Council for Affordable Health Insurance

STATE HEALTH INSURANCE INDEX 2006:
A 50-State Comparison of the Nation's Health Insurance Market

Contributors:

Merrill Matthews, Ph.D
Director

JP Wieske
Director of State Affairs

Victoria Craig Bunce
Director of Research and Policy

October 2006

127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone 703.836.6200
Fax 703.836.6550
www.cahi.org

Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked health insurance legislation in all 50 states. Once implemented, some of the laws have had a dramatic impact on the individual and small group health insurance markets, sometimes improving the markets and sometimes harming them. And in some cases virtually destroying the market. As state legislators consider future health insurance legislation, they need to understand how state laws affect insurance coverage.

Purpose of the Index. CAHI's 2006 State Health Insurance Index provides a snapshot of the health insurance environment in each state.

- Which states provide a dynamic, competitive market for health insurance, where consumers have a wide range of affordable options?
- And which states undermine their markets so that consumers have few health insurance options, and what is available is very expensive?

Surveys of the uninsured consistently show that the cost of health insurance is the primary reason for their being uninsured. Thus, the most efficient way to reduce the number of uninsured Americans is to ensure that people have access to a wide range of affordable health insurance polices. Some states largely achieve that goal, some don't. This Index identifies those states that are doing the best and worst jobs of ensuring access to affordable coverage. Health insurance may not be cheap in any state, but it can be available and affordable if states implement the right policies.

It is important to note, however, that the Index does not measure whether consumers can choose from different types of benefit plans. For example, consumers in Minnesota and California have access to affordable health coverage. But restrictive rating rules have driven many for-profit carriers from Minnesota, and Californians face a market dominated by HMOs. Consumers have *some* choice, but they could have more.

State Laws Affect Premiums. The general public and the media are largely unaware that state legislatures have a significant impact on the cost of health insurance premiums in the small group (i.e., 2 to 50 employees) and individual (i.e., individuals buy their own policies) health insurance markets. Because regulations vary from state to state, the cost of health insurance premiums can differ widely depending on the state where one lives.

Of course, a number of state legislatures have implemented a type of price control known as "community rating" or "modified community rating," which severely limits the amount insurance companies can charge. The result is that the young and healthy — typically those who earn the least and are most likely to be uninsured — are forced to subsidize the rates of older and generally wealthier individuals. Like any price control mechanism, community rating can drive insurers out of the market, reducing competition and increasing prices.

Some Insurance Is Exempt from State Law. This index only looks at the individual and small group markets. That's because large employers generally self-insure under the Employee Retirement and Income Security Act of 1974 (ERISA), and are governed by federal law outside of state regulation and oversight. Since this is a state health insurance index, it makes no evaluation of ERISA plans pre-empted from state law.

Indices Are Subjective. Like all indices — e.g., the Index of Leading Economic Indicators, the Dow Jones Industrial Average and the Russell 2000 Index — there is an element of subjectivity in choosing the factors that make up this Index. Knowledgeable people can differ on which factors to include, how much weight to give them and whether adjustments need to be made to control for distorting variables. However, the CAHI staff has vetted the measures included in this Index and their weights by numerous actuaries and health policy experts. So while we acknowledge that some may differ with our approach, we believe this Index provides a fair and accurate snapshot of each state's health insurance environment.

Blending the Individual and Small Group Markets. Certain measures blend the individual and small group markets. For example, the Index includes each state's percentage of uninsured. That rate can be a result of laws and regulations affecting both the individual and small group markets. But other factors also affect the number of uninsured, such as the state's average annual income or generosity of Medicaid coverage. Generally speaking, states with lower per capita income have a higher percentage of uninsured.

In addition, while the individual and small group markets tend to mirror each other — it is, after all, the same state legislature regulating both — that isn't always true. In some states the individual markets function better than their small group

markets. For example, Maryland and Colorado have pretty good individual markets, but struggle in the small group. Conversely, Georgia tends to have a functioning small group market, but struggles in the individual market.

The CAHI State Health Insurance Index. CAHI's Index includes six important measures of state health insurance viability that total to 100 points (the best score). It is important to note that we do not measure the effect of the Health Insurance Portability and Accountability Act's (HIPAA) guaranteed issue requirements in the small group market — which are common to every state — but we do measure the way states choose to implement the guaranteed issue requirement in the individual market.

The Index measures are:

1. *The percentage of uninsured.* This is one of two components receiving a smaller weight (10 points maximum for those with the lowest percentage) because so many other factors largely outside of state control have a direct impact on the number of uninsured. In other words, state laws and regulations affect the number of uninsured, but they are not the only factors to do so.

2. *The number of state mandates.* Although CAHI and many others have long asserted that mandates increase the cost of health insurance, determining how much depends on what is being mandated and the specifics of each piece of mandate legislation. So the mandate measure, like the percentage of uninsured, also receives a lower weight (10 points maximum for those with the fewest mandates). (See CAHI's "Health Insurance Mandates in the States" for a full listing of all state mandates.)

