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Some Preliminary Thoughts on the Deregulation of Insurance to Advantage the Working Poor

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SOME PRELIMINARY THOUGHTS ON THE DEREGULATION OF INSURANCE TO ADVANTAGE THE WORKING POOR

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Introduction

The regulatory framework in which employee benefits products are marketed and consumed by individuals and groups seeking to reduce exposure to covered events creates a set of background rules. These rules influence the way in which insurance products are developed and impact the number of people who will enjoy the protection these insurance products afford. This means that every proposal to regulate an employment related insurance product likely will affect both the quality and quantity of insurance available to consumers. For example, over the past decade, as the public and professionally-interested parties have grappled with the insurance implications of the AIDS epidemic, the very function of insurance and, in particular, risk classification, has come into question.[1] Risk classification rules and other regulatory initiatives have

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1. Because the focus of today's symposium is healthcare resource allocation, I limit most of my remarks to the market for health insurance products. Much of the discussion, though, is applicable generally to other insurance product lines. Several scholars have examined the effects of risk classification in other insurance markets. For example, Gary Williams has argued that all forms of "territorial rating" (*i.e.*, the classification by automobile insurers of risk based on geographical location) ought to be prohibited by state insurance commissioners on the ground that "[t]erritorial rating has no relationship to individual responsibility. The practice discriminates against people of color and the urban poor, with the anomalous result that those individuals least able to pay are assessed the highest rates for a product that the state requires them to purchase." Gary Williams, *'The Wrong Side of the Tracks': Territorial Rating and the Setting of Automobile Insurance Rates in California*, 19 HASTINGS CONST. L.Q. 845, 907 (1992). Regina Austin has written that the arguments about risk classification reflect the tension between individual mobility and group solidarity. She notes that the arguments "advanced in the controversy reflect the general regulatory debate about the extent to which the law should structure the economic sphere so as to promote either free competition, on the one hand, or social welfare on the other." Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 518 (1983). With respect to life insurance, others have taken the position that equitable considerations require insurers to classify risks and that "[i]nsurers are not concerned with stereotyping individuals on the basis of whim, prejudice or surmise, but rather seek to classify them on the basis of factors with statistically demonstrable relationships to the cost of providing coverage." Herman T. Bailey et al., *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779, 824 (1976).

important implications for everyone, particularly those residing in impoverished urban areas. The optimal regulation of employee benefits, specifically those designed to protect against ill health and its consequences, has enormously important implications for the so-called working poor. In many cases the value to low wage employees of their employee benefits exceeds 15 percent of their total compensation.[2]

This paper examines the important role that various forms of insurance play in the total compensation of low wage employees, focusing in particular on disability and health insurance. Disability and health insurance share a common purpose of protecting employees against ill health and/or the inability to work and generate an income.[3] This paper evaluates the current regulatory regimes in which these welfare plans are provided and considers ways in which meaningful access by the working poor might be enhanced. The working poor, however, are not limited to urban areas, the principal focus of this discussion. Nonetheless, urban environments generally contain large numbers of low wage employees whose often limited access to medical care constitutes a constant concern of policy makers. The normative viewpoint of this paper is

2. *See* SILVERMAN ET AL., EBRI DATABOOK ON EMPLOYEE BENEFITS 18 (3d ed. 1995).

