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HIV: Insurance, Employment, and Mandatory Testing Issues

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HIV: INSURANCE, EMPLOYMENT, AND MANDATORY TESTING ISSUES

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The Missouri General Assembly recently passed an AIDS Bill containing provisions dealing with insurance companies as well as mandatory testing. Those provisions are the focus of this Article.

HEALTH INSURANCE

AIDS raises serious issues of public policy pertaining to health care in Missouri.[1] This section focuses on the question of health insurance for those who have tested positive for antibodies to the human immunodeficiency virus (HIV), but who otherwise are not ill and have no symptoms of illness. Those who actually have symptoms of illness, whether the acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), should be treated the same as others who already have been diagnosed with other illnesses, such as cancer or diabetes.

The Missouri AIDS Legislation of 1988

Although the legislation adopted in Missouri in 1988 did little to regulate insurance companies with regard to HIV in the issuance of health insurance policies, it did take one important step. The Act restricts insurance companies, upon renewal of a policy, from denying or altering the coverage provided under individual or group policies, solely because of the individual having HIV infection or an AIDS-related condition. It also prohibits insurance companies from adding riders that exclude AIDS treatment from coverage under individual or group policies that have been issued. Thus, the bill protects those who already have policies from having their policies changed. However, there

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1. This Article discusses only health insurance, as a denial of health insurance coverage or benefits can create enormous financial burdens for the individual, as well as burdens on the taxpayers. Life insurance raises separate issues, but not ones that are critical to the health of the individual.

appears to be a loophole available for insurance companies if they can establish that the change in coverage was not "solely" due to the individual having been diagnosed with HIV infection or AIDS-related illness.[2] Thus, the Act provides limited protection only for those who already have insurance.

In addition, the Act requires the Division of Insurance to establish regulations for the use of HIV tests by insurers, health services corporations, and health maintenance organizations.[3] At the time of the writing of this Article, the Division of Insurance had issued proposed regulations and held public hearings.[4]

Under current Missouri law, therefore, insurance companies whose policies are subject to underwriting can: 1) ask applicants whether or not they have ever been tested for the presence of antibodies to HIV; 2) require applicants to be tested for exposure to HIV before considering their insurance application; 3) selectively ask some applicants, but not others, to take the HIV test;[5] 4) use test procedures that are not 100 percent accurate to determine the applicant's HIV status; 5) fail to provide for informed consent from applicants who are asked to take the HIV test;[6] and 6) fail to provide pre- and post-test counseling for an insurance applicant who is asked to take the HIV test.

The Issue

In considering the insurance industry's responsibility to those who test positive for HIV, the whole purpose of health insurance should be remembered: to spread the risk of illness across a large population of insureds, so that no one insured will have to bear the entire burden of a medical bill. Thus, it is entirely expected that many insureds (and probably most, at one time or another) will make claims on their health insurance policies. If insurance were sold only to those who never would need it, then there would be no purpose in applying for insurance. With a large enough population of insureds, the cost of large, and even catastrophic, claims by some insureds can be paid from premiums and other earnings of the company.[7] Insurance actuaries use

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2. Act approved June 1, 1988, 1988 Mo. Legis. Serv. 285 (Vernon) (S. COMM. SUBST. H. COMM. SUBST. H.B. Nos. 1151 & 1044, § 8.2) [hereinafter H.B. Nos. 1154 & 1044].

3. *Id.* § 8.3.

4. *See* 13 MO. CODE REGS. 1382-85 (Sept. 1, 1988). The proposed regulations propose to require informed consent, to restrict dissemination of test results, to allow testing only if an insurance company tests all applicants of the same risk class, to prohibit inquiry into and discrimination based on sexual orientation, and to prohibit insurance companies from refusing to cover ARC and AIDS, although they could make reasonable limits as to lifetime benefits for such diseases.

5. This is true unless the proposed regulation of the Division of Insurance is adopted.

6. This is true unless the proposed regulation of the Division of Insurance is adopted.

7. Insurance companies also make money by investing the premiums that are earned until the money is needed to pay claims.

statistics on morbidity and mortality to predict the expected loss of the class of insured persons, so that the premiums necessary to cover those losses can be set.

