

An Evaluation of New York's Reform Law

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Introduction and Methods

Content and Purpose of Reform

New York enacted comprehensive reforms of its individual health insurance market, effective 1 April 1993, as part of a package of legislation that also implemented small-group reforms. This legislation was prompted by mounting losses at Empire Blue Cross Blue Shield, whose reserves had sunk far below the required level and were quickly approaching insolvency. Although this claim was later shown to be somewhat inaccurate,¹ Empire Blue Cross claimed at the time that this rapid deterioration was largely attributable to its block of community-rated and open-enrolled individual and small-group business and its inability to compete effectively in these market segments with commercial insurers who were able to select risks. New York has several separate Blue Cross plans, but Empire—which markets in the southern part of the state, including New York City—had by far the largest block of individual subscribers, many of whom had chronic or serious illnesses. Empire also has historically been a strong force in the development of New York's health policy (Marmor 1991). Other Blue Cross plans offered community-rated

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1. Many of Empire's financial troubles are now seen as having been caused by mismanagement, and most of its losses were from its large group, experience-rated block. For a full history, see Best 1998.

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and guaranteed-issue individual coverage in other parts of the state, as did a number of HMOs. Although these other plans were not experiencing the same difficulties as Empire, they too were eager to require commercial insurers to offer coverage on the same terms as they were, to prevent the serious adverse selection that results when there is only one “insurer of last resort” in the market. This legislative strategy was considered necessary to avoid either the bankruptcy of Empire Blue Cross or a huge increase in Medicaid enrollment, which was already overburdened (Hackey 1998, Sparer 1996).

The 1993 law requires all insurers that sell in either the individual or the small-group market to offer each of their products on a guaranteed-issue basis. Insurers must also use pure community rating within each of these market segments. Pure community rating allows no rate adjustment for age, gender, health status, occupation, group size, or other risk-based factors. Adjustments are allowed only for location, family size, or scope of covered benefits.

Initially, the small-group market was defined as groups with three to fifty employees, but in 1997 this was reduced to groups of two to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The self-employed fall in a zone between these two markets. Insurers are permitted to sell them community-rated individual insurance, but insurers may also include the self-employed in their small-group block, although they are not required to do so. Thus, group insurers other than HMOs are not required to market to either individuals or to the self-employed, and they are allowed to include only the self-employed. If they do sell to the self-employed, they must do so on the same terms of community rating and guaranteed issue that apply to small groups.

In 1996, the reform law was amended when Empire Blue Cross decided, despite these reforms, to withdraw its indemnity products from the individual market and cancel its existing subscribers, due to the large losses it was continuing to suffer in this block of business. This would have left a major portion of the individual market without any plan offering comprehensive coverage with free choice of physician—plan characteristics that are especially desired by chronically or seriously ill people. In place of Empire and other indemnity insurers, the 1996 law requires all HMOs to offer a standardized HMO and point-of-service (POS) benefit plan in the individual market. Previously, all insurers could decide whether or not to sell in the individual market, and insurers could sell any plan design and benefit package they wished. Following the 1996

Table 1 New York's Individual and Small-Group Reforms

Reform Element	1993 Law	1996 Amendment
Guaranteed Issue	Insurers may not decline coverage for any product they choose to sell in either market segment.	All HMOs, and only HMOs, must guarantee issue in the individual market.
Standard Benefits	None	Only standard HMO and POS plans may be sold in the individual market.
Community Rating	Pure community rating, which allows adjustments only for location, family size, and plan design.	Same.
Risk Adjustment	Two separate mechanisms, each covering both market segments: one for demographic characteristics, and the other for specified high-cost medical conditions.	New mechanism that expands the medical conditions pool but actually will use risk measures that are more prospective than retrospective.

amendments, all HMOs must participate and only the two standardized managed care plans may be sold in the individual market. Indemnity insurers may participate only by contracting with HMOs to cover the out-of-network portion of the POS plan (see Table 1).

Another component of New York's insurance reform law is an administered mechanism to help spread risks evenly among insurers. Rather than the voluntary reinsurance pools used by some states in which insurers choose which risks to reinsure, New York adopted a mandatory risk-adjustment system that attempts to calculate how each insurer's risk pool compares to the market average. The system requires insurers with lower risks to make transfer payments to those with higher risks. Initially, New York had two risk-adjustment pools: one based on the demographic factors in each insurer's combined individual and small-group blocks, and another that reimbursed insurers for a portion of the costs incurred in covering four designated high-cost medical conditions (AIDS, premature birth, certain cancers, and ventilator dependency). The 1996 amendments changed the structure and operation of these pools by phasing out the demographic pool and replacing it with an expanded medical conditions pool. The new medical conditions pool has not yet been formulated, but it is likely to operate on a prospective rather than a retrospective basis;

that is, it will assess health status at the time of enrollment based on health risk measures, including demographics, rather than paying claims as they arise from actual high-cost illnesses.

This article assesses the impact of these reforms with a variety of statistical and descriptive data, none of which are conclusive about the actual and full impact. This degree of certainty is impossible to achieve because a host of other economic and social conditions were changing simultaneously, and the individual market reforms occurred alongside other reforms that affect this market segment. Nevertheless, solid conclusions can be drawn by comparing New York with other states, and by using multiple sources of data to corroborate or refute each other.

Methods

This is part of an intensive case study funded by the Robert Wood Johnson Foundation of seven states that have enacted varying health insurance reforms. This multiple-case study consists primarily of two rounds of in-depth, open-ended interviews, as well as an analysis of documentary and secondary data. The principal reforms under study are (1) guaranteed issue and open enrollment, (2) renewability and portability, (3) rating bands and community rating, (4) restrictions on underwriting practices such as risk selection and preexisting-condition exclusions, (5) reinsurance and risk adjustment, and (6) public purchasing cooperatives.

The primary sources of information are insurance regulators, insurers (commercial, nonprofit, and HMOs), agents/brokers, and administrators of purchasing cooperatives and reinsurance or risk-adjustment pools. In New York, twenty-four interviews were conducted of thirty-four people in the spring, summer, and fall of 1997, and an additional round of eighteen interviews was conducted with twenty-two of these same people (or their designated substitutes) in the summer and fall of 1998. Represented in this interview pool were four officials with the New York State Insurance Department (hereafter the Insurance Department), six independent agents active in small-group or individual market sales, twenty-two people at eight insurance carriers (two carriers headquartered in-state and six out-of-state), and administrators from a risk-adjustment pool and a purchasing cooperative. These were semistructured interviews based on an interview guide, but the discussions were free-ranging and the coverage of topics varied somewhat among them. Most interviews were conducted by the author one-on-one and in person lasting one to two hours. However, some interviews were conducted by phone, some were in groups of two or

three subjects, and some were conducted by the author's colleagues, Elliot Wicks and Janice Lawlor. Also, eight of the initial interviews (covering seventeen subjects) were conducted with national insurers in which New York issues were addressed only briefly. Interview subjects were told the purpose of the study and promised anonymity to the extent feasible.

