

8

Disparate Treatment of Smokers in Employment and Insurance

Stephen D. Sugarman

This chapter focuses on disparate treatment of smokers and nonsmokers in the overlapping arenas of employment and insurance. The first section identifies public policy justifications for such treatment. The heart of the chapter, section II, considers several objections to disparate treatment. Smokers' rights laws, a new response to disparate treatment, are discussed in section III.

The Case for Disparate Treatment

In recent years, a small, but apparently growing, number of employers, both public and private, have begun openly treating smokers worse than nonsmokers. Some require employees who smoke to make larger contributions to employee benefit plans (such as group health and group life insurance).¹ Some offer financial rewards in their "wellness" programs to nonsmoking employees. Some go so far as to refuse to hire people who smoke off the job. It is much more difficult to identify employers who actually fire existing employees because they smoke, although tough controls on smoking at work may well have the effect of encouraging some smokers to quit their jobs (rather than quit smoking).

In the past two decades, more and more sellers of individual private insurance policies have begun to charge insured smokers higher rates for life insurance, health insurance, and disability insurance, and even occasionally for auto and homeowner's insurance. Although social insurance programs, like Medicare, don't currently disfavor smokers, they might (for example, by demanding larger monthly "premiums"), and some have suggested that they should.

These ideas and practices have gained considerable recent attention (Muchnik-Baku 1992; Stout 1991; Bureau of National Affairs 1990a and 1990b; New York Business Group on Health 1990). It is not yet clear whether disparate treatment of smokers in these ways represents an important trend or merely a modest, and perhaps only temporary, deviation from traditional practice. Especially because of this uncertain future, it is an apt time to explore whether these practices seem well advised or counterproductive.

From the public policy perspective, three basic stances are open to society: to encourage (or require) this differentiation, to discourage (or prohibit) it, or to leave its extent to be determined by private decisionmaking (by the market, so to speak). In fact, government cannot take a completely hands-off policy; in its roles as employer and provider of insurance, government must decide whether or not it will treat smokers and nonsmokers alike.² Of course, public policy need not take a common stance with respect to the full range of disparate treatments examined here. For instance, the law might ban the practice of refusing to hire smokers, require private term life insurance to contain nonsmoker discounts, and leave unregulated the pricing of group health insurance to smoking and nonsmoking employees.

Advocates of such disparate treatment are often unclear about what, if anything, government should actually be doing to influence employers and insurers. Moreover, they sometimes misdirect their calls to the insurance industry when their real target should be the employer (in the case of employee group insurance plans, for example).³ Nor are they always altogether clear about the reasons why they favor disparate treatment (for some illustrative proposals, see ASH 1987b; Somers 1984; Stokes 1983; and Brailey 1980).

Nevertheless, I have identified three different public policy arguments that may be advanced on behalf of disparate treatment:

- One rationale is equity based. It rests first on the factual belief that smokers disproportionately use insurance and employee benefit programs, and second on the moral assertion that, absent disparate treatment of smokers and nonsmokers, smoking costs are unfairly “externalized” to nonsmokers (or, in some interpretations, employers) who are forced to “subsidize” smokers. Supporters of this argument typically assume that smoking is, at least in important respects, a voluntary activity⁴—although it is by no means clear that this is a necessary predicate to this argument.
- A second rationale is incentive based. Here, too, smoking is seen as a matter of choice, and the underlying belief is that disparate treatment will cause some smokers to stop smoking (or smoke less) and will cause other people to remain nonsmokers. Paternalism generally lies behind this desire to use incentives to shape conduct: smokers would be better off if they quit or would not relapse after having previously quit. Disparate treatment might also be justified on self-paternalism grounds, however—as pressure that is privately welcomed by many smokers (and former smokers) as a tool to help them quit (or not relapse).⁵
- A third rationale for disparate treatment is that it helps tobacco-control advocates maintain public attention on the risks of smoking. In turn, the more vividly people see that smoking is dangerous, the easier it may be for tobacco-control advocates to secure the adoption of smoking-control policies generally. Disparate treatment may, for example, facilitate the following argument: “Each year about 400,000 Americans die too early from smoking. That’s why term life insurance costs smokers up to twice what it costs nonsmokers. But smoking typically starts in childhood. So we need your support now to elimi-

nate cigarette sales from vending machines in all places accessible to minors.” In short, disparate treatment may serve a valuable rhetorical or symbolic function.

It is critical to understand that private actors may have self-interested reasons for disparate treatment that are rather different from the public health and antismoking rationales just offered. For example, insurers may charge different premiums to smokers and nonsmokers, not because of a belief that uniform premiums are unfair to nonsmokers, but rather in order to avoid adverse selection and to have available a competitively priced product. So, too, employers may utilize disparate treatment as an incentive mechanism, not because they think it would be better for smokers, their families, and society for them to quit, but because they believe that the more smoker-employees they have, the more they are burdened with higher health care costs, greater absenteeism, higher employee turnover, greater difficulties in maintaining smoke-free work places for nonsmokers, and lower employee productivity in general. Disparate treatment may also be thought to improve the morale of nonsmokers with consequent benefits to the enterprise. (The extent to which these beliefs are true is another matter.)

Two implications follow from this insight: First, private adoption of disparate treatment may in fact have little to do with the clamor for such practices from public health and antismoking advocates. Second, absent self-interested reasons or legal requirements, private actors may well be unresponsive to disparate treatment advocacy.⁶ This is not to deny that disparate treatment advocacy could have an indirect impact; for example, it might rile up employees and consumers, forcing employers and insurers to become responsive.

Qualms About Disparate Treatment

There is, of course, another side to the disparate treatment debate, and it is that side to which I will devote my main attention here. Perhaps disparate treatment is inequitable, the symbolism of disparate treatment is all wrong, and the intended incentive effect will backfire or will simply be inconsequential. These are possible direct rejections of the tobacco-control campaign’s justifications for disparate treatment. Other objections might acknowledge at least some of the force of those justifications, but counter that disparate treatment has more-than-offsetting social costs which make it, on balance, undesirable. Indeed, from this side of the argument, it may be socially unacceptable to permit private decisions to discriminate against smokers for whatever reason (although actually preventing such discrimination may also be difficult).

To be sure, it is not necessarily an all-or-nothing matter; as already noted, some disparate treatment might be urgent, some intolerable, and some simply innocuous. It is also important to realize that, although some public-health and antismoking advocates favor disparate treatment in the realms examined here, not all do; some strongly oppose such practices, others are largely indifferent.

Privacy

One objection to the disparate treatment of smokers draws upon the value of privacy.⁷ The privacy claim rejects interference in people's personal lives by government and others with power. Examined more closely, privacy has several meanings, many of which are potentially relevant here. The thrust of this discussion will not be that disparate treatment of smokers constitutes an *illegal* violation of privacy (although it might be in some circumstances).⁸ Rather, I mean to emphasize that the privacy invasions that occur or are threatened by disparate treatment are morally troubling.

