FREEDOM OF CHOICE IN HEALTH INSURANCE

John C. Goodman
National Center for Policy Analysis

and

Gerald L. Musgrave
Economics America, Inc.

NCPA Policy Report No. 134
November 1988

National Center for Policy Analysis
12655 N. Central Expressway, Suite 720
Dallas, Texas 75243
(214) 386-6272

EXECUTIVE SUMMARY

The number of Americans without health insurance has increased by 25 percent since 1980 and now totals 37 million people. A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance.

In recent years there has been an explosion of state laws requiring health insurance policies to cover specific diseases and specific health care services. These laws are called mandated health insurance benefit laws.

- In 1970, there were only 30 mandated health insurance benefits in the United States.
- Today there are 686 mandated benefits, including legislation passed by every state in the union.

Mandated health insurance benefits cover ailments ranging from AIDS to alcoholism and drug abuse and services ranging from acupuncture to *in vitro* fertilization. These laws reflect the fact that special interest groups now represent virtually every disease and disability and virtually every health care service. Currently,

- Thirty seven states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture, and two states require coverage for naturopaths (who specialize in prescribing herbs).
- At least 13 states limit the ability of insurers to avoid covering people who have AIDS, or who have a high risk of getting AIDS.
- Laws in 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction, and 30 states require coverage for mental illness.
- Five states even mandate coverage for *in vitro* fertilization.

Mandated benefits cover everything from the life-prolonging procedures to purely cosmetic devices. They cover heart transplants in Georgia, liver transplants in Illinois and hairpieces in Minnesota. Collectively, these mandates have added considerably to the cost of health insurance, and they prevent people from buying no-frills insurance at a reasonable price.

Using an econometric model of the health insurance marketplace, we estimate that

- As many as one out of every four uninsured people lack health insurance because state regulations have increased the price of insurance.
- This means that as many as 9.3 million people lack health insurance because of current government policies.

Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace.

INTRODUCTION

By some estimates, there are as many as 37 million Americans without health insurance, and the number has been growing. Since 1980, the number of non-elderly people without health insurance has increased by 25 percent. At the urging of Governor Michael Dukakis, the state of Massachusetts has passed legislation intended to provide all Massachusetts residents with health insurance beginning in 1992. Legislation to require employers to provide health insurance for all employees nationwide has been introduced in Congress by Senator Edward Kennedy.

Yet, close inspection of the health insurance marketplace reveals that the problem is too much government regulation, not too little. Regulation of health insurance by state governments is causing millions of Americans to be priced out of the market for health insurance.

HEALTH INSURANCE BENEFITS MANDATED BY STATE GOVERNMENTS[1]

Mandated health insurance benefit laws are laws that require health insurance contracts to cover specific diseases and disabilities and specific health care services. The vast majority of mandated benefit laws require insurers to include coverage for the benefit as part of a standard insurance policy. In some cases, the law requires insurers to offer the benefit as an option for which an additional premium may be charged. Over the last two decades there has been an explosion of such legislation at the state level:[2]

- In 1970, there were only 30 mandated health insurance benefit laws in the United States.
- Today, there are 686 mandated benefits laws.

Mandated benefits cover diseases ranging from AIDS to alcoholism and drug abuse. They cover services ranging from acupuncture to *in vitro* fertilization. They cover everything from life-prolonging surgery to purely cosmetic devices -- from heart transplants in Georgia and liver transplants in Illinois to hairpieces in Minnesota. These laws reflect the fact that the provision of health insurance is becoming increasingly political. Special interest lobbies now represent almost every major disease and disability, virtually every important group of health care providers, and virtually every

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[1]Many of the statistics in this section were obtained from various sources in the health insurance industry. The interpretations of the statistics are those of the authors, and they do not constitute legal opinions. In fact, in many states lawsuits currently are underway to determine the exact meaning of various statutes and regulations.

[2]Information obtained from the Blue Cross and Blue Shield Association. For a discussion of the growth of mandated benefits, see Greg Scandlen, "The Changing Environment of Mandated Benefits," in Employee Benefit Research Institute, *Government Mandating of Employee Benefits*, (Washington, D.C.: EBRI, 1987), pp. 177-183.

type of health care service. As a result, the health insurance marketplace is being shaped and molded by political pressures, rather than by competition and consumer choice in a free market.

Mandated benefits legislation invariably makes health insurance more expensive. Yet under federal law, companies with self-insured health care plans are exempted from these state regulations; and virtually all large companies and a large percentage of medium-size companies are now self-insured. Federal employees and people covered by Medicare also are exempt. In addition, it is common practice for state govenments to exempt state employees and people covered by Medicaid from state regulations. As a result, the burden of mandated benefits regulations falls heavily on employees of small firms and on people who purchase individual and family policies. In general, these are people who have no economic or political power, and who are not represented by well-organized, special interest group lobbyists.

The sections that follow contain brief summaries of the types of regulations imposed by state governments and an explanation of how these regulations are increasing the cost of private health insurance.

Misguided Attempts to Shift Costs from the Public to the Private Sector

An important principle of insurance is that the insured event must be a risky event -- one which has not already occurred. It is in this sense that pure insurance is like a gamble. If we knew in advance which specific policyholders will become ill, there would be no insurable (risky) event, and there would be no market for insurance against unexpected illness. Yet a number of states require insurers to insure people who are already known to have an illness that will incur future medical costs in excess of the insurance premiums they pay. The result is that all other policyholders must pay higher premiums to cover these costs.

Another important principle of insurance is that individuals must not be able to make claims as a result of their deliberate and intentional behavior. Thus, fire insurance reimburses for accidental fires, but not when policyholders burn down their own buildings. Life insurance reimburses for accidental death, but not for intentional suicide soon after the policy is issued. Yet a number of states require health insurance to cover treatment for alcoholism and drug abuse for policyholders who are already engaging in substance abuse at the time the policy is issued.[3] The result is that social drinkers, teetotalers and non-drug users must pay higher premiums to cover these costs.

Regulations such as these are partly the result of lobbying pressures from health care providers and from high-risk groups. But they also reflect a desire on the part of state legislators to force the private sector to pay for costs that would otherwise be paid for by government.

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[3]Whether or not alcoholism and drug abuse are properly classified as "diseases," they are the direct result of the purposeful behavior of the victims. Thus, insurance against alcoholism or drug abuse often is not insurance against the possibility that someone "accidentally" will become a substance abuser, but is instead a commitment to pay medical expenses for a policyholder who *already* is an alcoholic or drug abuser at the time the policy is issued.

AIDS. The cost of treating AIDS patients currently runs between $75,000 and $150,000.[4] Since most AIDS patients are unable to pay these costs from their own resources, the cost of treating uninsured AIDS patients often is borne by government. In an effort to shift these costs to the private sector, the District of Columbia prohibits insurers in the District from refusing to issue a policy or charging a higher premium to individuals *already* diagnosed as having AIDS.[5] A number of states are moving in this same direction:

- In California, insurers may not test insurance applicants for the presence of AIDS antibodies.
- Three states (Florida, New Jersey and Wisconsin) prohibit AIDS testing for group insurance and a similar regulation has been proposed in Rhode Island.
- In 12 states, insurers may not ask applicants if they have ever been tested for AIDS and similar regulations are being proposed in five other states.[6]

Alcoholism and Drug Abuse. Substance abuse, particularly drug abuse, can be even more expensive to treat than AIDS. This is partly because the treatment is prolonged, typically takes place in an expensive treatment facility, and requires intensive use of trained personnel. In addition, after a single course of treatment, the patient frequently is not "cured" and must return for further multiple courses of treatment. As in the case of AIDS, the cost of much of this treatment is a cost that government might have to bear unless private health insurance pays for it.

A majority of states now have regulations governing health insurance for alcoholism. Of these, 31 states make coverage for alcoholism mandatory and nine states require that the insurer offer coverage for alcoholism as an option. At least 20 states have regulations governing health insurance for drug addiction. Of these, 17 states make benefits mandatory, and three states require coverage as an option. In some cases, the regulations are ludicrous from the point of view of genuine insurance. For example,

- In Louisiana, group insurers are required to offer coverage for treatment of alcoholism or drug abuse as an option -- an option that few policyholders would pay for unless they intended to file a claim.
- In Connecticut, insurers are required to provide at least 30 days of inpatient care for the "accidental ingestion" of cocaine, marijuana, morphine, amphetamines, barbituates, hallucinatory drugs and other controlled substances.

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[4]In certain "managed care" programs the cost may be as low as $35,000. See Roger Rickles, "Firms Turn to 'Case Management' to Bring Down Health Care Costs," *The Wall Street Journal*, December 30, 1987, p. 13.

[5]Note: The 1989 Congressional appropriations bill contains language that will force the District of Columbia to repeal this law. In effect, Congress told the District that no federal funds would be available unless the law was rescinded.

[6]With the exception noted above, insurers may conduct their own tests, but such testing is expensive and adds to the overall cost of insurance.

TABLE I

RESTRICTIONS ON HEALTH INSURANCE
RELATING TO AIDS*

(As of June 1, 1988)

Regulation	States With the Regulation	States Where Regulation Is Proposed
1. HIV testing prohibited for all insurance.	1	0
2. HIV testing prohibited for group insurance.	3	1
3. Insurers may not discriminate on the basis of sexual orientation.	13	4
4. Insurers may not use sexual orientation, occupation, age, sex or marital status to predict whether an individual will develop AIDS.	10	3
5. Insurers may not ask questions about sexual orientation or lifestyle.	13	4
6. Insurers may not ask if the applicant has been tested for HIV or ask the results of such tests.	12	5
7. Insurers may not ask if the applicant had a blood transfusion.	2	0
8. Insurers may not ask if the applicant has been rejected as a blood donor or been advised not to donate blood.	2	0

*Does not include Washington, D.C. (which prohibits insurers from denying coverage or charging higher premiums to individuals diagnosed as having AIDS or who exhibit AIDS symptoms). Note: Companies that have self-insured plans for their employees are exempted from these regulations.

