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UNINSURED RATES RISE DRAMATICALLY IN STATES WITH STRICTEST HEALTH INSURANCE REGULATIONS

MELINDA L. SCHRIVER AND GRACE-MARIE ARNETT

During the heated debate on health care reform several years ago, some states jumped ahead of the rest by aggressively regulating their health insurance markets to speed reform. The data are now in, and they show that these attempts have backfired by harming the very citizens they were designed to help.

Between 1990 and 1994, 16 states passed the most aggressive laws designed to increase access to health insurance for their uninsured citizens. They imposed mandates and regulations on health insurance for small employers and individual citizens, implementing at the state level many of the provisions contained in the failed Clinton health care bill.

The results: In 1996, all 16 states experienced an average annual growth in their uninsured population *eight times* that of the other 34. In 1996, the one-year average growth rate in the uninsured population in the 16 regulatory states was 8.14 percent; in the other 34 states, however, it had fallen to only 1.02 percent. In 1990, before the blizzard of health care reform legislation, the two groups of states had been nearly equal at 4.6 percent and 3.9 percent, respectively.

Although the primary intention of insurance reforms is to make insurance coverage more affordable and available, thereby increasing the number of people covered by private health insurance, the 16 states that implemented these more comprehensive reforms have had the exact opposite experience. The result:

- **More** citizens uninsured.
- **Fewer** citizens covered by private insurance.
- **Fewer** citizens covered by individual insurance.

Among the mandates passed by these 16 states were requirements that insurers sell policies to anyone who applies and agrees to pay the premium—even those who wait until they are already

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sick before buying insurance (guaranteed issue); prohibitions on such underwriting practices as excluding coverage for some medical conditions (pre-existing condition exclusions); and requirements that insurers charge the same price to everyone in a community, regardless of the differences in risk individual policyholders represent (community rating).

The 16-state study included Idaho, Iowa, Kentucky, Louisiana, Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont, and Washington State. These states were identified by the U.S. General Accounting Office as having passed aggressive regulations affecting both their small-employer and individual health insurance markets between 1990 and 1994.

The health sector is the most heavily regulated in the American economy. In every other industry, Americans recognize that regulation drives up prices, restricts innovation, dries up competition, and forces businesses to cater to regulators instead of consumers. This is exactly what is happening in the health sector.

These data show that Americans are paying a high price for the mistakes of well-intended but flawed legislation. The misguided efforts of lawmakers to over-regulate insurance markets have backfired, squeezing more and more people out of the system.

HOW TO HELP THE UNINSURED

Lawmakers should focus on policies that allow individuals to purchase health insurance that they own and control themselves in a free, competitive, and well-informed marketplace. Such policies would enable consumers themselves to transform the health sector into a market driven by competition, innovation, value, and choice. There are several actions that states can take to help reach this goal. Among them:

- **Encourage** changes in federal tax laws.
- **Initiate** the delivery of state tax relief.
- **Review** all currently enacted health care regulations and eliminate those found to be harmful.
- **Dismantle** regulatory boards established with previous reforms.
- **Abolish** pure community rating.
- **Stop** expanding benefit mandates.
- **Promote** experimentation of coverage for the uninsurable.

The results examined in this study show that regulation at the state and federal levels is counterproductive in responding to the challenge of increasing access to health insurance in the individual and private health insurance market. A far better approach would be to empower individuals and families to make health care choices that suit their own needs, restore the independence and integrity of the medical profession, and force insurance companies to compete for consumers' dollars. The health care delivery system at all levels should be accountable directly to the individuals and families being served.

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UNINSURED RATES RISE DRAMATICALLY IN STATES WITH STRICTEST HEALTH INSURANCE REGULATIONS

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> The most melancholy of human reflections, perhaps, is that, on the whole, it is a question whether the benevolence of mankind does most good or harm.
>
> —Walter Bagehot, *Physics and Politics*, No. v

During the heated debate on health care reform several years ago, some states jumped ahead of the rest by aggressively regulating their health insurance markets to speed reform. The data are now in, and they show that these attempts have backfired by harming the very citizens they were designed to help.

Between 1990 and 1994, 16 states were most aggressive in passing laws designed to increase access to health insurance for their uninsured citizens.[1] They imposed mandates and regulations which primarily affected health insurance for small employers and individual citizens, and put into law at the state level many of the provisions of the failed Clinton health care bill.

The results: In 1996, all 16 states experienced an average annual growth in their uninsured populations *eight times* that of the other 34. In 1990, before the blizzard of reforms was enacted, the one-year average growth rate in the uninsured population in these 16 states was roughly equivalent to that of the other 34 states. By 1996, the one-year average growth rate in the uninsured population in these 16 states was 8.1 percent; in the other 34, it was only 1 percent.

Even before the gavels went down on bills attempting to redesign the health insurance markets, the number of uninsured citizens in the 16 states was escalating

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1. The 16 states in the study sample were Idaho, Iowa, Kentucky, Louisiana, Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont, and Washington. Many other states also passed reforms; however, the reforms passed by these 16 states were more comprehensive and aggressive.

steadily, growing by more than 25 percent over the six-year period compared with an increase of only 7 percent during this period in the other 34 states.

The rise in the number of people losing health insurance in these 16 states shows up in a number of other measurements as well:

- Each of the 16 states experienced a *decline* in private and individual health insurance coverage and an *increase* in the number of uninsured citizens.
- About 1 percent of the citizens in the 16 states *lost* job-based coverage, while more than 1 percent of the residents of the other 34 states *gained* job-based insurance.
- More than 10 percent of the citizens in the 16 states were covered by individually owned health insurance in 1990; by 1996, the figure had dropped to under 6 percent.

The factor that distinguished these 16 states from the others was passage of significant health insurance regulations. It appears that these states actually ended up harming their citizens by increasing the regulation of their insurance markets, inadvertently squeezing more and more people out of the system. These data show that Americans are paying a high price for the mistakes of well-intended but flawed legislation.

THE CONTINUING CRISIS OF COST AND COVERAGE

The number of Americans covered by health insurance, either public or private, increased steadily from the 1940s through the 1970s. Employers began offering health insurance to their workers in response to favorable tax policy changes that became popular during World War II. Job-based health insurance became the most attractive option for working Americans. In addition, Congress in 1965 created Medicaid and Medicare, two government-funded programs of medical care for the poor and the elderly.

Both employment-based private insurance and public health programs continued to expand through the 1970s. Since 1980, however, the percentage of Americans under 65 with private health insurance, either purchased individually or obtained through the workplace, has been declining. The drop has been steep: 79.5 percent in 1980 to 70.5 percent in 1995.[2] At the same time, the number of Americans covered by Medicare and Medicaid has increased significantly.

Similarly, health care costs increased at growing rates during the 1980s and into the early 1990s. Between 1980 and 1992, health care spending in the United States rose from 8.9 percent to 13.4 percent of gross domestic product (GDP). In 1996, health care expenditures totaled $1,035 billion, or 13.6 percent, of GDP.[3]

Challenged by these increasing costs, companies of all sizes increased co-payments, raised deductibles, limited coverage, and reduced health benefits.[4] Many of these efforts to reduce costs, or at least minimize the growth in health costs, shifted larger shares of the visible costs to the employee and also limited employees' choice. In the process, more people lost or declined job-based health insurance.

As the cost of private health insurance has increased, the number of Americans without coverage has risen, from 11.8 percent in 1980 to 17.3 percent in 1995.[5] Meanwhile, government health expenditures also have risen dramatically.

2. U.S. General Accounting Office, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, GAO/HEHS–97–122, July 1997, p. 4.
3. Health Care Financing Administration, Office of the Actuary, National Health Statistics Group, "National Healthcare Expenditures Aggregate, 1960–96," 1997.
4. Paul B. Ginsburg and Jeremy D. Pickreign, "Tracking Health Care Costs: An Update," *Health Affairs*, July/August 1997, p. 154; U.S. General Accounting Office, *Employment-Based Health Insurance: Cost Increase and Family Coverage Decreases*, GAO/HEHS–97–35, February 1997, pp. 9–21; and Congressional Budget Office, "Trends in Health Care Spending by the Private Sector," April 1997.

Political Intervention

Concerns over rising health care costs, the increasing percentage of the GDP dedicated to health care, and the growing number of Americans without health insurance prompted impressive political efforts to overhaul America's health care system. Public interest grew during the early 1990s, and health care reform became a major issue in the 1992 presidential election.

Alternatives for reform included a pay-or-play system, whereby employers would be mandated to provide insurance or pay into a pool of funds to provide insurance to individuals; a single-payer health care system; a series of less comprehensive efforts targeted at increasing the provision of insurance to the poor and uninsured; and proposals to reform the tax policy that causes many of the distortions in the private health care marketplace. The variations in these proposed alternatives derived from the power struggle between competing ideologies and the expected efficacy of either traditional market incentives empowering the individual or political regulation empowering the government to resolve the challenges posed by an evolving health care industry.

The Clinton Plan

Following the 1992 election, the Clinton Administration proposed a universal health care coverage system that would have required sweeping changes in the U.S. health care system.[6] Although the Clinton Administration argued that neither effective cost control nor significant insurance coverage expansions could be achieved without a fundamental overhaul of the health care system, the public was not prepared to support the transfer of so much control over the private health care system to government.[7]

But while Congress thwarted the Clinton Administration in its efforts to implement its proposed comprehensive reforms, the media attention and intense public debate, combined with the imposition of managed care and dramatic changes in employment-based health insurance, laid the groundwork for less comprehensive reforms at the state level.

Hearing the thunder of the health care crisis on the national horizon, many states started exploring insurance market reforms and were preparing to adopt such reforms on their own. As the health care storm grew in ferocity, some state officials took advantage of the political atmosphere and implemented state reforms, believing that comprehensive federal reforms would be enacted. State legislative reforms, whether Clinton-style or market-oriented, were targeted primarily to controlling costs and increasing access and insurance coverage.[8]

Clinton-Style State Reforms

Evaluation of state reforms has focused primarily on the states that enacted comprehensive reform plans modeled on the universal coverage health plan proposed by the Clinton Administration. Much has been written about specific efforts to implement such plans by three states: Kentucky, Massachusetts, and Washington.[9]

In each of these states, the plans have been described as containing most of the Clinton plan's key elements, including:

5. GAO, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, p. 18.
6. White House Domestic Policy Council, *The President's Health Security Plan* (New York: Random House, 1993).
7. For a detailed examination of the Clinton plan, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.
8. U.S. General Accounting Office, *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms*, GAO/HEHS–95–161FS, June 1995, p. 8; D. L. Rogal and W. D. Helms, "State Models: Tracking States' Efforts to Reform Their Health Systems," *Health Affairs*, Summer 1993, pp. 27–30; and Joel C. Cantor, Stephen H. Long, and M. Susan Marquis, "Challenges of State Health Reform: Variations in Ten States," *Health Affairs*, January/February 1998, pp. 191–200.

- Increased and more intrusive government bureaucracies;
- Increased regulation;
- Coverage, treatment, and provider mandates;
- A government-defined health package;
- Mandatory managed care; and
- Government restrictions on insurance premiums and revenues available for health care.

Previous studies show that these states' attempts to achieve universal coverage proved both politically and economically disastrous. In all three states, the implementation of these comprehensive reforms resulted in a loss of individual choice and control over health care decisions and led to steeply rising costs for health insurance. As costs soared, the numbers of uninsured swelled. Additionally, competition within each state dwindled, with many insurers withdrawing from these highly regulated insurance markets.[10]

More Modest State Reforms

Based on the evidence in Kentucky, Massachusetts, and Washington, the destructive results of efforts to achieve universal coverage through regulation are demonstrable. But while these states have received much of the attention, other states also have been very aggressive in efforts to increase the coverage, accessibility, and affordability of health care.

All of the states that have enacted health insurance regulations give policymakers solid data that can be extremely useful as federal and state officials frame future legislative initiatives. The experience of these states yields valuable information on the advantages and disadvantages of various interventions and offers lessons on what can or cannot be accomplished by these reforms.

For Congress, this is particularly important in light of the passage in 1996 of the Health Insurance Portability and Accountability Act (HIPAA), popularly known as the Kennedy–Kassebaum bill. Data from these states give Members of Congress some insight into potential problems that are likely to result from compliance with HIPAA.[11]

A review of the available data on health care coverage among the 16 states implementing the most aggressive insurance market reforms affecting both the small-employer and individual health care markets indicates that, *in all instances*, these states experienced:

- An **increase** in the number of uninsured;
- A **decrease** in the rate of coverage in the private insurance market;
- A **decrease** in the rate of coverage in the individual insurance market; and
- A **reduction** in patient choice in the design of their coverage packages.

The pattern is consistent. In fact, only one data point of 48 varies from the conclusions drawn for all data points.[12] While the number of uninsured citizens in New Hampshire increased between 1990 and 1996, the percentage of the population that was uninsured in those same years decreased slightly.

The New Hampshire Insurance Department recently commissioned a study to review the impact of the state's insurance reforms. The independent evaluators note that the state has experi-

9. Robert Cihak, M.D., Bob Williams, and Peter J. Ferrara, "The Rise and Repeal of the Washington State Health Plan: Lessons for America's State Legislators," Heritage Foundation *Backgrounder* No. 1121/S, June 11, 1997, and Rachel McCubbin, "The Kentucky Health Care Experiment: How 'Managed Competition' Clamps Down on Choice and Competition," Heritage Foundation *Backgrounder* No. 1119/S, June 6, 1997.
10. Cihak, Williams, and Ferrara, "The Rise and Repeal of the Washington State Health Plan"; McCubbin, "The Kentucky Health Care Experiment"; and Charles Baker, Ken Heithoff, M.D., and Phil Dyer, "Lessons on Reforming Health Care at the State Level: Massachusetts, Minnesota, and Washington State," *Heritage Lecture* No. 548, June 13, 1995.
11. An analysis of the regulatory impact of HIPAA is being prepared by Carrie J. Gavora, Health Care Policy Analyst at The Heritage Foundation.

enced a slight decrease in the percentage of its uninsured population but conclude that this can be attributed not to the reforms, but to the overall economic boom in New Hampshire, which has the lowest poverty rate and one of the lowest unemployment rates in the nation.[13]

WHY STATES ENACTED HEALTH INSURANCE REGULATIONS

States have many ways to exercise control over health plans and insurers, including health benefit mandates (mandating treatments, providers, etc.), solvency standards, premium taxes, and qualified plan standards, as well as underwriting regulations, such as guaranteed issue and renewal, preexisting condition exclusions, premium rate setting (community rating), and open enrollment. Appendix 1 identifies the specific regulations that have been implemented in each of the 16 study states.[14]

Broad state reform options ranged from government mandates that employers provide health coverage to their workers to the imposition of a single-payer system or some other comprehensive overhaul of the health care delivery system.

Extensive data and numerous reports are available describing the number and characteristics of uninsured Americans.[15] Many of the uninsured simply cannot afford to buy health insurance in the individual market. Many others are employed, typically by a company that may provide coverage; they also decline this coverage, however, because they find it too expensive.[16] Other employers, typically very small businesses, may not provide health insurance at all.

Many state legislators passed laws designed to increase access to insurance coverage for these populations. Wary of sweeping industry changes, these legislators favored less extensive programs of reform. Ultimately, several states passed laws to artificially manipulate premium pricing, mandate coverage, or impose other regulatory mechanisms in their attempts to increase access to health insurance for their uninsured populations.

The Private Market and the Uninsured

The estimated total U.S. population and respective medical costs for 1996, by specific insurance market populations, are identified in Table 1. Roughly 16 percent of the population, or nearly 41 million Americans, were without health insurance at some point in 1996. As of 1998, the number has grown to more than 42 million.

