



# Assessing the Impact of Mandated Health Insurance Benefits on Cost and Coverage

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## Introduction

All states have regulations that require health plans to provide coverage for specific health benefits, specific health care providers, and specific population groups. The number and scope of such regulations have expanded since they first were enacted in the mid-1960s. At the end of 2001, there was a total of 1,471 mandates covering specific health benefits, providers, and population groups. By 2006, 1,843 total mandates were reported, and in 2006 alone, 40 mandates had been enacted in New Jersey (see box at right), ranking it 16th nationally.

Coinciding with the growth of mandates in New Jersey and across the nation are growing concerns regarding the impacts of such mandates on health insurance costs and enrollment and whether the costs associated with mandates outweigh the benefits of requiring insurers to cover more services, provider types, and population groups. Proponents of mandates cite their role in achieving greater equity in the provision of valued health services and in contributing to enhanced social welfare by addressing the underutilization of such services. Critics of mandates cite a wide range of potentially adverse consequences, most prominently their contribution to rising health insurance costs, to the reluctance of some employers to make coverage available to their workers, and to the growing numbers of uninsured Americans.

This Issue Brief provides a review of empirical research literature on mandates to assist policymakers in balancing the potential benefits and costs. Three key questions are addressed: Do mandates increase premium costs? Do they decrease the likelihood that firms will offer coverage? And do mandates increase uninsurance rates? Ideally, such a review would include a discussion of research on the social and medical benefits of mandates. However, the research literature provides little guidance in addressing this question,

and thus it is not covered in this review. The discussion does, however, provide an overall framework for considering both the benefits and costs of mandates and describes the challenges faced by researchers in assessing the impact of mandates. This Issue Brief draws on a detailed report prepared by the Rutgers Center for State Health Policy, *Mandated Health Insurance Benefits: A Critical Review of the Literature*, which will be available shortly for download at the Rutgers Center for State Health Policy website ([www.cshp.rutgers.edu](http://www.cshp.rutgers.edu)).

### Mandates in New Jersey

According to a 2001 study, New Jersey ranked 11th nationally in the number of health insurance mandates enacted.<sup>1</sup> In 2006, according to data from the Council for Affordable Health Insurance, New Jersey dropped to 16th.<sup>2</sup> While not requiring coverage of as many benefits, providers, or populations as some states, New Jersey mandates include some services known to be costly, such as infertility treatment. In 2003, in response to concerns about the costs and benefits of mandates, the New Jersey Legislature created the Mandated Health Benefit Advisory Commission to provide expert review of the social and financial impact and medical efficacy of selected proposed mandates (see <http://www.nj.gov/dobi/mandated.htm>).

Source: Council for Affordable Health Insurance. *Health Insurance Mandates in the United States: 2006*. Alexandria, VA: March 2006.

This review concludes that evidence of adverse impacts of mandated benefits on cost, coverage offer rates, and the uninsured is weak and inconsistent. Some early studies have shown significant adverse impacts, but more recent studies using improved methodologies have not. Still, flaws in available data and complexities of health insurance markets preclude making definitive conclusions about the impact of mandates. Moreover, the dynamic and cost-increasing nature of innovation in medical technology suggests that conclusions from earlier studies should be applied to new mandates only with great caution. These findings should reassure

policymakers that most previously enacted mandates have not significantly increased premium costs or contributed greatly to growth in the number of uninsured. Nevertheless, policymakers should be aware of the potential incremental impact of future mandates, particularly for very expensive services, on health insurance markets.

### ***A Framework for Assessing the Impact of Mandates***

It is generally assumed that laws mandating the provision of specific health insurance benefits, the inclusion of certain providers, or the coverage of specific populations, inevitably lead to higher premium costs, lower employer offer rates, and more uninsured individuals. The research literature reviewed in this Issue Brief suggests that these assumptions are not necessarily accurate. To understand why mandates may not directly lead to higher costs and more uninsured individuals, it is important to consider the underlying demand for and supply of health insurance benefits. The box below lists some of the circumstances that can affect the impact of mandates on cost and coverage.

