Community Rating: New York's Empire Blues

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Introduction

Health care and health insurance have caused the nation to enter a deep crisis.1 “[T]he United States spends approximately fourteen percent of its gross domestic product on health care.”2 This figure amounts to over $2 billion per day, or $23,000 per second.3 The country’s exorbitant doctor bill, however, is still

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1. See Angelo A. Stio III, Note, State Government: The Laboratory for National Health Care Reform, 19 Seton Hall Legis. J. 322, 324 (1994); see id. n.8 (citing The President’s Health Security Report to the American People; Chapter 2, Principles of Reform, Oct. 27, 1993, available in 1993 WL 7132185 (stating that “[t]he things that are wrong with the current system are threatening everything that is right with American health care.”)).

2. Id. at 325 (stating that “economists projecting that the number may rise to nineteen percent by the year 2000.”); see also Mark A. Rothstein, Health Care: Public and Private Systems in the Americas, 17 Comp. Lab. L.J. 612, 615 (1996) (comparing the U.S., which spends 14% of its GDP on health care, to Canada (9.9%), Chile (6.0%) and Uruguay (8.04%)).

failing to provide health care for over forty million people in the United States. Additionally, there are fifty-six million Americans that lack an insurance package that can adequately cover their needs and an estimated two million Americans who lose their health insurance coverage each month.

Health care reform has, of late, been one of the top priorities for the federal government. However, Congress is not currently working on a health care bill that would effect sweeping reforms. Instead, its focus has been on issues such as private insurance, pre-existing conditions and portability. State governments are now taking on the struggle over affordable health care. "[T]wenty percent of an average state's budget [is] being spent on medical insurance and Medicaid expenditures, and [it is being projected] that these figures will reach an annual growth rate of twenty-one percent per year . . . ." States throughout the country are initiating health care strategies, such as community rating, that attempt to cut costs and provide coverage for all of their citizens.

soar in the near future as they did in the 1980s and 1990s. See Pear, supra.

4. See Stio, supra note 1, at 325.

5. See id. at 325-26; see also Knox, supra note 3 (explaining that even with the 1996 decrease in health spending, the number of uninsured continues to expand steadily). People continue to decide that they cannot afford individual health insurance or the insurance offered by their employer. See generally Knox, supra note 3 (discussing the increases that consumers have experienced in health insurance premiums, as well as the insurance industry's continued desire to raise rates).


An Act to amend the Internal Revenue Code of 1996 to improve the portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services, to simplify the administration of health insurance, and for other purposes.

Id. This law was passed, in part, to enable people to move between jobs without fear of being denied coverage by a new employer because of a pre-existing condition.)

7. See Debow, supra note 6, at 15.


9. See Stio, supra note 1; Theresa Williams, Note and Comment, "Going Bare": Insurance and the Pre-Existing Condition Problem, 15 J.L. & Com. 375, 384 (1995).

10. Stio, supra note 1, at 323.

11. See id. at 322-23.
Part I of this Comment outlines the community rating system. Part II presents a brief history of community rating, and the criticisms that surround it. Part III discusses New York's insurance crisis with Empire Blue Cross/Blue Shield, the State's attempt at solving the dilemma through the use of community rating and the results of this attempt. Part IV compares community rating in New York with the community rating efforts in Maine, Massachusetts, New Jersey and Vermont. Part V concludes by assessing New York's difficulties with community rating. The purpose of this Comment is to demonstrate that adverse selection and New York's problems with Empire Blue Cross/Blue Shield have prevented New York from successfully implementing its community rating laws and regulations. New York's willingness to treat Empire preferentially has allowed the non-profit insurer to become too big to fail. The New York State Legislature and Insurance Department, as a result, have created laws that protect the interests of Empire rather than the interests of New York's citizens. This legislative action is causing the State's attempt at health reform to suffer.

I. COMMUNITY RATING

A. History

The market pricing of health insurance is one of the major problems with American health care. "There are two competing models of how to provide for the payment of medical insurance." The first model is typical of how insurance companies traditionally operate. The traditional model requires the policyholder to pay a premium to the insurer. The premium's actual...
price is based on an individual's or group's health risk. "[A]n insurance provider prices insurance based on the probability that the risk being insured against will occur and the amount that the insurer will have to pay if the risk being insured against occurs." 21 The second model of health insurance is known as community rating. "In this model, individuals pay a certain amount to be included in a program, but this amount does not relate to their actual or expected medical care needs or to the amount of their medical expenses." 22

Community rating is not a new method of insurance pricing; in fact, it has existed for almost sixty years. 23 Under this

21. Id. at 115-16. “The price of insurance, referred to as the gross premium, is composed of two parts: the ‘pure premium’—the portion that pays for anticipated losses, and the ‘loading’—the cost of selling and administering insurance policies and a risk charge to cover fluctuations of actual loss from the anticipated losses that were used to calculate the premium.” Id. at 116 n.29 (citing J. DAVID CUMMINS ET AL., RISK CLASSIFICATION IN LIFE INSURANCE, at 12 (1983)).

22. Id. at 110-11. The author contrasts the traditional model of health insurance with the community rating model by observing that “[t]hese models of health care payment are not merely distinct—they are antagonistic to each other.” Id. A traditional insurance market pricing system undermines the goal of collective insurance by discriminating against those who are seriously ill and determined to be a high risk. Id. These individuals are charged a higher premium rate. Id. Similarly, attempts at community rating regularly undermine actions that are necessary for a “properly working private insurance market.” Id. For example, a traditional insurer’s attempt to “exclude from its membership individuals who have developed catastrophic illnesses in order to preserve lower rates for other members illustrates this basic conflict.” Id.; see also infra notes 39-49 (discussing the function of community rating and regulation of insurance). More recently, Managed Care has taken center stage in the area of health insurance. See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 372-73 (2nd ed. 1995) (“[M]anaged Care is provided through Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and ‘managed’ fee-for-service insurance plans that require utilization controls and review.”); Erik Eckholm, Healing Process—A Special Report; While Congress Remains Silent, Health Care Transforms Itself, N.Y. TIMES, Dec. 18, 1994, § 1, at 1. Managed care plans control costs by taking an active role in medical decisions. See Eckholm, supra. Such plans place limits on medical tests, surgery, referrals to specialists and hospital stays that the plans consider unnecessary. See id. Managed care providers also pay lower fees and promote prevention and efficiency. See id. For the purposes of evaluating insurance, managed care differs fundamentally from the traditional model of health insurance. See generally James P. Freiburg, The ABCs of MCOs: An Overview of Managed Care Organizations, 81 ILL. B.J. 584, 584-85 (1993) (“[M]anaged care is a comprehensive term describing a system of health care cost containment that deviates from the traditional health care delivery system”). This Comment focuses on the traditional model of insurance and how community rating interacts with it. The role that managed care plays in the insurance industry is beyond the scope of this Comment.

23. Williams, supra note 9, at 386.

There are actually two different kinds of community rating: strict community rating, which requires health insurers to accept all applicants regardless of their health status and to charge the same premiums, and modified community
system, all people are provided with health coverage regardless of their medical history. People who have "a pre-existing condition may still be denied coverage for a limited time, however." Community rating also protects individuals from having their policies terminated by an insurer because of claims they have filed. Under community rating, companies set premium rates "based on the average number of claims submitted by the general public in a geographic area. All of the persons located in this specific area will then be required to pay a [premium] based on the amount of risk assessed."

The idea of health insurance and community rating originated in the 1930s with the founding of what today is known as the Blue Cross hospital insurance plans. The Great Depression hampered hospital finances and also created the need for a system that would cover hospital expense payments. Hospitals developed a system that provided certain services to employers for a set annual fee. "Medical societies quickly began offering similar set-fee arrangements to pay doctors' bills, and thus created the Blue Shield medical insurance plans." Blue Cross premiums were not based on a projection of individual health care costs. The rates came from "the average health care costs of the community in which the provider was located."

rating, which would allow insurers to charge different premiums among different age groups while barring distinctions on the basis of poor health or pre-existing conditions.

Williams, supra note 9, at n.79.
24. See id. at 386.
25. Id.
26. Id.
27. Id.
28. See id. at 112-13.
29. See id. at 112.
30. See id.
31. Id.
32. Id.; see also Francis J. Serbaroli, The Future Of Blue Cross/Blue Shield Plans, N.Y. L.J., July 30, 1996, at 3. According to Mr. Serbaroli:

Blue Cross plans . . . [are] generally traced to Baylor University Hospital in Houston Texas. In 1929, Baylor Hospital was experiencing financial difficulties because of the inability of patients to afford the costs of their hospitalization. Officials of the hospitals and the university agreed to experiment by identifying and enrolling groups of subscribers for pre-paid hospital care. For 50 cents a month, subscribers could receive up to 21 days of hospital care each year. The first and most obvious group identified and enrolled was Baylor's own teaching faculty. The idea caught on, and soon other groups of workers in banks, oil companies and other businesses were included. In short order, other hospitals were offering competing plans. As individual hospital plans prolifer-
By 1937, the nationwide enrollment in Blue Cross plans had grown to 800,000. Three years later enrollment soared to six million. 33 “By 1980 there were more than 100 [Blue plans] in existence.” 34 “Today, there are sixty-three Blue Cross/Blue Shield plans covering more than sixty-five million subscribers.” 35 In 1964, the Blue plans grew in financial clout when the federal government asked Blue Cross/Blue Shield to help administer its Medicare program. 36 This contractual agreement helped give the Blues a competitive edge on the market. 37 The Blues also held competitive advantages over private insurers because of their non-profit and tax exempt status. 38 These advantages, however, were accompanied by the substantial burdens of having to use community rating and open enrollment. 39

ated, the next logical step was to consolidate the collection of premiums and the processing of claims. In 1932, a community-wide plan was developed in California in which subscribers paid their premiums to the plan rather than to the hospitals, thus eliminating competition among individual hospitals and centralizing administration of the plans. Since they were regarded as a community benefit, the plans were set up as not-for-profit corporations, which also helped to keep down costs. These entities came to be known as Blue Cross plans.

Serbaroli, supra.

33. See Serbaroli, supra note 32, at 3.

Commercial insurers, taking note of this phenomenon, began offering health care insurance in 1934. They differed from Blue Cross coverage in that most commercial policies provided for cash payments to be made directly to the individual subscriber, rather than to the hospitals. The other significant difference was that the cash payments made by commercial insurers to their subscribers could be used to pay either their hospital bill or their physician's bill. Up to this point, Blue Cross plans only covered their hospitalization expenses and not the physician’s charges incurred during hospitalization. In the late 1930s and 1940s, the Blue Cross plans worked with physicians to develop another health insurance program to pay for physician fees incurred by patients during their hospitalizations, and the Blue Shield plans were born.

Id.

