INDUSTRY WARRIORS: ACTUARIES, ACTIVISTS, AND THE QUEST TO DEFINE INSURANCE IN TWENTIETH CENTURY AMERICA

by

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(Under the Direction of Shane Hamilton)

ABSTRACT

Two components made possible the growth of the insurance industry in the twentieth century; first, an ever more complex hierarchy of risk classification based on company statistics and actuarial science, and, second, a tight locus of personalized information exchange between insurers, employers, and credit rating agencies. However, consumer activists increasingly recognized these institutional practices as facilitating unfair discriminatory underwriting. In the latter half of the twentieth century, social movements, especially second-wave feminism and HIV/AIDS activists challenged both components of insurance by pressing Congress to pass anti-discrimination legislation such as the Fair Credit Reporting Act and the Economic Equity Act. In these efforts to redefine access to insurance as a civil right, consumer-activists would ultimately fail. Instead, insurance companies successfully framed underwriting as a strictly economic matter best left to the expertise of individual insurance companies and the structures of a theoretically free market.

INDEX WORDS: United States, twentieth century, insurance, risk, social movements, political history, gender discrimination, actuarial science, HIV/AIDS.

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B.A., Agnes Scott College, 2009

M.A.T., Lewis & Clark College, 2010

A Thesis Submitted to the Graduate Faculty of the University of Georgia in Partial Fulfillment of the Requirements for the Degree

MASTER OF THE ARTS

ATHENS, GEORGIA

2014

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May 2014

DEDICATION

for my parents and grandparents

ACKNOWLEDGEMENTS

A work as lengthy and time consuming as this always requires the efforts of many. I could not have conceptualized, researched, or written this project without the help and encouragement of faculty, friends, and family. I am sincerely grateful to my advisor Shane Hamilton, as well as my other committee members, Stephen Mihm and Bethany Moreton. Pamela Voekel, Reinaldo Román, Dan Rood, and Jamie Kreiner, also all contributed in various ways to the completion of this project. Laurie Kane, Sheila Barnett, and Sharon Cabe always made sure I was in the right place and got my paychecks on time. Additionally, this project would not have been possible without the generous financial support of the UGA History Department and the continued donations of Amy and Greg Gregory.

Further, I am especially grateful to the History of Capitalism cohort at UGA. Ashely Roseberry, Alisha Cromwell, and James Owen have taught me a thing or two about friendship and solidarity over the past two years. Other friends and colleagues in Athens and around the country kept me sane, fed, lodged, caffeinated, and happy. Tim and Kate Johnson, Tore Olsson, Kelli Guinn-Olsson, Derek and Chelsea Bentley, Chris Shannon, Mariette Moore, Lauren Whitton, Anna Cox, Lauren Gregg, Shil Patel, and Nina Guzman have made my experience in Athens and in graduate school truly wonderful. Lastly, my family has sacrificed more for me than I could ever repay, and I could not have done this without them. Thank you Dad and Candace, I love you both.

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CHAPTER 1

INTRODUCTION

In 1988, during his opening address at a conference on HIV/AIDS and insurance underwriting, Ian M. Rolland, soon to be President of the Society of Actuaries and CEO of Lincoln National, congratulated his insurance “industry warriors,” who had recently waged a successful legislative campaign to protect insurers from additional federal and state governmental regulation in the wake of the HIV/AIDS crisis. Specifically, Rolland rejoiced that actuaries, underwriters, and industry lobbyists had persuaded so many state legislatures to ensure the industry’s right to test individuals for the presence of HIV infection before issuing health and life insurance policies as a necessary step in evaluating HIV/AIDS risks. Yet, in the same breath, he cautioned against complacency. “Let me suggest that in spite of our victories, there is still a war to be won,” he proclaimed.[1]

This thesis documents the pitted, rhetorical battles of insurance company ″warriors″ against a broad-based consumer movement, who vied for greater access to insurance in the United States over the course of the latter half of the twentieth century. In this political struggle, actuaries, underwriters, and insurers strived to safeguard their methods of risk objectification, calculation, and commodification that had become ingrained in insurance underwriting departments across the United States beginning in the early twentieth century. This thesis argues that the disagreements between actuaries and activists sprouted from two central questions—what role should insurance play in public and private life in the twentieth century

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[1] Ian M. Rolland, “The Impact of AIDS on American and Canadian Insurers,” *Insurance and the AIDS Epidemic: Proceedings of a Two Day Symposium*, (Chicago: The Society of Actuaries, 1988), 8.

U.S. and who should have the power to make this decision. The answer to these questions rotated around two competing definitions of economic and social fairness promulgated by actuaries, underwriters, and insurers, on the one hand, and consumer rights advocates, feminists, and HIV/AIDS activists, on the other.

Insurance companies, represented by their underwriters and actuaries, framed insurance as a commodity. Over the course of the twentieth century, insurers characterized their product as strictly a market response to hedge against risk, and as a market response, they argued the market should play the primary role in dictating access to insurance. Fairness, then, would be measured by a theoretical market rationality. In doing this, insurers highlighted one of the defining tensions of their industry in the closing decades of the twentieth century; the ability for insurance to collectivize and individualize risks simultaneously. Insurers contended that their business pooled risks together to spread financial loss, however, they also argued that to evaluate an individual risk either too high or too low and then charge a corresponding premium meant that some individuals would subsidize the insurance costs of others. Hence, insurers positioned their product as both risk sharing and risk individuating.

Additionally, insurance companies fought for what scholar Caley Horan has called an "actuarial way of thinking."[2] Actuarial thinking assumed that the qualitative details of everyday life such as race, gender, occupation, sexuality, and character could be objectively quantified through actuarial science and statistics, and then turned into personalized, individual risk that could be classed and rated. In the early twentieth century, actuaries developed a complex "numerical rating system" to differentiate individual risks and group them into a hierarchical ordering scheme of standard, substandard and uninsurable. Based on the sophistication of this

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[2] Caley Horan, *Actuarial Age: Insurance and the Emergence of Neoliberalism in the Postwar United States*, (Ph.D., Diss., University of Minnesota, 2011).

system and the expertise it required, insurance companies contended that only they and their actuarial, statistical, and underwriting departments had the authority to decide how risks would be rated and who would qualify for an insurance policy.

Consumer activists, like insurers, pictured insurance as a security measure to protect against financial loss, however, they deemphasized the role of the market. Rather, they pressed that without the benefits of a universal health insurance system and only limited benefits provided by Social Security, individuals required insurance no matter what the risks to insurance companies. From this premise, they concluded that insurance represented more than a commodity; it was a social and civil right. Consumer activists included a broad range of individuals and groups loosely held together by their mission to expand access to economic security and citizenship by making insurance more affordable and available. These activists rarely saw themselves as part of the same fight as their arguments often emanated from an identity-based politics. Consequently, they each offered a limited critique of insurance companies and risk that failed to see how the full dynamics of class, race, gender, and sexuality crisscrossed in actuarial modes of thinking. This aspect of the battle between insurers and activists had important historical and material roots.

Activists’ fight against insurance companies occurred in response to and within the larger context of the social and economic pressures of post-World War II America, which transformed how individuals viewed themselves in relationship to the state and the economy. For one, consumer activists concerned with insurance directly grew out of the demands of civil rights activists, second wave feminists, and the expanding homophile movement launched by gays and lesbians in the 1950s. As many historians have documented, these social movements envisioned equity in employment and fair pay along with the ability to purchase affordable consumer goods as the benchmark for economic inclusion in America's prosperous postwar society.[3] These political arguments were transformed into law in the form of the Civil Rights Act of 1964, the Equal Pay Act, the Equal Credit Opportunity Act, and other anti-discrimination legislation. The expanding rights discourse and the enactment of anti-discrimination legislation acted as a significant catalyst for moving forward the legal and legislative battles that many insurance minded activists engaged in during the 1970s and 1980s.

However, in these decades, social and consumer activists also responded to an ever expanding "age of inequality." The early 1970s ushered in a period of inflation and deindustrialization that marked a major turning point in the U.S. economy's trajectory. From 1970 to 1980, the United States, for example, lost more than 30 million jobs. When adjusted for inflation, the average wages for American workers peaked in 1973 before beginning a downward trend that has continued to the present.[4] The disappearance of jobs and the shrinking of real wages directly impacted people's need for the financial security provided through life, health, and disability insurance. Employer provided group insurance had offered the most affordable and easily accessible insurance starting in the 1930s when group benefits became more common. Employer provided programs largely bypassed insurance companies' risk rating system. Yet, rising unemployment and the decline of unionized labor beginning in the 1950s, made these fringe benefits less available to an ever increasing number of Americans. Inflation further made

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[3] These historians include Meg Jacobs, *Pocketbook Politics: Economic Citizenship in Twentieth-Century America*, (Princeton: Princeton University Press, 2005), Nancy MacLean, *Freedom is Not Enough: The Opening of the American Workplace,* (Cambridge: Harvard University Press, 2006), Lizabeth Cohen, *A Consumer's Republic: The Politics of Mass Consumption in Postwar America*, (New York: Knopf, 2003), Louis Hyman, *Debtor Nation: The History of America in Red Ink*, Princeton: Princeton University Press, 2011), John D'Emilio, *Sexual Politics, Sexual Communities: The Making of a Homosexual Minority in the United States, 1940-1970*, (Chicago: University of Chicago Press, 1983), and Alexandra Chasin, *Selling Out: The Gay and Lesbian Movement Goes to Market*, (New York: St. Martin's Press, 2000).

[4] Judith Stein, *Pivotal Decade: How the United States Traded Factories for Finance in the Seventies*, (New Haven: Yale University Press, 2010), Jefferson Cowie, *Stayin' Alive: The 1970s and the last Days of the Working Class*, (New York: The New Press, 2010); Thomas Borstelmann, *The 1970s: A New Global History from Civil Rights to Economic Inequality,* (Princeton: Princeton University Press, 2012), 133.

it more difficult than ever before for individuals to buy insurance on the private market. Thus, consumer advocates, feminists, and HIV/AIDS activists located the availability of insurance as an economic necessity rather than an economic privilege.

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The project consists of three chapters, each attendant to the discourse of risk classification and calculation that animated the debate between insurance companies and consumers. Chapter two explores the growth of the insurance industry in the first half of the twentieth century. Drawing from publications by actuaries including journals and textbooks, as well as corporate accounts of the industry, this chapter argues that two key components encompassed the development of the insurance industry at the turn of the twentieth century. The first involved the creation of an ever more highly complex risk classification system that categorized individuals by quantifying their qualitative characteristics using statistics and mortality tables. The second, and less often explored aspect of the rise of insurance companies, pertained to the information sharing networks developed by credit lenders, employers, and insurance companies that accompanied and made possible risk classification. Historians who have examined both the nineteenth and twentieth century insurance industry have largely ignored these connections between financial institutions as a key development that made possible the institutionalization of risk rating in insurance, despite its roots in the nineteenth century and its growing sophistication in the twentieth.[5]

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[5] See Viviana Zelizar, *Morals and Markets: The Development of Life Insurance in the United States*, (New York: Columbia University Press, 1979), and Zelizar, *Economic Lives: How Culture Shapes the Economy*, (Princeton: Princeton University Press, 2011), Jonathan Levy, *Freaks of Fortune: The Emerging World of Capitalism and Risk in America*, (Cambridge: Harvard University Press, 2012) , Sharon Murphy, *Investing in Life: Insurance in Antebellum America*, (Baltimore: John Hopkins University Press, 2010), Dan Bouk, "The Science of Difference: Developing Tools for Discrimination in the American Life Insurance Industry, 1830-1930," *Enterprise & Society* 12, no. 4 (2011), 717-731, and Horan, *Actuarial Age*.

This second aspect of insurance grew in response to insurers' need for information to rate risks. To facilitate the sharing of personalized information, a sophisticated locus of data exchange arose to link insurance companies to other information gathering apparatuses. These mechanisms of the personalized information used to turn qualitative characteristics into individualized risk kept the underwriting departments of insurance companies moving. If statistics, mortality tables, and their calculations of risk were the mechanical parts of the risk machine, then information on individual's morals, character, habits, and lifestyles signified the lubricant that kept the wheels spinning. Insurance companies relied on both these components to compute risk and protect against financial uncertainty.

Chapters three and four turn to the latter half the twentieth century to focus on how social activists criticized and contested at the national level these two aspects of insurance underwriting. Chapter three examines the Fair Credit Reporting Act (FCRA) passed by Congress in 1970. The Fair Credit Reporting Act targeted primarily the information web that connected financial institutions. However, the reach of the FCRA was limited by the fact that it only regulated these channels if companies shared data about individuals that could be proven inaccurate. Individual consumers, who wished to use the FCRA to contest the underwriting practices of insurers had to show that the information collected about them was not only damaging but also untrue. The FCRA did not apply to the issue of relevancy, which most consumers directed their complaints at. Thus, while the FCRA inadvertently regulated insurance companies, it did little to alter the risk rating practices of underwriters.

The final chapter documents how the rhetorical fight between insurance companies, feminists and HIV/AIDS activists crescendoed during the 1980s. Insurers believed that feminists and HIV/AIDS activists jeopardized their risk rating practices since they contended that discrimination based on gender or sexuality, two human qualities activists argued could not be helped or changed, was inherently unfair. Insurance companies responded by offering a different conception of fairness. They argued that true inequality came when insurers charged premiums not commensurate with individualized risk for this meant that some would pay more in a given insurance pool than what their risk warranted. In other words, not letting insurance companies rate risks would lead to an insurance system where some individuals would pay for the risk of others. Social activists' efforts to dismantle insurers' rating classification methods largely failed. For feminists, the Nondiscrimination in Insurance Act, which would have barred the use of gender in calculating risk, did not pass in Congress in the early 1980s. Instead, two judicial decisions *City of Los Angeles Department of Water and Power et al. v. Manhart et a*l and *Arizona v. Norris* decided in 1978 and 1983, respectively, forbid insurance discrimination in employer provided benefits but not in benefits purchased by individuals in the private insurance market. Further, HIV/AIDS activists were unable to convince legislators that insurance companies should not be allowed to use a person's HIV/AIDS status in assessing their individualized risk.

Congress instead passed the Americans with Disabilities Act and the Health Insurance Portability and Accountability Act, which protected against discrimination in employment and ensured the privacy of medical information, but left in place insurance companies' fundamental premise that risk is real, measurable, and should be used in underwriting individuals in the insurance market. Additionally, it reinforced a structured "welfare capitalism," in which economic benefits such as life, health, and disability insurance funneled through employer provided and managed group insurance programs, channeling welfare out of the hands of the public sector and into the private.[6] As Alice Kessler-Harris has explained, in the American welfare state, the title of "worker" entails to individuals a number of social and economic benefits. This becomes especially obvious when looking at how federal legislation and judicial decisions provided financial security to people through life, health, and disability insurance based on their employment status in the 1970s and 1980s.[7] By the 1990s, the participation of individuals as full economic citizens in the American body politic depended on their access not only to a job but a job with fringe benefits. Thinking more carefully about the debates between insurance companies and consumer activists in the waning decades of the twentieth century helps explain how this came to be.

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[6] The term "welfare capitalism" is taken from Jennifer Klein, "The Politics of Economic Security: Employee Benefits and the Privatization of New Deal Liberalism," *The Journal of Policy History* 16, no. 1 (2004), 34-65 and *For All these Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*, (Princeton: Princeton University Press, 2004).

[7] Alice Kessler-Harris, *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in 20th Century America*, (Oxford: Oxford University Press, 2001), 6.

CHAPTER 2

RISK CLASSIFICATION AND CORPORATE INFORMATION SHARING IN THE EARLY TWENTIETH CENTURY

In a presentation given before the Actuarial Society of America at their annual meeting in the spring of 1911, Arthur Hunter, Chief Actuary of the New York Life Insurance Company, enthusiastically told the audience about the new “numerical rating system” that he believed would radically transform the actuarial profession and the business of underwriting insurance. The central provision of this risk rating equation harped as revolutionary by Hunter involved taking the variety of human characteristics insurance companies decided important in rating risks and equating each with a statistically produced number. This number, according to Hunter, would be based on actuarial models and function as the numerical equivalent of whatever the characteristic being calculated was. The more risky the characteristic, the higher the number would be. This would benefit underwriters, Hunter argued, since it would be easy for them to add or subtract together these isolated, numerically expressed risks into a single value. That value signified the whole of a person’s individualized risk. With this neat tidy number in tow, a simple comparison of one person’s risk to a standard or norm could determine whether they qualified as a standard, substandard, or uninsurable risk. Hunter praised this system as eliminating the messiness and subjectivity of underwriting. Unlike the “judgment system,” the numerical rating system had the potential to recast the work of actuaries as a more scientific, objective process. Consequently, Hunter predicted that the underwriters and medical directors of insurance companies would no longer need to rely on their own experience, company tradition, or prejudiced judgment when selecting individuals for coverage.[8]

Hunter, on the one hand, was correct in his summation of this new vehicle for risk management. The numerical system became hegemonic in the insurance industry. Yet, Hunter′s optimistic rhetoric heralding the awesome power of mathematics and science to solve the problems of risk classification in insurance concealed what in actuality made the systems of risk classification tick—the massive collection of individualized and aggregate information on policyholders. Without both aggregate and individualized knowledge about people, especially potential policyholders, insurers knew no matter how sophisticated their probability formulas and mortality tables, their underwriting could be neither accurate nor reliable. Further Hunter′s grand pontification hid the extent to which workers in underwriting departments would continue to rely on their own judgments not quantified statistics when making underwriting decisions. Political scientist Brian Glenn has explained this as ″the Janus″ face of underwriting. Underwriters, Glenn argues, relied and continue to employ a discourse of objectivity buttressed by appeals to actuarial science and statistics to convince legislators and consumers that they do not practice overt, unfair discrimination based on race or gender. Yet as Glenn points out, actuaries and underwriters also use subjective narratives about risks when making final decisions about who to underwrite. In this way, racial and gender prejudice creeps into underwriting choices despite the public perception that underwriting decisions are primarily based on cold calculations.[9]

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[8] Arthur Hunter, “Selection of Risks from the Actuarial Standpoint,” *Transactions of the Actuarial Society of America* 12, no. 45 (May 1911), 1-17.

[9] Brian Glenn, “The Shifting Rhetoric of Insurance Denial,” *Law & Society Review* 34, no. 3 (2000), 780-782. For understanding how the history of statistics contributed to a public rhetoric of objectivity see Ian Hacking, “How Should we do the History of Statistics?” *The Foucault Effect: Studies in Governmentality*, eds. Graham Burchell, Colin Gordon, and Peter Miller, (Chicago: University of Chicago Press, 1991), 181-195, Theodore Porter, *The Rise of Statistical Thinking, 1820-1900*, (Princeton: Princeton University Press, 1986), and Theodore Porter, *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life*, (Princeton: Princeton University Press, 1995).

Actuaries and underwriters, in particular, had trouble quantifying “moral hazard” and “adverse selection” risks. Moral hazard referred to a person’s character or habits. Usually, it meant to invoke a person who stepped outside the normative bounds of prescribed gender, class, racial, or sexual behavior. Since the word “moral,” as underwriter F.I McGraw explained in 1931, originated from the Latin word for “mores” or “folkways,” moral hazard applied to the norms of behavior set by a given society.[10] Adverse selection more specifically referenced people who were considered unscrupulous in their business dealings and took out insurance policies not to protect against financial loss but as a gamble. Importantly, this kind of knowledge about qualitative characteristics could not be found on census records. Nor could policy applicants be trusted to come forward and admit to anything that might increase their premiums or cause them to be rejected entirely. Therefore, insurers needed another way to accumulate this type of information.

