Executive Memorandum
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RUSH!

WHY CONGRESS SHOULD NOT IMPOSE MANDATES ON PRIVATE HEALTH INSURANCE

Congress is poised to enact legislation which, for the first time, would require private commercial health insurance carriers to provide specific benefits. Such federal mandates inevitably increase costs while limiting consumer choice and competition. In particular, these proposed mandated benefits would increase the costs of health insurance premiums for employers, who then would either limit health benefits or pass the higher costs on to workers and their families in the form of lower wages. Worse, Congress would be establishing a precedent for legislative determination of what medical benefits, treatments, or procedures Americans must have in their personal insurance plans.

Making Health Policy Through the Appropriations Process. During consideration of H.R. 3666, the Veterans Administration and Housing and Urban Development appropriations bill, the United States Senate by voice vote approved an amendment offered by Senator Bill Bradley (D-NJ) that would require insurers to cover a mother and newborn for at least two nights in the hospital after a normal birth, and at least four nights after a caesarean section. Coverage for fewer days would be permissible if agreed to by the attending physician in consultation with the mother.

In addition, by a vote of 82 to 15, the Senate adopted a mental health "parity" amendment offered by Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN). This amendment—a scaled-down version of the mental health parity provision dropped from the recently enacted Kennedy-Kassebaum health insurance reform bill—would require group health insurers who offer mental health coverage and apply aggregate lifetime and annual payment limits on coverage either (a) to include plan payments made for mental health services under the aggregate lifetime and annual payment limits for medical or surgical services, or (b) to establish a separate aggregate lifetime and annual payment limit for mental health that is equal to or greater than the limit established for medical and surgical services. On September 11, the House of Representatives, by a vote of 392 to 17, passed a nonbinding instruction to conferees on the VA-HUD bill to adopt both provisions. Both the Bradley and Domenici-Wellstone amendments represent a not-so-subtle creep of government control over the health care market.

Compounding State Regulation. The overregulation of health insurance at the state level is a problem for both small businesses and insurers. In 1970, there were 48 mandated benefit laws (laws requiring specific treatments, benefits, or procedures) nationwide. As of 1995, because of intense lobbying by medical practitioners and advocates seeking coverage for various diseases, the number had risen to over 920. And this does not include almost 100 so-called anti-managed care laws (such as "any willing provider" and "mandatory point of service" laws) by which states restrict the ability of managed care plans to contract with providers and establish cost sharing.[1] The most prominent form of federally tax supported, employer-based health insurance is managed care. Because of the rapid expansion of this form of health care, with its restrictions imposed on both doctors and patients, state legislatures are rapidly increasing their regulation of the insurance industry. More than 1,000 managed care bills are being considered in state legislatures in 1996; 56 have been passed into law in 35 states so far.[2]

Imposing Higher Costs. The Congressional Budget Office (CBO) estimates that Senator Bradley's maternity benefit mandate would cost the federal government alone some $223 million over four years in increased outlays for Medicaid and the Federal Employees Health Benefits Program (FEHBP), and in lost revenues due to lower wages from increased health costs. The CBO also says that the new maternity benefit would increase aggregate premium payments for employee-based and individually purchased health plans by 0.06 percent. In addition to the extra costs for government programs, the CBO estimates that direct private-sector costs would increase by $180 million in 1998 and $220 million in 2001.

According to a CBO analysis conducted on behalf of the Senate Budget Committee, the estimated cost of the Domenici-Wellstone mental health parity provision of the VA-HUD appropriations bill is less than the earlier version—estimated at $618 million over 5 years (the provision sunsets in 2001).[3] The potential cost also was reduced somewhat by a modifying amendment, offered by Senator Phil Gramm (R-TX), stipulating that if a group health policy experienced a premium increase of 1 percent or more in a given year due to this provision, that insurance policy could be exempted from the mandate.

While both amendments attempt to address real issues—namely, the equitable treatment of mental health services and the health and safety of mothers and newborns—they are bad public policy. The federal government should not be in the business of determining what benefits, treatments, or procedures private health insurance must provide to patients. This should be a contractual decision between consumers and insurers, and between doctors and patients. Whether to cover treatment for mental illness (or any illness) should be an insurance contract issue, not a political decision or an area for congressional intervention.

Moreover, experience at the state level indicates that mandates typically are the product of intense lobbying by provider interests rather than sound health policy. Thus, Congress should realize that once one group of practitioners begins to benefit from legally mandated coverage for its services, others will argue for similar legal guarantees. In the meantime, the price of legally privileged medical benefits hurts legally underprivileged medical practitioners, because businesses or insurers have to cut back other benefits to accommodate the new law. Desperately fighting for equal treatment, the excluded practitioners and advocates for certain disease groups lobby intensively for expansion of the mandates. The slippery slope of mandated benefits is transformed into spiraling costs.

Let Consumers Fire Bad Insurance Companies. Rather than adopt bad health care policy, Congress should allow consumers to choose not only their health insurance coverage, but also the kinds of medical treatments and procedures they want at the prices they wish to pay. In a consumer choice system, individuals and families —not employers or managed care companies—would choose the health plans and benefits that best suit their needs. The mother of a newborn forced out of a hospital before her time should have the right to fire her insurance company. Individuals and families, given tax relief regardless of where they work, should be able to purchase comprehensive health insurance, including catastrophic coverage, without imposing high costs on the private health insurance plans of other workers and their families with different needs. While rhetorically packaged with phrases like "incremental reforms" or "patient protections," federal mandates—especially on top of state mandates—do nothing to reform America's health care system. All they do is raise costs and limit consumer choice and competition.

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1 Blue Cross/Blue Shield 1995 Survey of Plans.

2 *American Medical News*, September 9, 1996.

3 The mental health parity provision agreed to earlier this year by the Senate would have imposed huge new costs on working families. The CBO estimated that premiums for traditional fee for service plans would increase by 5.3 percent, while managed care plans would cost the consumer an additional 4 percent. Understanding that it is workers and their families that ultimately bear the costs of mandated benefits, the CBO predicted that this provision would force employers either to cut back other benefits—or health insurance altogether—or to pass the higher cost of insurance on to workers in the form of lower wages.