrath, *Insurance Reform Cracks Logjam: Breakthrough Clouded by Continued Disputes*, AM. MED. NEWS, Aug. 12, 1996, at 1.

³⁰⁰ *Id.*

³⁰¹ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2045 (1996).

³⁰² See *id.* The demonstration terminates earlier than 2000 if the maximum number of permitted active MSA participants is reached. *Id.*

³⁰³ See *id.*

³⁰⁴ *Id.*

³⁰⁵ *Id.*

the Act's tax benefits may be realized. An eligible individual is allowed to deduct from her federal taxes the payments into her MSA up to, for a person with individual coverage, sixty-five percent of the annual deductible of the health plan, and for family coverage, seventy-five percent of the annual deductible.³⁰⁶

The compromise that gave life to the Act permitted a limited demonstration project that will test the market interest in and effect of MSAs. When the demonstration has run its term, Congress will be faced with the task of reviewing the results of the experiment on the basis of independent analysis of the effects of MSAs on cost, health access, and the risk level of comprehensive insurance pools.³⁰⁷ With additional facts in hand, replacing the competing projections of MSAs as saviors or demons, Congress will once again be faced with the question of whether to permit MSAs to receive favorable tax treatment.

In sum, the market reform provisions of the 1996 Act enforce *intraplan* social pooling at the expense of precision in risk selection. The Act accomplishes this enforcement in two ways. It limits preexisting condition provisions in self-funded or insured group plans of any size, requiring carriers to write and renew coverage for small groups regardless of actual or expected claims experience. The Act also prohibits employment-based plans from transferring to "high-cost" employees the marginal cost to the plan of having a high-cost member — all members must be treated equally by the plan regardless of the member's actual or expected claims experience. It does not, however, enforce *interplan* risk pooling, or pooling in the individual market.

³⁰⁶ See *id.*

³⁰⁷ The Act contains provisions for the contemporaneous collection and study of data regarding the use of MSAs by the Secretary of the Treasury. *Id.* Results of an independent study, commissioned by the Comptroller General, will be submitted to Congress, by January 1, 1999, on the effects of MSAs in the small group market on

- (1) selection, including adverse selection;
- (2) health costs, including any impact on premiums of individuals with comprehensive coverage;
- (3) use of preventive care;
- (4) consumer choice;
- (5) the scope of coverage of high deductible plans purchased in conjunction with such accounts; and
- (6) other relevant items.

Id.

Portability provisions and limitations on preexisting illness may have some interplan effect, as carriers and plans are limited in their use of actuarial risk-segmenting tools. However, the 1996 Act does not adopt the provisions of some state statutes that impose rate bands or community rating in the market for individual or small group insurance. The Act therefore leaves open the likelihood that high *cost* will present continuing barriers to insurance coverage for high-risk individuals and groups.³⁰⁸ The federal market reform provisions, however, carefully do not preempt state efforts in this regard and thereby allow more progressive state statutes enforcing interplan equity and risk pooling in individual markets to exist side by side with the federal requirements.³⁰⁹

Taken as a whole, the Act is a clear step toward social pooling of risk: the market reform provisions limit actuaries' ability to discriminate on the basis of risk, enforce risk pooling by workplace rather than risk group, and extend a sense of self-ownership in one's insurability by allowing an insured to move from job to job, and in and out of the workplace. The provisions for favored tax treatment of MSAs runs counter to that tendency. They segment the population, for purposes of at least³¹⁰ the non-catastrophic portion of coverage, leaving each participant to make her own way without risk sharing. The MSA provision was the child of compromise, necessary to gain the

³⁰⁸ See *supra* notes 231-34 and accompanying text (discussing significance of Health Insurance Portability and Accountability Act).

³⁰⁹ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 111(a), 110 Stat. 1936, 1979 (1996) ("Nothing in this section shall be construed . . . to restrict the amount of the premium rates that an insurer may charge an individual for health insurance coverage provided in the individual market under applicable State law . . ."); *id.* § 101(a) (limiting preemption of state market reform statutes to those state provisions that prevent application of federal law).

³¹⁰ The 1996 Act does not describe any limitations on risk selection for the catastrophic health insurance that MSA participants must acquire, although state insurance departments will retain the ability to regulate underwriting practices in that marketplace. See *id.* § 101(a). This omission leaves open the possibility of further risk segmentation; should high-risk persons, contrary to expectations, be interested in participation in MSAs, restrictive medical underwriting of the catastrophic policies could frustrate their attempts to enter the program.

dissenters' acceptance of the more significant and comprehensive portability provisions. Further, MSAs are limited to a demonstration project, limited in scope and limited in duration. On balance, the Act furthers the trend toward communal acceptance of health risk.

IV. NEXT STEPS

The progress in American health insurance law toward social pooling and away from risk segmentation is not along a clean, unbroken line. The three recent developments described in this Article fit within a framework of increased regulation that facilitates coverage regardless of risk level. First, in prohibiting genetic underwriting, state legislatures have increased social pooling by instructing insurers to ignore one type of actuarially relevant risk. Second, in advancing a "comparative fairness" application of the ADA to health coverage, the EEOC permits the exclusion or severe limitation of coverage for the disabled only if actuarially similar conditions are similarly treated. The *effect* of this policy will be to reduce risk segmentation. Employers and plans will find that public opinion bars them from limiting those with "favored" conditions, such as heart disease or cancer. As a result, they will also find themselves barred by *law* from limiting those with "disfavored" conditions such as AIDS. Third, in the Health Insurance Portability and Accountability Act of 1996, Congress has forced social pooling in selected segments of the population, while holding at arms-length the risk-segmenting effect of MSAs.