34. Id.

35. Id.

36. See id.

37. See id.

For example, hospitals often purchased health coverage for their employees through the local Blues plan. These hospitals also relied on the plans for timely payment of their many Medicare and Blue Cross claims. Thus, there was a significant disincentive for hospitals to shop around for better deals on their employees’ health insurance.

38. See id. (explaining that Blue Cross plans enjoyed tax-exempt status as 501(c)(4) social welfare organizations).

39. See id. The Blues were usually structured to accept anyone who applied for insurance. See id.
B. Common Criticisms of Community Rating

Many insurance scholars believe that community rating and open enrollment create unmanageable burdens for insurers. These experts insist that these regulations prevent the practice of risk classification, a process which enables an insurer to price insurance according to an individual’s health risks. Insurers normally use "factors that relate to risk, group a large number of similar risks and insure all members of the risk class at the same rate." An insurance company’s use of risk classification enables it “to set rates in a manner that accurately reflects the expected loss value of the insurance policy.”

Community rating prevents accuracy in pricing health coverage; something that community rating’s detractors contend is the key to success in the insurance underwriting market. If the premium cost of a particular class of health risks does not correspond to its expected loss, or if a classification is established that mixes a high health risk class with a low health risk class, the insurer offering such a classification will not succeed in the market.

Individuals who have low health risks, particularly younger policyholders, who have been placed in a high risk classification will often choose not to purchase insurance at all. Young and

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40. See Abraham, supra note 22, at 2-3 (discussing the function of insurance: risk-transfer, risk-pooling and risk-allocation).

41. Ford, supra note 6, at 116. “In addition to using classifications, some forms of insurance also modify rates based on the insured’s particular characteristics that influence the risk of loss.” Id. at 117 (noting that one example of a common characteristic could be that the insured individual is a smoker).

42. Id. at 117; see generally Leah Wortham, The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping, 47 Ohio St. L.J. 835, 842-51 (1986). “Health related classifications (for example, blood pressure or medical history) as well as age, gender, and marital status are taken into account. In individual health/disability policies, extensive questioning on health history is likely to be taken and factored in, along with occupation, gender, and age.” Wortham, supra, at 849-50.

43. See Ford, supra note 6, at 118. It is important to note that some forms of health insurance do not involve strict underwriting. See supra notes 20-22 (discussing theories and methods of administering health insurance).

44. See supra notes 20-22 (discussing theories and methods of administering health insurance); cf. Abraham, supra note 22, at 3 (discussing the obstacle to perfect competition as being imperfect information). “Without perfect information, the products sold and the prices charged for them vary from the optimum.” Abraham, supra.

45. See Ford, supra note 6, at 118; see also Abraham, supra note 22, at 3-4 (discussing the problem of adverse selection); Wortham, supra note 42, at 844 (“[P]eople who believe they are likely to use a particular insurance coverage will be more likely to purchase it and more willing to purchase it at higher prices than those who see their risk as remote.”).
healthy people would pay an exorbitant amount of money for something they neither want nor need. The inflated costs will strike many of them as unfair, and they will likely retaliate by "going bare." On the other hand, individuals who have a pre-existing condition or some other costly health care need will view community rating as a bargain. The aged and the unhealthy will flood the insurance pool. The end result will be that low risk people buy less insurance and high risk people purchase more. Eventually, only the high risk individuals will remain in the pool and insurers will have to adjust premiums in light of these increased risks. The insurance that was supposedly available to everyone will now be unaffordable. The ability to spread risks from those who do not suffer losses to those who do is removed when community rating splits the market. Simply put, some experts maintain that insurance is a business that depends on discrimination in order to entice low risk consumers into the market. Insurers rely on the ability to rate premiums based on individual and group characteristics and when this ability is removed by a regulation such as community rating, the market suffers from the phenomenon discussed above—adverse selection.

II. HISTORY AND PROBLEMS LEADING TO COMMUNITY RATING IN NEW YORK

Rising health care costs have been no different in New York than in the rest of the country. In 1990, New York health insurance costs soared “with double-digit increases the norm.” Major

46. See Ford, supra note 6, at 118; see also Williams, supra note 9, at 375 n.1, 387 n.86, (“‘Going bare’ is a term used by the insurance industry to identify the uninsured.”).

47. See Ford, supra note 6, at 118; see also id. at 118 n.40 (observing that community rating is a bargain because “those with low risks are paying more than their expected loss value, effectively subsidizing those with high expected loss values.”).

48. See id.

49. See generally Wortham, supra note 42.

50. But see id. at 846 (challenging the market pricing arguments made by insurers). Insurers choose classifications for reasons other than assessing risk. They also choose classifications based on “stability, reliability, and administrative convenience.” Id. The classifications used by insurers actually only predict a small percentage of losses. “Insurers are [also] not always under strong pressure to price at expected cost, and insureds are willing to buy insurance priced at higher than expected cost.” Id. at 861. State statutory insurance levels “protect existing companies from competition,” thus enabling insurers to keep prices artificially high. Id. Many consumers will accept these prices because they are so averse to going bare. See id. They may also be unaware that the price is inflated. Often, it is simply a matter of consumers behaving irrationally. See id.

factors contributing to this increase included "hospital and physician fees, increased utilization of existing benefits, defensive medicine practices, AIDS, and insurance fraud." In October 1991, Empire Blue Cross/Blue Shield, which provides coverage for the downstate New York area and is "one of the country's oldest and largest Blues plans," requested rate adjustments to compensate for its increased costs. These requests were denied by the acting Superintendent of Insurance, Salvatore Curiale.

Empire filed for another rate increase in December, 1991. Superintendent Curiale granted approximately one-half of the increase for individuals and small groups. "The action was necessary due to losses Empire [was] suffering on this business." Curiale also urged the Legislature to adopt a comprehensive health reform package so that further rate increases would not be necessary. Empire's biggest complaint was that other insurers, not obligated to employ community rating, were able to

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52. Id.
53. Serbaroli, supra note 32, at 3.
54. See 1991 N.Y. SUPERINTENDENT INS. ANN. REP. 3 (1992) [hereinafter 1991 ANNUAL REPORT] (noting that the rate adjustments would have impacted 350,000 direct pay subscribers and 350,000 small group subscribers in the company's New York region). "The first proposal would have significantly increased the rates for certain individual health insurance (direct pay) contracts. The second would have introduced a new rating methodology to divide Empire's community-rated pool into two categories—one for groups with unfavorable health histories and one for all others . . . . Empire estimated that rates would have ballooned by as much as fifty percent for some poor risk groups, while some healthy groups would have seen decreases of an equivalent amount." Id.; see also Curiale Says No to Empire Proposals, THE BULLETIN (New York State Insurance Department), Sept.-Oct. 1991, at 1 [hereinafter Curiale Says No, THE BULLETIN]. Curiale decided to have BC/BS "monitored monthly rather than quarterly." Curiale Says No, THE BULLETIN, at 1. This change would "allow the Superintendent to respond quickly" to the company's depleting surplus. Id. "As of June 30, 1991 Empires' surplus had fallen to $238.2 million—a $56.3 million decline since the beginning of the year." Id. Empire's proposal to split the existing community rated pool was an attempt to prevent "the flight of its most profitable business (the healthiest groups)." Id. The company claimed that about 10,000 group policyholders a month were lost as a result of "predatory pricing practices on the part of commercial carriers." Id. Empire had estimated that splitting the pool would have increased the cost to bad risk policy holders by 50%, but would have decreased the costs to good risks by 50%. See id. Curiale did not believe such a plan made for good public policy. He wanted to continue risk sharing "instead of dividing the healthy from the sick." Id.
55. See 1991 ANNUAL REPORT, supra note 54, at 3. The average rate increase was "14.6% for the New York City Metropolitan area, 10.5% for the Albany area and 5.4% for the mid-Hudson area." Id.
56. Id.
57. See id.
“cherry-pick” the healthier customers by charging them lower rates. Empire argued that as a consequence it was left with the sicker insureds who were causing its reserves to dwindle.

Governor Cuomo, in response to the rising costs that were forcing people to drop coverage, recommended a comprehensive approach to the problem in 1991. He submitted legislation that would have required all health insurers to community-rate their policies for small employers and individuals. This plan, dubbed the Governor’s Program Bill, was defeated in committee that year.

“Empire Blue, with more than seven million subscribers, has traditionally been known as New York’s largest insurer of last resort. As a result of its status as the insurer of last resort, Empire has been left with “a subscriber pool disproportionately populated by elderly and sick subscribers.” This has been a significant factor in Empire Blue’s financial shortcomings and its need for rate increases. However, this was not the only contributing factor. The company’s administrators had a “history of inattentiveness to Empire’s management and operations.” This mismanagement prompted Superintendent Curiale to contact Empire’s Board of Directors personally and to call on them to “actively oversee the management and direction of the company or resign.”

58. See Matthew Schwartz, Empire Blues Sue to Get Rate Hike, NAT'L UNDERWRITER, LIFE & HEALTH, Aug. 10, 1992, at 2 (“John Kelly, a spokesman for Empire Blues, said that . . . [Empire] ha[d] lost 485,000 good-risk customers ‘to private insurers that continue to cherry-pick!’ ”); see also 1992 N.Y. SUPERINTENDENT INS. ANN. REP. 8 (1993) [hereinafter 1992 ANNUAL REPORT].

59. See 1991 ANNUAL REPORT, supra note 54, at 3-4; see also Health Insurance Blues to Solve Empire Blue Cross’s Financial woes, Make All Insurers Abide by the Same Rules, NEWSDAY, Oct. 5, 1991, at 14 [hereinafter Health Insurance Blues, NEWSDAY].

60. See generally 1991 ANNUAL REPORT, supra note 54, at 3-4; Health Insurance Blues, NEWSDAY, supra note 59.

61. See 1990 ANNUAL REPORT, supra note 51, at 3-4 (“Premiums for community-rated health insurance contracts are based on the claims experience of all subscribers in a given geographic area, rather than the specified claims experience of one small group or individual subscriber . . . [whereas] commercial insurers are permitted to pick and choose the healthiest customers, while Blue Cross/Blue Shield plans take everyone regardless of age, sex, medical condition or occupation.”).


63. Id.

64. Id.

65. Id.; see infra Parts II.A.-IV; see also Mary Jane Fisher, High Drama at Senate Hearing on Empire Blues, NAT'L UNDERWRITER, LIFE & HEALTH, July 12, 1993, at 10 (discussing staff report of the Senate Permanent Subcommittee on Investigations which revealed, after a six month investigation, that “gross mismanagement wasteful expendi-
The Blue Cross/Blue Shield Association criticized Empire, among other Blues, for mismanagement and misuse of funds. To help deal with these troubles the Association took action which included: "[A]nnual reviews of individual plans' compliance with the national association's financial standards; regular meetings with key local plan managers as well as state regulators; and changes in the makeup of boards of directors." The criticism regarding the need for Empire Blue to reorganize did not come to New York State's political forefront until 1994. In order to understand the significance of these changes, one must first understand how community rating is tied to the problems of Empire.