As noted, most Americans rely on private health insurance, either purchased individually or obtained through their employers, to help pay for medical expenses. These data show that more than 90 percent of people with private health insurance

12. Although many more data were analyzed, three specific factors were evaluated for each of the 16 study states. The three factors were the change in the percent of the state's population (1) with private health insurance, (2) with individual health insurance, and (3) uninsured. The change is the difference in the percent of the population in these categories before reform and after reform. See Table 6 for a breakout of these data points.

13. A. James Lee, Ph.D., Nancy T. McCall, Sc.D., Chuan Fen Liu, Ph.D., *et al.*, "An Investigation Into the Effects of the New Hampshire Health Insurance Reform Law, RSA 420–G," Center for Health Economics Research, Waltham, Mass., December 17, 1997.

14. Among the study sample, the number of mandates enacted range from a low of 7 in Idaho to a high of 37 in Minnesota. Idaho has the fewest mandates in the United States. Only Maryland, with 42, is more heavily mandated than the study states. On average, the states are subject to a premium tax of 2 percent. Eight of the study states have created a high-risk pool to cover the population defined as "high risk."

15. Jon R. Gabel and Gail A. Jensen, "The Price of State Mandated Benefits," *Inquiry,* Vol. 26 (Winter 1989), pp. 419–431; Michael A. Morrisey, Gail A. Jensen, and R. J. Morlock, "Small Employers and the Health Insurance Market," *Health Affairs*, Winter 1994, pp. 149–161; and H. E. Freeman and C. R. Corey, "Insurance Status and Access to Health Services Among Poor Persons," *Health Services Research,* Vol. 28, No. 5 (December 1993), pp. 531–541.

16. Paul B. Ginsburg, Jon R. Gabel, and Kelly A. Hunt, "Tracking Small-Firm Coverage, 1989–1996," *Health Affairs*, January/February 1998, pp. 167–180.

coverage obtain insurance through the workplace (roughly 140 million out of a total of 155 million with private insurance). Some people, however, particularly those unable to get employment-based health benefits, buy health insurance directly in the individual insurance market.

Table 1 B 1211

1996 Private, Public, and Uninsured Insurance Market: Their Populations and Medical Costs

	Population (in Millions)	% of Total	Medical Cost (in Millions of Dollars)	% of Total
Private Insurance (1)				
Individual	15	5.8%	$28	2.4%
Employment-Based				
Small Group	20	7.7	37	3.2
Large Group	120	46.1	222	19.3
Total Employment-Based	140	53.8	259	22.5
Total Private	155	59.6	287	24.9
Public Insurance (2)				
Medicare	35	13.5	186	16.2
Medicaid	30	11.5	126	11.0
Total Public	65	25.0	312	27.2
Uninsured	40	15.4	34	3.0
Nursing Home (3)	n/a		100	8.7
Dental, Vision (4)	n/a		60	5.2
Other (5)	n/a		357	31.0
Total, All Markets	260	100.0	$1,150	100.0

Note: Population numbers are rounded to the nearest 5 million.
(1) Private medical costs include only the cost of insurance.
(2) Public medical costs include health services and supplies (hospital care, physician services, other professional services, home health care, drugs and other medical nondurables, and other personal health care). These public medical costs exclude nursing home costs and dental/vision services.
(3) Nursing home costs include public nursing home costs ($48M), other public costs ($24M), private insurance costs for nursing home care ($4M), and private out-of-pocket expenses ($25M).
(4) Dental/vision costs include private insurance costs for dental care ($23M), private out-of-pocket costs for dental care ($22M), public dental care ($2M), private insurance costs for vision care ($600K), private out-of-pocket costs for vision care ($7M), and public vision care ($6M).
(5) Other costs include private out-of-pocket expenses for health services and supplies ($117M), private program administration costs ($46M), public program administration costs ($15M), public health initiatives ($36M), private research and construction expenses ($11M), public research and construction expenses ($21M), and other public costs including CHAMPUS, prisoner costs, active military, and other miscellaneous costs.
Sources: U.S. Bureau of the Census *Current Population Survey* data as reported in "Selections and Adverse Selections in Health Insurance," Council for Affordable Health Insurance, December 1996. Break out of cost numbers from HCFA, *National Health Expenditures, Select Calendar Years 1991–1996*, 1997.

Additionally, according to a 1997 U.S. General Accounting Office (GAO) report on private health insurance, nearly 40 percent of individuals enrolled in employment-based health plans (almost 56 million people) belong to a self-insured plan.[17] The prevalence of self-insured plans varies with the size of the firm. In 1993, approximately 11 percent of employees in small firms (1–100 employees) belonged to a self-insured plan. Over 60 percent of workers in the largest firms (over 500 employees) were enrolled in a self-insured plan. Roughly 45 percent of all individuals employed by firms categorized as "large group" or greater than 100 employees were enrolled in a self-insured plan.[18] Thus, the private employment-based insurance market is further subdivided as indicated in Table 2.

17. GAO, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, p. 3. A self-insured plan is defined as a health plan offered by a self-insured firm: one that itself bears the risk of covering the health care expenditures of its employees and is not funded by a third party.

The composition of the private health insurance market, and particularly of the employment-based health insurance market, reflects the characteristics of each specific submarket.

Table 2 B 1211

1996 Private Employment-Based Insurance Market: Sub-Market Composition

	Population in Sub-Market (in Millions)	Percent of Total
Individual	15	9.7%
Employment-Based		
Small Group	20	12.9
Not Self-Insured*	18	11.6
Self-Insured	2	1.3
Large Group	120	77.4
Not Self-Insured*	66	42.6
Self-Insured	54	34.8
Total Employment-Based	140	90.3
Total Private Market	155	100.0

Note: Population numbers are rounded to the nearest 5 million.
* Some of these health plans may be covered under ERISA; however, if the plan purchases insurance from a third-party health insurance carrier that is subject to state mandates and regulations, the health plan itself is indirectly subject to state regulations. Only those health plans that are fully self-insured are exempt from state mandates and regulations under ERISA.

Source: Author calculations based on U.S. Bureau of the Census data as reported in "Selections and Adverse Selections in Health Insurance," The Council for Affordable Health Insurance, December 1996, and on self-funded percentages reported in *GAO/HEHS-97-122* and in Acs, Long, Marquis, and Short, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," *Health Affairs*, Summer 1996, pp. 266-278.

Self-Insured Firms (Small or Large Group Employers). Employers offering a self-insured plan are protected from state insurance regulations and mandates through the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, self-insured firms—those bearing the risk of covering health care expenditures for their employees—are exempt from state insurance laws. Self-insured plans are not required to comply with state mandated benefit laws, though most self-insured plans offer plans that are at least as generous as those required by mandates.[19]

Large Group Employers (Not Self-Insured). The majority of these firms, employing over 100 persons, are able to purchase commercial insurance at an advantageous price because of the balanced risk pool based on the size of these employee groups. The financial profitability of such a large group would not be destroyed due to high health costs for any one employee in any one year. The large number of employees enables the large firm to spread the cost of the risk of any one employee having a high-cost year over the entire employee base.

Small Group Employers (Not Self-Insured). These firms also purchase commercial insurance, which typically is priced based on the health care expenditure experience of comparable groups. Few small firms realize any pricing advantages because these groups are not large enough or diverse enough to be considered a balanced risk pool. These employers have little bargaining power. If one employee has a high-cost year, premiums for these groups are likely to increase dramatically or their insurance could be canceled, as variations in expenditures per person cannot be spread sufficiently over the group because of the group's small size.

Earlier studies point consistently to the high and rising cost of insurance as the key factor preventing small employers from offering coverage to their workers.[20] An earlier report suggested that two-thirds of small firms that dropped coverage

18. Gregory Acs, Stephen H. Long, M. Susan Marquis, and Pamela Farley Short, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," *Health Affairs*, Summer 1996, pp. 266–278.

19. U.S. General Accounting Office, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS–95–167, July 1995.

did so because the premiums for health insurance they could obtain increased substantially.[21] Some insurance practices exacerbate the problem by substantially increasing costs or denying coverage for some firms and workers.

The Market for Individuals. Candidates for the individual health insurance market primarily include self-employed people; people whose employers do not offer health insurance coverage; people out of the labor force; early retirees who no longer have employment-based coverage and are not yet eligible for Medicare; and people who lose their jobs and who have exhausted coverage or who are ineligible for continued coverage.[22]

For 10.5 million Americans under 65 years of age—4.5 percent of the non-elderly population—individually purchased health insurance was the only source of coverage available to them in 1994.[23] In 1996, this number increased to 13.9 million, or 5.9 percent of the non-elderly population.[24] Those with individual health insurance tend to be older than those with employment-based coverage. People between 60 and 64 years of age are nearly three times as likely to have individual insurance as those 20 to 29 years old.

Price is a paramount concern for persons in this market. These individuals also have diverse health needs and economic resources. Insurance carriers therefore try to offer a variety of products with a wide range of cost-sharing options. Consumers who do not expect to need medical care obviously are more likely to demand products with the lowest possible monthly premiums (if they purchase health insurance at all). These products typically have comparatively high co-payments or deductibles. Other individuals may be able to afford only coverage with high cost-sharing options, regardless of their health.

Persons in the individual market must pay their entire premiums directly out of pocket. A few may get a partial tax deduction for their premium costs: Self-employed individuals may deduct a percentage of their insurance costs, ranging from 45 percent in 1998 to 100 percent by 2007. Whether individuals qualify or do not qualify for a deduction, the cost of health insurance largely determines which type of insurance product is purchased, or whether the individual can purchase coverage at all.

In the majority of states that still permit medical underwriting, individuals may be denied coverage in the private insurance market, may be able to obtain only limited benefit coverage, or may pay premiums that are significantly higher than the standard rate for similar coverage. Unlike employer-sponsored coverage, where risk is spread over the entire group, carriers in these states may assign rates to each individual on the basis of the risk indicated by such characteristics as age, gender, location, and smoking status. Thus, many states have sought to increase the health coverage options available to otherwise uninsurable individuals by passing insurance market reforms designed to restrict insurance underwriting in an effort to improve access and affordability of insurance for this segment of the population.

The Uninsured. This group consists of those persons unable to purchase insurance in the private market (including many who once were in the small group market and later were dropped by

20. Ginsburg, Gabel, and Hunt, "Tracking Small-Firm Coverage, 1989–1996," and Gabel, Ginsburg, and Hunt, "Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence," *Health Affairs*, Vol. 16, No. 5 (September/October 1997), pp. 103–110.

21. Morrisey, Jensen, and Morlock, "Small Employers and the Health Insurance Market."

22. U.S. General Accounting Office, *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs*, GAO/HEHS–97–8, November 25, 1996.

23. *Ibid*.

24. This percentage differs slightly from that shown in Table 1 because the population numbers in Table 1 are rounded to the nearest 5 million.

their insurer) and those choosing not to purchase insurance.

STATE ENACTMENT OF PRIVATE INSURANCE MARKET REFORMS

This continuation of circumstances—rising health care expenditures, increasing numbers of the uninsured, diminishing accessibility to the various insurance markets—encouraged state legislators to increase access of persons to health insurance. State officials believed their reforms in the small-employer and individual markets would simultaneously increase the affordability of health insurance and decrease the number of uninsured Americans. These private health insurance markets were targeted specifically by states, since ERISA exempts self-insured plans from state regulations.

This regulatory impulse also has been fostered by understandable social policy concerns. Health care legislation often aims to help those who cannot afford insurance. But this impulse to regulate often overlooks the possibility of harm caused by what Walter Bagehot, the great 19th century English theorist, called the "benevolence of mankind."

Between 1990 and 1994, most state governments passed legislation designed to improve portability, access, and rating practices for the small-employer health insurance market and, to a lesser extent, for the individual health insurance market. For that same time period, the GAO identified 45 states that enacted reforms regulating the small-employer health insurance market.[25]

The GAO also identified 25 states that passed individual market reforms by early 1995.[26] Not all of these 25 states passed "comprehensive reforms"; some included only minor regulatory restrictions regarding pre-existing condition exclusions and/or portability. A total of 16 states implemented the more comprehensive regulations in the individual and small business insurance market.

Regulations implemented at the state level are described below. For purposes of this study, states were selected based on the specific regulations enacted. Regulations vary in their impact on the insurance market, and the study sample includes states that enacted the regulations that are most influential.

Insurance market regulations include numerous policies that can be implemented in many combinations. These component policies include guaranteed issue, renewability, portability, limits on pre-existing condition exclusions, mandated benefits, community rating, and others.[27]

A recent study conducted by the Urban Institute attempted to quantify the impact of each of these policies individually.[28] Although the report indicated that guaranteed issue itself may decrease the number of uninsured, it showed that other policies, particularly community rating (or premium rate restrictions generally), offset any gains from guaranteed issue itself. More important, the Urban Institute study also points out that most states implement insurance reforms as a "package" of reforms. In fact, only five states did not implement premium rate restrictions along with the other small-employer insurance reforms, and all of the states that implemented individual insurance market reforms included some form of premium rate restrictions.

As a result of insurance market regulations, affordability and access to insurance coverage may improve for a few specific populations, such as the elderly or those already ill, based on community

25. U.S. General Accounting Office, *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms*, GAO/HEHS–95–161FS, June 12, 1995.

26. GAO, *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs*.

27. American Association of Health Plans, *The Regulation of Health Plans: A Report from the American Association of Health Plans*, February 3, 1998.

28. Jill A. Marstellar, Len M. Nichols, Adam Badawi, *et al.*, *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: Urban Institute, June 1998).

rating and guaranteed issue. However, such regulation also is likely to impose an offsetting increase in cost and decrease in access to insurance for other populations, such as young families and the healthy. The net effect of such regulatory policies in relative cost will depend upon the success with which the currently insured are able to retain coverage.

Major State Regulatory Policies

The six major insurance market reforms include:

POLICY #1: Guaranteed Issue. The guaranteed issue rule requires that insurers sell health coverage to any "eligible party" agreeing to pay the stated premiums and to fulfill other specified requirements.[29] State regulators did not require insurers to offer all products as guaranteed issue products; most often, states stipulated that at least one or two guaranteed issue products must be offered.

Guaranteed issue rules generally apply only during a specific open-enrollment period each year. Health insurance premium pricing is not addressed by this provision.

POLICY #2: Guaranteed Renewability. The guaranteed renewability rule is designed to ensure that currently covered individuals cannot have their coverage discontinued by their current insurer. Guaranteed renewability is intended to eliminate the cancellation of coverage to groups or individuals, even or especially those who have incurred substantial medical expenses. Most states enacting this policy limited the cancellation of an insurance policy to incidents of fraud or failure to make required payments. Like guaranteed issue, premium pricing is not addressed by this provision.

In the small group market, insurers are not allowed to cancel a contract or to single out an individual for premium increases. All decisions involving rates and coverage must apply to the whole group. Insurers can, however, cancel a group policy or raise rates for everyone in the group—or simply exit the market.

POLICY #3: Restriction of Pre-Existing Condition Exclusions. Many group policies have pre-existing condition waiting periods, which means that coverage for expenses related to medical conditions that existed before the new enrollee signed up for coverage would be excluded from insurance coverage under the policy. Some insurers, particularly those in the private individual insurance market, may permanently disallow coverage of treatments related to any previous conditions.

States that impose legislative limits on pre-existing condition exclusions establish maximum time periods for which medical conditions could be excluded from coverage. Typically, reform proposals set these limits at 6 to12 months.

POLICY #4: Requirement of Portability. Portability allows individuals to move from one job with employment-based insurance to another job that offers employment-based insurance without fear of being excluded from insurance coverage based upon a previously existing medical problem. Under portability rules, individuals maintaining continuous coverage would be exempt from pre-existing condition exclusions applying to new policies.