The trend, if not overwhelming, is evident. America's repeated failure to enact comprehensive national health coverage does not, then, evidence a broad rejection of the treatment of health care access as a public good. Nor do Americans necessarily favor consigning health coverage issues to a private market where entry is regulated only by ability to pay and private rules of the game. Rather, the tendency toward social pooling of risk indicates that the American health care system is evolving in its own unique manner to broaden access to coverage by blunting the effect of risk selection. From this perspective, the failure to adopt national health insurance reflects Americans' longstanding bias against broad government solutions to social problems³¹¹

³¹¹ See Robert J. Blendon et al., *What Happened to Americans' Support for the Clinton Health*

and the political complexity of redesigning a huge portion of the American economy populated by many powerful and well-entrenched stakeholders.³¹²

Several trends, then, coexist in the American political and legal landscape: there is an inclination to use modest regulatory steps to move toward broad social sharing of health care costs; distrust of more dramatic changes in the power of government; and respect for private institutions that have, in the absence of national health insurance, insinuated themselves into positions of power in the health care finance and delivery systems. This confluence prescribes an incrementalist approach to health reform, in which existing public and private institutions advance risk pooling and government intervention is capped at an amount necessary to avoid market failures.³¹³

Specifically, these trends suggest that the United States will pursue its goal — pooling risk to expand access to health coverage — within the current framework of a competitive private health financing system, augmented by government programs when market failures become evident. If we are to further the tendency toward shared social risk and away from exclusionary segmentation of risk, and make evolutionary progress in expanding health coverage, three features of incremental reform must be addressed. First, the conduct of insureds known as “adverse selection” must be considered. Uninsured individuals tend to

Plan?, HEALTH AFF., Summer 1995, at 7, 12-13 (reporting “overwhelmingly negative views about government” in polling data); see also GLASER, *supra* note 2, at 24 (describing American belief in individualism, self-reliance, and competition); Lawrence R. Jacobs, *Health Reform Impasse: The Politics of American Ambivalence Toward Government*, 18 J. HEALTH POL. POL’Y & L. 629, 634 (1993) (discussing public’s ambivalence toward governmental efforts to reform health care).

³¹² See GLASER, *supra* note 2, at 21 (noting place of private insurance industry in American market); Steinmo & Watts, *supra* note 15, at 330 (arguing that American political institutions are structurally biased against comprehensive national insurance system).

³¹³ See John G. Day & Katharine Lanza Wade, *The Political Viability of Health Care Federalism*, 28 CONN. L. REV. 151, 156 (1995) (discussing public desire for incremental change in health care system with government as facilitator); Paul M. Ellwood & Alain C. Enthoven, “Responsible Choices”: *The Jackson Hole Group Plan for Health Reform*, HEALTH AFF., Summer 1995, at 24, 26-29 (discussing five step plan for government to cooperate with private sector to achieve health care reform); Judith Feder & Larry Levitt, *Steps Toward Universal Coverage*, HEALTH AFF., Summer 1995, at 140, 142-48 (discussing three steps leading toward secure and affordable health care coverage for all Americans).

avoid purchasing coverage until care is needed, and the voluntary acquisition of coverage is dominated by high-risk individuals. Those who perceive themselves as unlikely to need care tend not to purchase coverage. Second, the continuing self-interest of insurers and plan administrators to segment risk groups still needs to be confronted. Recent regulatory limitations on risk segmentation are not comprehensive, and further methods must be devised to limit “cream skimming” — selection against high-risk members. Recent work in health financing suggests that this goal might best be achieved by combining a version of community rating with a system that separately compensates plans for the risk level of their membership. Finally, it must be recognized that universal access cannot be achieved with market reform alone. Expansion of coverage will cost something, and that cost must be accounted for. These three issues are addressed in turn.

A. *The Effects of Adverse Selection*

Social pooling increases as regulators reduce underwriters' ability to select risk. This process makes the risk pool more heterogeneous, moving toward pure community rating, in which, within a given community, an identical charge for coverage is assessed for each member of the pool, regardless of that person's actual or predicted health status.³¹⁴ Commentators often describe a practical barrier to the effectiveness of community rating as a method of risk spreading: the purported tendency of insureds, where risk selection is limited, to purchase less coverage if they perceive themselves to be low-risk, and to purchase more coverage if they perceive themselves to be high-risk.³¹⁵ The insurance product is said to be “mispriced,” and low-risk insureds regard the price to be higher than the product's marginal value to them. High-risk insureds regard the price to be a bargain.

Adverse selection is an important problem from the perspective of social risk spreading and increased access to coverage for three reasons. First, the tendency of those who perceive themselves to be low-risk to refuse to buy coverage³¹⁶ is counter to

³¹⁴ See *supra* text accompanying note 26 (defining community rating).

³¹⁵ See ABRAHAM, *supra* note 34, at 15; Wortham, *supra* note 68, at 855-56.

³¹⁶ This example includes those in the individual market who forego the purchase of

the goal of full coverage. Second, it is argued that adverse selection can destabilize an insurance market, leading to a “death spiral” of premiums. Third, depending on the validity of the first two concerns, adverse selection may suggest that the purchase of health insurance should be mandated — a politically problematic conclusion.

The first concern arises if those who perceive themselves to be low-risk opt out of an insurance pool because they are charged an “average” rather than a “low-risk” premium.³¹⁷ This result harms the goal of full coverage because people aren’t always accurate in judging themselves to be “low-risk” — they may have a serious undiagnosed condition. Furthermore, even people with low actuarial risks suffer injuries and illnesses. If a system of premium pricing induces a portion of the population to opt out of insurance, it can have the perverse effect of reducing coverage. For all of the reasons described above, social policy should favor programs that result in *everyone* being insured.³¹⁸ While a utilitarian calculus might, all things being equal, be willing to sacrifice the insurance status of the low-risk individual for gains in the insurance status of the high-risk (by definition, after all, the high-risk need the coverage more), the prospect of attrition in insurance coverage among the low-risk is still troubling.

The second concern flows from the first, and from the observation that the high-risk in a community pool are not unaffected by the attrition of the low-risk from the pool. Rather, all pool members are arguably harmed if the premium structure results in a substantial number of low-risk members leaving the pool. The attrition of low-risk members will raise the average risk level of the pool, leading to the need for further premium increases, which in turn would spark an additional round of attrition

individual insurance, those in groups with cost sharing features who forego the opportunity to join the group, and groups that forego coverage altogether due to perceived cost unfairness.

