



NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

White Paper on State-Level Health Insurance Market Reforms

October 2005

The National Association of Health Underwriters (NAHU) is a trade association that represents over 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance needs of millions of Americans. As an association of health insurance professionals, NAHU's two top public policy objectives are: (1) reducing the number of uninsured Americans through private-market solutions, and (2) making sure that state-level private health insurance markets are as vibrant and competitive as possible.

NAHU recognizes that state health insurance markets are both extremely diverse and complex. Certainly, market reforms that work well in one state might not work as effectively in another. Furthermore, no one state has what could be termed the perfect health insurance climate. However, the fact remains that some state health insurance markets work much more efficiently than others—more carriers compete in these markets, costs are lower and there are fewer uninsured. This paper will identify some of the key elements of successful health insurance markets, explain why these reforms are important, and give examples of why some state health insurance markets work, and why others have failed.

Key Components to Health Insurance Market Stability

Ability to Medically Underwrite in the Individual and Small-Group Markets

One of the most important characteristics of a successful state health insurance market is the ability for health insurers to accurately assess risk for policies sold to both individuals and small businesses. Health insurance is a risk management mechanism and the level of risk varies amongst the insured population. The price of health insurance must reflect these differences in risk, because if everyone paid the same amount for health insurance, only those with the greatest need for expensive medical care would purchase coverage, thereby creating a dysfunctional health insurance market.

The way carriers can accurately assess individual market and small-group risks is through the practice known as medical underwriting. In states that allow for this, each individual applicant or employee is required to complete an individual questionnaire with detailed health information on the individuals to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable to obtain information

necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive. So, for example, if an underwriter sees that a person has a history of high blood pressure that is controlled with medication and has a weight within normal limits, but he or she is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

All states but seven¹ allow for medical underwriting in the individual market, and 40 states² allow for medical underwriting in the small-group market. The ability of insurers to accurately assess risk is extremely important, particularly in markets such as the individual and small group markets where the ability to spread risk is limited, and is even more important in states that allow for self-employed individuals to qualify as business groups of one.

The most common type of state small-group rating law is based on a variation of model legislation developed by the National Association of Insurance Commissioners (NAIC) and allows groups to be rated X percent above or X percent below an “indexed” rate. The indexed rate is determined by averaging the lowest possible rate and the highest possible rate. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time³. Even with these initial rate fluctuations for a new group, small employer rates in these states tend to be much lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal, and in order to rate the group correctly; the correct information on the initial application is essential.

In the individual market, it is most common for states that allow for medical underwriting to do without imposing any type of rating limitations on the carriers. So rates can vary significantly based on an individual applicant’s medical history. Only a few states employ rating bands in the individual market. This is not to say the individual market itself does not regulate its rates. In the vast majority of states that allow for medical underwriting without restriction, this rating mechanism is complimented with either a private high-risk health insurance pool or a designated private health insurance carrier of last resort. High-risk pools and carriers of last resort provide individual market consumers with the most serious of medical conditions with private coverage, at a higher rate. In most states, these rates range from 125-200 percent of the average premium.

¹ Maine, Massachusetts, New Jersey, New York, Oregon, Vermont and Washington all either require community rating or modified community rating in their individual health insurance markets.

² Connecticut, Florida, Maine, Maryland, Massachusetts, New Jersey, New York, Oregon, Vermont and Washington all allow for either modified community rating or community rating in their group markets. However, New Hampshire will return to modified community rating in their small group market on January 1, 2006 .

³ Variations of the NAIC model legislation allow for a 15 percent cap on renewal rate increases for claims experience plus what is necessary to cover overall increases in the cost of providing health insurance coverage by the company, such as changes in laws that may impact operating costs. These costs are known in the industry as “trend.”

The alternative to medical underwriting in both markets is community rating or a modified form of this rating mechanism. Certain states employ the community rating mechanism, which requires insurers to charge all individuals who live in the same zip code the same exact premium regardless of their age or health status. So, for example, in a small group market community-rated state, one employer's cost to insure a healthy 27-year old non-smoking male with no health conditions would be the same cost another employer in the area would pay to insure a 55-year old male smoker who is suffering from prostate cancer and a heart condition.

