The Broken State of American Health Insurance Prior to the Affordable Care Act

A Market Rife with Government Distortion

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Executive Summary

- The health insurance system in America is plagued with problems, such as continually rising premiums and the difficulty of finding coverage. The Obama administration's diagnosis of the situation was clear: health insurance companies have too much freedom. The solution, therefore, is for the government to restrict this freedom, through provisions of the Patient Protection and Affordable Care Act (ACA).
- Many in America accept President Obama's diagnosis and solution because they assume that the health insurance industry pre-ACA was an essentially free industry. This paper challenges that assumption.
- A survey of some of the major controls pre-ACA reveals that health insurance was already one of the most government-controlled industries in America. This is the context in which we must assess the causes of our problems in health insurance.
- Contrary to proponents of further intervention, evidence presented in this paper suggests that government regulation plays a major role in the poor state of health insurance today. We must be willing to entertain the possibility that our diagnosis is mistaken: the patient's illness stems not from too much freedom but from too many controls.

Introduction

[T]he health insurance industry is the shark that swims just below the water, and you don't see that shark until you feel the teeth of that shark.
—Senator Jay Rockefeller, February 2010

It was sentiments like these that President Obama's signature legislation addresses. One of the main goals of the Patient Protection and Affordable Care Act, signed into law on March 23, 2010, is to control health insurance, an industry plagued with problems, all of which supposedly share a common diagnosis.

At the White House health summit, at which Rockefeller made the above comment, he continued (mixing metaphors), "Nobody has particular oversight of [health insurers]. . . . They can do what they want . . . . [Y]ou have to go at them to clip their wings in every way that you can." He repeated, "This is a rapacious industry that does what it wants."[1]

Two weeks later, the president echoed these sentiments in a speech at Arcadia University: "Every year, insurance companies deny more people coverage because they've got preexisting conditions. Every year, they drop more people's coverage when they get sick right when they need it most. Every year, they raise premiums higher and higher and higher . . . . And they will keep on doing this for as long as they can get away with it. This is no secret."[2]

The president's diagnosis was clear: health insurance companies had too much freedom. The solution, therefore, was for the government to restrict this freedom. Nancy Pelosi, Speaker of the House at the time, put it succinctly. According to her, insurance companies were "the villains" in the story of America's health care woes.[3] Government was to be the hero by reining in the free market.

On this view, legislation like the Affordable Care Act was the obvious prescription, full of so many government controls that some analysts predict it will cause private health insurance companies to "topple like tenpins"[4]—a consequence not unexpected or unwelcomed by Pelosi, Obama and others who have long called for the demise of private health insurance.[5]

But what if this diagnosis is based on an incomplete patient history?

What is missing from the usual story is the crucial recognition that the status quo before the passage of the Affordable Care Act was not a free, or even mostly free, health insurance market.[6] In reality, the government already deeply controlled the business of health insurance, dictating how insurers can operate—from licensing who can sell insurance and where, to regulating how insurers organize their finances, to dictating how they price their policies, to demanding to whom they must sell their services, to mandating what conditions they must cover, to restricting how they advertise. The list goes on.[7]

This reality is rarely acknowledged. And in the absence of this knowledge, the knee-jerk reaction of most people, understandably, is to blame the problems in health insurance on the free market. What other factor could be responsible?

But if we recognize that health insurance was already one of the most controlled industries in the United States before the Affordable Care Act, the diagnosis is much more difficult. How do we know which factor, existing government controls or the remaining elements of economic freedom, is responsible for the problems in the health insurance market? Before we swallow another heavy (and expensive—almost $1.8 trillion) dose of controls, it would be good to know the actual cause of the symptoms.[8]

A paper of this length cannot, of course, definitively establish the proper diagnosis. But if we examine just some of the major controls that were already in place before the Affordable Care Act became law, it is clear that government interventions are at least a major cause of the symptoms we are experiencing. Why not, then, consider repealing these controls instead of introducing new ones?

How Government Controls Created Employer-Based Health Insurance

Let's begin with an interesting fact. We so often obtain health insurance through our employer, but not our auto or homeowners insurance. Why this difference?

It's an artifact of World War II wage and price controls, during which time employers were outlawed from offering higher salaries. As a result businesses turned to enhanced fringe benefits such as health coverage in order to attract employees. In 1943 the Internal Revenue Service ruled that if your employer pays for your health insurance, you don't have to pay taxes on the value of those premiums. Because of this preferential tax treatment, the practice continued after wartime controls were lifted.[9] Today it is seen less as a perk and more as a standard benefit expected in many jobs.

