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PRIVATE HEALTH INSURANCE

Federal and State Requirements Affecting Coverage Offered by Small Businesses

GAO-03-1133

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Federal and State Requirements Affecting Coverage Offered by Small Businesses

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Highlights

Highlights of GAO-03-1133, a report to the Ranking Minority Member, Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Governmental Affairs, U.S. Senate

Why GAO Did This Study

Most employees in the U.S. have health coverage through employers. Small businesses with fewer than 50 employees, however, are less likely to offer coverage than larger businesses. Many say they cannot afford it. When they do provide coverage, small businesses typically purchase insurance policies, while larger businesses are more likely to use their own funds to pay for some of their employees' health care, a practice known as self-funding.

One proposal to make health coverage more affordable for small businesses would establish Association Health Plans (AHP), which could offer coverage to small businesses subject to different federal and state requirements than currently exist. In light of this proposal, GAO was asked to summarize current federal and state requirements for health coverage offered by small businesses, including mandated benefits, premium-setting requirements, and requirements regarding availability of coverage.

To identify these requirements, GAO reviewed federal and selected states' laws and literature from the Department of Labor (DOL), National Association of Insurance Commissioners (NAIC), and other sources. For further detail on some states' insurance requirements, GAO reviewed 8 states with a range in the number of mandated benefits and 4 states with different types of premium-setting requirements.

www.gao.gov/cgi-bin/getrpt?GAO-03-1133.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

Federal law does not require private employers of any size to offer health coverage, nor does it require those that do offer coverage to include specific benefits. However, employers choosing to offer mental health, mastectomy, and maternity benefits generally must meet certain federal requirements. States, which have primary responsibility for regulating insurers, require health insurance policies offered by businesses of any size to include certain benefits, but the number, type, and scope of these requirements vary substantially among states. For example, 7 states each had 30 or more benefit mandates, while 5 states each had fewer than 10 benefit mandates.

Federal requirements for premiums prohibit variation among similarly situated individuals in an employer group for businesses of any size based on health status, and these requirements apply whether the employer purchases health insurance or self-funds the health coverage. State requirements that limit premium variation among small businesses apply only to insurers, therefore affecting only employers that purchase health coverage from insurers. State requirements varied widely in the extent to which they restricted the amount that premiums may vary among small businesses and in the characteristics of the groups that may be used to set premiums. Differences among states in whether and how factors such as age, gender, and health status are considered can affect the extent to which small businesses with employees having higher risk factors pay more for coverage. For example, a small business with older, higher-risk employees and dependents in Texas could have been charged nearly four times as much as a small business of the same size with younger, healthier employees and dependents. In New York, the two small businesses would have been charged the same premium. Most states also had restrictions on how premiums may be adjusted at renewal.

Federal laws require insurers selling coverage to small businesses to make all policies available and require that employers offer continuation of health coverage for a period of time for certain individuals who otherwise would lose group coverage. All but one state had laws that conformed with federal requirements for small businesses, and some states' requirements exceeded the federal minimums. For example, 39 states extended the federal continuation of coverage requirements to policies covering groups with fewer than 20 employees.

The DOL, NAIC, and 10 states provided technical comments on a draft of this report, which were incorporated as appropriate. NAIC also provided written comments emphasizing, among other things, the importance of states' consumer protections.

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Abbreviations

AHP	Association Health Plan
BCBSA	Blue Cross Blue Shield Association
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DOL	Department of Labor
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
ER	emergency room
ERISA	Employee Retirement Income Security Act of 1974
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	human immunodeficiency virus
NAIC	National Association of Insurance Commissioners
HMO	health maintenance organization
ICD	*International Classification of Diseases*
OB/GYN	obstetrician/gynecologist
PKU	phenylketonuria
PPO	preferred provider organization
RBC	risk-based capital

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

September 30, 2003

The Honorable Richard J. Durbin
Ranking Minority Member
Subcommittee on Oversight of Government Management,
the Federal Workforce, and the District of Columbia
Committee on Governmental Affairs
United States Senate

Dear Senator Durbin:

Nearly three-fourths of employed individuals in the United States have health coverage that many employers offer voluntarily as an employee benefit. Many employees without coverage are employed by small businesses. In 2001, small businesses with fewer than 50 employees were about half as likely to offer health coverage to their employees than were larger businesses. The reason small businesses most often gave for not offering coverage is the high cost, which makes it difficult for small businesses to afford it. A key distinction between how small and larger businesses provide health coverage to their employees is that small businesses typically purchase health insurance policies sold by insurers,[1] while larger businesses are more likely to set aside their own funds to pay directly for at least some of their employees' health care, a practice referred to as self-funding a plan. This distinction between purchasing health insurance policies and self-funding a plan affects which federal and state requirements the health coverage is subject to. All private employer-sponsored health coverage, regardless of whether it is a purchased health insurance policy or a self-funded plan, is subject to certain federal requirements, such as fiduciary obligations that require assets related to the health coverage to be managed prudently. Health coverage that is purchased from an insurer is subject to state regulatory requirements, which can include mandating coverage of certain benefits and providers and restricting how premiums may be set. As a result, most of the health coverage offered by small businesses is subject to both federal and state requirements, whereas self-funded plans offered by businesses—typically larger businesses—are subject only to federal requirements.

[1]For the purposes of this report, the term "insurers" is used to include insurance carriers that provide fee-for-service health insurance coverage and managed care organizations such as health maintenance organizations (HMO). In some cases, states may have somewhat different requirements for HMOs than for other insurers.

In an effort to make health coverage more affordable for small businesses, Congress is considering allowing groups of businesses that are part of or join an association to offer health insurance policies that would not be subject to some state health insurance requirements.[2] This Association Health Plan (AHP) proposal would also establish additional federal requirements for health coverage offered through the AHPs.

In light of the AHP proposal, you asked us to summarize current federal and state requirements for small business health coverage. Specifically, we identified existing federal and state requirements for (1) health benefits and available data on the costs of state-mandated benefits, (2) premium setting, (3) availability of coverage, (4) patient protections regarding denied claims and access to specialists, and (5) employers' fiduciary and insurers' financial responsibilities.

To identify existing federal and state requirements,[3] we reviewed federal and selected states' laws; information from the Department of Labor (DOL), the National Association of Insurance Commissioners (NAIC), the Blue Cross Blue Shield Association (BCBSA), and Georgetown University's Institute for Health Care Research and Policy; other literature; and prior GAO reports.[4] The information available did not always distinguish between state requirements that apply to health insurance sold to small businesses (referred to as the small group market) and those that apply to insurance sold to larger businesses and individuals (the large group and individual insurance markets, respectively). To obtain more detailed information on how benefit mandates in the small group market differ across states, we reviewed states' laws, regulations, and insurance department bulletins and contacted department of insurance officials in eight states (Alabama, Colorado, Georgia, Idaho, Illinois, Maryland, Nevada, and Vermont), which, based on a BCBSA report, exhibited a range in the number of state health insurance mandates. To obtain more detailed information on how premium-setting requirements differ across states, we reviewed the laws of four states (Colorado, Maine, Rhode Island, and Texas) that have adopted different approaches to regulating insurers'

[2]The *Small Business Health Fairness Act of 2003* (S. 545) was introduced on March 6, 2003. Similar legislation, also entitled the *Small Business Health Fairness Act of 2003* (H.R. 660), passed the House of Representatives on June 19, 2003.

[3]Throughout the remainder of this report, unless otherwise noted, the District of Columbia is included as a state.

[4]A list of related GAO products is at the end of this report.

premiums for coverage sold to small businesses. Our work was conducted from March through September 2003 according to generally accepted government auditing standards.

Results in Brief

Overall, employees working for small businesses could have substantially different benefits, premiums, and protections available to them, depending on the states in which their employers are located. While federal law generally requires all private employers offering health coverage to their employees to meet certain minimum requirements, states have primary responsibility for regulating health insurance policies sold by insurers. As a result, substantial variation exists across states in the extent to which they impose requirements on health insurance, such as mandating coverage of certain benefits or placing limits on premiums.

Federal law does not require that any business offer health coverage or require coverage of specific benefits. However, federal law has minimum benefit requirements for businesses that choose to offer health coverage that includes certain benefits, whether it is purchased from an insurer or is a self-funded plan. For example, businesses of any size offering mastectomy coverage must also cover related reconstructive surgery and other mastectomy-related benefits. While all states have mandated that certain benefits be covered by health insurance policies, the number, type, and scope of the states' requirements varied substantially. According to a BCBSA survey published in 2002, the total number of benefits mandated in the small group, large group, and individual markets varied among states from fewer than 10 in five states to more than 30 in seven states. The two most commonly mandated benefits—required by 43 or more states—were mammography screening and diabetic supplies. Less commonly mandated benefits—required by five or fewer states—included hair prostheses (wigs) for individuals with cancer or other diseases, blood lead screening, prescription drugs, and chemotherapy. In eight states where we reviewed mandated benefits applicable specifically to the small group market, we found that the specific terms and scope of certain mandates also varied. For example, four of the eight states mandated coverage for mental health services, but these states varied in the diagnoses for which coverage must be provided and the number of inpatient days and outpatient visits for which coverage was required. When estimating the costs associated with mandated benefits, few studies have taken into account the fact that many businesses would offer some similar benefits even absent a mandate. However, two studies estimated that the additional costs associated with state-mandated benefits represented about 3 to 5 percent of total premium costs.

Federal requirements related to premiums apply to any size business and prohibit variation among individuals within the same employee category—which could include the same geographic location or employment status—on the basis of health-status related characteristics. Most states set limits on how premiums that insurers charge small businesses could vary, but states varied widely in the extent to which they allowed premiums to vary and the characteristics of the group that could be used to set or vary premiums, both initially and upon policy renewal. Differences among states in their premium requirements can substantially affect the extent to which small businesses that have employees with higher-cost risk factors would be charged more for coverage. For example, in New York, a small business covering older employees and dependents, including one in poor health, would have been charged the same premium as a small business of the same size with younger, healthier employees and dependents, while in Texas, the employer covering higher-risk employees and dependents could have been charged nearly four times as much as an employer of lower-risk people.

With regard to availability of coverage, federal laws require that insurers offer small businesses with 2 to 50 employees the option to purchase coverage and that small businesses with 20 or more employees allow employees and their dependents to continue to purchase health coverage under certain circumstances, such as when individuals, with certain exceptions, lose their health coverage due to a loss of employment. States had requirements for availability of health insurance and continuation of coverage for individuals with coverage through small businesses that in some cases exceeded the federal requirements. For example, 39 states extended the federal continuation of coverage requirements to policies covering groups with fewer than 20 employees.

With regard to patient protections, federal law requires that coverage offered through businesses of any size, whether it is through an insurance policy or a self-funded plan, have an internal review process for appeals of denied claims, and most states required an independent external review process for appeals of denied claims. Specifically, 43 states had laws in 2002 establishing independent external review of denied claims for insurance policies, although states varied significantly in the kinds of appeals eligible for external review, individuals' accessibility to the external review process, the independence of the reviewer, and the time allowed for completion of external review. In addition, in response to concerns about appropriate access to health care services, particularly regarding managed care, most states adopted protections that allowed

patients direct access to certain health care providers and services, such as obstetricians/gynecologists and emergency services.

Regarding employer fiduciary responsibilities and insurer financial requirements, federal law focuses on the responsibilities of fiduciaries—persons with discretionary authority over plan assets. Federal law requires that fiduciaries for any employer-sponsored health coverage act prudently and in the exclusive interest of the covered individuals. Federal requirements do not include specific financial requirements, such as protections against insolvency. In contrast, all states generally required that insurers maintain sufficient funds to cover unexpected losses and to invest conservatively in order to ensure that insurers were financially sound and able to pay the claims of policyholders. State requirements include oversight of insurers' financial soundness, such as through periodic on-site financial exams. States with set requirements to protect against unexpected losses for health insurers required that insurers maintained a minimum of $150,000 to $3.6 million, with a median of $1.3 million. In addition, some states required certain insurers to maintain more than the minimum amount, depending on their financial risk. According to data from NAIC, the median amount insurers selling health coverage reported having to protect against unexpected losses in 2002 was $15 million. All states also required certain insurers to contribute to state-administered guaranty funds, which are used to pay for claims if an insurer fails.