While Hunter and members of actuarial and underwriting departments conceived of statistics as the saving grace of insurance, in reality, the building of a highly complex risk rating system in the insurance industry during the first half of the twentieth century comprised two components. The first one aligned with Hunter’s vision of more quantitative based classification that could be couched in a rhetoric of scientific objectivity. The second involved the building of information sharing networks between insurers, employers, and credit firms that kept the flow of knowledge about individual’s risk uninhibited. The development of these two processes cannot be untangled as they were in some sense mutually constitutive. Insurers’ desire to simplify the massive amounts of data collected on individuals spurred quantification and statistical analysis, while the empiricism of underwriting could not function without more information therefore

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[10] F.I. McGraw Hill, “Moral Hazard in Life Insurance,” *Proceedings of the Home Office Life Underwriter’s Association and the Inter-Company Conference on Occupational Hazards* 2 (Philadelphia: George S. Ferguson Co., 1931), 109

producing an unending cycle of data gathering and data classification. Understanding the many aspects that made up insurers' underwriting and risk calculating system is important because it helps explain how in the latter half of the twentieth century, consumer activists came to see insurers' practices in rating risks as unfairly discriminatory.

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In an actuarial textbook from 1964, Solomon S. Huebner, a professor of insurance at the Wharton School of Business at the University of Pennsylvania and Kenneth Black, a professor of insurance at the School of Business at Georgia State, described what they termed "the judgment method of rating" in underwriting.[11] They explained that this form of underwriting had dominated in nineteenth century life insurance. Judgment based rating occurred when the medical, actuarial, and other underwriting departments of an insurance company came together and made a decision about an individual application largely based on their own personal and subjective judgment. Historian Sharon Murphy has explained the early emergence of this risk classification method as one of the limitations of early insurance companies. In the nineteenth century, insurers used statistics and mortality tables, but they were built in mind to measure the risk of male individuals in the Northeast and Mid-Atlantic region only, since these were the individuals life insurance companies were most familiar with. As the geographic and occupational market of insurance companies expanded, they had to rely on their own judgment to rate risks. In public, insurers presented their risk rating as scientific and objective, but, in truth, insurance companies relied heavily on hearsay and judgment often when making decisions.[12]

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[11] The textbook *Life Insurance*, written by S.S. Huebner, the first person to teach a course in insurance at the collegiate level, has been considered the basis of any actuarial education and was the first of its kind produced in the United States with prior editions released in 1915, 1923, 1935, 1950, 1956. See "About Huebner," The S.S. Huebner Foundation for Insurance Education, Wharton School, University of Pennsylvania, *http://www.huebnergeneva.org/huebner/*, (accessed March 4, 2014).

[12] Sharon Murphy, *Investing in Life: Insurance in Antebellum America*, (Baltimore, John Hopkins University Press, 2010), 13-47.

Huebner and Black contrasted the judgment system with the numerical rating system, which had been developed by fellow actuary Arthur Hunter and insurance company medical director Oscar H. Rogers in the early twentieth century.[13]

Huebner and Black argued that the numerical system was based on the premise that a large number of factors entered into the composition of an individual risk. Further, they thought the impact of each of these factors on the life of the risk could be determined by a statistical study of other lives possessing that same factor. Each of the factors that might influence the risk—build, physical condition, personal history, family history, occupation, habits, morals, sex, etc., could be assigned a numerical value. With each factor quantified, those values could be calculated together into one number that signified the rating of an individual risk. In most companies, they explained, a number falling between 75 and 125 represented a standard risk.[14] Anything higher than 125 signified either a substandard or uninsurable risk.

This description of the numerical rating system reflected well the model developed by Hunter and Rogers at the turn of the twentieth century. Hunter, who had been had been born in Scotland and immigrated to the United States in 1892, worked for the Fidelity Mutual Life Insurance Company in Philadelphia. He left Fidelity and later joined the New York Life Insurance Company where he served as their Senior Vice President and Chief Actuary until his retirement in 1941. During his tenure at New York Life, he became actively involved in the professional organization the Actuarial Society of America, which later merged with the American Institute of Actuaries to form the present day Society of Actuaries. Hunter was obsessed with the classification methods of insurance companies, especially with some of the most tenuous topics for insurers—ratings based on sex, location, moral hazard, and race—and

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[13] S.S. Huebner and Kenneth Black Jr., *Life Insurance*, 6th Edition, (New York: Appleton-Century-Crofts, 1964), 456

[14] Ibid, 456

published numerous articles on the subject during his lifetime.[15] In explaining the numerical model's genesis, Hunter stated that his work had been in response to the exponential growth of the insurance industry. New and growing companies hired a vast cohort of young, inexperienced actuaries and medical directors annually, he thought, with little experiential knowledge of risk classification. These young actuaries and medical directors required an objective, universally applicable model that could calculate and evaluate individual risks removing from the equation the possibility of human error.[16]

To provide the statistical information necessary to make the numerical system function, Hunter, along with the Actuarial Society of America oversaw the making of a number of major U.S. based statistical and mortality tables to guide underwriting departments in making their risk calculations. Importantly, Hunter and other actuaries believed that their mortality tables and studies of risks could be separated from the surrounding social and cultural milieu in which they lived and worked. For them, actuarial models existed in a vacuum world of objective science structured by careful calculations of probability. These calculations could then be correlated to the qualitative characteristics of everyday life. However, at the most basic level, in the choice of which classes to count and measure as potential risks, actuaries offered up a specific classed, racialized, gendered, and spaced vision of their world.[17] This vision reflected the ideological

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[15] C.F. Wood, "Memoir: Arthur Hunter," *Journal of the Institute of Actuaries* 90, (1964), 366-367.

[16] Hunter, "Selection of Risks," 1-2.

[17] The example referred to most often by scholars of how this works has been in the construction of racial categories. For instance, in 1896, Frederick Hoffman, a German born published an article "Race Traits and Tendencies of the American Negro," which set a precedent for the use of statistics and actuarial science in shoring up the major tenants of scientific racism. Hoffman collected statistics and used morbidity tables to show that African Americans on average had shorter life spans than whites and increased health problems making them more risky and uninsurable. In turn, it became difficult for African Americans to get life insurance as companies stopped underwriting these risks. Insurance companies took little time to consider how the economic positions and racism experienced by African Americans might have a direct impact on mortality. Thus, morbidity tables were used to actualize racial distinctions into physical reality making them measurable and quantifiable, and further allowing for the commodification of those differences by translating race into risk. See Beatrix Hoffman, "Scientific Racism, Insurance, and Opposition to the Welfare State: Frederick L. Hoffman's Transatlantic Journey, *The Journal of the Gilded and Progressive Era* 1, no. 2 (April 2003), 150-190, and Megan J. Wolff, "The Myth of the Actuary: Life

underpinnings of the early twentieth century more than any objective risk based reality. Yet, statistics and mortality tables also had the power to turn actuaries' cultural and social visions into a potential reality. Mortality tables proved prejudices, made them real, measurable, and quantifiable.[18]

The Specialized Investigation, published in 1904, was the first such study overseen by the Actuarial Society of America. *The Specialized Investigation* measured the death rates of 140,622 persons divided up into 76 distinct classes. Each class pertained to age, weight, and build.[19] Following the development of mortality tables over the course of the early twentieth century demonstrates an increasing level of sophistication and complexity in the divisions of risk classes. With each newly published mortality table new classes were added on. In 1908, the Society published a new statistical table with 98 classes that used company data from several major insurance corporations including Aetna, John Hancock Mutual, Manhattan Life, Metropolitan Life, and Mutual Benefit. The table documented information about all male lives insured between the ages of 15 and 70 at U.S. and Canadian companies from 1869 to 1900. As actuary Emory McClintock, head of the Society's research committee, explained the table meant to help companies in their underwriting provide a basis on which to accept or reject applicants.[20]

What he did not mention was how the differentiation of categories themselves transformed qualitative characteristics into quantifiable knowledge making them legible and

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Insurance and Frederick L. Hoffman's Race Traits and Tendencies of the American Negro," *Public Health Chronicles* 121, (January/February 2006), 84-91.

[18] My thinking here comes directly from French theorist Francois Ewald, who has argued that in the context of insurance, a given risk, rather than represent an actual risk, signifies a socially and culturally constructed risk. "Nothing is a risk in itself" he notes, but, at the same time, "anything can be a risk." The classification of human risks by underwriters then does not signal actual risks, but rather demonstrates what a particular society considers important and risky. Thus, risk changes overtime as ideology itself changes. See François Ewald, "Insurance and Risk," *The Foucault Effect: Studies in Governmentality*, eds., Graham Burchell, Gordon Colin, and Peter Miller, (Chicago: Chicago University Press, 1991), 197-210.

[19] Rufus W. Weeks, "An Experiment with the Specialized Investigation," *Transactions of the Actuarial Society of America* 8, (1904), 817-23.

[20] Emory McClintock, et al., *Experience of Thirty-Four Companies Upon Ninety-Eight Special Classes of Risks*, (New York: Actuarial Society of America, 1908), IV-V.

workable for the processes of the insurance business. As McClintock went through each category noting which risks had been profitable to insurers and which had not, he created new knowledge about who was economically viable for insurers and who was not. Under unprofitable and therefore a bad risk, he grouped, Irishmen, African Americans, steel grinders, glass workers, those occupied in jobs in the liquor industry, reformed alcoholics, theatre, and individuals living in Montgomery, Alabama, New Orleans, Louisiana, Santa Fe, New Mexico, Shelby, Tennessee, and Bexar, Texas. For many occupations, he noted the real difference between a good risk and a bad risk was age. For example, he stated that for laborers mortality was high except for "young entrants."[21] In 1912, the Actuarial Society of America worked with the Association for Life Insurance Medical Directors of America to publish another mortality study *The Medico-Actuarial Mortality Investigation*. Arthur Hunter oversaw the research and publication of the study as an updated version of *The Specialized Mortality Investigation*. The massive study collected information on insured lives from 1885 to 1908 and solicited insurance companies to provide a list of classifications to be included in the study. Companies suggested over 600 categories. To make the list more manageable, Hunter and his research team divided company suggestions into "required classes," "optional classes" and "special classes." Required classes consisted of categories in the "highest demand." "Optional classes" Hunter defined as ones without enough to data to make conclusive decisions about, while racial and gender categories made up the "special classes."

In total the table divided the mortality experience of insurance companies into 295 different categories, significantly more than in previous years. Further, the classes made displayed the kind of gendered lens actuaries used in rating risks. Employing a framework of female dependency, the table sorted women into categories based on their position within

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[21] Ibid. x-xi.

households. Women were labeled either widows, divorced, spinsters, married women with husband as beneficiary, or married women with someone other than husband as beneficiary. Only married women with their husbands listed as beneficiary were considered good risks.[22] This exercise in human individuation showed that actuaries could not only create mortality tables that mirrored their social and cultural surroundings, they also produced new knowledge while reinforcing old beliefs. Actuaries, underwriters, medical directors, and insurers might then best be seen as a certain kind of cultural interlocutor. In deciding whom to insure, they fashioned new classes and statistical tables that policed the bounds of acceptable behavior, rejecting those who fell out of the line they drew. However, their power went beyond culture since the choice to underwrite or not had highly visible economic strings attached.

The ways in which actuaries and underwriters functioned as cultural brokers was especially clear in how they handled moral hazard and adverse selection risks. In addition, actuaries had trouble in quantifying these types of risks. Actuaries understood their tables to work accurately with huge amounts of aggregate data about people. What insurers termed moral hazard and adverse selection could not be statistically measured since actuaries and underwriters simply did not have enough statistical data about moral hazard and adverse selection to make their numbers count. Other types of knowledge such as age, geographic location, occupation, health were more accessible to insurers. They used medical examinations to document health history and questionnaires and census records to build company statistics about occupation and geography, but information about a potential policyholder’s prospects for adverse selection or moral hazard could not be found in census records or obtained through medical examinations. These risk factors pertained to the nitty-gritty details of everyday life, income, family dynamics,

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[22] Arthur Hunter, et al., *Medico-Actuarial Mortality Investigation*, *Vol. 1* (New York: Association of Life Insurance Medical Directors of America and the Actuarial Society of America, 1912).

character, and home environment. Insurance companies had to devise a different way to handle these risks, and so began the construction of a complex locus of information sharing between insurance companies, employers, and credit rating firms, who collected and shared with each other (always for a fee) individualized personal information on policy applicants, employees, and borrowers. Companies such as the Retail Credit Company, later renamed Equifax, were able to build highly sophisticated and profitable businesses off this system of information brokering.

Insurers in the nineteenth and twentieth century greatly worried over the moral character of policy holders. This was partly a response on behalf of insurers to the growing anonymity and urbanization of the U.S population. When early U.S. life insurers began underwriting, they issued most policies for men in the professional and middle classes in the highly urban center of the East coast. Insurers felt protected from potential moral hazards and adverse selection by insuring a specific economic and geographical class of people, but as Sharon Murphy has demonstrated, as insurers enlarged their coverage areas to incorporate people outside their class and geographic comfort zone, insurers worried about the character of people applying for policies. Did these new applicants truly want life insurance or was taking out life insurance more akin to gambling or speculation? To warn against this type of risk, insurers created the categories of moral hazard and adverse selection.[23]

The defining feature of moral hazard was its slippery-ness and flexibility as a risk rating tool. As underwriter F.I. McGraw openly admitted moral hazard was difficult to define, hard to detect, and especially frustrating when applied to underwriting. [24] Yet, this made moral hazard an especially useful tool for underwriters. In McGraw's laundry list of things covered under moral hazards, he included, "good faith, the character and reputation of the applicant; speculation

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[23] Murphy, 48-49.

[24] F.I. McGraw Hill, "Moral Hazard in Life Insurance," 109.

through concealment of motives, finances and physical defects; lack of insurable interest; overinsurance; environment, miscellaneous irregularities, and questions of an indefinite nature not easily classified."[25] If his placing of "miscellaneous irregularities," and "questions of an indefinite nature," at the end of the list had been an accident, it was a fitting one. Moral hazard worked best as an umbrella term that could include or exclude whatever was convenient in the moment. It was the flexibility inherent in its difficulty to define that let insurers be so "Janus" faced in their underwriting. If actuarial science supposedly transformed underwriting into an objective science, the rating of moral hazards reversed the process. For instance, moral hazard let insurers always be on the lookout for the moral character of individuals who were unmarried, worked in bars, hotels, the circus, or in the theatre with these behaviors and occupations themselves defined as morally corrupting.[26] Racism and nativism often went hand in hand as well with moral hazard. In his proselytizing account of morally hazardous risks, prominent underwriter Harry Dingman cautioned his fellow underwriters to be on the look out for "Foreign borns," who might be "slow to subscribe to the American code of morals."[27] Moral hazard reincorporated in a distinctly subjective way the dominant narratives of class and race into the underwriting process.

Additionally, moral hazard as a term that described risk managed the borders of acceptable gender and sexual behavior. The term meant to evoke in the minds of underwriters a dishonest man or woman, sexually promiscuous, cad-like, often transitory in their living arrangements, and seedy in their business dealings. Fittingly, the President of the Actuarial

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[25] Ibid, 109.

[26] See Harry W. Dingman, *Selection of Risks for Life Insurance, Health Insurance, and Accident Insurance*, (Cincinnati: The National Underwriter Co., 1933).

[27] Ibid, 176.

Society of America referred to moral hazards as “rascals,” “rogues,” and “Don Juans.”[28] In other words, for men and women, moral hazard most often translated into an individual who did not fit the gendered or classed expectations of appropriate male or female behavior. Women, in particular, could be categorized as moral hazards when they applied for an insurance policy that bucked the standard narrative of female dependency. Arthur Hunter, for example, believed that companies should be wary of insuring women who applied for substantial amounts of insurance especially in cases when her husband had none or less than she would have. He also cautioned against underwriting elderly women with already self-supporting children questioning the need for life insurance for a women, whose children already found themselves financially cared for. He made no such warning against men in similar situations. Further, he thought that married women could be granted insurance policies “freely” but stipulated that due care should be given in “cases of suspected speculation.”[29] Hunter seemed skeptical of any woman who desired to be independently insured separate from her husband or another dependent. Instead, he assumed the responsibility of protecting the family with life insurance fell to the husband or male children as the breadwinning, working, heads of households.[30]

While underwriters and actuaries defined moral hazard as an important tool for differentiating standard, substandard, and uninsurable risk, the perplexing problem of how to quantify or make legible this kind of information persisted. Insurance companies were able to produce numerous mortality tables that measured the relationship between body build, weight, neighborhood, age, and sex, but they published only one statistical table that documented the relationship between mortality and sexual behavior. This table was produced by the Statistical

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[28] John Reiley, “Moral Hazard in Life Insurance,” 116.
[29] Hunter, “Mortality Among Women,” *Transactions of the Actuarial Society of America* 11, no. 4, (May 1910), 450.
[30] Hunter, “Mortality Among Women,” 447.

Department at Mutual Life Insurance Co. in 1930 and 1931. Mutual tried to make a meaningful statistical table that correlated sex and death by tracking down policyholders and applicants that had been denied insurance for a moral hazard of a “sexual nature,” but statisticians and underwriters had trouble interpreting results because of the tiny amount of data they had to work with. The study included only 910 samples to start with, which was later cut down to 503, as these were the only cases that could be tracked down. Out of the 503, 45 had died and 14 were described as “in poor health.” The rest were characterized as “in good health.” Unsatisfied with those results, Vice President of the Statistics Department, Frank Hallan expressed his frustrations by noting “too much reliability cannot be placed in the ratio of those in good health to those in poor health,” since it was likely “moral hazards” would lie about their current health conditions. To bolster his point, he made a perhaps farfetched point that 25 individuals included in the study had a recent run in with the legal system and were in jail, under bail, or fugitives.[31] Actuaries, underwriters, and insurers relied on a discourse of objectivity buttressed by their use of statistics and actuarial science, but in reality, as Hallan demonstrates, sometimes these tables represented more the wishes and desires of statisticians instead of a real world of risk.

Leading actuaries characterized adverse selection as another one of the primary threats to the business of insurance throughout the nineteenth and into the twentieth century. Like moral hazard, adverse selection was difficult to detect, although actuaries had an easier time defining it. Adverse selection referred to a person who applied for an insurance policy based on some falsity that let them be insured or charged a premium less than what actuaries, under truer circumstances, would have calculated the worth of their risk. One way for insurers to lessen the danger of adverse selection involved the kinds of premiums they would write. If insurers refused to write large policies for potentially risky individuals, they would avoid the problem of adverse

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[31] Frank A. Hallan, “Moral Hazard in Life Insurance,” 118.

selection. In an 1898 address before the Actuarial Society of America, actuary Emory McClintock, cautioned insurers when formulating policy plans and deciding premium rates to make their offers attractive to the average buyers but not so attractive as to “attract on average the poorer class of risks,” which would open up the door to “fraud” and “false witness.”[32] Actuaries also imagined that they could protect against moral hazard and adverse selection through the gathering of personalized information on every policy applicant. With an investigative report made on every policyholder, insurers could thoroughly shield against insuring anyone who could be a financial risk to the company.

