

“Entrepreneurs’ Coverage”: An Alternative Health Policy Reform

By Benjamin Zycher, Ph.D.



tangled up in regulations?

“Entrepreneurs’ Coverage”:
An Alternative Health Policy Reform
By Benjamin Zycher, Ph.D.

January 2010

Pacific Research Institute
One Embarcadero Center, Suite 350
San Francisco, CA 94111
Tel: 415-989-0833/ 800-276-7600
Fax: 415-989-2411
Email: info@pacificresearch.org

www.pacificresearch.org

Download copies of this study at www.pacificresearch.org.

Nothing contained in this report is to be construed as necessarily reflecting the views of the Pacific Research Institute or as an attempt to thwart or aid the passage of any legislation.

©2010 Pacific Research Institute. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopy, recording, or otherwise, without prior written consent of the publisher

“Entrepreneurs’ Coverage”: An Alternative Health Policy Reform

By Benjamin Zycher, Ph.D.

Contents

Acknowledgements	7
Executive Summary	9
I. Introduction.....	11
II. Some Basic Economics of Health Insurance	13
III. Benefit Mandates and Their Effects	18
Table 1: Empirical Findings on Marginal Cost of Benefit Mandates.....	21
IV. Enrollment in and Characteristics of Entrepreneurs' Coverage	22
Table 2: Benefit and Provider Mandates 2009 / Insured and Uninsured Populations 2008....	23
Table 3: Average Annual Health Coverage Premiums 2008-2009.....	25
Table 4: Imputed Premium Increases Caused by Mandates	27
Table 5: Imputed Increases in Annual Health Coverage Premiums.....	28
Table 6: Enrollment Effects of Entrepreneurs' Coverage.....	30
Table 7: Summary Characteristics for “Best-Selling” HAS/HDHP Coverage	32
Table 8: Summary Characteristics for Non-HSA/HDHP Coverage	33
V. Conclusions: Entrepreneurs' Coverage Is a Policy Worth Pursuing.....	34
Endnotes	35
About the Author	40
Statement of Research Quality.....	41
About the Pacific Research Institute.....	42

Acknowledgements

Sincere thanks are due to John R. Graham, Robert E. Litan, and Merrill Matthews for very insightful comments, but they bear no responsibility for any remaining errors or omissions. Gratitude is due also to the Ewing Marion Kauffman Foundation for its generous financial support. The views expressed are those of the author alone, and do not purport to represent those of the Pacific Research Institute or any of its officers or trustees.

Executive Summary

This paper reports findings on the prospective enrollment and other dimensions of an alternative approach to reform of the U.S. health coverage system: implementation of a federally chartered “entrepreneurs’ health insurance policy,” the specifics of which would be determined by competition in the market for health coverage. In particular, entrepreneurs’ policies would be freed from the numerous requirements (“mandates”) for coverage of specific services and types of providers now imposed by state laws. They would, however, be regulated, as current policies are, for safety, soundness, good faith, and other such matters, either by a new federal insurance commissioner or by at least one state regulatory commission.

The analysis assumes that any individual or group would qualify as an “entrepreneur” and thus could opt for such coverage subject to fewer regulatory requirements. At the same time, it must be acknowledged that the ability of individuals and groups to switch between entrepreneurs’ coverage and regular coverage offering mandated benefits might yield the familiar adverse-selection problem, particularly in states in which other regulations guarantee coverage regardless of health status and set premiums in such a way as to transfer wealth from the healthy to those with various medical conditions.

The analysis places entrepreneurs’ coverage in the context of the McCarran-Ferguson Act of 1945, the Employee Retirement Income Security Act of 1974, and the basic economics of health insurance. In particular, the analysis emphasizes the distinction between insurance against catastrophic events and “prepayment” for medical services as encouraged by federal tax policy. The adverse-selection bias inherent in many current reform proposals is discussed as well. After undertaking a review of the empirical literature and applying a simple market simulation model to 2008–2009 data, we find that enrollment in entrepreneurs coverage would be about 13.6 million individuals now covered by private policies, and about 3.2 million individuals now uninsured (out of about 10 million uninsured—after adjustment of the commonly cited figure of about 46 million—who are ineligible for government programs), and not poor, unhealthy, young, childless, and noncitizen status.

The analysis is disaggregated for the 50 states and the District of Columbia; the projected entrepreneurs’ enrollment ranges from a low of 1.6 percent of those insured privately or uninsured in Idaho, to a high of 11.9 percent in Rhode Island. For the nation as a whole, entrepreneurs’ enrollment, at 16.8 million, would account for about 8 percent of those now insured privately or uninsured.

By eliminating the numerous benefit and provider mandates now imposed by state law, entrepreneurs’ coverage might represent an important step toward restoring health insurance as protection against catastrophic events, rather than as prepayment for medical services, the dominant current system that yields reduced incentives to economize on the consumption of medical services. More generally, an entrepreneurs’-coverage approach would represent a sharp departure from the policy “reforms” now dominant in the public discussion, which can be fairly characterized as a centralization of resource allocation decision making in the market for health coverage, and thus in the market for health care itself.

Instead, entrepreneurs' coverage would engender greater competition in the market for health insurance, thus decentralizing decision making and offering patients greater choice than is possible, even in principle, for an agency of the federal government. If the federal government is interested in true reform, it should allow a market for entrepreneurs' coverage to develop without imposing its own demands for coverage of particular services and types of providers—demands that would reflect the usual array of interest-group pressures.

I. Introduction

The economic and political debate over reform¹ of U.S. health care policy (or, more narrowly, of the health insurance market), as it has evolved recently at the national level in Congress, has exhibited one clear characteristic: the absence of serious measures to make health care coverage less expensive. “Less expensive” in this context means less costly in terms of the use of economic resources for society as a whole in the consumption of medical goods and services; health care coverage obviously can be made “less expensive” for any given group of individuals through the use of subsidies, which represents a shifting of costs rather than a reduction in costs. To the extent that total government spending were to rise to pay for the subsidies, the costs of the subsidies would be shifted onto current or future taxpayers. To the extent that the subsidies were financed by cutting other government programs, the costs would be borne by the beneficiaries of those programs.

Also not prominent in the discussion are policy prescriptions intended to provide incentives yielding greater discipline in the demand for medical services.² Quite the reverse is true. While final legislative language for the various proposals in Congress largely has yet to be made available for review, the summaries of the provisions make it clear that annual and/or lifetime limits on benefits are to be raised or proscribed altogether, public policies favoring high-deductible coverage are to be removed or weakened, the minimum coverage acceptable under a requirement (“mandate”) that individuals obtain health insurance is far greater than coverage merely for catastrophic events, and so forth. In short, the central proposals now under consideration in Congress would reduce the degree to which individuals would bear the marginal economic costs that they impose upon the health care system.

The only exception to this latter observation is the set of proposals to tax “Cadillac” health insurance plans—that is, plans that cost more than a given amount per insured individual (or family) per year. These proposals have elicited the strong opposition of many labor unions that have negotiated highly generous health coverage packages for their respective memberships, presumably in exchange for cash wages lower than they otherwise would have received; one proposed compromise is a “grandfather” exemption for health coverage negotiated by unions and in force at the time when the reform legislation is enacted. In any event, this taxation feature of the current proposals is broadly acknowledged to be a revenue-raising device rather than one intended to reduce demands on the system. President Obama has argued for a bill costing no more than \$900 billion in total for fiscal years 2010 through 2019, and adding nothing to projected budget deficits.³

This taxation feature of the current proposals is broadly acknowledged to be a revenue-raising device rather than one intended to reduce demands on the system.

In 1869, the U.S. Supreme Court, in *Paul v. Virginia*⁴ ruled that “Issuing a policy of insurance is not a transaction of [interstate] commerce.”⁵ This made it clear that the states had the power to regulate the insurance sector within their respective borders. In 1944, the Court implicitly overturned *Paul v. Virginia* with its ruling in *United States v. South-Eastern Underwriters Association*,⁶ in which it found that the federal government has the power under the Commerce Clause of the Constitution (article I, section 8) to regulate insurers’ interstate transactions if such transactions are in restraint of trade. This decision raised concerns about the continued viability of insurance regulation and taxation of insurance premiums by the states; Congress responded by passing the McCarran-

Ferguson Act of 1945.⁷ McCarran-Ferguson prohibits application of federal antitrust laws and various provisions of the Federal Trade Commission Act, as well as most other federal laws, to the “business of insurance” as long as that business is regulated by state law.⁸

The Employee Retirement Income Security Act of 1974 (ERISA, Public Law 93-406), among other provisions, allows large employers to self-insure—that is, to cover claims themselves rather than pay premiums to a third-party insurance company to cover claims. (The employer may contract with an insurer to provide such purely administrative functions as claims review.) This allows for greater uniformity of benefits among employees working for a given employer in different states. Foremost among such state requirements are benefit mandates for particular medical services: Most states require that health insurance policies cover particular medical goods and services (e.g., pregnancy services), but these benefit mandates are not uniform across the states.⁹

Therefore, it is reasonable to view benefit mandates as a mechanism for the transfer of wealth to specific constituencies, achieved through the use of the implicit taxation imposed by regulation.

Accordingly, these benefit mandates result not from a competitive process of explicit or implicit negotiation between insurers and covered individuals (or the employers representing them). They result instead from an implicit process of political competition in which interests—whether concentrated, such as a given group of providers, or perhaps more diffused, such as a given group of patients—are able to prevail upon policy makers to constrain the allowed limits of negotiated health insurance contracts. Therefore, it is reasonable to view benefit mandates as a mechanism for the transfer of wealth to specific constituencies, achieved through the use of the implicit taxation imposed by regulation.

Because of ERISA, such state mandates do not apply to the coverage offered by large employers that insure themselves; instead, they apply largely to coverage purchased by individuals and families in the non-group market and to employee coverage offered by (smaller) employers that do not insure themselves. This paper examines the prospective implications of a new national public policy allowing individuals, families, and smaller groups to purchase an entrepreneurs’ policy free of the benefit mandates imposed by state laws.

For purposes of simplicity, we assume that entrepreneurs’ coverage would be regulated for safety, soundness, good faith, and other such purposes either by a new federal insurance commissioner or by at least one state regulatory commission. This assumption allows us to focus upon analysis of the effects of eliminating benefit mandates. The analysis assumes also that any individual or group would qualify as an entrepreneur, and thus could opt for such coverage subject to fewer regulatory requirements. At the same time, it must be acknowledged that the ability of such individuals and groups to switch between entrepreneurs’ coverage and regular coverage offering mandated benefits might yield the familiar adverse-selection problem, discussed below, particularly in states in which other regulations guarantee coverage regardless of health status and institute a system of premiums that transfer wealth from the healthy to those with various medical conditions.

Section II offers a brief discussion of the basic economics of health insurance. Section III summarizes the available evidence on the implementation of benefit mandates and their costs. Section IV applies the empirical literature to the question of the market appeal of an entrepreneurs’ health coverage policy freed from the benefit

mandates imposed by state laws, and reports the findings of a simulation analysis of enrollment in such policies on a state-by-state basis. The likely characteristics of such policies are discussed briefly as well. Section V offers conclusions and a caveat.

