Applying the Brakes on Mandated Benefits?

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Brief Background

- Health insurance regulation at state rather than federal level.
- Although some standardization, insurers operating in numerous states subject to separate and non-uniform requirements.
- Mandated benefits: provisions that regulate (specify) the content of health insurance policies (*see Table 1)*.
- Policymakers enact mandates because it requires no new public expenditures.
- Political economist Uwe Reinhardt warns: “just because the fiscal flows triggered by a mandated benefit do not flow directly through the public budget does not detract from the measure’s status of a boda fide tax.”

The Policy Analytic Pros/Cons

- Mandating employer provision of benefits as means to finance and to expand benefit coverage.
- (Academic) proponents: insurance markets may fail to provide the appropriate level of benefits so that requiring benefit inclusion in all plans can be "welfare-increasing."
- Academic opponents: inclusion of expensive benefits increases the premium cost to the employer, then some employers may opt to offer no health insurance at all.
- IF policy serves objectives that are not narrowly economic in character, an analysis that focuses only on technical efficiency will not constitute a comprehensive explanation for policy action.

Beyond Market Failure and Capture: The Politics of Mandated Benefits

- Regulation deliver (concentrated) benefits to providers or suppliers of goods or services.
- Benefits accrue to a small group; costs are spread across a broad number of workers, consumers and purchasers.
- Policymakers prefer (MB's) because their incidence is confused: hard for any voter, consumer or worker to know for sure how he/she is affected by a confusing tax.
- Helps policymakers foster the fiscal illusion that benefits can be provided and no one pays.
- Non-redistributive character of mandated benefits is a direct consequence of the fact that, as with benefit taxes, workers pay directly for the benefits they receive (Summers 1989).

“A Self-Enforcing Mechanism: Stop me Before I Mandate Again?”

- Policymakers concerned about the cost and coverage (higher premiums; more uninsured).
- Congress and state legislatures examine the “costs and benefits” or “social and financial impact” of benefit mandates.
- Mandate review statutes establish a formal legislative process for the proposal, review, and determination of mandated benefit “necessity.”
- Variation in forms and rules as it relates to credibility and independence of review entities as well as the objectivity and quality of their regulatory impact analyses.
- Review processes vary in terms of enforcement rules: whether and how they set rules that prohibit them (legislatures) from considering legislation that contains mandates unless certain conditions are met.

Update: Congress and the States

- Congress requires (state/local) governments as well as private sector to expend resources to meet certain goals. Resources not counted or allocated in the federal budget nor are the goals constrained by ability to pay.
- The 1995 Unfunded Mandates Reform Act (UMRA) ensures Congress carefully weighs those costs before imposing mandates.
- Requires the CBO Health and Human Resources Division to provide a statement to the authorizing committees about whether reported bills contain federal mandates.
- Despite some analytical problems (i.e., insufficient time, uncertainty about statutory content, data unavailability, and limited academic work), CBO claims to have been able to provide Congress with “substantially more information about mandates and their costs” (*see Table 2*).

In the States: Standing Independent Commissions

- Four (4) models of state mandatory review processes: (see Table 3).

- Model 1: Professional and independent staff evaluate mandates and make recommendations to the legislature.
- (7) states use standing independent commissions: MD, PA, VA, TX, CO, SC, and AR.
- For example, the Maryland Health Care Commission contracts with Mercer to conduct a financial analysis of current mandates and also the financial, social, and medical impact of proposed mandates.

MODEL 2

Administrative Agencies

- Administrative agencies, usually the Department of Insurance (DOI), evaluate mandates and make recommendations to the legislature.
- (9) states use administrative agencies: GA, IA, KY, ME, WI, VA, CA, LA, and IN.
- For example, in 2001, the Louisiana legislature passed a law requiring an “actuarial cost analysis” to be conducted by the Department of Insurance on existing mandates and proposed mandates.

