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PRIVATE HEALTH INSURANCE

Wide Variation in State Insurance Departments' Regulatory Authority, Oversight and Resources

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SUMMARY

The rapidly rising cost of health insurance and the growing number of uninsured have pushed the debate over health care reform to the forefront. State insurance departments have played an important role in previous state efforts to address problems with the cost and availability of health insurance. Because most national health care reform proposals include provisions that could fundamentally change the health insurance marketplace, states and their insurance departments could play a large role in enforcing new requirements should any of these proposals be adopted.

Although the state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the market, and varies widely among states. Moreover, since the passage of the Employee Retirement Income Security Act of 1974 (ERISA), more and more firms have elected to self-insure their health plans under ERISA, thereby avoiding state regulation. Currently, about 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments.

The state insurance departments' role in regulating health insurance is also affected by their state's legal framework and business regulation philosophy. The resources state legislatures allocate to their insurance departments and the proportion the department dedicates to regulating health insurance also vary widely among states.

States try to protect consumers through a variety of regulatory activities--performance of solvency, rate and policy form reviews and resolution of consumer complaints. Past GAO studies have raised serious questions about the effectiveness of states' efforts to monitor insurer financial solvency. Further, our current survey of states' regulatory activities found wide variations in the practices and procedures used to approve premium rates and policy forms.

As the Congress debates various health care reform proposals, it needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers. A reform plan should clearly specify what state insurance departments are expected to do to carry out these responsibilities. These expectations need to consider the wide variation in state insurance departments' existing legal authorities, regulatory activities and resources, and what actions need to be taken to ensure that the departments have the necessary tools to enforce new requirements on health insurers.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the results of our survey of how state insurance departments regulate health insurance, the resources they commit to these efforts, and the implications health care reform could have on their regulatory roles and responsibilities.

The rapidly rising cost of health insurance and the growing number of uninsured have pushed the debate over health care reform to the forefront. State insurance departments have played an important role in previous state efforts to address problems with the cost and availability of health insurance. Because most national health care reform proposals include provisions that could fundamentally change the health insurance marketplace, states and their insurance departments could play a large role in enforcing new requirements should any of these proposals be adopted.

In response to concerns about the implications of health care reform on the enforcement roles and responsibilities of state insurance departments, we were asked to determine:

-- what portion of the health insurance market is regulated by state insurance departments,

-- the standards state insurance departments follow and the extent of their regulatory responsibilities,

-- the budget and staff resources state insurance departments commit to regulating health insurance, and

-- the key activities departments perform, including monitoring solvency, reviewing rates and policy forms and responding to consumer complaints.

To address these issues, we conducted a questionnaire survey of the insurance departments of the 50 states and the District of Columbia,[1] and visited insurance department officials in 7 states--California, Colorado, Illinois, New York, Texas, Vermont and Virginia. We also reviewed model laws, regulations, and guidelines for health insurance regulation developed by the National Association of Insurance Commissioners (NAIC), and interviewed representatives of NAIC and the Health Insurance Association of America.

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[1]Mississippi did not respond to our questionnaire.

BACKGROUND

In 1945, the McCarran-Ferguson Act assigned the states primary responsibility for regulating the insurance industry. In general, state legislatures establish the rules under which insurance companies must operate, and state insurance departments enforce these rules.

The major responsibilities of state insurance departments typically include:

-- Licensing insurance companies and the agents who sell insurance to assure that companies are financially sound and reputable and that agents are qualified.

-- Setting standards for, and monitoring the financial operations of insurers to determine whether they have adequate reserves to pay policyholder claims.

-- Reviewing and approving rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies.

-- Reviewing and approving insurance policies to make sure that they are not vague or misleading, and assure that they meet state requirements, such as mandatory benefit provisions.

-- Monitoring insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers, and assisting consumers by investigating their complaints, answering questions and conducting educational programs.

To encourage uniformity in state approaches to regulation, the state insurance regulators established a national association--NAIC--to help coordinate their activities. NAIC consists of the heads of the insurance departments of the 50 states, the District of Columbia, and four U.S. territories. NAIC develops and adopts model laws and regulations that state insurance commissioners collectively believe are needed to regulate the insurance business. Many states adopt NAIC's models, but NAIC has no authority to require individual states to adopt these models.