#### **Factors that Can Affect the Impact of Mandates on Premium Costs and Coverage**

- Certain market segments are exempted from a mandate,
- Persons were already enrolled in health plans offering a benefit before it is mandated,
- Health plan benefits are modified (e.g., deductibles or co-payments are increased) in response to a mandate,
- Employees are willing to sacrifice other work-related benefits and/or wage compensation for the mandated benefit,
- The mandated benefit generates offsetting savings by reducing the use of other services (e.g., as may occur when coverage of preventive services are mandated), and
- Consumers value and are willing to pay for the mandated benefit.

States are precluded under federal law from regulating employee benefit plans, hence employers that self-fund their plans (i.e., bear financial risk) are exempt from state mandates. Additionally, in some circumstances state legislators elect to exempt certain classes of health plans from state mandates. These

exclusions can significantly reduce the overall impact of mandates on costs and coverage. Table 1 highlights the New Jersey populations that are subject to state health insurance mandates.

There are factors other than state jurisdiction and legislated exemptions that can influence the impact of mandates on cost and coverage. If a benefit was voluntarily included in health plans before it was mandated, it would not increase costs or affect offer or take-up rates. Even if only some plans included a given benefit prior to implementation of a mandate but many of the individuals demanding that service had elected to join plans covering that service, the impact of the mandate on cost and coverage would be significantly moderated. As well, in instances in which mandated benefits increase the scope of health plans, health plan sponsors and purchasers may elect to adjust benefit packages in ways that mitigate the impact on premiums such as increasing deductibles or co-payments. The willingness of employees to accept reductions in other forms of work-related compensation (including wages) will also mediate the effect of mandates on costs and coverage. Laws mandating coverage of some services (e.g., preventive care) can reduce the use of other services, offsetting the net cost impact. Finally, if a service covered under a new mandate was highly valued by consumers, premium increases could have little or no impact on decisions to purchase coverage. These varied and complex circumstances have significant implications for the potential impact of mandates on cost and coverage; and it is within this market framework that the research summarized in the Issue Brief is assessed.

This Issue Brief draws upon both “actuarial” and “econometric” studies of the impact of mandates. Actuarial studies make assumptions, based on historical experience, about the cost and expected utilization of the mandated service. Then they extrapolate those cost impacts following the implementation of a given mandate. Econometric studies, on the other hand, seek to directly analyze responses of health insurance markets following the implementation of mandates. While the latter approach relies on economic models of behavior of health insurance markets, it goes beyond actuarial studies by observing actual market responses to mandates. There are,

**Table 1: Application of New Jersey Health Insurance Mandates, 2004 (by population)**

<b>NJ Mandates Apply:</b>	<b>Number of NJ Residents</b>
Individual Health Benefit Program*	78,000
Small Employer Health Benefit Program (2 to 50 workers)	915,000
Large Employer (fully insured)**	1,587,000
<b>Some NJ Mandates Apply:</b>	
State Employee Health Benefit Program	710,000
Medicaid and NJ FamilyCare	746,000
<b>NJ Mandates Do Not Apply:</b>	
Medicare, Medicare Advantage, & Medigap plans	990,000
Federal Employee & Military	243,000
Self-Funded Employer Plans	1,999,000
Uninsured Residents	1,322,000

Source: Estimate based on information assembled by the New Jersey Department of Banking and Insurance

\* Some mandates do not apply to approximately 1,400 persons covered under the Individual Health Benefit Program's "Basic and Essential Plan" (2004).

\*\* Plans purchased from state-regulated health insurance carriers.

however, drawbacks to econometric studies, particularly their extensive data requirements and the fact that they can only be applied after the implementation of mandates, so they are often not as timely as actuarial studies. While the negative impacts of mandates on cost and coverage are clearly important, so are their potentially positive social or medical impacts. Unfortunately, there is strikingly little research on the positive impacts of mandates, and thus the remainder of this Issue Brief focuses on costs and coverage.