MODEL 3

Legislative Research/Fiscal Staff

- Legislative staff analyze the impact of mandates before legislative consideration.
- Many states require the Senate and House fiscal staffs to submit a report on the fiscal impact of any mandated health benefit.
- (9) states use legislative research/fiscal staff: HI, OK, NV, TN, FL, NC, ND, OK, and KY.
- For example, North Dakota approved legislation in 2001 requiring the state to perform a cost-benefit analysis of existing coverage mandates.

MODEL 4

Proponents Submit Information

- Proponents of mandate legislation submit information about the impact and costs of mandates before legislative consideration.
- (6) states have proponents submit information: AZ, CO, FL, KS, OR, and WA.
- For example, the Washington legislature passed a statute in 1997 that requires proponents of mandated benefit proposals to provide impact statements that assess their social and financial impact and provide evidence of their health care efficacy.

Improving Policy Outcomes?

- Wide variation in the credibility and the quality of the impact analysis, which has implications for their objectivity and usefulness in the legislative decision-making process.
- Few would argue against improving the quality of information available to policymakers.
- Evaluation and review processes have met mixed success due not only to the politics for or against reform, but also due to lack of independence of the review entity, lack of internal legislative or executive staff analytical capability or capacity, limited data, sporadic funding, and tight legislative timetables.

Improving Impact Analysis?

- 10. Structure: Who should oversee the review process? How can independence and credibility be maximized?
- 9. Procedure: Is the review mandatory? Should legislators create a commitment mechanism to have any proposal reviewed or retain discretion to refer proposals?
- 8. Review or study: Should the entity review existing data or contract for new studies?
- 7. Analysis: Should existing staff or external consultants do the analysis? How can the credibility of consultants or external analytical sources be maximized?
- 6. Review requirements: What costs and benefits should the impact analysis include?

Improving Impact Analysis?

- 5. Data: How can full disclosure of data, methods, and assumptions be assured?
- 4. "Stakeholder" information: How should stakeholders offer submissions?
- 3. Assessment of review process: How can assessment and reform of the review process be built into its structure?
- 2. Timetable: How can the timeliness of analyses during active session be assured?
- 1. Funding: How should the review entity and independent analysis be funded? Legislative appropriation? Regulatory assessment fee? Foundation support?

A Public-Private Partnership?

- The empirical literature has yielded wide ranges, which permit analysts to pick and choose, within limits, among the available estimates.
- A Model: Supported jointly by the U.S. Environmental Protection Agency (EPA) and industry, the Health Effects Institute is an independent, nonprofit corporation chartered in 1980 to provide high-quality, impartial, and relevant scientific data on the health effects of pollutants from motor vehicles and other sources in the environment.
- Important that research be undertaken to assess the impact of the cost, quality and access to care of regulations aimed at plans so future efforts to enact statutes may be aided by empirical evidence.

Will “Real Life” Economics Drive the Future Politics?

- State-mandated benefits, by raising the minimum cost of providing any coverage, make it impossible for (smaller) firms which would have desired to offer minimal health insurance at a low cost?
- Economic theory suggests that it is typically the employee who bears the cost of fringe benefits. Fringe benefits and take-home pay tend to be substitutes for one another, as increases in the cost of one fringe benefit will come at the expense of either take-home pay or other fringes? Cost of premium shifted to workers?
- These causal empirical claims about who “bears the costs” are still up for grabs politically – awaiting a “plausible, credible” causal story.

Beyond Marketeers and Mandaters?

- How did we get here? By mandating minimum coverage, forced the good risk individuals to become part of the risk pool, and enabling insurers to price the insurance at the average market rather than a market retracted due to adverse selection.
- Let's not discredit the state regulatory role: state health regulation (was) is intended to protect consumers by overseeing health plans' financial solvency, monitor insurers' market conduct to prevent abuses, and requiring coverage for particular services.
- Another cycle of reform? Policy challenge remains to find creative mix of politics and markets rather than recreate the problems of an earlier era.
- For competition to work, there needs to be a reasonable degree of standardization of benefits and other rules across competitors.