The objective of such a rule is to decrease the problem of "job lock." Studies indicate that workers would have much more flexibility in changing jobs if they did not fear losing insurance coverage for existing medical problems.

POLICY #5: Imposition of Community Rating. Pure community rating requires the insurer to charge the same price to everyone in the community regardless of the differences in risk they represent. The young, old, sick, healthy, men, and women all pay the same price.[30]

29. Although many state regulators followed the definition proposed by the National Association of Insurance Commissioners (NAIC), states were given discretion to modify the definition of eligible party to meet their specific needs.

Modified community rating is less restrictive. Modified community rating allows insurers to charge varying rates based on a limited number of factors such as gender, age, and family composition. Age rating, for example, sets broad age bands, across which premiums may vary. State policymakers often limit the differences to a particular range, requiring, for example, that the highest premium be no more than three times the lowest premium.

By implementing community rating, state lawmakers attempt to spread the higher costs of less healthy groups over all of the groups covered by the same insurer. Unfortunately, one result is that the healthier individuals or groups pay more than they would without the imposition of community rating, and the less healthy individuals or groups pay less than they would otherwise. As a result, the healthiest consumers often drop out of the health insurance market altogether. This leaves sicker citizens in the pool, and premium prices rise again.

Regardless of the good intentions underlying these regulations, both community rating and guaranteed issue rules disrupt the basic risk-spreading characteristic of health insurance. Guaranteed issue allows buyers the right to acquire insurance coverage at any time: in other words, to forgo insurance coverage when they are well and purchase coverage when they are sick. This imposes significant costs. Community rating breaks the relationship between an individual's risk and the price paid for insurance. The result is that the premium pricing does not accurately reflect the risk.

Absent community rating laws, insurers typically use characteristics of the insured group, including past patterns of health service utilization for that group and other groups similar to it in composition, to determine premium prices. For example, insurers may charge groups that have had above average spending in the recent past more than they charge other groups.

POLICY #6: Imposition of Mandated Benefits. As indicated in Appendix 2, every one of the 50 states has passed legislation to require insurance carriers and health plans to cover certain specified medical treatments and providers. The number of mandates in each state ranges from a low of 7 in Idaho to a high of at least 42 in Maryland.[31] The total number of state mandates has increased tremendously from a low of 7 in 1965 to over 1,000 today. Despite their costs, states and even the federal government are considering imposing numerous additional mandates during their 1998 legislative sessions.

Some states establish standard benefit packages that specify which services must be covered by insurance, which providers are to be covered, and often what cost-sharing obligations are to be imposed on workers and their families. Standard benefit packages, of course, restrict consumer choice of an insurance package suitable to the needs of the consumer.

STUDY DESIGN AND METHODS

The goals of insurance market reforms were to increase accessibility to insurance coverage in the private market and to decrease the uninsured population. The objective of this study is to assess the success of these insurance market reforms in attaining the desired goals.

- **Design:** Retrospective national cohort study using U.S. Bureau of the Census Current Population Survey (CPS) survey data from 1989 to 1996 with a detailed study of a select sample of 16 states: Idaho, Iowa, Kentucky, Louisiana, Maine, Minnesota, New Hampshire, New Jer-

30. Price differences can be based only upon geographic location, specific benefit package selected, and the family size (or total number covered under a family policy).

31. For an analysis of the impact of health care regulations in Maryland, see Dale Snyder, "Building Bureaucracy and Invading Patient Privacy: Maryland's Health Care Regulations," Heritage Foundation *Backgrounder* No. 1168, April 17, 1998.

sey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont, and Washington.

- **Setting:** A study sample of the 16 states that passed small business reforms between 1990 and 1994 and also passed individual market reforms by early 1995 was compared with the 34 other states and with average data for all 50 states.
- **Main Outcome Measures:** Level and rates of change in the uninsured population, private insurance market, and individual insurance market coverage. For both pre- and post-reform rate calculations, the health insurance coverage rate was calculated as an average over a two-year period. Pre-reform period rates were calculated as average rates for 1989 and 1990. Post-reform period rates were calculated as average rates for 1995 and 1996. Averaging the data accounts for the timing differences in dates of enactment and effectiveness (reforms typically are implemented or modified incrementally) and avoids contamination of the pre- and post-findings with selection effects.

Study Sample and Data Files Used

Census Bureau data sources were used to provide the study sample and data to address the study objective. CPS data from 1989 to 1996 were used to identify the number and percentage of non-elderly individuals with (1) private insurance coverage, (2) employment-based insurance coverage, (3) Medicaid coverage, (4) Medicare coverage, and (5) no coverage for each year between 1989 and 1996. The population covered by individual insurance was calculated as the difference between the total number identified with private insurance and the number identified with employer-based insurance.

CPS reports are known to report lower than actual numbers for Medicaid and Medicare populations. Adjustments based on information from the Medicaid and Medicare administrator records have not been made. The analysis of the data from the CPS focuses on the rate of change in the uninsured population and the private insurance market.

The 16-state sample was selected from the total 50-state population based on the identification of states that had passed both small-employer market reforms between 1990 and 1994 and individual market reforms by early 1995.

- States passing small-employer market reforms between 1990 and 1994 were identified in the U.S. General Accounting Office report *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms* (GAO/HEHS–95–161FS, June 12, 1995).
- States passing individual market reforms by early 1995 were identified in the GAO report *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS–97–8, November 25, 1996).

To be included in this study, a state must have been included in both reports.

A total of 25 states passed reforms in both the small-employer and individual markets. Not all of the 25 states passed comprehensive reforms, however; some included only reforms regarding pre-existing condition exclusions and/or portability.

States that did not implement guaranteed issue and premium rate restrictions were excluded from the study sample. Based on these criteria, seven states were excluded from the study sample.

The Leading Examples of State Regulation

The 16 states under study vary substantially in the size and urban/rural distribution of their populations, the size of their individual insurance markets, and the degree and type of other forms of insurance regulation. In general, they are representative of the range and variation of circumstances and regulation across all of the states.

Collectively, these states are very similar to the nation on measures of employment, earnings, and health care system characteristics, as noted in Table 3 and as discussed later. Data from these 16

Table 3 B 1211

General Characteristics of the Non-Elderly Population, 1995

	16 Study States	34 Other States	All States
Per Capita Income			
Average	$21,815	$22,334	$22,168
Range	$18,125–$30,071	$16,683–$31,776	$16,683–$31,776
% Below Poverty			
Average	12.6%	12.3%	12.4%
Range	5.3%–25.3%	7.1%–23.5%	5.3%–25.3%

Note: The non-elderly population consists of persons under age 65.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

states generally reflect the pattern of economic conditions nationally.

For example, average personal income per capita in 1995 was $22,168 in all states and $21,815 in the 16 study states, while the range was $16,683–$31,776 over all states and $18,215–$30,071 over the 16 study states. The percent of the population below poverty was an average of 12.4 percent in all states and 12.6 percent in the 16 study states, while the range was 5.3 percent–25.3 percent for both the 16 study states and all states as both the lowest and highest states were included in the 16 study-state population. The uninsured population ranges from 9.0 percent–28.3 percent in the 16 study states, while the range was 8.1 percent–28.3 percent for all states.

Appendix 3 provides greater detail on the characteristics of the 16 study-state population.

The employment, earnings, and health care circumstances of people in the 16 study states vary substantially, again reflecting the variation in health care circumstances nationwide. The percentage of the non-elderly population without health insurance coverage in 1995 varied over threefold, from 28.3 percent in New Mexico to 9.0 percent in Minnesota. State rankings based on per capita income ranged from No. 3 (New Jersey) to No. 48 (New Mexico). Rankings based on the percentage of the population below poverty also varied from No. 1 (New Mexico) to No. 50 (New Hampshire).

While there is great variation among the 50 states in terms of population size, employment base (high tech, factory, etc.), employer size (large, medium, or small), Medicaid program generosity, rural versus urban population, and any number of other factors, this variation is common among the three groupings of states examined here: the 16-state sample, the 34 other states, and all states. Accordingly, one can attribute the differences in the rates of change in the uninsured population and private and individual insurance market coverage to the criteria used to isolate this 16-state sample—specifically, the enactment, by early 1995, of both small-employer and individual insurance market reforms.

Additional evidence of this common variation in characteristics of the 16-state sample is illustrated in Table 4. Here the variation in the top third and bottom third of states in the 16-state sample (5 states), the top third and bottom third of the other 34 states (11 states), and the top third and bottom third of all states (16 states) is examined.

Again, the average and variation in the percentage of the uninsured is comparable among the three groups, supporting the determination that differences in the rate of growth in the uninsured population may be attributed to the primary difference among the groups. That primary difference is the implementation of reforms in the private individual insurance market.

The breakout of the one-year change in the uninsured population from 1995–1996 is comparable across all three groups. The bottom third performers in each group experienced an increase in the uninsured population while the top third experienced a decrease. However, the 16-state study sample population realized a much larger

Table 4 B 1211

Percentage of the Non-Elderly Population That Is Uninsured and the Rate of Growth in This Population

	16 Study States		Remaining 34 States		All 50 States	
	Top Third	Bottom Third	Top Third	Bottom Third	Top Third	Bottom Third
Percent Uninsured, 1996						
Average	11.8%	20.6%	11.5%	21.5%	11.6%	21.2%
Range	10.9–13.1	24.7–17.6	9.5–13.1	27.5–17.8	9.5–13.1	27.5–17.6
Uninsured Growth, 1995–1996						
Average	(9.5)	22.1	(14.3)	18.4	(12.8)	19.6
Range	(16.7)–(3.0)	29.7–18.0	(26.4)–(7.4)	31.0-11.5	(26.4)–(3.0)	31.0–11.5
Uninsured Growth, 1990–1996						
Average	10.8	54.4	(9.9)	44.0	(9.9)	44.0
Range	2.8–20.9	43.8–70.7	(27.8)–1.1	28–113.1	(27.8)–1.1	28–113.1

Note: Parentheses ( ) indicate a negative rate of growth. The non-elderly population consists of persons under age 65.
Source: Author calculations based on U.S. Bureau of the Census *Current Population Survey* data.

increase and a much smaller decrease in the uninsured population than did the other 34 states and all 50 states on average.

Strikingly, the growth in the uninsured population from 1990 to 1996—the period in which the 16-state study sample implemented reforms specifically designed to reduce the number of uninsured—is much worse for the study sample. In fact, both the top third and the bottom third of the 16 states experienced an increase in the uninsured population while the top third performers in the 34-state group and all 50 states experienced a decrease in the uninsured population.

HOW STATE INSURANCE REGULATIONS HAVE HURT INDIVIDUALS AND FAMILIES

The good intention behind insurance regulation, particularly community rating and guaranteed issue, is to make insurance coverage more affordable and more available to individuals and families. However, the data show that states that have implemented these regulations have experienced *the exact opposite effect*. In every one of the 16 states that implemented these regulations, the number of persons without health insurance has increased and has increased faster than in states that did not enact these regulations. Coverage or provider mandates, moreover, have diminished the ability of consumers to purchase insurance plans designed to meet their specific needs.

This paper examines the regulatory impact on private insurance coverage, including both employment-based and individual insurance, and the number of uninsured. The trends are based on an analysis of the coverage data in each insurance sub-market of a sample of 16 states individually and the other 34 states and all 50 states collectively. This paper also compares trends in these 16 states with states that have not imposed similar levels of regulation.

What the Data Show

As indicated in Table 5, a review of the results for these 16 states as compared with the other 34 states (most of which implemented small business reforms, though nine have enacted neither small

business reforms nor individual reforms) indicates that the effect of these combined reforms was to:

- **Increase** the number of the uninsured population;
- **Decrease** the rate of coverage of individuals in the private insurance market; and
- **Decrease** the rate of coverage of individuals in the individual insurance market.

Between 1990 and 1996, the 16 states demonstrated an aggregate increase in the number and percentage of uninsured individuals. The overall uninsured population in these states increased from 13.3 percent to 16.7 percent. This is a 25.6 percent increase in their uninsured populations. The 16 state populations covered by private insurance declined from 76.7 percent to 71.6 percent. Overall, the percentage of the state population covered by private individual insurance declined sharply from 10.1 percent to 5.9 percent, a 41.6 percent drop.

Table 5 B 1211

Composition of Insurance Markets in the Non-Elderly Population

	1990	1996	Percentage Point Change	Percent Change
All States				
% Uninsured	15.7%	17.6%	+1.9	+12.1%
% w/Private Ins.	73.8	70.7	-3.1	-4.2
% w/Emp.-Based Ins.	64.1	64.8	+0.7	+1.1
% w/Individual Ins.	9.8	5.9	-3.9	-39.8
% w/Medicaid	9.9	12.0	+2.1	+21.2
16 Study States				
% Uninsured	13.3	16.7	+3.4	+25.6
% w/Private Ins.	76.7	71.6	-5.1	-6.7
% w/Emp.-Based Ins.	66.6	65.8	-0.8	-1.2
% w/Individual Ins.	10.1	5.9	-4.2	-41.6
% w/Medicaid	10.1	12.4	+2.3	+22.8
34 Other States				
% Uninsured	16.7	17.9	+1.2	+7.2
% w/Private Ins.	72.8	70.4	-2.4	-3.3
% w/Emp.-Based Ins.	63.2	64.5	+1.3	+2.1
% w/Individual Ins.	9.6	5.9	-3.7	-38.5
% w/Medicaid	9.8	11.9	+2.1	+21.4

Note: The non-elderly population consists of persons under age 65.
Source: Author calculations based on U.S. Bureau of the Census *Current Population Survey* data.

These 16 states experienced an increase in the size of the uninsured population that was more than *twice* the increase in all states and over *three times* greater than the increase in the other 34 states. Similarly, the 16-state study population realized a *decrease* in health coverage in the private insurance market that was 1.5 times the decrease in all states and *twice* that of the other 34 states.

The decrease in the individual insurance market experienced by all three groups during this time period was relatively similar. Still, the 16-state study population covered by the private individual insurance market decreased more than both the 34 states and all 50 states.

Thus, although the original intent of these state regulations was to increase access to insurance coverage and decrease the number of uninsured, *the effect of these insurance market reforms was the exact opposite of the intended effect*. This is indicated in Appendix 4 and summarized in Table 6. Each of the 16 states examined in this study experienced an *increase* in its uninsured population and a *decrease* in coverage in both the private market and the private individual market. An examination of the impact on individuals and families in the private insurance markets shows the following:

Increase in Numbers of Uninsured. The 16 states that implemented broad insurance market reforms experienced an increase in the percent of the population that is uninsured from 13.3 percent in 1990 to 16.7 percent in 1996. This is much greater than the 1.2 percentage point increase in the population of uninsured in the other 34 states and greater than the 1.9 percentage point increase

in the population of uninsured within the United States. From 1995 to 1996, the uninsured population in the 16 states increased on average *eight times more* than the uninsured population in the other 34 states.

Decrease in Private Insurance Market Coverage. The 16 states that implemented broad insurance market reforms experienced a decrease in the percent of the population that is covered through the private insurance market from 76.7 percent in 1990 to 71.6 percent in 1996. This is a much greater decline than the 2.4 percentage point decrease in the other 34 states and greater than the 3.1 percentage point decrease in the population covered in the private insurance market within the United States.

Decrease in Private Individual Insurance Market Coverage. The 16 states that implemented broad insurance market reforms experienced a decrease in the percent of the population that is covered by the private individual insurance market from 10.1 percent in 1990 to 5.9 percent in 1996. This is a 4.2 percentage point *decrease* in the population covered in the individual insurance market. While both the 34-state group and all 50 states also experienced a decrease in coverage, the decrease was greatest in the 16-study state population.