In January 1992, Empire requested another rate increase of up to forty percent for the New York City Metropolitan area. It also requested smaller increases in Albany and the Hudson areas. These rate increases were to affect the direct-pay, non-Medicare customers as well as the small group, major-medical subscribers. Empire initiated the rate request because it was projecting losses of $372 million for 1992. Its reserve fund had fallen to $144 million, which is about two percent of its premium volume. The plan's reserves should have been at 7.5% of the premiums. Officials at the company believed that the reserves would be depleted by the middle of 1992 if the State

tures, fraud and a history of inattentiveness and non-action by its board of directors and the State Insurance Department have left it critically ill."). But see 1992 ANNUAL REPORT, supra note 58, at 2; Empire BC/BS Plan Operations Audited, BUS. INS., May 24, 1993, at 10 (claiming that the community rating law's mandated audit of Empire Blue revealed that the company's financial troubles, mismanagement and organizational deficiencies were largely the result of Empire's practice of insuring all risks and the spiraling costs of health care).

66. See Mark A. Hofmann, Blues Take 'Step Forward': Senate Hearings End with Blues Promising Accountability, BUS. INS., Aug. 15, 1994, at 25; see also infra Parts II.A.-IV (discussing criticisms and changes in Empire Blue).

67. Hofmann, supra note 66, at 25. President and Chief Executive Bernard Tresnowski of the Blue Cross & Blue Shield Association noted that Empire would be "stripped of the right to use Blue Cross & Blue Shield in its name if it fails to meet the national group's standards." Id.; see also Matthew P. Schwartz, Empire Turns to Briggs To Restore Its Credibility, NAT'L UNDERWRITER, LIFE & HEALTH, July 12, 1993, at 1 (discussing Empire's hiring of Philip Briggs as its new chairman and interim CEO in wake of the U.S. Senate's investigations). Briggs, commenting on the state of Empire, stated, "The place isn't falling apart . . . [we need to make some organizational changes and fill some key [management positions]." Schwartz, supra.


69. See id.

70. See id.
did not approve an increase.\textsuperscript{71} Empire requested another increase in March, for downstate individual and small group community-rated members.\textsuperscript{72} Albert Cardone, the company's chief executive officer, claimed that the present rate filing was "necessary for Empire 'to simply break even' in the current year and would have no impact on Empire's depleted surplus condition."\textsuperscript{73} The company was granted half of the requested rate increase.\textsuperscript{74} Superintendent Curiale stated that "it was necessary due to Empire's losses."\textsuperscript{75} Curiale also stated that unless the State Legislature passed new insurance reforms, the remainder of the request would be granted in October.\textsuperscript{76} Empire Blue's financial dilemma forced the State government to take action.\textsuperscript{77} In March 1992, Assemblyman Alexander "Pete" Grannis (D-Manhattan), the Chairman of the Assembly Insurance Committee, revived Governor Cuomo's community rating bill from 1991 and incorporated new provisions, "including one that mandated a manage-

\textsuperscript{71} See id.

\textsuperscript{72} See Empire BC/BS Granted Partial Rate Increase, THE BULLETIN (New York State Insurance Department), Mar. 1992, at 1 [hereinafter Partial Rate Increase, THE BULLETIN] ("Curiale urged enactment of Governor Cuomo's community rating bill, which would require all health insurers—commERCials, HMOs and non-profits—to cover any individual or small group that applies.").

\textsuperscript{73} Id. at 2.

\textsuperscript{74} See Rate Denial Prompts Empire BC/BS Lawsuit, THE BULLETIN (New York State Insurance Department), Sept.-Oct. 1992, at 1 (explaining that Empire filed suit against the Department because it would not grant the second half of the proposed 28\% rate increase). Empire also sued because the Department would not approve a three year plan to restore the company's reserves. See id. Justice Harold Hughes of the New York State Supreme Court, Albany County, ruled in favor of Empire on Oct. 2, 1992. See id.

\textsuperscript{75} Partial Rate Increase, THE BULLETIN, supra note 72, at 1. "The rate increases affect Empire's 1.2 million individual and small group subscribers . . . ." Id. There was to be a 12.9\% increase for the New York City Metro area, 7.6\% for Albany and 7.5\% in the Mid-Hudson region. See id. The Insurance Department claimed that commercial insurers' ability to discriminate against high risk groups (for example, elderly and sick people) caused Empire to suffer large losses on its individual and small group business. See id.

\textsuperscript{76} See id. at 1.

\textsuperscript{77} See Dena Bunis, Break from High Costs for Now, But State Help for Empire Is No Guarantee for Future, NEWSDAY, Jan. 12, 1993, at 4 (discussing the plight of New Yorkers under expensive health coverage from Empire Blue and how it is hoped that community rating will remedy this problem: "Hugh and Denise Collins already work six days a week at their Lake Ronkonoma transmission repair shop so they can afford the $7,000 it costs them for their Empire family policy and the annual $2,000 deductible. Hugh, a liver transplant recipient, can't get insurance anywhere else."); see also 1992 ANNUAL REPORT, supra note 58, at 8 ("Empire's policyholders, many of whom had nowhere to turn, became hapless victims caught in a health insurance maelstrom."); Partial Rate Increase, THE BULLETIN, supra note 72, at 1 (noting that in September 1992 Superintendent Curiale selected Arthur Anderson & Company to perform the audit).
ment audit of Empire Blue Cross/Blue Shield." The bill received Assembly approval on June 30th and the Senate passed it in July of 1992. The bill became chapter 501 of the Laws of 1992 and became effective on April 1, 1993.

The law requires all health insurers who offer individual or group coverage to sell policies to any applicant regardless of age, sex, occupation or prior health history. The rates for this coverage are to be community-rated. As a result, an insurer must base coverage on the entire pool of individual or small group policyholders in a particular geographic area. In short, anyone in New York State can apply for health insurance from a com-

78. 1992 ANNUAL REPORT, supra note 58, at 8; see also Partial Rate Increase, THE BULLETIN, supra note 72, at 1 (discussing Curiale's claim that people had been asking for reforms of Empire itself). In 1992, there was growing public support for performing an audit of Empire's management, salaries and other expenses. See Partial Rate Increase, THE BULLETIN, supra. Superintendent Curiale delivered testimony at public hearings in New York before the Senate's Standing Committee on Insurance. See id. He urged the Senate to support the governor's new community rating bill. See id. Curiale claimed that "as better risks moved to lower-cost alternatives, Empire Blue Cross and Blue Shield . . . was badly hurt. While commercial, for-profit carriers were picking and choosing the healthiest and youngest groups, the worst risks gravitated to or remained with Empire." Id. The problems that New York is facing with health insurance, according to Curiale, stem from community rating being forced to compete against experience rating. See id. The Superintendent contended that the governor's bill, requiring all carriers to community-rate, with open enrollment, would be a step towards solving New York's health insurance crisis. See id.

80. See 1992 ANNUAL REPORT, supra note 58, at 3.
81. See 1992 ANNUAL REPORT, supra note 58, at 2; see also N.Y. INS. LAW § 3231 (McKinney 1996). Prior to the changes brought on by this law, most private insurers used experience rating, whereas the Blues used community rating. See Ford, supra note 6, at 116-18 (discussing the private sector's traditional approach to the business of health insurance).

82. See 1992 ANNUAL REPORT, supra note 58, at 8; see also N.Y. INS. LAW § 3231(a) (McKinney 1985 & Supp. 1998).

Any individual and dependents of such individual and any small group [that is, 50 or fewer people], including all employees or group members and dependents of employees or members, applying for individual health insurance coverage, including medicare supplemental insurance, must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer to individuals or small groups in the state . . . the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. N.Y. INS. LAW § 3231(a); see also N.Y. COMP. CODES R. & REGS. tit. 11 § 360.5 (1995) (prohibiting underwriting practices and eligibility rules affecting individual and small group health insurance). These practices include: lists of occupations, medical tests, medical examinations, questions about hobbies, doctor statements, investigations into health status, family health status or sexual orientation. See N.Y. COMP. CODES R. & REGS. tit. 11 § 360.5.
pany offering such coverage and they cannot be denied. An insurance company must also charge everyone in a specific region the same price regardless of age, sex or pre-existing condition.83

The passage of this bill made "New York [the] first state in the nation to provide its residents with health insurance system in which all who apply must be accepted and offered a rate that cannot vary because of their age, sex, occupation or medical condition."84 Governor Cuomo in an Executive Memorandum expounded on the goals of community rating:

[Community rating] suggests that [New Yorkers] will actually use the health care system. They can no longer be terminated by an insurer because they do, in fact, need medical care. They will no longer have to pay higher rates for health insurance simply because they age or get sick. And health insurance rates should stabilize over a large pool which will be better able to absorb the cost. In addition to community rating and open enrollment for individuals and small group health insurance, the bill makes other important reforms to the State's system of health insurance. For instance, it requires insurers to credit the time a person was covered under a prior health insurance package in determining whether to apply a pre-existing condition limitation. This change, commonly referred to as portability of health insurance, addresses the problem faced by those who want to change employment or insurers but are not able to because they cannot afford to be without coverage for the period that a new pre-existing condition exclusion would be in effect with a new insurer.85

Although Governor Cuomo focused on how the law would help New York State citizens, Empire Blue's financial troubles were the driving force behind this legislation. In his 1992 Annual Report, Superintendent Curiale indicated that prior to community rating and open enrollment, Empire Blue had been unable to compete with private insurers who were permitted to price their insurance according to an individual's or group's risk.86 This disparity had enabled the commercial insurers to absorb all of the good risks (that is, healthy people).87 Healthy individuals could obtain private insurance at prices that were

83. See N.Y. INS. L. § 3231(a); see also N.Y. INS. L. § 3233(3) (providing that community rating, "shall include reinsurance or a pooling process involving insurer [and HMO] contributions to, or receipts from, a fund which shall be designed to share the risk of or equalize high cost claims.").
85. Id.
86. See 1992 ANNUAL REPORT, supra note 58, at 8.
87. See id.
lower than anything that Empire could offer. Curiale contended that this cherry-picking helped send Empire Blue Cross/Blue Shield into an economic tailspin. As the good risks flocked to the private market, Empire's rates continued to increase, which in turn prompted more policyholders to leave. This process resulted in a vicious circle. Community rating did not become fully effective until April 1, 1993. As a result, Empire's economic difficulties continued.

It was expected that after community rating took effect that Empire would gain a foothold in the market due to the legislatively mandated level playing field. In December 1992, Empire requested another rate increase of 26.3%. Nearly one and a half million community-rated subscribers were to be affected. The company expected that without the rate increase, its net would be about $30 million at the end of 1992 (a $114.5 million decrease from 1991). Albert Cardone claimed that "[community rating was] doing nothing at this point in time to control the financial hemorrhaging of Empire, or stop the upward pressure on our premiums."