II. Some Basic Economics of Health Insurance

Insurance traditionally is a vehicle with which individuals purchase participation in a large pool for which aggregate losses are relatively predictable because of the ordinary laws of large numbers. By accepting a small, predictable loss—the insurance premium, the deductible, and co-payments (or co-insurance)—at the beginning of the current time period, a given policyholder avoids large future losses that can be predicted to occur with some nontrivial probability greater than zero. Risk aversion on the part of policyholders enables insurers to charge premiums higher than the losses expected actuarially (statistically), so that the costs of administering the insurance programs can be recovered. An equivalent way to view traditional insurance is as a payment made by a policyholder during the current time period that yields increased income during future time periods characterized by adverse health events.

A bit more rigorously, the availability of an insurance market enables risk-averse consumers to shift income from time periods during which dollars are relatively less valuable (that is, have relatively low marginal utility) into time periods during which dollars are relatively more valuable. An example of a time period characterized by the latter condition would be a year in which an individual's house burns down, or a year in which a household's breadwinner passes away.

Advocates of reform in the U.S. health sector fall essentially into two camps: those in support of some variant of a government single-payer system of health coverage, such as a Medicare-type system expanded to cover all U.S. citizens or residents, and those favoring mechanisms designed to increase the effectiveness of competitive incentives and market processes among patients, providers, and insurers. Hybrid proposals for preservation of a highly regulated private coverage system also have been made, but the viability of private insurance under the dominant regulatory constraints under discussion is far from obvious.¹⁰ A single-payer system can be summarized reasonably as a centralization of health care finance and administration, while a competitive system can be summarized as a decentralization, or deregulation, of the health care sector.

A single-payer system can be summarized reasonably as a centralization of health care finance and administration, while a competitive system can be summarized as a decentralization, or deregulation, of the health care sector.

Supporters of reforms intended to yield greater competition and decentralization criticize current public policies that undermine discipline in the consumption of health care resources, and that introduce various rigidities into the insurance market. The most prominent example is the favored tax treatment of employer-provided health insurance, a tax environment that, predictably, has yielded private insurance policies with low deductibles and co-payments. Such benefits are very likely to be worth less (on the margin) to consumers than their total costs, but are chosen because of the tax savings enjoyed privately.¹¹

It is likely as well that this favored tax treatment has yielded insurance covering more medical services than otherwise would have been the case. In any event, the tax subsidies have yielded a system of private finance in health care in which insurance has evolved largely into a de facto system of prepayment for most health care consumption rather than risk pooling for large and expensive adverse health contingencies. The obvious outcome of such

“Coverage” for medical expenses is not the same as the actual delivery of health care, and single-payer “coverage” cannot yield enhanced access to actual health care services unless costs—that is, budget outlays—are allowed to rise substantially.

third-party payment by insurers is overconsumption—that is, consumption of some services not worth their total cost by consumers paying substantially less than that total cost, yielding sharply rising social costs for medical services in the aggregate. Moreover, the bias in favor of employer-provided insurance over individual policies not given the same favored tax treatment has the effect of reducing labor mobility and creating other distortions.¹²

Advocates of a single-payer system—Medicare for all, so to speak—criticize instead the presence (or purported plight) under the current system of many without health insurance, with an implicit (or explicit) assertion that those individuals are priced out of the market, and therefore consume too few medical services. A single-payer system ostensibly would “cover” everyone, yielding greater fairness in terms of both those currently without health insurance and those suffering disproportionately from adverse health conditions, who otherwise would face higher (“unaffordable”) insurance premiums or who might find themselves uninsurable.¹³

The argument that a single-payer system would “cover” everyone is not the same as saying that all services demanded would be “covered” (i.e., approved for public payment), because resources by definition are limited always and everywhere. In other words: In the absence of some parameter or system to restrain demands, they inevitably will exceed the availability of resources. Just as market processes in general allocate—that is, ration—resources largely through the price mechanism, a single-payer system cannot avoid similar allocation decisions, because demands always must exceed available resources, by definition. Unlike the case for the private sector, nonprice criteria are likely to prove far more important in practice for a single-payer system.

Such nonprice criteria include waiting lists (“queuing”), exclusion from coverage of a broad range of services or products by government agencies, exclusion of certain classes of patients, such as the elderly, from such given procedures as organ transplants, exclusion of particularly costly (and effective) treatments, particularly for certain patient classes, and the like. Another important mechanism with which to impose rationing indirectly is the enforcement of an aggregate budget for such given medical goods as dialysis services; providers and other entities making coverage decisions under the terms of the single-payer system would be forced to engage in rationing on the basis of criteria either imposed or approved by government agencies.¹⁴

Greater government “coverage” in a real sense is the opposite of improved health care.

Individuals demanding procedures that are not covered in effect are rationed out of the market, except to the extent that they choose (and are permitted) to pay privately for the excluded goods and services. In short, both market-based insurance systems and single-payer systems must engage in some form of rationing, because resources are limited. “Coverage” for medical expenses is not the same as the actual delivery of health care, and single-payer “coverage” cannot yield enhanced access to actual health care services unless costs—that is, budget outlays—are allowed to rise substantially.¹⁵ Those rising costs inexorably would lead to rationing in some form, because

government institutionally has powerful incentives not to allocate services by price;¹⁶ and because government agencies have powerful incentives as well to reduce budget costs by lowering the fees paid to providers for given services, thus yielding a decline over time in the quantity (and/or quality) of such services supplied. There is also likely to occur a long-run reduction in actual supply conditions—a downward shift of the supply schedule—but that is a topic outside the focus of this study.

Note that government does not have patients; instead, it has competing interest groups, among which budget competition means that “savings” in government health coverage can be reallocated to other programs. For both of those reasons, therefore—resource limitations and the incentives of public officials—greater government “coverage” in a real sense is the opposite of improved health care.

It is incontrovertible that a competitive market for private health insurance, driven by self-interested consumers and profit-seeking insurers, tends to eliminate cross-subsidies among classes of consumers.

No one disputes the basic law of demand: As the perceived price of a good declines, more of it is demanded. Whether third-party payment for health care services is organized through a subsidized private insurance market or through a government single-payer system, an increase in the consumption of health care resources and aggregate costs is inevitable. This basic finance problem for government insurance programs—sharply rising costs engendered by a population growing and/or growing older—is well recognized, not only for such U.S. programs as Medicare and Medicaid, but emphatically for single-payer systems in other advanced Western economies.

Consider, conceptually, the provision of health insurance services by numerous insurers competing in a national market relatively free of regulatory constraints on the ability of insurers and patients (or those negotiating on their behalf) to arrive at mutually agreed terms for the provisions of the insurance contract. Compare that hypothetical world with an alternative system characterized by important geographic limits on such competition and substantial regulatory constraints on the contracts arranged between insurers and their customers. Compare that hypothetical system also with a single-payer system in which government is the insurer, financed with some combination of premiums and current or future tax revenues. As we move along that spectrum, we can predict an increase in the size and complexity of implicit or explicit cross-subsidies among various groups, with providers, patients, and insurers the central classes among them.

Market forces provide powerful incentives for insurers to invest resources in underwriting.

In order to see that, it is useful to remember that under a market system—capitalism—the pursuit of self-interested goals by individuals and businesses yields as well, as if “by an invisible hand,” the advancement of aggregate economic well-being under most circumstances.¹⁷ The proper definition of aggregate economic well-being lies beyond the scope of this paper, but it is incontrovertible that a competitive market for private health insurance, driven by self-interested consumers and profit-seeking insurers, tends to eliminate cross-subsidies among classes of consumers, claims (or coverage) not included in agreed insurance contracts, and costs not justified by the services, savings, and efficiencies that they yield. Moreover, the incentives of consumers to minimize their own net costs of coverage will drive premiums to reflect the risks (or expected costs) that particular consumers impose upon the risk-pooling group as a whole.

Consider, first, cross-subsidies among classes of consumers—that is, premiums for one group lower than the administrative and medical costs that they impose upon the system. That gap between premiums paid and costs imposed must be financed in some way or the insurer will not be able to stay in business. One obvious way is to charge other groups premiums higher than the costs that they impose upon the system, by an amount sufficient to finance the gap created by the first group. This would represent a cross-subsidy to the first group from others. But such cross-subsidies would prove untenable in a competitive market for insurance services, because competing insurers would offer lower premiums to the group(s) paying more than the costs they generate.

Market pressures to align premiums with costs are efficient, in the sense that they provide a somewhat subtle service valued by consumers: avoidance of premiums that subsidize others.

As those consumers opted for less expensive policies, the premiums needed to cover the gap for the first group would rise, leading to ever-greater abandonment of the first group by other consumers. While political considerations might lead insurers to subsidize one group at the expense of another, such political pressures are outside the realm of competitive behavior, and competition would impose limits on the size of such cross-subsidies.

And so market forces provide powerful incentives for insurers to invest resources in underwriting—that is, the evaluation of individuals and groups in terms of the costs that they can be expected to impose upon the system (in the form of health-care consumption and administrative costs), and the alignment of premiums with those expected costs. That is why, as a simple example, smokers pay more than nonsmokers for life insurance. Unless regulations or other legal constraints prevent or impede such underwriting efforts, insurers will be forced by market pressures to align premiums with costs, because insurance, by its very nature a market for the pooling of risks, is not charity, and indeed cannot be a charitable endeavor in a world in which consumers pursuing their own interests can be predicted to opt for premiums lower rather than higher, holding the quality of the insurance product constant.

Note that efforts by individuals and groups to avoid the costs of subsidizing others is not a phenomenon limited to the private sector. Such competition for lower costs is a prominent feature of public finance as well, as interest groups prefer—strongly—to enjoy increases in their preferred programs at the expense of others’ programs, and to shift the tax burdens necessary to support public spending programs onto others. In the context of allocating costs, neither private nor public health insurance is a charitable endeavor, a truth illustrated by the efforts in several states and by Congress to force the purchase of health coverage even by those for whom the perceived benefits are less than the costs. As noted above, this is one way to finance “guaranteed issue” regulations requiring insurers to cover patients with (expensive) pre-existing medical conditions while charging them premiums substantially lower than their expected costs.

Indeed, public programs cannot be “charitable” under a proper definition, because government has no resources of its own to “donate.” Instead, it must take from some in order to give to others. This is not to say that subsidies for the consumption of health care services necessarily are inefficient. As a matter of social policy, such subsidies for, say, the poor are supported widely and thus may be efficient in terms of the preferences of consumers/voters even if delivered through the tax system rather than through private charity.

Moreover, some would-be consumers of health insurance are not insurable for given medical conditions (or at all), because those conditions would yield costs higher than any premium that they would be willing to pay.¹⁸ Their attempts to shift their future costs, both high and relatively predictable, onto other insurance consumers is a standard process of adverse selection, that is, a shift of known costs onto others by consumers charged a premium lower than those costs. It is not “insurance” defined properly, that is, participation in a system of risk-pooling in which individuals and groups pay an actuarially fair price to avoid the highly adverse financial effects of future events that are uncertain.¹⁹ The evaluation of applicants’ medical conditions, therefore, is a function that emerges in competitive markets for health coverage, because such evaluations help to avoid the creation of cross-subsidies among consumers, cross-subsidies that are not tenable in a competitive market.

