The Rhetoric of Insurance Law: The Debate over AIDS Testing

Deborah A. Stone


The debate over AIDS testing by health and life insurance companies opens a window on the nature of the American moral economy. It reveals societal expectations and conflicts about what citizens of a community owe each other when the chips are down—how much and in what ways we will exchange help, and who and what kinds of troubles we will include in our networks of helping exchanges. These expectations are encoded in the institutional rules and practices of insurance, and they also lie just beneath the surface of legal argument about public policy.

Since AIDS affects a relatively small number of people (as compared with, say, heart disease or cancer), one might understandably ask whether the resolution of the testing question is really so important and whether

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Deborah A. Stone is the David R. Pokross Professor of Law and Social Policy at Brandeis University. Ph.D. 1976, Massachusetts Institute of Technology. She is the author of Policy Paradox and Political Reason (Glenview, Ill.: Scott, Foresman, 1988). This essay is related to a longer work on insurance she is currently writing.

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1. In 1986, 10,324 people died of AIDS. The corresponding figures for other diseases were heart disease—768,350; cancer—465,980; cerebrovascular disease (mostly stroke and hypertension)—147,790. Projections for 1990 show a quadrupling of AIDS deaths to about 44,600, but deaths due to other causes will be vastly greater as well. W. Winkenwerder, A. Kessler, & R. Stolec, "Federal Spending for Illness Caused by the Human Immunodeficiency Virus," 320 New Eng. J. Med. 1598, table 5 (June 19, 1989).
this policy issue is really so revealing of larger social issues. But the question is bigger than it seems for three reasons.

First, the AIDS antibody test is one of a growing number of predictive diagnostic tests. Other predictive tests can reveal genetic markers for conditions such as Alzheimer's disease, manic-depressive disorder, muscular dystrophy, cystic fibrosis, and some forms of cancer, diabetes and heart disease. The findings of epidemiological research also lead to the use of medical tests to make predictions. For example, the finding that high levels of blood-serum cholesterol are associated with heart disease leads to the use of serum-cholesterol tests as a predictor for heart disease. Other such risk factors for which there are predictive tests are high blood pressure, obesity, and smoking.

Predictive diagnostic tests put people in an in-between category—they do not yet have the disease in question and may never develop it, but they are regarded as closer to it, more in danger of it, than other people. They are designated "high risk." The AIDS antibody test, for example, does not tell whether someone "has AIDS" (i.e., a diminished immune system), but only that they have antibodies to the human immunodeficiency virus (HIV) virus in their blood, have therefore been exposed to the actual HIV virus, and stand a high likelihood of developing the symptoms of HIV. (Thus, what is popularly called the "AIDS test," is technically an HIV antibody test.)

Predictive tests are generally designed to be overinclusive so as to allow physicians to monitor people who might become sick and to detect any problems before they become serious. But insurers also use such predictive tests as the basis for denying insurance coverage or charging higher-than-normal premiums. Therefore, the more predictive tests we have available, and the more broadly risk categories are drawn, the fewer people private insurance will serve.

Second, insurers' use of HIV antibody and other predictive tests is significant because insurance in some form is the primary mode by which people provide for their own needs that are too great to meet through normal work income. Insurance is also the mechanism most families use to shore up the fiscal side of family bonds; it is through health insurance, life insurance, disability insurance, pensions, and their attendant dependent benefits that people create their own networks of social aid within the larger society of strangers.

Third, we have a public system of social protection that makes private insurance the first line of defense against catastrophe when personal income and savings are exhausted. People are expected to provide for themselves through work and to participate in health insurance and pension plans. Social insurance, such as Social Security pensions, disability insurance, and Medicaid, are designed to be safety nets under a more secure
source of support, not primary sources of support in themselves. Therefore, the policies of the private sector with regard to who and what kinds of troubles are covered will, to a large extent, determine the set of people and troubles that fall to public sector insurance and welfare programs.

Thus, the straightforward policy question in this debate—should private health and life insurers be permitted to test for HIV antibodies in their applicants?—actually entails several puzzles of social theory. What is the nature and purpose of insurance as a social institution? What is the relation between public and private systems of social protection? And what definition of equity is used to structure our social institutions?

This debate also richly illuminates strategies of legal and policy argument. The two sides rhetorically construct and reconstruct the issues. They seek to shape the terms of the debate in order to win persuasive advantage before a listening public—in this case, insurance regulators, state legislators, and judges, all of whom potentially have authority to mediate this controversy. Through a close analysis of rhetorical strategy, I hope to reveal some of the major strategies in policy argument more generally, and to show how rhetorical strategies in policy debate conceal the full range of available policy choices.

As a focal point, I use two articles from the Harvard Law Review that I believe make the most articulate and compelling cases for their points of view. They are the cream of the crop, analytically, and they appear in a prominent, prestigious, and influential forum. As it happens, the authors are also representatives of the two institutions that have participated most vigorously in lobbying, litigation, and the general public debate—the commercial insurance industry and the gay rights movement. Karen Clifford was at the time of writing the article assistant counsel for the Health Insurance Association of America (HIAA), a trade association whose membership includes about 355 companies that write about 85% of all private health insurance in the United States. Russel Luculano, coauthor of the first article, is senior counsel with the American Council of Life Insurance (ACLI), a trade association with 635 member companies that account for about 95% of life insurance sales.2 Benjamin Schatz, author of the second article, is director of the Civil Rights Project of the National Gay Rights Advocates in San Francisco. Moreover, these same people, or other members of their institutions, are frequent authors of position papers and analyses that have appeared elsewhere.3 Thus, these two articles articulate institutional as

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2. Schatz, at 1788–89 n.47.
well as (one presumes) individual viewpoints.

These same institutions also do almost all of the data gathering on the issue of testing and insurance. Insurance companies are quite sensitive, if not secretive, about their underwriting practices, since they are an essential element in a company's competitive strategy. The HIAA and ACII have done surveys of their member companies about their claims experience as well as their underwriting policies. The National Gay Rights Advocates has conducted a survey and also keeps files on clients' experiences with insurance companies, employers, and landlords. These surveys are cited by nearly everyone writing on the issue, and they seem to be the primary source of data. Thus, by virtue of their monopoly on the data, these organizations "own the problem," in Joseph Gusfield's evocative phrase. They are the only ones in a position to tell the public and the policymakers what the facts are, and public institutions have left them de facto responsible for the problem by not collecting their own data.