Table 6 B 1211

Non-Elderly Population Health Insurance Coverage Status: 16 Study States Before and After Small-Employer and Individual Insurance Market Reforms

	Before Reforms	After Reforms	Percentage Point Change
Idaho			
% with Private Health Ins.	77.3	73.1	-4.2
% with Individual Health Ins.	12.2	9.9	-2.3
% Uninsured	17.1	17.3	+0.2
Iowa			
% with Private Health Ins.	84.7	81.1	-3.7
% with Individual Health Ins.	16.1	12.0	-4.1
% Uninsured	8.9	13.0	+4.1
Kentucky			
% with Private Health Ins.	73.9	67.3	-6.6
% with Individual Health Ins.	9.5	4.7	-4.8
% Uninsured	15.1	17.2	+2.1
Louisiana			
% with Private Health Ins.	65.7	60.6	-5.1
% with Individual Health Ins.	9.9	6.8	-3.1
% Uninsured	21.1	23.1	+2.0
Maine			
% with Private Health Ins.	78.5	77.0	-1.6
% with Individual Health Ins.	11.0	6.8	-4.3
% Uninsured	11.5	14.7	+3.2
Minnesota			
% with Private Health Ins.	82.1	80.3	-1.8
% with Individual Health Ins.	13.4	93	-4.1
% Uninsured	9.9	10.1	+0.2
New Hampshire			
% with Private Health Ins.	83.2	81.5	-1.7
% with Individual Health Ins.	11.1	5.7	-5.4
% Uninsured	12.6	11.2	-1.4
New Jersey			
% with Private Health Ins.	82.2	75.1	-7.1
% with Individual Health Ins.	9.6	5.2	-4.4
% Uninsured	11.5	17.7	+6.2
New Mexico			
% with Private Health Ins.	63.0	53.1	-9.9
% with Individual Health Ins.	9.9	4.5	-5.4
% Uninsured	24.0	26.5	+2.5
New York			
% with Private Health Ins.	74.6	66.8	-7.8
% with Individual Health Ins.	8.5	4.3	-4.2
% Uninsured	13.5	18.2	+4.7
North Dakota			
% with Private Health Ins.	82.4	80.7	-1.7
% with Individual Health Ins.	25.3	16.2	-9.1
% Uninsured	8.6	10.3	+1.7
Ohio			
% with Private Health Ins.	81.3	76.2	-5.1
% with Individual Health Ins.	8.0	4.3	-3.7
% Uninsured	10.7	13.3	+2.6
Oregon			
% with Private Health Ins.	79.1	73.7	-5.4
% with Individual Health Ins.	9.8	6.7	-3.1
% Uninsured	15.1	15.7	+0.6
Utah			
% with Private Health Ins.	83.8	81.7	-2.1
% with Individual Health Ins.	10.5	8.1	-2.4
% Uninsured	9.9	13.2	+3.3
Vermont			
% with Private Health Ins.	82.4	75.4	-7.0
% with Individual Health Ins.	10.3	8.2	-2.1
% Uninsured	10.1	13.5	+3.4
Washington			
% with Private Health Ins.	77.5	74.6	-2.9
% with Individual Health Ins.	11.1	8.3	-2.8
% Uninsured	13.0	14.3	+1.3

Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data. See Appendix 4 for more details on the rates before and after reforms.

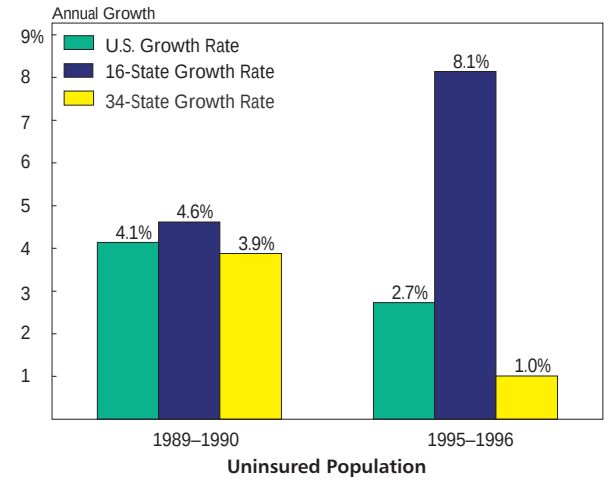
Decrease in Employment-Based Insurance Market Coverage. The 16 states that implemented broad insurance market reforms experienced a *decrease* in the percent of the population that is covered by the employment-based insurance market from 66.6 percent in 1990 to 65.8 percent in 1996. This is in contrast with a 1.3 percentage point *increase* in the employment-based insurance market in the other 34 states and a 0.7 percentage point *increase* in the employment-based insurance market in the population covered in the employment-based insurance market within the United States.

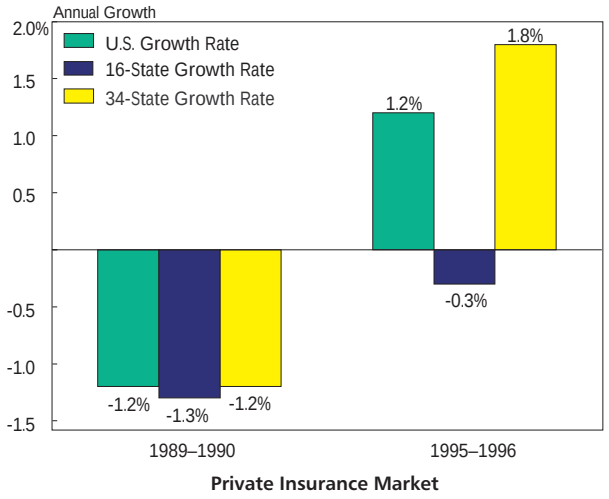
As indicated, the 16 states have not been able to sustain the positive performance of the nation as a whole or the other 34 states, despite the enactment of reforms expected to increase coverage in the private insurance market and to decrease their uninsured populations.

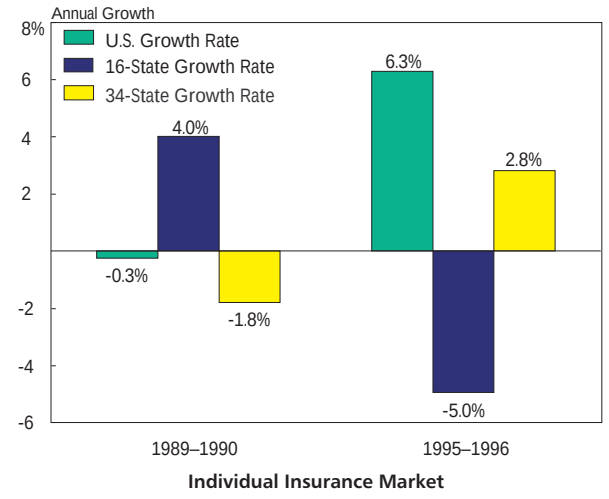
- Between 1989 and 1990, all three groups experienced an increase in their uninsured population. After the period of insurance market reforms in the 16-state sample, these 16 states experienced an average one-year growth in their uninsured populations during 1996 of 8.14 percent, whereas the one-year growth in the 34 states was 1.02 percent—an eightfold difference. In all states, the uninsured population grew by 2.7 percent.
- In 1990, all three groups of states also experienced a decrease in coverage in the private insurance market. Again,

Chart 1 B 1211

Change in Annual Growth Rates in the Non-Elderly Insurance Markets Before and After Regulation Boom







Note: Non-elderly population consists of persons under age 65.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

following the period of insurance market reform in the 16-state sample, *this group alone* continues to experience a decline in coverage in the private insurance market.

- In 1990, the 16 states constituted the only group to experience an increase in coverage in the private individual insurance market. By 1996, following the insurance market reforms implemented to increase coverage in this market specifically, the 16 states constituted the only group to have experienced a *decrease* in coverage in its individual insurance market.

HOW REGULATION HAS AFFECTED INDIVIDUAL STATES

Idaho. In 1994, Idaho passed the Small Employer Health Insurance Availability Act to ensure that "every small employer carrier shall actively offer to the small employer at least three health benefit plans."[32] This law applied to small employers with 2 to 50 employees who work 30 or more hours per week.

The law included a guaranteed issue provision requiring any insurer or HMO in the small-employer health insurance market to provide coverage to any small employer who applies as long as minimum participation is met. Carriers were not allowed to deny coverage based on health status, claims experience, age, or gender.

The law also included rating restrictions requiring that rates not vary based on health status, claims experience, or policy duration. Rates are allowed to vary with regard to age, gender, smoking history, or geography. Regulated health benefit plans could not deny, exclude, or limit benefits for a covered individual for a pre-existing condition for a period more than 12 months following the effective date of enrollment. A pre-existing condition could be defined only as one that required treatment during the six months prior to enrollment.

At the time of enactment, the Idaho Department of Insurance reported that 44 carriers qualified to offer, and did offer, insurance coverage to small employers under the requirements of this law.

In 1995, the Idaho legislature enacted the Individual Health Insurance Availability Act to "promote the availability of health insurance coverage to persons not covered by employment-based insurance regardless of their health status or claims experience."[33] Carriers in the individual insurance market were required to offer at least three health benefit plans. Each carrier was required to offer two 45-day "open enrollment" periods beginning January 1 and July 1 of each year. No limits on pre-existing conditions were allowed.

The Department of Insurance reported that 13 carriers were qualified to offer, and did offer, coverage in the individual insurance market at the time of enactment of this act.

Rather than attain the stated objectives, Idaho experienced a decrease in the coverage of its citizens in the private health insurance market, including both the private individual and employer-based health insurance markets. The number of Idaho's citizens without insurance increased.

Costs also increased dramatically. On May 18, 1998, Blue Cross of Idaho and Blue Shield of Idaho announced that they were raising premium rates for individual policyholders by up to 30 percent this year due to losses on individual health insurance policies.[34] Combined, the Blues cover approximately 600,000 of Idaho's citizens.

Cost is the primary reason that individuals do not purchase health insurance in the private individual insurance market. This projected premium

32. Idaho Department of Insurance, "Small Employer Health Insurance Availability Act," January 25, 1995.

33. Idaho Department of Insurance, "Individual Health Insurance Availability," January 1, 1995.

34. Bureau of National Affairs, "Idaho Blues Raise Premiums Sharply on Individual Policies Due to Losses," *Health Care Policy Report*, Vol. 6, No. 20 (May 18, 1998).

IDAHO INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	77.3	73.1	-4.2
% with Individual Health Ins.	12.2	9.9	-2.3
% with Empl.-Based Health Ins.	65.1	63.2	-1.8
% with Medicaid	5.8	11.6	5.9
% with Medicare	1.2	1.6	0.4
% Uninsured	17.1	17.3	0.2
No. of Uninsured (in 000)	158	179	

IOWA INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	84.7	81.1	-3.6
% with Individual Health Ins.	16.1	12.0	-4.1
% with Empl.-Based Health Ins.	68.6	69.1	0.5
% with Medicaid	6.6	8.0	1.4
% with Medicare	1.1	1.3	0.2
% Uninsured	8.9	13.0	4.1
No. of Uninsured (in 000)	215	330	

increase is likely to result in a further reduction in the number of individuals covered in Idaho's private individual market.

Julie Taylor, Director of Governmental Affairs at Blue Cross, noted that "while some of the recent losses have been due to small group coverage, most have been due to individual coverage." Although the new laws have been in effect for several years, Ms. Taylor said that "it took awhile for the effects of the increased individual enrollment to show up."[35]

Iowa. Individual health insurance reform has been effective in Iowa since April 1, 1996. The stated purpose of the reform is to "promote the availability of health coverage to individuals regardless of health status or claims experience, to prevent abusive rating practices, and to improve the overall fairness and efficiency of the marketplace."[36] Here is what actually happened: The per-

35. *Ibid*.

36. Iowa Insurance Division, "Individual Health Insurance Market Reform (Chapter 513C)," *Chapter 513C Bulletin*, May 27, 1997.

KENTUCKY INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	73.9	67.3	-6.6
% with Individual Health Ins.	9.5	4.7	-4.8
% with Empl.-Based Health Ins.	64.4	62.6	-1.8
% with Medicaid	9.4	13.4	4.0
% with Medicare	2.1	2.4	0.3
% Uninsured	15.1	17.2	2.1
No. of Uninsured (in 000)	475	583	

centage of Iowa's citizens covered in the private insurance market declined, as did coverage in the individual health insurance market. Iowa has also experienced an increase in the number of its citizens who are without insurance.

Kentucky. In 1994, Kentucky passed a Clinton-style universal coverage health care reform called the Kentucky Health Care Reform Act of 1994.[37] Incorporating subsequent revisions in 1996, the act requires rules for guaranteed issue, a ban on premium rate-setting based on health status, and a prohibition on pre-existing condition exclusions.

As indicated in the box above, and as noted in a 1997 Heritage Foundation report, the Kentucky plan can hardly be counted a success. Since passage of health care reform in 1994, a greater number of Kentucky's citizens are without insurance. Moreover, the proportion of its citizens with coverage in the private individual and employer-based health insurance markets has declined.

Kentucky attempted a massive experiment in health insurance reform. In September 1997, Governor Paul Patton, a Democrat, said that, "In spite of good intentions and noble purpose, it didn't work…. One of the undeniable effects of our laws has been to cause 45 insurance companies to quit selling health insurance."[38] Only one company still offers private health insurance in Kentucky as of this writing.

"The entire cost of the system went up," Patton said.[39] Kentucky citizens paid the price: 107,500 fewer citizens (out of a population of 3.4 million) had health insurance in 1996 than in 1990.

In April 1997, Kentucky Insurance Commissioner George Nichols III presented the Market Report on Health Insurance, which concluded that information gathered on the health insurance market in Kentucky confirms that the market is unstable and cannot sustain itself over the long term.[40] In August 1997, the *Kentucky Journal of Commerce and Industry* issued a report on proposed legislation to repeal the provisions of the Health Care Reform Act of 1994 which "started the unfortunate process in Kentucky that has led us to higher rates

37. See McCubbin, "The Kentucky Health Care Experiment."

38. "Health Care Special Session Remarks," speech by Governor Patton to the Joint Session of the General Assembly, September 30, 1997.

39. *Ibid.*

40. Kentucky Department of Insurance, "Market Report on Health Insurance Released," press release, April 23, 1997.

LOUISIANA INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	65.7	60.6	-5.1
% with Individual Health Ins.	9.9	6.8	-3.1
% with Empl.-Based Health Ins.	55.8	53.8	-2.0
% with Medicaid	12.1	15.0	2.9
% with Medicare	2.7	2.9	0.2
% Uninsured	21.1	23.1	2.0
No. of Uninsured (in 000)	761	880	

with fewer choices, but has failed to bring coverage to uninsured Kentuckians as promised."[41]

In April 1998, Governor Patton directed the Commissioner of the Department of Insurance to terminate the activities of the Kentucky Health Purchasing Alliance (KHPA). KHPA was a statewide insurance cooperative permitted to operate as a statewide purchasing alliance. The alliance attracted a high-risk population based on its rules for guaranteed renewability and prohibition on pre-existing condition exclusions.

Louisiana. Louisiana implemented regulations in its individual insurance market in January 1994. These regulations included guaranteed renewal, a 12-month look-back period for pre-existing conditions, and a 12-month period excluding coverage for pre-existing conditions. Louisiana's premium rate restrictions were adopted as an adjusted community rating.

Variation of plus or minus 10 percent is allowed for health status, and unlimited variation is allowed for specific demographic characteristics and other factors approved by the Department of Insurance.

Yet, as indicated in the box above, Louisiana's efforts to increase coverage in the private insurance market and to decrease its uninsured population have been unsuccessful. Since implementation of its insurance market regulations, Louisiana has experienced a decrease in private insurance coverage reflecting a decrease in individual coverage partially offset by an increase in employment-based coverage. It also has experienced an increase in its uninsured population and an increase in the number of its citizens on Medicaid.

