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Report to the Honorable
James M. Jeffords, U.S. Senate

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HEALTH INSURANCE REGULATION

Varying State Requirements Affect Cost of Insurance

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GAO

United States
General Accounting Office
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Health, Education, and
Human Services Division

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The Honorable James M. Jeffords
United States Senate

Dear Senator Jeffords:

As concern about the affordability of health coverage has grown, the costs attributed to state regulation of health insurance have been increasingly debated. State health insurance regulation is intended to protect consumers by overseeing health plans' financial solvency, monitoring insurers' market conduct to prevent abuses, and requiring coverage for particular services. Although these state actions benefit consumers, they also result in costs that are borne by insurers and often ultimately passed on to consumers in their premiums. These costs may in some cases affect an employer's decision to offer health coverage through an insurer that is subject to state insurance regulation or to self-fund[1] its health plan, which avoids state insurance regulation.

This report responds to your request that we provide additional information on the costs of state health insurance requirements as a follow-up to our earlier report on the Employee Retirement Income Security Act of 1974 (ERISA).[2] In particular, you requested that we examine the costs associated with (1) premium taxes and other assessments, (2) mandated health benefits, (3) financial solvency standards, and (4) state health insurance reforms affecting small employers. We examined the impact of these requirements on the cost of insured health plans compared with the cost of self-funded health plans. Our earlier report, prepared at your request, more comprehensively describes the advantages and disadvantages of ERISA preemption.[3]

To develop this information, we interviewed officials from the National Association of Insurance Commissioners (NAIC) and state insurance regulators in Iowa, Maryland, North Carolina, Oregon, and Virginia. We

[1]Employers that self-fund their health plans bear much of the financial risk for employee health claims. Many of these employers purchase stop-loss insurance to mitigate their potential losses. Health plans under these arrangements are referred to as self-funded.

[2]Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

[3]For additional information on the benefits of state insurance regulation, see also Patricia Butler and Karl Polzer, Private-Sector Health Coverage: Variation in Consumer Protections Under ERISA and State Law, George Washington University, National Health Policy Forum (Washington D.C.: June 1996).

also interviewed actuaries, health insurance executives, benefits managers for self-funded employers, and officials from national trade associations representing each of these groups. We reviewed documents and used data provided by these groups as well as available studies on mandated benefits and other state regulatory actions. In addition, we updated information from previous GAO reports on state insurance regulation and ERISA.[4] Our review was conducted between January and June 1996 in accordance with generally accepted government auditing standards.

Results in Brief

State health insurance regulation imposes requirements on health plans offered by insurers that employers' self-funded health plans do not have. Although these requirements benefit consumers, they also add costs to insured health plans. The extent to which these requirements increase insured health plans' costs compared with self-funded health plans' costs varies by state. The cost impact depends on the nature and scope of each state's regulations and on health plans' typical operating practices.

State premium taxes and other assessments are the most direct and easily quantifiable cost that insured health plans face. Premium taxes increase costs to commercial health insurers by about 2 percent in most states. Other assessments not only tend to be smaller than the premium tax but can often be deducted from premium taxes. These include assessments for guaranty funds that pay the claims of insolvent plans and high-risk pools that provide coverage for individuals unable to get private coverage because of preexisting conditions.

Most states mandate that insurance policies cover certain benefits and types of providers, such as mammography screening, mental health services, and chiropractic services, which raises claims costs to the extent that such benefits would not otherwise have been covered. The cost effect varies due to differences in state laws and employer practices. For example, Virginia's mandated benefits accounted for about 12 percent of claims costs, according to a recent study. Earlier studies estimated that mandated benefits represented 22 percent of claims in Maryland and 5 percent in Iowa. In general, such cost estimates are higher in states with more mandated benefits and in states that mandate more costly benefits, such as mental health services and substance abuse treatment. These cost estimates represent the potential costs of mandated benefits to a health plan that does not voluntarily offer these benefits. Because most

[4]See Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993) and GAO/HEHS-95-167, July 25, 1995.

self-funded plans offer many of the mandated benefits, their additional claims cost—were they required to comply—would not be as high as the studies' estimates. If required to comply with state mandates, however, self-funded plans would lose flexibility in choosing what benefits to offer and in offering a single, uniform health plan across states.

State financial solvency standards have limited potential effect on costs because many insurers exceed the state minimum requirements and typically perform tasks like those associated with the state financial reporting requirements. Most insurers maintain higher levels of capital and surplus than the minimum state requirements, indicating that the effect of the capital and surplus requirements on health insurance costs is generally minimal. Although states require financial information and actuarial reports that in some cases differ from the insurers' general business practices, insurance executives indicated that the added administrative cost of preparing these documents was marginal and that the additional information was also valuable to the insurer.

The cost implications of small employer health insurance reforms, such as limits on preexisting condition exclusions recently adopted in many states, remain unclear. The cost information to date is mostly anecdotal and provides an incomplete view of these reforms' effects. Moreover, the rapid changes in health care markets, such as the continued growth and evolution of managed care, make it difficult to isolate the independent effect of the reforms.

Background

Every state regulates the terms and conditions of insurance sold in the state and nearly all tax insurers. States require health insurance policies sold there to include specific benefits, such as mental health services, mammography screening, chiropractic services, and coverage for newborns. States use a variety of methods to monitor health insurers' solvency, including minimum capital and surplus levels, investment restrictions, and financial reviews. In addition, many states have enacted reforms to improve access and affordability of health insurance for small employers. Prominent examples of these reforms are guaranteed issuance and renewal, portability, and premium rate restrictions. These reforms are intended to address concerns about certain individuals being excluded from coverage or priced out of the market. These individuals include those who change jobs or experience costly medical conditions while in the small employers' insurance market.

Although states regulate health insurance, state regulation does not directly affect 4 of 10 people with private employer-based health coverage. ERISA[5] preempts states from directly regulating employer provision of health plans, but it permits states to regulate health insurers. Of the 114 million Americans with health coverage offered through a private employer in 1993, about 60 percent participated in insured health plans that are subject to state insurance regulation. However, for plans covering the remaining 40 percent—about 44 million people in 1993—the employer chose to self-fund and retain at least some financial risk for its health plan.