We provided a draft of this report to DOL, NAIC, and 12 states whose benefit or premium requirements for the small group market were discussed in the report. DOL and 10 states provided technical comments, which we incorporated as appropriate; 2 states did not provide comments. In written comments, NAIC expressed agreement with several findings in our report and also stressed the important role that states play in providing protections to consumers with health insurance. NAIC also provided technical comments, which we incorporated as appropriate.

Background

Most small businesses that offer health coverage to their employees purchase health insurance policies from insurers, such as local Blue Cross and Blue Shield plans or other private insurers, or managed care organizations, such as health maintenance organizations. Few small businesses offer a self-funded plan—12 percent of the small businesses with fewer than 50 employees that offered coverage in 2001 had a self-funded plan. In contrast, the larger businesses are more likely to offer self-insured plans, with nearly 60 percent of businesses with 50 or more employees self-funding at least one of the health plans they offered.[5] Many businesses that self-fund purchase stop-loss insurance to moderate their risk, as such insurance caps the amount of claims the business will pay directly for either an individual or the group.

The Employee Retirement Income Security Act of 1974 (ERISA)[6] established certain federal requirements for benefits that employers offer their employees, retirees, and dependents including health coverage as well as pensions and other benefits. ERISA requirements generally apply to all private employer-sponsored health coverage regardless of the size of business or whether the coverage is through a health insurance policy or a self-funded plan. ERISA also preempts employer-sponsored health coverage from direct state regulation (but maintains states' role in regulating insurance). ERISA establishes certain reporting requirements, disclosure requirements, fiduciary obligations, and claims-filing procedures that are enforceable by the Employee Benefits Security Administration of DOL.

Since ERISA was enacted in 1974, it has been amended several times to establish additional federal requirements for employer-sponsored coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[7] requires employers to offer continued coverage for individuals, with certain exceptions, who would have otherwise lost employer-sponsored health coverage. COBRA allows individuals who change or lose

[5]About 76 percent of businesses with 500 or more employees offering health coverage offered at least one self-funded plan. See Agency for Healthcare Research and Quality, *2001 Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics*. (Rockville, Md.: September 2003), http://www.meps.ahrq.gov/mepsdata/ic/2001/index101.htm (downloaded September 22, 2003).

[6]Pub. L. No. 93-406, 88 Stat. 829.

[7]Pub. L. No. 99-272, 100 Stat. 82 (1986).

their jobs to maintain coverage for a minimum of 18 months, but the individual may be required to pay the full premium. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[8] guarantees the availability of health insurance for small businesses that choose to purchase coverage and provides greater continuity in coverage for individuals who change health plans when they change employers or who change to an individually purchased insurance policy. Three subsequent laws established additional minimum requirements that businesses must meet if they offer coverage for mental health, maternity, or mastectomy benefits.[9]

States have primary responsibility for regulating insurance. Therefore, health insurance sold within a state must meet federal and state requirements, but businesses' self-funded plans are subject only to federal requirements because ERISA preempts states' regulation of employer-sponsored health coverage.[10] State requirements may apply to all health insurers, whether they are selling coverage to small or larger groups or to individuals, or they may be specific to coverage sold in the small group market. In addition, state requirements may be based on model laws, regulations, and guidelines developed by NAIC.

Proposed federal legislation would establish new rules for health coverage sponsored by associations for the employees of member businesses.[11] These new rules would apply only to AHPs that obtain certification from DOL and would vary depending on whether the AHP coverage is through a self-funded plan or an insured policy. The proposed legislation would change current federal and state requirements for health coverage in several respects: (1) self-funded AHP plans would be subject to new federal financial requirements, (2) insured AHP policies could be approved in one state and sold in other states without meeting all the requirements for approval in the other states, and (3) all AHP coverage would be exempt

[8]Pub. L. No. 104-191, 110 Stat. 1936.

[9]These laws are the Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, 110 Stat. 2874, 2944; the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, Title VI, 110 Stat. 2874, 2935; and the Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, Title IX, 112 Stat. 2681, 2681-436.

[10]The McCarran-Ferguson Act, March 9, 1945, Ch. 20, 59 Stat. 33, establishes the primary authority of the states to regulate the business of insurance, unless federal law provides otherwise.

[11]S. 545 and H.R. 660, 108th Congress.

from every states' health benefit mandates and in some cases could be subject to premium-setting requirements that differ from current state requirements. As deliberations on this proposed legislation proceed, however, the specific proposals and requirements could be subject to change.

Health Benefit Requirements

While federal law does not require businesses to offer any specific health benefits, those that choose to cover maternity, mental health, or mastectomy benefits generally must meet minimum federal requirements. Every state mandated that certain health benefits be included in insurance policies sold within the state (in the small group, large group, or individual insurance markets); however, the number and type of benefits required varied significantly from state to state. In eight states where we reviewed mandated benefits applicable specifically to the small group market, we found that the specific terms and scope of certain mandates also varied. In estimating the costs associated with mandated benefits, few studies have taken into account the fact that many businesses would offer some similar benefits even without a mandate to do so. However, two studies estimated that the additional costs associated with mandates represented about 3 to 5 percent of total premiums.

Coverage for Certain Benefits Must Satisfy Minimum Federal Requirements

Federal laws include minimum benefit requirements for businesses that choose to offer certain benefits:

- The Pregnancy Discrimination Act[12] requires businesses with 15 or more employees to cover expenses for pregnancy and medical conditions related to pregnancy on the same basis as coverage for other medical conditions.
- The Newborns' and Mothers' Health Protection Act of 1996 requires that employer-sponsored health coverage that includes hospital stays in connection with childbirth must cover a minimum length of stay for mothers and newborns following delivery. For vaginal deliveries, the coverage provided cannot restrict hospital stays to less than 48 hours; for caesarean births, the coverage provided cannot restrict hospital stays to less than 96 hours.

[12]Pub. L. No. 95-555, 92 Stat. 2076 (1978).

- The Mental Health Parity Act of 1996 requires that mental health benefits included in employer-sponsored health coverage cannot have annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. The law does not apply to (1) coverage sponsored by a small business with 50 or fewer employees and (2) coverage sponsored by larger businesses that experience an increase in total claims costs of at least 1 percent as a result of complying with the act. The health coverage may still contain other limits, such as those on the number of days or visits covered.[13]
- The Women's Health and Cancer Rights Act of 1998 requires that employer-sponsored health coverage that provides coverage for mastectomies also cover related reconstructive surgery and other mastectomy-related benefits, such as coverage for prostheses and physical complications (including lymphedemas).

DOL is responsible for enforcing the minimum federal requirements for the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act for self-funded plans.[14] In cases where a state does not enforce these requirements for coverage purchased from an insurer, the Centers for Medicare & Medicaid Services (CMS) assumes the responsibility for enforcement. As of July 2003, nearly all states were enforcing the federal requirements—only Colorado, Massachusetts, Wisconsin, and Rhode Island had not enacted fully conforming legislation and relied on CMS to enforce one or more of these federal requirements.

Health Insurance Mandates Vary Substantially among States

All states mandated that certain benefits and providers be included or offered in health policies sold in their states. State mandates may apply to insurance products sold in the small group, large group, or individual insurance markets; however, some states altered requirements specifically for insurance policies sold in the small group market. The most common types of mandates required health insurers to cover certain procedures or treatment of illnesses (mandated benefits) or to pay for covered services

[13]U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited,* GAO/HEHS-00-95 (Washington, D.C.: May 10, 2000).

[14]The Equal Employment Opportunity Commission enforces the Pregnancy Discrimination Act.

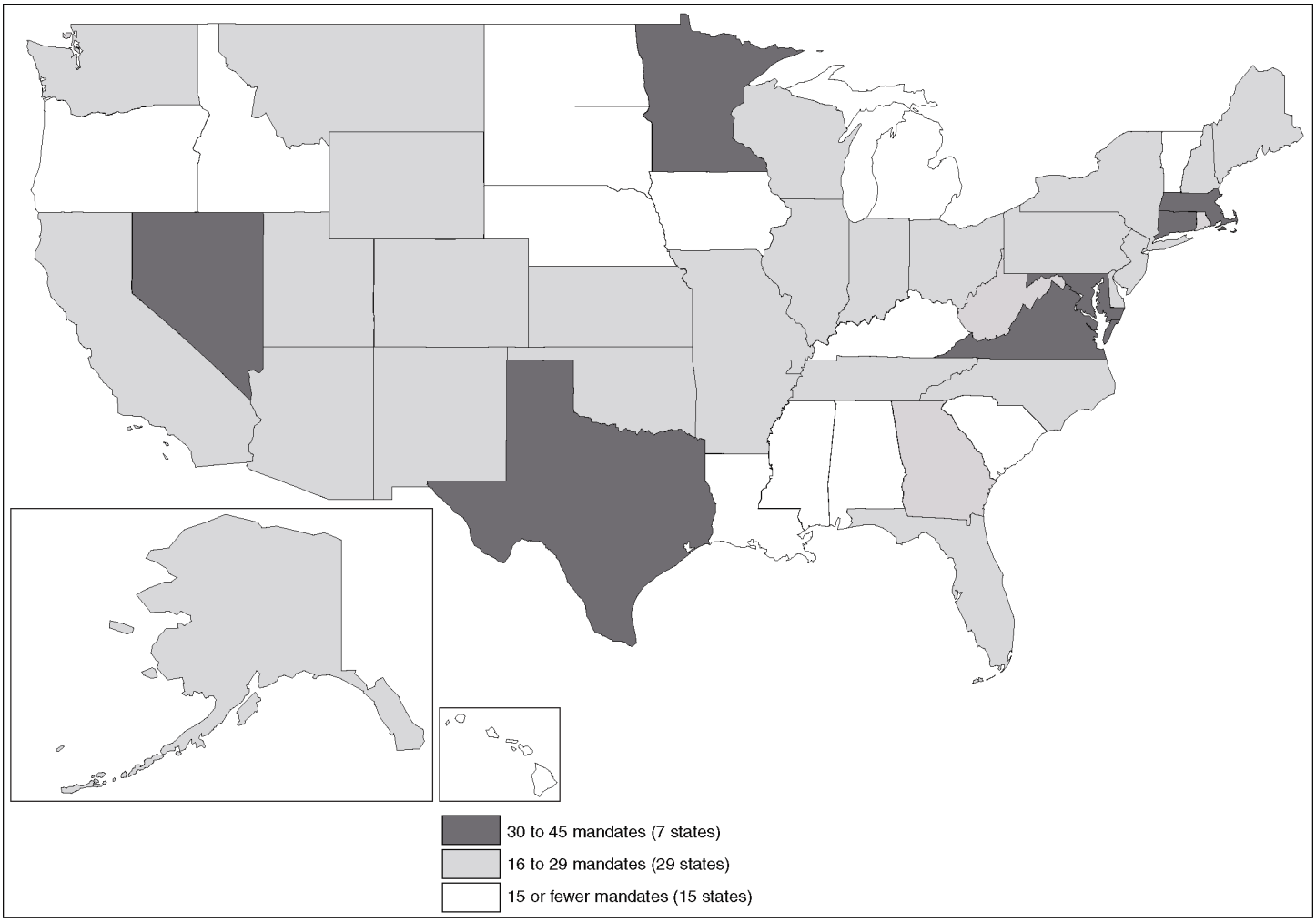
provided by certain physician specialists or nonphysician providers (provider mandates).[15]

Number and Type of State Benefit and Provider Mandates for All Insurance Markets

The total number of mandates applicable to all insurance markets—small group, large group, and individual—varied from state to state. (See fig. 1.) According to a 2002 survey by BCBSA, 7 states—Connecticut, Maryland, Massachusetts, Minnesota, Nevada, Texas, and Virginia—each had 30 or more mandates. Fifteen states had 15 or fewer mandates; 5 of these states—Alabama, Idaho, Iowa, Vermont, and the District of Columbia—each had fewer than 10. The median number of mandates required by states for all three insurance markets was 17.

