Unintended Consequences

The Probable Effects of Mandated Medical Insurance

Simon Rottenberg

Most Americans have some form of private or government medical insurance. As of late 1987, 147 million individuals were covered by employer-provided medical insurance plans. Another 34 million were covered by individual private insurance. In addition, the government finances medical insurance for almost all the elderly through Medicare and for about half of the poor through Medicaid.

But some 33 million Americans remain uninsured. The probability of having no medical insurance is higher for individuals employed only sporadically—such as part-time, seasonal, or temporary workers—and for young adults. Still, an estimated two-thirds of the uninsured are in households in which the primary earner is employed year-round, most of them full-time. The vast majority of these workers are employees of small firms in the retail trade, services, and construction industries. One study indicates that nearly 60 percent of the uninsured in Massachusetts are in families with an annual income of $20,000 or more.

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Not surprisingly, the uninsured use less medical service per person and per household than do the insured. This condition is consistent with several alternative interpretations. The uninsured may receive insufficient care. The insured may demand excessive care. Or individuals who expect to need more care may be more likely to be insured than their healthier neighbors. The available evidence probably reflects some combination of each of these conditions.

The Basic Health Benefits for All Americans Act

Congressional hearings on the plight of the uninsured have been carefully orchestrated. Committee staff identify poor, unskilled, uninsured families who are confronted by medical bills they cannot pay. A typical story includes a wife who has suffered a series of miscarriages and a recent high-risk pregnancy and one or more children who have endured a serious viral infection. Sen. Edward Kennedy and Rep. Henry Waxman have used such hearings to build a case that the uninsured are underserved by the medical market and have introduced into their respective houses of Congress the Basic Health Benefits for All Ameri-

cans Act. This bill would require all employers to arrange medical insurance coverage for employees and their dependents. Proponents estimate that two-thirds of the currently uninsured would be newly insured through employer-sponsored plans if the legislation were enacted.

The Basic Health Benefits for All Americans Act would require all employers to arrange medical insurance coverage for all employees who work more than 17.5 hours per week and for their dependents. Benefits would include hospital care, physician care, diagnostic tests, prenatal and well-baby care, catastrophic coverage, and a limited mental-health care.

The proposed law would require that firms arrange medical insurance for all employees who work more than 17.5 hours per week and for their dependents. The bill defines a minimum acceptable package of medical health insurance benefits as one that includes hospital care, physician care, diagnostic tests, prenatal and well-baby care, catastrophic coverage, and a limited mental-health benefit. Employees could not be excluded from coverage because of preexisting health conditions. Annual direct costs to patients for covered services could not exceed $3,000 per family. Deductibles could not exceed $250 per individual or $500 per family, and deductibles would not be permitted for prenatal and well-baby care. Coinsurance could not exceed 20 percent. Employers would be required to pay 80 percent of the premium. For employees earning less than 125 percent of the legal minimum wage, employers would be required to pay the whole premium. Alternative cost-sharing and premium arrangements could be offered, but only if they were "actuarially equivalent or better than the minimum plan," and any acceptable alternative would have to include the basic required minimum benefits of the bill.

A system of six to eight insurance regions would be established. The Secretary of the Department of Health and Human Services (HHS) would "certify" acceptable regional insurers and insurance plans and options other than the one defined in the legislation. Insurers would not be allowed to base premiums on "age or gender of employees (or their families), [or] on other factors relating to the projected or actual use of health services under the plan." The legislation would allow insurers to charge premiums based on experience within particular "communities," but no community defined for the purposes of setting premiums could be smaller than the whole of a single state. Finally, the bill would provide for a public federal-state program to supply the minimum package of benefits to the poor who do not qualify for the mandated employer-based insurance.

There is disagreement over whether the coverage provided by the proposed law is miserly or generous. Congressional proponents generally argue that the bill would provide a "bare bones" package of mandated benefits, while opponents say it is excessively lavish. There is no doubt, however, that there would be pressures from suppliers of specialized medical services to expand the basic insurance package once it became law. For example, there are now some 690 state mandates that specify coverage that must be included in basic medical insurance contracts, whether the individual buying the insurance feels a need for them or not. These state mandates include wigs, herbal medicine, in-vitro fertilization, special diets for some gastroenterological diseases, treatment for Alzheimer's disease and for drug and alcohol abuse, the services of psychologists, psychiatric social workers, chiropractors, and nurse midwives. As with the current government medical insurance programs, the cost per person served is likely to increase over time.