Source: Information compiled by Security Life of Denver.

Adopted Children. Eight states have regulations mandating coverage for adopted children -- usually a requirement that adopted children be given the same coverage as other dependents. In Minnesota, however, an insurer must cover preexisting conditions. This means that if an adopted child has an expensive-to-treat condition, the insurance company (and therefore other policyholders) must bear the costs of treatment from the moment of adoption. This regulation encourages families to adopt children who might otherwise remain in state institutions at taxpayer expense. Yet while saving some money for Minnesota taxpayers, the regulation also raises the cost of health insurance for other Minnesota families.

Special Interest Pressures from Health Care Providers

All health insurance contracts require some specification of who is authorized to diagnose an illness, and who is authorized to treat the illness. Under traditional contracts, this authority was reserved to licensed MDs. Thus, the treatment of mental illness would include psychiatrists, but not psychologists. Diagnosis and treatment of diseases of the eye would include ophthalmologists, but not optometrists. In general, podiatrists and chiropractors were excluded as well.

In recent years, however, we have witnessed a flood of regulations designed to open the market for health insurance reimbursement to scores of allied practitioners who are not medical doctors. Chiropractors are an example:

- Currently, 37 states mandate coverage for the services of chiropractors.
- In general, chiropractors have the right to diagnose and treat diseases (including taking diagnostic X-rays) under standard insurance policies.
- In Nevada, insurers must reimburse chiropractors at the same fee as the reimbursement rate for physicians performing similar services, even though the chiropractor's fee to non-insured patients may be from one-half to one-third of that amount.

These regulations can significantly raise the costs of conventional health insurance. In general, patients of chiropractors tend to be heavy users of services. Because they practice a different style of medicine, chiropractors often will diagnose illnesses that will be dismissed by MDs and prescribe courses of treatment that would not have been prescribed by MDs.

Chiropractic services are not an isolated example. Table II gives an indication of the extent to which other "allied practitioners" have succeeded in obtaining access to the health insurance marketplace. In some cases, such as the use of nurse midwives, the cost of health care may actually be reduced. But in most cases, these regulations lead to more diagnoses, more procedures performed and higher insurance costs. For example,

- In California, if an insurance policy covers the services of a psychiatrist, it must also cover similar services performed by marriage counselors and child and family counselors.
- In Alaska and Connecticut, insurers must cover the services of naturopaths (who specialize in prescribing herbs).

TABLE II

MANDATED BENEFITS:
EXPANDING THE MARKET FOR SERVICES
(As of August, 1988)

Type of Service	States with Mandates[1]
Chiropractors	37
Psychologists	37
Optometrists	31
Dentists	27
Podiatrists (Chiropodists)	25
Nurse Midwives	20
Other Types of Nurses[2]	16
Social Workers	14
Psychiatric Nurses	6
Physical Therapists	5
Professional Counselors[3]	4
Speech/Hearing Therapists	4
Oriental Medicine/Acupuncturists	3
Occupational Therapists	3
Naturopaths	2
Pharmacists	1
Dieticians	1

[1] Includes mandated coverage and mandated offerings.

[2] Includes nurses, nurse practitioners and nurse anesthetists.

[3] Includes marriage, family and child counselors.

Source: Blue Cross and Blue Shield Association.

- In Florida and Nevada, insurers must cover acupuncture, and in California coverage for acupuncture must be offered as an option.

The potential for further mandates covering allied practitioners is almost endless. Currently there are at least 142 distinct health-related professions, with as many as 240 occupational job classifications.[7]

Building Constituencies for Specific Diseases and Disabilities

As in the case of AIDS, with increasing frequency legislators are facing pressure from groups who are affiliated with a particular disease or disability or who have a high risk of affliction. In terms of the number of regulations, it would appear that the blind have the most effective special interest lobby. Beyond blindness, constituencies for diseases extends from pregnant mothers who have been exposed to cancer-causing substances to virtually every form of mental illness. The following are some examples.

DES Mothers. In the 1950s and 1960s a number of pregnant women took the drug diethylstilbestrol (DES) to control morning sickness. Subsequently it was discovered that exposure to DES could cause cervical and uterine cancer in the daughters of these women. Despite this knowledge, at least six states limit the ability of insurers to act on it. For example, in California an insurer may not charge higher premiums or refuse to cover an individual either because the person has conditions attributable to DES or has been exposed to DES.

Sickle Cell and Other Genetic Traits. Some individuals carry a genetic trait which does not affect the health of the carrier but may produce a disease or disability in the person's offspring. Examples are the Sickle Cell trait (which almost exclusively is found in black men) and Tay-Sachs trait (which almost exclusively affects certain individuals of Jewish descent). Even when it is known that an applicant has such a genetic trait, many states restrict the ability of insurers to act on this knowledge. For example,

- At least six states have regulations governing the sale of insurance to individuals who have a Sickle Cell trait.
- In California, Florida and North Carolina, insurers may not deny coverage or charge a higher premium based on the likelihood that a Sickle Cell trait may affect an individual's offspring.
- In North Carolina, this same restriction is extended to individuals with hemoglobin C trait.
- In California the same restriction applies to all genetic traits.

[7]John B. Welsh, Jr., "Legislative Review of Third-Party Mandated Benefits and Offerings in the State of Washington," in *Government Mandating of Employee Benefits*, p. 194.

Physical and Mental Handicaps. The vast majority of states have regulations governing the sale of health insurance to handicapped or disabled individuals. For example,

- At least 34 states have regulations covering all physical handicaps or all general handicaps and disabilities.
- At least 30 states have regulations specifically covering mental disabilities.
- At least 35 states have regulations specifically covering blindness, or partial blindness.

In general, these regulations inhibit insurance companies from selling policies for actuarially fair prices. As a result, the cost of insurance is higher for all other policyholders.

- In many states insurers cannot refuse to cover the handicapped, but may charge higher rates if based on actuarial experience.
- In North Carolina, insurers have flexibility with respect to handicapped adults, but must cover handicapped minor children at the same rates as other children.[8]

When insurers are allowed to charge higher premiums to handicapped persons, the insurance company usually bears the burden and expense of proving that the rate differentials are justified. For example,

- In Missouri, insurance regulators assume there is no differential risk among classes of people unless the insurers can produce statistical evidence that there is a difference.
- In Minnesota, insurers may not charge higher premiums because of a disability unless they can prove that there are substantial and significant differences in health care costs for people who have those disabilities.

On the surface, it might seem fair to ask that differential premiums be related to differential costs of insurance. Yet, the burden of proof may be too costly or even impossible for insurers to bear. For example, in Louisiana, insurers must cover individuals with spinal cord injuries, amputations, autism, epilepsy, mental retardation and any other neurological impairment. A higher premium may be charged only if insurers can justify the higher premium based on actuarial experience. In many cases, however, the disability is so rare and infrequent that no actuarial tables exist.

As a result of these restrictions, the premiums charged are less fair than they would otherwise be. Handicapped policyholders often are undercharged, and all other policyholders are overcharged to make up the difference.

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[8]In this instance (as in most other cases discussed in this section) the insurer is not required to pay the cost of treating a preexisting illness. However, the insurer is precluded from charging a higher premium even though a disability (such as blindness) increases the likelihood of future claims because of a higher probability of future accidents and injuries.

Misguided Attempts At Cost Control

A number of mandated benefits regulations are designed to encourage substitution of outpatient surgery for impatient surgery, substitution of home care for hospital care, second and even third opinions prior to surgery, and certain types of preventive medical care. Although, these regulations may have been encouraged by provider groups who have an economic interest in the regulation, in some cases regulations also appear to be influenced by the desire to reduce health care costs. In all cases, however, these regulations are misguided attempts to substitute the judgment of politicians for freedom of choice in the marketplace.

Outpatient Care. Ten states require insurers to cover outpatient care as an alternative to inpatient care, and six of these states require that the benefits be identical to the benefits covering inpatient care. If surgery is performed in an independent outpatient clinic, usually there are opportunities for important cost savings. Yet with increasing frequency, hospitals are setting up their own outpatient services and the costs of these services may be higher than inpatient care. Cataract surgery is an example. A survey conducted by Medical Care International found that[9]

- The average price for cataract surgery performed in a hospital was $1,350.
- The average price for cataract surgery in an independent ambulatory surgical center was $860 -- about 36 percent less.
- But, the same surgery performed outpatient by a hospital was $2,020 -- about 50 percent more than the cost of inpatient hospital surgery.

Home Health Care. At least 18 states have regulations governing home health care. In 12 of these coverage is mandatory and in six others coverage must be offered as an option. New Jersey, for example, requires coverage in the home for anything that would have been covered in a hospital on the same reimbursement basis. Yet, because home care often results in the utilization of more services over a longer period of time than is the case for hospital inpatient care, home care can cost more than inpatient care.

Second Opinion Surgery. Four states require insurers to cover a second opinion prior to surgery, and Rhode Island requires coverage for a third opinion if the first two physicians disagree. Yet the experience of large corporations has been that blanket policies requiring second opinions save very little money. The reason is that second opinions are costly, and for many procedures the cost may be greater than the benefit.[10]

Preventive Medical Care. Both Massachusetts and Kansas now require coverage for Pap Smear tests and 12 states mandate coverage for mammography. Yet evidence indicates that the costs of such tests may exceed the benefits.[11] The most

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[9]Information obtained from Medical Care International. Note: these prices exclude professional fees.

[10]See Glenn Ruffenach, "Health Costs: Second Thoughts on Second Opinion," *The Wall Street Journal*, July 27, 1988, p. 21.

