Approved February 15, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague
Chairperson
at

3:30 xx a.m./p.m. on February 14, 19 90 in room 531-n of the Capitol.

All members were present except:
Representative Delbert Gross, excused

Committee staff present: Chris Courtwright, Research Department
Emalene Correll, Research Department
Bill Wolff, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order at 3:50 p.m.

Representative Bryant made a motion to approve the minutes of February 12, 1990. Representative Turnbaugh seconded. The motion carried.

The Committee began topic briefings presented by the Health Insurance Association of American (HIAA), Washington, D.C.

Stephan Robertson, Assistant General Counsel, HIAA gave an overview of the purpose of the HIAA. Mr. Robertson explained that the HIAA is a trade association of Health Insurance Companies with 340 companies who write approximately 85% of the health insurance in the United States today, which excludes the portion that Blue Cross/Blue Shield writes. Mr. Robertson stated that the purpose of the HIAA is to put forth its position on the various health issues that are faced in this state and everywhere else in the nation at this time. As a trade association they provide statistical and research data supporting HIAAs position, also providing information needed to make decisions that states will be faced with.

Harvey Raymond, HIAA provided testimony Attachment 1) examining the HIAAs proposal for the uninsured, small group market and discussed their reinsurance mechanism concept. Mr. Raymond also stated in summary that quality and cost of care are essential components of health care financing and encouraged the creation of an environment that promotes low-cost insurance and managed care benefits, not subject to state mandates or other restrictions.

Jon Gabel, HIAA provided testimony (Attachment 2) discussing the issue of mandated benefits and suppliance of costs factors and graphics on what other states in this area are doing. Mr. Gabel summarized the position of the HIAA regarding mandates, that they increase the costs of health insurance, increase the probability that small firms will no longer offer health insurance and the they drive large firms to self-insure. Mr. Gabel also provided a copy of an article (Attachment 3) which explained the statistical methods used to derive that mandated benefits legislation impede the flexibility and uniformity of cost-effective health insurance.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N Statehouse, at 3:30 ~~xx~~n./p.m. on February 14, 19~~89~~.

Harvey Raymond, HIAA once more appeared before the Committee to discuss managed care and concerns associated with managed care; whether or not the care is appropriate, the setting in which the care is provided, and the intensity of the care. Mr. Raymond explained that managed care is a mechanism designed to satisfy these concerns by using techniques such as prospective and utilization review, free admission certification, continued state of review, discharge planning and 2nd surgical planning. Manage care operates through HMOs, PPOs, and EPOs seeking to combine these techniques into an integrated finance and delivery system. Mr. Raymond stated that HIAA believes managed care is the product of the future. He concluded that HIAAs position is that payers and providers should cooperatively establish the relationship between cost and quality and thus actively seek opportunities for the health insurance industry to cooperate with providers to develop programs that promote efficient delivery of high quality care.

There were no others wishing to testify and the meeting was adjourned at 5:10 p.m.

GUEST LIST

COMMITTEE: Ins Committee DATE: 2/14

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Tom Gress	Topeka	KS Hosp Assn
Roland Smith	Wichita	WIBA
Stephen W Robertson	Des Plaines, Ill	Health Ins Assn America
Jon Goebel	Washington D.C	HIAA
Harvie Raymond	Washington D.C.	HIAA
Jim Oliver	Topeka	PIA
Dick Block	"	Ins Dept
M Conklin	Olathe	Rep. McClure
Alan Cobb	Wichita	KS Rcsp Care Soc.
Larry Magill	Topeka	HAIL

HIAA

HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL FOR FINANCING HEALTH CARE FOR AMERICANS

SUMMARY

I. The problem is complex because of the heterogeneous nature of the population without health insurance.

A. Thirty percent are below the federal poverty level; 30 percent are near poor, between 100 percent and 200 percent of the poverty level; and 40 percent are above 200 percent of the poverty level.

B. Eleven percent are the self-employed and their families, 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

II. HIAA proposes a four point plan:

A. Reform and expand Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status.

1. Eliminate categorical restrictions.

2. Uncouple eligibility for Medicaid from eligibility for welfare cash payment.

3. Low-income individuals above the poverty level should be able to "buy into" an income-related package of primary and preventive care.

4. "Spend-down" program should be required in all states for the medically needy.

5. For those Medicaid-eligible people who are working, option "buy-out" program should allow state to pay the employee share of employer group insurance to provide transition coverage for those coming off Medicaid.

B. Allow insurers to offer more affordable coverage:

1. Extend ERISA preemption of state mandated benefits given to self-insured plans to insured employee plans.

2. Allow insurers to market lower-cost prototype plans.

C. Help small businesses afford coverage by allowing a 100 percent tax deduction for the self-employed as long as they provide equal coverage for their employees.

D. Guarantee availability of private health insurance:

1. For uninsurable individual, state pools with losses financed by state general revenues or other broad-based funding should be established; if a state does not act, HHS should set up a pool in that state with losses paid with federal funds that HHS would otherwise spend in that state.

2. For uninsurable groups, a private reinsurance mechanism should be established, with losses spread equitable through the private sector.

III. HIAA also believes that quality and cost of care are essential components of any health care financing proposal, and we encourage the creation of an environment that promotes low-cost insurance and managed care benefits, not subject to state mandates or other restrictions.

HIAA

Health Insurance Association of America

PROPOSAL FOR SMALL EMPLOYER MARKET REFORM

The Health Insurance Association of America has developed a fair and equitable proposal to assure that all small employers can avail themselves of relatively affordable health insurance coverage. The HIAA plan would:

1. guarantee that employers with fewer than twenty-five employees who seek to purchase health insurance for their employees will not be denied such health insurance coverage even if one or more employee might otherwise be either uninsurable or a high risk in today's world;

2. provide that once insured, neither the group nor an individual in the group may be denied continued coverage because the group's or the individual's health deteriorates;

3. limit the rate of year-to-year premium increases relative to other groups insured by the same carrier;

4. permit medical underwriting only for the purpose of determining the level of risk, and thus anticipated health claims;

5. not deny coverage or apply new preexisting condition restrictions to an insured individual in a group changing either employers or insurance carriers;

6. establish a privately funded and administered reinsurance mechanism through which insurers could reinsure high risk persons;

7. assure that any group would pay no more than 150 percent of the average cost of similar groups for basic coverage.

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

TO THE

KANSAS HOUSE INSURANCE COMMITTEE

ON

HEALTH INSURANCE AND THE EFFECT OF

HEALTH INSURANCE MANDATES ON INSURERS, BUSINESSES AND EMPLOYERS

Jon R. Gabel

Stephen W. Robertson

February 14, 1990

Attachment 2

HEALTH INSURANCE ASSOCIATION OF AMERICA TESTIMONY ON MANDATED BENEFITS BEFORE THE KANSAS HOUSE INSURANCE COMMITTEE

Good morning Mr. Chairman and members of the Task Force. I am Jon Gabel, Associate Director of Policy Development and Research with the Health Insurance Association of America (HIAA). My colleague is Steven Robertson, Counsel with HIAA's Legal Department. Our purpose today is to share with you results from a recent study conducted by myself and Gail Jensen, Associate Professor of Economics at Wayne State University regarding the effects of mandated benefits on the cost and availability of health insurance.

Few health care issues raise greater passion with greater frequency than mandated benefits -- state legislation that prescribes the content of health insurance purchased from Blue Cross-Blue Shield and commercial insurers. In 1988 alone, state legislatures in 38 states considered 316 bills to mandate that insurers cover the services of specific providers such as chiropractors. State legislators also introduced 320 bills in 34 states mandating that insurers cover specific services, such as mammography. Today, state governments have enacted over 730 mandates, up from 343 in 1978 (Figure 1). Kansas has enacted more mandates than many other states (See Figure 2). State mandated benefits are a predictable strategy for a society whose fondness for public services far exceeds its willingness to pay

for them. One appealing facet of employer mandated benefits is that they seemingly extend the protection of society's safety net without raising taxes. In reality, however, mandated benefits constitute a tax on employer-sponsored health insurance -- pricing out of the market many of the most vulnerable members of the workforce.

The article measured quantitatively the price of health insurance three ways. First, we determine the cost of added benefits. Second, we examine how many fewer small firms forego offering health insurance to their employees as a result of mandates. Third, we assess how many large firms choose to self-insure their health benefits because of mandated benefits. As you know, federal legislation exempts employers who self-insure from mandates and other state regulation of their health plans.

We have attached a copy of the article which will explain in more detail the statistical methods used to derive our findings. For our purposes this morning, I will summarize key findings.

Increased Cost of Coverage

Mandates increase the price of health insurance. They are not, as proponents have argued, merely offsets that substitute efficient care for costly care. Figure 3 shows the average premium increase (or decrease) for family coverage resulting from the inclusion of specific benefits by a firm. The percentage figures indicate the average change in premiums for family coverage (measured in

constant 1983 dollars) that resulted from adding each specific benefit.

Many of the commonly mandated benefits significantly increased the price of family coverage. Chemical dependency treatment coverage increased premiums by 8.8 percent. The addition of coverage for psychiatric hospital stays increased premiums by 12.8 percent. Adding benefits for psychologists visits increased premiums by 11.8 percent. Coverage for routine dental services increased costs by 15 percent.

One striking finding is that self-insurance raised premiums by 12.3 percent, other factors held constant. However, since self-insured plans can avoid offering mandated coverages such as chemical dependency and psychologists' visits, firms can easily offset the higher administrative costs by avoiding one or two mandated coverages. Thus, mandates encourage employers to convert to more administratively inefficient self-insurance to circumvent mandates passed by state legislatures.

Effects on Small Group

About 300,000 residents of Kansas, one of every seven residents of the state, lack any health insurance coverage. Nationally, of the 37 million Americans without health insurance protection, nearly three-fourths are from families in the work force. The media has recently highlighted the economic hardships faced by the small business community in attempting to provide insurance coverage in an atmosphere of escalating costs. The October 1

edition of the New York Times noted that "millions (sic) of small American businesses that provide health coverage for their employees have been staggered in recent months by insurance rate increases of 20 percent to more than 100 percent." Noting that these increases may force a percentage of small employers to drop their coverage if they cannot find a less expensive policy, representatives of the business community stated that, "sharp rises in health insurance costs could chill growth in the sector of the economy that has provided many new jobs in recent years. The 3.8 million businesses with fewer than 500 employees account for 53 percent of the American workforce, and they have created nearly two of three new jobs in the past six years, according to the Small Business Administration.

By raising the price of coverage, mandates discourage many small firms from offering health insurance to their employees, thereby increasing the number of uninsured individuals in Kansas (Figure 4). Each new mandate enacted between 1982 and 1985 lowered the likelihood that a small firm would offer coverage by 1.5 percent.

To determine the collective effect of mandated benefits, we asked the question, "How many more firms would offer health insurance to their employees if there were no mandates for alcohol and drug abuse treatments, mental illness, psychotherapy, insurance risk pool taxes, continuation-of-coverage requirements and if no other new requirements had been enacted since 1982?" Using our

statistical model, we simulated the resulting picture of coverage

We found that approximately 16 percent of the firms not offering health insurance would have under these conditions. Which firms would likely have offered health benefits in a world essentially free of mandates? The largest gains would have occurred for firms most able to afford health insurance -- firms already providing life but not health insurance.