Quantitative and documentary information was also collected in the form of market activity data, sales literature, and newspaper articles. This information came from multiple sources, including from insurers, insurance regulators, agents, and from a computer search of the Nexis database. Finally, a market-testing study was conducted in March 1998 to determine the ability of an actual small employer and unhealthy individual to obtain insurance. An employer with three employees, one with juvenile diabetes, contacted twenty-three agents throughout the state to inquire about the availability of coverage for both the group and for the unhealthy individual.² These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

Before discussing the findings, a word or two is required about terminology. Health insurance, like any other industry, has a specialized vocabulary with terms of art that sometimes differ from common understandings, and that often are used inconsistently even within the industry, due in part to regulatory differences among the states. For the present purposes, it is best to sacrifice some degree of precision for the sake of simplicity, so this article uses a lay vocabulary that glosses over many of the distinctions that are important within the industry. Thus, *insurer* or *carrier* includes, generically, both indemnity carriers and HMOs. *Policy* or *plan* refers to the type of coverage offered by an insurer. *Managed care* refers primarily to HMO plans, including point-of-service, in contrast with *indemnity*, which refers to both traditional unconstrained fee-for-service as well as more managed forms of indemnity, such as preferred provider plans. *Agents* includes both captive agents who represent one insurer and independent brokers. The terms *premium*, *price*, and *rate* are used interchangeably to refer to how much insurance costs. And *health insurance* means comprehensive major medical, in contrast with more limited or specialized coverages. Other more technical terms are defined later in the context in which they are important.

2. Selection of agents was stratified so that six were referred by the insurer, and seventeen were contacted directly. Among the latter, thirteen specialized in health insurance and four were agents that sold a broad range of insurance products. The referred agents were contacted through the largest indemnity insurer and the largest HMO and through two other indemnity insurers and two other HMOs with significant market share. The agents contacted directly were selected randomly within their categories.

A final piece of important background information is to note how New York's demographic, health care, and economic profile compares with other states. It has a large and diverse population of over 15 million people. Its demographic and economic characteristics (based on 1990–1992 data) are similar to national statistics, with the following notable exceptions. The population is more ethnically and racially diverse and a great deal more urbanized (8 percent rural versus 20 percent nationally). Although average income and employment figures are close to national norms, there are large pockets of deep poverty. Nevertheless, New York's rate of uninsurance in 1992 was close to the national average, although a greater portion of the uninsured had no connection with the workplace (22 percent versus 14 percent nationally). The consequences of lacking health insurance are more severe in New York because of significantly worse health status measures such as infant deaths, births with no prenatal care, AIDS cases, and the death rate. Also, health care costs are much higher than national averages (\$9,185 versus \$7,739 per family in 1993).

Effects of Reform

Enrollment

Quantitative Measures. Following the enactment of New York's health insurance reforms, the portion of the overall nonelderly population without insurance worsened from 16.5 percent in 1992, which was better than the national average, to 18.3 percent in 1994 and 20 percent in 1997, which are worse than the national average (Table 2). In the individual market, enrollment has declined following the law, whereas small-group enrollment has increased. This is reflected in both Current Population Survey (CPS) data and in enrollment counts collected from insurers and reported by the Insurance Department. As displayed in Table 3, individual enrollment reported by insurers has fallen steadily in the five years following reform, to a level 38 percent below where it began, whereas small-group enrollment initially dipped but has since risen to 7 percent higher than when reform was enacted.³ Data from the CPS (see Table 2) show an even sharper drop in individual enrollment (50 percent through 1997), whereas enrollment in employer-based private insurance (including large insurers) has risen 4 percent.

These data sources suffer from a number of imperfections. First, enroll-

3. These figures reflect the number of family units enrolled and so do not equate with total enrollment.

Table 2 Health Insurance Coverage of the Nonelderly (< Sixty-Five Years Old and Nonmilitary), 1992–1997

New York	1992	1993	1994	1995	1996	1997
Nonelderly population	15,679,099	15,802,584	15,772,651	15,950,097	16,098,853	15,675,074
With employer coverage (%)	61.1	60.6	61.5	63.6	61.7	61.2
With individual coverage (%)	8.1	8.5	6.3	4.6	3.9	4.3
With Medicaid (%)	14.5	16.2	15.3	15.7	17.0	15.2
With other public coverage (%)	2.7	1.8	2.2	1.7	1.8	1.8
Uninsured (%)	16.5	16.6	18.3	17.2	19.2	20.0
Total (%)	102.9	103.6	103.6	102.8	103.8	102.5
United States	1992	1993	1994	1995	1996	1997
Nonelderly population	223,791,925	226,228,966	228,092,631	230,275,591	232,476,381	234,691,115
With employer coverage (%)	61.9	60.8	64.8	65.0	65.1	65.3
With individual coverage (%)	8.5	9.2	6.3	6.0	6.0	5.8
With Medicaid (%)	11.8	12.8	12.6	12.6	12.1	11.1
With other public coverage (%)	3.5	3.3	3.7	3.4	3.3	3.2
Uninsured (%)	17.8	18.1	17.3	17.5	17.8	18.4
Total (%)	103.5	104.2	104.7	104.4	104.3	103.7

Source: Alpha Center analysis of March Current Population Survey

Note: Totals exceed 100 percent due to double counting.

ment counts from insurers are only partially audited and most likely contain a number of inaccuracies. Second, the wording and order of the relevant CPS questions changed during this time span in a manner that may have exaggerated these trends or masked different or more pronounced trends. Third, to the extent the perceived trends are real, there is no certainty they were caused by the reform law. Table 3 reveals that the decline in individual enrollment continues a trend that began prior to the law (although this data source goes back only six months prior, and CPS data in Table 2 indicate the contrary). Also, the fact that small-group reforms

Table 3 New York Health Insurance Enrollment by Market Segment (Number of Insured Units), 1992–1998

	9/30/92	4/1/93	4/1/94	4/1/95	4/1/96	1/1/97	1/1/98
Small-Group Market							
Commercial	314,000	268,000	276,000	188,000	162,000	135,000	125,000
HMO	163,000	180,000	248,000	409,000	526,000	585,000	664,000
Nonprofit	484,000	465,000	371,000	301,000	234,000	207,000	185,000
Total	961,000	913,000	895,000	898,000	922,000	927,000	974,000
Individual Market							
Commercial	178,000	150,000	124,000	100,000	82,000	71,000	56,000
HMO	29,000	32,000	48,000	76,000	99,000	103,000	130,000
Nonprofit	194,000	187,000	151,000	120,000	86,000	50,000	42,000
Total	401,000	369,000	323,000	296,000	267,000	224,000	228,000