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Large scale credit rating agencies such as the Retail Credit Company (Equifax) solved insurance’s information gathering problem. Retail Credit Co. collected information on potential borrowers and then sold that information as a commodity to insurance companies, employers, and credit lenders.[33] This arrangement provided the essential information needed to evaluate potential policy holders, employees, and borrowers in the impersonal world of twentieth-century finance capitalism and allowed companies to make decisions about the riskiness of a potential individual. In particular, these knowledge pathways provided a way for companies to communicate with each other and spread knowledge about moral hazard and adverse selection risks. As William Flinn succinctly put it in the opening of his 1959 history of the company: ″the story of the Retail Credit Co. typified and to a certain extent paralleled, the emergence of a new

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[32] Emory McClintock, “General Principles” *Transactions of the Actuarial Society of America* 5, no. 20 (October 1898), 294.

[33] W. Lee Burge, Congress, Senate, Committee on Banking, Housing, and Urban Affairs, Subcommittee on Consumer Affairs, “Fair Credit Reporting Act Amendments of 1975,” 94th Cong., 1st Sess, October 22, 23, 29 and November 18, 1975, 159. While other companies operated on a similar basis as Retail Credit Co., my choice to focus on them in particular stems from the size and importance of the company. Retail Credit Co. quickly became the largest company of its kind. Further, as consumer movements in the 1960s and 1970s built up against businesses such as Retail Credit, consumers turned most of their anger and lawsuits against the Retail Credit Co. This means that for source material, archives on Retail Credit are also typically more easily accessible for researcher.

industry—an industry based on the recognition of an economic need for information about persons rather than businesses; and moreover, about specific individuals rather than about people as classes or specified groups."[34] In 1956, Paul S. Morton, an underwriter for Nationwide, estimated that at least 75 percent of the male population of the United States had had some kind of inspection report made on them. "If you have purchased anything on a time payment plan, borrowed money, mortgaged a house, accepted a position of responsibility, or bought insurance," he noted, "you have probably been the subject of an investigation."[35]

It is unclear at what point insurance companies began to use credit rating agencies to furnish information collection in underwriting, but this kind of business dated back in the United States to at least to the 1880s. In an "inspection report," from 1886 made by Manhattan Commercial Agency of New York for an unknown insurance company, the inspector recorded the income, $25,000, and profession "he makes a specialty of compound oxygen treatment…in partnership with Dr. Pa. n." of the man under investigation. Also, he noted that the man was "of good character and habits, is apparently in good health."[36] This early use of inspection reports with an emphasis on the character and habits of the person being investigated demonstrates a certain level of continuity. Stretching from the 1880s through the late twentieth century, investigative reports sought the same kinds of information on moral character and habits.

While this evidence supports the position that these kinds of information exchange between insurers and credit rating agencies dated further back than the early twentieth century, Retail Credit Co. would not enter the business until 1901.[37] Before the company began selling inspection reports to insurers, it had operated as a credit firm. The company had been founded in

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[34] William Flinn, *The History of the Retail Credit Company: A Study in the Marketing of Information about Individuals,* Dissertation, (Columbus: Ohio State University, 1959), 1.
[35] Paul S. Morton, "Just the Facts, Ma'am," *Inspection News* 41, no. 2, (Feb. 1956), 13.
[36] Inspection Report by Manhattan Commercial Agency, dated 1886, reprinted in Flinn, 165.
[37] J.S. Robert, *The Spirit of Retail Credit Company: A History*, (Atlanta: Retail Credit Co., 1965), 10.

1898 by brothers Guy and Cator Woolford in Atlanta and originally confined its business to keeping files on customers of local grocery retailers.[38] Company historian J.S. Roberts cited the choice to enter insurance as the pivotal moment in the history of Retail Credit Co. According to Roberts, insurance reporting, once added to Retail Credit's company products, rapidly became the "life blood" of the company.[39] William Flinn further noted in his history of the company that the profitability curves of Retail Credit and the insurance industry matched almost perfectly during the first sixty years of the twentieth century.[40] In 1908, Retail Credit began writing reports for automobile insurance. Spurred by the growth of the automobile industry and increased state regulation that required drivers to maintain car insurance, profits from automobile insurance climbed doubling company earnings annually throughout the 1920s.[41] The credit reporting division of the company, on the other hand, grew more slowly than insurance reporting and was consolidated in 1934 as a separate subsidiary known as the Credit Bureau Inc. of Georgia. By 1915, insurance reports accounted for 98 percent of all company sales.[42]

The company's business worked by making contractual arrangements with life insurance companies in which Retail Credit Co. would be responsible for finding out information on individuals who applied for life insurance. As a lengthy company mission statement from 1929 explained,

> The business of the Retail Credit Company is to furnish underwriting information to insurance companies. Reports are made as to health, habits, reputation, and finances on people who apply for insurance, to advise the company of any facts which might affect

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[38] Ibid, 4, 10-13.
[39] Ibid, 24.
[40] Flinn, 239.
[41] Roberts, 26-29.
[42] Flinn, 240.

> the classification rate, or acceptability for the policy applied for. The purpose of the report is to disclose any physical or moral hazard in the risk."[43]

The contract importantly stipulated that Retail Credit Co. held no liability to the insurer if the information they reported turned out to be untrue.[44] Insurance companies communicated to Retail Credit Co. what information they wanted included on investigative reports for risk evaluation. This included age, income, occupation, total worth, health, health history, drink habits, reputation, character, and recommendation.[45] In a report blank from 1901, questions asked for details about income, health, family history, illness, history of insanity, hereditary disease, alcoholism, and general reputation.[46] In addition, inspection reports were made in secret. Insurers such as New York Life Insurance Co. stipulated in their inspection report requests, "Note: Do not let the subject of this inquiry know he is being investigated."[47]

Inspection reports were made by individual company agents, who became more professionalized and centralized as the twentieth century progressed. F.I. McGraw imagined inspectors to be the "Master Painters" of "moral hazards." "In this field," he praised, "the sketching he [inspection agent] does for us determines in large measure, our underwriting."[48] Here, McGraw unveils a significant aspect to underwriting often overlooked in analyses of risks management. The inspection report and the individual who prepared the report were central to this process. Although largely invisible to outsiders, inspection reporting gathered the minutiae of everyday life that let underwriters construct the highly subjective risk narratives they needed.

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[43] *Inspection News* 14, no. 11 (Dec. 1929), 169.
[44] Retail Credit Co. Contract between Retail Credit Co. and United Family Life Insurance Company, Georgia State Archives, Atlanta, Georgia.
[45] Roberts, 14-15.
[46] Retail Credit Co. Blank, dated 1901, reprinted Flinn, 198.
[47] New York Life Insurance Co. Request, Undated, reprinted in Flinn, 54.
[48] McGraw, 110.

Overtime, Retail Credit Co. became more sophisticated in how it collected its information. They moved from producing one type of blank to many. By World War II, they had three main types of reports, one for employers, one for credit lenders, and one for insurance companies. Within these three different company blanks existed a host of more complicated differentiation. For example, a practice discontinued in 1927 involved distinguishing the race and sex of an applicant using color codes. Forms for white men were white, forms for white women were pink, while forms for African Americans were yellow.[49] Further, the company developed special forms for certain occupations. Individuals who worked in hotels, restaurants, and as store keepers had different forms from machinists, for example, while youths got their own forms.[50] A typical investigation report would have a front and a back. The front provided space for basic questions. Usually made up of a of long list of habits such as smoking, alcohol use, actuaries were asked to check boxes for either yes or no. The back was reserved for additional comments. Some blanks provided detailed 2-3 page long narratives on potential policy holders.[51] Once amassed, the Retail Credit Co. then sold the data for an agreed upon fee to the insurance company charging more to clients depending on how detailed they demanded reports to be. A copy of the investigative report would be kept on file in the regional office so that the information would be there for future use.[52]

Retail Credit Co. and other credit rating agencies were not the only businesses who participated in this form of data sharing. Parallel networks crisscrossed over and under the arms of Retail Credit Co. For example, the Medical Information Bureau (MIB) was a key locus for the

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[49] Flinn, 198.

[50] Ibid, 200.

[51] Henry Geller, Congress, Senate, Committee on Banking, Housing, and Urban Affairs, Subcommittee on Consumer Affairs, “Fair Financial Information Practices Act,” 102nd Congress, 2nd Session, February 10 and April 22, 23, and 30, 1980, 10.

[52] Roberts, 16-19.

exchange of information in health and life insurance. The MIB, founded in 1902 by the Association of Life Insurance Medical Doctors, functioned as a nonprofit trade association that easily allowed doctors and life and health insurance companies to share information about particular patients or policyholders. In 1947, the MIB disassociated from the Association of Life Insurance Medical Doctors, and came under the direction of insurance company medical directors and other senior insurance company officers. The MIB operated as a kind of "alert system" for insurers. Physicians and insurers funneled into the central knowledge network of the association the medical reports of individuals who applied for insurance. The MIB coded different qualitative characteristics into a three digit numerical code. Each health hazard got its own code. Further, the MIB coded whether an individual had been denied insurance at some point in their lives and what the reason for the rejection was. The MIB and insurance companies kept these codes confidential. When a person went to apply for health insurance with a given insurance company, that company could pull up the individual's MIB record and see their health history and whether they had been rejected by a past insurer or lapsed on previous premium payments. This system blocked individuals from getting insurance that had in the past been calculated as bad risks or proved unprofitable to insurers.[53] Like the role inspection reporting played at Retail Credit Co., the MIB guarded the gateways of economic inclusion and the accessibility to insurance despite the fact that they were not a formal part of the insurance industry.

In employment, as well, the Retail Credit Co. participated in a similar kind of gatekeeping. As William Flinn noted in his history of the Retail Credit Co., during World War II, Retail Credit began producing investigation reports for employers. In 1939, the company secured

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[53] John C. Wilberding, Congress, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, "Commercial Health and Accident Insurance Industry, Part 1," Senate, 2nd Sess. May 10, 11 1972 and June 6, 7, and 9 1972, 6-7.

a government contract that allowed them to investigate U.S. government employees in the Civil Service. Flinn speculated that industries especially concerned about hiring "only persons loyal to the principles of Democracy," used Retail Credit to vet potential workers. In May 1940, Lockheed Martin, for instance, asked Retail Credit to make 545 individual reports on current or potential employees. That same year, Retail Credit added a "fifth column" to their inspection report, one that detailed an individual's "subversive" activities. By 1943, running investigative reports on employees accounted for approximately 36 percent of the firm's total revenue.[54] Nate Holdren, in his work on disability insurance, has argued that employers incorporated the risk thinking strategies of insurers into their hiring decisions in the early twentieth century. This happened in response to the creation of mandatory disability laws in states that required employers to pay disability in case of a workplace accident. Insurers, consequently, began to calculate the riskiness of potential employees just as insurers evaluated the riskiness of potential applicants.[55] Building on Holdren's thesis, thinking about the connections between employers and insurers mitigated through firms such as Retail Credit Co. demonstrates the possibility that these different financial and economic institutions were literally linked through their information sharing practices.

The general outline of this information exchange system between employers, credit firms, and insurers changed little over the course of the twentieth century. Even after Retail Credit Co. became Equifax, they continued to rely on inspectors to collect information into the 1980s. For instance, on their "Special Service Character Financial Report" from 1976, company blanks included questions about character, habits, morals, and class of associates similar to the 1901 blanks used by the company. The same sorts of questions were asked on forms for life, health,

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[54] Flinn, 293-294.
[55] Nate Holdren, "Incentivizing Safety and Discrimination: Employment Risks Under Workmen's Compensation in the Early Twentieth Century United States," *Enterprise & Society* 15, no. 1 (March 2014), 31-76.

and automobile insurance, as well.[56] The stability of this system, however, opened it up to attack in the latter half of the century, as consumers and legislators began to see these tightly interlocking data sharing pathways between major financial institutions as dangerous and discriminatory.

In the early twentieth century, the underwriting departments of insurance firms including actuaries turned to the "numerical" risk rating system to produce more scientific and objective risk calculations. Yet, the numerical system contained is own subjectivities. First, in bringing into being risk categories, actuaries structured a world based on their own notions of class, gender, and race. This process of increasingly complex and highly individuated risk classes continues to this day. As Brian Glenn notes today, "complex rating systems" have "as many as 234,360 categories in which an applicant can be placed and in theory, each category must have its rate supported through statistics."[57] Further, actuaries knew their rhetorical appeals to objectivity could never truly work. The point of the numerical rating system would not be to provide a perfect formula in which to calculate risk but to offer the appearance of unbiased ratings and fairness. Additionally, throughout the twentieth century, risk computation only worked with the input of information. To facilitate the systematic gathering and dispersing of individualized information, companies such as Retail Credit Co. and the Medical Information Bureau formed contractual agreements with insurance companies in which they agreed to sell information about persons for a fee. Thus, the quantification and commodification of individualized risk impinged on the objectification and commodification of information. As the

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[56] Copy of "Special Character Financial Report of 1976," reprinted in "Fair Credit Reporting Act Amendments of 1975," 307. These congressional hearings also contain copies of all the new blank forms in use by Equifax starting in 1976. See "Fair Credit Reporting Act," 307-364. Despite W. Lee Burge's insistence that clients and business required different information to be included on investigative reports almost all blank forms in 1976 included questions about individual's moral character and habits.

[57] Brian Glenn, "The Shifting Rhetoric of Insurance Denial," 793.

twentieth century progressed, however, this network of data sharing made vulnerable the entire risk classification system. A growing consumer movement, influenced by the discourse of economic citizenship in the Civil Rights and feminists' movements, challenged insurers' risk rating methods and the information sharing network that existed between financial institutions. Consumer activists' growing cries to fair and equal access to insurance put insurers on the defensive and reframed how the public would perceive insurance as a civil and economic right.

CHAPTER 3

INSURANCE, CONSUMER ACTIVISM, AND THE LIMITS OF THE FAIR CREDIT REPORTING ACT

The New York Times ran a story in 1972 on a pending lawsuit in New Jersey that involved a junior faculty member at Princeton University. Galen Cranz had bought an automobile policy from State Farm that past January, and in February, Cranz had been notified by State Farm that her policy had been cancelled because of an investigative report made by the Retail Credit Company that indicated Cranz lived with a man "without the benefit of wedlock." Cranz sued State Farm and Retail Credit Co. for violating the Fair Credit Reporting Act (FCRA) passed by Congress in 1970. She accused Retail Credit Co. and State Farm of invading her right to privacy citing the means by which the investigation was made and the maintenance and dissemination of information about herself that was personal and intimate. Further, Cranz believed her living situation held "no apparent actuarial relevance" in the evaluation of her as a potential risk and claimed State Farm had been wrong in assuming her domestic situation had anything to do with her driving ability.[58]

The dispute between Cranz and State Farm over what should be relevant in insurance underwriting highlights a larger debate that took place between consumers and insurance companies in the 1960s and 1970s. While the first half of the twentieth century was defined by insurers, credit agencies, and employers building up risk classification systems and the information networks that made underwriting possible, the latter half consisted of consumers fighting back against these institutional mechanisms. Consumers, influenced by the expanding

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[58] Joan Cook, "Suit Challenges Cancelled Policy," *New York Times*, (January 3, 1974), 75.

discourse of consumer and financial rights embedded in the Civil Rights Movement, second-wave feminism, and burgeoning gay and lesbian political activism, challenged what they saw as unfair discriminatory underwriting policies that quantified the qualitative characteristics of gender and sexuality into risk. Consumers believed that underwriters who classified the general population into adverse risk categories—divorcees, women, gays and lesbians—unfairly denied those placed into these groups full access to their economic rights. Namely the ability to obtain insurance at a standard rate. The Fair Credit Reporting Act enabled this changing boundary of economic rights by putting in place federal regulation that gave consumers for the first time the ability to sue insurance companies.

However, there were specific limitations to the FCRA that prevented many policyholders from successfully winning their lawsuits against insurance companies. In litigation, insurers exploited a key loophole in the FCRA that stipulated that information on a given individual could only be protected under the FCRA if said information was first deemed inaccurate. This gave insurers a way out of government regulation if they could show that the data they used in the underwriting process was correct. For example, Galen Cranz settled her case outside of court in 1975, but if she had gone to court, she likely would have lost.[59] This is because both State Farm and the Retail Credit Co. could show the information used to evaluate Cranz was accurate. She did live with a man she was not married to. According to provisions in the Fair Credit Reporting Act, decisions about relevancy in insurance underwriting were best left up to individual insurance companies, who could provide legislators with actuarial data and quantitative company studies to support their risk categorization.

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[59] Albert Foer, Congress, Committee on Banking, Housing, and Urban Affairs, Subcommittee on Consumer Affairs, "Fair Credit Reporting Act Amendments of 1975," 97th Congress, 1st Session, October 22, 23, 29, and November 18, 1975, 33.

Further, consumers and insurance companies disagreed about what characteristics should be classified as risks. Set against the backdrop of changing gender and sexual norms, individuals such as Galen Cranz thought that living with a man "without the benefit of wedlock" did not qualify as a calculable risk that should single her out from the larger pool of policyholders.[60] Cranz's case marked just one amongst many, who complained about insurers' risk rating practices, and by the end of the 1970s, a string of lawsuits had been brought before Federal district courts that used the FCRA as the legal instrument to charge discrimination. Insurers, however, claimed that from their experience in underwriting, factors that pertained to one's gender and sexuality could be calculated, objectified, and commodified into risk. Legislators and academic policy experts either supported insurance companies' interpretations of risk or largely ignored this disagreement. Instead, they cited the potential invasiveness of the highly interlocking financial system that they believed opened the gateway for inaccurate reporting as the chief threat to consumers. Hence, Congress passed the Fair Credit Reporting Act, which did not directly regulate insurance companies. Instead, legislation aimed at controlling the middle men of the financial sector, the credit and investigation bureaus.

This aspect of the FCRA has been largely ignored by historians, who have tended to focus on how this legislation specifically affected the credit industry.[61] Nor has the relationship between insurance and consumer movements been explored.[62] While it is true that the Fair Credit

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[60] For a history of traditional female gender norms and how these norms began to break apart, especially in the 1950s and 1960s, see Alice Kessler-Harris, *Out to Work: A History of Wage Earning Women in the United States*, (Oxford: Oxford University Press, 1982.)

[61] See Louis Hyman, *Debtor Nation: A History of America in Red Ink*, (Princeton: Princeton University Press, 2011), especially chapter six "Legitimating the Credit Infrastructure: Race, Gender, and Credit Access," 173-219.

[62] While little literature exists on the topic of insurance and social movements, a number of excellent texts have been written on the importance of economics to social movements. For a sampling of this literature, see Alice Kessler-Harris, *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship*, (Oxford, Oxford University Press, 2001), Lizabeth Cohen, *A Consumers' Republic: The Politics of Mass Consumption in Postwar America*, (New York: Knopf, 2003), Nancy MacLean, *Freedom Is Not Enough: The Opening of the American Workplace*, (Cambridge, Harvard University Press, 2006). Meg Jacobs, *Pocketbook Politics: Economic Citizenship in Twentieth*

Reporting Act targeted the credit lending industry, the FCRA circuitously affected the insurance industry by managing the data gathering networks that existed between insurance companies, credit lenders, and credit agencies. Importantly, designing the Fair Credit Reporting Act in this way ultimately helped insurers win the battle against consumers because it supported insurers' position that framed insurance both conceptually and materially as a commodity that should remain an economic privilege and not an economic or civil right. This debate between consumers, insurers, and legislators over the Fair Credit Reporting Act illustrates the growing divergence between how the business community, on the one hand, and consumers, on the other, defined economic fairness and economic citizenship during the 1970s.