THE BROADER CONTEXT: INSURANCE UNDERWRITING DEMYSTIFIED

To understand the HIV-testing controversy, it is useful to have some background about insurance underwriting. HIV testing, after all, is only a very small part of underwriting in health and life insurance. Underwriting is the process insurers use to decide whom they will accept among many applicants for their policies. Insurers sometimes define underwriting as "the selection of risks." The main purpose of underwriting is to ensure the fiscal solvency of the insurer as well as its profitability in the case of for-profit companies. Underwriting, therefore, is essentially a process of examining applicants and their situations to determine whether their


5. I know of only two exceptions. In 1987, the Massachusetts Division of Insurance surveyed life insurance companies doing business in the state about their claims experience with AIDS, and tried (unsuccessfully) to use the findings to restrict insurers' use of HIV testing in the state. See Peter Hiam, "Insurers, Consumers, and Testing: The AIDS Experience," 15 Law, Medicine and Health Care 212 (1987/88). The Office of Technology Assessment conducted a major survey of insurance company underwriting practices for its report, Medical Testing and Health Insurance, Doc. No. OTA-H-384 (Washington, D.C.: Government Printing Office, Aug. 1988) ("OTA, Medical Testing"). Even this survey, however, was designed in cooperation with, and endorsed by, the HIAA and the Group Health Association of America (a trade association of health maintenance organizations and other prepaid group health plans). Id. at 55.
probable loss experience is similar to that assumed by the insurer in setting its premium rates.

As is often true in the field of insurance, the technical usage of the term underwriting is quite different from its common usage. In ordinary language, underwriting means something like backing, financing, or assuming financial risk. In insurance, the term is sometimes used this way, but its more prevalent usage is quite opposite. Underwriting means screening and separating out good and bad risks. It is a process of examination in order to exclude. When insurers say that a particular type or line of insurance is underwritten, they do not mean that they offer coverage for it, but rather, that individual applicants will be examined for their particular risks, and the insurer will not assume financial risk for some of them.

Medical underwriting can include questionnaires about applicants' health history, including medical histories of blood relatives; questionnaires to be filled out by applicants' own physicians, on the basis of a physical exam; examination by physicians chosen and paid by the insurance company; and required laboratory and clinical tests, such as blood tests, urinalyses, or electrocardiograms. Beyond the routine blood chemistry tests used in clinical practice to determine the presence of disease, insurers sometimes also screen blood for prescription drugs and for evidence of substance abuse. Screening for prescription drugs can tell an insurer whether an applicant is following a prescribed treatment and therefore has a disease "under control." Also, screening can tell whether applicants are being treated for some disease that they have not disclosed. For example, a blood test might reveal that a person is taking drugs for heart disease or diabetes. Screening for substance abuse could include tests for nicotine, to confirm whether someone is a nonsmoker, and tests for cocaine. Thus, the testing performed as part of medical underwriting is already conducted in something of a spirit of distrust. Tests are used in part to determine whether applicants are concealing medical knowledge from insurers.

The question of whether HIV or other predictive testing becomes a part of underwriting practices is important because its resolution will significantly shape access to health and life insurance. Unlike many other countries, the United States does not have a universal national health insurance system. The Medicare program might be considered a partial universal system, in that it covers all people over the age of 65. Medicaid, the other major government program, covers only people whose income falls below a certain floor (set by the states). Outside these large government programs, there are two broad types of health insurance—employee group insurance and individual insurance. Group insurance covers the vast majority of people; about 85 to 90% of all health insurance policies outside of government programs are group policies. The remaining 10 to 15% of
nongovernment health insurance coverage is through individual policies with commercial companies or Blue Cross-Blue Shield plans.

Historically, only applicants for individual policies and groups with fewer than 10 or 15 employees have been subject to medical underwriting. In the larger group market, all members of an employee group are generally accepted simply because they are employees, without any medical inquiry, and all are charged the same rate for their insurance coverage. Thus, with respect to health insurance, the question of using or requiring HIV antibody tests has applied only to about 10 to 15% of the nongovernmental health insurance market, or about 15 million people.\(^6\) But this situation seems to be changing. A recent survey found that a significant portion of insurers either screen or plan to screen group applicants for high-risk status.\(^7\)

As screening and underwriting exclude more people from the private health insurance market, the costs of their care will fall to either Medicaid or Medicare, if they qualify, or they will be uninsured. If they seek and obtain treatment without insurance, the hospital or physician has to absorb any costs of their care beyond what they can pay for themselves. Hospitals and physicians, in turn, will try to increase their charges to all other payers (Medicare, Medicaid, other government programs, Blues and commercial insurance plans, and private patients who pay for themselves) in order to cover the costs of their free care and bad debts. Hospitals are less and less able to engage in such "cost shifting," however, because of policies of the various other payers. Thus, despite the nominal separation of numerous health insurance plans, they are connected through their relationship to the same health care providers—hospitals and physicians—so that the underwriting rules and policies of any one plan have systemwide effects.

Unlike health insurance, whose primary function is to provide access to crucial services, the primary function of life insurance is to provide financial security to the dependents of policyholders or, in the business context, to protect the business assets of partners when one partner dies. Sometimes life insurance is a prerequisite for certain jobs ("key person coverage") or for obtaining financial credit (mortgage life insurance). Therefore, rules and policies of insurance companies that restrict the ability of individuals to obtain life insurance also limit the ways people can

\(^6\) In the OTA survey, which seems to be the best (if not only) data on the question, 86% of commercial companies, 73% of Blue Cross–Blue Shield plans, and 50% of health maintenance organizations said they either screened or planned to screen individual applicants for AIDS, OTA, Medical Testing, 80–90.