3. With regard to pension plans, it is well documented that few low wage workers have coverage and even fewer elect to participate. Pension participation data is available, *inter alia*, by income, education level, occupation, sex, race, and age. For 1993, only eight percent of those earning under $10,000 annually were participating in a private pension plan. For the $10,000 to $14,999 income group, the rate rose to 27 percent; at $15,000 to 19,999 it rose further to 42 percent. The same trend is at work as education levels increase. In 1988, for example, participation rates were lowest among both males and females with less than 12 years of schooling. The data for participation by occupation are consistent: for the period May 1988 through April 1993, professional, managerial, technical, and administrative support — occupations with relatively high wages — enjoyed high rates (*i.e.*, more than 50 percent) of private pension participation. Service workers, farmers, and laborers all enjoy rates of less than 50 percent. In general, at low income levels, women tend to participate in employer sponsored pensions at higher rates than men. Consistent with their generally lower income, blacks tend to participate in pensions at lower rates than whites. For 1993, full time white workers had an overall rate of 51 percent; for comparable black workers, the figure is 44 percent. Finally, age is positively correlated to pension participation. In general, younger workers earn less than older ones, which probably accounts for some of the participation gap. In 1993, only 21 percent of all workers under the age of 25 participated in a pension plan. Participation peaked at 63 percent for the 45 to 49 year old cohort; after the age of 50, participation rates slowly decline. *See generally*, U.S. DEP'T OF LABOR, PENSION BENEFITS OF AMERICAN WORKERS: NEW FINDINGS FROM THE APRIL 1993 CURRENT POPULATION SURVEY, TABLE B11 (Preview Ed. 1994); *see also*, Virginia P. Reno, *The Role of Pensions in Retirement Income*, *in* PENSIONS IN A CHANGING ECONOMY Table 2.9 (Richard V. Burkhauser & Dallas L. Salisbury, eds., 1993).

as follows: it seeks to understand the ways in which the applicable regulatory framework might be altered to improve access and coverage. In many cases this implies a move away from government regulation and toward a regime that will flexibly meet the needs of the largest number of individuals possible.

I. Some Economics of Insurance

Disability insurance and health insurance should be viewed as devices for protecting employees against bearing the full weight of certain occurrences — such as income loss due to injury in the case of disability coverage and large economic loss due to medical expenses in the case of health insurance. As Kenneth Abraham has noted, insurance serves many functions, most notably risk transfer, risk pooling, and risk allocation.[4] Risk allocation is critical because it is the process of identifying risks and determining appropriate prices for coverage. This process often results in a price structure that makes coverage unaffordable for low wage workers. Thousands of non-employment related temporary and long term disabling injuries affecting low wage workers every year are not compensable via workers' compensation.[5] Employees without private health insurance and disability insurance frequently face the twin crises of income loss and enormous bills for medical care. Only in some cases does a low wage worker with a long term disability (expected to last at least one year) become eligible for wage replacements under the public long term disability program created by the Social Security Act.[6]

Why is it that so many low wage workers go without disability and health insurance coverage? What can be done, given the current constraints (political and otherwise), to enhance access to these products? In order to understand the forces that have coalesced and resulted in unaffordable insurance rates for many, it is critical to examine the market pressures which push insurers to classify risks and the laws which attempt to regulate the way in which the classification process functions. As Abraham and others have noted, insurance is simply a device for distributing the risk of

4. *See generally*, KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 2 (2d ed. 1995).

5. Injuries which are expected to result in a disability of less than six months are normally treated as short term; those expected to last longer (and in any event longer than a year) are generally classified as long term disabilities. I focus on non-employment related injuries because work related injuries are typically the province of workers' compensation insurance programs.

6. 42 U.S.C. § 423 (1994).

loss associated with any covered event.[7] From the point of view of the purchaser, insurance permits a risk averse person to shift the risk of loss from herself to the insurer. The cost of this risk shifting is the premium.[8] Thus, the insured essentially trades a small, certain cost (the premium) for the risk of a large loss. In many respects, insurance is a product like any other. Its price is a function of supply and demand; as its cost rises, demand generally declines.[9] This is critical for our analysis today because for many of the urban working poor, the price of health and disability insurance simply is prohibitive.[10]

In a competitive insurance market, insurers are compelled to engage in risk classification to the extent permitted by law for two reasons. First, the failure to offer competitively priced products will cause an insurer to lose attractive, low risk customers to insurers who price coverage commensurate with underlying risk. The well known Blue Cross example,[11] and the experience of nine-

7. ABRAHAM, *supra* note 4, at 2.

8. Premiums are based on the size and frequency of the insured's expected loss—*i.e.*, the size of the loss multiplied by its probability. An additional charge is added to cover the insurer's administrative expenses.

9. *See generally*, Maria O'Brien Hylton, *Insurance Risk Classifications After McGann: Managing Risk Efficiently in the Shadow of the ADA*, 47 BAYLOR L. REV. 59, 70 (1995).