A variation on this rating mechanism is known as modified community rating. In states that use this mechanism, health plans are allowed to vary the community rate based on limited factors, such as age, gender and/or smoker status. So, for example, in a state that allows modified community rating with variations for age in its small group market, an employer would pay more to insure the 55-year old male smoker with cancer and a heart condition. However, the insurer would have to use the same rate when calculating premiums for the healthy 27-year old male as it would for a male employee of a different company who is the same age but suffers from juvenile diabetes.

Also, it is important to note that state-level modified community rating laws vary greatly. Some allow for many adjustment factors, but others allow for just a limited few, such as gender, age and family composition only. Modified community rating has a severely negative impact on health insurance rates in all states that employ the mechanism, but the more limited the rate adjustment factors, the more severe the problem.

NAHU has observed that in all states with the community rating and modified community-rating mechanisms, younger healthier individuals and workers are penalized since carriers cannot account accurately for these healthy risks. This causes much higher overall health insurance rates than in the states that allow for the use of medical underwriting in the individual and small-group markets. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which in turn limits consumer choice, reduces competition and leads to overall price increases.

Appropriate Group Size Definitions

How states define and divide their health insurance markets also has a strong impact on market stability. State health insurance markets are generally divided into three categories—the individual, small-group and large-group markets. Individual markets serve people who for some reason do not have access to employer-sponsored health insurance coverage. In almost every state, the small-group health insurance market serves employer groups with less than 50 employees, and the large group market serves those with more. The majority of states define an employer group as at least two

individuals, but 13 states allow for self-employed individuals to be considered a business group of one⁴.

In studying state-level health insurance markets nationally, NAHU has found that the most successful states define their group markets as follows—small-groups as 2 to 50 employees, and large-groups as 51 employees and above. The states that allow for business groups of one typically have much higher overall small-group rates for a variety of reasons. First of all, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health insurance be guaranteed issue for all employer groups. This is a requirement that only three of the 13 states place on their traditional individual market⁵. The guaranteed issuance of health insurance in the individual market and for groups of one has historically been a problem, because with individual policies and groups of one, there is absolutely no means for an insurer to spread risk. If an insurer has to cover all individuals who make up groups of one regardless of any medical conditions, then the insurer is forced to assume that each of these one-person groups is a medical risk, and rate all small-group products accordingly. In addition, in the nine of these states (Colorado, Connecticut, Delaware, Florida, Hawaii, Maryland, Michigan, Mississippi and North Carolina) that permit medical underwriting in the individual market, the laws create a perverse incentive for individuals with serious medical conditions to try and “game” the system and attempt to obtain guaranteed issue group coverage as a business group of one, even if they do not operate legitimate businesses. This is known as “adverse selection,” which inevitably leads to higher rates for all individuals in the small-group market.

High-Risk Health Insurance Pools

NAHU has found that another key component to health insurance market stability in a state is the existence of a well-functioning, appropriately funded, health insurance high-risk pool for medically uninsurable and HIPAA-eligible individuals. High-risk health insurance pools have been created in 33 states⁶ in order to provide affordable and quality private health insurance options for individuals with catastrophic medical conditions who

⁴ Colorado, Connecticut, Delaware, Florida, Maine, Maryland, Massachusetts, Mississippi, North Carolina Rhode Island and Vermont all define small employer groups for the purpose of providing health insurance coverage as 1-50 employees. Michigan defines a small employer group as 2-50 employees, but has a separate class for sole proprietors. Hawaii does not have a statute that defines the size of their small group market. Most carriers define it as 1-50 however some use the definition of 1-100. Individuals who attempt to obtain coverage as a business group of one must satisfy criteria set by the carrier.