### ***Do Mandates Increase Premium Costs?***

Frequently cited studies of the actuarial cost of mandates suggest that they lead to increased premiums in the range of 3 to almost 8%. However, these studies may overstate the cost of mandates. Few of these studies make the distinction between the cost of adding a specific benefit to plans that did not previously offer that benefit and the incremental impact on premiums in the event that a mandate enhances an existing health plan provision. As discussed above, several factors can offset the cost impact of adding a mandate, but only a few actuarial studies have considered such factors. Albee

et al., found that the cost of mandating benefits for treatment of chemical dependency, HIV/AIDS, serious mental illness, and childhood immunizations (among others) were offset by reductions in the use of other services. One report by the US Congressional Budget Office provided an estimate of the effective "marginal" or incremental cost of mandates (i.e., the net of offsetting savings minus costs associated with plans that would cover the services in the absence of a mandate), of 0.28-1.1%, finding that mandated benefits in general would increase premiums by 5% over what they would have been without mandates. Finally, a 2001 review by the Minnesota Department of Public Health concludes that while mandated benefits raise premium costs to some extent, the increases are generally more modest than figures commonly cited.

Econometric studies seek to directly evaluate the market-level impact of mandates on premiums and coverage. Some of these studies have found a positive association between certain mandates and premium costs. For example, Jensen and Gabel, drawing upon the findings from previous work on the cost of specific benefits, concluded that mandated benefits have a significant impact on premium costs. Similarly, Acs, Winterbottom, and Zedlewski, applying

more direct tests of mandates and costs, found that for larger firms (>1000 employees) each additional mandate adds \$1.50 to the monthly premium, while the number of mandates has a negligible impact on premiums for mid-sized firms (10-999 employees). Data limitations precluded the examination in this study of smaller firms.

Congdon, Kowalski, and Showalter, in their analysis of non-group market premiums, found positive cost impacts of the number of mandates. The authors found that each additional mandated benefit increases premiums, on average, by 0.4 to 0.9%. In an unpublished manuscript, Henderson, Seward, and Taylor found that while the overall number of mandates has no statistically significant impact on premium levels, there are mixed results based on mandate type (e.g., benefit, provider, and coverage) and type of health plan (e.g., HMO vs. PPO, individual vs. family coverage). Their findings suggest that one should not uniformly categorize mandated benefits as potentially cost-enhancing.

Studies of the impact of mandates on premiums provide a mixed and incomplete picture. Most of these studies are of state mandates in the 1980s and 1990s and do not reflect more recent legislative trends. Moreover, even careful econometric studies face limitations in sorting out the causal relationship between mandates and premium costs, and most examine the average effects of mandates without considering which specific benefits are involved. Nevertheless, it seems clear from this literature that the cost contribution of mandates is smaller than is suggested by simple actuarial studies that do not account for changes in market conditions and consumer behavior.

### ***Do Mandates Decrease the Likelihood that Firms will Offer Health Insurance?***

Since workers and their dependents dominate the uninsured population and since lack of health insurance among workers has been most pervasive for those employed by small firms, considerable attention has been directed to understanding the factors affecting the decisions by small employers to provide coverage to their employees. As discussed earlier, the evidence of the impact of mandates on health insurance premium costs is decidedly mixed, reflecting a number of measurement and methodological challenges. Consequently, if mandates are believed to

raise health insurance costs, but if the evidence in this regard is not consistent, then one may have to appeal to other factors – cost-enhancing or otherwise – to explain impediments to coverage availability at small firms.

Four econometric studies stand out in the discussion of mandates and the decisions of the firms to offer health insurance. In the previously cited article by Jensen and Gabel, the authors found that each new mandate enacted between 1982 and 1985 reduced the likelihood of insurance offers by 1.5%, yet they found that a sizable number of mandates (including some classified as “expensive” in other work) were not statistically significant correlates of small firms’ decisions to offer coverage. Although these authors’ earlier work reveals a generally positive relationship between the presence of a selected set of mandates and premiums, many of the same mandates fail to achieve statistical significance in their analysis of health insurance offers. In a later study, Jensen and Gabel built upon their earlier work but provide little evidence that individual high-cost benefit mandates have an impact on employer offer decisions.

In a frequently cited paper, Gruber provided a more rigorous approach to assessing the impacts of mandates on decisions by employers to offer health insurance, using more accurate information on state mandates than other studies. He found little evidence that mandates yield a reduction in the likelihood that a worker employed by a small firm will obtain health insurance, or in the probability that an employer will offer coverage. He noted that small firms may not be particularly sensitive to changes in the price of coverage, that employees may value mandates at close to their costs to the employer (and by implication, are willing to pay for such benefits through reduced wages), and that mandates may not be binding on a firm’s insurance decision (i.e., the firm may already provide the benefit in the absence of a mandate).