Most centrally, privacy concerns the right to be left alone—to be free to do in your home (or in other private places) what you want, including smoke, if that is your wish. This value is broadly protected by court decisions applying the Fourth Amendment's prohibition against unreasonable searches and seizures. As a deterrent to police interference with people's right to be left alone, these decisions exclude from criminal and related proceedings incriminating evidence that has been illegally obtained (e.g., without a search warrant) in violation of the right of privacy of the accused.

These days, few deny that employers ought to be allowed to make the workplace smoke free or to serve only healthy food in the employee cafeteria. It may even be generally acceptable for employers to conduct suitable group-exercise sessions for employees, mimicking media accounts of Japanese business practices. But these behavior regulations all concern the work day. Disadvantaging people with respect to work because they smoke off the job is a different matter, and frightening to many. While, of course, no one is currently imagining police bursting unannounced into smokers' homes, conditioning continued employment on not smoking clearly infringes upon the in-home freedom otherwise enjoyed by smokers. Furthermore, some fear this will lead to the opening of a dangerous Pandora's Box, with the powerful enterprises of this nation having far too much influence over the private lives of ordinary citizens.

Indeed, in the view of some, this is already happening: smoking is but one private behavior that employers and insurers are identifying as the basis for disparate treatment. Those employers who "risk-rate" employee contributions to the firm's group health insurance plan may well require extra payments, not only from those who smoke, but also from those who are overweight and who have high cholesterol counts (both often indicating poor diet and/or inadequate exercise).

The same goes for "wellness" programs. While these programs traditionally include free health screening, dietary advice, and lunchtime exercise classes, some employers have recently added financial payments to employees meeting certain "healthy" criteria. Typically, rewards (say, \$10 a month) are paid not only to non-smokers (and those smokers participating in a smoking cessation program), but also, for example, to those who have normal blood pressure (or adopt a regime to lower theirs) and to those who agree regularly to wear auto safety belts.

So, too, those few employers who formally announce that they won't hire people based upon lifestyles that risk poor health may target not only smokers. Those with high cholesterol, excess body fat, and the like have also been explicitly denied jobs for those reasons. (The extent to which employers informally pass over

job applicants who display indicators of poor health prospects is a matter about which there is little hard information.)

The picture is roughly the same in the private, individual-insurance realm. Several personal lifestyle factors, including whether the applicant smokes, are typically taken into account in the underwriting process. Life insurers often have special rate tables for smokers and nonsmokers that they do not have for other groups. In term life insurance, for example, published smoker rates are not infrequently at least 50 percent more than those of nonsmokers with substantial differences at all ages.⁹ Moreover, some insurers in other lines have routine discount amounts that they offer to nonsmokers (other things being equal), such as 10 percent in health insurance and 25 percent in disability insurance. Although the treatment of those with high blood pressure or excess weight, for example, is usually not quite so standardized, nevertheless, on an individualized basis they may be denied life, health, or disability insurance coverage altogether, or placed in a much higher premium category.¹⁰

This outlook has been facilitated, I believe, because in our culture, one's health is increasingly viewed more as a matter of choice than chance. With bad health linked to smoking, drinking too much, eating the wrong things, failing to exercise, and engaging in dangerous activities (sexual and other), commentators increasingly tie early death, disability (both permanent and temporary), and the use of health care services to personal lifestyle decisions. Some fear that disparate treatment based on "lifestyle" may spread even further. Consider the privacy implications if employers and insurers next disfavor those who spend their time at home watching too much (or too little) TV or those who don't marry and have children (or who do) on the ground that one group is healthier and/or more productive than the other.

Yet a different notion of privacy involves the protection from intrusion. This sense of the right is invaded, for example, by unauthorized wiretaps, eavesdropping, and "peeping Toms." A key objection here is to unwarranted monitoring of one's conduct. So, too, a policy of disparate treatment of smokers raises an image of non-worktime monitoring: company investigators talking with neighbors about one's conduct and snooping on the weekend to see if one is smoking. Here the privacy interests of nonsmokers are equally at risk.

Thoughtful employers, of course, appreciate employee concerns about their privacy, and employers are also concerned about the cost of monitoring rules that distinguish smokers from nonsmokers. These factors together push some employers to rely exclusively on employee assurances: "I haven't smoked in twelve months." Insurers, too, typically start simply by asking for this sort of representation. If that is all that is required, then the intrusion concerns are minimized. But the danger is that some employees and insureds will make misrepresentations (and secretly smoke); that, of course, undermines the enterprise's objectives. Moreover, if other employees learn about the misrepresentations and nothing is done about them, then the negative morale costs incurred may outweigh any gains the program might have had in the first place. (Insurer representatives I interviewed suggested that perhaps up to 10 percent of insurance applicants misrepresent their nonsmoking status.)

Insurers might put off worrying about fraud until a claim has been made, and when they then find out that the insured lied and was a smoker after all, they may be

able to void the contract and deny the insured and/or his heirs the insurance benefit. Indeed, in some jurisdictions the rules are quite harsh on insureds, who may have their insurance contract voided if they lied about their smoking status, even if they end up dying (or becoming sick or disabled) for reasons wholly unrelated to smoking.¹¹ On the other hand, a subsequent challenge of the insured's smoking status may be barred by the normal two-year incontestability clause in life insurance (or other insurance); and in any case, many insurers are not likely to be content with the hope that they might uncover something later that was concealed from them at the outset. (Employers, even if they could void benefits to secret smokers, may be more reluctant to take advantage of such rights in the employee's time of need.)

In keeping with these conflicting pressures, many employers and insurers who distinguish among smokers and nonsmokers have chosen to use what they consider to be inexpensive and easy-to-administer tests of compliance—such as blood, saliva, and breath tests that check for cigarette use. However, many also consider it privacy-invading to make people give urine or blood, or even saliva or breath, for external appraisal. Analogously, this accounts for one objection to randomized blood testing for the use of illegal drugs.

One fear here is that once a smoking-control regime requires employees and insurance applicants to submit their, say, blood for testing for the presence of nicotine, other things can be detected as well (e.g., whether the person is HIV-positive or has used illegal drugs), and word of that finding might be spread in ways that the employee believes are highly privacy invading. More generally, greater employer and insurer attention to individual health risks from smoking threatens to put everyone's medical records into the hands of more and more people.

In addition, widespread compulsory testing can be seen to violate people's right to bodily integrity. Beyond that, smoking itself, of course, also involves the private use of one's body. The connection between the right to privacy and the control over one's body has been made most importantly in the area of sexual and reproductive freedom. The U.S. Supreme Court's recognition of a woman's constitutional right to an abortion as part of the right to privacy is but the most discussed example of an array of rights that people currently enjoy concerning control over their bodies. Body searches by the police are also restricted by the Fourth Amendment because of this idea. Indeed, this meaning of privacy partly explains the vigorous objection by some motorcyclists to mandatory helmet-wearing laws.