Source: New York Insurance Department, as of 10 September 1998

Note: An insured unit is one person, employee, or family.

were enacted simultaneously enabled some people to switch from the individual to the small-group market, with no net loss in enrollment. It is significant that total enrollment in the two reformed markets combined has remained virtually the same over five years. Also, it is encouraging that, according to a 1996 study by the Insurance Department, 20 percent of enrollees in individual plans were previously uninsured. Nevertheless, from all indications enrollment has not been as favorable in New York's individual market as in its small-group or overall private insurance markets, and declines in its individual market are greater than individual enrollment declines nationally.⁴

Marketing Efforts and Agent Behavior. The reform's impact on enrollment can also be assessed through the informed opinion of industry sources and regulators. Most industry subjects view market reforms in New York as being successful for the small-group market but not for the individual market. Regulators view both sets of reform as successful, but concede that individual market reforms have been more problematic. Agents' views deserve special credence, since they have the closest contact with purchasers and they understand the dynamics within the industry (Hall 2000).

The agents interviewed in this study have a fairly dim view of the individual market. One indication is the fact that, despite efforts to find as many agents as possible who sell individual coverage, only two of the six agents interviewed sold any significant amount of individual insurance, and only one of these sold a substantial amount of true individual insurance (in contrast with group coverage for the self-employed). This agent explained, "Because they cut the commissions — . . . they used to pay 20 percent or whatever; now they are paying 10 percent or 5 percent, depending on the insurance company — many agents kind of left the business. They just said it wasn't worth their time to get involved in it. So you either have to do a lot of it to survive or just not [at all]. You couldn't really be meddling with it on a very part-time basis. So only a few of us are left in New York really specializing in insuring the individual."

This was prior to the 1996 change in the law that eliminated commercial indemnity coverage in the individual market. Since then, virtually no insurer pays commissions for individual policies since all are now sold by HMOs through direct marketing. Even those that use some independent

4. See also Haslanger et al. 1998:1, which concludes that "by nearly any measure of health insurance coverage, New York State is worse off than it was at the beginning of the 1990s, and worse off than the nation as a whole."

agents do not pay commissions on their individual products, since they view these sales as essentially a public service rather than business they are seeking to develop. As a consequence, the role that agents and marketing usually play in selling individual insurance has been supplanted to a considerable extent by public interest advocacy groups, which have been successful in getting the word out to affected people about how guaranteed issue and community rating work, and where coverage can be obtained. The Insurance Department also provides a substantial amount of consumer information and guidance.

Nevertheless, the absence of independent agents motivated to find insurance for their clients has created some compliance problems. The Insurance Department conducted a field investigation to determine the extent of compliance in 1996, shortly after all HMOs were required to sell individual insurance (Muhl 1996). It found that most HMOs were complying, but there were problems with a few. A small number responded to inquiries by saying they sold no individual insurance at all. In some other instances, callers were unable to reach anyone at the HMO who knew about these products. Some callers were promised enrollment materials that were never received. It should be noted, however, that many of these HMOs had previously not offered individual insurance and this field investigation occurred in the first half of the year in which the new law took effect. Nevertheless, similar problems persisted over a year later, when the state attorney general found that 16 percent of 463 calls to thirty-one HMOs asking about individual coverage resulted in no response, and six of these HMOs failed to respond in 25 percent or more of the 16 calls made to each of them (Vacco, Gold, and Oechsner 1998).

A similar market-testing study was conducted for the purposes of this study, in which a potential purchaser asked twenty-three agents throughout New York whether an adult with juvenile diabetes could obtain individual coverage. Only one agent indicated individual coverage was not available. However, six other agents (for a total of 30 percent) indicated that this person would have some trouble finding coverage. Also, the agents contacted in New York were notably less responsive to inquiries than in other states. The market tester rated only 48 percent of the New York agents as reasonably responsive, compared with an average of 83 percent from seven other states studied.⁵ These other states also have small-group market reforms, but only one (Vermont) also has community

5. Colorado, Florida, Iowa, Minnesota, New Mexico, Ohio, and Vermont were studied.

rating in the individual market. However, in Vermont, agents were highly responsive. This study does not reveal whether this lower responsiveness is due to the general agent culture in different states, or to some aspect of New York's reform law. However, it is notable that, in the small group market, commissions are lower in New York than in any of the other study states, and only in New York are no commissions paid by any insurer in the individual market.

Another reason that potential purchasers may have difficulty finding individual coverage is that insurers do not actively market it. An Insurance Department representative explained that, although the law requires "fair marketing," this does not mean that insurers must give equal attention to all products and sell in all areas of the state. They must sell to anyone from any area covered by their license (which is statewide for commercial indemnity insurers but can be regional for HMOs and nonprofit insurers), but insurers do not have to maintain the same sales force and use the same kinds of advertising everywhere and for every product. The result is that insurers can send a clear message to agents about what products they do and do not want to sell. One agent explained, "They don't really want that [individual guaranteed-issue] business. It's almost like pulling teeth to get them to sell it. . . . I don't think they're really killing each other to try to get this business. They're not advertising. As a matter of fact [name of carrier deleted] would be just as happy if nobody calls them for individual type coverage."

On the other hand, when agents are involved in the sale of individual insurance, they are well positioned and motivated to resist any pressure from insurers to avoid sending them higher risks (Hall 2000). Agents are independent brokers paid on commission, whose professional loyalty includes the purchaser. Agents interviewed acknowledged that insurers create some pressure, but they explained that for the most part it is suggestive, not overt, and that ethical agents effectively resist. A third agent described the pressure as being somewhat more overt, but still something that agents appropriately ignore or counteract. They also said that insurers do *not* engage in overt risk-avoidance strategies like attempting to drive off high-risk subscribers by not paying claims, refusing to process applications, or varying commissions according to the profitability of the health insurance business that agents send them.

Microgroups. The contrasts that have been drawn between reforms to the small-group and the individual markets point to the question of how microgroups of one or two employees are treated under the reform law.

Insurers tend to regard these groups as inherently less desirable because of the greater marketing and administrative expense and the greater potential for adverse selection when the purchasing decision is being made for a unit this small. Some insurers find it difficult to make profits from this size group because New York law imposes more intensive regulatory scrutiny on insurers whose loss ratios fall below 75 percent. Insurers feel this loss ratio is not sufficient for agent commissions, which are usually much higher for sales to microgroups because of the greater work involved per covered life in selling the policy.

