The Folly of Health Insurance mandates

Just under eighty-five percent of Americans are covered by health insurance – a proportion that has changed little over the past decade or so. According to the Census Bureau, 15.3% of the population lacked coverage in 2007 – the same percentage as was uninsured in 1993.

Nearly 46 million Americans currently lack coverage according to the Census Bureau. If you ask them, many will likely tell you that they simply cannot afford coverage, don't have access through work or it isn't worth the money it costs.

Of those who lack coverage:

- 30% already qualify for public coverage but have not enrolled.
- 40% live in households that earn more than $50,000 annually (half of which earn more than $75k).

The remaining portion of the uninsured has household income between $25,999 and $50,000. They likely cannot afford private coverage but earn too much to qualify for public coverage. A tax credit might help this group afford health coverage. Moreover, past studies have found that one-in-five of the uninsured have access to coverage through an employer but have declined coverage.

It's statistics like these that cause many progressive politicians, public health advocates and supporters of universal coverage to argue that the United States needs an individual mandate that would compel all U.S. residents to have health insurance; and impose an employer mandate that would force firms to subsidize much of the cost. In addition to these two mandates, supporters would require insurers to accept all applicants at premiums not rated for the health status. But rather than make coverage affordable, these regulations will drive up the cost of insurance for most applicants.

Employer mandates. Benefits substitute for cash wages in a worker's compensation package. If their workers are unwilling to forgo wages in return for health insurance, firms are unlikely to offer coverage. Forcing employers to provide health benefits to workers who are unwilling to bear the premium costs themselves is tantamount to forcing employees to accept a health insurance fringe benefit in lieu of wages. This doesn't make coverage more affordable. Instead it forces employees to bear the cost — whether they like it or not. To the extent employers are forced to provide benefits that workers are unwilling to pay for, it becomes a tax on labor that inhibits job creation.

Individual Mandates. All but three states have an auto insurance mandate — but in many states the proportion of people who lack auto liability coverage is similar to those who lack health coverage. On average about 15 percent of motorists are uninsured — a figure very similar to

those that lack health coverage. It may well be many of the same people. Considering how little success states have had enforcing relatively inexpensive auto liability coverage, it would be much more difficult to enforce a costly health coverage mandate.

Special Interests. Another problem is that individual mandates are vulnerable to special interests. With mandated coverage, some governmental body must have the authority to appoint an oversight board which decides when the mandate is met. These groups are typically stacked with public health advocates, union officials, and representatives from medical societies, hospital associations and other so-called "stakeholders," all of whom dislike lower-cost plans that include employee cost-sharing and self-insurance for small medical expenses. They tend to qualify only expensive, comprehensive plans with lavish benefits, low deductibles and high lifetime payment caps.

Connector boards, state legislatures or Congress will be lobbied by special interests to mandate coverage of their industry's services. In fact, across all 50 states there are nearly 2,000 benefits and providers that health insurers are required to cover. Proponents of these mandated benefits claim their respective benefits cost little. But they add up. In fact, several studies have estimated that about one-quarter of the uninsured have been priced out of the market by costly mandates. According to a University of Minnesota study, up to 12 million additional people would have health coverage if there were a national market that allowed people living in states with costly mandates to purchase coverage across state lines in states that have fewer costly mandated benefits and providers. By allowing people to comparison shop in other states, residents could choose the coverage they want for the prices they want to pay.

Mandated Acceptance. If individuals are compelled to have health coverage, many argue it is only fair to force insurers to accept all people who apply, and charge premiums not adjusted for health status. These regulations are known as *guaranteed issue* and *community rating*. Banded rates are supposed to ensure the sickest patients pay premiums that aren't much greater than the healthiest enrollees.

The problem is that mandated acceptance raises premiums. In every state where *guaranteed issue* and *community rating* are in effect, health insurance premiums are two to three times the national average. If insurers cannot charge premiums that reflect the expected costs of the person insured, others must be charged higher rates to subsidize them. And if insurers must cover all who apply, people tend to wait until they are sick to enroll since there is no penalty for waiting.

Mandated coverage for the poor. Under an individual mandate, many moderate income families will find it difficult to afford the costly plans forced on them by well-meaning bureaucrats. This obligates taxpayers to subsidize the cost of those who cannot easily afford coverage on their own. All proposals to require an individual mandate would also expand public programs, such as Medicaid and SCHIP. Some propose to solve the affordability issue by letting

non-seniors obtain coverage in a Medicare-for-All type plan. Such a plan, if it were free of all the obligation private insurers are required to follow, including the ability to avoid taxes, forced taxpayers to subsidize losses and use the force of law to extract provider discounts similar to what Medicare pays, would essentially crowed out private insurers who did not have the same advantages. According to the Lewin Group, if enrollment in such a plan were open to all and paid below-market provider rates, about 131 million people would join the plan. Of this number, 119 million people would likely either have dropped (or lost) private coverage. This would ultimately result in a government take-over of the health insurance — which would hold nearly an 80% market share. It unlikely that private insurers would be able to stay in business once they've lost that much negotiation power.