The State Legislature and Governor Cuomo were able to mitigate this premium increase with a settlement from a lawsuit initiated by Empire and several other insurers in 1992.
These suits represented an attempt to recover $210 million in surplus funds from the New York State excess medical malpractice insurers; funds that had been wrongfully moved to the State's general fund. The settlement provided that a one-time $100 million infusion would be given to Empire in order to ensure that its rate increase would not exceed 25%. As a result, the average increase was only 19.5%.

Curiale stated that the rate increase was essential for Empire's financial solvency. He believed that the steady escalation of health care costs and the increased use of health care services by those covered under community-rated contracts had caused the company's woes. Empire had estimated that at the end of 1992 it would have a meager surplus of $29.7 million, or 0.4% of its premium income. The law, however, required insurers to carry $543.4 million. Empire's community-rated contracts were expected to lose $268 million in 1992. The $100 million from the settlement enabled the company to keep its surplus at just below $100 million and decrease its community-rated losses to $143.6 million. Empire also planned to receive $130 million from the new insurance pool created by the new community rating regulations.

subscribers would have paid a 59% increase).

98. See id.

99. See id.

100. See id.

101. See id.

102. See id.

103. See id.

104. See id.

105. See id.

106. See id.

107. See Community Rating and Pooling Regulations Proposed, THE BULLETIN (New York State Insurance Department), Nov. 1992, at 1. This particular article explains that the pooling mechanism has two elements in the new community rating law: First, "[m]easurement of distribution of each insurer's business by age and sex categories and the translation of that measurement into a relative risk factor for each insurer." Id. Insurers with high risk factor would receive money from the pool while others that have only average risk factors would contribute to the pool. Second, there will also be "pooling
In April 1993, community rating took effect in New York. About forty insurers offered coverage to individuals and there were more than fifty doing the same in the small group market.\textsuperscript{108} Curiale expected "more insurers to enter the small group and individual markets as the benefits of the community rating/open enrollment approach became more apparent."\textsuperscript{109}

Soon after the start of community rating, Arthur Anderson released its report on Empire Blue.\textsuperscript{110} The management audit recommended a "realignment of Empire's management function to decentralize decision making [in order] to enhance the insurer's response to changing market conditions."\textsuperscript{111} It indicated that the chief executive officer and chairman of the board should be replaced.\textsuperscript{112} "In addition, the Anderson Report point[ed] to economic and market forces beyond Empire's control as the main reason for the company's financial problems over the past few years."\textsuperscript{113} It also stated that the new community rating law "was critical to addressing . . . the major problem confronting Empire, [the uneven playing field that made it] the insurer of last resort . . . ."\textsuperscript{114}

of large claims which helps protect insurers from the adverse financial effects of incurring a disproportionate number of such claims." \textit{Id.} Each insurer is to contribute a predetermined percentage of its premiums. \textit{See id.} The money will be distributed in proportion to the amount of large claims under a company's control. \textit{See id.; see also} Dena Bunis, \textit{Insurance Law Battle; HMOs Sue State Over Bill that Will Aid Blue Cross}, \textit{Newsday}, Mar. 11, 1993, at 45 (discussing HMO suit which claimed "the pooling provision violates the federal Employee Retirement Income Security Act, which prohibits using employee benefits to subsidize other plans"); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (finding in favor of Empire Blue and New York State).


\textsuperscript{110} \textit{See Empire BC/BS Management Audit Completed}, \textit{The Bulletin} (New York State Insurance Department), May 1993, at 2 [hereinafter \textit{Audit Completed, The Bulletin}] (noting that Arthur Anderson consulting firm was awarded contract to audit Empire Blue, and that the audit was mandated by the new community rating law); \textit{see infra} notes 143-58 and accompanying text (discussing audit).

\textsuperscript{111} \textit{Audit Completed, The Bulletin, supra} note 110, at 1.

\textsuperscript{112} \textit{See id.}

\textsuperscript{113} \textit{Id.}

\textsuperscript{114} \textit{Id.}
The report noted that Empire’s management was not as flexible as that of its for-profit competitors because Empire was moving from a non-profit business model to a “hybrid” business model—a change that would allow Empire to compete with commercial insurers for large group, for-profit business. Empire’s social mission is in conflict with ‘modern reality’ of rising health care costs and competitive market forces [and] this is the main reason for [its] current financial difficulties.” The audit concluded that Empire needed to change its business practices.

The report explored the public criticisms facing Empire and claimed that: (1) administrative costs were not the cause of the company’s rising premiums, (2) experience-rated business was not a financial drain, (3) the number of officers and their levels of compensation were reasonable, and (4) travel expenses and entertainment were reasonable. The audit offered two final suggestions: first, that Empire’s tax and financial preferences be removed in fairness to other insurers; second, that the State require all insurers in New York to underwrite both large and small markets. This report verified Empire’s and the Insurance Department’s claims that commercial cherry-picking was the primary cause of the company’s financial woes. It also supported the actions taken by the State in implementing community rating to level the industry playing field. According to Arthur Anderson, Empire and New York were moving in the proper direction to reform the health insurance market.

III. REACTION TO NEW YORK’S COMMUNITY RATING REFORM

The insurance industry in New York State resisted community rating. The New York State Association of Life Underwriters (NYSALU) felt that Governor Cuomo “uncritically . . . swallowed the well publicized claims of Empire that commercial insurers should somehow pay for cherry-picking Empire’s good risks.” The NYSALU admitted that Empire lost a significant share of the small group market between 1988 and 1992. This

115. See id.
116. Id.
117. See id.
118. See id.
loss totaled about 400,000 insureds. It denied, however; that private insurers lured these policyholders away. Commercial insurers reportedly only insured about 300,000 people in the small group market and more recent figures did not indicate a significant change in those numbers.\(^\text{121}\)

The NYSALU claimed that Empire had in fact shown a consistent gain in its community-rated business and that Empire's HMO and experience-rated business were the true sources of its losses.\(^\text{122}\) Cherry-picking, according to the NYSALU, was not Empire's problem. The NYSALU urged that community rating be struck from the Budget Bill. The industry resented the advantages that Blue Cross/Blue Shield insurers already held in New York.\(^\text{123}\) It believed that "community rating as proposed in this bill would further tilt the playing field in favor of the Blues which are regionally organized with an already dominant market share."\(^\text{124}\) The industry predicted that the advantages of Empire would force many commercial insurers to withdraw from the market.\(^\text{125}\) The NYSALU also claimed that the “pure” community rating prescribed by this law would force young and healthy insureds to forego health coverage because of the rise in costs from being pooled with higher risks. All policyholders

\(^{121}\) Id.

\(^{122}\) Id.

\(^{123}\) Blue Cross/Blue Shield insurers already enjoy a 13% hospital discount advantage over their commercial competitors; they are also exempt from premium and franchise tax. See Memorandum in Opposition to Sections 64-68 & 93-99 of A. 9306, S. 6806 Budget Bill from Benjamin Y. Brewster, Jr., Director of Government Affairs, New York Association of Life Underwriters, Inc. (Mar. 12, 1992) (on file with Buffalo Law Review).

\(^{124}\) Memorandum in Opposition to Sections 64-68 & 93-99 of A. 9306, S. 6806 Budget Bill from Benjamin Y. Brewster, Jr., Director of Government Affairs, New York Association of Life Underwriters, Inc. (Mar. 11, 1992) (on file with Buffalo Law Review); cf. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company, 514 U.S. 645 (1995). In Travelers, the insurance industry tried to level the playing field by filing suit against State officials. 514 U.S. at 651-52. New York had passed a law requiring hospitals to collect surcharges from patients covered by a commercial carrier, but not from patients insured by a Blue Cross/Blue Shield plan. See id. at 649-50. The New York law also subjected certain HMOs to surcharges. See id. Private Insurers claimed that § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) (codified as amended at 29 U.S.C. § 1144(a)) pre-empted surcharges on patients' bills whose commercial coverage was purchased by an ERISA plan, and also pre-empted surcharges on HMOs insofar as their membership fees were paid by an ERISA plan. See id. at 651-52. The Court held that New York's surcharge provisions did not "relate to" employee benefit plans within the meaning of § 514(a) and that as a result, ERISA did not pre-empt the surcharges. See id. at 687.

under the new law would be paying the same premium rate, which would be higher for the young when compared with their rates prior to the law. Industry leaders felt that the Legislature had become hostage to Empire and that community rating would not benefit New York as promised.

Commercial carriers' fears were not unfounded. Several private insurers withdrew from the individual and small group markets rather than community-rate their policies. "[O]nly three private insurers who sell individual health insurance remain in New York. They are: International Life Investors Ins. Co., Mutual of Omaha, and Nation Wide Life. Fourteen commercial insurers remain in the small group market.”

The law also caused health insurance rates to increase "an average of nineteen percent in the small group market and eighteen percent for individuals." The average young male experienced a startling increase of 170%. "[T]he price of a standard


Empire BC/BS reports the average age of its direct pay insureds has been consistently increasing and is now in the 50s, and Mutual of Omaha found that in the first 18 months under community rating the average age of both its individual and small group business increased by five years.

Id.

127. See Barbara Forster, Community Rating: Do Not Resuscitate?, CENTRAL N.Y. BUS. JOUR., July 27, 1992, § 1. In this article, the author quotes Emily Crandall, Vice President and Associate General Counsel to The Guardian, who claimed that "sixty percent of our younger policy-holders will see rate increases. Furthermore, those with younger employees making less money will drop out and take a chance on getting sick.” Id. Roseanne Hennessey, spokesperson for The Travelers Company in Hartford, Connecticut, "feels that community rating defeats the concept of managed care. There is no financial incentive to keep costs down if a company is grouped with employers who don't.” Id.

128. David Bauder, New Health Insurance Rules Take Effect, BUFFALO NEWS, Apr. 1, 1993, at A9 ("Nine companies already have abandoned the state and sent notices to about 50,000 people that their health insurance coverage would be dropped today."); see also Schwartz, Big Rate Increases, supra note 108, at 2. Mr. Schwartz has reported on the continuing exodus of private insurers from New York's small group and individual markets. See Schwartz, More Cos. Leaving, supra note 108, at 6. The author notes that seven more companies pulled out of New York State: State Farm Mutual Automobile Ins. Co.; Massachusetts Mutual Life; ITT Corp.'s Hartford Life unit; Liberty Mutual; Cigna Corp.'s INA Life Ins. Co. of New York; Nation Wide Ins. Co. and Equitable Cos. Id.