One effect of purchasing health insurance through your employer is that you have limited choices when it comes to picking health plans. Consider all the different companies that offer different types of coverage for your home or your car. When it comes to health insurance, you must often pick between the two or three plans your employer offers, whether or not any are really suited to your needs, and which may all be from the same insurance company anyway.

Another consequence of getting insurance through your employer is that if you leave your job, you have to eventually find new insurance, which is a non-trivial consideration in today's market.[10] If you are unable to find another job that offers health benefits or if you want to take some time off, you have to apply for insurance on the individual market.

Consider now if you developed a medical condition while at your previous employer. When re-applying for insurance, your premiums will be higher than they would have been if you had continued to stay on your previous plan because you now have a pre-existing condition (i.e., you are now in a higher risk category). Your application for insurance may even be turned down entirely.[11]

According to many health policy experts, government distortion of how people purchase insurance is the main cause of the "pre-existing condition problem" that the Affordable Care Act is meant to solve.[12]

In addition to helping create the pre-existing condition mess, the tax law distorting how we purchase health insurance also distorts the amount of coverage we buy. Since plans purchased through an employer are paid for with pre-tax dollars, we tend to spend more on such benefits rather than collect a similar amount in income, which is then taxed. An employee earning, for example, $40,000 can face a marginal tax rate, including federal income, social security, Medicare and state income taxes, of up to nearly 50 percent. Health care analyst and physician David Gratzer explains, "Rather than seeing nearly 50 cents on the income dollar lost to taxes, [the employee] gets a full dollar of health benefits."[13]

This is one reason health insurance covers expenses insurers in other industries typically don't, such as routine procedures. Health insurance policies include services like annual physicals and routine cancer screenings, while auto insurers don't cover routine maintenance. In health care, we seek to use pre-tax dollars for all our expenditures, even everyday ones.

How Government Price Controls Distort Premiums and Penalize Healthy Individuals

Almost every state, in some form, bars health insurance companies from doing what they—and all other types of insurers—are fundamentally supposed to do, which is accurately assess your likelihood of filing claims, a process known as underwriting.[14] When an insurance company is restricted from underwriting, it is forced, in many cases, to sell you policies at higher premiums than it otherwise would.

To illustrate, it is helpful to consider shopping for insurance in a different context, say, to protect our homes or to protect our vehicles.[15] We'll contrast that with what occurs when we shop for health insurance.

To earn our business, insurers have to figure out what premiums they have to charge us in order to be able to pay off their expenses—administrative costs and the costs of the claims we will file—and still earn a profit. If they charge premiums that are too low, they will suffer a loss when paying out our claims. If they charge premiums that are too high, they risk losing our business to a competitor.

How do insurance companies figure out how to offer us the coverage we are looking for at a price we are willing to pay while making a profit? They first gather relevant information about a prospective client. For example, if you are shopping for homeowner's insurance, the insurer will consider your living conditions, such as where your home is located, what materials it is constructed with and the lifestyle habits of those who will be living in the house.[16] Insurers then analyze this information using a variety of mathematical and statistical models—a field known as actuarial science—to assess your particular chances of incurring future claims.

It's a complex field, but the fundamental way underwriting works is this: if your conditions suggest that you are more likely to have damage inflicted to your home, your premium is set higher than for someone who is less likely to, because the insurer expects you to file more claims. So if you're a non-smoker who lives in a home constructed of fire-resistant materials, such as brick, concrete or stone, in a low-crime neighborhood like Irvine, California, the chances of you filing a claim are lower than those of a chronic smoker living in a house made of wood in a high-crime area like Detroit. The financial risk the insurer has to take on to cover you is lower and so you would expect to be charged a lower premium.

The more accurately an insurer can assess your risk, the better able it is to offer you the coverage you are looking for at a more attractive rate than a competitor's. To this end, insurers continually seek to find innovative ways to better learn about your specific conditions and improve their actuarial models to factor in this new information.[17]

For example, auto insurers have historically estimated future claims based on factors such as your age, zip code, claims record, and vehicle make, model, and year. Fifteen years of its own data collection has demonstrated to auto insurer Progressive, however, that individual driving behavior is the most accurate predictor of future claims. That knowledge, combined with cost-effective technology to measure such behavior, led the company to recently begin offering a service called Snapshot, which involves installing a device in a policyholder's car. The device measures how fast you drive and calculates how frequently and how hard you brake, giving the company a better idea of how safely you drive. Taking individual driving behavior into account in this way has allowed Progressive to cut premiums for some by up to 30 percent.[18]

A British auto insurer called Young Marmalade recently started the same practice. For teenagers—who are generally charged higher premiums than adults because statistically they are involved in more accidents—this new technology allows the company to cut premiums by more than half if they demonstrate safe driving.[19]

Consider now what would happen if the government barred insurance companies from taking certain factors into account when pricing policies, such as how safely you drive. This means that, all other conditions being equal, for the same policy, an insurer could not charge a relatively unsafe driver a higher premium than a safe driver.