Most employers who have treated their employees differentially in insurance and wellness programs make participation voluntary. They provide discounts or incentive payments for those who choose to join the program and then test "healthy." No one proposes making a smoker take a job reserved for a nonsmoker and forcing him to stop smoking; and no one is required to apply for a life or health insurance policy with a nonsmoking discount. Hence, as a formal matter, those smokers who are eager to protect their ability to smoke outside of work and those smokers and nonsmokers alike who are eager to shield themselves from scrutiny by others can do so. But, of course, they must pay for their privacy. If strong privacy rights really are at stake here, most people would probably have grave doubts about the fairness of making people pay in these ways to protect those rights. Imagine, for example, the furor that would be created if insurers and ordinary employers refused to hire, or

imposed higher financial charges on, those who engage in sexual intercourse at home. Or consider the actual furor that has been created by allegations that insurers disfavor gays and those who work in occupations that stereotypically are disproportionately associated with gays—for example, florists, antique dealers, and so on (Stone 1990).

On the other hand, sweeping claims to privacy may go too far. First of all, secrecy is considered, at least in some cases, to be trumped by the public's legitimate right to know; our persistent interest in the personal doings of political aspirants is a good example. Perhaps even more important, what one party asserts is a personal matter can be seen by other people as having undesirable external effects on them or third parties. The abortion battle is, of course, partly about this; so, too, is the strong push for drug testing of those who perform acutely sensitive jobs, such as airline pilots.

In the smoking context, some see the external effects as equally important: smokers are blamed for imposing burdens on employers, fellow employees and insureds, the health care system, and family members. And, as a possible analogy, no one doubts that it is a matter of public concern when people who get drunk in the privacy of their own homes then go out and run others down with their automobiles (or come into work drunk and cannot perform their jobs). Any response to this argument from the smoker's perspective requires, I think, the introduction of a more general point, to which I now turn.

Individualized Treatment

Another widely shared value in our society is that of individualized fair treatment. Along with this ideal often comes the insistence that judges or other neutral monitors should ensure fidelity to it. And from this value arises a second cluster of objections to disparate treatment of smokers.

The clamor for individualized fair treatment is well reflected, with respect to actions taken in the public sector, in the widespread demand since the late 1960s for due process of law: in welfare determinations, school disciplinary proceedings, juvenile courts, driving-license revocations, civil commitments to mental institutions, transfers of children from one foster family to another and of nursing home patients from one facility to another, and so on. At the heart of due process is the notion that each person is to be treated individually, on the merits, and with dignity. The goal is accurate application of rules and standards to every case, giving the person being measured an opportunity to be heard and fairly judged.

In a similar vein but outside the constitutional context, individuals have successfully pressed in recent years for an end to "arbitrary" and rule-of-thumb treatment by private actors, as illustrated, for example, by the growth of lawsuits for "wrongful discharge," by attacks on banking and insurance "redlining" (where, in its purest form, service is simply excluded from specific neighborhoods), and by efforts to prevent landlords from simply refusing to rent, say, to families with children.

Individual smokers may make similar objections when they are subject to a firm rule that treats all smokers alike. This is because normally an employer cannot

demonstrate that off-work smoking affects how the *individual* employee currently performs on the job, her absentee rate, or her use of health care services—even if the employer may have some data on general tendencies of employees who smoke. The same goes for an insurer's judgment about an individual smoker applicant. While many people who smoke will eventually get lung cancer, emphysema, or heart disease as a result, most won't.

This means that, although many smokers would concede that they are at risk of ill health from cigarettes, at the same time they would insist that they are not now ill in the conventional way that term is used. Hence, when they are subjected to disparate treatment, they see themselves as being penalized, not because they cost the company more today or because they have been shown to perform worse at present, but rather because of speculation that they might do so in the future. They may legitimately view themselves as being judged on the basis of statistics and not as individuals. (Feelings of injustice are likely to be greatest if the individual smoker considers herself to be a productive worker, in good health, and so on.)

Our national civil rights laws (starting most significantly with the federal Civil Rights Act of 1964) are, in an important respect, but a special example of the demand for due process in response to perceived impermissible group treatment. At their core (putting aside issues of affirmative action and "quotas"), civil rights laws stand for the proposition that members of legally protected groups must not be treated in terms of an unacceptable stereotype. For example, rather than assuming that women simply cannot be fire fighters, these laws insist that we find out whether any particular female applicant is actually fit for the job. This same drive for individualized treatment explains the age-discrimination laws and the end to mandatory retirement.

In this regard, smokers may be able to invoke disability discrimination laws, such as the Americans with Disabilities Act (ADA) (P.L. 101-336) that was adopted by Congress in 1990 and recently came into effect. This law, and similar state laws protecting the disabled, generally require that a person must have an impairment or handicap before she can invoke it. At first blush it might seem that merely being a smoker would not in itself qualify a person as disabled or handicapped; indeed, as just explained, the smoker's point is that she isn't currently impaired.

However, under the ADA and similar laws, if a prospective employee is rejected because he or she is "regarded as" having a qualifying impairment, he or she may be protected by the statute after all.¹² Suppose, for example, an apparently healthy young person is accepted for a job subject to a preemployment physical exam and that exam uncovers a congenital back problem previously unknown to and not currently bothering the job applicant. If the employer, now fearing this condition may lead to a back injury and high replacement, retraining, or benefit costs, rejects the applicant, this will be illegal (or at least some courts so have held¹³) because the employer is seen as "regarding" the person as having a qualifying impairment when there is nothing about the person which prevents him or her from now performing the job. (Case law, at least in some jurisdictions, has clearly rejected the defense that the employer fears increased costs from hiring this employee.¹⁴)

It is certainly possible that the refusal to hire a smoker would be subject to the

same analysis if the employer bases that decision on fears of higher costs in the future from health claims and absenteeism owing to disabling conditions brought about from smoking. The core idea of the ADA, after all, is that disabled people are capable of work (at least where "reasonable accommodations" are made for them) that employers have too quickly assumed they cannot do, and that the disabled are entitled to an individualized appraisal of their ability, not a blanket rejection based on stereotypes. As expanded by the "regarded as" concept, it is just as improper to deny a job to a person with a potentially disabling condition as it is to refuse to hire someone with an actual disability who can still do the job in question. Whether the ADA and similar laws will actually be interpreted to apply to smokers in this way is uncertain; at present there is insufficient case law to say much more as a legal matter.¹⁵ But in many respects the analogy to the job applicant with the congenital back problem is striking.

Even if otherwise within the reach of the ADA, some employer practices are specifically authorized by the act. Key here is specific language that exempts certain insurance pricing practices that have actuarial validity. However, none of the examples about such pricing practices in either the legislative history or the regulations go precisely to the sorts of disparate treatment of smokers addressed in this chapter.¹⁶ Furthermore, it is by no means clear that group health and group life plans that disfavor smokers, to say nothing of wellness plans, would have sufficient data support to qualify as exempt from ADA coverage on actuarial grounds.

Although the individualized treatment ideal remains potent, there are arguments against insisting upon its application to all circumstances. First, many argue that rules of thumb are often fair and efficient and that the demand for individualized treatment properly applies only to the use of arbitrary categories. For example, many would strongly defend some uses of rules of thumb such as insisting that a job applicant have a college degree or have previously been employed in this field of work. Our experience in administrative law teaches that uniform treatment achieved through rule-making proceedings is sometimes superior to individualized adjudication. In public assistance, for example, there may be advantages all the way around in providing all poor people with a standardized grant, rather than empowering a welfare worker to decide whether some individual claimants need more, and others less, for blankets, cooking equipment, bus fare, and the like.