[15]States also required that certain benefits be offered (mandated offers) in at least some policies but allow insurers to offer other products that do not include those benefits.

Figure 1: Number of Benefit and Provider Mandates for Small Group, Large Group, and Individual Insurance Markets, by State, 2002

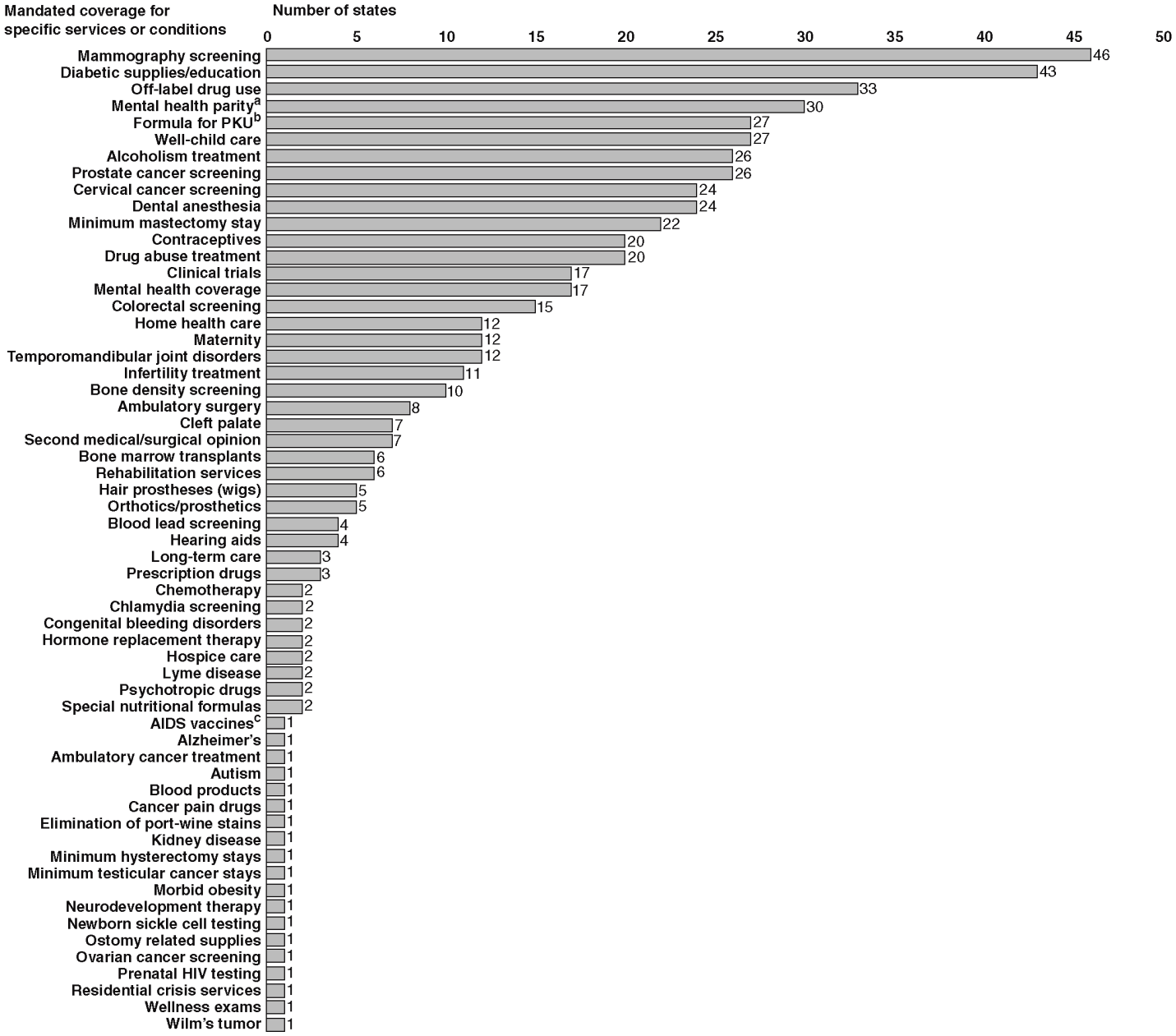


Source: GAO's analysis of Blue Cross Blue Shield Association, 2002 Survey of Plans, December 2002.

Note: Includes benefit and provider mandates as identified by BCBSA. BCBSA also identified ambulance transportation and emergency service requirements as mandated benefits, but we classified these as patient protections because they involve access to health services. Additionally, we did not include state laws related to the federal requirements for breast reconstruction or minimum maternity stay.

The types of mandates required varied from state to state, with some mandates required more often than others. Of the 59 different types of benefits that states required for all insurance markets, 8 were required by more than half the states. The two most commonly mandated benefits were mammography screening and diabetic supplies, with 43 or more states requiring coverage of each of these benefits. Other benefits were less frequently required—such as hair prostheses (wigs) for individuals being treated for cancer or other diseases (5 states), blood lead screening (4 states), prescription drugs (3 states), and chemotherapy (2 states). Further, 19 of the mandates were required by only 1 state, such as coverage for Alzheimer's disease, treatment for morbid obesity, prenatal HIV testing, and wellness exams. (See fig. 2.) Common provider mandates included chiropractors (42 states), psychologists (41 states), and optometrists (36 states).

Figure 2: Frequency of State Benefit Mandates for Small Group, Large Group, and Individual Insurance Markets, 2002



Source: Blue Cross Blue Shield Association, December 2002.

[a]Mandate goes beyond federal minimum requirement.

[b]Phenylketonuria (PKU) is an enzymatic disorder that affects the way the body processes protein.

[c]Mandate requires coverage of vaccines once approved by the Food and Drug Administration.

Number, Type, and Scope of State Mandates in the Small Group Market

The benefit requirements in eight states we reviewed—Alabama, Colorado, Georgia, Idaho, Illinois, Maryland, Nevada, and Vermont—illustrate the extent of variation in the number, type, and scope of state benefit requirements specifically for the small group health insurance market. The number of benefit mandates that applied to health insurance policies sold to small businesses in these states ranged from 5 in Idaho to 32 in Maryland. Four of the 5 mandates required in Idaho—coverage for congenital abnormalities, mammography screening, maternity care, and complications of pregnancy—were also required by some of the other states we reviewed. Similarly, 27 of Maryland's mandates, such as diabetic supplies and mammography screenings, were also mandated by one or more of the other seven states, while 5 mandates, including bone density screenings and hearing aids for children, were not required in any of the other states we reviewed. (See table 3 in app. I for more detail on benefit and provider mandates in these eight states.)

Among states that required health insurance to cover certain services, the scope of the benefit mandates often varied. For example, mandates varied in their terms and conditions (such as the diagnosis for which coverage must be provided) and the minimum level of benefits required (such as the number of inpatient days or outpatient visits). The following illustrates the variation in the scope of mandates for the small group market among the eight states we reviewed for four specific types of mandates:

Well-child care: Five of the eight states—Colorado, Georgia, Illinois, Maryland, and Vermont—required that well-child care be covered, but varied as to the age of children and types of services for which coverage was required. For example, Colorado required coverage of preventive services and immunizations for children up to the age of 13, while Georgia required coverage for reviews of the physical and emotional status of a child through age 5. Maryland specified comprehensive requirements listed under the recommendations from the United States Preventive Services Task Force.[16] Further, Georgia and Colorado exempted well-child care services from deductibles and dollar limits.

[16]U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, *Guide to Clinical Preventive Services, Third Edition: Periodic Updates* (Rockville, Md.: March 2003). The U.S. Preventive Task Force, convened by the Public Health Services, is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

Mental health services: Five of the eight states—Colorado, Illinois, Maryland, Nevada, and Vermont—required insurance sold in the small group market to include mental health benefits, but the extent of the required coverage varied among the states.[17] For example, Nevada required coverage for a minimum of 40 days of inpatient care and 40 days of outpatient care and limited this coverage to six "biologically based" conditions.[18] Maryland required coverage for 60 inpatient days and, in addition to requiring the coverage of outpatient services, required insurers to pay at least 70 percent of the cost for outpatient services. Maryland also required coverage of residential crisis services.

Parity in mental health and other medical/surgical services: Four of the eight states we reviewed—Colorado, Georgia, Maryland, and Vermont—had mental health parity requirements that applied to smaller businesses exempt from the federal Mental Health Parity Act, which applies only to employers with 51 or more employees. These states' parity laws varied, however, in the diagnoses for which parity was required, whether separate cost-sharing amounts for mental health care were permitted, and whether parity extended to limits on the number of covered days or visits. For example, Colorado required that mental health benefits for six biologically-based conditions be no less extensive than those for physical illness. Vermont prohibited insurers from establishing any rate, term, or condition that placed a greater financial burden on the insured individual than that for the treatment of physical conditions, including parity regarding limits on the number of covered visits.

Organ transplants: Two of the eight states—Illinois and Maryland—had provisions mandating coverage for organ transplants. Illinois generally required coverage for organ transplants with the exception of experimental and investigational procedures, while Maryland required

[17]Georgia also mandated that mental health services be offered as a benefit, but insurers could also offer products without mental health services. Illinois mandated coverage of mental health services, but groups with fewer than 50 employees were exempt from the requirement.

[18]The six biologically based conditions, as specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* were schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, and obsessive-compulsive disorder. See American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (Washington, D.C.: 2000)

coverage of bone marrow, cornea, kidney, liver, heart, lung, and pancreas transplants.

Appendix I provides additional detail about these four types of mandated benefits in the eight states.

Estimated Costs of State-Mandated Benefits

While the number, type, and scope of benefit and provider mandates in a state can affect the cost of insurance, the additional costs beyond what businesses would typically incur are estimated to be relatively small. Most studies that have addressed the costs of mandated benefits have not examined the additional (marginal) costs of mandates but have instead reported the total costs associated with benefit mandates, even though employers may have chosen to cover some or all of these benefits even in the absence of any mandate.[19] Maryland—the state with the most mandated benefits—analyzed both the total and marginal costs of its mandated benefits. Whereas Maryland found that the total costs associated with its benefit mandates were about 14 percent, the marginal costs represented about 3 percent of premiums.[20] In another study, the Congressional Budget Office estimated that the marginal costs of five state health insurance mandates were 0.28 to 1.15 percent, and estimated that mandated benefits in general could increase premiums by about 5 percent over what they would have been without mandates.[21] (See app. II for additional information on the estimated cost of mandated benefits.)

[19]Estimates of the total costs associated with state-mandated benefits vary widely, with studies by three states—Maryland, Texas, and Virginia—estimating that mandates in their states accounted for 14 percent, 6 percent, and 29 percent of premiums, respectively.

[20]Mercer Human Resource Consulting, *Mandated Health Insurance Services Evaluation,* a report prepared at the request of the Maryland Health Care Commission, 2002.

[21]The five state mandates were alcoholism treatment, drug abuse treatment, mental illness treatment, chiropractic services, and mandated continuation of health insurance for terminated employees and their dependents. See Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Washington, D.C.: January 2000).

Premium Requirements

Federal premium requirements prohibit any employer-sponsored health coverage from charging employees a higher premium based on health-related factors than the premium charged to other similarly situated individuals. Employers may treat groups of individuals differently if the groups are based on an employment class (such as full-time or part-time) that is consistent with employers' usual business practices. State premium requirements for insurance sold in the small group market limited how premiums were set and the amount by which they could vary for different small businesses. In 2003, almost all states had premium-setting requirements, but states varied widely in the degree to which they limited the individual characteristics that could be used to set premiums and how much the premiums could differ among small businesses buying the same insurance product. Also, for the small group market in 2002, many states limited how premiums were set for renewal policies but did not restrict how often premiums could be adjusted.

