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PROHIBITING AIDS TESTING IN THE HEALTH INSURANCE CONTEXT: PATCHING UP A PATCHWORK SYSTEM

Suzanne M. Russell*

AIDS has shown in harsh light the cracks and flaws and holes in the American health care system. It is a crystallization of the worst problems in preventing illness and caring for the sick. AIDS has shown that our insurance system is unfair. If you lose your job - because of economics or because of illness - you lose your insurance. AIDS has shown that Medicaid is shallow and inadequate. AIDS has shown that we can produce medical miracles for the rich and plain neglect for the poor. AZT is priced for kings and Medicaid is for people who have been made paupers. These failures, however, are not unique to AIDS. AIDS has only shown them in bold relief.¹

Since the onset of Acquired Immune Deficiency Syndrome (AIDS) in 1981, Americans have been terrified by the disease's severity and finality. We have been deluged with information concerning such topics as how one can and cannot contract AIDS in schools or in the workplace or in the home. As the number of AIDS victims has grown, the issue of the cost of caring for AIDS patients, many of whom are uninsured, has sparked particularly intense debate. Who should pay for the treatment of those AIDS patients who have neither financial resources nor insurance? The AIDS crisis has highlighted the inherent weakness of our "patchwork" health care system, a system that is comprised of various public and private segments

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and that, to a large extent, relies on private means to pay for health care - a general social welfare need. As a result, the system excludes those who lack the requisite resources, and consequently, their basic health care needs are not met. Our system of health insurance, in which private companies strive to limit their own risk and to ensure their own profitability, can protect the healthy while systematically rejecting the sick either by refusing to cover them or by charging them unaffordable premiums.

Unfortunately, the insurance industry has won the privilege of being able to require all applicants for individual health insurance policies to be tested for AIDS. A 1988 Congressional survey revealed that most insurers exercised this right. Moreover, companies routinely deny coverage to those who are infected. Health insurers should not be allowed to screen prospective insureds for human immunodeficiency virus (HIV) infection, and policymakers should not let them. The primary goal of public policy should be to achieve justice in society. A just society, consisting of both public and private spheres, should provide for the basic needs of its citizens - those needs which relate to well-being. Health care is such a basic need. Unlike many other countries, the United States, in its peculiarly "patchwork" system relies on the cooperative efforts of public and private hospitals and insurers to provide health care. But, AIDS has stunned the system, and private insurers have sometimes tried to insulate themselves from this disease's high costs by screening the blood of prospective insureds. However, this practice contradicts the social obligation of health insurers. Specifically, it exempts insurers who, because they have achieved and maintained a preeminent role in our health care system, have a concomitant duty along with other players in the health care sector to fulfill their role responsibly. Certainly, neither insurance companies, the public sector, for-profit and not-for-profit hospitals, nor any private individual should be unduly strained. Accordingly, the most equitable way to spare any single element of society from excessive burden is to reach a compromise which "spreads the risk" among these entities.


3. Id. at 19. See also Lambert, Insurance Limits Growing to Curb AIDS Coverage, N.Y. Times, Aug. 7, 1989, at A1, col. 1 (reporting that one company rejected all applicants from San Francisco and that coverage has been denied to unmarried men, or to men with jobs like hairdressing, that are stereotypically associated with gay and bisexual men).

4. Lambert, supra note 3.
In this way, our scarce health care resources will be directed to those who most need them, and the resources of neither the public nor the private spheres of society will be unfairly depleted.

This student article will summarize the basic principles of health insurance. In addition, it will discuss why social concerns, distributive justice, and Catholic Church teaching mandate that health insurers be prohibited from testing the blood of prospective insureds. Finally, it will explore how AIDS is currently being treated, how costs for these treatments are currently being allocated and could possibly be reduced, and how private insurers could and should participate in assuming some of the costs. The following proposals for improving access to health care for AIDS patients will be developed:

1) Health insurers should not be allowed to test prospective insureds for the human immunodeficiency virus (HIV), or to deny coverage based on AIDS-related information.

2) Companies who make drugs that are effective in combatting AIDS should not take advantage of the vulnerable positions of the afflicted by charging excessive prices. They should cooperate with patients, and private and public insurers to provide their products at a reasonable cost and accrue a reasonable profit. Moreover, promising experimental drugs should be more accessible. Private insurers can help to accomplish this goal by expanding their coverage to include these drugs.

3) Nontraditional methods of care, (home health care, hospices, visiting nurse programs), which are generally less expensive than inpatient hospital care, should be encouraged. Insurers should cover such care and hospitals should seek to foster programs in their own communities.

I. INSURANCE LAW THEORY

Insurance is contractual in nature, and insurance underwriting is based upon the distribution of risk among the insured. This process is regulated by insurance law and presents enormous economic and social implications. Insurance is a free-market enterprise seeking to be profitable like other for-profit organizations. Yet it has a responsibility to the community. Like any other component of the legal system, the goal of insurance law should be to ensure justice. Accordingly,
health insurance law should strike a balance between economic efficiency and access to care in a just manner to help ensure that the needs of AIDS patients are met.

A. Insurance Mechanics

By definition, insurance is a contract in which, in exchange for money, one party assumes the risks of another and promises to pay a sum of money in the event of a certain contingency. Actuarial and underwriting principles are integral to the health insurance industry. Actuaries are responsible for rate making — the establishment of premium rates for insurance products. Actuaries must set premiums appropriately to ensure that the insurance company can meet claims and operating expenses. The actuarial functions of health insurance focus upon morbidity statistics, that is, the probability that a person at a certain age will incur illness or disability. Insurance company underwriting departments assess applications for insurance and classify them for risk. Health insurers consider both medical and nonmedical factors in evaluating applications for coverage. After they accumulate and analyze relevant information, underwriters assign individuals to risk classes — groups of people whose risk to the insurance company is similar. They consider additional factors in underwriting individual health insurance policies. First, insurers must contend with the problem of “antiselection.” Antiselection refers to one’s purchase of health insurance in order to acquire benefits for a condition of which the insurance company is not aware. Pre-existing condition provisions in policies protect insurance companies from antiselection, typically by stating that one may not collect benefits for a specified period (usually two years) for a condition that was apparent before the date of issue and was not disclosed on the application. Second, insurers may modify insurance to reduce their risk. For example, the insurer may reduce the benefit paying period of the policy or reduce the benefit amount. Additionally, the insurer