[11]A contributing reason is that Pap tests fail to detect cervical cancer about 30 percent of the time. See Walt Bogdanich, "Physicians' Carelessness With Pap Tests is Cited in Procedure's High Failure Rate," *The Wall Street Journal*, December 29, 1987, p. 15.

extreme form of mandated benefits for preventive care for children has occurred in Florida. Legislators in that state have mandated coverage for a specific number of physician visits for children at different ages with a requirement that the insured not be charged any deductible in connection with the visit.

Case Study: Maternity and Child Birth

Of all of the issues in mandated health care benefits legislation, none more completely reflects the pressures on state legislators than pregnancy and childbirth -- in terms of the emotional impact of the issue and in terms of pressures brought by medical providers and their potential patients. Every state in the Union has some regulation governing health insurance for newborn children, and at least 45 states require that newborn care be included both in individual and group policies.[12] It's not hard to understand why:[13]

- In 1986 Sheraton Corporation spent $1.2 million (about 10 percent of its total health care costs) on three premature babies born to company employees.
- In 1984, Sunbeam Appliance Co. spent $500,000 (half of its entire employee health care costs) on four premature babies.
- That same year Ameritrust Corporation spent $1.4 million on one premature baby.

Clearly, having a child is a risky and potentially costly event. Yet many state regulations are forcing the health insurance marketplace to ignore that fact. For example,

- Arizona requires that a policy covering an insured person's dependents must also cover a newborn child (including coverage for premature births and congenital abnormalities) at the same premium that is being paid for other dependent children.
- In Montana, coverage for a newborn child is mandated, even if other dependent children are not covered.
- In Minnesota and Ohio, a policy covering a dependent's daughter must also cover the newborn child of the (unwed) daughter.

Since newborn children are more expensive to insure than existing children, the costs of these mandated benefits must be borne by other policyholders -- including single men, and women who do not or cannot have children.

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[12]Linda L. Lanam, "Mandated Benefits -- Who Is Protected?," in *Government Mandating of Employee Benefits*, p. 186.

[13]Rickles, "Firms Turn to 'Case Management' to Bring Down Health Care Costs," p. 13; and Cathy Trust, "Corporate Prenatal-Care Plans Multiply, Benefiting Both Mothers and Employers," *The Wall Street Journal*, June 24, 1988, p. 15.

A majority of states also have regulations covering the costs of maternity and complications of pregnancy. In addition, at least 15 states prohibit discrimination on the basis of marital status -- despite the fact that unwed mothers have a higher incidence of complications of pregnancy. For example, in Colorado and New Jersey, single women and divorced women must be given the same coverage on the same terms as married women.

Nor is that all. Even if pregnancy is viewed as a risky and unplanned event, surely the same cannot be said for *in vitro* fertilization. Yet,

- Four states -- Arkansas, Hawaii, Maryland and Massachusetts -- mandate benefits for *in vitro* fertilization, and in Texas it must be offered as an option.

- Moreover, because the procedure can cause multiple conceptions (leading to multiple abortions or multiple births) the resulting health care expenses can be enormous.

Other Types of Mandated Benefits

In addition to the medical benefits described above, a number of states also regulate the terms and conditions on which policies may be sold. For example, some states mandate that a policy must be "guaranteed renewable" for a certain period of time. This means that an insurer cannot stop covering a group of people, regardless of actuarial experience. Some states also mandate that Medicare supplemental policies must be "guaranteed issued." This means that the insurer cannot refuse to sell the policy, regardless of the health of the applicant. In some cases, states refuse to allow coordination of insurance claims among companies covering the same individual. This means that an individual with coverage by more than one insurer can collect full benefits under each policy and could actually "profit" from being sick.

As with other types of mandated benefits, little is known about how much any single type of regulation adds to the rising cost of health insurance premiums. However, Golden Rule Insurance Company (the nation's largest seller of individual and family policies) has made a few estimates of how some of these regulations have increased the average policy premium in some states. Specifically,[14]

- Because Texas mandated that major medical plans must be guaranteed renewable for the first five years, Golden Rule's premiums in the state were increased by 15 percent.

- Because Georgia does not allow claims to be coordinated among insurance carriers, Golden Rule policies in that state are 15 percent higher than they otherwise would be.

- Maryland's requirement that Medigap policies be guaranteed renewable adds 13 percent to premium prices.

- Michigan's requirement that Medigap policies be guaranteed renewable and guaranteed issue adds 30 percent to premium prices.

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[14]Information obtained from Golden Rule Insurance Company.

- Because of unisex legislation in Montana, Golden Rule no longer markets insurance in the state.

Price Regulation, Insurance Company Profits, and High-Risk Individuals

As Lloyd's of London has shown us, almost any risky event is insurable for a price. Lloyd's not only insures communications satellites headed for upper earth orbit, it also has insured Bruce Springsteen's voice and the beards (against fire or theft) of 40 members of the Whiskers Club in Derbyshire, England. When Cutty Sark offered $2 million to anyone who could capture the Loch Ness monster alive, Lloyd's even insured Cutty Sark against having to honor its promise.

If Lloyd's of London can insure men's whiskers and a $2 million reward for the capture of the Loch Ness monster, why do so many Americans have difficulty buying something as common and everyday as health insurance? The answer seems to be that in almost every state, health insurance premium prices are regulated.

Since health insurance costs are continuously rising, regulation of premium prices usually consists of a restriction on how much premium prices may increase to cover those costs. In most states, insurance companies may not increase premium prices unless benefits paid are at least equal to a certain percentage of premium income. In all cases, regulation of premium prices translates into regulation of insurance company annual profits. Without annual profits to retain, the company cannot build a reserve to cover costs that are unusual enough to occur once in every five, ten or 20 years. This type of regulation, in turn, can have a devastating effect on the ability of individuals with a higher-than-average probability of illness to obtain health insurance.

Risk and Profit. A basic principle governing all financial markets is: The higher the risk, the higher the rate of return. For example, in order to induce investors to purchase riskier financial assets (stocks, bonds, etc.), those investors must expect to earn more than they can earn on less risky assets. If we made it illegal to earn more than, say, a ten percent return in the bond market, investors would be unwilling to purchase bonds from any but the most financially sound corporations. If we made it illegal to earn more than a eight percent return on bonds, then it is possible that investors would only be willing to purchase government securities.

A similar principle applies to the market for health insurance. When insurers sell policies to high-risk individuals, they are taking on more financial risk. Other things being equal, the more high-risk policyholders an insurer has, the more risky the total portfolio. Insurers will be willing to voluntarily accept additional risk, however, only if they can earn a higher return. When state governments limit the rate of return insurers can earn, the inevitable result is that higher-risk individuals will not be able to obtain health insurance at any price. One way to think of many mandated benefits laws is to see them as an attempt by state governments to force insurers to sell policies to individuals who have been regulated out of the market by state insurance regulators.

Such attempts are destined for failure, however. If state governments were really successful in forcing insurers to take on additional risk without allowing them to earn a corresponding higher rate of return, insurers would simply quit selling policies in the state and leave the market altogether. For example, primarily because of

regulation of premium prices, in September, 1988, Golden Rule Insurance Company ceased marketing its policies in seven states: Alabama, Georgia, Massachusetts, Mississippi, North Carolina, New Mexico and West Virginia.[15]

The Creation of Risk Pools. One way that state governments have attempted to deal with the problem of health insurance for high-risk individuals is through the creation of risk pools. These are a form of mandated benefit in the sense that all insurers operating in the state usually are forced to participate in the pool.

Currently, 15 states have established risk pools and similar legislation has been proposed in 22 other states.[16] Under this arrangement, insurance is sold to individuals who are unable to obtain policies outside the pool. Premium prices are regulated and generally are set as a percentage of the prices of similar policies sold in the marketplace. For example,[17]

- In most states, the premium for risk pool insurance is 50 percent higher than the price of comparable policies.
- In Florida, however, risk pool premiums may be twice as high as premiums for comparable policies, and in Montana they may be four times as high.
- In Minnesota, the most generous state, risk pool insurance is only 25 percent more expensive.

Since all states cap the price of risk pool insurance, risk pools almost always lose money.[18] In most cases, losses are covered by assessing insurers -- usually in proportion to their share of the market. However, in Maine, losses are covered by a tax on hospital revenues. In Illinois, losses are covered from general tax revenues. In most states that assess insurers for the losses of risk pools, companies are allowed to fully or partially offset their assessment against premium taxes paid to state governments.[19]

Problems With Risk Pools. The most serious problem with risk pools is that they raise the cost of health care and/or health insurance for everyone not in the pool. When risk pool losses are paid for by a tax on hospital revenues, the burden is being placed on sick people. When losses are covered by assessing insurers, the burden is being placed on other policyholders to the exclusion of uninsured people and employees of self-insured companies. Even when insurers are allowed to offset their assessments against state taxes, this practice creates additional pressure to maintain (or even increase) taxes on insurance premiums. This causes further distortion in the health insurance marketplace.

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[15]Information obtained from Golden Rule Insurance Company.

[16]For a state-by-state survey of risk pools, see Aaron K. Trippler, *Comprehensive Health Insurance for High-Risk Individuals,* 2nd edition, (Minneapolis: Communicating for Agriculture, 1987).

[17]*Ibid.*, pp. 23-24.

[18]Among operating pools, Florida is the only state that has not had losses. *Ibid.*, p. 47.

[19]*Ibid.*, pp. 35-37.

SOME CONSEQUENCES OF MANDATED BENEFITS BY STATE GOVERNMENTS

The flood of mandated benefits legislation at the state level has had two major consequences: (1) All those who can opt out of regulated health insurance and purchase nonregulated insurance tend to do so; and (2) among those who cannot obtain unregulated insurance, an increasing number have no insurance at all.