As for determining whether a rule of thumb is arbitrary or not, some argue that, at least in the private sector, market forces themselves generally will serve to police decision making by employers and insurers so as to prevent the use of inefficient rules of thumb. On this view, external monitoring of enterprise decision making (by courts or public agencies, for example) is wasteful and unduly burdensome on business.

Furthermore, a sweeping attack on rules of thumb strikes at the heart of the whole basis for insurance classifications. Insurance, after all, is about risk pooling in the face of uncertainty about the future. If people could be charged only on the basis of their known individual future, it would no longer be insurance. But if insurers were required to go to the other extreme and treat all insureds alike, as though they all had the same predicted future, this would create other problems. If insurers had to charge everyone the same price, the first concern from the insurer's

point of view would be that the individual company would be subject to adverse selection (getting too many high-risk and not enough low-risk customers). This is because, although the precise future of individuals may be uncertain, a group of people with certain characteristics is often known to have a greater or lesser chance of incurring the loss that is being insured, and those who are in the higher-risk class may well realize this about themselves. On a "one-price" basis, insurance may become especially attractive to the higher-risk people. Out of fear of attracting too many of the latter customers, companies would be under great pressure to engage in secret ways of doing business that would exclude high-risk applicants anyway (such as not having agents open offices in certain places).

If this strategy were unsuccessful, the concern then becomes that low-risk people would then decide that the insurance is too expensive (because they would be subsidizing the claims made by the high-risk class). If low-risk people began withdrawing from the market, this could create a spiral effect that either drastically reduced, or possibly completely destroyed, the market for the insurance in question; that is, the more the low-risk people drop out, the more money the insurers have to charge those remaining; the more money charged, the more other low-risk insureds will be forced out. These considerations argue strongly against the individualized-treatment norm and in favor of allowing insurers to classify on the basis of actuarially valid rules of thumb.

Nevertheless, in some situations states already legislatively bar certain insurance classifications that might otherwise be actuarially justified, such as establishing life insurance premiums on the basis of race, and, in a few places, pricing auto insurance on the basis of gender. Moreover, even where the relevant insurance classification practices are currently legal, complaints are continually raised about some of them. For example, many motorists detest being charged more for auto insurance not because of their own driving record, but because of a high accident rate in the neighborhood in which they live. (This objection was partly responsible for the passage in California in 1988 of the initiative petition called Proposition 103, which sought to eliminate the use of "territorial rating" in auto insurance.) And many obstetricians are outraged because they are charged more for medical malpractice insurance, not because they have committed medical malpractice in the past, but because others in their specialty have.

These latter objections to statistics-based group treatment may appear to draw their moral force from the idea that a person is being unfairly put in a higher-cost risk pool for reasons that are beyond her control. To deal more generally with the question of who may be fairly thought of as inside or outside of any risk pool, I want to introduce yet a third broad social value—collective responsibility.

Collective Responsibility

Collective responsibility for misfortune has been much emphasized in the past two or three decades. At base here are public judgments that in certain circumstances social intervention is needed so that people will be taken care of and treated alike—which would not be the result were the matter left to be determined privately (and through the market).

The adoption in 1965 of Medicare (perhaps best seen as publicly provided health insurance for the elderly) is an important example of this idea. Simply put, everyone who qualifies for Social Security at age sixty-five is entitled to medical and hospital services funded by the government. Moreover, to the extent that modest individual payments are required in the form of premiums, deductibles, and coinsurance payments, all Medicare participants are treated alike. The current chorus of demands that America adopt some sort of universal national health insurance plan also draws broadly on the idea of a collective duty to provide reasonably equal access to health care for all.

Other recently adopted programs reflecting this ideal include California's fund to compensate victims of the 1989 earthquake, Virginia's and Florida's funds to compensate seriously neurologically disabled newborns, and the congressionally created fund to provide compensation for children injured or killed by the side effects of childhood vaccines.

How critical is the innocence of the claimant to the invocation of collective responsibility ideal? Many health and mortality risks remain largely beyond an individual's control. Some people contract certain diseases or suffer certain accidental injuries despite their best efforts at avoidance. Others are genetically predisposed to suffer (and perhaps die) from particular ailments. Yet insurers and employers have a selfish financial reason to take into account the health and life expectancy of workers and insureds whether or not those with poor prospects can do anything about it.

The collective responsibility value leads many to conclude that it would be unfair to permit differential treatment in employee group health insurance plans, for example, on the basis of factors that are beyond the employee's control. They would find it outrageous, for instance, for an employer to demand higher premiums from employees who have contracted multiple sclerosis (or have been diagnosed as at risk for that disease), and would favor laws that precluded such differential treatment.

Turning to the smoking context, the first issue is whether smoking is really a matter of choice. Is it best understood as a voluntary "lifestyle" (as the earlier discussion in this chapter has implicitly assumed), or is it better seen as an addiction that began in childhood when the young person was too immature to make an informed choice? This is obviously a controversial issue that has not been laid to rest by the Surgeon General's recent report on smoking as an addiction. We know that as many people have quit as continue to smoke; yet we also know that most who smoke have tried to quit and have failed. Once more the parallel with other "indicators" of unhealthy lifestyles is revealing. High blood pressure or obesity may also sometimes be beyond the individual's control.

One possible way for employers to finesse the "choice" issue is to grant favorable treatment both to those who are not smokers and to those who agree to participate in a program designed to help them to quit. In fact, employers who treat smokers disparately seem rather more willing to adopt this stance in wellness programs than in insurance pricing and hiring practices. But even then, for some "hooked" smokers, forcing them to try one more "stop smoking" program may be worse than fruitless.

For supporters of the idea of collective responsibility, differential treatment may

even be inappropriate where we are convinced that those seeking equal treatment have chosen to engage in riskier behavior. Consider, for example, our current practices toward those people who through negligence allow themselves to become injured, ill, or killed. Although tort law has traditionally paid considerable attention to the fault of the victim in awarding compensation for losses, carelessness (even knowing carelessness) is generally ignored when it comes to awarding benefits in social security, workers' compensation, and public and private health insurance schemes. Such conduct by the victim could be the occasion for the reduction or denial of benefits in those programs, but it is not. Rather, collective protection in these programs is generally extended even to those who have put themselves in a position to draw disproportionately on the common fund. To be sure, there are extreme situations, generally involving deliberate self-injury, which are treated differently, and such conduct in effect excludes the actor from the community.

Where do smokers fit? Those supporting the idea of collective responsibility are likely to want to set narrow limits on the category of those who may be excluded. Smoking probably would not be put in the same category as acts such as self-maiming and suicide, because the latter typically involve more certain and immediate consequences. Rather, smoking is more apt to be categorized along with dangerous driving. (Of course, people may feel differently about disparate treatment before and after times of need; we may be reluctant to deny care to those who hurt themselves while driving dangerously, but not reluctant to charge dangerous drivers more for auto no-fault insurance.)