10. A recent report found that almost one in five American adults went without health insurance during the previous year:

> Forty-five percent of the uninsured had trouble getting health care when they needed it, and more than a third had difficulty paying their medical bills. More uninsured people . . . were reported to a bill collection agency than were given free or discounted care. Even people with insurance weren't fully protected. Eleven percent could not get the medical help they needed; 12 percent had problems footing their bills. The . . . statistics point to "millions of individual crises" in getting and paying for health care.

Health Care: 'Millions of Individual Crises', U.S. NEWS & WORLD REP., Nov. 4, 1996, at 12.

The chart accompanying this story reports that the main reason given for the lack of health insurance by survey respondents was "too expensive" by 55 percent of those polled, followed by "no employer coverage" with 10 percent and "change in jobs" with nine percent. *Id.*

11. In 1933, when Blue Cross was established, premiums were assessed using a community rating standard. That is, premiums were the same for all subscribers in the group without regard to the actual experience of the group. Years later, Blue Cross was forced to switch to experience rating in the face of fierce competition from for-profit insurers which lured away many low-risk customers by classifying them separately and charging a lower premium. Community rating results in a situation in which low-cost (*i.e.*, relatively healthy) customers subsidize high cost customers. In a non-competitive market, this situation can persist indefinitely—the low-cost customers have nowhere else to go. In a competitive market, though, this situation is volatile and ultimately fatal to the practice of community rating.

teenth century "assessment societies" demonstrate this point.[12] Second, adverse selection (which occurs when those who know or expect their losses to be unusually high join an insurance pool in unusually large numbers) drives insurers to classify. Adverse selection is the direct result of consumer self-interest; the corollary is that those who know or expect their losses to be low leave the group or decline to join altogether. Beam and McFadden provide the following examples:

> Employees who are likely to have claims tend to pick benefits that will minimize their out-of-pocket costs. For example, an employee who previously selected a medical expense option [from a cafeteria plan] with a high deductible might switch to a plan with a lower deductible if medical expenses are ongoing. An employee who previously rejected dental insurance is likely to elect this benefit if dental care is anticipated in the near future.[13]

Risk classification can take three basic forms: rating, coverage, and underwriting.[14] Rating, of special interest here, is the practice of assigning different premiums (prices) to different risk categories. Coverage is self evident: an insurer can elect to reduce exposure by reducing the amount of coverage or the number of covered events. Underwriting refers to an insurer's threshold decision about whether to accept a potential customer. For example, an insurer might refuse to underwrite anyone with a history of intravenous drug use as a way of reducing exposure to claims for AIDS and AIDS-related illnesses. Using some combination of these three classification functions, insurers strive to accurately predict risk and to set premium prices competitively.

The other major factors affecting these risk management practices are essentially external — legal constraints imposed by the various state insurance commissioners and legislatures. The Unfair Trade Practices Act ("UPTA"), which was developed by the National Association of Insurance Commissioners ("NAIC") in conjunction with the insurance industry, states that an insurer is

12. For a discussion of the early "assessment societies" and their community rating practices, see Jill Gaulding, *Race, Sex, and Genetic Discrimination in Insurance: What's Fair?*, 80 CORNELL L. REV. 1646 (1995).

13. BURTON T. BEAM & JOHN J. MCFADDEN, EMPLOYEE BENEFITS 412 (4th ed. 1996).

14. *See generally*, Leah Wortham, *Insurance Classification: Too Important to Be Left to the Actuaries*, 19 MICH. J. OF L. REFORM 349, 350 (1986).

prohibited from engaging in an unfair method of competition or deceptive acts or practices.[15] Specifically, the Act prohibits:

> [m]aking or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other terms and conditions or such contract.[16]

Not surprisingly, the challenge in each state has been to determine which specific practices are unfair and which are acceptable — all this in the context of an industry that routinely discriminates in order to compete and avoid adverse selection.