3. *State regulatory environment.* CAHI has developed an index that measures the impact of several state regulations. It is a snapshot of the state regulatory environment rather than a comprehensive assessment. State regulations, especially guaranteed issue and community rating, can have a significant impact on the availability and cost of health insurance. Those states with the best regulatory environment receive 20 points. (For a more extensive discussion of the regulatory index, see the Methodology at www.cahi.org.)

4. *High risk pools.* It is very clear that states with well-functioning high risk pools provide a valuable safety net for individuals who have a pre-existing medical condition and have been denied health insurance coverage. However, since each risk pool's structure and funding depend on state enabling legislation, some high risk pools function better than others. For example, Florida has had a risk pool for years but never funded it, so it is of little use. And California caps enrollment time at three years, which limits access to needed coverage. Like the regulatory environment, CAHI has developed a short index (20 points maximum) to assess those risk pools that do the best job. (For a more extensive discussion of the high risk pool index, see the Methodology at www.cahi.org.)

5. *Individual and small group premiums.* Few indicators provide more information about the availability of affordable insurance than the average premiums people actually pay for their coverage. America's Health Insurance Plans (AHIP) has created a survey drawn from actual premiums in the individual market (Note: for those states not included in AHIP's survey, we extrapolated from another survey). And the U.S. Medical Expenditure Survey (MEPS) regularly tracks premiums for the small group market. Those states with the lowest premiums in the individual and small group markets receive a maximum of 20 points for each market segment.

Application of Points. So there are four measures with a maximum of 20 points each and two measures with a maximum of 10 points each — for a total of 100 points.

The four measures receiving a total of 20 points each are broken down into quintiles, with the top states receiving 20 points, the next quintile receiving 15 points, etc., and the bottom getting a 0. The two 10-point categories are broken down into thirds, with the best score being 10 points, then five points and 0.

Accuracy of the Index. Are these six factors the only, or even the best, ingredients for the Index? Fortunately, there is a retrospective way to test the accuracy of the Index. Those states with high scores should have vibrant, competitive health insurance markets, with more and more insurers eager to provide a product in the state. Those with low scores will likely have seen an exodus of insurers from the state, and premiums will be much higher than normal.

And that is exactly what the Index shows.

It would be a mistake, however, for someone to look too closely at a state's specific ranking. It would be very hard, for example, to compare the viability of a state that comes in at, say, 25 (the middle) on the list from one that is 23 or 27.

Rather, the Index should be viewed as a snapshot. Those states receiving 65 points or more generally have well-functioning health insurance markets. There could be improvements, of course, but people have access to affordable coverage and they have a safety-net option if they are uninsurable.

Those states receiving between 45 and 65 points may be functioning, but are in need of improvement. Those states receiving 40 points or less are generally dysfunctional; people there have very few health insurance options and what options they do have are often very expensive. Those states need reform — and they need it now.

Alternative Approaches. In some cases where states have undermined their health insurance markets, people and insurers have found alternative ways to get affordable coverage. For example, Florida's individual market is burdened with regulations and an overzealous insurance department, which has made those policies expensive and reduced competition. As a result, a number of insurers are selling policies in the association group market, where individuals gain access to usually less-regulated and less-expensive policies from licensed insurance companies, due to their membership in an association. In other words, individuals do have access to more-affordable policies in Florida, but primarily through the association group rather than the individual market.

However, people shouldn't be forced to look for alternative avenues to affordable coverage. Ensuring residents have access to those policies should be the goal of every state.

What Can States Do? The good news is it is never too late to reform. Both Kentucky and South Carolina had passed laws that devastated their health insurance markets. They saw the error of their ways, changed the laws and insurers are returning with more options at affordable prices — and more people are getting coverage once again.

Eliminate guaranteed issue. Guaranteed issue laws require insurers to accept all applicants regardless of a pre-existing medical condition. We have a decade of experience and know that guaranteed issue may provide access to health insurance in the short term, but these laws eventually drive the cost of health insurance out of reach for all but the richest Americans.

Establish a high risk pool. Every state that does not have a high risk pool should start one. As evidenced by the high premiums, it is clear that states with community rating and guaranteed issue do not fairly manage health insurance costs. High risk pools spread risk more broadly, and provide a cost-effective way for those with medical conditions to obtain insurance. High risk pools are a better, more equitable and affordable way to provide universal access to health insurance.

Eliminate community rating. States with community rating, which requires insurers to charge everyone the same price regardless of age or medical condition, should eliminate that requirement. In addition, narrow rate bands, which severely limit premium variations, should be relaxed in favor of rate bands that balance affordability with the needs of those with medical conditions. Establishing rate bands that mirror those once supported by the National Association of Insurance Commissioners' small group model rate (that is, +/-25 percent of the standard premium, or wider) will go a long way in ensuring coverage is both accessible and affordable.

Create laws that streamline the regulatory requirements. Health insurers face a complicated patchwork of state regulations, which are difficult to navigate. Some states have further complicated that environment by using subjective standards, or by taking months to review rate and form filings, or by creating impossible standards for certain kinds of products. There are many proposed efforts to deal with this problem, including the Health Care Choice Act, the interstate compact, optional federal charter, the State Modernization and Regulatory Transparency Act, and others. (See CAHI's "State Legislators' Guide to Health Insurance Solutions.")