STATE INSURANCE DEPARTMENTS' ROLE, AUTHORITY AND RESOURCES FOR REGULATING HEALTH INSURANCE

Although the state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the market and varies widely among states. Moreover, since the passage of the Employee

Retirement Income Security Act of 1974 (ERISA),[2] more and more firms have elected to self-insure their health plans under ERISA, thereby avoiding state regulation.

Each state insurance department's role in health insurance regulation is also affected by its legal framework and business regulation philosophy. The resources state legislatures allocate to their insurance departments and the proportion the department dedicates to regulating health insurance also vary widely among states.

Insurance Departments' Role in Regulating Health Insurance is Limited

State insurance departments' oversight of health insurance coverage is limited to only a portion of the health care expenditures in each state. This is due, in part, to ERISA, which has constrained states' ability to regulate employer-sponsored health plans that choose to self-insure. Although ERISA was designed to correct serious problems with the solvency of employer-funded pension plans, the act also covers all employee welfare benefit plans, which include health and other employee benefits.

While ERISA confirmed the states' authority to regulate insurance companies, it preempted states from regulating self-insured health plans. ERISA's preemption provision enables employee benefit plans to serve employees in many jurisdictions without becoming subject to conflicting and inconsistent laws of the various state and local governments. The ERISA exemption has produced a divided system for regulating health benefits in each state, such that the federal government has authority to regulate self-insured employee health plans, but not health policies sold by insurance companies. Conversely, states can regulate insurance companies and their policies, but not employee health benefit plans provided by employers who self-insure.

About 34 percent of the United States' national health expenditures is paid for out-of-pocket by individuals or through self-insured employer health plans. The self-insured plans, regulated by ERISA, cover over half of all U.S. workers. About 42 percent of health care is funded and regulated by the federal government through programs such as Medicare, and jointly by federal and state agencies for programs such as Medicaid. The

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[2]The Employee Retirement Income Security Act of 1974 (ERISA) established limited federal standards for welfare benefit plans, which include health and other employee benefits. ERISA plans are regulated by the Department of Labor.

remaining 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments.

ERISA's preemption provision has also created regulatory confusion in states' efforts to oversee the use of multiple employer welfare arrangements (MEWAs). In a MEWA, a group of small businesses pool funds as a way to pay for benefits or to buy group insurance at rates that are affordable for their employees. Others have contracted with firms offering health benefits at reduced rates to groups of employers.

A 1983 ERISA amendment created dual federal and state authority over MEWAs, thereby enabling states to subject MEWAs to state insurance laws. However, continued confusion about states' regulatory responsibilities has enabled fraudulent MEWAs to delay state enforcement actions by claiming that they are employee benefit plans covered by ERISA. Between January 1988 and June 1991, fraudulent MEWAs left at least 398,000 participants with over $123 million in unpaid health claims, and others without health insurance.

Many States Have Not Adopted NAIC Guidelines for Regulating Health Insurance

Each state maintains its own legal framework for regulating insurance in which the roles and responsibilities for each insurance department may differ. Over the years, NAIC has developed about 200 model laws, regulations and guidelines designed to foster state acceptance of the legal and regulatory authorities necessary to effectively regulate insurance. However, NAIC has no authority to require states to adopt or implement its model policies. This responsibility falls to state legislatures. In some cases, states have not adopted NAIC's models. However, they may have adopted their own law addressing the same issue, which in some cases, may be more stringent than those NAIC recommended.

As of April 1993, many states had not adopted NAIC models addressing health insurance regulation, even though this guidance had been in existence for at least 5 years. For example,

-- 19 states had not adopted NAIC's model regulation that sets authority and standards for identifying insurers whose hazardous financial condition threatens the public or policyholders,

-- 16 states had not adopted NAIC's model on minimum reserve standards for health insurance contracts that establishes how health insurance companies must determine cash reserves for paying future claims,

-- 44 states had not adopted NAIC's model on HMO investments that sets limitations on what HMOs may invest in so that solvency problems from bad investments can be minimized, and

-- 28 states had not adopted NAIC's model minimum standards for individual accident and health insurance designed to eliminate health insurance policy provisions that are misleading or confusing, and provide reasonable standardization.

Resources Committed to Health Insurance Regulation Vary Widely

State insurance departments are responsible for regulating many different types of insurance. In addition to health insurance, they also regulate other insurance such as life, auto, homeowners and other property and casualty. Thus, their resources are spread over a wide range of insurance products.