³¹⁷ See ABRAHAM, *supra* note 34, at 15.

³¹⁸ After all, the same ethical and political impulses that lead to the provision of care to any uninsured, seriously ill person applies to the supposedly low-risk person who finds herself in need of care. See David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 S. CAL. L. REV. 1, 90-98 (1992) (considering necessity of comparing economic theory to ethical or human values).

among the lower-risk members. This process would create market instability, as insurers and insureds would be unable to settle on an equilibrium price for coverage: as soon as a price was set, a number of low-risk insureds would exit, resulting in a need for premium increases. This "death spiral," the theory goes, would soon result in unaffordable premiums for a substantial group of consumers.³¹⁹ Segmentation-blunting regulation, then, is self-defeating because it destroys the integrity of the risk pool, driving out good risks and leaving an unaffordable product for the bad risks.

But is the theory right? It is clear that people buy health insurance at premiums above the actuarially-accurate marginal cost of coverage.³²⁰ The reason may be that consumers are uninformed about the true risk of loss, or they may be "bad at probabilistic thinking."³²¹ They may simply be sufficiently risk-averse to purchase insurance even above its actuarial value. The problem must be separated into two parts: the effects of adverse selection where low-risk consumers may choose between risk-rated and risk-pooled products, and the effects where those consumers may choose only between risk-pooled products and no coverage. In the absence of a gross failure in consumer education,³²² even risk-averse, low-risk people will select the lower price offered by a risk-rated product.³²³ If regulation enforces limits on risk selection throughout the relevant market, however, this effect is minimized. This theory is being put to the test. As

³¹⁹ See Wortham, *supra* note 68, at 854-56; see also Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment*, HEALTH AFF., Spring 1994, at 132, 133-34 (describing premium "death spiral" experience by community-rating Blue Cross entities when experience-rating commercial insurers began luring away low-risk Blue Cross insureds).

³²⁰ See Wortham, *supra* note 68, at 861.

The reality of the insurance market varies from the neoclassical model in many ways. . . . Consumers may buy insurance at higher than the actuarially fair premium for several reasons. Expected utility theory may be incorrect about the demand function for insurance. Rational decision making may be an impossible condition to meet because people's rationality is bounded.

Id. (citations omitted).

³²¹ *Id.* at 872.

³²² See *id.* at 873-74 (describing substantial information deficits in insurance markets).

³²³ See *id.* at 854-58; see also Thomas Bodenheimer, *Should We Abolish the Private Health Insurance Industry?*, INT'L J. HEALTH SERVS., Summer 1990, at 199, 204 (describing movement of consumers from Blue Cross to commercial insurers).

is described above, there are several states that have placed limits (in some cases approaching pure community rating) on the extent to which all or most insurers in the individual and small group market may vary premiums on the basis of risk. Studies of the effects of those rating schemes are under way in order to test the actual effects of limiting risk selection for an entire market.³²⁴

Tentative results for several studies of state market reform plans have not demonstrated that adverse selection is reducing insurance coverage in states that have moved to limit risk selection throughout individual and small group markets. An early study produced by the Intergovernmental Health Policy Project at George Washington University studied the results of such reforms in five states.³²⁵ The report was guardedly optimistic about the ability of the reforms to increase access to health insurance:

The early tests of community rating (with its associated insurance reforms) suggest that it is making insurance more available and affordable to those who could not obtain it before, while raising prices for others. The overall impact on coverage seems to depend on how the program is designed and implemented, with Vermont and New Jersey experiencing net gains and New York experiencing a loss in coverage in affected plans during the first year of implementation. . . . Market effects on the number of insurers do not appear to be as strong as predicted. Carrier flight has been minimal. . . . Several insurance officials commented on the increased price competition they saw as a result of community rating.³²⁶

³²⁴ The term "entire market" should be used with caution in this context. The state statutes cannot, of course, regulate the activity of self-funded plans due to the preemptive effects of ERISA. See *supra* note 144 and accompanying text (discussing effect of ERISA preemption on state law). Federal legislation could, of course, correct for this factor by mandating *interplan* pooling through community rating requirements. However, the 1996 Act, while requiring some *intraplan* pooling, does not extend to *interplan* risk pooling. See *supra* notes 306-09 and accompanying text (comparing consequences of 1996 Act's market reform provisions in group and individual markets).

³²⁵ KALA E. LADENHEIM & ANNE R. MARKUS, THE COMMONWELTH FUND, COMMUNITY RATING: STATES' EXPERIENCE 1 (July 1994). The five states studied were Vermont, Massachusetts, New York, New Jersey and Maine. See *id.* at 1.

³²⁶ *Id.* at 13.

Other reports suggest similarly positive results.³²⁷ These reports are tentative, and it is possible that more complete analyses will uncover significant problems that have not yet surfaced. However, the classical economist's view of the behavior of insureds is at least not evident at this point.³²⁸

Should further study expose a tendency of low-risk insureds to flee reformed markets, the third concern with adverse selection would arise. This concern is that the flight of low-risk insureds would require that the government impose a mandate on people to enter and remain in the insurance market.³²⁹ Such a mandate, as President Clinton is painfully aware, can be politically explosive, but would it be fair? The mandate would be imposed for two reasons. First, it would be imposed to prevent "free riders," or those who would decline to purchase health insurance knowing that they would nevertheless be permitted, on humanitarian grounds, to gain treatment should it become medically necessary.³³⁰ On this same theory, we routinely levy uniform payment requirements (in the form of taxes) for other primary goods³³¹ such as police and fire protection. Second, the mandate would be imposed as a redistributive tax, requiring low-risk insureds to subsidize high-risk insureds.³³² Again,

³²⁷ See Janice Somerville, *No Fleeing of Healthy Because of Community Rating*, AM. MED. NEWS, Dec. 4, 1995, at 4 (reporting on survey of New Jersey and New York conducted by Kaiser Family Foundation).

³²⁸ See Wortham, *supra* note 68, at 858.