129. Schwartz, Big Rate Increases, supra note 108, at 2. According to Karen Olson, President of Benefits Design Group (an insurance brokerage house that serves the small group market), rates have increased primarily for the young and healthy. See id. "We're concerned that the individuals [in New York] will drop their coverage because their rates are too high, thus increasing the uninsured population in New York," said Chris Peterson, assistant general counsel for the Health Insurance Association of America." Id.
fee-for-service plan escalated from $1,200 to $3,240” for a thirty
year-old male.130 These price increases caused a significant num-
ber of people to go bare. According to a study conducted by Mill-
iman and Robertson, Inc., a New York actuarial firm, “individ-
ual coverage in New York fell from 1.2 million on March 1,
1993, to less than 500,000 on January 1, 1994.”131 However, New
York’s Department of Insurance severely criticized this report.132
The Department released its own figures which indicated that
“1.2%, or 25,477, fewer people were insured in the individual
and small groups markets as of Jan. 1, 1994, nine months after
the community rating and open enrollment law went into ef-
fect.”133 The individual market decline of 12.4% was more severe,
as it left 43,666 fewer individuals insured.134

130. Carol Goldberg, Generation Gap in Community Rating, L.I. Bus. News, Aug. 29,
1994, § 1, at 1 (according to a Washington Post report (July 17, 1994), New York’s
community rating law will cost people under the age of 35 at least $40 billion yearly to sub-
sidize individuals between ages 45 and 64). “If each single person, regardless of age,
pays the same $2,000 premium per year, the 25-year old pays 100% more, losing $1,000
a year, while the 60-year old pays 40% less and gains $1,500 a year.” Id. The sponsor of
the community rating law, Assemblyman Peter Grannis when asked about the report,
replied, “I seriously question the validity of those numbers.” Id.

But, Charles Eggleton, vice president, Delphi Insurance Brokerage (Kings
Park) says, “I do a fair amount of group health business and I agree with the
report. When the law became effective, the rates on my oldest clientele fell
somewhat, but the rates on young people climbed precipitously. It’s fair to say
that most of this has been on the backs of the young single workers. What is
happening is that a number of young people are simply opting out of the insur-
ance market and going uncovered.”

Id.

131. Curiale Blasts Milliman and Robertson Study, BEST WIRE, Sept. 15, 1994, at 1,
available in LEXIS, News Library, Wires File. New York Insurance Superintendent, Sal-
vatore Curiale “asserted that the decline suggested by the report is incorrect because the
report inappropriately compared pre-reform Census Bureau reports, which represented
people covered by both group and individual policies, to post-reform figures that only
represented people covered by individual policies.” Id. He also criticized Milliman and
Robertson for not revealing that the report was funded by “certain commercial insurance
companies and others opposed to health care reform efforts.” Id.

132. See id.

133. Matthew Schwartz, Sparks Flying Over N.Y.’s Community Rating Law, Nat’l
UNDERWRITER, LIFE & HEALTH, June 6, 1994, at 66 (“At Mutual of Omaha, 58% of those
who let their coverage lapse did so because of cost . . . . Among those without coverage,
51% were between the ages of 26 and 35 and 21% between the ages 36 and 45.”). Be-
tween April and November 1993, “the number of individual policies written by Mutual of
Omaha dropped by more than 30%.” Id. “Premiums rose for approximately 60% of indi-
vividually insured persons, while 30% experienced premium increases of more than 20%.”
Id. But see Census Report: NYS Uninsured Rate Unchanged, THE BULLETIN (New York
State Insurance Department), Sept.-Oct. 1994, at 1 (State refers to federal survey to
support community rating success).

134. See id.
A. The U.S. Senate Looks into Empire's Problems

In June of 1993, the United States Senate Subcommittee on Investigations, a permanent subcommittee of the Committee on Governmental Affairs, decided to examine the plight of Empire Blue.\textsuperscript{135} After a six month investigation, the Subcommittee's investigative staff testified to the following problems with the management, operations and regulations of the Empire Plan:

an inability to properly execute the most basic function of an insurance company, resulting in abysmally poor service to subscribers and providers; a severe lack of internal controls, leading to a high degree of vulnerability to fraud; excessive expenditures of the benefit of senior officers and members of the board of directors; a propensity on the part of the plan Management to blame external factors for the plan's failings and to rely upon external sources of relief to keep it afloat; inadequate oversight of management activities by the board of directors and ineffective regulation of the plan by the State Department of Insurance.\textsuperscript{136}

The Subcommittee staff claimed that Empire's senior officers and board of directors, along with the State Department of Insurance were in a "state of self-delusion and denial."\textsuperscript{137} According to the Subcommittee investigation, Empire refused to accept that the plan's mismanagement had caused the current crisis.\textsuperscript{138} The Subcommittee went on to report that these three groups "place[d] nearly all of the blame for the plan's financial predicament on external sources, such as the economy, inflation, unfair competition, and commercial insurers."\textsuperscript{139}

Empire and the Insurance Department have consistently placed the blame for the plan's financial losses on cherry-picking. The investigative reports, however, revealed that "Empire's own small-group cancellation study, dated January of

\textsuperscript{135} See Oversight of the Insurance Industry: Blue Cross/Blue Shield-Empire Plan (New York): Hearings Before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs United States Senate, 103d Cong. 1 (1993) [hereinafter Oversight Hearing] (opening statement of Chairman Sam Nunn). This investigation was initiated after the failure of Blue Cross and Blue Shield of West Virginia. See id. "In 1990, that plan became the first, and so far the only, Blue Cross plan to fail. As a result of that failure, over 51,000 individuals were left with outstanding unpaid medical claims." Id. The Subcommittee discovered that the West Virginia plan failed because of "waste and mismanagement . . . combined with inadequate oversight of the plan on the part of the board of directors, the State Insurance Department, and the National Blue Cross and Blue Shield Association." Id.

\textsuperscript{136} Id. at 5 (testimony of John F. Sopko, Deputy Chief Counsel).

\textsuperscript{137} Id. at 6.

\textsuperscript{138} See id.

\textsuperscript{139} Id.
1992, using data provided by the Gallup company, show[ed] that less than half of those groups that canceled the Empire coverage in 1991 went to commercial carriers."140 In a separate Gallup report, taken in February 1992, thirty-six percent of the policyholders that canceled their Empire coverage did not purchase insurance from another company.141

The Subcommittee seriously criticized the Arthur Andersen report.142 New York State had both commissioned and paid for this audit.143 Throughout the Subcommittee's investigation, Empire and the New York Insurance Department had contended that the Arthur Andersen report would support Empire's position.144 The Subcommittee staff, however, "believe[d] the report may be fatally flawed and question[ed] [its] overall objectivity . . . the thoroughness of the Insurance Department's contracting process for the Arthur Andersen contract; the accuracy, completeness, and independence of the report; and the undue reliance upon representations of the plan without any independent verification."145

The New York legislature placed only one restriction on the Insurance Department's authority to grant the audit contract: The Department could not appoint any organization that had done work for Empire in the last five years, unless the Department could demonstrate the organization's independence and objectivity.146 The Subcommittee staff discovered that Arthur Andersen had consulting contracts with Empire in 1991 for $447,000 and in 1992 for $371,000.147 "The size of those contracts made Arthur Andersen one of the highest-paid consultants listed on documents submitted by the plan to the Insurance Department."148

Arthur Andersen offered a professional assurance that the firm's interest in its contracts would not compromise the legitimacy of its work, and indicated that this assurance should be enough to end any speculation to that effect.149 It also provided the audit to the Insurance Department at a discounted rate.150

140. Id. at 11.
141. See id.
142. See id. at 11-13.
143. See id. at 11 (noting that the audit cost New York $1.9 million).
144. See id.
145. Id. at 11-12.
146. See id. at 12.
147. See id.
148. Id.
149. See id.
150. See id.
When asked why Arthur Andersen had wanted the contract for the auditing of Empire, the firm explained "to be helpful, improve our credentials, and to also get more business from the Blues!"\textsuperscript{151} The Insurance Department did nothing to assure Andersen's independence or competency.\textsuperscript{152} Arthur Andersen conducted its investigation in an unprofessional manner. It never questioned any of the information that Empire provided.\textsuperscript{153} The firm also failed to conduct any independent interviews of national accounts, subscribers or former board members.\textsuperscript{154} Most importantly, Andersen never reviewed the National Blue Cross/Blue Shield documents, nor did it verify the cherry-picking argument.\textsuperscript{155} Arthur Andersen's audit consisted of a report that merely repeated the assertions and arguments of Empire.\textsuperscript{156} It did nothing to reveal the mismanagement of Empire. The report acted as a "bone to be thrown to the State legislature and the New York Times to make them go away."\textsuperscript{157}

In brief, the Subcommittee staff found that Empire was mismanaged. "[The] plan appeared incapable of effectively carrying out the most basic functions of an insurer. They couldn't price, they couldn't collect, they couldn't pay. They couldn't adequately collect their premiums, and they couldn't efficiently and timely pay their claims."\textsuperscript{158} As a result, Empire was unable to compete or provide adequate service.\textsuperscript{159}

\begin{enumerate}
\item\textsuperscript{151} Id. at 12.
\item\textsuperscript{152} See id.
\item\textsuperscript{153} See id. at 13.
\item\textsuperscript{154} See id. at 13-14. National accounts are large accounts with corporations like IBM, CBS, AT&T and the accounting firm, Deloitte and Touche. See id. at 14.
\item\textsuperscript{155} See id. at 14-15.
\item\textsuperscript{156} See id. at 15.
\item\textsuperscript{157} Id. at 16 (quoting a former vice president of Empire).
\item\textsuperscript{158} Id. at 17; see also id. at 141-431 (staff statement providing detailed analysis of Empire Blue, used as basis for staff testimony during hearing).
\item\textsuperscript{159} See id. at 18-20. Approximately 4,200 complaints were received from subscribers with individual direct pay policies. See id. at 18. Thousands of complaints were received from hospitals and employees of Empire's large national accounts. See id. at 18-19. Hospital administrators constantly complained that Empire "loses claims or denies ever receiving them." Id. at 18.

One hospital administrator told the staff that his sister submitted a claim to Empire for $2,600 and received four checks, each for $2,600. She called Empire Customer Service to explain the mistake and was told it "was her lucky day" and to just keep the checks. Uncomfortable with this, the woman actually took the checks to Empire's offices and attempted to return them to the customer service representatives. She was told the system couldn't handle returned checks and that she should just keep them.

Id. Hospital administrators do not believe that people are leaving Empire because of cherry-picking, they claim it is because of the poor service. See id. Empire, in 1992, "re-
The Subcommittee staff also revealed that the plan's officers were paid exorbitant salaries for a company that was not financially sound. In addition to overcompensation, the staff found that Empire's CEOs spent outlandish amounts of money on entertainment and perks. Empire has also admitted that fraud resulted in over $64.5 million in losses in 1991 and 1992 alone.

Superintendent Curiale offered his testimony in support of Empire. He contended that although Empire was having its difficulties, the new reform in New York's health insurance law would help the company to rebound. He agreed with the Subcommittee staff that there had been mismanagement problems, but he disagreed with the staff's contention that mismanagement was the root of Empire's financial deterioration.