5. 44 C.J.S. Insurance § 1 (1945).
6. Since this article addresses individual rather than group insurance, actuarial functions for individual insurance policies will be examined. For information on group health insurance, see K. Huggins, Operations of Life and Health Insurance Companies 176 (1986) and Nussbaum, Group Insurance and AIDS, Best's Rev., Apr. 1988, at 26.
7. K. Huggins, supra note 6, at 140.
8. Id. at 175.
9. Id. at 194.
10. Id. at 204.
may increase the waiting period before benefits become payable. Finally, insurers may attach impairment riders limiting or excluding coverage for specific health impairments.\(^{11}\)

AIDS presents much uncertainty, particularly in terms of risk groups and patterns of health care utilization. The unusual, costly, and uncertain nature of AIDS clashes with the conservative nature of insurance underwriting practices.\(^{12}\) Accordingly, because of their risk averse tendencies, insurers have responded in such ways as post-claim underwriting (attempting to deny benefits to insureds who develop AIDS after the policy is in effect),\(^{13}\) precluding payments for experimental treatments,\(^{14}\) denying benefits based on a theory of pre-existing condition,\(^{15}\) and rejecting those applicants who “appear” to be, or who fit a lifestyle prototype of being gay or bisexual.\(^{16}\) In addition to underwriting tools such as medical histories, and examination of socio-demographic characteristics, private insurers have relied on antibody testing such as the Enzyme-Linked Immuno-Absorbent Assay (ELISA) or Western Blot (WB) to screen out poor risks by identifying those infected with Human Immunodeficiency Virus (HIV).\(^{17}\)

Proponents of testing offer several justifications for such testing. First, they argue that testing is necessary to keep the insurance industry intact.\(^{18}\) Second, they maintain that AIDS should be treated like other diseases.\(^{19}\) Finally, they claim that otherwise, the healthy public will be unreasonably burdened.\(^{20}\) In contrast, opponents claim that insurers’ economic fears are exaggerated.\(^{21}\) Second, they argue that social costs outweigh

\(^{11} \text{Id. at 205. For a criticism of the basically unfettered discretion of insurance companies in risk classification and an argument for more government regulation, see Wortham, Insurance Classification: Too Important to be Left to the Actuaries, 19 U. Mich. J.L. Reform 349 (1986).} \)

\(^{12} \text{Oppenheimer & Padgug, supra note 2, at 19.} \)

\(^{13} \text{Schatz, The AIDS Insurance Crisis: Underwriting or Overreaching? 100 Harv. L. Rev. 1782, 1786 (1987).} \)

\(^{14} \text{Id.} \)

\(^{15} \text{Id.} \)

\(^{16} \text{Id.} \)

\(^{17} \text{Oppenheimer & Padgug, supra note 2, at 20.} \)

\(^{18} \text{See generally Clifford & Iuculano, AIDS and Insurance: The Rationale for AIDS-Related Testing, 100 Harv. L. Rev. 1806 (1987) and Schweiker, Why Should Insurance Companies Bear All the Costs of AIDS Care?, USA Today, May 1988, at 32.} \)

\(^{19} \text{Id.} \)

\(^{20} \text{Id.} \)

\(^{21} \text{Editorial, N.Y. Times, Aug. 8, 1989, at 12, col. 1 and Schatz, supra note 13, at 1794.} \)
the benefits of testing. Third, and most importantly, they say that testing the blood of AIDS patients can preclude these people from access to health care.

II. Why Health Insurers Should Be Prohibited from HIV Testing

Insurance companies should not be allowed to test the blood of prospective insureds for two general reasons. First, testing imposes excessive social costs. Second, an adverse result may, as a practical matter and without changes elsewhere in the system, preclude one who cannot afford it from access to needed health care. This outcome contradicts the conditions of a just society which, as will be shown, should satisfy its citizens' basic needs.

A. Costs to Society

Four key social costs accompany HIV testing. First, discrimination against gay and bisexual men would probably result since it is common knowledge they constitute an overwhelmingly high percentage of the AIDS population. In order to reduce expenses, insurers may want to test only apparently "high risk" applicants. Accomplishing this would mean identifying those believed to be gay or bisexual, and finding a pretext in an applicant's medical record to justify screening.

Second, HIV testing which ignores the concomitant obligation to provide counseling is counterproductive. In light of the enormous psychological, economic, medical, and social implications of a positive HIV result, appropriate counseling and medical evaluation are essential companions to the screening process. Such counseling serves two important functions. First, it educates people who undergo testing about AIDS and test result interpretation. Second, it helps them to cope with the emotional problems which they may face in taking the test.

Third, problems with confidentiality are inherent in testing. Employers may uncover information about applicants

22. Schatz, supra note 13, at 1799-1802.
23. Id. at 1792, 1803.
25. Schatz, supra note 13, at 1800 (citing Memorandum of Tom Zuck, Director of Blood and Blood Products, FDA (Jan. 29, 1986)).
26. Id. at 1800.
27. Id.
who have been rejected for individually screened small group coverage. As a result, a person may suffer employment and sexual orientation discrimination.\textsuperscript{28}

Finally, from a public health standpoint, insurer testing perpetuates the sense of fear and mistrust associated with AIDS testing. Accordingly, many public health experts and researchers believe that testing should be restricted to the voluntary or clinical context.\textsuperscript{29} Additionally, questioning applicants about prior test results serves to discourage them from seeking voluntary testing.\textsuperscript{30} Understandably, potential candidates fear discrimination.\textsuperscript{31} Individuals may also be deterred from participating in research studies which may help them and the AIDS population in general.\textsuperscript{32}

All of these arguments suggest that the adverse effects of allowing insurance companies to conduct HIV testing before underwriting health coverage render it bad public policy. However, to some extent, these costs could be overcome by such measures as implementing counseling and stricter confidentiality provisions. Accordingly, these objections are comparatively weak in relation to the one which generates the central theme of this student article — insurance screening is bad public policy because it precludes some people's access to health care.