A . . . justification for classification based in classical economic argument is: (1) The most efficient allocation of resources is achieved when the price for products equals their marginal cost. (2) Marginal cost for the insurance product is the expected loss of the insured plus variable costs. (3) The competitive market will keep costs to a minimum. (4) Therefore, the most efficient allocation of resources is achieved when insureds are charged in accordance with expected loss.

Id. (citations omitted). While these studies do not suggest that the classical view of pricing in this market is inaccurate, it suggests that varying from marginal pricing does not do violence, under these facts, to furtherance of a normative goal.

³²⁹ Raising again, of course, the question of the ability of some consumers to afford coverage. See *supra* Part II (examining provisions and plans that guarantee universal coverage and explaining effects on insurance market).

³³⁰ See Frankford, *supra* note 318, at 90-98.

³³¹ See *supra* notes 100-03 and accompanying text (discussing universal desire for health care).

³³² That this system of mandatory payment above the actuarially expected cost is a tax is as indisputable as it would be difficult for elected officials to admit. It would almost certain-

redistributive taxes are not uncommon for the support of primary goods, but this would be an odd redistributive tax — levied on low-risk persons, without regard for ability to pay, in favor of the high-risk, again without ability to pay. Depending on how one feels about theories of tax equity,³³³ such a proposal could lead us to reexamine the possibility of a more general, and perhaps more equitable, system of statutory health coverage.

Adverse selection, then, presents a theoretical problem for regulatory mechanisms that interfere with marginal pricing and accurate risk segmentation. Should significant adverse selection appear, it could interfere with the goal to which community rating and its risk pooling cousins are put: the enhancement of health coverage access for all. Early empirical evidence casts doubt on the seriousness of the adverse selection problem, at least in the individual and small group markets. The results are tentative, and the reasons for the lack of effect are unknown. Perhaps with the growth of health care inflation, the fear of uncovered catastrophic losses are making us all — low or high-

ly be more efficient to charge each person the “true” cost of their coverage, and then to assess progressive taxes to those able to pay them in order to provide subsidies for those unable to pay the cost of their premiums. See Roger Feldman & Bryan E. Dowd, *Biased Selection — Fairness and Efficiency in Health Insurance Markets*, AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 64, 75 (Robert B. Helms, ed., 1993) (discussing inefficiency of community rating methods in subsidizing high-risk insureds). Two central premises of this Article relegate this observation to a footnote. First, as the treatment of, for example, genetic underwriting demonstrates, legislatures have made the judgment that Americans value some aspects of equity over efficiency in the pricing of health coverage. Second, there is at least one school of thought among public opinion analysts that the failure of the health reform effort of 1993-94 turned, among several internally inconsistent reasons, on the public's balking at the notion that their desire for universal coverage might result in some tax increases. See Yankelovich, *supra* note 109, at 15. Simply stated, the incrementalist efforts to modify the health care financing system in this country would not be undertaken were the political system driven simply by logic and plain speaking. While the accretion of various steps of incremental health reform may approximate in ultimate effect the single, coherent plan of achieving full insurance for all, incrementalism seems more palatable to the electorate, perhaps because it can consider and test individual components one at a time.

³³³ See Marjorie E. Kornhauser, *The Rise of Rhetoric in the Tax Reform Debate: An Example*, 70 TUL. L. REV. 2345, 2347-50 (1996) (discussing debate over policy implications of tax reform); Nancy C. Staudt, *Taxing Housework*, 84 GEO. L.J. 1571, 1571-75 (1996) (addressing gender issues in tax policy); see also John F. Coverdale, *The Flat Tax Is Not a Fair Tax*, 20 SETON HALL LEGIS. J. 285, 288-91 (1996) (discussing social equity in tax policy).

risk — sufficiently risk averse to purchase health insurance so long as we are able to afford it. Should adverse selection pose a serious problem, it could be cured by mandating the purchase of coverage for all in the affected community — but such a move would substantially raise the political stakes.

B. Risk Adjustment

Risk adjustment is an acid test of the technical viability of any broad-scale attempt to reduce or eliminate risk segmentation in the insurance market. The problem of consumer behavior, in the form of adverse selection, appears on first review of the state reform statutes to be less prevalent than expected: consumers appear to want insurance, and in the process of obtaining it, appear to disregard neoclassical models of marginal pricing. And as a last resort, treating the purchase of health coverage as an obligation — a tax — solves the technical problem. But the behavior of health plans and insurers is more intractable. Risk selection — assessing the cost of potential insureds and, if permitted, “accurately” pricing premiums — is the life blood of insurance in a competitive market.³³⁴ When we prohibit differential premium pricing based on risk, competitive activity is channelled into risk selection. Competitive advantage in anything approaching a single-price system in health coverage is most easily measured by a carrier’s or plan’s ability to attract low-cost members and reject high-cost members.³³⁵ Incrementalism’s melding of competition and regulation requires that the government identify those aspects of competition that must be restrained or modified, and prescribe effective and efficient means to do so.³³⁶

Competitive plans face an enormous incentive to select among risks. Estimates have suggested that the large bulk of health

³³⁴ See Feldman & Dowd, *supra* note 332, at 71 (describing tendency of insurers to actively recruit low-risk groups in order to maximize profits).

³³⁵ See ABRAHAM, *supra* note 34, at 97 (stating that when price differences are regulated, insurers’ competition based on risk selection will “neutralize the effects of the classification system” by excluding high-risk applicants).

³³⁶ See *id.* (stating that “[o]nly strict enforcement of mandatory offer and acceptance rules could restrict the effects of this phenomenon”).

expenditures are devoted to a very small percentage of the population: one percent of the population accounts for twenty-five percent of expenditures; four or five percent of the population accounts for fifty percent of expenditures.³³⁷ If plans could select against the high-risk, marketing to and retaining only the low-risk, they could reap huge rewards. The competitive pressure on insurers, particularly where differential pricing options are limited, to attract the “good” ninety-five percent and avoid the “bad” five percent will drive plan behavior. Not all risk can be known beforehand, even by the most inquisitive underwriter, but underwriters exist to segment risk. Regulators, on the other hand, eliminate or limit price differentiation so that people with different risk factors can be treated similarly. The regulatory task, then, is to overcome insurers’ incentives to compete by selecting among risks; behavior that would defeat the government’s social pooling purpose of limiting risk segmentation.