Effects on Large Group

Mandates encourage large firms to self-insure. (Figure 5 shows that most large firms in the United States avoid state regulation of health insurance by self-insuring.) Most mandated benefits increased the likelihood that a firm self-insured (Figure 6). For, example, states which mandated coverage of psychologists services were 93 percent more likely to self-insure than firms in states without mandates, other factors held constant. Firms in states mandating alcoholism and drug abuse treatment were also more likely to convert to self-insurance (although the effects were not statistically significant).

To determine the collective effects of mandated benefits, we asked the question, "How many fewer firms would have chosen to change to self-insurance, assuming there were no new mandates imposed between 1981 and 1984, no mandates for mental health coverage, drug treatment, alcoholism treatment, psychologists services, no risk pool or premium taxes, or continuation-of-

coverage mandates?" Using the statistical model, we simulated the results and found that 51 percent of sample firms would not have converted to self-insurance if they had operated in an essentially mandate-free world. Firms most sensitive to mandates were mid-sized firms and those in industries where premiums tended to be higher such as construction, transportation, mining and services.

Several deleterious consequences occur as a result of the migration to self-insurance:

o The state loses revenue due to the non-payment of premium tax by self-insured plans.

o The state lacks the ability to regulate solvency of self-insured plans.

o The consumer loses the protection and comfort afforded him or her through the regulation of the state insurance department.

o Should the economy experience a serious downturn, no state protection exist for individuals covered by self-insured plans.

The forgoing demonstrates the wisdom of creating public policy that encourages participation in the insured community. All parties stand to gain from such an approach.

Position of HIAA

HIAA traditionally has opposed mandated benefits for reasons not necessarily addressed by this study. Mandated benefits legislation usually provide for benefits already available in the marketplace. From a public policy standpoint, it is illogical to mandate the purchase of something already available to individuals and groups who would choose to purchase the product.

Following that thought process, mandated benefits interfere with both the individual and/or the employer's freedom to tailor their employee benefits package to their needs. It has long been HIAA's position that employers and employees can shape a health plan that meets their needs better than the government. When government requires the purchase of certain benefits, they may force employers to forego other more essential benefits. Another adverse consequence is that mandates interfere with the collective bargaining process, thereby alienating both business and labor in the process.

In short, mandated benefits legislation generally impede two necessary ingredients of any cost-effective health insurance package: flexibility and uniformity. Flexibility is hampered by an employer's being forced to give up more appropriate and, perhaps, necessary benefits due to the existence of mandates. When multistate employers are forced to comply with a myriad of state mandated benefit laws, compliance and administrative cost escalate substantially resulting in employees of the same employer receiving varying benefits dependent on their residency.

These factors, taken in conjunction with mandates' effect on costs and the incentives of small and large employers to drop employee benefits and become self-insured, respectively, should clearly deliver the message to policymakers that mandated benefits legislation is not a prudent approach to the coverage difficulties being faced by society.

Legislative Solutions

HIAA would like to offer several legislative solutions to the problem. They are as follows:

1. Impact Analysis. Several states have adopted a cost-benefit approach to the issue of mandates. Prior to sponsorship of mandated benefits bill, states must analyze the bill's social impact assessing factors such as, but not limited to, public demand (as opposed to provider demand), current availability, and projected costs. Attached is a copy of a New Hampshire law setting in place a systematic review of such proposals. This approach prevents the passage of mandated benefits in an informational vacuum and provides a greater likelihood of a reasoned, methodical approach.

2. Allowance of Coverage Exempt from Mandated Benefits. States should enact legislation that would allow certain insurers to provide benefits exempt from the mandates of

state law, but which provide quality inpatient and outpatient diagnostic and treatment coverage. This would positively impact small employers who currently are grappling with their near inability to provide the "Mercedes" coverage required by the state of Kansas. It would also allow some small employers who currently cannot provide coverage in keeping with Kansas rich mandates to provide benefits to their employees, thereby helping to alleviate the problems of the uninsured in Kansas.

Conclusion

While the financing challenges posed by our health care system are great, they are clearly not insurmountable. There exists significant potential to develop legislative solutions that balance the needs of the consumer, employer and insurer in a cost-effective fashion. Public policy must be set that provides a balanced approach that allows flexibility, not rigidity. Progress should not be dictated; it should be facilitated. The two solutions offered above attempt to do just that . HIAA offers its future assistance, if necessary.

Thank you for allowing us the opportunity to present this testimony today.