Objections to disparate treatment are intensified when a rule of thumb has the effect of singling out for worse treatment a group that has traditionally been subject to what society now considers impermissible discrimination. In this respect, it should be understood how the 1964 Civil Rights Act might possibly be invoked to prevent employers from discriminating against smokers if the consequence would be to disadvantage, say, African-Americans.

Title VII of the 1964 Civil Rights Act protects various groups (including racial and religious minorities and women) from employment discrimination. As the law has developed, two classic sorts of lawsuits may be brought. One is the "disparate treatment" case, where an employer explicitly treats women differently from men, for example. But protected groups may also bring cases under Title VII on what is known as the "disparate impact" theory.¹⁷ Given that smoking may be associated with lower socioeconomic status, and the concentration of blacks in lower-status jobs, a finding of disparate impact is by no means a speculative possibility in firms whose black workers are largely restricted to and largely comprise the blue-collar ranks. Title VII plainly covers differences in employee benefits—not just job access, promotions, and salary levels—although some legal experts detect a reluctance of courts to use the disparate impact theory aggressively in the employee benefit context.

Once the claimants have proved disparate impact, the question becomes whether the employer's practice is justified by business necessity. The phrase "business necessity" is somewhat misleading, because such a "necessity" need not be truly proved in any strict sense. Its precise meaning has not been clarified by the new definition set out in the 1991 amendments to the Civil Rights Act (Congressional

Quarterly 1991; Gewirtz 1991). So how those amendments will be interpreted remains highly uncertain.

Nevertheless, a demonstration that the employer could readily accomplish its goals in a different way would probably serve to discredit a claim that the disparate treatment is a business necessity. For example, if a firm refused to hire smokers in order to provide a smoke-free workplace, and this practice had a disparate impact on blacks, the practice might be struck down on the ground that the employer could simply insist on a smoke-free workplace—a far less restrictive approach.

But suppose the employer practice challenged is that existing employees who smoke are charged more for insurance; no obvious alternative practice is available. Would this practice pass the “business necessity” test after a finding of disparate impact? It is difficult to predict with confidence. In any event, once the disparate impact has been identified it can become a basis for agitation and strife quite apart from its legality.

On the other hand, the call for collective responsibility and uniform treatment clashes with resurgent political emphases on self-reliance. This viewpoint is often heard from conservative quarters in debates on the American welfare system. It seeks to resonate with older American ideals of rugged individualism and personal accountability. Put in the smoking context: if employers and insurers choose to disfavor you because you smoke, that is your problem; nonsmoking workers and insureds should not have to share their more favorable premium rate, wage level, or employee benefit package with you.

In the end, I believe that the pressure for collective responsibility is most powerful when what is at stake is seen as part of the basic social safety net. Compare our attitudes toward health and life insurance. Concerning life insurance, there is relatively little public resistance to underwriting decisions based on an insured’s mortality risk, regardless of whether that risk is under the control of the insured. Except for certain socially objectionable classifications (such as race), only actuarial soundness determines the legitimacy of the insurer’s risk categories. If a life insurer wants to charge more or even refuse coverage to someone who has a long history of cancer in the family, or who has multiple sclerosis, or who has high blood pressure (even if it can’t be controlled through medication, exercise, and diet), or who shows some genetic “defect” in a blood test, that is generally thought to be a legitimate practice—at least so long as there is a statistical basis for the differentiation. Moreover, the market is counted upon to play a useful policing role here: if an insurer arbitrarily sought to either charge some people more or refuse to sell to them without any actuarial basis for the distinction, it would simply lose good business to other carriers. In light of this, it seems difficult to object to nonsmoker discounts.

The central role of life insurance is to provide for the income needs of survivors or the retirement needs of the insured. These are matters of important public concern. Nevertheless, the families of nearly all breadwinners in America are already partially protected through the Social Security system, which provides a basic level of life insurance. On the death of a worker or former worker covered by Social Security, the system pays monthly benefit payments to dependent elderly spouses and to dependent minor children and their surviving caretaker parent. And, of

course, Social Security also provides a basic pension for nearly all retirees. Hence, because life insurance today is best viewed as a voluntary add-on to our Social Security insurance base, the pressure to apply the collective responsibility value there is lessened.

By contrast, for most people, health insurance provided through the private sector is not supplementary, but rather is basic. To be sure, the elderly and the poor rely upon publicly funded Medicare and Medicaid for their health care protection. But most of the rest of us depend for our primary protection upon work-based protection. This makes the force of the collective responsibility principle greater, and makes us less willing to defer to market forces even where health insurance is privately provided.

Suppose that all of us were randomly signed up for health insurance with different insurers while we were still in the womb and continued with the same insurer throughout our lives. In that case, there would be no issue about excluding "preexisting conditions" when people buy insurance, and insurers would face no adverse selection problems either. Under this scenario, to charge people more only when it is shown they need or will need the insurance more seems unacceptable. But in the real world some people do acquire health insurance when they already have health problems or known health risks. This is where the moral conflict arises in permitting differential treatment in individual health insurance plans. On the one hand, it is hard to resist the insurers' concerns about adverse selection and preexisting conditions; yet to allow those factors to be taken into account undermines the equal provision of a basic service (and because of that, some states are now considering legislation that would require health insurers to take all comers at uniform rates).

In contrast with individual insurance, group health insurance has traditionally been thought of as the general collective responsibility of those participating. Moreover, reinforcing the community solidarity notion, group health insurance has traditionally not excluded "preexisting conditions" in the way individual health insurance has.

Of late, because of market pressures, the tradition of rating group health insurance according to a geographic community has broken down. As a result, when employers with a fair number of employees fund their health-care plan through insurance today, that insurance is very likely experience rated—that is, it is based upon the claims experience of the employees in that firm (whether better or worse than average).

But the destruction (through experience rating) of the idea of sharing health care burdens across the greater geographic community need not also mean the destruction of the community within the enterprise when a social function of the enterprise is to provide a key element of the basic safety net. And it is within-the-workplace community sharing, after all, that is at stake in proposals to differentiate among employees and would-be employees based upon whether they smoke.

Of course, employer concerns about excess health care costs of smoking employees is only part of a more general concern employers have about rapidly escalating health-care costs. Employers can contain health-care costs in a variety of ways. They can reduce the quality of their health-care plan. They can shift to provider

networks that are committed to more carefully managed care. They can try directly to save money and over time reduce utilization through higher deductibles or coinsurance requirements. (Some firms can encourage older employees who are more likely to draw more heavily upon the health plan to retire; but many large firms today are committed to providing continued health care benefits for retirees.)

Finally, they can simply shift more premium costs onto employees. And here some firms might find it advantageous to do so through risk-rating dangerous lifestyles. That way perhaps only some of the employees need face higher costs, and the plan might be presented to the workforce as an incentive scheme designed to reduce the overall health-care bill for everyone. The policy question nonetheless remains whether an employer's wish to adopt this approach should be trumped by the collective-responsibility norm when the employer is the source of the basic health-care service. In this respect it is perhaps noteworthy that I have been able to find no serious discussion of imposing smoker/nonsmoker health insurance differentials in countries with national health-care systems. In those countries, if smokers are to be asked to pay more, it is through the tax system.