The Impact of Mandated Medical Insurance

The Kennedy-Waxman legislation sounds like a simple enough solution to the problems facing individuals who lack medical insurance. Forcing employers to provide coverage would also allow Congress to offer assistance without adding substantial costs to the federal budget. But a more careful examination of the Basic Health Benefits for All Americans Act demonstrates that it would have a substantial negative impact on both the labor and the health-care markets.

Labor Markets. A requirement that employers provide a minimum medical insurance package to employees working more than 17.5 hours per week would reduce the number of jobs available, reduce money wages, and reduce the availability of other fringe benefits. These negative effects would fall disproportionately on the less-skilled,

lower-wage segments of the work force. To understand these effects, it is useful to examine the market for labor services more closely.

Labor services are exchanged in markets where employers demand labor and workers supply it. The price at which an individual worker and a specific employer will strike an agreement is obviously determined by a myriad of forces. The price of labor is the entire compensation package: money wages and bonuses; paid vacations, holidays, sick days, and parental leave; life, health, and disability insurance; retirement plans; childcare assistance; educational aid; subsidized parking; a company car; and a whole range of other benefits. Firms that buy labor services are interested in the total cost of labor, in whatever forms payment is made, and employers are generally indifferent to whether an incremental dollar an hour is paid in cash or in providing a fringe benefit.

If all other things were equal, workers would prefer to receive their entire pay in the form of money wages. Money paid for labor services is not conditional upon the occurrence of a sometimes uncertain event such as the use of sick days or parental leave. In addition, money paid directly to workers, rather than to others who provide in-kind benefits, would allow each individual employee to determine the mix of goods and services that he finds most attractive. Thus, if all wages were paid in money, an employee could determine whether he wants to pay for parking near the office or ride the bus and purchase a new CD player with what he saves, for example. Money wages give workers the maximum individual choice in purchasing amenities they view as attractive. In-kind benefits, by contrast, foreclose choice; they must be used in the form provided or they are lost.

Because all other things are not equal, in-kind and conditional benefits constitute a large fraction of the compensation package of most American workers. The most important condition favoring in-kind benefits is the tax code. Cash receipts are subject to income tax, while the value of most fringe benefits is not. In addition, firms purchasing services for a large number of employees may enjoy economies of scale and buying power advantages that allow the firm to supply the service to each worker more cheaply than employees could manage if they purchased it individually.

Labor markets in the United States offer a wide variety of compensation packages. Some contain large money components with few fringe benefits, while others offer a substantial portion of employees' pay in the form of fringe benefits. Workers sort themselves among the competing employment opportunities open to them according to their preferences for money income versus in-kind income, depending on individual and family needs. For example, workers with small children may be attracted to a firm that offers childcare assistance. Workers who are strongly risk-averse or who expect to have higher than average medical bills may choose employment that offers a generous medical insurance plan as part of the payment for their services. Other workers may choose more paid vacation or more flexible hours. This freedom of choice allows employers and employees to arrive at the employment contracts that best satisfy both parties.

Given that the new medical insurance requirement would increase the price paid for labor by a substantial amount, adjustments would take place in other parts of the compensation package. Other fringe benefits could be reduced or eliminated. Adding required medical insurance coverage where it is not now offered could result in reduced paid holiday and vacation leave, for example. For at least some workers, less appropriate compensation packages would be offered and would force these workers to accept a contract that will make them worse off.

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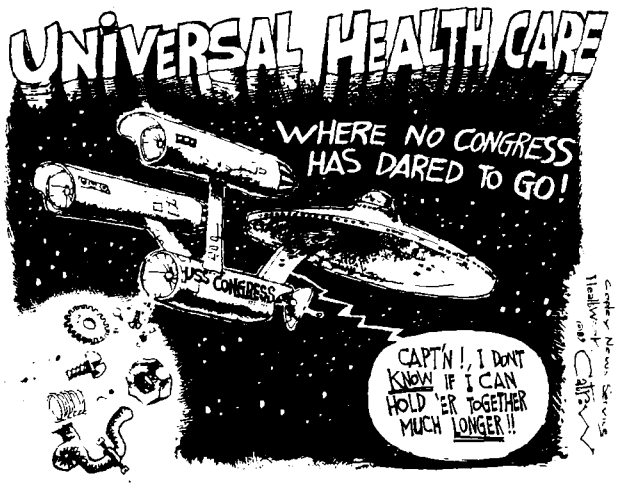
This is true even among firms that already provide medical insurance. Medical insurance plans vary widely across companies, in large part because the employees of different firms vary. Some firms employ mostly young workers, others tend to hire older individuals. Male employees predominate in some firms, while females predominate in others. For some firms turnover rates are high and for others low.