In August 1996, Louisiana Insurance Commissioner Jim Brown released a report showing that Louisiana has one of the most costly health delivery systems in the country serving a population that is among the least healthy in the nation. In this report, entitled "Louisiana's Health Care Crisis," Commissioner Brown described the "inefficiencies" in the state's Medicaid program as a Medicaid crisis.[42] The declines in Louisiana's private market coverage are even more serious in

41. "Special Session on Tap: Health Insurance Reform Needed," *The Kentucky Journal of Commerce and Industry,* August 7, 1997.

42. Louisiana Department of Insurance, "It May Be Expensive, but the Louisiana Healthcare System Sure Gets Poor Results," press release, August 15, 1996.

MAINE INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	78.5	77.0	-1.5
% with Individual Health Ins.	11.0	6.8	-4.3
% with Empl.-Based Health Ins.	67.5	70.2	2.7
% with Medicaid	10.0	8.3	-1.7
% with Medicare	1.5	3.0	1.5
% Uninsured	11.5	14.7	3.2
No. of Uninsured (in 000)	126	155	

light of an increasing number of citizens on the state's Medicaid program.

Maine. Effective December 1, 1993, Maine enforced reforms in the private individual health insurance market. These regulatory reforms included guaranteed renewal, guaranteed issue for all plans, limits on pre-existing condition exclusions, and certain premium rate restrictions. Maine enacted adjusted community rating with premium rate variations of no more than plus or minus 20 percent of the community rate for age, smoking status, occupation, industry, or geographic area.

As indicated in the box above, Maine has experienced a decrease in coverage in the private health insurance market. This includes a steep drop in the individual health insurance market, partially offset by an increase in coverage in the employment-based health insurance market. The percentage and number of Maine's citizens lacking any insurance coverage have increased since regulations were imposed.

Minnesota. In 1992, Minnesota enacted HealthRight, now called MinnesotaCare, which, along with other measures passed between 1992 and 1995, guaranteed universal coverage for all citizens of Minnesota by January 1, 1997. State legislators also created a subsidized health insurance program.

In addition, lawmakers enacted many insurance reforms in the small-employer and private individual insurance markets. Small-employer regulations included guaranteed issue and renewal, limits on pre-existing condition exclusions, and a higher minimum loss ratio. The damaging community rating was scheduled for implementation by 1997.

Individual market reforms included guaranteed renewal, limits on pre-existing condition exclusions, and a higher minimum loss ratio. Guaranteed issue was not required in the individual market.

In 1995, however, the state rejected its goal of universal coverage in favor of reducing the uninsured population to 4 percent by January 2000. Also in 1995, the legislature repealed plans for community rating of insurance. Minnesota's repeal of community rating is to be applauded and may have kept a bad situation from becoming much worse.

The less restrictive reforms in the small-employer market, combined with repeal of the community rating requirement, may have contributed to what the Minnesota Department of Commerce calls a “success” in the small-employer

MINNESOTA INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	82.1	80.3	-1.8
% with Individual Health Ins.	13.4	9.3	-4.1
% with Empl.-Based Health Ins.	68.7	71.0	2.3
% with Medicaid	9.3	12.2	2.9
% with Medicare	0.8	1.0	0.2
% Uninsured	9.9	10.1	0.2
No. of Uninsured (in 000)	375	425	

insurance market. But while the small-employer insurance market reforms may be viewed as effective in expanding employee coverage, they also have caused the number of insurance carriers issuing policies to small employers to drop substantially: 43 percent of insurance carriers that served small groups in 1992 had left that market by 1994.

Minnesota legislators predict no future small-employer insurance market reforms because they expect employers to shift to self-funded plans whenever possible.

While the small-employer insurance market reforms may have resulted in an increase in the coverage of citizens of Minnesota in the employment-based insurance market, coverage in the private insurance industry declined. This was due to a larger decrease in coverage in the individual health insurance market, which more than offset the improvements in the employment-based health insurance market. The percentage and number of Minnesotans without health insurance coverage increased during this same period.

In 1997, the Minnesota Department of Health reported an increase in premiums in the small-employer market, with most premiums rising approximately 9 percent. Trends indicate that many Minnesota employers will see premium increases in 1998. The Department of Health reports that Minnesota's growth in premiums appears to be outpacing national trends.[43] These expected increases in premiums may reduce, or even halt, the improvement in coverage in the small-employer insurance market.

New Hampshire. New Hampshire has experienced a decrease in coverage of its citizens in the private health insurance market, including the individual insurance market. The number of uninsured citizens has also increased.

The guaranteed issue and community rating laws in the individual market were "designed to increase access to coverage," but these laws have been "problematic given the selection and cost of available products," reports David Sky, who is Life, Accident, and Health Actuary in New Hampshire's Insurance Department.[44]

In March 1998, New Hampshire insurance regulators reported that they have seen a "decline in the number of carriers writing business, a cancellation of active policies, and an increase in premi-

43. Minnesota Department of Health, "Health Policy & Systems Compliance: Questions and Answers on Health Insurance Premiums," *Issue Brief* 97–15, October 1997.

44. Alpha Center, "New Hampshire Seeks to Improve Access in the Individual Insurance Market," *State Updates*, March 1998.

NEW HAMPSHIRE INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	83.2	81.5	-1.7
% with Individual Health Ins.	11.1	5.7	-5.4
% with Empl.-Based Health Ins.	72.1	75.8	3.7
% with Medicaid	4.0	7.1	3.1
% with Medicare	0.7	1.8	1.1
% Uninsured	12.6	11.2	-1.4
No. of Uninsured (in 000)	107	110	

ums since comprehensive reform laws were enacted in 1995."[45]

Since the guaranteed issue and community rating laws went into effect in 1995, David Sky reports, only 5,000 individual policies have been written. Blue Cross Blue Shield, the state's largest individual insurer, announced in July 1997 that it would terminate all individual policies beginning January 1998 because of heavy losses in that market.

While the number of uninsured citizens in New Hampshire increased from 107,000 in 1990 to 110,000 in 1996, this number could have been worse if not for two factors: the expansion of Medicaid and a growing economy. David Sky indicated that the state enacted legislation expanding Medicaid in the late 1980s and into 1990 and 1991. In 1988, the number of citizens covered by Medicaid was roughly 17,000, or 1.8 percent of the state's population. This number increased to 42,000 (4.4 percent of the state's population) in 1990 and 74,000 (7.5 percent of the state's population) in 1991.

The state Insurance Department recently commissioned a study to evaluate the impact of the insurance reforms. While the study concludes that the state did, in fact, see an improvement in the percentage of the population that is uninsured, it also indicates that this cannot be attributed to the reforms, but rather is likely a benefit of the very strong economy and the increased competition for employees in New Hampshire, which has the lowest poverty rate and one of the lowest unemployment rates in the nation.

New Jersey. To solve the problems of lack of access in the private small-employer and individual insurance markets, concentration of risk, and the rising number of uninsured, the New Jersey legislature in 1992 enacted sweeping reforms in the small-employer and individual insurance market, including guaranteed access and community rating, and created an Individual Health Coverage Program (IHC) and Small Employer Health Benefits Program (SEH).

New Jersey law created five standard health benefits plans which carriers in the small-employer and individual insurance markets would be required to offer. Variations among the plans include the coinsurance levels and deductible options. In the individual market, a carrier is

45. *Ibid.*

NEW JERSEY INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	82.2	75.1	-7.1
% with Individual Health Ins.	9.6	5.2	-4.4
% with Empl.-Based Health Ins.	72.6	69.9	-2.7
% with Medicaid	6.8	7.7	0.9
% with Medicare	1.2	1.4	0.2
% Uninsured	11.5	17.7	6.2
No. of Uninsured (in 000)	772	1,207	

legally required to offer a standard plan to everyone at the same rate, regardless of age, gender, profession, health status, geographical location, or any other factor. In the small-employer market, carriers could vary rates only on the basis of age, gender, and the location of the business.

As indicated in the box above, New Jersey has not achieved its goals. In fact, coverage in the private insurance market has declined, with decreases in both the individual and small-employer health insurance markets. More seriously, the number of citizens without insurance has increased significantly.

In 1996, Kevin O'Leary, Executive Director of the IHC Program Board and the SEH Program Board, reported that Blue Cross was the only carrier with an experience-pricing, guaranteed issue plan in New Jersey. O'Leary indicated that first-time carriers, including Time Insurance Company, The Mutual Group, and National Casualty Company, all "misjudged the risk of enrolling individuals on a guaranteed issue basis."[46] These carriers initially offered low rates. Then, based on actual claims experiences, they raised their rates. These rate increases have "created instability in the market and disruption for policyholders."[47]

As of March 1998, monthly health insurance premium rates in New Jersey for an individual varied from a low of $148.47 per month with a $2,500 annual deductible under Plan B from Blue Cross Blue Shield to a high of $2,830.00 per month with a $500 annual deductible under Plan E from Celtic Life Insurance Co.

New Mexico. In January 1995, New Mexico enacted private individual insurance market reforms, including guaranteed renewal, a six-month limit on pre-existing condition exclusions, a six-month look-back period for pre-existing conditions, and certain premium rate restrictions.

These rating restrictions included limits on variations other than for age, gender (no greater than a 20 percent variation), geographic area of employment, smoking status, and family composition (no greater than 250 percent variation). Since July 1, 1998, however, carriers cannot vary rates on the

46. New Jersey Individual Health Coverage Program Board and New Jersey Small Employer Health Benefits Program Board, "Individual and Small Employer Health Insurance Markets," *Progress Report August 1993–April 1996*.

47. *Ibid.*

NEW MEXICO INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	63.0	53.1	- 9.9
% with Individual Health Ins.	9.9	4.5	-5.4
% with Empl.-Based Health Ins.	53.1	48.6	-4.5
% with Medicaid	10.4	20.0	9.6
% with Medicare	1.7	1.9	0.2
% Uninsured	24.0	26.5	2.5
No. of Uninsured (in 000)	329	436	

NEW YORK INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	74.6	66.8	-7.8
% with Individual Health Ins.	8.5	4.3	-4.2
% with Empl.-Based Health Ins.	66.1	62.5	-3.6
% with Medicaid	12.6	16.4	3.8
% with Medicare	1.8	1.5	-0.3
% Uninsured	13.5	18.2	4.7
No. of Uninsured (in 000)	2,118	2,921	

basis of demographic characteristics or health status.

As indicated in the box above, New Mexico has experienced a significant decrease in coverage in the private health insurance market, reflecting a decrease in the individual market, partially offset by a slight improvement in the employment-based market. Additionally, the state's already large population of uninsured persons has increased dramatically.

New York. New York enacted substantial reforms in the private small-employer and individual insurance markets in 1993, reflecting an effort by the state to broaden access to insurance in these markets. In 1993, the state implemented legislation requiring open enrollment, guaranteed portability, and pure community rating. Carriers were required to charge all enrollees the same price, regardless of age or sex, with variations only among geographic areas.

As indicated in the box above, there has been a significant loss of coverage in the private market, including both the individual and small-employer insurance markets. New York's effort to expand coverage and access is clearly unsuccessful. Higher

NORTH DAKOTA INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	82.4	80.7	-1.7
% with Individual Health Ins.	25.3	16.2	-9.1
% with Empl.-Based Health Ins.	57.1	64.5	7.4
% with Medicaid	6.8	7.9	1.1
% with Medicare	1.3	1.8	0.5
% Uninsured	8.6	10.3	1.7
No. of Uninsured (in 000)	48	57	

premiums, less coverage, and limited benefit packages have been the experience in New York.

The New York State Insurance Department announced on April 22, 1998, that $110 million will be distributed from two insurance pools to "avert major rate increases" for New Yorkers in the private individual and small-employer health insurance markets.[48] Oxford Health Plans had planned a stunning 69 percent rate increase for individual customers, and Empire Blue Cross and Blue Shield had planned a 56 percent increase for individual customers. State Insurance Superintendent Neil D. Levin indicated that many policyholders had stated that "they would have no choice but to drop the coverage" if these excessive premium increases had been implemented.[49]

North Dakota. In 1995, North Dakota enacted private individual insurance market reforms, including guaranteed renewal, a 12-month limit on pre-existing condition exclusions, a six-month look-back period for pre-existing conditions, and certain premium rate restrictions.

The premium rates charged to individuals within a class for the same or similar coverage cannot vary by a ratio of more than 5:1 for differences in age, industry, gender, duration of coverage, geography, family composition, healthy lifestyles, and benefit variations. As of January 1, 1997, rates could no longer vary for gender and duration of coverage.

As indicated in the box above, North Dakota has experienced a decline in coverage in the private insurance market based on a decline in the individual health insurance market. This was partially offset by an increase in coverage in the small employment-based health insurance market. Overall, the proportion and number of North Dakota citizens without insurance coverage has increased significantly.

Ohio. On January 1, 1993, Ohio enacted regulations in the private individual health insurance market, including guaranteed renewal, guaranteed issue in at least one plan, limits on pre-existing condition exclusions, and certain premium rate restrictions. Carriers were limited to charging premiums to individuals that could not exceed 2.5 times the highest rate charged to any other individual with similar case characteristics.

As indicated in the box on the following page, private health insurance coverage declined in Ohio. The decline in private coverage was due to a decline in both the individual and small-employer

48. Bureau of National Affairs, "New York State to Use Insurance Pool Funds to Avert Major Health Premium Increases," *Health Care Policy Report*, Vol. 6, No. 17 (April 27, 1998).

49. *Ibid*.

OHIO INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	81.3	76.2	-5.1
% with Individual Health Ins.	8.0	4.3	-3.7
% with Empl.-Based Health Ins.	73.3	71.9	-1.4
% with Medicaid	8.6	10.8	2.2
% with Medicare	1.5	2.1	0.6
% Uninsured	10.7	13.3	2.6
No. of Uninsured (in 000)	1,009	1,306	

OREGON INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	79.1	73.7	-5.4
% with Individual Health Ins.	9.8	6.7	-3.1
% with Empl.-Based Health Ins.	69.3	67.0	-2.3
% with Medicaid	6.5	13.4	6.9
% with Medicare	1.3	1.7	0.4
% Uninsured	15.1	15.7	0.6
No. of Uninsured (in 000)	379	445	

health insurance markets. Overall, the proportion and number of citizens lacking insurance increased.

In September 1997, the Ohio Department of Health issued a report, "Synthetic Estimation of Uninsured Rates by County in Ohio," which revealed that Ohio's uninsured rate increased in 1995. The report cited Medicare and Medicaid enrollment, family income, and type of employment as the factors most closely associated with access to health insurance.

Oregon. In October 1996, Oregon authorized various regulations in the private small-employer and individual insurance markets. Small-employer regulations included guaranteed issue, limits on pre-existing exclusions, portability, and premium rate restrictions.

Carriers were allowed to vary premiums only on the basis of geographical location, dependent enrollment, and the age of employees. Age variations were to be uniformly applied and were to be limited within a 3:1 rate band; thus, the highest premium could not be more than three times greater than the lowest premium within the range, based on the age of employees.

Individual market reforms included guaranteed renewal, a limit on pre-existing condition exclusions, and premium rate restrictions. Carriers were allowed to vary premiums only on the basis of geographic location, dependent enrollment, and

UTAH INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	83.8	81.7	-2.1
% with Individual Health Ins.	10.5	8.1	-2.4
% with Empl.-Based Health Ins.	73.3	73.6	0.3
% with Medicaid	6.7	6.7	0.0
% with Medicare	1.1	0.9	-0.2
% Uninsured	9.9	13.2	3.3
No. of Uninsured (in 000)	154	238	

age. Age variations were to be uniformly applied, but there was no rate band limit.