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Regulatory measures in the Fair Credit Reporting Act pinpointed at both the credit and insurance industry had been intentional by Congress. William Proxmire (D-WI), primary sponsor of the FCRA, made this clear during the bill's introductory remarks before the Senate Subcommittee on Financial Institutions in 1969.[63] He stated that the bill would affect both

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Century America, (Princeton: Princeton University Press, 2005), Robert Weems, *Desegregating the Dollar: African American Consumerism in the Twentieth Century*, (New York: New York University Press, 1998), Thomas Minchin, *Hiring the Black Worker: The Racial Integration of the Southern Textile Industry, 1960-1980*, Chapel Hill: University of North Carolina Press, 1999), Susan Ashmore, *Carry It On: Poverty and the Civil Rights Movement in Alabama, 1964-1972*, (Athens: University of Georgia Press, 2008), Robert Zieger, *For Jobs and Freedom: Race and Labor in America since 1865*, (Lexington: University Press of Kentucky, 2007), and Gavin Wright, *Sharing the Prize: the Economics of the Civil Rights Revolution in the American South*, (Cambridge: Belknap Press, 2013). For a different interpretation of how the Civil Rights Movement lost its emphasis on economic justice, see Risa Goluboff, *The Lost Promise of Civil Rights*, (Cambridge: Harvard University Press, 2007).

[63] William Proxmire, Congress, Senate, Committee on Banking and Currency, Subcommittee on Financial Institutions, "Fair Credit Reporting," 91st Congress, 2nd Session, May 19, 20, 21, 22, 23 1969, 1; Partly why the FCRA did not directly regulate the insurance industry was because it had long managed to bypass federal regulation as a consequence of the McCarran-Ferguson Act of 1945. This piece of legislation had beed enacted in response to the Supreme Court decision in *United States v. South-Eastern Underwriters Association et al*., which overturned the precedent that exempted the insurance industry from the U.S. Constitution's Commerce Clause. The ruling found that the insurance company South-Eastern Underwriters had violated the Sherman Anti-Trust Act by forming a monopoly and price-fixing premium rates. To prevent the further growth of monopolies in the insurance industry, the Court ruled that it was in the public's best interest to regulate the insurance industry as interstate commerce. However, Congress nullified the Court's decision with the McCarran-Ferguson Act. The act exempted insurance from most federal regulation of commerce including the Sherman Anti-Trust Act and the Federal Trade Commission Act. Instead, the states would be charged but not required to regulate life, health, and casualty insurance. See *United*

"traditional credit bureaus" and "insurance reporting agencies." To target both industries, legislators crafted the Fair Credit Reporting Act to apply to the services provided by credit reporting agencies such as the Retail Credit Co., who supplied data about potential borrowers or policy holders to credit lenders and insurance companies.[64] The two main components of the bill that would rectify discrimination in insurance and credit Senator Proxmire believed were the provisions that allowed consumers to have access to their credit and insurance reports by calling or visiting either the insurance company or credit agency.[65] Under the legislation, customers would be entitled to have their reports read aloud to them, but they were not entitled to actual copies of the reports. If information in the report seemed inaccurate to the customer, they had the right to ask for a reinvestigation and to offer a supplement to the report disputing the information.[66] Therefore, the FCRA from a legislative perspective would fix one of the main problems in credit lending and insurance underwriting—the over reliance on inaccurate information. However, for consumers it left untouched the issue of what information should be relevant in the evaluation of risk by insurers, strengthening the insurance industry′s position that they alone could dictate what could be included in calculating adverse and moral hazard risks.

The tight web of information sharing between insurers, credit agencies, and credit lenders that the FCRA meant to control had been slowly building over the course of the twentieth century but had its roots in the nineteenth century. Access to the personal information of individuals became a top priority for early American insurers, who wanted to build accurate statistical and mortality tables to help them calculate an individual's risk. Without this kind of

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States v. South-Eastern Underwriters Association et al, 322 U.S. 533; 64 S. Ct. 1162; 88 L. Ed. 1440; 1944 U.S. LEXIS 1199; 1944 Trade Case. (CCH) P57,253, *www.lexisnexis.com/hottopics/lnacademic,* date access January 10, 2014, and Congress, House, "S. 340" 79th Congress, 1st Session, January 29, 1945, 3-5

[64] William Proxmire, "Fair Credit Reporting," 1, 65.

[65] Ibid, 2.

[66] Congress,"Fair Credit Reporting," 6-8.

knowledge, insurance companies would have been unable to charge individualized premium rates.[67] Large scale credit rating agencies such as the Retail Credit Company stepped in to fill the information void. Companies such as Retail Credit Company (Equifax), along with insurance firms, and employers developed in tandem a network of personalized information sharing. Retail Credit, the largest of such firms, became the primary target for consumers, who wanted to contest insurance underwriting policies and for legislators, who were concerned about this locus of consumer data sharing.[68]

In a major study conducted by Congress on automobile insurance in 1967, consumers complained about an underwriting system that contained, according to many, "inherent defects." Consumers worried that significant economic decisions in insurance were being made and produced in a system that relied on the subjectivity of credit agency inspectors.[69] Consumers constantly cited the use of inaccurate information in the underwriting process transmitted to insurers through investigative agencies such as Retail Credit Co., Hooper Holmes Bureau, and O'Hanlon as a main problem for consumers. In their criticisms, consumers and legislators attacked the lack of internal company policies designed to prevent the dissemination of inaccurate information and the over-reliance in underwriting on investigative reports that contained only hearsay or gossip. They also took issue with the "piecemeal" basis under which many inspectors were paid and "the desire to increase output" which might lead to "less than thorough verification of the facts."[70]

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[67] Sharon Murphy, I*nvesting in Life: Insurance in Antebellum America*, (Baltimore: John Hopkins University Press, 2010), 13-46.
[68] For more on the Retail Credit Company, see the second chapter of this thesis.
[69] Congress, House, Committee on Judiciary, Subcommittee on Antitrust, "Automobile Insurance Study," 90th Congress, 1st Session, September 30, 1967, v.
[70] Ibid, 92-93.

On this point, consumer advocate Alan Westin, a professor of public policy and law at Columbia University, who also served as the Director for American Liberties, criticized Retail Credit Co. and the relationship it formed with its clients, terming it "one large unitary information system." He denounced the cabal-esque "national fraternity" Retail Credit Co. and other agencies participated in arguing that businesses such as Retail Credit Co. could not be trusted to regulate themselves. Rather, the federal government needed to put in place guidelines that would protect the public from the "private intelligence and information network."[71] Other public intellectuals and scholars joined Westin in these attacks. In Vance Packard's *The Naked Society* and Arthur Miller's *The Assault on Privacy*, both writers questioned the legitimacy of financial institutions gathering so much data on individuals and voiced concern over how that data would be used. As Miller noted, life insurance companies bought data from credit bureaus to evaluate risks. ″This supposedly justifies inquiries into the customer′s vocational duties, his finances, health, use of alcohol, mode of living, sporting activists, and sexual capers—both natural and unnatural,″ he scolded, citing Retail Credit Co. and Hooper Holmes as the main offenders.[72] Packard, similarly, chided credit and insurance investigators for sticking, "to a man like a shadow," when it came to collecting information.[73]

Not everyone agreed with these criticisms of credit bureaus and insurance companies. Thomas J. McIntyre, the Democratic Senator from New Hampshire took issue with Westin's testimony contending that focusing solely on the amount of information companies like Retail Credit Co. collected and who they sold it to ignored the critical role this played in business. McIntyre wanted to know why Westin would think it unreasonable that an insurance company

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[71] Alan Westin, "Fair Credit Reporting," 74, 79.
[72] Arthur R. Miller, *The Assault on Privacy: Computers, Data Banks, and Dossiers,* (Ann Arbor: The University of Michigan Press, 1971), 69-70.
[73] Vance Packard, *The Naked Society*, (New York: David McKay Co. Inc., 1964), 169.

would want to do a background investigation on a man who took out a $500,000 policy of life insurance since that policy could cost a company a substantial loss if taken out fraudulently.[74] Westin clarified his position responding that he did not think companies should be denied the information they needed, but that there was a problem with companies' decision to investigate "morals" and decide to "issue a policy or not" based on this information.

He cited the example of "homosexuals" in insurance underwriting, who were considered an "extra special risky" category, yet this practice, he further noted had been kept secret from the general public, who he believed had little knowledge of how insurers classified individuals. Westin thought the Retail Credit Co. and companies like it operated on a "secret level instead of being open to the public" and that they judged applicants on moral grounds.[75] The conversation between McIntyre and Westin emphasized the growing tensions between the public and insurers who had begun to disagree on the role of insurance in the national economy. Consumers started to see health, life, and casualty insurance as an economic necessity and thus an economic right. Therefore, parts of the business model of the Retail Credit Co. that threatened to deny consumers access to insurance were considered a threat to a newly defined economic fairness. As Westin made clear in his discussion of homosexuals, this conception of economic fairness granted more equal financial rights to those before excluded from areas of the economy including gays and women. Insurers however conceived of economic fairness differently. To them categorizing homosexuals as more risky did not qualify as inequality because according to studies of risk classification, homosexuality comprised a legitimate risk factor. Thus, excluding gay men and lesbians as policyholders simply meant practicing sound insurance underwriting. Those more

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[74] Thomas J. McIntyre, "Fair Credit Reporting," 81.
[75] Alan Westin, "Fair Credit Reporting," 81.

familiar with the methods of actuarial science and the underwriting process viewed insurance as a privilege and not a right and characterized the industry as necessarily discriminatory.

Insurance companies tiptoed around these issues cautiously. For instance, they agreed with consumers and legislators that using investigative reports was expensive and made them more liable to defamation suits. In a letter from the company chair of State Farm to Congress, the chairman recognized that the "collection of secret and confidential information about the personal life of individuals," represented a major business risk and caused "substantial problems," however, he also asserted that any regulatory procedures put in place by legislation or changes in internal company regulations "should safeguard the legitimate business interest of the insurance companies." Here, he referred to making sure personal information on individuals remained available and easily accessible to keep business operations running and affordable.[76] In debates held in Congress on the eve of the passage of the FCRA, company heads sent a clear message to the federal government. They admitted that the system of information exchange between insurance companies and credit bureaus contained some flaws based on human error. Yet, they also argued that for insurance businesses to continue to underwrite and offer competitive premium rates, they required the easily obtainable and affordable information provided by credit bureaus and inspection agencies. Representatives for insurance companies understood better than consumers and politicians the importance of the flow of information to maintaining this aspect of the economic system. Insurance companies were unwilling to jeopardize the easy flow of human data through the credit and insurance network with added federal regulation. Further, insurers thought that the consumer failed to properly understand the risk classification system, which appeared inequitable, but to insurance companies was supported with objective evidence in the form actuarial science. At a meeting of the Society of Actuaries in

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[76] Congress, "Automobile Insurance Study," 93-95.

1978, actuary Darrel W. Ehlert, a fellow of the Casualty Actuarial Society, railed against this misunderstanding. He argued that some consider discrimination in any form an "evil," but for the actuary, not to discriminate was the true evil.[77]

Insurers emphasized the same point nearly a decade earlier in 1967 when questioned before Congress on automobile insurance rates. Legislators had asked major casualty companies to send a "description of any actuarial statistical experience" that pertained to divorcees, age, geographic location, military-service, moral character, employment, and any other classification companies treated as "exceptional risks."[78] Legislators, who had received complaints from consumers over the last year, 520 in total, wanted to know if insurance companies actually possessed studies or actuarial data that supported their choices to evaluate certain categories of people as more risky than others.[79] Several companies responded to this inquiry by citing company studies including Aetna Casualty & Surety Co., Allstate Insurance Co., Automobile Club of Southern California, Continental Insurance Co., Farmers Insurance Exchange, Detroit Auto Inter-Insurance Exchange, Government Employees Insurance Co., Criterian Insurance Co., Hartford Insurance Group, Home Insurance Company, and Nationwide Mutual Insurance Co. Yet, before answering any questions, many companies, in step with their predecessors such as Arthur Hunter and Solomon Huebner "acknowledged that ratemaking for these classification and underwriting determinations on individuals," were not always "based on precise statistical background." "Of equal or greater importance," insurers noted were "judgment considerations."[80] Just as in the early twentieth century, partly this stemmed from the information available to insurers. Divorcees, for example, represented a major special risk

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[77] Harry Woodman, Jr., "Classification Areas," *Record of Society of Actuaries* 4, no. 1 (1978), 82.
[78] Ibid, 133.
[79] Ibid, 76-77.
[80] Ibid, 133.

category because data on marriages and divorces was easily attainable by insurance companies through census records. Data on whether a given individual engaged in same-sex sexual relationships or identified as a homosexual contrastingly was harder to come by, and insurers relied on hearsay gathered through investigative reports to obtain this information.

For insurers, the statistics provided to the Automobile Insurance Study in the late 1960s supported their position that insurance underwriting, to remain a viable business that protected individuals from unforeseen loss, needed to discriminate against certain groups in the general population into risk categories. Insurance industry representatives gave Congress their studies and characterized their work not as unfairly discriminatory but necessarily discriminatory. Insurance representatives illustrated this with data about divorcees. In the case of this risk group, several companies stated that divorced men and women did not constitute a separate class.[81] However, other companies did note they had special policies on writing insurance for those who were divorced based on company studies that showed this group to be an adverse risk. Insurers supported their risk assessment with quantified numbers, yet their qualitative descriptions of divorcees revealed the gendered assumptions held by insurers about women and marital status. Farmers Insurance Exchange reported that they did not underwrite divorcees for one year based on "statistical evidence" that showed a higher than average frequency with divorced women than men for getting into accidents. Divorced women, the company claimed had an accident frequency 144 percent greater than the average driver; divorced men 112 percent greater frequency.[82] Government Employees Insurance Company also judged divorced women as a special class citing that divorced women could be 'highly emotional" and that the "transition

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[81] These companies included Aetna Casualty & Surety Co., AllState Insurance Co., Automobile Club of Southern California, Continental Insurance Co., and Detroit Auto-Inter Insurance Exchange.

[82] Ibid, 139.

from married life" carried "new pressures and responsibilities."[83] Criterian Insurance Company believed that divorced women embodied an elevated risk exposure and that inspectors would need to carefully collect information on occupation, emotional stability, habits and reputation, and the names of additional drivers and their relationship to the insured before writing a policy for divorced women.[84] Continental Insurance Co. stated they did not include divorced men or women as a separate risk class, but they often did not issue insurance for men who were married and under 21 years of age based on their belief that marriage in men that young indicated "emotional problems that produce a below average risk."[85]

Nationwide Mutual Insurance Company provided the most detailed response to the congressional commission's questionnaire. The company cited a massive research study conducted by Nationwide that recorded data from 400,000 automobiles for a period of one year. The Nationwide statistics underlined more clearly for Congress the problems consumers had with insurance classification where it became quite obvious that partly what insurers measured was how well one fit with hegemonic standards of morality and social norms. The study tracked 78 different characteristics for each driver and then analyzed which factors most often corresponded to increase traffic accidents and violations.[86] According to Nationwide's research, those with poor morals had an accident frequency 11 times that of the group, whereas those with heavy drink habits had accidents 7 times more than the average. Others who had a higher than normal accident frequency included those who lived in a "poor home environment" defined as a house that was "poor," "unclean," and characterized by an "absence of normal family relationships." Long term and recently divorced people and those that lived in common-law

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[83] Ibid, 142.
[84] Ibid, 143.
[85] Ibid, 137.
[86] Ibid, 148.

marriages also had significantly more accidents according to Nationwide's numbers. The highest accident frequency could be found in people classified as "antagonistic-anti-social." Nationwide characterized this person as someone who was resentful of authority, law enforcement agencies, superiors at work, and relatives. It also included people who seemed "belligerent" toward inspectors and failed to cooperate when being questioned about personal life and habits.[87]

State Farm answered the question of moral character by noting that it was "a factor of risk selection only when the individual characteristic circumstance represents a sufficiently significant departure from today's generally acceptable standards of conduct," reasoning that morals carry "over to the highways and is reflected in the automobile loss records of these individuals." Companies such as State Farm were careful in admitting to using "moral character" as a selection criteria. They constantly reminded legislators that using moral character constituted a legitimate business interest and was necessary to properly manage company risk. Similarly, Hartford Insurance Group pointed out that the basis of the insurance business was to evaluate good and bad risks to earn a profit. "Since each company is charged with the responsibility of producing an underwriting profit," Hartford pointed out, "there is no desire to insure any risk not likely to contribute to that profit. Insurers stressed too that their risks standards were "not arbitrarily chosen nor...absolute." [88] Insurers insisted that if polices discriminated unfairly in classifying risk, this arose from the legitimate needs of insurers to hedge against adverse risk. Insurance companies used company studied, mortality tables, and actuarial models to define economic fairness and economic rights differently than consumers. Insurance policies that did not distinguish risk factors between certain groups would be more unfair according to the logic of the insurance industry, since this would in turn cause premiums

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[87] Ibid, 149.

[88] Ibid, 148.

to rise for standard risks that would be forced to make up the monetary difference of underwriting substandard risks.

The Fair Credit Reporting Act supported this position by leaving alone the issue of relevancy, targeting narrowly the inclusion of inaccurate information in insurance and consumer reports, and leaving out possible regulatory mechanisms that insurers thought could close or increase substantially the cost of preserving the vital information pathways that linked insurers and credit agencies. Once the FCRA became law, consumers geared their complaints to try to fit within the regulations of FCRA charging that companies failed to provide credit and insurance reports when requested or would not reinvestigate if the customer believed the information to be wrong. At the heart of consumers' complaints, however, was always the issue of relevancy.

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In the 1960s and 1970s, individual consumers began to take issue with both the system of information sharing that existed between Retail Credit Co. and insurers and insurer's risk classification schemes, often attempting to dismantle both simultaneously. Consumers importantly recognized that these components comprised the same interlocking system. The Fair Credit Reporting Act of 1970 gave individual policyholders a new tool in which to attack the web of knowledge sharing between insurers, creditors, and employers. Before the FCRA was passed however, individual consumers had little recourse in which to file complaints or enact lawsuits.

For example, Edith Wetherby and Mary Dunnigan, two women who lost their insurance after an investigative consumer report labeled them as "lesbians," would be cited in congressional debates on the Fair Credit Reporting Act as prime example of how putting in place a governmental policy that allowed consumers to challenge the accuracy of their credit and insurance reports would help those negatively affected by the complex system of financial information exchange.[89] Wetherby and Dunnigan, two Maryland residents, who lived together as roommates and jointly ran a real estate and mortgage business, could not obtain life insurance coverage when they applied for it in the early 1960s. Despite their financial stability and adequate income, the pair was denied coverage from several insurance companies. Wetherby and Dunnigan eventually discovered that they had been rejected as potential policyholders because of "adverse" information contained in an investigative insurance report drafted by the Retail Credit Company. The Retail Credit Co. report claimed the two women "gave loud parties," and that neighbors believed them to be "Lesbians." [90] This information amounted to enough for insurers to label Wetherby and Dunnigan as a "moral hazard," and consequently, the two could not qualify for life insurance. In response, they sued the Retail Credit Company for libel and slander.