While private companies generally sell health insurance, the private insurance industry is regulated in all states. This is due to the fact the industry is expected to meet at least some of the social need for payment of the health care costs of our population. Unlike most other industrialized nations, the United States has not adopted universal health care as the preferred method of providing for the health care needs of the population.

As in most states, the Division of Insurance in Missouri regulates rates, form and content of policies. It also has the power to ensure that companies do not violate the Unfair Practices and Fraud Act.[8] For example, pursuant to its authority, the Division of Insurance has issued a regulation that prohibits discrimination based on blindness and partial blindness, and on physical or mental impairment, unless such a denial of insurance based on physical or mental impairment is related to actual or reasonably anticipated experience or on sound actuarial principles.[9] The Missouri General Assembly has, in addition, specifically prohibited sex or marital status discrimination as to benefits or coverage.[10]

Further, on social policy grounds, various states have restricted the insurer's ability to deny insurance, or increase rates, based on sex, sexual orientation, marital status, physical and mental disability, certain genetic traits (e.g., sickle cell anemia, Tay Sachs), and/or predisposition to certain medical problems (e.g., prohibiting discrimination against women whose mothers used DES, or against those who have tested positive for antibodies to HIV).[11] The

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8. MO. REV. STAT. §§ 375.930-948 (1986). Under the Unfair Practices and Fraud Act, insurance companies in Missouri may not engage in "unfair discrimination between individuals of the same class and of essentially the same hazard" in the issuance of health insurance. *Id.* § 375.936(11)(b). Insurance companies design different classes for purposes of rates. For example, all the employees of a large company that has a group health insurance plan might be considered one class for purposes of establishing rates.

9. MO. CODE REGS. tit. 4, § 190-13.170 (1985).

10. MO. REV. STAT. § 375.995 (1986).

11. Hoffman & Kincaid, *AIDS: The Challenge to Life and Health Insurers' Freedom of Contract*, 35 DRAKE L. REV. 709, 720 (1986-1987); Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1798 (1987). For HIV, see D.C. CODE ANN. § 35-223 (1988), CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1988); in addition, the insurance departments in Arizona, Delaware, Massachusetts, Michigan, and North Dakota have issued regulations prohibiting insurance companies from testing applicants for HIV antibodies and from asking applicants about prior tests. *See* Schatz, *supra*, at 1793 n.67. The validity of the Massachusetts regulation on HIV testing was upheld in Life Ins. Ass'n v. Singer, No. 87-5321 (Sup. Ct. Suffolk Co., Mass. June 7, 1988); the validity of the District of Columbia Act was upheld in American Council of Life Ins. v. District of Columbia, 645 F. Supp. 84 (D.D.C. 1986); while the court struck down a similar regulation issued by the New York Superintendent of Insurance in *In re* Health Ins. Ass'n v. Corcoran, No. 01-

issue for the Missouri legislature is the degree to which health insurance companies should be restricted or regulated with regard to use of information about HIV, or with regard to the manner in which such information is obtained.

There are many more persons who are infected with HIV than those who actually have contracted ARC or AIDS. The exact number of those with HIV is unknown, but estimates range from 276,000 to 1,750,000 persons nationwide, with the most commonly accepted estimate being between 1,000,000 and 1,500,000.[12] This number will continue to grow in the foreseeable future until education programs and/or a cure succeed in slowing the spread of the virus. The incidence of HIV infection is disproportionately high among male homosexuals and bisexuals, IV drug users, hemophiliacs, and heterosexual partners of these persons, as well as among blacks and Hispanics.[13] The vast majority of those infected with HIV do not have any symptoms of AIDS or ARC, and many do not even know they have the virus. As of July 4, 1988, 66,464 people in the United States had been diagnosed with AIDS since the disease was first recognized in 1981.[14]

Some of those who are infected with HIV will develop ARC or AIDS. The exact percentage is unknown,[15] as are the reasons that a person will or will not progress from HIV infection to ARC or AIDS. Scientists are examining the role of "co-factors" (other factors in a person's health that may interact with HIV in such a way as to result in the onset of ARC or AIDS), as well as differences in genetics, immune response, virulence of different strains of the virus, number of exposures to the virus, and environmental factors which may affect the onset of ARC or AIDS.[16] Moreover, scientists are developing drug therapies to halt or slow the progression of HIV; AZT has already

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87-ST1078 (Sup. Ct. N.Y., Albany County, N.Y. April 16, 1988).

