

HEALTH CARE: TO MANDATE OR NOT TO MANDATE?

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In the 1960s, when health care was not such a national issue, there were only a handful of state mandates in existence related to health insurance. However, as of this year, the Council for Affordable Health Insurance ("CAHI")¹ has identified 1,961 health insurance mandates nationwide. There are arguments for and against health insurance mandates. It has been estimated that approximately 46 million Americans are uninsured.² This fact has sparked a national debate over whether to expand coverage through employer mandates or individual mandates, with the purpose of getting to the goal of universal coverage, where every American would have some form of health insurance. On the other hand, mandating health insurance coverage, while popular, carries with it a cumulative price tag which makes health insurance less affordable for individuals, small employers and increasingly even large employers. So, what is the answer?

The answer may in large part depend upon which side of the political coin one happens to occupy: generally speaking, Democrats support mandates, while Republicans typically oppose mandates primarily because of the cost associated with such forced coverage. Regardless, one thing is certain: health insurance mandates are a topic currently being debated in every state and on a national level and will be a relevant topic for years to come. And regulators, primarily insurance departments, are also wrestling with mandates. Regulators have testified before Legislative Committees both in support of and against mandates and are charged with enforcement of legislation once passed. This article will define health care mandates, identify types of health care mandates, provide an analysis of the arguments for and against such mandates in a health care context and then identify current trends.

What Are Health Care Mandates?

Simply put, a mandate is a requirement that an insurance company, a health maintenance organization or other entity that sponsors health plans (such as a self-insured employer) offer specified providers, procedures or benefits, or provide coverage to certain classes of individuals. On the insured side, in order for a health insurer or health maintenance organization to do business in a state, it must comply with state-legislated health insurance mandates. Accordingly, the vast majority of health mandates come from state legislatures. However, the federal government, in the last two decades, has been increasingly willing to impose mandates nationwide that impact both insured and self-funded plans. Most state mandates affect small and large employers and occasionally, individual policyholders, which can mean the self-employed. Employers can escape state mandates by self-funding and sponsoring a qualified health plan under the Employee Retirement Income and Security Act ("ERISA").³

While mandated benefits may in fact make health insurance broader, in that more people may obtain more coverage, there is no doubt that health mandates in turn make coverage more expensive. But one thing is certain. Once a state mandate is enacted, it is almost impossible to get it repealed.

Types Of Health Care Mandates.

Essentially, there are three types of mandates in health insurance coverage. The first and most commonly known mandate has to do with benefits. Identification of a specific medical benefit or treatment and a

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government requirement that such medical benefit or treatment be covered by a regulated health plan is the most popular of all health mandates. A few examples would include mandates to require coverage of treatment for mental illness, alcoholism, diabetes, autism or mammograms. In a report issued this year, the CAHI identified sixty-five benefit mandates that have gained acceptance in the fifty states, such that they are not considered anomalies or outliers in coverage any longer. One example would be mammograms, which are currently mandated in every state.⁴ Benefit mandates easily represent the fastest way that mandates as a whole may grow in the future, as arguments are put forth regarding the need for coverage of different conditions and medical procedures.⁵

The second type of health care mandate, one that is becoming increasingly common, requires plans to cover the services of certain types of providers. Again, according to the 2008 report issued by the CAHI, there are apparently thirty-three different provider groups that enjoy mandates which require health plans to pay for their services in certain coverage situations. Providers enjoying the benefits of such mandates include chiropractors, dentists and podiatrists, who are usually represented by large lobbying groups, as well as lesser known providers such as lay midwives, naturopaths, pastoral counselors and various types of social workers. Mandates in this area generally find their genesis in the legislative lobbying power of the providers who are affected, as opposed to patient activism.

The final type of health care mandate is in the area of eligibility, otherwise referred to as "covered persons." Mandates in this area tend to require coverage that is linked to the age or status of the individual. Examples would be coverage for adopted children, newborns and non-custodial children, as well as dependent students. Another example would be where employees and dependents move from primary coverage to continuation coverage, or to conversion coverage for non-group individuals. The person's eligibility for the additional coverage is based upon his or her status as a person who has lost primary coverage usually due to a life-changing event. Continuation/conversion coverage is found in virtually every state and certainly, we have the federal mandate under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. The status or age of an individual is the determining factor in the area of eligibility mandates.

Arguments For And Against Health Care Mandates.