Stop passing laws that increase the cost of health insurance. Health insurance mandates and minimum coverage levels continue to be popular in a number of states. Legislators need to stop passing these additional costs to their constituents. Short of that, many states have enacted mandate-study commissions that at least provide legislators with an estimate of the cost of the mandate they have proposed.

(Note: Breakdowns of all six categories and explanations of how the points are attributed to each category are available in the Methodology Section of this paper, available at www.cahi.org.)

	REGULATION SCORE	MANDATE SCORE	% UNINSURED SCORE	HIGH-RISK POOL SCORE	INDIVIDUAL MARKET SCORE	SMALL GROUP MARKET SCORE	INDEX TOTAL
AK	20	10	0	20	5	0	55
AL	20	10	5	20	10	15	80
AR	20	5	0	20	0	15	60
AZ	15	10	0	0	10	10	45
CA	15	0	0	10	20	15	60
CO	10	5	5	20	20	0	60
CT	10	0	10	20	0	0	40
DE	10	10	5	0	20	5	50
FL	10	0	0	10	10	0	30
GA	15	5	5	0	0	15	40
HI	10	10	10	0	0	10	40
IA	15	10	10	20	20	20	95
ID	15	10	5	20	20	15	85
IL	20	5	5	15	10	10	65
IN	20	5	5	20	15	10	75
KS	15	5	10	20	20	10	80
KY	20	5	5	15	20	15	80
LA	15	5	0	10	0	10	40
MA	0	5	10	0	0	10	25
MD	15	0	5	20	0	10	50
ME	0	0	10	0	0	0	10
MI	20	10	10	0	20	0	60
MN	20	0	10	20	20	20	90
MO	15	5	10	20	15	15	80
MS	10	10	0	10	5	10	45
MT	15	5	0	20	10	15	65
NC	10	0	5	0	10	5	30
ND	15	5	10	15	10	20	75
NE	20	10	10	15	15	10	80
NH	10	5	10	20	0	5	50
NJ	5	5	5	0	0	0	15
NM	20	0	0	20	20	10	70
NV	15	0	0	0	15	10	40
NY	0	0	5	0	0	0	5
OH	15	10	10	0	15	10	60
OK	15	5	0	15	0	5	40
OR	5	10	0	20	20	10	65
PA	20	5	10	0	20	5	60
RI	10	5	10	0	20	0	45
SC	20	10	5	20	0	10	65
SD	15	10	5	20	0	10	60
TN	15	5	5	5	0	5	35
TX	20	0	0	20	0	5	45
UT	20	10	5	15	20	20	90
VA	15	0	5	0	15	15	50
VT	0	10	10	0	0	5	25
WA	5	0	5	20	0	10	40
WI	20	5	10	20	15	0	70
WV	20	5	0	5	0	10	40
WY	15	5	5	15	5	10	55

With a special thanks to: Mike Abroe, Adam Brackemyre, Bill Dowden, Peter Hendee, Mark Litow, Mike Phillips, Vlasta Prikazsky, Rod Turner and Kyle West.

Other CAHI state health reform publications available at www.cahi.org:

- "2006 State Legislators' Guide to Health Insurance Solutions," by JP Wieske
- "Health Insurance Mandates in the States, 2006," by Victoria Craig Bunce, JP Wieske and Vlasta Prikazsky
- "Trends in State Mandates, 2006," by Victoria Craig Bunce
- "HSA State Implementation Report," by Victoria Craig Bunce

127 S. Peyton Street, Suite 210
Alexandria, VA 22314
www.cahi.org

For additional information please contact the Council for Affordable Health Insurance at 703/836-6200 or by email at publications@cahi.org

Methodology

Regulatory Index Categories

The Regulatory Index includes six factors, for a total of 55 points, that indicate what kind of regulatory environment exists in each state. The Regulatory Index is then divided into quintiles, giving the best states 20 points, for the Health Insurance Index.

It is important to note that CAHI does not favor eliminating all regulations. There are some regulations that ensure consumer protections and a properly functioning market. We outline the proper role and extent of state regulation in our "State Legislator's Guide to Health Insurance Solutions."

Group Rating (10 points maximum)

Does the state require community rating — where everyone is charged the same premium — (or modified community rating), or are carriers allowed to underwrite (i.e., assess what a policy should cost based on several factors, including age, health status, etc.)?

As a result of HIPAA, states have lost control over many factors governing the small group market. One of those factors is "rating," or the amount insurers can charge for their policies. While studies have shown that rate restrictions inevitably lead to increasing costs and therefore an increasing uninsured rate, we have chosen to consider this factor with only the narrowest of parameters

Those with community rating receive 0 points; those with fewer rating restrictions can receive a maximum of 10 points.

Group Size (10 points maximum)

HIPAA standardized the small group market to include between two and 50 employees. States that have moved outside these parameters create adverse selection problems for carriers. Typically, companies with more than 50 employees have the option to self-insure, and those with fewer than two lives (the so-called "groups of one") are eligible for the individual market (which in most states doesn't usually include HIPAA guaranteed issue requirements).