Mr. Curiale, on behalf of the State Insurance Department, claimed that Empire was having difficulty because the state's health insurance system was in need of reform due to the drastic over five million complaints and telephone inquiries . . . directly from subscribers and over 13,000 [of these] complaints . . . had been forwarded to the plan from outside agencies, such as the Office of Consumer Affairs and U.S. Senate Offices . . . " Id.

In 1991, one subscriber actually had to sell her home to pay $20,000 in medical bills for her father-in-law, which should have been paid by Empire. After the father-in-law died in 1987, Empire made several payments to the hospital but failed to pay an outstanding hospital bill of $20,000 until February 1991. By that time, the hospital had received a judgment against the woman and her husband who sold their home to pay the bill. When Empire eventually reimbursed the couple, they included a letter apologizing for "taking so long to resolve this issue, particularly since it was Empire's error in the first place."

Id. at 19.

160. See id. at 21, 218, 219. Empire has 65 executives overall. See id. at 21. CEO Al Cardone received $600,000 in 1991. See id. at 218. Despite Empire's continued poor performance, its executives were granted incentive bonuses that increased each year. See id.

161. See id. at 22-25 ("Empire operates as if it is a profitable Fortune 500 company rather than a non-profit health insurer."). The company purchased 82 automobiles for its executives for a total cost of $1 million. See id. at 23. Empire also owns 41 pool cars. See id. at 22. In 1992, the plan spent $50,000 on limousines. See id. at 23. In 1991 it spent $91,000 on limousines. See id. Company gifts to employees cost subscribers $1 million over the past 5 years. See id. at 24. For $20,000, 12 of Empire's officers attended a seminar in Orlando, Florida entitled "The Disney Approach to Quality Service." See id. at 25.

162. See id. at 30-31.

163. See id. at 127 (testimony of Salvatore R. Curiale, Superintendent of Insurance, State of New York). Superintendent Curiale delivered a prepared statement after giving his testimony. See id. at 268.

164. See id. (responding to the subcommittee's inquiry as to whether Empire is too big to fail, Curiale stated, "Under the laws that existed in New York prior to April 1, 1993, the effective date of health insurance reform legislation, I would agree, Empire was too big to fail.").

165. See id. at 127.
tic market changes over the past ten years.\textsuperscript{166} Despite the staff findings, he still maintained that Empire was suffering because it was the insurer of last resort.\textsuperscript{167} Mr. Curiale again asserted that Empire’s difficulties resulted from the fact that commercial insurers cherry-picked their customers.\textsuperscript{168} He stated that the policyholders who complained about Empire’s rising rates also complained that they had nowhere else to turn for coverage.\textsuperscript{169}

The Superintendent continued to testify that the company’s problems had been exacerbated by the plan’s commitment to community rating and open enrollment of individuals, whereas other companies were able to use experience rating to turn away poor risks.\textsuperscript{170} Mr. Curiale contended that the most promising solution to Empire Blue’s problems was to spread the insurance risks to all carriers.\textsuperscript{171} This spreading, he reasoned, would be possible under the new community rating law. Under this law, the Insurance Department believed that Empire was “no longer too big to fail.’ In the event Empire ha[d] to fold, the remaining insurers and plans would, over a relatively brief time period, absorb Empire’s business.”\textsuperscript{172} Community rating, according to Superintendent Curiale and the Department, would be the safety net for New York and its citizens.\textsuperscript{173}

IV. COMPARING COMMUNITY RATING PLANS

In 1993, the Department of Insurance claimed that its community rating plan was off to a strong start.\textsuperscript{174} It battled the insurance lobby and implemented this plan in an effort to prevent people from dropping coverage.\textsuperscript{175} The new reform law was the

\textsuperscript{166} See id.
\textsuperscript{167} See id. at 127-28.
\textsuperscript{168} See id. at 128-30.
\textsuperscript{169} See id. at 130. In relevant part, Curiale discussed the cherry-picking argument from the Empire rate-hike hearings:

They come in, individuals who buy their insurance directly, but lots of small groups, small groups that are small employers who come in and complain bitterly about the high rates that Empire is charging, but on the other hand say, I have got nowhere else to go. Why? No one else will take me.

\textit{Id.}

\textsuperscript{170} See id. at 131.
\textsuperscript{171} See id. at 135-36.
\textsuperscript{172} Id. at 379.
\textsuperscript{173} See id. at 383-84; see also Legislature Passes Historic Community-Rating Bill, \textit{The Bulletin} (New York State Insurance Department), July 1992, at 1.
\textsuperscript{175} See Oversight Hearing, supra note 135, at 131; see also Superintendent Testifies Before NYS Senate, \textit{The Bulletin} (New York State Insurance Department), Apr. 1992,
State’s attempt at “bringing people into the system and doing a better job of managing their care and protecting them from the instability that results from widely fluctuating premium rate increases.” A comparative study with four other states with similar community rating plans, however, revealed that New York’s health insurance reform was failing. The community rating plan enacted in New Jersey resulted in twenty new carriers and eleven thousand previously uninsured people entering the market. Vermont, too, has seen success. Small group coverage increased by fifteen percent in the first year of that state’s new law. Although the plans in Massachussetts and Maine have not been in existence long enough to allow for solid data collection, preliminary evidence as well as reports from state insurance regulators seem to indicate that there have been no major problems.

The overall findings of the Special Report are mixed. More states have reported favorable rather than unfavorable results. “As predicted, there are anecdotal reports of improved availability among firms that have previously had difficulty obtaining coverage, offset by complaints from firms with relatively young and healthy workers.” New Jersey has seen the greatest initial success with community rating. Insurance Department data indicated that twenty to twenty-five percent of the people purchasing new community-rated individual coverage reported that this is their first time with coverage. The structuring of

at 3 [hereinafter Superintendent Testifies, THE BULLETIN] (testimony offered to evaluate Governor Cuomo’s community-rating and open enrollment bill).


178. See id.

179. Id. at 7.

180. See id.; see also id. at Table A-3. The report contains a survey of The New Jersey Plan. The following data was extracted directly from that survey:

Features

For small groups (2-49), age (5-year intervals), gender, geography (6 areas). Effective on renewal dates. There are no adjustments for individuals. Full community rating for new policies as of August 1, 1993; a phase-in for old policies; and full community rating for all after July 1, 1995.

Carriers
the individual market was the principal reason that New Jersey achieved high enrollment. First, new individual policies were immediately community-rated. Second, renewed policy premiums were phased into these rates over a two year period (1993-1995).\textsuperscript{181} Finally, "[t]he law also require[d] all carriers to subsidize the losses of insurers offering nongroup plans, unless they themselves enroll a specified share of the nongroup market in their standardized plans."\textsuperscript{182} This policy resulted in twenty-one new carriers entering the individual market and eleven thousand previously uninsured people receiving coverage.\textsuperscript{183}

The positive results for Vermont include a fifteen percent increase in small group coverage during the first year of its modified community rating.\textsuperscript{184} Individual community rating was phased in the following year. Initially, some carriers that had a small percentage of the market withdrew when the law was

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Twenty-two carriers in the individual market now (as opposed to one BC/BS virtually cornering the market). This is due to "insurer play or pay" risk adjustment based on all insurance business.

\textit{Coverage}

Over 60,000 persons are now covered under the new individual policies. An estimated 11,000 (22\%) are newly covered individuals.

\textit{Features}

The Vermont Commissioner sets allowable factors. The Commissioner also sets the demographic factors, industry, and geography; no health or experience; effective July 1, 1992 for group size 1-49 people and effective July 1, 1993 for individuals.

\textit{Carriers}

There were 11 small group carriers as of July 8, 1992. As of Aug. 8, 1994, there were 16 registered carriers selling small group policies and eight registered carriers selling nongroup coverage in Vermont. A June 1994 study by William M. Mercer, Inc. found that while some carriers pulled out in response to the legislation, some new carriers entered and the exiting companies has relatively little business in Vermont.

\textit{Coverage}

There were 44,105 covered lives in small group plans as of year end 1992. This number grew to 50,768 by year end 1993, an increase of 6,663 or 15\%.
passed. Several new companies, however, have entered the market and are actively seeking subscribers. The law has greatly expanded coverage with only a small overall cost increase; an increase countered by stabilized premiums. As insurers become comfortable with the new law, increased affordability should follow.

Maine has witnessed both rate increases and decreases. Unlike New York, Maine used a rolling start-up date based on policy renewal dates. The greatest increase, however, was for a carrier that implemented full community rating at once, rather than phasing it in according to Maine's enacted schedule. Three insurers with only six percent of the market left the state, but no major providers left. Small businesses are pleased with the plan. Some owners have commented that the new law has provided an increase in carrier options without a hike in rates. They are happy that they no longer have to resort to Blue Cross/Blue Shield.

Massachusetts has been phasing in a complex multi-tiered modified community rating since 1992. There have been no re-

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185. See id. at 8.
186. See id.
187. See id.
188. See id. at 10 & Table A-1. The report contains a survey of the Maine Plan. The following data was extracted from that survey:

**Features**
- Age, gender, occupation/industry, geographic area, smoking. Effective after 7/15/93 for small groups. Individuals added 12/1/93.

**Carriers**
- 20 carriers in the small group market; no major carrier left. Blue Cross has 65.3% of the market. Seven carriers in the individual market. Golden Rule (3.6%) of the market, American Republic (2.3%), State Farm (0.3%), and Blue Cross (75.5%). Blue Cross has lost some market share in the small group market to U.S. Life based on rates and anecdotal reports.

**Coverage**
- A base line survey was conducted prior to the starting date. A second survey was done in summer 1993, but there have been computer problems with the data, and the material was gathered before the plan had begun for most participants. A third one may be conducted in 1993 and should provide a picture after a full year of participation.

See id.

189. See id. at 10.
190. See id.
191. See id.
192. See id. at 11.
193. See id. & Table A-2. The report includes a survey of the Massachusetts Plan. The following data was taken from that survey:

**Features**
- Age, sex, industry, participation rate and group size, geographic area, well-
ports concerning changes in carriers or coverage. Businesses that had been denied under the old system are now able to obtain coverage, but younger businesses are complaining that rates are increasing.\textsuperscript{194} Managed care has expanded significantly following the law, but it already had held a large share of the market.\textsuperscript{195} These rating limits are beneficial to HMOs because they do more risk management than underwriting.\textsuperscript{196}

New York's experience with community rating has not been as positive as the other states.\textsuperscript{197} "In the first nine months [March 31, 1993-January 1, 1994] overall coverage in the affected markets—individual, small group and Medicare supplemental—declined by 1.2%."\textsuperscript{198}

The New York law appears to have affected the individual market the most. Companies that continued to offer coverage to

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\textsuperscript{194} \textit{See id. at 11.}
\textsuperscript{195} \textit{See id.}
\textsuperscript{196} \textit{See id.}
\textsuperscript{197} \textit{See id. at 11 & Table A-4. The report contains a survey of the New York Plan.}

The following data was gleaned from that survey:

**Features**
Geographic region, individual versus family, individual versus small group.
Began on Apr. 1, 1993 for individual and small groups (up to 50 people).

