

The Doubt of the Benefit: Why State Benefit Mandates are a Poor Prescription for Health Insurance

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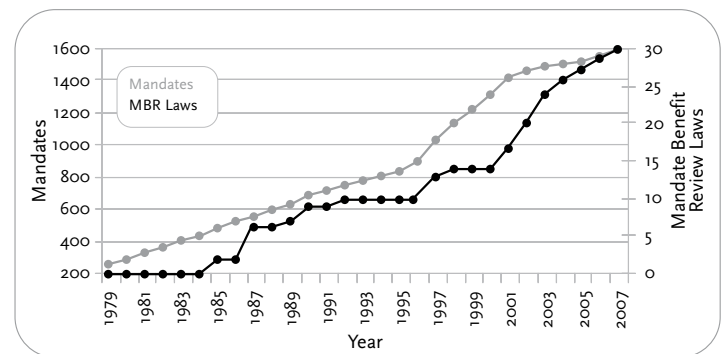
- From heart transplants to hairpieces, state legislatures have conducted a series of poorly understood experiments on their residents without the subjects' consent, by using political power to distort the benefits that health plans offer to beneficiaries.
- Even though most states now have statutory requirements that legislators consider external analyses of the costs as well as the benefits of mandates, legislators are not bound by these analyses and are unlikely even to understand them.
- There was an average of 32 mandates per state in 2007, up from an average of only five per state in 1979, and the pace has recently accelerated.

A benefit mandate is a state law that commands a health plan to pay for, or at least offer, a specified treatment or type of provider, removing the benefit from negotiation between beneficiaries and health plans. For example, a mandate may require a health plan to cover treatment of alcoholism, or chiropractic services.

In 2007, there were 84 separate benefit mandates in force in at least three states. In total, there were 1,594 state laws, averaging out to 32 mandates per state. This marks a significant increase from 1979, when 252 mandate laws were in force—an average of only five per state. The pace has now picked up again. Among the benefit mandates introduced since 2000 are: hearing aids, hormone replacement therapy, and reimbursement for clinical trial participation. In 2007, soon after it was introduced, 13 states mandated coverage for the human papillomavirus vaccine.

Most of these mandates were legislated without formal review of costs and benefits. Not until 1985 did states begin to assess proposed mandates before legislators voted on them. Today 30 states carry out such statutory evaluations.¹ Increased oversight, however, has not slowed the torrent of mandates. In Arizona, Oregon, and Pennsylvania, for example, legislatures have passed even more mandates than before.² There is no interstate standard for evaluations, and states differ greatly. Indiana fails to specify any criteria for the review!³

The chart below shows the growth in state benefit mandates throughout the 50 states and Washington, D.C., from 1979 through 2007. In order to avoid counting idiosyncratic mandates, it includes only those in force in at least three states (or two states plus D.C.) in a given year. The chart also shows the number of states that have laws requiring an assessment of the consequences of mandates before they are passed.



Source: Graham 2008⁴

On balance, econometric research shows that state benefit mandates increase health insurance premiums, causing large firms to incur the extra costs of self-insuring, as well as reducing wages and increasing employees' hours worked, and depriving some workers of health benefits altogether.

Indeed, according to a recently published briefing paper from PRI, each additional benefit mandate explains an increase in the number of uninsured of about 0.25 percent in a state.⁵ This estimate is uncertain, but Americans would expect that such a conclusion would promote restraint in the imposition of new benefit mandates. Regrettably, that is not the case.

Twenty years ago, health economists John C. Goodman and Gerald L. Musgrave observed that "mandated benefits cover everything from life-prolonging procedures to the purely cosmetic. They cover heart transplants in Georgia, liver transplants in Illinois, and hairpieces in Minnesota."⁶ Couples who cannot have children must

pay for maternity care. Under mandates, people who are not alcoholics or drug abusers must pay for those who are. And those who do not value chiropractors, psychologists, or marriage counselors must subsidize those who do.⁷

As recently as 2006, scholars concluded that “there have been relatively few studies examining the effects of managed-care regulations on cost and quality. Laws intended to govern the scope of benefit packages share the nominal intent to improve quality, but the extent to which those laws are capable of doing so and the extent to which they have succeeded (and at what cost) are unclear . . .”⁸

Indeed, the obstacles facing politicians who are trying to get these questions right are daunting. According to a joint report of the U.S. Department of Justice and the Federal Trade Commission: “For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal costs. This task is challenging under the best of circumstances—and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans.”⁹

The most current estimate of the total cost of mandated benefits is provided by the annual report of the Council for Affordable Health Insurance.¹⁰ The CAHI, a trade association for health plans, has access to the claims data of member companies and is able to categorize any mandate’s cost into one of four baskets: less than 1 percent of premiums, 1 to 3 percent, 3 to 5 percent, and 5 to 10 percent.