Mental health

optometrist

dentists

podiatrists

psychologists

Specialists clinical workers

Continuation group

Divorced parent rule

discrimination

Chemical dependency

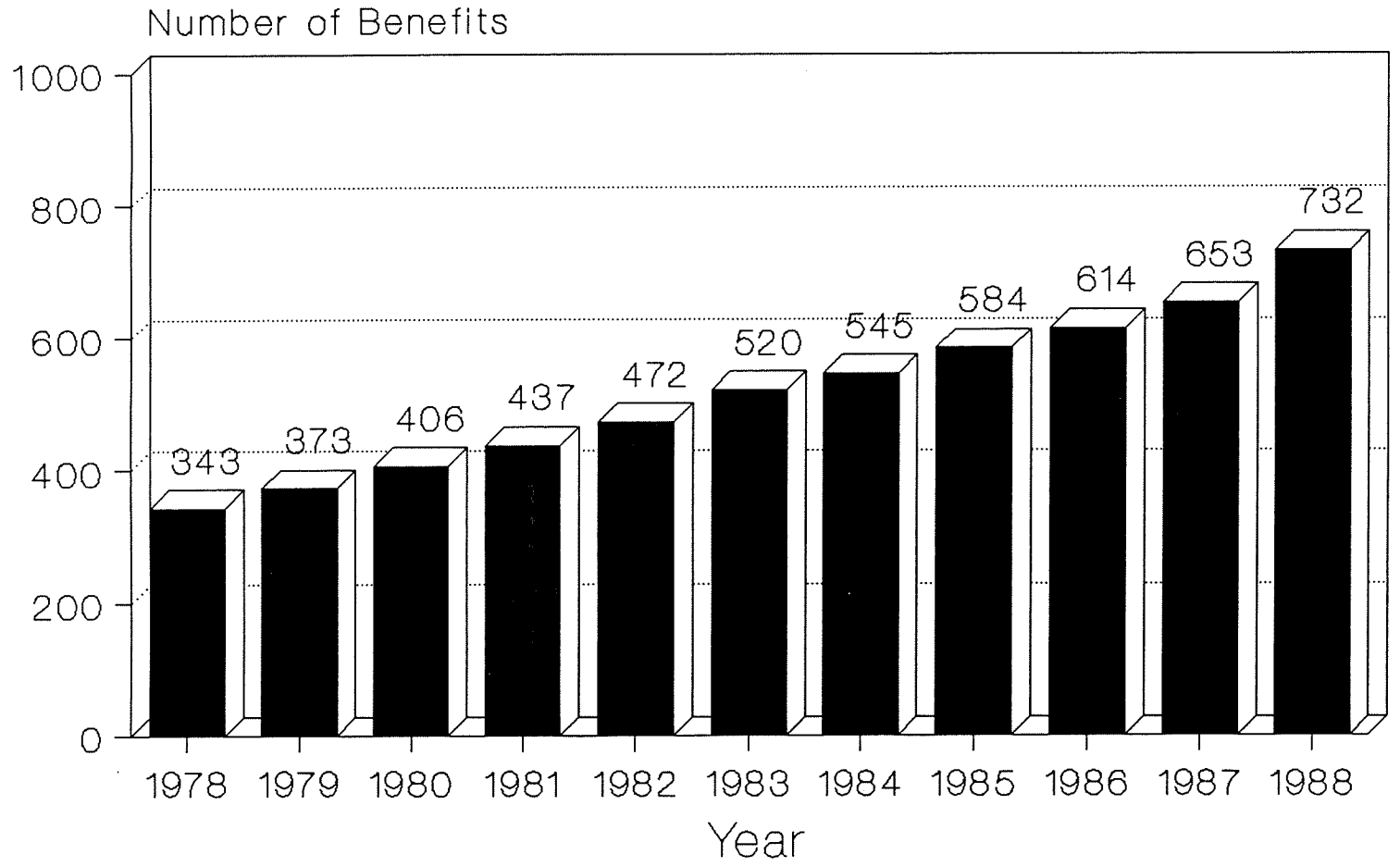
new born children

complications of pregnancy

mammography

pap smears

Growth of State Mandated Benefits, 1978-1988



Source: Blue Cross and Blue Shield Assocation, January 1989

Figure 1

2-12

State Mandated Benefits: 1988

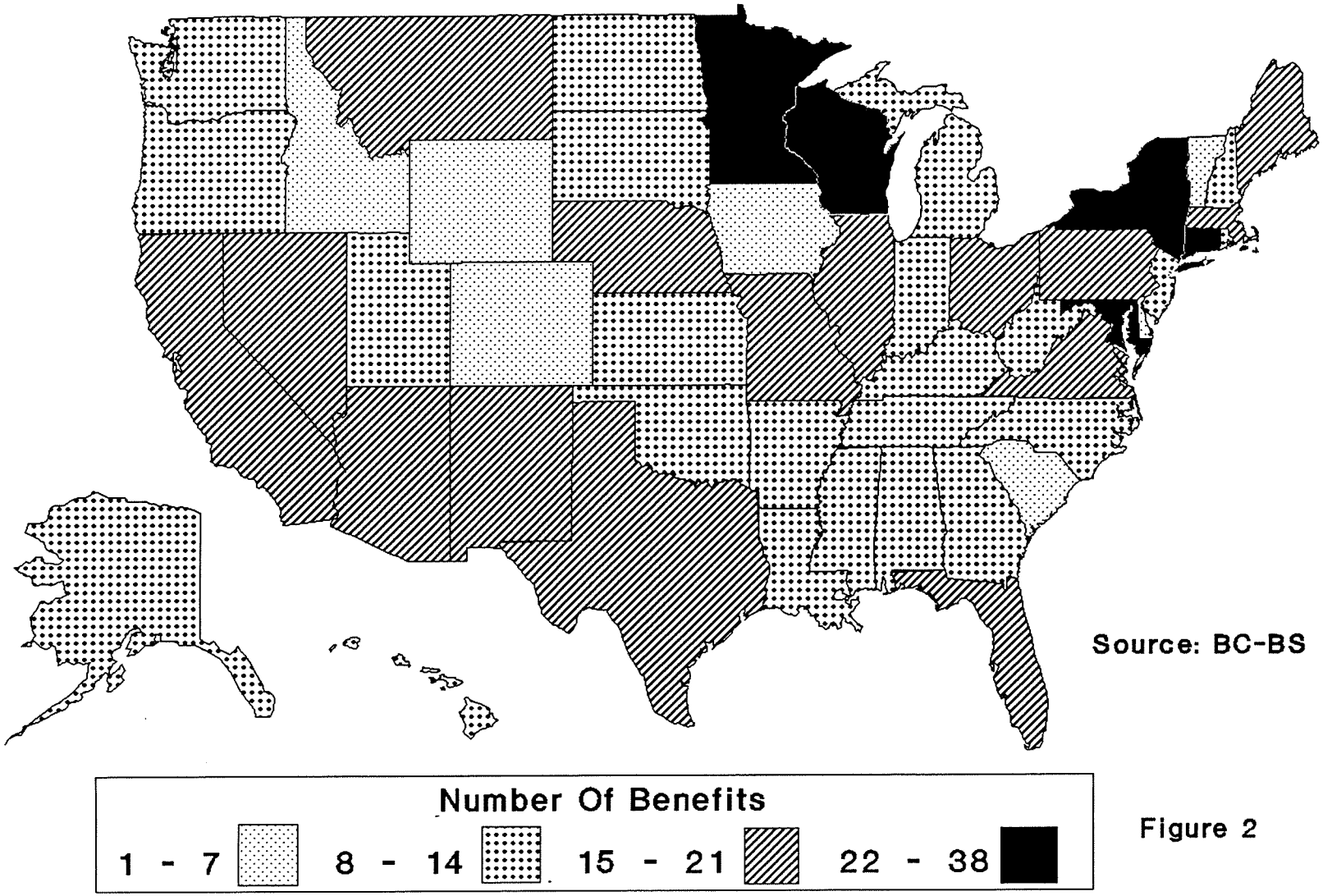
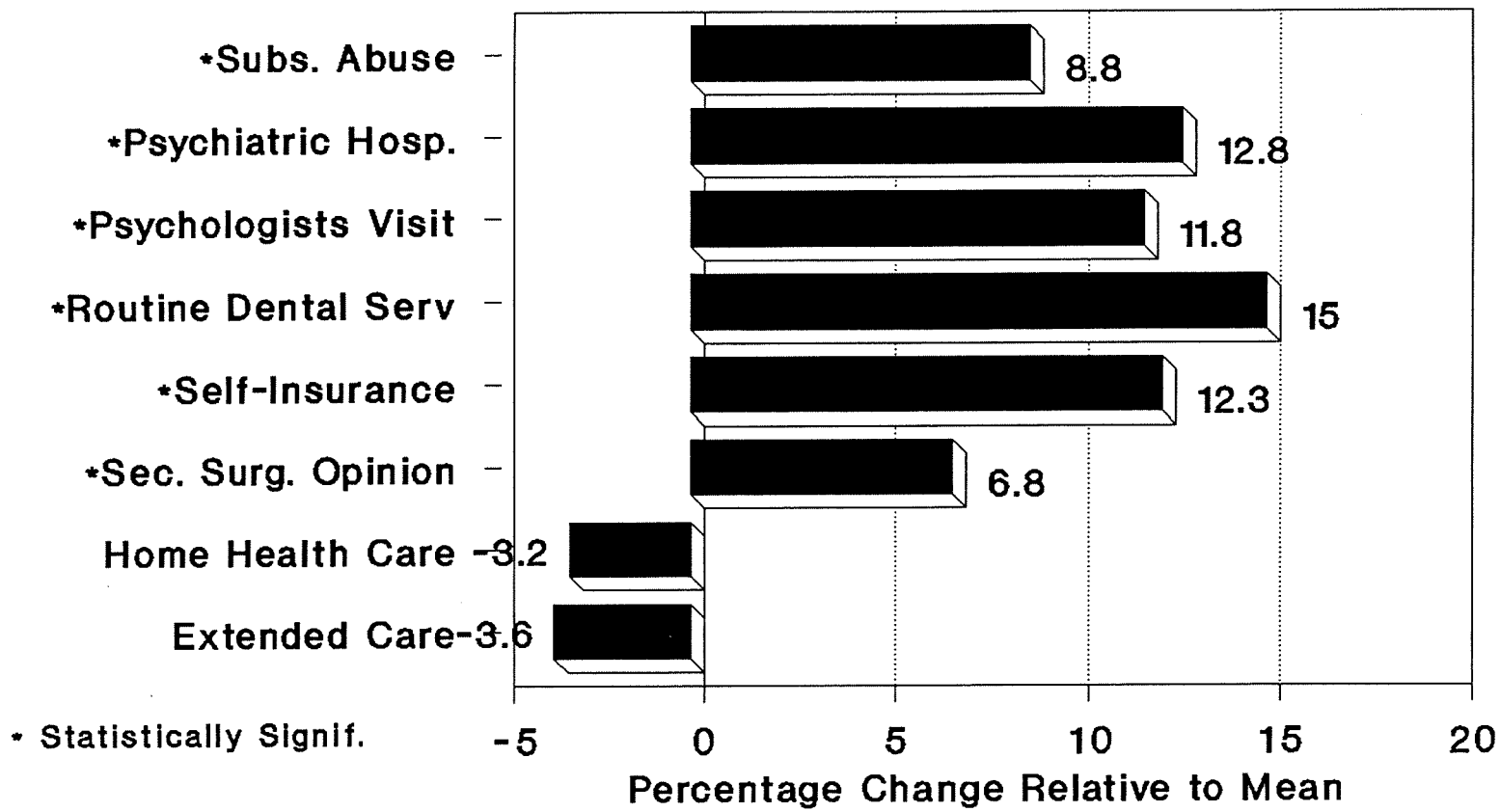


Figure 2

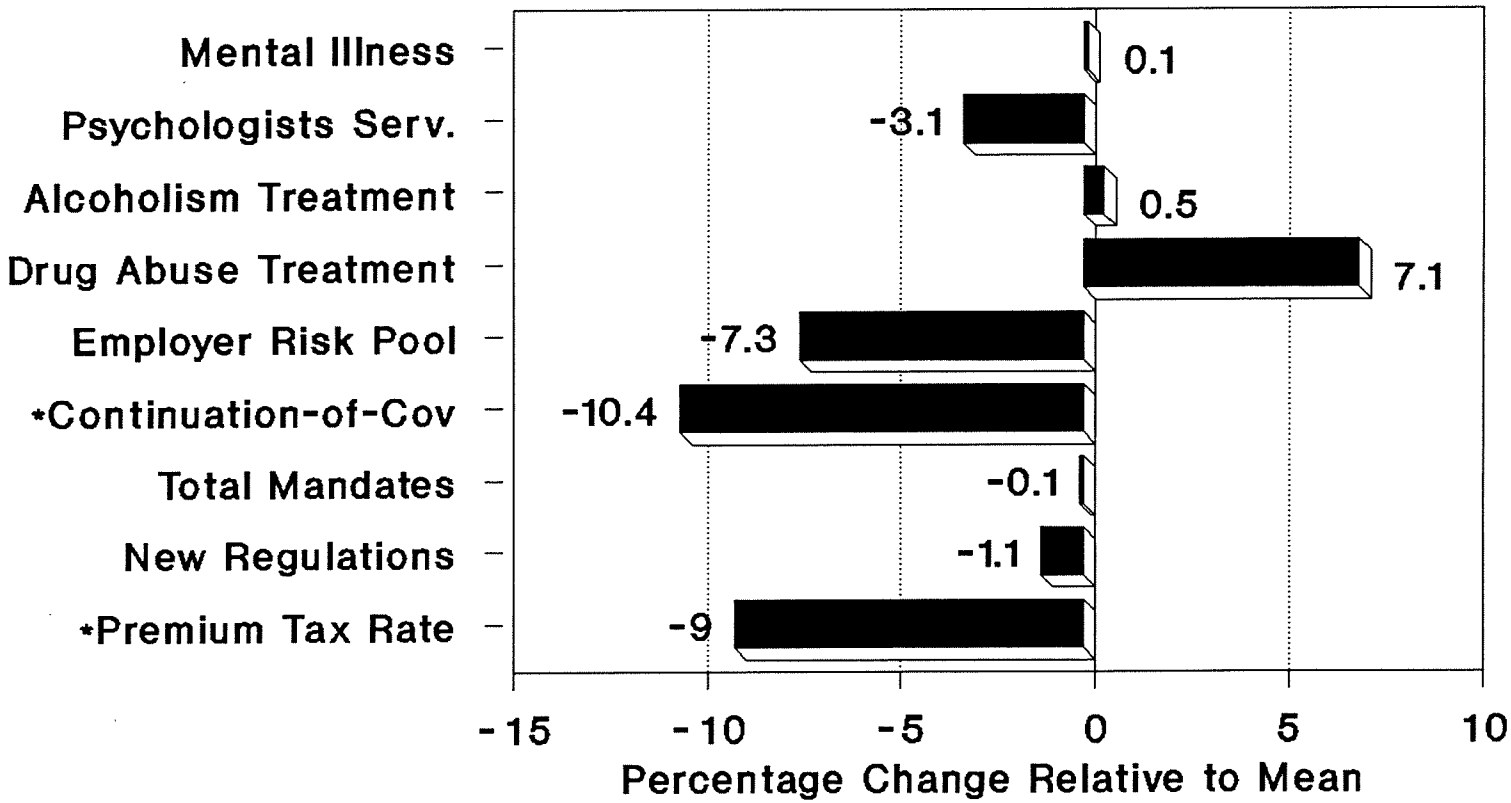
Percentage Change In The Price Of Family Coverage By Adding Specific Benefits



Data Source: BLS Employee Benefit Survey
Estimates from Jensen and Morrisey, 1988

Figure 3

Effect Of Mandates On The Likelihood That A Small Firm Will Provide Health Benefits To Their Workers



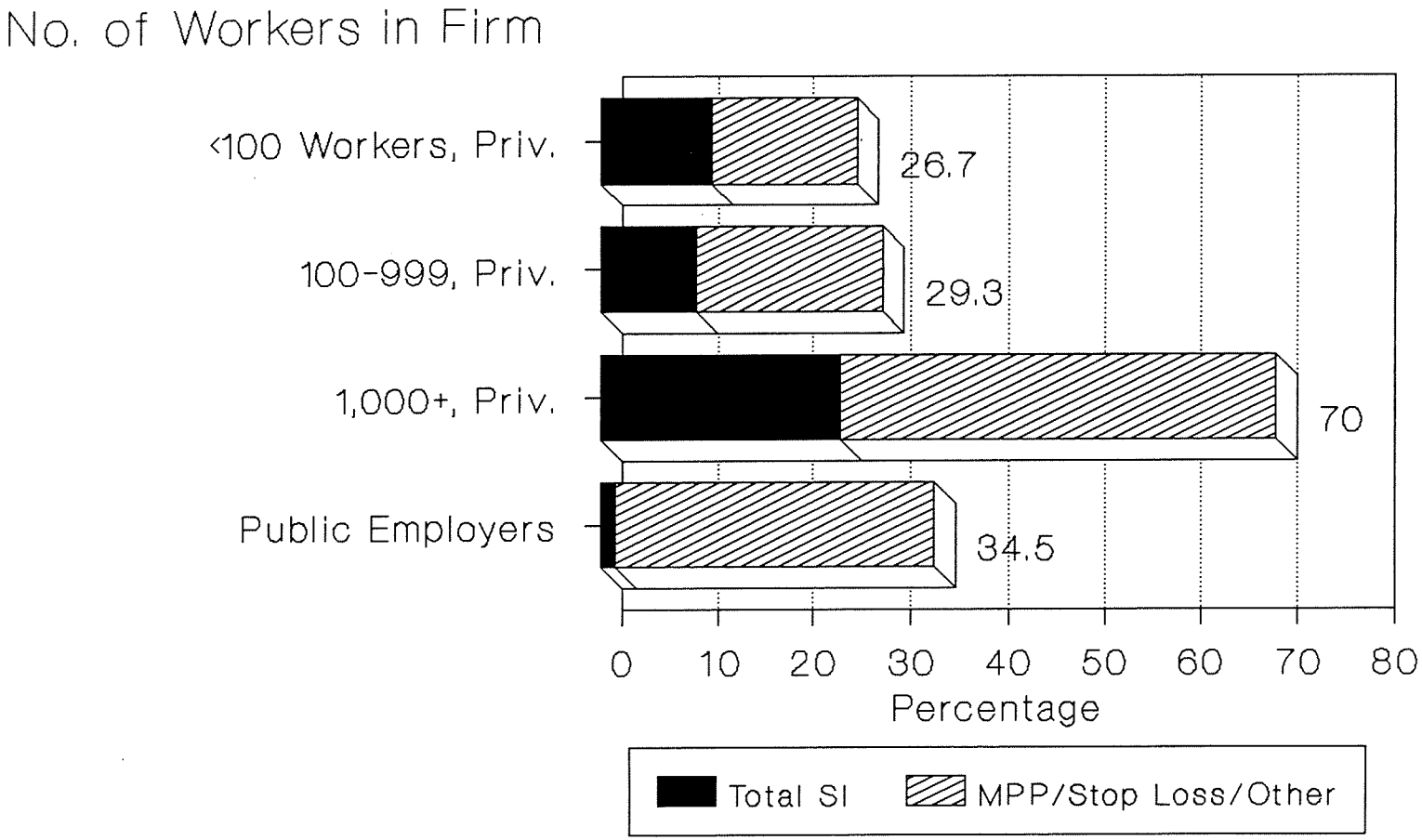
Data Source: National Federation Of Independent Businesses, 1985
Jensen and Gabel, 1989

*Statistically Signif.