The arguments in favor of health care mandates generally depend upon the type of mandate involved. In the area of benefit or coverage mandates, there are many reasons legislatures desire to enact and introduce mandates, including the desire to guarantee coverage for individuals with a particular disease or condition. But, as mandates now expand beyond benefits and include mandates requiring usage of certain providers, coverage of certain treatments and coverage of certain classes of individuals, the arguments can be more complex.

The base argument in favor of employer or individual mandates has already been mentioned -- the fact that a sizeable portion of America's population is currently uninsured. This argument is closely followed by the conclusion that without mandates, America will not achieve universal coverage. Studies have found that even if we experience insurance market reforms, more managed care, administrative streamlining and health alliances, nonetheless, a system without mandates would still leave 20 million to 28 million Americans without insurance. The chief reason for this is money. Small employers, individuals and families, if given a choice, would weigh economic risk and benefits and not purchase coverage if they don't have to. In the private sector, decisions regarding non-mandatory items usually come down to whether the decision-maker has money to support the purchase.

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Another argument in favor of mandates is in the area of access to health care and access to better health. Supporters see mandates as producing better health outcomes. It is argued, for example, that people will receive more preventive care if they are covered by insurance. Another argument also advanced in favor of mandates has to do with those in the system who are getting a free ride at the expense of taxpayers. When an individual does not have health insurance, he or she still receives medical treatment and indeed, hospitals are legally required to provide care regardless of the ability of the patient to pay. In fact, uncompensated care costs an estimated \$40.7 billion per year, with 85% of that cost being borne by federal, state and local governments.⁶ Therefore, advocates of a mandate will argue that if government can mandate automobile insurance in order to protect society from costs imposed by uninsured drivers, then government should also be able to do the same for health insurance.

The arguments against mandates are many. The first and most immediate is that mandates have been proven to increase the cost of health care coverage.⁷ The amount of the cost increase will depend upon the nature of the legislation, the geographic location and the usage patterns of the particular population affected. For example, mandates requiring treatment of drug abuse may result in higher utilization in inner cities as opposed to in largely rural areas. However, it should be noted that not all mandates are equal in this respect. Some mandates have a marginal cost and others, a significant impact on the cost of health insurance. For instance, the overall increase in health care premiums has been well documented as a result of the passage of the Mental Health Parity Act nationwide. Compare this to mandates involving hair prostheses, given that there may not be that many hair prostheses needed across the United States at any given time.

A second argument against employer and individual mandates is ideological in nature: the government should not tell private business or individuals what to do. After all, the American way is entrepreneurship and free enterprise, as opposed to government intervention, although that has certainly begun to diminish over time. However, as an example that Americans still favor private health insurance options over mandates, a recent Gallup Survey asked Americans their views on twelve different reform options for health care, from tax breaks and deregulation to mandates in a national health care system (similar to that of Canada and Europe). The most favored policy and one receiving near universal support (94%) was tax breaks to small businesses for providing insurance to employees. The policy most opposed (44%) was a mandate for every American to have health insurance.⁸

Other problems created by mandates that have been put forth are that they increase health insurance utilization, create health insurance dependency, cause employers and individuals to cancel their policies and thus, actually cause more Americans to become uninsured. A mandate may encourage individuals to use their health insurance for therapies not previously covered, thus increasing utilization which supports higher health care prices and perhaps minimizes competition. Mandates create health insurance dependency, as the consumer increasingly depends upon the health insurer to pay the cost of the medical treatment or procedure, as opposed to paying first dollar for that treatment or procedure, as was done long ago. Finally, the idea that employers and individuals are canceling their policies and will cancel their policies is also well founded.

Trends For The Future.

One of the phenomena seen in the industry is what can be termed as "catch on" mandates. That is where one or two (or a handful of) states pass a mandate and then legislators in other states hear about it -- often through special interest groups or lobbying groups -- and then introduce a version of the legislation in their own states. An example of such a mandate is one related to the treatment of autism and its various complications. In 2008 alone, several states have either considered or passed legislation related to autism.⁹

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Another trend is in the area of eligibility mandates that can be termed "slacker" mandates. Slacker mandates are those in which health insurance coverage is extended to unmarried dependents or students up to the age of thirty, or at least over the age of twenty-four to some cutoff age. In addition to this type of mandate, new categories of health insurance coverage eligibility have recently emerged, such as coverage for illegal aliens or elderly parents. As an example, Maine has extended eligibility for health insurance coverage to include an individual who is not yet a United States citizen, but who is residing legally in the United States. Oregon has added elderly parents who meet certain criteria.