Two competing models of fairness have been advanced in recent decades. Bailey argues that risk classification has at its core differentiation — the separation of good risks from bad — and that this function serves the vital interests of both insurers and the insured. Bailey notes that equity, which is equivalent with "fairness," is not the same as equality:

> The insurance industry has experienced the disastrous results of treating unequals equally — the financial failure of the undifferentiated assessment system in the United States, in part the result of a very human rebellion against treating unequals equally. Working against the insurance industry's movement toward more refined risk classification and more equitable treatment of the insured is a legislative and regulatory trend which would compel a return to the sort of total equality which marked the assessment system in its pure form. If, as we believe, the concept of insurance and its multifaceted economic contributions to our society are worth preserving, this trend must be identified and analyzed. . . . [W]e believe[ ] that the civil rights legislation, constitutional doctrines and substantial portions of the civil rights movement are addressing unfair discrimination, not discrimination per se. Insurers are not concerned with stereotyping individuals on the basis of whim, prejudice or surmise, but rather seek to classify them on the basis of factors with statistically demonstrable relationships to the cost of providing coverage.[17]

This debate has important implications for the task before us: to increase access by working poor people to affordable insurance. The Bailey position suggests, correctly I argue, that the ability of

15. Bailey et al., *supra* note 1, at 782. By 1960, the Unfair Trade Practices Act had been adopted in all 50 states and the District of Columbia.

16. Model Unfair Trade Practices Act § 4(g)(1) (Nat'l Ass'n Ins. Comm'rs 1993).

17. Bailey et al., *supra* note 1, at 823-24.

insurers to offer properly priced products is negatively affected by the push toward a kind of formal equality which has marked the state insurance regulatory regimes for the past forty years. By formal equality, I am suggesting an equality that fails to take into account actuarially based distinctions which are observable in the real world. For example, the prohibition against using race to classify risks, because it is thought to be unfair in some sense, means that insurers cannot offer blacks the life annuity discounts to which they are otherwise entitled. It has been true for many years that whites outlive all other racial groups, including blacks, by as much as six or seven years.[18] This observed statistical difference ought to mean, in a properly functioning market (one without state regulatory interference) that blacks would pay less to purchase a life annuity product, and more for life insurance. The race-neutral tables insurers must now rely on do not permit this practice. Also, as some have suggested, the ban on racial classification appears to have had the perverse effect of reducing the ability of blacks to purchase certain kinds of insurance products. "Insurers who could not charge blacks more for property insurance, for example, chose not to offer insurance in certain [predominantly black] locales."[19] This redlining practice has not been found to violate race discrimination bans, since it relies on classifications other than race. This state of affairs — state regulation aimed at eliminating "unfair discrimination" which makes it harder for the protected group to obtain coverage on any terms — cannot reasonably be described as a success by any measure.

The other model for applying the "unfair discrimination" standard is described by Martin J. Katz as one that is hostile to bigotry or "irrational discrimination."[20] By irrational discrimination, Katz means behavior "generally symptomatic of racial animus [as opposed to] rational discrimination [which] is motivated only by financial concerns."[21] The case for prohibiting classification by race (which is usually extended to include sex and other sensitive categories) is generally made in terms of traditional civil rights rhetoric. In *In re November 14, 1989, Non-Group Rate Filing By Blue Cross and Blue Shield of New Jersey*,[22] the appellate division considered a

18. *See* Gaulding, *supra* note 12, at 1658-59.

19. *Id.* at 1660.

20. *See* Martin J. Katz, *Insurance and the Limits of Rational Discrimination*, 8 YALE L. & POL'Y REV. 436, 436-37 (1990).

21. *Id.* at 437.

