

AN EVALUATION OF NEW YORK'S HEALTH INSURANCE REFORM LAWS

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I. Executive Summary

This study evaluates how well New York's health insurance market reforms have met their objectives and whether they have avoided possible harms and failures. This is part of an intensive case study of seven states that have enacted varying reforms, funded by the Robert Wood Johnson Foundation. This multiple-case study consists primarily of two rounds of structured, in-depth, open-ended interviews, as well as an analysis of documentary and secondary data. The principal reforms under study and those, enacted in 1993, that provide for the following in the individual and small group markets: (1) guaranteed issue of all products, (2) renewability and portability of coverage, (3) community rating, (4) restrictions on underwriting practices such as risk selection and pre-existing condition exclusions, (5) an administered risk adjustment mechanism, and (6) sales through business associations and purchasing cooperatives. This report is intended to inform lawmakers, market participants, and the public policy community whether and how these reforms have achieved their multiple purposes or caused any negative consequences, and how these reforms might be improved. The following is a summary of the major findings.

A. Enrollment

On balance, insurance market reforms in New York have produced mixed results, with the individual market suffering more than the small group market. Insurance is now readily available at average market rates for both small groups and individuals, regardless of health status. However, the overall percent of the population with insurance has worsened following reform. Total enrollment in the individual and small group markets combined has remained essentially level since reform, but in the individual market, enrollment has steadily diminished to a point that, in 1998 is 38 % or 50% lower than when reform began, depending on which data source is used. In the small group market, enrollment increased 7% by 1998, perhaps as a result of some individuals now purchasing insurance as self-employed groups. This increase in small group coverage has not kept up with the growth in the number of small firm employees, however. As a consequence, the percentage of small firm workers with private insurance has declined 7-12% in the four years following reform, in contrast to national trends which have remained almost level. The percent of self-employed workers with private coverage has not shown a statistically significant change in either New York or nationally.

B. Prices

Prices in the individual market have increased substantially more than in other portions of the market, due to adverse selection. However, price increases have not been precipitous, nor have they resulted in a "death spiral" for the individual market as a whole. In the small group market, prices have held remarkably steady for HMO coverage, and have been higher but still moderate for PPO indemnity products. Only traditional, unconstrained indemnity has been effectively priced out of the small group market, due both to adverse selection and to the absence of cost controls.

In 1998, a young, healthy family without employer sponsored insurance looking for individual 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% more than the rates available in the small group market for coverage that has substantially lower deductibles.

C. Individual Market: Competitors and Benefit Packages

Market reforms initially caused a large drop in the number of insurers active in the individual market. Two years after reform, although a few HMOs had entered the individual market, comprehensive indemnity coverage had virtually disappeared, with the announced withdrawal by Empire Blue Cross. The individual market still survives and is reasonably competitive by virtue of a 1996 change in the law that requires all HMOs to offer two standardized plans, but indemnity insurers now participate only by offering the out-of-network portion of point-of-service coverage.

Views differ on whether Empire's withdrawal of its comprehensive indemnity product constitutes a failure of reform. Viewed in stark political terms, reform failed to achieve its primary political objective of stemming the huge losses Empire Blue Cross was reportedly suffering in the individual market. However, 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. Viewed from a broader social perspective, others see the reform law as mostly successful with or without Empire. 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 at rates that are remarkably competitive with each other. Nevertheless, the fact remains that it is difficult for lower-risk individuals to find affordable coverage, and indemnity plans (including PPOs) have disappeared from the individual market. 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.

D. Small Group Market: Competitors and Benefit Package

The small group reforms have been much less controversial, despite having the same basic components. Although many insurers are not happy with the reforms, most are willing to accept guaranteed issue of all small group products even in a market with pure community rating. Those that pulled out of the small group market did so mainly because their market position was not significant enough to justify remaining. Although this set of laws may result in some degree of adverse selection, insurers in the market view the prior-approval rate review process as being sufficiently responsive and flexible to allow them to remain profitable or avoid excessive losses. Agents, who for the most part reflect the views of employers, are generally pleased with the small group reforms as a whole. The portability provisions and limits on pre-existing condition exclusions are especially popular. Also, the small group market remains very competitive with stable prices and ample diversity in product offerings, with the exception of traditional, unconstrained indemnity products, which have been priced out of the market.

E. Risk Adjustment and Administration

Although the risk adjustment mechanism has been widely criticized, it appears to have performed an essential function. Many more insurers might have left the market on account of pure community rating if this mechanism were not in place. Ongoing efforts to improve risk adjustment may resolve some of the complaints about how it has worked, but risk adjustment is likely to remain contentious, both because of the unresolved technical difficulties and because it so clearly results in mandatory subsidies among different components of the industry.

Administratively, New York's insurance reforms have not imposed a large burden or created serious

problems. Although insurers have used to their advantage whatever flexibility remains in the rating rules and whatever control they have over marketing and over their agents, there are inherent limits to how far they can carry these risk selection strategies. We found no evidence of widespread and continued noncompliance, and the Insurance Department has been attentive when compliance issues are raised. Sufficient incentives and checks appear to be in place to keep this set of regulations functioning reasonably well without intensive monitoring.

F. Affordability versus Availability

Despite these several moderate accomplishments, it is clear that this set of reforms has not resolved the fundamental social concerns that surround health insurance. Although health status is no longer a barrier to obtaining health insurance for individuals and small groups, affordability remains a major barrier to more universal coverage. As one agent summarized, it is just as difficult to sell small employers on health insurance after reform as before: "Basically [I hear from clients], 'I couldn't afford it before. What makes you think I can afford it now. I'm not paying this kind of money for my employees.' "

II. Background and Methods

A. Methods

The primary sources of information for this study are from various components of the insurance industry. In New York, we conducted 24 interviews of 34 people in the spring, summer and fall of 1997 and an additional round of 18 interviews were conducted with 22 of these same people (or their designated substitutes) in the summer and fall of 1998. Represented in this interview pool were three officials with the Insurance Department, six independent agents active in small group or individual market sales, 22 people at eight insurance carriers (two in-state and six out-of-state), and one administrator each of the risk adjustment pools and of a purchasing cooperative. Most interviews lasted 1-2 hours, except for eight that were conducted out of state (covering a total of 17 of the interview subjects), in which New York issues were addressed only briefly. We also collected quantitative and documentary information in the form of market activity data, sales literature, and newspaper articles. Finally, we conducted a market testing study in March 1998 to determine the ability of an actual small employer and unhealthy individual to obtain insurance. An employer with three employees contacted 23 agents throughout the state to inquire about the availability of health insurance for the group of three as well as for a group of two plus individual coverage for one unhealthy employee. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

This report is organized in two main sections. The first section reviews the history, purpose, and content of these reforms. The second section presents our findings, to evaluate whether these reforms achieved their purposes and avoided potential harms or failures.

Before we begin, 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 our present purposes, we value simplicity over precision, so we will use a lay vocabulary that glosses over many of the distinctions that are important within the industry. Thus, we use "insurer" to include, generically, both indemnity carriers and health maintenance organizations (HMOs). We use "managed care" to refer primarily to HMO plans, including point-of-service (POS), in contrast with "indemnity," by which we mean both traditional unconstrained fee-for-service as well as more managed forms of indemnity such as preferred provider plans. When we speak of agents, we generally intend to refer to independent agents, which are sometimes called brokers. We use the terms premium, price, and rate interchangeably to refer to how much insurance costs. And, by health insurance, we mean comprehensive major medical, in contrast with more limited or specialized coverages. Other, more technical terms will be defined later in the context in which they are important.

As a final piece background information is to note the important ways in which New York differs from other states. New York 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% rural versus 20% nationally). Although average income and employment figures are close to national norms, there are large pockets of deep poverty. Jobs are concentrated in the service sector, where employment-based insurance is less common. Nevertheless, its 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% versus 14% nationally). The consequences of lacking health insurance are more severe in New York due to 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).

B. Content and Purpose of Reform

In New York, the major piece of insurance reform legislation took effect April 1, 1993, applying to both the individual and the small group markets. It was prompted by mounting losses Empire Blue Cross and Blue Shield, whose reserves had sunk to far below the required level and were quickly approaching insolvency. Although later shown to be somewhat inaccurate,¹ Empire 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 risk select. 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. Other Blue Cross plans offered community rated and guaranteed issue individual coverage in other parts of the state, as did a number of HMOs. Thus, the legislative strategy was to require commercial insurers to offer their coverage on the same terms to prevent the serious adverse selection that Empire and the other Blue Cross plans and HMOs were suffering under.

The law's basic requirement is to require small group and individual insurers to accept any applicant for any of their major medical policies, and to charge only pure community rates. Pure community rating allows only geographic area, covered benefits, and family composition to be used as rating factors. Initially, the small group laws covered groups with 3-50 employees, but in 1997 this was reduced to groups of two to comply with the federal Health Insurance Portability and Accountability Act (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 the self-employed, and they may elect 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 1995, the reform law was amended (effective 1996) when Empire Blue Cross decided, despite these reforms, to withdraw its indemnity products from the individual market. Empire was continuing to suffer large losses 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. The 1996 law required all HMOs to offer a standardized HMO and point of service (POS) benefit plan in the individual market. Previously, HMOs could decide whether or not to sell in the individual market. Traditional indemnity coverage can no longer be sold in the individual market (except by renewing existing coverage).

In addition to these basic requirements, the insurance reform law promotes continuity and portability of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment or similar malfeasance. Second, insurers are prohibited from riding out specific health

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 Jeremy Best, "Community Rating: New York's Blues," *Buffalo Law Review*, 46:467-506; 1998.

conditions, and limits are set on the length of pre-existing condition exclusions. Insurers may exclude for 12 months any condition manifested within six months before the date of coverage. This recognizes that some form of pre-existing exclusion is necessary in a market where the purchase of insurance remains voluntary, in order to counteract the tendency of subscribers to delay purchase until they are sick. Third, these reforms address the problem of "job lock" that arises when employees are afraid to change jobs for fear of having to undergo an additional exclusion period. "Portability" is promoted by requiring that subscribers, once enrolled, be able to transfer coverage to a new insurer, either by changing jobs or changing insurers within the same workplace, without undergoing a new exclusion period, so long as the gap in coverage does not exceed two months.

The reforms discussed so far are aimed only at availability, not affordability, meaning they are only designed to offer insurance to any willing purchaser at prices that do not far exceed the market average, not to impose rate regulation or reduce prices across the market. Some other states, but not New York, create government-sponsored purchasing cooperatives for the small group market to help bring down costs by increasing competitive pressures and lowering administrative costs. Instead, New York leaves these mechanisms to the private market by clarifying how private purchasing cooperatives may function under community rating and guaranteed issue. Small group insurers who sell through such arrangements, are allowed, with approval of the Insurance Department, to charge lower rates that reflect administrative cost savings, but not to lower rates to reflect a healthier risk pool. These private cooperatives must also have membership criteria that do not select or exclude businesses according to health status and must otherwise follow the small group reform rules. One such private purchasing cooperative has been created in Long Island, and another is being discussed in New York City. It is important to distinguish these purchasing cooperatives from the purchasing groups that have existed in a number of other forms under the name of multiple employer welfare arrangements (MEWAs), or in the form of trade association groups such as those sponsored by chambers of commerce or professional associations. Purchasing cooperatives differ in several crucial respects. Membership is not restricted. Administration is more proactive in that purchasing cooperatives usually actively oversee marketing, pricing and enrollment. And purchasing cooperatives usually have several or many insurers from which to choose. The reform law also allows some private associations to offer insurance at rates that differ from community rates, but only if they existed prior to the law's enactment, have a larger and diverse membership, and offer guaranteed issue within their membership.

The last major component of New York's individual reform law is an administered mechanism to help spread risks evenly among insurers. Rather than the voluntary reinsurance pools used by some states, New York adopted a mandatory risk adjustment system that attempts to calculate how much greater or lesser each insurer's risk pool is than the market average and requires insurers with lower risks to make transfer payments to those with higher risks. New York at first had two risk adjustment pools, one based on the demographic factors in each insurer's combined individual and small group blocks, and the second which reimburses insurers for a portion of the costs incurred in covering four designated high-cost medical conditions (AIDS, premature birth, certain transplants, and ventilator dependency). The 1996 amendments phased out the demographic pool and called for the high-cost conditions pool to be revamped.

C. The Dangers of Reform

These reforms have attracted some vocal critics that warn about possible adverse consequences, and a number of quieter voices that warn against setting hopes too high about their success. The strongest fear is that these reforms could be counterproductive, since they have the potential to increase prices and decrease coverage. These reforms may raise prices because they make insurance most attractive to the highest-risk subscribers by holding prices to less than the policy's actuarial value to them. The excess is built into the

premiums paid by all purchasers, which will inevitably drive an undetermined number of lower-risk purchasers out of the market, thus raising the market average even more. This phenomenon is known as "adverse selection" against the market as a whole. This potential exists because the decision to purchase insurance remains voluntary, and existing purchasers are thought to be highly price sensitive, especially in response to pure community rating, which causes the most severe rate compression and therefore has the greatest potential to drive out younger, healthier subscribers. This, critics fear, will result in not simply a one-time loss in coverage but an escalating, destabilizing dynamic that may destroy the market. When the first round of subscribers drop out and the community rate increases, this might force still more cycles of subscribers to drop out and subsequent price increases, thus setting into effect an adverse selection spiral that eventually could result in insurance that is so expensive almost no one would buy it.