Federal Requirements Restrict Variation in Premiums for Individuals with Employer-Sponsored Health Coverage

Federal requirements do not address how premiums for employer-sponsored health coverage are set but rather HIPAA's nondiscrimination provision prohibits, for businesses of all sizes, premiums from differing for similarly situated individuals on the basis of health-related factors.[22] Similarly situated employees might share the same geographic location or employment status. HIPAA does not prohibit health insurers or employers that self-fund from taking into account the health of the employees and their dependents when setting the group's premiums, but it does prohibit them from charging employees or their dependents different amounts based on this health information. Further, HIPAA does not prohibit premiums from varying among employees for other reasons. For example, employees in different employment categories, such as those in different geographic locations or with different employment status, may be charged different amounts for health coverage.

[22]HIPAA specifies that health-related factors include: (1) health status, (2) medical condition—including both physical and mental illness, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability—including conditions arising out of acts of domestic violence, and (8) disability.

Most States Limited How Insurers Could Vary Premiums for Different Small Businesses

In 2003, nearly all states (47) had some restrictions on how premiums were set for insurance sold in the small group market. These requirements focused on limiting the extent to which premiums offered to small employers purchasing the same coverage could differ. State requirements varied in the extent to which they restricted the amount premiums could reflect the heath and other demographic characteristics of the group's employees and dependents. Further, while states tended to adopt one of three types of premium-setting requirements for coverage sold to small businesses—pure community rating, modified community rating, or rating bands—the specific restrictions varied widely with some states adopting aspects of more than one type of requirement. (See app. III for a summary of state premium requirements.) In general, pure community rating requirements were the most restrictive, allowing insurers to vary premiums among small businesses of the same size purchasing the same coverage for geographic area and family size only. Variation for health or other demographic characteristics of the group's employees and dependents such as age or gender was prohibited. Modified community rating requirements prohibited insurers from varying premiums among small businesses on the basis of health but allowed some variation for other factors in addition to geographic area and family size, such as age and gender of the employees and dependents. The most common approach used was rating bands, which allowed insurers to vary premiums on the basis of the employees' and dependents' health as well as other factors (such as age, type of industry of the business, or size of the group) but set some restrictions on the variation allowed. Premium-setting requirements in rating band states, however, may have included aspects of other types of premium-setting requirements as well. For example, we classified Rhode Island as a rating band state because premiums could vary on the basis of the group's health, but it also had elements of modified community rating because insurers developed a community rate from which adjustments could be made. (See table 1.)

Table 1: Number of States with Premium-Setting Requirements for the Small Group Market, by Type of Rating, 2003

Type of rating	Number of states	Description of requirements
Pure community rating	2	Prohibits use of health status and other factors such as age, group size, and gender. Premiums can vary among small businesses only for geographic area and family size.
Modified community rating	10	Prohibits use of health status. Premiums can vary among small businesses for geographic area and family size and for other factors within limits, such as age and gender.
Rating bands	35	Premiums can vary among small businesses for health and other factors, such as age, group size, and industry, within limits.
No restrictions	4	No limits on factors that can be used or amount premiums can vary among small businesses.

Source: GAO analysis of data from BCBSA, NAIC, and selected state requirements.

Other than the two states that required pure community rating (New York and Vermont), states differed greatly in their specific restrictions even if they had the same type of premium-setting requirement. All states with modified community rating prohibited consideration of individual employees' health but differed in the other factors they allowed insurers to consider in setting premiums. For example:

- Colorado allowed premiums to vary among small businesses for three factors—age, geographic area, and family size—based on actuarial data but did not otherwise set limits on the amount that premiums could vary for any of these factors.
- Maine allowed premiums to vary among small businesses for seven factors—age, employees' occupation or employer's industry, geographic area, group size, smoking status, participation in wellness programs, and family size—but limited to 20 percent the total amount premiums could vary above or below the community rate for age, occupation or industry, and geographic area.

Similarly, states with premium rating bands allowed premiums to vary based on health but differed in their restrictions on other factors that could be used in setting premiums. For example:

- Rhode Island allowed premiums to vary among small businesses from the community rate for health, age, gender, and four types of family composition: (1) enrollee, (2) enrollee and spouse, (3) enrollee, spouse, and children, or (4) enrollee and children. Of these factors, premium variation among small employers was not limited for age or gender, whereas variation from the community rate for health was limited to 10 percent, and variation among employer groups was limited to 400 percent of the lowest premium rate for the same type of family composition.
- Texas required insurers to set premiums using two steps. First, the insurer could determine a base premium using criteria including geographic area, age, gender, industry, and group size. Variation was limited for only industry and group size; specifically, the highest factor for industry and group size could not exceed the lowest factor by more than 15 percent and 20 percent, respectively. Second, the insurer could adjust the amount of the base premium by as much as 67 percent on the basis of health status, duration of coverage, or other characteristics related to the health status or experience of a small group or of any member of a small group.

Differences among states in their premium requirements can substantially affect the amount that premiums varied among small businesses with employees and dependents with different risk factors. For example, in New York, a small business whose employees and dependents had higher-risk characteristics would have been charged the same amount as a small business with younger, healthier employees and dependents; in Texas, the small business with higher-risk employees and dependents could have been charged several thousand dollars more per year than the small business with younger, healthier employees and dependents. (See table 2.)

Table 2: Average Annual per Enrollee Premium Quotations for Three Hypothetical Small Business Groups, with Increasing Risk Characteristics, in Selected Localities, 2000

		Group 1—Lower risk: Primarily young, with no health conditions and few high-risk characteristics	Group 2—Medium risk: similar to Group 1 but 1 adult has a serious health condition (juvenile-onset diabetes)		Group 3—Higher risk: same serious health condition as Group 2, but other enrollees have other increased-risk characteristics, including older, male and smoker, and the business was a higher-risk industry	
Premium-setting requirement	**Location**	**Annual premium**	**Annual premium**	**Percentage increase from Group 1**	**Annual premium**	**Percentage increase from Group 1**
Pure community rating	Albany, New York[a]	$2,580	$2,580	0%	$2,580	0%
Modified community rating	Baltimore, Maryland[b]	2,113	2,113	0%	3,977	88%
Rating band	Sacramento, California[c]	2,513	2,513	0%	3,614	44%
Rating band	Springfield, Illinois[d]	1,259	1,504	19%	2,946	134%
Rating band	Austin, Texas[e]	1,810	2,934	62%	7,051	290%

Sources: U.S. General Accounting Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage* (GAO-02-8, Oct. 31, 2001), and unpublished premium quotations.

Notes: Amounts reflect average annual per enrollee premiums for 10 enrollees: 5 employees purchasing single coverage and 2 employees purchasing family coverage for a total of 3 dependents.

[a]Premium for preferred provider organization (PPO) coverage that has a $500 out-of-network deductible and $10 in-network copayment for office visits.

[b]Premium for PPO coverage that has a $750 out-of-network deductible and $10 in-network copayment for office visits.

[c]Premium for PPO coverage that has a $300 out-of-network deductible and $10 in-network copayment for office visits.

[d]Premium for PPO coverage that has a $1,000 out-of-network deductible and $25 in-network copayment for office visits.

[e]Premium for PPO coverage that has a $300 out-of-network deductible and $10 in-network copayment for office visits.

Most states set additional requirements for the small group market in how premiums could be adjusted upon renewal but did not limit the total amount that premiums could increase in the small group market or how often premiums could increase. According to information from NAIC, in 2002 many of the 44 states with renewal requirements had requirements that were based on or similar to those in the NAIC model regulation, which allowed insurers to adjust premiums up to the sum of (1) the

percentage that premiums have increased for new business, (2) adjustments not exceeding 15 percent for claims experience, health status, and duration of coverage of a particular small business, and (3) adjustments, as determined by the insurer's rating manual, for changes in coverage or individual characteristics (other than claims experience, health status, and duration of coverage).[23] Further, according to information from NAIC, only 8 states in 2002 limited the frequency with which insurers could adjust small businesses' premiums for insurance policies that had already been purchased. These states tended to require that premiums remain unchanged for at least 1 year unless certain factors, such as the composition of the group or the benefits of the plan, changed.

Requirements for Availability of Health Coverage

Federal laws—HIPAA and COBRA—have established requirements to ensure the availability of health coverage for small businesses and for employees, with certain exceptions, who lose group coverage. All states except Missouri had laws that conformed with the federal minimum requirements for the availability of health coverage for small businesses, and some states had requirements that exceeded the federal minimums.

Federal Requirements for Availability of Coverage for Small Businesses Represent the Minimum for State Requirements

Federal laws require that insurers in the small group market offer small businesses with 2 to 50 employees the option to purchase coverage and that employees in businesses with at least 20 employees be allowed to continue to purchase health coverage for themselves and their dependents under certain circumstances, such as when individuals lose their health coverage due to loss of employment. Specifically, for small businesses, HIPAA requires that insurers make all policies available and issue coverage to any small business that applies (a standard known as guaranteed issue). For small or large businesses, HIPA requires that:

- all health coverage must be renewable upon expiration of the policy term (guaranteed renewal) with limited exceptions, such as if an employee does not pay required premiums or an insurer leaves a geographic area;
- the maximum length of time that coverage can be excluded for preexisting conditions is 12 months from enrollment for most individuals and 18

[23]This information is based on NAIC model number 115. NAIC model number 118 also addresses premium setting for small employer health insurance using an adjusted community rating approach and, according to an NAIC official, has been adopted by some states.

months for individuals who enrolled late,[24] and 6 months is the maximum time an insurer or other group health plan can "look back" to determine whether a condition was preexisting; and

- a health plan must credit an individual's period of prior group coverage against the plan's preexisting condition exclusion period (group-to-group portability).[25]

COBRA generally requires that employers with 20 or more employees allow individuals who lose their health coverage for specified reasons, such as changes in employment, to continue their coverage.[26] The individual is responsible for paying up to 102 percent of the group premium for COBRA continuation coverage, which can generally last for up to 18 months.[27]

[24]For a new enrollee, the enrollment date is the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period. An individual is considered to be a late enrollee if he or she enrolls in a group plan at a time other than when he or she is first eligible or during a special enrollment period.

[25]In order for a period of prior coverage to be considered creditable coverage, there must have been no significant break in coverage. In general, breaks of more than 63 days are considered significant. Individuals with creditable prior coverage would not need to meet a new employer plan's exclusion period or would have the period shortened. For example, an individual who was covered for 6 months who changes employers may be eligible to have the subsequent employer plan's 12-month exclusion period for preexisting conditions reduced by 6 months. Time spent in a health plan's waiting period may not count as part of a break in coverage.

[26]Employees or their covered spouses are not eligible for continuation of coverage under COBRA if they were terminated for "gross misconduct."

[27]COBRA continuation coverage can be extended an additional 11 months for most individuals who qualify for disability under the Social Security Act; however, they may be charged up to 150 percent of the group cost. Also, under certain circumstances unrelated to job loss, such as the case of a covered employee's death, spouses and dependent children are able to continue group coverage under COBRA for up to 36 months.

Some States Exceeded Federal Minimum Requirements for Availability of Health Coverage for Small Businesses

All but one state—Missouri—met or exceeded the federal minimum requirements for the availability of health coverage through small businesses. States had responsibility for enforcing these regulations, while CMS had responsibility for enforcing the federal requirements for insurers in states that did not establish conforming requirements.[28] CMS determined that all but one state—Missouri—had enacted requirements that conform with HIPAA's requirements.[29]

Some states had requirements for the availability of insurance that exceeded the federal minimums. In these instances, insurers were required to meet the more stringent state requirements. For example, according to NAIC, as of 2002, 14 states required insurers to have a shorter period of time to exclude coverage for preexisting conditions for newly enrolled individuals than the federal maximum of 12 months. Specifically, 10 states limited exclusionary periods to between 3 and 9 months, and 4 states prohibited exclusions for preexisting conditions entirely.

Some states had requirements that exceeded federal COBRA continuation requirements. The majority of states (39) extended the federal COBRA requirements to individuals covered by businesses that had fewer than 20 employees. For example, in a previous study examining state programs to provide health insurance for unemployed individuals, we found that each of the six states we reviewed had health insurance continuation of coverage laws for employers that had fewer than 20 employees and thus were not subject to federal COBRA requirements.[30] The states varied in the eligibility requirements and the maximum length of continuation coverage provided. New Jersey provided up to 12 months of continuation coverage and required that the individual have coverage on his or her last day of employment prior to losing group coverage. Colorado, North Carolina, Ohio, Oregon, and Utah provided from 6 to 18 months of continuation coverage and required that eligible individuals had to have been insured

[28]DOL is also responsible for ensuring that private employers that offer group health coverage comply with HIPAA's portability and nondiscrimination requirements.