In short, market pressures to align premiums with costs are efficient, in the sense that they provide a somewhat subtle service valued by consumers: avoidance of premiums that subsidize others. They are efficient in addition because the presence of cross-subsidies would mean that some consumers would face premiums higher than otherwise would be the case, and so could be predicted to purchase less insurance than would be observed in the absence of the cross-subsidies. Because the pooling of risk in insurance markets is efficient, an artificial reduction in the size of that market means that too little insurance is being purchased, that is, that the allocation of risk is inefficient.²⁰ In other words, the presence of cross-subsidies leads to too little risk pooling and too much self-insurance. The administrative costs borne in efforts to avoid cross-subsidies thus yield greater resource productivity in the insurance market.

Accordingly, the deeper issue inherent in the debate over reform of the health insurance system is fundamental: Is the system to be viewed as a mechanism with which to pool risks efficiently? Or is it more appropriate to view it as an institution through which wealth is to be redistributed under political and regulatory processes?

Competitive pressures tend to drive cross-subsidies toward zero, whereas regulations and policies that impede such competition tend to preserve the cross-subsidies. Constraints on underwriting are one example; another is the current effective proscription under the McCarran-Ferguson Act of the interstate sale of health insurance policies, which prevents consumers from avoiding the costs of benefit mandates and underwriting restrictions imposed by state officials.

Insurers also face powerful market pressures to scrutinize claims, so as to ensure that the services for which coverage is claimed actually are included in the insurance contract, and that the prices charged by providers are within the limits specified in contracts with the providers. Claims for reimbursement for services and prices not included in the contract would create costs not covered by the agreed premiums, and thus would have to be spread among the other policyholders. But just as in the case with the underwriting problem discussed above, an insurer failing to scrutinize claims carefully will lose customers to other insurers that devote greater effort to such examination. Those competing insurers will be able to charge lower premiums, satisfying a central preference of consumers.

And so, just as is the case with underwriting, resources devoted to the examination of claims serve the interests of consumers, and thus cannot be “wasteful” by definition. Yes, consumers prefer that their own claims be paid; but they also prefer premiums lower rather than higher. Competitive pressures lead insurers to balance such conflicting goals in the context of perceived consumer preferences.²¹

Modern government, on the other hand, is an institution that explicitly seeks to engender cross-subsidies among groups, whether through the tax/expenditure system or the regulatory mechanism. Single-payer health insurance accepts all those eligible and does not base taxes and fees on health status. Thus it necessarily creates subsidies, and the tax system prevents competition on the basis of price.²² Accordingly, the deeper issue inherent in the debate over reform of the health insurance system is fundamental: Is the system to be viewed as a mechanism with which to pool risks efficiently? Or is it more appropriate to view it as an institution through which wealth is to be redistributed under political and regulatory processes?

The mandate is very likely to transfer wealth among patient groups.

To say this a bit differently, it is implausible to argue that the tax system allocates tax burdens in proportion to the benefits received from government spending programs—in this case, government health coverage—and so the tax system must engender cross-subsidies among interest groups. Moreover, the argument that health care is a “right,” and that, therefore, cross-subsidies are a beneficial outcome of public health insurance programs, is highly problematic, because resources are always limited, and so even government must make choices among the competing demands of patients for coverage of the costs of given medical goods and services.²³ Even in a single-payer system financed by government, health care cannot be a “right” because resources are not infinite.

Just as a single-payer system inexorably yields wealth redistribution, the same can be said of much regulation of private insurance markets. Benefit mandates—a requirement that certain medical goods and services be covered in insurance contracts—obviously supersede the terms of the contracts that otherwise would be negotiated. These constraints might serve the interests of some patients, who are pursuing insurance coverage of medical services that insurers otherwise would choose not to offer; or they might serve the interests of some providers, whose services insurers otherwise would choose not to cover; or both.

If a given mandate results from political pressures exerted by patients, the effect is likely to be premiums higher than otherwise would be observed, paid by all policyholders but disproportionately yielding benefits for the subset of patients with relatively high demands for the mandated service. This is likely to result in, or exacerbate, an adverse-selection problem in terms of the mix of patients choosing to buy coverage; it also will result in too much self-insurance. In any event, the mandate is very likely to transfer wealth among patient groups. If the mandate is imposed as a result of political pressures from providers, the result would be, again, coverage more expensive than otherwise would be the case, with the same results: adverse selection, too much self-insurance, and a wealth transfer among patients and from patients to specific providers.

III. Benefit Mandates and Their Effects

Coverage of certain medical goods and services mandated by state law rather than emerging from a negotiation process obviously cannot be “free,” as the delivery of such services consumes resources, and patients disproportionately benefiting from the coverage would make up an increased share of the overall insurance pool.

Again, this is a standard adverse-selection process, making health coverage more expensive not only because of the

costs of the mandated services observed narrowly, but also because of the attendant change in the characteristics of the insured population. With respect to the prices of the mandated services, there may be a long-run increase in the supply of such services if prices under the coverage mandates are sufficient to cover long-run marginal costs. In that case, the increased supply might offset the price effects of the adverse-selection process in whole or in part. If, however, prices are not sufficient to cover long-run marginal costs, there would be a reduction in supply, exacerbating the price effects of the adverse selection.

Accordingly, benefit mandates cannot be “pro-consumer”; instead, they transfer wealth among classes of consumers and between consumers and providers. Some argue that benefit mandates can increase economic efficiency in the health coverage market. Lawrence Summers, for example, offers four arguments.²⁴

First, individuals may underestimate the likelihood that they will face various medical problems; thus they may undervalue insurance coverage and consume too little of it. This raises the question of the source of superior information on the part of the government, and the source of its incentives to implement policies that actually yield net efficiency improvement. Summers offers no enlightenment on that dimension of the problem.

Second, individuals may consume too little insurance coverage and too little medical care in the context of contagious conditions, as the costs of contagion would be borne by third parties. Again, the ability and incentive of the government to implement policies actually achieving greater allocational efficiency is not addressed.

Third, there is a variant of the free-rider problem: Those without coverage or the ability to pay for medical services will not be denied such services, thus imposing a cost upon others. That may be true, but, again, whether government action to deal with this problem will result in a net improvement in efficiency is not addressed by Summers.

Finally, there is the problem of adverse selection, in which employers cannot distinguish between healthy and unhealthy employees when hiring, and so would lose money on health coverage or end up with a workforce disproportionately unhealthy. This seems to be a problem that underwriting is designed to avoid; the inability of employers to differentiate among prospective employees in terms of their health status is less than obvious in principle unless physical examinations and the like are proscribed. More generally, Summers argues explicitly that the presence of a market failure of one kind or another provides an “efficiency argument for government action.” That is a non sequitur, since there is no a priori reason to believe that government policy systematically yields allocational improvement.

Estimation of the costs of the benefits mandated by state laws is difficult, because of the substantial variation in state laws and because of the complex nature of the shift in a given state’s pool of insured individuals, as patients’ decisions about coverage are influenced by the various mandated benefits. Further, the total cost of a given mandate is not the same as its marginal cost, for three reasons.

First, the mandated benefit is likely to be offered in some insurance plans even in the absence of a legal requirement.²⁵ Second, the benefit mandates are likely to change the composition of the insured pool, as adverse selection leads patients who expect to utilize the mandated benefits disproportionately to acquire health insurance.

And, third, the cost of the mandate is likely as well to induce some individuals (or groups) to give up health coverage altogether. That lost coverage may reduce the marginal cost of the mandate *as measured*; but in a broader economic context the loss of coverage is a real cost of the mandated benefit.²⁶

As a result of these empirical difficulties, most of the available literature offers estimates of the cost of benefit mandates as a function of the number of mandates in a given state rather than as the sum of the estimated costs of the respective mandated benefits themselves. In 2000, the Congressional Budget Office (CBO), in an analysis of the effects of proposed new legal arrangements for health coverage for small employers, assumed, based upon a review of the literature, that the marginal cost of all state benefit mandates taken together was 5 to 10 percent of total claims between 1990 and 1998, with the marginal cost increasing with the number of mandated benefits.²⁷

Since claim payments are about 88 percent of total premium income for private coverage, this implies that the marginal cost of the state benefit mandates was, roughly, about 4 to 9 percent of premiums.²⁸ This assumption of an increase in marginal cost as a function of the number of mandates is reasonable, as a rise in the number of mandated benefits would increase the adverse-selection problem and thus the total cost of health coverage as driven by the characteristics of the insured pool, even as increasing numbers of other individuals would be driven out of the market, thus increasing the “lost coverage” cost of the mandates.

A review of the literature by the Pacific Research Institute’s John R. Graham finds, as a crude but conservative summary, that the marginal cost of a given mandated benefit is at least 0.25 percent of the cost of the health insurance policy, with various estimates ranging up to 1 percent and above.²⁹ Graham notes that with “an average of 23 mandates per state, this suggests that the marginal increase in premiums for all mandates was between 5 [percent] and 8 percent for individual policies and between 5 percent and 23 percent for family policies.”³⁰ This range is roughly consistent with the findings of the CBO analysis noted above.

A comprehensive survey by Victoria Craig Bunce and J. P. Wieske finds an upward effect on “the cost of basic health coverage” of somewhere between 20 percent and 50 percent.³¹ It is unclear from the discussion whether that is an estimate of total cost or marginal cost; but the authors note that their cost estimates for individual mandates are made under the assumption that “the mandate [is] added to a policy that did not include the coverage.” This is consistent with a marginal-cost calculation; but there is no discussion in the paper of coverage lost or not purchased because of the costs of the mandates. Accordingly, the lower bound of the Bunce-Wieske survey may be roughly consistent with the CBO and Graham analyses.

Michael J. New finds an upward effect of about \$0.75 per month (about 0.6 percent of the premium) per mandated benefit; his econometric model yields estimates of marginal effects, but it does not examine the issue of coverage lost or not purchased.³² With his finding of an average of 26 mandated benefits per state, this implies an increase in premiums of \$19.50 per month, or \$234 per year—an increase of about 15 percent. William J. Congdon, Amanda Kowalski, and Mark H. Showalter find a marginal effect of mandated benefits (above a level of 20 mandates) of about 0.3 percent for individuals, and about 0.7 percent for families, in the market for high-deductible policies in 42 states; these findings are somewhat sensitive to econometric specification.³³

Wisconsin's Office of the Commissioner of Insurance examined the costs of five specific benefit mandates; as a rough approximation, it found that the mandates, respectively, increased benefit payments by amounts ranging from under 1 percent of total premiums to somewhat over 3 percent.³⁴ The General Accounting Office, in a 2003 survey of the literature, found estimates of the marginal cost of benefit mandates of about 3 to 5 percent of premiums.³⁵

Gregory Krohm and Mary Grossman compared claims costs in five states in the late 1980s, finding a marginal cost of two percentage points for benefits mandated in some states but not others. Graham calculates from the Krohm-Grossman data a marginal cost per mandated benefit of about 0.2 percent of claims costs.³⁶ In a 2008 report prepared for the Maryland Health Care Commission (MHCC), John Welch et al. examined the cost effects of five mandated benefits in Maryland, finding impacts upon "average cost per group policy" ranging from 0.01 percent to more than 1 percent.³⁷ Graham notes that an earlier MHCC report, using data for 2004, found a marginal cost of 2 percent for all mandates taken as an aggregate.³⁸

Table 1 summarizes this empirical literature on the marginal cost of benefit mandates. The analysis here uses this body of empirical findings to drive the simple simulation analysis underlying the findings reported below. Note that the implicit assumption of a linear relationship between the number of mandates and their marginal costs is somewhat artificial, but this is the best we can do given the state of the empirical literature.