These reforms also create the potential for administrative and regulatory complexity, circumvention, and strategic manipulation. High risk individuals might pose as small groups to obtain more favorable rates, or low-risk employers might try to artificially aggregate into groups that appear larger than the 50-worker threshold in order to avoid these laws. Insurers might attempt to avoid higher risks through various legitimate or illegitimate strategies, or they might pull entirely out of these regulated market segments. Also, these rules might cause distortions or unlevel parts of the competitive playing field that tend to favor some types of insurers over others.

This outline of the purposes of these reforms and their potential harms and failings points to four central criteria that can be used to evaluate the success of these reforms: the extent to which they promote (1) insurance *availability*, measured through increased enrollment; (2) *affordability*, measured through average prices; (3) market *competition*, measured in a variety of ways; and (4) regulatory *administrability*, also assessed in a variety of ways. This report organizes its analysis of the empirical evidence by focusing on these four criteria.

Various components of the reforms have importance across each of these categories. For instance, guaranteed issue, which points primarily to availability, also might increase prices or lead to various circumvention techniques that affect administrability. Or, rating restrictions, which affect primarily affordability, might result in less insurance being purchased. Many components of the reforms affect market competition, and some components, such as purchasing cooperatives, affect each of the criteria in equal measures. Therefore, this categorization scheme does not result in a neat pairing of each component and each effect. This is true to the complexity of this regulatory scheme, however, since each component interacts with all the others and with market and social conditions that are independent of these laws. Also, keep in mind as various statistical and descriptive data are presented that it is impossible to know for certain the actual and full impact of these reforms. A host of other economic and social conditions were changing simultaneously and so we will never know what the conditions would have been absent reform, even if we can tell what they are before and after reform. Nevertheless, by following the interwoven threads of information in this complex tapestry, it is possible to draw some solid conclusions about whether these reforms have worked as intended, and, if so, why, and, if not, why not.

III. The Effects Of Health Insurance Market Reforms

A. Availability

1. Enrollment Generally

Following the enactment of New York's health insurance reforms, the portion of the overall nonelderly population without insurance increased from 16.5% in 1992, which was better than the national average, to 20.0% in 1997, which is worse than the national average (Table 1)². This disappointing failure to significantly reduce the level of uninsurance might be taken as suggesting a failure of the reform laws, but these overall uninsured rates reflect on many other social and market segments than just the small groups and individuals to which the law is targeted.

A better perspective can be had by focusing on the enrollment trends statewide in the particular market segments affected by the reform law: small groups and individuals. Considerable controversy has surrounded various reports of enrollment trends in New York. Using the Insurance Department figures that appear the most reliable,³ it appears that enrollment in the individual market has declined following the law, whereas small group enrollment has held steady. As displayed in Table 2, individual enrollment has fallen steadily in the five years following reform, to a level 38% below where it began, whereas small group enrollment initially dipped but has since risen to 7% higher than when reform was enacted. Data from the Current Population Survey (Table 1) show an even sharper drop in individual enrollment (50% through 1997), whereas enrollment in employer-based private insurance (including large insurers) has risen 4%.

The same pattern is seen in enrollment figures from nine large indemnity insurers, which as a group covered about 60,000 individual policyholders and 200,000 small group employees when the reform law took effect. Total enrollment among these insurers in the individual market declined 12% one year after reform (1994) but increased 5% at the same time in the small group market. More significantly, their number of new enrollees declined 20% in the individual market but increased 168% in the small group market one year after reform.

Naturally, it is a matter of some speculation or dispute whether these trends can be attributed to the reform law or instead are the result of underlying economic and labor market conditions. Table 2 indicates that

² These and other figures from the March Current Population Survey may be affected by changes in the wording and order of the questions relating to 1994 and later years. However, these changes would not affect trends that appear from 1994 onward, and probably would not affect comparisons among states. Also, the likely direction of any change in the questions, if corrected, would not only increase the number of uninsured and decrease the number with employer-based insurance in recent years. The only trend this change is likely to have accelerated is a decrease in those with individual insurance, and again this would be true only for the 1993-1994 interval. See Katherine Swartz, "changes in the 1995 Current Population Survey and Estimates of Health Insurance coverage," *Inquiry* 34:70 (1997).

³ These enrollment counts from insurers are only partially audited and most likely contain a number of inaccuracies. Nevertheless, they are the most accurate available, and the trends over time should be fairly accurate, even if the absolute levels are not. Note that these figures reflect the number of family units enrolled and so do not equate with total enrollment. A rough approximation is to assume an average of two people per insured unit.

the decline in individual enrollment is a continuation of a trend that began before the law (although Table 1 indicates the contrary), and Table 1 indicates that declining individual enrollment from 1993 to 1997 was a

Table 1
Health Insurance Coverage of the Nonelderly, 1992-1997*

State	1992	1993	1994	1995	1996	1997
New York						
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						
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%

* < 65 and not active military

Note: Totals exceed 100% due to double counting

Source: Alpha Center analysis of March Current Population Survey

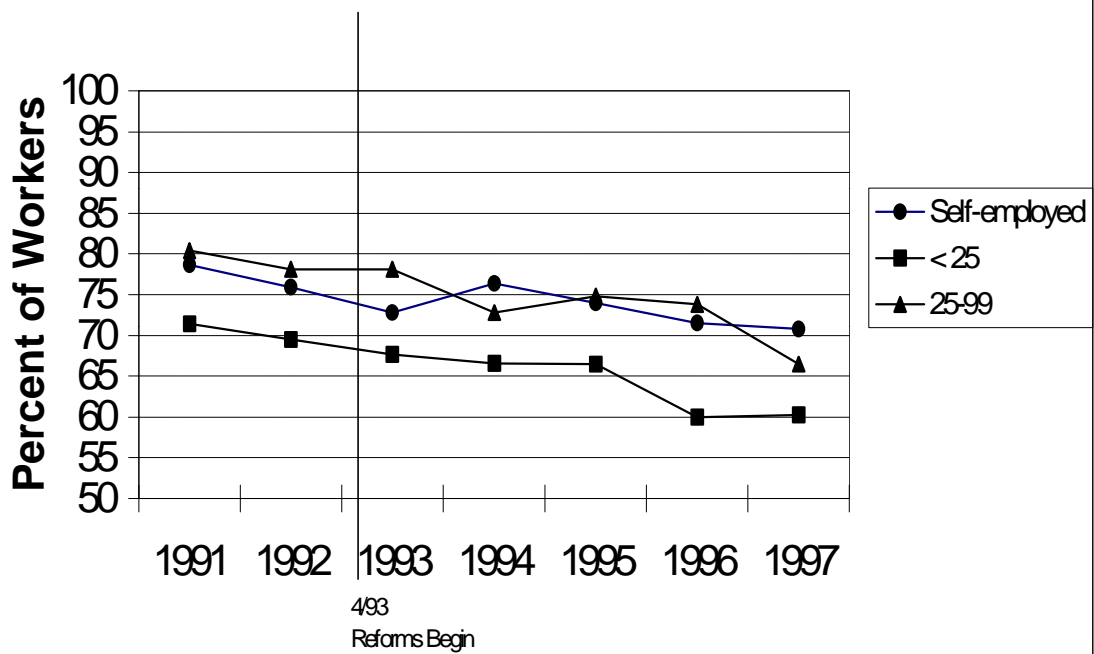
Table 2: New York Health Insurance Enrollment by Market Segment, 1992-1998

	<u>Number of Insured Units¹</u>						
	9/30/92	4/1/93	4/1/94	4/1/95	4/1/96	1/1/97	1/1/98
<u>Small Group Market</u>							
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
<u>Individual Market</u>							
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

¹Insured unit = one person, employee, or family

Source: NY State Insurance Department, as of 9/10/

Figure 1: Private Health Insurance Coverage in New York



Source: March Current Population Survey

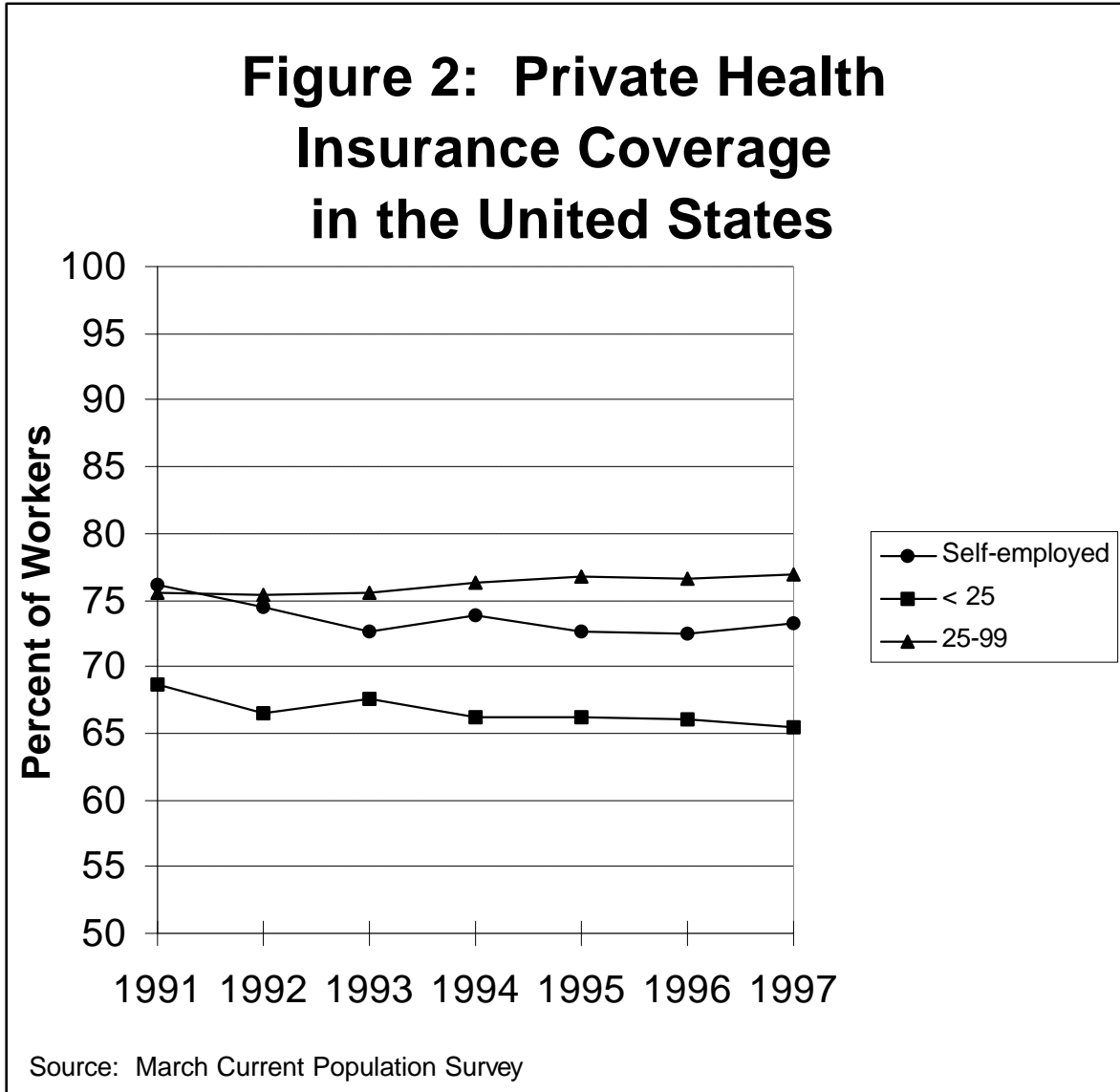


Table 3: Private Health Insurance Coverage in New York by Group Size, 1991-1997

Group Size	Percentage of Workers						
	1991	1992	1993	1994	1995	1996	1997
Self-employed	78.7	75.9	72.8	76.4	74	71.5	70.8
< 25	71.4	69.5	67.7	66.6	66.5	60	60.2
25-99	80.4	78.1	78.1	72.8	74.8	73.8	66.5

Source: Analysis of March Current Population Survey by Reenie Wagner

national trend, although only slightly so since 1994. Table 2 also shows a declining trend for small group enrollment, but there the trend was halted following reform, consistent with national trends. Nationally, employment-based enrollment for both small employers and larger groups has climbed significantly since 1993, but less so in New York. The growth in employer-based coverage that has occurred in New York may be due partially or entirely to job creation sparked by economic improvement. This is suggested by Table 3 and Figure 1, which show employer-based coverage as a percentage of workers in various size groupings for small employers. For each grouping except the self-employed, the percent of workers with private insurance declined in the years following reform, although in the early years the rate of decline is slight and is no greater than in the two years prior to reform. For the self-employed, there appears to be an initial modest improvement and then a return to the previous moderate decline, but these changes are not statistically significant. For small firms, however, the decline accelerated in 1996 and 1997, so that in 1997, four years after reform, private insurance coverage had dropped seven percentage points for workers at firms with less than 25 employees, and had dropped 12 percentage points for workers in firms with 25-99 employees. These drops are statistically significant at the level of $p < .05$ or better. The self-employed fell only two percentage points over this time span, which is not statistically significant. See Table 3 and Figure 1. Nationally over the same period, private insurance coverage among workers in firms under 25 dropped only two percentage points. There were no statistically significant changes in private coverage among the self-employed or workers in firms with 25-99 employees. See Table 4 and Figure 2.