This factor is also given 10 points, because it reflects the damage that can be done to the market when states alter industry-standard definitions.

HIPAA Mechanism (Individual Market) (10 points maximum)

The passage of HIPAA required states to provide guaranteed issue coverage for HIPAA-eligible individuals. But states can choose from a variety of options — from guaranteed issue of all plans to guaranteed issue of certain plans to high risk pools.

High risk pools have proven the most effective method to appropriately spread risk equally among carriers, and provide lower-cost insurance to those with serious health conditions. States using high risk pools were give the full 10 points.

The second most common method under HIPAA is to require guaranteed issue of a limited number of benefit plans. Carriers are usually not limited in the rates they may charge, making this a more expensive option for individuals. It is also problematic for carriers because individuals may choose one carrier over another resulting in an unfair distribution of HIPAA individuals. A few states use a modified method that limits the number of HIPAA-eligible individuals by assigning them to carriers or limiting them to a certain number. They receive five points.

The least favorable option is providing guaranteed issue for all plans, which subjects carriers to serious adverse selection issues and dramatically drives up the cost of insurance. This approach was given 0 points.

Guaranteed Issue (Individual Market) (10 points maximum)

While HIPAA requires guaranteed issue in the small group market, it does not require guaranteed issue in the individual market. Most states have recognized the damage that individual guaranteed issue causes and have chosen other methods — such as high risk pools — to provide insurance for the uninsurable. States without guaranteed issue in their individual markets are given 10 points and those with guaranteed issue are given 0 points.

Rate Bands (Individual Market) (10 points maximum)

Similar to the small group market, community rating is extremely damaging to the individual market. States allowing underwriting are given 10 points, those with community rating or modified community rating are given 0 points.

Elected Commissioner (5 points maximum)

While most commissioners are appointed, some are elected. Unfortunately, elected commissioner's seeking to curry favor with the public sometimes artificially limit rate increases, create inappropriate regulatory standards, and create other problems for their markets. Appointed commissioners are given five points — the smallest in this section of the index.

State	Group Rating	Points	Group Size	Points	Individual HIPAA Mechanism	Points	Individual GI?	Points
AL	yes	10	2 to 50	10	risk pool	10	no	10
AK	yes	10	2 to 50	10	risk pool	10	no	10
AZ	yes	10	2 to 50	10	federal fallback	5	no	10
AR	yes	10	2 to 50	10	risk pool	10	no	10
CA	yes	10	2 to 50	10	2 most popular plans	5	no	10
CO	modified com rate	0	1 to 50	0	high risk pool	10	no	10
CT	modified com rate	0	1 to 50	0	risk pool	10	no	10
DE	modified com rate	0	1 to 50	0	fed fall	5	no	10
FL	yes	10	1 to 50	0	2 most popular plans	5	no	10
GA	yes	10	2 to 50	10	doi assign	5	no	10
HI	yes	10	1 to 50	0	fed fall	5	no	10
ID	yes	10	2 to 50	10	GI std plans	5	yes - specific plans	5
IL	yes	10	2 to 50	10	risk pool	10	no	10
IN	yes	10	2 to 50	10	risk pool	10	no	10
IA	yes	10	2 to 50	10	std plan	5	no	10
KS	yes	10	2 to 50	10	risk pool	10	no	10
KY	yes	10	2 to 50	10	risk pool	10	no	10
LA	yes	10	2 to 50	10	risk pool	10	no	10
ME	modified com rate	0	1 to 50	0	gi	0	yes	0
MD	modified com rate	0	2 to 50	10	risk pool	10	no	10
MA	modified com rate	0	1 to 50	0	GI all plans	0	yes	0
MI	yes	10	2 to 50	10	bc/bs last resort	10	no	10
MN	yes	10	2 to 50	10	risk pool	10	no	10
MS	yes	10	1 to 50	0	risk pool	10	no	10
MO	yes	10	2 to 50	10	fed fall back	5	no	10
MT	yes	10	2 to 50	10	risk pool	10	no	10
NE	yes	10	2 to 50	10	risk pool	10	no	10
NV	yes	10	2 to 50	10	GI std plans	5	no	10
NH	modified com rate	0	1 to 50	0	fed fall back	5	no	10
NJ	modified com rate	0	2 to 50	10	gi plans	0	yes	0
NM	yes	10	2 to 50	10	risk pool	10	no	10
NY	mod com rate	0	1 to 50	0	GI all plans	0	yes	0
NC	yes	10	1 to 50	0	fed fall back	5	no	10
ND	yes	10	2 to 50	10	risk pool	10	no	10
OH	yes	10	2 to 50	10	gi plans capped	5	yes capped	5
OK	yes	10	2 to 50	10	risk pool	10	no	10
OR	modified com rate	0	2 to 50	10	risk pool / gi	0	yes	0
PA	yes	10	2 to 50	10	bc/bs last resort	10	no	10
RI	modified com rate	0	1 to 50	0	fed fall back	5	yes (limited)	5
SC	yes	10	2 to 50	10	risk pool	10	no	10
SD	yes	10	2 to 50	10	guaranteed issue	0	no	10
TN	yes	10	2 to 50	10	fed fall back	5	no	10
TX	yes	10	2 to 50	10	risk pool	10	no	10
UT	yes	10	2 to 50	10	risk pool / gi	10	no	10
VT	modified com rate	0	1 to 50	0	gi	0	yes	0
VA	yes	10	2 to 50	10	fed fall	5	no	10
WA	modified com rate	0	2 to 50	10	gi/ risk pool	0	yes (limited)	5
WV	yes	10	2 to 50	10	risk pool	10	no	10
WI	yes	10	2 to 50	10	risk pool	10	no	10
WY	yes	10	2 to 50	10	fed fall back	5	no	10