Ironically, those without insurance tend to represent both extremes on the spectrum of the potentially ill. Those who are very healthy (and who have a low probability of becoming ill) chose to remain uninsured because the price of regulated insurance (inflated by unwanted mandatory benefits) is too high. At the other extreme, those who have a high probability of becoming ill are uninsured because insurers go to considerable lengths to avoid insuring them.

The Escape from Regulation By Large and Medium-Sized Firms

On January 1, 1988 the Circle K Corporation, the nation's second largest convenience store chain, sent an interesting letter to its 8,000 employees. The letter announced that the company would no longer provide health care coverage for certain "life-style-related" illnesses, including alcohol and drug abuse, self-inflicted wounds and AIDS (unless acquired accidentally through a blood transfusion).[20] Since the Circle K Corporation operates in 27 states, it undoubtedly operates in states where health insurance benefits for the excluded diseases are required by state law. Yet because the company does not purchase insurance, federal law exempts it from state regulations mandating health insurance benefits.[21]

The Circle K Corporation is not alone. It is one of a large and growing number of companies that have chosen to self-insure rather than purchase conventional health insurance. Just as there has been an explosion of mandated benefits legislation over the last decade, there has been an equally dramatic increase in the number of companies that self-insure and manage their own employee health care plans.[22] For example,[23]

- In 1976, employer self-insurance accounted for only five percent of all health insurance.

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[20]Kenneth B. Noble, "Health Insurance Tied to Life-Style," *The New York Times*, August 6, 1988, p. 1.

[21]Note: In the fall of 1988, Circle K rescinded its new policy in response to pressure from activist pressure groups. Failing to comply with state mandates, however, is common practice among self-insured employers.

[22]For a description of the types of employer self-insurance and the benefits of self-insurance, see John Goodman and Gerald Musgrave, "The Changing Market for Health Insurance: Opting Out of the Cost-Plus System," NCPA Policy Report No. 118, September, 1985.

[23]Ross H. Arnett and Gordon Trapnell, "Private Health Insurance: New Measures of a Complex and Changing Industry," *Health Care Financing Review*, Vol. 2, Winter, 1984, p. 31.

- By 1983, 32 percent of all health insurance was accounted for by plans that were either self-insured or largely self-insured.

Today, virtually all large firms and probably a majority of medium-sized firms have turned to self-insurance. One reason for self-insurance is that companies are better able to manage their own health care plans and hold down rising health care costs. Another reason is that self-insured companies avoid state taxes on insurance premiums and other costly and inefficient regulations. Yet, the most important reason may be that self-insured companies bypass the regulations and costs of mandated health insurance benefits.[24] In other words, employers who self-insure have the freedom to provide insurance tailored to the wants and needs of their employees. They are doing what any sensible consumer would do, were it not for government interference.

When companies self-insure, they usually institute cost management techniques that are at odds with the direction of state health insurance regulations. For example, while the trend of regulations has been to increase the number and types of services required under conventional health insurance, the tendency among self-insured companies has been to restrict and limit employee choices -- to certain physicians, certain hospitals and certain types of care.[25]

Other people also are exempted from state mandated benefits. For example, all federal employees and all people covered under Medicare are exempted from the mandates by federal law. In addition, it is a common practice for state governments enacting the mandates to exempt state employees and all Medicaid patients.

The upshot is that the burdens and costs of mandated health care benefits are falling on the shoulders of the rest of the population: people who work for small firms, the self-employed and the unemployed.

The Rising Cost of Regulated Health Insurance

With few exceptions, mandated health care benefits legislation raises the cost of conventional health insurance. Moreover, as more and more companies self-insure, the burden and costs of these regulations are being imposed on a smaller and smaller proportion of insured individuals. In some states, it is believed that as much as 75 percent of the workforce is covered by self-insured plans. This means that the full burden of mandated benefits regulation falls on the shoulders of the remaining 25 percent of the workers.[26] The following are some consequences of these developments.

Higher Premiums for All Insured People. Mandated benefits legislation raises the cost of regulated health insurance in a variety of ways. As we have seen, some regulations force insurers to pay for the health care of people who are

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[24]U. S. Congress, Office of Technology Assessment, *Medical Testing and Health Insurance*, OTA-H-384, (Washington, D. C.: U. S. Government Printing Office, August, 1988), p. 7.

[25]Rhonda L. Rundle, "Insurers Step Up Efforts to Reduce Use of Free-Choice Health Plans," *The Wall Street Journal*, May, 1988.

[26]Scandlen, "The Changing Environment of Mandated Benefits," p. 182.

already sick (e.g., AIDS victims); other regulations force insurers to cover procedures more related to people's choices and preferences (e.g., *in vitro* fertilization, and marriage and family counseling) rather than to well-defined, risky events; and many regulations expand the definition of illness, and its cost of treatment, by expanding the range of covered providers (e.g., to acupuncturists and naturopaths).

Take coverage for the services of chiropractors, for example. A study by Peat Marwick Main & Co. found that,[27]

- Under Hawaii's current practice of not mandating coverage for chiropractic services, there was no evidence that lack of chiropractic coverage resulted in inadequate care or financial hardship for people using those services.

- On the other hand, were Hawaii to mandate coverage, the total cost of the mandated benefit would be as high as $8.1 million.

In a separate study, Peat Marwick found no evidence that lack of coverage for well-baby care resulted in inadequate care or financial hardship. Yet mandating coverage for well-baby care in Hawaii would increase health insurance costs by as much as $1.7 million.[28] Researchers also found only anecdotal evidence that lack of coverage for alcoholism and drug dependence resulted in lack of treatment. Yet the cost of mandating coverage for alcoholism and drug abuse in Hawaii would be as much as $2.3 million.[29] The cost of mandating coverage for inpatient mental health care in Hawaii was estimated to be as high as $12.3 million, and the cost of mandating outpatient treatment for mental illness could be as high as $6.8 million.[30]

Hawaii, incidentally, is one of a handful of states (including Arizona, Pennsylvania and Washington) that now require social and financial impact statements prior to the passage of any additional mandates.[31] For example, because of concern about costs, in 1983 the state of Washington began putting the burden of proof on the proponents of a mandated benefit to show that the benefits of the mandate exceed the costs. Interestingly, no new mandates have been adopted by the Washington legislature since the new policy was put into effect.[32]

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[27]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandated Health Insurance for Chiropractic Services: A Report to the Governor and the Legislator of the State of Hawaii*, January, 1988.

[28]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Well-Baby Services: A Report to the Governor and the Legislature of the State of Hawaii*, January, 1988.

[29]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness: A Report to the Governor and the Legislature of the State of Hawaii*, January, 1988.

[30] *Ibid.*

[31]Jack Myer, *Mandated Benefits for Employees: A Policy Analysis*, (Washington, D.C.: National Chamber Foundation, 1988), forthcoming.

[32]Employee Benefit Research Institute, "Employee Benefit Notes," Vol. 8, No. 9, Sept., 1987, p. 7.

TABLE III

THE COST OF PROPOSED MANDATED BENEFITS IN HAWAII

Benefit	Low Estimate	Middle Estimate	High Estimate
Chiropractic Services[1]	$2,734,000	$6,245,000	$8,089,000
Well-Baby Care[2]	1,267,750	1,521,280	1,774,810
Alcohol and Drug Abuse[3]	284,088	414,048	2,305,308
Inpatient Mental Health Care[4]	948,175	2,657,315	12,325,305
Outpatient Mental Health Care[5]	892,164	3,556,098	6,815,627
Total	$6,126,177	$14,393,741	$31,310,050

Note: These estimates would be considerably higher were it not for the fact that many Hawaiian insurance policies already have full or partial coverage for the benefit.

[1]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Chiropractic Services: A Report to the Governor and the Legislature of the State of Hawaii*, January, 1988, Table 4.2, p. 46.

[2]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Well-Baby Services: A Report to the Legislature of the State of Hawaii*, January, 1988, Table 4.5, p. 45.

[3]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness Services: A Report to the Governor and the Legislature of the State of Hawaii*, January, 1988, Appendix A, p. 108.

[4]*Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness Services*, Appendix B, p. 111.

[5]*Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness Services*, Appendix C, p. 114.

Excessive Premiums for Low-Risk Individuals. A basic principle governing the health insurance marketplace is that, in any given year, a small percentage of people will generate a majority of the health care costs. For example, a survey of employers by Johnson and Higgins found that,[33]

- About one percent of all employees account for 22 percent of company health care costs.
- About 5.6 percent of all employees account for 50 percent of company health care costs.

The experience of employers undoubtedly reflects the experience of the health insurance market as a whole. Accordingly, a major objective of health insurers is to expand coverage for the vast majority of people who will generate small claims and avoid coverage for individuals who are likely to generate larger claims. One purpose of mandated benefits legislation, however, is to try to force insurers to cover the high-risk population.

To the extent that the regulators are successful, insurers will cover more and more high-risk individuals and attempt to pay for the cost of this coverage by over-charging the low-risk population. As average premiums rise, health insurance becomes less and less attractive to people who are at low risk and fewer of them will buy insurance. As a result, a vicious cycle threatens to occur: As fewer low-risk people buy insurance, the pool of the insured becomes increasingly risky -- leading to higher premiums and even fewer low-risk people who choose to insure.

The Impossibility of Obtaining No-Frills Catastrophic Health Insurance Tailored to Individual and Family Needs. Another factor which encourages people (especially low-risk people) not to insure is that mandated benefits legislation prevents them from buying insurance tailored to their needs. In some states, couples who cannot have children cannot buy policies that do not provide for newborn infants coverage. Moderate drinkers and people who abstain from using drugs cannot buy policies that do not cover alcoholism and drug abuse. People who do not intend to see chiropractors, psychologists or marriage counselors cannot buy policies that exclude such coverage. As a result, people cannot buy the type of insurance they want for a price which reasonably reflects their wants and needs.