**Carriers**
There was no substantial change in the small group market. Two carriers, Preferred life and Prudential, terminated indemnity policies but offered managed care policies in their place. Another five carriers withdrew, with 22,914 or roughly six percent of the commercial market or less than two percent of the total market for these categories. The remaining commercial carriers are Mutual of Omaha, National Casualty, and International Life Investor in addition to the non-profits and HMOs. The Commercial market share rose by .5% and HMOs gained 5.5%, while the non-profits' share dropped 6%.

**Coverage**
State wide, coverage dropped from Mar. 31, 1993 to Jan. 1, 1994 by 1.2% (25,477) among individual, small group and Medicare supplemental policies. The greatest drop (12%) in coverage occurred in the individual market while total coverage increased very slightly for small group and medicare supplemental policies. Non-profits (Blues) lost subscribers in all three categories, commercials lost individual subscribers, and HMOs were big gainers overall.

\textsuperscript{198} \textit{Id. at 8. This percentage is better understood when compared to the year preceding the start of community rating. At that time, total coverage in New York also fell 1.2% in the overall population. See id. at 8-9.}
individuals, like Mutual of Omaha, experienced a significant drop in individual policies from April to November 1993. The Department of Insurance contends that some of the change "was due to movement among different types of plans and points to an increase in coverage among older workers and group plans during the same period." The limited availability of 1994 data concerning the state population as a whole made it difficult to pinpoint whether the law was failing or if it was merely being distorted by insureds moving between coverage. What is clear, however, is that "insurance coverage among groups affected by the new law did decline, with a 12.3% decline in the individual market between 3/31/93 and 1/1/94."

The available data has allowed researchers to determine some of the changes which most likely occurred as a result of New York's community rating law. High risk individuals who could not afford coverage could now obtain health insurance. People who were in a low risk pool, who either experienced a rate increase or whose carrier fled the market, may have chosen to go bare or move to a spouse's large group insurance plan. Small group coverage became available to employers who previously could only find insurance for its employees in the individual market. Young and healthy workers, in order to avoid the rate increases caused by community rating, purchased plans with higher deductibles. Finally, small businesses with a young and healthy work force began aggressively looking for ways to self-insure as rates rose under community rating.

199. See id. at 9. Mutual of Omaha experienced a 30% drop in individual coverage. More than half of those who left were under age 35. See id.

200. Id. ("Some of the decline may reflect a loss of market share to HMOs, which generally offer lower premiums."). Under the law, HMOs and other managed care plans are also required to offer open enrollment with community-rated premiums. See id.

201. See id.

202. Id. The extent to which this decline has been caused by community rating is a disputed issue between the industry and the State Insurance Department. Id. at 8-9. "The greatest drop (-16.58%) was in coverage in Blue Cross/Blue Shield plans, which were already community rated before the law." Id. at 9. The data collected by the department does not distinguish loss of coverage (people becoming uninsured) from loss of business (people finding coverage with another company). See id. Without this information one cannot tell why people dropped coverage. See id.

203. See id. This determination is most appropriately applied to individuals who were denied coverage from their employers, rather than people in the individual market. See id.

204. See id. at 9.

205. See id.

206. See id.

207. See id. (noting that self-insured plans are exempt from state laws, such as community rating, due to ERISA). First, insurance rates were on the rise overall (Em-
Comparing these five states allows one to see that the greatest problems emerged where rate changes were implemented without a phase-in period.\textsuperscript{208} New York and one carrier in Maine went to full community rating in one single step and both suffered as a result of this choice.\textsuperscript{209} Those states that phased in the reform law in increments had little trouble with their new plans. Gradually phasing in a community rating plan, over a three or four year period, allowed each state to eliminate adverse rating factors.\textsuperscript{210} The phase-in period has proven to be beneficial because the insurance market has maintained historically low rates of inflation.\textsuperscript{211} The rate increases that New York saw were diluted in the other states because they were not much higher than the rates of inflation experienced before reform.\textsuperscript{212}

V. ASSESSING NEW YORK'S DIFFICULTIES WITH COMMUNITY RATING

The lack of a phase-in period was not the cause of New York's community rating difficulties. It was merely part of the bigger problem of trying to rescue Empire Blue. The irony of the situation is laughable. Empire Blue was in financial distress

\textsuperscript{208} See id. at 11. Three key lessons were revealed by the Special Report. The leading lesson is to "[p]hase in rate restrictions to avoid rate shock." Second, insurers should "[s]hare risks." States should make an effort to spread high risk individuals among the various insurers. This has proven difficult in states, like New York, where a community-rated Blue Cross/Blue Shield plan already insured the worst risks. Third, states should "[i]ntegrate individual and small group markets." Id. at 11-12. But cf. Health Reforms Damaging, Study Claims, THE INSURANCE REGULATOR, Apr. 15, 1996, at 1 ("The combination of guaranteed issue [also known as open enrollment] and community rating has caused deterioration in both the health insurance business and to the consumer, according to a new report released by the Council for Affordable Health Care [Insurance] ['CAHI'].") CAHI is an association of small and mid-sized insurers, brokers, agents and some physicians based in Alexandria, Va., that espouses market based reform." Id. The data used for the report was taken from seven reform states, including New York, New Jersey, Vermont and Massachusetts. See id. The Consumer Federation of American Insurance Director, Bob Hunter, however, claimed that CAHI's findings were "phony." Id. Hunter criticizes the report for not using data from all insurers. See id.

\textsuperscript{209} See SPECIAL REPORT, supra note 177, at 11.

\textsuperscript{210} See id.

\textsuperscript{211} See id.

\textsuperscript{212} See id.
and its rates were soaring faster than anyone could pay for them.\textsuperscript{213} The State Legislature, in an effort to save the big Blue, passed the community rating law with the hope of leveling the playing field and spreading higher risk individuals to commercial insurers.\textsuperscript{214} There was no phase-in period because the Department of Insurance was hoping for an easy remedy for the Empire problem.\textsuperscript{215} The Department and the Legislature, however, misjudged the factors which were causing Empire's rates to increase.\textsuperscript{216} Now, Empire's failures are causing New York's community rating law to fail.

If insurer cherry-picking was the only problem plaguing Empire, the passage of the community rating law would have ended the crises, as predicted by Governor Cuomo and Superintendent Curiale.\textsuperscript{217} Since the law's passage, however, Empire has still been raising its premiums, which in turn has forced people to drop the expensive coverage.\textsuperscript{218} The more that people choose to go bare, the less of a chance community rating has to succeed.

Early in 1994, Empire again asked for a rate increase.\textsuperscript{219} This time it wanted an 8.8\% increase that would have affected 993,000 individual and small group community-rated subscribers.\textsuperscript{220} Superintendent Curiale denied the increase based on the continued availability of $94.7 million from the lawsuit and the anticipated economic gain for Empire due to community rating.

In July of that same year, Governor Cuomo, in a letter to the \textit{Washington Post}, admitted that Empire Blue Cross/Blue Shield was still floundering even with the new community rating law. In this letter he tried to explain that the law could be viewed as successful if one ignored Empire's losses.\textsuperscript{221} It is diffi-
cult, if not impossible, however, to ignore how Empire is faring under the community rating law. To do so would be to ignore one of the primary reasons for the law's passage, that is, to stabilize Empire Blue and create a level playing field among insurers.222

The Department of Insurance attempted to refute industry attacks on community rating by pointing to the annual Federal Bureau of the Census population survey, released October 6, 1994.223 The survey revealed that "New York State's 1993 uninsured rate remained unchanged from 1992, contrary to assertions by the commercial health insurance industry."224 Curiale used this information to argue that community rating was succeeding. The Census data showed that for four years prior to community rating, uninsured numbers grew in the following way: 1988—10.7%, 1989—11.8%, 1990—12.1%, 1991—12.3%, 1992—13.9%.225 In 1993, the percentage of uninsured people remained at 13.9%, although the nationwide average rose from 15% to 15.3%.226

The 13.9% figure, when examined out of context, gives the illusion that community rating may have prevented the rate of uninsured individuals from increasing. If one looks back on 1993, however, and analyzes the percentage of uninsureds throughout the year, the meaning behind the 13.9% changes. Community rating became effective in April 1993.227 Research has shown that from this date until the end of 1993, the percentage of covered individuals dropped 1.2%.228 Looking at the percentages from this perspective, one can see that prior to community rating, the number of uninsureds was apparently only 12.7%. The percentage of uninsureds reached 13.9% only after the passage of community rating. This analysis does not prove that the increase was caused by community rating,229 but it does...
show that the law has not been the success that the State pur-
ports it to be.

Another obvious sign that community rating is not perform-
ing as promised is the continued rate increases and economic
difficulties of Empire Blue Cross/Blue Shield. According to those
who supported it, the law was supposed to eliminate cherry-
picking and allow Empire to compete on a level playing field. The
field is not level yet, and Empire is still the legally favored
company. Even with the field tilted in the favor of Empire, it
still applied for a rate increase of up to 43.5% for 500,000 of its
customers in 1995. The average increase under this request
was 21.4%, which would also affect subscribers with AIDS, can-
cer and other serious diseases.

Superintendent Edward J. Muhl scaled back Empire’s re-
quest and only granted a 15.7% increase for its 727,000 individ-
ual, small group and Medicare supplement community-rated

230. See supra Part II.
231. See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (explaining that Empire was not required to pay hospital surcharges whereas commercial carriers were required to pay those surcharges).
232. See Jeffrey L. Reynolds, Medical Coverage for All, NEWSDAY, Feb. 16, 1995, at A41 ("Following enactment of the Community Rating Law . . . commercial insurers have stopped selling individual policies or offer only bare-bones plans, leaving Empire as the only insurer for those who have chronic illnesses."); see also Empire Blue Cross and Blue Shield: Seeks Rate Increase, HEALTH LINE, Dec. 18, 1997, available in LEXIS, News Li-
brary, Hltline File (discussing rate hikes ranging from 18 to 52% for 15,000 of the in-
surer’s customers, this request included a 10% hike for upstate small group policy
holders).
fer its special comprehensive health care package, used mainly by cancer and AIDS vic-
tims. See id. The company claimed that these policies were costing it millions of dollars. See id. The 17,000 special comprehensive policy holders would continue to receive ser-
vice. See id. New applicants would instead be offered coverage by an HMO. See id.; see also Judy Temes et al., Health Care: Taking the Temperature of 40 Health Care Players,
CRAN's N.Y. Bus., Jan. 23, 1995, at 21 ("Empire’s large account business, which has 4.1
million members, lost $22 million in the first nine months of the year, following a $97
million loss in 1993. [The company’s] community rated business with 852,000 members
was $100,000 in the red.").
234. Susan Harrigan, Insurance Chief Nominee Got Flak Over Blue Cross, NEWSDAY, Jan. 17, 1995, at A35. Edward J. Muhl was Governor George Pataki’s choice as a re-
placement for Superintendent Curiale. See id. Muhl was Maryland’s insurance commis-
sioner from 1982 to 1988. See id. He then became vice president of “an insurance com-
pany that is 49.5% owned by Saul Steinberg, a New York financier who was the second-
largest donor to Pataki’s gubernatorial campaign.” See id. This past job made Muhl re-
sponsible for government and industry relations, which included lobbying. See id. Muhl
is also a former president of the National Association of Insurance Commissioners. See id.
subscribers. Muhl demanded that the "company achieve cost savings, become more efficient, and expand its product line to include HMOS." In the past, Empire refused to develop a managed care alternative for the direct pay market. It has also refused to implement necessary changes such as providing an out-of-network option and limited prescription drug benefits with a managed care product. Superintendent Muhl also wanted increased fraud detection. In 1994, with limited efforts, Empire uncovered twenty-five million dollars in fraud. The Department believed the company could detect up to forty million dollars in fraud in 1995. Muhl was displeased with Empire's administrative costs because it continued to pay executives exorbitant bonuses while it was struggling to find its identity in the market place. The 1995 administrative costs were expected to be 9.4% of the premiums. Superintendent Muhl wanted this figure to be only 7%, as it had been in the past. The declining enrollment would support this percentage.