Our study found that, on average, the state insurance departments devoted about 24 percent of their 1991 resources to regulating health insurance. However, estimates of individual resource commitments varied widely, ranging from 4 to 57 percent of their budgets. (Appendix I lists state insurance department budgets and the percent devoted to health insurance regulation.)

It is difficult for states to estimate the number of staff that oversee a particular type of insurance because state insurance departments are typically organized by regulatory activity--not line of business. However, 28 states estimated that the number of full time staff[3] expended on regulating health insurance ranged from 1 to 153, with the median number of 18 staff members. Eight of the 28 states estimated that they had less than 10 full time staff involved in regulating health insurance[4], and 22 state insurance departments were not able to provide an estimate of the number of full time staff involved in regulating health insurance. (Appendix II lists the states' total department staff, full time equivalent staff spent on health insurance regulation, and the number of actuaries working on health insurance regulation.)

Actuaries are particularly important employees of insurance departments because of the role they play in estimating future claims payments. Based on these estimates, they are able to

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[3]These numbers represent full-time-equivalent staff.

[4]The eight states were Delaware, Illinois, Massachusetts, New Jersey, Rhode Island, South Dakota, Vermont, and Wyoming.

judge the adequacy of an insurers loss reserves. They can also review an insurer's investments to make sure their maturities provide sufficient liquidity to pay future claims. Finally, they can review premium rate increases to ensure that they are sufficient to cover an insurer's expected losses.

Our survey found that 21 states have one or more actuaries on staff to work on health insurance matters, and 11 others have an actuary under contract, but none on staff. However, 14 states did not have an actuary either on staff or under contract to work on health insurance.

Some states we visited reported that new responsibilities resulting from health insurance reforms placed an increasing strain on their resources. Almost all the states have implemented reforms designed to improve access to affordable health insurance for small firms and their employees. Typically, these reforms impose new restrictions on how health insurers set premium rates and medically screen applicants. In particular, these restrictions address insurance company practices that have made obtaining and keeping health insurance difficult or impossible for some people, including those who have an expensive medical condition and change jobs, or work in a firm that changed insurance companies. Implementing these new reforms has increased state insurance department workloads in several areas, including preparing new regulations and ensuring compliance with new policy and rate provisions.

KEY HEALTH INSURANCE REGULATORY ACTIVITIES

State insurance departments' major responsibilities include regulation of insurers to protect consumers from insurer failures, unfair policy provisions, unscrupulous insurer business practices, and, in many states, excessive premiums. Any one of these problems could be financially devastating to policyholders. States try to protect consumers through a variety of regulatory activities. Past GAO studies have raised serious questions about the effectiveness of states' efforts to monitor insurer financial solvency, and our survey of states' regulatory activities found wide variations in the practices and procedures used to approve premium rates and policies.

Monitoring Insurer Financial Solvency is Principal Insurance Department Responsibility

The principal responsibility of state insurance departments is to protect consumers by monitoring the solvency of insurance companies. The consequences of an insurance company failure can be catastrophic to consumers. This was demonstrated by the failure of West Virginia Blue Cross/Blue Shield in 1990, where

about 50,000 policyholders were left with nearly $40 million in unpaid claims. Blue Cross/Blue Shield did not pay hospitals and other health care providers for their services, and many providers held policyholders personally liable for these claims.

The West Virginia Blue Cross/Blue Shield failure, the failure of several large life insurance companies, and concern about the financial health of other Blue Cross/Blue Shield plans have focused attention on state insurance departments' ability to protect consumers. Each state has now established a life/health guaranty association to pay the claims of failed companies; however, we remain concerned about the ability of state insurance departments to identify and resolve troubled and failing insurance companies.

We found that the number of health insurer failures nationwide has increased since the mid-1980s. State insurance departments responding to our survey reported that in 1991, they liquidated 46 companies selling health insurance.[5] Over 70 percent of the failures occurred in four states--Illinois, Louisiana, Pennsylvania and Texas. Officials told us that the six companies liquidated in Texas in 1991 had insured over 20,000 Texans. They did not know the number of policyholders who were unable to obtain replacement health insurance due to pre-existing conditions or were unable to afford the new premiums.

To try to prevent these types of failures, state insurance departments monitor insurers' financial solvency through two primary means--analyses of an insurance company's financial data and on-site examinations of insurers. Although insurance departments rely on these activities to identify troubled and failing insurance companies, we found that these reviews have significant limitations.

