
The Human Genome Project and the Future of Health Care

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The Implications of the Human Genome Project for Access to Health Insurance

Deborah A. Stone

The Human Genome Project does not augur well for the current system of health insurance in the United States. We have a patchwork combination of public programs and private contracts, all built on deep ideological commitments to preserving competition between insurers for market share and autonomy of employers in deciding upon fringe benefits. In such a system, everybody has an incentive to avoid sick people. And since insurance is a contract to pay for future needs or claims, predictive information about people's likelihood of getting sick turns out to be key.

Predictive medical tests—tests that predict a disease someone might get rather than confirming one they already have—are an old feature of medical practice, of employer hiring practices, and of the insurance enterprise. Genetic information may hold a special fascination in our collective imagination, but its use in and impact on health insurance will be only a change in degree from the status quo, not a fundamental transformation. New information yielded by the Human Genome Project is problematic, I would argue, not because of anything new in the character of this information, or even the scale, but rather because of the institutional context of health insurance into which the results of the Human Genome Project will flow.

The key feature of the institutional context is the splintering of the

health insurance market since the mid-1970s, and the consequent erosion of risk-pooling. The institutions of health insurance—commercial, nonprofit, and government carriers, as well as self-insured employers—are less capable of mixing low-risk and high-risk people together in the same pool, and so of spreading the costs of illness among members of a large community. The result is that over 35 million people are relatively permanently uninsured for medical care,¹ an estimated 60 million are uninsured for two months or more during any 18-month period,² and untold millions are “underinsured,” meaning that their health insurance does not cover much of the care they need.

The major concern about information generated by the Human Genome Project is that it will be used by insurers to further segment insurance pools into smaller, more homogeneous groups, creaming off people who are likely to remain healthy, and leaving the public sector to care for the sick and potentially sick. Thus, in a situation where the nation's health insurance mechanisms are already failing to an important degree, the availability of genetic information about individuals will only hasten the disintegration.

Many analyses of this problem to date have centered on whether and how much insurers and employers actually perform genetic diagnostic testing, and their intentions to perform genetic testing in the future.³ The two major insurance trade associations, the American Council of Life Insurance and the Health Insurance Association of America, emphasize that no insurer currently uses genetic tests, and that insurers will be cautious about adopting genetic tests because of their expense and low predictive value.

No insurer—life or health—currently requires genetic tests. One simple and practical reason is cost. . . . Above all, it cannot be emphasized enough that insurers are not using genetic tests in risk assessment, nor are there any plans to do so.⁴

At the same time, the industry has announced its intention to use genetic information the same way it uses other predictive medical information, and defends the economic necessity and fairness of doing so.⁵

Many health policy makers, insurance advocates, and social reformers concerned about both health insurance availability and the ethical implications of the Human Genome Project have called for bans on the use of genetic test information by insurers. These proposals take many forms, including state legislation to prohibit the use of genetic information by insurers, a temporary moratorium on the use, and federal legislation to restrict the use of genetic information by insurers.

Much of this discussion, this chapter argues, is misdirected. First,

whether insurers and employers actually perform genetic tests is almost irrelevant to the problem of health insurance access, because they do and will have virtually unlimited access to the information from genetic tests performed in the medical sphere. Second, bans and moratoria on insurers' use of genetic information are unlikely to be effective without addressing the entire structure of health insurance underwriting, benefit design, risk-pooling, and marketing.

Why Insurers Want Genetic Information

Insurers generally give three reasons why they need access to predictive medical information, including genetic test results: fiscal solvency, profit, and fairness.⁶ Because they bear the financial risk for the contingencies they insure, insurers need to predict how much money to collect in order to cover their expected payouts. (Insofar as insurers are public agencies, such as Medicaid, they have other sources of revenue besides policy holder premiums; private commercial insurers are limited to premiums and the investment income from premiums and reserves.) Whether they are public, commercial, or nonprofit, insurers need to remain solvent in order to make good on the claims or liabilities represented by their policyholders. Commercial insurers seek to make a profit in addition to being able to pay claims fully. Thus, the purpose of risk classification is to allow insurers "to exercise their right to earn a reasonable profit, and [to provide] an equitable insurance system to policy holders."⁷

Insurers, like any business, have many ways of influencing the balance between revenues and costs. For example, they might seek to trim their administrative costs, to monitor claims more closely, or to control payments to medical care providers more aggressively. One strategy that stands out as extremely important, however, is to *select policyholders who are relatively healthy* and therefore unlikely to incur high medical costs in the future. If an insurer can know in advance that a group is likely to be healthier than average, the insurer can offer a group package at a lower-than-average price, and thus gain a competitive advantage over other insurers.

To use this strategy, an insurer must acquire information about applicants to help predict their likely future claims, and then either reject those with unusually high expected costs or charge them higher prices. This selection strategy is most readily available to commercial insurers. Public programs, though they do select their clientele, must do so according to eligibility rules established in enabling legislation and ad-

ministrative regulations; nonprofits, such as Blue Cross Blue Shield, are constrained to some extent by their charters and state laws, although they, too, can and do use some risk selection and differential pricing according to risk.

Insurers, especially commercial insurers, see themselves engaged in a strategic game with consumers in which both sides are taking a gamble about expected future costs. (In public programs such as Medicare, Medicaid, or the Veterans Administration system, clients are made eligible relatively automatically and so do not self-select into the programs. People over 65, for example, are not allowed to decline membership in Medicare, even if they think they are extremely healthy or wealthy and will not need medical insurance.) Success in this game requires having more or better (or at least equal) predictive information about future costs than the other side.

There is a widespread, if not universal, perception in the industry that people are more likely to buy insurance when they know they will have occasion to need it. A typical expression of this view is:

There is a *natural tendency* on the part of the consuming public who need [health insurance] coverage to seek it only when there is a perceived need for medical care, and to cancel the insurance when the immediate need no longer exists.⁸ (Emphasis added)

Given this perception of consumers, insurers want to use any information that enhances their ability to predict the need for costly medical care, whenever the information is available to the would-be purchasers of insurance. They want, as the ubiquitous insurance metaphor would put it, "a level playing-field," where they have the same access to predictive medical information as the buyers of insurance. Otherwise, insurers will be "selected against," meaning that people who have taken medical tests and/or know they are at high risk for disease will be highly motivated to purchase insurance and to conceal their condition from the insurer. "Select, or be selected against," goes the old adage taught to every beginning student of insurance.⁹ Insurers call this phenomenon "adverse selection." Although there is precious little empirical information on actual consumer behavior in insurance markets, insurers are profoundly influenced by this belief that consumers have a "natural tendency" to buy insurance after they learn of some adverse medical condition.