\(^7\) Seventy-seven percent of commercial small-group insurers, 58% of commercial large-group insurers, 77% of Blue Cross–Blue Shield small-group plans, and 7% of Blue Cross–Blue Shield large-group plans either screened or planned to screen for high-risk applicants. OTA, Medical Testing 80, 85.
provide for the financial security of themselves, their dependents, and their business partners. These other ways include private pensions (which can be left to beneficiaries), Social Security pensions, and inheritances.

In life insurance, the majority of policies (about 58%) are provided on an individual basis, with the remaining 42% provided on a group basis.\(^8\) The structure of the market is, thus, essentially the reverse of the health insurance market. Applicants for individual life insurance are medically underwritten; it is here that medical testing has its biggest direct impact.

Although the health and life insurance market is composed of nominally separate, competitive firms, in practice such widespread information centralization and sharing exist that the would-be purchaser of individual policies effectively faces only one supplier. The insurance industry maintains a central laboratory, the Home Office Reference Laboratory (HoRl), that performs most of the testing for medical underwriting, though insurers do use other labs and results of tests ordered by applicants' own physicians. The HoRl shares its test results with a central data bank, the Medical Information Bureau (MiB). The MiB is a membership organization of about seven hundred insurance companies. When a person applies for health, life, or disability insurance to any of these companies, he or she must sign a consent form allowing the company to report any of its findings to the MiB and to seek information about the applicant from the MiB. Thus, once an applicant's blood has been sent to the HoRl, results of testing will be available to virtually any other insurer to whom that person later applies.\(^9\)

This is the institutional context in which medical underwriting occurs. Two key points bear summarizing. First, HIV antibody tests are only one of the many predictive tests insurers use, and what may be more important to them than HIV tests per se is their autonomy in conducting and using predictive tests more generally. Second, although medical underwriting applies only to parts of the health and life insurance markets, the selection practices within those parts affect other parts of our complicated social protection system.

THE ARGUMENT FOR TESTING

The immediate burden of the Clifford and Iuculano article is to de-

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9. In response to pressure from gay rights advocates, the MiB has modified these data-sharing policies for AIDS antibody tests. It announced in 1987 that it will no longer keep records of positive HIV test results; and it now codes these results as “abnormal blood count.” OTA, Medical Testing 80. Still, it is not clear that this new coding method offers any great protection. Since insurance underwriters know what it means (or can mean), they may simply reject applicants with this code.
fend insurers' use of the HIV antibody test against legislative and regulatory restrictions. At other times in history the industry has had to defend its use of classification factors that legislative and social sensitivities no longer sanctioned—notably, race and gender. The industry argument against restrictions on HIV testing follows the structure of its argument against other restrictions on underwriting. Indeed, for their conceptual structure, Clifford and Luculano rely heavily on a 1976 article whose authors were concerned with civil rights statutes that challenged the life insurance industry's use of gender, race, and handicaps as rating factors.¹⁰

Clifford and Luculano believe that most critics of the insurance industry do not understand the fundamental principles of insurance. Well-meaning state legislatures, in their desire to protect people with AIDS, have enacted laws that abandon "time honored and sensible underwriting principles" and thus "endanger the financial status of many insurers" (at 1806). The article seeks to educate the lay public and policymakers about the technicalities of the insurance business, and it assumes that once people understand the principles of insurance, they will accept the necessity for the use of antibody tests.

The basic principles of insurance are, at bottom, notions of fairness. An insurer has the "responsibility to treat all its policyholders fairly by establishing premiums at a level consistent with risk represented by each individual policyholder" (at 1808). On the other side is the "right of the insurer to create classifications to recognize the many differences which exist among individuals" (at 1808).¹¹

Since, in this view, differentiation is central to the selling and pricing of insurance, the key question is what kinds of differentiation are "fair." This question is governed by the Unfair Trade Practices Act (UTPA), a model law developed by the National Association of Insurance Commissioners (NAIC) and adopted by all states in some form by 1960. The UTPA makes a distinction between unfair and fair discrimination; it forbids the former and compels the latter (at 1810). Neither concept is defined generically, but the essence of fair discrimination seems to be that "each insured [person] will pay in accordance with the quality of his risk" (at 1810).¹² Those with more serious risks to life or health are in a sense getting a more valuable insurance policy than those with lesser risks, so they ought to pay more for the extra value. On this view, fairness in insurance means each person pays for him or herself.

This is the heart of the industry argument, and it deserves scrutiny.

¹⁰ Herman T. Bailey, Theodore M. Hutchinson, & Gregg R. Narber, "The Regulatory Challenge to Life Insurance Classification," 25 Drake L. Rev. 779 (1976). All three authors were listed at time of publication as counsel for Bankers' Life Company.

¹¹ Quoting from id. at 780.

Differentiation is not central to the selling and pricing of insurance unless the principle of "each person pays for himself" is accepted in the first place as the way to structure insurance. As I have already noted, the insurance industry itself does not apply this principle in group life and health insurance contracts.

Insurance can be designed to be more or less redistributive, but it is redistributive by its very nature. People could theoretically use their savings to provide financial security for any of the contingencies we commonly insure against. The difference between personal savings and insurance as institutions for providing financial security is that insurance is a collective enterprise. Individuals join with others to "pool" their risks and their savings. Some people in the pool will experience the harm against which they insured (say, fire, theft, or illness), and some will not. Since only those who experience the harm will receive a payout from insurance, but all will have contributed, those who do not experience harm necessarily pay to help those who do.

This economic redistribution built into insurance is sometimes called cross-subsidy, and insurers often treat it as anathema to fairness. Thus, Clifford and Luculano argue that the UTPA imposes a "positive duty" on insurers "to separate the insured with identifiable, serious health risks from the pool of insureds without those risks. Failure to do so represents a forced subsidy from the healthy to the less healthy" (at 1811, emphasis added). That argument makes sense only if we understand insurance as allocative rather than redistributive; that is, if we see its purpose as allocating costs to the people who generate them rather than as redistributing resources from the more fortunate (in fate) to the less fortunate. The debate about HIV testing in insurance, then, comes down to a fundamental disagreement about the purpose of insurance as a social institution, whether it is operated as a commercial enterprise, a social program, or some other variant. Ultimately, the disagreement is over whether the benefits of insurance should be distributed according to prior contributions or according to need.