[29]For example, Missouri's requirements for availability of health insurance defined a small employer as having 3 to 25 employees, necessitating CMS to enforce the HIPAA requirements for insurance sold to Missouri employers with 2 or 26 to 50 employees. See U.S. General Accounting Office, *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve,* GAO-01-652R (Washington, D.C.: May 7, 2001).

[30]U.S. General Accounting Office, *Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals*, GAO-03-193 (Washington, D.C.: Oct. 25, 2002).

for 3 to 6 months prior to losing group coverage.[31] (App. IV provides more detail on states that exceed the federal requirements regarding preexisting condition exclusions and that have continuation of coverage requirements for small businesses with fewer than 20 employees that are not covered by COBRA requirements.)

Patient Protection Requirements Regarding Appeals of Denied Claims and Access to Certain Health Care Services

Federal law requires employer-sponsored health coverage for businesses of any size to have an internal review process for individuals who appeal a denied benefit claim. Most states had established requirements for independent external review processes for health insurers, although these review processes varied substantially among states in their specifics. In addition, most states had patient protections that allowed patients direct access (without prior approval) to certain health care providers and services, such as emergency services and obstetricians/gynecologists.

Federal Requirements Establish Internal Review Procedures for Appeals of Denied Claims

Federal requirements include provisions for internal claims review in settling appeals regarding denied claims. Under ERISA, health insurers or employers' self-funded plans must maintain procedures for an internal review process for considering individuals' appeals of any denied claims. DOL's regulatory requirement generally allows the plan administrator flexibility in designing its process.[32] However, under the regulation, plan administrators generally must specify reasons for claims denial within 90 days after a claim has been filed. In the case of a claim involving urgent care, the plan administrator must notify an individual of the plan's decision no later than 72 hours after the plan administrator receives the claim, unless the individual has not provided sufficient information to make a decision.

[31]In addition, California allows individuals 60 years or older and with 5 years of previous employer-sponsored group coverage to maintain continuous coverage until reaching Medicare eligibility at age 65.

[32]29 C.F.R. pt. 2560 (2002).

Most States Established External Review Procedures for Appeals of Denied Insurance Claims and Provided Other Patient Protections

Most states had a requirement that some or all insurers establish a process for independent external review of appeals of denied claims, but the states' programs varied substantially in the kinds of denials eligible for external review, individuals' accessibility to the program, independence of the reviewer, and the time allowed for completion of external review. Based on information from a May 2002 report prepared by the Institute for Health Care Research and Policy at Georgetown University, 43 states had laws related to external grievance reviews.[33] Most states limited the types of denials, such as those based on medical necessity, that are eligible for external review. Nearly all states required individuals to first exhaust their federally required internal appeals process before seeking the state-established external review. Further, in 27 states, an individual had less than 180 days in which to request an external review following the insurer's final adverse determination. Requirements for the independence of the external review also varied—some states selected the external review entity themselves, others allowed the insurer or individual to select the reviewer. Twelve states also specified a maximum time of 30 or fewer business days for completion of the external review. Other states allowed 90 days or more. Tables 7 and 8 in appendix V compare states' requirements for external review programs.

States also had other patient protection requirements, which came about in response to concerns about access to health care services, particularly regarding managed care, but that apply to other health insurance products as well. These included requirements for open communication between providers and patients as well as access to certain providers and services. For example, according to BCBSA, in 2002:[34]

- Forty-seven states prohibited "gag clauses" (restrictions on certain communications) in insurers' contracts with health care providers. These laws enable physicians to speak openly with their patients about treatment options not covered by the health insurance policy.
- Forty-two states required insurers to cover emergency services, defined on the basis of what a prudent layperson (that is, a nonmedically trained person) would reasonably assume to be an emergency, to prevent a

[33]See Karen Pollitz et al., Georgetown University, Institute for Health Care Research and Policy, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*, prepared for The Henry J. Kaiser Family Foundation (Washington, D.C.: May 2002). Officials we contacted in Illinois, Maine, and Vermont also provided additional information regarding external reviews in their states.

[34]BCBSA did not include information on the District of Columbia.

patient from being denied coverage when the individual believes emergency treatment is necessary.

- Forty-one states required that insurers allow individuals direct access to obstetricians and gynecologists (OB/GYN). Some state requirements allowed women to designate an OB/GYN as their primary care physician, while other states prohibited insurers from requiring prior authorization or referral for coverage of certain obstetric or gynecologic services.

Table 9 in appendix V provides certain patient protection requirements for all states.

Fiduciary and Financial Requirements

Federal requirements establish responsibilities for fiduciaries; specifically, that individuals with discretionary authority over assets related to any employer-sponsored health coverage must act prudently and in the exclusive interest of enrolled individuals. In contrast, states established financial requirements for insurance policies sold in the small or large group market. The state requirements aimed at ensuring the solvency of insurers, including requirements that insurers set aside money for the payment of future expected and unexpected claims and expenses and follow guidelines on investment activities. All states also had requirements whereby certain insurers would have to contribute to a state-administered guaranty fund to pay for outstanding claims if an insurer became insolvent. Also, as part of their oversight activities, states monitored the financial soundness of insurers by conducting financial analyses and periodic on-site financial examinations.

Federal Requirements Limited to Fiduciary Responsibilities, Not Solvency or Other Financial Protections

Federal requirements for employer-sponsored health coverage do not specify solvency or other financial requirements for that coverage. Rather, ERISA requires that fiduciaries—persons who have control or authority over assets related to the health coverage—act prudently and in the exclusive interest of enrolled individuals. These fiduciary responsibilities, however, are limited; unlike private pension plans where in most cases assets are held in a trust, most employers do not prefund their health coverage and instead operate on a pay-as-you-go basis, using assets from general funds and employee contributions. Also, since most coverage offered by small businesses is through an insurance policy, fiduciary responsibilities primarily relate to the payment of premiums. DOL can and does take legal action to enforce fiduciary duties when, for example, fiduciaries fail to forward employee contributions for health premiums to an insurer. In such cases, DOL may obtain voluntary compliance, have the fiduciaries reimburse all losses and pay penalty amounts (when

applicable), or permanently bar them from serving as fiduciaries in the future.

Federal requirements do not include mechanisms such as guaranty funds to ensure that individuals' outstanding claims will be paid if an insurer becomes insolvent or a self-funded plan becomes bankrupt and ceases to exist. When a self-funded plan fails and its sponsor (such as the employer) goes bankrupt, individuals with unpaid health claims must file a proof of claim with the bankruptcy court requesting that, when the assets of the employer are liquidated to pay its creditors, these outstanding claims be considered for payment. However, since bankruptcy courts establish priority arrangements for paying an employer's liabilities, some claims may not be paid.

State Financial Requirements for Insurers in the Small or Large Group Market Include Insolvency Protections, Reporting Rules, and Oversight Activities

State financial requirements for insurers selling in the small or large group market focused on ensuring that the insurers were financially sound and likely to be able to pay claims.[35] According to NAIC officials, all states required insurers to maintain adequate reserves (funds set aside to pay for outstanding claims). These reserve requirements focused on ensuring that insurers can meet pending claims and benefits, based largely on incurred liabilities, prior experience, and projections that assume moderately adverse conditions. According to information from NAIC, 36 states had requirements that insurers selling health insurance in 2003 maintain certain minimum levels of reserves. Most of these 36 states based their requirements on NAIC's model regulation, which specified minimum standards for the estimation of reserves.[36] In general, NAIC's model required that reserves be sufficient to cover three types of liabilities—claims that have been incurred but not paid, premiums that were paid beyond the period for which coverage has been provided, and contractual benefits that are anticipated to exceed the value of premiums. The NAIC model also required that reserves be calculated using specified morbidity,

[35]State financial requirements may be different for different types of insurers. For example, all states had requirements for aspects of HMO operations. According to information from NAIC, in 2003, 31 states' requirements were similar to their Model Health Maintenance Organization Act. Included in this model were financial requirements for the maintenance of reserves for unearned premiums and unpaid claims as well as an initial net worth—that is, a financial cushion similar to capital and surplus for insurers to ensure they can withstand unexpected losses—of $1.5 million dollars.

[36]States with requirements applying only to individual policies were not included in this count.

mortality, and interest rates. Based on filings with NAIC, the median reserve levels kept by insurers selling health insurance nationwide in 2002 was $5.9 million, with levels ranging from $490,000 for the quarter of companies with the lowest to $35.7 million for the quarter of companies with the highest amount of reserves.[37]

State requirements for capital and surplus levels generally called for insurers to maintain a set minimum amount or an amount based on the insurer's level of financial risk. Capital and surplus requirements aim to ensure that insurers have a sufficient financial cushion to withstand unexpected losses that were the result of events more extreme than those that reserve requirements are meant to protected against. In 2002, every state had set minimum capital and surplus requirements—amounts that did not vary according to the size, risk, or experience of the insurer—for life or health insurers. According to NAIC, 29 states had set minimum requirements for life insurers (including those that also sell health insurance) or other types of insurers, while 22 states had minimum capital and surplus requirements specifically for health insurers. In 2002, these set minimum requirements for insurers ranged from $150,000 to $10 million, with states most often requiring minimums of $1 million to $2 million.[38] Among states with specific requirements for health insurance, the median set minimum requirement was $1.3 million, with requirements ranging from $150,000 to $3.6 million. (See app. VI for a summary of states' financial requirements.)

Following several insolvencies among multistate insurers in the late 1980s and early 1990s, states added risk-based capital (RBC) requirements whereby the minimum amount of capital and surplus an insurer must maintain varies according to the level of financial risk of the company. RBC also attempted to provide regulators with an early warning mechanism to identify companies that are weakly capitalized and

[37]GAO analysis of unpublished NAIC data. This analysis included data reported by life insurers that also sold health insurance, health insurers, Blue Cross Blue Shield plans, and HMOs for four types of reserves: unpaid claims, claims adjustment expenses, aggregate policy reserves, and aggregate claims reserves. The analysis excluded property and casualty insurers and companies that offered only limited benefits, such as vision or dental coverage.

[38]Amounts reflect initial requirements for insurers that were publicly traded, for-profit companies; the amount that must be maintained after the initial requirements were met was lower in some states. Also, requirements for mutual insurers (companies that operate for the benefit of the contract holders and their beneficiaries) may be different.

therefore at risk of becoming insolvent in the future. NAIC developed different RBC formulas depending on the line of insurance sold. These RBC formulas include one for insurance sold by life insurers, including health insurance (Life RBC), and one for health insurance sold by Blue Cross Blue Shield companies or HMOs (Health RBC). According to NAIC, all states had Life RBC requirements, while less than half of states (22) had Health RBC requirements in 2003. Thus, all health insurance sold by life and property/casualty insurers was subject to RBC requirements. Whether insurance policies sold by Blue Cross Blue Shield companies and HMOs were subject to RBC requirements, however, depended on where the company was headquartered. Based on filings with NAIC, the median amount of capital and surplus retained by insurers nationwide in 2002 was $15 million, with levels ranging from $4.4 million for the quarter of companies with the least to $66.8 million for the quarter of companies with the highest amount of capital and surplus.[39]

Other state requirements to promote solvency included limits on insurers' investment activities. According to NAIC, in 2003, all states had requirements for insurer investments. Twenty-three of these states based their requirements on NAIC models, which included rules for the kinds of investments that insurers were permitted to make or the amount that could be invested in any one entity or type of investment. For example, funds for reserves or capital may be required to be invested in conservative and secure investments such as government bonds and mortgages.