The most appropriate medical insurance coverage and insurance financing arrangements depend in part on the characteristics of worker groups in each firm. The differences among industries and firms lead to nonuniform medical insurance packages. Plans vary with respect to types of treatment covered, dollar ceilings on benefits, percentages of medical costs paid by the insurance company, and deductibles and copayments faced by employees. Some firms do and others do not cover dental and vision treatment, treatment for alcohol or drug abuse, hearing care, hospice care, routine physical examinations, well-baby care, and routine immunizations and inoculations. Some employers provide continued medical insurance as part of their retirement packages, while others do not.

The proposed law would define minimum coverage and prescribe financing arrangements. This would reduce the rich diversity that now marks the market for employer-provided medical insurance. No HHS-sponsored certifying process designed to identify "actuarially equivalent" plans could possibly match the immense variety of plans available today.

The expected value of medical insurance varies among individuals. Neither illness nor its severity is uniformly distributed among workers. Some illnesses are concentrated among the very young and others among the elderly. The probability of events requiring a diagnostic and therapeutic response varies greatly among individuals and is affected by age, gender, and life style. When workers are permitted to exercise individual judgment, some conclude that premium payments subtracted from their money earnings are higher than the benefits they expect to receive, and employers offering medical insurance as an option have found that some employees choose to remain uninsured. One large firm that offered catastrophic coverage for which employees had to pay 25 percent of the premium found that only 2 percent of its workers elected to accept the coverage.

Mandated medical insurance is equivalent to an off-budget tax on employment. It is a cost imposed by law that does not produce revenue for the Treasury. Employers are told that they must provide insurance to their workers up to a mandated minimum standard, and workers are told that when they sell their services, they must accept payment, in part, in the form of medical insurance.

The proposed law prescribes that the lion's share of the premium cost is to be paid directly by the employer. From the economic theory of taxation, we know that the ultimate incidence of a tax is almost always different from its direct incidence. The fact that employers must pay at least 80 percent of the premium for all workers and the whole premium for low-wage workers does not mean that employers would bear those proportions of the insurance cost. How much of the premium cost falls upon employers and how much upon workers depends, in economic terms, upon the conditions affecting the demand for and supply of labor. Most of the effective differences are on the supply side of the labor market.

For most adult males, the amount of labor supplied appears to be nearly invariant to their wage rate. For this group, the primary long-term cost of mandated medical insurance would be a reduction of real wages—with little effect on employment.

By defining minimum coverage and prescribing financing arrangements, the proposed law would reduce the diversity that now marks the market for employer-provided medical insurance.

An increasing proportion of the labor force, however, consists of workers for whom the supply of labor is more "elastic" with respect to their wage rate. This group includes teenagers, working wives, those nearing retirement age, those for whom welfare is a close alternative, and all those

whose wage is close to the minimum wage. For this group, the primary long-term cost of mandated medical insurance would be a reduction in employment—with little effect on the wages of those who remain employed. A primary effect of mandated medical insurance on those with a weaker attachment to the labor force, thus, would be to reduce the employment of this group.

There would also be efforts to avoid the proposed tax on employment by adjusting employees' work schedules. Because medical insurance would be required only for workers employed more than 17.5 hours each week, some employees would be encouraged to reduce their hours to fewer than 17.5. Indeed, some workers currently working full time might find it necessary to rearrange their schedules so that they are employed for fewer than 17.5 hours per week by each of several different firms. To the extent that such adjustments took place, the proposed law would generate transactions, transportation, and inconvenience costs.

Schedule rearrangements could also move in the opposite direction. Workers employed 17.5 hours per week would be covered by the same medical insurance benefits package as full-time employees. Thus, the additional cost imposed by the law would be higher for part-time employees on a per-hour-worked basis than it would for full-time employees. Employers would tend to prefer employees who could work substantially more than 17.5 hours. This would place at a disadvantage those workers whose life styles or competing responsibilities make it convenient to offer their services for only half a work week.