Self-funding is most common among large employers. Only 11 percent of employees in firms of 100 or fewer employees were in self-funded health plans compared with 34 percent of those in firms of 101 to 500 employees and 63 percent of those in firms of more than 500 employees, according to a 1993 Robert Wood Johnson Foundation survey.[6] As stop-loss coverage with less risk to the employer becomes available, however, more small employers may start to self-fund. The NAIC has adopted a stop-loss model act that attempts to define the levels of risk that can be assumed by stop-loss carriers for determining which state insurance laws should apply. State insurance regulators are concerned that some employers may purchase stop-loss coverage in which the stop-loss carrier assumes most of the risk and believe, therefore, that the plan should be subject to state health insurance laws.[7]

Because self-funded health plans may not be deemed to be insurance, ERISA preempts them from state insurance regulation and premium taxation. Although ERISA includes fiduciary[8] standards to protect employee benefit plan participants and beneficiaries from plan mismanagement and other requirements, in other areas no federal requirements comparable with state requirements for health insurers exist for self-funded health

[5]ERISA is the federal law that covers employer-based pension and welfare benefit plans, including health plans. P.L. 93-406, 88 Stat. 829 (classified as amended at 29 U.S.C. 1001 et seq. (1994)).

[6]The Robert Wood Johnson Foundation Employer Health Insurance Survey was conducted in 10 states. See Gregory Acs and others, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," Health Affairs, Vol. 15, No. 2 (1996), pp. 266-78.

[7]Maryland and Missouri promulgated regulations similar to the NAIC stop-loss model act, but both regulations were found by federal courts earlier this year to be preempted by ERISA. American Medical Security, Inc. v. Bartlet, 915 F. Supp. 740 (D. Md. 1996) and Associated Industries of Missouri v. Angloff (unreported). Maryland is planning an appeal. Missouri argued its appeal on July 3, 1996, and is awaiting the court's decision.

[8]ERISA defines a fiduciary as anyone who exercises discretionary control or authority over the management of a plan or renders investment advice to a plan.

plans. Table 1 compares the requirements that fully insured and self-funded health plans must meet.

Table 1: Comparison of State and Federal Provisions Affecting Fully Insured and Self-Funded Health Plans

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[a]
Market conduct requirements		
Plan benefit coverage and description	States review and approve insurance policies to ensure they are not vague or misleading and they meet state requirements, such as mandatory benefit provisions.	Disclosure requirements to provide summary plan description to participants and the Department of Labor. No requirements to provide specific benefits. However, group health plans covering more than 20 employees must offer coverage (at the employees' expense) for 18 to 36 months following termination of employment and other qualifying events.
Small group reforms	Most states require insurers selling to small employers to accept and renew employees who want health insurance coverage, establish short waiting periods for preexisting conditions, and require portability of coverage when an individual changes jobs or insurers.[b]	No comparable requirements. States are preempted from applying small group reforms to self-funded health plans.
Consumer protections and complaints	States monitor insurers' actions to ensure they are not engaging in unfair business practices or otherwise taking advantage of consumers and assist consumers by investigating their complaints, answering questions, and conducting educational programs.	Plan must reconsider denied claims at participants' request. Federal courts, not state courts, have jurisdiction over litigation of denied claims. States have no authority to pursue consumer complaints about self-funded plans. Department of Labor has responsibility for complaints about self-funded health plans.
Financial requirements		
Licensing	States license insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable and that agents are qualified.	No comparable requirements.
Financial solvency	States set standards for and monitor financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims. States restrict how insurers invest their funds.	No solvency requirements but fiduciary duty to act in a prudent manner solely in the interests of plan participants and beneficiaries.

(continued)

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[a]
Rate reviews	States review and approve rates or require actuarial certification to ensure that rates are reasonable for consumers and sufficient to maintain the solvency of insurance companies.	No comparable requirements.
	Some states regulate insurer rating practices in the small group market to determine the factors insurers may use in setting premiums.[b]	No comparable requirements.
Tax requirements		
Premium taxes	Nearly all states assess premium taxes on insurers.	States are preempted from assessing premium taxes on self-funded health plans.
Guaranty funds	States assess insurers to finance guaranty funds that provide financial protections to enrollees who have outstanding medical claims in case of insurer insolvency.	States are preempted from requiring self-funded health plans to participate in guaranty funds.
High-risk pools	Some states assess insurers to finance losses in high-risk pools that provide health coverage for individuals who otherwise had been denied coverage because of a medical condition.	States are preempted from requiring self-funded health plans to participate in high-risk pools.

[a]ERISA requirements apply to all private employer and union health plans, including fully insured and self-funded health plans. See GAO/HEHS-95-167, July 25, 1995. Although states are preempted from regulating self-funded health plans directly, some states regulate third parties that provide administrative services for self-funded health plans and stop-loss insurance carriers that reimburse self-funded health plans for claims that exceed a predetermined threshold.

[b]For a list of states that have enacted these reforms, see Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

State Taxes Typically Increase Insured Health Plans' Costs

One of the most direct and quantifiable costs that insured health plans incur compared with self-funded health plans results from state premium taxes and other assessments paid by health insurers. Most of the costs associated with taxes result from premium taxes that increase costs to insured health plans by about 2 percent in most states. In addition, states also assess insurers for other purposes, but these assessments are generally small and, in many states, the insurer may receive a credit from its premium taxes for these payments.

Most states tax health insurance premiums. State revenues from premium taxes on all types of insurance, including property, casualty, life, and health insurance, totaled over $8 billion in 1993. Premium taxes for commercial health insurers range from 0 to over 4 percent; most states

have premium tax rates of about 2 percent. Many states exempt or have lower rates for Blue Cross and Blue Shield plans as well as health maintenance organizations (HMO). In some states insurers receive credits that lower their premium tax rates, such as credits for insurers who are headquartered locally or invest in state securities. In addition, the expense of state taxes can be deducted from insurers' federal taxes, reducing their net cost. See appendix I for a list of premium tax rates by state and type of insurance.

Health insurers may also be liable for paying other miscellaneous assessments collected by the states, including assessments for guaranty funds and high-risk pools. Guaranty funds provide financial protections to enrollees who have outstanding medical claims in the case of an insurer insolvency. In years that monies are drawn from the guaranty funds due to an insurance failure, states assess insurers a fee on the basis of their market share within the state to pay for the guaranty fund expenses. States cap the maximum rate insurers may be assessed in a year, typically at about 2 percent of gross premiums. Except in a few states where a relatively large insurer has failed, however, actual assessments are much lower than the maximum rate. In 1993, actual assessments against life and health insurers for guaranty funds averaged 0.34 percent, and guaranty fund assessments exceeded 1 percent of premiums in only seven states. Most states allow insurers to deduct some or all of the guaranty fund assessment from their premium taxes. Appendix II shows state assessments for guaranty funds and deductions from premium taxes.