⁵ The three states that allow for business groups of one and mandate that all insurers in the individual market guarantee issue coverage to all individuals are Maine, Massachusetts and Vermont. In three other states, Hawaii, Michigan and North Carolina, Blue Cross/Blue Shield serves as a carrier of last resort for the individual market. Furthermore, in Delaware, Florida, Hawaii, Maine, Massachusetts, North Carolina, Rhode Island, and Vermont, the traditional private individual market serves as the guarantee issue purchasing option for people who are exercising their group-to-individual portability rights under HIPAA.

⁶ The states that have created health insurance high-risk pools are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming. Idaho has created an individual market reinsurance pool, which essentially serves the same function.

do not have access to the group insurance market. The vast majority of these states also use these pools as an alternative mechanism to the guaranteed group-to-individual health insurance portability provisions required by HIPAA.

Risk-pool consumers are often self-employed individuals, early retirees or employees of small businesses that do not offer benefits. They generally have very serious preexisting medical conditions, such as cancer, diabetes, or another chronic illness that would cause them to be turned down if they applied for traditional private-market individual insurance. For most people who buy coverage in these pools, the risk-pool is an intermediate coverage solution. The average amount of time an individual spends in a risk-pool is 30 months, since many individuals eventually obtain group coverage or qualify for Medicare or another government-sponsored health insurance program.

High-risk health insurance pools help stabilize insurance markets, because they allow insurers to segment the severely unhealthy people seeking individual coverage, but still offer these individuals access to private market coverage. Consumers that need to purchase coverage in the high-risk-pool have access to comprehensive private-market coverage options that might not otherwise be available to them. These individuals pay higher rates than other individual market consumers, but these rates are capped, generally at about 125-200 percent of the average individual market rate. This arrangement benefits both consumers and insurers. Consumers are provided with a very important safety net, and insurers are provided with a predictable means of accounting for uninsurable risks. This allows individual market carriers to keep rates much lower for all traditional consumers, and since state laws cap risk-pool participant premiums based on the average individual market rate, the high-risk consumers also significantly benefit from these lower rates. Furthermore, small-group health insurance carriers and consumers also greatly benefit from stable high risk-pools, since the availability of a risk-pool in a state significantly decreases the risk that a person with a serious medical condition will try and “game” the system and obtain guaranteed issue group coverage. This, in turn, helps keep small-group rates in the state much lower.

In addition to the existence of a high-risk health insurance pool, stable funding for the pool is crucial. State risk-pool rates are capped, and because the individuals that utilize the pool often have the highest possible loss ratios, premiums alone would never be sufficient to satisfy claims. Therefore, the 33 states that have created high-risk pools to serve their individual health insurance markets have also established additional funding mechanisms to offset pool losses. State funding sources for high-risk pools range from legislative appropriations, to tobacco settlement funds, to hospital use surcharges. The most common funding source is some type of assessment levied on health insurance carriers in the state. While NAHU favors an assessment based on the number of covered lives a carrier insures for offsetting risk-pool losses, our organization has found that the most important item necessary in creating a successful risk-pool is selecting a stable funding source.

File and Use vs. File and Approve

NAHU has also found that state regulations regarding the filing of health insurance rates also have an important impact on market stability, especially in the individual and small-group markets. In most states, insurers are permitted to simply file their rates with the state insurance departments and then immediately be able to “use” them. However, in some states, insurers are required to submit their rates to the state department of insurance for approval prior to use. This can be problematic, especially in the individual market, where rates are more volatile, due to the inability of health insurance carriers to spread risk. Rate increases in “file and approve” states tend to be higher than in “file and use” states because carriers have to build in reserve funds for every rate increase request, to compensate for the possibility of future rate change denials. In addition, “file and approve” requirements can hinder carriers from bringing new insurance products into the market in a timely basis, which also hurts consumers, since it can limit choice in health products.