The fear of adverse selection drives insurers' decisions about whether to acquire and use medical information. One early report of the American Council of Life Insurers explained why insurers would want access

to prior genetic testing results *even* if they might prefer not to order genetic tests themselves:

If test results were unavailable to insurers, applicants who already knew from tests performed by their own physician that they were predisposed to illness or early death could buy large amounts of insurance coverage . . . at rates that do not properly reflect their known risk. If a large number of such applicants bought insurance, or if large amounts of insurance were purchased, the ensuing claims would markedly exceed projected losses.¹⁰

From an insurer's point of view, the more genetic testing is used in clinical and preventive medicine, the greater the possibility for adverse selection and therefore the more insurers' need to acquire genetic information themselves. This logic is played out vividly in another section of the same report.¹¹ People who undergo genetic testing and receive negative results, according to the report, will be less inclined to buy health insurance than they might have been without testing, while people who receive positive results will be more inclined to buy. Therefore, the greater the scope of genetic testing in normal medical practice, the greater the proportion of all insurance applicants who will be motivated by knowledge of their higher risk. In a situation where genetic testing has become widespread, if an insurer had no information about the genetic characteristics of its applicant pool and continued to assume the standard mortality or morbidity risks, it would find itself with excess mortality and morbidity, and a resulting imbalance between premium intake and claims payouts.

If insurers feel threatened by potential adverse selection with respect to some disease and are unable to obtain good predictive information, they are likely to use proxy information, even if its predictive value is not very accurate. When California banned the use of HIV antibody tests in health and life insurance underwriting in 1985-86, insurers tested applicants with the T-cell test instead.¹² They used the T-cell test, knowing it was much less specific for AIDS, because to them, avoiding a few infected policy holders was more important than losing sales to a larger number of noninfected people. Similarly, before the advent of good HIV-antibody tests (and to some extent, even afterwards), some insurers used homosexuality as a proxy measure for risk of AIDS, even though that was an extremely crude measure.¹³ Some companies took the proxy concept one step further, and used zip codes of residential areas thought to have high concentrations of gays, as well as stereotypically gay occupations, as proxies for risk of AIDS.¹⁴

Insurers also think that extensive medical underwriting leads to fair-

ness in the allocation of medical care costs. The insurer's definition of fairness is that "each insured [person] will pay in accordance with the quality of his risk."¹⁵ Unfairness occurs when "equal risks are treated differently and/or unequal risks are treated equally."¹⁶ An insurer treats its policyholders fairly when it "establish[es] premiums at a level consistent with the risk represented by each individual policyholder."¹⁷ To do this, insurers must assess each policyholder's risk as accurately as possible, and medical information is the best way to assess the risk.

This definition of fairness is tantamount to saying that ideally, each person should pay for the costs he or she generates, and that cross-subsidy—or healthy people paying for sick people—is unfair. If we had perfect predictive medical information, in this logic, each person *would* pay exactly the cost of his or her own medical care. Of course, self-payment would no longer be insurance, because insurance is by definition risk-pooling, and that is what makes it different from individual savings accounts. Nevertheless, to understand why insurers want to use genetic information, it is crucial to understand the concept of fairness they are pursuing.

How Insurers Acquire Medical Information

Insurers select policyholders through a process of examining applicants called underwriting. Not to be confused with the conventional meaning of underwriting as providing financial backing, the term as used by insurers means the *selection of risks*, or the decision about whom to insure and at what rates. In this sense, the term *underwriting* might better be understood as "close examination." When insurers say they underwrite a certain class of health insurance (such as small group policies), they do not mean they accept all comers in that class, but rather that they subject applicants in that class to a process of individual scrutiny that is not applied to applicants in other classes. In life and health insurance, most of the information insurers need to predict future mortality or morbidity is medical information, and so most of the underwriting is *medical underwriting*. (Insurers also collect information on an applicant's occupation, avocations, and financial situation, for example.) For life insurance, insurers are primarily interested in factors that might lead to a premature death, and for health insurance, they are interested in factors that might indicate a greater-than-average use of expensive medical care.

Although insurers are quick to assure the public that no insurer is currently doing genetic testing,¹⁸ we need to distinguish between *performing the tests* and *using the information* generated by them. Insurers

often do perform their own laboratory testing of blood and urine samples in the course of medical underwriting, but their own testing is by far the least important source of medical information on applicants.¹⁹ The vast bulk of information comes from applicants and their medical records. If genetic test results are part of the knowledge of applicants or part of their medical records, the results would be available to insurers. Insurers' access to individuals' medical histories is so extensive that as soon as genetic tests enter into medical practice—even if they are performed only in high-technology centers and not in routine medical practice—the results will be available to underwriters.

Medical Information Provided by the Applicant

Whenever insurance is medically underwritten, the application form asks applicants for medical information about themselves, and often about close blood relatives as well. Typical family history questions ask whether an applicant's parents have had specific diseases, whether either parent died early (e.g., before age 60), and if so, of what cause. Family medical history questions are the most obvious source of genetic information. As one insurance medical director noted, "insurance companies already use genetic data. . . . *To some extent, one might consider family history data a proxy for more specific confirmatory genetic tests.*"²⁰ If states were to write legislation or regulations prohibiting insurers' use of genetic test results in underwriting decisions, insurers would be likely to use cruder family history information as a proxy. Judging from a common industry claim that use of genetic tests in underwriting would actually increase access to health insurance, many insurers apparently already do use family history information in this way:

Consider applicants with a family history of Huntington's Disease who have no manifestations themselves. Without genetic testing, no one would know whether these people have inherited the disease. *They would be considered risks that it would be very difficult to insure at reasonably low rates.* But if a genetic test indicated that they were not carrying the Huntington's disease gene, then insurance coverage could be offered at favorable rates.²¹

Most application forms ask whether the applicant has had or has been treated for a variety of medical conditions. If applicants answer yes to any of the health history questions, they are asked to provide more detail. While such medical information is used for all kinds of nongenetic medical conditions, genetic information is and would be caught in this net as well. One medical director evocatively terms this mode of acquir-

ing genetic information "a systems review for footprints of genetic conditions."²²

Insurers have several ways of inducing applicants to make a full disclosure of their medical conditions and histories. First, all applications require the applicant to sign a statement to the effect that the insurance will not be valid if the applicant has not fully disclosed true answers to the questions. For example, a typical form reads:

The proposed insured declares that to the best of his (her) knowledge and belief the above answers and statements are complete and true. . . . The undersigned agrees that . . . no insurance shall take effect . . . unless the answers and statements in each part of this application continue to be complete and true as of the date of delivery. . . .²³

These clauses refer to the insurer's right of rescision, the right to deny payment or cancel the insurance within a specified time if the insurer can prove that the policyholder misrepresented or withheld information on the application. Such clauses are invoked often, and could be one vehicle by which insurers could seek not to pay for treatment of genetic diseases.