While this may sound good for the unsafe driver, it comes at the expense of better drivers. Each policyholder's risk of accident remains unchanged and, therefore, so does the overall risk the insurer must assume. What changes is that an insurer is less able to price your policy according to your individual risk. But somebody's got to make up the costs for covering the risk of the policyholders who are bad drivers—and that's the policyholders who are good drivers.

What such a regulation—called a rate restriction—would result in is that instead of drivers paying premiums that most accurately reflect their likelihood of accident, those who are less likely to be in an accident would have to pay higher premiums so that those more likely to be in an accident pay less.

For instance, if you were a teenager who is a safe driver, you would have to pay a premium for the risk of covering not only your own driving but also—to the degree of the restriction—that of a teenager who races with his friends. The result of this government-caused rise in your premium is that you either pay more for car insurance or are forced to go without it, because you can no longer afford coverage.

This is exactly what has happened in health insurance—people have been priced out of the market because premiums have been raised due to increasing government controls.[20]

There are a multitude of factors that affect your likelihood of requiring medical attention in the future, but here are just a few obvious ones: your age (medical costs tend to increase on average 1–4 percent with every year of age[21]), your medical history (people with diabetes have more than double the medical expenditures of those not afflicted[22]), your lifestyle choices (medical costs for smokers can be as much as 40 percent higher than for nonsmokers[23]), your family medical history (a family history of diabetes significantly increases the chances you'll develop the disease[24]), and your gender (women tend to visit physicians far more often than men[25]).

Ideally insurers would be able to take these factors—and many more—into account in order to price your policy in a way that most accurately reflects the amount of risk the insurance company has to take on to cover you. So if you're a healthy 25-year-old who does not smoke or drink excessively, you would expect your premium to be far lower than that of a 45-year-old smoker with hypertension.

But this is not so, because government interferes in two basic ways with how health insurers set premiums.

Some states impose rate bands, which limit the degree to which premiums can vary based on your health status and other factors. This is done by determining an average premium—known as the "index rate"—around which everyone's premiums can vary by a maximum percentage. For example, if an average monthly premium for a policy is $500 and the rate band in that state restricts premium variation to 20 percent, then the lowest premium the insurer can charge for that policy is $400 and the highest is $600. Even if an insurer is willing to charge you less than $400, say, because you are young and relatively healthy, it is forced by the government to charge you at least that much.

Prior to the passage of the Affordable Care Act, 36 states imposed some type of rate band in the small-group market (which serves small businesses) and 11 required them in the individual market (which serves individuals looking to purchase their own policy).[26]

The other, even more restrictive way in which government dictates premiums is by requiring "community rating," which mandates that everyone with the same policy is charged the same, or essentially the same, premium. In states that impose community rating, insurers cannot take into account your health, age, and other factors when determining your premium.

For example, in New Jersey, where "modified" community rating is enforced, insurers selling policies in the individual market can factor in your age, gender, and where you live, but not whether you have diabetes, a thyroid disease, or any other medical condition.[27] In New York, which is a "pure" community rating state, insurers can't even take those limited factors into account.[28] Everyone with the same policy, that is, the same benefits package, must be charged the same premium, regardless of how often they are likely to file claims.

What community rating means in practice is that younger and healthier people are forced to pay higher premiums so that older and unhealthier people pay less. Prior to the Affordable Care Act, community rating of some form was imposed in the small-group market in 11 states and in the individual market in 7 states.[29]

Among the reasons the government imposes community rating is that it is trying to bandage the effects of other controls it has imposed, such as "guaranteed issue" laws that force insurers to accept all applicants, regardless of current health status. Such laws actually dismantle the insurance apparatus.

Insurance as such works by people pooling together their risks of incurring expenses, not knowing whether they will in fact file claims but choosing to insure for the emotional and financial security coverage provides. Statistically, only a small minority of policyholders will end up having claims to file, which the insurer pays.

If the government imposed guaranteed issue in the homeowner's insurance market, it would mean people could purchase coverage after the fire is already raging in their house. There would be no benefit, therefore, for them to pay for coverage before that time.

