

STATE HEALTH INSURANCE INDEX 2006:
*A 50-State Comparison of the Nation's Health
Insurance Market*

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Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked health insurance legislation in all 50 states. Once implemented, some of the laws have had a dramatic impact on the individual and small group health insurance markets, sometimes improving the markets and sometimes harming them. And in some cases virtually destroying the market. As state legislators consider future health insurance legislation, they need to understand how state laws affect insurance coverage.

Purpose of the Index. CAHI's 2006 State Health Insurance Index provides a snapshot of the health insurance environment in each state.

- Which states provide a dynamic, competitive market for health insurance, where consumers have a wide range of affordable options?
- And which states undermine their markets so that consumers have few health insurance options, and what is available is very expensive?

Surveys of the uninsured consistently show that the cost of health insurance is the primary reason for their being uninsured. Thus, the most efficient way to reduce the number of uninsured Americans is to ensure that people have access to a wide range of affordable health insurance policies. Some states largely achieve that goal, some don't. This Index identifies those states that are doing the best and worst jobs of ensuring access to affordable coverage. Health insurance may not be cheap in any state, but it can be available and affordable if states implement the right policies.

It is important to note, however, that the Index does not measure whether consumers can choose from different types of benefit plans. For example, consumers in Minnesota and California have access to affordable health coverage. But restrictive rating rules have driven many for-profit carriers from Minnesota, and Californians face a market dominated by HMOs. Consumers have *some* choice, but they could have more.

State Laws Affect Premiums. The general public and the media are largely unaware that state legislatures have a significant impact on the cost of health insurance premiums in the small group (i.e., 2 to 50 employees) and individual (i.e., individuals buy their own policies) health insurance markets. Because regulations vary from state to state, the cost of health insurance premiums can differ widely depending on the state where one lives.

Of course, a number of state legislatures have implemented a type of price control known as "community rating" or "modified community rating," which severely limits the amount insurance companies can charge. The result is that the young and healthy — typically those who earn the least and are most likely to be uninsured — are forced to subsidize the rates of older and generally wealthier individuals. Like any price control mechanism, community rating can drive insurers out of the market, reducing competition and increasing prices.

Some Insurance Is Exempt from State Law. This index only looks at the individual and small group markets. That's because large employers generally self-insure under the Employee Retirement and Income Security Act of 1974 (ERISA), and are governed by federal law outside of state regulation and oversight. Since this is a state health insurance index, it makes no evaluation of ERISA plans pre-empted from state law.

Indices Are Subjective. Like all indices — e.g., the Index of Leading Economic Indicators, the Dow Jones Industrial Average and the Russell 2000 Index — there is an element of subjectivity in choosing the factors that make up this Index. Knowledgeable people can differ on which factors to include, how much weight to give them and whether adjustments need to be made to control for distorting variables. However, the CAHI staff has vetted the measures included in this Index and their weights by numerous actuaries and health policy experts. So while we acknowledge that some may differ with our approach, we believe this Index provides a fair and accurate snapshot of each state's health insurance environment.

Blending the Individual and Small Group Markets. Certain measures blend the individual and small group markets. For example, the Index includes each state's percentage of uninsured. That rate can be a result of laws and regulations affecting both the individual and small group markets. But other factors also affect the number of uninsured, such as the state's average annual income or generosity of Medicaid coverage. Generally speaking, states with lower per capita income have a higher percentage of uninsured.

In addition, while the individual and small group markets tend to mirror each other — it is, after all, the same state legislature regulating both — that isn't always true. In some states the individual markets function better than their small group

markets. For example, Maryland and Colorado have pretty good individual markets, but struggle in the small group. Conversely, Georgia tends to have a functioning small group market, but struggles in the individual market.

The CAHI State Health Insurance Index. CAHI's Index includes six important measures of state health insurance viability that total to 100 points (the best score). It is important to note that we do not measure the effect of the Health Insurance Portability and Accountability Act's (HIPAA) guaranteed issue requirements in the small group market — which are common to every state — but we do measure the way states choose to implement the guaranteed issue requirement in the individual market.

The Index measures are:

1. *The percentage of uninsured.* This is one of two components receiving a smaller weight (10 points maximum for those with the lowest percentage) because so many other factors largely outside of state control have a direct impact on the number of uninsured. In other words, state laws and regulations affect the number of uninsured, but they are not the only factors to do so.