\textbf{B. Health Care and Justice in Society}

1. Establishing the Right to Health Care

The goal of this student article is to show that AIDS patients have a right to adequate health care and that health insurance companies should not be permitted to impose barriers by requiring people to submit to having their blood screened for HIV. The right to health care cannot be proven in any absolute way — that is, it is not a natural right, nor is it a Constitutional right. Rather, I submit that in the context of the American society and its health care system, for the United States to allow those who, ironically, are most in need of health care services to be deprived of them is inhuman.

One may ask from where a right to health care arises. The answer is a complex one. We must look to our society, to the

\textsuperscript{28} Id. at 1800-01.
\textsuperscript{29} Id at 1801 & n.16.
\textsuperscript{30} Id. at 1802.
\textsuperscript{31} Id. (citing \textsc{Institute of Medicine, National Academy of Sciences, Confronting AIDS} 169 (1986)).
\textsuperscript{32} Id.
functions of health care, to the priority which our society has placed upon health care institutions, and to the strength of the needs of AIDS patients and other catastrophically ill persons. If this combination is strong enough, then one may say that a right has arisen — a right which is powerful enough to entitle one to a particular share of society’s health care resources. Reduced to its simplest terms, a person’s right to access to health care and the duty of society to provide it rest on two concepts. The first has to do with being human — what it means and what it requires. The second relates to community and society, specifically, how individuals and social entities interact with and respond to each other.

Basic human needs must be satisfied for human functioning to occur. One may establish a hierarchy and determine that those needs are basic which must be satisfied so that well-being, that is proper human functioning, is not endangered. Readily apparent among these needs would be food, shelter, and medical care in times of illness. These needs apply to the disadvantaged as well as to the advantaged. They are intrinsically human. We must meet them if we are to act to our human potential, to fulfill any of our purposes. Each of us recognizes how this applies to ourselves, and, conversely we should recognize and respect it in others.

It is reasonable to suggest that some criterion must be established in order to distinguish between true needs and mere wants. Again, we look at human functioning. We require a certain degree of health in order to pursue our lives — to take advantage of the opportunities which are open to us, to find happiness and to find satisfaction. We define health as the absence of disease. When we are sick, our ability to pursue opportunities which would otherwise be available to us is impaired. If the sickness is serious enough, we need health care whether or not we actually want it.

Health care institutions, those whose function it is to help us regain health and overcome disease, play an important role in our society. We hold the medical profession in high esteem.

33. See generally Daniels, Health-Care Needs and Distributive Justice, 10 Phil. & Pub. Aff. 146, 149-54. Daniels draws upon the work of the American philosopher, John Rawls. Id. at 160-68.
34. See generally A. Gewirth, Human Rights 199-200 (1982) and Daniels, supra note 33, at 152-54.
35. Gewirth refers to this as the Principle of Generic Consistency (PGC). “Act in accord with the generic rights of your recipients as well as yourself.” A. Gewirth, supra note 34, at 3.
36. See Daniels, supra note 33, at 153-54.
As a society, we have invested large amounts of time and money in medical facilities and medical technology. This strong commitment reflects the importance which American society has placed on health care. Different types of health care services include the preventive (to maintain health), the curative (to alleviate illness), and the rehabilitative (to help cope with the effects of illness or injury). Another is the palliative, such as the care for the terminally ill which hospices provide.

2. Catholic Social Teaching

Catholic social teaching, which emphasizes social justice, human dignity, and human rights recognizes a right to health care. We regard health care needs as objectively important because health is so vital in enabling us to accomplish our lifetime goals, to pursue available opportunities, to restore, maintain or compensate for deficiencies in human functioning. Catholic social teaching emphasizes human qualities and human life. In his 1963 encyclical, *Pacem in Terris*, Pope John XXIII ranked the right to health care highly, placing it before the right to freedom of speech and association. In addressing personal and bodily rights, the Pope noted that all have "the right to life, to bodily integrity, and to the means which are necessary and suitable for the proper development of life; these are primarily food, clothing, shelter, medical care . . . ." Further, in their 1981 Pastoral Letter, "Health and Health Care," the American Catholic Bishops applied the touchstone of Catholic social teaching — the sanctity of human life and human dignity — in affirming a right to health care. Similar to the rationale discussed in the preceding section, Catholic social

37. *Id.* at 158.


39. *Id.*

40. Every person has a basic right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God. It implies that access to that health care which is necessary and suitable for the proper development and maintenance of life must be provided for all people regardless of economic, social or legal status. Special attention should be given to meeting the needs of the poor. With increasingly limited resources in the economy, it is the basic rights of the poor that are frequently threatened first. The Church should work with the government to avoid this danger.

teaching recognizes a right to health care as a means of preserving human functioning.

Currently, no known cure exists for AIDS. Accordingly, a full restoration of normal human functioning is not possible. Rather, treatment for AIDS patients can prolong to the greatest extent possible a level close to normalcy and can serve to minimize the deviation from normalcy. Additionally, recent findings on drug therapy are optimistic about the efficacy of drugs in delaying the onset of AIDS in HIV-infected but asymptomatic people, thereby extending the time that they may pursue their normal everyday lives.

3. The Obligation Which Arises from the Right

The above discussion has sought to establish that health care is special in our society and why this is so. It has tried shown that, in the context of our society, because of the close nexus between receiving health care and fulfilling one's human purposes, health care is an objectively important need, so fundamental and so basic that it rises to the level of a right.