The wide variation in the expected cost of plan members raises concerns for risk adjustment even absent conscious attempts by plans to segment the market. Plan behavior to “cherry-pick” or “cream-skim” can be expected, and must be guarded against³³⁸ to avoid the injection of non-price risk selection into the process. Allowing plans to obtain compensation, apart from premiums, commensurate with the risk of their membership offers the opportunity to hold down health care costs and encourage efficient behavior.³³⁹ As is described below, the two categories of regulatory actions that can address the cream-

³³⁷ See Anne K. Gauthier et al., *Risk Selection in the Health Care Market: A Workshop Overview*, INQUIRY, Spring 1995, at 14, 15; Newhouse, *supra* note 319, at 139.

³³⁸ See Feldman & Dowd, *supra* note 332, at 71 (rejecting attempts to label such plan behavior as “perverse,” pointing out that, in absence of price competition, attempts at risk segmentation are expected and natural activities of competitive commercial actors).

³³⁹ See U.S. GEN. ACCOUNTING OFFICE, *MEDICARE MANAGED CARE: GROWING ENROLLMENT ADDS URGENCY TO FIXING HMO PAYMENT PROBLEM* 7-10 (Nov. 1995) [hereinafter *GAO REPORT: GROWING ENROLLMENT*] (stating that Medicare’s HMO capitation rate, which limits adjustment to “four demographic factors: beneficiary age, sex, Medicaid status, and institutional status, . . . does not maximize the potential of managed care to yield cost savings and, in some cases, can even discourage HMO participation in the program”).

skimming problem are behavioral limits (e.g., prohibiting a plan from nonrenewing on the basis of a member's health history), and a financial risk adjustment mechanism intended to calibrate plan compensation according to aggregate risk levels.

Many behavioral limits exist in state regulatory reform statutes and in the 1996 Act. Guaranteed issue and renewal, open enrollment, and limitations on preexisting illness conditions sharply limit insurers' ability to select members on the basis of risk.³⁴⁰ Even with these limitations, regulators fear that carriers will structure products in order to attract or discourage membership on the basis of the structure of the insurance product. For example, it is often asserted that HMOs are able to report lower average costs than other types of health plans because they attract healthier members who require less care.³⁴¹ In order to prevent carriers from constructing plans so as to surreptitiously achieve risk segmentation and to enhance the consumers' ability to comparison shop, many states have mandated that guaranteed issue regulations apply to uniform products defined and approved by regulators.³⁴²

In order to monitor activities and prevent inappropriate risk selection, ongoing oversight of the marketing process, itself, takes place in connection with patients' enrollment in Medicaid³⁴³ and Medicare³⁴⁴ capitated plans. Close oversight and ef-

³⁴⁰ See *supra* notes 75-94 and accompanying text (discussing option to bar use of genetic testing results in evaluating insurance applications).

³⁴¹ See Newhouse, *supra* note 319, at 134-35 (reporting on comprehensive study of Medicare participants suggesting "not only that healthier persons enrolled in HMOs, but that HMOs were able to differentially avoid the high costs associated with the last few months of life" by *disenrolling* members before they entered their final illness).

³⁴² See GAO REPORT: GROWING ENROLLMENT, *supra* note 339, at 9, 18-19, 24-25 (describing state statutes).

³⁴³ See Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?* 26 SETON HALL L. REV. 1007, 1019 (1996) (describing need to regulate means of marketing Medicaid plans); see also U.S. GEN. ACCOUNTING OFFICE, MEDICAID: STATES TURN TO MANAGED CARE TO IMPROVE ACCESS AND CONTROL COSTS 46 (Mar. 1993) [hereinafter GAO REPORT: MANAGED CARE] (same); SARA ROSENBAUM & JULIE DARNELL, MEDICAID SECTION 1115 WAIVERS: APPROVED AND PROPOSED ACTIVITIES AS OF FEBRUARY 1995, tab E, p. 32 (Feb. 1995) (same).

³⁴⁴ See Carol S. Jiminez, *Medicare HMOs: A Consumer Perspective*, 26 SETON HALL L. REV. 1195, 1201-02 (1996) (describing marketing problems and proposed solutions); see also DONNA O. FARLEY ET AL., DESIGNING A CAPITATION PAYMENT PLAN FOR MEDICARE END STAGE RENAL DISEASE SERVICES 24 (1994) (describing need for regulatory oversight of Medicare managed care plans for end-stage renal patients).

fective grievance procedures are necessary to avoid covert risk selection. Some plans have been accused of marketing bias that discourages high-cost patients from joining a plan in the first instance.³⁴⁵ Other plans intentionally create staffing deficiencies in high-cost specialties, and long waiting times to see specialists, as means of discouraging high-risk members to renew their plan membership.³⁴⁶

Regulatory oversight is expensive and far from perfect. The choice to use competitive commercial firms forces us to recognize that competitive commercial firms will pursue their own self-interest where possible. It is the nature of the beast. At some point, we must recognize that the "discipline" and efficiency we find attractive in the competitive market comes at a price: the self-interested management of its participants. In recognition of this reality, many commentators have concentrated their attention on "risk adjustment"; varying the amount paid to plans on behalf of but not *by* insureds in order to blunt the incentive to favor low-risk and disfavor high-risk members. Risk adjustment tries to match the payment level to expected cost and, therefore, mimics the marketplace in some respects.³⁴⁷

It may seem, then, that the process has gone full circle: after tremendous effort to *separate* marginal cost from pricing, the new efforts to derive methods of risk adjustment seem to reinject that relationship. But there are two important differences. First, the movement to derive appropriate methods of risk adjustment is in part driven by the view that commercial underwriting methods, by which many people are simply excluded outright from coverage or are priced out of the market, is an example of market failure requiring a regulatory solution.³⁴⁸ The market failure arises when the rational price charged by a

³⁴⁵ See Newhouse, *supra* note 319, at 137 (describing "targeted advertising" and "tie-in sales" with, for example, health club memberships as means to attract only good risks).