12. Centers for Disease Control, *Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge*, 36 MORBIDITY & MORTALITY WKLY. REP., no. S-6, Dec. 18, 1987, at 14-18.

13. *Id.* at 10-11, 18, 36.

14. Heyward & Curran, *The Epidemiology of AIDS in the U.S.*, 259 SCI. AM. No. 4, at 72, 75 (Oct. 1988).

15. The court in Life Ins. Ass'n v. Singer referred to five different scientific studies. The studies made the following varying estimates of the time probability of a person with HIV developing AIDS: 1) 2-19% likelihood within 2 to 5 years; 2) 34% likelihood within 3 years; 3) 20-30% likelihood within 4 years; 4) 50% likelihood within 2 years; and 5) 25-50% likelihood within 5-10 years. *See* Life Ins. Ass'n. v. Singer, No. 87-5321, slip op. at 5 (Sup. Ct. Suffolk, Co., Mass. June 7, 1988). It has also been estimated that half of the persons with HIV will develop AIDS within 10 years. Heyward & Curran, *supra* note 14, at 80. A recent British study concluded that the average time to progress from HIV infection to AIDS is 15 years. Rees, *The Somber View of AIDS*, 326 NATURE 343 (1987).

16. J. Campbell, Medical Aspects of AIDS-Related Litigation, *AIDS Practice Manual: A Legal and Educational Guide* II-3 n.40 (P. Albert, L. Graff, & B. Schatz eds. 1988); *see also* Gallo & Montagnier, *AIDS in 1988*, 259 SCI. AM. No. 4, at 41, 47 (Oct. 1988).

proven to have some success in this regard.[17] Thus, it is entirely possible that some asymptomatic carriers of HIV will never develop ARC or AIDS.

The likelihood that a person infected with HIV will be able to obtain health insurance varies, depending on whether he or she is an employee, or is self-employed, or is unemployed. Among employees, insurance availability depends upon whether or not the employer provides insurance for its workers, and, if so, whether the employer is self-insured, or has a large group or small group insurance plan.

Persons to whom insurance is least likely to be denied, even if they have been exposed to HIV, are those working full-time for employers who purchase large group policies through insurance companies. Normally, these employees automatically are provided with group health insurance coverage after they have been employed for a certain minimum period, without having to undergo any type of physical examination.[18]

Those who work for employers with small group health insurance plans (normally under 50 employees), as well as the self-employed or unemployed, usually must be approved by underwriting before obtaining insurance.[19] Persons who test positive for HIV in these groups, if there are no restrictions on the use of HIV antibody tests, will face the greatest problems in obtaining health insurance.

While the denial of health insurance coverage to those who are asymptomatic carriers of HIV most directly affects the individuals denied coverage, as well as their dependents, a decision to allow insurance companies to deny health insurance coverage based on the fact that a person is a carrier of HIV also will impact on the general public. This impact will focus on two crucial areas: 1) payment of the health care expenses of those who are uninsured; and 2) the precedent set for genetic screening by insurance companies.

First, who will pay any future medical bills of those who are healthy but have been unable to obtain insurance because of a positive HIV test? If a financially ruinous illness of any sort strikes, uninsured persons and their dependents most likely will look either to the taxpayer (through public hospitals, Medicaid, or, if disabled for over two years, Medicare) to pay the bills, or will look to the bankruptcy court to discharge their medical debts. This can occur regardless of whether the illness is due to or unrelated to AIDS. Thus, the health care bills of such uninsured are likely to be passed, in whole or in part, onto taxpayers and health care providers.

While the total average lifetime cost of care of someone who actually gets AIDS is significant,[20] and such an expense can be devastating to an uninsured

17. Yarchoan, Mitsuya, & Broder, *AIDS Therapies*, 259 SCI. AM. No. 4, at 110-19 (Oct. 1988).

18. The potential problems faced by those employed by self-insuring employers, who do not buy private insurance, are discussed in Part II of this Article.