The next step is to determine who has the obligation to fulfill the right. Again, this must be considered in terms of the context of medical care in our society. Who controls the allocation of health care resources in our society? As stated earlier, a multitude of public and private entities are involved. The institutions which govern our health care resources are numerous and diverse. Some are public and others are private. Some are church-affiliated and others are secular. Some are administrative and others provide direct care. Many universities have medical schools, and major cities usually have many hospitals, often including some which are specialized. In light of the

41. Note that Daniels casts some doubt on the application of needs-based reasoning to terminal care, since full restoration to normal functioning cannot be achieved. Daniels, supra note 33, at 169, 171. However, it seems relevant if we think of health care for AIDS patients as a means of approximating normalcy to the greatest extent possible or maintaining or prolonging it.

42. See infra notes 68-86 and accompanying text.

43. For example, Boston medical facilities include Children's Hospital Medical Center; Dana Farber Cancer Institute; Shriners Burns Institute (provides free medical care for children who are burn victims); Massachusetts Eye, Ear, Nose and Throat Infirmary; Joslin Diabetes Institute; Brigham and Women's Hospital; St. Margaret's Hospital for Women; MacLean Hospital (psychiatric care); Spaulding Rehabilitation Center; Beth Israel Hospital; Massachusetts General Hospital; New England Deaconess Hospital; New England Baptist Hospital; New England Medical Center; and Boston University Medical Center.
importance which society has placed on health care, the responsibilities of the various players in the health care sector are heavy. Accordingly, even the private players cannot act in a purely capitalistic and free-market fashion. Rather, to some extent, they must respond to human needs and human rights. Sickness, well-being, health, and health care are all very personal individual matters. Because of the personal nature of health-related issues, decision-makers must maintain a sensitivity to and a respect for the individual and society's relationship to individuals. None of the entities involved has unlimited resources and none should assume the entire burden of caring for all the sick or for all AIDS patients, for that matter. Yet, when one entity which has voluntarily placed itself in a pivotal role in the health care system — such as the private insurance system — consciously decides to exclude a group, to effectively deprive that group of resources and services which it needs to maintain some level of physical well-being, I suggest that a social injustice results.44

It is helpful to consider the rights and relative positions of AIDS victims and insurers, specifically insurers' rights to profits and their available resources as opposed to AIDS victims' rights to health care and their resources. One who asserts his own rights, should, as a practical matter, acknowledge these rights in others. This is so because of the equality with which individuals or entities hold the rights. One should not deprive another of a right when it would not be burdensome for that person or entity to fulfill the right; because of their relative positions, the more advantaged has a duty to the less advantaged.45 Both public and private health care institutions, because of their particular positions in the health care field and their control over resources, must cooperate with each other. When an insurance company decides to exclude groups of those most in need of health care from coverage, an injustice results. In our society, having health insurance serves as a proxy for receiving health care. Insurers violate justice when

44. This is particularly true in light of the fact that private insurers have opposed a national health insurance program. If the private health insurance industry is so determined to maintain its position of control in the health care sector, it seems only fair that it assume some of the burden. See, e.g., Schatz, supra note 13, at 1805 (citing Hanson, The Private Insurance Industry and State Insurance Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation, 6 U. Tol. L. Rev. 677, 737 (1975) and Fuchs, From Bismarck to Woodcock: The "Irrational" Pursuit of National Health Insurance, 19 J.L. & Econ. 347 (1976)); Gifford, An Insidious Test for AIDS, N.Y. Times, Dec. 14, 1989, at A31, col. 3.

45. See generally A. Gewirth, supra note 34, at 199-202.
they implement testing procedures and effectively deprive people in need when, at least according to current data,\textsuperscript{46} it would not be excessively burdensome to accommodate them.

The main objective of this student article is to suggest that private insurance companies should not be exempted from the responsibility to care for AIDS patients. Quite simply, the private sector should honor its social obligation to the community.\textsuperscript{47} However, insurers should not be forced into insolvency by providing coverage to AIDS patients. Such a result would render all insureds unprotected and the system would clearly fail. Yet, neither should their freedom to contract be absolute, in view of the equities at stake. True legitimate concern for financial viability must be distinguished from exaggerated "pseudo-fear" feigned to shield insurance companies from all obligation. A fair policy would incorporate the resources and concerns of insurers and other public and private providers of health care. First, a fair determination of the capacity of insurance companies to withstand insurance losses requires a consideration of cost estimates. Factors affecting cost include inpatient length of stay, availability of alternatives to inpatient care, patient population and new treatments and therapies. Despite the significant cost of AIDS, state commissions believe that the disease is not yet affecting the solvency of insurance companies.\textsuperscript{48} Although most people are insured through group health insurance plans, insurance companies are preoccupied with the people who apply for individual health insurance—a much smaller number. Insurers maintain that the pool of people is too small to spread the costs of AIDS patients. However, at least for now, that is not true. The rising burden of AIDS still remains small in relation to the general increase in medical costs.\textsuperscript{49} Nonetheless, the costs of AIDS care are sub-

\textsuperscript{46} Currently, at least, the actual cost for caring for a person with AIDS is substantially less than insurance companies had previously estimated. Gifford, supra note 44.

\textsuperscript{47} See Pastor, AIDS Patient Care: A Social Responsibility, Health Progress, Mar. 1988, at 28, 30 (citing A.A. Berle, Jr., The Twentieth Century Revolution 167-69 (1954)):

[Corporation managements] must consider the kind of a community in which they have faith, and which they will serve, and which they intend to help to construct and maintain. In a word, they must consider at least in its more elementary phases the ancient problem of the "good life" and how their operations in the community can be adapted to affording or fostering it.


\textsuperscript{49} Id. Kevin Foley, deputy superintendent of the New York State
stantial. Wherever possible, these costs should be minimized, and policies which are as creative, innovative, and efficient as possible should be implemented. I do not suggest that insurers abandon their profit-making goals, but rather that they look at their resources and at their important role in American health care. They should compromise with other public and private players in the health care sector in assuming some fraction of the cost of caring for AIDS patients. For example, when insurers cover relatively inexpensive modes of health care, they encourage these and help to effect overall cost savings.