Figure 4

2-12

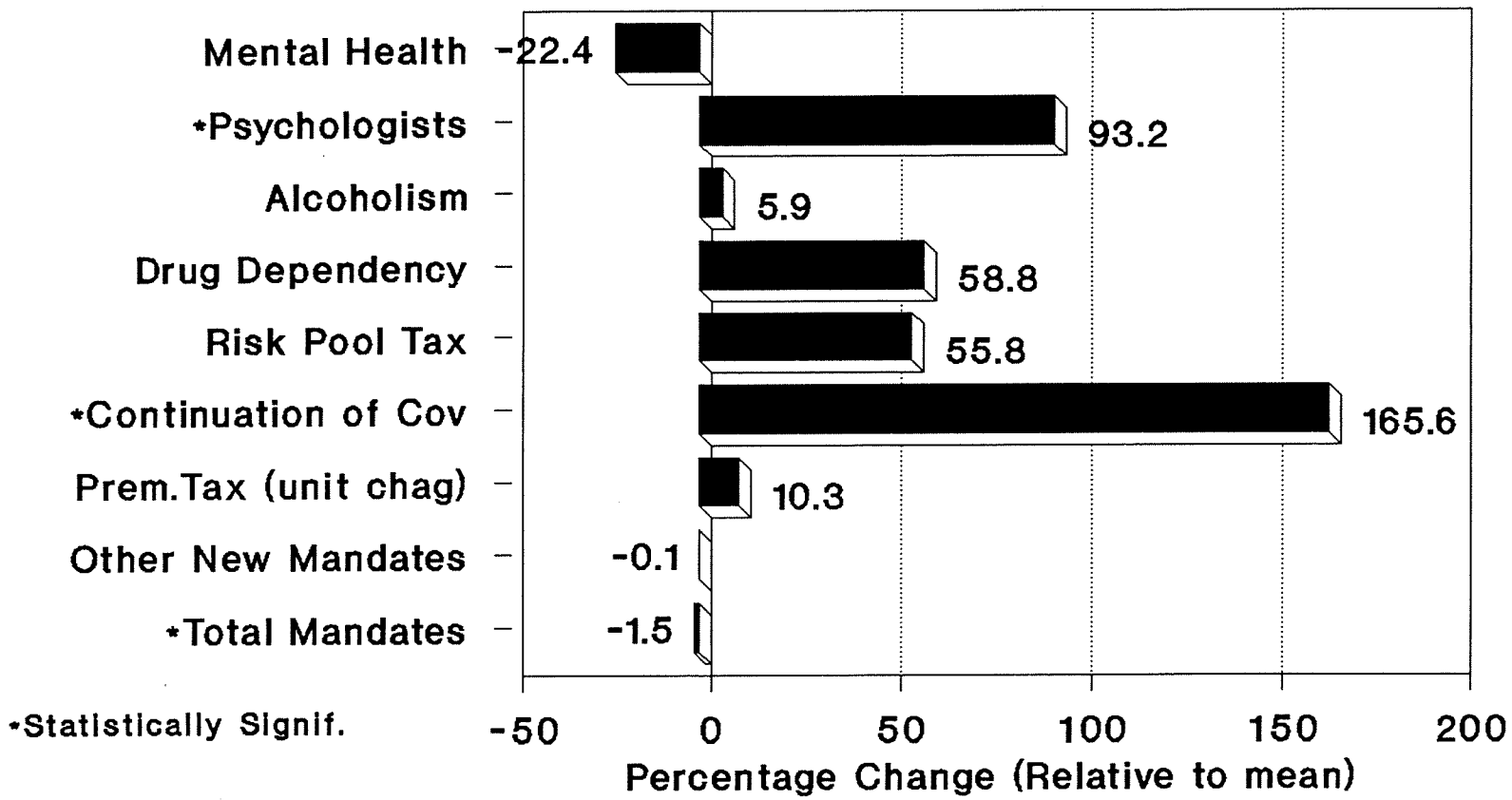
Percentage of Firms That Self-Insure, 1988, For Private and Public Employers



Source: HIAA-Johns Hopkins Survey of 1457 Firms, 1988

Figure 5

Percentage Change In The Likelihood That A Large Firm Converts To Self-Insurance, If State Adopts Mandate.



Data Source: BLS Employee Benefit Survey
Jensen and Morisey, 1988

Figure 6

2-17

Jon R. Gabel
Gail A. Jensen

The Price of State Mandated Benefits

States have passed more than 700 statutes mandating that insurers cover specific providers, diseases, or people who otherwise might have difficulty obtaining coverage. We report findings from three econometric studies that examine the effects of mandates on the cost of insurance, the small employer's decision to offer health insurance, and the large employer's decision to self-insure. Study results indicate that mandates raise the price of health insurance substantially, that nearly one of every six small firms that do not offer health insurance would in an essentially mandate-free environment, and that about half of the large firms that are converting to self-insurance would not if there were no mandates.

On a spring day in 1985, a fervent group of constituents brought a test tube baby into a packed hearing room of the Maryland General Assembly, hoping to convince Maryland lawmakers to mandate that insurers cover in vitro fertilization. Despite previous expressed sentiment to the contrary, Maryland's citizen-representatives found the gesture compelling, and passed the legislation (Demkovich 1986a).

With less drama, similar scenes reoccur in state legislatures throughout the nation. Few health care issues raise greater passion with greater frequency than mandated benefits—state legislation that prescribes the content of health insurance purchased from Blue Cross and Blue Shield and commercial insurers. In 1988 alone, state legislatures in 38 states considered 316 bills to mandate that insurers cover the services of specific providers such as chiropractors. State legislators also introduced 320 bills in 34 states mandating that insurers cover specific services, such as in vitro fertilization.[1] Today, state governments have enacted over 730 mandates (Blue Cross and Blue Shield Association 1989), up from 343 in 1978 (see Figure 1).

State mandated benefits are a predictable strategy for a society whose fondness for public services far exceeds its willingness to pay for them. Health care is little different from other issues, such as family leave or pensions. An electorate that overwhelmingly favors legislation that would have the Federal government guarantee all Americans a job is almost as strongly opposed to higher federal taxes (see Figure 2). One appealing facet of employer mandated benefits is that they seemingly extend the protection of society's safety net without raising taxes. In reality, mandated benefits constitute a tax on employer-sponsored health insurance—paid by workers to those persons and providers benefiting from the expanded coverage.[2]

This article measures the price of mandated benefits in three ways. First, we determine the cost of added benefits. Second, we examine how many fewer small firms forgo offering health insurance to their

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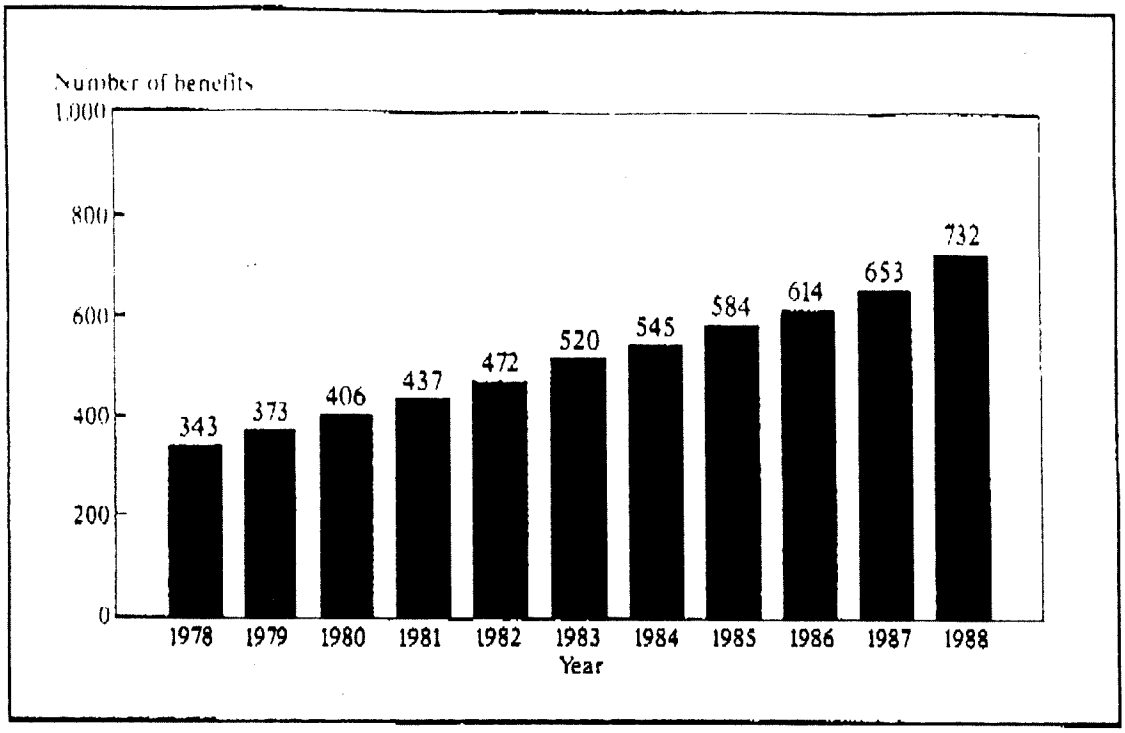

Figure 1. Growth of state mandated benefits, 1978–88 (source: Blue Cross and Blue Shield Association, January 1989)