Table 1

Empirical Findings on Marginal Cost of Benefit Mandates	
Study	Marginal Cost
CBO (2000)	4 to 9 percent of premiums, all mandates aggregated
Graham (2008)	5 to 23 percent of premiums, all mandates aggregated
Bunce and Wieske (2009)	20 to 50 percent of premiums, all mandates aggregated
New (2006)	15 percent of premiums, all mandates aggregated
Congdon et al. (2006)	0.3 to 0.7 percent of premiums, per mandate above 20
Wisconsin OCI (2002)	1 to 3 percent of premiums, five specific mandates aggregated
GAO (2003)	3 to 5 percent of premiums, all mandates aggregated
Krohm and Grossman (1990)	0.2 percent of claims, specific mandated benefits
Maryland HCC (2006)	2 percent of premiums, all mandates aggregated
Maryland HCC (2008)	0.01 to 1 percent of premiums per each of five specific mandates

Source: References cited in Section III discussion

IV. Enrollment in and Characteristics of Entrepreneurs' Coverage

This section examines the implications of a prospective new national public policy allowing individuals, families, and small groups to purchase an “entrepreneurs’ health insurance policy” free of the benefit mandates imposed by state laws. Apart from the elimination of benefit mandates, it is difficult to know how the specifics of such prospective coverage policies would evolve. It is clear that the market would offer a number of alternatives with differing deductibles, premium costs, and other features appealing to a heterogeneous health insurance market. It is reasonable to hypothesize, however, that consumers opting for an entrepreneurs’ coverage policy disproportionately would be interested in low premiums relative to specific types of coverage—that is, they would attempt to avoid the very nature of the adverse-selection problem engendered by benefit mandates—and thus they would seek coverage closer to traditionally defined insurance against catastrophic events rather than de facto prepayment for medical services.³⁹ Such an assumption is useful analytically, consistent with the pro-competitive nature of an elimination of benefit mandates.

Table 2 shows the number of benefit and provider mandates by state, as found in the survey data provided by Bunce and Wieske. Unlike the Bunce-Wieske survey, however, table 2 does not include mandates for particular classes of covered individuals.⁴⁰ As shown in the table, the average and median numbers of benefit and provider mandates per state are close, at 35.1 and 34, respectively. Table 2 shows also the number of individuals covered by insurance, by private insurance, and by private insurance for those aged 65 and above.⁴¹

It is clear that the market would offer a number of alternatives with differing deductibles, premium costs, and other features appealing to a heterogeneous health insurance market.

Finally, table 2 shows the total number of uninsured as reported by the U.S. Census Bureau, and a lower figure prorated by state. The Census Bureau estimates the uninsured population at 46.3 million; but that figure is problematic for several reasons. Among the estimated 46.3 million uninsured, there is a Medicaid “undercount” estimated at a little over six million—that is, people who were enrolled in Medicaid but misreported their status to the Census Bureau. About four million individuals eligible for Medicaid and the Children’s Health Insurance Program (CHIP) are unenrolled, but they would become enrolled when they seek medical care. About nine to 10 million are noncitizens (both documented and undocumented aliens), about 10 million have incomes above 300 percent of the federal poverty level, and about five million are adults both young and childless. This leaves about 10 to 12 million American citizens who might be said to be unable to afford insurance;⁴² we assume the lower figure here for purposes of being conservative. The conservative nature of the analysis is strengthened by the implicit assumption that none of the 10 million uninsured with incomes above 300 percent of the federal poverty level would opt for entrepreneurs’ coverage.⁴³

In the analysis below, we apply the CBO elasticity estimate to all of the privately insured population by state, and to the 10 million classified as uninsured, prorated by state in proportion to the U.S. Census Bureau estimates. This proration is a bit artificial, but the available data do not allow us to allocate the various subgroups among the uninsured across the states.

Table 2

Benefit and Provider Mandates 2009 and Insured and Uninsured Populations 2008						
STATE	MANDATES	INSURED (thousands)		UNINSURED (thousands)		
		Total	Private	Private 65+	Census Bureau	Imputed
Alabama	20	4,159	3,199	409	561	121
Alaska	30	539	418	31	133	29
Arizona	40	5,264	3,891	398	1,273	275
Arkansas	36	2,322	1,638	177	505	109
California	49	29,868	22,848	2,115	6,822	1,472
Colorado	45	4,136	3,421	317	780	168
Connecticut	46	3,094	2,575	293	343	74
Delaware	25	769	626	80	94	20
D.C.	20	533	404	37	59	13
Florida	44	14,430	11,129	1,653	3,619	781
Georgia	38	7,850	6,166	443	1,703	368
Hawaii	19	1,159	899	125	98	21
Idaho	8	1,282	1,079	127	236	51
Illinois	40	11,065	9,103	957	1,638	353
Indiana	27	5,522	4,447	568	722	156
Iowa	18	2,707	2,332	293	283	61
Kansas	34	2,394	1,981	222	330	71
Kentucky	34	3,574	2,701	312	682	147
Louisiana	43	3,465	2,539	237	869	188
Maine	46	1,182	896	141	137	30
Maryland	57	4,870	4,171	424	669	144
Massachusetts	47	6,069	4,899	608	352	76
Michigan	22	8,665	7,126	917	1,151	248
Minnesota	59	4,676	3,931	487	444	96
Mississippi	24	2,388	1,647	182	519	112
Missouri	35	5,132	4,020	446	739	159
Montana	32	819	648	96	158	34
Nebraska	25	1,565	1,328	156	211	46
Nevada	46	2,097	1,714	119	487	105
New Hampshire	37	1,168	1,009	98	133	29
New Jersey	38	7,323	6,201	723	1,201	259
New Mexico	48	1,510	1,058	128	468	101
New York	42	16,617	12,567	1,369	2,720	587
North Carolina	43	7,832	5,974	687	1,421	307
North Dakota	26	552	481	60	74	16
Ohio	22	10,088	8,109	970	1,309	282
Oklahoma	34	3,060	2,363	309	498	107
Oregon	32	3,194	2,659	336	621	134

**Table 2 Continued:
Benefit and Provider Mandates 2009 and Insured and Uninsured Populations 2008**

STATE	MANDATES	INSURED (thousands)		UNINSURED (thousands)		
		Total	Private	Private 65+	Census Bureau	Imputed
Pennsylvania	44	10,984	9,040	1,224	1,211	261
Rhode Island	62	921	738	85	123	27
South Carolina	23	3,762	2,882	340	707	153
South Dakota	23	698	577	89	100	22
Tennessee	33	5,252	3,764	429	931	201
Texas	49	18,110	13,464	1,146	6,084	1,313
Utah	15	2,396	2,155	141	364	79
Vermont	22	555	434	52	57	12
Virginia	53	6,786	5,522	539	962	208
Washington	49	5,732	4,519	459	808	174
West Virginia	31	1,528	1,192	217	271	58
Wisconsin	27	5,020	4,131	477	535	115
Wyoming	27	458	375	40	72	16
Total	1,789	255,143	200,992	22,287	46,340	10,000
Average	35.1	n.a.	n.a.	n.a.	n.a.	n.a.
Median	34	n.a.	n.a.	n.a.	n.a.	n.a.

Note: Privately insured includes privately insured 65+; average and median are unweighted. n.a.: not applicable.

Source: Victoria Craig Bunce and J. P. Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance, 2009; U.S. Census Bureau, http://www.census.gov/hhes/www/cpstable/032009/health/h05_000.htm; and author computations.

Table 3 shows average annual premiums for health coverage, by state, for individuals and families in both the group and the non-group markets. For group coverage, median individual and family premiums in 2008–2009 were \$4,360 and \$12,254, respectively. For coverage in the non-group market, median individual and family premiums in 2008–2009 were \$2,930 and \$5,974, respectively. To some degree, the differences between the group and non-group premiums are driven by the tax preference for employer-provided health coverage, which

Individuals purchasing coverage outside the scope of employment would not receive the tax preference, and so would have an incentive to opt for coverage with less generous features.

induces a shift toward more expensive policies oriented more toward prepayment, as opposed to a traditional insurance model. Individuals purchasing coverage outside the scope of employment would not receive the tax preference, and so would have an incentive to opt for coverage with less generous features. Perhaps equally important, underwriting (alignment of premiums with expected costs for given policyholders) in many states is more constrained in the group market than in the non-group market, so that individuals with adverse medical conditions would be underwritten out of the non-group market. Equivalently, the group market is subject to more serious adverse-selection problems. The upshot is that premium costs are lower in the non-group market than in the group market.

Table 3

Average Annual Health Coverage Premiums 2008–2009 (2008 Dollars)				
State	Group: Individual	Group: Family	Non-Group: Individual	Non-Group: Family
Alabama	4,139	11,119	2,391	4,983
Alaska	5,293	13,383	n.a.	n.a.
Arizona	4,214	12,292	2,961	5,292
Arkansas	3,923	11,220	2,332	5,297
California	4,280	12,254	2,943	6,567
Colorado	4,303	11,952	2,777	5,939
Connecticut	4,740	13,436	3,503	8,477
Delaware	4,733	13,386	2,541	n.a.
D.C.	4,890	13,427	n.a.	n.a.
Florida	4,517	12,697	3,191	6,527
Georgia	4,160	11,659	3,228	7,408
Hawaii	3,831	11,044	n.a.	n.a.
Idaho	4,104	10,837	2,172	4,875
Illinois	4,643	12,603	2,843	6,317
Indiana	4,495	13,504	2,930	6,236
Iowa	4,146	10,947	2,606	5,609
Kansas	4,197	11,662	2,615	5,529
Kentucky	4,009	11,506	2,740	5,980
Louisiana	4,055	11,207	3,657	7,766
Maine	4,910	13,102	4,061	7,260
Maryland	4,360	12,541	2,391	5,475
Massachusetts	4,836	13,788	5,143	13,288
Michigan	4,388	11,321	2,034	4,460
Minnesota	4,432	13,639	2,978	7,013
Mississippi	4,124	11,363	2,696	5,431
Missouri	4,124	11,557	2,725	5,657
Montana	4,355	11,438	3,305	5,968
Nebraska	4,392	11,648	2,950	5,979
Nevada	3,927	11,487	3,276	6,119
New Hampshire	5,247	13,592	3,427	7,672
New Jersey	4,798	12,789	5,768	11,261
New Mexico	4,074	12,071	3,641	n.a.
New York	4,638	12,824	6,630	13,296
North Carolina	4,460	12,308	2,613	5,120
North Dakota	3,830	11,178	2,508	5,106
Ohio	4,089	11,425	2,724	5,701
Oklahoma	4,072	11,053	3,220	5,947
Oregon	4,384	12,585	1,405	5,011
Pennsylvania	4,499	12,339	2,873	6,381

**Table 3 Continued:
Average Annual Health Coverage Premiums 2008–2009 (2008 Dollars)**

Rhode Island	4,930	13,363	4,779	11,107
South Carolina	4,477	12,068	3,204	6,128
South Dakota	4,233	11,382	3,156	7,132
Tennessee	4,276	12,302	3,150	5,957
Texas	4,205	11,967	3,208	6,459
Utah	4,197	11,783	1,705	3,529
Vermont	4,900	13,091	n.a.	n.a.
Virginia	4,202	11,935	3,229	6,383
Washington	4,404	13,036	2,182	n.a.
West Virginia	4,892	12,887	2,751	5,520
Wisconsin	4,777	12,956	1,358	3,343
Wyoming	4,622	12,734	2,911	5,838
Average	4,386	12,298	3,052	6,508
Median	4,360	12,254	2,930	5,974

Note: Averages and medians are not weighted. n.a.: not available in referenced datasets.