The Lack of Availability of Health Insurance for High-Risk Individuals. Ironically, an unintended consequence of mandated benefits legislation is that it probably makes it more difficult for higher-risk individuals to obtain insurance. When insurers are prevented from charging a premium that reflects the risk of insuring a group of individuals, they will attempt to find ways to avoid insuring them. As more and more low-risk individuals drop out of the market, insurers face even more pressure to avoid high-risk policyholders. At the extreme, as we have seen, insurers can refuse to sell any insurance within a state.

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[33]Reported in Rickles, "Firms Turn to 'Case Management' to Bring Down Health Care Costs."

The Growing Number of Uninsured Individuals

From World War II until the mid-1970s, the percentage of the population covered by private health insurance grew steadily. For example,[34]

- The percentage of the population covered by private health insurance for hospital care grew from 69 percent in 1960 to 83 percent in 1978.
- The percentage of the population covered by private health insurance for physician care grew from 46 percent in 1960 to 78 percent in 1974.

Since the mid-1970s, however, this trend has been reversed. Specifically,[35]

- The percentage of people with private hospital insurance fell from a peak of 83 percent to 79 percent by 1984.
- The percentage of people with private physician insurance fell from a peak of 78 percent to 73 percent by 1984.

By 1985, nearly 37 million Americans had no health insurance coverage -- either public or private.[36] Who are the uninsured? Primarily, they are people who are unemployed, self-employed and employees of small firms. Specifically,[37]

- About half of the uninsured population is not working.
- Among those who are working, about two-thirds were either self-employed or employees of firms with fewer than 25 workers.

The uninsured population also tends to be a low-income population:[38]

- Among full-time uninsured workers, 69 percent earned less than $10,000 in 1985.
- Nearly 92 percent earned less than $20,000.

Why are we witnessing a steady growth in the percentage of the population without health insurance? One reason may be tax reform.[39] Another reason may be a

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[34]U. S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1987*, Table No. 137, p. 89.

[35]*Ibid.*

[36]Employee Benefit Research Institute, *Issue Brief No. 66*, May, 1987, p. 2.

[37]*Ibid.*, pp. 4-5. Statistics given are for the nonagricultural population under 65 years of age.

[38]*Ibid.*, p. 15.

[39]Under federal tax law, employer-paid premiums for health insurance are not counted in the taxable income of employees. This tax subsidy is not available to the self-employed or to people who purchase health insurance on their own, although the Tax Reform Act of 1986 does allow self-employed people to deduct 25 percent of their premium payments. The tax subsidy to employer-provided insurance becomes less important at lower marginal tax rates, however. Thus, the lowering of

shift in employment from manufacturing to services and the retail trades.[40] But it's hard to escape the conclusion that an increasing number of consumers are being regulated and priced out of the market for health insurance.

TO WHAT EXTENT ARE MANDATED BENEFITS CAUSING PEOPLE TO BE UNINSURED?

An econometric model of the health insurance marketplace is contained in Appendix A. To our knowledge this is the first model ever developed that produces statistical estimates of the factors causing people to be without health insurance. Although certain information about the market for health insurance is not available to researchers, the model nonetheless explains 94 percent of the variation in the percent of the population without health insurance across the 50 states.

Various versions of the model were tested, and in each test the number of mandated benefits was a strong and statistically significant cause of lack of health insurance. Specifically,

- As much as 25.2 percent of all uninsured people nationwide lack health insurance because of mandated benefits.

- This means that mandated benefits are causing as many as 9.3 million people to be without health insurance.

The number of mandated benefits varies considerably among the states -- from a low of four in Delaware and Idaho to a high of 32 in Maryland. Moreover, the impact of the mandates is mitigated by other factors, such as the prevalence of employer-provided insurance and/or the ability to escape regulation through employer self-insurance. For these reasons, the percent of uninsured people who lack health insurance because of mandated benefits is substantially different in different states. Table IV shows those states where mandated benefits are having the greatest impact. As the table shows,

- People who lack health insurance because of mandated benefits exceeds 60 percent of the uninsured population in Connecticut, Maryland and Minnesota.

- That figure equals 41 percent in New York and exceeds 30 percent in California, Maine and New Jersey.

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tax rates in the 1980s also reduced the attractiveness to employees of employer-provided health insurance. See Gary A. Robbins, "Economic Consequences of the Minimum Health Benefits for All Workers Act of 1987 (S. 1625)," testimony presented to the U. S. Senate Committee on Labor and Human Resources, November 4, 1987.

[40]More than one-half of uninsured workers in 1985 were employed in retail trade and services. See EBRI, *Issue Brief No. 66*, p. 15.

TABLE IV

PEOPLE WHO LACK HEALTH INSURANCE
BECAUSE OF MANDATED BENEFITS

(Selected States in 1986)

State	Number of Uninsured	Percent of Uninsured Population
Arizona	131,000	20%
Arkansas	72,000	15%
California	1,650,000	32%
Connecticut	220,000	64%
Florida	406,000	18%
Kansas	82,000	27%
Maine	46,000	32%
Maryland	370,000	60%
Massachusetts	168,000	28%
Minnesota	232,000	60%
Missouri	211,000	30%
Montana	28,000	21%
Nebraska	62,000	26%
Nevada	45,000	30%
New Jersey	281,000	34%
New Mexico	53,000	16%
New York	1,057,000	41%
Ohio	394,000	28%
Texas	701,000	18%
Virginia	188,000	30%
Washington	183,000	30%

Source: Appendix A

The state of Massachusetts is of special interest. As we shall see, legislation recently passed in Massachusetts at the urging of Michael Dukakis will be a costly attempt to make health insurance available to all Massachusetts residents. Yet as Table IV shows,

- As many as 168,000 Massachusetts residents already lack health insurance because of regulations imposed by the state government.
- This amounts to 28 percent of the state's uninsured population.

PROPOSALS TO FORCE EMPLOYERS TO PROVIDE HEALTH INSURANCE TO THEIR EMPLOYEES

At the urging of Michael Dukakis, Massachusetts has passed legislation intended to provide all Massachusetts residents with health insurance, beginning in 1992. Dukakis and others have proposed similar legislation at the federal level, although the details of these proposals are still somewhat vague. Senator Edward Kennedy has proposed legislation designed to force employers to provide health insurance for all employees nationwide. These proposals would be enormously expensive, with the burden of the expense falling on workers -- who would receive less in take-home pay and other fringe benefits and who would have reduced job opportunities in the labor market. What follows is a brief summary of what is being proposed.[41]

The Massachusetts Health Care Plan.[42] Under the Dukakis proposal, employers would be forced to pay a tax of 12 percent on the first $14,000 of wages, but would be allowed to deduct the cost of employer-provided health insurance from the tax. Thus, employers would be forced to spend (either in taxes or on health insurance) $840 for an employee earning $7,000 per year and $1,680 for employees earning $14,000 or more per year.

These amounts are considerably lower than the expected premiums for individual and family policies. Moreover, the Dukakis proposal at the national level would allow states to continue passing mandated health insurance benefit laws and also would open the door to special interests to push for mandated coverage at the federal level. These additional mandates are destined to increase further the cost of private health insurance.

Under the Dukakis proposal, strong incentives exist for employers to choose to pay the optional tax and turn the obligation of providing health insurance over to the government. The government will offer its own health insurance policy to all

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[41]A more complete analysis of these plans will be contained in a forthcoming NCPA policy report.

[42]For more details about the Massachusetts health care plan, see Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?*, (Boston: The Pioneer Institute for Public Policy Research, 1988); and Gail R. Wilensky, "The 'Pay or Play' Insurance Gamble: Massachusetts Plan for Universal Health Coverage." Paper presented to the House Wednesday Group, Washington, D.C., September 26, 1988.

uninsured individuals, with unspecified subsidies for low-income individuals. No one will be obligated to purchase the government's health insurance policy, however. As a result, it seems likely that the number of uninsured people will rise, not fall.

Despite the fact that many of the details of the Massachusetts health care plan are still uncertain, economists Attiat Ott and Wayne Gray have made the following estimates of the minimum cost of the plan for employers and their employees:[43]

- In Massachusetts, the plan will impose an additional cost of at least $642 million on private industry in its first year of operation and will lead to as many as 9,000 fewer jobs for Massachusetts workers.

- If the plan were extended nationwide, the additional cost for employers and employees would be $23 billion and the number of lost jobs would be as high as 358,000.

The Kennedy Proposal. Unlike the Massachusetts plan, the Kennedy proposal would require employers to provide a specific package of health insurance benefits to their employees. The cost of the health insurance package would be determined by the market. Moreover, unlike the Massachusetts plan, the Kennedy proposal would not allow workers to be without health insurance. Since Senator Kennedy's required package of benefits is considerably more generous than policies now provided by most employers, the cost of the Kennedy proposal (at least in terms of the direct cost for private industry) is much higher than the Dukakis proposal. Specifically,[44]

- The Kennedy proposal would impose a cost on employers and employees of at least $100 billion.

- The proposal also would lead to one million fewer private sector jobs.

One virtue of the Kennedy proposal is that it would override all state mandated benefits legislation. This virtue is offset by the fact that special interest warfare at the state level would immediately be transferred to the national level, however. Thus, the cost estimates above apply only to the initial package of benefits.

Experience at the state level teaches that once the federal door has been opened, hordes of special interest lobbyists will descend on Washington. Every group from acupuncturists to naturopaths will be pressuring Congress for inclusion in the federal mandates. Whatever the initial package of benefits, it inevitably will expand. Whatever the initial costs, they eventually will be higher. In the politics of health insurance at the state level, special interests have been exploiting the politically weak, i.e., those not represented by a disease lobby or a provider lobby. The Kennedy bill would elevate this process to the status of national policy.