2. *The number of state mandates.* Although CAHI and many others have long asserted that mandates increase the cost of health insurance, determining how much depends on what is being mandated and the specifics of each piece of mandate legislation. So the mandate measure, like the percentage of uninsured, also receives a lower weight (10 points maximum for those with the fewest mandates). (See CAHI's "Health Insurance Mandates in the States" for a full listing of all state mandates.)

3. *State regulatory environment.* CAHI has developed an index that measures the impact of several state regulations. It is a snapshot of the state regulatory environment rather than a comprehensive assessment. State regulations, especially guaranteed issue and community rating, can have a significant impact on the availability and cost of health insurance. Those states with the best regulatory environment receive 20 points. (For a more extensive discussion of the regulatory index, see the Methodology at www.cahi.org.)

4. *High risk pools.* It is very clear that states with well-functioning high risk pools provide a valuable safety net for individuals who have a pre-existing medical condition and have been denied health insurance coverage. However, since each risk pool's structure and funding depend on state enabling legislation, some high risk pools function better than others. For example, Florida has had a risk pool for years but never funded it, so it is of little use. And California caps enrollment time at three years, which limits access to needed coverage. Like the regulatory environment, CAHI has developed a short index (20 points maximum) to assess those risk pools that do the best job. (For a more extensive discussion of the high risk pool index, see the Methodology at www.cahi.org.)

5. *Individual and small group premiums.* Few indicators provide more information about the availability of affordable insurance than the average premiums people actually pay for their coverage. America's Health Insurance Plans (AHIP) has created a survey drawn from actual premiums in the individual market (Note: for those states not included in AHIP's survey, we extrapolated from another survey). And the U.S. Medical Expenditure Survey (MEPS) regularly tracks premiums for the small group market. Those states with the lowest premiums in the individual and small group markets receive a maximum of 20 points for each market segment.

Application of Points. So there are four measures with a maximum of 20 points each and two measures with a maximum of 10 points each — for a total of 100 points.

The four measures receiving a total of 20 points each are broken down into quintiles, with the top states receiving 20 points, the next quintile receiving 15 points, etc., and the bottom getting a 0. The two 10-point categories are broken down into thirds, with the best score being 10 points, then five points and 0.

Accuracy of the Index. Are these six factors the only, or even the best, ingredients for the Index? Fortunately, there is a retrospective way to test the accuracy of the Index. Those states with high scores should have vibrant, competitive health insurance markets, with more and more insurers eager to provide a product in the state. Those with low scores will likely have seen an exodus of insurers from the state, and premiums will be much higher than normal.

And that is exactly what the Index shows.

It would be a mistake, however, for someone to look too closely at a state's specific ranking. It would be very hard, for example, to compare the viability of a state that comes in at, say, 25 (the middle) on the list from one that is 23 or 27.

Rather, the Index should be viewed as a snapshot. Those states receiving 65 points or more generally have well-functioning health insurance markets. There could be improvements, of course, but people have access to affordable coverage and they have a safety-net option if they are uninsurable.

Those states receiving between 45 and 65 points may be functioning, but are in need of improvement. Those states receiving 40 points or less are generally dysfunctional; people there have very few health insurance options and what options they do have are often very expensive. Those states need reform — and they need it now.

Alternative Approaches. In some cases where states have undermined their health insurance markets, people and insurers have found alternative ways to get affordable coverage. For example, Florida's individual market is burdened with regulations and an overzealous insurance department, which has made those policies expensive and reduced competition. As a result, a number of insurers are selling policies in the association group market, where individuals gain access to usually less-regulated and less-expensive policies from licensed insurance companies, due to their membership in an association. In other words, individuals do have access to more-affordable policies in Florida, but primarily through the association group rather than the individual market.

However, people shouldn't be forced to look for alternative avenues to affordable coverage. Ensuring residents have access to those policies should be the goal of every state.

What Can States Do? The good news is it is never too late to reform. Both Kentucky and South Carolina had passed laws that devastated their health insurance markets. They saw the error of their ways, changed the laws and insurers are returning with more options at affordable prices — and more people are getting coverage once again.

Eliminate guaranteed issue. Guaranteed issue laws require insurers to accept all applicants regardless of a pre-existing medical condition. We have a decade of experience and know that guaranteed issue may provide access to health insurance in the short term, but these laws eventually drive the cost of health insurance out of reach for all but the richest Americans.