Source: Kaiser Family Foundation at <http://www.statehealthfacts.org/comparetable.jsp?typ=4&ind=270&cat=5&sub=67> and <http://www.statehealthfacts.org/comparetable.jsp?ind=271&cat=5>; America's Health Insurance Plans at <http://www.ahipresearch.org/pdfs/IndividualMarketSurveyDecember2007.pdf> and <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>; Council of Economic Advisers, *Economic Indicators*, October 2009 (Washington, D.C.: U.S. Government Printing Office), p. 23; and author computations.

From the discussion in section III, a conservative estimate of the marginal cost of a mandate, in terms of increased premiums, is about 0.3 percent.⁴⁴ Table 4 shows the imputed percentage premium increase caused by the mandates aggregated for each of the states.

Table 4

Imputed Premium Increases Caused by Mandates (Percent)				
State	Increase		State	Increase
Alabama	6.0		Nebraska	7.5
Alaska	9.0		Nevada	13.8
Arizona	12.0		New Hampshire	11.1
Arkansas	10.8		New Jersey	11.4
California	14.7		New Mexico	14.4
Colorado	13.5		New York	12.6
Connecticut	13.8		North Carolina	12.9
Delaware	7.5		North Dakota	7.8
D.C.	6.0		Ohio	6.6
Florida	13.2		Oklahoma	10.2
Georgia	11.4		Oregon	9.6
Hawaii	5.7		Pennsylvania	13.2
Idaho	2.4		Rhode Island	18.6
Illinois	12.0		South Carolina	6.9
Indiana	8.1		South Dakota	6.9
Iowa	5.4		Tennessee	9.9
Kansas	10.2		Texas	14.7
Kentucky	10.2		Utah	4.5
Louisiana	12.9		Vermont	6.6
Maine	13.8		Virginia	15.9
Maryland	17.1		Washington	14.7
Massachusetts	14.1		West Virginia	9.3
Michigan	6.6		Wisconsin	8.1
Minnesota	17.7		Wyoming	8.1
Mississippi	7.2		Total	n.a.
Missouri	10.5		Average	10.5
Montana	9.6		Median	10.2

Source: Table 2 and author computations. n.a.: not applicable.

Table 5 shows the imputed increase in the group and non-group premiums for each state, under the simplifying assumption that the mandates affect the four classes of policy premiums (group individual, group family, non-group individual, non-group family) by the same percentage.⁴⁵ This assumption is very unlikely to be strictly correct, but the available data do not allow disaggregation of state mandates by policy class. At the same time, the assumption is unlikely to do great damage to the simulation discussion below, as the estimates are constructed and intended to be viewed as reasonable approximations.

Table 5

Imputed Increases in Annual Health Coverage Premiums (2008 Dollars)				
State	Group: Individual	Group: Family	Non-Group: Individual	Non-Group: Family
Alabama	248	667	143	299
Alaska	476	1,204	n.a.	n.a.
Arizona	506	1,475	355	635
Arkansas	424	1,212	252	572
California	629	1,801	433	965
Colorado	581	1,614	375	802
Connecticut	654	1,854	483	1,170
Delaware	355	1,004	191	n.a.
D.C.	293	806	n.a.	n.a.
Florida	596	1,676	421	862
Georgia	474	1,329	368	845
Hawaii	218	630	n.a.	n.a.
Idaho	98	260	52	117
Illinois	557	1,512	341	758
Indiana	364	1,094	237	505
Iowa	224	591	141	303
Kansas	428	1,190	267	564
Kentucky	409	1,174	279	610
Louisiana	523	1,446	472	1,002
Maine	678	1,808	560	1,002
Maryland	746	2,145	409	936
Massachusetts	682	1,944	725	1,874
Michigan	290	747	134	294
Minnesota	784	2,414	527	1,241
Mississippi	297	818	194	391
Missouri	433	1,213	286	594
Montana	418	1,098	317	573
Nebraska	329	874	221	448
Nevada	542	1,585	452	844
New Hampshire	582	1,509	380	852
New Jersey	547	1,458	658	1,284
New Mexico	587	1,738	524	n.a.
New York	584	1,616	835	1,675
North Carolina	575	1,588	337	660
North Dakota	299	872	196	398
Ohio	270	754	180	376
Oklahoma	415	1,127	328	607
Oregon	421	1,208	135	481
Pennsylvania	594	1,629	379	842
Rhode Island	917	2,486	889	2,066

**Table 5 Continued:
Imputed Increases in Annual Health Coverage Premiums (2008 Dollars)**

South Carolina	309	833	221	423
South Dakota	292	785	218	492
Tennessee	423	1,218	312	590
Texas	618	1,759	472	949
Utah	189	530	77	159
Vermont	323	864	n.a.	n.a.
Virginia	668	1,898	513	1,015
Washington	647	1,916	321	n.a.
West Virginia	455	1,198	256	513
Wisconsin	387	1,049	110	271
Wyoming	374	1,031	236	473
Average	462	1,294	321	685
Median	445	1,250	299	609

Source: Tables 2, 3, and 4; and author computations. n.a.: not available.

The CBO in 2005 published a detailed analysis of demand conditions in the market for non-group health coverage; the study both reviewed the literature and reported its own analysis of the demand elasticity in that market.⁴⁶ In brief, the analysis focused upon the importance of various factors—one of which is premiums—on the decision to enroll in non-group coverage; the estimated demand elasticity is -0.57 , which means that a 10 percent increase in premiums, holding other factors constant, would result in a 5.7 percent decline in enrollment.⁴⁷ Moreover, elimination of the mandates would change the package of benefits offered by the insurance, in particular reducing or eliminating the adverse-selection problems created by the mandates. This suggests that the actual demand effect of an entrepreneurs' policy might be greater than that suggested by the CBO elasticity estimate, as the pool of insured would be less expensive to cover.⁴⁸

In the analysis presented here, elimination of benefit mandates in entrepreneurs' policies would yield (relative) premium declines for two groups: those with private coverage and those without coverage, who, analytically, are self-insured.⁴⁹ For those with private insurance, we assume that introduction of an entrepreneurs' option would induce a shift out of existing private insurance toward entrepreneurs' policies; and we use the CBO elasticity finding to estimate that shift for each state, as follows: Percentage change in enrollment/percentage change in premium = -0.57 .

For the uninsured, the availability of an entrepreneurs' policy represents a relative price decline for an alternative to self-insurance.

For the uninsured, the availability of an entrepreneurs' policy represents a relative price decline for an alternative to self-insurance; an example is the unweighted average annual premium for the "best-selling" HSA/HDHP (Health Savings Account/High-Deductible Health Plans) for individuals in the non-group market.⁵⁰ That premium is assumed to fall because of the elimination of benefit mandates in the entrepreneurs' coverage option. We assume the same enrollment response (demand elasticity) as in the case of those with private coverage. Table 6 presents these computations.

Table 6

Enrollment Effects of Entrepreneurs' Coverage							
State	Current Privately Insured (thousands)	Uninsured (thousands)	Total	Shift from Private Insurance	Shift from Uninsured (Percent)	Shift from Private/Uninsured (Percent)	Entrepreneurs Enrollment (thousands)
Alabama	3,199	121	3,320	109	19	3.9	129
Alaska	418	29	447	21	7	6.3	28
Arizona	3,891	275	4,166	266	87	8.5	353
Arkansas	1,638	109	1,747	101	31	7.6	132
California	22,848	1,472	24,320	1,914	572	10.2	2,486
Colorado	3,421	168	3,589	263	60	9.0	323
Connecticut	2,575	74	2,649	203	27	8.7	230
Delaware	626	20	646	27	4	4.8	31
D.C.	404	13	417	14	2	3.8	16
Florida	11,129	781	11,910	837	272	9.3	1,110
Georgia	6,166	368	6,534	401	111	7.8	511
Hawaii	899	21	920	29	3	3.5	32
Idaho	1,079	51	1,130	15	3	1.6	18
Illinois	9,103	353	9,456	623	112	7.8	735
Indiana	4,447	156	4,603	205	33	5.2	239
Iowa	2,332	61	2,393	72	9	3.4	80
Kansas	1,981	71	2,052	115	19	6.5	134
Kentucky	2,701	147	2,848	157	40	6.9	197
Louisiana	2,539	188	2,727	187	64	9.2	251
Maine	896	30	926	70	11	8.8	81
Maryland	4,171	144	4,315	407	65	10.9	472
Massachusetts	4,899	76	4,975	394	28	8.5	422
Michigan	7,126	248	7,374	268	43	4.2	311
Minnesota	3,931	96	4,027	45	11	1.0	441
Mississippi	1,647	112	1,759	68	21	5.1	89
Missouri	4,020	159	4,179	241	44	6.8	285
Montana	648	34	682	35	9	6.5	44
Nebraska	1,328	46	1,374	57		4.8	66
Nevada	1,714	105	1,819	38	9.5	9.5	173
New Hampshire	1,009	29	1,038	64	8	7.0	72
New Jersey	6,201	259	6,460	403	78	7.4	481
New Mexico	1,058	101	1,159	87	38	10.8	125
New York	12,567	587	13,154	903	195	8.3	1,098
North Carolina	5,974	307	6,281	439	104	8.7	544
North Dakota	481	16	497			5.0	25
Ohio	8,109	282	8,391	305	49	4.2	354
Oklahoma	2,363	107	2,470	137	29	6.7	166
Oregon	2,659	134	2,793	146	34	6.4	179

**Table 6 Continued:
Enrollment Effects of Entrepreneurs' Coverage**

Pennsylvania	9,040	261	9,301	680	91	8.3	771
Rhode Island	738	27	765	78	13	11.9	91
South Carolina	2,882	153	3,035	113	28	4.7	141
South Dakota	577	22	599	23	4	4.4	27
Tennessee	3,764	201	3,965	212	53	6.7	265
Texas	13,464	1,313	14,777	1,128	510	11.1	1,638
Utah	2,155	79	2,234	55	9	2.9	65
Vermont	434	12	446	16	2	4.1	18
Virginia	5,522	208	5,730	500	87	10.3	588
Washington	4,519	174	4,693	379	68	9.5	446
West Virginia	1,192	58	1,250	63	14	6.2	78
Wisconsin	4,131	115	4,246	191	25	5.1	215
Wyoming	375	16	391	17	3	5.3	21
Total	200,992	10,000	210,992	13,592	3,236	8.0	16,828
Average	n.a.	n.a.	n.a.	n.a.	n.a.	7.0	n.a.
Median	n.a.	n.a.	n.a.	n.a.	n.a.	6.6	n.a.