About half of the states maintain high-risk pools to provide health coverage for individuals denied health coverage because of a medical condition. In 1994, about 100,000 Americans were covered by high-risk pools.[9] Although participants in these plans pay a premium for their coverage, the costs of the high-risk pools exceed the premiums collected. To compensate for the difference in premiums collected and claims paid, 20 states have the authority to assess insurers who participate in the high-risk pool.[10] In 1994, 15 states actually assessed insurers to cover high-risk pool losses. Minnesota, with the largest high-risk pool in the nation, assessed insurers 1.7 percent of their premiums in 1995 to cover high-risk pool losses. Most states with assessments (although not

[9]See Communicating for Agriculture, Inc., Comprehensive Health Insurance for High-risk Individuals: A State-by-State Analysis, Ninth Edition (Bloomington, Minn.: 1995) for information on high-risk pools, their financing, and enrollment.

[10]States also use general revenues or taxes from other sources to fund the additional costs of high-risk pools.

Minnesota) allow insurers to offset at least some of the expense of the high-risk pool assessments from their premium taxes. Appendix III shows state assessments for high-risk pools.

Table 2 summarizes the costs to health insurers of the various state taxes. Most insurers and HMOs are likely to pass on the costs of these taxes to their customers through higher premiums. However, their ability to do so depends on such factors as the competitiveness of the market, size of the employer, and insurer's marketing strategy.

Table 2: Taxes on Insured Health Plans as a Percent of Premiums

	Commercial insurers		Blue Cross and Blue Shield plans		HMOs	
	Range	Median	Range	Median	Range	Median
Premium taxes[a]	0.0-4.3	2.0	0.0-4.0	0.5	0.0-3.5	0.0
Guaranty fund assessments	0.0-3.2	0.3	0.0-1.3[b]	0.0[b]	n/a[b]	n/a[b]
High-risk pool assessments	0.0-1.7[c]	0.0	0.0-1.7[c]	0.0	n/a	n/a

[a]Premium tax rates do not reflect credits or rebates for locally based insurers or other credits.

[b]Guaranty funds in 27 states do not include Blue Cross and Blue Shield plans. Only three states include HMOs in their guaranty funds, and four states establish separate HMO guaranty funds. In states that do not include these plans in the guaranty fund, Blue Cross and Blue Shield plans and HMOs are not responsible for these assessments.

[c]Data on assessments as a percent of premiums are not available for every state. Minnesota's assessment of 1.7 percent is listed as the high end of the range because Minnesota's total assessment to members ($44 million in 1994) greatly exceeds that of any other state. Wisconsin, with a total assessment of $17 million in 1994, was second highest.

Mandated Benefits Increase Health Insurance Costs but Magnitude Varies

The cost impact of mandated benefits varies because states differ in the number and type of benefits mandated. The available studies reflect this cost variation, estimating higher claims costs in states with the most mandated benefits and more costly benefits, such as treatment for mental health and substance abuse. However, the studies are limited because their measurement of costs does not account for certain other cost elements, including administrative costs for multistate employers and a loss of flexibility claimed by employers in designing cost-effective benefit packages. In addition, reported cost estimates often do not measure the incremental cost of adding a mandated benefit to a health insurance

package; instead, the estimates represent the fraction of total health insurance claims that are paid for each of the mandated benefits. Furthermore, claims costs may exaggerate the differences in costs between insured and self-funded health plans because many commonly mandated benefits are often covered by employers who self-fund even though they are not subject to state regulation.

Number and Type of Mandated Benefits Adopted by States Vary

On average, states have enacted laws mandating about 18 specific benefits. As shown in figure 1, 16 states have over 20 mandated benefits; 8 states have 10 or fewer mandates. Maryland (39), Minnesota (34), and California (33) have the most mandated benefits. In contrast, Idaho has only six mandated benefits; Alabama, Delaware, Vermont, and Wyoming each have eight mandated benefits.[11]

[11]The number of mandated benefits includes requirements that insurers provide or continue coverage for specific populations, such as dependent students, as a mandated benefit. Thus, the number of mandated benefits per state includes these requirements as well as treatment- and provider-related mandated benefits. See Blue Cross and Blue Shield Association, State Legislative Health Care and Insurance Issues: 1995 Survey of Plans (Washington, D.C.: Blue Cross and Blue Shield Association, 1995) for a list of mandated benefits for each state.

Figure 1: Mandated Benefits by State

Source: Blue Cross and Blue Shield Association.

States most frequently mandate coverage for preventive treatments, such as mammograms and well child care, or for treatment of mental illness or alcohol and drug abuse. In addition, states often require coverage for some types of providers such as optometrists and chiropractors. States typically mandate that insurers cover specific benefits in all plans sold, but some states merely mandate that each insurer make the mandated service available in at least one plan that it offers. Appendix IV shows how many states have enacted each of 20 commonly mandated benefits.

In addition, many states have recently begun considering mandating that health insurance cover minimum postpartum hospital stays. For example, a state may require the insurer to cover 48 hours of hospitalization following a vaginal delivery or 96 hours following a caesarian delivery if recommended by the doctor, although in some states shorter stays may be allowed if they are accompanied by a home visit by a nurse or other medical professional. According to the American College of Obstetricians and Gynecologists, as of July 28, 1996, 28 states have enacted laws requiring coverage for postpartum care.

Estimates of the Costs of Mandated Benefits Vary by State

Studies conducted in several states between 1987 and 1993 provide varying estimates of the claims costs associated with mandated benefits. (See table 3.) The Virginia State Corporation Commission, for example, has required insurers to report cost and utilization information annually for each of the mandated benefits in the state. Overall, the commission's report, the most recent of these studies, estimated that Virginia's mandated benefits accounted for about 12 percent of group health insurance claims in 1993. An earlier study in Maryland, the state with the most mandated benefits, estimated that mandated benefits represented 22 percent of average claims costs in 1988. In Iowa, a state representing the other extreme, a 1987 study estimated that the potential costs of introducing several commonly mandated benefits would be about 5 percent of claims costs.

Table 3: Studies of the Claims Costs of Mandated Benefits in Selected States

State	Year	Percent of total claims costs
Maryland	1988	22.0
Massachusetts	1990	18.0
Virginia	1993	12.2
Oregon[a]	1989	8.1
Wisconsin[b]	1989	7.9
Iowa[c]	1987	5.4

Note: The studies estimated the percent of total claims costs represented by the benefits mandated in a state. This differs from the incremental costs an employer would face from a mandated benefit because the employer may provide similar benefits before the mandate.

[a]This includes 16 of over 20 mandates that were in force at the time of the study. The other mandates were excluded because of data deficiencies. Included in the study's cost estimate were mandates for mental/nervous disorders, newborn coverage, alcoholism and drug dependency treatment, and optometry services.

[b]This includes six mandated benefits: mental health and substance abuse treatment, chiropractic care, diabetes care, home health care, skilled nursing facility care, and kidney disease treatment. Wisconsin also had mandates for other benefits that were not included in the study.