19. Hoffman & Kincaid, *supra* note 11, at 717 n.51.

20. Andrulis, Beers, Bently, & Gage, *The Provision and Financing of Medical*

individual, the expense is well within the range of other serious illnesses that are covered by insurance. For example, liver transplant patients have lifetime medical costs that are three to four times as high as that of an AIDS patient,[21] and kidney dialysis patients have lifetime health care costs of approximately $158,000, which is considerably higher than the cost of AIDS.[22] By the end of 1991, when it is projected that 270,000 persons will have been diagnosed with AIDS since the beginning of the epidemic,[23] experts project that the cost of treating people with AIDS will be only 1.4 percent of the total national health care bill.[24] But, because many diagnosed with AIDS lack insurance, 40 percent of persons with AIDS are covered by Medicaid — at taxpayer expense.[25]

Second, advances in medical technology may make, and in some cases already have made, it possible to determine those who have a genetic predisposition to certain illnesses, such as Huntington's disease, cystic fibrosis, some cancers, manic depression, adult polycystic kidney disease, and other diseases.[26] If we allow insurance companies to require applicants for insurance to be tested for HIV, we are setting a precedent that insurance companies later will use, as testing technology improves, to argue that they should be permitted to require testing for predisposition to a wide variety of other serious illnesses. Indeed, anyone who drives a motor vehicle is "predisposed" to having an accident that will cause personal injury or requiring medical care. Once we establish a standard that those who are merely "predisposed" to serious illness or accident (rather than those who already have actual diagnosed diseases), may not obtain health insurance, we are establishing a dangerous precedent that will affect far more people than merely those who are infected with HIV.

Legislative Proposals

There are a number of issues that should be addressed by the Missouri legislature in the 1989 session. The critical one is whether underwriters may use HIV test results in underwriting. For the reasons below, such use of HIV test results should be prohibited. But, even if the legislature allows the use of test results, it must provide for quality control, right to contest the decision of

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Care for AIDS Patients in U.S. Public and Private Teaching Hospitals, 258 J.A.M.A. 1343, 1345 (1987) gives an estimate of $20,320 per patient; Fineberg, *The Social Dimensions of AIDS*, 259 SCI. AM. No. 4, at 128, 133 (Oct. 1988) gives an estimate of $50,000 to $60,000; a figure of $33,000, based on a survey by the Health Insurance Association of America and the American Council of Life Insurance, is cited by Levi & Schatz, *AIDS-Related Issues and Insurance*, 1 N.A.I.C. PROC. 661 (1987).

21. Fineberg, *supra* note 20, at 133.

22. Sullivan, *Cost of AIDS Care is Half What Was Projected, Economist Reports*, N.Y. Times, June 8, 1986, § 1, at 30, col. 1.

23. Centers for Disease Control, *supra* note 12, at 14.

24. Schatz, *supra* note 11, at 1794.

25. Fineberg, *supra* note 20, at 134.

26. Schatz, *supra* note 11, at 1798; Otten, *Price of Progress: Efforts to Predict Genetic Ills Pose Medical Dilemmas*, Wall Street J., Sept. 14, 1987, at 27, col. 3.

the insurance company, informed consent, pre- and post-test counseling, and confidentiality.[27]

Use of HIV test

Insurance companies should not be allowed to require an HIV test as a part of the underwriting process for four reasons: 1) the financial burden that will be placed on the taxpayer and health care providers; 2) unfair discrimination; 3) lack of accuracy of the tests; and 4) better tests exist.

1. Financial Burden

Someone will have to pay the health care bills, regardless of the nature of the illness, for those who are uninsured. Since health insurance is designed to spread the risk of illness over a large pool of insureds, better public policy requires insurance companies to include those who test positive for HIV in their national pool of insureds. Doing so avoids foisting these health care costs onto the taxpayers and health care providers of municipalities and states having the highest number of uninsured HIV carriers. Indeed, the insurance industry has long opposed universal federally funded health care on the grounds that it (the insurance industry) is better equipped to manage health care costs than is the federal government.[28] It should not now be allowed to dump the future health care costs of those who are currently healthy onto the taxpayers and health care providers, simply because it fears lower profits.