Note: Totals may not sum because of rounding. Percentage shift average and median not weighted.

n.a.: not applicable.

Source: Table 2; and author computations.

Under these conservative assumptions, the introduction of an entrepreneurs' policy freed from the benefit and provider mandates imposed by the states would shift about 13.6 million individuals from other private insurance, or about 6.8 percent of the 201 million individuals currently covered by private insurance. This shift presumably would include individuals previously covered in both the group and non-group markets; and it is likely that some entire groups would opt for entrepreneurs' policies. In the latter case, the reduction in coverage costs borne by the employer can be predicted to result in higher wages for employees.

Entrepreneurs' policies would enroll as well about 3.2 million of the 10 million individuals currently uninsured (as derived above), or about 32 percent. Total entrepreneurs' enrollment would be about 16.8 million.

The likely percentage shifts from the ranks of the privately insured and the uninsured range from a low of 1.6 percent for Idaho to a high of 11.9 percent for Rhode Island. Note that the assumption of an uninsured population of only 10 million is another source of conservatism in our projection of enrollment in entrepreneurs' coverage. Were we, for example, simply to take the Census Bureau figure of 46.3 million uninsured, then likely enrollment in entrepreneurs' coverage by those previously uninsured would be about 15 million rather than the 3.2 million estimated here.

Stephen T. Parente et al. examine the consumer response to a national market for individual health coverage in which the various state benefit mandates and certain other regulatory constraints are removed.⁵¹ Their conceptual experiment is similar to that reported here, although they examine only the individual and small-group markets,

as well as the effects on the uninsured population. In their moderate scenario, the increase in enrollment among those previously uninsured is about six million out of an (assumed) existing uninsured population of 28.8 million; their minimum and maximum scenarios are 1.3 million and 9.1 million, respectively.⁵²

It was noted above that implementation of a national policy allowing entrepreneurs' coverage to be sold without the various benefit and provider mandates currently imposed by state laws would be likely to engender a wide variety of options and plan features designed to appeal to the heterogeneous preferences of consumers. Accordingly, it is impossible to specify in advance the particular features that such policies would incorporate. It is reasonable, however, to assume that those opting for entrepreneurs' coverage would prefer lower premiums rather than additional benefits; and that such consumers would disproportionately shift toward the insurance dimension of health coverage and away—relatively—from the prepayment effect brought about by current tax subsidies. Accordingly, it is reasonable to hypothesize that entrepreneurs' policies might be similar to the HSA/HDHPs that have grown so substantially in popularity since 2005.⁵³

A recent survey for America's Health Insurance Plans (AHIP) provides many details, summarized in table 7.⁵⁴

Table 7

Summary Characteristics for Best-Selling HSA/HDHP Coverage (2008 Dollars)			
	Non- Group	Small Group	Large Group
Premium			
Individual	2,806	3,449	2,911
Family	5,375	9,036	6,901
Deductible			
Individual	3,005	2,091	2,088
Family	5,920	3,764	3,986
Out-of-Pocket Limit			
Individual	3,312	2,435	3,172
Family	6,485	4,325	5,457
Lifetime Maximum			
Individual	4.5 million	5.0 million	5.2 million
Family	4.2 million	5.1 million	5.3 million

Note: Non-group premiums are unweighted averages for three age groups.

Source: AHIP, "January 2009 Census Shows 8 Million People Covered by HSA/High-Deductible Health Plans," May 2009.

Simply for purposes of crude comparison, table 8 presents similar data for standard policies, as reported in surveys by AHIP and by the Kaiser Family Foundation and the Health Research & Educational Trust (HRET).⁵⁵

Table 8

Summary Characteristics for Non-HSA/HDHP Coverage (2008 Dollars)			
	Non-Group	Small Group	Large Group
Premium			
Individual	2,985	4,824	4,824
Family	6,328	13,375	13,375
Deductible			
Individual	1,818	1,069	567
Family	4,242	2,581	1,184
Out-of-Pocket Limit			
Individual	3,576	n.a.	n.a.
Family	7,191	n.a.	n.a.
Lifetime Maximum			
Individual	5.1 million	n.a.	n.a.
Family	5.0 million	n.a.	n.a.

Note: Non-group premiums are unweighted averages for three age groups.

n.a.: not available. For groups, Kaiser/HRET reports percentage distribution of out-of-pocket limits by amount class, but no weighted average.

Source: AHIP, "January 2009 Census Shows 8 Million People Covered by HSA/High-Deductible Health Plans," May 2009; Kaiser Family Foundation/HRET, "Employer Health Benefits 2009 Annual Survey," <http://ehbs.kff.org>; and author computations. See also table 3.

V. Conclusions: Entrepreneurs' Coverage Is a Policy Worth Pursuing

The contrasts presented in tables 7 and 8 are rough, and are intended to offer only a crude illustration of the prospective characteristics of entrepreneurs' coverage. But an entrepreneurs'-coverage approach—elimination of the benefit and provider mandates now ubiquitous in state laws—represents a sharp departure from the policy proposals currently dominant in the public discussion. Those proposals can be summarized reasonably as a centralization of health care finance and administration. Modern government is an institution that explicitly seeks to engender cross-subsidies among groups. Thus, in a real sense, providing greater government coverage is the opposite of reforming health care.

Entrepreneurs' coverage would engender greater competition in the market for health insurance, thus decentralizing decision making and offering patients greater choice than is possible, even in principle, for an agency of the federal government.

The federal government should allow the market for entrepreneurs' coverage to develop without imposing its own demands for coverage of particular services and providers—demands that would reflect the usual array of interest-group pressures.

A competitive system, on the other hand, can be summarized as a decentralization, or deregulation, of the health care sector. Instead of extending government control of the market, entrepreneurs' coverage would engender greater competition in the market for health insurance, thus decentralizing decision making and offering patients greater choice than is possible, even in principle, for an agency of the federal government. "Reform" must mean a change in policy that can be predicted to yield net improvement. The

Endnotes

- ¹ The term “reform” properly means a change in policy that can be predicted to yield net improvement in the context of agreed criteria; whether the approaches dominant in the public discussion today actually would produce such improvement is far from obvious. I use the term “reform” here solely as a convenience, and do not imply any belief or finding that economic or other improvements actually would be observed as a result of any given set of such policy changes. This latter question is not the focus of this paper, and is touched upon in the analysis that follows only as it becomes indirectly relevant to the topic under discussion.
- ² The central policy shift favoring high-deductible coverage was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. See Benjamin Zycher, “HSA Health-Insurance Plans after Four Years: What Have We Learned?” Center for Medical Progress, Manhattan Institute for Policy Research, Medical Progress Report No. 8, February 2009, at http://www.manhattan-institute.org/html/mp_r_08.htm. Indirectly, the proposals, if implemented, are likely to lead over time to explicit or implicit government rationing of medical services; whatever the disciplinary effects of such rationing, it can be predicted to yield outcomes very different from those attendant upon alternative policies strengthening private incentives for increased demand discipline on the part of patients.
- ³ See http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/. Under a set of controversial (or, more accurately, dubious) assumptions, the Congressional Budget Office has “scored” the “markup” (a summary of principles prior to the drafting of actual legislative language) passed by the Senate Finance Committee (“Chairman’s Mark: America’s Healthy Future Act of 2009”) at \$829 billion, with a projected reduction in future budget deficits of \$81 billion. See the letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Max Baucus, Chairman of the Committee on Finance, U.S. Senate, October 7, 2009, at http://cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf. To pick one such assumption as illustrative, the markup and CBO budget scoring assume a 20 to 25 percent reduction in Medicare reimbursements for physicians, with no subsequent annual increases over the 10-year budget horizon. Note as well that for the initial 10-year period, the various revenue provisions in the proposal take effect years before the spending provisions do, thus introducing a serious bias in the fiscal analysis. See Joseph Antos, “Health Reform: A Fiscal Fantasy Land,” October 15, 2009, at <http://www.aei.org/article/101170>. See also the statement by Senator John McCain, October 15, 2009, at http://mccain.senate.gov/public/index.cfm?FuseAction=PressOffice.Speeches&ContentRecord_id=58b78d59-0042-454c-bca2-4907f90e6ef3&Region_id=&Issue_id=.
- ⁴ 75 U.S. (8 Wall) 168 (1869).
- ⁵ The Court ruled in this case as well that a corporation is not a citizen within the meaning of the Privileges or Immunities Clause of the 14th Amendment.
- ⁶ 322 U.S. 533 (1944).
- ⁷ 15 U.S.C. § 1011 et seq.
- ⁸ Federal antitrust laws remain applicable to the business of insurance if a practice by an insurer “amounts to a boycott.” For a fuller discussion, see Janice E. Rubin, “Courts Narrow McCarran-Ferguson Antitrust Exemption for ‘Business of Insurance’: Viability of ‘State Action’ Doctrine as an Alternative,” Congressional Research Service Report RL33683, March 12, 2007, at <http://88.80.13.160/leak/crs/RL33683.pdf>.
- ⁹ Other types of mandates require coverage for particular classes of providers (e.g., psychologists) and particular classes of beneficiaries (e.g., foster children). For purposes of deriving a marginal cost estimate for mandated benefits, this paper includes the former, but not the latter.
- ¹⁰ For example, there is broad approval of proposals in Congress for “guaranteed issue” regulations forcing insurers to accept all applicants without regard to pre-existing medical conditions, and without actuarially fair insurance pricing. (Note that guaranteed-issue regulations would be meaningless if premiums were actuarially fair; but the literature often distinguishes the issue of premiums separately as one of “community rating”—that is, permitting premiums that reflect differences in health status only partially or not at all.) This would lead to an adverse-selection death spiral for the private insurance sector, unless the relatively healthy could be forced to buy coverage at prices not only higher than actuarially fair, but sufficiently high to offset the net costs imposed by those with pre-existing medical conditions. In other words, the requirement (“coverage mandate”) that the relatively healthy buy coverage would be necessary so that the costs imposed by those suffering from expensive conditions could be financed; under this sort of system, most individuals would have powerful incentives not to obtain coverage until they became sick.
- ¹¹ Or, at a minimum, deductibles and co-payments lower than otherwise would be the case; in effect, higher tax-deductible premiums are accepted in exchange for lower deductibles and co-payments, which are not tax-deductible. See, e.g., John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler, *Healthy, Wealthy, & Wise* (Washington, D.C.: AEI Press, 2005); David Gratzner, *The Cure* (New York: Encounter Books, 2006); Regina Herzlinger, *Who Killed Health Care?* (New York: McGraw-Hill, 2007); Arnold Kling, *Crisis of Abun-*

dance (Washington, D.C.: Cato Institute, 2006); and Sally C. Pipes, *The Top Ten Myths of American Health Care* (San Francisco: Pacific Research Institute, 2008).