[c]The study in Iowa examined potential costs of selected commonly mandated benefits, including mental health, alcohol and drug abuse, podiatrists, optometrists, registered nurses, and physical therapists. Iowa has not adopted all of these mandates; according to the Blue Cross and Blue Shield Association, Iowa's current mandates are mammography screening, well child care, chiropractors, dentists, registered nurses, optometrists, and diabetes education.

Sources: Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," Journal of Public Economics, Vol. 55 (1994), pp. 433-64; Michael L. Hand and G. Marc Choate, "The Impact of State-Mandated Health Care Benefits in Oregon" (Salem: Associated Oregon Industries Foundation, 1991); Gail Jensen and Jon Gabel, "The Price of State Mandated Benefits," Inquiry, Vol. 26 (1989), pp. 419-31; Gregory Krohm and Mary H. Grossman, "Mandated Benefits in Health Insurance Policies," Benefits Quarterly, Vol. VI, No. 4 (1990), pp. 51-60; Virginia State Corporation Commission, The Financial Impact of Mandated Health Insurance Benefits and Providers, (Richmond: 1995), p. 15.

The differences in the cost estimates reported by the various studies are in part due to the number of mandated benefits included in each state. For example, the studies that reported the highest estimated costs were those for Maryland and Massachusetts, which have more mandated benefits than most states. Thus, these cost estimates cannot be generalized to other states.

Although the studies reported varying total costs in different states, they generally agreed that several specific mandated benefits accounted for a large share of the costs. In particular, obstetrical care and mental health care were cited as among the most costly mandated benefits; other commonly mandated benefits, such as mammography screening, account

for less than 1 percent of costs. For example, in Virginia, obstetrical care, mental health care, and substance abuse benefits accounted for over half of the total claims costs associated with mandated benefits in 1993. Table 4 lists the costs of individual mandates in Virginia.

Table 4: Average Claim Cost per Group Contract for Mandates in Virginia

Mandates	Cost per contract (dollars)	Percent of total claims costs
Treatment-related benefits		
Obstetrics	116.47	3.85
Mental health	106.25	2.39
Alcohol and drug abuse	26.95	0.77
Well child care	14.72	0.46
Mammography	10.04	0.10
Provider-related benefits		
Chiropractor	18.87	0.61
Physical therapist	10.27	0.46
Dentist	10.41	0.44
Psychologist	15.18	0.43
Podiatrist	7.27	0.27
Clinical social worker	5.77	0.20
Optometrist	2.21	0.11
Professional counselor	2.55	0.09
Audiologist	1.16	0.09
Clinical nurse specialist	0.61	0.04
Speech pathologist	1.81	0.03
Optician	0.44	0.02
Other		
Newborn children	58.91	1.72
Disabled dependent children	16.87	0.14
Total	**426.76**	**12.22**

Source: Report of the State Corporation Commission on the Financial Impact of Mandated Health Insurance Benefits and Providers, Commonwealth of Virginia (Richmond: 1994).

In some cases, mandated benefits covering services offered by some alternative types of providers, such as nurse midwives, may reduce costs because they substitute for more costly forms of care. Some provider mandates, however, may also increase the demand for services, increasing costs. For example, although chiropractic services may be a less expensive

alternative for some treatments, mandating their coverage may also lead to increased use.

One limitation of most studies on mandated benefits is that they have examined the cost effect of mandated benefits using the fraction of the total health insurance claims costs paid for each benefit, instead of estimating the incremental cost of adding a benefit to the health insurance package. In addition, the reported cost estimates do not necessarily capture the actual effect on employers' costs, especially in cases in which all costs associated with a mandate do not occur at the same point in time. For example, one actuary estimated that including in vitro fertilization services in health plans would increase premiums by less than 1 percent. In the case of one self-funded employer, however, the total costs to the employer of in vitro fertilization would be greater than the initial cost of the service because multiple attempts are often required and its use may lead to costly, high-risk pregnancies or multiple childbirths.

Moreover, multistate employers note that the variation in state-mandated benefits results in additional administrative cost that is not reflected in the studies' estimates. Employers that purchase health insurance may need to modify their plans to meet differences in state-mandated benefits. Furthermore, employers are concerned that, to the extent that they must comply with mandated benefits, they lose the flexibility to design the most cost-effective health benefit plan to meet their employees' needs.

Employers and managed health care plans have also expressed concern about the potentially high costs associated with any-willing-provider laws. The actual cost impact of these laws, however, as they have been enacted by states is likely to be limited. Any-willing-provider laws require managed health care plans to accept any qualified provider who wants to participate and is willing to accept the plans' contract terms. The few available studies have examined only hypothetical results of broad any-willing-provider laws and provide no definitive measure of actual costs of the laws that have been implemented.[12] The actual costs of enacted laws would be more limited than the studies' estimates because most states have passed versions with narrow scopes. The American Association of Health Plans (AAHP) reported that, as of April 1996, 19 of the 24 states with any-willing-provider laws limit them to particular providers, such as pharmacists, or particular types of managed care plans. Furthermore,

[12]For example, one study found that any-willing-provider laws could increase premiums for HMOs by 9 to 28 percent. See Atkinson and Company, The Cost Impact of "Any Willing Provider" Legislation (1994). Some of this study's assumptions have been criticized, including the effects of any-willing-provider laws on provider participation rates and negotiated discounts.

any-willing-provider laws have been enacted mostly in states with relatively low managed care penetration. AAHP reported that 24 percent of HMO enrollees are in states with limited any-willing-provider requirements, and less than 2 percent are in states with broad any-willing-provider laws.

Self-Funded Health Plans Often Cover Benefits Commonly Mandated by States

The actual cost effect of mandated benefits to employers also depends on whether the employer offers a comprehensive or limited health plan, which in turn often depends on the size of the employer. Employers frequently offer many of the commonly mandated benefits, even employers who self-fund and are not subject to the state mandates. In general, large employers are more likely to self-fund their health plans and tend to offer more comprehensive benefits than small employers. For small employers, who typically purchase fully insured health plans and are less likely to offer any health coverage, mandates may impose claims costs for benefits that they otherwise might not have covered. Studies conflict about whether increased costs associated with mandated benefits lead small employers to drop health insurance coverage.[13]