From all indications, insurance enrollment following the reform law has not been as favorable in New York as nationally, and enrollment in the New York individual market has been worse than in the small group market, compared with pre-reform trends in New York.⁴ On the other hand, the fact that individual market and small group reforms were enacted simultaneously enables some people with individual coverage to switch to

⁴ See also K. Haslanger, et al., *Taking Steps, Losing Ground: The Challenge of New Yorkers without Health Insurance* (United Hospital Fund, 1998), 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 1990's, and worse off than the nation as a whole".

Table 4: Private Health Insurance Coverage in the U.S. by Group Size, 1991-1997

Group Size	Percentage of Workers					
	1991	1993	1994	1995	1996	1997
Self-employed	76.08	72.69	73.83	72.56	72.55	73.26
< 25	68.66	67.59	66.26	66.24	66.02	65.46
25-99	75.50	75.53	76.25	76.76	76.66	76.84

Source: Analysis of March Current Population Survey by Reenie Wagner

the small group market, with no net loss in enrollment. This is suggested by the figures just cited, which show little or no decline in enrollment by the self-employed. Also, the Insurance Department figures show that total enrollment in the two reformed markets combined has remained virtually the same over five years (Table 2). Still, total enrollment as a percent of those working for small employers has declined.

Additional insight on the connection of the law with enrollment trends comes by observing the portion of new enrollees who were previously uninsured, since it might be expected that this would capture increased enrollment from previously uninsurable people taking advantage of guaranteed issue. In the individual market, a 1996 study by the Insurance Department of enrollees in the new standardized individual plans found about 20% were previously uninsured, which is a sizeable number, although it is difficult to interpret without knowing for sure whether it represents people who are chronically uninsured or instead only those who were temporarily without insurance or are switching from group or public coverage to individual coverage.

In the small group market, there has not been a large increase in purchasing by previously uninsured small groups. The Long Island Alliance, which is discussed below, finds that only 2-3% of small groups purchasing through it are previously uninsured. This is much lower than we have seen in other states, although we are not confident that the data in the other states reflect a true measure of the chronically uninsured for reasons just noted. The lack of a major impact on chronically uninsured small groups is confirmed, though, by explanations from several agents that almost all of their new small group business involves an employer looking to change coverage or a start-up company, but rarely an existing employer previously without insurance.

2. Agents' Views on Small Group Reforms

Lacking conclusive data, another good indication of the law's impact on availability in the individual and small group markets is the informed opinion of industry sources and regulators. Most of our subjects view guaranteed issue 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

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been more problematic. Agents' views deserve special credence since they have the closest contact with purchasers and they understand the dynamics within the industry.

In favor of small group reform, agents are the most enthusiastic, since guaranteed issue makes it easier to sell insurance. Of the six agents interviewed, three were strongly in favor of the reform law, and three had mixed or neutral views. Representative favorable comments include one from an agent who said that the law had been "a real boon to [our] business. . . . I'd venture to say our business has increased 50% to 60% at least. It was wild." Another said:

[The law] helped us tremendously because we were able to bring our rates down. Everybody said that [community rating] would put people like us out of business . . . because people didn't need us and this and that and the other thing. I hate to tell you our business has quadrupled. . . . I saw it as a marketing opportunity because I think a lot of people fell asleep and really didn't keep on top of what was going on. So there was a lot of opportunity for businesses throughout most of Manhattan because it's right here on our fingertips to go in and explain what was going on with community rating, explain what the options were.

A third agent said the benefits of the law were "phenomenal" and "absolutely spectacular" because of the increased access it has allowed for small employers.

An example of a more mixed view is an agent who commented that the law "opened up a flood gate of business that normally might not have been there . . . because it very obviously [said that] anybody who was going to apply was going to get it." Nevertheless, this agent was opposed to the concept of guaranteed issue because it violated the fundamental premise of insurance:

To me, basically, by having guaranteed issue you're going away from the word insurance. It's no longer insurance. There is no selectivity; therefore it can't be insurance. You're not really identifying risks. You know I cut my teeth in the insurance industry explaining to clients insurance is something you buy when [you're still healthy because] . . . you never know when something is going to happen. The moment you take out the element of [risk selection], . . . there is no incentive to get it until something happens. One of the jokes I used to have is that I had a [broker who] . . . I wouldn't get a call from until one of his clients had a wife who got pregnant. That's when I got the business.

Another agent said the law spurred many sales initially, but the interest quickly died down:

There was a phenomenal amount of interest and an initial influx of business, but then there was a retraction in the respect that the rates were so astronomical that case by case it just went off the books. . . . The moment that the initial influx was over with, and that may have been about three months, . . . let's say from about April to July or so of [1993], then it became very difficult to sell because basically it was, "I couldn't afford it before. What makes you think I can afford it now? I'm not paying this kind of money for my employees."

One of these same agents also commented that community rating caused his agency initially to lose about 15% of its clients, and "those who we kept, we had to work very hard to keep." But they were able to replace the lost groups with about as many new ones by taking advantage of guaranteed issue:

It was a lot of work to keep the same level [of enrollment], but we had to do it. . . . 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.

3. Agents' Views on Individual Market Reforms.

It is important to stress that most of these comments were with respect to the small group market only,

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for that is what most of these agents focus on. 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 [insurers] cut the commissions to -- they used to pay 20% or whatever; now they are paying 10% or 5%, 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.

Agent commissions have been cut also for small group insurance, from 10% or higher to 4-5%, which is much lower than the 8-10% we have seen in other states. However, the economies of scale in selling to groups rather than individuals makes this low rate acceptable to a number of agents, such as the following:

Q: Well, [taking a cut that large is] quite a blow. I don't see how you could take a third or two-thirds less [in commissions].

A: Well, you learn to work harder and you start developing the ancillary business, the dental, the disability, the prescriptions, . . . life, all that stuff.

Q: But do you view this 1993 law in sort of negative terms because it sort of took the wind out of your commission sails?

A: At the beginning I did, but it's like anything else. After you learn to live with it, you pretty much develop other lines to sell and to educate clients.

Since the 1996 change in the law that eliminated commercial indemnity coverage in the individual market, virtually no insurer pays commissions for individual policies since all are now sold by HMOs that use direct marketing. Even those that use some independent 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 works, 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 in 1996, shortly after all HMOs were required to sell individual insurance, to determine the extent of compliance. 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.

In our market test study, only one out of 23 agents throughout the state indicated that an adult with juvenile diabetes could not get individual coverage. However, six other agents (for a total of 30%) indicated that this person would have some trouble finding coverage. Also, the agents contacted in New York were notably less responsive to our inquiries than in other states. The market tester rated only 48% of the New York

agents as reasonably responsive, compared with an average of 83% from 7 other states we studied.

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 state-wide for commercial indemnity insurers but can be regional for HMOs and nonprofit insurers), but insurers don't 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:

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.

4. Field Underwriting

Selective marketing and lowering agent commissions are two ways that insurers might attempt to avoid receiving unwanted business. There are a variety of other potential techniques we inquired about, which fall under the general heading of field underwriting. This term refers to a practice of encouraging agents to screen out applicants they know or suspect are higher risks. This is a legitimate practice in many parts of the insurance industry generally such as property, casualty, and life, because it efficiently avoids unnecessary work for the insurer and agent, and helps to steer subscribers to the plans and carriers that are most likely to offer affordable coverage. This practice also helps to detect when applicants are not being truthful about their risk factors. In part, this practice and these reasons explain why agents refer to themselves as underwriters in their professional certifications and trade association names, even though they do not perform the full underwriting function that insurers do in the home office. Nevertheless, for health insurance in a guaranteed-issue environment, field underwriting of this sort is not legitimate and violates the statutory requirement of fair marketing.

Is it happening in New York? Almost everyone we asked acknowledged that some degree of field underwriting occurs, but that it is not undermining the law. Independent agents are well positioned and well motivated to resist efforts by insurers to encourage field underwriting. This was confirmed by our market testing study, which assessed the ability of an actual small employer and unhealthy individual to obtain insurance. We retained a small employer with three employees to contact 23 agents throughout the state to inquire about the purchase of insurance. The group was composed of two people in good health and one with juvenile diabetes. The employer inquired about coverage for group sizes of both three and two, as well as individual coverage for the person with diabetes. None of these agents indicated that coverage would be unavailable for either of the group sizes, and only one agent indicated that the unhealthy employee could not get individual coverage. However, three agents (13%) indicated that insurers would be reluctant to cover the group of three that includes the person with diabetes, and seven agents indicated that this person would have some trouble getting coverage individually. Also, the agents contacted in New York were notably less responsive to our inquiries. The market tester rated only 48% of the agents as reasonably responsive, compared with an average of 83% from seven other states we studied.

In our interviews with agents, one said that insurers put no pressure on agents to avoid high-risk business:

A: *That's not expressed. Of course they feel that way, but they don't ask us for our good business and*

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only our good business . . . They want it all. They just want us to give all of our business to them.

Q: They don't come and say, "Hey, you just sent us a bunch of 55-year-olds with diabetes. Would you spread some of that around? We'll take our share."

A: *No, not at all. Not at all.*

Another agent acknowledged that pressure exists, but explained that for the most part it is suggestive, not overt, and that ethical agents effectively resist it:

A: *The only time I would say that we get pressure is if you don't write enough business with a carrier and you place a case that just doesn't look good because of the occupation of the people or because of the background of the people, you would probably hear a couple of negative comments like, "You haven't been giving us business and this is what you're coming with?" You know what I'm saying? They can't say no to it. They have to write it. But they kind of give you a hint that if you want us to write business like this, you're going to have to be giving us a lot of business, good business. So, it's never been done in a direct way.*

Q: So it would be just sort of gentle nudges or something of that manner?

A: *Yes, usually their group rep is the person who usually says the comment. Because I assume the group is held accountable to the kind of business they bring. . . .*

Q: But is there really no repercussion for you? They can just take you off their list of certified agents, I suppose.

A: *No, I'm a licensed individual. They can't take me off unless there is an ethical reason. If I'm a broker and I do not commit any fraud toward them, then I'm able to submit business. I'm sure I could sue them if they stopped accepting business from me. But I don't think that would be the case. They would never do that. That would be a major mistake. . . . If the agent is ethical, then he's going to serve the client regardless of who they are, where they come from, and what their needs are. He's going to lay out the plans to the consumer and say, "Here's the best deal . . . ," regardless of who the carrier is For example, I got a call from a well-known rock group . . . [with one member whose] daughter is having a major situation going on. She needed something that is quite unique. Operations all over the country. They were looking for surgeons from all over the world. Now when somebody like this comes to you and says, "Which is the best insurance company?", an unethical insurance agent who is defending an insurance company or protecting an insurance company, may steer her to one direction or the other. Because in reality, we could be influential in affecting the bottom line of that insurance company if we know the facts. . . . People tell you, they call and say, "Listen, I was just diagnosed with cancer. What should I do?" That's where an ethical agent is important. He or she should direct the consumer to where the best care is done and the best policy and the best service. And that's where I feel like, "How is the insurance company going to deal with all this?"*

A third agent described the pressure as being somewhat more overt, but still something that agents appropriately ignore or counteract:

A: *How they make their money is they really try to screen away the really sick people.*

Q: And how do they do that?

A: *They start dancing, you know. They know a group as a bad group -- if they have a reputation in a smaller town, you might know that. Then they don't want to quote it.*

Q: So they just say, "We won't quote that"?

A: *No, they can't say that. They give you all kinds of stories. And we say, "No, no, no, you have to do it." Then the fun begins.*

Q: So, they do it, but not willingly.

A: *Right.*

And, another agent said that, although insurers do not blatantly refuse to enroll sick employees or family members, they do let their displeasure be known:

We haven't had any problem like [refusing to enroll]. The only time we've had a problem is when they go in and they accidentally trip over Bob Smith, whose wife is critically ill. Then they get a little testy.

An agent who does mostly large group business said, however, that there is no pressure whatsoever from insurers to avoid older groups or attract younger ones.

We were told that other forms of field underwriting that we inquired about are not present. For instance, we were told that insurers are not more reluctant to pay claims for high-risk subscribers, hoping to drive them to switch to another insurer:

Q: So you're saying that even though they're not happy about [taking high-risk groups at community rates], . . . they don't decrease the level of service that they provide?

A: *No, never had that problem. First of all, they have to deal with us. And what we've done to build our business over the years is service, service, service. No, they don't do that.*

We were also told that insurers do not vary commissions according to the profitability of the health insurance business that agents send them, not that agents wouldn't like this to happen:

Q: Do [insurers] do anything to kind of reward agents that send them better business?

A: *On health insurance, not that I've ever been aware of. If they have, they've been holding out on me. Is there something that you know that I don't?*

5. Micro Groups

It has been noted so far that guaranteed issue works somewhat better for small groups than for individuals. This contrast leads to the question of how micro-size groups 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 adequate profits from this size group because New York law imposes more intensive regulatory scrutiny on insurers whose loss ratios fall below 75%. This is not sufficient to pay adequate agent commissions, which are usually much higher for sales to micro groups due to the greater work involved per covered life in selling the policy.