Both sides in this debate try to claim the high ground of equity for their position. They do this by portraying a distributive problem and shifting the definition of what is being distributed and who the recipients are. Clifford and Luculano portray the distributive justice issue as a conflict entirely within the circle of insurance policyholders and buyers:

If the insuring process is to remain fair to other applicants and policyholders, insurers must be permitted to treat tests for infection by the AIDS virus in the same manner as they treat medical tests for other diseases. To ignore the risk levels associated with infection and treat a seropositive individual on the same terms as one not similarly in-
fected would constitute unfair discrimination against non-infected insureds. (At 1811–12)

This formulation implicitly defines equity as a matter of how insurance companies distribute costs of health care or life insurance monies among their policyholders. Fairness requires equal pricing among equal risks (horizontal equity) and different pricing between potentially healthy and potentially sick members of an insurance pool (vertical equity).

From this standpoint inside the circle of policyholders, Clifford and Luculano characterize state laws and regulations prohibiting testing as granting a “favored status” to people with AIDS (at 1815). Here is yet another implicit portrayal of the distributive conflict. This time, what is being distributed are legislative or regulatory exemptions from the norms of medical underwriting. As it happens, they suggest, among groups of people with different diseases or health problems, people with HIV antibodies are the only ones who get an exemption. Clifford and Luculano don’t acknowledge the numerous state laws prohibiting insurance discrimination on the basis of physical and mental handicaps and singling out specific diseases and handicaps (such as genetic traits, exposure to the drug DES, or blindness) for protection.13

Alternative conceptions of the distributive conflict might consider equality of the financial burdens of AIDS between those inside the insurance pool and those left out; among all people who are potentially sick; or among all people who pay for health services in whatever fashion. From the latter vantage point, for example, HIV testing and exclusion from commercial health insurance plans shift the costs of care for AIDS onto public financing mechanisms, which means general revenues, which means taxing everyone who earns income, including members of insurance plans.

Insurers might rightly argue that even under a regime of testing and exclusion, their policyholders still pay for AIDS care through their income taxes. But this formulation raises several difficult questions: Why should AIDS, but not other illnesses, be socially financed? In a mixed public-private system of health insurance coverage, do diseases and populations insured by public programs receive as much and as good treatment as those insured by private programs? And should insurers be the ones to decide, through their medical underwriting policies, which diseases taxpayers will have to finance and which ones private insurers will cover?

There are parallel issues in life insurance. Insurers have decided that certain diseases render people ineligible for life insurance coverage. These

13. In a footnote, Clifford and Luculano recognize that there are laws prohibiting use of sickle-cell trait in actuarial rating. But they use the footnote to explain that the sickle-cell trait doesn’t usually increase the risk of illness or death, and so they feel justified in dismissing these laws as irrelevant.
generally include diabetes, leukemia, schizophrenia, emphysema, uncontrolled hypertension, coronary artery disease, and now AIDS. The rationale for excluding people with these diseases from life insurance is that they have a very high probability of early death. If they die prematurely, they would not have paid enough premiums to cover the losses they would generate, unless the insurer could charge them such high rates that the insurance would hardly be affordable. From inside the circle of policyholders of any one insurance company, it looks quite fair to keep such people out.

Things look rather different outside the circle, however, from the vantage points of people who have these diseases or might get one of them. What distinguishes the people with these particular diseases is that they have something scientists and insurers have recognized as leading to early death. But everyone is in some sense a living bundle of risk factors. We all have a multitude of characteristics that are or could be associated with illness or premature death—things such as our socioeconomic status, race, gender, education level, place of residence, family status, type of work, degree of happiness, driving habits, and who knows what else. Scientists have investigated only some of these factors, and insurers have chosen to use only some of them. Many people have risk factors that science hasn’t yet recognized or that insurers simply ignore. People with recognized risk factors are in effect penalized for our scientific knowledge. From a Rawlsian perspective, that is, standing behind a veil of ignorance before the formation of the social contract, people would probably not choose rules that arbitrarily penalize those who fall ill with the diseases science comes to understand first.

People who have diseases with a high risk of early death are distinguished in another way. To the extent they have dependents, they need life insurance all the more as a means of continuing the well-being of those for whom they provide. From a societal perspective, the people who need life insurance the most are precisely the ones commercial life insurance companies find it economically necessary and fair to exclude. Thus, vantage point makes all the difference in assessing fairness.

The last argument put forth by Clifford and Iuculano (and all defenders of medical underwriting) is that exclusion of people with very high risks of illness or death is absolutely crucial for the fiscal solvency of insurance firms. People who test positive for HIV antibodies have a risk of dying that is tremendously higher than average. Of 1,000 people who test positive for AIDS antibodies, about 200 will die within 7 years, as compared with only about 7 in a group of 1,000 people with “standard” health risks (at 1814). People whose risks are so out of proportion to the average are labeled “medically uninsurable,” or simply “uninsurable.” If firms are

forced to insure people with such overwhelmingly greater risks, they will be unable to pay all claims for other policyholders, and the financial stability of the entire industry will be jeopardized.

Leaving aside the accuracy of the numbers (because they are scientific guesses that are changing monthly), but granting that there is some relatively large difference in mortality between the two populations, let us look at the strategic functions of the solvency argument. It portrays a political conflict between an indivisible, holistic value on one side and divisible, discrete values on the other. On one side is survival of an industry—not merely economic loss but continuation of its very existence. On the other side are measurable economic hardships for individuals who might suffer from AIDS. Oversimplifying just a bit, this is a contest between life (the insurance industry's) and dollars, and between a collective enterprise and individual troubles.

This is a standard form of political argument (and Schatz, we will see, uses it as well). One casts the conflict so that one's favored policy represents a principle or a value that must stand as an all-or-nothing proposition. The opponents' policy is cast as something that merely satisfies accumulation of more benefits or fewer harms. In such a contest, principle (or life) always seems more compelling than divisible units.

The problem of the extraordinarily high risk of people who test positive is complicated by the more subtle problem of "adverse selection." This means that people are especially prone to buy insurance against some condition they know they have or are likely to encounter. People who know they test positive for HIV antibodies, so the argument goes, are more likely to purchase life and health insurance as soon as they discover their antibody status. Since insurers are essentially gambling when they write policies, they are at a disadvantage if applicants know something they don't know—particularly if applicants know they have higher than average risks for the thing they are insuring against.