³⁴⁶ See *id.* at 137-38.

³⁴⁷ Cf. Wortham, *supra* note 68, at 858 (describing "neoclassical economic" argument for efficient pricing by reference to marginal cost).

³⁴⁸ See Katherine Swartz, *Reducing Risk Selection Requires More Than Risk Adjustments*, INQUIRY, Spring 1995, at 6, 6 (discussing problems with unaffordable premiums and potential need for public remedy).

plan excludes the purchaser from the market. Risk adjustment attempts to pay the insurer a rational price, while saving coverage for the high-cost person. Second, there are normative reasons to separate the insured and the premium level, permitting an insured to pay less than her "true cost," even if an administrative mechanism must be created to permit the *insurer* ultimately to obtain payment *as though* it were being paid according to market principles. Risk adjustment permits resource allocation among insurers according to market-based principles while permitting consumers access to coverage without regard for their actual or predicted health status.

In concept, the notion of risk adjustment is easily stated. A central payer (e.g., Medicare, Medicaid, or a state health benefits coordinator) contracts with a series of plans to provide services to a group of individuals who will participate (gain coverage) without regard for their own level of risk. The plans, in turn, are asked to participate in an open enrollment period, during which they are required to accept any applicant from among the qualified group without regard for risk level. The program coordinator controls for the behavioral faults described above: the plan's services, marketing methods, and staffing requirements are not permitted to covertly accomplish risk selection. Finally, the coordinator applies some mechanism to ensure that the plans are compensated not simply on a per capita basis, which may encourage creative and covert risk selection, but on the basis of its enrolled members' risk level. Risk adjustment, thus, is intended to eliminate the economic incentive for plans to subvert the equitable structure of the enrollment process: "[u]nless the risk adjustment brings the revenue for an individual (or family) close to the cost for that individual (or family), however, plans have an incentive to avoid high-cost individuals The plan's bottom line will always look better with the high-cost individual elsewhere."³⁴⁹

³⁴⁹ Newhouse, *supra* note 319, at 140.

Much has been written about risk adjustment.³⁵⁰ As Professor Newhouse notes, however, “[t]he good news . . . is that there is a substantial literature on risk adjustment. The bad news is that the literature could be summarized as: We don’t know how to do it very well despite years of trying.”³⁵¹ Medicare considers the limited demographic factors of age, sex, Medicaid status and whether the beneficiary is the resident of an institution, and also adjusts for geographic differences in the costs of medical care. Medicare’s method of paying for HMO coverage has been criticized as creating “incentives [for participating HMOs] to enroll only relatively healthy Medicare beneficiaries.”³⁵² Far more complex methods of risk adjustment are now under study, using the analysis of more detailed predictive information, including “[p]erceived health status and functional health status,” and detailed sociodemographic information.³⁵³ This additional information is both difficult and expensive to obtain, and of limited predictive value. Measurement of recent uses of services, such as hospitalizations, stays in nursing homes, and the number and service intensity of office visits, have substantial predictive power but are expensive to obtain. Furthermore, they could “create perverse incentives, inappropriately encouraging HMOs to hospitalize or provide [unnecessary] outpatient treatment.”³⁵⁴ Such measures could penalize HMOs that provide good preventive

³⁵⁰ See, e.g., *id.* (suggesting experimentation with paying plans on basis of risk adjusted capitation); Bryan Dowd et al., *An Analysis of Selectivity Bias in the Medicare AAPCC*, HEALTH CARE FINANCING REV., Spring 1996, at 35, 36 (examining risk adjustment in relation to Medicare Tax Equity and Fiscal Responsibility Act of 1982); Richard Kronick et al., *Diagnostic Risk Adjustment for Medicaid: The Disability Payment System*, HEALTH CARE FINANCING REV., Spring 1996, at 7, 10-11 [hereinafter Kronick et al., *Diagnostic Risk*] (describing system of diagnostic categories from Medicaid programs to health plans that enroll people with disabilities); Richard Kronick et al., *Making Risk Adjustment Work for Everyone*, INQUIRY, Spring 1995, at 41, 49 [hereinafter Kronick et al., *Risk Adjustment*] (concluding that risk adjustment systems are feasible for people with disabilities); Harold S. Luft, *Potential Methods to Reduce Risk Selection*, INQUIRY, Spring 1995, at 23, 31-32 (concluding that risk adjustment will allow health care plans to focus on providing higher quality and lower cost medical care); *Risk Adjustment: What is its Real Potential for Reducing Risk Selection?*, HEALTH CARE FINANCING & ORG. NEWS & PROGRESS (Robert Wood Johnson Foundation, July 1996).

³⁵¹ Newhouse, *supra* note 319, at 139.

³⁵² GAO REPORT, *supra* note 245, at 14.

³⁵³ Randall P. Ellis et al., *Diagnosis-Based Risk Adjustment for Medicare Capitation Payments*, HEALTH CARE FINANCING REV., Spring 1996, at 101, 102.

³⁵⁴ *Id.*

care, thereby avoiding counted encounters. Recent proposals would attempt to improve on these methods by allowing risk adjustment using the member's diagnostic information.³⁵⁵

While further research is necessary, it is clear that promising systems of risk adjustment are nearly ready for trial. And Professor Newhouse's pessimism is not universal; Richard Kronick, in a recent discussion of the use of risk selection to encourage plans to willingly enroll disabled persons, sounded more hopeful:

We do not need perfect risk adjustment systems. We do need systems that are good enough to provide protection to vulnerable populations and encourage health plans to want to serve them, and we need a process that will allow such systems to improve. Our analysis shows that such systems are feasible for persons with disabilities.³⁵⁶

In an extremely competitive market, even small differences between regulatory risk adjustment analysis and a plan's own assessment of risk could, in theory, lead to covert risk selection.³⁵⁷ As is the case with the behavior of insureds, however,³⁵⁸ plan behavior in reality might react appropriately to somewhat imprecise adjustments.³⁵⁹

³⁵⁵ See *id.* at 101-03; Jonathan P. Weiner et al., *Risk-Adjusted Medicare Capitation Rates Using Ambulatory Inpatient Diagnoses*, HEALTH CARE FINANCING REV., Spring 1996, at 77, 78-79.