Of course, smokers in America also pay special state and federal excise taxes which are imposed on the sale of tobacco products. This raises a "macro-fairness" question. Even if smokers do disproportionately use medical services, by dying younger they are also less of a burden on both the Social Security system (Shoven et al. 1989) and presumably the private pension systems of employers who have defined benefit plans (since those plans are structured to favor longer-service employees). And when both these factors and the excise taxes are taken into account, it can be argued that smokers already pay, or perhaps more than pay, their way—that is, assuming the lost productivity of smokers who work fewer years because of their smoking is considered a private loss to them and not a separate cost to the society (Manning et al. 1989; see also Schelling 1986b). From this wider perspective, to make smokers pay more for basic health care may also seem unfair.

Desirable Incentive Effects?

So far, I have considered whether the trio of values—privacy, individual fair treatment, and collective responsibility—may lead some to the conclusion that disparate treatment of smokers by insurers and employers is an unfair practice, at least in some contexts. Nevertheless, were disparate treatment actually to change smoking behavior, this benefit might, in the view of some, trump those other concerns.

At \$10 a month in lowered insurance premiums or wellness program benefits, it is fair to conclude that few smokers will actually be enticed to quit smoking. Thirty-three cents a day is a modest, although not trivial, addition to the typical smoker's current cost of cigarettes. But coming in the form they do, these wellness and insurance charge differentials are likely to have even less impact than would an equivalent new tax on each pack purchased. This is because the smoker would be aware of the tax (in the form of the higher price) each time he buys the product. By contrast, given administrative realities, the financial disadvantages imposed by insurance and wellness plans are effectively one-time or once-a-year charges. And once the smoking employee decides that it isn't worth, say, \$120 in the next year to

stop smoking, the marginal burden of continuing to smoke disappears. Moreover, the smoker is not likely to be reminded of his decision regardless of what is printed on his monthly pay stub. It is fair to point out, however, that to the extent that these schemes have little behavioral bite, they primarily amount to a tax on private lifestyle rather than a coercive alteration of private conduct; as such, they may be somewhat less offending of privacy values.

Differential premiums for smokers and nonsmokers in individual life, health, and disability insurance policies are also not likely to have an important impact on smoking behavior. Although the amounts involved may be substantial, especially in term life insurance, the smoking applicant typically won't become eligible for the lower rates for at least one year into the future, and only provided that he immediately quits and continues not to smoke for the full period. It is possible that learning about the premium difference from a life-insurance salesman is the final straw that secures the resolve of a relatively few smokers to quit (although some of those surely would relapse before the year is out). But for most smokers, the decision to quit or not is dominated by other factors; the prospects of lower future insurance premiums is simply too tenuous a reward. Perhaps they just purchase less insurance, or none at all (thereby leaving their dependents at greater risk).

Denying a person a job if she smokes, by contrast, might well have an impact—either forcing her to quit, or forcing her to take an otherwise less-desired job (if available). And if most employers were to adopt this policy, it could well become quite effective in forcing many people to stop smoking. Indeed, it is the very fact that such a policy is potentially so coercive that makes it especially objectionable to those groups such as the American Civil Liberties Union (ACLU) which are eager to protect people's off-work privacy rights.

Smoking-control advocates who favor disparate treatment of smokers in insurance and wellness plans have not seemed willing to take a visible public stance urging employers to refuse to hire smokers. Of course, they realize that some smokers would be unable to quit even if their job depended on it and that others would intensely dislike quitting even if they could. At the same time, smoking-control advocates must appreciate that gaining access to a job is itself considered to be a kind of basic right in our society. The upshot is that, in the smoking context, moderate incentive devices that promise, at best, to affect only those on the verge of stopping (or otherwise starting) smoking may be more acceptable than potentially far more effective behavioral channeling devices that threaten much greater penalties. In the end, I suppose, this is because denying smokers jobs feels too much like outright prohibition, which itself is something that most smoking-control advocates probably would not favor (for adults) even if it could be enforced.

Appropriate or Necessary Symbolism?

With respect to the symbolic or rhetorical function of disparate treatment of smokers, it is by no means clear that this is important in the way it might have been fifteen to twenty-five years ago. Then, when the connection between smoking and higher mortality rates was less widely accepted and more vigorously contested, it was useful for tobacco-control advocates to be able to point to the fact that life

insurers were increasingly offering nonsmoker discounts. Having this old industry with its staid and cautious image putting its money behind the proposition that smoking kills was good ammunition for the cause.

Today, however, it is much less clear that this sort of support is needed. Studies now show that nearly everyone believes that smoking is dangerous. Yet, it is disingenuous to point to certain insurance classifications and other disparate treatments of smokers in support of the proposition that smoking is the cause of anything: actuarial soundness and causation are not the same thing.

To take one illustration from a different context, when auto insurers charge young men more than young women, they are not necessarily capturing real gender differences. Rather, gender under age twenty-five may simply be a good proxy for how much overall driving you do or how much driving at night you do. But insurers might find it administratively simpler to use the proxy of gender than to try to tie rates to the underlying explanation. The point here is not that using such proxies is an unacceptable insurance practice in some situations (although young men who drive little may be justly angered by it). It is rather that many people find it inappropriate to rely on correlation for rhetorical purposes that imply (or assert) causation.

Turning to the smoking context, it may also be factually correct that people who smoke are involved in proportionately more auto accidents than those who don't. But probably only a very small portion of that excess accident rate is caused by the smoker attending to her cigarette instead of the road. Rather, being a smoker might, in effect, be a proxy for other factors that are more properly understood to be the underlying causes of higher auto accident rates. That is, there might be a fairly strong correlation between smoking and drinking before driving, or between smoking and having an aggressive and risk-taking personality, and so on (DiFranza et al. 1986; Grout et al. 1983).

As a different example, suppose a correlation study shows that smokers are decidedly more often absent from work than are nonsmokers. This might suffice to support certain employer and insurer practices that differentiate smokers from nonsmokers. But what if, on more careful study, it turns out that what is really being captured by the smoking variable is an employee's socioeconomic status? (For doubts about whether smoking causes greater absenteeism, see Bonilla 1989, and Tollison and Wagner 1988:25). Then to point to the increased absenteeism as a symbol of the dangers of smoking would seem inappropriate.

This same point may apply even to the question of differential health care use by smokers and nonsmokers. A consulting firm studied the utilization of health care benefits by employees of the Control Data Corporation, and its well-publicized report revealed that smokers had higher average claims levels than nonsmokers (Milliman and Robertson 1987). But this study does not appear to have adjusted for several other factors that might differentiate smokers from nonsmokers. For actuarial purposes this may not matter, but for rhetorical purposes it should.

Backlash: Smokers' Rights Legislation

As of mid-1992, about half of the states have passed some form of legislation protecting the rights of smokers in employment (McGrath 1992). A few states have considered and so far rejected such legislation, and others are currently considering enacting smokers' rights laws. The laws being considered and enacted by the states vary widely in the scope of the protection that they offer to smokers. This is a very new phenomenon that could potentially have a sharp impact on the ability of employers to differentiate between smokers and nonsmokers.