According to NAIC officials, states required that insurers submit quarterly and annual reports and conducted financial analyses and periodical on-site financial exams to verify information on the annual statements. In 2003, states typically had requirements that on-site financial exams of insurers headquartered in the state occur every 3 to 5 years. For multistate insurers, on-site exams were conducted under the supervision of the state in which the insurer was headquartered and representatives from the other states in which the insurer sells could request to participate.

[39]GAO analysis of unpublished NAIC data. This analysis included data reported by life insurers that also sell health insurance, health insurers, Blue Cross Blue Shield plans, and HMOs. The analysis excluded property and casualty insurers and companies that offered only limited benefits, such as vision or dental coverage.

All states had provisions related to the payment of outstanding claims for policyholders whose insurer became insolvent, but few states had similar requirements for HMOs. In cases where a failing insurer's funds were insufficient, each state had provisions to assure payment for certain incurred claims up to a specified amount through guaranty funds. Solvent insurers were required to contribute to these guaranty funds, usually on an as-needed basis and according to prescribed limits. According to NAIC, the maximum amount an insurer could be assessed for a guaranty fund varied among the states from 1 percent to 4 percent of the premiums charged in the state in 2003, with the majority of states (49) setting the limit at no more than 2 percent. Also, some states allowed insurers to recover the amount they had been assessed for a guaranty fund through reductions in their state premium taxes. According to information from NAIC, most states did not extend their health insurance guaranty fund requirements to HMOs[40] and 6 states had requirements allowing for the establishment of a fund specifically for HMOs in 2003.

Comments from External Reviewers

We provided a draft of this report to DOL, NAIC, and 12 states whose benefit or premium requirements for the small group market were discussed in the report. DOL and 10 states provided technical comments that we incorporated as appropriate; 2 states did not provide comments.

In written comments, NAIC highlighted several of the report's findings. Specifically, NAIC agreed with our finding that the costs associated with benefit and provider mandates over what businesses would normally incur are estimated to be relatively small. NAIC also commented that mandates provide important protections for consumers and help prevent insurers from limiting their risk by denying coverage for certain benefits or limiting access to certain providers. NAIC further noted that such mandates have been carefully considered and adopted by state legislators. NAIC also emphasized that federal law does not include solvency requirements or financial protections for consumers in self-funded health plans and that, in its view, these responsibilities are best left to the states. Finally, NAIC highlighted the states' long-standing role in providing consumer protections for health insurance, such as small group market reforms for premium rates and eligibility practices, internal and external review requirements, marketing standards, and fraud prevention. As we noted in the report, states have primary responsibility for regulating health

[40]In 15 states, Blue Cross Blue Shield plans were not included in the guaranty fund.

insurance, but substantial variation exists across states in the extent to which they impose certain requirements. NAIC also provided technical comments that we incorporated as appropriate.

As agreed with your office, unless you publicly announce this report's contents earlier, we will not distribute it until 30 days after its date. At that time, we will send copies to the Secretary of Labor, interested congressional committees, and other parties. We will also make copies available to others on request. Copies of this report will also be available at no charge on GAO's Web site at http://www.gao.gov.

Please call me at (202) 512-7118 or John E. Dicken at (202) 512-7043 if you have any questions. Major contributors to this report include JoAnne Bailey, Romy Gelb, and Pamela Roberto.

Sincerely yours,

Kathryn G. Allen
Director, Health Care—Medicaid
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Appendix I: State-Mandated Benefits for the Small Group Health Insurance Market in Eight States

To obtain more detailed information on benefit and provider mandates applicable to the small group market, we conducted a review of eight states—Alabama, Colorado, Georgia, Idaho, Illinois, Maryland, Nevada, and Vermont. We selected these states because they represented a range in the number of mandates.

Table 3 identifies certain health care benefits and provider mandates for the small group health insurance market and whether they were mandated in each of the eight states for 2003. Of these states, Maryland had the largest number of mandates (32) applying to the small group market, which included five types of benefits, such as bone density screenings and hearing aids for minors, not offered by the other states we reviewed. Idaho had the fewest mandates (5), with four of the five found in other states we reviewed.

Table 3: Health Care Benefit and Provider Mandates Applicable to the Small Group Market in Eight States, 2003

	Maryland	Georgia	Illinois	Colorado	Nevada	Vermont	Alabama	Idaho
Benefits								
Alcoholism treatment	✓		✓		✓	✓		
Asthma treatment		✓[a]						
Autism treatment		✓[a]		✓[a]				
Blood products	✓		✓					
Bone density screening	✓							
Breast implant removal			✓					
Cervical cancer screening	✓	✓	✓		✓			
Chemotherapy or related treatments						✓		
Chlamydia screening	✓	✓						
Cleft palate/congenital abnormality treatment	✓	✓	✓	✓				✓
Clinical trials	✓	✓				✓		
Colorectal screening	✓	✓	✓		✓[a]			
Complications of pregnancy	✓	✓[a]	✓	✓	✓			✓[a]
Contraceptives	✓	✓[a]			✓[a]	✓[a]		
Craniofacial disorders treatment						✓		
Dental anesthesia	✓	✓	✓	✓				
Diabetic supplies/education	✓	✓	✓	✓	✓	✓		
Drug abuse treatment	✓				✓	✓		
Family planning	✓							
Formula for metabolic disorders	✓			✓[a]	✓	✓		
Hearing aids for minors	✓							
Home health care	✓				✓			
Hormone replacement therapy					✓[a]			
Hospice care	✓				✓			
Infertility treatment	✓	✓	✓					
Mammography screening	✓	✓	✓	✓	✓	✓	✓	✓[a]
Maternity care	✓	✓[b]	✓[b]	✓		✓		✓
Mental health services	✓		✓[b]	✓	✓	✓		
Mental health parity	✓	✓		✓		✓		
Minimum mastectomy stay	✓	✓	✓					
Off-label drug use		✓	✓[a]		✓[a]		✓	
Organ transplants	✓		✓					
Orthotics/prosthetics	✓[c]			✓				
Ovarian cancer screening		✓						

	Maryland	Georgia	Illinois	Colorado	Nevada	Vermont	Alabama	Idaho
Prenatal HIV testing			✓					
Prostate cancer screening	✓	✓	✓	✓				
Rehabilitation services	✓		✓[b]					
Residential crisis services	✓							
Second opinion	✓							
Temporomandibular joint disorders treatment	✓	✓			✓	✓		
Well-child care	✓	✓	✓[b]	✓		✓		
Providers								
Acupuncturist					✓			
Athletic trainer		✓						
Chiropractor		✓		✓	✓	✓	✓	
Dentist			✓	✓			✓	
Marriage therapist				✓	✓			
Nurse				✓	✓			
Nurse, registered first assistant[d]		✓						
Nurse midwife		✓						
Optometrist		✓	✓	✓			✓	
Osteopath				✓				
Physician/surgical assistant							✓	
Podiatrist			✓	✓			✓	
Professional counselor			✓	✓				
Psychologist		✓	✓	✓	✓		✓	
Public and other facilities[e]								✓
Social worker			✓	✓	✓			
Total state mandates (benefits and providers)	**32**[f]	**27**	**26**	**23**	**21**	**15**	**8**	**5**

Source: GAO interviews with state officials, July 2003.

Note: Provider mandates only apply if the policy covers the services that the provider is qualified to provide.

[a]These mandates set minimum requirements that apply only if policy covers a specified benefit.

[b]Applies only to HMO plans.

[c]Excludes coverage of orthotics.

[d]The registered nurse first assistant is responsible for providing technical assistance under the direct supervision and direction of an operating surgeon.

[e]Requires coverage for care provided in state institutions or by the department of health and welfare.

[f]Maryland small group regulations do not list mandated providers by specialty, but require that the insurer cover benefits covered under the contract if (1) the services are provided by a health care provider licensed under the Health Occupations Article and (2) the provider is acting within the scope of his or her license.

Table 4 illustrates the variation among the eight states in terms of the scope of the requirements for four categories of mandates (well-child care, mental health coverage, mental health parity, and organ transplants) for the small group market. The mental health coverage category included states that required insurers to provide some level of mental health care benefits. A state was considered to have a mental health parity mandate if its requirements for equivalence of benefits between mental health care and physical health care applied to the small group market. (The federal Mental Health Parity Act exempts business with 50 or fewer employees.) Mandates for organ transplants required coverage of specific organs or specified guidelines under which transplantation could be denied, and well-child care pertained to the preventative services insurers were required to cover for minor children. Although several states mandated coverage for the same benefit, their requirements varied substantially in the range of treatment or services covered and the minimum level of benefits required. For example, Colorado mandated coverage of well-child care services through age 13, while Georgia restricted coverage to children under the age of 5.

Table 4: Variation in Scope of Selected Mandates for Small Group Market in Selected States

State	Key Features
Well-child care (5 of 8 states reviewed)	
Well-child care mandates varied in the states we reviewed as to the scope of services required as well as to the age of children covered under the mandate.	
Colorado	• Immunizations and preventive services through age 13 • Exempt from deductibles/dollar limits
Georgia	• Physical/emotional exam through age 5 • Insurer may not require deductible
Illinois	• Appropriate preventive services/immunizations • Only applies to HMOs
Maryland	• Preventive services recommended by U.S. Preventive Services Task Force • Includes audiology screening for newborns limited to one screen and one confirming screen • Insurer may not require deductible for well-child care visits for children under age 2 and immunization visits for children under age 13
Vermont	• 31 days of newborn coverage without additional premiums • May not reduce coverage for pediatric vaccines below May 1, 1993, levels
Mental health coverage (4 of 8 states reviewed)	
Mental health mandates varied in the diagnoses for which coverage was required; the types of services (inpatient, outpatient, and residential) that were covered; and the number of inpatient and outpatient visits.	
Colorado	• Autism excluded from definition of mental illness • Minimum annual coverage: 45 days inpatient • Coverage for outpatient services required
Illinois	• Minimum annual coverage: 10 inpatient days, 20 outpatient visits • Only applies to HMOs
Maryland	• Minimum annual coverage: 60 inpatient days • For outpatient care, 70% coverage • Coverage of residential crisis services required
Nevada	• Mental illness defined as 6 biologically based conditions[a] • Minimum annual coverage: 40 inpatient days, 40 outpatient visits • Does not apply to groups whose premiums rise more than 2% as a result of mandate
Vermont	• Coverage of conditions or disorders involving mental illness or alcohol or substance abuse listed in the mental disorders section of the ICD[b]

Appendix II: Estimated Costs of State-Mandated Benefits

State	Key Features
Mental health parity (4 of 8 states reviewed applying parity to the small group market)	
State parity laws varied in the diagnoses for which parity was required as well as whether parity extended to the number of services (days or visits) and/or the cost-sharing amounts.	
Georgia[c]	• Coverage to same extent as physical illness for ICD/DSM[d] conditions • May impose mental health cost-sharing that does not apply to other benefits but deductible may not exceed deductible for medical/surgical benefits
Colorado	• Biologically-based mental illness may not be less extensive or have more restrictive prior authorization requirements than physical illness • Deductible same as for physical health benefits; copayment may not exceed 50%
Maryland	• No separate lifetime maximums, out-of-pocket limits, or separate deductible/copayment amounts for mental health benefits
Vermont	• No rate/term/condition that places greater financial burden on insured than treatment of physical conditions • Out-of-pocket limits/deductible must be comprehensive for both mental and physical conditions • Number of covered visits may not differ for mental and physical conditions
Organ transplants (2 of 8 states reviewed)	
Organ transplant mandates varied in the states we reviewed as to the types of procedures for which the mandates applied.	
Illinois	• Organ transplants must be covered with the exception of experimental and investigational procedures
Maryland	• Bone-marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants

Source: GAO interviews with state officials, July 2003.

[a]The six biologically based conditions were schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, and obsessive-compulsive disorder.

[b]The International Classification of Diseases.

[c]Georgia requires insurers to offer coverage for treatment of mental disorders.

[d]Diagnostic and Statistical Manual of Mental Disorders.