The adverse-selection argument serves to cast moral doubt on people with high risk for AIDS, the people insurers would exclude from their risk pools. Something of an unspoken assumption exists that people who behave in this way are cheating. Clifford and Iuculano say that people who believe they have been infected with the AIDS virus are likely to "misrepresent" their health history to insurers (at 1819), and adverse selection, in turn, "not only endangers the financial stability of insurance companies but also unfairly burdens the other policyholders who must support the increased claims through higher premiums" (at 1817). Thus, people who buy insurance knowing they test positive or even knowing simply that they are at high risk for AIDS are portrayed as social parasites.

Insurers describe adverse selection as if it were a classic free-rider problem, wherein individuals selfishly refrain from paying for a common
good (insurance), knowing that it will be supplied anyway and they will be able to use it. But two aspects of insurance markets would seem to undermine the free-rider charge. First, since life insurance is something one buys to provide for others, the act of buying insurance upon learning one is in danger of severe illness and death is not necessarily to be regarded as selfish. Second, individual strategies to obtain medical care or financial security are strongly influenced and constrained by the rules and policies of hospitals, insurance companies, employers, and tax law. Without a system of universal health insurance, we have no mechanism by which many healthy people—even working people—can affordably contribute to insurance even if they want to.

Clifford and Iuculano recognize that somebody ought to provide health insurance for people at high risk of AIDS, or as they put it more generally, people who are "medically uninsurable." (Since insurability is not a natural property of individuals, but rather a policy decision by insurers, Clifford and Iuculano are really saying that somebody ought to pay the bill for the people insurers choose not to cover.) Not surprisingly, they reject any legislation or regulation that would prohibit their use of HIV antibody testing or, in their words, "force insurers to discard the underwriting process" (at 1822).

Instead, they propose that the industry continue its underwriting practices but that states form "high-risk pools" to cover all the people insurance companies refuse to insure—a solution that has in fact been tried in some 15 states. Because the people in these pools are by definition (or assumption) at high risk for disease, they pay up to twice the usual rate; since the payments do not cover the actuarial value of their expected losses, the pools run at a loss. Insurance companies are then assessed to subsidize the pools, based on their pro rata share of business in the state. Clifford and Iuculano see this solution as a potential threat to the insurance industry, however. Because of a provision in the Employee Retirement and Security Act of 1974 (ERISA), employers who self-insure cannot be required to contribute to these pools. Thus, if states form pools and levy contributions from insurance companies, employers will have even more incentive to self-insure so that they and their employees need not contribute to the costs of caring for people with poor health. The number of people insured through commercial insurance will diminish. In the end, therefore, Clifford and Iuculano call for federal legislation that would offer tax incentives for states to form high-risk pools and that would tax employers who do not voluntarily participate in the pools.

THE ARGUMENT AGAINST TESTING

Schatz makes a strong argument for prohibiting insurers from pricing
their policies or selecting applicants on the basis of either sexual orientation or HIV testing. In contrast to the scientific posture of Clifford and Iuculano, Schatz takes a frankly moral stance. Excluding people with HIV antibodies from insurance only adds to historical discrimination against homosexuals, and discrimination is wrong. He also makes a utilitarian argument. The harms to society from testing are worse than the harms to insurers from not testing.

Schatz first presents evidence that insurance companies use sexual orientation as a proxy for AIDS risk. The evidence is based on assorted memoranda and underwriting guidelines issued by insurers, and on reports to the National Gay Rights Advocates by people who have been denied insurance. One company requested its agents to separate applications from “single males without dependents [who] are engaged in occupations that do not require physical exertion” (at 1787). Such occupations included those who worked as interior decorators, florists, fashion designers, restaurant employees, and antique dealers. Other guidelines singled out unmarried males who designated someone other than a spouse or child as beneficiary of their policies. Others use “living arrangements,” residence zip codes (presumably singling out neighborhoods with high concentrations of gays), and promiscuous lifestyles (at 1787) to imply sexual orientation.

Exclusion of people from insurance on the basis of sexual orientation has several bad side effects, according to Schatz. It can lead to employment discrimination, denial of mortgages and other forms of credit (because lenders often require life insurance on the loan holder), and increased costs for other medical assistance programs. It can drive the gay community underground, and it might possibly induce people to conceal or deny their high-risk status rather than take precautionary measures with their sex partners.

Yet for all these harsh consequences for individuals and for collective enterprises (such as gay communities or medical assistance programs), Schatz is clear that “the most powerful argument against the denial of insurance to gay and bisexual men is a moral one” (at 1788). Stereotyping is wrong, and “to decline coverage to an entire social class because a small percentage of its members are likely to develop a disease represents stereotyping at its worst” (at 1788, emphasis added). This is the crux of Schatz’s argument. It goes to the question of whether all overgeneralization is in fact stereotyping or what we mean by stereotyping when we use the term pejoratively and assume that Americans share a basic ideological commitment to eradicating it.

Schatz does not engage this question. Instead, he argues metaphorically, likening this situation to “religious, racial, and gender discrimination” and citing examples of differential treatment of Jews, blacks, and
women by insurance companies (at 1788). The metaphor—likening gays to Jews, blacks, and women—is a useful form of argument here because it creates political alliances. It places gays inside a figurative circle with other groups who, though not the most powerful in American politics, have had their claims of discrimination accepted to a large extent by the dominant political institutions. Treating people on the basis of their sexual orientation is often pernicious, but, still, Schatz hasn’t argued the case. He has leapt there from the simple fact of overgeneralization.

Of course, a long history of civil rights jurisprudence has as its central preoccupation the question of when laws that overgeneralize are legitimate and permissible, and when they are not. All policymaking requires rules and classifications that almost inevitably overgeneralize, and the commercial insurance industry is one that operates to a particularly large extent on making predictive generalizations and classifications. It is perhaps unfair to expect anyone writing an article on insurance to undertake a full analysis of sexual-orientation discrimination, and yet, the question of what kinds of overgeneralization ought to be prohibited is so central to the insurance debate that one’s persuasiveness will depend in large measure on how sharply one analyzes that question. By what criteria does one judge that a principle of classification (or generalization) is fair?