Another way insurers might obtain genetic information is with more general questions on the application about diseases that have not yet been treated or even manifested themselves. Typical questions ask whether applicants or family members have any "indication" of any disease not disclosed in other questions, whether they have ever been advised to have special examinations, tests, or consultations, and even whether they have ever "discussed" testing or treatments not yet performed. A person who had a positive result for some genetic disease, even one that was only partially genetically determined, or someone who had been merely advised about the possibility of genetic testing would have to disclose that information or risk being denied coverage later.

Physicians' Medical Records

Whenever applicants answer that they have seen a doctor for some problem, they are asked for more detailed information about the problem, as well as the name and address of the treating physician or hospital. Even if an applicant answered "no" to all the questions about specific medical problems, life and health insurance applications typically contain a more general question that will almost always elicit the name of a phy-

sician: the forms ask whether the applicant has been hospitalized or seen by a physician in the last five years and request the names and addresses of all treating physicians and hospitals during that period.

All applications require the applicant to authorize the insurer to obtain medical information about the applicant from a wide variety of sources, including physicians, other medical practitioners, hospitals, clinics, other medical facilities, insurance companies, and sometimes employers. In addition, applicants must grant the insurer permission to seek information from any "organization, institution, or person that has any records or knowledge" of their health.

Insurers may request what is known as an Attending Physician's Statement or copies of complete medical records from these physicians and other medical sources. The typical form for an attending physician statement asks the doctor to fill in specific information, but insurers very often ask for copies of complete medical records as well. Significantly, regardless of how insurers *ask* for information, most physicians delegate the completion of these forms to their office staff, and many, if not most, *simply send copies of the medical record*. Photocopying the record is far easier and less time-consuming than abstracting from it. Few physicians are willing to take the time to dictate a special letter or narrative summary for individual insurance requests.²⁴

From the medical records, insurers have access to a wide range of information that might not be on the application. Typically, a physician's record includes a family medical history completed at the patient's first visit. Since the norms of primary care practice emphasize prevention through early identification of people at risk for disease, the whole climate of medical practice encourages an expansive disclosure of personal and family medical history. Patients, moreover, are more inclined to give an inclusive medical history and disclose family medical information to physicians (e.g., family histories of cancer, heart disease, or hereditary disease) if they believe that providing the information could help the physician monitor them and prevent disease. Thus, even if an insurer did not ask family history questions on an application, and even if insurers were forbidden to ask questions about family history of genetic diseases, they might still have access to this information via the applicant's medical records.

In addition to family medical history, an applicant's medical records will contain information about diagnostic tests, referrals to specialists, and reports from specialists back to the referring physician, *including any genetic testing or counseling* that has been recommended or performed. Physicians may be very careful to send out only their own

notes, and not copies of reports from other physicians, but there is growing evidence that insurers will sometimes take the mere fact of a specialist consultation or the mere ordering of a diagnostic test as evidence of high risk. For example, an insurer excluded coverage of eye disease from a child's health insurance policy, because her mother had once taken her to an ophthalmologist to have her eyes checked, although there turned out to be no problem.²⁵

These examples suggest the flavor of the strategic game that insurers are playing. Because the underwriting process is dominated by the fear of adverse selection, insurers are looking for any hint that applicants might know they have a costly disease. Similarly, because expensive illnesses are costly for insurers, they try to use medical records to screen out people who are at high risk for costly diseases. It is easy to see how insurers, in such a mindset, are likely to take the ordering of a diagnostic test, a referral to a specialist, or a visit to a specialist as evidence that the patient or doctor knows something troubling.

Often, medical records contain information about suggestions that were made, fears the patient expressed, and possibilities that were discussed, in addition to tests actually done and specialist visits actually made. The accumulating anecdotal evidence suggests that some information used by insurers to deny insurance comes from fairly informal conversations with physicians and informal notes. One woman was denied disability income insurance on the basis of her father's Huntington's disease, although the application had nowhere asked about family medical history or risk of genetic disease. She later learned that her doctor had written her father's diagnosis on the folder and the office had photocopied the folder notes as well as the inside records for the insurer.²⁶ Another woman was denied life insurance after she had questioned her obstetrician about the possibility of Huntington's disease in her mother. The physician had made a note of this conversation in her medical record, which was subsequently sent to an insurer.²⁷

Most practicing physicians are probably not very knowledgeable about the underwriting practices of insurers. They are probably inclined to make their records as complete as possible, partly because the norms of good practice call for complete records, and partly out of a general concern with being able to defend themselves in potential malpractice suits. If they are wavering about whether to enter a notation about something a patient mentions—such as a concern about a family history of genetic disease—they are more likely to act on the side of inclusion for the above reasons, than to be influenced by thoughts of protecting their patients from future adverse underwriting decisions.

The Medical Information Bureau

In addition to answering questions about their health and sources of medical care and granting insurers access to their medical records, applicants for life and health insurance must usually sign an authorization for the insurer to seek information from the Medical Information Bureau (MIB). MIB is an insurance industry-run data bank, accessible to nearly 800 member companies in the United States and Canada. Insurers not only check the MIB database to find out whether an applicant has some impairment or disease not disclosed on the application; they also report to the MIB any information turned up in the course of underwriting that suggests an applicant has any risk factors relevant to underwriting.

Even applicants who have never applied for health insurance might have a record with the MIB if they have ever applied for life insurance, because most life insurance is medically underwritten. Member companies send information acquired in the course of underwriting to the MIB *daily*,²⁸ so that the data bank is extremely up-to-date. Thus, despite common parlance about the "competitive private market" in insurance, the consumer faces a monopolist seller in the sense that insurers can choose their customers, and virtually all insurers have access to the same information about a potential customer.