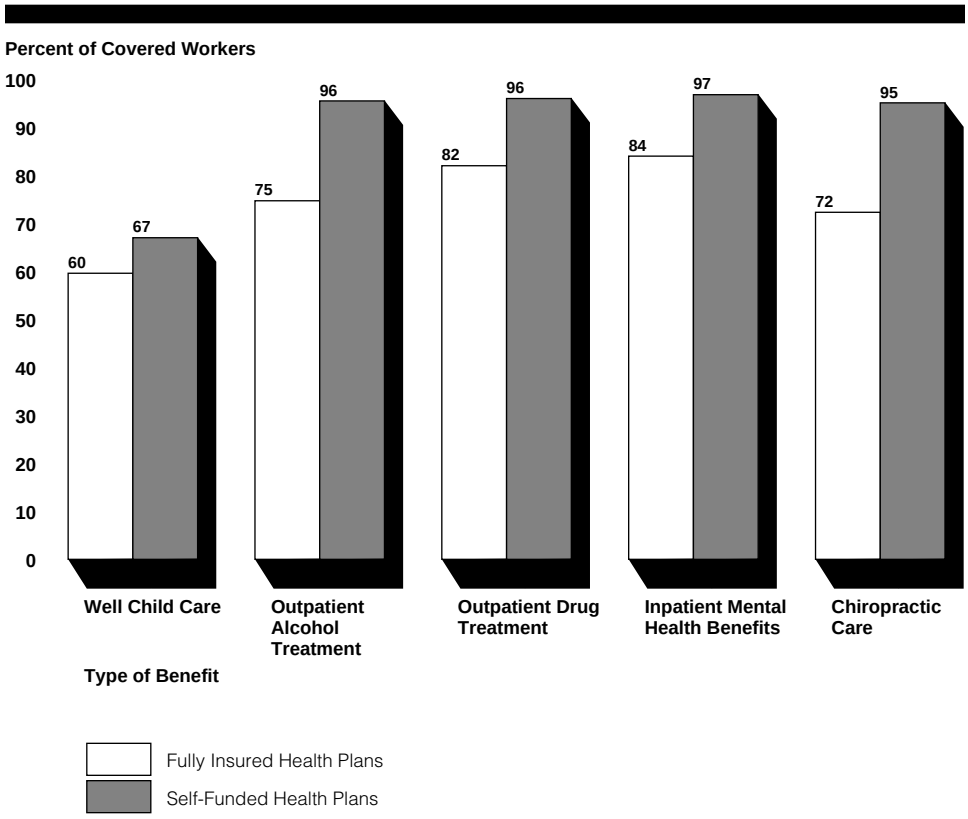
Self-funded health plans typically offer many of the benefits commonly mandated by states for fully insured health plans, according to studies. This may be due in part to the labor market, where firms must offer competitive health plans to compete for labor. As shown in figure 2, a KPMG Peat Marwick survey of employer benefits among all firm sizes indicates that self-funded health plans are more likely to offer well child care, outpatient alcohol treatment, outpatient drug treatment, mental health benefits, and chiropractic care than fully insured health plans. This survey also reported similar patterns for other benefits that are not typically mandated, including prescription drugs, adult physicals, and dental benefits.[14] Similarly, a survey of Wisconsin insurers also found that "self-funded health plans provide at least as many of the mandated benefits as insured health plans and in some cases provide more generous

[13]Studies differ on the proposition that mandated benefits force small businesses to drop coverage. See Gruber, pp. 433-64. This study contradicts findings from an earlier study that had concluded that small firms are likely to forgo insurance coverage as a result of continued growth in mandated benefits. See Gail Jensen and Jon Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," Journal of Regulatory Economics, Vol. 4 (1992) pp. 379-404.

[14]The data in figure 2 represent percentage of covered workers in conventional health plans. KPMG Peat Marwick reports similar findings for workers in preferred provider organizations and point-of-service plans that are either self-funded or fully insured. KPMG Peat Marwick is examining to what extent these differences in rates of benefit coverage among self-funded and fully insured health plans can be explained by differences in firm size and premium levels.

coverage."[15] This result may partially be due to the tendency of large employers to both self-fund and offer more comprehensive benefits.

Figure 2: Comparison of Selected Benefits Offered by Fully Insured and Self-Funded Health Plans



Source: KPMG Peat Marwick, March 1996, based on 1995 employer surveys.

Although self-funded plans often offer the same types of benefits states commonly mandate for insurers, self-funded plans may include features that differ from those required by state mandates. For example, state mandates generally specify a minimum number of days of care that insurers must cover for inpatient mental health care. One employer association indicated that many employers prefer designing more flexible mental health benefits, for example, requiring case management rather

[15]See Krohm and Grossman, p. 56. The mandated benefits surveyed include substance abuse, diabetes care, home health care, skilled nursing facility care, kidney disease treatment, and chiropractic care.

than specifying a limited number of days of care. Thus, even though 97 percent of self-funded plans offer inpatient mental health care services, some of these plans would not meet the state requirements for fully insured health plans.

Assessing the cost differences between self-funded and fully insured health plans resulting from mandated benefits is difficult. To the extent that self-funded health plans offer benefits that are like state-mandated benefits, their claims costs would not significantly differ because of their exemption from state-mandated benefit laws. For less commonly offered benefits, such as in vitro fertilization, self-funded employers would face additional claims costs if they were required to meet the state mandates. In addition, if employers who self-fund their health plan were required to comply with state mandates, they would lose flexibility in choosing the benefits to offer and in offering a single uniform health plan in many states.

State Solvency Standards' Impact on Insurers' Costs Is Limited

State solvency requirements add costs only to the extent that they exceed prudent industry practices a health insurance carrier would follow in the absence of state requirements. States use a variety of methods to monitor health insurers' solvency, including minimum capital and surplus levels, investment restrictions, and financial reviews. The specific requirements vary both by state and by type of insurance.

State laws generally require insurers to maintain a minimum level of capital or surplus to become licensed, but this level is a small fraction of most insurers' assets. The minimum levels of capital and surplus vary by state and by type of insurance, ranging in 1993 from $200,000 to $5 million. Most insurers have capital and surplus levels that exceed these minimum requirements. For example, Maryland requires insurers selling both life and health insurance to have a minimum of $3.75 million in capital and surplus to be licensed.[16] In comparison, as of December 31, 1994, the actual capital and surplus level for life and health insurers licensed in Maryland averaged $200 million. The cost effect of the minimum requirements can be more significant for small insurers, however. According to data from the Maryland Insurance Administration, 19 percent

[16]Insurers selling only health insurance in Maryland must have $1.875 million. HMOs must have $1.5 million to become licensed and then must maintain the greater of $750,000 or 5 percent of premiums, up to $3 million. When an insurer operates in more than one state, it must meet other states' minimum capital and surplus requirements only to the extent that they exceed the domiciled state's. For example, an insurer based in Maryland that sells health insurance only would have to demonstrate that it has an additional $1.125 million in capital and surplus to meet Virginia's $3 million minimum capital and surplus requirement.

of life and health insurers licensed in Maryland had less than $10 million in capital and surplus.