State	Individual Rate Bands	Points	Elected Commissioner	Points	Total	Regulations Score
AL	yes	10	no	5	55	20
AK	yes	10	no	5	55	20
AZ	yes	10	no	5	50	15
AR	yes	10	no	5	55	20
CA	yes	10	yes	0	45	15
CO	yes	10	no	5	35	10
CT	Yes	10	no	5	35	10
DE	yes	10	yes	0	25	10
FL	yes	10	yes	0	35	10
GA	yes	10	yes	0	45	15
HI	yes	10	no	5	40	10
ID	yes	10	no	5	45	15
IL	yes	10	no	5	55	20
IN	yes	10	no	5	55	20
IA	yes	10	no	5	50	15
KS	yes	10	yes	0	50	15
KY	yes	10	no	5	55	20
LA	yes	10	yes	0	50	15
ME	Modified com rate	0	no	5	5	0
MD	yes	10	no	5	45	15
MA	Modified com rate	0	no	5	5	0
MI	yes	10	no	5	55	20
MN	yes	10	no	5	55	20
MS	yes	10	yes	0	40	10
MO	yes	10	no	5	50	15
MT	yes	10	yes	0	50	15
NE	yes	10	no	5	55	20
NV	yes	10	no	5	50	15
NH	yes	10	no	5	30	10
NJ	Modified com rate	0	no	5	15	5
NM	yes	10	no	5	55	20
NY	Modified com rate	0	no	5	5	0
NC	yes	10	yes	0	35	10
ND	yes	10	yes	0	50	15
OH	yes	10	no	5	45	15
OK	yes	10	yes	0	50	15
OR	Modified com rate	0	no	5	15	5
PA	yes	10	no	5	55	20
RI	yes	10	no	5	25	10
SC	yes	10	no	5	55	20
SD	yes	10	no	5	45	15
TN	yes	10	no	5	50	15
TX	yes	10	no	5	55	20
UT	yes	10	no	5	55	20
VT	Modified com rate	0	no	5	5	0
VA	yes	10	no	5	50	15
WA	Modified com rate	0	yes	0	15	5
WV	yes	10	no	5	55	20
WI	yes	10	no	5	55	20
WY	yes	10	no	5	50	15

State Mandates

CAHI tracks all state mandates and publishes a list of them annually (See CAHI's "Health Insurance Mandates in the States" for a full listing of all state mandates.) Currently, we have identified 1,843 of them. In addition, we provide an actuarial estimate of each mandate category. A more precise estimate of each specific mandate in each state would require a close examination of the legislation for each of the more than 1,800 mandates.

Although CAHI and many others have long asserted that mandates increase the cost of health insurance, determining how much depends on what is being mandated and the specifics of each piece of mandate legislation. So the mandate measure, like the percentage of uninsured, receives a lower weight (10 points maximum for those with the fewest mandates).

We listed each state with its number of mandates. The top third of states with the fewest mandates received 10 points, the next third five points, and the third with the most mandates received 0 points.

State	Mandates	Mandate Score
Alabama	18	10
Alaska	24	10
Arizona	29	10
Arkansas	41	5
California	49	0
Colorado	37	5
Connecticut	50	0
Delaware	24	10
Florida	49	0
Georgia	40	5
Hawaii	22	10
Idaho	13	10
Illinois	37	5
Indiana	34	5
Iowa	23	10
Kansas	37	5
Kentucky	33	5
Louisiana	40	5
Maine	46	0
Maryland	60	0
Massachusetts	40	5
Michigan	25	10
Minnesota	62	0
Mississippi	28	10
Missouri	39	5
Montana	39	5
Nebraska	30	10
Nevada	50	0
New Hampshire	34	5
New Jersey	40	5
New Mexico	45	0
New York	49	0
North Carolina	44	0
North Dakota	33	5
Ohio	25	10
Oklahoma	36	5
Oregon	31	10
Pennsylvania	37	5
Rhode Island	41	5
South Carolina	28	10
South Dakota	28	10
Tennessee	39	5
Texas	51	0
Utah	21	10
Vermont	23	10
Virginia	54	0
Washington	48	0
West Virginia	35	5
Wisconsin	32	5
Wyoming	32	5

The Uninsured

One of the most oft cited numbers in health policy is a state's percentage of uninsured. The number is very important, because it gives us a snapshot of how many people in a state lack coverage — though the number tells us very little about *why* they are uninsured.