The majority of states with legislation protecting the employment rights of smokers have used language similar to that of traditional civil rights laws. They make it illegal for an employer to require as a condition of employment that a person abstain from smoking during nonworking hours, and they prohibit an employer from discriminating with respect to hiring, firing, compensation, terms, conditions, or privileges of employment because an employee smokes during nonworking hours.

Many states with these types of statutes make at least two exceptions for employers. For example, under the laws in South Dakota, New Mexico, and Colorado, employers can place restrictions on smoking during nonworking hours if these restrictions relate to a bona fide occupational requirement and are reasonably and rationally related to the employment activities or if restricting smoking outside the workplace is necessary to avoid a conflict of interest. These exceptions might, for example, permit fire departments and the American Cancer Society to refuse to hire smokers.

On the other hand, some states create much more limited rights for smokers. The Colorado and South Dakota statutes, for example, cover only discrimination in decisions to terminate employees. Virginia prohibits discrimination only against smokers who are state employees. Oregon allows discrimination against smokers when a collective bargaining agreement limits off-duty smoking.

Most of these statutes clearly preclude most employers from refusing to employ smokers, and that is their primary purpose. However, many of these statutes also seek to prevent disparate treatment in insurance and wellness plans. In Title VII litigation, the U.S. Supreme Court has rejected the argument that employers who charge smokers more than nonsmokers for their insurance are requiring only that each employee pay for the risk he or she creates and hence are not "discriminating." The Court's reasoning is that the core point of the antidiscrimination laws is that employers should treat people as individuals and not stereotypically as part of a group.

On the other hand, some smokers' rights laws (for example, South Dakota and New Jersey) do specifically allow employers to make distinctions between employees in the type or cost of health or life insurance provided based on whether the employee is a smoker.

The smokers' rights movement is a recent one. The majority of the legislation in this area has been passed in the last three years. The tobacco industry—not smokers themselves—has in fact been the major proponent of smokers' rights legislation.

Obviously, the industry would also like to diminish the stigma attached to smoking and provide smokers as a group with a rallying point. The other main proponent of smokers' rights legislation is the ACLU, which, as noted above, does not want employers to be able to regulate the legal activities of their employees outside of the workplace.

The primary opponents of the legislation have been public-health and antismoking groups. These groups make the policy argument that smokers should be given incentives to quit, not expansive rights to continue a destructive habit; however, these groups don't seem willing to argue that employers should be enticed or required to refuse to hire smokers. Traditional civil-rights proponents have also sometimes joined the battle against smokers' rights laws. They argue that smokers should not be a protected group, because the right to smoke is not as important as other rights such as freedom of religion, and that elevating smoking to a civil right would diminish the traditional importance of the other protected categories.

Smokers' rights laws have not yet been aimed at insurers. Moreover, although the issue has not yet been resolved, it is possible that attempts by these state smokers' rights laws to control what employers wish to do through their employee benefit plans (i.e., group insurance pricing practices and wellness plan features) will be deemed preempted by federal employee benefit regulation under the law known as ERISA (Employee Retirement Income Security Act of 1974).¹⁸ Were that to come about, the smokers' rights laws would be left with hiring, promotion, and firing decisions as their basic target. This core protection would make it unnecessary in those states for smokers to attack disadvantageous practices in the more indirect ways discussed earlier—relying on disability rights laws and traditional employment discrimination laws.

Conclusion

Important values are at stake in the decision to permit, encourage, or prevent employers and insurers from treating smokers worse than nonsmokers. For their part, opponents of disparate treatment appeal to recognized privacy rights and to the strong norm that people should be judged as individuals rather than as stereotypes. Furthermore, they resist having smokers treated as outcasts, as beyond the circle of those for whom we feel a sense of collective responsibility. I have also expressed doubts about both the public health need for this disparate treatment on symbolic grounds, and the ability of this sort of disparate treatment to significantly change smoking behavior (short of a widespread refusal to hire smokers). Nevertheless, supporters of disparate treatment unquestionably can draw on a certain sense of fairness on behalf of their position: why should nonsmokers subsidize smokers in any respect?

The right policy choice is made more complicated here for several reasons. First, because government itself is the largest employer in America, as well as the provider of all sorts of insurance or insurance-like programs, it is difficult for it to escape taking a stance. Second, private enterprises—both employers and insurers

have their own legitimate financial interests at stake, interests we normally permit them to pursue without public interference. Yet these same private enterprises control access to certain basic needs in our society—health insurance and jobs.

In other contexts our society has sharply restricted the ability of those with economic power to use rules of thumb in making decisions about individuals. But those people who are protected ordinarily have an unchangeable status for which they are not responsible (e.g., race, gender, and disability). Are smokers really to be thought of in similar ways? Although smokers are now (perhaps unfairly) despised in many circles (a traditional basis for civil-rights protection), many in the public would more readily classify smokers along with drunk drivers and drug addicts than with the blind, the elderly, and religious minorities in terms of their claims to legal protection. As other chapters in this book explore in more detail, the increasing concentration of poorer and less-educated people in the smoking population has generated more stigma than sympathy. This is perhaps symptomatic of the general decline of liberalism and the growing impatience with self-destructive conduct that have marked the past dozen years.

Given my values, I'd like to see employers tread lightly, giving smokers who can do the work an equal opportunity to be hired. The health insurance pricing problem faced by employers could be happily eliminated if the United States were to join most other modern industrial societies and provide sensible access to health care through a single national program that treated all Americans alike. (I admit that it may be wildly optimistic to expect the United States to adopt such a national health insurance plan in the short run.) With basic health care taken care of by the government scheme, private insurers would sell only supplementary health, life, and disability insurance, which are themselves supplemental to basic public programs like Social Security. In that environment, since insurance serves the function of spreading risk created by individual private conduct, actuarially justified premium differences between smokers and nonsmokers should be allowed. But it would not be seemly for antismoking advocates to make too much of the fact. Furthermore, with a national health insurance scheme, employers would have considerably less interest in offering significant financial rewards to nonsmokers through their wellness plans, and would probably choose to discourage smoking primarily through a combination of the sponsorship of smoking cessation programs and controls on smoking at the workplace.

Public efforts to discourage smoking and make smokers "pay their way," as the public sees it, would be pursued primarily at the point of smoking itself—by manipulation of the excise tax imposed on the purchase of cigarettes and, perhaps, by advertising and other educational campaigns against smoking. This approach has the virtue of avoiding many of the privacy problems created by disparate treatment by employers and insurers. Moreover, by taxing, in effect, the act of smoking, rather than treating people differently because of predicted individual consequences of smoking, smokers (whether rationally or not) are less likely to feel that they are treated as stereotypes. (Analogously, drivers who object strongly to paying higher auto insurance premiums because they live in areas with higher accident rates are not likely to have the same objection to differential premiums based upon miles driven.)