Establish a high risk pool. Every state that does not have a high risk pool should start one. As evidenced by the high premiums, it is clear that states with community rating and guaranteed issue do not fairly manage health insurance costs. High risk pools spread risk more broadly, and provide a cost-effective way for those with medical conditions to obtain insurance. High risk pools are a better, more equitable and affordable way to provide universal access to health insurance.

Eliminate community rating. States with community rating, which requires insurers to charge everyone the same price regardless of age or medical condition, should eliminate that requirement. In addition, narrow rate bands, which severely limit premium variations, should be relaxed in favor of rate bands that balance affordability with the needs of those with medical conditions. Establishing rate bands that mirror those once supported by the National Association of Insurance Commissioners' small group model rate (that is, +/-25 percent of the standard premium, or wider) will go a long way in ensuring coverage is both accessible and affordable.

Create laws that streamline the regulatory requirements. Health insurers face a complicated patchwork of state regulations, which are difficult to navigate. Some states have further complicated that environment by using subjective standards, or by taking months to review rate and form filings, or by creating impossible standards for certain kinds of products. There are many proposed efforts to deal with this problem, including the Health Care Choice Act, the interstate compact, optional federal charter, the State Modernization and Regulatory Transparency Act, and others. (See CAHI's "State Legislators' Guide to Health Insurance Solutions.")

Stop passing laws that increase the cost of health insurance. Health insurance mandates and minimum coverage levels continue to be popular in a number of states. Legislators need to stop passing these additional costs to their constituents. Short of that, many states have enacted mandate-study commissions that at least provide legislators with an estimate of the cost of the mandate they have proposed.

(Note: Breakdowns of all six categories and explanations of how the points are attributed to each category are available in the Methodology Section of this paper, available at www.cahi.org.)

	REGULATION SCORE	MANDATE SCORE	% UNINSURED SCORE	HIGH-RISK POOL SCORE	INDIVIDUAL MARKET SCORE	SMALL GROUP MARKET SCORE	INDEX TOTAL
AK	20	10	0	20	5	0	55
AL	20	10	5	20	10	15	80
AR	20	5	0	20	0	15	60
AZ	15	10	0	0	10	10	45
CA	15	0	0	10	20	15	60
CO	10	5	5	20	20	0	60
CT	10	0	10	20	0	0	40
DE	10	10	5	0	20	5	50
FL	10	0	0	10	10	0	30
GA	15	5	5	0	0	15	40
HI	10	10	10	0	0	10	40
IA	15	10	10	20	20	20	95
ID	15	10	5	20	20	15	85
IL	20	5	5	15	10	10	65
IN	20	5	5	20	15	10	75
KS	15	5	10	20	20	10	80
KY	20	5	5	15	20	15	80
LA	15	5	0	10	0	10	40
MA	0	5	10	0	0	10	25
MD	15	0	5	20	0	10	50
ME	0	0	10	0	0	0	10
MI	20	10	10	0	20	0	60
MN	20	0	10	20	20	20	90
MO	15	5	10	20	15	15	80
MS	10	10	0	10	5	10	45
MT	15	5	0	20	10	15	65
NC	10	0	5	0	10	5	30
ND	15	5	10	15	10	20	75
NE	20	10	10	15	15	10	80
NH	10	5	10	20	0	5	50
NJ	5	5	5	0	0	0	15
NM	20	0	0	20	20	10	70
NV	15	0	0	0	15	10	40
NY	0	0	5	0	0	0	5
OH	15	10	10	0	15	10	60
OK	15	5	0	15	0	5	40
OR	5	10	0	20	20	10	65
PA	20	5	10	0	20	5	60
RI	10	5	10	0	20	0	45
SC	20	10	5	20	0	10	65
SD	15	10	5	20	0	10	60
TN	15	5	5	5	0	5	35
TX	20	0	0	20	0	5	45
UT	20	10	5	15	20	20	90
VA	15	0	5	0	15	15	50
VT	0	10	10	0	0	5	25
WA	5	0	5	20	0	10	40
WI	20	5	10	20	15	0	70
WV	20	5	0	5	0	10	40
WY	15	5	5	15	5	10	55

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Other CAHI state health reform publications available at www.cahi.org:

- “2006 State Legislators’ Guide to Health Insurance Solutions,” by JP Wieske
- “Health Insurance Mandates in the States, 2006,” by Victoria Craig Bunce, JP Wieske and Vlasta Prikazsky
- “Trends in State Mandates, 2006,” by Victoria Craig Bunce
- “HSA State Implementation Report,” by Victoria Craig Bunce



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