22. 571 A.2d. 985 (N.J. Super. Ct. App. Div. 1990).

challenge to the rate increase insurers were permitted to charge for non-group health contracts. The briefs of the amici curiae focused on two issues: the use of a gender risk factor in the new rating model and the demographic focus of the model which would permit demographic location to affect premiums.[23] The NAACP Legal Defense Fund argued that this kind of classification "constitutes effective racial discrimination in violation of constitutional and statutory prescriptions by concentrating the premium burden on African American residents of this state, a majority of whom would by reason of relevant demographics, fall into high risk categories."[24] In other words, the Legal Defense Fund recognized that there are in fact higher costs associated with insuring certain demographic locations; its position was that imposing these additional costs was unfair because demographic location is highly correlated with race. Under a disparate impact-type theory, drawn presumably from analogies with Title VII,[25] the essence of "unfair discrimination" is forcing groups that have traditionally been the object of invidious (or "irrational") discrimination to pay more for insurance, even where the insurer can demonstrate that higher risks exist. Bailey and others would, of course, argue that treating unequals (from an actuarial standpoint) equally results in an equally unfair kind of discrimination against those who are forced to subsidize the coverage of others.[26]

Oddly, this debate is central to the question we are grappling with today, namely, how to expand coverage for health and disability insurance products to low income individuals. The dominant view is the equality model, ascendant since the National Association of Insurance Commissioners. The insurers essentially dropped racial classifications voluntarily in the face of what they thought might be an even harsher response if they waited any longer.[27] The fear that any kind of racial line drawing was somehow suspect appears to have informed the move away from a practice that, at least in some instances, should have resulted in lower insurance prices for racial minorities. I suggest it is time to reevaluate the ban on racial and other "sensitive" classifications, not because so-called "irrational discrimination" has disappeared from the marketplace (I make no such claim), but because a reduction in actuarially use-

23. *See id.* at 989.
24. *Id.* at 990.
25. *See* 42 U.S.C. §2000e to 2000e-17 (1994)
26. *See* Bailey et al., *supra* note 1, at 782-84.
27. *Id.* at 793-94.

ful categories of classifications raises the cost of doing business and reduces the amount of insurance available to certain target groups, namely, racial minorities and high risk consumers. In addition, and as part of this reevaluation of NAIC's regulations, I will suggest that there is an additional culprit: ever expanding state mandates which, in combination with the restraints on risk classification, have further reduced the amount of insurance available to the working poor.

II. The Regulatory Response Reconsidered

The present regulatory regime in which insurers operate is characterized by several important features. First, most of the direct regulation insurers face comes from state legislatures and insurance commissioners, as contemplated by the McCarran-Ferguson Act.[28] McCarran-Ferguson provides in pertinent part: "[T]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."[29] In addition, it states: "[T]he continued regulation and taxation by the several States of the business of insurance is in the public interest, and . . . silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."[30] Finally, the statute provides that "[N]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance."[31] The McCarran-Ferguson deference toward the state role in regulating insurance is unusual and not without its detractors.[32] For our purposes, the important aspect of state regulatory regimes is their growing tendency, since the early 1980s, to impose mandates on insurers who wish to do business within their borders.

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28. 15 U.S.C. §§ 1011-1015 (1994).
29. 15 U.S.C. § 1012(a) (1994).
30. 15 U.S.C. § 1011 (1994).
31. 15 U.S.C. § 1012(b) (1994).
32. *See, e.g.*, Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990); 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 (1992); Frederick Rose, *Congressional Proposals on Insurance Would End Primacy of State Regulation*, WALL ST. J., Aug. 5, 1991, at B4 (describing bills introduced in Senate and House).

An insurance mandate is a directive to include a substantive term of coverage in a group or individual contract. For example, many states require insurers to provide coverage for mental health services, drug addiction, or certain reconstructive surgery procedures. "Mandates typically stipulate that certain benefits be included in a group plan, if one is offered. By making insurance more expensive, minimum coverage rules may price some firms out of the insurance market."[33] Mandates have proliferated over the past fifteen years for a variety of reasons described below. At the same time the number of workers whose employers cannot offer them health insurance coverage has also increased dramatically. The two phenomena are related.