Initially, the Insurance Department interpreted the law to require groups of 1-2 employees to be treated as part of the small group market and therefore they must be offered guaranteed issue and community rating for the same products and on the same terms as groups up to 50. 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 micro groups if they don't 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. We were told that 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 law had improved or worsened availability for micro groups. We heard two points of view, depending in part on group size. For groups of 2-10, 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 under 10. But now all small group insurers must offer guaranteed issue down 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 fall 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 2), the reform law may have diminished availability. Most of the insurers we spoke to decline to sell to this size, and several agents commented that it is difficult to find affordable coverage for this size. 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.

6. Portability and Pre-existing Condition Limitations

The portability and pre-existing condition provisions in the law are widely popular among our interview subjects and appear to have been implemented without much difficulty. Several agents said something to the effect that these are the "most important" features of the law. No one complained explicitly that the pre-existing limits were too short, or too long. However, one agent observed that some HMOs that originally had shorter or no pre-existing exclusion periods reacted to the imposition of guaranteed issue by imposing or lengthening the exclusion period. In addition, a few subjects said there were some difficulties interpreting or administering portability provisions, for instance, in deciding what types of prior coverage are similar enough to qualify.

One related puzzle was raised, having to do with lifetime maximum claims that are common in indemnity coverage, and increasingly in HMOs. Previously, these set real constraints because someone who incurred claims of \$1 million, for instance, obviously could be excluded by another insurer as uninsurable or subject to a pre-existing condition. However, under the reform law, such a person might be entitled under portability and guaranteed issue to a fresh policy from a new insurer even after the existing limits are exhausted. One agent raised this issue and said he had never received a satisfactory response. One possibility is that the new insurer could claim that a person switching from coverage that has been exhausted does not have "comparable coverage." Another possibility is that the claims incurred under a prior policy could be transferred to the new coverage so that it begins with proportionately lower lifetime limits, even if the prior limits were not exhausted.

7. Overall

On balance, the insurance reforms in New York have produced mixed results with respect to the availability criterion. Although insurance coverage is now widely and readily available to any individual or small group regardless of health status, continuing problems of affordability have kept the reform law from producing a huge influx of new subscribers, nor has the law reduced the overall level of uninsurance statewide; indeed, these measures have worsened. Small group enrollment has increased and total enrollment in both markets has remained about the same, but enrollment as a percent of overall population and as a percent of small employers has declined. Whether these positive and negative indicators are attributable to the law or instead to economic and demographic factors is impossible to disentangle conclusively. At least it can be said that the deterioration in the small group market that preceded these laws has been slowed, and possibly reversed. However, enrollment in the individual market continues on a steady decline, due more to problems of affordability than to any barriers to availability.

B. Affordability

1. Average and Relative Prices in the Individual Market

There are several indications that premiums for individual insurance have risen substantially following reform, whereas some small group rates have held remarkably steady over the past few years, especially compared with the double-digit increases that were common in the late 1980s.

The view one has of trends in prices in the individual market 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' rates for individual indemnity coverage rose approximately 40% 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% in 1994 in New York City for its individual indemnity products. An anonymous indemnity insurer profiled by the Insurance Department in its early report on the effects of community rating increased its individual rates an average of 43% in the first year of reform (1993).

In contrast, HMO rate increases have been more moderate. Table 5 shows the median rates for HMO coverage in 1994 and 1998 for 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 that a variety of competitive choices are available.

However, these increases are considerably greater than the trends in medical costs and than the trends in the small group market, discussed below. Also, insurers claim that rates in the individual market have been artificially dampened by the regulatory environment in New York, masking the true deterioration that has occurred. On the other hand, the presence of rate regulation 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 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 in

turn 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%. Most such plans in most years have kept their increases at or just 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 a very large one-year increases ranging from 50% to 80%. Most notable were rate requests by Oxford and Empire for increases averaging 65% and 56% respectively. These are by far the two largest individual insurers, accounting for about half of the market state-wide and the vast majority of the market in the New York City area.⁵

After a hearing, the Insurance Department denied the requests by these two largest insurers, limiting them to the automatic 10%, 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% to three HMOs with small enrollment.) The Department's 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 multi-million 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.

Some interview subjects reacted with considerable dismay to this solution. They attributed it to election-year politics, and called it a short-sighted attempt to avoid the inevitable. Others thought this was a reasonable, although unusual, compromise that avoided a huge price shock to many of New York's most vulnerable chronically ill people. Although this solution cannot be repeated, there is some anticipation that, following the 1998 elections, the legislature may look at alternative structures to create a broader base for subsidizing prices in the individual market.

2. Average and Relative Prices in the Small Group Market

Rates in the small group market have not risen as consistently or sharply as in the individual market. The Insurance Department provides median rates for each type of insurer in each of nine regions of the state. Table 6 displays these median rates over six years, for a selection of five regions, chosen to reflect a range of population densities and economic bases. Figure 3 depicts the average among these medians. As can be seen, in most regions HMO rates for small employers have held nearly flat, whereas rates for nonprofit insurers which offer both indemnity and HMO products have increased at 6% a year, and rates for commercial indemnity insurers have increased 10-14% a year.

There are several explanations for why different types of insurers and products have experienced different rates of increase. Insurance reform laws took effect at the same time that competition from HMOs was greatly intensifying. This may have caused a selection effect in which good risks left indemnity products for HMOs, at the same time that HMOs were aggressively pricing their product to obtain market share. Several

⁵ 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 in earlier years.

interview subjects spoke of one indemnity insurer in particular that "low-balled" rates in order to "buy market share," meaning it initially underpriced in order to gain volume, but shortly thereafter raised rates sharply in order to recoup mounting losses, thereby losing much of the business it had gained.

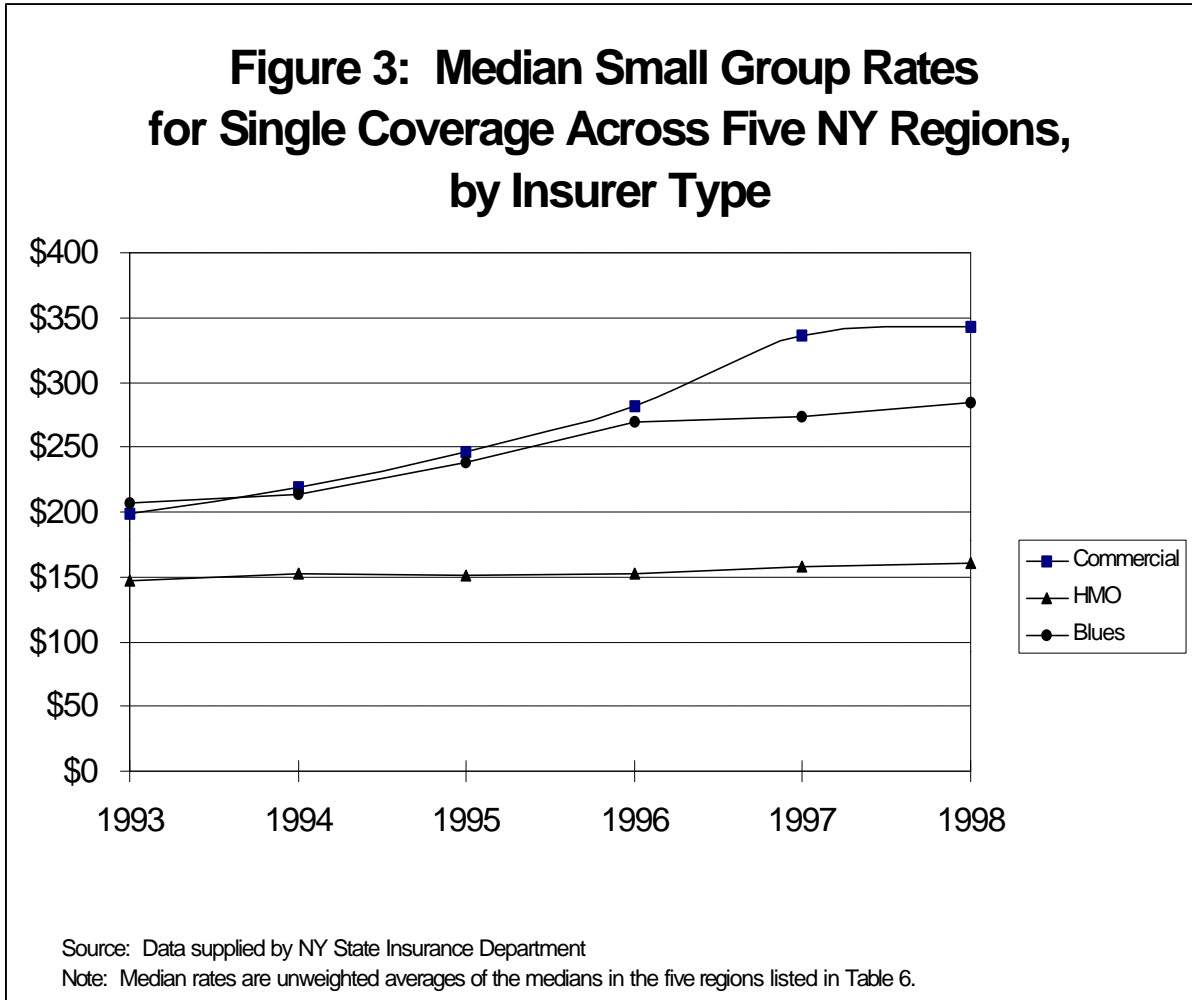


Table 5: New York Individual Rates for Single HMO Coverage, by Region: 1994 & 1998

Region	7/1/94	7/1/98	Annualized increase
			1994-1998
<u>New York City Area</u>			
Number of Plans	11	17	5%
Median Price	\$215	\$261	
Hi-Lo Spread	1.82	1.73	
<u>Utica/Watertown Area</u>			
Number of Plans	7	10	3%
Median Price	\$193	\$215	
Hi-Lo Spread	1.40	1.48	
<u>Westchester Area</u>			
Number of Plans	13	15	7%
Median Price	\$196	\$259	
Hi-Lo Spread	1.88	1.50	
<u>Buffalo Area</u>			
Number of Plans	4	6	13%
Median Price	\$114	\$185	
Hi-Lo Spread	1.74	1.34	
<u>Mid-Hudson Area</u>			
Number of Plans	15	19	6.5%
Median Price	\$189	\$243	
Hi-Lo Spread	1.71	1.63	

Source: Calculated from data supplied by the NY State Insurance Department

Table 6: New York Median Small Group Rates for Single Coverage, by Region: 1993-1998

<u>New York City</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	255	286	328	385	438	447	12%
HMO	174	181	181	184	182	185	1%
Blues	269	269	322	365	371	371	12%
<u>Utica/Watertown</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	155	170	183	202	231	250	10%
HMO	147	150	150	138	145	147	0%
Blues	136	146	146	161	169	185	6%
<u>Westchester</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	242	267	309	341	402	408	11%
HMO	160	170	170	178	182	184	3%
Blues	269	269	322	365	371	371	6.5%
<u>Buffalo</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	149	150	163	195	231	238	10%
HMO	98	101	101	105	113	113	3%
Blues	171	198	172	193	193	236	6.5%
<u>Mid-Hudson</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	196	220	249	282	377	374	14%
HMO	157	156	156	159	166	173	2%
Blues	190	190	229	260	264	264	7%
<u>Unweighted Average Across Five Regions</u>	1993	1994	1995	1996	1997	1998	Annualized Increase 1993-1998
Commercial	199	219	246	281	336	343	12%
HMO	147	152	151	153	158	161	2%
Blues	207	214	238	269	273	285	6.5%

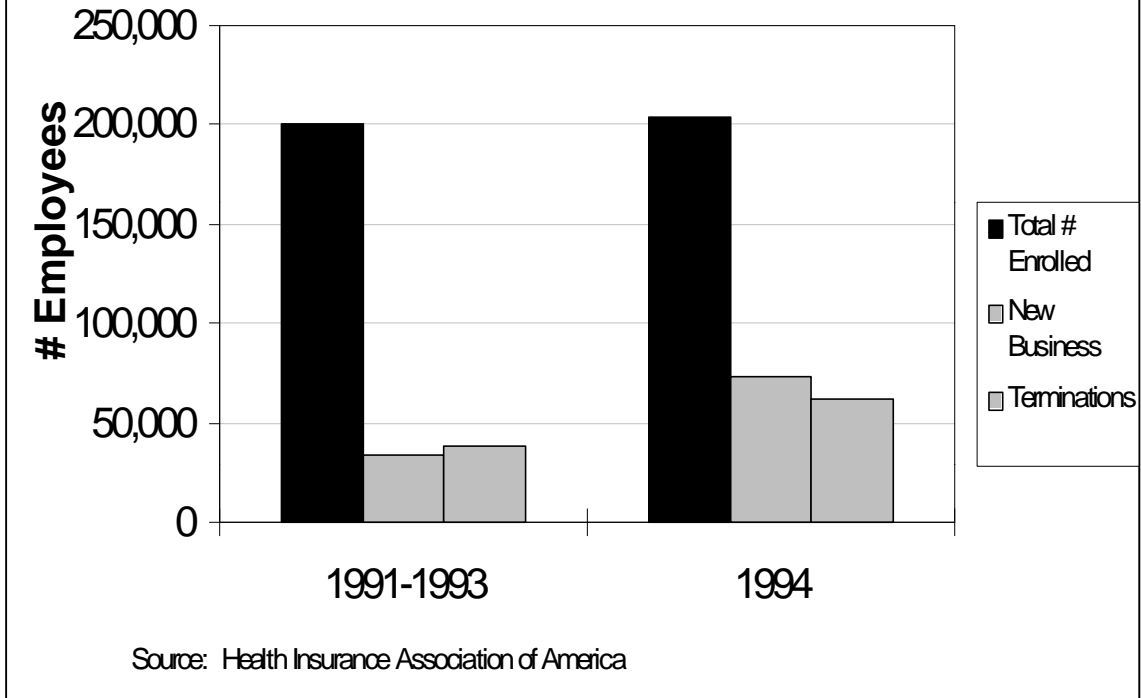
Source: Calculated from data supplied by the NY State Insurance Department

As a consequence, the small group market in New York is regarded by all of our interview subjects as being highly price competitive. One indicator of price competitiveness is the high loss ratios that many market leaders experience for small group business. New York law encourages commercial insurers to maintain substantial loss ratios by waiving prior rate review if they guarantee a minimum loss ratio of 75%. One Insurance Department source said this regulatory impetus presently has little impact since price competition has forced loss ratios for most insurers into the high 70s or low 80s. Another indication is the extent to which prices are comparable among insurers for similar products. Most subjects thought they were, in the small group market. According to one agent, "The experience has been remarkably similar for all the companies in the marketplace, because the rates are all right in line with each other."

