Insurance testing for HIV (human immunodeficiency virus) infections has generated much controversy and disagreement among insurers, insurance regulators, insurance applicants, legislators, and other policy makers. Yet, there is little information on who insurers test and what tests they require. This survey is therefore an attempt to provide a view of HIV testing in the context of other routine tests required by health insurers and had a twofold purpose: 1) to collect basic information on underwriting practices and the use of medical screening by health insurers; and 2) to document how health underwriters are responding to the AIDS epidemic.

This survey was conducted as part of an Office of Technology Assessment (OTA) assessment on medical testing and health insurance that will be published at a later date. OTA is also monitoring AIDS-related developments for the U.S. Congress, and the survey results are being published by OTA as the second in a series of Staff Papers on AIDS-related issues.

Background

About 14.5 million non-Medicare individuals and their family members have health insurance without the benefits of group membership. These are the principle individuals that must meet underwriting standards to obtain health coverage, and their insurers were the focus of the OTA survey. Commercial companies insure 9.3 million; Blue Cross and Blue Shield (BC/BS) plans, 4.2 million; and Health Maintenance Organizations (HMOS), 1 million.

In order to evaluate an individual's insurability, health insurers ask pertinent questions regarding the applicant's medical history, gather information on the applicant's past and current medical condition through statements and records provided by the applicant's attending physician, and in selected instances, require the applicant to undergo a physical examination and medical testing. AIDS antibody testing, which, when positive, reflects infection with the AIDS virus, is considered by insurers to be a logical and essential component of this overall risk assessment.

The survey was sent to 88 commercial insurers who comprise 70 percent of the commercial, individual health insurance market; to 15 of the 77 BC/BS plans; and to the 50 largest local and national HMOS in the United States. Seventy-three of the eighty-eight commercial insurers responded, although only 62 met the survey requirements; approximately 57 percent of the commercial, individual health insurance market is represented in the survey findings. All 15 BC/BS plans completed the survey, and 39 of the 50 HMOS responded, but only 16 reported that they allow individually underwritten enrollment. Overall, 83 percent of the commercial carriers, BC/BS plans, and HMOS that were surveyed responded.

Survey Results

Medical and Other Factors in Risk Classification

There are three basic outcomes of risk classification: the applicant is covered on a standard or substandard basis, or not at all. Almost three-quarters of individual applicants for commercial health coverage are classified as "standard" by the responding insurers and can purchase a policy without extra premiums

or special limitations. Twenty percent are rated as "substandard" and issued policies that exclude preexisting medical conditions, have a higher than standard premium, or both. The exclusion may be for a specific condition, such as gallstones, or for an entire organ system, such as reproductive disorders. Finally, 8 percent of applicants are judged uninsurable and denied coverage. Most serious diseases are uninsurable, including severe obesity, diabetes mellitus, emphysema, alcoholism, coronary artery disease, cancer, schizophrenia, and AIDS.

Risk classification by the responding BC/BS plans is similar to the commercial approach except for four "open enrollment" plans that accept all applicants regardless of health status. The respondents accept 83 percent of individual applicants as standard, 9 percent with substandard policies, and deny coverage altogether to 8 percent.

HMO risk classification differs from the o the rs. Federally qualified plans are restricted to either accepting applicants at a community rate or denying membership altogether. As a result, exclusion waivers and substandard premiums are not common. The responding HMOS, however, were no more willing to underwrite high-risk applicants than the commercial insurers or BC/BS plans. They accept 73 percent on a standard basis and deny membership to 24 percent of individual applicants.

Other factors besides ill health can seriously hamper access to commercial health coverage by individual applicants and their family members. Dangerous health habits (e.g., drug abuse), illegal or unethical behavior (e.g., criminal business practices), age, occupation, and financial status were most commonly cited by commercial insurers as critical to determining insurability. Healthy habits, such as non-smoking, were also rated as important, an indication of the increasingly common use of premium credits for non-smokers. Place of residence was an important factor to a significant minority of commercial insurers, mostly due to concerns about insurance fraud known to occur in certain localities and because of regional variations in health care costs. Contrary to guidelines issued by the National Association of Insurance Commissioners (NAIC), thirteen companies use sexual orientation in underwriting and five consider it important or very important. Three companies request an attending physician statement (APS), and two order a physical exam based on sexual orientation. It is unclear how insurers ascertain an applicant's sexual preference. Most of the respondents (48/61) provided samples of their health insurance applications, none of which included any questions concerning sexual orientation or lifestyle.