A more recent paper by Jensen and Morrissey examined the number of mandates in a state and insurance offers by small employers with 1 to 49 employees. This study found that an additional mandate reduces the probability of offer by 0.004 percentage points overall, but the results are driven by firms with 10-49 employees and not by very small firms. The authors offered little in terms of explaining their findings and they did not account for the extent to which

benefits required by mandates may have already have been included in health plans

### ***Do Mandates Increase Uninsurance Rates?***

If mandated benefits are viewed as causing an increase in health insurance premiums, and in turn, yielding a reduction in the proportion of employers offering health insurance benefits, then one might also expect a rise in uninsured rates to be a direct consequence of mandates. However, only a few studies have attempted to empirically assess the magnitude of this relationship. The paucity of such analyses may reflect the mixed and questionable evidence regarding the relationship between mandates and health insurance premiums, and mandates and offers of health insurance. Solid evidence on these relationships would appear to be an important prerequisite for undertaking an analysis to determine whether mandates increase uninsured rates.

An early study by Goodman and Musgrove found mandated benefits to be a major determinant of the lack of coverage among a state's non-elderly population. The authors estimated that each mandate increases the percentage of uninsurance by 0.17 to 0.28% and, depending on their research assumptions, that state mandates are responsible for 14 to 25.5% of the uninsured. This study, however, has been criticized as flawed for several reasons. For example, Conover noted that the study relied upon inaccurate data on mandates and failed to account for the possibility that states with higher costs might be more likely to enact mandates. Gruber also notes that the study does not account for other policy initiatives, such as differences in Medicaid eligibility criteria during this period, which could also explain differences in uninsured rates. More recently, Marsteller et al. examine the impact of state insurance regulations including the presence of high-cost state benefit mandates, on state-level uninsured rates. The authors provide statistically weak evidence that high-cost mandates may result in increased uninsured rates, however the methodology of this study leaves uncertainty regarding the interpretation of the findings.

Finally, other analyses suggest that the elimination of state insurance mandates would have little effect on the size of the uninsured population.

Gruber's analysis of state insurance mandates finds little evidence that mandates would affect worker insurance status and hence the likelihood that a worker would be uninsured. At most, he suggests that imposing a set of high-cost mandates would lower coverage by one percent, a result that is not statistically significant. Additionally, the actuarial study for the State of Texas concludes that elimination of mandates would likely have an insignificant impact on the number of uninsured in Texas.

### ***Implications for Policymakers***

Reaching a consensus on the impact of mandates is a difficult task given the mixed set of research findings, the variety of data used, and alternative empirical approaches that have been applied to identify the effect of such provisions. However, it is clear that there is not a consistent and compelling body of evidence to support the notion that mandates have had a major impact on health insurance premiums, employer decisions to offer health insurance, and coverage. While several earlier studies showed greater impacts of mandates on cost and coverage, more recent studies using improved methods found only small impacts or, in some cases, no statistical associations of mandates with cost or coverage. In this regard, the empirical evidence is far less convincing than one might expect based on the claims made from the more normative policy pronouncements regarding mandates. The failure to obtain results that consistently support the claims that mandates may have adverse consequences on such outcomes should give pause as policy makers seek to question whether mandated benefits are a primary reason for rising health insurance costs.

While the results presented in this review suggest that the focus on mandates as a primary cause of rising health insurance premiums and declining coverage rates may be misplaced, policy makers still need to be cognizant of the implications of adding additional mandates in an environment of dynamic health care technology. Given the cost-enhancing nature of most new medical technologies, and the desire to ensure that individuals have access to such care, this review should not be interpreted simply as a *carte blanche* for the implementation of new mandates in

response to the presence of new technology. Recall that most of the studies cited are nearly a decade old, a time when “high cost” mandates consisted of services such as alcohol treatment, drug abuse treatment, benefits for the treatment of mental illness, chiropractic care, along with continuation of coverage mandates (as in Gruber’s analysis). In considering new mandates for services focusing on advanced technologies, policymakers should draw from the lessons of the present report. However, at the same time, decision makers need to provide careful consideration of both the true incremental costs of mandates and the benefits likely to emerge from their implementation.

## Endnotes

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