Although some insurers may need to keep higher levels of capital and surplus to comply with the minimum levels that states require under the NAIC-developed model risk-based capital standards, most insurers also exceed these levels.[17] Under risk-based capital, a level (called the "control level") is calculated for each health plan based on its unique characteristics. If a health plan's reserves were to fall below this level, the state is authorized to take control of the insurer.[18] A range of regulatory actions would occur if an insurer were to approach this control level. At 200 percent of the control level, the state requires an insurer to prepare a plan to increase its capital; at the extreme, if the insurer's capital were below 70 percent of the authorized control level, the insurance commission would have to take control of the insurance company. However, standard industry practices tend to be similar to or exceed these minimum state requirements. For example, a representative of the Health Insurance Association of America told us that 90 percent of insurers in 1995 exceeded 250 percent of the authorized control level for risk-based capital. In addition, a Virginia state official noted that, since Virginia adopted enforcement actions based on NAIC's risk-based capital formula in July 1995, no insurers have fallen below the level where state standards would require action.

Blue Cross and Blue Shield plans have different requirements under state laws. For example, many states set target capital and surplus levels for Blue Cross and Blue Shield health plans to ensure that they have sufficient funds to cover, for example, 1 or 2 months of claims. Furthermore, to maintain their nonprofit status, some states require that Blue Cross and Blue Shield plans' surplus not exceed a target level, such as 7 months' claims.

In addition, states restrict how insurers invest their funds, potentially imposing an opportunity cost on insurers who might otherwise invest in higher yielding assets. These investment restrictions vary by state, but in general states regulate the type and amount of assets in which health plans invest to diversify insurers' investments and minimize their risk. For

[17]The existing risk-based capital formula applies only to insurers that sell life and health insurance. NAIC is drafting a standard formula for other types of health plans, including HMOs.

[18]For example, the minimum surplus level is set by a formula that takes into account the type of insurance sold and the company's investments and assigns risk factors that measure the variability of these products and investments.

example, many states limit the amount of funds that a health insurance carrier may invest in certain types of investments, such as common stocks and foreign securities, with potentially higher return rates than other permitted investments. The risk associated with these investments is also greater, however, so the insurer could get a lower rate of return than with permitted investments. An insurer could even lose money, possibly damaging its solvency. Furthermore, actuaries note that investments typically provide a smaller share of income to health insurers than other types of insurance such as life insurance.

States' oversight of health insurers' solvency may also add administrative costs to insurers who must comply with reporting and review requirements, but industry officials note that such costs are difficult to quantify. The administrative costs include preparing audited financial statements and actuarial analyses for state review, functions insurers would likely perform anyway. States require insurers to report financial information using NAIC's accounting standards, however, which differ from generally accepted accounting principles in their valuation of assets. In some cases, this may require an insurer to maintain two sets of accounting data, but insurance company executives we spoke with said this is a marginal additional cost.

The costs of actuarial certification vary by type of insurance. Insurers selling only health coverage may prepare a simplified actuarial certification that requires few resources. Insurers selling health and life coverage must prepare a more extensive actuarial certification that would be more costly. One insurer, however, noted that the information developed for the actuarial certification provides the insurer with valuable information on the adequacy of the insurer's reserves for meeting anticipated costs.

Finally, many states charge the insurer for the costs of on-site financial examination, which typically occur once every 3 to 5 years. The costs of these exams vary depending on their length and complexity, but one state reported that the cost can be as high as $1 million for a complex review of a large insurer; less complex ones may cost less than $100,000.[19]

[19]States also conduct market conduct exams that include reviews of insurers' advertising, compliance with licensing requirements, claims practices, and handling of consumer complaints. These exams are typically conducted less often and are less costly than financial reviews.

Cost Effects of State Small Employer Reforms Difficult to Assess

Most states have recently passed legislation designed to improve portability, access, and rating practices for the small employer health insurance market. It is too early to assess the cost effects of these reforms definitively because most available information is anecdotal. Moreover, even if more systematic data were available, isolating the effect of small group reforms from other factors would be difficult in the currently dynamic health care market.

The small group reforms include provisions to help ensure that (1) employees who want health insurance coverage will be accepted and renewed by insurers; (2) waiting periods for preexisting conditions will be relatively short, occur only once, and be based only on recent medical history; (3) coverage will be continuous and portable, even when an individual changes jobs or the employer changes insurers; and (4) wide variation in premium rates will be narrowed to fall within state-specified ranges. In an earlier report, we identified 45 states that passed legislation between 1990 and 1994 regulating the small employer health insurance market (typically fewer than 25 or 50 employees).[20] We also noted that the specific state requirements vary both by state and from the NAIC model act.

The available evidence on states' early experience with small group reform is mostly testimonial, anecdotal, and often contradictory. Following are examples of some of this evidence.

- The Colorado Insurance Division reports that small employer reforms, including guaranteed issue and rate restrictions, have moderated premium increases and increased the number of individuals covered by small group health plans.
- Some initial reports on New York's experience stated that insurers left the state and premiums increased. Subsequent reports, however, have questioned the extent of these problems. Furthermore, state officials note that most changes occurred in the individual market rather than the small employer market and resulted from other factors, particularly the financial status of the state's largest insurer.
- Minnesota and Colorado officials point to the decline in enrollment in their high-risk pools as evidence of the success of small group reforms in making private health coverage more available.
- Washington's reforms, which were partially repealed before implementation, resulted in a surge in high-cost, high-risk enrollees that has led insurers to warn of high premium increases and their potential withdrawal from the state.

[20]See GAO/HEHS-95-161FS, June 12, 1995.

- Maryland officials asserted that in the first year of implementing small employer reforms competition in the small group health insurance market has increased and premiums have declined, but they acknowledged that data on premiums before the reforms were sparse.

As these examples illustrate, the results across states are not consistent or generalizable to other states' experiences. Furthermore, even within the states noted above, conflicting views exist about the success or failure of the small group reforms.

Some states have specifically designed their reforms to minimize potential cost increases. For example, the task force that developed Maryland's reforms designed the benefits package to cost less than 12 percent of average wages in Maryland. Ohio state officials scaled back their original reforms after receiving estimates that they could increase costs. As a result, Ohio enacted less generous requirements for guaranteed coverage.

In addition, because the private insurance market has been changing rapidly, the effect these reforms have had on health insurance premiums is difficult to isolate. Besides the small employer insurance reforms, factors affecting insurance premiums include nationwide declines in the growth rate of health care costs, the growth of managed care, changes in health benefits, and the expansion of Medicaid coverage. Small group reforms may also have redistributive effects, with some enrollees facing increased costs while others face reduced costs, making the net effect unclear. Changes resulting from small group reforms may take several years to play out fully. Finally, the paucity of data preceding the enactment of reforms may hamper before-and-after comparisons of insurance premiums.