Limits on Mandated Benefit Laws

Another important component of a stable state health insurance market is a limited number of health insurance mandated benefit requirements. In recent years, the number of mandated benefit laws, or laws that place requirements on the content of private health benefit plan contracts have increased significantly. Mandate laws range from statutes that require health plans to cover services by particular types of providers (e.g., chiropractors, optometrists), requirements to cover specific diagnostic or treatment services (e.g., mammography, infertility) or laws to extend certain benefits to certain populations (e.g., continuation coverage of employees or health plan liability). While individual mandates are often very popular since they are intended to provide specific populations with greater access to particular services, there is a cumulative price tag associated with ensuring such access. The sheer volume of mandated benefit laws being passed in the states has caused health insurance premiums to rise substantially. Research shows that there are now well over 1800 benefit mandates in existence, and various studies indicate that they have caused health insurance premiums to increase as much as 25 percent⁷. Therefore, an increase in the number of mandates that are imposed leads to more people being priced out of health insurance, further swelling the ranks of the uninsured. A large number of health insurance mandates hits the small-group and individual health insurance markets particularly hard, since larger employer groups are more likely to self-insure, thus exempting them from state-level mandated benefit laws, as provided by the federal Employee Income Retirement Security Act of 1974 (ERISA).

⁷ Sources: Bunce, V.C. and Wieske, J.P. Council for Affordable Health Insurance. “Health insurance Mandates in the States: 2004.” July 2004.

Jensen, G. and Morrissey, M. “Mandated Benefits Laws and Employer-Sponsored Health Insurance.” Health Insurance Association of America, January 1999.

Certain states, like Minnesota (62) and Maryland (58)⁸, lead the pack when it comes to mandates. However, in recent years, many states have taken action to curb state-level mandated benefit requirements, as one way to keep health insurance costs under control. States have taken various approaches to this task. Virginia, for example, with 54, has a very high number of mandated benefit requirements. However, a number of those mandated benefit requirements, including some of the more expensive mandates, like morbid obesity treatment and bone marrow transplants, are mandatory offer laws.⁹ This means that employers and individuals only have to be given the option of choosing policies that include those benefits. This can substantially reduce costs for employers and individuals, since they do not have to select the benefits that do not meet their individual needs. Twenty-five states¹⁰ have requirements that all mandated benefit proposals go through some type of cost-evaluation before enactment. However, in only five of those states, Maryland, Pennsylvania, South Carolina, Virginia and Washington, are those cost review impact studies mandatory and completed on a regular basis. Finally, a few states, like Louisiana, North Carolina and Oregon, have passed legislation in recent years limiting the number new mandates that can be enacted, due to the impact those mandates have on health insurance costs in the states.

Appropriate Regulation of Managed Care Carriers

While the problem of appropriate regulation of managed care carriers has only arisen in a few states, it can be a very serious impediment to market stability. The vast majority of states make the appropriate distinction in their laws between health maintenance organizations (HMOs) other types of managed care health insurance products, such as preferred provider organization (PPOs). HMOs exercise a great deal of control over the health care treatment of their policyholders, while PPOs typically do not strictly control the medical treatment of policyholders. However in a few states, like Rhode Island, all managed care insurance companies, including both PPOs and HMOs, are considered “health insurance issuers” without any regard to the particular products they offer in the marketplace. The result is that all of the operations of the insurance company, including non-HMO products, become subject to the requirements of the state’s HMO law.

Unlike HMOs, PPOs simply make decisions concerning the reimbursement of health care expenses of policyholders based upon the insurance contract. Additionally, PPOs do not use a gatekeeper or require referrals from a primary care physician in order to see a specialist. However, in states where PPOs are subject to all HMO requirements, these plans can be forced to implement very expensive and unnecessary reforms, such as hiring a full-time medical director. NAHU has found that placing additional regulation on entities that only finance health care services creates additional financial burdens on these companies without any benefit to consumers. The result has been massive carrier

⁸ Bunce, V.C. and Wieseke, J.P. Council for Affordable Health Insurance. “Health insurance Mandates in the States: 2004.” July 2004.

⁹ Source: Blue Cross Blue Shield Association. “State Legislative Health Care and Insurance Issues; 2001 Survey of Plans.” January 2001.

¹⁰ Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin are the states with mandated benefit evaluation laws.

withdrawal from these states. For example, Rhode Island is down to one individual market insurer, two small-group insurers, and four large-group insurers.