In health insurance, guaranteed issue leads people to wait to purchase a policy until they need medical care, and once they regain their health, they drop their coverage. For example, when Washington State imposed guaranteed issue in the 1990s, women would sign up for insurance a few months before they needed maternity care and then drop it after the insurer paid the hospital bill. When canceling her policy, one woman wrote to the company, "We will do business with you again when we are pregnant." A year later, she once again purchased coverage and then dropped it after giving birth to her second child.[30]

Because insurers are forced to accept all applicants, those in the insurance pool, at any one time in a guaranteed issue market, are mainly the minority who know they have or will have claims to file. As a consequence, insurers are forced to raise everyone's premiums to pay the claims of those remaining in the insurance pool.

To offset the effect of higher premiums brought on by guaranteed issue laws, especially for those policyholders with known underlying medical conditions, state governments impose price controls in the form of rate restrictions, so that those who will incur the most medical expenses do not have to proportionately pay in premiums.[31]

In New York, which in 1993 imposed guaranteed issue and community rating laws for the small-group and individual markets, many people had no choice but to go without insurance. Within a year of the law's passage, 30-year-old single men saw their annual premiums rise from $1,200 to $3,240—an increase of 170 percent. Those additional premiums were taken to pay for the coverage of 60-old single men, who can have six times as high medical costs based on their age alone[32] but enjoyed a drop in their premiums from $5,800 to $3,240—a decrease of 44 percent. By 1994, one in six New Yorkers with a policy from the individual or small-group market either dropped his coverage or saw his employer drop it.[33]

And things are just as bad, if not worse, today. Premiums in the individual market are twice as high, on average, for New Yorkers than for the rest of the nation. Studies find that removing community rating

and guaranteed issue laws would lower premiums in the state by more than 40 percent and thereby make insurance affordable for more than a third of New Yorkers who find it unaffordable now.[34]

Despite these facts, starting in 2014, the Affordable (isn't that ironic?) Care Act imposes modified community rating and rate bands on the federal level to all plans sold on the small-group and individual markets. When pricing policies, insurers will be restricted to considering only your age, where you live, and if you are buying a policy for yourself or your family. Premiums can vary based on age by a maximum of three to one. Insurers can only charge smokers 1.5 times what they charge nonsmokers.[35]

How Government Controls Force You to Buy Costly Coverage You Don't Want or Need

Not only does the government distort the price of health insurance policies by restricting insurers' ability to assess individual risk, it also largely dictates what goes into each policy.

State and federal governments force insurance companies to provide coverage for certain benefits, regardless of whether the policyholder actually wants or needs that coverage. Some mandates require insurance companies to include the benefit in all policies. Others require them to include it in at least one.[36]

The first mandates were passed in Pennsylvania in 1949 for the coverage of osteopathy and dentistry.[37] Today there are more than two thousand in effect. Rhode Island, Virginia, and Maryland top the list, each requiring insurance policies in their state to offer coverage for more than sixty-five benefits, which include everything from treatment for drug abuse and alcoholism to chiropractic care. This is in addition to the mandates operating on the federal level.[38]

This is vastly different from how other types of insurance work. For example, when you are purchasing insurance for your home, you can decide what events you want to cover. If you live in Oklahoma, you may choose a policy with robust windstorm coverage, since the area is prone to tornadoes. Damage from earthquakes is rare in the state, so you may forego buying coverage for that. But someone living in the earthquake-prone state of California may make the opposite choices. If you live along the Gulf Coast, you may, in particular, decide it's a good idea to purchase protection from hurricane damage.

The greater level of coverage you purchase, the higher your premium. In the homeowners insurance market, people are free to purchase the coverage that best fits their needs and pay for it accordingly.

But when it comes to health insurance, government prevents many such choices to you or to your employer.

In 28 states you must buy coverage for the contraception pill, even if you are male or a female past child-bearing age.[39] In 31 states you must buy coverage for autism, even if nobody in your family is afflicted by the disorder or will be having children.[40] In at least 19 states you must buy coverage for alcohol rehabilitation, even if you are a teetotaler.[41]

Why force insurers to sell coverage consumers may not want or need? "The non-users subsidize the users," explains health economist Austin Frakt, "who . . . benefit with a lower net cost of contraceptives than they would otherwise pay without insurance."[42] According to health policy analyst Greg Scandlen, "State government decides it would be good social policy to have someone pay for the fertility treatment of infertile couples, so it assesses a fee on a group of citizens who will never themselves benefit from the service. . . . State lawmakers had an opportunity to enact social policy on the cheap—at no direct cost to the taxpayers."[43]

But such mandates are not really free—the indirect costs of these regulations are higher premiums for all policyholders. Each mandate can increase the cost of your policy.[44] Cumulatively, mandates can increase the cost of insurance in a state by up to 15 percent, and some estimates are even higher.[45] If your employer purchases health coverage for you, this additional cost is most often reflected in lower wages.[46]

If this were not bad enough, another consequence of mandated benefits is that they increase consumption of health services.