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[43]Ott and Gray, *Massachusetts Health Plan*. Note: These estimates are based on the assumption that employers pay no more than the required 12 percent of the first $14,000 of wages for each employee. As noted above, this amount is considerably less than the cost of providing health insurance.

[44]See Gary Robbins and Aldona Robbins, "Mandating Health Insurance," Institute for Research on the Economics of Taxation, July 8, 1987. Note: These estimates apply to the original Kennedy proposal. Estimates of the cost of the revised committee version of the Kennedy bill (an even more expensive proposal) will be contained in a forthcoming NCPA policy report.

CONCLUSION: INCENTIVES VS. CONTROLS

Millions of Americans lack health insurance today because of government regulations and controls. Rather than enacting more regulations and more controls, we would do better to eliminate the distortions government already has imposed on the market for health insurance and give the market a chance to work. Specifically,

1. Congress should exempt all Americans from the pernicious effects of state mandated health insurance benefits legislation, not just employees of self-insured companies, federal employees and Medicare patients.

2. Congress should override price controls and other state regulations that prevent the operation of a competitive market for health insurance.

3. Congress should extend to all individuals an opportunity now made available only to employees of firms that provide health insurance -- the opportunity to spend a certain percent of family income on health insurance with pre-tax dollars.

4. If Congress fails to override state regulations for all individuals, at a minimum it should retain the ability of companies that self-insure to avoid the payment premium taxes and to ignore state mandated benefits laws.

5. At the state level, legislatures should immediately repeal the most costly mandated benefits and, at a minimum, should require social and financial impact statements from those who propose new mandates.

6. If states establish risk pools, these ventures should be subsidized from general tax revenues rather than by a "tax" on other policyholders or by a "tax" on hospital patients.

Above all, government should encourage individuals in the private sector to use their intelligence and creativity to find imaginative solutions to health care problems and give the private sector the freedom to implement those solutions.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder passage of any bill before Congress.

APPENDIX A

A model of the market for health insurance is described as follows. The demand for health insurance in state i at time period t is given by the equation

$$(1) \quad P^{d}_{it} = \alpha_0 + \alpha_1 Q^{*}_{it} + \alpha_2 M_{it} + \alpha_3 U_{it} + \alpha_4 GSP_{it} + u_{1it}$$

where P^d is the maximum price consumers will pay, Q* is the equilibrium amount of health insurance, M is the number of mandated benefits, U is the unemployment rate, GSP is the gross state product per capita, and u_1 is an error term.

The supply of health insurance in state i at time period t is given by the equation

$$(2) \quad P^{s}_{it} = \beta_0 + \beta_1 Q^{*}_{it} + \sum_{j=2}^{4} \beta_j R_{jit} + \sum_{j=5}^{18} \beta_j \left(\frac{OUT}{TOT}\right)_{jit} + \beta_{19} TAX_{it} + \beta_{20} M_{it} + u_{2it}$$

where P^s is the minimum price sellers will accept, R_j is a binary variable indicating the presence or absence of rate regulation of type j, $(OUT/TOT)_j$ is the percent of total state output produced in industry j, TAX is indirect business taxes per capita; and u_2 is an error term.

Partial Adjustment Model

Equilibrium in the health insurance market in state i occurs when supply equals demand. That is when $P^{s}_{it} = P^{d}_{it}$ or when the premium price the buyers are willing and able to pay is equal to the premium price providers are able and willing to accept.

We know that equilibrium is not achieved instantaneously in the health insurance market. Equilibrium is reached by a combination of accommodations by suppliers and demanders of health insurance. One way to express the process of reaching an equilibrium is through a partial adjustment process. That process of adjustment can be symbolized as $Q_{it} - Q_{i,t-1} = \gamma(Q^{*}_{it} - Q_{i,t-1})$, where $0 \leq \gamma \leq 1$. This means that the adjustment moves toward the equilibrium value Q* over a period of

time, and γ is the adjustment coefficient indicating how fast we reach equilibrium. After one period of time, the gap between the actual and the equilibrium level of insurance coverage is closed by the factor Υ. Note that $(1-\Upsilon)$ is the remaining gap between the actual and the equilibrium insurance coverage in the state.

Under these assumptions, the model can be expressed as a distributed lag model. The equilibrium conditions are:

$$(3) \quad P^d_{it} = P^s_{it}$$

$$(4) \quad Q_{it} - Q_{i,\,t-1} = \gamma(Q^*_{it} - Q_{i,\,t-1})$$

The reduced form for Q^*_{it} is

$$(5) \quad Q^*_{it} = -\left(\frac{\alpha_0-\beta_0}{\alpha_1-\beta_1}\right) - \left(\frac{\alpha_2-\beta_{20}}{\alpha_1-\beta_1}\right)M_{it} - \left(\frac{\alpha_3}{\alpha_1-\beta_1}\right)U_{it} - \ldots + \frac{u_{2it} - u_{1it}}{\alpha_1 - \beta_1}$$

Our estimation process is slightly different from the supply and demand model given above because of technical considerations. The data for the number of uninsured people for 1985 and 1986 may not be exactly comparable because of the sampling differences between the two years. The uninsured percentages for the two years are comparable, however. Because of this, we estimated the model using the percent of the population uninsured. This allows us to interpret the estimated coefficients in terms of the percent of individuals who are uninsured (directly) because of regulations mandating health insurance benefits. One can obtain the parameters of the conventional supply and demand model very easily from our results.

Suppose we rewrite equation (5) as: $Q = (A_0 + A_1M + A_2U + \ldots)$. From this equation we know that:

$$(5a) \quad \frac{POP-Q}{POP} = \frac{POP - (A_0 + A_1M + A_2U + \ldots)}{POP}$$

where POP is the total population and Q is the number of people with health insurance.

The left hand side of (5a) is the percentage of people who are uninsured. In our estimation process we multiply both sides of the equation by POP. The result is POP - Q = POP - ($A_0 + A_1M + A_2U + ...$) or -Q = - ($A_0 + A_1M + A_2U + ...$). This means that all of the parameters in our model are identified, but the signs have been reversed. In other words, what causes a higher percent of people to be insured causes a lower percentage to be uninsured.

Under conventional assumptions concerning the statistical nature of the stochastic disturbance terms u_{1it} and u_{2it}, ordinary least squares regression is an appropriate estimation technique. Under these conditions our methods lead to consistent and asymptotically efficient estimates of the model's parameters.

The estimated model is obtained by replacing Q^*_{it} in equation (5) by

$$(6) \quad \frac{\left(Q_{it} - (1-\gamma)Q_{i,\,t-1}\right)}{\gamma}$$

which yields

$$(7) \quad Q_{it} = (1-\gamma)Q_{i,t-1} - \frac{\gamma(\alpha_o-\beta_0)}{\alpha_1-\beta_1} - \frac{\gamma(\alpha_2-\beta_{20})}{\alpha_1-\beta_1}M_{it} - \ldots + \left(\frac{\gamma}{\alpha_1 - \beta_1}\right)(u_{2it} - u_{1it})$$

In this case Q_{it} represents the observed percent of people without health insurance and the u's are normally distributed, with

$$E(u_i) = 0, \ \text{var}\ (u_i) = \sigma^2 \ \text{and} \ \text{cov}\ (u_i, u_j) = 0.$$

Variable	Definition and Data Source
NHINS	Percent of non-elderly population with no health insurance for 1985 and 1986. (Employee Benefit Research Institute, Issue Brief, May, 1987; and May, 1988.)
MANDATES	Number of mandated health care benefits required by various states. (Blue Cross and Blue Shield Association, Office of Government Relations, State Services Department, January, 1988.)
Rate Regulations: EAUTH IAUTH IAUTHNO	Three binary variables indicating the nature of the rate regulations prevailing in the states (i.e., explicit authority to regulate premium rates, implicit authority to regulate rates, and no implicit authority to regulate rates). Note: a fourth variable (no explicit authority to regulate rates) was dropped. (Price and DeLaney/NCPA.)
PCGSP	Per capita gross state product. (Department of Commerce, Survey of Current Business, May, 1988.)
PCTAX	Per capita indirect business taxes. (Department of Commerce, Survey of Current Business, May, 1988.)
Structural Variables:	Gross state products by industry. Note: federal military was dropped. (Department of Commerce, Survey of Current Business, May, 1988.)
FARMS	Farms.
AGRI	Agricultural services, forestry and fisheries.
CONSTR	Construction.
MINE	Mining.
DURABLES	Manufacturing - durable goods.
NDURABLES	Manufacturing - nondurable goods.
TRANSP	Transportation and Public Utilities.
WTRADE	Wholesale trade.
RTRADE	Retail trade.
FINANCE	Finance, insurance, and real estate.
SERVICES	Services.
FEDGOV	Federal civilian government.
STLCGOV	State and Local Government.

UNEMP Unemployment rate for civilian noninstitutionalized population 16 years old and over. (Bureau of Labor Statistics, Graphic Profile of Employment and Unemployment.)

Three states were omitted from the analysis because the number of non-insured was too small to be statistically significant, and were not listed in the data for 1985. Those states were North Dakota, Vermont and Wyoming. (See EBRI, Issue Brief, May, 1987, Table 9.)