Concluding Observations

State requirements on health insurance and their effects raise two questions: who is affected directly, and what factors determine the size of the requirements' cost impact? Under the ERISA statute, state governments cannot tax or regulate self-funded plans established by an employer who bears most of the financial risk. By contrast, states continue to have authority to tax and regulate health insurance. As a result, enrollees in insured health plans have the benefits associated with state regulation but also bear an additional cost relative to enrollees in self-funded health plans. This cost differential can differ considerably by state. Specifically, state taxes on health insurers raise the costs of fully insured plans by about 2 percent in most states, with the actual level determined by state tax rate and type of health plan. In addition, the extent to which mandated

benefits and solvency requirements raise costs differs by state, depending upon the scope of state laws. Furthermore, the extent to which a cost differential between self-funded and insured health plans would be apparent depends on whether state regulation results in a change in employers' and insurers' behavior. At the extreme, for health plans that provide comprehensive benefits and maintain surpluses exceeding state minimum requirements, the cost differential may be nonexistent.

The burden of state requirements on large versus small employers depends on the employers' use of self-funding. Because large employers' health plans are predominantly self-funded (and outside the states' purview) and small employers generally purchase health coverage from private insurers, the costs associated with state requirements fall largely on small employers. But this may be changing. Some small employers are also beginning to self-fund, partly to avoid state regulation and taxation of their health plans. Whether this trend will continue, and at what rate, is unclear.

NAIC's Comments

NAIC officials provided us with comments on a draft of this report. They pointed out that although the costs associated with state requirements are accurately described, the benefits to plan participants are addressed only to a limited extent. We acknowledge that participants benefit from many state requirements. As noted earlier, our ERISA report[21] more comprehensively describes the state and employer perspectives on the implications of ERISA preemption of state regulation. As agreed to with our requester, our primary focus in this report was to provide additional information on the costs associated with these state requirements.

In addition, NAIC officials noted that the report could also address "the costs that employers and employees might face when covered through ERISA-governed plans." Indeed, ERISA requirements, such as reporting, disclosure, and fiduciary responsibilities, may have associated costs. As noted in the report, however, these costs are borne by all ERISA-governed plans, including both fully insured and self-funded health plans. Thus, they do not lead to a differential in costs between fully insured and self-funded health plans in the way that state requirements applying only to fully insured health plans may.

NAIC officials also provided technical comments, which we incorporated where appropriate.

[21]GAO/HEHS-95-167, July 25, 1995.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to interested parties and make copies available to others upon request.

Please call me on (202) 512-7114 if you or your staff have any questions about this report. Other major contributors are listed in appendix V.

Sincerely yours,

Jonathan Ratner
Associate Director,
Health Financing and Systems Issues

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Figures

Abbreviations

AAHP	American Association of Health Plans
ERISA	Employee Retirement Income Security Act of 1974
HMO	health maintenance organization
NAIC	National Association of Insurance Commissioners

State Health Insurance Premium Tax Rates

	Health insurers (percent)	Blue Cross and Blue Shield plans (percent)	HMOs (percent)
Alabama	1-4[a]	1-4[a]	1[b]
Alaska	2.7	6[c]	2.7
Arizona	2	2	2[d]
Arkansas	2.5	1	2.5[e]
California	2.35	0	0
Colorado	2.25	5¢ per enrollee	0[f]
Connecticut	1.75	2[g]	1.75[g]
Delaware	2	0	0
District of Columbia	2.25	0	0
Florida	1.75	1.75	0
Georgia	2.25	2.25	2.25[h]
Hawaii	4.265	0	0
Idaho	1.4-2.75[i]	4¢ per enrollee[j]	4¢ per enrollee[j]
Illinois	2[k]	0	0
Indiana	2	0	0
Iowa	2	2	0-2[l]
Kansas	1-2[a]	1-2[a]	0.5-1[l]
Kentucky	2[m]	2[m]	2[m]
Louisiana	2-2.25[n]	2-2.25[n]	2-2.25[n]
Maine	2	0	0
Maryland	2	0	0[o]
Massachusetts	2-2.28[p]	0	0
Michigan	0[q]	0	0
Minnesota	2	0	0
Mississippi	3	0	0
Missouri	2	0	0
Montana	2.75	0	0
Nebraska	0.5-1[r]	1	1
Nevada	n/a	3.5	3.5
New Hampshire	2[s]	0	2[s]
New Jersey	1.05	2¢ per subscriber	0
New Mexico	0.9-3[j]	0.9-3[j]	0.9-3[j]
New York	1	0	0
North Carolina	1.9	0.5	0
North Dakota	1.75	1.75	1.75[t]
Ohio	2.5[u]	2.5[u]	0

(continued)

	Health insurers (percent)	Blue Cross and Blue Shield plans (percent)	HMOs (percent)
Oklahoma	2.25	2.25	2.25[v]
Oregon	2.25[w]	0	0
Pennsylvania	2	0	2[x]
Rhode Island	2	0	0
South Carolina	1.25	1.25	0[y]
South Dakota	2.5	2.5	2.5[b]
Tennessee	2.5	2.5	2
Texas	1.75	0	1.75[z]
Utah	0	0	0
Vermont	2	0	0
Virginia	2.25	0.75[aa]	0[bb]
Washington	2[cc]	2[cc]	2[cc]
West Virginia	3	0	0
Wisconsin	2	0	0[dd]
Wyoming	0.75	0.75	0.75

Note: Premium taxes expressed as percentage rate assessed on premiums unless otherwise noted.

[a]Domestic (state-based) insurers pay lower rate.

[b]Credit for HMOs with home office.

[c]Tax based on gross premium less claims paid.

[d]Tax assessed on net charges.

[e]Credit for HMOs with state home office and local salaries and wages.

[f]Fee collected on the basis of premium volume.

[g]Tax collected on the basis of net direct premiums.

[h]City license fee deducted.

[i]Lower rate applies to insurers investing in state securities.

[j]Per month.

[k]Domestic insurers meeting certain requirements are tax exempt.

[l]HMOs less than 6 years old pay the lower rate.

[m]Additional tax of $0.25 per outpatient pharmaceutical drug if tax is not paid by pharmacist.

[n]Tax set as $140 for $7,000 or less in premiums received and $225 for each additional $10,000 in premiums received.

[o]HMOs are tax exempt except where HMO benefits are offered by a for-profit commercial insurer. HMOs offered by nonprofit insurer are tax exempt.

[p]Lower rate is paid by insurer if also licensed as life insurance company. Preferred provider organizations taxed at 2 percent.

[q]Insurers pay business tax.

[r]Lower rate applies to group plans.

[s]Minimum payment of $200.

[t]HMO credits for exam fees and home office.