Estimates vary widely regarding the costs of state-mandated health benefits, depending in part on the assumptions made to develop the estimates. Adding mandates to employer-based health coverage raises total costs only to the extent that employers would not have otherwise offered the benefits. However, few studies have examined the additional costs—referred to as marginal costs—of adding mandated benefits to a health insurance policy. Several studies have estimated the total costs

associated with mandated benefits even though many businesses may have offered these benefits without the mandate.[1]

Two studies that evaluated the marginal costs of adding mandated benefits—accounting for the extent to which employers otherwise may have included similar benefits—estimated relatively small cost increases. In 2000, the Congressional Budget Office (CBO) developed an estimate based on an earlier study that examined the frequency with which health insurance policies covered five benefits even though the state in which the policy operated did not require such coverage.[2] Because many policies would have covered some of the benefits even in the absence of a legal mandate, CBO concluded that the effective marginal cost of these state mandates was in the range of 0.28 to 1.15 percent. CBO estimated that benefit mandates in general might increase premiums by about 5 percent.

Maryland conducts an annual evaluation of the costs for each of its mandates.[3] In addition to estimating the total costs associated with the mandates, Maryland estimates a marginal cost, defined as the difference between the total cost of the benefit and the cost of the services that would be covered in the absence of the mandate. In 2001, the marginal cost of mandates in Maryland's small group market represented 3.4 percent of premiums, whereas the total cost accounted for 14.1 percent. In determining the marginal cost, Maryland considered the likelihood of coverage for certain benefits in the absence of state

[1]However, the benefits mandated may still increase costs if the benefits already being offered by the employer are less comprehensive than the minimums required by the mandate.

[2]The five benefits CBO included in its study—alcoholism treatment, drug abuse treatment, mental illness treatment, chiropractic services, and mandated continuation of health insurance for terminated employees and their dependents—were those identified by Jonathan Gruber in *State Mandated Benefits and Employer Provided Health Insurance* (National Bureau of Economic Research Working Paper, Cambridge, Mass: December 1992). See Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," (Washington, D.C.: January 2000).

[3]Mercer Human Resource Consulting, *Mandated Health Insurance Services Evaluation*, a report prepared for the Maryland Health Care Commission (2002).

mandates based on a survey of self-funded employers exempt from benefit mandates.[4]

Some other states, including Texas and Virginia, have assessed the cost of state benefit mandates, but did not measure the marginal costs associated with mandates. In 2000, Texas contracted with the actuarial firm Milliman & Robertson to estimate the cost of 13 specific mandated benefits.[5] Assuming that none of the benefits would be covered by a policy in the absence of a mandate, the 13 benefits accounted for 6.3 percent of the average small group premium.[6]

Virginia requires all insurers, health service plans, and health maintenance organizations to report cost and utilization information for each of the state's mandated benefits and providers. Based on actual claims experience, insurers calculate the share of the overall average premium attributable to each mandate. Without taking into account whether benefits would be covered without a mandate, in 2000 the total costs associated with Virginia's mandates represented 26.87 percent and 29.28 percent of the overall premiums for individual and family group policies, respectively.[7] The study also did not distinguish total costs between the small and large group markets.

[4]Maryland's estimate represents what benefits self-funded businesses voluntarily cover, but because few small businesses self-fund and larger businesses may be more comprehensive in the benefits they voluntarily cover, this does not directly represent what small employers might choose to cover without mandates.

[5]Benefits included chemical dependency, complications of pregnancy, oral contraceptives, congenital defects, HIV/AIDS, mammography, prostate testing, serious mental illness, minimum maternity stay, minimum mastectomy stay, reconstructive surgery for mastectomy, handicapped dependents, and childhood immunizations. See Milliman & Robertson, *Cost Impact Study of Mandated Benefits in Texas*, (2000).

[6]This cost estimate accounts for indirect health care costs, such as follow-up screenings, and offsetting cost savings, such as lower future costs due to earlier detection and treatment of a disease, associated with the mandates.

[7]Commonwealth of Virginia, *Annual Report of the State Corporation Commission on the Financial Impact of Mandated Health Insurance Benefits and Providers*, (Richmond: 2002).

Appendix III: State Premium Requirements

State requirements varied widely in the extent to which they restricted the amount that premiums could vary among different small businesses purchasing the same coverage and the characteristics of the group that could be used to set or vary premiums, both initially and upon renewal. In 2003, 47 states had premium-setting requirements which generally followed one of three types of premium-setting requirements for coverage sold to small businesses—pure community rating, modified community rating, or rating bands—however, the specific restrictions varied widely and states may have adopted aspects of more than one type of requirement.

- Pure community rating allowed insurers to vary premiums among small businesses of the same size for geographic area and family size only, prohibiting variation for health or other demographic characteristics of the group's employees and dependents, such as age or gender.
- Modified community rating prohibited insurers from varying premiums among small businesses based on health but allowed some variation for other factors, such as age and gender.
- Rating bands allowed insurers to vary premiums based on the health of the small group's employees and dependents as well as other factors, such as age, type of industry of the business, or the size of the group, but set some restrictions on the variation.

Also, in 2002, 44 states set requirements for how premiums are adjusted upon renewal.

Table 5 summarizes state premium-setting requirements for initial policies and for policies being renewed.

Table 5: State Premium Requirements

State	Type of premium setting requirement (2003)	Sets limits on premium-setting for renewals (2002)
Alabama	Rating band	
Alaska	Rating band	✓
Arizona	Rating band	✓
Arkansas	Rating band	✓
California	Rating band	✓
Colorado	Modified community rating	✓
Connecticut	Modified community rating	✓
Delaware	Rating band	✓
District of Columbia	None	
Florida	Rating band	✓
Georgia	Rating band	✓
Hawaii	None	
Idaho	Rating band	✓
Illinois	Rating band	✓
Indiana	Rating band	✓
Iowa	Rating band	✓
Kansas	Rating band	✓
Kentucky	Rating band	✓
Louisiana	Rating band	✓
Maine	Modified community rating	✓
Maryland	Modified community rating	✓
Massachusetts	Modified community rating	✓
Michigan	None	
Minnesota	Rating band	✓
Mississippi	Rating band	✓
Missouri	Rating band	✓
Montana	Rating band	✓
Nebraska	Rating band	✓
Nevada	Rating band	✓
New Hampshire	Modified community rating	✓
New Jersey	Modified community rating	✓
New Mexico	Rating band	✓
New York	Pure community rating	✓
North Carolina	Modified community rating	✓

State	Type of premium setting requirement (2003)	Sets limits on premium-setting for renewals (2002)
North Dakota	Rating band	✓
Ohio	Rating band	✓
Oklahoma	Rating band	✓
Oregon	Modified community rating	✓
Pennsylvania	None	
Rhode Island	Rating band	✓
South Carolina	Rating band	✓
South Dakota	Rating band	✓
Tennessee	Rating band	✓
Texas	Rating band	✓
Utah	Rating band	✓
Vermont	Pure community rating	
Virginia	Rating band	✓
Washington	Modified community rating	
West Virginia	Rating band	✓
Wisconsin	Rating band	✓
Wyoming	Rating band	✓

Source: GAO analysis of data from Blue Cross Blue Shield Association, National Association of Insurance Commissioners, and selected state requirements.

Appendix IV: States Exceeding Federal Availability of Coverage Requirements

Some states have extended federal requirements that increase the availability of health coverage for small employers and for certain employees who lose group coverage. Forty states extended continuation coverage to employer groups with fewer than 20 employees (and therefore not covered by COBRA) for certain employees who lose their health coverage. Similarly, 13 states had more stringent requirements than the federal maximum of 12 months for the amount of time insurers can exclude coverage for preexisting conditions for newly enrolled individuals. See table 6.

Table 6: Selected Availability of Coverage Protections, by State

State	Continuation of coverage to employers with fewer than 20 employees (2003)	Exclusion of coverage for preexisting condition for less than 12 months (2002)
Alabama		
Alaska		
Arizona		
Arkansas	✓	
California	✓	✓
Colorado	✓	✓
Connecticut	✓	✓
Delaware		
District of Columbia	✓	
Florida	✓	
Georgia	✓	
Hawaii		✓
Idaho		
Illinois	✓	
Indiana		✓
Iowa	✓	
Kansas	✓	✓
Kentucky	✓	
Louisiana	✓	
Maine	✓	
Maryland	✓	✓
Massachusetts	✓	✓
Michigan		
Minnesota	✓	
Mississippi	✓	

State	Continuation of coverage to employers with fewer than 20 employees (2003)	Exclusion of coverage for preexisting condition for less than 12 months (2002)
Missouri	✓	
Montana	✓	
Nebraska	✓	
Nevada	✓	
New Hampshire	✓	✓
New Jersey	✓	✓
New Mexico	✓	✓
New York	✓	
North Carolina	✓	
North Dakota	✓	
Ohio		
Oklahoma		
Oregon	✓	✓
Pennsylvania		
Rhode Island	✓	✓
South Carolina	✓	
South Dakota	✓	
Tennessee	✓	
Texas	✓	
Utah	✓	
Vermont	✓	
Virginia	✓	
Washington	✓	✓
West Virginia	✓	
Wisconsin	✓	
Wyoming	✓	
Total	**40**	**13**

Sources: Blue Cross Blue Shield Association, January 2003, and National Association of Insurance Commissioners, 2002.

Note: State continuation of coverage information current as of January 2003, except information for the District of Columbia, which was current as of December 2002.

Appendix V: State External Review Programs and Patient Protections for Access to Health Care Providers

Tables 7 and 8 compare state requirements for insurers' external review programs in terms of the kinds of denials eligible for the review, consumer accessibility to the program, independence of the reviewer, and the time allowed for completion of external review. Nine states did not limit the types of denials eligible for external review program while 32 states limited external reviews to denials based on medical necessity determinations or other clinically-based reasons. Forty states required individuals to first exhaust their health policy's internal appeals and grievance process before seeking external review. In 27 states, the individual had 180 days following the insurer's final adverse determination to request an external review.

Table 7: Claims Denials Eligible for Review and Individual Accessibility to State External Review Programs

State	Any type of denial eligible for external review	Only denials based on medical necessity or other clinically-based reasons eligible for external review	Internal plan appeals process must be exhausted prior to start of external review process	Individual must file a request for an external review within 180 days of insurer's adverse determination[a]
Alabama				
Alaska		✓	✓	
Arizona	✓		✓	✓
Arkansas				
California		✓	✓	
Colorado		✓	✓	✓
Connecticut		✓	✓	✓
Delaware		✓	✓	✓
District of Columbia		✓	✓	✓
Florida	✓		✓	
Georgia	✓		✓	
Hawaii	✓		✓	✓
Idaho				
Illinois		✓	✓	
Indiana		✓	✓	✓
Iowa		✓	✓	✓
Kansas		✓	✓	✓
Kentucky	✓		✓	✓
Louisiana		✓	✓	✓
Maine		✓	✓[b]	
Maryland		✓	✓	✓
Massachusetts		✓	✓	✓
Michigan	✓		✓	✓
Minnesota	✓		✓	
Mississippi				
Missouri		✓		
Montana		✓	✓	
Nebraska				
Nevada				
New Hampshire		✓	✓	
New Jersey		✓	✓	✓
New Mexico		✓	✓	✓

State	Any type of denial eligible for external review	Only denials based on medical necessity or other clinically-based reasons eligible for external review	Internal plan appeals process must be exhausted prior to start of external review process	Individual must file a request for an external review within 180 days of insurer's adverse determination[a]
New York		✓	✓	✓
North Carolina				
North Dakota				
Ohio	✓		✓	✓
Oklahoma		✓	✓	✓
Oregon		✓	✓	
Pennsylvania		✓	✓	✓
Rhode Island		✓	✓	✓
South Carolina		✓	✓	✓
South Dakota				
Tennessee		✓	✓	✓
Texas		✓	✓	
Utah		✓	✓	
Vermont		✓	✓	✓[c]
Virginia		✓	✓	✓
Washington	✓		✓	
West Virginia		✓	✓	✓
Wisconsin		✓	✓	✓
Wyoming				
Total	**9**	**32**	**40**	**27**

Source: Karen Pollitz et al., Georgetown University, Institute for Health Care Research and Policy, Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation, prepared for The Henry J. Kaiser Family Foundation (Washington, D.C.: May 2002) and select state officials.