Parameter Estimates: Partial Adjustment Model

EQUATION: 1

DEPENDENT VARIABLE: NHINS86 (Percent of people without health insurance in 1986)

TOTAL OBSERVATIONS: 47 DEGREES OF FREEDOM: 25

R**2: .99831265 RBAR**2: .99689528

SSR: .91844588E+09 SEE: 6061.1744

DURBIN-WATSON: 1.64232279

No.	Label	Coefficient	Stand. Error	T-Statistic
1	CONSTANT	15.38724	41.32565	.3723411
2	MANDATES86	.1668048	.0639550	2.608157
3	UNEMP86	-.0680815	.2929591	-.2323926
4	EAUTH	-2.498613	1.412862	-1.768476
5	IAUTH	-5.303481	1.919794	-2.762526
6	IAUTHNO	-2.882711	1.393590	-2.068550
7	PCGSP86	-.3836934	.3484659	-1.101093
8	PCTAX86	2.644120	2.313734	1.142793
9	FARMS86	-36.98915	44.10623	-.8386377
10	AGRI86	-60.29810	233.9657	-.2577219
11	MINE86	-8.003193	40.33954	-.1983958
12	CONSTR86	-26.97017	59.56049	-.4528199
13	DURABL86	-14.51591	39.36198	-.3687799
14	NDURABL86	-25.88435	50.33370	-.5142548
15	TRANSP86	7.392113	48.06914	.1537808
16	WTRADE86	49.72888	32.44955	1.532498
17	RTRADE86	63.44863	74.91162	.8469798
18	FINANC86	-45.57886	46.38196	-.9826850
19	SERVIC86	-39.02915	45.35369	-.8605507
20	FEDGOV86	-95.64868	66.64619	-1.435171
21	STLCGO86	16.22694	55.41544	.2928234
22	NHINS85	.9576672	.0920499	10.40378

Our results show that the single most significant factor contributing to the growing number of uninsured people is mandated health care benefits. According to our data, approximately 37 million people have no health insurance. We estimate that 14 percent of them, or a total of 5.2 million people, are without health insurance as a direct result of state mandated health care benefits.

In terms of economic markets, the coefficient $(1-\gamma)$ has a large t-statistic which is to be expected if the insurance market is slow to adjust to equilibrium. In our case the adjustment is very slow About four percent in any disequilibrium gap is closed in one year. This means that state regulations (mandates and rate regulations) produce inefficient allocations of resources. Consumers and suppliers cannot adjust to their desired level of insurance purchase and sales.

The rate regulation variables are the only other variables where specific coefficients had separately identifiable effects. We did not expect any of these variables, nor the industry structural variables, to have individually quantifiable influences on the percent of people uninsured. We did expect unemployment, gross state product and indirect business taxes to have identifiable impacts. When all of the economic factors in the model are included, unemployment does not have a separate effect. Higher state income is associated with lower levels of people without health insurance, as we expected. Also, higher indirect business taxes are consistent with higher percentages of people without health insurance. We do not make any claims concerning the interpretation of these individual coefficients. However, one can see part of the economic process in action. For example, of the structural variables, wholesale trade has the highest t-statistic. It is well known that wholesale and retail trade plus services have relatively low rates of health insurance coverage. In addition, the federal government has high coverage. Our model is in agreement with these facts. We also note the relatively high value of the coefficient of determination after correcting for degrees of freedom. The model and the data seem to be consistent.

We were not satisfied with a single result, even if that result was dramatic. Our results seem to indicate that we have slow adjustment to equilibrium. It might be possible to obtain confirming results by reestimating reduced form annual models where the year to year changes are not present.

Annual Models

We reestimated two additional annual versions of the model. The first model is for 1985 and the second is for 1986, the most recent year for which data are available. The results are as follows:

Parameter Estimates: 1985 Annual Model

EQUATION: 2

DEPENDENT VARIABLE: NHINS85 (Percent of people without health insurance in 1985)

TOTAL OBSERVATIONS:	47	DEGREES OF FREEDOM:	26
R**2:	.94888226	RBAR**2:	.90956093
SSR:	989012.41	SEE:	195.03574
DURBIN-WATSON:	1.93276861		

No.	Label	Coefficient	Stand. Error	T-Stastic
1	CONSTANT	121.5406	61.66898	1.970854
2	MANDATES85	.2402324	.1102901	2.178187
3	UNEMP85	.6824406	.4773556	1.429628
4	EAUTH	-3.310617	2.642282	-1.252939
5	IAUTH	-6.814506	3.375479	-2.018827
6	IAUTHNO	-4.255663	2.601649	-1.635756
7	PCGSP85	-.3718421	.6054451	-.6141633
8	PCTAX85	-5.867217	4.390963	-1.336203
9	FARMS85	-93.86216	65.94504	-1.423339
10	AGRI85	-128.0080	382.4854	-.3346743
11	MINE85	-42.70966	57.32271	-.7450739
12	CONSTR85	2.336543	87.13869	.0268140
13	DURABLES85	-130.7575	53.94302	-2.423993
14	NDURABL85	-126.3279	70.07460	-1.802764
15	TRANSP85	-202.7656	76.73359	-2.642462
16	WTRADE85	58.28214	65.25377	.8931613
17	RTRADE85	10.32106	167.1523	.0617464
18	FINANCE85	-119.1641	70.94300	-1.679716
19	SERVICES85	-93.33781	64.92925	-1.437531
20	FEDGOV85	-222.8615	92.66268	-2.405083
21	STLCGOV85	-142.3675	90.73053	-1.569125

Parameter Estimates: 1986 Annual Model

EQUATION: 3

DEPENDENT VARIABLE: NHINS86 (Percent of people without health insurance in 1986)

TOTAL OBSERVATIONS: 50 DEGREES OF FREEDOM: 29

R**2: .94411261 RBAR**2: .90556958

SSR: 1275482.2 SEE: 209.71921

DURBIN-WATSON: 1.69857393

No.	Label	Coefficient	Stand. Error	T-Statistic
1	CONSTANT	89.20582	70.63262	1.262955
2	MANDATES86	.3005725	.1223011	2.457644
3	UNEMP86	1.048330	.5341898	1.962468
4	EAUTH	-4.889916	2.825964	-1.730353
5	IAUTH	-9.836038	3.427377	-2.869844
6	IAUTHNO	-5.681983	2.644034	-2.148982
7	PCGSP86	-.0108217	.7120041	-.0151990
8	PCTAX86	-3.174815	4.296943	-.7388545
9	FARMS86	-110.5493	76.05452	-1.453554
10	AGRI86	-135.9224	378.4848	-.3591223
11	MINE86	-53.38495	67.55392	-.7902568
12	CONSTR86	-18.92929	96.47855	-.1962020
13	DURABL86	-123.1774	59.51452	-2.069703
14	NDURABL86	-113.8465	77.16567	-1.475352
15	TRANSP86	-129.6379	81.58208	-1.589049
16	WTRADE86	36.53968	70.40693	.5189784
17	RTRADE86	146.6216	161.1671	.9097490
18	FINANC86	-112.6120	77.41692	-1.454618
19	SERVC86	-119.2101	68.96267	-1.728618
20	FEDGOV86	-257.1540	104.4142	-2.462826
21	STLCGO86	-64.44493	99.80877	-.6456840

The most striking feature of the results is the stability of our finding across all models.[1] In the two annual models, mandates were highly significant influences in increasing the percentage of individuals with no health insurance. These short-run results show that higher levels of causation may be appropriate. For example, in 1985 our estimate is that each mandate increases the percentage of people with no health insurance by 0.284 compared to 0.167 in the partial adjustment model. The 1986 model results in a coefficient of 0.301. By comparison with the partial adjustment model, the 1986 results would indicate that 4.5 percent of the nonelderly population or 25.2 percent of the noninsured population are uninsured because of mandated health insurance benefit regulations.[2]

In the short-run annual models, unemployment has a much stronger impact on lack of health insurance. Apparently, the generally short-term nature of most peoples' unemployment results in short-term absence of health insurance. However, as time progresses these individuals reobtain or purchase health insurance. State level fluctuations in other measures of economic activity produce unstable results in their impact on health care insurance. The general structure of the state's economic development has a more stable pattern of influence on the provision of health care coverage in comparison to short-run impacts of transitory changes in economic activity. These results are remarkably consistent.

Conclusion

Our overall finding is that the economic process of supplying and demanding health insurance is rational and produces expected results. Economic markets for health insurance are hindered by regulations. The structure of industry within a state, as well as its short-term level of economic activity, influence the number of individuals without health insurance. Health insurance rate regulation also is important.

In terms of statistical reliability, the major determinant of the lack of health insurance is mandated benefit regulations. More mandates mean more people without health insurance. We estimate that between 14.0 and 25.2 percent of those without health insurance have no insurance because of regulations that mandate coverage. That is, in 1986 between 5.2 million people and 9.3 million people had no health insurance coverage because state governments imposed special interest regulations mandating

[1]The model for 1986 has three additional states because in 1986 these states had enough residents who were uninsured as to be statistically significant. These states were thus added to the data base.

[2]See Table A-1.

health insurance coverage. The accompanying table shows the distribution by state. Since the number of mandates is growing, these estimates probably have lower values than the effects of mandates in 1988.