[u]Domestic insurers pay lesser of 2.5 percent or franchise tax.

[v]Federal payments (Medicare and Medicaid) to HMOs are tax exempt; credit if invested in state securities; credit for HMO state home office.

[w]Domestic insurers pay income tax instead.

[x]Nonprofit or benevolent HMOs are tax exempt.

[y]Taxed as a corporation at 5 percent; also have a license tax.

[z]For first $450,000 of gross reserves collected, HMO tax rate is 0.875 percent. HMOs receive a credit for Texas investments not to exceed $2 per enrollee.

[aa]Tax assessed on subscriber fees.

[bb]Pay insurance commission maintenance assessment of no more than 0.1 percent of premium, with a minimum of $300.

[cc]Additional fee assessed for Department of Insurance operations, not to exceed 0.125 percent of receipts.

[dd]HMOs pay franchise tax of 7.9 percent.

Source: National Association of Insurance Commissioners, “Premium Tax Rate by Line,” Compendium of State Laws on Insurance Topics (Kansas City, Mo.: NAIC, 1995).

State Life and Health Guaranty Fund Assessments

State	Assessment cap (percent)	Actual assessment, 1993 (percent)	Percent offset from premium taxes
Alabama	1	0.31	100[a]
Alaska	2	1.48	0
Arizona	2	0.43	100[b]
Arkansas	2	0.24	100[a]
California	1	0.31	0
Colorado	1	0.22	0[c]
Connecticut	2	0.01	50
Delaware	2	0.65	100[a]
District of Columbia	2	0.00	100[d]
Florida	1	1.30	n/a
Georgia	2	1.32	100[a]
Hawaii	2	3.19	100[a]
Idaho	2	0.63	100[a]
Illinois	2	0.18	100[e]
Indiana	2	0.11	100[a]
Iowa	2	0.19	100[a]
Kansas	2	0.00	100[a]
Kentucky	2	0.36	100[a]
Louisiana	2	0.21	100[a]
Maine	2	0.12	0[c]
Maryland	2	0.30	0
Massachusetts	2	0.41	50[f]
Michigan	2	0.00	0
Minnesota	2	0.81	0
Mississippi	2	0.68	50[g]
Missouri	2	0.23	100[a]
Montana	2	1.06	100[a]
Nebraska	2	0.34	100[a]
Nevada	2	0.70	100[a]
New Hampshire	2	0.00	100[a]
New Jersey	2	0.15	50[h]
New Mexico	2	1.27	0
New York	2	0.00	80[i]
North Carolina	2	0.74	100[a]
North Dakota	2	0.65	100[a]
Ohio	2	0.04	100[a]

(continued)

State	Assessment cap (percent)	Actual assessment, 1993 (percent)	Percent offset from premium taxes
Oklahoma	2	0.71	100[a]
Oregon	2	0.16	100[a]
Pennsylvania	2	0.48	100[a]
Rhode Island	3	0.21	50[j]
South Carolina	4	0.00	100[a]
South Dakota	2	0.49	100[k]
Tennessee	2	0.31	100[l]
Texas	1	0.05	100[m]
Utah	2	0.24	100[a]
Vermont	2	0.05	100[a]
Virginia	2	0.00	See note[n]
Washington	2	0.40	100[a]
West Virginia	2	0.44	0
Wisconsin	2	1.63	100[a]
Wyoming	2	0.94	100[d]

[a]20 percent for 5 years following assessment.

[b]Offset graduated over several years until 100 percent recovered.

[c]Recoup health guaranty fund assessments by surcharge of premiums.

[d]10 percent for 10 years following assessment.

[e]20 percent for 5 years following assessment; offset only allowed if aggregate assessment of all insurers exceeds $3 million.

[f]10 percent for 5 years following assessment if aggregate assessment for all insurers exceeds $3 million.

[g]25 percent for 2 years following assessment.

[h]10 percent for 5 years beginning third year after assessment but no more than 20 percent of tax liability.

[i]Offset effective when aggregate assessments for insurers exceed $100 million.

[j]10 percent for 5 years following assessment.

[k]20 percent for 5 years beginning year after assessment, up to $2 million per year.

[l]10 percent for 10 years beginning year after assessment or 1 percent of premiums written.

[m]10 percent for 10 years beginning year after assessment; assessments for administrative expenses may be subtracted from year's tax owed.

[n]May offset 0.05 percent of gross premium for insurance written for account each year.

Sources: National Association of Insurance Commissioners, "Life and Health Guaranty Fund Laws," Compendium of State Laws on Insurance Topics (Kansas City, Mo.: NAIC, 1995) and National Organization of Life and Health Insurance Guaranty Associations, Comparison of Assessments and Estimated Assessment Capacity (Herndon, Va.: NOLHGA, 1995).

State Assessments for High-Risk Pools

State	Participants (Dec. 31, 1994)	Insurer assessments (1994)
Alaska	128	$ 600,000
Arkansas	n/a[a]	n/a
California	19,353[b]	No[c]
Colorado	1,921	No[c]
Connecticut	1,364[d]	8,365,979
Florida	2,387	11,814,627
Illinois	4,755	No
Indiana	4,638	10,717,539
Iowa	1,341	3,000,000
Kansas	619[e]	0
Louisiana	386	No[c]
Minnesota	33,477	44,424,903
Mississippi	610	See note[f]
Missouri	931	1,934,854
Montana	268	0
Nebraska	3,331	6,200,000
New Mexico	1,124	3,426,625
North Dakota	1,422	1,500,000
Oklahoma	n/a[a]	n/a
Oregon	4,313[g]	3,956,818
South Carolina	1,264	n/a
Utah	710[h]	No[c]
Washington	1,307	11,499,657
Wisconsin	10,864	17,107,689
Wyoming	200	517,350

[a]Legislation enacted in 1995.

[b]As of April 1995.

[c]Insurer assessments not used to finance high-risk pool.

[d]Number of policies, not individuals.

[e]As of March 15, 1995.

[f]Each insurer is assessed an amount no more than $1 per policy per month. The rate in 1994 was $0.50 per policy per month.

[g]As of June 1995.

[h]As of May 1995.

Source: Comprehensive Health Insurance for High-risk Individuals: A State-by-State Analysis, Communicating for Agriculture, Inc. (Bloomington, Minn.: 1995).

Health Insurance Benefits States Commonly Mandate

	Number of states		
	Cover	Offer	Total
Treatment-related benefits			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
Provider-related benefits			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14

Note: In some cases, states limit mandates to particular types of health plans such as HMOs or group insurance plans.

Source: NAIC, Compendium of State Laws on Insurance Topics: Mandated Benefits (Kansas City, Mo.: NAIC, 1995).

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