In *Wetherby et. al v. Retail Credit Company*, Wetherby and Dunnigan contended that the information contained in the investigative report made by Retail Credit Co. and used by various insurers to assess them as potential risks was false and recklessly collected by the Retail Credit Co. inspector. The two denied they were lesbians. Rather, they said Retail Credit had demonstrated malice by relying on hearsay evidence from neighbors without proving conclusively whether they were lesbians or not.[91] The two lost the lawsuit after the presiding judge, Kathryn Shook, directed the jury to disregard the truth or falsity of the investigative report as irrelevant to the case. As Joseph Simpson Jr., attorney for Retail Credit Co. argued, and Shook agreed, the company's inspector reports as part of the "regular course of its business and sent only to its own customers" meant that investigative insurance reporting fell under the protection

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[89] "Credit Investigations and the Right to Privacy: Quest for a Remedy" *Georgetown Law Journal* (February 1969) reprinted in "Fair Credit Reporting," 470.
[90] "Wetherby, et al. v. Retail Credit Company: Opinion of the Court," *Maryland Reports: Cases Adjudged in the Court of Appeals of Maryland*, (Charlottesville: The Miche Company, 1965): 238-39.
[91] Ibid, 237.

and precedent of "qualified privilege." As long as the information contained in the report, even if it pertained to one's sexuality and originated from possibly unreliable sources, was used narrowly for business purposes and remained private information between the insurer and Retail Credit Co., the issue of what the report said or how the information was used in risk evaluation was immaterial.[92] Wetherby and Dunningan appealed their case to the Maryland Court of Appeals. The appellate court decided again in favor of the defendant and upheld the ruling of the circuit court.[93] *Wetherby* importantly pointed to the future of legislation such as the Fair Credit Reporting Act. The courts, in upholding that insurance companies had the right to decide what kind of criteria should be used in underwriting, supported the arguments of insurers that they best understood how risk should be evaluated and used. Additionally, the court's decision demonstrated the information network that existed between insurers and credit agencies, while potentially invasive to the consumer, needed to be protected to continue the business of insurance underwriting and credit lending.

If Wetherby and Dunningan had filed their lawsuit at the end of the decade after the enactment of the Fair Credit Reporting Act, the court might have reached a different conclusion. Since the FCRA contained provisions that stipulated that credit companies and the businesses that relied on their services such as insurance companies could be held accountable to customers who wished to challenge the accuracy of the information collected about them, the FCRA would have given more weight to the plaintiffs' arguments that labeling them as lesbians without incontestable proof violated their rights as consumers. Under the FCRA, if it was found that Wetherby and Dunningan were not lesbians, then the Retail Credit Co. would have been forced by the new regulations to change the investigative report to reflect this, therefore erasing the

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[92] Ibid, 239-40.
[93] Ibid, 238, 243-44.

information used by insurance companies to classify Wetherby and Dunningan as substandard risks. However, if during the trial information had been presented that in the eyes of the jury conclusively proved that Wetherby and Dunningan were lesbians, then the provisions of the FCRA would not apply. The question of whether details about a person′s sexuality should be included in classifying risk did not enter into the debate during *Wetherby* in 1964 and was brought up only minimally as the case was discussed in congressional debates before the passage of the Fair Credit Reporting Act in 1969. Yet, Edith Wetherby and Mary Dunnigan highlighted for many consumers after the FCRA′s enactment the underlying problem with insurance underwriting; the use of arbitrary or erroneous information that did not accurately predict individual risk.

After the Fair Credit Reporting Act was passed, the courts returned to the same questions raised in the *Wetherby*—how much weight should be given to qualified privilege, what counted as legitimate business interests, and what power did the state have in determining how businesses classified risk. *Peller v. Retail Credit Co.*, the first major case decided using the FCRA, set up the framework for how this piece of legislation would answer these questions. *Peller,* decided by the District Court of Appeals for the Fifth Circuit in 1974, revolved around Gary Peller, who sued Retail Credit Co. for an investigative report that revealed that Peller used marijuana, LSD, and other narcotics while in college. The inspection report was later distributed to his employer Arthur Andersen Company during a routine background check. Peller, as a result, lost his job.[94] Peller sued Retail Credit Co. for selling information about him to an employer that he deemed too personal and irrelevant. The court decided against Peller reasoning that his case did not truly pertain to the Fair Credit Reporting Act. Since Peller admitted to using drugs, the portrayal of

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[94] "Order from the U.S. District Court of Northern Georgia, Atlanta Division," *Gary Peller v. Retail Credit Co. et al*, 021-75A1781, Box 65, National Archives Building, Atlanta, Georgia.

him by Retail Credit Co. was accurate. Further, the court thought that information on drug use could be counted as a “legitimate and vital interest to a prospective employer.” The official opinion of the court stated:

> ...in an attempt to establish logical precedent and avoid the possibility of creating a flood of conceivably untenable litigation, the Court hereby finds that in order to pursue a cause of action based upon a willful or negligent violation the report sought to be attacked must be inaccurate. Only then will the issue of reasonableness as verification procedures become viable.[95]

Interestingly, in the Peller case, the issue of whether a person previously used drugs as a legitimate piece of information that employers could search for in vetting potential job applicants was not considered controversial or worthy of debate. The courts, as well as Peller himself, shared a common agreement that this was within the appropriate bounds of what an employer could ask a future employee. In other words, the court shied away from the issue of relevancy and stuck to the question of accuracy.

Peller was somewhat atypical though of cases tried using the FCRA. In legal proceedings, women most often seemed the target of these unfair practices as normative ideas of appropriate gender behavior shaped how insurance companies evaluated them. Specifically, women were denied insurance, had their policies revoked, or were asked to pay extremely high premiums based on investigative reports that accused them of failing to meet normative cultural gender or sexual standards such as failing to marry, to run a tidy household, or having children out of wedlock. These women viewed their difficulties in accessing insurance as a fundamental

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[95] Ibid, 5.

violation of their economic rights and as unfairly discriminatory. Insurers, meanwhile, cited their history of using actuarial science to calculate risks and employed a rhetoric of scientific objectivity to shore up their arguments that their risk rating accurately measured real potential hazards. They insisted that their methods of risk analysis supported by actuarial science and quantitative company studies that demonstrated certain categories—divorcees, single-women, individuals who used drugs and alcohol, or worked in dangerous occupations—constituted a legitimate adverse risk in underwriting. From the prospective of insurers to require them to provide policies for these individuals at standard rates would put the insurance as a whole on shaky financial and ideological footing.

Women's complaints about violations of the Fair Credit Reporting Act did not mark the first time that consumers had been angered by the gendered risk rating system of insurance companies. In the early years of 1970s, during Congressional hearings over the Equal Rights amendment, self-identified feminist groups such as the National Organization for Women (NOW) characterized the insurance industry as an economic site where women continued to be unfairly discriminated against. Virginia R. Allan, head of President Nixon's Presidential Task Force on Women's Rights and Responsibilities, suggested in the Task Force's policy recommendations that the federal government needed to address immediately inequities in unemployment, medical, and disability insurance.[96] Yet, even if passed, women could not count on the ERA as a fix-all mechanism for the issue of gendered discrimination in insurance. When the issue of risk classification came up in ERA debates, House member Andrew Jacobs Jr. (D-IN),for example, insisted that the ERA would not affect how insurers' calculated risk even while

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[96] "A Matter of Simple Justice," dated 1971, reprinted in Congress, Committee on the Judiciary, Subcommittee No. 4, "Equal Rights for Men and Women 1971," House, 92nd Cong., 1st Sess,, March 24, 25, 31 and April 1, 2, 5 1971, 683.

women's activists such as Lucille H. Shriver, Director of the National Federation of Business and Professional Women's Clubs, Inc. disagreed.[97]

In the 1970s, insurers themselves were not completely deaf to the demands of women either. Recognizing the potential public relations crisis that a women's led consumer movement against gendered risk classification could cause in 1976 the National Association of Insurance Commissioners (NAIC), the group responsible for coordinating uniformity in state insurance legislation, produced a piece of model legislation to provide a blueprint for states on prohibiting sex and marital status discrimination in insurance, which many states adopted. However, this model legislation was drastically limited in scope and applied only to the issue of coverage. The NAIC kept clear of putting in place rules for setting the prices of premiums, which according to the tenets of the legislation would be left to the discretion of insurers. The NAIC, in crafting this model legislation for states produced a clear message; women should have access to insurance if they could afford to pay the rates that insurance companies set for them. These rates would still be based on morbidity tables that included sex as a class and thus women would still pay more or less for certain lines of insurance compared to men.[98]

With limited alternative legal options, women, used the FCRA to attack indirectly insurers risk classification practices. Susan Young, a resident of West Virginia, for example, sued Retail Credit Co. after she had been forced by State Farm to pay an extra $80 a month premium on her automobile insurance after she had been evaluated as a substandard risk. Young, in her testimony before the Subcommittee on Consumer Affairs believed she should have had no problem getting automobile insurance after she purchased a new car. She had been a driver for

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[97] Lucille Shriver, "Equal Rights for Men and Women 1971, 148-154.

[98] "NAIC Model Regulation to Eliminate Unfair Sex Discrimination," dated 1976, reprinted in Congress, Committee on Energy and Commerce, Subcommittee on Commerce, Transportation, and Tourism, "Nondiscrimination in Insurance Act of 1981," House, 97th Cong., 1st Sess., May 20, 1980, 100.

thirty years and in that time have never been in an accident or arrested. She also never drank alcohol, but she was denied outright for insurance by Nationwide when she applied for a policy. Through her own investigating, she found out that she had been vetted by Retail Credit Co. at the request of Nationwide.[99] The Retail Credit inspector had collected data on Young's income, her employment, whether she was married, had kids, drank alcohol, or had any car accidents. There were also blanks that asked for information about her home environment and an open-ended section that instructed the inspector to elaborate on any problems or concerns he had about the potential policy holder. In this section of the report, the inspector recorded that Young's husband did not work or have any income that he was an alcoholic, and for this reason Young had left him for several weeks indicating to the inspector marital discord. Further, the report noted that she lived in a "lower grade rural residential area," and her yard was filled with trash.[100] These strung together details about marriage and environment illustrated the kinds of information that interested inspection agents as cultural brokers. Most important to the agent was whether Young fit certain assumptions about gender, class, and space.

After Young hired a local attorney William Carey, and threatened to sue, she managed to have certain parts of the investigative report that related to her husband and inadequate income removed. This was only after she provided the company with information about her husband that showed he did receive disability income from the United State military and forced them to note that she had a job at a local antique store stripping furniture that gave her enough income to be self-supporting. Young stressed in Congressional hearings that she did not understand how any of the details collected about her personal life predicted her ability as a driver.[101]

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[99] Susan Young, "Fair Credit Reporting Act Amendments of 1975," 106.

[100] Retail Credit Co., Automobile Insurance Report on Susan Young, "Fair Credit Reporting Act Amendments of 1975," 115.

[101] Young, "Fair Credit Reporting Act Amendments of 1975," 119.

W. J. Burge, president of Retail Credit Co, when asked about Young, presented a different way of thinking about how insurance related to economic rights and citizenship. He responded to Congressional questing about the case with the optimistic perspective that Young's experience demonstrated exactly how the Fair Credit Reporting Act helped consumers. Young because of the FCRA had been able to receive full disclosure over the phone and correct the inaccurate parts of her credit reports. Burge also contended that the information his company gave to the insurance companies was completely relevant to the underwriting process since the poor upkeep of the home and the trash in the yard combined with the use of chemicals used by Young when she worked from home stripping furniture constituted a potential fire hazard. In other words, Young's story then demonstrated not a moment of gender or class discrimination, but rather showed a credit agency and insurance company acting responsibly in evaluating a consumer's risk. Underwriting Young at a standard rate, according to Burge, could potentially jeopardize an insurance companies' financial solvency and consequently put other policy holders at risk in the event that the company became too economically strained to pay claims.[102]

Similar to Young, Barbara Collins was also turned down for automobile insurance she believed because of inaccurate information contained in an investigative report made by Retail Credit Co. In the Collins' case, she took Retail Credit to court after she found out an investigative report the company had made about her labeled her as an "excessive drinker," who had been kicked out of a local bar after a causing a drunken scene. The report also implied she had "low morals" by including a statement that discussed the number of men she had dated after her husband disappeared. The report stipulated that several different men had spent the night at

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[102] W. Lee Burge, "Fair Credit Reporting Act Amendments of 1975," 246-47.

Collins' home since her husband's leaving. [103] Collins denied the information in her report. She believed that she did not have "low morals," nor did she see anything wrong with dating many men. She disputed the characterization that anything was wrong with the way she lived her life and did not think she should be evaluated as a risk based on anything other than her employment and credit.[104]

In court, Retail Credit Co. argued that what they had reported about Collins was true and that anything besides questions of accuracy was not relevant to the case. Using the precedent set in *Peller*, they contended that what they had reported on Collins had been true, therefore, the case, they believed, should be dismissed since the Fair Credit Reporting Act only applied in situations where the reported data could be shown to be inaccurate. In cross-examination, Retail Credit Co. attorney Richard Smith tried to establish the accuracy of the report by intimidating and embarrassing Collins by asking questions about her personal life. He eventually got her to admit to most of the information contained in the report.[105]

Despite Retail Credit's arguments though, Collins won the lawsuit after a 10 day jury trial in which it was ruled that the Retail Credit Co. had violated the Fair Credit Reporting Act by not letting Collins hear her file in full on the first request and not letting a second party accompany her.[106] The jury made their decision without establishing the accuracy of the report, and instead argued that the other two factors in the case, which held no relationship to accuracy, had violated the Fair Credit Reporting Act. In this instance, the Fair Credit Reporting Act worked for the consumer by targeting the reluctance of credit bureaus to make their information

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[103] Barbara Collins, Congress, Senate, Committee on Baking, Housing, and Urban Affairs, Subcommittee on Consumer Affairs, "Fair Financial Practices Act," 2nd Session, February 21 and April 22, 23, and 30, 1980, 217.

[104] *Barbara Collins v. Retail Credit Company*, 410 F. Supp. 924; 1976 U.S. Dist. LEXIS 17229; 1 Fed. R. Evid. Serv. (Callaghan) 550, *www.lexisnexis.com/hottopics/lnacademic*, (date accessed January 10, 2014).

[105] Collins, "Fair Financial Practices Act," 217.

[106] *Barbara Collins v. Retail Credit Company*, 410 F. Supp. 924; 1976 U.S. Dist.

more publicly available. Yet, it bypassed the issue of relevancy leaving intact the rule among insurance companies and credit bureaus that they could collect whatever kinds of information on the individual they wanted for risk evaluation.

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From the testimony provided to Congress by Young and Collins, the outline of the developing tension between consumers and insurers in the 1970s becomes clearer. On one level, consumers such as Cranz, Wetherby, Young, and Collins disagreed with insurance companies' assessment of them as a morally hazardous risk. In each case, these defendants argued against the inclusion of qualitative information based on gender or sexual stereotypes in underwriting practices. These women thought that these aspects of their lives could not be calculated and commoditized into risk in the same way other factors like age and income could, which they thought more appropriate in the evaluation of risk. Insurers argued the reverse. They claimed in court and before Congress that not adequately assessing an individual's risk would pass undue costs onto other consumers who would have to pay higher premiums to make up for the individuals included in the risk pool who did not pay their fair share. The American Life Insurance Association, an insurance lobbying group, for example, noted in Congressional hearings that for this reason, regulating relevancy in insurance would "unduly inhibit the underwriting process and introduce inequities in the classification of applications."[107] They also explained that underwriting was a "constantly evolving process," and consequently, a static definition of relevancy written into law had the potential to quickly become defunct.[108]

On another level, the disagreement between the two reached into the far larger question of how to define economic fairness and rights in the 1970s within the context of changing racial,

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[107] American Life Insurance Association, "Fair Credit Reporting Act Amendments of 1975," 592.
[108] Ibid, 594.

gender, and sexual politics. The Fair Credit Reporting Act, and other similar legislation, opened up new pathways for an expanding discourse of economic citizenship that potentially defined access to credit and insurance no longer as a privilege but as a right. However, the FCRA also limited the scope of this politics because it did not approach the issue of relevancy. Therefore, insurers could retain the underwriting practices and risk classification system that they had been building since the early twentieth century. Ultimately, the FCRA supported insurers' position that access to insurance should be defined as a privilege and remain available only to those who could both afford it and qualify as a standard risk. Yet, it importantly brought to the table in an expanded way the idea that risk classification unfairly discriminated against women and the poor. As the 1970s closed and the 1980s began a thriving feminist movement and HIV/AIDS activists would latch on to these politics and push consumer activism ever further in demanding insurance as a civil and economic right. Meanwhile, insurers would stick to the rhetoric they had been developing since the early twentieth century; their risk measuring methods as market-driven, objective science were best left in the expert hands of individual insurance companies and not the federal government or consumer groups.

CHAPTER 4

FEMINISTS, HIV/AIDS ACTIVISTS, AND THE BATTLE TO DEFINE INSURANCE

A movement built of insurance consumers who questioned the validity of insurance companies' risk rating practices crescendoed in the 1980s as large scale feminist organizations and women's professional groups along with HIV/AIDS activists more directly disputed insurers' claims that incorporating categories of gender and sexuality into risk calculations was fair or necessary to the maintenance of insurers' business. Especially in the 1980s, consumer activists mounted pointed campaigns against insurance discrimination instead of relying on the political maneuverings of the Fair Credit Reporting Act that only inadvertently attempted to change the process of risk calculation amongst insurance companies. Scholars in numerous fields and disciplines have examined the politics of anti-discrimination in second-wave feminism and the HIV/AIDS crisis, yet, very little has been written about how these social movements challenged the discriminatory practices of the insurance industry. Further, scholars have spent even less time critically examining how the mechanisms of risk denied women and gay men access to the full inclusion of economic citizenship during the waning decades of the twentieth century.[109]

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[109] The only historical analysis of the unisex insurance debate can be found in Caley Horan's *Actuarial Age: Insurance and the Emergence of Neoliberalism in the Postwar United States*, (Ph.D., Diss., University of Minnesota, 2011). While there is a dearth of writing on HIV/AIDS, there is less scholarship on anti-discrimination debates as they pertained to insurance. See Neil Cobb, "Queer(ed) Risks: Life Insurance, HIV/AIDS, and the 'Gay Question,'" *Journal of Law and Society* 37, (Dec. 2010), 620-650, J. Blake Scott, *Risky Rhetoric: AIDS and the Cultural Practices of HIV Testing*, (Carbondale, Southern Illinois University Press, 2003), and Katy Chi-Wen Li, "The Private Insurance Industry's Tactics Against Suspected Homosexuals: Redlining Based on Occupation, Residence, and Martial Status, *American Journal of Law & Medicine* 22, (1996), 477-502. Treatments of the anti-discrimination insurance debates more generally has been confined to studies of public policy and critical legal studies. See Jonathan Simon, "The Ideological Effects of Actuarial Practices," *Law & Society Review* 22 (1988), 771- 800, David Knights & Theo Vurdubakis, "Calculations of Risk: Towards an Understanding of Insurance as a Moral and

In federal and state legislation, second wave feminism and HIV/AIDS activism were cast as disparate political and social issues, but actuaries tended to see both as part of a singular, larger problem—the misunderstanding by the public and politicians of how the fundamental principles of risk classification in insurance worked. Insurers complained that feminists and gay rights groups highjacked the insurance debate, politicizing it as a civil rights issue when in reality, they argued, it was primarily a business venture. Insurers reasoned that their industry should be defined by the economic terms of the market and left up to individual insurance companies to regulate. James W. Dederer, Senior-Vice President and head physician of Transamerica Life Companies in Los Angeles summed this up neatly during a presentation before the Society of Actuaries. ″The problem on the legal, legislative, and regulatory front,″ he said could be attributed to ″the extraordinary degree of ignorance and misconception that exists about insurance and how it works.″[110] Dederer blamed this misunderstanding on the public′s own misconception of risk. Risk, he imagined to be just like ″gravity.″ ″It′s not something you debate,″ he believed, rather ″it′s just there.″ This metaphor of risk as gravity is telling. The actuarial vision, deeply rooted in the nineteenth century and refined in the twentieth, could by the 1980s, take for granted the wide acceptance amongst actuaries and underwriters that risk was, indeed, just like gravity—a fundamental, objective property of the knowable world. The public, Dededer thought, however, continued to see risk, or at least certain aspects of it, as more arbitrary than objective. Liberal activists, in the feminist, civil rights, and gay rights movement,

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Political Practice," *Accounting Organizations and Society* 18 (1993), 729-764, Bernard Harcourt, Against Prediction: Profiling, Policing, and Punishing in an Actuarial Age, (Chicago: University of Chicago Press, 2007), Brian Glenn, "The Shifting Rhetoric of Insurance Denial," *Law & Society Review* 34 (2000), 779-808, and Carol A. Heimer "Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation through Insurance," in *Embracing Risk: The Changing Culture of Insurance and Responsibility*, eds. Tom Baker and Jonathan Simon (Chicago: University of Chicago Press, 2002), 116-145.