After implementation of these reforms, Oregon experienced a decrease in coverage in the private health insurance market, including a reduction in both the private individual and small-employer insurance markets. Additionally, the proportion and number of uninsured citizens in Oregon increased.

Utah. In January 1996, Utah authorized more regulation of the private individual health insurance market, including guaranteed issue in at least one plan, guaranteed renewal, limits on pre-existing condition exclusions, portability, and premium rate restrictions. Utah enacted premium rate restrictions limiting the variation in rates to plus or minus 25 percent for health status and duration of coverage.

Carriers also were allowed to vary premiums according to differences in age, gender, family composition, and geographic area. The premium rate that carriers use for their individual business (the "index rate") may be lower than or equal to, but not higher than, the rates they use for their small-employer business. The premium rate charged for an individual in a standard group plan cannot be higher than the premium rate charged for an individual with similar characteristics also purchasing a standard plan in the individual market.

Following the familiar pattern, Utah experienced an increase in its uninsured population. Additionally, coverage in the private insurance market declined, reflecting a decrease in the private individual health insurance market. This decline was partially offset by an increase in coverage in the employment-based health insurance market.

In February 1997, Norma Wagner of *The Salt Lake Tribune* reported that claims costs rose 12 percent to 22.5 percent statewide in the small-employer market, excluding additional costs from inflation. Michael Bahr, chief actuary at IHC Health Plans, predicted a rate increase of about 10 percent to 20 percent in the small-employer market. Blue Cross and Blue Shield of Utah's chief actuary, Todd Trettin, indicated that it also had experienced similar soaring increases in claims costs.

Carriers in Utah report that out-of-state insurance companies are moving into Utah to take advantage of its open-enrollment laws. Utah's citizens thus may unwittingly purchase coverage from companies that are considered "risky and often disreputable by full-coverage insurers because these companies anticipate that customers angered

VERMONT INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	82.4	75.4	-7.0
% with Individual Health Ins.	10.3	8.2	-2.1
% with Empl.-Based Health Ins.	72.1	67.2	-4.9
% with Medicaid	7.4	15.6	8.2
% with Medicare	1.4	1.8	0.4
% Uninsured	10.1	13.5	3.4
No. of Uninsured (in 000)	50	72	

by premium-rate hikes will be looking for less expensive, bare-bones coverage."[50]

Vermont. Vermont's Act 52, which took effect in July 1992, applies to private small-employer insurance markets. Act 160, which took effect in July 1993, applies to private individual insurance markets. Both require guaranteed issue of health insurance, time limits on exclusions of coverage for pre-existing medical conditions, and premium rate restrictions requiring insurers to charge the same premium to all their customers for the same type and amounts of coverage, allowing only for small deviations.

As indicated in the box above, Vermont has experienced a decrease in coverage in the private health insurance market reflecting a decrease in coverage in both the employment-based and private individual health insurance markets. Overall, Vermont's uninsured population increased.

Once again, it appears that the decline of coverage in the private insurance market was offset with public-sector insurance coverage. In fact, coverage in a children's health care program called "Dr. Dynasaur" more than doubled to 14,571 participants. The Vermont Health Access Plan, designed to cover the uninsured working poor through an expansion of Medicaid, has grown from no participants in 1994 to 14,611 enrollees.

Washington. In 1993, Washington State passed comprehensive Clinton-style legislation replete with employer mandates and substantial insurance regulations, as well as programs to achieve universal coverage. It was a political disaster.

In 1995, the employer mandate and universal coverage requirement was repealed. Still remaining, and further strengthened with 1996 reforms, are reforms requiring guaranteed issue for individuals and small-employer groups, a three-month limit on pre-existing condition restrictions, group-to-group and group-to-individual portability, and modified community rating for small employers (less than 50 employees).[51]

Each insurer in the private individual and small-employer insurance market must offer a government-designed Basic Health Plan (BHP) to all potential purchasers. Carriers are required to reimburse enrollees for services rendered by any category or "provider" as long as those services are within their statutorily determined "scope of practice" and covered by the government-designed standard plan. The state Insurance Commissioner retains the power to grant or deny premium rate

50. Norma Wagner, "Study: Health Reforms Cost Insurers," *The Salt Lake Tribune*, February 23, 1997.

51. Urban Institute, "Health Policy for Low-Income People in Washington," *State Reports*, November 1997, p. 26.

WASHINGTON INSURANCE COVERAGE: PRE- AND POST-REFORMS

	1989–1990 Avg. Pre-Reform	1995–1996 Avg. Post–Reform	% Point Change
% with Private Health Ins.	77.5	74.6	-2.9
% with Individual Health Ins.	11.1	8.3	-2.8
% with Empl.-Based Health Ins.	66.4	66.3	-0.1
% with Medicaid	7.5	12.6	5.1
% with Medicare	1.3	2.6	1.3
% Uninsured	13.0	14.3	1.3
No. of Uninsured (in 000)	560	718	

increases in the individual and small-employer health insurance markets.

These regulations put Washington at the forefront of comprehensive state insurance market regulation.

As indicated in the box above, Washington has experienced an increase in its uninsured population while also experiencing a decline in coverage in the private health insurance market. This decline in coverage in the private individual health insurance market reflects a decrease in coverage in both the employment-based and private individual health insurance markets. Coverage in the employment-based health insurance market may decline further, as 1996 was the first year of modified community rating in the private small-employer health insurance market.

The private individual health insurance market in Washington is a matter of concern for policymakers. A former consultant to the state Health Care Policy Board, Jesse Malkin, reported that another 14,000 people dropped individual coverage during the first half of 1997. Insurance carriers are staying in the market, despite continuing losses and declining enrollment, but they also are planning additional premium rate increases and are offering policies with fewer benefits and higher deductibles.

WHAT POLICYMAKERS CAN LEARN FROM THE DATA

Previous studies have shown that between 1988 and 1993, the rate of coverage through private, employer-sponsored plans fell, while the rate of coverage through the publicly funded Medicaid program rose throughout all states.[52] This changed composition of insurance coverage, therefore, is not unique to the 16 states analyzed here.

However, the rate of change for these 16 states was much greater than the rate of change for the 34 states with fewer reforms in the individual insurance market. Moreover, the 16 states in the sample continued to experience these declines in coverage and growth in the uninsured population despite the fact that they each enacted reforms specifically designed to improve coverage in the private insurance market and to decrease the number of uninsured citizens.

Declining Coverage

Private health insurance coverage has declined slowly but steadily in the United States. Between 1980 and 1995, the population under age 65 cov-

52. John Holahan, Colin Winterbottom, and Shruti Rajan, "A Shifting Picture of Health Insurance Coverage," *Health Affairs*, Winter 1995, pp. 253–264.

ered by private health insurance decreased from 79.5 percent to 70.5 percent.[53] This trend has continued despite a strong U.S. economy and increased employment.

In 1980, 8 percent of Americans under age 65 had public health insurance; by 1995, the percentage had risen to nearly 13 percent—an increase of more than 50 percent. Over the same period, the percentage of Americans under age 65 with private health insurance declined by more than 11 percent to 71 percent. In 1990, 10 percent of Americans received assistance from Medicaid; by 1996, nearly 14 percent received Medicaid—an increase of over 35 percent.

Coverage for children, early retirees, and near-poor families has declined faster than for the overall population.[54] Among all states, declining private health coverage has been accompanied by a growth in the uninsured population and an increase in Medicaid enrollment, which in turn has increased government health expenditures. Again, this is not unique to the 16 study states. Yet the rate of change for these states was much greater than the rate for the 34 states with fewer reforms.

Discrimination Against Individuals

A major reason for declining private health coverage is the rising cost of health insurance.[55] Rising health insurance costs continue to absorb a growing share of business and family incomes and to influence the health insurance decisions of both employers and employees. An employer's decision to offer coverage is only one important determinant of the level of health insurance coverage.

Recent studies indicate that the increasing cost of health insurance has influenced more individuals to choose not to purchase insurance even though it is offered by an employer. Employees of firms that offer coverage are being asked to pay a higher share of premiums. Over 60 percent of employed, uninsured family heads report that the main reason they do not have health insurance coverage is that health insurance is too expensive.[56] For those without employer-based coverage, the rise in premiums for policies purchased in the individual insurance market has been borne exclusively by those individuals who are forced to drop health insurance altogether in the face of rising costs.

Pressure on the Public Purse

Medicare and Medicaid are providing a safety net not only for the poor and elderly, but also for the mistakes of policymakers. The number of people losing health insurance following these state reforms would have been even greater had there not been an increase in the number of people covered by taxpayer-financed health programs.

These data suggest that individuals and families are paying a high price for the mistakes of well-intended but misguided legislators. The number of people in taxpayer-financed health programs has risen dramatically, while the number of people with private health insurance has fallen. This steady creep toward a greater and greater number of Americans covered by government-run health programs is the very policy objective that Americans rejected so vehemently during the 1993–1994 health care reform debate.

Clearly, these misguided state attempts to impose political will on the marketplace are proven failures. Individual citizens struggling to buy health insurance on their own or small employers struggling to pay higher and higher health insurance premiums out of small profit margins are the biggest victims of these policy errors.

53. GAO, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*.

54. Holahan, Winterbottom, and Rajan, "A Shifting Picture of Health Insurance Coverage."

55. GAO, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*.

56. Charlton Research Company, "Health Care Reform Executive Summary," A Public Opinion Study, Winter 1998.

WHAT STATE POLICYMAKERS SHOULD DO

The improvements anticipated from small business and individual insurance market reforms enacted at the state level have not been realized. These policies have neither increased access to coverage in the private health insurance market nor decreased the number of uninsured citizens.

In fact, exactly the opposite has transpired. State lawmakers, therefore, should reverse course, and Members of Congress should take heed. They are likely to see similar outcomes from the federal requirements imposed by the Health Insurance Portability and Accountability Act of 1996.

The experience of the states suggests a number of actions that policymakers should take. Among them:

1. **Encourage changes in federal tax laws.** Instead of adding more federal regulatory and bureaucratic shackles through misguided patient protection legislation, Congress should put on the brakes and focus instead on tax reform as the key to health care reform. The central structural defect in the market for private health insurance is the discriminatory tax treatment of health insurance.

   Workers do not pay taxes on the part of their compensation package that they receive in the form of health benefits provided through the workplace. This generous subsidy, worth an estimated $100 billion a year, is the cornerstone of the system in the United States that ties private health insurance to the workplace.

   The tax provision distorts the efficiency of the health care market in a number of ways:

   - It restricts employees' choices to the selection the employer offers.
   - It undermines cost consciousness by hiding the true cost of insurance and medical care from employees.
   - Because the full cost of health insurance is not visible to employees, it artificially supports increased demand for medical services and more costly insurance.
   - As a result, inefficient health care delivery is subsidized at the expense of efficient delivery.
   - Cash wages are suppressed.
   - Many employees with job-based coverage are frustrated because they have little choice and control over their policies and their access to medical services.
   - The self-employed, the unemployed, and those whose employers do not offer health insurance are discriminated against because they receive a much less generous subsidy, if any at all, when they purchase health insurance on their own.

   States should encourage federal legislators to address the underlying problems in federal tax law. Federal legislators can begin building incentives for a better system and also undo some of the damage done by federal and state regulation of the insurance markets by providing targeted tax credits to the uninsured to purchase their own health insurance.

   The self-employed should be able immediately to deduct 100 percent of their health insurance costs, medical savings accounts should be expanded and unshackled, and employees should be allowed to roll over from one year to the next any health care money remaining in their flexible spending accounts.

2. **Undertake, consistent with their tax structure, the delivery of state tax relief to individuals and families** to make access to insurance more affordable for lower-income families. State legislators should provide tax credits and defined contributions to targeted populations for the purchase of health insurance.

   One immediate opportunity for states is the option to provide tax credits and vouchers for the purchase of private insurance to cover uninsured children through the Children's Health Insurance Program. This is preferable

to expanding government-run health care through Medicaid.

3. **Review and repeal.** Conduct a thorough review of health care laws and regulations to determine their impact, especially the degree to which regulatory intervention:
   - **Exacerbates** the decline in access to insurance for individuals and families;
   - **Increases** the cost of health insurance and medical care; and
   - **Compromises** the quality of health care and choices available to citizens.

   Once this review has been conducted, state legislators should have the courage to step forward and repeal the laws that are doing the most damage in their states and that are ensuring the triumph of unintended consequences. They should seek every opportunity to free the health sector from the regulatory and bureaucratic shackles that are frustrating consumers, driving up prices, and increasing the number of uninsured.
4. **Dismantle regulatory boards** established to monitor centrally planned private insurance markets. There is no compelling reason to maintain these state regulatory institutions, and other states should follow the lead of Washington and Kentucky in getting rid of them. Improvements in the private health insurance market will not be achieved by their activities.
5. **Abolish pure community rating.** Those states that have implemented pure community rating should abolish this policy. It clearly is driving up the price of health insurance to prohibitive levels in many states and forcing citizens who would purchase health insurance coverage if it were affordable to be uninsured.
6. **Stop expanding benefit mandates.** Not everyone needs or wants coverage for such things as chiropractic care or *in vitro* fertilization. Legislators should realize that while coverage for various medical specialties may satisfy special interests, it also drives up health care costs. Higher costs make insurance less affordable for struggling families. Further, mandates deny consumers the choice of health plans that best suits their needs, forcing insurers to cater to regulators rather than citizens.
7. **Promote experimentation of coverage for the uninsurable.** States should continue to experiment with pilot programs to expand access to health care for uninsured and low-income citizens and other high-risk individuals. But they would be well advised to focus on structuring incentives properly. Policymakers should refer to the work of Stephen J. Entin, executive director of the Institute for Research on the Economics of Taxation, on this subject.[57]
8. **Practice "good medicine"** by emphasizing demonstration projects at the state level. Just as physicians and research scientists must apply rigorous testing to proposed drugs or treatment protocols, policymakers should demonstrate the success of proposed policies in meeting their stated goals before they are widely implemented. Just as in medicine, this testing will also identify the effective dosage range and potential side effects—or unintended consequences—before full-scale implementation. In health policy, this will enable policymakers to make needed changes or adjustments to minimize damage. For policymakers as well as physicians, the first dictum should be, "First, do no harm."

CONCLUSION

Congress already has enacted federally imposed insurance regulations in the Health Insurance Portability and Accountability Act of 1996, and data on the impact of these reforms are not yet available. But the states are laboratories for federal

57. Stephen J. Entin and Norman B. Ture, "Health Care Reform: Why Not Try Real Insurance?" in Grace-Marie Arnett, ed., *Empowering Healthcare Consumers through Tax Reform*, soon to be published by the University of Michigan Press.

legislation, and the data recounted in this study indicate that the mix of aggressive insurance regulation affecting the individual and small-business health insurance markets has blown up in their faces. Adding to this chemical mix at the federal level will create an even larger explosion.

Congress, now on the threshold of passing new legislation to regulate this already crippled industry even further, must heed the experience of the states. Governor Patton had it right: "In my opinion, most of the general assembly believes that we in Kentucky have experimented enough for the time being."

With the number of Americans losing health insurance rising by about a million a year to nearly 43 million today, it is clear that a new approach is needed. In a prosperous economy with low unemployment rates, the number of people with health insurance should be going up, not down. Lawmakers also must heed the wisdom of America's voters, who four years ago said they did not want further government encroachment into the health sector.

The results examined in this study show that regulation at the state and federal levels is counterproductive in responding to the challenge of increasing access to health insurance in the individual and private health insurance market. Lawmakers should focus instead on policies that allow individuals to purchase health insurance that they own and control themselves in a free, competitive, and well-informed marketplace. If this is done, consumers themselves will begin to transform the health sector into a market driven by competition, innovation, value, and choice.