TABLE A-1

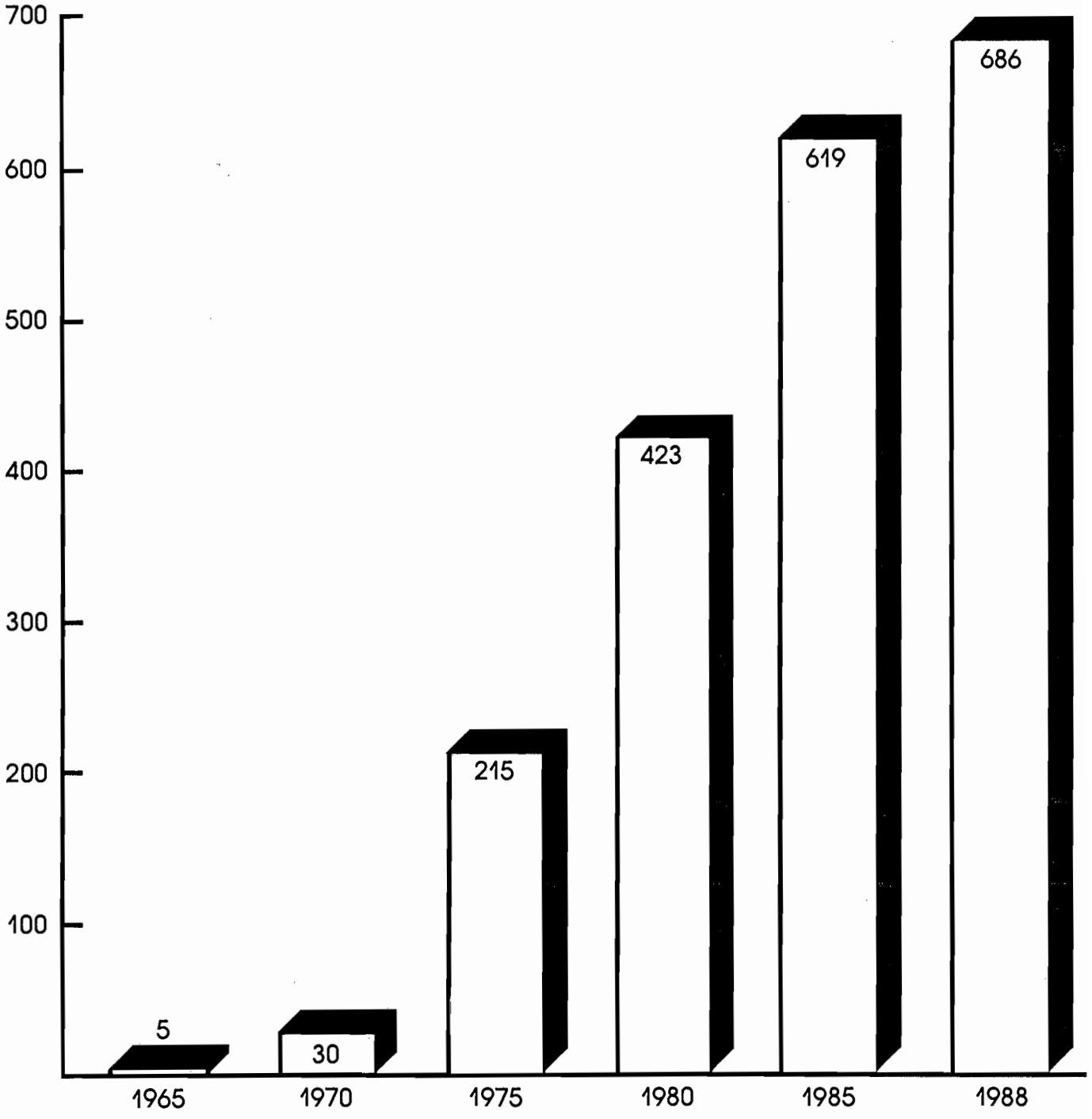
	Population Uninsured (Thousands)	Estimates of Uninsured Population Due to Mandates (Thousands)	
		Low[1]	High[2]
ALABAMA	859	42	75
ALASKA	97	5	8
ARIZONA	651	72	131
ARKANSAS	487	40	72
CALIFORNIA	5142	916	1650
COLORADO	450	42	75
CONNECTICUT	345	122	220
DELAWARE	99	4	7
FLORIDA	2242	225	406
GEORGIA	954	80	144
HAWAII	107	10	18
IDAHO	196	6	10
ILLINOIS	1481	185	334
INDIANA	833	78	140
IOWA	295	30	53
KANSAS	299	45	82
KENTUCKY	659	58	104
LOUISIANA	904	78	141
MAINE	145	25	46
MARYLAND	617	205	370
MASSACHUSETTS	605	93	168
MICHIGAN	965	136	244
MINNESOTA	389	129	232
MISSISSIPPI	606	41	74
MISSOURI	714	117	211
MONTANA	134	16	28
NEBRASKA	234	35	62
NEVADA	154	25	45
NEW HAMPSHIRE	101	13	24
NEW JERSEY	825	156	281
NEW MEXICO	325	29	53
NEW YORK	2556	586	1057
NORTH CAROLINA	985	89	161
NORTH DAKOTA	87	10	18
OHIO	1409	218	394
OKLAHOMA	636	37	67
OREGON	478	44	79
PENNSYLVANIA	1185	199	358
RHODE ISLAND	69	8	15
SOUTH CAROLINA	468	33	60
SOUTH DAKOTA	103	9	16
TENNESSEE	826	87	157
TEXAS	3833	389	701

UTAH	253	34	60
VERMONT	69	4	7
VIRGINIA	622	104	188
WASHINGTON	603	102	183
WEST VIRGINIA	295	22	39
WISCONSIN	444	124	224
WYOMING	78	5	9
TOTAL	36913	5162	9301

[1]Based on the equilibrium values of the partial adjustment model.

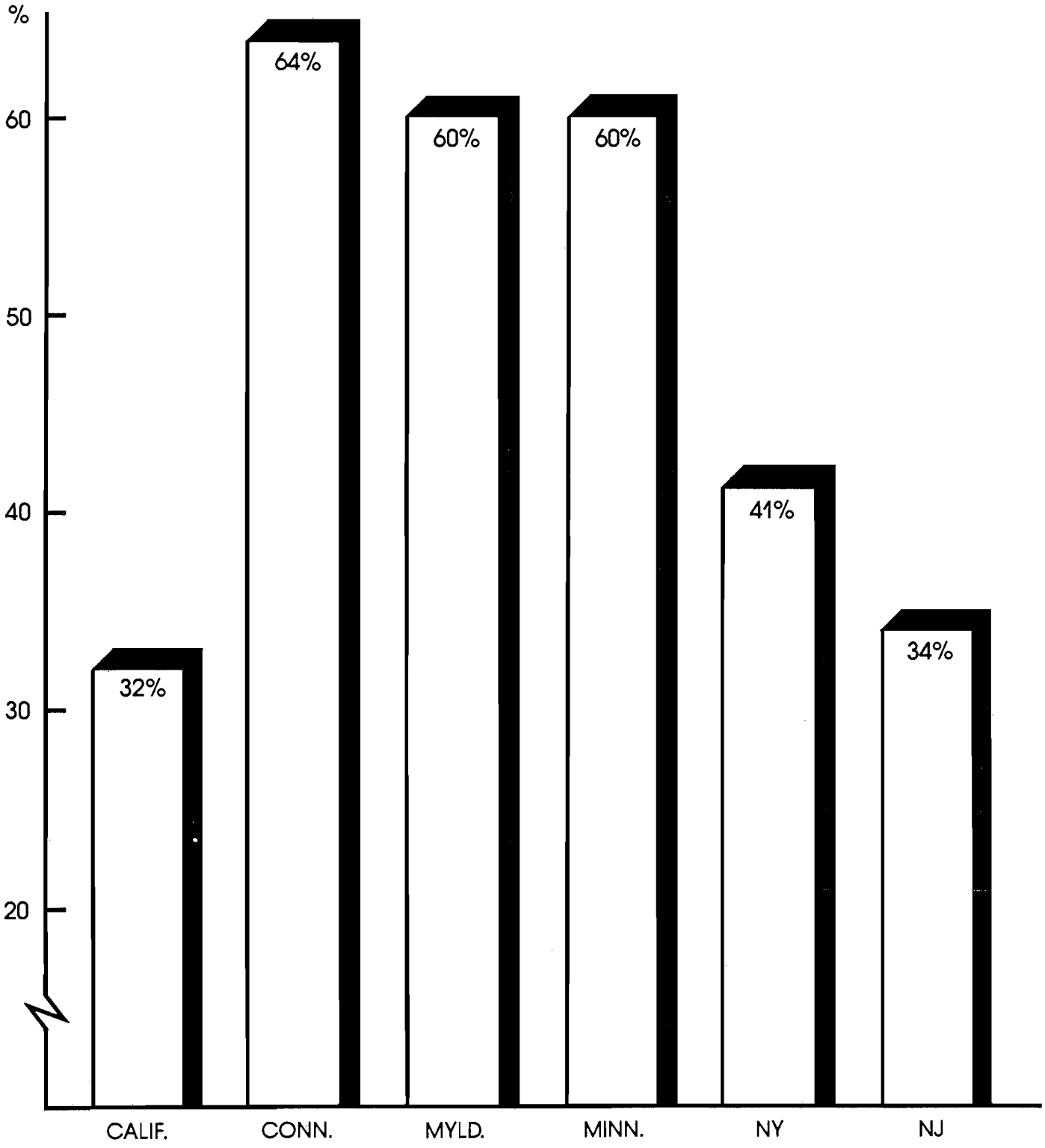
[2]Based on the 1986 annual model.

NUMBER OF MANDATED HEALTH INSURANCE BENEFITS ENACTED BY STATE GOVERNMENTS



SOURCE: BLUE CROSS AND BLUE SHIELD ASSOCIATION

PERCENT OF UNINSURED PEOPLE WHO LACK HEALTH INSURANCE BECAUSE OF MANDATED BENEFITS



SOURCE: NATIONAL CENTER FOR POLICY ANALYSIS

ABOUT THE AUTHORS

JOHN C. GOODMAN is President of the Dallas-based National Center for Policy Analysis. He has written widely on health care, Social Security, the welfare state and other public policy issues. He is author of six books, including *National Health Care in Great Britain* and *Regulation of Medical Care: Is the Price Too High?*

GERALD L. MUSGRAVE is President of Economics America, Inc., a consulting firm in Ann Arbor, Michigan. A former Adjunct Professor of Economics at the University of Michigan, Dr. Musgrave also has written widely on health care and other issues. He is the Chairman of the Health Economics Roundtable of the National Association of Business Economists and a White House appointee to the National Institute of Health Recombinant DNA Advisory Committee. Among Dr. Musgrave's publications is: "Health Care for the Elderly: The Nightmare in Our Future."