We confirmed this impression with our market testing study, in which we obtained two sets of quotes each for group sizes of two and three. One set of three quotes came from the New York City area and the other set of two quotes came from Buffalo. The three New York City quotes included two HMOs and one PPO. The two HMO quotes were within 11-13% of each other for both group sizes, and the PPO quote was only 10-20% higher than the higher HMO quote for the group of three, and essentially the same for the group of two. In Buffalo, the two HMO quotes were within 16-17% of each other for both group sizes. Since products are not exactly standardized, these ranges could be justified entirely by differences in benefits, although we did not undertake such an analysis. Similarly, in the Long Island Association Health Alliance, discussed below, there is a very tight spread in rates among five competing plans, both for HMO and POS products. In the third quarter of 1997, the top rates were only 20% and 25% higher, respectively, than the lowest rates for each of these products.

It is a separate question whether and which of these mixed results are attributable to the reform law or to underlying market conditions. The market was already competitive before these laws, and the intensely competitive environment that kept market-wide averages down in the small group market exists across the country, in large part due to the shift to managed care. Of course, these reform laws also were enacted across the country, and it is possible that they facilitated or precipitated the move to managed care. but the laws may have amplified the extent of price competition. First, portability makes it easier for subscribers to switch insurers in order to save a few dollars. Insurers in other states report that their retention (or persistence) rates (the percentage of subscribers that renew, or the length of time they stay with the carrier) have dropped significantly following enactment of these laws, resulting in much greater market volatility. This can be seen in Figure 4, which reflects pooled data we obtained from nine large indemnity insurers. In the year following reform, the portion of each insurer's existing subscribers who terminated coverage doubled from the prior three years' average, but so did the number of new subscribers to each company, resulting in essentially no gain in net enrollment. Thus, although the number of new and terminating employees was approximately same both before and after the reforms, the volume of market activity roughly doubled for these nine insurers the year after reform. This was not the case, however, for their individual business, which had the same termination rate but a decrease in the number of new

Figure 4: New York Small Group Enrollment for Nine Commercial Carriers, 1991-1994



subscribers. Also, two agents said that there is no greater turnover in their small group accounts now than before the reform law.

Second, as discussed below, the law may have precipitated the move to managed care, which is one of the main drivers of the intensified price competition in recent years. As one agent explained:

The [focus] of the market is not [total] premium dollars any longer. It's members. So [insurers] sure want to be competitive so that they can get members on board so they can contract with more doctors and have a stronger network and bring on more members.

Regardless of whether the reform law is responsible for increasing price competition, it is clear the law did not squelch price competition in the small group market.

Not everyone views this degree of price competitiveness and market activity in positive terms. Some interview subjects characterize aggressive pricing as "low-balling" or "buying market share," and they cite the example of Colonial-Chubb Life as an insurer that seriously underpriced in the first year of reform, gained market share rapidly, but then had to implement steep rate hikes to keep up with mounting losses, and soon lost most or all of the business they had gained. One agent told the following story:

When community rating first started Chubb Life was notorious in undercutting everybody, every carrier. I mean they picked up business all over the place. And I did a lot of business with Chubb prior to community rating and after community rating. And I told them that they really need to re-look and re-think what they were doing. And the very next year they . . . changed their premiums. The premiums basically skyrocketed, and they lost a lot of business, which made agents absolutely crazy because we had to go shopping around all over again. That was a killer year, 1993.

Finally, it is important to recognize that, despite this level of price competition, many potential purchasers still find health insurance unaffordable, as illustrated by this anecdote from an agent:

There are some people who legitimately just can't [pay for health insurance]. I came across one particular situation where there was a small business here in Queens. They basically create these neon signs and so forth. The business barely supports three families that happen to be related and basically the girl who [I spoke with] said to me "it's not that we don't want to have the coverage, we truly can't afford to have the coverage. We have a number of children between us and so forth and we're lucky we're still in business." . . . I wish that there were an alternative for them other than going . . . to the emergency room.

3. Adverse Selection Against the Market

We evaluated the extent to which the reform law may have increased average prices and destabilized the market by causing adverse selection against the market as a whole. Community rating has this potential by increasing costs for healthier subscribers, thereby at the margin driving some from the market, and by lowering costs for higher risks, thereby attracting more into the market. Flat community rating, coupled with guaranteed issue, was expected to increase average prices dramatically. We lack sufficient data over time to make a conclusive determination of the extent to which this is or is not true in each market segment, 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 each of 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, and so the impact there may be masked. An analysis by Buchmueller and DiNardo, 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.⁶ 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 .2 years per quarter, but in three years following reform the quarterly increase in average age almost quadrupled to .77 years per 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 its experience less adverse selection than these other plans.

We also received extensive data about Oxford and Empire. 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 27 times higher. Smaller HMOs report somewhat smaller, although still substantial (2-3 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% of its business initially due to 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

⁶ Thomas Buchmueller and John DiNardo, Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania and Connecticut (Sept 1998).

he and others had seriously overestimated the potential for adverse selection by initially adding 10-20% to their small group rates to anticipate increased morbidity, but looking back he now thinks that 3-5% would have been more realistic. Based on this experience, both this actuary and one at another insurer said they do not load their rates at all for adverse selection when other states adopt small group guaranteed issue. They figure that, at worst, claims will increase only 1-2% which is an amount that, if it materializes, they can pick up later in subsequent increases based on claims experience. One insurer with a significant block of both indemnity and HMO small group business had only a modest 14% increase in average claims per employee from 1994 to 1996.

Actuaries at three large insurers with mostly indemnity coverage each said that, although some degree of adverse selection has occurred, a destabilizing or destructive adverse selection spiral has not occurred in the small group market. It is particularly encouraging that the initial pricing overreaction in the small group market did not become a self-fulfilling prophecy by producing the very selection effects the actuaries wrongly anticipated. Price increases at these insurers have been driven almost entirely by market-wide medical cost trends and not by selection factors. Although most of these insurers have lost considerable market share and their blocks of business have aged, they have been able to reflect this deterioration in their rates and so their loss ratios have not significantly worsened. Moreover, these trends are not materially different in New York than in other states where small group business is sold and there is no pure community rating. An actuary at one insurer that sells small group indemnity products nationwide said their small group block behaves pretty much in sync nationwide in response to systemic forces such as medical cost increases or the growth of managed care, rather than in response to local laws. Thus, the increase in average indemnity claims in New York could be due to healthier indemnity subscribers switching to HMOs rather than to their dropping insurance entirely. Another national insurer, with primarily HMO products, said that selection effects vary from state to state depending on local market conditions in that small groups in some states are much more price sensitive (i.e., more likely to drop coverage when prices increase) than in other states, and they found that New York groups tend to keep their coverage.

The small group market more easily withstands adverse selection because groups blend risks and 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. An actuary with experience in many states said that the 10-fold or greater risk spread that theoretically might exist among groups is so rare in actual small groups that he is quite comfortable with 3:1 rating bands for age and gender, since this would capture the variation that exists among the vast majority of groups in most insurers' blocks of small group business. He viewed the 1:1 rating required by New York law as undesirable and prone to some adverse selection, but still manageable.

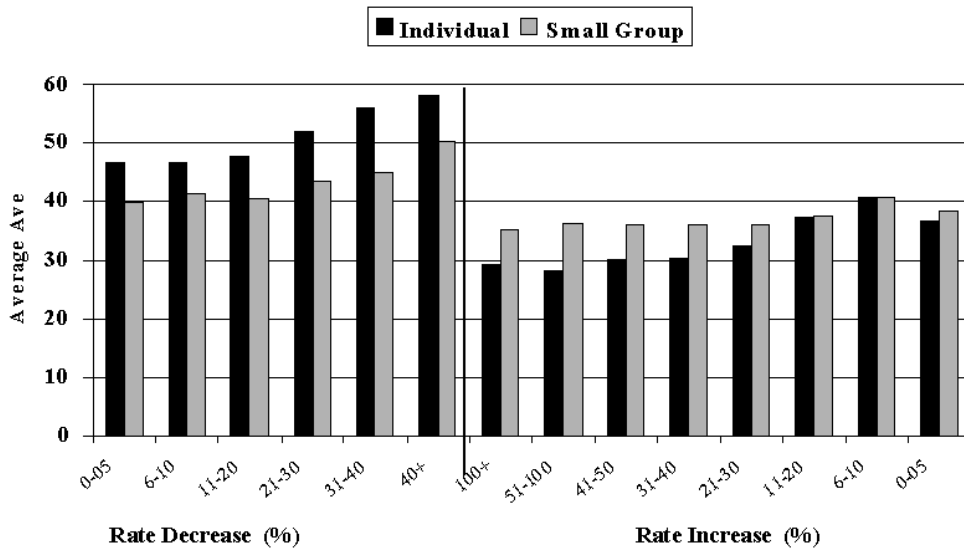
Despite the much more pronounced adverse selection in the individual market, most of the actuaries we spoke to do not think this market is out of control. Some insurers have been able to maintain acceptable loss ratios in the individual market because they have been permitted sufficient rate increases. 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 market 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.

4. Rate Shocks and Age Effects

So far, we have discussed mainly 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 Insurance Department established a toll-free number simply to handle inquiries and complaints about community rating. The fact that single males age 30 received a rate increase of 170% 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

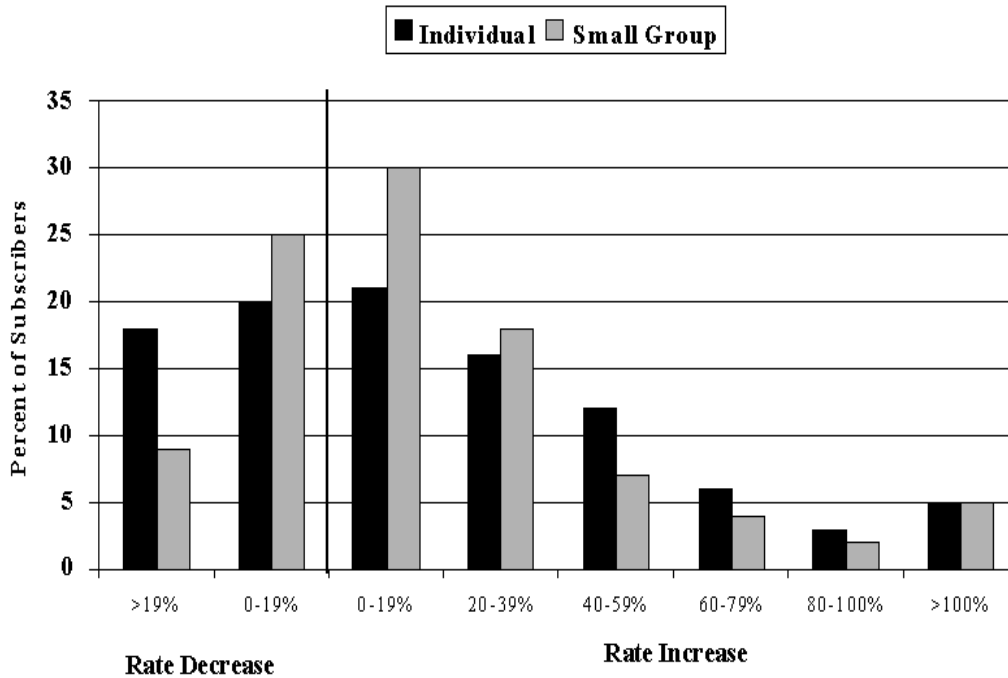
Figure 5: Age Distribution by Rate Change Following Community Rating, for Nine Commercial Insurers, 1993



Source: Health Insurance Association of America

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 didn't 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.

Figure 6: Rate Change Distribution of 10 Commercial Insurers Following Community Rating, 1993



Source: NY State Insurance Department

However, few of our subjects thought that these increases resulted in employer groups dropping coverage. Usually, after these groups came to understand the reason for the increase and learned that they could not obtain better prices elsewhere, they ended up keeping their coverage, or perhaps they opted for lower benefits or for a managed care plan. It may be possible, though, that rate increases caused some individuals within covered groups to decline coverage offered by their employer.