We know that lower-income states will have a higher percentage of uninsured, especially for workers who don't have access to employer-provided coverage. But we also know that state policies and regulations can have a significant impact on the uninsured. For example, states that passed guaranteed issue and community rating have significantly higher premiums than other states. Increasing the cost of coverage means that some people — especially younger, healthier and lower-income workers — will often forgo coverage.

In other words, state laws and regulations affect the number of uninsured, but they are not the only factors to do so.

We listed each state's percentage of nonelderly uninsured, as identified by the Kaiser Foundation (www.kff.org, for years 2003-4). The third of states with the lowest percentage of uninsured received 10 points, the middle third received five points, and the third with the highest percentage of uninsured received 0 points.

State	% Uninsured	% Uninsured Score
Alabama	15.7%	5
Alaska	19.5%	0
Arizona	19.6%	0
Arkansas	19.7%	0
California	20.6%	0
Colorado	18.8%	5
Connecticut	12.7%	10
Delaware	14.6%	5
Florida	22.7%	0
Georgia	18.6%	5
Hawaii	11.6%	10
Idaho	18.8%	5
Illinois	16.0%	5
Indiana	15.8%	5
Iowa	12.0%	10
Kansas	12.5%	10
Kentucky	16.3%	5
Louisiana	21.5%	0
Maine	12.0%	10
Maryland	16.1%	5
Massachusetts	12.7%	10
Michigan	12.7%	10
Minnesota	9.8%	10
Mississippi	19.9%	0
Missouri	13.6%	10
Montana	22.2%	0
Nebraska	12.9%	10
Nevada	21.0%	0
New Hampshire	12.4%	10
New Jersey	16.5%	5
New Mexico	24.5%	0
New York	16.7%	5
North Carolina	18.6%	5
North Dakota	12.8%	10
Ohio	13.3%	10
Oklahoma	23.7%	0
Oregon	19.3%	0
Pennsylvania	13.7%	10
Rhode Island	12.3%	10
South Carolina	16.8%	5
South Dakota	14.0%	5
Tennessee	15.6%	5
Texas	27.3%	0
Utah	14.5%	5
Vermont	11.9%	10
Virginia	15.5%	5
Washington	16.0%	5
West Virginia	19.4%	0
Wisconsin	12.1%	10
Wyoming	17.1%	5

Insurance Premiums

As we say in the Index, the actual cost of insurance is one of the best indications of whether people have access to affordable coverage.

We have provided premium levels for both the small group and individual markets. The best source of information for premiums in the small group market comes from the Agency for Healthcare Research and Quality, Center for Financing, Access to Cost Trends, 2003 Medical Expenditure Panel Survey (MEPS) — Insurance Component. However, it is important to point out the weakness in the data. The survey reflects what small businesses pay for health insurance, which is not necessarily a comparison of similar plans. For example, Michigan small businesses pay $1,926 on average for coverage, while California small businesses pay $1,885, but California, like Minnesota, has a far greater presence of HMOs than Michigan. So it is likely the plan design and delivery system in Michigan and California differ substantially.

There are a couple of good sources for premiums in the individual market. eHealthInsurance is an online broker that lists health insurance policies available in the large majority of states. As such, the company has developed a nationwide database of several hundred thousand in-force policies and what people are paying for those policies. eHealthInsurance then publishes the average premiums paid in each state (www.ehealthinsurance.com). The company also publishes other surveys, such as average premiums paid in selected cities.

America's Health Insurance Plans (AHIP) has also published a list of average premiums in each state, based on more than a million in-force policies. (See "Individual Health Insurance: A Comprehensive of Affordability, Access, and Benefits," August 2005, www.ahip.org.)

We had extensive discussions over which source to use. eHealthInsurance publishes updated information more frequently, since it has easier access to the numbers. AHIP has to go to its member companies for its data, which is a longer and more involved process, but also a much larger population. Both surveys had some states missing, in part because of small sample sizes. We decided to use the AHIP survey, and supplement the missing states with extrapolations from the eHealthInsurance numbers. Similar to the MEPS data, the AHIP premiums are based on what individuals actually pay for health insurance and not a comparison of similar plans. Because both AHIP and eHealthInsurance lack enough data for certain states, we extrapolated from eHealthInsurance data to fill in the missing AHIP states.

Finally, Vermont premiums remained a problem since so few carriers offer individual coverage in the state, a reflection of Vermont's regulatory excesses, not the number of people in the state. The Vermont Department of Insurance tracks insurance rates, and we decided to use its data. Since MVP Health, an insurer selling in Vermont, primarily offers limited benefit plans ($250,000 annual cap on benefits), we decided to use the Blue Cross premium numbers. But despite using the lowest premium numbers available, Vermont still scored a 0.

Unlike the other index components, premiums are ranked in quintiles based on their variation from the median. The top score was given to states with premiums that were more than 10 percent below the median, then between 5-10 percent lower than the median, and so on. As a result, minor differences in premiums are deemphasized.