By focusing on sexual-orientation discrimination, Schatz has reduced the problem of HIV testing to one group among the larger population of people with AIDS or people who might become sick with AIDS. The discrimination analysis ignores all the people who have AIDS or are at high risk for AIDS who are not homosexuals—about 30% of all reported cases. Among these are heterosexual drug abusers, hemophiliacs and other recipients of blood transfusions, and children. Alternative conceptions of equity might require that they be given access to health and life insurance, but the analysis based on overgeneralization about homosexuality has nothing to say about them. Like the insurance industry’s analysis, the discrimination analysis considers fairness from the vantage point of a particular group—in this case, homosexual men.

Schatz notes that both the Health Insurance Association of America and the American Council of Life Insurers have formally opposed the use

15. The point is argued quite compellingly by Elvia Rosales Arriola, “Sexuality and the Constitution,” 10 Women’s Rts. L. Rep., 143 (1988) (arguing that sexual orientation/sexual preference should be considered a suspect class for purposes of fourteenth amendment jurisprudence).

16. Barbara Underwood addresses exactly this question in “Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment,” 88 Yale L.J. 1408 (1979). She winds up in the same place as Schatz—that is, finding acceptable those classifications based on voluntary or controllable behavior—but she gives a more thorough defense of the position.

of sexual orientation in insurance underwriting. He suggests that the industry’s readiness to do this—despite practices to the contrary—is because sexual orientation is relatively hard to determine, and the industry naturally prefers underwriting factors that are easy to identify, inexpensive to administer, and clearly predictive (at 1791). But even if insurers could determine sexual orientation relatively easily and wanted to use it in their underwriting, they should not be allowed to do so. “The essential question,” he says, “remains whether insurers should be allowed to use the claim of ‘economic necessity’ to exempt themselves from the prohibitions against discrimination that are imposed on the rest of society” (at 1791, emphasis added). Again Schatz makes the analogy to Jews, blacks, and women by noting that insurers have been prohibited from using race as an underwriting factor and that “courts have refused to allow employers and landlords to discriminate against blacks, Jews, women, and others, even though the prejudice of neighbors, customers or coworkers makes a policy of non-discrimination more costly” (at 1791).

Schatz’s strategy here is to set up an implicit test of equity. Why should insurers not be treated like other business enterprises in the United States with respect to their ability to engage in discrimination? In other words, as government distributes various burdens and privileges related to doing business, insurers—among all classes of business enterprises—have received relief from one type of burden (restrictions on discriminatory behavior and rules). Thus, Schatz has flipped the “favored-status” argument of his opponents. Clifford and Iuculano portray people with AIDS as having favored status vis-à-vis other policyholders were HIV testing to be prohibited. Schatz instead paints the insurance industry as having favored status vis-à-vis other business enterprises were AIDS testing to be permitted.

Schatz also speaks to the industry’s fiscal-solvency argument. Insurers’ main reason for resisting state legislative bans on AIDS testing is economic. Without testing, their business would be financially unstable. Schatz maintains that the industry has used inflated estimates for the cost of medical care for AIDS patients. Moreover, insurers could use other strategies to reduce their AIDS costs, such as asking questions about AIDS symptoms on health history questionnaires and promoting and paying for care in places other than hospitals.

In fact, Schatz could make much more of a point that is only implicit in his suggestion for nonhospital-based care. Assessments of industry viability will vary depending on whether one takes the current institutional structure of providing for health and financial security as fixed. For example, estimates of the annual costs of medical care for a person with AIDS were reduced from $147,000 to about $28,000 when researchers considered using much less costly home- and community-based services rather
than in-hospital services.\textsuperscript{18} Arguments on grounds of efficiency (or the bottom line) should always be unpacked in this way. Efficiency is not an objective standard, but one that necessarily assumes some institutional structure of production—usually the status quo. Thus, one might argue that the fiscal condition of insurers would not be jeopardized were they to act as agents of reform, creating financial incentives for the development of home- and community-based care.

Whatever the merits of Schatz's arguments about the fiscal viability of the health insurers without HIV antibody tests, they ignore the whole area of life insurance, where the stakes for the industry are higher and where underwriting affects almost 60\% of the market. What about the adverse-selection problem? Here, too, one might note that institutional rules shape individual perceptions and behavior. Many people might not feel a need for life insurance if they did not have to deplete their estates in order to procure health care. People at high risk of AIDS with no health insurance coverage can expect to use most of their assets for medical care should they become sick. Moreover, the eligibility rules for Medicaid (which now pays the medical bills for about 40\% of all people with AIDS) and Social Security's Supplemental Security Income (a route into Medicaid for someone with AIDS) require that people have assets of less than about two thousand dollars. For people at high risk of AIDS with dependents but no health insurance, life insurance is the only way to leave some assets for their dependents.

Rather than exploring these institutional parameters of insurance, Schatz’s main strategy in dealing with the fiscal-solvency argument is to cast the testing issue as a contest between principle and divisible units. Of course, he reverses the terms so that a prohibition on testing now represents principle. The principle for Schatz (and for most authors who defend the same policy position from a gay rights perspective) is nondiscrimination. Widespread insurance requirements for HIV testing would probably exacerbate existing discrimination against homosexuals. Gay, or putatively gay, men might be required to undergo antibody testing more frequently than other applicants. The results of HIV tests, hard to keep confidential, would probably lead to discrimination in other contexts, such as employment and housing.

Counterpoised with the principle of nondiscrimination are dollar losses to one industry, and even the value of those losses is disputed. When the contest is cast in this way, principle, of course, must trump. According to the dominant American ideology, equal protection of the laws is not to be mitigated by monetary costs. To allow insurers to test for

HIV antibodies would be to allow fundamental constitutional (and moral) rights to be counterbalanced and diminished by economic claims.