Note: Eight states (Alabama, Idaho, Mississippi, Nebraska, Nevada, North Dakota, South Dakota, and Wyoming) did not have external review requirements.

The categories in the table columns are not exhaustive of all of the specific terms of these external review programs. Therefore, states with external review programs but without checkmarks for specific categories may have other provisions for the types of denials eligible for review or consumer accessibility. For example, Missouri requires an individual to receive an adverse determination letter from an insurer prior to starting the external review process.

The Henry J. Kaiser Family Foundation study did not specify which types of insurers were subject to the external review requirements. Some states may only apply external review requirements to certain types of insurers. For example, Illinois' external review requirements were for HMOs only.

[a]Within the time following insurer's final adverse determination.

[b]Under certain circumstances, the internal appeals process does not have to be exhausted prior to the start of the external review process.

[c]Applies to nonmental health.

Table 8 shows that in 27 states, the state selects the external review entity while, in 7 states, the insurer selects this entity.[1] Twelve states specify a maximum time of 30 or fewer business days for completion of the external review.

Table 8: Independence of Reviewer and Time Limits on Completion of Review Process for State External Review Programs

State	State selects external review entity	Insurer selects internal review entity	External review must be completed within 30 business days or less
Alabama			
Alaska		✓	✓
Arizona	✓		
Arkansas			
California	✓		
Colorado	✓		
Connecticut	✓		
Delaware	✓		
District of Columbia	✓		
Florida	✓		
Georgia	✓		
Hawaii	✓		
Idaho			
Illinois			
Indiana	✓		✓
Iowa			
Kansas	✓		
Kentucky		✓	
Louisiana		✓	
Maine	✓		✓
Maryland	✓		
Massachusetts	✓		
Michigan	✓		✓

[1]Wisconsin allowed individuals to select the review entity, and Rhode Island allowed individuals to select the entity when the individual (rather than the physician) appealed the denial.

State	State selects external review entity	Insurer selects internal review entity	External review must be completed within 30 business days or less
Minnesota	✓		
Mississippi			
Missouri	✓		
Montana			
Nebraska			
Nevada			
New Hampshire	✓		
New Jersey	✓		
New Mexico	✓		
New York	✓		
North Carolina			
North Dakota			
Ohio			✓
Oklahoma			
Oregon	✓		✓
Pennsylvania	✓		
Rhode Island			✓
South Carolina		✓	
South Dakota			
Tennessee		✓	✓[a]
Texas	✓		✓
Utah		✓	✓[b]
Vermont	✓		✓
Virginia	✓		
Washington		✓	✓[c]
West Virginia	✓		
Wisconsin			
Wyoming			
Total	**27**	**7**	**12**

Source: Karen Pollitz et al., Georgetown University, Institute for Health Care Research and Policy, Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation, prepared for The Henry J. Kaiser Family Foundation (Washington, D.C.: May 2002), and select state officials.

Note: Eight states (Alabama, Idaho, Mississippi, Nebraska, Nevada, North Dakota, South Dakota, and Wyoming) did not have external review requirements.

The categories in the table columns are not exhaustive of all of the specific terms of these external review programs. Therefore, states with external review programs but without checkmarks for specific categories may have other provisions for independence or the time allowed for completion. For example, New Jersey specifies a maximum time of 90 days for completion of the external review.

The Henry J. Kaiser Family Foundation study did not specify which types of insurers were subject to the external review requirements. Some states may only apply external review requirements to certain types of insurers. For example, Illinois' external review requirements were for HMOs only.

[a]The time limit is applicable if initiated by Department of Insurance.

[b]For preservice cases (instances where treatment or service has not been sought).

[c]25 calendar days plus 3 business days.

Table 9 summarizes states' requirements for select patient protections for access to certain health care providers. Overall:

- Forty-seven states prohibited "gag" clauses (restrictions on certain communications between physicians and their patients).
- Forty-two states required coverage of emergency room (ER) care services based on what a prudent layperson would assume to be an emergency.
- Forty-one states required direct access (access without a referral) to obstetricians and gynecologists (OB/GYN).

Table 9: Selected Patient Protections, by State, 2003

State	No "gag" clause	ER care covered per prudent layperson	Direct access to OB/GYN
Alabama		✓	✓
Alaska	✓	✓	
Arizona	✓		
Arkansas	✓		✓
California	✓	✓	✓
Colorado	✓	✓	✓
Connecticut	✓	✓	✓
Delaware	✓	✓	✓
Florida	✓		✓
Georgia	✓	✓	✓
Hawaii	✓	✓	
Idaho	✓	✓	✓
Illinois	✓	✓	✓
Indiana	✓	✓	✓
Iowa	✓	✓	
Kansas	✓		

State	No "gag" clause	ER care covered per prudent layperson	Direct access to OB/GYN
Kentucky	✓	✓	✓
Louisiana	✓	✓	✓
Maine	✓	✓	✓
Maryland	✓	✓	✓
Massachusetts	✓	✓	✓
Michigan	✓	[a]	✓
Minnesota	✓	✓	✓
Mississippi			✓
Missouri	✓	✓	✓
Montana	✓	[a]	✓
Nebraska	✓	✓	✓
Nevada	✓	✓	✓
New Hampshire	✓	✓	✓
New Jersey		✓	✓
New Mexico	✓	✓	✓
New York	✓	✓	✓
North Carolina	✓	✓	✓
North Dakota	✓	✓	
Ohio	✓	✓	✓
Oklahoma	✓	✓	
Oregon	✓	✓	✓
Pennsylvania	✓	✓	✓
Rhode Island	✓	✓	✓
South Carolina	✓	✓	✓
South Dakota	✓	✓	
Tennessee	✓	✓	✓
Texas	✓	✓	✓
Utah	✓	✓	✓
Vermont	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
West Virginia	✓	✓	✓
Wisconsin	✓	✓	✓
Wyoming	✓		
Total	**47**	**42**	**41**

Source: Blue Cross Blue Shield Association (BCBSA), January 2003.

Note: BCBSA did not include information on the District of Columbia.

[a]Prior authorization not required for medically necessary emergency services.

Appendix VI: State Financial Requirements

State financial requirements for health insurance sold to small employers focus on the solvency of insurers—that they are financially sound and likely able to pay the claims of policyholders.[1] States had differing requirements for the minimum amounts of capital and surplus that insurers must maintain and all states had guaranty funds to pay incurred claims for certain insolvent insurers. Specifically:

- All states had set minimum capital and surplus amounts—requirements that aimed to ensure that insurers have a sufficient financial cushion to withstand unexpected losses that are the result of more extreme events—however; only 22 states had specific requirements for health insurance.
- Since the early 1990s, all states have added a requirement for risk-based capital (RBC)—an approach that varied the minimum amount of capital and surplus a life insurer, including those that sell health or other lines of insurance, must keep according to its characteristics, which included the size, financial risk, and experience of the insurer. Twenty-two states had RBC requirements specifically for insurers whose primary business is health insurance, such as health maintenance organizations (HMO) or Blue Cross Blue Shield plans (health risk-based capital).
- The median amount of capital and surplus that insurers selling health insurance (including life insurers, health insurers, HMO plans, and Blue Cross Blue Shield plans) maintained and reported to NAIC varied among the states from $2.7 million to $198 million.
- While all states had provisions related to the payment of outstanding claims for policyholders whose insurers became insolvent, few states had similar requirements for HMOs. The maximum amount an insurer could be assessed for a guaranty fund varied among the states from 1 percent to 4 percent of premiums; 49 states limited assessments to no more than 2 percent.

Table 10 summarizes these features of state financial requirements.

[1]State financial requirements may be different for different types of insurers. For example, all states had requirements for aspects of HMO operations. According to information from NAIC, 31 states had laws in 2003 similar to NAIC's Model Health Maintenance Organization Act, which included requirements for the maintenance of reserves as well as an initial net worth—that is, a financial cushion similar to capital and surplus for insurers—of $1.5 million dollars.

Table 10: State Financial Requirements

State	Initial minimum capital and surplus amount[a]	Health risk-based capital	Median capital and surplus amount reported by insurers[b]	Maximum percent of premium insurers assessed for guaranty fund
Alabama	2,500,000		7,417,714	1
Alaska	2,000,000		[c]	2
Arizona	650,000	✓	7,041,211	2
Arkansas	862,500	✓	12,924,359	2
California	5,200,000		14,997,981	1
Colorado	1,500,000	✓	24,762,714	1
Connecticut	1,000,000	✓	25,118,329	2
Delaware	450,000		2,771,037	2
District of Columbia	1,500,000	✓	15,484,145	2
Florida	2,500,000		10,901,659	1
Georgia	1,500,000	✓	23,220,427	2
Hawaii	900,000		6,165,906	2
Idaho	2,000,000		15,047,046	2
Illinois	2,000,000	✓	6,975,443	2
Indiana	2,000,000		9,910,472	2
Iowa	10,000,000	✓	198,360,000	2
Kansas	1,200,000	✓	16,567,092	2
Kentucky	3,000,000	✓	21,960,695	2
Louisiana	2,000,000		14,809,038	2
Maine	2,000,000	✓	27,162,235	2
Maryland	1,875,000	✓	7,698,500	2
Massachusetts	300,000		17,663,021	2
Michigan	7,000,000		8,520,273	2
Minnesota	1,500,000		40,242,239	2
Mississippi	1,000,000		6,188,361	2
Missouri	1,600,000		12,780,191	2
Montana	600,000		2,838,613	2
Nebraska	2,000,000	✓	33,754,924	2
Nevada	1,500,000		6,473,093	2
New Hampshire	1,500,000	✓	8,678,075	2
New Jersey	3,550,000		7,109,223	2
New Mexico	1,000,000		2,743,572	2
New York	150,000		16,752,364	2
North Carolina	1,500,000	✓	6,627,896	2

State	Initial minimum capital and surplus amount[a]	Health risk-based capital	Median capital and surplus amount reported by insurers[b]	Maximum percent of premium insurers assessed for guaranty fund
North Dakota	1,000,000	✓	6,409,980	2
Ohio	2,500,000		10,597,782	2
Oklahoma	1,500,000		7,702,198	2
Oregon	3,000,000		11,897,051	2
Pennsylvania	1,125,000	✓	20,219,606	2
Rhode Island	3,000,000		50,546,340	3
South Carolina	1,200,000		17,053,445	4
South Dakota	500,000		6,508,404	2
Tennessee	2,000,000		17,490,787	2
Texas	1,400,000	✓	4,219,443	1
Utah	700,000	✓	17,016,615	2
Vermont	5,000,000		116,130,000	2
Virginia	4,000,000	✓	12,408,548	2
Washington	4,000,000	✓	21,657,387	2
West Virginia	2,000,000		23,079,209	2
Wisconsin	3,000,000		22,189,369	2
Wyoming	1,500,000		[c]	2

Source: NAIC's Compendium of State Laws on Insurance Topics, 2002 and 2003; NAIC's Model Laws Regulations and Guidelines, 2003; and unpublished data from NAIC.

[a]Requirements for new stock (publicly traded) insurers in 2002—amount of surplus that must be maintained for other types of insurers or insurers that are not new may be lower in some states. The amounts for the following states include requirements for life or other insurers because amounts for health insurance were not specified: Alabama, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Requirements in the remaining states are specific for insurers selling health insurance.

[b]GAO analysis of NAIC unpublished insurer filings data, 2002. Includes data reported by life insurers that also sell health insurance, health insurers, Blue Cross Blue Shield plans, and HMOs for 4 types of reserves: unpaid claims, claims adjustment expenses, aggregate policy reserves, and aggregate claims reserves. Excludes property and casualty insurers and insurers which sell only limited benefits, such as dental or vision only coverage. The amounts for the following states include requirements for life insurers that report earning premiums from health coverage since minimum capital and surplus data provided earlier in table did not have specific amounts for health insurers: Alabama, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. In the remaining states, data include health insurers only, such as HMOs and Blue Cross Blue Shield plans, that completed NAIC's health form.

[c]Median amount not reported for states that had data from fewer than four insurers.

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