The state initially interpreted the law to require groups of one to two employees to be treated as part of the small-group market and therefore to be offered guaranteed issue and community rating for the same products and on the same terms as groups up to fifty. A number of insurers selling only group insurance objected to this interpretation because they historically had not sold to groups this small, yet they did not want to withdraw from the small-group market entirely. As the result of a lawsuit, the Insurance Department now allows small-group carriers to decline to sell to these microgroups if they do not otherwise sell individual coverage. The department also allowed insurers who previously had sold to this group size to renew their existing subscribers without having to sell to new groups. These rulings were critical to the decision of two prominent indemnity insurers to remain in the New York small-group market.

We inquired whether the reform law had improved or worsened availability for microgroups. We heard two points of view, depending in part on group size. For groups of two to ten, we heard that availability has “improved tremendously.” Prior to the law, some group insurers covered only larger groups, and only Blue Cross plans and a few HMOs offered guaranteed issue to groups with fewer than ten members. But now all small-group insurers must offer guaranteed-issue policies to groups of two (initially, three). However, one subject said that some insurers adopted policies such as paying lower, not higher, commissions for smaller groups; charging fixed application-processing or administrative fees for each group, which naturally falls harder per capita on the smallest groups; or paying bonuses based on the profitability of business written by each agent. The Insurance Department subsequently prohibited each of these practices.

For the self-employed (which prior to HIPAA included groups of two), the reform law may have diminished availability. Most of the insurers we spoke to decline to sell group policies to this size, and several agents com-

mented that it is difficult to find affordable coverage for this size group. Other agents, however, say that although fewer insurers sell to these groups, an adequate selection of affordable offerings is available. The Insurance Department is considering options to address this issue, including allowing a rating adjustment based on group size that would permit a separate community rate for the self-employed that falls between rates for small groups and individuals, or simply requiring all small-group insurers to sell to the self-employed at their group community rates.

Trade Associations. Another border policing issue is the potential for good risks to leave the individual market by buying what appears to be a group product, through arrangements too complex to describe thoroughly here, but which can be loosely called private associations (Hall 1999a). This appears to be happening to some extent in New York. The reform law has a grandfather provision that allows business associations previously in existence to continue offering insurance to individuals at rates significantly lower than the community rate. We were unable to quantify the extent of this exception, but we heard almost a dozen of these associations named over the course of our interviews, and our impression is that the associations represent a fairly prominent way to purchase individual insurance at rates equivalent to those available to small employers.

Unlike other states, however (*ibid.*), this exception does not appear to be proliferating. New York law has fairly stringent requirements for associations to qualify for this treatment. (They must have a large and diverse membership, and they may not exist primarily to sell insurance.) We heard no examples of associations that were set up primarily to capitalize on this exception. However, these associations clearly allow some good risks to be bled off from the individual market, and to that extent they compromise community rating. That may be a necessary relief valve, though, since without this option these individuals might not purchase any coverage.

Prices and Products

Average and Relative Prices. The view one has of trends in prices following reform depends very much on which part of the product and geographic market one is looking at. On balance, there have been substantial and continuing price increases, but nothing at the level that indicates a premium spiral for the market as a whole. Some insurers have been hit especially hard, however.

For instance, Empire Blue Cross's rates for individual indemnity coverage rose approximately 40 percent a year for the first two years following reform, but its coverage was much more comprehensive than that available elsewhere. Other insurers in the initial years were either HMOs or indemnity insurers offering mainly catastrophic coverage. Therefore, higher-risk subscribers continued to stay with Empire. Nevertheless, other insurers also experienced large increases initially. Mutual of Omaha's average rates increased 35 percent in 1994 in New York City for its individual indemnity products. An anonymous indemnity insurer profiled by the Insurance Department in its early analysis of the effects of community rating increased its individual rates an average of 43 percent in the first year of reform (1993).

In contrast, HMO rate increases have been more moderate. Table 4 shows the median rates for HMO coverage in 1994 and 1998 in five of the nine regions chosen to reflect a range of population densities and economic bases. The annualized increases, when compounded over the four years, are significant but not dramatic and are less than had been feared. Moreover, the range in rates (high-low spread) is fairly tight, reflecting the reality that a variety of competitive choices are available.

However, these increases are considerably greater than in the small-group market. There, comparable figures show annualized increases of 10–14 percent for indemnity coverage and only 0–3 percent for HMOs, in these same five regions over a five-year span. Also, insurers claim that rates in the individual market have been artificially dampened by New York's requirement of obtaining prior approval for significant rate increases, which they feel masks the increase in claims expense that has occurred. On the other hand, prior rate approval has prevented the dynamic witnessed in some other community-rated individual markets, where the goal of most insurers is to maintain as high a price as possible in order to avoid attracting business. We were told in other states that no insurer wants to be the lowest price guaranteed-issue product available because mainly high-risk people purchase in the individual market and, considering that benefits are standardized, they will tend to go automatically to the cheapest plan. If true, this creates a race up the price ladder with each insurer near the bottom trying not to be the closest to the ground. Rate regulation prevents these artificial price escalations by requiring insurers to justify their rates prior to using them.

New York's rate regulation law requires a public rate hearing for HMOs and Blue Cross plans that adopt rate increases greater than 10 percent. Most such plans in most years have kept their increases at or just

Table 4 New York Individual Rates for Single HMO Coverage by Region, 1994 and 1998

			Annualized Increase
Region	7/1/94	7/1/98	1994–1998 (%)
<i>New York City Area</i>			
Number of plans	11	17	5
Median price	\$215	\$261	
Hi-lo spread	1.82	1.73	
<i>Utica/Watertown Area</i>			
Number of plans	7	10	3
Median price	\$193	\$215	
Hi-lo spread	1.40	1.48	
<i>Westchester Area</i>			
Number of plans	13	15	7
Median price	\$196	\$259	
Hi-lo spread	1.88	1.50	
<i>Buffalo Area</i>			
Number of plans	4	6	13
Median price	\$114	\$185	
Hi-lo spread	1.74	1.34	
<i>Mid-Hudson Area</i>			
Number of plans	15	19	6.5
Median price	\$189	\$243	
Hi-lo spread	1.71	1.63	

Source: New York Insurance Department data

below this level, to avoid the rate-hearing process. After a few years, however, excess losses experienced by the largest individual insurers and by several of the smaller ones prompted them in 1998 to ask for very large one-year increases ranging from 50 to 80 percent. Most notable were rate requests by Oxford and Empire for increases averaging 65 and 56 percent, respectively. These are by far the two largest individual insurers, accounting for about half of the market statewide and the vast majority of the market in the New York City area.⁶

After a hearing, the Insurance Department denied the requests by these two largest insurers, limiting them to the automatic 10 percent,

6. More precise market shares are not available since the Insurance Department refuses to release enrollment data by carrier, claiming it is sensitive competitive information, even from earlier years.

despite evidence of mounting losses and the fact that their reserves had fallen well below required levels. (The department granted rate increases of 15–29 percent to three HMOs with small enrollment.) Its primary reason for denying Oxford and Empire requested rate increases was the one-time decision to pay out accumulated surpluses from the risk-adjustment pools described below. The Department ordered that this multimillion-dollar infusion be used to offset the increases that otherwise would be due, although it also decided that the justified increases were much lower than requested.

