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The Cultural Policy Studies Project

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HOW HEALTH INSURANCE MANDATES MISDIAGNOSE THE DISEASE

Two recent developments in Washington underscore just how badly many policymakers misunderstand the root cause of the public's frustration with the health care system. At first glance, both developments seem sensible, as well as overdue. But both completely miss the point, and may even make things worse.

The first is President Clinton's decision to appoint an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The goal is "to find ways to ensure quality, and to ensure that the rights of consumers in health care are protected," and develop a "consumer bill of rights." The second seemingly reasonable development is the announcement of several bills that would require health insurance companies to cover services that most Americans believe should be in their health plans. Specifically, Senator Alfonse D'Amato (R–NY) and Representative Susan Molinari (R–NY) are sponsoring bills that would require insurers to cover minimum hospital stays for mastectomies. Other measures would mandate coverage of certain emergency services and lift contractual restrictions contained in physician contracts in some managed care plans to limit physician communication with patients (known as "gag clauses").

WRONG DIAGNOSIS

The problem is that these proposals, particularly the mandate bills, rush to cure the symptoms of the disease without recognizing its causes. The underlying problem is that typical working Americans do not choose and own their health insurance as they do their homeowner's insurance and life insurance. Instead, employers choose and own the plans. That part of the employee's compensation earmarked for a health insurance fringe benefit is tax-free to the employee, but there is a stiff price: Families lose control of their benefits. So insurance companies work for employers, concerned primarily with keeping costs down by trimming benefits, rather than for families concerned with quality and service.

Given this arrangement, families cannot do what they normally do when they are dissatisfied with a product or service: change to another company. Instead, the only way powerless families can force insurers to focus on their needs is to persuade their employers to change plans or hope the U.S. Congress will enact a mandate. That is why there is support for mandates. Yet mandates miss the underlying point: As long as the tax system effectively locks working Americans into employer-sponsored health coverage, families will be frustrated with how they are treated by health insurers.

Even as a Band-Aid "solution" to this much deeper problem, mandates raise a host of problems and unintended side effects.

(1) **Mandated benefit laws increase the cost of health care and make insurance even less affordable and accessible for many needy individuals.** This effect is particularly troublesome for the 40 million Americans currently uninsured for some period each year. Over 1,000 such laws have been enacted at the state level, each requiring that a specific benefit, procedure, or provider service be covered in every state-regulated insurance policy sold. The costs of these mandates vary from state to state, but can be heavy.

Example. The U.S. General Accounting Office (GAO) estimates that mandated benefit laws account for 12 percent of claims costs in Virginia and 22 percent in Maryland.[1]

Example. The Congressional Budget Office (CBO) estimates that the federal law enacted in 1996 requiring private health insurers to cover 48-hour maternity stays will cost the federal government $223 million over four years, and that direct private-sector costs (increases in health premiums paid by employers and employees) will increase by $745 million over four years.[2]

Example. According to the CBO, the mental health parity legislation adopted in the last Congress will increase the federal deficit by an estimated $590 million over six years. This is due to increased costs to the Federal Employees Health Benefits Program (FEHBP), which covers federal workers and dependents, and lost tax revenue because of lower employee compensation (because employers will reduce wages to accommodate increased health plan costs). The CBO's preliminary estimate is that this provision will raise private-sector costs by more than $100 million over this same period.[3]

(2) **Mandated benefit laws—particularly laws that define the duration and scope of specific benefits—lock in a standard of care that may be inappropriate in the future.** This is the case with proposals like 48-hour maternity stays or required coverage of inpatient stays for mastectomies. Once these mandates are in statute, it becomes very difficult to change insurance benefits later, when state-of-the-art medical practices

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1 U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS 96–161, August, 19, 1996.

2 Congressional Budget Office, letter to Congress, cost estimate of S. 969, Newborns' and Mothers' Health Protection Act of 1996, July 17, 1996.

3 Congressional Budget Office, memo to Congress, cost estimate of Mental Health Parity Amendments to VA/HUD appropriations bill, September 10, 1996.

change. It entails national debate, protracted lobbying by interest groups, opposition from interests favoring the old mandate, and an act of Congress. Imagine, for example, that Congress had enacted legislation in 1980 requiring insurers to cover mothers and newborns in an inpatient setting for the average length of stay for a normal delivery at that time (77 hours).[4] Any attempt to amend that law today so that resources could be used for more appropriate medical benefits would face heavy opposition from hospitals specializing in maternity care.

