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A Lexus or Walking: The Real Effect of Insurance Mandates

By Gregory L. Schneider

Health insurance costs continue to rise and as a result we have seen a big debate on health care at the national and state levels in this election year. What are some of the reasons for the higher costs of health insurance and what reforms might improve the situation?

One reason for the high cost of insurance lies in the mandates governing the insurers. Mandates are politically inspired and government-backed add-ons to insurance which raise the cost of insurance for everyone and blocks access for those without insurance.

The Council for Affordable Health Insurance (CAHI) has studied health insurance mandates in the fifty states. As of 2006, states had more than 1,800 mandated benefits requiring insurers to provide coverage for treatments ranging from mental illness, maternity or any number of other maladies. In this year's session the Kansas legislature heard testimony to provide a mandate for bariatric surgery (the gastric bypass surgery common as a solution to chronic obesity).

A 1999 study by economists Gail Jensen and Michael Morrissey of the Health Insurance Association of America showed that "as many as one in four individuals who are without coverage are uninsured because of the cost of health insurance mandates."

What is the problem with mandates? It forces insurance companies to provide benefits for people who don't want them and yet are still forced to pay for them. "Mandating benefits," according to CAHI, "is like saying to someone in the market for a new car, if you can't afford a Lexus loaded with options, you have to walk. Having that Lexus would be nice. . .but drivers with less money can find many other affordable options, whereas when the price of health insurance soars, few other options exist."

In CAHI's study of the states Kansas falls somewhere in the middle of the pack when it comes to mandates. Kansas has thirty-seven insurance mandates, eighteen catalogued as benefits and five for covered persons. Out of the eighteen benefit mandates only five are mandated by fewer than half the states (bone mass measurement, diabetes self-management, mastectomy, mastectomy stay, maternity). Out of that group only bone mass measurement is mandated by fewer than fifteen states.

In the provider category Kansas is more generous, with mandates covering nurse anesthetists, oral surgeons (only seven states mandated oral surgery), pain management specialists (only two states), pharmacists (only four states), physical therapists and physician assistants.

The thirty-seven insurance mandates make Kansas about average. Idaho, as of 2007, had 16

mandates (on the low end) while Minnesota had 63. As Merrill Matthews of CAHI concluded in a December 2007 Wall Street Journal editorial, “the people of Idaho aren’t dying in the streets for lack of mandates.”

Rather than placing more mandates designed by politicians responsive to lobbying efforts from a variety of groups and thereby raising the costs of health care for everyone, why can’t consumers determine which coverage is important for them and purchase a plan accordingly? There are some mandates which are beneficial for all plans—mental health coverage comes to mind—but should a thirty year old male pay for health insurance mandates which cover breast reconstruction or maternity?

Mandates are costly and too many mandates make health insurance more expensive thereby contributing to problems with access. One way to improve the situation is to allow the purchase of health insurance across state lines. If Idaho has fewer mandates than Kansas, then allow an average 30 year old male to purchase health insurance in Idaho (provided it meets the requirements of the Kansas Department of Insurance as a product salable in the state) to help lower his costs. Only when you have freed up the consumer market for insurance will states with more mandates, such as Minnesota, be forced to be competitive and perhaps reconsider the mandates they require.

Such a situation will not work for everyone. Some individuals, due to preexisting conditions or chronic diseases, will not be able to purchase health insurance. There will always be a need for a safety net of public care for such individuals. But it might just work for those struggling to purchase health insurance in states where mandates have made such insurance more costly. That would strengthen the private insurance market and guarantee wider access to insurance without additional governmental intervention in health care. It would also strengthen competition for health care between those states who offer a business environment conducive to competition and those who continue to favor regulation.

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