These criticisms are similar to those made by the Senate staff that investigated Empire. In 1993, the staff determined that cherry-picking was not the most serious problem facing Empire and that more than community rating was needed to save the non-profit company. Superintendent Curiale, how-

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236. Id. But see Department Ranks Health Insurers According to Complaints, BUSINESS WIRE, Dec. 24, 1997, at 1, available in LEXIS, News Library, Wires File (explaining that, in the overall ranking for complaints handled by insurance carriers, Empire moved up from 52 to 32).
238. See id.
239. See id.
240. See id.
241. See id.; see also Rosemary Metzler Lavan, Pols Targeting Empire's Raises, DAILY NEWS, Mar. 10, 1995, at 26. State Senate Republican leaders planned to propose legislation that would have prohibited Empire executives from receiving raises or bonuses when the company lost money. See Lavan, supra. Executives received a six-figure bonus and salary package in 1994, while Empire lost $118 million. See id. "Empire's new chief executive officer Michael Stocker received salary and other compensation totaling $482,000, including a $300,000 signing bonus, for just two months' employment." Id. Other executives, G. Robert O'Brien and Philip Briggs, received similar packages. See id. The proposed legislation would require the state to approve any salary increase for Empire employees earning more than $100,000 per year. See id.
243. See id.
244. See supra notes 135-62 and accompanying text (discussing Senate staff findings
however, insisted this law would solve the company's economic dilemmas. The department, under Superintendent Muhl, however, began realizing that community rating is not Empire's panacea. This realization has continued through the beginning of 1998. The current superintendent, Neil Levin, denied another rate increase request from Empire in April 1998. The Pataki administration, however, has announced that it will support Empire and other insurers who provide individual coverage by providing them with $110 million in State assistance. Of this $110 million from the State, Empire is scheduled to receive $16.8 million.

The Legislature and the Department of Insurance made two promises when community rating was proposed and passed. First, they promised that community rating would increase the number of people with health insurance in New York. Unfortunately, this increase has not materialized. In fact, the number of people with insurance in New York has decreased. Depend-

that Empire was poorly managed and losses were not due to cherry-picking); see also Scott Hensley, Empire Ex-CFO Convicted: Jury Finds Former Blues Official Lied, Doctored Records, MODERN HEALTHCARE, Mar. 10, 1997, at 44. Former Blue Cross-Blue Shield executive, Jerry Weissman, was convicted for lying to the Senate committee during its investigation. See Hensley, supra. In addition to lying to the Senate, Weissman had given doctored documents to the panel in an effort to hide Empire's book-keeping methods. See id.

245. See supra notes 163-73 and accompanying text (concerning Superintendent Curiale's testimony at Senate hearing with respect to how community rating would boost Empire's fortunes).


247. See supra notes 233-43 and accompanying text (discussing Superintendent Muhl's criticisms and demands of Empire).

248. See Ian Fisher, Albany Will Pay Health Insurers to Freeze Rates, N.Y. TIMES, Apr. 22, 1998, at A1 (revealing that 110,000 New Yorkers purchase individual health insurance and that the request would have caused up to a 69% increase in those premiums).

249. See id.

250. See Claire Hughes, Health Insurers Say Direct-Pay Plans Costly, TIMES UNION, Apr. 23, 1998, at E1 (explaining that an Empire rate increase would have caused insureds to be burdened with an additional $24 million in premiums).

251. See supra notes 82-91 and accompanying text (offering background on the nature and purposes of community rating).

252. See supra notes 197-202 and accompanying text (concerning an analysis of the Special Report on New York's community rating plan as well as the State's decrease in health insurance coverage). In New York, community rating caused rates for single young males to jump 170%. See Tony Snow, Dole's Bad Medicine Health-Reform Plan Would Raise Costs, Hurt Quality, USA TODAY, Mar. 25, 1996, at 11A (critically compar-
ing on how one interprets the data available, it is quite possible that community rating was responsible for this decrease.253

The second promise made by the State was that community rating would end cherry-picking, and thus relieve Empire Blue Cross/Blue Shield from being the insurer of last resort.254 Empire, however, remained the dominant health insurer in the state, largely due to the fact that it had continued to provide both individual policies and free choice of doctors and prescription drugs.255 Cherry-picking was no longer an issue, yet Empire continued to increase its rates and undergo internal transitions.256 These ongoing problems for Empire indicate that the

253. See discussion supra notes 214-30 and accompanying text.

254. See supra notes 76-92 and accompanying text.


256. Barbara Benson, Empire Chief Shuffles Execs, Plans Layoffs, CRAN'S N.Y. BUS., Jan. 23, 1995, at 1. Empire's new president, Michael Stocker, overhauled senior management and changed the focus of the company towards managed care. Id.; see also Serbaroli, supra note 32, at 3 (discussing Empire Blue joining a national trend in Blue Cross/Blue Shield moving from non-profit to for-profit). Empire "proposed the creation of two for-profit subsidiaries that could eventually assume most of its health insurance business. [The] proposal received preliminary approval from the New York State Insurance Department." Serbaroli, supra. The approval resulted in massive protests from consumer advocates. See id. Hospital associations and the state medical society expressed concern over the plan. See id. The proposal went to the Attorney General's office for review in the summer of 1996. See id.; see also Barbara Benson, Empire IPO Languishes As State Dallies: Insurer Cleans Up Balance Sheet, but Delay May Hamper Its Revival, CRAN'S N.Y. BUS., Mar. 17, 1997, at 1 [hereinafter Benson, Empire IPO Languishes]. In March of 1997, Empire president Mike Stocker expressed his hope that the conversion
U.S. Senate Subcommittee's findings were more accurate than the State Department of Insurance was willing to admit.\(^{257}\)

The continued failure of Empire Blue, combined with the overall rate increases or market-fleeing by other insurers, is forcing thousands of individuals to go without insurance.\(^{258}\) Community rating cannot become successful until Empire becomes economically stabilized and other insurers are forced to compete with the insurer of last resort.\(^{259}\)

Even if community rating becomes successful, it will not remedy the health insurance crisis that faces the nation. Community rating will only be an intermediary step towards larger reform, such as a single-government-payer system. Unfortu-

\(^{257}\) See supra Part III.A; see also Hughes, supra note 250, at 1 (revealing that the State Insurance Department recently admitted that Empire's poor management of administrative costs played a significant role in Empire's difficulties). The Insurance Department's admission, however, does not seem to imply that the State will act to remedy the problem. Rather, the new policy appears to involve the State pointing fingers and throwing money at this difficult situation. See Hughes, supra (discussing the $110 million disbursement to insurers).

\(^{258}\) See supra notes 119-34, 197-212 and accompanying text (discussing, among other issues, the number of uninsured in New York State); see also Alden Levy, New York's Ailing Health Care, J. COM., Jan. 9, 1997, at 6A ("After three years of community rating in New York, average premiums are 16.8% higher and the system insures 320,000 fewer people."). Mr. Levy is a business consultant in the health-care field. See Levy, supra, at 6A. He is also on the board of directors of "Third Millennium, a nonprofit advocacy group founded by people in their 20s and 30s to deal with social issues." Id. He has recently returned to New York and found that no company in the State is willing to write catastrophic health coverage (coverage for such things as being hit by a car). See id. He also notes that a young person who purchases an "all-inclusive" health insurance policy today in New York will pay the same rate as a 65 year old who has been smoking three packs of cigarettes a day for the past 40 years. See id. Not surprisingly, the average age of policyholders jumped by 3.5 years after the passage of community rating. See id. Mr. Levy is not the only one who dislikes community rating. See e.g., 1995 NY A.B. 5922, 218th Leg., Reg. Sess. (N.Y. 1995) (bill to repeal community rating introduced by State Assembly members Brown, Calhoun and Townsend—multi-sponsored by Anderson, Davidsen, King, McGee, Nortz, F.T. Sullivan and Winner). A bill repealing community rating, however, would undoubtedly encounter a great deal of opposition because community rating favors a large and relatively active segment of the voting population (that is, voters who are 45-65 years old).

\(^{259}\) Adverse selection will continue to plague the state. See A.B. 8713, 219th Leg., Reg. Sess. (N.Y. 1996) ("An act to amend the legislative law and the insurance law, in relation to mandated health insurance benefits").
nately, various states' use of community rating and other similar reforms drives up the cost of insurance and forces more people to go bare. This, in turn, makes larger national reforms more difficult and expensive to implement. The longer the federal government waits to take control of health care, the more ad hoc the system becomes.\textsuperscript{260} No cure for the nation's health care problems can be found in such a band-aid process.

\textsuperscript{260} See Dan Wise, \textit{While Disenchantment with Big Government Solutions Has Put Their Reform on Hold, Most States Seek Greater Flexibility To Implement Managed Care Solutions}, \textit{Business \& Health}, Jan. 1, 1995, at 61. "Forty-four states have enacted small-group market reforms to guarantee access to health insurance for individuals with pre-existing medical conditions." \textit{Id.} Of this number, twenty states have adopted some form of community rating. See \textit{id}. At least another twenty "are encouraging managed competition experiments, such as purchasing alliances that enable small group purchasers collectively to command more choice and better prices on health insurance." \textit{Id.} Physician-hospital organizations (PHOs), which are similar to HMOs, have been exempted from anti-trust laws in fifteen states. See \textit{id}. "Incremental reform seems to be the order of the day." \textit{Id.} (citation omitted).