A. The Politics of State Mandates

There are several now-standard explanations for the growth in state mandates. First, legislators are often attracted to the mandate device because, unlike other decisions to provide voters with a new service, mandates are "free" from the legislature's point of view in that they do not entail hard decisions with respect to raising taxes. A legislature can create the illusion of additional services while avoiding the usual hard choices that accompany any such decision.[34] The second explanation is the "public interest rationale" and it is put forth by the regulators as a justification for their interference in the market for insurance. Legislators argue that insurers and purchasers may unknowingly undervalue the benefits of some type of care, such as chemical dependency treatment, resulting in a demand for coverage which is "too low" from a societal perspective. "[W]ithout mandates adverse selection might occur which drives up employers' cost of particular coverages . . . . [A]dverse selection creates a market shortcoming, which a mandate may be partially able to correct."[35] Finally, the third, and possibly most cynical, explanation for the legislatures' enthusiasm for mandates is that they have the effect of reducing state expenditures by shifting these costs onto private employers. Mental health mandates provide the best example. Consider the case of a severely depressed or suicidal individual without mental health insurance benefits. If she would normally receive treatment at a state hospital at tax-

33. Gail A. Jensen & Jon R. Gabel, *State Mandated Benefits and the Small Firm's Decision to Offer Insurance*, 4 J. REG. ECON. 379, 380 (1992).

34. *See generally* Samuel Peltzman, *Toward a More General Theory of Regulation*, 19 J.L. & ECON. 211 (1976).

35. Jensen & Gabel, *supra* note 33, at 380.

payer expense, the legislature can shift these costs onto her private employer simply by mandating these benefits in contracts for private group insurance.

Probably each of these three explanations partially accounts for the explosive growth in state mandates. From 1979 to 1989, for example, the number of state mandates more than doubled.[36] As one might expect, the growth in mandates has not escaped the attention of both insurers and employers who purchase the large group coverage contracts for their employees. Jensen and Gabel's recent study of state mandates found that for 1985, 19 percent of noncoverage was directly attributable to state mandates; a mere three years later, mandates explained an incredible 43 percent of noncoverage in 1988.[37] What are employers doing? It appears that some are self-insuring (an ERISA[38]-sanctioned device that allows them to circumvent all state regulation). Others are dropping health insurance as an employee benefit altogether.

Thus, whatever the intentions of state regulators (honorable or otherwise), the effect of this push toward increased regulation of the markets for insurance has been a dramatic reduction in the amount of employer sponsored insurance available to employees.[39] The failure of an employer to offer health and/or disability insurance does not always mean, of course, that the employee does without.[40] Well-compensated employees and independent contrac-

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36. *Id.*

37. *Id.* at 396.

38. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 29 U.S.C.).

39. As many have noted, the increase in state mandates has been accompanied by a move toward the formation of ERISA risk retention plans by employers large enough to make self insurance attractive. Small employers, though, have no choice but to purchase the more expensive group contracts with their attendant mandates or to forego offering coverage altogether. As Jensen and Gabel note, many are electing to forego coverage. *See generally* Jensen & Gabel, *supra* note 33.

40. Although, in many cases employees who do not have access to group coverage do go without. A recent study by economists at the Federal Reserve Bank of Boston which looked at the reasons for the decline in the savings rate from 8 percent of personal income in 1977 to less than 4 percent today concluded that increased consumption has eaten into savings, in particular consumption of medical services which has risen to 13 percent of personal income from 7 percent in the mid-1990s. This figure includes direct payments by consumers and expenditures on their behalf by private insurance plans and government programs such as Medicaid and Medicare. The problem with this increase in medical services consumption is that employees have little control over that portion which they "consume" in the form of employer contributions to health insurance. Lynn Elaine Brown & Joshua Gleason, *The Saving Mystery, or Where did the Money Go?*, NEW ENG. ECON. REV., Sept.-Oct. 1996, at 15.

> [T]he bottom line is that the answer to the question—where did the saving go?—is medical care. Rising expenditures on medical services are absorbing

tors and consultants typically have the resources to purchase their own contracts for coverage. Low wage employees, however, often do not have disposable income sufficient to enable them to afford typically high priced individual contracts.[41] These individuals are the focus of our symposium today. The conclusion that state mandates have directly and negatively affected their ability to obtain employer sponsored insurance is unavoidable.