Most insurer subjects reacted with considerable dismay to this solution. They attributed it to the political desire in a gubernatorial election year to avoid approving large rate increases and called it a shortsighted attempt to avoid the inevitable. Regulators thought this was a reasonable, although unusual, compromise that avoided a price shock to many of New York's most vulnerable chronically ill people. Although this solution cannot be repeated, there is some anticipation that the legislature may look at alternative structures to create a broader base for subsidizing prices in the individual market.

Adverse Selection against the Market. Because of the unique regulatory environment in New York, claims experience may be a better indication than prices of the impact of the reform law. Using claims experience, we evaluated the extent to which community rating and guaranteed issue have caused adverse selection against the market as a whole. Community-rating increases costs for healthier subscribers, thereby at the margin driving some from the market, and guaranteed issue attracts higher risks into the market. The combined effect was expected by some to set into place an adverse selection spiral that would cause the market to collapse into a high-risk pool. We lack sufficient data over time to make a conclusive determination of the extent of adverse selection against the market, so we turn to more subjective and anecdotal indications.

One indication of marketwide trends relating to adverse selection is the demographic adjustment factor used in the combined small-group and individual demographic risk-adjustment pool. This factor is, roughly speaking, a sum of the actuarial weights given to the age and gender composition of each insurer's individual and small-group pools combined, based on standard actuarial assumptions. It is expressed as an index relative to the average demographic factors in seven regions in the state. The average demographic factor did not increase significantly from 1993 to 1996, suggesting that there has not been a large age

deterioration. However, this combined factor reflects mainly the small-group market, which is several times larger than the individual market, so the impact there may be masked. An analysis by Thomas Buchmueller and John DiNardo (1999), based on CPS data, found some age deterioration in New York among those with individual insurance but not substantially worse than in Pennsylvania, which has no comparable reform law. Their analysis, however, measures only age and not individual health status.

Data from individual insurers suggest that significant adverse selection is occurring in the individual market. In the year prior to reform, the average age of Mutual of Omaha's New York enrollees increased 0.2 years each quarter, but in three years following reform the quarterly increase in average age almost quadrupled to 0.77 years each quarter. Between January 1993 and April 1997, the average age of its individual indemnity pool increased 11.5 years. Over the same time span, the average age of policyholders who have dropped coverage was 37.5 years, whereas those who kept their coverage averaged 6.4 years older (43.9 years). These figures might be criticized for reflecting only a single carrier rather than marketwide effects. But Mutual of Omaha was the largest commercial indemnity carrier at the time, and the fact that its indemnity product had a very high deductible and lacked the generous drug coverage found in the Blue Cross and HMO plans would tend to make it experience less adverse selection than these other plans.

Extensive data was also obtained about Oxford and Empire, through their rate filings with the Insurance Department. The experience of these two carriers is especially relevant, since they have such a dominant share of the individual market in the New York City area and surrounding counties. (Empire dominated at the start of reform, and Oxford is now the dominant individual carrier.) For both insurers, adverse selection can be seen by comparing claims data between individual versus small and large group subscribers for similar coverage. This comparison reveals a strikingly worse risk pool among individuals. Average claims for individual subscribers are 2.3 times higher at Oxford and 3.5 times higher at Empire than for group subscribers to their POS coverage. Hospital days per 1,000 population are twice as great at Oxford and 3.5 times higher at Empire. (The differentials are not quite as great for HMO coverage, since POS tends to attract higher risks, but the differentials are still substantial.) Oxford reports that the prevalence of AIDS is eight times greater among its individual POS subscribers than among small-group POS subscribers, and that the rate of cirrhosis of the liver is twenty-seven times higher.

Smaller HMOs report somewhat smaller, although still substantial (two- to three-fold), differentials between individual and group enrollees.

For additional confirmation we turn to subjective opinions on the question. Several agents said that significant adverse selection has occurred. One explained that among his clients, “those who felt they were relatively healthy, many of them basically said, ‘I’m going to have to chance it that I stay healthy because I can’t afford these premiums. Now, . . . if there is going to be no medical underwriting, I can always go back into the plan.’” Another agent said his agency lost about 15 percent of its business initially because of community rating, but his staff worked hard to replace those clients with new ones by taking advantage of guaranteed issue: “The law is the law and you might as well take advantage of it and try to do as much business as possible. . . . I just told my brokers look for anybody you know is sick. This is a great opportunity. Go for it.”

Again, this contrasts sharply with the small-group market. There, most subjects, including both insurers and agents, said that adverse selection has not been severe or destabilizing. One actuary conceded that he and others had seriously overestimated the potential for adverse selection by initially adding 10–20 percent to their small-group rates to anticipate increased morbidity, but looking back he now thinks that 3–5 percent would have been more realistic. Based on this experience, both this actuary and one at another insurer said they do not increase their rates at all to anticipate adverse selection when other states adopt small-group guaranteed issue. They figure that, at worst, claims will increase only 1–2 percent, which is an amount that, if it materializes, they can pick up later in subsequent increases based on claims experience. The small-group market more easily withstands adverse selection because groups blend risks, so risk differentials across purchasers are not as extreme. Also, because the purchasing decision for groups is made by the employer, it is not so directly influenced by the anticipated health needs of any specific person.

Despite the much more pronounced adverse selection in the individual market, most of the actuaries we spoke to do not think this market is out of control. Some insurers have been able to maintain acceptable loss ratios in the individual market because they have been permitted sufficient rate increases. As long as this is the case, adverse selection will not force them to leave the market, although they do expect prices to continue on a steady incline. Representatives we spoke to in the Insurance Department shared these views. They did not see the move to community rating as imposing a great burden on the individual market since the mar-

ket leaders (Blue Cross and HMO plans) were already community rating, and rate increases have adequately absorbed the adverse selection that has occurred. This is not to say that the risk pool has not worsened, but prices and health risk are not spiraling out of control as some predicted they would. Nevertheless, there are other ill effects from adverse selection that will be discussed below, especially with regard to the range of product offerings in the individual market.

Rate Shocks and Age Effects. So far, we have mainly discussed the effects of reform on average prices, either marketwide or for particular carriers. Also important, however, are the effects on prices for particular subscribers at either the high end or the low end of the range in prices. Community rating requires price reductions for some age groupings but price increases for others. We inquired whether the adoption of community rating resulted in any “rate shock” in which some subscribers received large increases and decided to drop coverage.