In contrast, BC/BS insurability is almost purely a question of medical condition. All the responding BC/BS plans, except the four that hold open enrollment, reject some applicants in poor health. Nearly half of the plans deny nongroup applications because of alcohol or drug abuse. No BC/BS plan reported using sexual orientation in underwriting.

Access to HMO membership is fundamentally a matter of health status as well. However, age, type of occupation, health enhancing behavior (e.g., non-smoking), and sexual orientation were also considered key to insurability by 19 percent or more of the responding plans. As in the case of the commercial carriers, it is not clear how sexual orientation is identified by the four HMOS that consider it a key underwriting factor.

Sources of Medical Information

Beyond the health information provided directly in insurance applications, an APS is the most common supplemental source of information. The commercial carriers require an APS for 20 percent of their applicants. Almost three-quarters of BC/BS plans order a physician statement for at least 30 percent of their applicants, and more than half the responding HMOS require one. In fact for most applicants, in lieu of ordering a laboratory test, traditional insurers and HMOS alike usually rely on the test results reported by the applicant's physician. HIV testing is

an exception in a few cases: three responding commercial carriers require an HIV test on every applicant in areas of high prevalence, such as New York and California.

Health insurance applicants are rarely subjected to physical examinations and medical tests. Only 4 percent of applicants to the responding commercial insurers were required to have a physical exam or some type of blood and/or urine test. Just two of the BC/BS plans require physical exams, and one requires medical tests for some of its individual applicants. Only three of the HMOS sometimes require physical exams or medical tests.

AIDS Policies

Fifty-one (86°h) of responding commercial insurers either screen or plan to screen individual applicants for HIV infection; 41 do it currently and 10 plan to. The most common approach is by incorporating questions in the health history portion of the application. Asking AIDS-related questions is often less an effective screen than it is an important tool for contesting preexisting condition claims. If an applicant knowingly misrepresents his or her health condition (e. g., HIV seropositivity, recognized symptoms of AIDS, or fully diagnosed AIDS or ARC), the insurer may have grounds for denying reimbursement for the condition. An admission of AIDS, ARC, or HIV seropositivity results in immediate denial of the application. Forty-two of these fifty-one companies request a physician statement for selected applicants in order to determine the presence of AIDS symptoms or other risk factors. The APS may contain the applicant's HIV status as well. HIV testing is also quite common. Thirty-one companies routinely test individual health insurance applicants for HIV antibodies; of these, 7 test all applicants, 14 test only those considered to be "high-risk," and 10 test according to various criteria (e.g., State of residence, medical history, policy amount, etc.). All those who test use the ELISA-ELISA-Western blot series. In States and localities where HIV testing is prohibited, 17 insurers require T-Cell subset studies as a substitute.

Eleven of the responding BC/BS plans either screen or plan to screen individual applicants for AIDS exposure; of these, eight currently do, and three plan to. All eleven plans ask an AIDS-related question in their applications. If applicants answer that they have had or have been treated by a physician for AIDS or ARC, coverage is denied. As in the case of the commercial insurers, BC/BS plans ask about AIDS not only for screening purposes but also as an important means for contesting preexisting condition claims. In addition, nine of the eleven plans sometimes request an APS to help evaluate an applicant's risk for AIDS. Only one plan intends to test high-risk applicants for HIV infection.

Eight of the fifteen responding HMOS screen individual applicants for exposure to the AIDS virus. Three of the plans that do not are prohibited from doing any medical screening by State law. All the plans that screen ask an AIDS-directed question in the health history portion of their enrollment form. As in the case of the commercial insurers and BC/BS, an admission of AIDS, ARC, or HIV seropositivity results in denial of the application, and the AIDS-related questions on the application are used not only to screen, but also to contest preexisting condition claims (where allowed). Six HMOS request an APS to determine the presence of any AIDS symptoms or other risk factors. HIV testing of high-risk applicants is done by only two plans and is under consideration by a third.