³⁵⁶ Kronick et al., *Risk Adjustment*, *supra* note 350, at 54.

³⁵⁷ See Newhouse, *supra* note 319, at 140-41 (stating that there are strong incentives for selection in absence of any risk adjustment); Swartz, *supra* note 348, at 6 (discussing competition in insurance market to attract low-risk people and use of any available device to select out high-risk people).

³⁵⁸ See *supra* note 96 and accompanying text (stating that insurers are denied relevant information when calculating expected risk of loss from applicants).

³⁵⁹ As a part of the state insurance reform statutes, several states have created very rough risk adjustment measures in the form of "reinsurance pools," in which "all carriers participate, paying a share of the losses equivalent to their share of the market the pool protects." LADENHEIM & MARKUS, *supra* note 325, at 12. In this way, carriers are encouraged to participate in a system where they are deprived of traditional risk selection tools with the assurance that their losses, if any, will be shared among other market participants. New Jersey has adopted variation on this scheme, allowing "medical loss ratios" to serve as a proxy for the risk level of a plan's business in the regulated market. The medical loss ratio measures the percentage of premium devoted to medical care, rather than profit or administrative expense. All else being equal, a higher loss ratio corresponds to higher risk insureds. Participating plans in the regulated market are permitted to participate in a system that permits plans with high loss ratios (and presumably high risk insureds) to collect assessments from participating plans with low loss ratios. *Id.* Although these very rough after-the-fact risk adjustment systems are too new to be evaluated fully, preliminary results

Risk adjustment is a natural component of an incremental reform strategy. It attempts to use market incentives to drive efficiency in plans, while preserving the social pooling of risk. If effective, then, it will enable people to gain coverage regardless of their health status, while preserving marketplace discipline and cost-containment. The concept is simple: separate the means by which individuals gain coverage from the means by which plans account for variable risk level. Risk adjustment raises privacy concerns along the way. In gathering accurate information to adjust plans' risk, the government must avoid probing into individuals' confidential health-related information. In selecting from among methods of risk-adjustment, then, regulators should favor methods that test a plan's risk level based on factors separated from the individual health status of the members.

C. It Takes a Budget

Finally, and most fundamentally, the cost of insurance expansion must be addressed. If the function of America's private insurance system is to provide access to health coverage, it has been failing in recent years,³⁶⁰ particularly with children and the low-income.³⁶¹ The steps toward social pooling described in this article, and particularly the legislative steps taken to shore up the breadth of risk pools, are calculated to address this erosion. But the fundamental issue of finances is not addressed by structural market reform. While structural reforms may enable those with financial means to retain coverage, thereby stemming

indicate that plans are comfortable enough with the system to stay in the market. *Id.* at 13. New Jersey's plan in particular, which effectively would correct covert risk selection after the fact by forcing a plan with a low loss ratio to disgorge surplus for the benefit of other plans, bears study.

³⁶⁰ See Rowland, *supra* note 235, at 283 (describing increase in number of uninsured); see also Bodenheimer, *supra* note 323, at 204-05. A portion of the increasing number of uninsured can be attributed to a shift in the American economy from high-wage, often unionized manufacturing jobs to lower-wage, seldom unionized service jobs; a rise in cost shifting to employees, leading to the lower wage employees' dropping coverage; and to an increase in part-time employment which is often unaccompanied by health benefits. *Id.*

³⁶¹ See U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE FOR CHILDREN: PRIVATE INSURANCE COVERAGE CONTINUES TO DETERIORATE 2 (June 1996). "The number of children without health insurance coverage was greater in 1994 than at any time in the last eight years In addition, the percentage of children with private coverage has decreased every year since 1987, and in 1994 reached its lowest level in the past eight years" *Id.*

the tide of uninsurance, they will not permit the bulk of the currently uninsured — who are overwhelmingly low-income³⁶² — to obtain coverage. With the number of Americans living in poverty remaining stable or increasing,³⁶³ and the cost of health care rising due to an aging population and improving high technology interventions,³⁶⁴ the problem of redistributive politics cannot be avoided.

The structural reforms created by the 1996 Act and the more comprehensive state statutes will smooth out the peaks and valleys of insurance access, but will not provide subsidies for those simply priced out of insurance.³⁶⁵ When the movement toward broader-scale health reform in 1993 and 1994 failed, many read this rejection as a refusal to fund universal access to health care for those unable to afford it. Indeed, America seemed unwilling to pay for immediate broad reforms in health access.³⁶⁶

The movement to broad national health reform has run its course for the near term, and the institutions of private markets in health financing and delivery will be pivotal in any attempts to incrementally increase access to health care.³⁶⁷ A more

³⁶² Rowland, *supra* note 285, at 283-84.

³⁶³ See U.S. BUREAU OF THE CENSUS, *Current Population Reports*, in STATISTICAL ABSTRACT OF THE UNITED STATES 1996, at 475 (116th ed.) (stating that percentage of people below poverty level has risen from 11.7% in 1979 to 15.1% in 1993).

³⁶⁴ See Kathleen A. Buto, *How Can Medicare Keep Pace with Cutting-Edge Technology?*, HEALTH AFF., Fall 1994, at 137, 137.

³⁶⁵ See *Insurance Market Reforms Unlikely to Help Many Workers Get Coverage*, HEALTH CARE FINANCING & ORG. NEWS & PROGRESS (Robert Wood Johnson Foundation, July 1995); *Kassebaum-Kennedy Health Insurance Bill Clears Congress: Medical Savings Accounts Limited to Demonstration Program*, FAMILIES USA (Aug. 1996) <<http://epn.org/families/fakeka.html>>.