Indeed, there were a large number of vocal complaints at the time community rating took effect. This produced such a “flood of calls” to the government that the state established a toll-free number simply to handle inquiries and complaints about community rating. The fact that single males, age thirty, received a rate increase of 170 percent for individual coverage at one large indemnity insurer received widespread news publicity. Some of the outcry was precipitated by insurers and agents who, when they sent out notices of rate increases to subscribers, explained that the increase was mainly due to the recent reform law and encouraged subscribers to write their legislators and call the Insurance Department if they did not like it. This furor was amplified by the fact that the law took effect in the midst of the national debate over the Clinton health care reform plan, and New York was held out as a poster child for the ills of community rating. It is notable, however, how quickly the outcry died down. An article in a business journal reported that one year after community rating, the issue did not “create even a murmur,” and the toll-free complaint number was shut down in 1994 from lack of interest. However, a steady stream of complaints continue to come into the department.

Naturally, there were also offsetting decreases for older subscribers. Figure 1 shows for a group of ten commercial insurers (mostly indemnity) that only a small percentage of policyholders received very large rate increases, and many more received moderate to small decreases. About 20 percent of small-group and 25 percent of individual subscribers received rate increases of 40 percent or more, while about 10 percent

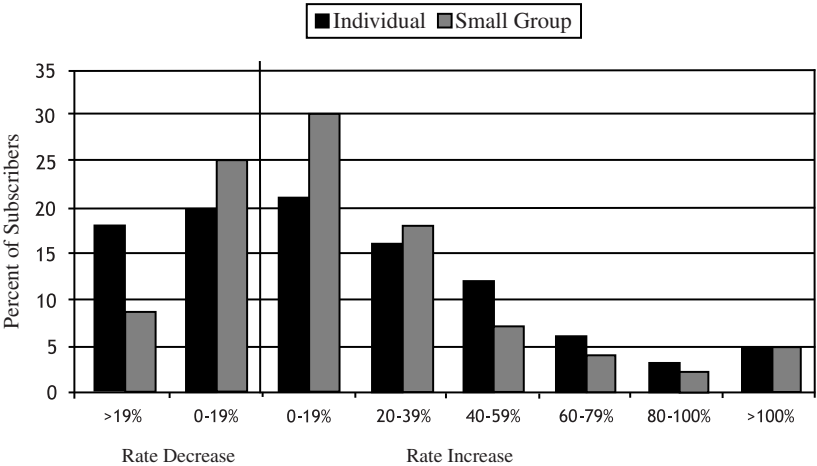


Figure 1 Rate Change Distribution for Ten Commercial Insurers Following Community Rating, 1993. *Source:* New York State Insurance Department.

of small-group and 20 percent of individual subscribers received rate decreases of 20 percent or more. About 60 percent of subscribers, both small group and individual, received rate increases of less than 20 percent or rate decreases. Figure 1 also reflects that the extremes are more muted for small groups than for individuals.

It is human nature that those who enjoyed the decreases did not loudly voice their gratitude, but the benefits were real nonetheless. One agent spoke of “precipitous” rate reductions, such as \$1,000 a month for family coverage reduced to \$500 a month. Another agent concluded, “I think it was a pretty easy conversion. . . . People didn’t start complaining if they were sick and going to the doctors and suddenly they were getting a better situation out of community rating. You don’t hear those kinds of stories.”

Viewed from both sides of the age divide, there is considerable difference of opinion about whether it is wise social policy to adopt the implicit cross-subsidy that lowers cost for the old and raises costs for the young, considering that, all things being equal, income distribution tends to be in precisely the opposite direction.⁷ However, we were told that this social effect is not the intended purpose of community rating. Instead, the law arose out of a desire to level the playing field and equalize risk distribu-

7. Community rating also creates cross-subsidies from the healthy to the sick, but the desirability of that effect is not nearly as controversial. Also, that effect exists in all versions of rating reforms, both pure and modified community rating, so it is the age effect that is unique to pure community rating.

tion among insurers in order to implement marketwide guaranteed issue. Flat community rating was chosen rather than age-adjusted rating, not because of a deliberate policy to favor older ages but simply because that was the rating practice currently used by Blue Cross and HMO plans. The intent was to bring the rest of the market in line with these existing rating practices. A need was seen for age-based adjustments in order to counteract gaming incentives and biased selection among insurers, but it was decided that this could be done just as well behind the scenes through the demographic risk-adjustment mechanism discussed below. Nevertheless, whether intended or not, the age-based social effects of community rating are clearly felt by purchasers.

Market Structure and Dynamics

Market Concentration and Product Offerings. There was a dramatic exodus of indemnity insurers from New York's individual market following the reform law. Before, there had been over a dozen commercial indemnity insurers selling individual coverage. Nine withdrew immediately and two more within approximately the first year, so that soon the only significant commercial indemnity insurer left was Mutual of Omaha. (A few insurers remained, but they had very small market shares or they sold only specialized products or only through trade associations.)⁸ Mutual of Omaha initially chose to remain in the New York individual market because it had a very large block of business and a very effective and well-trained network of over seven hundred agents and brokers, who were also selling a good bit of nonhealth products. Critical to its decision to remain in the market, however, was the fact that New York, unlike New Jersey and some other states, at first permitted Mutual to continue selling its own benefit packages rather than mandating standard plans.

Indemnity insurers used this flexibility to design their products to avoid attracting the highest-risk subscribers. Mutual of Omaha is the most notable example. Shortly after reform, it raised its lowest deductibles to \$1,000, and then moved to \$2,500 and higher. Essentially, it was sell-

8. Some subjects attributed this withdrawal to the unique circumstances relating to hospital rate regulation at the time, which exempted Blue Cross from collecting the surcharge imposed on hospitals to pay for uncompensated care (Hackey 1998; Sparer 1996) and therefore, in combination with tax exemptions, gave Blue Cross a significant rate advantage. But few insurers we spoke to attributed decisions to withdraw to this now-defunct rate differential, and most said that the major Blue Cross plans were priced significantly higher than their own despite this rate advantage because of years of accepting high-risk subscribers.

ing only catastrophic coverage. From the beginning of reform until it ceased selling in the individual market in 1997, Mutual's lowest-deductible plan available in New York City was \$5,000. Similarly, National Casualty, the only other statewide commercial indemnity insurer in the individual market, started under reform with a \$1,000-deductible policy, but in 1995 it raised its deductible to \$4,000–\$5,000 in most regions of the state.