Maryland deploys the greatest number of benefit mandates and Idaho the fewest. The CAHI’s estimated range of costs implies that Maryland’s 54 mandates account for between 24 and 57 percent of the state’s total health costs, while Idaho’s nine mandates account for between 6 and 20 percent of its costs. In other words, roughly one-quarter to a little more than one-half of Maryland’s total health care costs are represented by state mandates, while Idaho’s mandates represent roughly one-twentieth to one-fifth of the state’s total health care costs.

Of course, many Americans would demand some of these benefits from their health plans even without the state mandate, in which case the mandate is redundant. However, state benefit mandates cause some Americans (usually through their employers) to pay for “benefits” they do not value. Because of the rapid increase in the number of state benefit mandates, estimates of this marginal cost are out of date almost as soon as they are published.

In 2000, the Congressional Budget Office (CBO) recognized a wide range of estimates of the total cost of mandates, between 5 and 22 percent of claims, and a marginal cost for each mandate of between 0.25 and a little over 1 percent of claims. The CBO put forward the reasonable assumption that the marginal cost of all mandates was about 5 percent of claims in 1990 (when the total number of mandates was less than half what it is today). However, the CBO also gave an upward estimate of 10 percent or more toward the decade’s end, when the total number of mandates was four-fifths what it is today.¹¹

The most painful way for Americans to bear the high cost of benefit mandates is to lose health insurance, but even those who have it pay the price. Professor Jonathan Gruber of MIT examined the labor market consequences of states’ mandatory maternity benefits in 1976 and 1977. Pregnancy is not a disease but (hopefully) an intended event. Because of this, health plans that offer maternity benefits are subject to higher than usual moral hazard: beneficiaries will switch to plans with maternity benefits when they decide to have babies. In order to avoid this, health insurers offered no or very limited maternity benefits until states started to mandate coverage, which 23 states did from 1975 through 1979.

Comparing states with mandatory maternity benefits to those without, and women of childbearing age (and their spouses) with other workers in states with maternity mandates, Gruber found that women and their spouses bore *all* the cost of mandatory maternity benefits. Analyzing Current Population Survey data, he concluded that women of childbearing age in the states that imposed the mandate suffered a relative decrease in wages of about 5 percent, versus women in states that did not. The affected workers, in states that introduced mandatory maternity coverage, worked longer hours.¹²

Despite a convincing body of evidence, legislators are working zealously to impose more restrictions on Americans’ ability to choose health insurance policies of their preference. For decades, state governments have recklessly engaged in a series of uncontrolled and poorly designed experiments, subjecting their residents to interventions in their choice of health benefits without informed consent. If a pharmaceutical company or a manufacturer of medical devices conducted similar experiments, it would be thrust in front of a judge and jury.

The unemployed American, struggling to pay health insurance premiums out of pocket, likely bears the greatest cost of state benefit mandates. He cannot pay for benefit mandates by having his wages reduced, working longer hours, or choosing to work for a firm that can switch to self-insurance from state-regulated insurance. He must become uninsured, the victim of overweening and irresponsible legislative zeal.

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Endnotes

- ¹ Victoria Craig Bunce and J. P. Wieske, *Health Insurance Mandates in the States 2008* (Alexandria, VA: Council for Affordable Health Insurance, 2008).
 - ² Gail A. Jensen and Michael A. Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," *The Milbank Quarterly*, Vol. 77, No. 4 (1999), p. 429.
 - ³ Nicole M. Bellows, Helen Ann Halpin, and Sara B. McMnamin, "State-Mandated Benefit Review Laws," *HSR: Health Services Research*, Vol. 41, No. 3, Part II (June 2006), p. 1114.
 - ⁴ John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (San Francisco, CA: Pacific Research Institute, July 2008), p. 6.
 - ⁵ John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (San Francisco, CA: Pacific Research Institute, July 2008).
 - ⁶ John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, NCPA Policy Report No. 134 (Dallas: National Center for Policy Analysis, November 1988), executive summary.
 - ⁷ *Ibid.*, pp. 2, 15, 18.
 - ⁸ Robert L. Ohsfeldt and John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington, D.C.: AEI Press, 2006), p. 86.
 - ⁹ David A. Hyman, Sarah M. Mathias, Patricia Schultheiss, et al., *Improving Health Care: A Dose of Competition* (Washington, D.C.: Federal Trade Commission, and Washington, D.C.: U.S. Department of Justice, July 2004), p. 24.
 - ¹⁰ Bunce and Wieske, *Health Insurance Mandates in the States 2008*.
 - ¹¹ CBO, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts* (Washington, D.C.: Congressional Budget Office, January 2000), pp. 21–22.
 - ¹² Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84, No. 3 (June 1994), pp. 622–641.
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