- ¹² For a useful summary discussion, see “Effects of Changes to the Health Insurance System on Labor Markets,” Economic and Budget Issue Brief, Congressional Budget Office, July 13, 2009.
- ¹³ See, e.g., Paul Krugman, “Health Economics 101,” *New York Times*, November 14, 2005. Note that the uninsured in the U.S. are hardly without access to medical services. Recent analysis finds that, on average, uninsured individuals consumed \$2,262 in medical services in 2006. About 45 percent are uninsured for six months or less, as for example during the interval between successive employers, and many opt to go without health insurance because of its cost and/or because of a low perceived likelihood that an adverse health condition will occur over, say, the ensuing year. About 57 percent are under age 35, clearly a group disproportionately healthy. See J. P. Wieske and Merrill Matthews, “Understanding the Uninsured,” monograph, Council for Affordable Health Insurance, 2007. See also Merrill Matthews, “Conventional Wisdom in Health Care Reform: And Why Most of It Is Wrong,” monograph, Council for Affordable Health Insurance, May 2007; and Jack Hadley and John Holahan, “Covering the Uninsured: How Much Would It Cost?” *Health Affairs*, vol. 22 (June 4, 2003, web edition). See also Benjamin Zycher, “Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?” Center for Medical Progress, Manhattan Institute for Policy Research, Medical Progress Report No. 5, October 2007, at http://www.manhattan-institute.org/html/mpr_05.htm. Hennessey estimates that of the estimated 46 million Americans without health coverage, about 6.4 million are undercounted in the Medicaid and/or Children’s Health Insurance Program totals because they are listed erroneously in the Census Bureau surveys as uninsured; about 4.3 million are eligible for subsidized government coverage, but have not enrolled; about 9.3 million are not U.S. citizens (both documented and undocumented); about 10.1 million have incomes above 300 percent of the official poverty level; and about 5 million are adults aged 18–34 without children. This leaves about 10.6 million individuals. See Hennessey at <http://keithhennessey.com/2009/04/09/how-many-uninsured-people-need-additional-help-from-taxpayers/>. Similar estimates are provided in Devon Herrick, “Crisis of the Uninsured: 2009,” Brief Analysis No. 676, National Center for Policy Analysis, September 11, 2009.
- ¹⁴ One proposal now prominent is a combination of a global budget and a fine (or fee reduction) imposed upon providers in the top, say, decile of all providers in the given specialty. Since a given provider at best would have incomplete information about his ranking when making a treatment decision, this would provide an incentive to ration treatments that are relatively more expensive, regardless of expected effectiveness for the given patient. Thus would such a system provide physicians and hospitals with powerful financial incentives inconsistent with the medical interests of their patients.
- ¹⁵ See Paul Krugman, “Medicine: Who Decides?” *New York Times*, December 26, 2005: “. . . the public sector . . . sooner or later [would] have to make key decisions about medical treatment.” . . . “. . . . health care—including the decision about what treatment is provided—[would become] a public responsibility.”
- ¹⁶ Such price allocation would defeat the central political purpose of wealth redistribution, abstracting from the uses to which the government would put the revenues. Note that legislatures and government bureaus typically negotiate the delivery of an agreed basket of services for a given fiscal year in exchange for a lump-sum budget (although such entitlement programs as Medicare in principle spend whatever is demanded by program beneficiaries under the rules imposed by the administering department). For early discussions of this phenomenon, see William A. Niskanen, *Bureaucracy and Representative Government* (New York: Aldine, 1971), pp. 127–186; and James M. Buchanan, *Public Finance in Democratic Process: Fiscal Institutions and Individual Choice* (Chapel Hill: University of North Carolina Press, 1967), pp. 88–97. See also Dennis C. Mueller, *Public Choice III* (Cambridge, UK: Cambridge University Press, 2003), pp. 359–399.
- ¹⁷ “. . . by directing that industry in such a manner as its produce may be of the greatest value, he intends only his own gain, and he is in this, as in many other cases, led by an invisible hand to promote an end which was no part of his intention.” Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations*, ed. Edwin Cannan, 5th ed. (London: Methuen, 1904), book IV, chapter 2, paragraph 9.
- ¹⁸ Consider a patient suffering from cancer, the prognosis for which is uncertain, but who at the least faces a lengthy and expensive course of treatment. Insurance for this type of consumer, if priced at less than the actuarially expected cost, cannot appropriately be classified as participation in the pooling of risk; it is instead an adverse-selection process in which the consumer simply shifts known future costs onto others. An extreme example would be an attempt to purchase life insurance by an individual knowing that he has only days to live. It may be the case that such individuals are worthy of compassion and even subsidies, but that is not the same as saying that they are entitled to subsidies from other consumers of insurance services. If subsidies are an appropriate vehicle with which to express such compassion as a worthy social goal—a premise less obviously correct than some argue—then it is appropriate to finance them publicly.
- ¹⁹ Insurance thus can be viewed as a shift of income from time periods when income is relatively less important (has a relatively low “marginal utility”) into time periods when income is relatively more important because of such adverse events as a house fire or the

development of a serious medical condition.

- ²⁰ Government policies also can yield insurance markets that are too big, by hiding the true cost of coverage from the insured. A good example is the federal subsidy for storm damage in coastal regions, which yields incentives for overbuilding in those areas.
- ²¹ In his chapter on “Sloth,” David Hyman notes, bemusedly, that the failure of Medicare administrators to devote more than trivial amounts of resources to claims examination yields “savings” in the administration of the program viewed as a virtue by advocates of a single-payer system. See David A. Hyman, *Medicare Meets Mephistopheles* (Washington, D.C.: Cato Institute, 2006), pp. 53–56.
- ²² For an approving discussion of this inescapable outcome, see Paul Krugman, “Edwards Gets It Right,” *New York Times*, February 9, 2007.
- ²³ See Sally C. Pipes, *Miracle Cure* (San Francisco: Pacific Research Institute, 2004), for examples from the Canadian system. See also Krugman, “Medicine: Who Decides?” *New York Times*, December 26, 2009, and Cynthia Ramsay, “Michael Moore’s Sheer Fantasy: Canada’s ‘World-Class’ Health-Care System,” *Medical Progress Today*, June 22, 2007.
- ²⁴ See Lawrence H. Summers, “Some Simple Economics of Mandated Benefits,” *American Economic Review*, Papers and Proceedings, vol. 79, no. 2 (May 1989), pp. 177–183.
- ²⁵ See Jonathan Gruber, “State-Mandated Benefits and Employer-Provided Health Insurance,” *Journal of Public Economics*, vol. 55, no. 3 (November 1994), pp. 433–464.
- ²⁶ For a very useful discussion, see John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance*, (San Francisco: Pacific Research Institute, July 2008), pp. 16–23, at http://liberty.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf. The cost of the value of lost coverage is difficult to measure, unless we simply assume that the total lost value is the marginal value (the price of coverage) multiplied by the number of newly uninsured individuals. (Even measurement of the number of individuals newly uninsured because of a given benefit mandate would present a difficult problem.) This issue is outside the scope of this paper. The net effect of a given mandate on the number of insured is unclear on ex ante grounds, in that the adverse-selection problem will draw some consumers into the pool, while the higher costs will drive others out. Moreover, the costs of health coverage are, from the viewpoint of employers, merely a component of the cost of employment, and so are likely in many cases to be offset in part or in total by reductions in explicit wages and/or other benefits. This does not mean that either employers or employees are indifferent to the cost of health coverage: The form that compensation takes is important to employees, and differences in compensation packages are likely to yield differences in costs and in the pool of prospective employees available to the firm. For a discussion of the evolution of mandated benefits in the postwar period, see Miriam J. Laugesen et al., “A Comparative Analysis of Mandated Benefit Laws, 1949–2002,” *HSR: Health Services Research*, vol. 41, no. 3, part 2 (June 2006), pp. 1081–1103, at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1713218/#_secid679986. John Goodman and Gerald Musgrave estimate that about one-fifth of the uninsured are priced out of the market by regulatory mandates, although this estimate is somewhat dated. See John C. Goodman and Gerald L. Musgrave, “Freedom of Choice in Health Insurance,” National Center for Policy Analysis, Report No. 134, November 1988, at <http://www.ncpa.org/pdfs/st134.pdf>.
- ²⁷ Congressional Budget Office, “Increasing Small-Firm Health Insurance Coverage through Association Health Plans and HealthMarts,” January 2000, at <http://cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf>.
- ²⁸ See Zycher, “Comparing Public and Private Health Insurance,” http://www.manhattan-institute.org/html/mpr_05.htm.
- ²⁹ See Graham, *From Heart Transplants to Hairpieces*, pp. 16–23, http://liberty.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf.
- ³⁰ A recent comprehensive survey finds a total of 2,133 mandates for the 50 states and the District of Columbia, for an average of about 42; of those, 344 are mandates for coverage of such patient groups as dependent students. Another 543 mandates are for coverage of the services of such specific providers as psychologists. Obviously, there may some overlap among the mandates for given services and given providers. If we assume away such overlap, the survey finds mandates for 1,789 specific services and providers; that may be very crudely consistent with the implicit count of about 1,150 mandates in the Graham survey. See Victoria Craig Bunce and J. P. Wieske, “Health Insurance Mandates in the States 2009,” monograph, Council for Affordable Health Insurance, 2009. Differences in estimates of the numbers of mandates in the respective states may stem in part from differences in the benefit mandates applied to the individual and small-group markets for health coverage.
- ³¹ *Ibid.*
- ³² Michael J. New, “The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis,” Heritage Foundation Paper CDA06-04, July 25, 2006. New’s survey finds an average of 26 mandated benefits per state. His data are for individual plans only, for 2005–2006; inflation of the dollar figures to 2008 dollars would yield little difference. It is not clear from his discussion what variables were included in the econometric analysis to control for nonregulatory factors affecting premiums.
- ³³ William J. Congdon, Amanda Kowalski, and Mark H. Showalter, “State Health Insurance Regulations and the Price of High-Deductible Policies,” unpublished manuscript, September 2006, at http://econ.byu.edu/faculty/showalter/Assets/Papers/state_regulations_and_insurance_5.23.2008.pdf. This paper reports that the median state has 21 mandated benefits, while the mean is 23.