In Catholic social teaching, the cooperation at issue is referred to as socialization. Over twenty-five years ago, in Mater et Magistra, Pope John XXIII recognized that complex social structures implied the need for complex social relationships. Currently, socialization must take place among insurance, governmental, health, and corporate entities. Catholic social teaching addresses these entities relative to achieving justice in health care.

The Church's social teaching finds its roots in human dignity. In Gaudium et Spes, the Pastoral Constitution “On the Church in the Modern World” addressed human fear and anxiety, and the Christian duty to alleviate these conditions. The document notes that humans achieve dignity through community. “Human dignity is expressed in human community by human rights, which are attained and assured through structures of social justice.”

Insurance Commission states that “[t]here is no question the system is being strained. But it’s a little hysterical to say that AIDS is driving the problem.” In 1988, Empire Blue Cross and Blue Shield of New York paid out $100 million. While a large and growing amount, it still represents only 2.2% of all claims. Id.

50. Catholic Health Association of the United States, supra note 40, at 83. In Mater et Magistra, this concept is addressed in paragraphs 59-67: “the multiplication of social relationships, that is, a daily more complex interdependence of citizens, introducing into their lives and activities many and varied forms of association.”

51. Id. at 34 (citing Mater et Magistra, paras. 59-67).
52. Id.
53. Id.
54. Id. at 35 (citing Gaudium et Spes: Pastoral Constitution on the Church in the Modern World, Document of Vatican Council II (Vatican City, 1965), para. 1, in The Gospel of Peace and Justice (J. Gremillion ed. 1976)).
55. Id. at 36 (citing Gaudium et Spes, para. 24 et seq.).
social structures and systems by their provisions for human dignity and human rights.\textsuperscript{56}

In a recent encyclical on social concerns, \textit{Sollicitudo Rei Socialis},\textsuperscript{57} Pope John Paul II addressed the need to respect the development of the human person, calling for "a lively awareness of the need to respect the right of every individual to the full use of the benefits offered by science and technology."\textsuperscript{58} The Pope called for a preference for the poor "which cannot but embrace the immense multitudes of the hungry, the needy, the homeless, those without medical care and, above all, those without hope of a better future."\textsuperscript{59} To ignore them would mean becoming like the "rich man who pretended not to know the beggar Lazarus lying at his gate."\textsuperscript{60} Catholic social teaching, therefore, recognizes the obligations of the advantaged toward the less advantaged.

In recognizing the challenge which AIDS presents, the California Catholic Conference addressed two objectives towards serving the public good.\textsuperscript{61} They are first, preserving and protecting human dignity while ensuring the rights of all, and second, caring for those in need of help. Fairness and caring were emphasized.\textsuperscript{62} The Conference stated that a goal for AIDS legislation should be to provide adequate medical care\textsuperscript{63} and called for a public policy which would "demonstrate regard for the dignity of persons with AIDS or ARC."\textsuperscript{64} Furthermore, "[l]egislation must support and promote . . . community-based services, disability and health-care coverage, and [a right] to . . . insurance."\textsuperscript{65} In addition to their broad mandate that responsible society ensure that AIDS victims receive adequate care, the bishops specifically recommended that policy encourage hospitals specifically to implement services for AIDS patients, and to support hospice and home care programs. Recognizing that an integration of health care services involving AIDS units and outpatient and community based programs would alleviate the burden on health care providers, par-

\begin{itemize}
  \item \textsuperscript{56} \textit{Id.} at 37. See also \textsc{Pope John Center, Scarce Medical Resources and Justice} (1987).
  \item \textsuperscript{57} John Paul II (Dec. 30, 1987), \textit{reprinted in} 17 \textsc{Origins} 641 (1988).
  \item \textsuperscript{58} Para. 33, \textit{reprinted in id.} at 652.
  \item \textsuperscript{59} Para. 42, \textit{reprinted in id.} at 656.
  \item \textsuperscript{60} \textit{Id.} (citing \textit{Luke} 6:19-31).
  \item \textsuperscript{61} California Catholic Conference, \textit{Public Policy Regarding AIDS/ARC}, \textit{reprinted in} 17 \textsc{Origins} 561 (1988).
  \item \textsuperscript{62} \textit{Id.}
  \item \textsuperscript{63} \textit{Id.}
  \item \textsuperscript{64} \textit{Id.} at 563.
  \item \textsuperscript{65} \textit{Id.}
\end{itemize}
particularly in those areas in which the virus is most concentrated, the bishops called for a "new and coordinated response among the different levels of government, the private sector, and voluntary organizations."66

The relationship between capitalistic organizations and the communities in which they reside is an intimate one. Organizations often derive their profits in their communities, and their decisions can exert a significant impact. The potential social impact is particularly visible in the case of health insurers and HIV testing. Insurers are not exempt from the requirements of making society just. Where the health insurance industry fails to incorporate the principles of justice into its goals independently, public policy should respond with coercive means. Ideally, policymakers will recognize that health care is a complex, interdependent system, in which many players fulfill particular roles.

III. PROVIDING AND PAYING FOR AIDS CARE

Although this student article primarily focuses upon the duties of insurance companies toward AIDS patients, insurance companies are not exclusively responsible for financing health care. Rather, they share the responsibility with others who administer and fund care to AIDS patients. Because of the interrelationships among the various members of the patchwork health care system, what affects one necessarily impacts upon the others. Various elements of society including the local communities, hospitals, drug companies, and public insurers67 must act in concert with private insurers to ensure health care for AIDS patients. Each has a unique role and a carefully constructed combination of efforts will facilitate the optimal policy.