For example, in 2010, at least 12 states required that insurance policies sold in their individual and small-group markets provide coverage for infertility treatments.[47] One round of in vitro fertilization can cost upwards of $15,000 (in Maryland, insurers must cover at least three rounds[48]).[49] How much more likely is a couple to elect such a procedure when it knows the insurance company will pay most of the expenses? According to one study, the rate of IVF is 277 percent higher in states that mandate this coverage than in states that don't.[50]

The point here is not to scrutinize the decisions of policyholders—once the insurance company includes certain coverage in the policy you've paid for, you are in the right to claim it. The point is that the couple's decision as to whether or not to elect the procedure is affected by the government mandate. As a result, some couples may elect for the procedure when they might not have otherwise. And that additional usage comes at the expense of *all* policyholders, who face higher premiums when their policy is renewed.

Of course only infertile couples make use of mandated fertility benefits. Services that are used more commonly can increase premiums much more significantly. For example, mandated mental health benefit laws can increase premiums by up to 10 percent, partly because of the increased consumption that results.[51]

For some organizations the greater cost is more than they can afford. For instance, in 2010, the Screen Actors Guild found that its health care costs would double if it expanded mental health benefits as a 2008 federal law required, and so dropped mental health benefits for its 12,000 employees the following year. Said a chief executive of the union: "We're not in a position to afford it. This is unfortunate because we would have liked to have retained our existing programs." In Wisconsin, Woodman's Food Market dropped mental health coverage for its 2,200 employees and in Illinois, the Plumbers Welfare Fund stopped offering mental health benefits for its 3,500 members.[52]

Most obvious of all consequences, perhaps, is that mandated benefits prevent, say, a healthy 25-year-old male from purchasing a policy that only covers his expenses in the case of a catastrophic event. Instead, he must purchase a more expensive policy that not only includes benefits he may judge not worth the additional monthly cost but also benefits he would never need.

This young man has two choices. He can buy an expensive policy that covers not only catastrophes but also birth control, in vitro fertilization, and autism. Or he can forego buying a policy entirely. Studies estimate that at least one out of four people who go without insurance—which equals more than 10 million individuals—do so for this reason,[53] even in states like Massachusetts where it was already illegal prior to the Affordable Care Act to not carry a policy.[54]

Despite all this, the Affordable Care Act introduces new federal mandates. It requires all policies sold on the individual and small-group markets to include "essential health benefits" within 10 federally determined categories, including maternity and newborn services, pediatric services, and mental health and substance abuse services.[55] State governments and the thousands of lobbyists buzzing in their ears recently wrapped up the process of deeming what counts as "essential."[56] According to one lobbying group, massage therapy, yoga, and meditation instruction certainly do.[57]

So Was There a Free Market, or Anything Close to It, in Health Insurance Before the Affordable Care Act?

The controls discussed thus far barely scratch the surface of the many ways the government intrudes in the health insurance market, but what is already discernible is the fact that the government has distorted health insurance so severely that it calls into question whether what we have today can even be called insurance.

Real insurance is procured to protect against unexpected, catastrophic events.[58] Geico has you covered if your house catches on fire, but it does not pay for you to replace your furnace's filter. Yet government manipulation, such as 60 years of mandated benefits and a tax code that encourages people to spend their earnings on evermore health benefits, has resulted in coverage for predictable, inexpensive expenditures as the standard in health coverage. Indeed, the Affordable Care Act mandates that all health plans include preventative care, such as routine cancer screenings, vaccines and contraceptives, and provide that care with no co-pays or deductibles charged.[59]

Real insurance also prices each policyholder's risk accurately. If you have a history of getting into car accidents, Progressive will charge you a higher premium than someone with an accident-free record. As we've seen, in health care, government manipulation undermines, if not completely obliterates, the underwriting process.

These controls are not conducive to the actuarial science of insurance, and it is why more than 89 million Americans who probably think they have insurance from an insurance company actually don't. These are individuals whose employers provide them health coverage by "self-funding."