Beyond the fiscal-solvency argument, insurers claim that a ban on HIV testing would give special treatment to one class of applicants and would be unfair to people with high risk of heart disease, stroke, and other risks that insurers are permitted to measure. Schatz rightly notes that a ban on HIV testing would not constitute special treatment in the sense of being unique treatment, because there are already legislative bans on insurance testing for other risk factors, such as sickle-cell trait, exposure to DES, and Tay-Sachs carriers. To put this conflict in the language of equity, insurers portray a distribution of legislative protections among all potential disease carriers in which one type of disease is singled out for more favorable treatment; only potential AIDS carriers get a legislative protection. Schatz portrays the distribution of legislative protections as one in which a few, but not all, types of potential disease carriers receive legislative protection. From a broader perspective, both distributions could appear inequitable. One distributes privilege to a single disease group, the other distributes it to a few groups, but neither distributes it broadly among the many.

Schatz has an answer to this dilemma. Why is it equitable to grant legislative protections to some types of diseases but not to others? Because, he says, some risk factors for disease are things the individual can control, and some are not. According to Schatz, high blood pressure, obesity, blood-cholesterol levels, and smoking (risk factors for stroke, heart disease, and lung cancer that are commonly tested by insurers) are all within individual power to eliminate. Using them as underwriting factors may therefore be "motivating" and "medically constructive" (at 1798). Schatz thus establishes categories of "deserving" and "undeserving" risk groups to legitimize the differential distribution of legislative protection.

This conception of equity has important consequences for political alliances. Schatz's argument creates a division between diseases considered immutable and those considered controllable, and he has placed AIDS within the immutable set. This moral map of the world of disease would leave people in the risk groups for heart disease, stroke, and lung cancer to fend for themselves in the insurance market, while people in the risk groups for immutable diseases would join together to fight against underwriting for "their" diseases. That may be a short-sighted political strategy.

For one thing, immutability is always a socially contested concept. Whether and to what degree humans have voluntary control over their problems is a key issue in the definition of policy problems, and once a problem is on the agenda of public discussion, fights over interpretations of its causation are inevitable. Such contests over causal stories are already very much in evidence with AIDS. There is a great deal of public belief and
assertion that people with AIDS "get it" because of their irresponsible, promiscuous, or illegal behavior. Disputes rage, too, over whether being homosexual is a voluntary or immutable condition. And even the levels of different types of immune cells in the body may be subject to some degree of voluntary control. Thus, the mantle of immutability is not the impenetrable shield Schatz might think.

For another thing, the number of people in the risk groups for heart disease, stroke, and cancer is enormous, if we are to believe the public health literature. These people have already been mobilized, or at least had their consciousness raised, by public health campaigns against these diseases. And they probably far outnumber those in the risk groups for diseases that have managed to hang on to the aura of immutability. Thus, for the gay rights movement to espouse a conception of equity that abandons these people as potential allies would seem politically naive. Schatz seems to have an inkling of this political potential when he says that the insurance industry's real fear "is not that those at coronary risk will want others to be rejected from insurance pools but rather that they will lobby to be insured as well" (at 1798); but he doesn't make the connection that these industry fears could be translated into political alliances.

Schatz concludes that the primary responsibility for paying for AIDS-related medical expenses should fall on the insurance industry because insurers have the ability to spread the costs more evenly. If AIDS care is not financed through increased health insurance premiums in the private sector, then costs in the public sector must increase; perhaps more importantly for considerations of equity, costs will fall disproportionately on a few cities and states. Ultimately, he argues, "the problems inherent in a privately underwritten insurance system . . . point to the need for some form of guaranteed health insurance for all Americans" (at 1805).

WHAT'S MISSING?

The institutional players in this debate control the discourse in ways that conceal or leave unexplored the enduring choices about moral economy embedded in the very concept of insurance. Each tells a compelling story about insurance and HIV testing. But on close examination, it becomes evident that the stories gain their persuasiveness largely by restricting their vantage points. The industry tells its story from the vantage point of policyholders who are already inside the circle of industry custom-
ers. This in itself is a subtle device, because the industry appears to be defending not its own profitability, but instead, the equity and cost concerns of its customers—ordinary people. The gay rights movement tells its story from the vantage point of homosexuals, including people who are categorized on the basis of putative sexual orientation and people whose exposure to the AIDS virus probably came through homosexual encounters. Just as the insurance industry attempts to make its interests seem congruent with those of a broad mass of ordinary people (its customers), the gay rights movement tries to identify itself with a broader constituency of people who have been discriminated against on the basis of immutable traits.

Restricted vantage points contribute to the persuasiveness of a story by giving it coherence. But they also create a certain reductionism in policy analysis. They take as problematic only some features of a phenomenon, and they necessarily ignore aspects of a problem that are not visible from their own viewpoint. Thus, Clifford and Iuculano define the problem of HIV testing as allocation of costs among policyholders but not as allocation of costs among all members of society who pay, in one form or another, for social aid. 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.

Selection of viewpoint is probably the most important instrument of rhetorical control in policy argument, but the following devices also enhance this control:

1. Social choices are presented as if they were natural laws or basic principles. Insurers use the mantle of expertise (actuarial science) to belittle opinions of those who disagree with these choices. Gay rights advocates use the mantle of moral authority in the same fashion.
2. The correctness of one choice is made to seem obvious by ignoring the multiple and often competing goals that insurance is meant to serve.
3. One choice is made to seem necessary by ignoring or obscuring elements of existing institutional arrangements that could be changed to enable new choices.
4. Both sides invoke equity, one of the bedrock values of American political discourse, to legitimate their positions. Each side claims that its policy position maximizes societal equity. However, they each "prove" the equitable nature of their policy solutions by selecting different definitions of what is being distributed.
5. Each side casts the issue as a contest between an all-or-nothing principle and a set of divisible, incremental entities, and each side draws the issue so that its favored policy solution represents principle.

In their struggle to control the representation of the issue, the two sides are so concerned with making their preferred policy seem necessary
and obvious that they ignore broader societal choices. One set of choices has to do with the degree of redistribution built into any insurance system. There is a central tension in all insurance programs between risk pooling on the one hand and actuarial rating on the other.