Allow For the Widespread Availability of Different Plan Choices

Perhaps the most important element of a successful state health insurance market is the availability of a wide variety of plan options for consumers to choose from. Competition lowers prices, and with many competitively priced plan options out there, less people will go uninsured. States can help ensure that individuals have a wide array of plan options by implementing laws that allow for the introduction of innovative products in their markets, such as health saving accounts. But the most important thing a state can do to ensure a greater degree of consumer choice is to make sure that the state maintains a regulatory and legislative environment that encourages many health insurance carriers to actively market products in the state.

Accurately tracking the number of health insurance carriers actively marketing in a state can be problematic, since HIPAA requires a five-year ban on reentry for all carriers that officially withdrawal from a state health insurance market. As a result, many carriers get around this requirement by simply limiting their marketing efforts, or by only servicing current policyholders. As such, state insurance department records of the number of health insurance carriers in a state are not always precise.

However, NAHU has found a high degree of correlation between the states that do not always follow the criteria listed in this paper for successful health insurance markets and states where health insurance producers report a high rate of insurance carrier exodus. Furthermore, in these states we also have seen evidence of higher rates, and higher number of uninsured individuals. As such, NAHU strongly recommends that states allow for the use of medical underwriting in the small-group and individual markets, prohibit business groups of one, create high-risk pools, allow rates to be filed and then immediately used, limit the number of mandated benefit requirements, regulate PPO plans appropriately, and allow for the development of effective plan networks. This will keep health insurance rates down, the level of competition high, and the number of uninsured as low as possible.

Examples of Both Successful and Unsuccessful Recent State Health Insurance Market Reform Efforts

Colorado—A Success Story

For almost 10 years, the Colorado small-group health insurance experienced an exodus of carriers, and in NAHU's view the problem could be traced primarily to two significant factors—the use of modified community rating for products sold in that market, and the existence of one-life employer groups. Carriers in Colorado only were allowed to adjust rates based on the limited factors of age, geographic location and family composition. As such, carriers in this market had no means of underwriting products based on health status, which caused rates in the state to skyrocket.

Furthermore, the Colorado small-group market is plagued by adverse selection. This is due in part to the fact that the state allows business groups of one to purchase guaranteed issue group coverage. The volume of claims associated with one-life groups is significantly higher than with larger groups where there is more spreading of risk. Furthermore, one-life groups in Colorado tend to purchase coverage on an episodic basis, with the average contract length being only nine months. Other factors contributing to adverse selection in the small-employer market are ironically the state's competitive individual market and unique state laws that make it relatively easy for even very small healthy groups to self-fund, and therefore qualify for exemption from state mandates as rating laws, as provided by ERISA.

The end result of all of these problems is that in 1994, before rate reforms were instituted in Colorado, 83 carriers marketed health insurance in the state. Currently, the small-group health insurance market in the state is actively served by only 12 carriers, with only four carriers actively marketing coverage in the vast rural portions of the state.

However, at the end of the 2003 legislative session, Colorado lawmakers took an important step towards improving their state's small group health insurance market. Legislation was enacted that, among other things, allows health insurers to vary small group market rates based on health status, smoking status, claims experience and industry classification. Beginning September 1, 2003 small-group premiums may be discounted below the indexed rate by up to 15 percent based on those criteria, and effective September 30, 2004, the rates may vary by up to 10 percent above the index rate and 25 percent below it based on the criteria. The reform measure does not address the problem of one-life groups in the state, but it will allow small group carriers to more accurately assess risk and price products more appropriately.

Since the reforms have been implemented, anecdotal reports from NAHU members, who sell small group health plans to employers, show that more groups have received discounts than increases. Our membership also reports that the market has become more competitive, with the five major carriers competing harder for business and the market share of the dominant carrier decreasing. Furthermore, two new carriers have indicated plans to enter the state in 2006.

Maine—A Failure

The Maine health insurance market has been in trouble for a long time. In 1993, market reforms were enacted that created guarantee issue and very restrictive modified community rating for the individual and small group markets.