Employers who self-fund assume most of the financial risk of their employees' health care expenses, versus those employers who contract with an insurance company to do so. In such cases, employers pay the insurance company to simply process claims and administrate the system, not to take on the task of insuring risk. 60 percent of those who purchase health benefits through their employer are enrolled in self-funded plans.[60]

Why would an employer choose to self-fund? One reason, according to health policy experts John C. Goodman and Gerald L. Musgrave, is that "health insurance companies are not performing any real insurance function" anyway.[61] "At the end of each year," they explain, "the insurance company compares the employer's total premiums with the reimbursements that the insurance company actually made. If reimbursements are greater than premiums, the employer's premiums are raised in the following year. Insurance companies that act in this way are doing little more than processing claims. Thus, one way to look at self-insurance is to view [employers] as simply formalizing an arrangement that has already existed de facto."[62]

Health insurance in America has not been a remotely free, market-based industry for decades. Government manipulation thoroughly pervades the whole process.

In many respects, health insurance today has become a tool used by the government to forcibly collect money from some people in order to give health benefits to others. Rate restrictions like community rating and rate bands, for example, force younger and healthier people to pay more so that older and unhealthier people can pay less. Mandated benefits force everyone to purchase coverage for certain services in order to lower the cost for those who actually use the service.

Conclusion

An accurate diagnosis of the troubles in the health insurance market requires taking into account the regulatory environment in which insurers are functioning—an environment of almost total government control. It is in this environment, where normal insurance practices are outlawed, that we are seeing rising premiums, fewer choices, and all the other problems we associate with health insurance today.

If we actually look at the health insurance industry in America today, it is evident that many of its ills are caused by government controls and not, as is so readily assumed, by the free market. What would a comprehensive examination reveal?

The Affordable Care Act introduces a massive layer of new controls. What if we are administering more of the poison that is already killing the patient? Health care is too vital an industry for us to not seriously investigate this possibility.

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Endnotes

1 Transcript, White House Health Summit, February 25, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022503941.html

2 Barack Obama, "Remarks by the President on Health Insurance Reform" (speech, Glenside, PA, March 8, 2010), The White House, http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-arcadia-university.

3 Richard Cowan and Sandra Maler, "Pelosi Lashes Out Against Insurance Companies," *Reuters*, July 30, 2009, http://www.reuters.com/article/2009/07/30/us-usa-healthcare-insurance-idUSTRE56T4CZ20090730.

4 Richard A. Epstein and David A. Hyman, "Why Obamacare Will End Health Insurance as We Know It," March 2012, http://www.manhattan-institute.org/html/ir_7.htm.

5 Ezekiel J. Emanuel and Jeffrey B. Liebman, "The End of Health Insurance Companies," *New York Times*, January 30, 2012, http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/.

6 The health care market more broadly was already largely controlled by government prior to the Affordable Care Act. In 2010, 45 cents of every dollar spent on health care was spent by the government (see Veronique de Rugy, "Health Care Spending in the United States Before the Affordable Care Act," Mercatus Center, March 27, 2012, http://mercatus.org/publication/health-care-spending-united-states-affordable-care-act). The other 55 cents was spent by insurers, employers and private individuals on a market that was heavily regulated [see Robert I. Field, *Health Care Regulation in America* (New York: Oxford University Press, 2007)].

7 U.S. Department of Health and Human Services, Office of Health Policy, "The Regulation of the Individual Health Insurance Market," 2008, http://aspe.hhs.gov/health/reports/08/reginsure/report.pdf.

8 Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

9 David Gratzer, *The Cure: How Capitalism Can Save American Health Care* (New York: Encounter Books, 2006), 25.

10 The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires employers who offer group coverage to continue offering their plan to terminated employees for 18 months. In most cases, the premiums for this coverage must be paid entirely by the employee [see Department of Labor, "FAQs about Portability of Health Coverage and HIPAA," accessed September 9, 2013, http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html].

11 The Health Insurance Portability and Accountability Act Of 1996 (HIPAA) requires insurers to accept applicants who want to continue their COBRA coverage after the 18-month mandated period, regardless of their existing medical conditions (see Department of Labor, "FAQs about Portability of Health Coverage and HIPAA").

12 Avik Roy, "Why Mitt Romney's Plan for Pre-Existing Conditions Is Better Than Obamacare's," *Forbes*, October 9, 2012, http://www.forbes.com/sites/aroy/2012/10/09/why-mitt-romneys-plan-for-pre-existing-conditions-is-better-than-the Affordable Care Acts/.

13 Gratzer, *The Cure*, 26–27.

14 Kaiser Family Foundation, "Health Insurance Market Reforms: Rate Restrictions," June 2012, http://www.kff.org/healthreform/upload/8328.pdf.