Another trend associated with mandates is in the area of mandated benefit studies. There are now at least thirty states requiring mandated costs to be assessed before the mandate is implemented.¹⁰ Independent advisory commissions, both at the state and federal levels, are being established to proactively evaluate the impact of mandates and to ensure that they will result in improved care and value. Increasingly, legislators are recognizing that mandates must promote evidence based medicine, which in turn promotes high quality care.

Individual Mandate For Health Insurance.

A final note on individual health care mandates, or a watered down proposal for achieving universal health insurance. Individual health care mandates are laws that require individuals to purchase health insurance and threaten punishment for those individuals who do not. Individuals would be required to receive such coverage through their employers or some other group to which they have membership or would be required to purchase their own individual coverage. Those who fail to do so would be subject to fines or other penalties. Massachusetts is one state that has already created a health care policy with an individual mandate. A similar plan has been proposed by Governor Schwarzenegger for California. Proposals for an individual mandate respond to a legitimate concern about those uninsured who nonetheless receive treatment and pass the cost along to taxpayers or individuals with private health insurance. Some observers see an individual mandate as an achievable step on the road to universal coverage. As mentioned above, having long equated insurance coverage with access to health care and access to better health, they see an individual mandate as producing better health outcomes.¹¹

The problem with individual mandates is that such a requirement may not be workable in the real world as part of health care reform. First, individual coverage can be mandated but it does not mean much unless the coverage is affordable. How does the low income sector of society find the funds to purchase required insurance coverage? Moreover, what benefits should the individual coverage mandate? And what about enforceability? What sort of penalties would be assessed for violation of the mandate and will the punishments be punitive or adversely impact certain segments of society, such as those with a low income? Finally, how should individual mandated coverage be rated? These are practical problems of an individual mandate, but are nonetheless important problems that need to be addressed. Perhaps the Great Massachusetts Experiment will give us valuable insight on these issues.

Conclusion.

Health care mandates have been part of the landscape for the last few decades and will occupy the health care debate for years to come. An understanding of the arguments, both in favor of and against mandates, is critical for consumers, employers, regulators and legislatures as the debate increases from state-to-state and on a national level.

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Endnotes

1. The Council for Affordable Health Insurance ("CAHI") is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance producers. *See*, <http://www.cahi.org/index.asp>.
2. Carmen DeNavas-Walter W. Alt, Bernadette Proctor, and Cheryl Hill Lee, "Income, Poverty and Health Insurance Coverage in the United States, 2004," U.S. Census Bureau, August 2005.
3. When employees incur health care expenses under a self-funded plan, the employer, rather than an insurance company, pays the medical bills.
4. "Health Insurance Mandates in the States 2008" by Victoria Craig Bunce and J.P. Wieske. *See* http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.
5. Additionally, the CAHI identifies twenty other benefit mandates that appear in very few states but which may have wider acceptance in the future. *See*, "Health Insurance Mandates in the States 2008" by Victoria Craig Bunce and J.P. Wieske.
6. Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.
7. For instance, a long awaited report issued on July 7, 2008 by the Division of Health Care Finance and Policy in Massachusetts concludes that 12¢ of every one dollar paid for health insurance in Massachusetts goes toward twenty-six state mandated benefits, from maternity and mental health care to infertility and diabetes services. Statewide, the price tag is \$1.3 billion a year. *See*, Boston Globe, Kay Lazar, July 8, 2008.
8. Source: Gallup Telephone Survey of 1,006 national adults aged 18 and older, conducted September 24,-27, 2007, "*any health care reform plan will do for Americans: broadest support for plans that expand access to private health insurance*," October 25, 2007: www.gallup.com/poll/102349/any-healthcare-reform-plan-will-americans.aspx.
9. Autism mandates were passed in Pennsylvania, West Virginia and Louisiana in 2008, and are under consideration in Florida, Michigan and Washington.
10. *See*, "Trends & Ends," CAHI, Council for Affordable Health Insurance, Victoria Craig Bunce, Director of Research and Policy, May 2008.
11. *See*, "Individual Mandates for Health Insurance," Cato Institute Policy Analysis, Michael Tanner, April 5, 2006.