Currently, in the Maine individual market, all products must be offered on a guarantee issue basis. Individual market carriers may not medically underwrite, and can only adjust rates on a modified community rated basis, with variations of plus or minus 20 percent of the community rate only allowed for age, occupation, geography and/or smoker status. Carriers may not use elimination riders and must provide credit for all prior coverage. If an individual does not have prior creditable coverage, a health insurance carrier may only look-back at and exclude preexisting conditions for the preceding 12 months.

Furthermore, in Maine the entire individual market serves as the guarantee issue option for individuals who are exercising their group-to-individual portability rights under HIPAA.

The small group market in Maine is also struggling. Since Maine allows self-employed individuals to obtain guarantee issue group coverage as a group-of-one and there is clearly a lack of affordable options in the individual market, there is a perverse incentive for very sick individuals to try and create a “group” in order to obtain needed health coverage. These uninsurable “groups,” in addition to being oftentimes fraudulent, hurt the overall small group health insurance market pool since there is no need for people to create them unless they anticipate that they will be costly high-end users of the health insurance system. Medical underwriting is also prohibited in this market, and as with the individual market, carriers can only adjust rates on a modified community rated basis, with variations of plus or minus 20 percent of the community rate only allowed for age, occupation, geography and smoker status.

Over the course of the past 13 years, these “reform” measures have caused rates in both markets to skyrocket, have increased the number of uninsured Mainers and Medicaid recipients, and have caused carriers to leave the state in droves. Now, only four carriers serve these two markets. Two, United and Harvard Pilgrim, have a minor market share, Aetna covers a moderate number of residents in these markets, and Anthem Blue Cross Blue Shield of Maine has market dominance. Cigna recently ceased marketing health insurance policies in the individual and small group markets in Maine.

While both markets have suffered dramatically, the state’s individual health insurance market has been particularly hard-hit. Rates in this market are now among the highest in the country. Only New Jersey and Vermont rival them, and the products available are perhaps the most limited in the country. Between 1993 and 2003, the state’s individual market declined from over 90,000 insured to just over 36,000.

Approximately 136,000 Mainers under age 65 are uninsured, which represents one out of every eight residents. Of this group, 83 percent are adults, a firm employs 52 percent, and 28 percent are self-employed, for a total of 80 percent employed uninsured. Forty-six percent of these uninsured have family incomes of 200 percent of the federal poverty level (FPL) or greater.

In June 2003, Governor John Baldacci and the state legislature attempted to address the health insurance crisis in Maine by enacting the Dirigo Health Reform Act, which became effective in September of that year. This bold measure has three primary components—a massive Medicaid program expansion; a subsidized state-designed insurance plan to compete with the existing private health insurance market and sold primarily to individuals, small employers and the self-employed known as Dirigo Choice; and extensive regulatory controls over health care providers and the health insurance industry in the state.

Unfortunately, but predictably, the Dirigo Health Reform Act has had little success thus far at achieving its stated goals of reducing the number of uninsured Mainers and overall

health care and health insurance costs. The Dirigo Choice component of the program is particularly a failure, having enrolled only 7,897 people—a far cry from the 31,000-enrollee projection by Governor Baldacci for the first year. Furthermore, only approximately 700 businesses have elected to purchase Dirigo coverage, with an average group size of approximately four enrollees. Also, a recent state survey of Dirigo Choice members shows that approximately 1,800 of the enrollees or 22.4 percent, were previously uninsured which means 77.6 percent of the program’s participants were drawn away from the state’s existing private health insurance market.

In addition to the dismal enrollment statistics for this program, it is also running into significant cost issues. The program has cost just the state \$15 million so far in 2005 to insure approximately 8,000 people (this excludes the costs incurred by Anthem Blue Cross Blue Shield, which administers the plan). Pricing for the Dirigo Choice product is not less than comparable plans in the private market, as was hoped, but instead is at least 2.5 percent more. And to finance next year’s expansion of Dirigo, which is expected to cost \$48 million, private health insurance consumers are about to be taxed. The state is currently in the process of determining how much the assessment on private health insurance premiums to finance the program will be; the maximum can’t exceed 4 percent of annual paid claims. Finally, there is significant concern within the state about how to finance the Medicaid expansion of the program in the coming years. The full phase in will represent a 30 percent increase in the state’s Medicaid rolls, and the state is already struggling to pay for its current Medicaid expenditures. Without including the new Dirigo expansion, 44 percent of all new state spending in FY 2006 will be on the Medicaid program.