State	Average Annual Premiums for Individual Policies	Score
Alabama	$2,548	10
Alaska	$2,681	5
Arizona	$2,440	10
Arkansas	$3,435	0
California	$1,885	20
Colorado	$2,198	20
Connecticut	$2,963	0
Delaware	$2,224	20
Florida	$2,539	10
Georgia	$2,910	0
Hawaii	$3,168	0
Idaho	$2,207	20
Illinois	$2,591	10
Indiana	$2,330	15
Iowa	$1,965	20
Kansas	$2,260	20
Kentucky	$2,033	20
Louisiana	$2,858	0
Maine	$3,070	0
Maryland	$3,279	0
Massachusetts	$5,257	0
Michigan	$1,926	20
Minnesota	$2,121	20
Mississippi	$2,729	5
Missouri	$2,299	15
Montana	$2,418	10
Nebraska	$2,295	15
Nevada	$2,364	15
New Hampshire	$3,134	0
New Jersey	$6,048	0
New Mexico	$1,982	20
New York	$3,743	0
North Carolina	$2,623	10
North Dakota	$2,420	10
Ohio	$2,304	15
Oklahoma	$3,047	0
Oregon	$2,162	20
Pennsylvania	$1,989	20
Rhode Island	$2,106	20
South Carolina	$3,328	0
South Dakota	$3,133	0
Tennessee	$2,851	0
Texas	$2,836	0
Utah	$2,224	20
Vermont	$3,053	0
Virginia	$2,332	15
Washington	$2,991	0
West Virginia	$3,141	0
Wisconsin	$2,373	15
Wyoming	$2,734	5

State	Average Annual Premiums for Small Group Market	Score
Alabama	$3,257	15
Alaska	$4,286	0
Arizona	$3,390	10
Arkansas	$3,338	15
California	$3,237	15
Colorado	$3,933	0
Connecticut	$3,944	0
Delaware	$3,810	5
Florida	$3,967	0
Georgia	$3,367	15
Hawaii	$3,440	10
Idaho	$3,210	15
Illinois	$3,652	10
Indiana	$3,467	10
Iowa	$3,114	20
Kansas	$3,503	10
Kentucky	$3,260	15
Louisiana	$3,427	10
Maine	$4,093	0
Maryland	$3,703	10
Massachusetts	$3,678	10
Michigan	$3,944	0
Minnesota	$3,125	20
Mississippi	$3,555	10
Missouri	$3,202	15
Montana	$3,297	15
Nebraska	$3,560	10
Nevada	$3,610	10
New Hampshire	$3,831	5
New Jersey	$3,972	0
New Mexico	$3,525	10
New York	$4,103	0
North Carolina	$3,801	5
North Dakota	$2,945	20
Ohio	$3,399	10
Oklahoma	$3,772	5
Oregon	$3,671	10
Pennsylvania	$3,818	5
Rhode Island	$3,946	0
South Carolina	$3,461	10
South Dakota	$3,546	10
Tennessee	$3,857	5
Texas	$3,793	5
Utah	$3,054	20
Vermont	$3,739	5
Virginia	$3,251	15
Washington	$3,453	10
West Virginia	$3,477	10
Wisconsin	$3,941	0
Wyoming	$3,654	10

High Risk Pool Index Categories:

High risk pools have been around for more than 25 years. They are proven safety-net programs designed to serve a small segment of the health insurance market — those individuals who have a pre-existing medical condition or other chronic illness that causes them to be denied access to traditional health insurance coverage. Currently, there are 34 state risk pools in operation across the country. The average length of stay in a pool is two to three years.

How do high risk pools work? Typically, a risk pool is a non-profit, state-created entity that offers comprehensive health benefits to individuals who have been denied coverage due to a health condition. State laws cap the premiums that can be charged to individuals in the risk pool. Because those premiums do not cover the cost of the coverage, all pools rely on outside subsidies, usually from assessments on health insurance carriers operating in the state or funds from general state revenues. However, Congress has also made federal funds available since 2002 to those states with a qualifying high risk pool (though the funds are appropriated yearly and there is no guarantee of future funding).

The High Risk Pool Index

Just as some state insurance regulations and insurance company policies are better than others, some high risk pools function better than others. In an effort to ascertain the "best practices" of high risk pools, we assigned values to the areas of a risk pool's functionality that we deemed important and then submitted our approach to a peer review by actuaries and industry experts, some of whom sit on risk pool boards.

Sources for Data

Our information is compiled from the "Comprehensive Health Insurance for High-Risk Individuals State by State Analysis," 19th Edition, 2005/2006, published by Communicating for Agriculture & the Self-Employed (SelfEmployedCountry.org). There is little or no data for two states, Tennessee and West Virginia, that have recently implemented a risk pool. These two states were given only five points for having a state high risk pool under development but not operational for assessment purposes. We expect that in the future, their scores could increase substantially.

Criteria for the High Risk Pool Index :

The high risk pool index includes five measures, for a total of 55 points, which attempt to evaluate each state's high risk pool. The High Risk Pool Index is then divided into quintiles, giving the best states 20 points, for the Health Insurance Index. The 16 states that have no high risk pool received an automatic zero.

Access (10 points maximum)

How accessible is the risk pool to a consumer in need? Is the pool open to new entrants, or is it closed and only available to existing members? If the risk pool is open, we awarded the pool 10 points. If the risk pool is closed to new applicants (meaning either it is still operational, has caps and/or waiting lists) or is just starting out organizationally, we allotted it five points. As mentioned above, states that do not have a risk pool received 0 points.