It is also noteworthy 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 Insurance Department.

Naturally, there were also offsetting decreases for older subscribers. Figures 5 and 6 show for groups of 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% of small group and 25% of individual subscribers received rate increases of 40% or more, while about 10% of small group and 20% of individual subscribers received rate decreases of 20% or more. About 60% of subscribers, both small group and individual, received rate increases of less than 20% or rate decreases. Figures 5 and 6 also reflect 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/month for family coverage reduced to \$500/month. Another agent explained that, because he has mainly professional clients in their 40s or 50s, he saw rates drop about 25%, which was a "real boon to our business." A third 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. 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 distribution among insurers in order to implement market-wide 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.

5. Particular Rating Practices

Before concluding our discussion of community rating issues, we need to mention some technical aspects of how rating is done and some ways in which some insurers use rating techniques to their advantage. Although Insurance Department sources say that community rating is simple and straightforward, several actuaries pointed to various techniques for loading the allowable rating factors in ways that produce higher rates for less attractive groups. For instance, two subjects said that geographic rating factors are potentially problematic. New York's rating rules allow indemnity insurers to set separate rates for areas as small as 3-digit zip codes. This allows more populous counties or urban areas to be split in different ways. If these groupings are done to reflect economic, industry, or demographic factors, then geographic areas can be split in a fashion that reflects the health characteristics of the populations. For instance, some insurers separate Manhattan from

the rest of the city and the surrounding suburbs because experience in Manhattan is worse than average. The respective rates can be set strictly according to claims experience in each location, or various actuarial assumptions can be used to project claims and defend rates in ways that are more judgmental. In the latter event, it is possible for an insurer to price more favorably in some areas than others, for instance rural versus urban, in order to attract or avoid certain types of subscribers. Naturally, the same can be done more overtly through selective marketing, as discussed above. While these practices can obviously be criticized for their risk selection purposes, they are legal and they accurately reflect the risk characteristics of different geographic locations. Also, these techniques might help encourage insurers to develop HMO networks in more rural areas where they were previously lacking.

We also heard from one agent that insurers establish different categories for family composition. Some adopt a four-tier family structure (single, spouse with no children, one child, more than one child, etc.), which makes the price relatively more attractive for smaller family units. It is possible, also, that other insurers might go in the opposite direction, if they find, for instance, that larger families tend to be healthier. Having only one family rate would make the price less attractive for single parents and childless couples. For instance, in the Long Island Association Health Alliance, the private purchasing cooperative discussed below, the one-tier family rate in 1997 for one insurer with low benefits was \$435, compared with a range of \$344 to \$505 for a three-tier family rating structure. For another insurer with high benefits, the one-tier rate in 1997 was \$530, and the three-tier rates ranged from \$419 to \$627. In our market testing study, we found in quotes from five insurers that, for four insurers, single rates were about 25% less than rates for a family of four, but for one insurer the single rate was 33% less.

A similar, but somewhat more complex, rating technique can be applied to factors based on benefit differentials. Community rates are adjusted to reflect the actuarial value of different benefit packages, but again there is room for judgment in the actuarial science that estimates these differences. One technique is to simply reflect the claims experience that results from different benefit packages, but this captures both benefit differentials as well as differences in health status of the risk pools produced by selection effects. Sicker patients naturally tend to prefer a more comprehensive set of benefits than healthier patients. Therefore, the higher claims experience for a low-deductible plan may result as much from the sicker population than from the fact that the insurance covers more. Community rating is supposed to reflect only the latter factor, not the former, but there is no settled way to disentangle these combined effects.

We asked actuaries with insurers and with the Insurance Department whether this leeway is used to engage in some degree of risk rating. A few said no, but most conceded yes, after some prodding on our part (perhaps because the issue is complex enough that it is difficult for nonactuaries to grasp or articulate). One actuary explained that the amount of leeway is limited by outer constraints of plausibility. Thus, different actuaries might have steeper or gentler rate slopes due to the deductible size, but they could not price a \$100 deductible plan more than \$400 over a \$500 deductible plan. Another actuary, however, admitted that rating anomalies do occur, such as a point-of-service HMO plan costing more than a PPO indemnity plan, whereas the pure benefits effect should be the opposite. This actuary explained that this results from the way in which the Insurance Department reviews rates, since it starts from claims experience for each product and requires justification for any departure from actual experience. If insurers submit their experience separately for each product rather than pooling across products, this tends to result in rates reflecting the characteristics of the risk pool that are attracted to each product.

When we inquired of regulators about these issues, we observed an awkward ambivalence that suggests a mixed approach is followed. Insurers apparently are not allowed to maintain completely separate community rates for their different products such as HMO versus POS, but neither are rates based solely on

risk-neutral benefit differentials. Instead, rates are allowed to reflect the respective risk pools to some extent, in an undefined and discretionary manner.⁷

C. Market Competition

1. Small Group Market Competitors

As above, in evaluating the competitiveness of the New York health insurance market, we will distinguish between the individual and the small group markets. The market for small employers has been a highly competitive one over the past several years. This can be seen in several ways. Looking first at structural features, although the total number of carriers registered to sell small group insurance declined following enactment of the reform law, a large number of insurers are still in the market. When the law was first enacted, several prominent insurers withdrew or announced plans to do so, but not all did. And most of those who left had relatively small market shares since they were selling health insurance primarily as an accommodation for other lines, such as life or disability. Following reform, the number of competitors has remained steady or increased, in both segments of the market. From 1994 to 1996, the small group market had an average increase of two HMOs and two indemnity insurers in each of the five selected regions displayed in Table 6, and each of these five regions has 2-3 dozen insurers.

We spoke with a number of the more prominent insurers who either withdrew, stayed in, or changed their minds about the small group market to determine the reasons for their decisions. One insurer who specializes in small group insurance at first said it would withdraw but then decided to remain, for a variety of reasons. First, it is headquartered in New York and has a significant block of business, so it would "take an act of God" for the carrier to leave the market. Second, it received certain concessions and clarifications about the impact of the law on 1-2 life groups, which allowed the company to keep its existing subscribers without writing new business for this group size. The only change in the legal environment this insurer could easily imagine that might change its mind would be an "all-markets" law which requires all group insurers to sell in the individual market.

A small group insurer that did withdraw from New York attributed this decision in part to the law, but also to its lack of a good agent network and the fact that its existing block of business was seen as having problems. Also, this is an indemnity company that was consolidating and withdrawing from small group markets in other parts of the country in response to increased competition from managed care. Another insurer, one with both indemnity and HMO products, said it stayed in New York but withdrew from Vermont and Kentucky, which have similar laws, because the market potential in New York is so much greater and constitutes such a large portion of its existing business.

Some insurers who remain in the market do so only marginally, in order to keep the business of renewing subscribers. But these companies do not offer rates that are attractive for new subscribers, since rating rules do not permit insurers to set lower rates for new versus renewing business. If an insurer cannot offer a competitive community rate, then it faces the choice of either canceling all its small group business and leaving the state entirely, or keeping its renewing subscribers and setting rates high enough to anticipate the

⁷ 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 their deductibles each year.)

adverse selection that inevitably affects a block of business that is not attracting new subscribers (for reasons described more below). The consequence is that a number of insurers that are technically in the market do not effectively contribute to its price competitiveness or diversity in product offerings. Also, there has been some consolidation among small group insurers due to mergers. One agent expressed concern that there are only 5-6 small group insurers offering competitive products in New York City. Nevertheless, there is a sufficient number of insurers active in the small group market so that everyone we spoke to considered it to be competitive and dynamic. As summarized by one agent:

In the beginning, insurance companies had a knee-jerk reaction and many companies, as you know, pulled out of the market and raised prices and the whole bit. Again, competition comes back and people begin to find ways to work within the laws and eventually offer products.

An article in a business journal recounted one year after reform:

As for the fear that New Yorkers would be trampled by insurance carriers running for the state line, the stampede isn't even a minor traffic jam. "The massive exit from the market didn't happen," reports [an Insurance Department researcher]. . . . "All the major players are still here."

2. Individual Market Competitors and the Demise of Indemnity Coverage

We find a different story in the individual market, but it shares certain important elements. Unlike the small group market, the exodus of indemnity insurers from the individual market was dramatic. Before the law, there were over a dozen commercial indemnity insurers selling individual coverage, but 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 others remained, but they had very small market shares or they sold only specialized products or only through trade associations.) 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 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.

Representatives from Mutual of Omaha said that it remained in the market because it had a very large block of business and a very effective and well-trained network of over 700 agents and brokers, who were also selling a good bit of non-health products. Critical to its decision to remain in the market, however, was the fact that New York, unlike New Jersey and some other states, permitted Mutual to continue selling its own benefit package, rather than mandating a standard package. This was critical because it allowed Mutual to design its products to avoid attracting the highest-risk subscribers. Its products are notable for the large size of the lowest deductibles, beginning at first with \$1,000, and then moving to \$2,500 and higher. Essentially, it was selling 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 in leaner benefits is a notable feature of how the individual market has developed in New York. It is driven not so much by the desire to contain systemic health care cost trends, although that is certainly part of the story, 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.

Even with reduced benefits, however, most indemnity insurers were not able to remain in the individual market. Unlike the small group market, where the number of competitors stabilized or increased following the initial exodus, in the individual market insurers continued to withdraw in the initial years under reform. A few HMOs entered the individual market following reform, but the number of indemnity insurers decreased an average of one per region from 1994 to 1996, starting from only an average of three. The most important example is Empire Blue Cross, which in 1995 announced its intention to withdraw entirely from the individual market. Empire's indemnity coverage was costing about \$5,500 a year for single coverage by the end of 1995, even with a \$1,000 deductible. Despite 25-30% rate increases several years in a row, the Empire product was losing large sums of money. The prospect of leaving the chronically-ill population with no comprehensive coverage and choice of physician prompted the legislature to enact the requirement that all HMOs offer two standardized benefits packages in the individual market, one that is a pure 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. (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. They observe the following. First, comprehensive coverage with choice of physician is still available through point-of-service coverage, and there is more choice in that many more HMOs are now offering individual coverage, as reflected in Table 5. 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. 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 a lower-risk population are no longer available except through the group market.

3. Managed Care in the Small Group Market

This dynamic has not occurred to the same extent in the small group market. There, most subjects said that indemnity products are still available and are viable and they have not risen to catastrophic-level deductibles. Catastrophic coverage is available, but so are deductibles in the \$250-500 range. However, indemnity products remain viable only in the more managed care forms such as PPOs. Both agents and insurers we spoke to now feel that the price of traditional, unconstrained indemnity has increased at such a rate that it has effectively been priced out of the small group market. Rates for traditional indemnity are increasing about 25% a year, compared with 10-15% a year for PPO coverage and 4-9% a year for HMOs. (These are

approximations given by various interview subjects.) Virtually no new traditional indemnity coverage is being sold. New subscribers are buying either PPO or HMO coverage.

Again, it is debatable whether the demise of traditional indemnity is due to the reform law. In other states without community rating, unconstrained indemnity prices have also increased sharply in recent years, but not always to the same extent as in New York. In some other states we have studied (but not all), traditional indemnity remains a viable, although increasingly expensive, product in the small group market. Interview subjects in both New York and in other states attributed these trends to both the lack of cost controls in traditional indemnity, and to the adverse selection that results when healthier subscribers leave their existing coverage.

In addition to the shift from traditional indemnity to PPOs, the small group market has experienced a dramatic increase in new HMOs and in HMO enrollment following reform, from 20% to 68% of the market between 1993 and 1998 (Table 2). (These data reflect the licensure status of the insurer and not necessarily the structure of the plan sold. Nevertheless, the overall trends are clear.) This trend was confirmed by our market testing study of 23 agents. Although most agents (76%) offered both HMO and indemnity coverage, of the 11 agents (48%) that recommended one plan over another, 10 (91%) recommended an HMO plan, and of the five agents who provided actual price quotes, only one (20%) quoted indemnity coverage.

Opinions differ on whether the reform law is responsible for the rapid movement to HMOs. Most interview subjects opined that it is not, since this movement appears to be happening nationwide and independent of these laws. The small group market may be simply the next logical place for HMOs to look for sales growth after the large group market became saturated. Also, New York for a time had unique regulatory treatment of HMOs with respect to negotiating hospital discounts. New York maintained all-pay or rate regulation through 1995, which required indemnity insurers to pay regulated hospital rates but which allowed only HMOs to negotiate discounts, giving them a competitive advantage.

On the other hand, the movement to managed care in the small group market largely coincides with the insurance reform law, and this coincidence has happened in most other states. There are several possible theories about why the law might have helped to precipitate the move to managed care. First, since HMOs customarily offer open enrollment and community rating, the reform law helped to level the playing field by requiring other insurers to do business on the same terms. Second, since the law caused a rate shock effect for many existing subscribers, it may have provoked indemnity subscribers to look around for alternatives more aggressively than if prices had continued to climb at a more gradual pace. These speculations were confirmed by a few interview subjects. According to one agent:

You could have almost foretold the eventual movement toward the HMOs and PPOs because there was no other way to go. In that respect perhaps [the disruptive effects of the law were] good. It financially forced everyone to go toward managed care where everyone was basically trying to fight managed care.