[110] James W. Dederer, "The Future of Underwriting and Risk Classification," *Record of the Society of Actuaries*, Vo. 12, no. 4B (1986), 2954.

he worried, had convinced the public and legislators that discrimination in any form, even in risk calculation, was bad.[111] For many actuaries, underwriters, and insurers, Dederer accurately described what had become the volatile quagmire for insurance companies beginning in the 1960s and solidifying in the 1970s and 1980s. While insurers continued to view risk as objectively real and not arbitrary and believed discrimination as it applied to risk calculations were necessary and good, consumer advocates contrastingly saw the discriminatory practices of insurance companies as inherently unfair and limiting to their rights as economic citizens.

Although actuaries linked together women′s organizations and HIV/AIDS activists as a part of the same political front, differences between these two social movements made their politics against risk rating practices distinct. Feminist campaigns, led by large national women′s organizations and professional clubs such as the National Organization for Women, the Women′s Equity Action League, the National Federation of Business and Professional Women′s Clubs, and the American Association of University Women, benefited from their size, longevity, and experience gained during fights over the Equal Rights Amendment. In addition, while these groups tended to lay claim to representing women as a whole, in reality, their interests were far narrower and tended to focus on the political demands of white-collar women workers or dependent women in families with enough income to place them solidly in the middle class. As groups that claimed to protect a specific class, namely women as a whole, their activism raised a significant question about the challenges of a consumer politics in the context of the U.S. insurance industry—how can a broad consumer movement affectively collectivize against an industry constituted on human differentiation and personalized risk individuation? Feminists answered this question by promoting a liberal conception of the individual. Women, and

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[111] Ibid, 2954.

sometimes men, during Congressional debates over unisex insurance argued that insurers violated women′s individual rights by classing all women together based on their calculated risk. They contended a more fair system would be for insurers to consider all women and men as separate, personally responsible individuals. What should matter in risk calculations instead of gender, they argued, were other factors that they believed correlated more clearly to mortality such as occupation, smoking, or drinking. Therefore, the women who testified before Congress did not mind if insurers quantified and commodified some qualitative characteristics as long as they stayed away from gender. The women and men who made these arguments, unfortunately, failed to see the classed and racialized undertones embedded in them.

HIV/AIDS activists' demands, contrastingly, sprang from a sense of urgency. By 1982, one year after the first reported case of AIDS in the United States, the Centers for Disease Control (CDC) had identified 452 AIDS cases and 177 deaths from AIDS. By the end of 1987, that number had climbed to 49,743 reported cases and 27,909 deaths caused by AIDS.[112] HIV/AIDS patients, in the absence of a universal socialized health program managed by government entities, required access to health and life insurance to cover health care costs and provide for dependents and beneficiaries, but private insurers refused to write policies for any individual who had already been diagnosed with HIV or AIDS. Further, they rejected applicants, who they believed represented an increased risk for contracting the virus, targeting homosexual men. In turn, gay men, characterized as the group primarily affected by HIV/AIDS, became synonymous with HIV/AIDS risk. Insurers' heteronormative assumptions about gay men as effeminate, urban dwelling bachelors, pushed them to create what Katy Chi-Wen Li has termed

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[112] "AIDS Weekly Surveillance Report," United States AID Program, Centers for Disease Control, December 28, 1987, 5.

the “AIDS profile,” which turned these queer stereotypes into discernible risk.[113] To support their underwriting methods, insurers employed the same arguments against HIV/AIDS patients as they did against women in the unisex insurance debate. They emphasized that accessibility to insurance was foremost an economic and business decision. Underwriting HIV/AIDS patients would put the life and health insurance industry on unsound financial footing as costs theoretically would outweigh collective premiums. Set against the backdrop of continued inflation and deregulation, insurers’ arguments played well into already circulating beliefs about the role of the state in the economy, especially after the election of Ronald Reagan, who throughout his time in office positioned the U.S’s declining economy as due to the federal government’s overregulation of business.

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Debates on what insurance industry insiders pejoratively termed “unisex” insurance laws surfaced in the halls of Congress in the early 1970s during hearings over the Equal Rights Amendment.[114] Unisex insurance referred to the implementation of regulatory measures by Congress or state legislatures that would prohibit insurance companies from using gender as a category in determining premium rates or payouts. When first introduced as a serious issue in the early 1970s, women and feminist-consumer advocates made little progress in convincing legislators that equal insurance for men and women would be a good idea. Major feminists groups focused all their resources and attention instead on the passage of the ERA. They would not bring unisex insurance again into the Congressional limelight as a singular issue until the early 1980s after the fate of the Equal Rights Amendment became more precarious.[115]

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[113] Li, 486-487.

[114] See chapter three of this thesis, 20-22.

[115] On the defeat of the ERA, see Sara M. Evans, *Tidal Wave: How Women Changed America at Century’s End*, (New York: The Free Press, 2003), 176-178.

At this point, as legal scholar Patricia Seith has noted, female legislators led by Barbara Mikulski (D-MD) and feminists made it their top legislative priority to pass the "Economic Equity Act" an omnibus bill, originally designed as the implementation provisions of the ERA. The Economic Equity Act dealt specifically with women's economic rights and was first introduced in Congress in 1980. The Act contained several provisions all of which protected against discrimination in different economic areas including taxes, pensions, social security, insurance, and credit and it was meant to strengthen and extend other major anti-discrimination bills such as the Equal Pay Act and the Pregnancy Discrimination Act of 1978. The Nondiscrimination in Insurance Acts, as part of the Equity Act, would have made it illegal for insurance industries to include sex, race, color, creed, and national origin in the process of classifying risk, setting policy rates, or making payouts. In other words, the legislation intended to equalize insurance for men and women in all insurance lines and products. While many parts of the Economic Equity Act became law, the set of bills that might have made unisex insurance the reigning law of the land, failed to move out of Congressional committees where consumer-feminists and insurance industry representatives engaged in a national public battle to redefine the meaning of insurance and economic fairness.[116]

Similar to the rhetoric employed in fights over the Fair Credit Reporting Act, insurers argued that their rating classification system epitomized fairness. Industry lobbyists characterized feminists' arguments in favor of unisex insurance as a product of the public's own ignorance over how risk classification worked. Just because insurers relied on discriminatory tables, insurance lobbyists contended, did not necessarily imply unfairness. Their logic rested on the principle that asking individuals to pay more or less than what their individual risk demanded

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[116] Patricia A. Seith, "Congressional Power to Effect Sex Equality," *Harvard Journal of Law and Gender* 37 (Feb. 2013), 1-8. Seith's article contains a helpful chart in the Appendix that breaks down each individual provision contained within the Economic Equity Act and includes which ones passed Congress in what year, Seith, 76.

would be unequally discriminatory since other individuals would be forced to subsidize these insurance freeloaders. More importantly, insurers made it a point to define insurance as a commodity and thus an economic issue and not a civil rights issue. As a matter of economics not individual civil rights, insurers could position insurance as a matter best left regulated by the free market instead of Congressional legislation. Representatives of major national feminist and women's professional groups countered these claims by characterizing equal access to insurance as a fundamental civil right. These women argued that a better method of risk classification could be devised. In their eyes, the new way of evaluating risk would exclude gender or sex but include what they believed were far more salient categories such as whether someone smoked or engaged in other habits that might increase mortality.

Ultimately, the results of this fight between the insurance industry and feminists would be a mixed bag. On the one hand, feminists in terms of getting Congress to pass legislation would be soundly defeated. Legislators would side with insurers in agreeing that insurance was mostly an economic issue that should be left up to the markets, the states, or individual insurance companies to dictate. However, in the judicial system, some women found hope and victory. The U.S. Supreme Court in *City of Los Angeles Department of Water and Power et al. v. Manhart et a*l. (1978) and *Arizona v. Norris* (1983) outlawed gender discrimination in retirement insurance if the pension under consideration had been provided through an employer as a fringe benefit. The court based its rulings on Title VII of the Civil Rights Act and the Equal Pay Act. These two court decisions packaged together translated into a step forward for "equal pay for equal work." Yet, *Manhart* and *Arizona v. Norris* left unquestioned the central framework of the U.S. welfare system that structured economic benefits such as access to affordable health care through employment making vulnerable the unemployed or those who worked in jobs without access to fringe benefit packages, and effectively preserving what historian Jennifer Klein has called "the private welfare state."[117]

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The push on behalf of consumers to equalize insurance rates between men and women entered national debates as a potentially explosive political issue in 1978. That year the U.S. Supreme Court ruled in *City of Los Angeles Department of Water and Power et al. v. Manhart et a*l that state and private employers that charged men and women different monthly rates in their contributions to pension plans violated the Equal Pay Act of 1963 and Title VII of the Civil Rights Act of 1964.[118] The 6 to 2 ruling used the combined force of the Equal Pay Act and Title VII to specify that both private and public employer operated pension plans could no longer deduct more from the paychecks of women than from men in their retirement contributions. The Court agreed with insurers that mortality tables on average showed that women lived longer than men but disagreed that this alone meant that women should be required to pay more in employer benefits than men.[119] Importantly, the *Manhart* decision, even though it affected the life insurance industry and helped equalize employer benefits for women, was more about regulating the relationship between employer and employee than insurance. While the discriminatory practices of insurance companies in employer provided health and life insurance pools would be protected, individuals who found themselves unemployed or in a job without fringe benefits had to face the vulnerability and high costs of the private insurance market.

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[117] Jennifer Klein, *For All these Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*, (Princeton: Princeton University Press, 2004).

[118] *Manhart* marked the first case of its kind to reach the U.S. Supreme Court, but other similar lawsuits made it through the courts at the same time as *Manhart*. Most famously, in 1975, women workers in New York City sued the city arguing that it's Employee's Retirement System violated Title VII and the Equal Pay Act because it discriminated against women in the distribution of pension payments as fringe benefits. The U.S. Supreme Court never heard the New York case because city workers chose to settle out of court. Campbell, "City Studies Ruling on Bias in Pensions," *New York Times*, (April 26, 1981), 40.

[119] Ibid, 40.

When the case was decided, those both critical and enthusiastic about the *Manhart* decision recognized how narrow the Court's ruling had been, however neither side commented on how it might equate citizenship with employment or include some women at the cost of others. Michael Evan Gold, assistant professor at the New York State School of Industrial and Labor Relations and attorney for the plaintiffs in *Manhart*, touted the decision as a major step forward for equalizing pay gaps between men and women. Yet, he also reasoned that the limitedness of the ruling should be seen as one of the strength of the Court′s decision. Contrary to what insurance companies feared before the ruling—that *Manhart* would redefine the relationship between customer and insurer, the Court applied its decision only to the relationship between employer and employee.[120] *The New York Times* also heralded the decision as a major victory for "equal-rights" but then noted that the decision would not be applied retroactively forcing employers and insurers to redistribute past payments back to women.[121] Insurers also latched on to this point. When the Court made its decision it estimated that about 50 million people participated in private pension plans with assets of more than $400 billion, believed to be increasing by about $50 billion annually.[122] With the financial size of pension systems in mind, the majority opinion of the Court cautioned against imposing too great a financial liability against employers and insurance companies, who the Court believed might become insolvent if made to alter too quickly how they charged individuals in annuity payments.[123]

In emphasizing the limited nature of *Manhar*t, the opinions of the two dissenting judges Chief Justice Warren Burger and Justice William Reinquist might have been more fortuitous in

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[120] Michael Evan Gold, "On Women's Pay and Pensions: What is Equality of Compensation?" *New York Times*, (February 20, 1978), A16.

[121] Only Justice Thurgood Marshall disagreed with the Court's decision on this point and thought the ruling should be applied retroactively.

[122] Weaver, A1.

[123] Campbell, 40.

predicting where the debate over unisex insurance was likely headed in the near future. First, Burger and Reinquist reasoned that in passing the Civil Rights Act of 1964, Congress never thought about how the Act would affect things such as pensions, annuities, or insurance more generally. The Civil Rights Act had been intended to apply to employment and not to all economic areas. Further, they contended Congress never meant for the Civil Rights Act to promote an idea of reverse discrimination whereby men would be forced to subsidize the retirement packages of women.[124] The dual issues of reverse discrimination and the messiness of figuring out exactly who would benefit and how if universal unisex insurance laws were put in place became especially pressing as Congress debated unisex insurance bills from 1980 to 1983.

The American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA), the main lobbying organs for the life and health insurance industries, led the campaign to defeat the Nondiscrimination in Insurance Act in Congress.[125] Actuary Barbara Lautzenheiser, a self-described "industry prophet," headed both the efforts of the ACLI and the HIAA.[126] Together Lautzenheiser and the ACLI successfully framed the debate over using gender in risk calculation as an economic rather than a civil rights issue. Lautzenheiser argued that the real question was not about rights but about costs. First, she built on the long tradition of actuaries by presenting actuarial tables and statistics to legislators and the public as measurements of real, observable risk. "Yes, we do distinguish between men and women in insurance," she openly admitted, "but we do not do so in an arbitrary or capricious fashion." Distinguishing between male and female risks stemmed from the insurance industry's use of

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[124] Weaver, A22

[125] Nondiscrimination in Insurance Act of 1981, Committee on Energy and Commerce. Subcommittee on Commerce, Transportation, and Tourism, House. 97th Cong. 1st. Sess. May 20, 1981, 25.

[126] Lautzenheiser had become the insurance industry expert on unisex insurance while working as Vice President of the Actuarial Division of Phoenix Mutual. Lautzenheiser believed she foresaw the threat civil rights and feminist movements imposed on actuaries and underwriters' risk classification system before other industry representatives. See Barbara Lautzenheiser, "The Future of Underwriting and Risk Classification," *Record of the Society of Actuaries* 12, no. 4B (1986), 2964.

company and government statistics. Extrapolating from these numbers, she argued one could take it as verifiably true that women lived longer than men on average.[127] Additionally, she evoked the history of mortality rating to bolster her point. Differences between sexes in mortality, she noted, have been tracked in mortality tables in "all cultures and all ages." "Mortality statistics have been kept for two hundred years," she continued, "and consistently show female mortality substantially below male mortality."[128] Tethering her points to the history and science of mortality tables, Lautzenheiser recalled the rhetoric of prior actuaries, who decades earlier laid their professional claims on a discourse of objectivity in statistical knowledge and actuarial studies. In making this point though, Lautzenheiser did not have to work as hard as her actuarial forbears. Both proponents and opponents of unisex insurance agreed that mortality tables demonstrated women lived longer than men.

With this point firmly established, Lautzenheiser then reasoned to make insurance pools fair, individuals needed to be grouped, pooled, and charged on rates commensurable with their risk. Otherwise some individuals would wind up subsidizing the costs of others. "Insurance pricing is based on logic, statistical experience, and the most accurate methods we have for predicting future trends," she emphasized. Not using these methods to calculate risk would mean "charging the same life insurance premiums to deep sea divers, sky divers, crop dusters," as to "office workers, lawyers, or librarians."[129] In this exaggerated example of comparing ″sky divers″ to ″librarians,″ Lautzenheizeser stressed her underlying point—the real discrimination happened when actuaries and underwriters could not class individuals based on their personalized risk. If companies were not allowed to make distinctions among policyholders, they

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[127] Lautzenhesier, "Nondiscrimination in Insurance Act of 1981," 72.

[128] Barbara Lautzenheiser, Nondiscrimination in Insurance Act, S. 2477, Committee on the Judiciary. Subcommittee on Antitrust, Monopoly, and Business Rights. Senate. 96th Cong. 2nd Sess. April 30, 1980 28.

[129] Lautzenhesier, Nondiscrimination in Insurance Act of 1981," 72.

would not treat ″individuals as individuals,″ and thus violate the very principle on which many liberal feminists staked their contentions.[130]

Finally, Lautzenheiser emphasized that risk directly related to the costs of doing business in a free, competitive market. Here, she carefully differentiated between group insurance and private insurance. The unisex insurance question pertained not to employer group insurance pools or "benefits provided through a social system," she noted. *Manhart* already addressed the issue of insurance offered through employment. The stakes in the Nondiscrimination Insurance Act applied specifically to the private and "voluntary" insurance market.[131] She constructed a vision of how this kind of market worked. "In a voluntary insurance market, as in any other voluntary market prices must be based on costs," she reasoned, "any requirement that rates not be based on cost, that is, that equal rates be charged for unequal risks, is unfair to existing and to future insureds."[132] Importantly, Lautzenheiser collapsed costs and risks together. The two, in a free, voluntary insurance market had to equalize. Any vision of insurance as risk sharing, subsidizing, or spreading evaporated from her vision of how insurance worked. People got out of insurance only what they paid in, and insurance companies patrolled access with risk.[133]

Similarly, Diana Less, an actuary who testified before Congress on behalf of the National Association of Independent Insurers, rationalized the complexity of the risk classification system as a direct response to market competition.[134] Less contended that for insurance to work properly as a mechanism that reduced "the uncertainty of financial loss through the transfer of risk," of many individuals into a common fund, insurers had to accurately predict the probability of certain events such as disability, a car accident, or death. Without being able to measure the

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[130] Ibid, 73.
[131] Ibid, 73
[132] Lautzenheiser, Nondiscrimination in Insurance Act, S. 2477," 27.
[133] Ibid, 31.
[134] Diana Lee, Nondiscrimination in Insurance Act of 1981," 178.

probability of the hazards insurance meant to protect against, insurers could not know what amount of money to charge each policy holder to keep the shared fund solvent. Lee argued that for insurance to be "fair," it had to be in "proportion to the degree of uncertainty or risk being exchanged."[135] Like in arguments over the Fair Credit Reporting Act, insurers based their claims on a way of defining fair that used one's risk as the measuring stick of equity. Real equality, their message rang, came when each was treated according to their risk. By focusing on these points, Lautzenheiser, the ACLI, and other actuaries such as Diana Less, directed the debate away from the issue of gender discrimination towards one about markets, costs, and fair prices.