This progression toward leaner benefits is a notable feature of how the individual market has developed in New York. This is driven not so much by the desire to contain systemic health care costs, although that is certainly one reason, but more so by the desire to avoid attracting the highest-risk subscribers. Comprehensive coverage with lower deductibles and more generous prescription coverage is favored by patients who are chronically ill or anticipate the need for expensive treatment. In a guaranteed-issue environment, insurers fear that having the most generous benefits will attract all of the worst kinds of cases like AIDS and severe diabetes.

Initially, the impact was the greatest on Empire Blue Cross. By the third year after reform, Empire's indemnity coverage was costing about \$5,500 a year for single coverage, even with a \$1,000 deductible. Despite 25–40 percent rate increases several years in a row, the Empire product was losing large sums of money, so in 1995, Empire announced its intention to withdraw entirely from the individual market. The prospect of leaving the chronically ill population with no comprehensive coverage that allows choice of physician prompted the legislature to enact the requirement that all HMOs offer two standardized benefit packages in the individual market: one that is a classic HMO and the other that is a POS plan. This codified the reality that no insurer had been able to maintain a viable comprehensive indemnity product in New York's individual market. Indemnity carriers remain in the market only by partnering with HMOs to cover the out-of-network portion of a POS plan, since only licensed HMOs may sell nonindemnity coverage. (Also, some indemnity insurers with healthier risk pools agreed to renew coverage for existing subscribers.)

Most interview subjects attributed the demise of individual comprehensive indemnity to the reform law and considered this an example of one of the law's failings. Some subjects, primarily with the Insurance Department, however, do not interpret this history as negatively. First, they observe that comprehensive coverage with choice of physician is still available through POS coverage, and there is more choice in that

many more HMOs are now offering individual coverage, as reflected in Table 4. Indeed, several HMOs voluntarily entered the individual market after reform. Second, Empire's individual indemnity market was disintegrating before reform, and these subjects believe it almost certainly would have withdrawn from the individual market in any event, and probably sooner without reform.

On the other hand, to the extent that the reform law was intended to salvage Empire's comprehensive indemnity product, it has not succeeded. HMOs (notably Oxford) have taken Empire's place, but for most of them this is only because of the "all-market" requirement that forces them to sell individual coverage if they want to do group business in the state. This may prove to be a stable political compromise that has the result of providing affordable coverage for the uninsurable population. Indeed, one subject described the net effect of the law as having converted the individual market into a high-risk pool, which may not be ideal, but it is practical enough, considering that some pooling arrangement is necessary to make high-risk coverage available. There is a downside, of course, in that indemnity products designed for the lower-risk population are no longer available except through the group market.

Moreover, despite the move to standardized products and the elimination of indemnity, biased selection patterns still remain in the choice between HMO and POS coverage, with higher risks favoring the latter. The impact can be seen in the 1998 requests for rate increases. Most insurers, including Oxford and Empire, requested 10 percentage points more for their POS than their HMO plans. This is supported by data from Oxford and Empire that their claims costs under POS coverage are 66–68 percent higher than under HMO coverage, although rates are only 30–40 percent higher.

This selection effect between HMO and POS coverage presents a dilemma for rate regulators (Hall 1999b). One way to respond is to allow rates for each plan to accurately reflect the risk pools that develop, but this undermines the goal of community rating to keep risk differentials from being reflected in rates. Instead, benefit differentials between plans are to be based solely on their actuarial value assuming a uniform risk distribution. When we inquired which of these two philosophies is enforced by regulators, we observed an awkward ambivalence that suggests both approaches are followed to some extent. Insurers apparently are not allowed to maintain completely separate community rates for their HMO and POS products, but neither are rates based solely on risk-neutral benefit differentials. Rather, rates are allowed to reflect the

respective risk pools to some extent, in an undefined and discretionary manner.⁹

Risk Adjustment. The preceding discussion focuses on biased selection among different plans offered by the same insurer. Also of concern is biased selection among insurers. The reform era began with a strong awareness of the problems faced by Empire Blue Cross as the primary carrier of last resort, whose risk pool was much worse than other insurers and therefore was unable to compete effectively for healthier subscribers. Requiring all insurers to community rate and guarantee issue was expected to help but not to fully resolve this problem, and the reform law had the potential to expose other insurers to biased selection. The reform law attempted to address the concerns by creating two risk-adjustment pools that are intended to provide a relief valve for insurers who are forced to accept risks that are not adequately covered by the allowable premiums. The purpose is not only to correct historical or systemic risk-selection patterns, but also to counteract insurers' incentive to engage in covert risk avoidance by eliminating the financial reward for favorable selection and protecting those who are selected against. Also, adjusting for differences in risk pools is intended to promote price competition and economic efficiency by making rates more comparable and more reflective of each insurer's efficiency in controlling costs.

New York created two risk-adjustment pools, which have since been revised. One was based on the demographics of each insurer's individual and small-group blocks combined. Each insurer paid in or received from the demographic pool based on its market share and on a comparison of its demographic factor with the average in each of seven regions. The demographic factor is, roughly speaking, a simple sum of the actuarial weights attributed to different age and gender categories, based on standard actuarial assumptions. As discussed below, the demographic pool is being phased out to be replaced with a more sophisticated methodology that has not yet been devised. The second pool is entirely different. It reimburses insurers set amounts for their actual cases in four designated high cost areas: AIDS, premature birth, certain cancers, and ventilator

9. For instance, we were told in response to a hypothetical that one benefit package with a deductible \$500 higher than another could not be priced more than \$500 less, even if this is justified by the claims experience of the resulting risk pools. However, the price difference may reflect this claims differential to some extent that is greater than the pure actuarial value of the increased benefit (which is considerably less than \$500, since not everyone exhausts the deductible each year).

dependency. These payments are made from assessments that insurers pay based on their enrollment in the small-group and individual markets combined. The demographic pool was about four times larger than the medical conditions pool. The following discussion considers each pool separately and then offers some overall evaluations.

The demographic pool was widely disliked by insurers. HMOs and commercial insurers viewed this as purely a “bail out” of Blue Cross, for they consistently paid into the pool and Blue Cross plans received large subsidies. In 1994, Blues plans received about \$100 million, split roughly 50/50 between assessments from HMOs and from commercial insurers. Although Blue Cross plans received the most benefit from the demographic pool, Empire Blue Cross also was not entirely happy with how the pool functioned. The Empire representative we spoke with observed that age/sex adjustment captures only about half of the risk differential because it misses the part that is due to individual health status unrelated to age or gender. Only about 6 percent of annual individual and small-group premiums were transferred through the demographic pool. Individual health risk is captured in the medical conditions pool, but the restrictive conditions discussed below keep this pool from having much less impact than the demographic pool. If the two pools worked effectively, one would expect to see Empire’s rates and net expenses drop to much closer to the level of others in the market with similar benefits, but they have not. The rate differentials in 1994 and 1995 cannot be attributed solely to Blue Cross’s inefficiency. Therefore, there appears to be a large component of risk differential that was not being adjusted for.