Private and public insurers, hospitals, and communities are limited in the amount of resources which they can direct to AIDS care. Accordingly, these scarce resources must be allo-

66. Id. at 564.
67. Note that detailed examination of the complexities of such programs as Medicaid and Medicare is beyond the scope of this paper which focuses upon private insurers. However, in general, such programs can be instrumental in furthering the right to health care by reducing their barriers and to the extent that they are able, increasing their funding levels. For more on the role of Medicaid and Medicare, see Buchanan, State Medicaid Coverage of AZT and AIDS-Related Policies, 78 AM. J. PUB. HEALTH 432 (1988); National Health Law Program, Health Benefits: How the System Is Responding to AIDS, 22 CLEARINGHOUSE REV. 724 (1988); Rowe & Ryan, Comparing State-Only Expenditures for AIDS, 78 AM. J. PUB. HEALTH 424 (1988).
cated to ensure the fairest distribution and to provide the most appropriate level of care for the individual with respect to his condition and prognosis. For some, this may be hospital care, for others, drug therapy, and for still others, home or hospice care. A public policy should be sensitive to the various needs of AIDS patients and should enable them to obtain the care they require. For example, when insurance covers only hospital care, which is very expensive, it encourages people to seek this kind of care when a less costly mode may be more beneficial and more economically efficient. The following section of this student article considers the current modes of treatment for AIDS and how the costs for these treatments have been allocated. Moreover, it suggests ways to increase the fairness with which these costs are distributed within society.

A. Drug Therapy

Treatment with drugs which delay and ameliorate the effects of AIDS can vastly improve the lives of those with AIDS and HIV infection. Research during the summer of 1989 led to a change in perception of the AIDS virus as an “invariably fatal disease that killed sufferers quickly once they developed symptoms,” to one whose effects can be postponed for years if those who are infected receive drugs before they begin to experience symptoms. As of yet, one of these drugs, azidothymidine (AZT), which is made by the Burroughs Wellcome Company, has been approved to treat AIDS directly and has been on the market since March 1987. AZT works by slowing the multiplication of the AIDS virus in cells. By reducing the number of opportunistic infections and increasing the number of healthy cells, AZT can improve the lives of AIDS patients. One of the most expensive drugs ever sold, until recently, AZT cost patients with AIDS up to $8,000 a year. In addition, researchers found that another drug, pentamidine, held off the deadly type of pneumonia which often accompanies AIDS, increasing the time many patients would require AZT by prolonging their lives. Because of these findings, the National Institute of Allergy and Infectious Disease estimated that up to 400,000 infected people who do not exhibit symptoms might be eligible

69. Id. at A1, col. 1.
70. Id. at C10.
for AZT use, in addition to the 100,000 to 200,000 with mild symptoms, and the 45,000 presently sick with AIDS.\textsuperscript{71}

The findings presented major implications for the cost of treatment; people will require AZT earlier and longer. Accordingly, analysts predicted worldwide sales of AZT to rise to $880,000 by 1992, while another predicted sales to rise from $230 million to $1 billion in 1989.\textsuperscript{72} Activists responded to this expected increase in demand for the often prohibitively costly drug by protesting to Burroughs Wellcome. Critics accused the company of "price gouging" and of preventing those without health insurance from obtaining the drug.\textsuperscript{73} In response to the protest, increased demand, and lower production costs, Burroughs Wellcome decided to lower the cost by 20%, reducing cost to advanced patients to $6,500 and to asymptomatic patients to $2,700.\textsuperscript{74}

In addition, in an even more meaningful response, Lyphomed, maker of pentamidine, announced that it would give the drug away to the uninsured, although it would not reduce the price for others.\textsuperscript{75} Although AIDS patients and advocates had often severely criticized the company for overcharging for the drug, the company maintained that it was giving the drug away not because of this pressure, but rather because it is "a socially responsible company and is committed to being part of the solution, making this drug available to the patients who need it."\textsuperscript{76} This event marked the first time a company gave away approved drugs to needy patients in the United States.\textsuperscript{77} In the United States, Lyphomed's wholesale price is $99.54 per vial, while doctors and pharmacists often charge $150 to $200 per vial. Before the announcement, advocates had begun trying to obtain the drug from England, where it is much less expensive — $30 per vial. At least 200,000 American AIDS patients require one vial of the drug monthly


\textsuperscript{72} Moreover, a pharmaceutical analyst with Salomon Brothers in New York indicated his belief that the company has already recovered its initial investment of $80 million to $180 million in the drug, and estimates that the company enjoys annual profits ranging from $25 million to $100 million, depending on the method of calculation. Hiltz, \textit{supra} note 68, at C10, col. 5.

\textsuperscript{73} \textit{Id.} at A1, col. 1.

\textsuperscript{74} \textit{Id.} at A1, C10.


\textsuperscript{76} \textit{Id.} at 11, col. 1.

\textsuperscript{77} \textit{Id.}
to prevent pneumocystis carinii pneumonia, the leading killer of people with AIDS.

These two examples demonstrate that, whether motivated by negative publicity, threatened business, sincere social responsibility, or a combination of these factors, private entities can respond and have responded to their obligation to contribute to the costs of caring for AIDS patients. To Burroughs Wellcome and Lyphomed, one way or another, it has been made clear that an epidemic of a fatal disease does not provide an appropriate opportunity for unlimited profiteering. Private health insurers should learn from the examples of these pharmaceutical companies.