Members of Congress must realize that mandating a sensible practice today means locking in what could become a costly, outmoded practice tomorrow. Thus, mandated benefits can impede progress, innovation, and improvements in the delivery of health care. Dr. Janet Roberto, a family physician, explained the problem at a recent congressional briefing. Benefit mandates imposed ostensibly to help doctors and patients, noted Dr. Roberto, can impede the doctor–patient relationship by creating a situation in which the patient, whose insurance offers something different or more comprehensive, begins to question the physician's judgment regarding what treatment is best. "When a patient knows of a benefit that is mandated or in their terms 'automatically covered,' they immediately utilize that service as a need, whether it is or is not personally in their best interest.... Mandates can, in effect, take away the physician judgment as to what is best for the patient."[5]

(3) **Although mandated benefit laws do not prohibit advances in medicine directly, they can diminish the incentive to find new and better ways to deliver care.** Nurse Lillie Shockney of Johns Hopkins University Hospital in Baltimore, Maryland, recently testified before the Maryland state legislature on the politically charged issue of outpatient mastectomies. Shockney is both an oncology nurse caring for cancer patients and a double mastectomy breast cancer survivor. She spoke of the Johns Hopkins outpatient mastectomy program's success in discovering improved treatment modalities for breast cancer patients, testifying that the program's emphasis on outpatient mastectomies was due to effectiveness and patient satisfaction, not to pressure from managed care. Advances in anesthesia, as well as a recognition of the primary role that family support plays in the healing process for breast cancer victims, have allowed Johns Hopkins to convert the majority of its mastectomy cases to the outpatient setting.

Shockney stresses that the ultimate decision is between the patient and her doctor. She fears, however, that legislation mandating inpatient coverage will block the development of new programs like that at Johns Hopkins:

> I hope that this legislation [mandated inpatient mastectomy coverage] doesn't discourage hospitals from developing such programs though, since this bill will make it easier for them to simply continue to provide care the "old way." The breast cancer patient isn't being done justice if hospitals continue doing this procedure the old way.[6]

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4 U.S. General Accounting Office, *Maternity Care: Appropriate Follow-Up Services Critical with Short Hospital Stays*, GAO/HEHS 96–207, September 11, 1996.

5 Statement of Dr. Janet M. Roberto on behalf of Concerned Women for America at congressional health care briefing, February 21, 1997.

6 Testimony of Lillie Shockney, RN, on behalf of Johns Hopkins University Hospital before Maryland state legislature,

(4) With the growth of physician-sponsored and hospital-sponsored health plans, mandated benefit laws will hurt many of the providers now advocating their passage. The National Association of Insurance Commissioners (NAIC) reports that 39 states have provider service organization (PSO) regulations and that PSOs are operating currently in 27 states. A PSO is a voluntary network of physicians and hospitals that both insures and provides health services under contract with health care purchasers. Physician and hospital groups have lobbied actively for federal preemption of state regulations and separate federal regulations of PSOs as they seek entree into the Medicare market. One reason for this is that PSOs find certain state mandated benefit laws burdensome and costly as they take on the new role of both provider and insurer. If Congress continues to enact health benefit mandates, however, PSO operators will find themselves increasingly facing the same costly requirements at the federal level that they are seeking to avoid at the state level.

(5) By singling out mastectomies or maternity care, politicians grant favored status to those suffering from a particular disease or disability, often responding to organized pressure rather than to medical priorities. Increasingly—and disturbingly—both the attention Congress pays to medical issues and the actions it takes on those issues are determined by the political lobbying efforts of particular groups rather than by sensible medical priorities. In the case of mandates, of course, this lobbying is a result of a feeling among Americans that they are powerless in dealing with insurers. But the political "solution" favors those suffering from certain diseases at the expense of others afflicted with different diseases.

What is worse, Members of Congress overstep the bounds of their professional competence by determining not only the type of benefits, but also the duration and scope of those benefits. The politicians' penchant for playing doctor is summed up neatly by *Washington Post* columnist and trained physician Charles Krauthammer: "I am sorely provoked by the arrogance of a chamberful of lawyers stretching out its magic wand to anoint with special protection one, and only one, tragic affliction."[7]

The recent back-and-forth between Congress and the President (politicians) and the National Cancer Institute (scientists) regarding mammography screening standards shows just what can happen when politics and medicine are entwined. The NCI reported originally that "evidence does not support" the need for mammography screening for women under 50 years of age, but Congress, the Administration, and some advocacy groups were unconvinced. After much media attention and the passage of a congressional resolution indicating the displeasure of lawmakers, the NCI revised its guidelines. The only difference between mandating inpatient hospital coverage for mastectomies and passing a resolution that mammography screening should begin at 40 years of age—the efficacy and desirability of both of which are outside the scope of knowledge of most politicians—is one of degree. The question is not what the benefits or standards should be, but whether lawmakers are capable of making that determination. The answer is that they are not: By politicizing the practice of medicine, politicians endanger patients.

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7 Charles Krauthammer, "Play-Doctors on the Hill," *The Washington Post*, February 14, 1997.

DEALING WITH THE PROBLEM

The challenge for Congress is not to micromanage medicine, but to make it possible for Americans to walk away from a health plan that does not meet their individual needs and choose one that does. Members of Congress can do this thanks to the wide choice they have under the FEHBP. This power to "fire" their own insurer if they are dissatisfied is why Members of Congress rarely feel it is necessary to impose mandates on FEHBP plans. Changing the tax code to remove the financial penalties impeding choice for private-sector workers will give Americans real power over their own health insurers. Enacting mandates will not.

Carrie J. Gavora
Policy Analyst