The additional cost imposed by the law would be higher for part-time employees than for full-time employees, and employers would tend to prefer employees who could work substantially more than 17.5 hours.

In sum, the costs of mandated medical insurance would be paid in fewer fringe benefits, lower money wages, and lower employment. There would also be reduced flexibility to establish work schedules. Finally, most of these costs would fall most heavily on the less-skilled, lower-wage segments of the work force.

Estimates of the total costs and employment effects of the Kennedy-Waxman proposal vary widely. One advocate of this proposal, Professor Kenneth Thorpe of the Harvard School of Public Health, estimates an annual cost of about $33 billion, with a loss of up to 100,000 jobs and $5 billion in tax revenues. An independent study of the probable effects of the Massachusetts plan estimates that this plan, when effective in 1992, will cost employers and colleges about $700 million and reduce employment by about 9,000 jobs (net of those that move to other states). On a national basis, these estimates are equivalent to an annual cost of about $29 billion and a loss of about 375,000 jobs; this estimate of the national cost is likely to be low, because Massachusetts has an unusually low percent of uninsured. Other estimates range up to $108 billion and one million jobs. Most of the job losses would be low-skilled workers employed in small firms. A survey by the National Federation of Independent Business suggests that this plan might cause as many as one-quarter of small businesses to close, and others would reduce employment by substituting other production inputs including foreign sourcing.

Health Care Markets. The market for medical care would also be negatively affected by the introduction of mandated medical insurance. In particular, medical care resources—the services of doctors, nurses, and other medical care professionals, clinic and hospital facilities, etc.—are likely to become overburdened. This increase in usage would come about because additional insurance and cross subsidies would encourage more intensive use of medical care resources.

In addition to obtaining medical insurance to protect against the cost of illness, many individuals exercise care in life-style decisions so that the probability of serious illness is reduced. Proper exercise, a nutritionally balanced diet, refraining from smoking, and not abusing alcohol or drugs, for example, all contribute to lower overall medical care costs for the careful individual. The introduction of mandated medical insurance would create a "moral-hazard" problem, however. Once insured, the behavior of an individual may alter because most of the costs of medical care are met by others. Thus, these costs may cease to affect the individual's life-style choices. At the margin, less care would be taken to avoid illness because the cost of illness would have been shifted to the insurance companies. The Kennedy-Waxman bill

would prohibit insurers from varying premiums on the basis of age, sex, or other factors related to the use of medical services. Easily distinguishable groups, some of which would draw heavily on pooled funds while others draw only lightly, would pay the same premium rates for a given quantity of insurance. As a result, the young would subsidize the medical insurance of older workers; employees with few dependents would subsidize those with many; nonsmokers would subsidize smokers; and the prudent would subsidize the dissolute.

Of course, cross subsidies exist under current arrangements. No one can predict exactly which insured individuals will need to draw most heavily on their insurance plans. But insurers attempt to limit cross subsidies by taking into account certain variables—such as age, occupation, past medical history, personal habits, etc.—that offer some indication of expected future medical problems or the lack thereof. Such discipline would be substantially reduced under the Kennedy-Waxman proposal.

Cross subsidies also occur when medical care charges are not paid by patients or their insurers. The cost of unpaid medical bills are shared by uncompensated providers, philanthropic contributions, public appropriations, and insured patients whose premiums are raised to help cover the expenses of patients who do not pay.

Proponents of mandated medical benefits often argue that current subsidies are not "fair." But the proposed medical insurance mandate, particularly with the pricing restrictions it would impose on insurers, would increase the extent of cross subsidization. It is not clear that cross subsidies generated by the new law would be more equitable than those that already exist.

The extension of mandated medical insurance benefits and the increase in cross subsidies they would entail would increase the demand for medical services. At least some of the increase in demand would represent an inefficient use of society's resources.

Most illnesses are self-limiting. They are corrected by natural biophysical processes and by self-medication with nonprescription remedies. When medical care costs are paid out-of-pocket, the costs influence individual decisions about whether to visit a doctor. The more limited use of professional services that results helps reduce the overall costs of U.S. medical care.