New Hampshire—A Mixed Result

In 1995, the New Hampshire health insurance market was relatively healthy and competitive, with 34 carriers offering health insurance products. However, reforms enacted in the 1990s eliminated the use of medical underwriting in the state and required that individual market health insurance products, as well as group health insurance products, be offered on a guaranteed issue basis. Furthermore, for many years New Hampshire was the only state in the nation that defined a small employer for the purpose of providing health insurance as an entity that employs between 1-100 individuals. As a result, the state’s health insurance market began to rapidly deteriorate and costs began to rise, so that by 2000, the state was down to five carriers offering health insurance products, with two of those carriers dominating 90 percent of the small-employer market.

During the 2001 legislative session, members of the New Hampshire Association of Health Underwriters worked with legislators, health insurance carriers, business groups and other insurance agent trade associations on reform measures to repair the state’s private health insurance market. This effort was largely successful, and legislation was passed that eliminated the guaranteed issue requirement for individual market health insurance, allowed for the use of medical underwriting, and created a high-risk health insurance pool, amongst other changes. Based on these legislative changes, one very large insurance carrier immediately agreed to re-enter the New Hampshire individual and small group markets, and subsequently, since the risk-pool has become operational,

several other carriers have begun to market new products in New Hampshire, and costs are already beginning to drop.

During the 2003 legislative session, the New Hampshire Association of Health Underwriters and many coalition partners tackled the state's small group health insurance market laws and again they were very successful in getting market-friendly changes passed into law. The legislation passed in the spring of 2003 changed the size of a small employer group in New Hampshire for health insurance purposes from 1-100 employees to 2-50 employees, bringing New Hampshire in line with national standards. Furthermore, the new legislation eliminated modified community rating in the state's small group market and allows health insurance carriers to medically underwrite groups by plus or minus 25 percent, as recommended by the NAIC's model small group reform legislation. The new law also allows carriers to vary rates according age by a 4 to 1 margin (meaning that the highest rate adjusted for age can be no more than four times greater than the lowest rate charged). Furthermore, it allows rate variations for industry and group size of 20 percent, as well as a variation for geography of 15 percent.

Such dramatic changes to the New Hampshire small group health insurance market in such a short time were tough for some groups to swallow. During the 2005 legislative session, after much debate, changes were made to the previous small group reform law, which will take effect on January 1, 2006. The new law will return the state to modified community rating and only allows carriers to consider age, family composition, group size and industry classification when determining rates, and the use of health status, claims experience, duration of coverage, geographic location and other characteristics will be prohibited. Annual rate increases will be limited to 20 percent plus trend. The new law also creates a mandatory small-group reinsurance pool in the state to help reduce small group rates. All changes made to the state's individual market in previous years will remain in effect.

Conclusion

As a professional association of benefit specialists, NAHU members occupy a unique role in the health insurance marketplace. On a daily basis, our membership works with both individual and corporate health insurance consumers to help provide them with the type of coverage that best serves their individual needs. As such, NAHU members have an excellent understanding of what kinds of health insurance markets best serve consumers effectively. And after years of researching state health insurance markets nationally, NAHU has found time and time again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it through anti-market "reforms" like guaranteed issue, mandates or community rating, have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures, such as high-risk pools, "file and use" laws, and measures that do not hinder the development of extensive health plan networks, have higher degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured. NAHU urges all states to implement the market-friendly reforms discussed in this paper, and we look forward to working with state and federal-level policymakers to ensure that

our goals of reducing the number of uninsured and ensuring vibrant and competitive health insurance markets in all states are achieved.

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