Although AZT usually extends the lives of those who take it, it is most beneficial in the first 12 to 15 months of the disease's course. Beyond that, the death rate increases and the virus may resist the drug. In addition, some patients cannot tolerate AZT because of its high toxicity. Accordingly, clinicians and AIDS activists have been pressuring the Food and Drug Administration to approve those experimental drugs which serve as alternatives to AZT. Many insurers restrict the availability of effective but not yet approved drugs to AIDS patients, by excluding "experimental" drugs from coverage. Drugs are labeled "experimental" if they are prescribed for conditions other than those which the Food and Drug Administration officially lists. For example, some insurers refuse to pay for AZT when it is used in a preventive capacity by those who are infected and show immunological depletion, but who have not developed AIDS. Similarly, many insurers will not pay for the spray version of the drug pentamidine which is used to prevent pneumonia, although they will pay for it when used intravenously in a hospital to treat pneumonia. Those who treat and prescribe drugs to AIDS patients realize that a policy

79. Id. Bristol-Myers Co. has been working on an anti-viral drug called DDI which works similarly to AZT. Activists are determined to make this and drugs like it widely available to those in need of treatment. See Painter, A Plan to Dispense AIDS Drugs, USA Today, Aug. 18, 1989, at ID, col. 2.
81. Id.
82. Note that the Eighth Circuit Court of Appeals recently affirmed a Missouri District Court ruling that required the state's Medicaid program to pay for AZT treatment as part of the regimen of patients without full-blown AIDS. Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989).
83. Boodman, supra note 80.
which allows insurance companies to commandeer who is treated with what drug and when is a policy devoid of logic.\textsuperscript{84} Because patients are denied "experimental" treatments, they must often wait until they are sick enough to be admitted to the hospital to receive treatment — treatment which is usually more expensive than the preventive "experimental" drugs that could have kept them out. This irony directly contradicts the spirit of the right to health care which emphasizes maintaining a level of human functioning as close to normal as possible.\textsuperscript{85}

Drug therapy is emerging as a major weapon in the fight to spare AIDS victims from some of the disease's cruelest effects. Although drugs such as AZT cannot cure the disease, they can provide important benefits to those patients lucky enough to obtain them. Public policy should facilitate increased distribution of these drugs by decreasing the restrictive powers which insurance companies now enjoy. Cost benefits also arise when insurers subsidize drug therapy. For example, since patients who receive AZT are less vulnerable to opportunistic infections, they may require less hospital care. Some estimate that AZT use may reduce AIDS-related costs by $11,000 per patient per year.\textsuperscript{86} In short, to the extent that public and private insurers subsidize the costs of drugs such as AZT, these expenditures may be offset by savings elsewhere. Moreover, and most

\textsuperscript{84} Peter Hawley, medical director of Washington's Whitman-Walker Clinic, the area's primary AIDS service organization has stated: "It's really short-sighted. It's a lot cheaper to pay $1,200 for a year's worth of aerosolized pentamidine than $12,000, which is the average cost of hospitalization for pneumocystis." In addition, Dr. Larry Bruni, who specializes in AIDS treatment in Washington commented that "insurance companies — not physicians — are deciding who has access to lifesaving therapy. And the problem is that some of them don't want to spend the money; they'd rather let the patient die." \textit{Id.}

\textsuperscript{85} On a positive note, some cities, such as Chicago, Illinois have received grants from the National Institute of Allergy and Infectious Disease which will provide access to AIDS patients to experimental drug therapy and will allow them to be treated by their own physicians. Garza, \textit{Grant to Aid AIDS Treatment}, Chicago Tribune, Oct. 7, 1989, § 1, at 5, col. 4.

One experimental drug which has shown promise is CD4, a genetically engineered anti-AIDS drug which could prove to be "the ultimate weapon" against AIDS. Kotulak, \textit{Drug Designed to Decoy Virus New Salvo in War Against AIDS}, Chicago Tribune, June 11, 1989, § 1, at 4, col. 1 (quoting Dr. Robert C. Gallo, National Cancer Institute). \textit{See also Science Edges Closer to Designing Drugs to Defeat AIDS Virus}, Wall St. J., Mar. 3, 1989, at 1, col. 1.


importantly, such a public policy furthers the right to health care and becomes more “human” by enabling those suffering from AIDS and those who are HIV-infected to maintain a level of normalcy in their everyday lives.

B. The Role of Hospitals and Hospices

In addition to drug therapy, AIDS patients often require the services of medical care providers in hospitals, both inpatient and outpatient units, and hospices. The goals of these providers should always be to help AIDS patients live as normally as possible for as long as possible. Of course, when the capacity for normal human functioning decreases as the patient becomes more vulnerable to the disease’s cruel effects, the caretakers must try to maximize their patient’s comfort. Like drug therapy, medical care services for AIDS patients are expensive, and policymakers should strive to allocate the costs in an equitable way.

Hospitals must often absorb part of the costs of caring for AIDS patients. One reason for this is that hospital rates frequently exceed Medicaid reimbursement. Moreover, patients covered by neither private nor Medicaid coverage may be unable to pay their hospital bills. Initially, private hospitals bear the unreimbursed costs of caring for AIDS patients by profits and operating surplus.\(^\text{87}\) Yet, these costs are shifted to patients and their insurance companies whose rates are increased,\(^\text{88}\) for, to stay in business, these hospitals cannot operate indefinitely at a deficit.\(^\text{89}\) It is becoming more difficult for hospitals freely to “shift” costs, because of an increased emphasis on cost containment and competition.\(^\text{90}\) Ultimately, taxpayers will bear the excess costs of AIDS patients receiving


\(^{88}\) Id.

\(^{89}\) Hospitals have not been able to meet the costs of caring for AIDS patients. Private facilities in the Northeast lost more than $200,000 each in 1987, and private institutions in the South lost $3100 apiece. Additionally, private institutions in the West may have sustained losses. Public hospitals, which treated the largest proportions of low-income AIDS patients incurred even greater losses in the Northeast and South. In 1987, the average public hospital lost more than $600,000. Teaching hospitals were especially affected. Moreover, in the South, with its extremely restrictive Medicaid programs, AIDS treatment represents a “financial disaster” for public hospitals. They also lost more than $600,000 each in 1987. Andrulis, Weslowski & Gage, *The 1987 US Hospital AIDS Survey*, 262 *J. A.M.A.* 784, 793-94 (1989).

\(^{90}\) Bloom & Carliner, *supra* note 87, at 608.
care from public hospitals.\textsuperscript{91} If insurance companies were forced to share in the costs, the burdens on hospitals and public insurers would be reduced.