The MIB, in its public information brochure, assures "consumers and public representatives" that an insurer may not decline an application or charge more for coverage solely on the basis of the MIB's illness codes.²⁹ In theory, when an insurer receives information from the MIB that is not disclosed in the application or its own investigation, it is supposed to conduct its own research. In practice, there appears to be very little restriction on insurance companies' use of information obtained from the bureau in underwriting decisions. Moreover, although the MIB has procedures for individuals to correct information in their files, the procedures are cumbersome and it is often difficult for consumers to find out why they have been denied insurance in the first place.

Inspection Reports

Insurers sometimes request inspection reports from consumer reporting agencies. Investigators from an inspection agency interview friends, neighbors, and business associates, as well as the applicant, about the applicant's hobbies, lifestyle, financial situation, personal relationships, use of alcohol and drugs, driving record, and medical conditions. Un-

derwriters use these reports in part to obtain information about what they call "unadmitted health histories." According to the major underwriting text, "In most cases, this information [unadmitted health histories] comes from third parties via the inspection report. . . ." ³⁰ If a family were struggling with decisions about genetic testing because of a family history of disease, it is very likely that they would discuss their concerns with friends and possibly some neighbors who are also friends. Thus, an insurance company might very well find out about a family history of genetic disease via the inspection report. ³¹

In sum, the industry's standard procedures of medical underwriting entail extensive information gathering and information sharing, not only among all companies, but also between its life and health insurance branches. Medical records from any medical source, as well as health information from lay people, are widely available to, and used by, insurers. Such sharing creates numerous avenues by which insurers will inevitably acquire information about individuals' genetic make-up and family history, *even if insurers do no testing of their own and ask no specific questions about genetic disease.*

The Prevalence and Impact of Medical Underwriting

In public discussions about underwriting and access to health insurance, insurers claim that underwriting is a minor phenomenon. They use the term *underwriting* to mean examination of individuals for the purpose of selecting risks and pricing policies. Because most health insurance is sold to large employee groups, and because (insurers claim), large groups are not medically underwritten, very few people are affected by medical underwriting or put at risk of losing access to health insurance on account of their medical histories. Thus, the 1991 report of the ACLI-HIAA Task Force on Genetic Testing asserts:

Most health insurance is not individually underwritten and so genetic testing would have no effect on the vast majority of health insurance consumers. About 85-90 percent of health insurance is currently purchased through group plans which accept all full-time employees and dependents without evidence of insurability. ³²

The industry thus maintains that only 10 to 15 percent of people with health insurance are subject to underwriting, but this estimate is very misleading. First, 19 percent of workers who have employer-based coverage work for firms of fewer than 10 employees, where individual underwriting virtually always obtains. Another 17 percent work for firms

with between 10 and 25 employees, where individual underwriting is extremely common.³³ Second, over the last decade or so there has been a trend toward using individual underwriting with even larger employee groups. A 1990 survey of insurers by the Colorado Division of Insurance found a substantial degree of individual medical underwriting in large groups: 11 percent of all commercial accident and health insurers and nonprofits require individual medical underwriting for *all groups*, regardless of size; 18 percent underwrite groups up to 99 people; 25 percent underwrite groups up to 74 people; 33 percent underwrite groups of up to 49 people; and 40 percent underwrite groups of up to 24 people.³⁴

A third reason the industry estimate of the prevalence of underwriting is too low is that it ignores a major device for acquiring medical information about employees in large groups without obtaining it directly from the employees. Insurers often require a large-group employer to submit simple medical information about individual employees and their dependents. This information is obtained through what are known as "risk finder questions" or "gatekeeper questions" on the master application for a group. Typically, one question asks whether, to the best of the employer's knowledge, any employee or dependent had claims over a certain amount (say \$2,500 or \$3,500) during the previous year or two years. Other questions ask about more specific, but still quite general medical problems among employees and their dependents. This kind of *quasi-individual medical underwriting* is very common. The Colorado survey found that nearly three-fifths of insurers require a risk factor questionnaire for groups up to 49 people; nearly half require the questionnaire for groups of up to 99 people; and nearly one-third require it for all groups, regardless of size.³⁵

Though we still do not know exactly how many people are affected by medical underwriting, the number must be vastly greater than the 10–15 percent the industry claims. Consider that in 1989 about 44 percent of the workforce was self-employed or employed in firms of under 100 employees.³⁶ Of workers who *have* employer-based health insurance, 36 percent work in firms of 25 or fewer employees, and 60 percent work in firms of 100 or fewer employees.³⁷

When an individual or group is found to have high risks for disease, insurers might do several things besides offering a standard policy (or treating the person as a "standard risk," in insurance terminology). In the individual market, insurers can reject the applicant altogether as "uninsurable"; accept the applicant but charge a higher premium ("sub-standard rates"); accept the applicant but exclude coverage for a disease or organ or body system (called an "exclusion waiver"); or apply *both* an

exclusion waiver and substandard rates. Exclusion waivers, it might be noted, are a major contributor to under-insurance, because they deny coverage for precisely those medical conditions a person has and for which he or she is likely to need treatment.

In the group market the options are similar, but they also include treating some members of the employee group differently from others. Thus, an insurer can reject a whole group; accept most of the group but exclude individuals who are deemed high-risk; charge a higher rate for the whole group, or alternatively, increase the rates only for the high-risk individuals in the group; limit the conditions or amounts covered either for the whole group or for certain members of the group; or *both* limit coverage and charge higher rates.³⁸ Perhaps most important, because all insurance policies are contracts, usually for one year, insurers can change the terms of any policy yearly as they acquire new information about policyholders' medical conditions.

It is not easy to know what insurers *actually* do when faced with high-risk applicants, because underwriting is part of a firm's competitive strategy and no firm is eager to disclose its practices. We can get some indication of the impact of medical underwriting on access to health insurance from two surveys of health insurer underwriting practices. A 1987 Office of Technology Assessment survey found that within the commercial individual insurance market, where medical underwriting currently obtains, around 8 percent of applicants are rejected outright for medical reasons. Commercial insurers apply exclusion waivers to another 13 percent, charge higher premiums to 5 percent, and use both exclusion waivers and higher premiums for 2 percent.³⁹ Taking these groups together, fully 28 percent of applicants do not meet the medical criteria to qualify as standard risks.