2. Discrimination

The use of HIV test results is discriminatory. Only those not automatically covered by large group insurance policies will face testing. Thus, two classes of health insurance applicants will arise: those lucky enough to work for large employers that provide large group insurance automatically upon employment, and those who work for smaller employers, are self-employed or unemployed. Yet there is absolutely no reason to believe that people who are self-employed or who work for small employers are any more likely to have health problems than people who work for large employers. Thus, if insurance companies are allowed to use HIV tests results in underwriting, such use will be directed only at the small percentage of the population that is not covered by group insurance.[29]

Moreover, among the percentage of the population that is subject to

27. This is true unless the Division of Insurance does so before the 1989 legislative session.

28. Schatz, *supra* note 11, at 1805.

29. *Id.* at 1795; Perkins, *Prohibiting the Use of the Human Immunodeficiency Virus Antibody Test by Employers and Insurers*, 25 HARV. J. ON LEGIS. 275, 281 (1988).

insurance underwriting, a policy of allowing insurance companies to exclude persons with HIV from coverage will result in greater testing of racial minorities, hemophiliacs, and those thought to be gay or bisexual males or IV drug users, in that HIV is disproportionately concentrated in these minority groups.[30] Because of the cost of testing (an average of $6.00 for each ELISA test and $50.00 for each Western Blot test),[31] insurance companies are not likely to test everyone who applies for insurance. Indeed, the American Council of Life Insurers and the Health Insurance Association of America do not propose testing all applicants, nor even a random sample of applicants; instead, they seek to test only those whom they believe to be in groups that have a disproportionate degree of HIV infection.[32] Racial minority applicants are easy to identify, and are likely to be subjected to HIV testing at a much higher rate than whites. In addition, companies are likely to require testing of those men whom, rightly or wrongly, they suspect to be gay or bisexual. This will lead underwriters (often illegally) to use such factors as geographic location of residence, occupation, marital status, and various stereotypes to decide whom to test; it will be virtually impossible for an individual applicant to prove that an insurance company used improper or illegal factors in determining that the applicant should be tested.

The result is that those subject to HIV testing (whether based on assumptions as to the person's race, ethnicity, IV drug use, or sexual orientation), and who test positive, will be excluded from coverage, while those who are not tested will not be excluded even if they also would test positive. This will lead to unfair discrimination against those who are tested, compared to those not tested. Not tested will be those employed by large employers that provide insurance that does not require underwriting, and those who belong to the "right" sex, race, or class.[33]

3. Accuracy of Testing

Tests for antibodies to HIV are not 100 percent accurate and can lead to a denial of insurance due to false positive results. These occur for several reasons. First, the decision as to whether or not a test is positive depends in part on the darkness of the various colors or bands on the test strip. There is no uniform standard defining what constitutes a positive test; different labs use different criteria. Thus, whether a test result is labeled positive or negative is, in part, a function of the standards used by the particular laboratory. Second,

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30. Centers for Disease Control, *supra* note 12.

31. *Quality AIDS Testing: Hearing Before the Subcomm. on Regulation and Business Opportunities of the House Comm. on Small Business*, 100th Cong., 1st Sess. 41, 50 (1987) (statement of L. Miike, Analyst of Office of Technology Assessment) [hereinafter Miike].

32. Quoted in Schatz, *supra* note 11, at 1799.

33. Since intravenous drug use is concentrated in lower-income groups, it can be anticipated that insurance companies will disproportionately require testing of those who are from lower socio-economic classes.

human error can cause mistaken labeling of a test result. Third, the blood tested can show a reaction to the cultured human cells that are used for the test, again causing a falsely positive result.[34]

Even under ideal laboratory conditions, with highly trained technicians, there will be at least a few falsely positive and falsely negative test results. Studies by the College of American Pathologists under actual laboratory conditions (rather than idealized laboratory conditions) demonstrate that the ELISA and Western Blot tests, the two most commonly used tests, yield false positive results at significantly higher rates than those hypothesized under an ideal testing condition. The accuracy of the test results depends on two measures, the sensitivity and the specificity of the test. The *sensitivity* of the test measures the capacity of the test to identify correctly those blood samples that have HIV antibodies (*i.e.*, those samples that are positive). The *specificity* of the test measures the capacity of the test to identify correctly those blood samples that do not have HIV antibodies (*i.e.*, those samples that are negative).[35]