4. Non-price Competition

We next look at the nature and focus of competition following reform. As noted above, New York's insurance markets are strongly price competitive. Here, we examine what non-price factors are important competitive variables. Traditionally, health insurers have competed primarily based on their ability to select and accurately price risks, and by tailoring their benefit packages to consumer preferences. These laws are meant to greatly reduce the amount of risk selection and to focus competitive energies on managing the cost

and quality of care. We evaluated their success in this regard also.

As noted above, managed care plans, both PPOs and HMOs, have rapidly increased their market share in New York. This has focused competitive pressures on both price and on the structure of the insurance plan. As a result, insurers are competing much more on the basis of their ability to control the underlying costs of treatment rather than on the basis of their ability to select risk. We also heard the following intriguing explanation from an agent who sells individual insurance. Under guaranteed issue, price is not as much a factor as quality, because if you are sick, you will buy at almost any price; what you are most concerned about is quality. And so guaranteed issue has focused more attention on an insurer's reputation for quality.

What is noticeably absent are forms of competition based on outcome measures of quality. Naturally, this is relevant only to HMOs since indemnity insurers are not in a position to monitor or influence the quality of care, and one of the selling points of indemnity coverage is that subscribers are free to make their own decisions about which are the best providers. However, given the penetration of HMOs, one might expect at least some competitive focus on quality of care measures. To the contrary, in the vocabulary of most agents, "quality" refers to the richness of the benefits, the size of the provider network, and to how promptly and hassle-free claims are paid, not to the quality of care delivered. We reviewed the sales literature from leading insurers, including HMOs, that is targeted to the small group market and found no reference to outcomes measures of quality such as the HEDIS measures developed by the National Committee for Quality Assurance (NCQA). There were a number of generic references to the quality of providers in the network or to the insurer's accreditation status, and occasional references to patient satisfaction ratings, but these were not typical and were not the dominant focus. The focus of the sales literature is on the particulars of the benefit packages, and for HMOs on the composition of the network. Much of insurers' strategic market positioning appears focused on differences in benefit packages. Most sales brochures offer a dizzying array of ways to mix and match various components of coverage such as deductibles, co-payment levels, maximum payouts, and various riders for prescription drug benefits or mental health coverage. One agent said that HMOs promote their NCQA accreditation status, but that is not equivalent to detailed outcomes measures and even simple accreditation matters only to more sophisticated employers, most of which are larger groups. One other agent who works mainly with larger groups, however, said that she presents both accreditation and outcomes measures to small employers as well.

Much the same is true within the Long Island Association Health Alliance (LIAHA), the private purchasing cooperative that is supposed to embody a much more pure form of managed competition that focuses competition entirely on price and outcome-based quality, with most benefit differences neutralized. LIAHA is only now beginning to look at the possibility of using simple patient satisfaction measures, not the more complex outcome measures being developed by HEDIS. Their stress is on employee-level choice of plan, not based on quality measures, but based on which physicians are in which networks. The LIAHA provides detailed provider directories that index not only providers for each plan, but also which plans cover each provider.

Agents provide some insights into why outcomes-based quality competition has not taken hold in the small group market. One is that, with employers making the decision, cost is still the critical issue:

Q: Academic theorists would like to see the competitive focus on pure outcomes measures and patient satisfaction and stuff like that. You know, "We're not only cheaper but we're better in terms of quality of care, or we may be a little bit more expensive but it's worth it because if you come here you'll end up living longer and feeling better." Do you see that kind of focus emerging in the small group market?

A: *I think that's what they'll say. . . . In theory that's wonderful. I don't think it's going to be reality though. Carriers, in my opinion, are really looking at the bottom line. How much does it cost to give . . . quality care. Quality care is defined by them as how inexpensively can we do it for them. . . . Another thing that people look at is, when they get onto a plan, I think the first thing that most people do is check to see if their doctor is on the plan. Otherwise they kind of hem and haw a little bit. And in group plans it's the old adage, he who has the gold, makes the rules. The first thing that the decision maker is going to do is see if his or her doctor is on the plan and if not they might look at somebody else.*

Another barrier to aggressive quality competition is the desire to keep a low profile with respect to higher-risk subscribers in a guaranteed-issue environment:

I think the [insurance] companies are in a quandary. Here they are, they are forced to offer health insurance. If their service is great and their name reputation and all that is wonderful, everyone who is ill is going to go to them.

Finally, it is worth noting the point that was raised in some other states, but not here, namely, that portability undermines to some extent an insurer's incentive to invest in preventative measures to reduce health problems in the future, since, on average, most subscribers remain with a plan less than three years. Therefore, insurers' health status horizon tends to be very short term. Also, the fact that provider networks tend to be large, nonexclusive, and overlapping means that it is difficult for quality measures to not provide credible differentiation among networks.

5. Risk Selection and Benefit Packages

For these reasons, the New York small group market, similar to others we have studied, is far from the model envisioned by some reformers. Even though insurers do not use risk selection nearly to the same extent as before, risk selection was acknowledged by many of our interview subjects to still remain as an important factor determining insurers' profitability. Risk differentials still exist among insurers for a variety of possible reasons. First, insurers entered the reformed market with lower- or higher-risk subscriber pools and these historical patterns may have persisted. Second, insurers have available a number of covert risk selection techniques described above which may result in their systematically attracting better risks. Some of these techniques are perfectly legitimate, such as crafting benefit packages to appeal to healthier subscribers; others are not legitimate or are of questionable legality, such as encouraging field underwriting. Third, risk differentials may exist by virtue of subscribers' natural preferences, such as the tendency of sicker people to prefer more comprehensive coverage with greater choice of providers, or the reluctance of sicker subscribers to switch insurers. This is illustrated by the following account from an agent with respect to a large group:

We just wrote a case not too long ago that's about 60 or 70 lives in it and the [insurance] company representative was with us at the enrollment meeting and we stumbled upon this person who had a spouse that has \$2,000 a month in prescription drug bills. Well, the [insurance] company representative almost went ballistic, . . . because here, he's picking up this group and he's buying a \$2,000 a month claim. He didn't like that. So he told me to put this person in an HMO. And I said, "What am I supposed to do? Get a gun and tell this person, 'You have to go in an HMO. You can't go in this plan?'" So I presented both plans to the individual as we did to all the people there. We explained to them the HMO and how it worked and this person happened to like the HMO better because there was a \$5 copay for the prescription drug. Whereas with the indemnity plan . . . there was no drug card. So she would have had to lay \$2,000 out and she didn't have a credit card. She had no choice. Where would she get \$2,000? So she went in the HMO.

Indemnity insurers said they have had the same experience of adverse selection against their products. One indemnity insurer recounted a small group that purchased HMO coverage for all of its employees except for one who selected their product and then submitted a \$400,000 claim for an organ transplant. This insurer felt

its products had an unfortunate reputation for offering "gourmet" coverage and that its products are being promoted among certain disease or patient advocacy groups because of their more generous coverage of specialized and expensive problems.

As a consequence of these various factors, rate differences may still reflect risk segmentation to a considerable extent rather than underlying efficiency in the type of insurance or the delivery of medical care. There is no rigorous way to disentangle all these possibilities, but it is possible to glimpse at least some of them. One way to resolve the competing views on these issues is to observe the extent to which risk pools actually do vary across the industry. One measure of this is the size of the transfer payments that are made through the risk adjustment mechanism, a topic which we discuss more below.

Another indication of risk segmentation can be seen in the individual market. Despite the move to standardized products and the elimination of indemnity, biased selection patterns remain in the choice between HMO and POS coverage, with higher risks favoring the latter. The impact is revealed 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% higher than under HMO coverage, although rates are only 30-40% higher.

The potential for risk segmentation might be even greater in the small group market because of the absence of standardized benefits. Artful crafting of benefits can be both pro-competitive and anti-competitive. Innovative coverage arrangements that respond to consumer demands are pro-competitive. But altering benefit packages can also undermine price competitiveness by making it more difficult to make price-for-value comparisons among insurers. Also, changes in benefit structures can have the effect, whether intentional or not, of producing biased selection among risk pools. To evaluate this mixture of considerations, we inquired whether, following reform, benefit packages are becoming more or less similar among insurers in the small group market. (They are now standardized in the individual market.)

Several agents commented that benefit plans are largely the same. "I think the risk has been pretty much spread around. Since every company is offering similar products, similar rates, there is no reason to gang up on one company." Other agents, however, spoke of "little gimmicks that [insurers] can put in the contract." One agent said that, although benefit differences are narrow, insurers and purchasers still focus much attention on them:

One of the main ways to be successful in marketing health insurance used to be identifying the client's particular interest in a small area [of benefits] and finding the carrier that covered it. And that's how we used to market. . . . I don't think that's really changed [since the reform law].

In other states, we also heard about insurers offering health club membership as a way to attract health-conscious subscribers, and we saw some evidence of this in the brochure from one New York insurer. Another possible example of this tactic is the highly visible decision by Oxford Health Plan to offer coverage for alternative or holistic therapies. We are quick to acknowledge, though, that both these examples are subject to different interpretations, some completely benign. One agent, for instance, attributed Oxford's decision to a savvy marketing strategy to appeal to diverse ethnic groups:

I think Oxford has been very intelligent. As of late . . . they have gone to alternative medicines. So they are starting to say we are willing to cover and promote coverage by chiropractors or acupuncturists who are properly licensed and so forth. It's an incredibly smart move, I think especially given the multiplicity of ethnic makeup of the New York area. . . . So that kind of diversity is very crucial to their marketing plan, and by Oxford going to alternative medicines, it's recognizing that there are other forms of medicine in other parts of the world that are very common and popular and they want to be including those in their

realm.

Another insurer explained that it was changing benefits not so much as an offensive strategy to attract better risks, but as a defensive strategy to avoid being selected against because of its generous coverage. It was in the process of identifying high-cost prescription drugs that it covered more generously than other insurers in order to determine whether they were attracting subscribers with specialize health problems.

6. Purchasing Cooperatives

A final insight into market competition comes from the purchasing cooperative already mentioned several times, the Long Island Association Health Alliance (LIAHA). This is the only purchasing cooperative active in New York state, although there are a number of private trade association groups that offer insurance as well. We distinguish the two types of entities because private associations are not open to all businesses, and they typically offer only a single plan. We discuss them below under compliance and circumvention concerns. Here, the focus is on the purchasing cooperative concept described in the introduction to this report, which is meant to enhance competition and choice by offering a selection of plans with comparable coverage through a structured and centralized marketing vehicle that provides superior information, reduced administrative costs, increased choice for individual employees, and intensified price competition.

LIAHA is the only example of this model in New York State, so we inquired why it has not been replicated elsewhere, and what accounts for its success. LIAHA was formed by the Long Island Association, a very large trade association similar to a chamber of commerce, although LIAHA operates independently from the association. It began operations in 1995, and as of mid-1997 had about 11,000 covered lives in 1,600 groups, with an average of 3-4 employees each. Its start-up capital came partly from the association, but to a large extent from participating insurers, each of which contributed \$150,000 to overhead expenses. The alliance is now operationally at break-even, meaning its expenses are covered by the fees from subscribers. The initial three insurers had grown to five by 1997, all HMOs. There is no upper limit on the number of insurers that can participate. Each insurer makes independent pricing decisions without any negotiation or bidding with the alliance, responding simply to competitive pressures and according to the rates permitted by the Insurance Department.

As discussed more below, separate purchasing groups present the difficulty under a pure community rate law of determining how their rates should be set. If insurers are required to charge exactly the same rates as in the outside market, then these groups are not allowed to pass on any price advantage due to administrative savings or bargaining strength. However, if insurers are free to depart at will from their community rates, these groups could become mechanisms for segmenting risks within the community-rated market. The compromise adopted by the Insurance Department is to allow insurers in the alliance to give rate discounts based solely on administrative cost savings due to the role the alliance plays in facilitating marketing, enrollment, billing and collection, but the Insurance Department does not allow lower rates based on increased bargaining power. These savings amount to about 3-5% of premiums, but are offset to some degree by the fees that purchasers are required to pay the alliance (\$60 per group per year). The Insurance Department also requires the alliance to guard against risk segmentation by requiring the membership be open to any legitimate small business in the service area so that membership criteria do not serve as covert underwriting criteria. The alliance administrator views the reform law as helpful to the endeavor by requiring guaranteed issue and community rating in the outside market as well, but the law did not precipitate the alliance. He believes that the alliance does not benefit, nor is it hurt, by risk selection; rather, he believes the risk pool is equivalent to the market.

As previously noted, enrollment through the alliance is modest, but has grown rapidly. Unlike similar arrangements in other states, this one has survived and has become self-sustaining. Its prices are highly competitive, and it offers choice among plans to individual employees. The alliance administrator attributed its success to the following factors (in no particular order). First, its sponsorship is free from conflicts of interest or other handicapping factors. Unlike *public* purchasing cooperatives which have to fight anti-government suspicion, the sponsorship is wholly private. Also, unlike some other *private* purchasing groups we have seen, the sponsorship of this one appears free from ulterior motives. In other situations, purchasing groups have been established by trade associations as a way to generate membership fees for the association, or by general agents as a way to generate commission overrides. Here, the alliance is run by a separate nonprofit organization and no fees go back to the parent. It was a surprise to us and quite unique that employers may purchase through the alliance without joining the parent association; in fact, only about 15% of purchasers are association members.