15 Property and vehicle insurers are regulated by state and federal governments but have relatively more freedom than health insurers when it comes to underwriting.

16 HomeTown Quotes, "Factors That Affect Your Home Insurance Cost," accessed March 19, 2013, http://www.hometownquotes.com/homeowners/factors-that-affect-your-home-insurance-cost.html.

17 Robert J. Shiller, "Radical Financial Innovation," Cowles Foundation Discussion Papers, April 2004, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=537402.

18 Progressive Corporation, "Linking Driving Behavior to Automobile Accidents and Insurance Rates," July 2012, http://www.progressive.com/newsroom/images/snapshot_report_final_070812.pdf.

19 TotalInvestor, "Young Marmalade Offering to Provide Low-Cost Car Insurance for Young Drivers," April 17, 2012, http://www.totalinvestor.co.uk/i/ifanews/show/1758.

20 Mark V. Pauly, *Health Reform without Side Effects* (Stanford: Hoover Institution Press), 25.

21 Aon Hewitt, "2011 Health Insurance Trend Driver Survey," http://www.aon.com/attachments/thought-leadership/2011_Health_Insurance_Trend_Driver_Survey.pdf

22 American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2007," *Diabetes Care* 31 (2008), doi:10.2337/dc08-9017.

23 Jan J. Barendregt, Luc Bonneux, and Paul J. van der Maas, "The Health Care Costs of Smoking," *New England Journal of Medicine* 337 (1997), doi:10.1056/NEJM199710093371506.

24 American Heart Association, "Understand Your Risk for Diabetes," accessed August 6, 2013, http://www.heart.org/HEARTORG/Conditions/Diabetes/UnderstandYourRiskforDiabetes/Understand-Your-Risk-for-Diabetes_UCM_002034_Article.jsp.

25 Gary M. Owens, "Gender Differences in Health Care Expenditures, Resource Utilization, and Quality of Care," supplement to *Journal of Managed Care Pharmacy* 14 (2008): S2, http://www.amcp.org/data/jmcp/JMCPSupp_April08_S2-S6.pdf.

26 National Association of Insurance Commissioners and the Center for Insurance Policy and Research, "Rate Regulation," July 1, 2009, http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.

27 Kaiser Family Foundation, "New Jersey: Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals, 2012." Accessed March 19, 2013, http://www.statehealthfacts.org/profileind.jsp?ind=354&cat=7&rgn=32.

28 Kaiser Family Foundation, "New York: Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2012." Accessed March 19, 2013, http://www.statehealthfacts.org/profileind.jsp?rgn=34&cat=7&ind=354.

29 National Association of Insurance Commissioners and the Center for Insurance Policy and Research, "Rate Regulation," July 1, 2009, http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.

30 Carol M. Ostrom, "Why Washington State's Health Reform Faltered after Loss of Mandates," *Seattle Times*, March 27, 2012, http://seattletimes.nwsource.com/html/localnews/2017852301_insurancemandate28m.html.

31 Victoria Craig Bunce, "What Were These States Thinking? The Pitfalls of Guaranteed Issue," Council for Affordable Health Insurance, May 2002, http://www.cahi.org/cahi_contents/resources/pdf/guaranteedissue.pdf.

32 Avik Roy, "Putting the 'Insurance' Back in Health Insurance," *Forbes*, May 21, 2012, http://www.forbes.com/sites/aroy/2012/05/21/putting-the-insurance-back-in-health-insurance/.

33 Conrad F. Meier, "Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States," Council for Affordable Health Insurance and Heartland Institute, 2005, http://www.cahi.org/cahi_contents/resources/pdf/destroyinginsmrkts05.pdf.

34 Stephen T. Parente and Tarren Bragdon, "Why Health Insurance Is So Expensive in New York," *Wall Street Journal*, October 16, 2009, http://online.wsj.com/article/SB10001424052748703746604574461482860007734.html.

35 Kaiser Family Foundation, "Health Insurance Market Reforms: Rate Restrictions."

36 Miram J. Laugesen, Rebecca R. Paul, Harold S. Luft, Wade Aubry, and Theodore G. Ganiats, "A Comparative Analysis of Mandated Benefit Laws, 1949–2002," *Health Services Research* 41 (2006), doi:10.1111/j.1475-6773.2006.00521.x.

37 John R. Graham, "From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance," Pacific Research Institute, July 1, 2008, http://www.pacificresearch.org/search/article-detail/?tx_ttnews%5Btt_news%5D=5575.

38 Victoria Craig Bunce, "Health Insurance Mandates in the States 2011," Council for Affordable Health insurance, 2012, http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2011ExecSumm.pdf.