AIDS Claims Experience and Cost Projections

Forty-five commercial insurers had reimbursed at least one individual policyholder for AIDS-related care. More than half of the respondents reported 10 AIDS cases or less, while 4 had reimbursed more than 50 individuals. On average, each insurer covered the care of 22 AIDS-related cases. (Of the remaining responding insurers,

six reported no AIDS-related cases, 10 were unable to report their experience, and one had recently withdrawn from the individual market.)

Twenty-one insurers provided projections of AIDS-related claims costs for 1987, forecasting total claims of $11.04 million for individual health insurance, an average of $0.53 million per insurer. Two companies did not expect any AIDS cases in 1987--both specialize in insurance for seniors--while four projected costs of $1.3 to $2.3 million for individual health policies. (Cost projections were not furnished by 40 companies.) Twenty-two insurers who had received at least one AIDS-related claim reported linking no one with a preexisting condition for AIDS; 11 found 1 to 9 percent of cases to be preexisting; 10 companies, 10 to 50 percent; and two companies, more than 60 percent.

Ten BC/BS plans reported reimbursing 3,933 subscribers for AIDS-related care, an average of 393 subscribers per plan (although one plan alone accounted for 3,000 cases). (The BC/BS plans' AIDS case and cost data reflect both individual and group policy experience.) The seven plans that never hold open enrollment reported a total of 453 AIDS-related cases, an average of 65 subscribers per plan. Three of these plans are located in areas of high AIDS prevalence, In contrast, the three plans that are continuously open (and thus never screen) reported reimbursing 3,480 subscribers for AIDS-related care, an average of 1,160 cases per plan. Two of these plans are in areas of high AIDS prevalence, and all three have held large market shares. Only five plans provided 1987 projections of AIDS-related costs. Three non-open enrollment plans (two are located in high prevalence areas) forecast a total of $29.6 million in AIDS-related claims for 1987. Claims totaling $27 million were projected by two open enrollment plans; $20 million at one plan alone. Eight of the ten plans that have identified at least one subscriber with AIDS reported finding that 1 to more than 50 percent of these subscribers had a preexisting condition for AIDS. Two of these plans, both in areas of high AIDS prevalence, connected more than half of their AIDS cases with a preexisting condition.

Twelve HMOS reported 1,468 members with AIDS or ARC, an average of 122 members per HMO. The range varied from none at two HMOS to 940 patients at one HMO. (The HMOS' AIDS case and cost data reflect their individual and group membership experience.) Only two HMOS provided projections of AIDS-related costs for 1987. One plan that had identified 10 cases during the first 10 months of 1987 forecast total costs of **$750,000** for the year; the other had 11 cases in the year preceding September 1987 and forecast total costs of $700,000 for 1987. (An additional HMO did not project 1987 costs but estimated that its diagnosed members had average lifetime costs of approximately **$35,000.) One** HMO, located in a high prevalence area, reported that more than half of its individual members with AIDS or ARC were found to have a preexisting condition. According to State law and in contrast to the other insurers, this plan was obligated to provide services for preexisting conditions (without a waiting period) unless the applicant had deliberately misrepresented his or her health status before joining the HMO.

The commercials, BC/BS plans, and HMOS reported similar plans to reduce their exposure to the financial impact of AIDS. These include reducing exposure to individual and small group markets by tighter underwriting guidelines, expanding the use of HIV and other testing, adding AIDS questions to the enrollment applications, and denying applicants with a history of sexually transmitted diseases. Two commercial insurers intend to place dollar limits on AIDS coverage in new policies, and one is introducing a waiting period for AIDS benefits. One HMO intends to withdraw from the individual health insurance market altogether, and a commercial carrier reported withdrawing from the District of Columbia. A BC/BS plan intends to lengthen the waiting period for new subscribers with a history of hepatitis, lymph disease, and mononucleosis, and two others are expanding their AIDS education efforts.