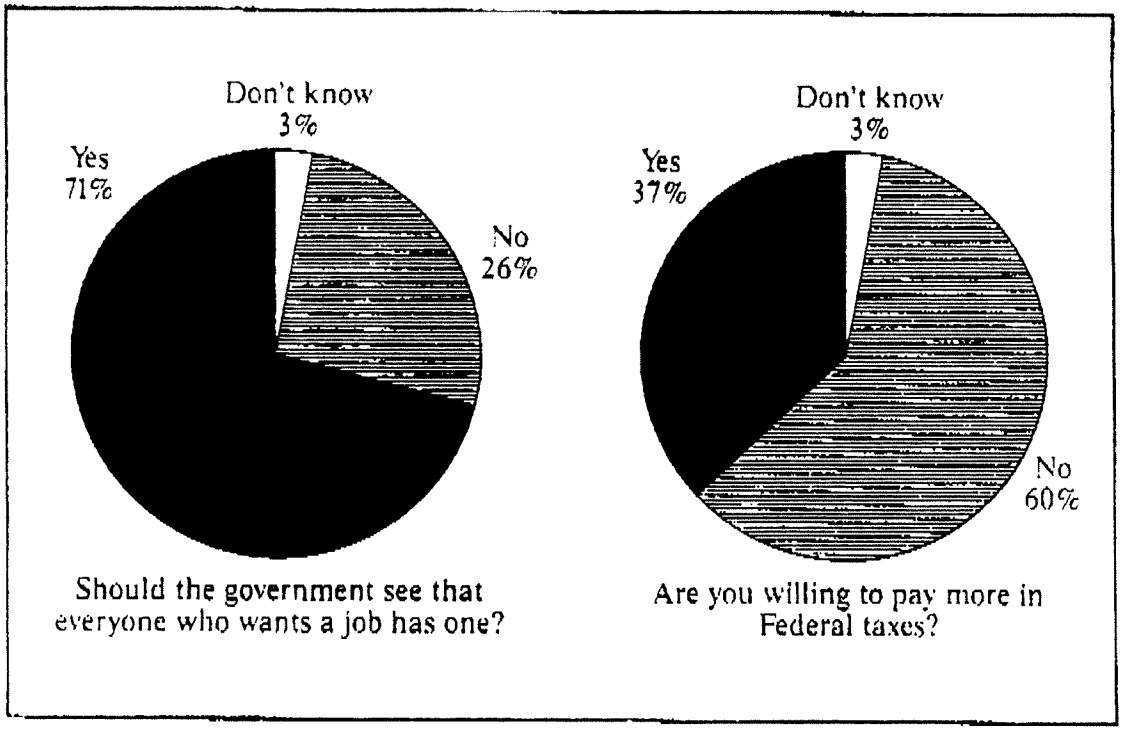

Figure 2. Americans' conflicting views about the role of government (source: New York Times/CBS News poll)

employees as a result of mandates. Third, we assess how many large firms choose to self-insure their health benefits because of mandates. As we discuss in greater detail later, federal legislation exempts employers who self-insure from mandates and other state regulation of their health plans.

Our paper is a nontechnical synthesis of recent work by the authors, including collaborative work with Michael Morrisey of the University of Alabama at Birmingham. Individuals desiring further details about the methods and findings of the research should refer to the cited publications and working papers.

State Mandated Benefits and State Regulation of Health Insurance

State mandated benefits take three general forms. First, states may require that insurers cover specific services or diseases. For example, 37 states require that insurers cover alcoholism treatment, 28 states require mental health coverage, and 18 mandate coverage of maternity services. Minnesota mandates coverage for hair transplants and three states require that insurers cover acupuncture (Ralston, Power, and McGinnis 1988). Although these make colorful anecdotes, most mandates are for more traditional services (see Table 1). States may require either that insurers cover the service or that they offer the special coverage for sale. The vast majority of mandates require that the coverage be part of the insurance plan (Goodman and Musgrave 1988, p. 5).

Second, states may mandate that insurers cover the services of specific providers. Thirty-six states require that insurers cover chiropractors, 36 require coverage of psychologists, and 30 optometrists (Ralston, Power, and McGinnis 1988, pp. 9–12). Arkansas and Connecticut mandate that insurers cover the services of naturopaths (who specialize in prescribing herbs), an unusual mandated coverage.

Third, states may require that insurance coverage be made available to persons who might otherwise have difficulty in finding coverage. For example, 38 states direct insurers to cover newborns, 33 require continuation of coverage of mentally/physically handicapped individuals, and 18 mandate coverage of adopted children. One of the most sweeping mandates (required by 33 states) directs insurers to extend plan participation to individuals for a period of time following the termination of their employment with the firm. This may take the form of the employee continuing as a member of the group plan (but paying the premium), or requiring the insurer to offer conversion rights (e.g., enroll the person on an individual basis with coverage similar to that of a group plan) (Demkovich 1986b). In 1986, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA). In requiring employers to offer 18 months of coverage to employees whose employment with the firm has terminated, COBRA largely superseded state laws.

The typical state has enacted 10 to 15 mandates (see Figure 3). Figure 4 shows the number of mandates enacted by individual states since 1983.

Other state laws affect the terms of insurance as well. To assure their financial solvency, insurers must meet state capital and financial reserve requirements. Reserve requirements average 20% to 30% of premiums (Demkovich 1986b). To protect consumers, States often require contract information disclosures, bonding, auditing, and standardized printing of terms of coverage. States also have established coordination-of-benefit regulations for determining who shall pay and how much when a family is covered by more than one insurance plan.

All states levy a premium tax on commercial insurers, and 26 tax Blue Cross and Blue Shield plans. A typical tax is 2% to 3% of premiums. Assuming the tax is shifted forward to the purchaser, a major corporation could potentially pay $30 million in premium taxes each year. Finally, 12 states tax insurance plans to subsidize a state risk pool established to provide health insurance to individuals who otherwise are "uninsurable" (Demkovich 1986a, p. 28).

With their recent growth, self-insured plans today enroll the majority of Americans enrolled in employer-sponsored conventional and preferred provider organization (PPO) plans. These plans are exempt from state regulatory oversight—from man-

Table 1. Ten most common state mandated benefits

Mandate	Number of states
1. Newborns	46
2. Psychologists	37
3. Chiropractors	35
4. Mental/physical handicap	33
5. Conversion privilege	33
6. Optometrists	31
7. Alcoholism	29
8. Dentists	27
9. Continue for dependents	27
10. Podiatrists	26

Source: Blue Cross and Blue Shield Association, 1989

dated benefits to premium taxes to reserve requirements. Section 514 of the 1974 Employee Retirement Income and Security Act (ERISA) preempts all state laws pertaining to employee benefit plans (Jensen and Gabel 1988). The courts have interpreted this as exempting self-insured plans from state regulation; states retain their authority to regulate fully insured plans (where insurers bear the total financial risk for payment of claims). Figure 5 shows that in 1988, the overwhelming majority of Americans employed in large firms and having conventional coverage were covered by a plan that self-insured in some capacity. In contrast, most individuals employed in small firms are enrolled in a fully insured plan subject to state regulations (Gabel et al. 1988).

The Political Debate Over State Mandated Benefits

The primary advocates for state mandated benefits are provider groups and constituents afflicted with a specific disease. Their political opposition are insurers and employers, the purchasers of care. Organized labor, which has vehemently opposed mandates at the national level as an infringement on the collective bargaining process, is conspicuously quiet in state arenas. So too are consumer groups.

What is the rationale for mandated benefits? Proponents argue that all individuals covered by insurance are entitled to be covered for specific services. Because insurers and purchasers have systematically undervalued the benefits of some services, such as mental health, the state must intervene in the marketplace. Proponents also maintain that the benefits will pay for themselves. For example, extending mental health benefits should reduce the use of other health care services. Covering chiropractors or clinical psychologists should result in a substitution of less-costly services for higher priced physician care.

Proponents also contend that without mandated coverage, insurers will experience substantial adverse selection. Sicker individuals will enroll in plans offering more extensive coverage such as mental health, and healthier individuals will choose low-benefit plans (McGuire and Montgomery 1982). Proponents argue that mandates thereby protect individuals suffering from chronic diseases. Lastly, advocates of mandates assert that continuation and conversion mandates extend needed protection when an in-

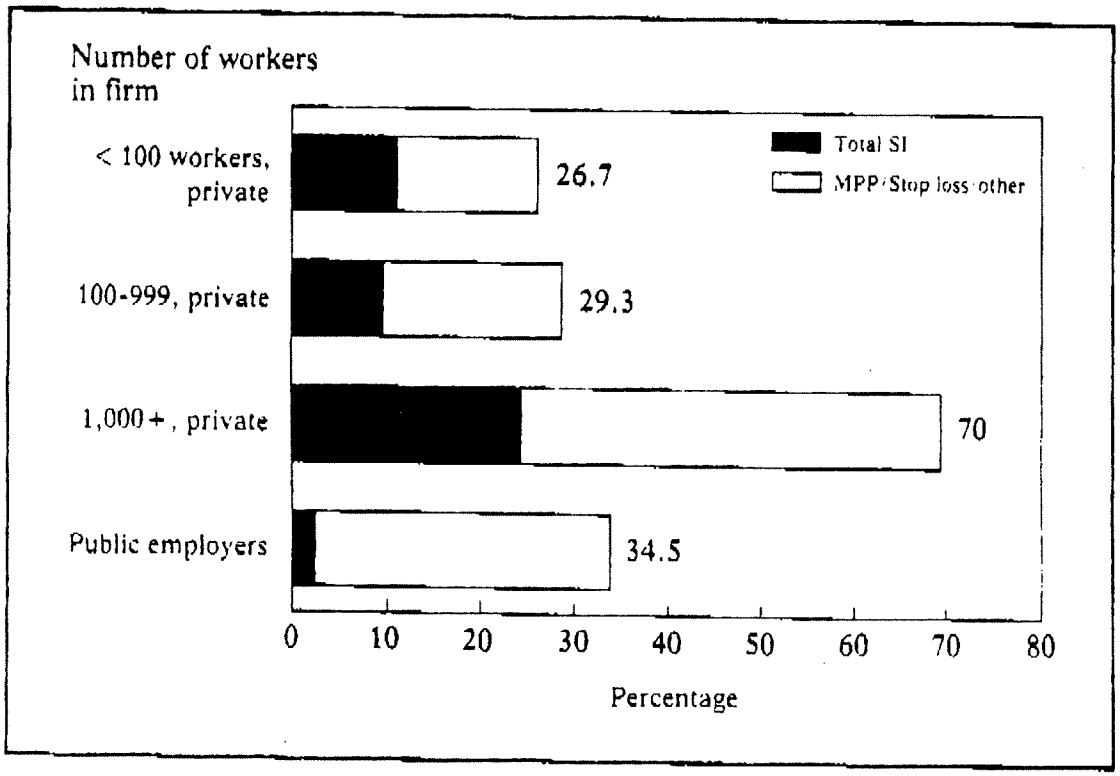

Figure 5. Percentage of firms that self-insure for private and public employees, 1988 (source: HIAA-Johns Hopkins survey of 1,457 firms, 1988)

dividual loses his or her job—and do so inexpensively because of economies of scale in group insurance purchasing.

Opponents of mandates dispute these arguments. Philosophically, mandates are onerous because they intrude in employee-management relations, imposing a benefit package for employees and employers different from what they might want. Why dictate "Cadillac care" when employers and employees want and can only afford "Chevrolet care"? Mandates increase plan costs because they result in an expansion rather than a substitution of services. If these services saved costs, then insurers would offer them as standard features to increase market share and profits. The increased cost of health insurance prices many small employers out of the health insurance marketplace. Additionally, state mandates encourage large employers to self-insure to escape state regulation.[3]

Mandated Benefits and the Price of Health Insurance

The few studies that have examined the cost of mandated benefits followed one of two methodological approaches. The first method examined insurer paid claims files and determined the percentage of paid claims for mandated benefits. Using this approach, Blue Cross of Maryland estimated that Maryland mandates accounted for 21% of all incurred claims in both 1985 and 1986. Blue Cross of Massachusetts estimated that mandates accounted for 18.5% of costs (Dyckman and Anderson 1985; Blue Cross/Blue Shield of Massachusetts 1988). Researchers at the University of Iowa estimated that mandated benefits accounted for 6% of claims costs in Iowa (Ralston, Power, and McGinnis 1988, pp. 45–46). There are two flaws with this method. First, it neglects to account for the effects of mandated coverage on the use of other health care services. Thus, it assumes that mandated services neither substitute for nor complement other services. Second, it assumes that providers are unaffected in their coding of services by whether insurers cover a category of care.