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State Regulation of Health Insurance in the 16-State Study Sample

		Idaho	Iowa	Kentucky	Louisiana
State Mandated Benefits	(1)				
# of Mandates - Cover		6	12	11	21
# of Mandates - Offer		1	1	1	2
Total Mandates		7	13	12	23
State Regulations					
Premium Taxes (%)	(2)				
Health Insurers		1.4 - 2.75	2	2	2.0 - 2.25
Blue Cross/Blue Shield		$.04 per enrollee	2	2	2.0 - 2.25
HMOs		$.04 per enrollee	0 - 2.0	2	2.0 - 2.25
Guaranty Fund Assessment	(3)				
As %		2	2	2	2
% Offset from Premium Tax		100	100	100	100
High Risk Pool	(4)				
# of Participants			1,341		386
$ Assessments			3,000,000		none
Small Business Reforms	(5)				
Employer Size		1 to 49	2 to 50	100 or less	3 to 35
Guaranteed Issue (# plans/emp. size)		2 plans/2 to 49	2 plans/2 to 50	1 plan/100 or less	no
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		30	90	60	60
Pre-Existing Conditions (mos:mos)		6:12	6:12	6:6	12:12
Premium Rate Restrictions		Only age and gender	No limit on # of classes; can't look at ind. or gender	Adjusted Community Rating	Adjusted Community Rating, Limit of 6 classes. Index rate +/-10%
Individual Market Reforms	(6)				
Guaranteed Issuance		Yes, 2 plans	Yes, 2 plans	Yes, all plans	no
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		30	no	60	60
Pre-Existing Conditions (mos:mos)		6:12	12:12	12:12	12:12
Premium Rate Restrictions		Yes, index plus 25% for age & gender only	Yes, index + 100%	Yes, variation.	Adjusted Community Rating w/ plus 10% for health status, no limit for geog.
High Risk Pool		no	yes	no	yes
Blues as Insurer of Last Resort		no	no	no	no

Note:
(1) *State Mandated Benefits and Providers,* Blue Cross and Blue Shield Association, December 1997.
(2) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 26.
(3) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 29.
(4) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 32.
(5) *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms,* GAO/HEHS-95-161FS, June 12, 1995, p. 24.
(6) *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS-97-8, November 25, 1996, p. 55.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

State Regulation of Health Insurance in the 16-State Study Sample

		Maine	Minnesota	New Hampshire	New Jersey
State Mandated Benefits	(1)				
# of Mandates - Cover		21	29	12	16
# of Mandates - Offer		4	8	4	6
Total Mandates		25	37	16	22
State Regulations					
Premium Taxes (%)	(2)				
Health Insurers		2.00	2.00	2.00	1.06
Blue Cross/Blue Shield		0.00	0.00	0.00	$.02 per subscriber
HMOs		0.00	0.00	2.00	0.00
Guaranty Fund Assessment	(3)				
As %		2	2	2	2
% Offset from Premium Tax		0	0	100	50
High Risk Pool	(4)				
# of Participants			33,477		
$ Assessments			44,424,903		
Small Business Reforms	(5)				
Employer Size		less than 25	2 to 29	1 to 100	2 to 49
Guaranteed Issue (# plans/emp. size)		all plans/less than 25	all plans/2 to 29	all plans/1 to 100	5 plans/2 to 49
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		30	30	Credit for prior coverage	30
Pre-Existing Conditions (mos:mos)		12:12	6:12	3:3:9	6:6
Premium Rate Restrictions		Adjusted Community Rating, No premium rate variation as of 7/15/97	Pure Community Rating	Adjusted Community Rating, Premium Rate +/- 50%, annual increase no > 25%	Adjusted Community Rating, Premium rate +/- 300%, only age, gender & geog.
Individual Market Reforms	(6)				
Guaranteed Issuance		yes, all plans	no	yes, all plans	yes, 5 plans
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		90	30	0	30
Pre-Existing Conditions (mos:mos)		12:12	6:12	3:09	6:12
Premium Rate Restrictions		Adjusted Community Rating w/ no > +/- 20% for age, job, smoking status, indus or geog.	Yes, index rate + no more than 25%. Adj. for health status, age, and geog.	Adjusted Community Rating w/ a max. variation of 3:1 for age only	Community rating
High Risk Pool		no	yes	no	no
Blues as Insurer of Last Resort		no	no	no	no

Note:
(1) *State Mandated Benefits and Providers,* Blue Cross and Blue Shield Association, December 1997.
(2) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 26.
(3) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 29.
(4) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 32.
(5) *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms,* GAO/HEHS-95-161FS, June 12, 1995, p. 24.
(6) *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS-97-8, November 25, 1996, p. 55.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

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State Regulation of Health Insurance in the 16-State Study Sample

		New Mexico	New York	North Dakota	Ohio
State Mandated Benefits	(1)				
# of Mandates - Cover		21	27	19	17
# of Mandates - Offer		2	3	3	0
Total Mandates		23	30	22	17
State Regulations					
Premium Taxes (%)	(2)				
Health Insurers		0.9 - 3.0	1.00	1.75	2.50
Blue Cross/Blue Shield		0.9 - 3.0	0.00	1.75	2.50
HMOs		0.9 - 3.0	0.00	1.75	0.00
Guaranty Fund Assessment	(3)				
As %		2	2	2	2
% Offset from Premium Tax		0	80	100	100
High Risk Pool	(4)				
# of Participants		1,124		1,422	
$ Assessments		3,426,625		1,500,000	
Small Business Reforms	(5)				
Employer Size		2 to 50	3 to 50	3 to 25	2 to 50
Guaranteed Issue (# plans/emp. size)		no	all plans/3 to 50	2 plans/1 to 25	2 plans/2 to 50
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		31	60	30	30
Pre-Existing Conditions (mos:mos)		6:6	6:12	6:12	6:12
Premium Rate Restrictions		Limit to 2 classes. As of 7/1/98 only adj. for age, <19 or >19	Adjusted Community Rating	Index rate w/in class +/- 15%; Premium rates w/in class = index +/- 20%	Cannot look at claims exp., health status, or duration of coverage
Individual Market Reforms	(6)				
Guaranteed Issuance		no	Yes, all plans	no	yes, 1 plan
Guaranteed Renewal		yes	yes	yes	yes
Portability (w/in days prior coverage)		31	60	90	30
Pre-Existing Conditions (mos:mos)		6:6	6:12	6:12	6:12
Premium Rate Restrictions		As of 7/1/98 only adj. for age, <19 or >19	Yes, community rating within specific geo. regions	Premium rates cannot vary by more than 5:1	Premiums rates cannot exceed 2.5x for similar
High Risk Pool		yes	no	yes	no
Blues as Insurer of Last Resort		no	no	no	no

Note:
(1) *State Mandated Benefits and Providers,* Blue Cross and Blue Shield Association, December 1997.
(2) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 26.
(3) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 29.
(4) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 32.
(5) *Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms,* GAO/HEHS-95-161FS, June 12, 1995, p. 24.
(6) *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS-97-8, November 25, 1996, p. 55.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

State Regulation of Health Insurance in the 16-State Study Sample

		Oregon	Utah	Vermont	Washington
State Mandated Benefits	(1)				
# of Mandates - Cover		17	16	10	19
# of Mandates - Offer		0	0	0	2
Total Mandates		17	16	10	21
State Regulations					
Premium Taxes (%)	(2)				
Health Insurers		2.25	0.00	2	2.00
Blue Cross/Blue Shield		0.00	0.00	0	2.00
HMOs		0.00	0.00	0	2.00
Guaranty Fund Assessment	(3)				
As %		2	2	2	2
% Offset from Premium Tax		100	100	100	100
High Risk Pool	(4)				
# of Participants		4,313	710		1,307
$ Assessments		3,956,818	none		11,499,657
Small Business Reforms	(5)				
Employer Size		3 to 25	1 to 50	1 to 49	Health Services Act of 1993
Guaranteed Issue (# plans/emp. size)		1 plan/3 to 25	no	all plans/1 to 49	all plans
Guaranteed Renewal		yes	yes	open enrollment	yes
Portability (w/in days prior coverage)		30	30	0	90
Pre-Existing Conditions (mos:mos)		6:12	6:12	12:12	3:3
Premium Rate Restrictions		Premium Rate = Average Rate Plus 33%. Increases No Greater than 15%	NAIC Banded rate	Adjusted Community Rating	Adjusted Community Rating
Individual Market Reforms	(6)				
Guaranteed Issuance		no	yes, 1 plan	Yes, all plans	yes, all plans
Guaranteed Renewal		yes	yes	open enrollment	yes
Portability (w/in days prior coverage)		60	90	0	90
Pre-Existing Conditions (mos:mos)		6:6	6:12	12:12	3:3
Premium Rate Restrictions		Geog. Rate + Variation for Plan Design, Family Composition, and Age Applied Uniformly	Index Rate + Variation; Index Rate Cannot Exceed Small Business Index Rate	Yes, Adjusted Community Rating, w/20% - Geo. Loc.	Adjusted Community Rating Premium rate cannot exceed 400% of the lowest rate
High Risk Pool		yes	yes	no	yes
Blues as Insurer of Last Resort		no	no	no	no

Note:
(1) *State Mandated Benefits and Providers,* Blue Cross and Blue Shield Association, December 1997.
(2) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 26.
(3) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 29.
(4) *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161, August 19, 1996, p. 32.
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(6) *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS-97-8, November 25, 1996, p. 55.
Source: Author calculations based upon U.S. Bureau of the Census *Current Population Survey* data.

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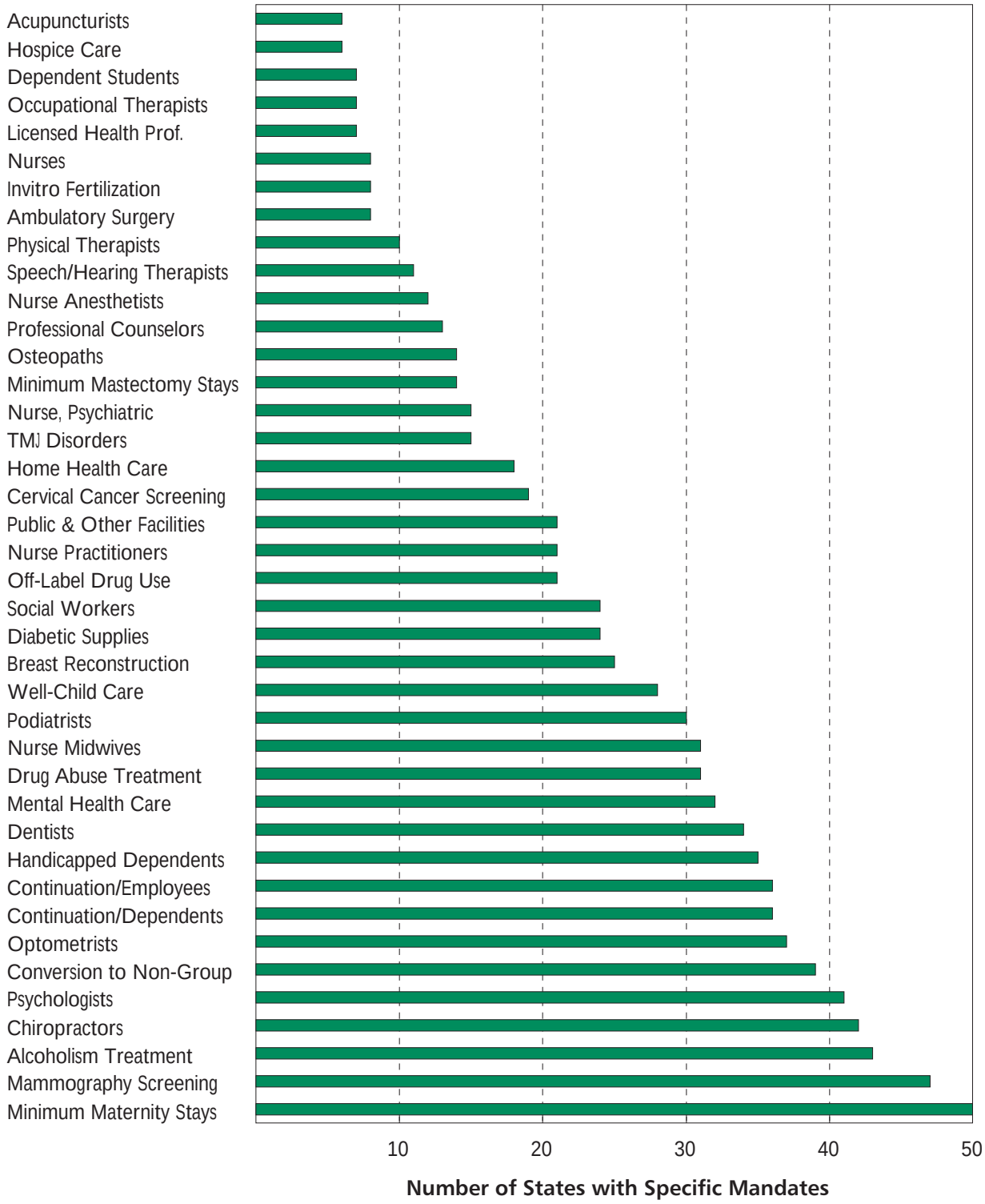
Frequency of Health Care Mandates: 1997



Source: *State Mandated Benefits and Providers*, Blue Cross and Blue Shield Association, December 1997.

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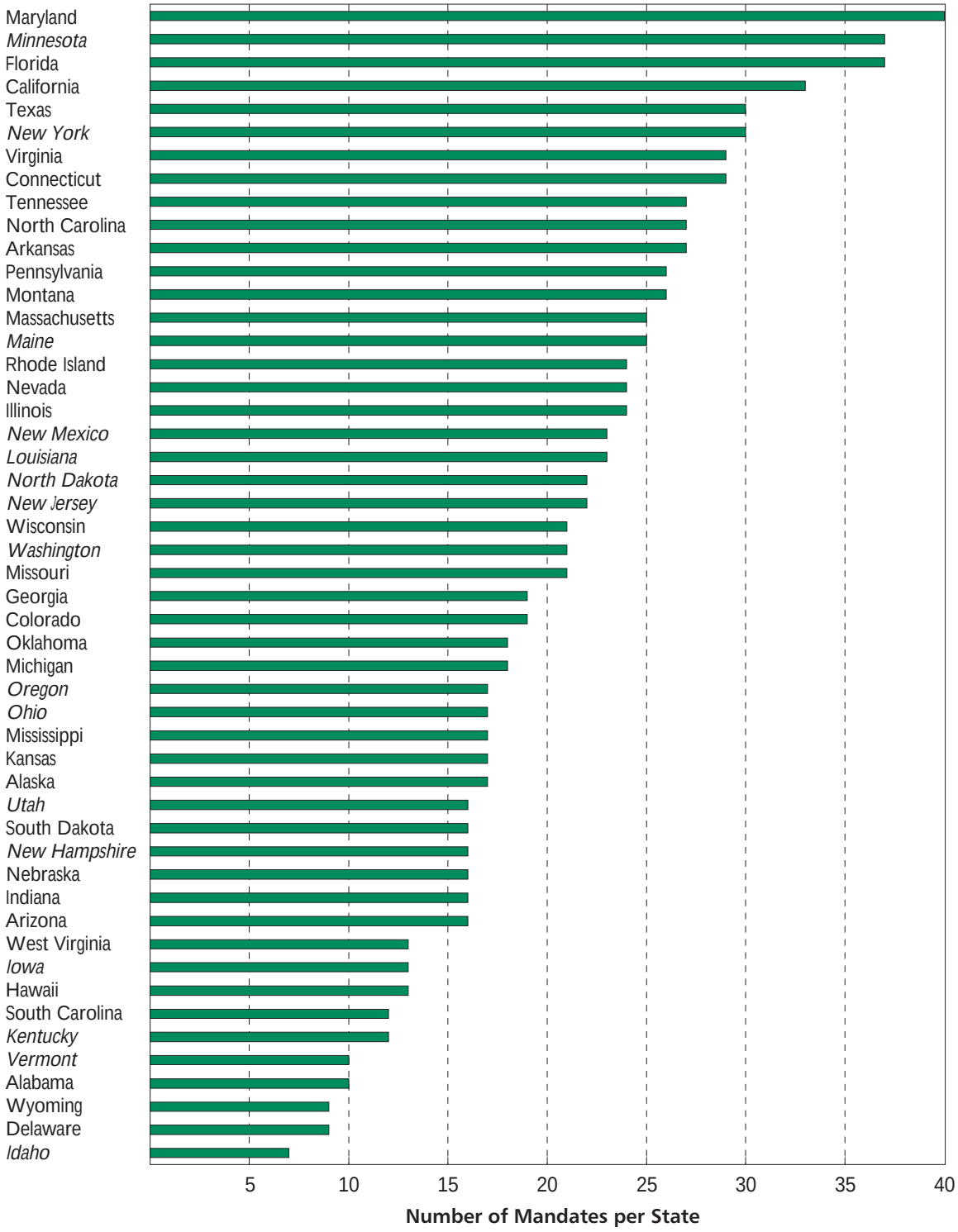
Number of State Health Insurance Mandates: 1997



Note: States in *italics* were members of the 16-state study sample.
Source: *State Mandated Benefits and Providers*, Blue Cross and Blue Shield Association, December 1997.