- ³⁴ The five mandates are for nervous and mental disorders and alcohol and other drug abuse, chiropractic services, diabetes treatment (equipment and supplies), temporomandibular joint (TMJ) disorders, and child immunizations. See Wisconsin Office of the Commissioner of Insurance, IP 37-2002, October 2002, at http://oci.wi.gov/pub_list/ip37_2002.pdf.
- ³⁵ See the U.S. General Accounting Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses," GAO-03-1133, September 2003, at <http://www.gao.gov/new.items/d031133.pdf>.
- ³⁶ Gregory Krohm and Mary H. Grossman, "Mandated Benefits in Health Insurance Policies," *Benefits Quarterly*, vol. 6, no. 4 (4th Quarter, 1990). In *Heart Transplants to Hairpieces*, Graham discusses a paper by Gregory P. Acs et al., in which the authors use a 1989 sample to derive an econometric finding that benefit mandates increase costs (in Graham's words) "by 4 to 13 percent for large employers . . . but negligibly for smaller employers . . ." Graham considers these findings "surprising." More critically, it seems likely that the source of the finding is econometric misspecification, in that smaller employers are more likely than larger employers to have dropped employee coverage altogether as an effect of the mandates. See Gregory P. Acs, Colin W. Winterbottom, and Sheila R. Zedlewski, "Employers' Payroll and Insurance Costs: Implications for Pay or Play Employer Mandates," *Health Benefits and the Workforce* (Washington, D.C.: U.S. Department of Labor, 1992).
- ³⁷ See John Welch et al., "Annual Mandated Health Insurance Services Evaluation," prepared for the Maryland Health Care Commission, December 31, 2008, at http://mhcc.maryland.gov/health_insurance/annualmandaterpt2008.pdf. The cost estimates purport to be the marginal costs of the five mandated benefits respectively, which are treatment of autism spectrum disorder, in vitro fertilization, 48-hour hospital stays following mastectomy procedures, prosthetic devices, and the herpes zoster (shingles) vaccine.
- ³⁸ Graham, *From Heart Transplants to Hairpieces*, pp. 16–23.
- ³⁹ See the discussion in section II. The quest for relatively low premiums has yielded over time rising enrollment in health plans categorized as Health Savings Account Qualified (HSA-qualified) or as High-Deductible Health Plans (HDHP). Such enrollment has increased from about one million individuals in early 2005 to about eight million in January 2009, an annual compound growth rate of about 68 percent. See America's Health Insurance Plans, "January 2009 Census Shows 8 Million People Covered By HSA/High-Deductible Health Plans," May 2009, at <http://www.ahipresearch.org/pdfs/2009hsacensus.pdf>, p. 4. See also Zycher, "HSA Health Insurance Plans after Four Years," pp. 13–18, in which the early growth of HSA-qualified/HDHP coverage is compared with the early growth of retirement savings vehicles enjoying tax preferences.
- ⁴⁰ An example is adopted children. The Bunce-Wieske survey is the most recent comprehensive survey available in the literature.
- ⁴¹ In table 2 the population aged 65 and above covered by private insurance is also counted in the figures for the total number of individuals covered by private insurance.
- ⁴² Analysis by Keith Hennessey at <http://keithhennessy.com/2009/04/09/how-many-uninsured-people-need-additional-help-from-tax-payers/>. Similar estimates are provided in Devon Herrick, "Crisis of the Uninsured: 2009," Brief Analysis No. 676, National Center for Policy Analysis, September 11, 2009.
- ⁴³ See U.S. Census Bureau, http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm.
- ⁴⁴ See table 1. For the median state with about 34 mandates, this implies a total increase in premiums of about 10.2 percent.
- ⁴⁵ It is assumed here that the supply of health coverage services is highly elastic, and that the demand for such coverage is moderately or highly inelastic. These assumptions are reasonable in that the supply of capital with which to underwrite coverage is part of the world capital market; and the empirical evidence, discussed in this section, is that the demand elasticity for health coverage is far below 1 (in absolute value). These assumptions imply both that the implicit tax imposed by a given mandate would raise premiums approximately dollar for dollar, and that any net increase in demand caused by a mandate would result in an increase in the size of the insured pool but not in a significant price increase.
- ⁴⁶ Congressional Budget Office, "The Price Sensitivity of Demand for Nongroup Health Insurance," August 2005, at www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf.
- ⁴⁷ The CBO's econometric analysis uses a "probit" model, meaning essentially that it uses data to estimate the change in the likelihood that an individual will enroll in non-group coverage if a relevant parameter changes; the CBO analysis focuses on the effect of subsidies for the rate at which individuals choose to buy insurance. This differs somewhat from the approach discussed in this section, but the two approaches are consistent, except to the extent that the mandates change the nature of the insurance good being purchased. The CBO estimate is at the low end of the limited range of such estimates available in the literature. *Ibid.*
- ⁴⁸ The CBO notes that its estimated demand elasticity for those with incomes less than twice the federal poverty level is substantially higher (in absolute value), at -0.84 . *Ibid.*, p. 12. As in the individual market, discussed in note 39, above, some combination of lower premiums and other perceived benefits has yielded growth in coverage under HSA/HDHP plans in the large-group market from 162,000 to 3.8 million in January 2009, an approximate annual compound growth rate of 119 percent. This is not an indirect elasticity measure, as this shift results from a number of changing factors, but it is implausible that lower premiums are not a significant factor. See AHIP, "January 2009 Census Shows 8 Million People Covered," May 2009.

- ⁴⁹ There is also the possibility that an elimination of benefit mandates would induce some consumers to shift from private to public coverage, to the extent that they are eligible for the latter. This may be the case in particular for those aged 65 and above and still covered by private plans. See table 2. This possibility is ignored here.
- ⁵⁰ See AHIP, “January 2009 Census Shows 8 Million People Covered,” p. 7. See also Zycher, “HSA Health-Insurance Plans after Four Years,” pp. 9–10. This unweighted average annual premium was \$4,091 in 2008. Strictly speaking, this specific assumption is unnecessary for the analysis presented here, but it is useful to explore a reasonable approximation of the market conditions facing a prototypical consumer.
- ⁵¹ Stephen T. Parente, Roger Feldman, Jean Abraham, and Xi Yu, “Consumer Response to a National Marketplace for Individual Health Insurance,” working paper, University of Minnesota, March 14, 2009. An earlier version is available at <http://ehealthplan.org>.
- ⁵² *Ibid.*, p. 22. In an earlier discussion in their paper (page 13), they report a figure of 8.5 million newly insured (rather than the 6 million) from the uninsured population, but that seems inconsistent with the figures shown in their Table 5. In either case, their projection for enrollment among the 28.8 million previously uninsured is roughly consistent with the finding here that 3.2 million of the 10 million previously uninsured would enroll in entrepreneurs’ coverage.
- ⁵³ Zycher, “HSA Health-Insurance Plans after Four Years.”
- ⁵⁴ AHIP, “January 2009 Census Shows 8 Million People Covered,” pp. 7–9.
- ⁵⁵ *Ibid.* See also table 3; and Kaiser Family Foundation/HRET, “Employer Health Benefits 2009 Annual Survey,” at <http://ehbs.kff.org>.

About the Author

Benjamin Zycher, a PRI senior fellow, has also served as a senior economist at the RAND Corporation, an adjunct professor of economics at the University of California, Los Angeles, an adjunct scholar at the Cato Institute, a senior fellow at the Manhattan Institute, and vice president for research at the Milken Institute. During the first two years of the Reagan administration, Dr. Zycher served as a senior staff economist on the president's Council of Economic Advisers.

Dr. Zycher's previous work for PRI includes *Pharmaceuticals and Price Controls* and *Attorneys General versus the EPA*, both co-authored with PRI President Sally Pipes. Dr. Zycher has also conducted considerable research on energy, the environment, and the effects of government regulation, taxation, spending, and debt. He is the author, with Charles Wolf Jr. et al., of *Fault Lines in China's Economic Terrain* and, with Tad Daley, of *Military Dimensions of Communist Systems*. His many publications include the "Defense Economics" and "OPEC" entries in *The Concise Encyclopedia of Economics* (2008), and "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" and "The Human Cost of Federal Price Negotiations: The Medicare Drug Benefit and Pharmaceutical Innovation," both for the Manhattan Institute. He also co-authored "The Truth about Drug Innovation: Thirty-Five Summary Case Histories on Private Sector Contributions to Pharmaceutical Science" (June 2008) and was sole author of "HSA Health-Insurance Plans after Four Years: What Have We Learned?" (February 2009), both Manhattan Institute Medical Progress Reports.

Dr. Zycher's articles have appeared in *Investor's Business Daily*, *Reason*, *The Hill*, and the *Wall Street Journal*, *Washington Times*, *Los Angeles Times*, *Orange County Register*, *San Diego Union-Tribune*, and many other publications. He serves on the advisory board of the quarterly journal *Regulation*, in which his work has also appeared, and on the advisory council of *Consumer Alert*.

Benjamin Zycher holds a Ph.D. in economics from the University of California, Los Angeles, where he also earned his bachelor's degree in political science. He also holds a master of public policy degree from the University of California, Berkeley.

Statement of Research Quality

The Pacific Research Institute is committed to accurate research and, to that end, submits all new PRI studies for review by a minimum of two researchers with expertise in the subject area, including a minimum of one external expert. To adjudicate any unresolved difference, deemed reasonable and substantive, between an author(s) and a reviewer, PRI maintains a Research Review Board (RRB). The RRB has final and determinative authority, and includes the following scholars:

Professor Robert Barro, Harvard University
Professor William Boyes, Arizona State University
Professor Steve Globerman, Western Washington University
Professor Jay Greene, University of Arkansas
Professor James Gwartney, Florida State University
Professor Eric A. Hanushek, Stanford University
Professor David Henderson, Naval Postgraduate School (Monterey)
Dr. W. Lee Hoskins, former president, Federal Reserve Bank of Cleveland (retired)
Professor Ronald W. Jones, University of Rochester
Professor Lynne Kiesling, Northwestern University
Professor Edward Lopez, San Jose State University
Professor Ross McKittrick, University of Guelph (Canada)
Professor Sandra Peart (Dean), University of Richmond
Professor David Schmidtz, University of Arizona
Professor Paul Zak, Claremont Graduate University

As part of its commitment, the Institute guarantees that all original factual data are true and correct to the best of our knowledge and that information attributed to other sources is accurately represented. If the veracity of any material fact or reference to an independent source is questioned and brought to the Institute's attention with supporting evidence, the Institute will respond in writing. If an error exists, it will be noted on the Institute website and in all subsequent distribution of the publication, which constitutes the complete and final remedy under this guarantee.

About the Pacific Research Institute

The Pacific Research Institute champions freedom, opportunity, and personal responsibility by advancing free-market policy solutions. It provides practical solutions for the policy issues that impact the daily lives of all Americans, and demonstrates why the free market is more effective than the government at providing the important results we all seek: good schools, quality health care, a clean environment, and a robust economy.

Founded in 1979 and based in San Francisco, PRI is a non-profit, non-partisan organization supported by private contributions. Its activities include publications, public events, media commentary, community leadership, legislative testimony, and academic outreach.

Education Studies

PRI works to restore to all parents the basic right to choose the best educational opportunities for their children. Through research and grassroots outreach, PRI promotes parental choice in education, high academic standards, teacher quality, charter schools, and school-finance reform.

Business and Economic Studies

PRI shows how the entrepreneurial spirit—the engine of economic growth and opportunity—is stifled by onerous taxes, regulations, and lawsuits. It advances policy reforms that promote a robust economy, consumer choice, and innovation.

Health Care Studies

PRI proposes market-based reforms that would improve affordability, access, quality, and consumer choice. PRI also demonstrates why a single-payer, Canadian model would be detrimental to the health care of all Americans.

Technology Studies

PRI advances policies to defend individual liberty, foster high-tech growth and innovation, and limit regulation.

Environmental Studies

PRI reveals the dramatic and long-term trend toward a cleaner, healthier environment. It also examines and promotes the essential ingredients for abundant resources and environmental quality: property rights, markets, local action, and private initiative.



PACIFIC
RESEARCH
INSTITUTE