B. Specific Proposals

The other salient feature of the regulatory climate for insurance over the last few decades has been the move — inspired by developments in civil rights law — away from unfettered risk classification. Unfortunately for low wage workers seeking access to affordable insurance products, this trend has had the same general effect (a reduction in the amount of insurance available) as the increase in state mandates. Together, the two have created a regulatory climate that is at best indifferent, and at worst outright hostile, to the insurance needs of the working poor.

The case for deregulating the risk classification process necessarily entails an attack on the values articulated in landmark decisions like *City of Los Angeles Dep't of Water and Power v. Manhart*[42] and the making of a conscious distinction between decisions motivated

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> a growing fraction of income. Thus, the saving problem is not about thrift versus profligacy, good versus bad; rather, it is a competition between two "goods"—more and better medical care, on the one hand, and more investment, on the other.

Id. at 25.

41. For a discussion of the reasons why group coverage is less expensive *per capita* than individual coverage, see Mark A. Hall, *The Role of Insurance Purchasing Cooperatives in Health Care Reform*, 3 KAN. J.L. & PUB. POL'Y 95, 98 (1993-94). As I have noted in a previous work:

> Employers with relatively small numbers of employees face special pricing problems when they enter the market and attempt to purchase insurance. Health insurance, for example, is considerably more costly for small groups and individuals than for large employers. This is because small group per-enrollee marketing costs are higher (a large, one-time fee to cover the cost of marketing the plan to an employer must be divided among fewer group members); small groups probably have less ability to bargain for advantageous rates; and the small group risk pool is smaller, which requires higher premium rates. Concerns about possible adverse selection effects are more pronounced in small groups as well.

Maria O'Brien Hylton, *Insurance Risk Classification After McGann: Managing Risk Efficiently In the Shadow of the ADA*, 47 BAYLOR L. REV. 59, 71 (1995).

42. 435 U.S. 702 (1978) (concluding that the use of gender-based actuarial tables in an employer-sponsored pension plan violates the Title VII prohibition against sex discrimination).

by bigotry and racial animus and the neutral use of racial characteristics to identify actuarially-significant distinctions. This is not an easy task given the nearly hysterical reaction that discussions of categorizations by race and sex generate. In spite of these certain difficulties, though, it is probably a worthy task in light of the obvious need for changes in the regulatory regime to address the substantial coverage gap affecting so many. Toward that end, I recommend two proposals for regulatory reform: first, discourage state mandates and second, permit explicit use of race and other sensitive risk classifications.

The case for limiting (or severely cutting back if this were politically feasible) the volume of state mandates is the easier case to make. It has come as no surprise to ERISA specialists to learn that employers, faced with mounting costs which are a function of both increases in the consumption and quality of medical care and insurers' obligations to meet growing state mandates, increasingly look to control or reduce health insurance expenses. The movement toward self-insurance is directly related to the intensified, micromanagement that the mandates imply. Mandates mean that insurers have lost their traditional flexibility to fashion an insurance product that meets the needs of an employer and its employees. By requiring coverage for conditions which may or may not be of value to group members, mandates have increased the costs of providing this one-size-fits-all coverage and reduced the amount of coverage being purchased by employers. In most states an employer cannot elect to purchase a basic, stripped down group health plan at moderate cost. Faced with the choice of forming a risk retention pool or dropping the benefit, those employers, which can afford to do so, self-insure. Those which are too small for self-insurance to be an attractive option simply drop coverage.

Jensen and Gabel's data, while stark, is not surprising. Policymakers must confront the choices before them: continued reliance on mandates will only result in further reductions in coverage. This is directly at odds with the stated goals of virtually everyone who purports to be concerned about the estimated 40 million or so uninsured persons in the United States. Backing away from mandates will mean, of course, that some people will find that particular medical conditions are not covered by their insurance. The question is one of breadth versus depth. Mandates provide for contracts with tremendous depth, but only for a limited portion of the population. Greater breadth of coverage could be achieved by

permitting less depth and allowing employers and insurers to figure out how much basic coverage they can afford at a given price.