Those who believe more in the virtue of leaving economic decisions wherever possible to the market and those (often the same people) who have a stronger commitment to personal responsibility and its application to smokers are likely to draw the line somewhat differently. Moreover, I will be quick to admit that telling employers not to refuse jobs to smokers, for example, is not the same as fully achieving that goal, as our experience with civil-rights laws generally makes clear. Nonetheless, in the spirit of tolerance, I think it far better, where the distinction is possible, to aim our public health pressures at smoking, rather than at smokers.

Notes

1. This is a rather new development in the group health field (Schauffler, this volume), and still exceedingly rare in employment-based group life and group disability plans. Arguably, section 79 of the Internal Revenue Code stands in the way of some employers charging differential premiums for smokers and nonsmokers in their life insurance plans. In the regulations implementing that section, the Internal Revenue Service (IRS) has published a premium table in which premiums vary by age. Section 1.79-0 of the regulations then provides that if some employees are charged more and others less than the table amounts (given their ages), those charged less are deemed to receive taxable income equal to the difference between their premiums and the rates in the table. Historically, the main idea behind this provision was to discourage employers from favoring older and typically higher-paid employees by charging all employees the same premiums for life insurance; which practice, of course, would benefit the older employees as a group. Many firms would find, however, that if they adopted nonsmoker differentials, nonsmokers at all ages would be charged less than the table amounts, and smokers more. Thus, on the face of it, the nonsmokers would have to give up some of their discount in federal income tax, and the enterprise would be burdened with complicated tax-reporting obligations. Given its history, whether the tax law would actually be interpreted to yield this result is rather uncertain, as was revealed to me in telephone interviews with officials of various insurers and employers. Coors Brewing Company, for example, offers a supplemental group life insurance plan with rates for smokers and nonsmokers on either side of the rates in the IRS's table, but does not treat its nonsmokers as receiving taxable income. Some employers, it turns out, have sufficiently good mortality experience with their workforce that, even with nonsmoker discounts in place, both smokers and nonsmokers would pay less than the tax table amounts; in that case, interestingly enough, the nonsmokers wouldn't owe any additional federal income tax after all. In a recent private ruling, the IRS adopted a creative solution allowing differential premiums without subjecting nonsmokers to tax: it decided that the employer could elect to treat the insurance as two separate policies, thereby avoiding the section 79 problem. Private Ruling 9149033, 1991 PRL Lexis 1964.

2. Some state and local government units formally distinguish between smokers and nonsmokers; the states of Colorado and Kansas, for example, differentially charge for health insurance. Within the federal government, however, despite the leadership role in the tobacco control campaign of individual national leaders and certain federal departments, smokers are not charged more for insurance, given financial incentives to quit, or formally refused employment.

3. Group insurance policies (health, disability, and life) are overwhelmingly provided through employment (American Council on Life Insurance 1990; Bucci 1991), and, generally speaking, what is offered (or provided) to employees is driven by the desires of employers,

not insurers. This is certainly true for employers with a significant number of employees. The matter of whether insurers charge employers more because they employ a disproportionate number of smokers is a different question. First of all, most medium and large employers are effectively experience-rated so that the cost of their plans simply reflects the experience of their own employee base. Hence, if smokers cost the plans disproportionately more, the cost to the employer is more without any special pricing practices by insurers that single out smokers. Second, and even more to the point, even if insurers were to charge employers more based upon the smoking practices of their employees (a practice engaged in by some insurers of firms with few employees), the employers are still free to treat all employees alike, or not, as they wish.

4. A position paper prepared by the antismoking group Action on Smoking and Health (ASH) argues that state insurance laws requiring premiums not to be "discriminatory" actually require smoker/nonsmoker differentials (ASH 1987a). Putting aside whether or not this legal argument is correct (and many would be unconvinced), ASH rests its case on the assumption that smoking is voluntary.

5. For more general discussions of the role of public policy in changing lifestyles, see, e.g., Goodin 1989; Schelling 1986a; Walsh and Gordon 1986; and Wikler 1978.

6. For example, sometimes the important extra health-care costs associated with an employee's health-threatening lifestyle are not likely to occur until well into the future, so that a firm may actually be little concerned about their impact on its health insurance program. Chain-smoking employees in their twenties may illustrate the point; if they continue to smoke, they face greatly elevated risks of lung cancer, emphysema, and so on—but, in the main, not for many years to come.

7. For more general concerns about the connections between loss of privacy and unfavorable treatment in employment, see Nelkin and Tancredi, 1989; Stone 1986.

8. The American Civil Liberties Union (ACLU) has started a national project aimed at employers who, in the ACLU's view, illegally invade people's privacy rights by refusing employment to those with indicators of unhealthy lifestyles outside of work. And the ACLU is involved in several states in litigation against government employers in cases of this broad sort. At least one of these cases involved smoking. *Arlene Kurtz v. City of North Miami, Dade County, Florida, Circuit Case No. 91-3165 CA-15 (smoker)*. Others, for example, involve obesity (*Cook v. State of Rhode Island, Dept. of Mental Health, Retardation and Hospitals, 783 F. Supp. 1569 (D.R.I. 1992)*), and high cholesterol (*Maltby and Rosenthal 1991*).

9. In permanent life insurance, the premium differentials are smaller because so much of the premium actually goes for the savings/investment feature of the policy rather than for insurance against the pure risk of mortality.

10. Indeed, the National Association of Insurance Commissioners (NAIC) has taken some measures to try to encourage insurers to make these distinctions. And in Delaware, home of the most active commissioner in the NAIC on this topic, special efforts have been made to get health insurers to adopt routine premium increases and decreases based on a variety of health indicators. Under the Delaware scheme, an insurance policy following this pattern can become "certified." See Delaware Insurance Regulation 60, Certificate and Standards for Health Plans or Policies (1989). But so far as I have been able to determine, no insurer has yet applied for "certified" status.

11. *Mutual Benefit Life Insurance Company v. JMR Electronics Corp.*, 848 F.2d 30 (2d Cir. 1988); *New York Life Insurance Company v. Johnson*, (923 F.2d 279 (3d Cir. 1991)); *Old Line Life Insurance Company of American v. Superior Court*, 228 Cal. Appl. 3d 855, 279 Cal. Repr. 80 (1991).

12. See 42 U.S.C.A. 12102(2)(C) and 29 CFR 1630.2(g) and (k).

13. *Sterling Transit Co. v. Fair Emp. Practice Comm'n*, 121 Cal. App. 3d 791, 195 Cal. Rptr. 548 (1981).

14. See *id.*

15. Most of the attorneys we interviewed who represent the disabled expressed doubt about whether the ADA or similar state laws would, in the end, cover smokers. The Equal Employment Opportunity Commission (EEOC) regulations implementing the ADA have been issued, but how they will be enforced is unclear, and they do not make completely clear how the "regarded as" idea is supposed to be interpreted.

16. See 42 U.S.C.A. § 12201(c) and 29 CFR § 1630.16(f).

17. See *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971).

18. ERISA's preemption clause is found at 20 U.S.C.A. section 1144. Assuming that smokers aren't already protected against such discrimination by federal law (such as by the Americans with Disabilities Act), state attempts to regulate employee benefit plans on behalf of smokers through state civil rights laws are probably invalid. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).