I have already noted the risk-pooling character of insurance. The collectivization of both savings and risks is necessarily redistributive. At the same time, insurance is to some extent always risk dividing. Rules and policies of individual programs or companies determine that not all risks in a community will be shared. For example, deaths due to suicide are usually excluded in life insurance policies, and particular diseases may be excluded from health insurance policies. The principle that “each insured [person] will pay in accordance with the quality of his risk” (Clifford & Iuculano at 1810) is called actuarial rating. Predictive tests such as the AIDS antibody test enable an insurer to estimate “the quality” of a person’s risk. With enough predictive tests of sufficient accuracy, insurers could virtually eliminate risk sharing and redistribution. In other words, if actuarial rating could be carried out perfectly, insurance would lose its redistributive character. And to the extent that premiums for an insurance program are actuarially rated, redistribution is diminished.

Given this inescapable tension between redistribution and cost allocation, the institution of insurance is more like a literary symbol with contradictory metaphorical meanings than like a science founded on laws or principles, as insurers would like it. With regard to its actuarial rating features, insurance is like private savings accounts. With regard to its needs-tested payout features, insurance is like public assistance. Theorists, policy planners, and advocates can emphasize either side of the symbol of insurance, and they can then declare that insurance “requires” either more redistribution or more actuarial pricing. They can also promote insurance schemes to legislators and the public by emphasizing the compensation aspect of insurance more than the pricing features.

The arguments put forth by Clifford and Iuculano emphasize the risk-dividing aspect of insurance and downplay its redistributive purposes. While commercial insurance (whose companies these authors represent in their institutional capacities) is in fact far less redistributive than social insurance (such as Social Security or Medicaid), no law or principle dictates where an insurance company must be located on the spectrum from perfect actuarial rating to maximum redistribution. Those are policy choices of individual companies, influenced of course by their perceptions of the competitive environment in which they operate, and by the requirements that regulatory bodies impose on them.

A second set of societal choices concerns whether government ought to have any say over where on the redistributive spectrum private-sector companies choose to operate. The struggle over state laws to prohibit HIV
testing (or any other kind of medical underwriting in insurance) is as much a fight over who should control industry policy as over the specifics of what kinds of risk factors can be used in insurance decisions. Ultimately, the industry argues that it cannot operate efficiently, and perhaps even at all, if it is burdened with all kinds of social objectives. (This is a familiar argument, typical of all industries seeking to resist public regulation.)

The argument might be persuasive in a world with a wall between the public and private sectors. But such a world does not exist. Private and public forms of social aid are intimately entwined. Whatever people or troubles commercial and employment-based policies do not cover will find their way into the public sector. There will be political pressure to fund these needs in public insurance programs, just as there is currently pressure to provide long-term care benefits for the elderly. If public programs accept these problems as part of their responsibility, the costs will be diffused onto (but paid nonetheless by) taxpayers, workers and employers, or program beneficiaries, depending on how financing is arranged.

If public insurance programs do not accept these problems, the people who bear them will wind up on the streets, on public assistance rolls, on the doorsteps of voluntary agencies, or on all three. The question, then, is whether the government social-protection sector will be a residual of private-sector actions, or vice-versa. If government takes a completely laissez-faire stance toward the underwriting practices of private insurers, then government will in fact insure or otherwise pay for the needs of those whom private insurers reject.

Here, a third set of choices becomes evident—the choice of risk factors an insurer uses to select applicants. The choice is not neutral; it defines the set of people who are excluded from the better coverage of private programs. Nor does epidemiology or medical science dictate the choice. There are probably an infinite number of risk factors for disease and premature death. Insurers' choices are influenced by their ability to collect data on various risk factors, by societal attitudes and beliefs about causes of illness and death, by moral attitudes about fault and innocence, and by political constraints that regulators and legislators impose.

Insurers would have us believe that actuarial soundness dictates their choice of risk factors. Actuarial data—basically the probability that losses will occur among any defined group of people—are treated by insurers as if they were laws of nature. But actuarial soundness means nothing more than business soundness. It means that an insurer should take in at least as much money in premiums and investment income as it expects to spend in claim payouts, operating expenses, and taxes. There are a lot of ways to manipulate that formula, including changing premium amounts, operating expenses, and investment strategies. Nothing about actuarial soundness dictates that an insurer must reject people with a certain risk factor.
The industry's preferred solution of establishing state high-risk pools leaves in place the privilege of insurance companies to use whatever risk factors they wish, to skim off the people who are least likely to become expensively sick, and to shunt others into a public program. This solution would further contribute to the segmentation of insurance pools into ever more homogeneous risk groupings. Those lucky enough to gain entry into a private program would face cheaper premiums because they share their expenses with others who are not very likely to get sick or die early. True, they might face higher income or property taxes to help pay for those who are financed by public programs. But precisely because they have been selected out for the privilege of cheaper and better private insurance, they are not likely to be strong advocates for improved public programs. (Ironically, greater use of actuarial rating in the private sector might create larger public programs, and that in turn might lead to larger and stronger constituencies for public programs and public regulation.)

The argument against HIV testing put forth by legal advocates from the gay rights community is narrow in a different way. Although it calls for commercial insurers to take a more redistributive role, it makes discrimination, not need, the basis for redistribution. It would have government prevent insurers from excluding groups who historically have been victims of societal discrimination. But that line of argument ignores people who are needy but do not fit one of the social groups judicially recognized as victims of discrimination.

Broad risk sharing can best be justified from a broader perspective that takes community as its starting point. Such a justification would begin with a view that the purpose of social aid systems (whether they are private or public) is precisely to distribute according to need. Otherwise, there would be no reason for them at all, since we already have market-distribution systems based on performance, achievement, investment, contribution, and ability to pay.

The difficulty for social policy is how to combine two distributive systems based on absolutely antithetical principles so that they can coexist without undermining each other. Thus, an effective defense of broader risk sharing in insurance has to begin with the acknowledgment that distribution according to need is the central purpose of social protection systems. It must acknowledge that the distinction between private and public social-aid systems is wholly artifice. The selection of people and troubles to be covered by each sector is a matter of conscious policy choice, and the decisions of either sector determine the scope of the other. And finally, it must deal realistically with the incentive effects of need-based distribution, considering individual motivation and behavior in the broader context of incentives created by institutional practices outside each separate insurance program.