Insurance departments conduct analyses of company financial data, referred to as desk reviews, by examining companies' financial statements and key financial ratios. Officials in the seven states we visited believe that because insurers' financial conditions can deteriorate rapidly, desk reviews should be performed at least annually. However, officials in two of the seven departments told us that they did not have sufficient resources to complete annual reviews on all health insurers in their states. In the states we visited, the amount of time spent on each desk review ranged from about 1 to 40 hours. Regardless of the time spent, an inherent limitation of desk reviews is that insurance company financial data is not verified to detect errors or misrepresentation.

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[5]Alabama, California, Colorado, Georgia, Missouri and Tennessee did not respond to this survey question.

NAIC assists states by attempting to identify companies whose financial condition appears vulnerable and by acting as a clearinghouse for states to share desk review software. However, it has not developed uniform standards for how desk reviews should be performed, and states continue to employ a wide variety of techniques.

State insurance regulators use on-site examinations to verify insurer-reported data and to detect weaknesses and financial problems that could cause an insurer to fail. In an on-site exam, insurance department examiners evaluate the insurers' finances by reviewing a variety of insurer accounts. We believe that these examinations are too infrequent--once every 3 to 5 years--for regulators to detect solvency problems in a timely manner. Our analysis of survey results showed that in 1991, departments performed on-site financial exams on about 20 percent of their health insurers.

NAIC developed a program to accredit individual state insurance departments that meet NAIC's minimum standards for insurer solvency regulation. As of April 1993, NAIC had accredited 19 states. Past GAO studies of this program, however, identified several problems with the accreditation program.[6] We reported that the program's standards are general and have been interpreted permissively by the accreditation review teams. We also found that the program focuses on a state's legal authority, rather than on how well the department acts on this authority. Finally, in some cases, accreditation decisions were inconsistent with problems identified by the review team. As a result, the NAIC accreditation program allows state insurance departments to become accredited without demonstrating that they are effectively regulating insurance company solvency.

To protect policyholders against losses that might otherwise occur after an insurer fails, each state has established a life/health guaranty association to provide limited continuation of coverage and pay benefits. Life/health guaranty funds are established under state law and administered and financed, at least initially, by assessments to insurance companies licensed with the state. In a separate study, we found gaps in the collective safety net for life and health policyholders. When a multistate insurer fails, policyholders in some states can find themselves totally unprotected because of the differences in the associations' rules of coverage. In addition, 30 state

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[6]Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27. April 9, 1992).

Insurance Regulation: Assessment of the National Association of Insurance Commissioners (GAO/T-GGD-91-37. May 22, 1991).

life/health guaranty associations currently do not cover policyholders in Blue Cross and Blue Shield plans.

Limitations in insurance department examinations, concerns about the effectiveness of NAIC's accreditation program, and the gaps in state guaranty associations' coverage raise questions about the ability of state insurance departments to detect solvency problems and adequately protect health insurance consumers.

Reviewing Health Insurance Premium Rates

States face a particular challenge in balancing consumers' interests for affordable insurance with insurance companies' needs to collect sufficient premiums to pay future claims. Some states rely on the market to police premiums and concentrate their attention on solvency concerns; others regulate both solvency and premiums, attempting to strike the best balance administratively. Thus, there is no consensus among insurance regulators about how best to manage these competing demands.

We found that states' approaches to regulating health insurance premium rates differ. For example, in six states, the insurance departments require detailed rate submissions, which they review prior to approving or denying the requested rates. In six other states, the insurance departments do not routinely receive health insurance rate information from insurers for first-time rates and four of these six do not receive information on rate changes. Several other states require companies to file rate information, but do not have authority to regulate insurance premiums.[7]

In response to our survey, five state insurance departments reported that they believed that their rate regulatory authority was inadequate. For example, Texas officials explained that when a health insurance company increases its rates more than 50 percent, the department contacts the insurer to ask why such a large increase is justified and whether it could be reduced, but can do no more. On the other hand, officials in Illinois do not believe that regulating health insurance premiums is in the consumers' interest. Rather, they believe that premiums are best controlled in the competitive market.

State insurance departments that have rate authority use a variety of approaches to perform this function. For example, New York requires insurers to submit detailed rate filing information for small group and individual insurance policies. Each rate filing is reviewed by an actuary to determine whether the premium rate is justified based on expected claims by policyholders. In

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[7]Insurance departments' rate authority varies depending on the type of policy and the type of insurer.