The Colorado survey described earlier asked insurers what actions they took and which action they take most frequently in the group market. Over half the insurers (54 percent) mentioned rejection of the group as the action most frequently taken when underwriting turns up adverse results. Fifteen percent said their most frequent action was to accept the group but exclude the high-risk individuals. Another 15 percent said their most frequent action was to limit coverage of high-risk individuals in the group.⁴⁰ Needless to say, each of these actions causes some people to be uninsured or underinsured.

Another way to estimate the impact of medical underwriting on access to health insurance is to determine what portion of the citizenry would be ineligible for standard risk insurance if they were subject to individual underwriting. The Citizen's Fund of Washington, D.C., used the underwriting manual of a large insurance company to identify

medical conditions that would lead to denials, rating, or waivers, and then estimated the prevalence of those conditions in the general population from epidemiological surveys. Using this method, the study found that 81 million people under age 65 would not qualify for standard insurance if they had to submit to medical underwriting.⁴¹

In addition to traditional medical underwriting, there is a vast amount of retrospective underwriting after an insurance policy is in force. When an insured person or his or her medical provider submits a claim for payment, the insurer must make a decision whether to pay the claim. At this point, medical information enters again. The key vehicle here is the *preexisting condition clause*, a typical feature of most health insurance policies, even large group policies.

Preexisting condition clauses exclude payment for any condition the applicant had prior to the insurance contract. Preexisting conditions are generally defined in insurance policies as conditions which "manifested themselves," "existed," or "were treated" before the effective date of the policy. These words leave some leeway for interpretation, especially the "existed" criterion. Insurers have insisted on their right to refuse payment even for treatment of conditions which had not been diagnosed prior to the claim, and of which the applicant had no knowledge. Courts have often upheld insurers on this point.⁴²

Preexisting condition clauses are far more potent than exclusion waivers and affect many more people. To write an exclusion waiver into a policy, insurers must detect some problem, from the applicant's medical records or the application, *in advance of issuing the policy*. The policy then specifically names the condition (or body part or system) as excluded. With the preexisting condition clause, insurers do not need any information about the applicant. The clause is like a wild card. It allows the insurer to refuse payment (tantamount to not insuring) for any condition the person had prior to the policy issue date, even when no information about the condition turned up in the medical underwriting process. Preexisting condition clauses thus have the same effect as exclusion waivers, without insurers having to do any underwriting at all, and unlike the exclusion waivers, they can be, and are, widely applied to group policies.

Yet another form of post-claims underwriting occurs when employers or insurers redesign the benefit package to exclude conditions for which a person has recently made claims. The most well-known instance of this strategy is the case of *McGann v. H & H Music Co.* After Mr. McGann filed his first claims for AIDS-related treatment, his employer switched from a commercial health insurance plan to a self-insured plan, and placed a \$5,000 cap on payments for AIDS while

leaving a \$1 million maximum for all other treatment. The Court of Appeals for the Fifth Circuit ultimately upheld an employer's right to change its self-insured benefit plan in response to diseases or expenses incurred by a single employee.⁴³ Of course, an employer might do the same thing for any other disease. No doubt it would be harder for an employer to cap benefits for relatively common diseases that affect many employees and dependents, such as cancer or heart disease. But, like AIDS, genetic diseases tend to be less common and thus easier and more likely targets for employers looking for ways to cut the costs of their fringe benefits.

Commercial insurers effectively do the same thing when they push group members with expensive claims into reapplying for lower rates and submitting to medical underwriting. The insurer can then add an exclusion waiver, which is the equivalent of eliminating a disease from the benefit package for a self-insured group plan.

Restricting Insurers' Use of Genetic Information

The commercial life and health insurance industries have made it clear that insurers intend to use genetic information, at least insofar as it becomes available to consumers through the medical care system, and possibly by testing applicants themselves. Representatives of the industry have already announced they will resist any attempts by regulators or state legislatures to restrict their use of genetic information in underwriting.⁴⁴

In response to public concern and pressure, the American Council of Life Insurance and the Health Insurance Association of America are promoting a program of confidentiality based on four "principles."⁴⁵ The program entails virtually no change from the current *modus operandi* of insurance companies, and would provide absolutely no more protection to insurance consumers than the status quo.⁴⁶ It addresses the problem of whether and under what circumstances an insurer may *redisclose* genetic information to a third party, but says nothing about whether and how an insurer may obtain such information or use it in making underwriting decisions. The trade associations take as a given that insurers will continue to collect genetic information, and will collect it and use it as in the same manner as they now collect and use all other medical information. Thus, the four principles of confidentiality all have to do with an insurer's redisclosure of individual information to other parties.

The most important principle is that (except in defined circum-

stances), a company may redisclose genetic information only "with the written consent or authorization" of the individual or his or her representative. The report suggests that "this consent could be obtained at the time an application is taken and would remain valid throughout the lifetime of the policy."⁴⁷ The consent would be "specific where possible, e.g., the MIB [Medical Information Bureau], and generic where otherwise necessary, eg. reinsurers, co-insurers, contractors, etc."⁴⁸ As we have seen, this is just the kind of written consent insurers already obtain on application forms; perhaps the committee contemplates adding specific mention of genetic information to the current standard waiver form. But even so, as we have also seen, the current "consent" is consent in name only. The applicant has no choice but to sign this waiver to release information because no company will consider an application without a signature of this waiver.

Many people concerned about the privacy issues as well as the insurance access issues raised by the Human Genome Project have proposed regulating insurers' use of genetic information in some fashion. Some have called for new state laws to prohibit insurers' use of genetic information in underwriting altogether.⁴⁹ Some have argued that state insurance commissioners should somehow regulate insurer practices in this sphere.⁵⁰ Others call for federal legislation, arguing that state jurisdiction might be too spotty or that insurance commissioners are unlikely to regulate these practices adequately.⁵¹ The Task Force on Genetic Information and Insurance, a part of the Working Group on Ethical, Legal, and Social Implications of the Human Genome Project itself, called on insurers to "consider a moratorium on the use of genetic information in underwriting" until national health reform makes health care available to everyone regardless of present or future health status.⁵²

Still others argue that we should distinguish between single-gene disorders, where a genetic defect definitively causes a disease, and genetic predispositions, and that we should prohibit only the first kind of genetic information in underwriting.⁵³ Another proposal would permit insurers to use genetic information in medical underwriting but use state "high-risk pools" to insure people who are medically uninsurable. These pools would be financed by some combination of individual premiums, state revenues, and payments by commercial insurers.⁵⁴