Another critical factor is that Long Island is an ideal market because it has a very heavy concentration of small businesses. Ninety percent of the population employed locally works for an employer with fewer than 10 employees. Because insurers viewed it as a good opportunity to gain market share, they were willing to pay \$150,000 toward start-up capital, which was crucial to get the system operational.

A final factor is the role of agents. Initially, the alliance attempted to operate without agents in order to save on commission costs, but it quickly changed, not because of any hostility or obstruction from agents themselves, but simply because the alliance found that its marketing efforts were not effective in reaching small employers. Most of its marketing now is directed to independent agents, not employers, because it has found that this is much more effective in producing leads and agents are more effective in closing sales once employers inquire. Agents receive a 4% commission, which is the legal limit allowed for HMOs throughout the state.

D. Administrability

1. General Compliance and Insurance Department Enforcement

Finally, we address a series of concerns about the administrability of these laws. The Insurance Department has been moderately proactive in administering these laws. In the first year or so under reform, the Insurance Department investigated and fined a few insurers for failing to comply. In 1996, the department conducted a field investigation to determine the degree of compliance with the new requirement that all HMOs sell guaranteed-issue individual coverage, and found some degree of noncompliance. The department also issues public information booklets and has maintained toll-free phone lines to respond to public questions and complaints. The department has a reputation for being tough in its review of requests for rate increases. In addition, the department collects and tabulates extensive information about rates and limited statistics about enrollment. And one insurer mentioned that the department responded to its complaints when the insurer found that some of its competitors were not following the rating rules.

In other respects, however, we heard some criticisms of the department's enforcement activities. The department does not regularly investigate compliance with the reform laws. Some field investigation occurs, as just noted, but for the most part, the department simply reviews the materials that insurers submit, and it relies on complaints before initiating an investigation. One insurer recounted having to do what it considered to be the department's own work of scrutinizing rate filings to learn that some insurers were still using prohibited industry and group size factors in their rates. We also heard from one source that the department is sometimes not responsive when it receives complaints. On the other hand, we heard from one source at Empire Blue

Cross that the department is too demanding in its review of its rates and that a "climate of hostility" has existed in the past between Empire and the department. Some at Empire believe that the "rank and file" in the department view it as the "evil Empire."

On balance, it appears to us that the Insurance Department is diligent and effective in enforcement, although not aggressively proactive with respect to this set of laws. Owing to the many competing demands on its resources, its enforcement is largely reactive, by reviewing filings and responding to complaints, rather than through department-initiated inspections or investigations. Consumers generally are not aware of the nuances of the law and therefore may not know on their own to complain if the guaranteed-issue or community-rating provisions are misapplied. This knowledge usually comes from agents, who are more inclined to take these issues up directly with the insurers rather than notify the Insurance Department.

This appears to be a satisfactory approach since the impression of all of our subjects is that noncompliance is not widespread or large scale. The only overt instances we heard about occurred early after the enactment of the original law or the 1996 amendments. Some of that can be attributed to initial misunderstanding over the law's requirements, but some may be due to insurers that were brazenly refusing to comply until enforcement actions were brought. The department's early enforcement actions appear, however, to have brought the entire industry in line. It also appears that systemic incentives and relationships work well to keep compliance in line for the most part. Agents are well motivated to enforce the law's basic requirements since doing so assists their clients. If agents complain to insurers about apparent noncompliance, insurers are usually responsive since they want to stay in the good favor of their agents. Similarly, most insurers are motivated to make sure they are in compliance in order to stay in the good graces of the department, which affects their business life in so many different ways. Most of the insurers we spoke with have well-staffed regulatory compliance positions to track legal developments and carry out corporate compliance.

We also found little indication that the law's implementation is being hampered or undermined by lack of knowledge. Almost all interview subjects were very knowledgeable about the law's requirements. Agents for the most part gain this knowledge directly from insurers, who send frequent operational instructions and updates with respect to their products and procedures.

2. Border Problems and Fraud

We also inquired into particular enforcement issues that might be especially troubling. One of those relates to field underwriting, which is discussed above. Other areas include list billing, self-insurance, and fictitious associations. These all concern what we refer to as "border-crossing" problems. The potential for these problems arises when one segment of the market is regulated differently than another. This creates possible strategic advantages for low- or high-risk groups or individuals to cross into or out of each market segment, thereby unraveling or eroding the market divisions that are necessary to sustain this regulatory structure. This potential at the small-size end of the market is somewhat less in New York than in other states because the basic reform requirements apply equally to individual and small groups. However, the fact that prices are significantly higher in the individual than the small group market, and are somewhat higher in the small group than the large group market, creates the potential for border crossing. We will discuss a variety of specific examples.

List billing. This refers to an insurer who excludes certain members from group coverage or sells individual coverage to members within an employer group, either with or without the employer contributing to the cost. This practice was common prior to the reform law for a variety of reasons. One use of list billing was for employers to purchase insurance for only selected employees by reimbursing them for the cost of individual

coverage. This might be done in order to offer insurance only to "key employees" such as managers. Other forms of list billing were done as an accommodation to employees whose employers were not willing to buy insurance for anyone, but who wanted to facilitate their employees' purchase of insurance through payroll deduction.

The reform law prohibits list billing, following the philosophy that all employees should receive equal treatment. We found little evidence of list billing. In the marketing testing study, of the 23 agents contacted, only one suggested or recommended arrangements under which the unhealthy member of a three-person group would not be covered by the group. One agent quoted above, however, told about an indemnity insurer that successfully encouraged an employee with a sick spouse to elect coverage from an HMO.

Associations. Another border policing issue that arises under insurance market reforms is the potential for good risks to leave the individual market by buying what appears to be a group product, through various arrangements too complex to describe thoroughly, but which can be loosely called private associations. Private associations might also be used by small groups to purchase insurance as if they were large groups, at rates lower than the small group community rate. 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 if they have a large and diverse membership. 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 they are a fairly prominent way to purchase individual insurance at rates equivalent to those available to small employers. One agent, who specializes in this kind of coverage, provided the following explanation:

A: *I do all those associations. I do New York State Trial Lawyers, New York Artists Equity, the Sculptor Society, the Models Guild. . . . So if you're a member of any of those groups, you are able to get about 30% less on your health insurance, which is quite a bit of a discount. That's how we have been able to stay in the business. Administering those groups and putting people in those groups.*

Q: Now how do those get to be 30% less?

A: *Because the insurers view it as a group, as an association discount. We negotiated that, obviously. It's a lot of work, a lot of relationships and pulling punches.*

Q: I thought the law requires that you community rate those.

A: *They treat it as a group, and a group community rate is different than an individual community rate. Just like Oxford today offers the individual contract point-of-service at \$316 a month with \$1,000 deductible, where it offers it at \$250 a month with a \$250 deductible to a group of three or more. It's still community rated but it's a group rate instead of an individual community rate. . . .*

Q: Do they get a full-fledged insurance contract or do they get a certificate under a master policy?

A: *They get a certificate of the master policy.*

Q: Is it dealt with as if it were employer-based insurance or do [subscribers themselves] just pay [the premiums] after taxes?

A: *No, it's out of their income. So it's totally taxable. . . .*

Q: Now do the artists have different rates than the lawyers, etc.?

A: No.

Q: There's one rate that covers all associations? For each carrier?

A: Yes.

It also appears that these private associations occupy the uncertain space in the market that separates the small group and the individual market, namely, micro-size groups of one or two. As discussed above, when these groups opt for employer-provided coverage, insurers do not have to sell to them as part of their guaranteed-issue and community-rated small group block, and most insurers are not willing to do so. It appears that private associations may be a vehicle that allows some insurers to offer small-group-type coverage while maintaining a separate rate for this block, although we are not certain about the precise regulatory treatment. Here is the explanation another agent gave:

A: *[Most insurers have] gone away from one-life groups altogether. The only way I manage to offer it . . . [is] through a federation of small businesses, and there are several of them, . . . maybe about a half a dozen of them that I know of that exist in New York and they negotiate directly with the carrier. However, . . . quite honestly, if they walk into [the insurer] directly they'll get a lower premium than if they buy it through the federation. What happens is we just try to market all the other benefits and throw them into a federation that has a little bit of bargaining power. Now if you think of those as a buying cooperative, which you mentioned earlier, they behave in a similar fashion and I don't know that they necessarily negotiate a lower premium. . . . You have to be in a legitimate type of business [but not any particular business]. Much like, for example, there is one called the National Association of Self-Employed. . . .*

Q: [If it's not cheaper,] why would they go through the association?

A: *Why? Service, service, service. Our service is second to none. We do the New York state continuation of coverage for them. If they're over 20 [employees], we do their COBRA for them. We help with the portability, make sure that they can get their certificates now that that's law [under HIPAA]. We take care of any claim problems they may have. So we give service for our money.*

Q: So how much more would they pay generally to go through your association?

A: *About 7% or 8%.*

Views can differ over whether this arrangement is good public policy. First, it appears to us to be permissible under the New York law. We heard no examples of associations that were set up purely to sell insurance, as we did in some other states. Unlike other states, then, this exception does not appear to be proliferating. 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 purchasers might not be able to afford any coverage.

Self-insurance. Yet another border-crossing concern is the threat that this law would induce medium-sized groups, those in the 25-50 range, to self-insure. This might occur if a group of good health risk felt it could save money by avoiding community rating. It is primarily for this reason that rating rules are not extended to groups any larger than 50. True self-insurance is not considered economically viable for a group this small, but it has been encouraged elsewhere in the country by insurers or brokers who craft stop-loss coverage with very low attachment points that effectively functions like catastrophic indemnity coverage rather than true reinsurance. We found no indication, however, that this was occurring in New York for groups under 50. New

York takes a tougher stance on this than do other states. The position in some other states is to allow stop-loss with low attachment points but to regulate it as being small group insurance. New York prohibits the sale of stop-loss altogether to groups under 50. Whether this is consistent with ERISA has apparently not been tested yet in the courts.

Employer Fraud. Other potential circumvention techniques are not as structurally sophisticated, and they are perpetrated primarily by employers, not insurers. An employer with a sick family member or friend might falsely claim the person as an employee in order to take advantage of group rates. Several subjects observed that, if circumvention and fraud is occurring in this market, it is probably of this nature, initiated by employers, rather than the forms initiated by insurers. One underwriter at a large insurer explained that, now that medical underwriting has disappeared as the result of guaranteed issue and community rating, an underwriter's main function is to determine eligibility. Previously, this was taken for granted based on documentation submitted by employers, but once this insurer started looking more closely, it found eligibility problems to exist in almost 50% of the cases selected for audit. One source at Blue Cross said that, at one time, it "had a tremendous amount of families with neighbors and relatives that weren't on the payroll."

We observed other indications, however, that agents and insurers are sensitive to this potential fraud and take steps to prevent it by being firm with their clients and by requesting payroll and tax documentation. One agent explained:

People naively will call us up and say "My mother-in-law just got laid off or just retired from this dress shop she worked at three days a week and they had a health benefit plan for her. Now she's retired and they can't keep it anymore. I'd like to put her on my plan." Well, I have to explain to them that that's illegal. That's when it hurts.

Another agent told us:

When we write a three-life case, you can tell [when there is fraud]. You know, we've been doing this a few weeks. You can tell when you're talking to somebody if they're playing games. We had a situation maybe two years ago now. And the people came to us because they were caught by the carrier. They were caught because they had people in Florida in their plan. They had people from Manhattan in their plan. They had people here who didn't work for them in their plan. I mean, you know, that's dishonest. And they wanted us to help them fix it. Well, we wouldn't have anything to do with it. Because people like that are criminals. And what's going to happen is they're going to get caught and I don't want to be caught with them.

And a third observed, "Actually I think that the majority of people happen to be honest. I know that's strange coming from somebody from New York. I really don't find that happening much." One reason is that, with guaranteed issue available in the individual market, there is less of a need to pretend that a sick person is a member of a group in order to obtain coverage, since coverage is always available individually, although at a significantly higher price.

3. Risk Adjustment

A final feature of the law that cuts across several of our categories of discussion is risk adjustment. Implementing regulations create 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 to counteract the incentive to engage in covert selection by eliminating the financial reward for favorable selection and protecting those who are selected against. Also, adjusting for differences in risk pools means that rates should be more comparable and that differences in rates should better reflect 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. 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-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. Each pool will be assessed separately and some overall evaluations will be offered.

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 pay 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 adjustments capture 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% of annual individual and small group premiums were transferred through the demographic pool. If the pool were to work 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 did not. The rate differentials that existed in 1994 and 1995 cannot be attributed solely to Blue Cross' 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. 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. 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 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 were set so high that patients sometimes died before the claim could be submitted. Also, the documentation establish that the clinical threshold was met required submitted results from tests that are no longer currently done, but 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% 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 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 an Insurance Department task force. This phase-out and revamping resulted in a decision in 1998 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 they had been undercompensated). As noted above, this pay out was used to justify denying Oxford 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 perspective, 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. 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.⁸

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, and then allow insurers to cede prospectively to a voluntary reinsurance pool the particular groups or individuals whose risk greatly exceeds the allowable rates 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 nit-pick about imperfections in the system.

⁸ 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."