Professional resources employed in the delivery of medical care are very costly. For example, self-care in the treatment of minor upper respiratory illness was found to reduce the cost of treatment by a factor of 15 from what it would have been if a visit to the doctor were required. The production of a physician requires costly training resources, and the delivery of medical care by physicians is very resource-intensive. When self-care relieves health care professionals of the need to treat self-limiting illness, it frees them to devote attention to patients who need their services more.

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An expansive insurance plan reduces the incentive to distinguish self-correcting illnesses from more serious ones, and as a result, professional care is consumed more intensively under such systems. This increases the price of medical services to everyone.

Insurance payments covered slightly less than half of all personal medical care expenditures as recently as 1965. In 1987 such payments represented about three-quarters of all such expenditures. Nationally, medical expenditures represented 4.4 percent of the gross national product of the American economy in 1950. In 1987 medical expenditures accounted for 11.1 percent of gross output. Many conditions have contributed to the increased importance of medical services in the U.S. economy. These include the increasing fraction of the population that is elderly and subject to more serious illness, the discovery of new diagnostic instruments and therapeutic techniques that prolong life, and the growth of redundant diagnostic testing ordered by physicians to provide protection against liability. But the sharp rise in the proportion of gross output attributable to medical care can also be explained in part by the displacement of self-care by professional care in the treatment of many self-correcting illnesses.

In a recent year, primary-care physicians in the United States provided an estimated 472 million office visits. If only 2 percent of nonprescription drug consumers had chosen to seek professional care rather than to resort to self-medication, the

number of patients would have increased to 721 million; the demand for the services of doctors would have risen by 53 percent. Thus, even trivially small fractional movements from self-medication to professional care would swamp the medical care system.

The Kennedy-Waxman bill would have substantial costs, and those costs would fall disproportionately on those people the bill was designed to help.

To charge "efficient" insurance premiums, a medical insurance provider needs to be free to assign individuals to proper risk categories. Risk categories or classifications are homogeneous enough when events that generate claims are randomly distributed among members of the risk class, that is when there is no further readily available information—personal habits or avocations, for example—that would lead the insurer to expect that some individuals within the group are more likely to draw on the insurance plan than others. Once proper risk categories are established, insurance premiums that cover expected outlays can be charged. Individuals who pay efficient insurance premiums in this sense will have the necessary incentives to take proper care in their personal habits and will exercise adequate judgment when deciding whether an illness or injury is serious enough to visit a doctor. But for the health care market to operate efficiently, individuals must be free to choose the amount of insurance coverage they will purchase, and the price paid for that insurance must be known to them.

Conclusion

The proposed legislation to mandate employer-provided medical insurance would distort the health care market on several scores. It would limit the ability of insurers to assign individuals to appropriate risk categories. The resulting cross subsidies would send the wrong price signals to consumers. The legislation would also limit the freedom of individuals to determine how much medical insurance they wanted to buy. Anyone working more than 17.5 hours would be forced to accept the government's mandated minimum. Finally, the price workers pay for the mandated insurance would be concealed from them as wages and other fringe benefits were adjusted to help cover the costs of the required insurance. Further confusing the issue is the fact that under the proposed mandates, wage adjustments would differ from firm to firm and from job to job.

Thus, the negative effects of requiring employers to provide a specified minimum medical insurance policy are substantial. Money wages and other fringe benefits would be reduced as a result. Jobs would be lost, including many "half-week" jobs. There would be pressure to reduce hours worked below 17.5 hours per week or to increase them substantially to spread the cost of medical insurance over more hours worked. These effects would fall disproportionately on the less-skilled, lower-wage employees in the most labor-intensive industries. Such adjustments would obviously make many workers worse off.

Mandating the expansion of medical insurance and specifying a minimum floor would also lead to more use of the nation's health care resources. Some individuals would take less care of their health because more costs would be borne by an insurer. More important, many self-limiting illnesses that are now treated at home would be brought to the attention of a doctor. This type of increased use would be wasteful of health care resources and facilities.

In short, the Kennedy-Waxman bill appears to address the problems created by a lack of medical insurance for some persons. A closer look reveals just how misleading this appearance is, however. The Basic Health Benefits for All Americans Act would have substantial costs, and the costs would fall disproportionately on those people the bill is designed to help.

Selected Readings

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