None of these proposals, I believe, would begin to address the problems of health insurance access created by medical underwriting, and even the most stringent bans on insurer use of genetic information would probably be ineffective in curbing either the specific use of genetic information or the general problem of insurance denials and exclusion waivers. To start with the most permissive proposal, high-risk

pools not only permit insurers to use genetic and other medical information to reject people, but *make it easier for insurers* to engage in risk-selection as a profit-seeking strategy by using state funds to subsidize care for the people whom insurers reject. In several states, even where insurers are assessed contributions to the high-risk pool, states allow the insurers to deduct these payments from their taxes. Self-insured employers cannot be taxed to support the pools, so that costly high-risk pools are another incentive for employers to self-insure, and pull out of risk-sharing arrangements with other employee groups. Moreover, high-risk pools have been in existence in 26 states for some years now, and they are barely making a dent in the uninsured population.⁵⁵

Each of the other proposals entails some sort of ban on insurers' use of some or all genetic information. The problem with all of these proposals is that *genetic information is too deeply embedded in the structure of general medical underwriting to be effectively regulated separately*. So long as the industry continues to use medical underwriting, it will be nearly impossible to prevent the use of genetic information. Genetic information about individuals is and will continue to be produced in the medical sector—in hospitals, laboratories, and doctors' offices. It will be recorded in physicians' records, in the form of written test results, family histories, informal talks, and physician referrals, recommendations, and advice. Even tests performed in commercial laboratories are likely to have some notation in physicians' records, and insurers' authorization to seek medical records are broad enough to encompass commercial laboratories anyway. Information about family genetic make-up will also be available to insurers through conversations with friends and neighbors in consumer credit agency inspection reports. So long as insurers are able to conduct general medical underwriting and compel applicants to release their medical records, genetic information will be available to them, even if some state or federal law prohibits them from using it as the basis of underwriting decisions.

If insurers *have* genetic information about individuals, legal prohibitions on its use in underwriting are unlikely to be easily enforced. Commercial insurers have demonstrated the intensity of their commitment to using this information in their published writing on the issue, in their fierce legislative lobbying on state and federal bills that curb underwriting prerogatives in any way, and in their actual behavior in the HIV testing controversy, where, when prevented from testing, they used the most statistically crude and discriminatory proxies to protect themselves from claims for AIDS. There is every reason to believe that insurers will use similarly crude family history information in lieu of genetic tests if they are prohibited from using genetic test results di-

rectly. Medical directors of large companies writing for the Committee on Genetic Testing of the ACLI have already acknowledged that insurers *do* use family history information as proxies, in the absence of good genetic tests.⁵⁶ Even if state or federal legislation also prohibited insurers from asking family history questions on application forms, insurers would still be likely to acquire this information from medical records.

Another way insurers might evade a prohibition on use of genetic information is by simply disguising their use of it. Insurers already make it difficult for applicants to find out why they are denied insurance by not volunteering this information in the first place. Typically, a consumer must ask the insurer in writing to release the reasons for rejection, and many companies will only release the information to a doctor. More importantly, insurers could simply find other reasons, besides genetic make-up, to find people uninsurable. One medical director of a large insurance company told the ELSI Task Force on Genetic Information and Insurance:

If a woman has family history of breast cancer, I'll ignore the breast cancer. I won't rate her for the breast cancer, but I'll scrutinize her record extra carefully. I'll rate her for hypertension. I'll hope there is something else I can find in the record to rate her on. I'll tell her I rated her on hypertension. I won't tell her I rated her higher than someone else with the same hypertension.⁵⁷

Medical underwriting decisions are highly discretionary and largely invisible. No legislative prohibition could reach the decision-making routines described by this underwriter, and consumers would be absolutely unable to police this kind of decision making.

Bans on the use of genetic information in underwriting would probably not reach post-claims underwriting. Even if insurers did not base an underwriting decision on genetic information, they could still deny claims at the payment stage for treatment of genetically based conditions by calling them preexisting conditions. Insurance law is based on state law, and there is as yet no settled doctrine on whether genetic or congenital conditions can be considered preexisting conditions by insurers for the purpose of nonpayment of claims. But judging from the kinds of insurance cases that get to court,⁵⁸ insurers probably will try to deny coverage for genetic conditions by using the preexisting condition clause. And again, policyholders are relatively powerless to police this kind of post-claims underwriting. Most do not have the knowledge, the financial resources, and sometimes the sheer physical energy to seek legal redress. Without an explicit statement in federal legislation mak-

ing genetically based conditions not subject to preexisting condition clauses, insurers will often seek to deny payment for treatment of genetic diseases.

The *McGann* case discussed earlier illustrates how state-based prohibitions on genetic underwriting will be undermined. Under the Employee Retirement Income Security Act (ERISA), employers who self-insure are exempt from state insurance regulations (both statutory and regulatory). If commercial insurers are not allowed by state regulation or law to use genetic information, employers could evade this ban by self-insuring. Expensive but uncommon genetic diseases, such as Huntington's disease or Duchenne muscular dystrophy, might be limited or excluded from coverage.

As long as insurers continue to use general medical underwriting, insurers will continue to require applicants to authorize release of their medical records. This means the only way to attack the problem of insurer access to genetic information would be to control the flow of information from medical offices and facilities to insurers. Physicians usually photocopy the entire record or sections of the record in lieu of writing new reports to meet insurer requests. Any kind of legislative restriction on insurers' use of genetic information would therefore have to find a way to make physicians, hospitals, and other medical sources separate genetic information from other medical information. This would require major changes in the way physicians keep records. For example, not only specific test results but also conversations about family history, advice about genetic disease, and recommendations and referrals related to genetic disease would all have to be stored separately from the rest of the medical encounter. Clerical personnel would have to develop new record-keeping systems, and because they are the people who most often send records to insurers, they would have to be trained and supervised to protect genetic information. The room for slippage is enormous.

For all these reasons, preventing insurers from using genetic information in health insurance underwriting decisions is not so simple as creating a statutory or regulatory prohibition. It is doubtful whether it is possible to prevent the use of genetic information, or even some kinds of genetic information, without addressing the whole system of medical underwriting. If we are concerned about access to health insurance in the first place, then it makes sense to think about medical underwriting *per se*. After all, medical underwriting works to keep people who are sick or likely to be sick from obtaining private insurance at all or from obtaining coverage for those body parts, systems, and diseases for which

they need medical care. Underwriting is a policy that makes perfect economic sense for the individual firm but is absolutely perverse to the individual and antithetical to the societal goal of universal access to health care. The Human Genome Project will have served a useful social purpose if it makes us reexamine the nation's commitment to our current private health insurance system.