California, only rate increases for individual policies must be filed. Although they are to be reviewed by an actuary, the reviewer said he is only able to closely review those rate increases greater than 30 percent because his other duties prevent him from performing a more detailed review. At least one state reviews rates to determine if they are competitive, rather than whether the expected losses justify the premium.

Reviewing Health Insurance Policies

Insurance regulators review health insurance policy forms because these documents are often complex and difficult for consumers to understand. Policy forms are reviewed for compliance with state laws, which often include provisions such as readability, required coverages, prohibited exclusions and a variety of administrative requirements.

In 1991, we reported that some long term care insurance policies included provisions whose restrictions would not necessarily be foreseen by the average consumer. For example, some terms for services and facilities were modified by definitions that differed considerably and could, in effect, preclude covering the intended service. One policyholder complained that his insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident. Because nursing homes in his area are not required to keep such records, it would be difficult for him to collect on his policy.

We found that all states review health policy forms and use a variety of procedures. For example, Texas uses a detailed checklist and reads each policy form line-by-line. In contrast, insurance regulators in Colorado require only that the insurer certify the form complies with all state laws and regulations. A copy of the form does not have to be submitted with the certification; however, Colorado holds the insurer responsible for checking policy forms for compliance with state law.

Investigating Consumer Complaints and Insurer Market Practices

Insurance consumers are vulnerable to unscrupulous practices by insurance companies, such as high pressure sales practices, improperly denied claims, unfair discrimination, and improper denial of coverage. To protect against these problems, insurance

departments investigate consumers' complaints regarding health insurers. In addition, most states perform market conduct exams to review the marketing, underwriting, rating, and claims payment practices of health insurers.

In 1991, health insurance complaints comprised about 37 percent of the approximately 344,000 consumer complaints received by 45 insurance departments. The other 5 states could not distinguish health insurance complaints from other insurance complaints in their tracking systems. Our survey found that 37 states believe that the number of health insurance complaints has increased in recent years.

The level of resources dedicated to investigating and resolving consumer complaints varies widely among states, often depending on the state's population and the number of insurers licensed to do business. As of 1991, Rhode Island and the District of Columbia did not have consumer complaint sections, while California had over 100 people available to receive and investigate consumer complaints. California's staff is multilingual and the department maintains access to a language institute so that complaints can be taken from individuals who do not speak one of the languages known by department staff.

All the states we visited use complaint information to target insurers for market conduct exams because complaints received may reflect a pattern of improper practices. Some states also use consumer complaints to target solvency reviews, because complaints of slow claims payment can be an indication of financial difficulties. Such complaints are immediately forwarded to their financial analysis units for investigation.

Our survey found that, in 1991, many states performed some market conduct exams. The number of market conduct examinations of health insurers performed by a state ranged from a high of 81 in Missouri to zero in nine states, with a median of seven examinations.

CONCLUSIONS

Although it is not clear what form health care reform may take, it may involve fundamental changes in the health insurance industry that increase competitive pressures and strain insurer finances. As the Congress analyzes various reform proposals, it needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers. A reform plan should clearly specify what state insurance departments are expected to do to carry out these responsibilities. These expectations need to consider the wide variation in state insurance departments' existing legal authorities, regulatory activities and resources, and what

actions need to be taken to ensure that the departments have the necessary tools to enforce new requirements on health insurers.

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Mr. Chairman, this concludes my prepared statement. We would be happy to answer any questions you may have.

STATE INSURANCE DEPARTMENT BUDGETS AND PERCENTAGE EXPENDED ON HEALTH INSURANCE REGULATION

State	1991 Insurance budget (000s)	Percent devoted to health
Alabama	$ 3,475	N/A[a]
Alaska	3,064	N/A
Arizona	3,066	50
Arkansas	3,200	40
California	72,122	N/A
Colorado	4,683	50
Connecticut	6,939	22
Delaware	2,998	10
District of Columbia	2,423	8
Florida	40,674	N/A
Georgia	14,322	16
Hawaii	1,660	4
Idaho	3,552	30
Illinois	14,727	19
Indiana	4,108	33
Iowa	4,061	20
Kansas	5,531	10
Kentucky	7,107	33
Louisiana	6,368	10
Maine	3,244	40
Maryland	8,486	25
Massachusetts	4,900	11
Michigan	8,644	13
Minnesota	5,488	50
Missouri	3,530	30