The second method for measuring cost is an actuarial approach, an approach that relies extensively on expert opinion. Using a subcommittee of actuaries, Health Insurance Association of America priced alternative insurance products in Maryland. They concluded that mandated benefits raised the price of individual coverage by 12% and family coverage by 17% (Health Insurance Association of America 1985).

To determine the cost of specific provisions of group health insurance, we draw upon the work of Jensen and Morrisey who used a hedonic price technique. The hedonic price method allows one to calculate the marginal effect of different benefit features on the prices that firms have paid for group insurance coverage. Widely used in the economics literature, hedonic price techniques can be better understood through an analogy with houses. By observing differences in the prices of houses, one can use econometric techniques to estimate the average added cost of central air conditioning, an attached garage, and other features.[4]

A limitation of their hedonic approach is that they measure the average change in cost. Thus, while there may be many dimensions for defining alcohol treatment benefits (deductibles, number of covered visits, days, etc.), their methods measure the effect on premiums of the average alcohol treatment benefit. A strength of their approach is that it fully accounts for substitutions among services arising from the extra coverage—assuming that premiums reflect overall historical claims costs.

The Bureau of Labor Statistics Employee Benefits Survey

Jensen and Morrisey's study data came from the BLS Employee Benefits Survey covering the years 1981 to 1984. This survey contains extensive information about the characteristics and premiums of group health insurance plans from a sample of randomly selected midsize and large firms throughout the U.S. The BLS conducts the survey with on-site interviews and analysis of health plan summary booklets. The response rate for the survey ranged from 80% to 85%, depending on the year, a rate exceeding that of other employee benefit surveys. There were 9,019 observations on conventional plans for their analysis.

Figure 6 shows the average premium increase (or decrease) for family coverage resulting from a firm's inclusion of specific benefits.[5] The percentage figures indicate the average change in premiums for family coverage (measured in constant 1983 dollars, see Table 2) that resulted from adding each specific benefit.[6]

Many of the commonly mandated benefits significantly increased the price of family coverage. Chemical dependency treatment coverage increased premiums by 8.8%. The addition of coverage for psychiatric hospital stays increased premiums by 12.8%. Adding benefits for psychologist visits increased

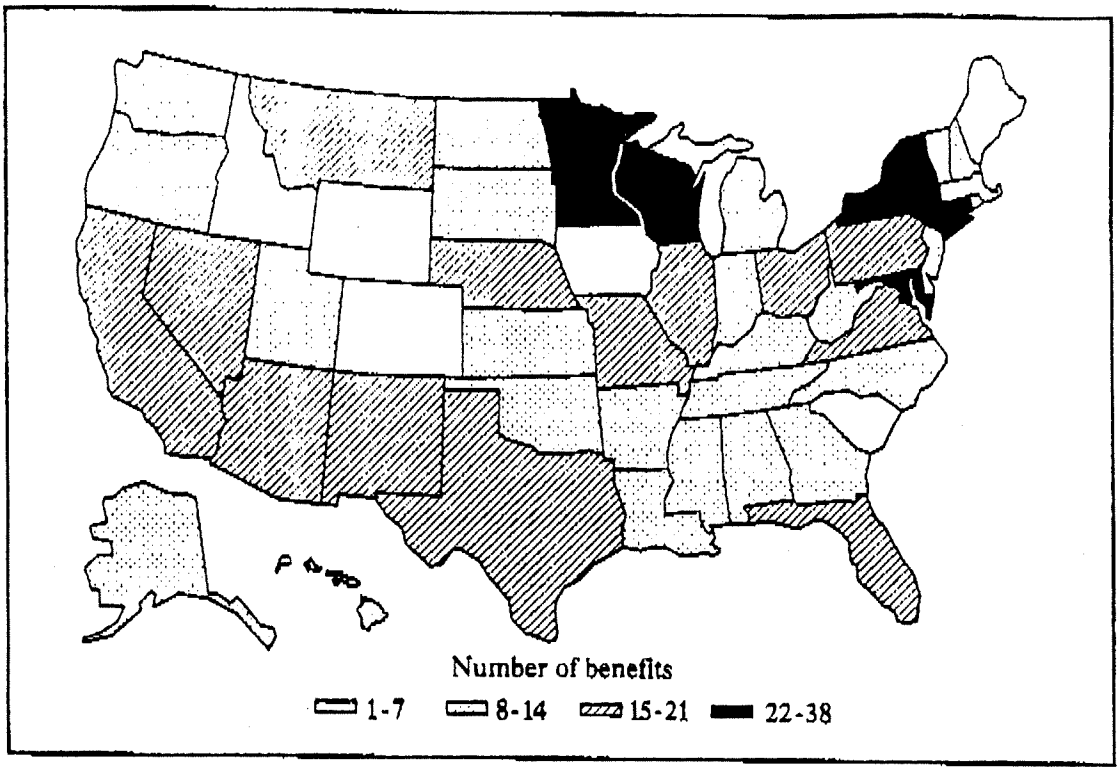

Figure 3. State mandated benefits, 1988 (source: Blue Cross and Blue Shield Association)

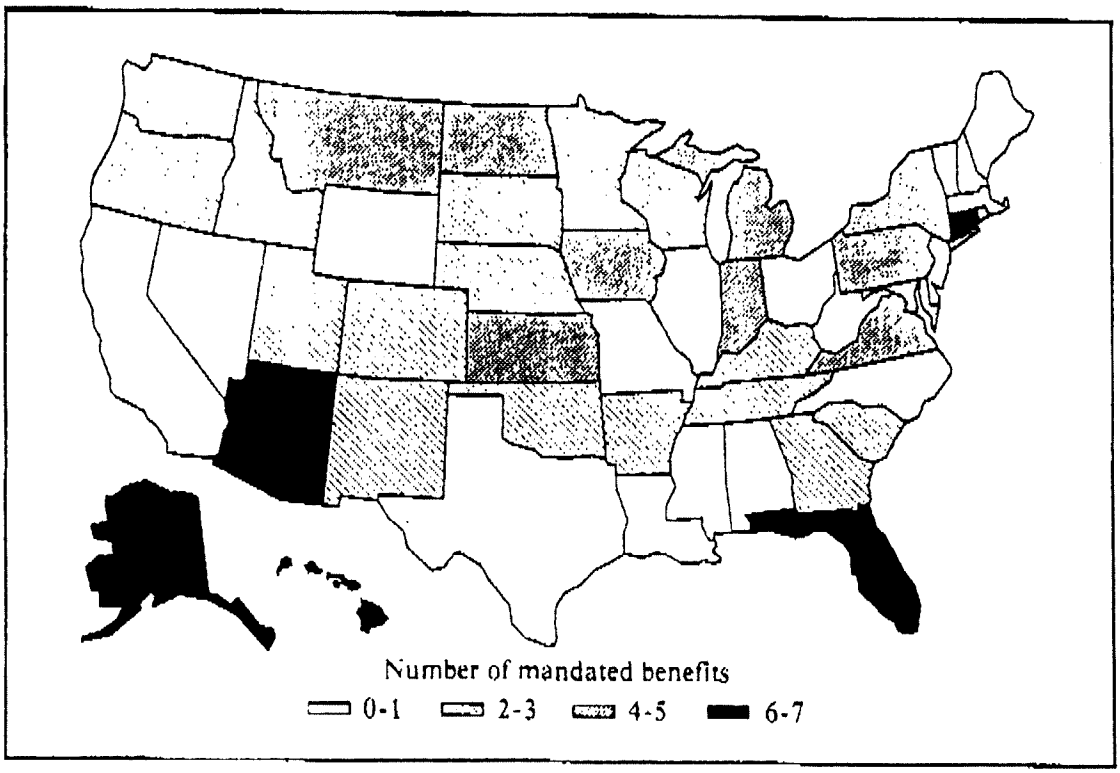

Figure 4. Increase in mandates for each state from 1983 to 1988

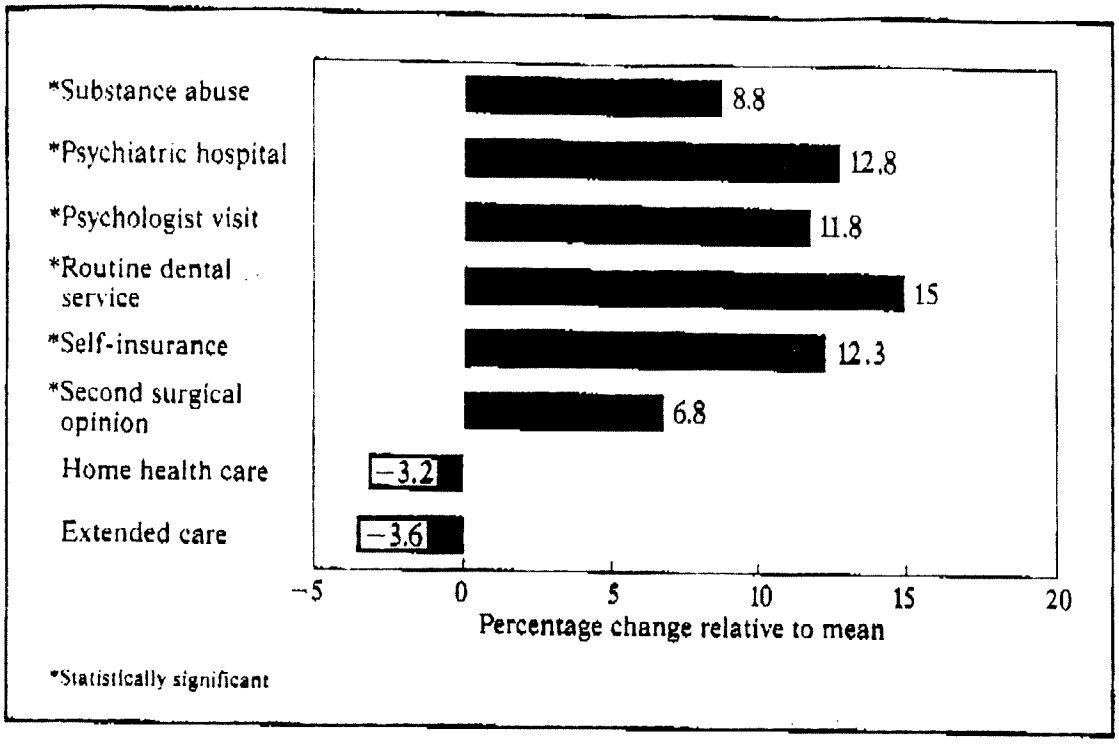

Figure 6. Percentage change in the price of family coverage by adding specific benefits (sources: BLS Employee Benefit Survey and estimates from Jensen and Morrisey 1988)

Table 2. Incremental monthly premium for selected group insurance provisions (in 1983 constant dollars)

	Average incremental premium among plans containing the provision			
	Individual coverage		Dependent coverage	
Coverage	Estimate	*t*-statistic	Estimate	*t*-statistic
Substance abuse	4.37***	2.94	6.59**	1.98
Psychiatric hospitalization	−.92	−.48	21.45***	5.22
Psychologists' services	5.74***	3.81	13.32***	4.01
Routine dental service	13.17***	8.10	12.46***	3.60
Self-insurance	10.52***	4.37	9.24*	1.64
Second surgical opinion	2.78	1.55	8.11**	2.12
Home health care	.08	.04	−5.25	−1.26
Extended care	−.23	−.14	−5.35	−1.48
R^2	.18		.13	
Observations	9019		4614	
Residual standard error	32.17		63.29	
Mean monthly premium	55.33		105.68	

Note: Other variables in these regressions were a constant term, dummy indicators for whether the plan was "major medical only," required front-end hospital cost sharing, or was a commercial plan; the plan's major medical deductible; its extent of stop-loss coverage; three location, four industry, and three year dummies; the number of HMOs offered by the firm; the percentage of males and percentage of blacks and hispanics in the firm; whether retirees were eligible to participate; and the plan's size. For the full regressions and details of the analysis see Jensen, Gail A., and Michael A. Morrisey, "Group Health Insurance: A Hedonic Price Approach," *The Review of Economics and Statistics*, forthcoming.