The case for permitting the unfettered practice of risk classification, especially when it involves the "sensitive" categories of race and sex, is more challenging because of the deep suspicion these classifications rightly engender. No reasonable person could deny the pernicious history of irrational discrimination and, indeed, its lingering influence on American society. It would be a mistake though to let this history preclude even a preliminary consideration of the benefits that risk classification confer generally. Few would quibble with the notion that people who engage in risky behavior ought to see that risk reflected in the cost of any insurance coverage they may seek to obtain. Risk loving teenage males who want automobile insurance, smokers who want health insurance, and owners of real estate with a history of suspicious arson claims on previous dwellings who want homeowners insurance all are subject to risk classification procedures that either result in relatively higher premiums, outright exclusion, or reduced coverage. Most are comfortable with these outcomes, assuming the underlying actuarial data properly justifies them.

Separating the smokers from the non-smokers, or the risk lovers from the risk averse is, in essence, no different from separating out women from men or blacks from whites, again assuming the data support these classifications.[43] There is no stigma associated with being, for example, black or Hispanic and thereby belonging to a group which tends to have a lower life expectancy than whites.[44] It is the simple fact of a distinction in life expectancy that concerns the insurer.[45] The insurer is emphatically unconcerned with why the distinction exists or who is to blame for it. These inquiries might well implicate the effects of irrational discrimination. The insurer simply seeks to incorporate this demonstrable fact into its calculations in order to offer the fairest possible premium price,

43. The Americans With Disabilities Act, 42 U.S.C. §§ 12101-12213 (1994), prohibits discrimination "against a qualified individual with a disability because of the disability in regard [to] employee compensation [and] other terms, conditions, and privileges of employment." 42 U.S.C. §12112(a). So long as an employee or plan sponsor does not use risk classification as a "subterfuge to avoid the purposes of" the Act, it is free to establish a bona fide plan and classify risks. 42 U.S.C. §12201.

44. The distinction does not even have any personal predictive power, in that no particular member of any of these groups can say anything definitive about their own life expectancy absent an intention to commit suicide or a diagnosis of terminal illness.

45. *See* Bailey et al., *supra* note 1, at 823-27.

i.e., one that accurately reflects the likelihood and size of an expected loss.

Some have suggested that unisex annuity tables of the sort at issue in *Manhart*[46] or uni-racial tables have the advantage of shifting the focus away from the inappropriate subjects of race and sex. This may be true in the context of public accommodations and employment, where the focus is properly on the equality of all citizens and job performance, respectively. It is nonsensical, however, in the insurance context where everyone benefits from accurate pricing and risk assessment. The risky driver who pays more for automobile insurance either drives more carefully or does not drive at all. In either case, the rest of us benefit from his added care or his decision to take the bus. The same analysis applies if the classification is based on sex or race. Even though these characteristics are immutable and one cannot move from one to another, there is nothing inherently unfair or inappropriate with avoiding the subsidies that unisex and uni-race tables create. Insurers that cannot explicitly take the higher costs of insuring certain racial minority populations into account will rationally choose to avoid coverage where possible. It is hard to see how a dramatic reduction in the availability of insurance is preferable to a regime in which insurance is available at a cost that accurately reflects the size and frequency of expected losses.

Conclusion

I do not expect that a return to the use of explicit racial (and, by extension sexual) classifications will be warmly welcomed as a step in the right direction. On the contrary, I recognize that the process of classification itself is an anathema to many, and that racial classifications have many negative associations. For those who can accept the appropriateness of the classification of risks in certain contexts such as automobile insurance, I suggest only that the analysis can be usefully extended to other areas.

My claim about the destructive effects of state insurance mandates is one that is supported by empirical work and an enormous amount of legal anecdotal evidence. It is hard to accept that well-intentioned regulatory efforts have gone awry (although this is not uncommon). A persistent refusal, though, to recognize state mandates as a major cause of the drop in employer-sponsored health and disability group insurance plans demonstrates a basic indiffer-

46. 435 U.S. 702, 704-11 (1978).

ence to the needs of millions of uninsured. Moving away from a regime dominated by mandates would free employers and insurers to fashion contractual arrangements that suit their particular needs and result in broader, yet shallower coverage. This arrangement might not be ideal in every sense, but it would certainly be preferable to the status quo which flatly excludes millions from any coverage at all.