Notes

1. Katherine Swartz, *The Medically Uninsured: A Special Focus on Workers*, Washington, DC, Urban Institute, 1989.
2. C. Nelson and K. Short, *Health Insurance Coverage 1986-88*. Bureau of the Census, U.S. Department of Commerce, Current Population Reports, Household Economic Studies, Series P-70, No. 17, March 1990, cited in Katherine Swartz and Timothy D. McBride, "Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, vol. 27 (1990): 281-85.
3. U.S. Congress, Office of Technology Assessment, *Genetic Monitoring and Screening in the Workplace*, Washington, DC, 1990; Larry Gostin, "Genetic Discrimination: Employers and Insurers," *American Journal of Law and Medicine*, vol. 15, nos. 1-2, 1991: 109-44, esp. 115-19; American Council of Life Insurance, *The Potential Role of Genetic Testing in Risk Classification*, Report of the Genetic Testing Committee to the Medical Section of the American Council of Life Insurance, Hilton Head, South Carolina, June 10, 1989 [hereafter cited as "ACLI, Potential Role"].
4. *Report of the ACLI-HIAA Task Force on Genetic Testing*, Washington, DC, American Council of Life Insurers and Health Insurance Association of America, 1991, pp. 5-6 [hereafter cited as "ACLI-HIAA Task Force"]. See also Robert Pokorski, "Public Relations and Government Issues," in ACLI, *Potential Role*, pp. 8-17, esp. pp. 9, 18.
5. See "ACLI-HIAA Task Force," *ibid.*; Steven Brostoff, "CEOs: Defend Genetic Test Use in Underwriting," *National Underwriter—Life and Health Edition*, April 27, 1992, p. 27; Brian Cox, "Genetic Tests Become Next Underwriting Frontier," *National Underwriter—Life and Health*, July 27, 1992, pp. 3, 6; Jude Payne, Letter to the Editor, *National Underwriter—Life and Health*, September 27, 1992, pp. 41, 44.
6. For a comprehensive treatment of these arguments, and the analysis on which most subsequent writing about risk selection relies, see Herman T. Bailey, Theodore M. Hutchison, and Gregg R. Narber, "The Regulatory Challenge to Life Insurance Classification," *Drake Law Review* vol. 25, no. 4 (1976): 779-827.

7. Philip Stano, "Trifling with the Risk Classification System," *Journal of Insurance Regulation*, vol. 9, no. 4 (June, 1991): 542-74; quotation on p. 543.
8. American Academy of Actuaries, testimony, hearing on "The Rising Cost of Private Health Insurance: The Rating System," Committee on Energy and Commerce, Subcommittee on Commerce, Consumer Protection, and Competitiveness, U.S. House of Representatives, 102d Cong., 1st sess., April 30, 1991, pp. 1-2.
9. Robert I. Mehr, *Fundamentals of Insurance*, Homewood, IL: Richard D. Irwin, 1983, p. 439.
10. Robert J. Pokorski, "Public and Government Relations Issues," in ACLI, *Potential Role*, quotation on pp. 9-10.
11. Mark Battista, "Genetic Data: Impact on Underwriting," in ACLI, *Potential Role*, pp. 23-24. See also "ACLI-HIAA Task Force," p. 8, esp. n.4.
12. Battista, *ibid.*, p. 26.
13. U.S. Congress, Office of Technology Assessment, *Medical Testing and Health Insurance*, Doc. No. OTA-H-384. Washington, DC: U.S. Government Printing Office, 1988, p. 64.
14. Benjamin Schatz, "The AIDS Insurance Crisis: Underwriting or Overreaching?" *Harvard Law Review*, vol. 100 (1987): 1782-1805, p. 1787.
15. Karen A. Clifford and Russell P. Iuculano, "AIDS and Insurance: The Rationale for AIDS-Related Testing," *Harvard Law Review*, vol. 100 (1987): 1806-25, p. 1810. For an extensive discussion of concepts of fairness in insurance, see Deborah A. Stone, "The Rhetoric of Insurance Law: The Debate Over AIDS Testing," *Law and Social Inquiry*, vol. 15, no. 2 (1990): 385-407; and Norm Daniels, "Insurability and the HIV Epidemic: Ethical Issues in Underwriting," *The Milbank Quarterly*, vol. 68, no. 4, 1990: 497-525.
16. Philip Stano, "Trifling with the Risk Classification System," p. 546.
17. Clifford and Iuculano, "AIDS and Insurance," p. 1808.
18. See "ACLI-HIAA Task Force," p. 6:

Above all, it can not be emphasized enough that insurers are not using genetic tests in risk assessment, nor are there any plans to do so.

19. U.S. Congress, Office of Technology Assessment, *Medical Testing in Health Insurance*, p. 69; and table 2-12, p. 72 and figure 2-2, p. 73; see generally, Richard Bailly, *Underwriting in Health and Life Insurance Companies* (Atlanta: Life Office Management Association, 1985).
20. Battista, "Genetic Data," p. 26. Emphasis added.
21. Pokorski, "Government and Public Relations Issues," p. 15 (emphasis added). See a similar point by Mark Battista: If genetic test results were incorporated into medical underwriting, "... [a]t least some applicants