39 National Conference of State Legislatures, "Insurance Coverage for Contraception Laws," February 2012. Accessed March 19, 2013, http://www.ncsl.org/issues-research/health/insurance-coverage-for-contraception-state-laws.aspx.

40 National Conference of State Legislatures, "Insurance Coverage for Autism," August 2012, Accessed March 19, 2013, http://www.ncsl.org/issues-research/health/autism-and-insurance-coverage-state-laws.aspx.

41 National Conference for State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits," December 2012. Accessed March 19, 2013, http://www.ncsl.org/issues-research/health/mental-health-benefits-state-mandates.aspx.

42 Austin Frakt, "Insurance Is Redistributive: Contraceptives Edition," *Incidental Economist*, August 9, 2012, http://theincidentaleconomist.com/wordpress/insurance-is-redistributive-contraceptives-edition/.

43 Greg Scandlen, "Myth Busters #11: Mandated Benefits," *John Goodman's Health Policy Blog*, October 11, 2011, http://healthblog.ncpa.org/myth-busters-11-mandated-benefits/.

44 Bunce, "Health Insurance Mandates in the States 2011."

45 Benjamin Zycher, "'Entrepreneurs' Coverage': An Alternative Health Policy Reform," Pacific Research Institute, January 2010, http://74.217.243.137/docLib/20100119_Entrepreneur_Coverage.pdf.

46 Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84 (1994), http://aysps.gsu.edu/isp/files/ISP_SUMMER_SCHOOL_2008_ERARD_INCIDENCE_OF_MANDATED_MATERNITY_BENEFITS.pdf.

47 Kaiser Family Foundation, "Mandated Coverage of Infertility Treatment, January 2010." Accessed March 19, 2013, http://www.statehealthfacts.org/comparetable.jsp?ind=686&cat=7.

48 Maryland Health Care Commission, "Study of Mandated Health Insurance Services: A Comparative Evaluation," January 1, 2012, http://mhcc.dhmh.maryland.gov/healthinsurance/Documents/sp.mhcc.maryland.gov/healthinsurance/mandated_2012_20120106.pdf.

49 Rachel Gurevich, "How Much Does IVF Cost?," *About.com*, August 16, 2011, http://infertility.about.com/od/ivf/f/ivf_cost.htm.

50 Tarun Jain, Bernard L. Harlow, and Mark D. Hornstein, "Insurance Coverage and Outcomes of In Vitro Fertilization," *New England Journal of Medicine* 347 (2002), http://www.nejm.org/doi/pdf/10.1056/NEJMsa013491 .

51 Bunce, "Health Insurance Mandates in the States 2011."

52 Russell Adams and Avery Johnson, "Law Prompts Some Health Plans to Cut Mental-Health Benefits," *Wall Street Journal*, December 23, 2010, http://online.wsj.com/article/SB10001424052748703395904576025410628499574.html.

53 National Center for Policy Analysis, "HIAA Study: Ten Million Americans Uninsured Due to Mandates," January 26, 1999, http://www.ncpa.org/sub/dpd/index.php?Article_ID=12536.

54 Abby Goodnough, "In Massachusetts, Insurance Mandate Stirs Some Dissent," *New York Times*, March 27, 2012, http://www.nytimes.com/2012/03/28/us/massachusetts-health-insurance-mandate-stirs-dissent.html?pagewanted=all.

55 Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage." Accessed March 19, 2013, http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html.

56 Abby Goodnough, "Interest Groups Push to Fill Margins of Health Coverage," *New York Times*, December 5, 2012, http://www.nytimes.com/2012/12/06/health/interest-groups-push-to-fill-margins-of-health-coverage.html?_r=1&.

57 Colorado Department of Regulatory Agencies, Division of Insurance, "Essential Health Benefits Public Comments," Christian Science Committee on Publication for Colorado, July 27, 2012. Accessed March 22, 2013, http://www.colorado.gov/cs/Satellite?c=Page&childpagename=DORA-HealthIns%2FDORALayout&cid=1251629086042&pagename=CBONWrapper.

58 John C. Goodman, *Priceless: Curing the Healthcare Crisis* (Oakland: Independent Institute, 2012), 123.

59 HealthCare.gov, "Preventive Services Covered Under the Affordable Care Act," September 23, 2010. Accessed March 19, 2013, http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

60 Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2012 Annual Survey," 2012, 160, http://ehbs.kff.org/pdf/2012/8345.pdf.

61 John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992), 217.

62 Goodman and Musgrave, *Patient Power*, 199.