Additionally, outside of the actuarial field, other critics of the Nondiscrimination in Insurance Act also complained about the possible ill economic effects the bill might have. Lindley H. Clark Jr., writer for the *Wall Street Journal*'s "Speaking of Business" column and University of Chicago trained economist, for instance, turned the tables on women workers who argued gendered pension funds violated Title VII of the Civil Rights Act. Instead, he argued that changing pension plans to a unisex model would unfairly discriminate against men and businesses that would have to bear the extra costs of paying women more than their fair share of mortality and warranted risk.[136] Lautzensheiser made a similar point when she noted in her Congressional testimony that the extra costs of a unisex insurance bill would be paid for by the consumer, who would see their premium rates raised to cover the additional costs of equalized insurance rates.[137] Further, Lindley pressed that unisex insurance would "incentivize discrimination," since employers would be less likely to hire women if they had to pay equalized costs between men and women in health, life, and disability insurance. While he relented that

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[135] Ibid, 178.

[136] Lindley H. Clark Jr. "Men of the World, Unite, You Have a Great Deal to Lose," *Wall Street Journal* (May 10, 1983), 35.

[137] Lautzenhesier, Nondiscrimination in Insurance Act of 1981, 72.

some women likely lived equally as long as men, based on the operations of business and the calculations of probability, an employer could not afford to plan on the assumption "he will get only short-lived women." Playing on the public and legislators' fears of rising costs and inflation as a holdover from the 1970s, Lindley and other critics, continually reiterated the negative financial consequences unisex insurance regulation would have on the average consumer. This "is hardly a result envisioned by the framers of the Civil Rights Act," Lindley snidely concluded.[138]

Women characterized legislation such as the Nondiscrimination in Insurance Act as a necessary response to the changing economic conditions of women and the family. Dr. Brown argued that in the past, men and women alike assumed that women worked simply for "pin money." If a woman become disabled and could no longer work for wages, the argument went, then she could simply rely on her husband's income to take care of her. Brown noted recent statistics that showed the falseness of this myth. She noted that 25 percent of women in the United Stated had never been married, while 40 percent were separated, divorced, or had been left by their husbands. Women, Brown argued, could no longer be seen as dependent on families and husbands to support, since women now headed a a significant proportion of households themselves. Denying women affordable and full coverage in disability, health, or life insurance meant taking away the financial security provided to male breadwinners.[139] Irma Brosseau, Executive Director of the National Federation of Business and Professional Women's Clubs (BPW), echoed these concerns. In a 1983 BPW study for example, she noted researchers found that for a husband and wife in their mid-30's who started a business together could not receive equal rates for disability insurance. Women paid 17 to 41 percent more than men where the

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[138] Clark, 35.
[139] Quincalee Brown, Nondiscrimination in Insurance Act, S. 2477, 15

dollar differences ranged from $75 to $500 per year. She further noted that disability insurance, especially in the coverage of pregnancy was limited and forced women "to shoulder all the financial risks of bearing children." These policies, she added, assumed women's earning were only marginal to their overall family and household earnings.[140]

Female witnesses challenged insurance companies' claims that civil rights and economics could be so easily divorced from each other. Judy Goldsmith, president of the National Organization for Women, opened her testimony before the Subcommittee on Commerce, Transportation, and Tourism by noting "insurance discrimination, as with other civil rights issues, is an economic one." Denying women access to affordable health, life, and disability insurance might support insurance companies' bottom lines, she argued, but it simultaneously hurt the pocketbooks of women and their families.[141] Brown focused on this aspect of the Nondiscrimination in Insurance Act too, calling it a step forward toward "economic and social justice."[142] Yet, while they saw the connections between social rights and economic rights, they also narrowly focused on the concerns specifically related to middle class employed women or women who worked from the home with enough income to afford insurance in a voluntary market. Rather than make insurance affordable for everyone, they agreed with the basic tenents of the free market system as the best mechanism for providing insurance.

The main thrust of women's arguments in Congressional debates rested around their liberal conception of the individual. First, they conceived of the individual as the primary unit protected by civil rights legislation and as the back bone of democracy. For example, Quincalee Brown cited the Nondiscrimination in Insurance Act as a good bill because it "preclude[d]

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[140] Irma Brosseau, Congress, Committee on Energy and Commerce, Subcommittee on Commerce, Transportation, and Tourism, "Nondiscrimination in Insurance Act of 1983," House, 98th Cong. 1st Sess., February 22 and 24, 1983, 224-225.

[141] Judy Goldsmith, "Nondiscrimination in Insurance Act of 1983," 255.

[142] Brown, 10.

treating individuals as if they are mere components of a racial, religious, sexual, or national grouping." "This basic principle," she argued, "that individuals deserve fair, unbiased treatment, is the cornerstone of our democracy and the essence of our freedom."[143] Second, they argued that rating by gender offended this notion of individualism. This was because a person's gender or sex, feminists argued could not be helped. Mary Gray of the Women's Equity Action League, contended "the only crime" of women unfairly discriminated against by mortality tables was possessing "the same sex organs as the few people in the longer lived group."[144] She rationalized that mortality tables then did not unfairly discriminate against all women only against the ones who had the same mortality as men. Occupation, health habits, and lifestyle, on the other hand, involved choice and individual responsible. This, they located, as the key distinction between fair discrimination and unfair discrimination.

This aspect of the Nondiscrimination in Insurance Act was less often discussed in detail. Rarely did witnesses' mention what new categories of risk would be created if gender was no longer incorporated into actuarial models. However, As Deborah Rankin, a reporter for *The New York Times* summed it up; "the question is whether sex is a legitimate factor to consider in pricing insurance and whether other factors, such as smoking habits, are just as good predictors of mortality."[145] In health and life insurance, smoking and occupation seemed to be the agreed upon substitute to sex. Brown noted in her testimony that studies conducted by Metropolitan Life demonstrated that occupation, smoking, and health habits worked as far better predictors of longevity.[146] Brosseau urged that she did not "disapprove of classifications, "in general but thought it would better to classify auto insurance at least based on the number of miles a person

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[143] Brown, Nondiscrimination in Insurance Act, S 2477," 10.
[144] Mary Gray, "Nondiscrimination in Insurance Act of 1983," 53.
[145] Deborah Rankin, "What's Sexual Equality in a Pension" *New York Times*, (April 10, 1983), F11.
[146] Quincalee Brown, Nondiscrimination in Insurance Act, S. 2477, Committee on the Judiciary. Subcommittee on Antitrust, Monopoly, and Business Rights. Senate, 96th Cong. 2nd Sess. April 30, 1980, 16.

drove, drunk driving records, and taking into account past accidents.[147] Representative James Florio (D-NJ), concurred, “The industry should not focus on the gender of the consumer, but on the consumer’s lifestyle.”[148] The argument that insurance companies should rate based on these other qualitative characteristics demonstrated the short memory—a la the Fair Credit Reporting Act— and the internal divisions between women based on class, race, and geography. Additionally, they bypassed the issue of whether occupation amounted to such an easy conception of choice ignoring the larger cultural and economic structures that shape the employment options available to individuals.

This lack of a more complex politics that recognized the intersection of women’s economic exploitation can be seen in how debates over unisex insurance whitewashed the issue of racial discrimination. While the Nondiscrimination in Insurance Act protected against more categories than sex including race, ethnicity, and national origin, insurers, legislators, and consumer advocates shared the common belief, however inaccurate, that gender was the only category that still required legislative protection. Most members on both sides of the debate agreed that insurers no longer racially discriminated and therefore, the debates in Congress circled around sex and not race. For example, Senator Mark Hatfield (R-OR), cosponsor of the bill, thought the sex provision constituted the only important part of the legislation.[149] When consumer-advocates mentioned race, they consistently positioned it as significant only in that it showed how insurers once used racial classifications in underwriting but now did not. Instead, they focused on how this switch in risk categorization only minimally affected the financial

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[147] Brosseau, “Nondiscrimination in Insurance Act of 1983,” 284.
[148] James B. Florio, “Nondiscrimination in Insurance Act of 1983,” 437.
[149] Mark Hatfield, “Nondiscrimination in Insurance Act, S. 2477,” 7.

solvency of insurance companies buttressing their arguments that a similar narrative would unfold in gendered discrimination if the unisex insurance bill passed.[150]

However, not everyone agreed to such an uncomplicated interpretation of racial discrimination in insurance. Althea Simmons, who represented the Washington D.C. Bureau of the National Association for the Advancement of Colored People, acknowledged that while insurers no longer used racial categories to classify risk in statistics or mortality tables, the practice of redlining had become ubiquitous in insurance. Redlining, as many other historians have explained, occurred when creditors, bankers, or insurers declined or charged higher premium rates to people in certain areas based on correlated racial and class data. Insurers called the practice of redlining "territorial classifications." Poor African Americans, she explained, who lived in central city areas such as Watts in Los Angeles or Bedford Stuyvesant in New York, to get insurance had to pay higher risk premiums than individuals who lived in wealthier suburbs. To support her arguments, she cited two studies "Homeworkers Insurance in Detroit: A Study of Redlining Practices and Discriminatory Rates" and a U.S Commission on Civil Rights report "Insurance Redlining, Fact not Fiction," published in 1979. These studies showed that insurance companies disguised racial discrimination by not placing agents in high poverty areas, requiring location inspections for policy applications in certain high poverty neighborhoods but not in wealthier neighborhoods, and varying underwriting based on ZIP codes.[151] As Simmons pointed out, racial discrimination in insurance had not yet become a thing of the past.

In convincing legislators and the press, insurance companies' stress on price seemed the more persuasive rhetoric, however. This is not surprising considering inflation hit 13.5 percent in

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[150] Examples such as this are numerous in Congressional testimonies. For one, see Mary Gray, "Nondiscrimination in Insurance Act of 1981," 53.

[151] Althea T.L. Simmons, Nondiscrimination in Insurance Act of 1981, 31. For a more sustained analysis of how racial discrimination continued in insurance in the latter half of the twentieth century, see Horan, 166-181

1980, while unemployment reached 8.5 percent in 1981 climbing to a highpoint of 10.8 percent in 1982.[152] The shrinking American economy and rising costs of living made insurance companies' arguments that unisex rates would increase costs for the average consumer especially worrisome to legislators. Debates on unisex insurance rates almost always collapsed into arguments over who most obviously financially benefited from this kind of industry regulation and who would pay any additional costs. At the time, women typically paid more in health insurance, annuities, and disability insurance; however, young single women paid less for auto insurance. In the wake of changing regulation, it was difficult for either side of the debate to predict with certainty how establishing the same rates for men and women in insurance products would affect overall premiums, but the main takeaway point for many was that women as a class did not necessarily benefit from equalized insurance rate.[153]

Conservative House member Norman Lent (R-NY) complained during Congressional testimony that if he voted to pass unisex insurance legislation, his constituents, including young women, and their fathers (he assumed fathers paid their daughters' car insurance premiums), would be angered by their increased automobile insurance payments. "I think a lot of members of Congress will be a little bit nervous about this piece of legislation once the word gets back home to our constituents what we are voting for," he said, adding that, "the insurance industry...will make that point very clear."[154] Lent cited insurance industry statistics that reported unisex insurance regulations would impose an additional $700 million in costs on women. NOW tried to calm the public and legislators by providing data to Congress that showed while women

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[152] Judith Stein, *Pivotal Decade: How the United States Traded Factories for Finance in the Seventies*, (New Haven: Yale University Press, 2010), 265.
[153] Jane Bryant Quinn, "Unisex-Insurance Proponents Wage Guerilla Warfare in States," *Washington Post*, September 9, 1985, 63.
[154] Norman Lent, "Nondiscrimination in Insurance Act of 1983," 283.

might pay additional costs in some areas, overall women would financially benefit from unisex insurance legislation.[155] Yet, their appeals largely fell on deaf ears.

The fight for a broad unisex insurance bill in Congress ended in 1983 when H.R. 100 received too few votes to make it out of the House Committee on Energy and Commerce. Three years later, Barbara Lautzenheiser would remember 1983 as the year that the issue of unisex insurance died at the federal level. Ever wary though, she immediately cautioned against complacency because, as she noted, feminists still actively struggled for unisex insurance regulation in the states.[156] Women consumer advocates, particularly in the National Organization for Women, followed the prescriptions of the McCarran-Ferguson Act after their defeat in Congress and disseminated their efforts to the states. The rhetorical battle, even in the states, centered on questions of civil and individual rights versus business necessities.[157]

Feminists consumer activists emphasized that insurance should be based on "controllable" habits "driver record, smoker-non-smoker, high stress job, etc.," and "not on the gender of a person."[158] Insurance companies, contrastingly claimed insurance as "an economic issue." Insurance representatives at the state level, like their federal counterparts, stressed that health, life, disability, and casualty insurance would be the most fair if left up to actuarial science, statistics, and the market to decide.[159] Despite the strength of the insurance lobby's efforts, NOW and other feminist groups met with some limited measure of success at the state level. Montana became the first state to enact unisex insurance protection laws in all lines of insurance in 1983 with Massachusetts enacting similar legislation two years later. Three more states, Hawaii, North Carolina, and Michigan followed in automobile insurance outlawing the

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[155] Goldsmith, 255-256.
[156] Lautzenheiser, "The Future of Underwriting and Risk Classification," 2964.
[157] Quinn, WB63.
[158] Nick Ravo, "Hartford Weights Insurance Curbs," *New York Times*, (February 28, 1988): 34.
[159] Ibid, 34.

setting of price differentials for men and women in issuing of car insurance.[160] After these early victories, however, the movement began to fizzle out. Further, the legal standing of these laws remained precarious throughout the 1990s and 2000s as insurance lobbyists continued to wage legislative campaigns to override them. Most recently, in Montana, HB 283 would have reversed the state's unisex insurance laws if Montana Governor Brian Schweitzer had not vetoed it during the 2011 legislative session.[161] Thus, shifting the fight for unisex insurance to states at best produced uneven results.

While these legislative battles in the states waged, the real capstone moment for unisex insurance occurred in the judiciary when the Supreme Court issued its ruling in *Arizona v. Norris*, fittingly in the same year support for unisex insurance legislation dissolved in Congress. The 5 to 4 *Arizona v. Norris* decision upheld the *Manhart* ruling from five years earlier. Further, it strengthened the court's position by expanding the 1978 ruling to apply to retirement payouts as well as contributions. The majority Court opinion in *Arizona v. Norris* reiterated that paying women less in monthly retirement benefits when they contributed equal amounts as men violated the Equal Pay Act and Title VII of the Civil Rights Act. Justice Thurgood Marshall, in authoring the Court's majority opinion, echoed the sentiments of many of the women, who testified in Congress on behalf of unisex insurance. "Title VII," Marshall wrote, "requires an employer to treat their employees as individuals not as simply components of a racial, religious, sexual, or national class." Marshall and the other members of the Supreme Court recognized that the underlying problem of insurers' gendered risk classification was that it measured women's risk based on their womanhood. Liberal feminists viewed this as an affront to their status as

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[160] Ibid, 34.

[161] Tom McCarthy, "Underwriting in a Brave New World of Risk Selection Tools and Perpetual Regulatory Change," presentation at *ReFocus 2012: A Global Gathering for Senior Life Insurance and Reinsurance Executives*, from *Record of Society of Actuaries*, (March 4-7, 2012).

individuals. The Courts in *Arizona v. Norris* agreed, but only if the benefits under discussion applied to the relationship between an employer and an employee as stipulated in Title VII. Other areas of economic discrimination based on actuaries' gendered interpretation of risk would be permitted.[162]

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While insurance companies' fears over unisex insurance subsided after 1983, the emergence of the HIV/AIDS crisis, and an increasingly vocal, well-organized political response especially by gay community members, alarmed insurance companies that again their risk calculations and management methods were under attack. Life and health insurance companies outraged HIV/AIDS activists when the industry began to reject any applicant diagnosed with HIV or AIDS to theoretically hedge against financial loss.[163] Further, they denied insurance to anyone they believed to be in a "high risk" group meaning more specifically gay men in urban areas. The logic of business, insurance companies argued, dictated these underwriting decisions. As actuary Ian Rolland explained at the opening of an actuarial conference on AIDS in 1988, "commercial health insurers will be asked to a pay a sizable portion of the direct as well as indirect costs of this epidemic." He predicted it could cost the industry billions within the next five years alone.[164] Additionally, two years earlier, in a 1986 American Council of Life Insurance and Health Insurance Association of America study, insurance companies paid an estimated $290 million in AIDS claims since 1981. The high costs associated with AIDS claims, actuaries noted, meant insurance companies could not underwrite individuals at risk for the

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[162] Reprinted in "Excerpts from High Court Decision on Inequality in Pensions," *New York Times*, (July 7, 1983), B8.

[163] See Jill Eden, "AIDS and Health Insurance," (Washington D.C.: Library of Congress, 1988), 1-12. This study completed by the Office of Information Technology in Congress showed that by 1988 commercial carriers on the whole rated all AIDS risks as uninsurable.

[164] Ian Rolland, "The Impact of AIDS on American and Canadian Insurers," *Insurance and the AIDS Epidemic: Proceedings of a Two Day Symposium*, (Chicago: Society of Actuaries, 1988), 5.

disease. However, in terms of costs, AIDS claims represented only about 0.5 to 4% of the annual claims of insurers.[165] Yet, in the rhetorical battles between insurance companies and HIV/AIDS activists, insurers emphasized the business rather than the human costs of the disease. Activists, contrastingly, explained HIV/AIDS and the access to quality health care in particular as a social issue that trumped the limited concerns of business.

These activists importantly reframed insurance as more than a commodity and more than consumer politics. Insurance, in their eyes, was both a civil and economic right. They reasoned health insurance, as the only way individuals could access even nominally affordable quality health care in the United States, meant that finding ways to offer health care access to every person through the insurance system had to move beyond the vacuumed world of actuarial science and the theoretical free market to account for how people interacted with insurance companies. The HIV antibody test or enzyme-linked immunosorbent assay (ELISA) test, made commercially available for the first time in 1985, marked the flashpoint in this debate. Companies contended they should be able to use the ELISA test to weed out individuals who had already contracted HIV or developed AIDS.[166] Insurance companies argued that the ELISA provided a conclusive way to distinguish HIV-positive individuals from non-positive individuals, thus, just as insurance companies tested for other diseases during medical examinations, they should be able to use ELISA tests to screen insurance applicants. Whatever fears the insurance industry held about testing would largely be resolved by the late 1990s after the passage of the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA), which left intact insurer's ability to test for HIV antibodies. Similar to the final

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[165] Society of Actuaries AIDS Task Force, *The Impact of AIDS on Life and Health Insurance Companies: A Guide for Actuaries* (New York: The Actuarial Society of America, 1988), 846; 848.

[166] To understand better the history and science behind the ELISA test, see Scott, chapter three "The HIV Test as a Disciplinary Technology: A Genealogy," 35-89.

resolution of the unisex insurance debate, ADA and HIPAA defined insurance foremost as a market issue not a civil rights issue.