Affordability (10 points maximum)

Access to affordable coverage is very important. How affordable are the risk pool premiums for enrollees? Typically, risk pool members pay between 125 percent and 200 percent of the standard health insurance rates available in the marketplace — *far less than what insuring their conditions would actually cost.* We scored high risk pool coverage affordability as follows: States with a premium cap above 200 percent of the standard premium received 0 points; those with premiums below 200 percent received five points. If the state provides a low-income subsidy program for the risk pool, then the state received an additional 5 points.

Benefits (15 points maximum)

We looked at risk pool benefits in each state.

- Risk pools offering standard benefits and at least a $1 million maximum benefit received five points. Those with benefits below $1 million received 0 points.
- If risk pool participation is limited to a set amount of time (e.g., three years), it received 0 points. If there is no limit, it received five points.
- Finally, it is important that even high-risk consumers have the opportunity to benefit from the consumer driven movement. Risk pools offering a Health Savings Account received and additional five points.

Pre-existing Condition Waiting Periods (10 points maximum)

A pre-existing condition is a medical condition or diagnosis that existed (or for which treatment was received) before health insurance coverage began. Most high risk pool applicants have a pre-existing condition, or they wouldn't need to turn to the risk pool for coverage. Risk pools must balance the competing interests of uninsured people who need access to coverage with the need to minimize adverse selection problems (in which people wait until the need coverage to apply).

We believe that high risk pool pre-existing condition waiting periods should be similar to what most states impose on health insurance: a 12-month waiting period and a 6-month "look back" period. States with those parameters received five points. States with longer periods received 0 points.

In addition, if the high risk pool provides "creditable coverage" for entrants and/or for HIPAA eligibles with prior coverage (i.e., they had qualifying insurance coverage for part of that period), it received an additional five points.

Broad-based Funding (10 points maximum)

Even with premiums in the 125 to 200 percent range, premiums do not cover the high risk pool claims. So insurers are assessed for the pool's losses — usually based on their share of the insurance market — to make up the difference. In addition, state governments typically supply some funding from state revenues. And since 2002 the federal government has provided funding for risk pools with qualifying plans.

If we believe it is a social good to provide the uninsurable with access to coverage, then society should be willing to subsidize the program. The broader the high risk pool funding the better. Risk pools with broad funding mechanisms earned five points. If the high risk pool solely relies on subscriber premiums and insurer assessments to fund the pool, it received 0 points. If a state provides a tax credit to insurers to offset losses of the plan, the state received an additional five points.

State	Open	Premiums	Benefits	Pre-Ex	Funding	Total	High-Risk Pool Score
Alabama	10	5	10	5	10	40	20
Alaska	10	5	15	5	5	40	20
Arizona	0	0	0	0	0	0	0
Arkansas	10	5	10	5	10	40	20
California	5	5	0	5	5	20	10
Colorado	10	10	10	5	10	45	20
Connecticut	10	10	10	10	5	45	20
Delaware	0	0	0	0	0	0	0
Florida	5	0	5	10	5	25	10
Georgia	0	0	0	0	0	0	0
Hawaii	0	0	0	0	0	0	0
Idaho	10	5	15	10	10	50	20
Illinois	5	5	10	5	10	35	15
Indiana	10	5	15	5	10	45	20
Iowa	10	5	10	5	10	40	20
Kansas	10	0	15	5	10	40	20
Kentucky	10	0	5	10	5	30	15
Louisiana	5	5	5	5	5	25	10
Maine	0	0	0	0	0	0	0
Maryland	10	5	15	5	5	40	20
Massachusetts	0	0	0	0	0	0	0
Michigan	0	0	0	0	0	0	0
Minnesota	10	5	15	5	10	45	20
Mississippi	10	5	0	5	5	25	10
Missouri	10	5	10	10	5	40	20
Montana	10	5	10	10	5	40	20
Nebraska	10	5	10	5	5	35	15
Nevada	0	0	0	0	0	0	0
New Hampshire	10	5	15	5	5	40	20
New Jersey	0	0	0	0	0	0	0
New Mexico	10	10	15	5	5	45	20
New York	0	0	0	0	0	0	0
North Carolina	0	0	0	0	0	0	0
North Dakota	10	5	10	5	5	35	15
Ohio	0	0	0	0	0	0	0
Oklahoma	10	5	5	10	5	35	15
Oregon	10	10	10	5	5	40	20
Pennsylvania	0	0	0	0	0	0	0
Rhode Island	0	0	0	0	0	0	0
South Carolina	10	5	15	5	5	40	20
South Dakota	10	5	15	5	5	40	20
Tennessee	5	0	0	0	0	5	5
Texas	10	5	10	10	5	40	20
Utah	10	5	5	5	5	30	15
Vermont	0	0	0	0	0	0	0
Virginia	0	0	0	0	0	0	0
Washington	10	10	10	5	5	40	20
West Virginia	5	0	0	0	0	5	5
Wisconsin	10	10	10	5	5	40	20
Wyoming	10	5	5	10	5	35	15