- whose family history or other medical data would previously have generated a declination would become insurable." Battista, "Genetic Data," p. 25.
22. Battista, in ACLI, *Potential Role*, p. 27.
23. This language is from a "typical form" reproduced in one of the textbooks used by the Health Insurance Association of America in its short courses for insurance education. Health Insurance Association of America, *Individual Health Insurance*, part A. Washington, DC, HIAA, 1991 ed., p. 135.
24. As part of a larger project, I am interviewing physicians and their staffs about their reporting practices with respect to insurers. Information here is gleaned from these interviews.
25. Gina Kolata, "New Insurance Practice: Dividing the Sick from the Well," *New York Times*, March 4, 1992, pp. A1 and A5.
26. Letter from Theresa Morelli, October 11, 1991, reprinted in U.S. House of Representatives, Committee on Government Operations, *Designing Genetic Information Policy: The Need for an Independent Policy Review of the Ethical, Legal, and Social Implications of the Human Genome Project*. 102d Cong., 2d sess. House Rept. 102-478. April 2, 1992, p. 16.
27. "Domestic and International Data Protection Issues," Hearings before the Subcommittee on Government Information, Justice and Agriculture of the Committee on Government Operations, U.S. House of Representatives, 102d cong., 1st sess., October 17, 1991, Testimony of Dr. Paul Billings, p. 247.
28. Bailey, *Underwriting*, p. 86; Charles A. Will, *Life Company Underwriting*, New York: Life Office Management Association, 1974, p. 50.
29. Medical Information Bureau, Inc., *A Consumer's Guide to the Medical Information Bureau*, Westwood, Mass. p. 7.
30. Bailey, *Underwriting*, p. 78.
31. While inspection reports are used less commonly in health insurance underwriting than in life, they are still used to a significant extent in individual and small-group insurance. See U.S. Congress, Office of Technology Assessment, *Medical Testing and Health Insurance*, p. 63. Moreover, the information from inspection reports would easily find its way to an underwriter of health insurance if the applicant had ever applied for life insurance, because any "reportable" information would have been entered into the bureau's files.
32. "ACLI-HIAA Task Force" p. 5.
33. Figures from the 1987 National Medical Expenditure Survey, cited in Health Insurance Association of America, *Health Care Financing for All Americans: Private Market Reform and Public Responsibility* (Washington, DC, 1991), p. 7, fig. 1.
34. Barbara Yondorff, *Health Insurance Availability and Affordability in Colorado: A report on underwriting and pricing practices*. Denver: Colorado Division of Insurance, 1990, p. 15, table 8.

35. Ibid., p. 15, table 9.
36. Citizens Fund, *Health Insurance at Risk* (Washington, DC, 1991) p. 22, table 4 (calculated from Current Population Survey, March 1990; figures are for 1989).
37. HIAA, *Health Care Financing*, p. 7; figures from 1987 National Medical Expenditures Survey.
38. In some states, insurers are required to accept or reject an entire group, and it is in these states that they are likely to reject a group with a few sick or high-risk members, because they cannot control the membership of their insured pool.
39. U.S. Congress, Office of Technology Assessment, *Medical Testing and Health Insurance*, p. 62.
40. Yondorff, *Health Insurance Availability*, p. 16.
41. Citizen's Fund, *Health Insurance at Risk*, p. 8. The study excluded people over 65 because they are eligible for Medicare with no medical underwriting.
42. *Dear v. Blue Cross of Louisiana*, 511 So. 2d. 73 (La. App. 1987) (insurer entitled to deny payment for a condition that predated the effective date of the policy, even though there had been no diagnosis or treatment but only symptoms); *Hanum v. General Life and Accident Ins. Co.*, 745 S.W. 2d 500 (Tex. App. 1988) (insurer may deny payment under preexisting condition clause for a condition which though not diagnosed prior to the policy, manifested itself in symptoms from which one learned in medicine could diagnose such a sickness or illness). See also Candace Goldstein, "Pre-existing Condition Medical Exclusion," *For the Defense* 30 (June 1988), pp. 2-7.
43. *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991); cert denied, 113 S. Ct. 482 (1992) (upholding rights of employers, under ERISA, to make changes in benefit plans).
44. See note 5 above and accompanying text.
45. This strategy is outlined in American Council of Life Insurance, Subcommittee on Privacy Legislation to the Task Force on Genetic Testing, *Genetic Test Information and Insurance: Confidentiality Concerns and Recommendations*, American Council of Life Insurers, Washington, DC, 1992.
46. The Task Force said as much in its report (ibid., p. 7): "Although the Task Force enthusiastically endorses these principles, it must be emphasized that they are largely a reaffirmation of existing industry practices."
47. Ibid., p. 4.
48. Ibid.
49. See, e.g., Marvin R. Natowicz, Jane K. Alper, and Joseph A. Alper, "Genetic Discrimination and the Law," *American Journal of Human Genetics*, vol. 50, 1992: 465-75, p. 473. Paul Billings et al., "Discrimination as a Consequence of Genetic Testing," *American Journal of Human Genetics*,

- vol. 50, 1992: 476-82, p. 481; Robert Lowe, "Genetic Testing and Insurance: Apocalypse Now?" *Drake Law Review*, vol. 40, no. 3, 1991: 507-32, p. 531.
50. Lowe, *ibid*.
51. Joseph Miller (comments), "Genetic Testing and Insurance Classification: National Action Can Prevent Discrimination Based on 'Luck of the Genetic Draw,'" *Dickinson Law Review*, vol. 93, no. 4, 1989: 729-57, pp. 75ff. See also, H.R. 2045, U.S. House of Representatives, 102d cong., 1st session (a bill to safeguard individual privacy of genetic information).
52. *Genetic Information and Health Insurance*, Report of the Task Force on Genetic Information and Insurance, NIH/DOE Working Group on Ethical, Legal, and Social Implications of Human Genome Research, National Institutes of Health NIH 93-3686, May 10, 1993.
53. Marne E. Brom, "Notes: "Insurers and Genetic Testing: Shopping for that Perfect Pair of Genes," *Drake Law Review*, vol. 40, no. 1 (1991): 121-48, pp. 145-46. Dennis S. Karjala, "A Legal Research Agenda for the Human Genome Initiative," *Jurimetrics Journal of Law, Science, and Technology*, vol. 32, no. 2, (Winter 1992): 121-222, p. 176.
54. Naomi Obinata, "Genetic Screening and Insurance: Too Valuable an Underwriting Tool to be Banned from the System," *Santa Clara Computer and High Technology Law Journal*, vol. 8 (May 1992): 145-76, pp. 161ff.
55. U.S. General Accounting Office, *Health Insurance: Risk Pools for the Medically Uninsurable*. Washington, DC, April 1988, Document No. GAO/HRD-88-66BR; U.S. General Accounting Office, *Access to Health Insurance: State Efforts to Assist Small Businesses*. Washington, DC, May 1992, Document No. GAO/HRD-92-90, esp. pp. 46-50.
56. See note 21 above and accompanying text.
57. Comments of a medical director at meeting of the Task Force on Insurance of the Ethical, Legal, and Social Issues Commission of the Human Genome Initiative, December 2, 1991, Bethesda, Maryland.
58. See *Goshorn v. Hospital Care Corporation*, 46 Ohio App. 3d. 47 (1989) (a preexisting condition in a hospital insurance policy did not apply to a congenital mitral valve condition that did not become manifest until after the effective date of the policy). The important thing to notice about this case is that the insurer *tried to deny payment* by labelling a congenital condition a preexisting condition. Insurers probably do this frequently, but few people fight in court.