The cheaper of the two tests, the ELISA test, has a sensitivity of 99.4% and a specificity of 98.3% as used in actual laboratories (as opposed to use under perfect conditions), while the Western Blot test has a sensitivity of 90.7% and a specificity of 95.3%. Put another way, only 0.6 percent of people who have HIV will be missed on the ELISA test, while 1.7 percent of those who do not have the virus will be labeled falsely as positive. The Western Blot test will miss 9.3 percent of those who have HIV and will label as falsely positive 4.7 percent of those who do not have the virus. While this may sound like a reasonable degree of accuracy, use of only one ELISA test to determine HIV status in a population with a low degree of infection (for example, Peoria, Illinois) would result in 1,700 out of 100,000 persons tested being labeled falsely as positive, with 99.4 *percent* of those testing positive being in fact negative. If a follow-up "confirmatory" Western Blot test, which would cost insurance companies approximately an additional $50.00,[36] is done on those who tested positive under the ELISA test, 80 will still be labeled falsely as positive for HIV, and 89.9 *percent* of those persons labeled as positive will in reality be negative.[37] Thus, while a small *number* of persons would be denied

34. Miike, *supra* note 31, at 58-63; Okie, *AIDS "False Positives": A Volatile Social Issue*, The Washington Post, July 23, 1987, at A3, col. 1.

35. Miike, *supra* note 31, at 2-4.

36. *Id.* at 50, 67.

37. *Id.* The data for blood donors in Peoria, Illinois are given in Mr. Miike's testimony, and are used in this Article, because it is likely that the degree of HIV infection in Missouri is similar to that of blood donors in Peoria. The calculations that show the results mentioned in the text are as follows: approximately 0.01% of blood donors in Peoria are infected with HIV. Therefore, in a population like that of Peoria, out of 100,000 people, 10 will have HIV, and 99,990 will not have HIV. If those 100,000 people are given an ELISA test, the 10 people who have the virus will test positive (99.4% X 10), but an additional 1,700 people who do *not* have the virus also will test positive (1.7% X 99,990). The *percentage* of positive test results that are false will be, therefore, 99.4% (1,700 false positives divided by 1,710 total positives). If a

insurance based on a false test result, (but who wants to be one of the victims of false test results?), a substantial *percentage* of those denied insurance by insurance companies because they test positive for HIV antibodies would not, in fact, have the virus. That is, they would become uninsured on the insurance company's belief that they have HIV, when they in fact do not. That only a small number of people are improperly denied insurance in this way will be little comfort to those unable to obtain insurance due to false test results. Finally, the taxpayer and unpaid health care providers will bear a significant portion of the burden of such unfair discrimination.

4. Better Tests

Even when accurate, HIV tests are not the best measure of a person's AIDS related health. One can be completely asymptomatic and still carry HIV. A far better measure of a suppressed immune system is the T4 cell count. When the number of T4 cells falls below a certain number, one's immune system is definitely, and probably irretrievably, compromised.[38] It would be appropriate for insurance companies to use substantially reduced T4 cell count, or other measures of an *already* compromised immune system, as a proper gauge of likely future health problems.

Regulation of Test Use

Should the legislature decide to allow insurance companies to continue using HIV test results in their decision as to whether to insure, it, at a minimum, should regulate this testing in the areas of: 1) the tests required; 2) discrimination; 3) use of prior test results; 4) informed consent, counseling, and confidentiality.

1. Tests Required

Despite the inaccuracy in HIV testing, particularly where only one test is conducted, Missouri law contains *no* provisions regulating the type of test required, nor any provision for an applicant to challenge an insurance company's positive test result. At a minimum, the law should require that testing be performed only in licensed laboratories, in accordance with the latest federal government's standards, and that more than one ELISA test and at least one

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·Western Blot test is then done on the ELISA positive tests, the Western Blot will confirm as positive only 9 out of the 10 people who actually are positive (*i.e.*, one person will test falsely negative) (90.7% X 10), and 80 of those falsely identified as positive on the ELISA will continue to be falsely labeled as positive (4.7% X 1,700). The *percentage* of positive test results that are false after both an ELISA and a Western blot test will be 89.9% (80 false positives divided by 89 total positives).