However, almost all subjects conceded that the demographic pool was successfully adjusting for a good portion of the biased selection and that rates would have been even further apart were it not for this partial correction. To this extent, the pool did succeed somewhat in stabilizing the market and creating a fairer basis for competition. Also, one large insurer said that its initial decision to remain in the New York small-group market (in contrast with Vermont, for instance) depended in part on the presence of the risk-adjustment pool.

The second risk-adjustment pool reimburses insurers when they pay for specified high-cost medical conditions, such as AIDS, premature birth, certain cancers, and ventilator dependency. This pool is also not popular with insurers. They complain of the administrative effort required to document cases for reimbursement. These difficulties are particularly acute for AIDS cases. Out of concern that the pool would be overwhelmed with AIDS cases, the threshold for establishing AIDS was set so high

that patients sometimes died before the claim could be submitted. Also, the documentation establishing that the clinical threshold was met required results submitted from tests that are no longer done. Insurers felt that confidentiality and sensitivity to patients kept them from insisting on performing tests solely to help the insurer get reimbursement. For these reasons, many insurers do not consider it worth the effort to submit claims for AIDS cases, even insurers like Empire that cover a great number of these cases. As a result, AIDS claims constitute less than 5 percent of claims from the pool. Similar problems with other medical conditions have resulted in the pool running huge surpluses.

Both pools got off to a bad start due to a lawsuit by HMOs claiming they were not subject to the system, which resulted in funds being held in escrow for a number of months. Also, there were technical misunderstandings or possible gaming strategies regarding how demographic factors were calculated.

As a consequence of this somewhat troubled history, the risk-adjustment pools were completely revised in the 1996 legislation that required all HMOs to offer standardized coverage in the individual market. As a partial quid pro quo to the HMOs, this legislation eliminates the demographic pool, phased over five years, and calls for the medical conditions pool to be revamped by a task force within the Insurance Department. This phase-out and revamping resulted in a 1998 decision to pay out to insurers the accumulated surplus of \$115 million, under a formula that results in Oxford and Empire receiving most of the funds (following the theory that they had been undercompensated). As noted above, this payout was used to justify denying Oxford's and Empire's requests for very large rate increases the same year.

It is still unclear what form the redesigned medical conditions pool will eventually take. At present, the focus is on simply enlarging the list of conditions eligible for reimbursement, but this is merely a transitional measure. A task force is also considering converting this pool to an entirely different system that is prospective rather than retrospective in nature, in which risk adjustments are based not on costs that insurers actually incur, but on risk assessments determined by patients' medical history and demographics when they enter the pool. Ironically, this second option would more accurately be described as an expansion of the supposedly discarded demographic pool than a discarding of the supposedly enhanced medical conditions pool.

On balance, although both pools have had a troubled history, they have served a useful function that could be enhanced. It is unlikely that any risk-adjustment methodology can be free from controversy or significant

imperfections. Nevertheless, even imperfect risk adjustors help to stabilize the market and improve the basis for competition. In addition, the decision to pool together the individual and small-group markets for risk-adjustment purposes had the incidental, but perhaps intended, effect of encouraging group insurers to sell in the individual market; small-group insurers who did not choose to sell individual insurance could expect to pay more into the demographic pool in order to make up for not carrying their share of the social burden.¹⁰

New York's risk-adjustment mechanism can be contrasted with the set of rules in other states that allow insurers some leeway in their rates to make adjustments for demographic health risk factors up front (Hall 1999b), and then allow insurers to cede prospectively to a voluntary reinsurance pool the particular groups or individuals whose risk greatly exceeds the allowable rate bands. Such a system strikes a different social policy compromise and creates its own administrative difficulties in running the reinsurance mechanism. However, it does not tend to create the sort of contentious political environment seen in New York, in which there are overt transfer payments with identified winners and losers. Also, in this contrasting set of rules, most of the critical risk-adjustment decisions are made by each insurer in its own rating and reinsurance strategies, so there is no centralized administrative authority to blame or nitpick about imperfections in the system.

Conclusion

On balance, individual market reform in New York has produced mixed results. Following reform, the overall percentage of the population with insurance has worsened, and enrollment in the individual market has steadily diminished. Prices have increased substantially more than in other portions of the market, due to adverse selection. Also, reform resulted in the demise of comprehensive indemnity products and the withdrawal of all commercial indemnity insurers. The individual market has remained viable only by restricting products to two standardized managed care plans and by imposing an all-markets requirement on HMOs and Blue Cross plans.

10. This incentive to sell individual insurance was not very strong, however, since the demographic adjustment accounted for only a portion of the risk differential; also because the individual market makes up only about one-fifth of the pooled markets, the portion of the payments based on the individual market was quite small. This subtle pressure contrasts with New Jersey's explicit "play-or-pay" arrangement that requires insurers who do not sell individual insurance to subsidize the losses of those that do. In New York, almost all indemnity insurers chose to "pay," whereas in New Jersey many indemnity insurers have chosen to "play."

Viewed narrowly, New York's reform law failed to achieve its immediate objective of stemming the huge losses Empire Blue Cross was reportedly suffering in the individual market. Despite reform, Empire was forced to stop selling its comprehensive indemnity coverage within about two years. Moreover, Empire's critics claim the true source of its losses at the time it lobbied for reform were in the large employer market due to mismanagement and that if the legislature knew then what it knows today, the reform law would never have passed. Success is also lacking if viewed from a broader social perspective, since the combination of individual and small group reforms has failed to expand coverage or reduce costs.

From another perspective, however, the reform law has achieved more limited goals. With or without Blue Cross, some mechanism is needed to provide coverage to the chronically ill. Although comprehensive indemnity coverage is no longer available to individuals, a system of mandatory HMO and POS coverage can accomplish the same objective. In this regard, the reform law has succeeded. Coverage is now readily available for high-risk individuals from a number of different insurers throughout the state. Rates among these insurers are remarkably similar to each other, and rate increases for most insurers have not been extreme.

Nevertheless, the fact remains that it is difficult for lower-risk individuals to find affordable coverage, and indemnity coverage has disappeared from the individual market. In 1998, a young, healthy family without employer-sponsored insurance looking for coverage in New York City would find about a dozen companies to choose from, but with rates for HMO products ranging from \$7,300 to \$10,400 a year and for POS products from \$9,600 to \$13,900 a year. These are about 40 percent more than the rates available in the small-group market for coverage that has substantially lower deductibles. Considering these realities, it seems likely that New York's individual market will become essentially a widely dispersed high-risk pool funded by HMOs and Blue Cross plans in which enrollment will continue to shrink and rates will continue to rise faster than medical inflation.

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