*** Significant at $\alpha = .01$.
** Significant at $\alpha = .05$.
* Significant at $\alpha = .10$.

premiums by 11.8%. Coverage for routine dental services increased costs by 15%.

Some benefits reduced premiums, presumably because they encourage the substitution of low-cost services for higher cost ones. Home health care benefits reduced premiums by 3.2%; extended care benefits by 3.5%. Coverage for these types of care—which are likely substitutes for long hospital stays—is usually conditional on prior hospitalization.[7] Second opinion surgery benefits, in contrast, raised the cost of coverage by 6.8%. In recent years many insurers have come to question the effectiveness of second opinion surgery review (Gabel et al. 1989).

One striking finding is that self-insurance raised premiums by 12.3%, with other factors held constant. However, since self-insured plans can avoid offering mandated coverages, such as chemical dependency and psychologist visits, firms can easily offset the higher administrative costs by avoiding one or two mandated coverages. In previous analysis of these same data, we found that firms that converted to self-insurance experienced greater increases in premiums during those years than did firms that remained fully-insured or self-insured throughout the period.[8] We also found that converters to self-insurance had the lowest premiums before conversion. Premiums rose for these firms after switching to self-insurance.

These hedonic price estimates might potentially overstate the added cost of mandated coverage for two reasons. First, if firms having higher numbers of workers with mental health problems in their families were more likely to offer mental health benefits, then these estimates include the effect of self-selection. Firms in the BLS sample may also have offered more generous benefits than those prescribed by most states, in which case these data would overstate the added cost of a mandate. Therefore, these estimates may apply to more extensive "Cadillac" coverages and not the "Chevrolet" mandates that some states have enacted. On the other hand, hedonic price estimates should capture the "woodwork effect"—where employees who previously deferred the use of services increase their use following an expansion in benefits. Expanded benefits may prove to be complements to the use of other services. For example, the alcoholic seeking detoxification may have his liver ailment discovered during treatment.

State Mandated Benefits and the Small Firm's Decision to Provide Health Insurance

Of the 37 million Americans without health insurance protection, nearly three-fourths are from families in the work force. Two-thirds of uninsured workers are employed in companies with fewer than 25 workers or are self-employed (Chollet 1987). Only 29% of the firms with fewer than 5 workers offer health benefits to their employees.[9]

If extending health coverage to the uninsured is foremost a problem of encouraging small employers to offer health benefits, the question arises, to what extent have mandated benefits discouraged small firms from providing coverage? To our knowledge, only one previous study has examined this issue. Goodman and Musgrave used data from the Current Population Survey in 1985 and 1986. Using the state as the observational unit, they found that, when other factors were held constant, each mandate increased the percentage of uninsured in the state by .17% to .28%. The authors concluded that between 14% and 25% of persons without health insurance have none due to mandated benefits (Goodman and Musgrave 1988, p. A-9).

The National Federation of Independent Businesses Survey

Drawing from a national survey of small businesses in 1985, our study took a different approach.[10] We observed whether small firms were less likely to offer health benefits, other factors held constant, in states mandating a wide range of benefits as opposed to states where few were required. Unlike Goodman's and Musgrave's study, we measured the effect of individual mandates, as well as the effect of total and new mandates. Since the firm was our unit of analysis, as opposed to the "state," we obtained more direct estimates of the effects of mandates than Goodman and Musgrave.

Our data were from the 1985 National Federation of Independent Businesses (NFIB) survey of small businesses. NFIB represents about 500,000 small firms distributed across the nation's regions and industries. Members tend to be somewhat larger (average size about 8 employees) and more financially established than small businesses in general. NFIB surveyed a random sample of 7,750 of its members and received responses from 1,439. Although this response rate is low, it is comparable to those obtained from other mail surveys of small businesses. For each firm, NFIB obtained data on what fringe benefits were provided to full-time employees, the major features of the health insurance plan, and characteristics of the employer and employees. Because

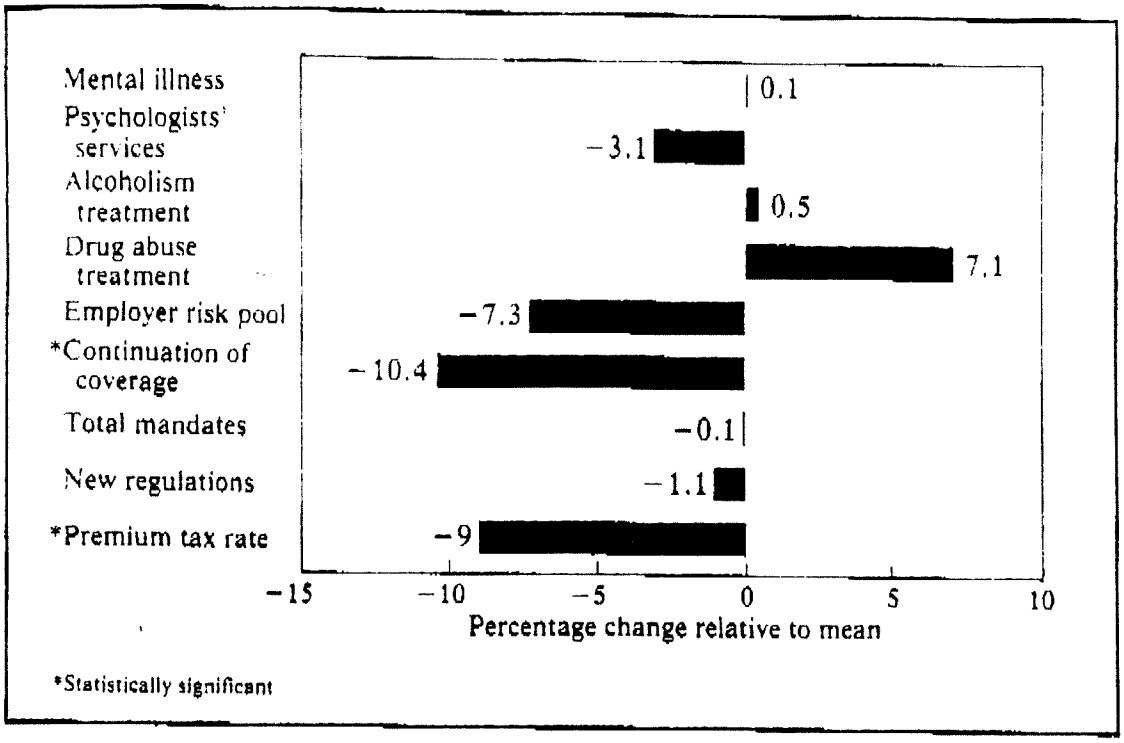

Figure 7. Effect of mandates on the likelihood that a small firm will provide health benefits to their workers (sources: National Federation of Independent Businesses, 1985 and Jensen and Gabel 1989)

we knew the geographic location of each firm, we were able to merge information about state mandates and other regulations with each observation in the sample. Using probit analysis, we then modeled the determinants of whether a small firm offered coverage. For this analysis, our sample was 1,320 firms, 923 of which offered health insurance.[11]

Findings

Collectively, mandates and premium taxes reduced the likelihood that a firm offered benefits to its employees (see Figure 7 and Table 3). A firm facing a 1% state premium tax had an 80% chance of providing insurance, whereas one facing a 3% tax had a 71% probability. States that taxed insured plans to subsidize a state risk pool reduced by 10% the likelihood that a small firm provided health coverage. Continuation-coverage mandates reduced by 13% the likelihood that firms would provide coverage. Each new mandate enacted between 1982 and 1985 lowered the likelihood that a small firm would offer coverage by 1.5%. The most common statutes enacted during these years were for nurse midwives (10 states), psychiatric nurses, counselors, and social workers (7 states), other allied health professionals (15 states), and continuation rights for dependents (7 states) and employees (8 states). The typical state enacted three new statutes during this period, thereby reducing by 4.5% the likelihood of coverage for small firms.

Several individual mandates were not statistically significant. These included psychologists' services, mental health benefits, alcoholism treatment benefits, and drug abuse treatment.[12]

Characteristics of the firm and its employees were strong statistical predictors of whether a small firm offered health insurance. Firms with more than ten workers were nearly twice as likely to offer health benefits as firms with fewer workers. Proprietorships were nearly 50% less likely to offer benefits than corporations, other characteristics held constant. Presumably, corporations were more financially secure and thus more able to offer health benefits. Moreover, in 1985, a self-employed person could not deduct the cost of his or her health insurance as a business expense, even if coverage was provided through the firm's plan. Corporations were allowed this deduction.

Our statistical model correctly predicted whether the firm offered health benefits for 80% of the sam-

Table 3. Effects of state insurance regulations on employers' insurance offerings

Mandate	Effects of regulation on the probability of: A small firm providing health benefits — Estimate	A small firm providing health benefits — *t*-statistic	A larger firm converting to self-insurance — Estimate	A larger firm converting to self-insurance — *t*-statistic
Mental illness (0,1)	.005	.12	−.04	−.49
Psychologists' services (0,1)	−.03	−.75	.13**	1.96
Alcoholism treatment (0,1)	.004	.11	.01	.11
Drug abuse treatment (0,1)	.07	1.58	.10	1.09
Employer risk pool contribution (0,1)	−.07	−1.62	.07	1.04
Continuation-of-coverage (0,1)	−.09***	−2.68	.31***	4.41
Total number of mandates	−.001	−.44	−.02**	−1.97
Mandates enacted within prior 3 years	−.01	−1.03	−.001	−.20
Premium tax rate	−.04*	−1.71	.02	.45
Sample proportion of 1's	.70		.20	
Proportion of correct predictions	.80		.86	
N	1320		280	

Note: Marginal effects were computed from a probit model for the probability of offer in 1985, which also included as regressors: a constant term, the proportion of teenagers in the firm, the proportion women, the proportion blacks, the proportion part-time, the area unemployment rate, average worker income, the size of the tax subsidy for health insurance, firm size, and two dummies for whether the firm was a proprietorship or incorporated. For the complete analysis and full model, see Jensen, Gail A., and Jon R. Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," Working Paper, Wayne State University, March 1989.

Marginal effects were computed from a logit model for the probability of conversion to self-insurance during the period 1981–84, conditional on offering coverage. Other variables in the model were: a constant term, the proportion of males in the firm, the proportion blacks and/or hispanics, two dummies for the workers' occupational category, four firm size dummies, four industry dummies, and the size of the plan measured by number of enrollees. For a complete reporting, see "Regulation and the Decision to Self-Fund," Working Paper, Wayne State University. Paper was presented at the American Public Health Association annual meeting, Chicago IL, October 1989.