38. *See* Gallo & Montagnier, *supra* note 16; Redfield & Burke, *HIV Infection: The Clinical Picture*, 259 SCI. AM. No. 4, at 90-98 (Oct. 1988).

other test be done before a blood sample is deemed positive for HIV.[39] The law also should allow applicants to have blood tests re-done by other licensed laboratories, and to challenge an insurance company's denial of insurance.

2. Discrimination

The law should prohibit discrimination based upon sexual orientation in insurance. The National Association of Insurance Commissioners, in December, 1986, recommended that insurance commissioners prohibit insurance underwriters' inquiries directed at determining sexual orientation and any use of sexual orientation in the underwriting process.[40] Such a prohibition of discrimination based on sexual orientation is necessary to avoid insurance companies from simply refusing to insure those whom they, rightly or wrongly, believe to be gay males, regardless of HIV status. To allow such discrimination would foist a substantial part of their health care cost onto the taxpayers or health care providers.

3. Use of Prior Test Results

Missouri should prohibit insurance companies from inquiring into past HIV testing or from using the results of prior HIV tests. Failure to include such a prohibition will deter voluntary or anonymous testing and research project participation. This deterrence will rise out of fear by individuals that they, their doctors, or researchers, will be asked about the results of prior HIV tests. Indeed, some people have been denied insurance simply for *taking* the HIV test, even though the result was negative. Such denials apparently were founded upon the belief that one must believe he or she is infected and is therefore a bad health risk.[41] Thus, the important public policy of encouraging voluntary testing of persons who have engaged in high-risk behavior will be thwarted. If the legislature decides to allow the insurance companies to test blood for HIV, it should at least forbid the companies from inquiring into past test results.

4. Informed Consent

It is crucial, if testing is allowed, that insurance companies be required to provide specific informed consent to the applicant before the applicant decides whether to proceed with the application. Insurers should be required to provide

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39. *See* Centers for Disease Control, *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 MORBIDITY & MORTALITY WKLY. REP., Aug. 14, 1987, at 509-515.

40. *See* National Association of Insurance Commissioners, Advisory Committee on AIDS, *Medical/Lifestyle Questions and Underwriting Guidelines Affecting AIDS and ARC*, Proposed Bulletin, 1 N.A.I.C. PROC. 659 (1987).

41. This is based on information given to the author by a client, as well as anecdotal stories heard from other attorneys.

pre- and post-test counseling if they test applicants, since counseling is an essential part of any HIV-testing program. Such counseling is imperative both to ensure those who test positive receive necessary emotional support and to refer positive testees to doctors and counselors. Further, such counseling will ensure that those who test negative do not neglect the necessity of safe-sex or safe needle use in the future. Finally, the legislature must protect the test result confidentiality of those tested by insurance companies. Insurance companies should not be permitted to disclose test results to *anyone* or any institution other than the applicant or the applicant's designated physician. Otherwise, the risk of discrimination is great, particularly in smaller communities.

EMPLOYERS

Another group that faces potential problems are those employed by self-insuring employers. Such employers do not purchase private insurance for their employees. Instead they pay for employees' health care needs out of reserves they establish. These companies could, for example, decide to eliminate ARC and AIDS as covered conditions under their self-insurance policies. They are not regulated by state insurance laws, but rather under the federal Employee Retirement Income Security Act of 1974 (ERISA). Approximately 50 percent of all employers provide health benefits through self-insurance plans.[42] While, under federal law there are severe limitations on state regulation of such insurance policies, the Missouri legislature should take the few steps it can to make sure that employees working for self-insuring employers have the same protections as those covered by individual and group insurance.

All employers should be prohibited from requiring HIV tests as a condition of employment, from inquiring into results of past HIV tests, and from requiring their employees to undergo HIV testing. Without such a measure, some employers, particularly self-insuring employers (or, large employers covered by group insurance policies and pressured by insurance companies to test), may require testing and fire or refuse to hire those who test positive. This will result not only in the denial of health insurance, but, in addition, such persons will be unemployed and, possibly, unemployable. This could result in increased demands on unemployment insurance and welfare systems, as well as reduced contributions to our beleaguered Social Security system. Further, because the virus is not casually transmitted,[43] there is absolutely no reason to discriminate in employment against those with the virus. Those subject to discrimination should have the right to file suit immediately, and avoid the delay of the Human Rights Commission complaint procedure.