Hospitals and insurers, public and private, should encourage non-conventional modes of treatment. It is ultimately in their best interest to do so, since it will reduce the financial burdens they incur. Hospitals should assist community groups in implementing creative, cost-efficient methods of caring for AIDS patients. For example, New York City is planning to convert a former school into a 230-bed nursing home exclusively for AIDS patients.\textsuperscript{92} The home is scheduled to open in 1991 and, hopefully, will alleviate the city's overcrowded hospital system by offering a long-term setting for nonacute patients. Most patients will be covered by Medicaid or Medicare.\textsuperscript{93}

Insurers can encourage alternatives to hospital care by covering their costs — again, costs which are less than conventional hospital costs.\textsuperscript{94} For example, "support group infrastructures" which assume some of the burden of caring for AIDS patients perform such services as providing information on drug access, offering basic hygiene and nourishment, and facilitating equipment rental.\textsuperscript{95} In addition, it is possible for

\begin{itemize}
\item \textsuperscript{91} Note that a disproportionate burden has fallen on public hospitals in New York City and San Francisco, since nearly 1/2 of all AIDS cases have occurred in New York and California. Accordingly, taxpayers in these locations are disproportionately burdened. \textit{Id.} This lends added support to proposals for increasing the availability of less costly hospice and home care services.

\item In March 1989, a New York City mayoral panel warned that because of the increasing number of AIDS patients, hospitals and other health institutions would lose their ability to care for those needing their services, since most hospitals reported being filled to nearly 100%. Lambert, \textit{AIDS Seen as Straining New York City Hospitals}, N.Y. Times, Mar. 3, 1989, at 9, col. 3.

\item A study by the National Association of Public Hospitals stated that hospitals spend an average of $681 a day to care for AIDS patients, but got back only $545 in payments. Lambert, \textit{Concentration of AIDS Cases Posing Serious Problems for Some Hospitals}, N.Y. Times, Aug. 11, 1989, at A12, col. 1.

\item Lubasch, \textit{Former School to be Converted to AIDS Home}, N.Y. Times, Apr. 18, 1989, at B3, col. 1.

\item \textit{Id.} \textsuperscript{92}

\item But, a study showed that while the average cost of an outpatient clinic visit was $237, average reimbursements were only $63. Lambert, \textit{Concentration of AIDS Cases Posing Serious Problem for Some Hospitals}, supra note 91.

\item Giovannis, \textit{Clinical Costs of AIDS Are Multidimensional}, \textit{Healthcare Fin. Mgmt.}, Nov. 1988, at 58. \textsuperscript{95}
\end{itemize}
AIDS patients to receive intravenous medications at home.\textsuperscript{96} Insurance coverage of less expensive, alternative modes of care would encourage these types of treatment.

Inpatient hospital care is certainly a necessary component to the realm of treatment offered to AIDS patients, particularly in the disease's most cruel stages when drastic measures are necessary. Competent hospital care can provide essential acute care and enable the patient to return to a level of normalcy. However, for less seriously afflicted patients, drug therapy and outpatient treatment provide two benefits. First, they are less expensive than inpatient care, thereby reducing the overall financial burden of AIDS. Second, these modes of treatment enable the patient to maintain a sense of control over his life. Similarly, when a patient is close to death, hospice care, which is less expensive than inpatient hospital care may provide a more comfortable, home-like environment for the patient. The Seaton Hill Manor in Baltimore, Maryland, is an example of a nursing home which has established a special unit to care the needs of AIDS patients.\textsuperscript{97} Unfortunately a shortage of such facilities exists.\textsuperscript{98} Public policy which required private insurers to cover alternative modes of care would accomplish the dual goals of lowering overall costs and providing more "human" treatment for AIDS patients.

\section*{IV. Conclusion}

Whether to allow health insurers to conduct HIV testing embodies many other issues — issues which are socially crucial — and presents far-reaching implications. Among the values at stake are human dignity, human rights, and justice. Ensuring access to health care fosters each of these values. Working toward a just society involves various segments of society acting in concert to provide for people's basic needs. For the person with AIDS, health care is a basic need.\textsuperscript{99}

\begin{footnotesize}

\textsuperscript{97} Adams, \textit{Financial Problems Inherent in the Admission of AIDS Patients into Long Term Care Facilities}, 10 J.L. MED. 89, 99-100 (1989).

\textsuperscript{98} Eubanks, \textit{AIDS Patients Need More Long-term Care Options}, \textit{Hospitals}, Nov. 5, 1989, at 64.

\textsuperscript{99} This symposium is about AIDS. Accordingly, this student article addresses the plight which people with AIDS face in obtaining health care and the obstacle which HIV testing by insurance companies presents. However, the right to health care of people suffering from other debilitating and life-threatening diseases such as cancer is equally strong. It does seem, though, that AIDS has served as the catalyst in demonstrating just how inadequate and unjust a patchwork health care system can be.
\end{footnotesize}
It is apparent that whatever policy is adopted for insuring and caring for AIDS patients, no one will be sheltered from the economic impact. The non-infected public will contribute either by taxes, increased premiums, or increased health care costs. Private insurance companies should not be allowed to immunize themselves from risk merely by claiming that they are not part of a social system and that AIDS is society's problem. When they engage in HIV testing, insurers ignore their social obligation. They should, in contrast, assume responsibility commensurate with the prominent role which they have assumed in the health care system. Private pharmaceutical companies and private hospitals have had to cope with the negative effects of AIDS on their profits. Why should private insurers be allowed to shield themselves by insuring only those with sufficiently pure blood? Legislation should ensure that insurers honestly and realistically assess how much of the risk they can assume. By covering nontraditional modes of care, insurers may encourage such treatment and ultimately achieve cost savings for themselves and others. Moreover, hospitals and communities should tailor programs which serve the needs of their local AIDS populations in the most innovative, cost-efficient ways possible.

All should have access to health care. The important role which health care plays in enabling people to maximize their human potential justifies this right. The AIDS crisis has highlighted the serious weaknesses in our nation's current health care system and has underscored society's obligation to provide competent care to those who suffer from AIDS and other catastrophic illnesses.