State	1991 Insurance budget (000s)	Percent devoted to health
Montana	966	57
Nebraska	3,698	10
Nevada	7,600	7
New Hampshire	2,400	N/A
New Jersey	14,299	20
New Mexico	2,700	13
New York	58,699	18
North Carolina	22,542	50
North Dakota	1,411	30
Ohio	12,437	40
Oklahoma	4,218	38
Oregon	5,366	N/A
Pennsylvania	13,488	40
Rhode Island	1,932	10
South Carolina	5,406	33
South Dakota	768	15
Tennessee	3,599	15
Texas	56,760	14
Utah	2,260	27
Vermont	1,857	10
Virginia	11,800	30
Washington	8,004	28
West Virginia	1,697	35
Wisconsin	5,460	40
Wyoming	2,317	8

[a]States that were unable to estimate the percentage of their budget expended on health insurance regulation.

INSURANCE DEPARTMENT STAFFING

State	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Alabama	N/A[a]	N/A	N/A	N/A
Alaska	30	N/A	0	0
Arizona	84	N/A	1	2
Arkansas	73	N/A	1	0
California	1,038	N/A	1	0
Colorado	91	N/A	1	0
Connecticut	74	15	1	1
Delaware	46	5	0	N/A
District of Columbia	42	N/A	0	N/A
Florida	N/A	N/A	5	N/A
Georgia	N/A	36	1	2
Hawaii	33	N/A	0	0
Idaho	62	9	N/A	2
Illinois	288	34	1	0
Indiana	86	N/A	0	2
Iowa	91	N/A	0	0
Kansas	147	21	0	0
Kentucky	98	N/A	0	1
Louisiana	134	4	0	1
Maine	67	27	1	N/A
Maryland	162	N/A	1	0
Massachusetts	113	13	1	N/A
Michigan	141	18	1	1
Minnesota	100	N/A	0	0
Missouri	101	18	0	N/A

State	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Montana	21	13	1	0
Nebraska	82	10	0	0
Nevada	46	N/A	1	1
New Hampshire	45	1	0	N/A
New Jersey	490	N/A	4	0
New Mexico	64	36	2	0
New York	797	N/A	10	0
North Carolina	310	N/A	1	N/A
North Dakota	39	18	0	1
Ohio	208	N/A	0	1
Oklahoma	99	38	0	0
Oregon	92	N/A	1	0
Pennsylvania	243	80	0	0
Rhode Island	40	3	0	2
South Carolina	115	19	1	0
South Dakota	22	9	0	N/A
Tennessee	98	30	0	1
Texas	1,187	153	2	N/A
Utah	52	N/A	0	1
Vermont	31	3	0	1
Virginia	157	N/A	0	12
Washington	138	24	1	0
West Virginia	49	22	0	0
Wisconsin	116	24	0	0
Wyoming	20	3	0	0

[a]Information not available from state insurance departments.

Related GAO Reports

Insurance Regulation: Weak Oversight Allowed Executive Life to Report Inflated bond Values (GAO/GGD-93-35, December 9, 1992)

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, September 22, 1992)

Insurer Failures: Regulators Failed to Respond in Timely and Forceful Manner in Four Large Life Insurer Failures (GAO/T-GGD-92-43, September 9, 1992)

Access to Health Care: States Respond to a Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Access to Health Insurance: States Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27, April 9, 1992)

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, March 27, 1992)

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (GAO/GGD 92-44, March 19, 1992)

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (GAO/HRD-92-27R, March 12 1992).

Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (GAO/HRD-92-40, March 10, 1992)

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, February 28, 1992)

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/HRD-92-14, December 26, 1991)

Insurance Regulation: Assessment of the National Association of Insurance Commissioners (GAO/T-GGD-91-61, July 29, 1991)

Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

Insurance Regulation: State Handling of Financially Troubled Property/Casualty Insurers (GAO/GGD-91-92, May 21, 1991).

Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/GGD-91-115, August 30, 1991).

Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (GAO/HRD-91-49, March 5, 1991)

Employee Benefits: Improvements Needed in Enforcing Health Insurance Continuation Requirements (GAO/HRD-91-37, December 18, 1990).

Insurance Regulation: The Insurance Regulatory Information System Needs Improvement (GAO/GGD-91-20, November 21, 1990)

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990)

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