Employers also should be prohibited from discriminating based on sexual orientation. Otherwise, those perceived as gay, regardless of HIV status, may

42. *See* Perkins, *supra* note 16, at 281.

43. Surgeon General's Report on Acquired Immune Deficiency Syndrome, at 13, 21-25 (1988).

become a class of unemployables, forced to resort to the unemployment compensation, welfare, and public health care systems for their financial and medical needs. Not only is it a matter of simple justice that persons should not be denied employment because of their sexual orientation, but as well the exclusion from employment will preclude their contributing money to Social Security or income tax, money that is essential to keep our Social Security system afloat, and to help reduce the massive federal deficit.

MANDATORY TESTING

The Act requires the mandatory testing of all prisoners, certain users of methadone treatment centers and certain inmates of state mental health facilities. The Surgeon General opposes mandatory testing because of the false negative and false positive problem, and the cost and inefficiency of such testing programs.

> Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior. The prevention behavior described in this report, if adopted, will protect the American public and contain the AIDS epidemic. Voluntary testing will be available to those who have been involved in high risk behavior.[44]

Accordingly, all mandatory HIV testing requirements should be deleted from the Act.

Under a mandatory testing scheme a substantial percentage of persons will falsely test positive for antibodies to HIV, as discussed previously. They are likely to face harassment, discrimination and social isolation, even though they do not have the virus.

Mandatory testing is a waste of precious economic resources that could better be spent on public education concerning AIDS and HIV transmission. Estimates of the cost of testing only prisoners run over $110,000 per year.[45]

Further, the confidentiality and identity of those who test positive cannot be assured. Indeed, the Act provides for disclosure to various officials of the results of the HIV tests. Under such circumstances, it is inevitable that the results of one's HIV tests will leak out to others. In fact, the Department of Corrections admits that inmates who have tested positive have been threatened by other inmates, indicating that the inmates' test results have leaked to other inmates.[46] Even if fewer people were given right of access, the mere existence

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44. *Id.* at 33.

45. Fiscal Note No. 2235-5 (March 24, 1988). Since the fiscal note estimates 36,000 tests of prisoners each year, it is likely that the estimate of the cost of testing is low. As the fiscal note points out, not only will the tests themselves cost money, but the state will have to hire additional employees to carry out and analyze the tests.

46. *See AIDS Testing of Inmates Shows Fewer Infected Than Was Feared*, St.

of the data gives rise to the threat of theft of computerized information. Such theft has occurred with regard to lists of HIV-antibody positive individuals. Given the pervasive discrimination (social, as well as in employment and housing) against those who are HIV-antibody positive, *any* breach of confidentiality, however slight, will be devastating to the person involved.

In addition, mandatory testing is counter-productive to the goal of halting the spread of HIV. Mandatory testing drives those most at risk underground, thwarting attempts at education. Drug addicts, for example, will avoid methadone clinics if they risk being tested at such clinics, and if the identity of those testing positive is reported to the Department of Health. This will retard our ability to deal with the problem of drug abuse. In contrast, without proper and intensive public education, those who test negative will likely have a false sense of security and may engage in unsafe practices. Moreover, persons can falsely test negative, as discussed previously.

Finally, mandatory testing is not necessary to track the spread of the disease. Public Health officials already have ample data concerning the manner in which the virus is spread and the practices that cause risk. The information now available could be used to develop educational materials specially targeted to the various groups most at risk, as well as the general population.

CONCLUSION

While the Missouri General Assembly made some beginnings in dealing with the AIDS crisis in the 1988 legislative session, it must look closely at the need to regulate the insurance industry and employers, so as to prevent the epidemic from being used as an excuse to dump a large number of our citizens onto the public welfare and health care systems. Moreover, while the legislature should be commended for limiting the number of groups subject to mandatory testing, it needs to eliminate mandatory testing altogether. Funds that would be used for mandatory testing should, instead, be appropriated for massive, detailed and specific public education programs on the modes by which HIV is transmitted.

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