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The 16 Study States: General Characteristics of Their Populations, 1995

Rank Based on Uninsured Population: 16 Study States	State	% of Population Uninsured	1995 Per Capita Income	Rank Based on Per Capita Income: All 50 States	% of Population Below Poverty	Rank Based on % Below Poverty: All 50 States
1	MN	9.0%	$23,971	15	9.2%	44%
2	ND	9.4	18,625	44	12.0	27
3	NH	11.4	25,587	8	5.3	50
4	IA	12.8	20,921	34	12.2	22
5	UT	13.0	18,237	47	8.4	47
6	OH	13.5	22,514	22	11.5	28
7	WA	13.7	23,774	19	12.5	20
8	OR	13.9	21,611	27	11.2	29
9	VT	14.5	21,231	30	10.3	35
10	ME	15.4	20,105	37	11.2	29
11	ID	15.9	18,906	42	14.5	17
12	NJ	16.2	29,848	3	7.8	48
13	KN	16.8	18,849	43	14.7	16
14	NY	17.2	27,678	5	16.5	10
15	LA	22.9	18,981	41	19.7	5
16	NM	28.3	18,206	48	25.3	1
Avg. for 16 Study States		15.6	$21,815			12.6
U.S. Average		17.3	$22,168			13.8

Source: U.S. Bureau of the Census *Current Population Survey* data.

Health Insurance Coverage Status Before and After Reforms

	Thousands of Persons as of March of the Following Year								Average Coverage Status 1989–90 to 1995–96	
	Before Reforms				After Reforms					
	1989		1990		1995		1996		Change in	Percentage
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Point Change
Idaho										
Private Health Insurance Coverage	707	78.0%	721	76.5%	756	74.4%	753	71.8%	40.5	-4.2
Employment-Based Health Ins. Coverage	600	66.0	604	64.1	650	64.0	655	62.4	50.5	-1.8
Private Individual Health Ins. Coverage	107	12.0	117	12.4	106	10.4	98	9.4	-10.0	-2.3
Uninsured	157	17.3	159	16.9	162	15.9	195	18.6	20.5	0.1
Medicaid Coverage	46	5.1	60	6.4	127	12.5	113	10.7	67.0	5.9
Medicare Coverage	10	1.0	12	1.3	19	1.9	13	1.2	5.0	0.4
Iowa										
Private Health Insurance Coverage	2,109	86.0	1,978	83.4	2,049	80.8	2,073	81.3	17.5	-3.7
Employment-Based Health Ins. Coverage	1,699	69.3	1,609	67.8	1,747	68.9	1,766	69.2	102.5	0.5
Private Individual Health Ins. Coverage	410	16.7	369	15.6	302	11.9	307	12.1	-85.0	-4.2
Uninsured	205	8.4	224	9.4	326	12.8	334	13.1	115.5	4.1
Medicaid Coverage	137	5.6	180	7.6	208	8.2	197	7.7	44.0	1.4
Medicare Coverage	18	0.7	33	1.4	23	0.9	41	1.6	6.5	0.2
Kentucky										
Private Health Insurance Coverage	2,350	74.9	2,305	72.8	2,301	68.0	2,269	66.6	-42.5	-6.6
Employment-Based Health Ins. Coverage	2,038	65.0	2,016	63.7	2,131	63.0	2,121	62.2	99.0	-1.7
Private Individual Health Ins. Coverage	312	9.9	289	9.1	170	5.0	148	4.4	-141.5	-4.8
Uninsured	471	15.0	479	15.1	567	16.8	598	17.6	107.5	2.2
Medicaid Coverage	268	8.5	327	10.3	435	12.9	470	13.8	155.0	4.0
Medicare Coverage	55	1.8	73	2.3	72	2.1	89	2.6	16.5	0.3
Louisiana										
Private Health Insurance Coverage	2,448	67.1	2,306	64.3	2,271	59.1	2,348	62.0	-67.5	-5.1
Employment-Based Health Ins. Coverage	2,103	57.7	1,930	53.8	1,958	50.9	2,144	56.7	34.5	-2.0
Private Individual Health Ins. Coverage	345	9.4	376	10.5	313	8.2	204	5.3	-102.0	-3.2
Uninsured	729	20.0	792	22.1	881	22.9	879	23.2	119.5	2.0
Medicaid Coverage	450	12.4	421	11.7	651	16.9	494	13.1	137.0	3.0
Medicare Coverage	90	2.5	104	2.9	108	2.8	112	3.0	13.0	0.2
Maine										
Private Health Insurance Coverage	882	80.5	839	76.5	816	76.1	811	77.8	-47.0	-1.6
Employment-Based Health Ins. Coverage	758	69.2	720	65.7	733	68.4	750	71.9	2.5	2.7
Private Individual Health Ins. Coverage	124	11.3	119	10.8	83	7.7	61	5.9	-49.5	-4.3
Uninsured	113	10.3	139	12.6	165	15.4	145	13.9	29.0	3.2
Medicaid Coverage	97	8.8	123	11.2	86	8.0	90	8.6	-22.0	-1.7
Medicare Coverage	11	1.0	22	2.0	29	2.7	33	3.2	14.5	1.5
Minnesota										
Private Health Insurance Coverage	3,158	84.6	3,080	79.5	3,387	82.1	3,349	78.4	249.0	-1.8
Employment-Based Health Ins. Coverage	2,603	69.8	2,616	67.5	2,992	72.6	2,963	69.4	368.0	2.3
Private Individual Health Ins. Coverage	555	14.8	464	12.0	395	9.5	386	9.0	-119.0	-4.2
Uninsured	366	9.8	384	9.9	370	9.0	480	11.2	50.0	0.2
Medicaid Coverage	259	6.9	454	11.7	495	12.0	524	12.3	153.0	2.9
Medicare Coverage	24	0.6	40	1.0	29	0.7	53	1.2	9.0	0.2

Note: An average of the coverage status for a two-year pre- and post-reform period was used for two reasons: first, due to the difference in date of enactment and effectiveness (typically implemented incrementally) and second, to avoid contaminating the pre- and post-reform findings with selection effects.
Source: U.S. Bureau of the Census *Current Population Survey* data from 1989 through 1996.

Health Insurance Coverage Status Before and After Reforms

	Thousands of Persons as of March of the Following Year								Average Coverage Status 1989–90 to 1995–96	
	Before Reforms				After Reforms					
	1989		1990		1995		1996		Change in	Percentage
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Point Change
New Hampshire										
Private Health Insurance Coverage	803	81.5%	822	84.8%	819	81.2%	822	81.7%	8.0	-1.7
Employment-Based Health Ins. Coverage	681	69.1	728	75.1	762	75.5	765	76.1	59.0	3.7
Private Individual Health Ins. Coverage	122	12.4	94	9.7	57	5.7	57	5.6	-51.0	-5.4
Uninsured	138	14.0	107	11.1	115	11.4	110	10.9	-10.0	-1.4
Medicaid Coverage	35	3.5	42	4.4	72	7.1	70	7.0	32.5	3.1
Medicare Coverage	7	0.8	5	0.5	15	1.5	20	2.0	11.5	1.1
New Jersey										
Private Health Insurance Coverage	5,486	82.3	5,532	82.0	5,244	76.6	5,039	73.6	-367.5	-7.1
Employment-Based Health Ins. Coverage	4,831	72.5	4,894	72.6	4,857	70.9	4,712	68.8	-78.0	-2.7
Private Individual Health Ins. Coverage	655	9.8	638	9.4	387	5.7	327	4.8	-289.5	-4.4
Uninsured	779	11.7	765	11.3	1,107	16.2	1,306	19.1	434.5	6.2
Medicaid Coverage	414	6.2	500	7.4	513	7.5	537	7.8	68.0	0.9
Medicare Coverage	83	1.2	72	1.1	103	1.5	91	1.3	19.5	0.3
New Mexico										
Private Health Insurance Coverage	881	65.0	839	61.0	824	50.6	923	55.5	13.5	-10.0
Employment-Based Health Ins. Coverage	752	55.5	696	50.7	751	46.1	848	51.0	75.5	-4.6
Private Individual Health Ins. Coverage	129	9.5	143	10.3	73	4.5	75	4.5	-62.0	-5.4
Uninsured	318	23.4	339	24.6	462	28.3	410	24.7	107.5	2.5
Medicaid Coverage	118	8.7	165	12.1	328	20.1	329	19.8	187.0	9.6
Medicare Coverage	20	1.5	24	1.8	34	2.1	28	1.7	9.0	0.3
New York										
Private Health Insurance Coverage	11,736	75.2	11,664	74.0	10,889	68.1	10,598	65.5	-956.5	-7.8
Employment-Based Health Ins. Coverage	10,465	67.1	10,248	65.0	10,148	63.4	9,964	61.6	-300.5	-3.6
Private Individual Health Ins. Coverage	1,271	8.1	1,416	9.0	741	4.7	634	3.9	-656.0	-4.3
Uninsured	2,084	13.4	2,151	13.6	2,748	17.2	3,093	19.1	803.0	4.7
Medicaid Coverage	1,824	11.7	2,122	13.5	2,507	15.7	2,744	17.0	652.5	3.8
Medicare Coverage	258	1.7	302	1.9	244	1.5	238	1.5	-39.0	-0.3
North Dakota										
Private Health Insurance Coverage	462	82.9	455	81.8	447	80.7	444	80.6	-13.0	-1.7
Employment-Based Health Ins. Coverage	313	56.2	322	57.9	348	62.8	365	66.2	39.0	7.5
Private Individual Health Ins. Coverage	149	26.7	133	23.9	99	17.9	79	14.4	-52.0	-9.2
Uninsured	56	10.0	40	7.2	52	9.4	62	11.2	9.0	1.7
Medicaid Coverage	21	3.8	54	9.7	47	8.5	40	7.3	6.0	1.2
Medicare Coverage	6	1.1	8	1.5	7	1.3	12	2.2	2.5	0.5
Ohio										
Private Health Insurance Coverage	7,804	83.1	7,580	79.5	7,455	75.9	7,490	76.4	-219.5	-5.1
Employment-Based Health Ins. Coverage	7,102	75.6	6,771	71.0	7,007	71.3	7,105	72.4	119.5	-1.5
Private Individual Health Ins. Coverage	702	7.5	809	8.5	448	4.6	385	4.0	-339.0	-3.7
Uninsured	901	9.6	1,116	11.7	1,326	13.5	1,286	13.1	297.5	2.7
Medicaid Coverage	752	8.0	871	9.1	1,144	11.6	969	9.9	245.0	2.2
Medicare Coverage	147	1.6	129	1.4	175	1.8	234	2.4	66.5	0.6

Note: An average of the coverage status for a two-year pre- and post-reform period was used for two reasons: first, due to the difference in date of enactment and effectiveness (typically implemented incrementally) and second, to avoid contaminating the pre- and post-reform findings with selection effects.
Source: U.S. Bureau of the Census *Current Population Survey* data from 1989 through 1996.

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Health Insurance Coverage Status Before and After Reforms

	Thousands of Persons as of March of the Following Year								Average Coverage Status 1989–90 to 1995–96	
	Before Reforms				After Reforms					
	1989		1990		1995		1996		Change in	Percentage
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Point Change
Oregon										
Private Health Insurance Coverage	2,001	78.4%	1,967	79.7%	2,109	73.9%	2,070	73.4%	105.5	-5.4
Employment-Based Health Ins. Coverage	1,769	69.3	1,710	69.3	1,952	68.4	1,848	65.5	160.5	-2.3
Private Individual Health Ins. Coverage	232	9.1	257	10.4	157	5.5	222	7.9	-55.0	-3.1
Uninsured	398	15.6	360	14.6	398	13.9	491	17.4	65.5	0.5
Medicaid Coverage	162	6.3	162	6.6	438	15.3	324	11.5	219.0	7.0
Medicare Coverage	32	1.2	32	1.3	40	1.4	52	1.9	14.0	0.4
Utah										
Private Health Insurance Coverage	1,279	83.8	1,333	83.7	1,472	80.8	1,486	82.6	173.0	-2.1
Employment-Based Health Ins. Coverage	1,134	74.3	1,153	72.3	1,327	72.8	1,336	74.3	188.0	0.3
Private Individual Health Ins. Coverage	145	9.5	180	11.4	145	8.0	150	8.3	-15.0	-2.3
Uninsured	151	9.9	156	9.8	236	13.0	239	13.3	84.0	3.3
Medicaid Coverage	95	6.2	114	7.2	129	7.1	112	6.2	16.0	0.0
Medicare Coverage	16	1.1	16	1.0	14	0.8	16	0.9	-1.0	-0.2
Vermont										
Private Health Insurance Coverage	412	83.6	401	81.1	405	75.4	395	75.3	-6.5	-7.0
Employment-Based Health Ins. Coverage	359	73.0	352	71.2	368	68.5	345	65.9	1.0	-4.9
Private Individual Health Ins. Coverage	53	10.6	49	9.9	37	6.9	50	9.4	-7.5	-2.1
Uninsured	47	9.6	52	10.5	78	14.5	65	12.4	22.0	3.4
Medicaid Coverage	33	6.7	40	8.1	75	14.0	89	17.1	45.5	8.2
Medicare Coverage	7	1.4	7	1.3	5	0.9	14	2.6	2.5	0.4
Washington										
Private Health Insurance Coverage	3,308	77.8	3,392	77.2	3,633	74.1	3,852	75.0	392.5	-3.0
Employment-Based Health Ins. Coverage	2,871	67.5	2,867	65.3	3,286	67.0	3,366	65.5	457.0	-0.2
Private Individual Health Ins. Coverage	437	10.3	525	11.9	347	7.1	486	9.5	-64.5	-2.8
Uninsured	562	13.2	557	12.7	674	13.7	761	14.8	158.0	1.3
Medicaid Coverage	305	7.2	329	7.5	673	13.7	305	648	172.0	5.3
Medicare Coverage	52	1.2	58	1.3	54	1.1	52	133	-2.0	1.4

Note: An average of the coverage status for a two-year pre- and post-reform period was used for two reasons: first, due to the difference in date of enactment and effectiveness (typically implemented incrementally) and second, to avoid contaminating the pre- and post-reform findings with selection effects.
Source: U.S. Bureau of the Census *Current Population Survey* data from 1989 through 1996.