³⁶⁶ See Reinhardt, *supra* note 4, at 34 (suggesting that lesson of victory of those advocating “personal responsibility” during 1993-94 debates was that “well-to-do Americans should be empowered to allocate their income to health care and other commodities as they see fit, and that poor and low-income households should be empowered to do likewise with their much more meager budgets”). Were this decision to be reconsidered, and were the United States to adopt a program of national health insurance similar to that in place in Canada or in Western European countries, the fiddling with the insurance market would bear a very different relationship to questions of access to health care: health care would be a political right of all, and resource allocation decisions would be political questions like those affecting police protection or public education. See William A. Glaser, *The United States Needs a Health System Like Other Countries*, 270 JAMA 980, 980-81 (1993) (comparing United States treatment of health care allocation with that of other countries); Priester, *supra* note 19, at 92-94 (describing ethical framework for broader allocation of health care resources).

³⁶⁷ See Steinmo & Watts, *supra* note 15, at 335-36 (describing enduring power of private

gradual attempt to extend health coverage to the uninsured will have to employ the current mixture of public and private financing mechanisms. The developing regulation of health insurance underwriting establishes that the government has learned this lesson and that state and federal governments intend to address inequities in health access by regulating the private market, not by supplanting it. The repeated failure of the United States to create a universal entitlement to health care renders it unavoidable that the poor and near poor will gain access to health care through subsidized membership in insurance provided by the marketplace.

The clear strategy for insurance expansion for the near future is for the government to modify the marketplace, and to purchase entry to that improved marketplace for those currently shut out. This trend in public-private partnership in health care financing is evident in Medicaid³⁶⁸ and Medicare,³⁶⁹ where the government has moved to get out of the business of being an insurer, and instead has moved toward becoming a purchaser of insurance and managed care products for those eligible for government programs. As the government breaks out of a system of rigidly defined public insurance and entitlement programs, states have attempted — with some success — to use their new flexibility as purchasers rather than insurers to add some low-income, previously uninsured persons to the roles of newly defined Medicaid programs.³⁷⁰

The majority of the uninsured will not gain insurance without funding, regardless of how equitably structured the health insurance market becomes. The recent political process has rejected

institutions in health care debate).

³⁶⁸ See Teresa A. Coughlin et al., *State Responses to the Medicaid Spending Crisis*, 19 J. HEALTH POL. POL'Y & L. 837, 855-56 (1994) (discussing states' approaches to Medicaid maximization); see also GAO REPORT: MANAGED CARE, *supra* note 343, at GAO/HRD-93-46.

³⁶⁹ See GAO REPORT: GROWING ENROLLMENT, *supra* note 339, at GAO/HEHS-96-21; Henry J. Aaron & Robert D. Reischauer, *The Medicare Reform Debate: What Is the Next Step?*, HEALTH AFF., Winter 1995, at 8, 8; Ellis et al., *supra* note 353, at 101; Weiner, *supra* note 355, at 77.

³⁷⁰ See Rosenbaum & Darnell, *supra* note 343; Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545 (1995) (discussing innovative state health care reform); see also John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, HEALTH AFF., Spring 1995, at 199, 199 (discussing states' use of section 1115 waivers).

the creation of a broad public system of health insurance, and the prospects of assisting the uninsured therefore implicate the private insurance marketplace. Current trends in state and federal health regulation point toward the incremental reform of that marketplace toward the end of enhanced social pooling. The success of that venture may influence the willingness of legislatures to further subsidize the purchase of health insurance for the uninsured. The government will be more willing to fund entry into a system with structural rules that comport with norms of fairness, social sharing, and equity than one based on price discrimination targeting for the highest prices those most in need of coverage, who are blameless for their high cost.

Structural reform of the competitive insurance market to require social pooling of risk, and to limit segmentation of risk, curtails the extent to which high-risk individuals can be absolutely excluded, or effectively excluded (by high cost) from the insurance market. Structural reform does not, however, address the most significant cause of uninsurance: the high cost of coverage, even if that coverage is priced without regard for individual risk. Structural reform is nevertheless a valuable process. From an ethical perspective, it forces the insurance market to more closely conform its practices with social norms forbidding the exclusion of coverage for those who suffer high-cost health conditions. From an instrumental perspective, it creates a necessary (but not sufficient) condition to increased government subsidization — or “buy-in” — to that market for those financially unable to enter on their own. That condition conforms the market more closely to accepted social norms, and therefore makes public participation in it more palatable.

In sum, there are three operational elements that must be examined before a market-wide system of social pooling will effectively make coverage available to all without regard for actual or expected health status. First, the insurance market must be guarded against adverse selection — conduct by which low-risk insureds are believed to avoid purchasing coverage if the cost of coverage exceeds the marginal cost to that low-risk person. Preliminary studies suggest that, if *substantially all* carriers in a market are barred from using risk selection, consumers' desire for coverage is sufficiently strong to lead them to accept the enhanced cost; as a last resort, purchase could be mandated.

Second, if carriers are precluded from using traditional means of price-based risk selection, means must be adopted to dissuade them from employing non-price risk selection mechanisms that would frustrate reform regulation. Risk adjustment mechanisms, ranging from the simple to the esoteric, are in use or under development and hold promise of resolving this issue. Finally, the government must consider subsidizing those who are unable to afford coverage, even in a reformed marketplace. While it is impossible to predict the political debate, subsidies will be more readily forthcoming if the system to which the subsidies are devoted is structured fairly and equitably.

CONCLUSION

America's national character, as well as the powerful institutions that have developed in a century of private health care finance, render comprehensive national health reform difficult or impossible in the near term. But health insurance law has evolved quietly and steadily during the century of national debate over more comprehensive measures. In recent years, the evolution has proceeded more quickly and dramatically, as genetic underwriting, access to coverage for the disabled, and mandated portability of coverage have modified the marketplace. That evolution reflects the American tension in the understanding of the ends of health insurance. The trend of regulatory involvement in the market of health coverage has shifted toward favoring a social pooling of risk, both in the interest of fair access to a deeply cherished public good, and in a pragmatic attempt to employ our idiosyncratic mix of public and private coverage systems to reach gradually and economically the goal of universal health coverage.