In attempting to understand the impact HIV/AIDS would have on individual insurance companies, insurers employed their actuarial departments to develop company models based on the quantitative data provided by the Centers for Disease Control. These probability models, while structured on statistics, also revealed insurance companies to be deeply embedded within the social and cultural discourse that framed HIV/AIDS as a disease that only infected gay men.[167] For example, in the 1980s, the probability model most often employed by American insurance companies to predict the risk of HIV/AIDS in individuals was the Cowell-Hoskins Model. This model, created by Michael Cowell and Walter Hoskins predicted that by the year 2000 approximately 2.5 million people would be infected with HIV/AIDS but those infected would mostly come from members of "high risk" groups including homosexual men and IV drug users.[168] Their model excluded the idea that individuals who identified as heterosexual would be affected in major numbers in the future. Cowell and Hoskins based their numbers on CDC studies that showed approximately 70 to 80 percent of all cases of AIDS occurred in gay men.[169]

They assumed that these percentages would remain stable in the coming decades based on the dominant medical discourse that promulgated homosexuality as a discrete sexual identity.[170] Therefore, they thought since homosexual men would not engage in sexual activities

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[167] For literature attendant to how HIV/AIDS became constructed as a "gay disease," in the early 1980s, while other communities, especially racial minorities and poorer communities remained underserved, see Phil Tiemeyer, *Plane Queer: Labor, Sexuality, and AIDS in the History of Male Flight Attendants*, (Berkeley: (University of California Press, 2013), Jennifer Brier, *Infectious Ideas*, (Chapel Hill: University of North Carolina Press, 2009), Michelle Cochran, *When AIDS Began* (New York: Routledge, 2004), Cindy Patton, *Inventing AIDS*, (New York: Routledge, 1990), and Paul Farmer, *AIDS and Accusations* (Berkeley: University of California Press, 2006).

[168] Society of Actuaries AIDS Task Force, 846.

[169] "AIDS Weekly Surveillance Report,"3.

[170] For an excellent history of the medicalization of homosexuality in the United States, see Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in Modern Society*, (Chicago: University of Chicago Press, 1999).

with heterosexual people and vice-versa, there would be no way for the disease to spread far beyond the homosexual community. From this presumption, they predicted that HIV/AIDS was and would continue to be a gay disease. Even if the model itself contained deep flaws based on the assumptions of its makers, it quantified HIV/AIDS as an alarming risk. The Cowell-Hoskins Model statistically showed that the average male with HIV exceeded the standard mortality rate for a nonsmoker male by 5,000 percent. Five hundred percent represented the maximum exceeding risk any company would willingly insure, thus making AIDS patients or anyone perceived to be at risk for AIDS, uninsurable.[171] Probability models such as the Cowell-Hoskins models actualized in measurable terms insurance companies' belief that the most risky class for HIV/AIDS infection was gay men. To locate and render legible these potential HIV/AIDS risks, insurance companies added additional layers to their already sophisticated risk classification system to guarantee "high risk" individuals would not be underwritten for insurance.

Insurers relied on previous methods of rating occupational hazards, marital status, and redlining to separate homosexuals from heterosexuals. These practices have been well documented, at least in the American context, by legal scholar Katy Chi-Wen Li.[172] As Li has argued, "private insurance companies" developed "methods to distinguish those who, because of their geographical location of residence, marital status, occupation, or beneficiary status has a higher risk for contracting HIV." Additionally, she has pointed out that insurance companies attempted to limit future claims by rejecting all applicants thought to be homosexual or bisexual or declining group insurance packages to employees believed to have a large gay work force.[173]

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[171] Society of Actuaries AIDS Task Force, 846.

[172] For an analysis of the British context of queer risk classification in response to HIV/AIDS see, Neil Cobb, "Queer(ed) Risks: Life Insurance, HIV/AIDS, and the 'Gay Question,'" 620-650. Cobb's article focuses on the ways in which British insurance companies hedged risk by discounting what he terms "the gay question" but by imposing questions on insurance applications about sexual behavior instead.

[173] Li, 478, 489.

For example, a Michigan study found that hair salons could not receive health care coverage because insurance companies refused to underwrite small businesses that they claimed employed in large numbers transient workers, women of childbearing age, or gay men.[174] Hair salons and theatre work she noted, in particular, were targeted by insurance companies as work homosexual men would be especially likely to perform.

One Congressional study on AIDS discrimination and underwriting found that insurance companies on average typically denied or discouraged their employers from using sexual identity when evaluating HIV/AIDS risks, but instead encouraged underwriters to look for factors that could potentially signal sexual identity including geography, occupation, marital status, and beneficiary.[175] Marital status played a key role in the construction of the "AIDS profile." Li cited two specific cases where two men, one in New York City and one in San Francisco, whose geographical location combined with their status as unmarried, signaled them as potentially homosexual and thus a risk for HIV/AIDS. Consequently, these men were denied life and health insurance.[176] Insurance companies used an odd mix of cultural and social assumptions about queer people combined with CDC statistics to construct a specific idea of the HIV/AIDS risk. This person, they imagined to be a homosexual, effeminate, single man, who lived in the urban enclaves of New York, San Francisco, or Los Angeles. These heteronormative, gendered, and spaced assumptions, of course, discounted more complex ways of thinking about sexuality, gender, and the disease of AIDS itself. This points to the decisive role insurance companies played in producing both the gay subject and the narrative of HIV/AIDS as a disease peculiar to gay men.

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[174] Li, 486.

[175] Kirk Nemer, *AIDS and Discrimination: Legal Limits on Insurance and Underwriting*, (Washington D.C.: Library of Congress, 1988), 7-8.

[176] Li, 487-488.

The weaving, translucent network of knowledge gathering and sharing between financial institutions blasted by consumers during debates over the Fair Credit Reporting Act, also had a role to play in insurance companies' attempts to determine the sexuality and sexual behavior of potential policy applicants. In the late 1980s, Congressional researchers found that at least thirteen major insurance companies considered "sexual orientation" in their underwriting practices. Confused about how an insurance company would find out this kind of personalized information, the research team did some further digging by interviewing the physicians who provided medical exams to insurance companies. They found out that physicians told insurance companies about an applicant's "homosexuality," or that insurance companies used inspection agencies to confirm "suspicions of homosexuality."[177] The same study showed that after HIV antibody testing became widely available, 70 percent of testing requests made by insurance companies originated with reports made by the Medical Information Bureau while 65 percent of cases had been generated by inspection reports.[178]

These practices leaked into the national press and caused for many insurance companies a public relations nightmare. *The New York Times*, for instance, cited how insurance companies had instructed company underwriters to screen applicants' personal lives and use marital status, age, and residence to screen out possible AIDS risks. A memorandum from the Lincoln National Life Insurance Co. advised health and life insurance underwriters to flag applications "if life style, habits, or medical history suggest a person is one of the AIDS risk groups." Al Parsons, a spokesperson for Lincoln National defended the company's decision noting the high treatment costs of AIDS forced this kind of underwriting practice.[179] In response, a year after the *Times*

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[177] Eden, 14.

[178] Ibid, 26.

[179] "Insurer Screening Unmarried Males: Underwriters Told to Examine Clues to Personal Lives as Way to Cut AIDS Loss," New York Times, (Oct. 7, 1985), A28.

published their story, the National Association of Insurance Commissioners released a new model legislation on how to underwrite HIV/AIDS cases. The model legislation recommended that insurance companies not use “sexual orientation” in underwriting, but stated that the use of redlining could be considered appropriate if statistical experience supported such practices. Importantly though, the NAIC model legislation only ever made suggestions to state legislators. States themselves had to pass the legislation to put it into effect, and in the early 1980s, while panic and hysteria defined many people’s reactions to HIV/AIDS, the majority of state legislatures seemed more likely to put in place laws that would quarantine HIV/AIDS patients rather than protect them from the discriminatory practices of insurance companies.[180] By 1988, only eight states, Colorado, Delaware, Florida, Iowa, Oregon, South Dakota, Texas, and Wisconsin barred using sexual orientation in determining insurability.[181]

The calculation of HIV/AIDS risk became especially divisive after the HIV antibody test became commercially available. Following the test′s release, California and Washington D.C. passed legislation that restricted the test′s use in underwriting. Elected officials in California and Washington D.C. argued that their choice had been based on the fact that little scientific evidence existed that proved the reliability of the test. Hence, it seemed hasty to make underwriting decisions based on them. The Washington D.C. law, in particular, as the strictest anti-testing law in the country, offended insurers who argued banning tests prevented them from rating risks and thus jeopardizing their ability to do business. The D.C. law banned insurance companies from requiring HIV/AIDS tests in underwriting insurance and forbid a positive test from being the reason a person was denied coverage. The law did not apply to people already

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[180] See Sara Rimer, “Fear of AIDS Grows Among Heterosexuals,” *New York Times*, (August 30, 1985), A1 and David Kirp, “California’s Anti-AIDS Quackery,” *New York Times*, (Oct. 5, 1988), A33 for descriptions of conservative legislation and public responses to HIV/AIDS.
[181] Eden, 14.

diagnosed with AIDS, which the District law stated could be denied coverage. An ad run during the industry2s lobbying efforts against the bill emphasized this point; 3Insurance premiums are normally based on risk—the lower the risk, the lower the premium. To keep premiums fair, insurance companies must be allowed to test for the risk of AIDS, as they do for other life threatening factors.3[182] Costs again became the focus for the industry. After the D.C. law passed, the ACLI and HIAA sued the District of Columbia unsuccessfully. Further, conservative Jesse Helms (R-NC) launched an unsuccessful campaign in Congress to have federal legislation overturn the D.C. mandate.[183]

A debate between Philip Briggs, Vice-Chairman of Metropolitan Life and Jeffery Levi, Executive Director of the National Gay and Lesbian Task Force succinctly summed up the diverging opinions. Briggs explained that insurance companies should be able to underwrite HIV/AIDS just as they would any other disease such as cancer or diabetes. This meant underwriting based on objectified and calculated risk. He articulated that the basic idea of insurance was to place people with the same risks in the same risk pool and then have "each pay their fair share of the cost." Echoing Barbara Lautzenheiser's construction of the voluntary insurance market, Brigs viewed insurance as a matter of in-payments and out-payments rather than risk spreading or sharing. In the specific case of HIV/AIDS, he also noted individuals with a risk of "dying in the near future" could not be insured "under any traditional mechanism" as they were altogether too risky. In a didactic tone, Briggs reasoned HIV testing as neither a matter of civil or social right but a matter of costs. He likened underwriting an individual already diagnosed with HIV or AIDS as akin to underwriting a house already on fire for fire insurance.

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[182] Sandra Evans, "AIDS Insurance Bill Lobbied Here," *Washington Pos*t, (May 13, 1986), B1.
[183] Arthur S. Brisbane, "D.C. AIDS Bill Draws Challenge in Congress, *Washington Post*, (June 20, 1986), B1.

Briggs using the simile of a house shifted attention away from the human costs of the disease, objectifying the individual as a commodity.[184]

Jeffrey Levi admitted if he looked at the issue of HIV/AIDS strictly from an "actuarial perspective," of risks and costs, he likely would agree with Briggs. But, he framed the question of providing access to health insurance for HIV/AIDS infected individuals as "a social issue not an actuarial issue." "In this country," he argued, "access to health insurance is the equivalent of access to quality health care." Health and life insurance "does not exist in a vacuum" he added. Without being able to buy insurance on the market at an affordable price, individuals with HIV/AIDS, he pressed would not have access to health care. The exception, he noted, was for individuals who qualified for Medicaid and Medicare, but as he concluded, relying on the private market, Medicaid, or Medicare still left open a large gap in coverage.[185]

The American with Disabilities Act and the Health Insurance Portability and Accountability Act, in the ways they applied to HIV/AIDS can be seen, on the one hand, as a compromise between HIV/AIDS activists and insurance companies. ADA, passed in 1990, strengthened the Rehabilitation Act of 1973 and extended it to individuals with HIV/AIDS. The legislation specifically protected infected patients from discrimination in employment and other public accommodations by including them under the umbrella of "disability."[186] ADA, importantly, put in place legal recourse for HIV/AIDS positive individuals if unfairly fired or barred from employment based on their HIV/AIDS status. HIPAA targeted the issue of information sharing putting in place stricter laws that protected the privacy of an individual's

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[184] Philip Briggs, reprinted in "AIDS: Should Insurers Be Able to Test?" *New York Times,* (May 17, 1987), 212.

[185] Jeffrey Levi, reprinted in "AIDS: Should Insurers Be Able to Test?" 212.

[186] See Nancy Lee Jones, *The Americans with Disabilities Act: An Overview of Major Provisions*, (Washington D.C.: Library of Congress, 1990), The Rehabilitation Act prohibited discrimination against a person defined as disabled in "any program or activity" that received federal financial assistance. ADA expanded the Rehabilitation Act by applying to public and private entities.

medical information. Specifically, HIPAA barred physicians and medical offices from sharing medical files with other “entities” including employers without first receiving the written permission of the patient.[187] ADA and HIPAA combined dealt with two major concerns of HIV/AIDS positive individuals and activists by protecting against job loss and the sharing of medical information used to rate risks. Yet, neither dealt with the issue of testing directly or providing more affordable health care to HIV/AIDS patients. Much like the *Manhart* and *Arizona v. Norris*, ADA and HIPAA positioned employment and employer’s fringe benefits provided through the privatized wealth state as the defining feature of economic citizenship and equity. Philip Briggs pressed this point in his concluding debate remarks with Jeffery Levi. “The group insurance mechanism, which applies to a very high proportion of the population does not involve examinations of tests or anything else,” he reminded readers, “As long as you’re employed...you’re covered.”[188]

In the 1980s, debates over unisex insurance and HIV/AIDS embroiled insurance companies, women, and HIV/AIDS activists in a political discussion about what insurance would be in the United States—a matter of business or an economic and social right—and who would have the power to make that decision. In doing so, social movements and insurance companies told different narratives about risk and insurance. Insurers characterized their product as a commodity that should be priced by risk calculations and the markets, however, their efforts to frame this dominant narrative went less smoothly than they anticipated. Forceful challenges emanated from women and HIV/AIDS activists who attempted to dismantle some of the key assumptions built into risk classification models in the early twentieth century including the idea that any qualitative characteristic could objectified, quantified, commodified, and turned into

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[187] Alissa Rubin, “Clinton Will Issue Sweeping Rules for Patients’ Privacy,” *Los Angeles Times*, (Dec. 20, 2000), A1.

[188] Briggs, 212.

risk. In particular, they disagreed with insurance companies that gender and sexual orientation and its assumed correlative factors should be fashioned into risk and then used to deny insurance coverage to individuals. Calling on the tradition of Title VII of the Civil Rights Act, women argued that these practices constituted unfair discrimination and policed the borders of economic inclusion too stringently. HIV/AIDS activists stretched these claims and argued for affordable health and life insurance coverage as a basic right for everyone. That actuaries, underwriters, and insurers emphasized costs revealing the pervasiveness of actuarial thinking by the latter half of the twentieth century. Further, while feminists and HIV/AIDS challenged specific policies of risk classification, they did not call for a complete overhaul of the voluntary insurance market. Instead, they asked for greater access to it demonstrating the extent to which actuarial science and risk calculations, even to those who criticized it, now seemed like the natural order.

CHAPTER 5

CONCLUSION

As the twentieth century opened, actuaries, underwriters, and insurers predicated the successful development of their business on their ability to effectively rate individualized risk. Partially, this depended on insurers developing risk calculating methods that looked objective and precise. Their reliance on statistics, mortality tables, and the numerical rating system offered one way to make real and measurable the socially and culturally constructed categories that discriminated against people along racial, gender, class, and sexual lines. This positioned underwriters as cultural and social gatekeepers of sorts, dictating who would and would not have access to at least one aspect of economic security in the early twentieth century. However, they encountered unexpected difficulties in this endeavor when it came to calculating moral hazards and adverse selection—two risk categories that were hard to define and difficult to collect information about. To make the rating of these risks easier, insurance companies put in place a locus of information exchange between themselves, credit firms including the Retail Credit Company and Hooper Holmes, employers, and other data gathering entities such as the Medical Information Bureau. This facilitated the smooth sharing of knowledge about individuals to evaluate their risk as workers, borrowers, and policyholders.

As the twentieth century progressed however, these aspects of risk rating began to seem unfair to consumers, who were denied coverage or rated as substandard based on the risk calculations of underwriters. In the post-World War II economic order, financial security seemed more in reach as a part of the rewards of postwar prosperity. As historian Judith Stein has noted, after World War II, the American economy grew on average 4 percent a year, and the poor and the working class benefited, as well as the rich, from these gains. One-third of the working class became unionized by the 1950s with greater access to discretionary income, pensions, disability, and health insurance.[189] In the flush times of the 1950s and 1960s, these economic benefits transitioned from luxuries to staples. Yet, risk calculations by insurers closed off access to this type of security and inclusion as full economic citizens for many people, but especially women, gays and lesbians, and African Americans. Since insurers imagined them as especially risky, they could not qualify for coverage even when they had the income to afford insurance.

Federal legislation such as the Fair Credit Reporting Act gave individual consumers for the first time a way to question insurance companies' risk rating methods by specifically targeting how insurance companies got their information. Yet, there were limits to the FCRA since it dealt in the accuracy of information only and did not apply to the issue of relevancy. With the FCRA a woman could still be denied coverage for living with a man outside of wedlock or living in a working class neighborhood. Throughout the 1970s and 1980s, legislators were far more apprehensive about engaging in a debate with insurers about what constituted risk. Individual consumers testified as witnesses in Congressional hearings about how they had been unfairly discriminated against by insurers based on what they believed were irrelevant to their evaluation as risk. They emphasized that if someone could pay for their insurance, then they should be able to get insurance. This discourse left untouched, of course, the question of what individuals who could not afford insurance should be expected to do.

This issue amplified during the 1980s as women's groups and HIV/AIDS activists directly attacked certain risk categories as meaningful in calculating an individual's potential

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[189] Judith Stein, *Pivotal Decade: How the United States Traded Factories for Finances in the Seventies*, (New Haven: Yale University Press, 2010), 1-2.

future loss. Feminists pivoted their argument around the idea that gender did not predict risk. Further, they argued that rating risk using gender violated the principle of individualism, where each individual person should be singled out for their own merits. One could not help being a woman, and more appropriate and important categories for risk involved people's individual choices such as the decision to drink alcohol or smoke. Basing risk calculations on these categories, women argued, endowed individual responsibility into the institutional practices of risk rating. HIV/AIDS activists similarly disagreed with insurance companies' position to rate gay men as higher risks for HIV/AIDS infection. Further, they argued against the ways insurers equated homosexuality with other qualitative characteristics including occupation, gendered stereotypes, and marital status.

These arguments dissipated after *City of Los Angeles Department of Water and Power et al. v. Manhart et a*l and *Arizona v. Norris* and the passage of ADA and HIPAA, which provided access to the benefits of insurance through employers. Channeling benefits through employer provided group programs, however failed to consider how structurally not everyone truly had equal access to employment especially beginning in the 1970s as the U.S. economy began to lose jobs. Providing welfare through employers additionally funneled economic security through employment equating citizenship with having a job. For the U.S.'s unemployed and service-sector workers without access to benefits, they would have to face insurers' risk calculation methods and the more expensive premiums of the private insurance market. This included many Americans. By 1987, for example, during the height of debates about HIV/AIDS and underwriting, about 14.5 million people received health coverage in the private American health insurance market as opposed to group markets.[190] Ultimately, the battle between insurers, actuaries, and underwriters, on the one hand, and social activists, on the other, to define

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[190] Jill Eden, *AIDS and Health Insurance*, (Washington D.C.: Library of Congress, 1988), 1.

insurance and the financial security that came with it reinforced a private rather than a public welfare state. In this private welfare state, access to a job became the primary factor in dictating the level of one's economic security. In a context where jobs are plentiful and there is equal employment opportunity for all, this has the power to provide legitimate economic inclusion and equity. However, in the United States, a country increasingly characterized by deindustrialization and the proliferation of service economy jobs, this left many vulnerable to a theoretical market rationality; the same market rationality insurers so forcefully staked their claims on in the waning decades of the twentieth century.

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