*** Significant at $\alpha = .01$.
** Significant at $\alpha = .05$.
* Significant at $\alpha = .10$.

ple. To determine the collective effect of mandated benefits, we asked the question, "How many more firms would offer health insurance to their employees if there were no mandates for alcohol and drug abuse treatments, mental illness, psychotherapy, insurance risk pool taxes, continuation-of-coverage requirements, and if no other new requirements had been enacted since 1982?" Using our statistical model, we simulated the resulting picture of coverage.

We found that approximately 16% of the firms not offering health insurance would have under these conditions. Which firms would likely have offered health benefits in a world essentially free of mandates? All industries and all size classes would have expanded coverage, but the largest gains would have occurred for firms most able to afford health insurance: mid-size firms, industries employing higher paid labor (transportation, utilities, manufacturing, and mining), corporations, and firms that were already providing life but not health insurance. Thus, as we would expect, more financially established firms rest at the "margin."

Mandated Benefits and the Decision to Self-Insure

Previously, we noted that the ERISA preemption has allowed plans to skirt mandates and other state oversights should the employer choose to self-insure. Employee benefit consultants generally agree that the ERISA preemption fosters self-insurance, but until recently there has been little research to support this belief.

When asked in telephone surveys, employee benefit managers have indicated that mandates are a contributing factor in their decision to self-insure. However, in these market surveys, employers that self-insure usually identified earning interest generated from claims reserve as the primary motive for self-insuring.[13] The interest, which serves as working capital for a business, is especially attractive when real interest rates are high, as they were in the early 1980s.

Methods

To observe how state mandated benefits affect the

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firm's decision to self-insure, we turn again to an analysis by Jensen and Morrisey (1988) of the BLS survey of midsize and large firms for the years 1981 and 1984.[14] They selected the 280 firms interviewed in both 1981 and 1984 that were fully insured in 1981. They excluded firms that were self-insured in 1981, on the assumption that once a firm self-insures, it is committed to self-insurance. Hence, the 280 firms were the potential pool of converters and most sensitive to changes in mandates and other state regulations.[15] In fact, 60 of the 280 firms converted to self-insurance during this period.

In the econometric model, the decision to convert to self-insurance was hypothesized to be a function of insurance regulations in the state, the size of the plan, the establishment's overall size, industry and regional location, and the demographic characteristics of the firm's work force.

Findings

Most mandated benefits increased the likelihood that a firm self-insured (see Figure 8). Firms located in states that mandated coverage of psychologists services were 93% more likely to convert to self-insurance than firms in states without mandates, other factors held constant. Firms in states mandating alcoholism and drug abuse treatment were also more likely to convert to self-insurance (although the effects were not statistically significant). New regulations enacted between 1981 and 1984 had little effect on the decision to self-insure; in contrast, the total number of mandates inexplicably decreased the likelihood of self-insuring (by 1.5% per mandate).

Premium taxes, risk pool taxes, and continuation-of-coverage regulations strongly encouraged firms to convert to self-insurance. Increasing the premium tax from 1% to 3% increased the probability of a conversion from 20% to 24% for sample firms. Imposing a risk pool tax raised the probability of a switch to self-insurance by 55%. Continuation-of-coverage mandates increased the likelihood of a firm converting to self-insurance about 1.5-fold.

There is one more puzzling result. Although not statistically significant, firms in states that mandated mental health coverage were less likely to self-insure. One possible explanation is that most midsize and large firms already offered mental health coverage, often in greater depth than defined by state legislation. Hence, the mental health coefficient may in fact measure the impact of other mandates correlated with state mandated mental health coverage.

The statistical model correctly predicted whether

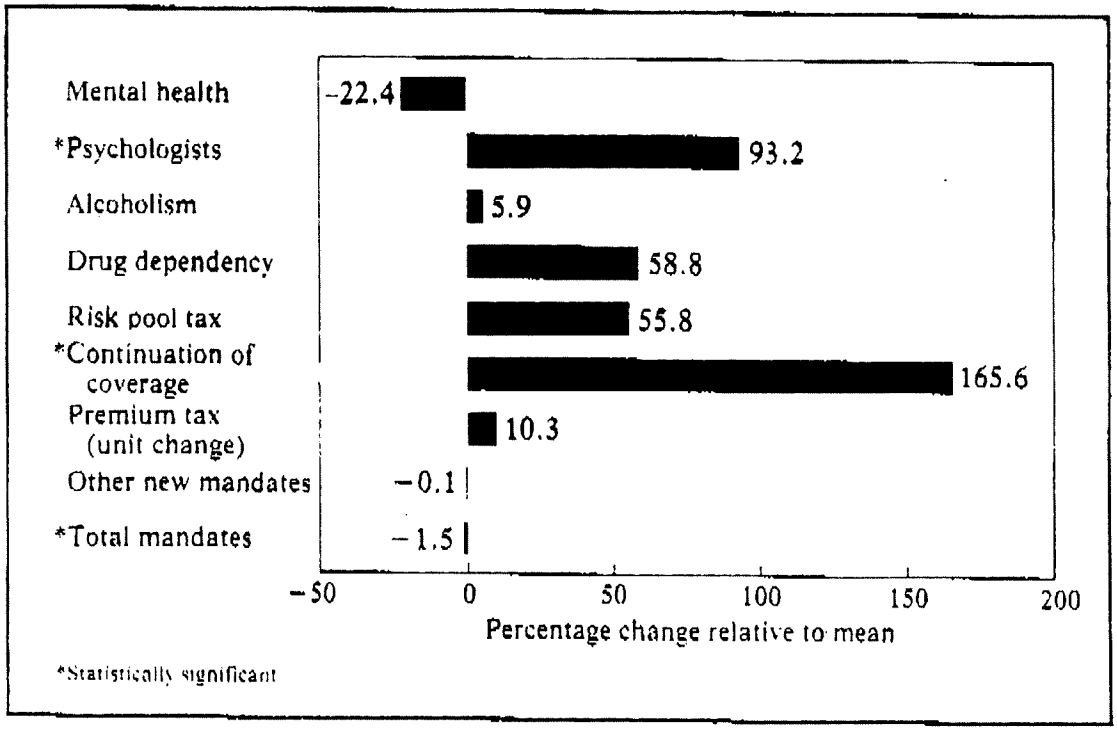

Figure 8. Percentage change in the likelihood that a large firm converts to self-insurance, if state adopts mandate (sources: BLS Employee Benefit Survey and Jensen and Morrisey 1988)

3-11

the firm converted to self-insurance for 86% of the firms in the sample. To determine the collective effects of mandated benefits, BLS asked the question, "How many fewer firms would have chosen to change to self-insurance, assuming there were no new mandates imposed between 1981 and 1984, no mandates for mental health coverage, drug treatment, alcoholism treatment, psychologists' services, no risk pool or premium taxes, or continuation-of-coverage mandates?" Using the statistical model, Jensen and Morrisey simulated the results and found that 51% of sample firms would not have converted to self-insurance if they had operated in an essentially mandate-free world. Firms most sensitive to mandates were midsize firms and those in industries where premiums tended to be higher, such as construction, transportation, mining, and services. These firms had more to gain from self-insuring; avoiding mandates meant greater net savings because of their larger size and higher cost of complying with new coverage rules.

Conclusion

The nearly 735 mandates passed by state legislatures constitute an understandable strategy for a society whose appetite for services greatly exceeds its willingness to pay for them. But the weight of the evidence indicates that society pays a price for mandated coverage.

First, mandates raise the price of insurance coverage—they are not, with few exceptions, cost-saving. Drug abuse treatment, coverage for psychiatric hospitals, and coverage for psychologist visits substantially increased the cost of a family coverage in midsize and large firms.

Second, collectively, mandates discouraged small employers from providing coverage. We estimate that approximately 16% of small businesses not offering health benefits to their employees would offer benefits in a less heavily mandated setting. Firms most likely to provide benefits if the burden of mandates were lifted are the better established small employers not currently offering health insurance. These firms employ larger numbers of individuals and tend already to offer life insurance benefits to their employees.

Third, state mandated benefits have encouraged firms to self-insure, and thereby escape state oversight—from mandated benefits to reserve and financial solvency requirements. We estimate that 51% of the firms that converted to self-insurance between 1981 and 1984 would not have, absent mandated benefits. State mandates of psychologists' services, risk pool taxes, and continuation-of-coverage requirements dramatically increased the likelihood that a firm would turn to self-insurance.

One mandate conspicuously affected small firms' decisions not to offer health benefits, and midsize and large firms' decision to self-insure more than any other—a state continuation-of-coverage requirement. Our analyses used data from the early and mid-eighties. Since then, the Federal Government has enacted legislation, the Consolidated Omnibus Reconciliation Act (COBRA), that has largely superseded these state laws requiring insurers and employers to extend coverage to workers whose employment with a firm has terminated. In analyses of individuals who have chosen to extend their coverage under COBRA, a recent study reports that expenditures per "COBRA beneficiaries" are 40% greater than for other employees (Spencer 1988). Thus, it appears substantial adverse selection ensued, as sicker individuals decided to retain their coverage, which thereby discouraged smaller firms from offering coverage and induced larger firms to self-insure.

Consequently, the price of mandated benefits is not only the increased price of health insurance, but a sense of lost control over a persistently rising portion of the firm's costs. At the margin, small firms may choose not to offer coverage. Large and midsize firms seem even more sensitive to mandates in their decision to self-insure. Whether the expanded benefits of mandates are worth the price is a question that ultimately rests on the values of the public decision-maker.

Notes

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1 Unpublished data, Legal/State Affairs Division, Health Insurance Association of America.

2 This suggests another politically attractive side of mandates. The benefits accrue to a small number of politically energized individuals, while the costs are borne by a diffuse and politically apathetic public.

3 See Employee Benefits Research Institute 1987.

4 For additional description of the hedonic approach, see Rosen 1974.

5 Readers interested in additional methodological detail should refer to Jensen and Morrisey, in press.

6 The family premium is the sum of individual and dependent premiums. Thus, to calculate the change in family premium, one sums the changes in individual and dependent premiums. Based on the premium data in Table 2, we used this summation procedure to construct Figure 6.

7 In fact, the coefficients for home care and extended care are not statistically significant.

8 See Jensen and Gabel 1988. In this article, we noted that firms that converted to self-insurance were also more likely to have increased their offerings of HMOs.

9 Health Insurance Association of America, unpublished data from the 1988 Survey of Employers.

10 Readers interested in further details should refer to Jensen and Gabel 1989.

11 The 1,320 firms were those firms for which complete data were available.

12 One possible reason for the lack of statistical significance is multicolinearity involving these variables. This was not a problem, however. Of the mandates in our model, the greatest correlation occurred between alcohol treatment and mental illness, but even this correlation was only .64.

13 See, for example, Health Insurance Association of America 1986, p. 12.

14 Readers interested in further details should refer to Jensen and Morrisey 1988.

15 The BLS reports data about the individual establishment. Thus, if a General Motors plant was located in Tennessee, we would capture information about the workers and health plan for the Tennessee plant, and the state mandates and regulations of the State. The shortcoming of this approach is that the decision to self-insure may depend on circumstances nationwide rather than on the establishment's predicament. This may not be a major flaw, however, because the BLS also captures information nationally about the size of the firm.

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