State Mandated Benefits and the Small Firm’s Decision to Offer Insurance

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Abstract
In the last decade, the number of Americans without health insurance has grown, partly due to an erosion in employer-based coverage among workers. This paper examines the extent to which state-mandated benefit requirements and other state insurance regulations discourage small firms in the private sector from providing health benefits. Using data on 1320 firms observed in 1985 and 492 firms observed in 1988, we estimate two models of small firms’ decisions to offer health insurance (one for each data set), and then use them to assess the effects that mandates had on purchasing decisions in both years. We estimate that 19 percent of noncoverage among sample businesses in 1985 and 43 percent of noncoverage in the 1988 sample was attributable to state-mandated benefits. State continuation-of-coverage requirements were particularly burdensome for firms. With continued growth in the number of state mandated benefit requirements, we should expect a steady rise in the small firm's propensity to forgo insurance coverage.

1. Introduction
In the midst of a prolonged economic expansion, the number of Americans without health insurance has grown, up from 14.6 percent of the under-65 population in 1979 to 18.5 percent in 1989 (Kronick 1991). This seeming paradox is partly the result of an erosion in employer-based coverage over the period, the source of protection against the cost of illness for nearly 150 million Americans. Fewer employees now receive health insurance as part of compensation (Small Business Administration 1990; Kronick 1991). Yet about three-quarters of all uninsured persons live in families headed by a worker, typically employed by a firm with 25 or fewer workers. This was true in 1977 and was again the case in 1987 (Monheit et al. 1985; Short et al. 1989).

To expand coverage among the uninsured, elected officials have sponsored legislation to increase workers' access to employer-sponsored coverage. The Consolidated Omnibus...
Budget Reconciliation Act (COBRA) of 1985 required firms with 20 or more workers to provide group coverage continuation rights to persons who might otherwise be uninsured due to separation from the firm. In 1986, Congress granted a 25 percent tax deduction to self-employed workers and their families for their cost of health insurance. More recently, proposals to require that all firms provide insurance to employees and their dependents have received national attention.

At the state level, 28 states have passed legislation requiring firms to provide continuation-of-coverage benefits to terminated workers or their dependents (Jensen 1992). Oregon and Kentucky have begun to subsidize small firms’ new insurance purchases with state tax credits, and California will do so beginning in 1993 (The Alpha Center 1991). Hawaii and Massachusetts have passed legislation requiring that all employers provide health insurance coverage. In Massachusetts, however, the mandate has not yet taken effect.

Efforts to enhance the “quality” of employer-sponsored coverage, through state-mandated minimum benefit requirements may thwart attempts to increase access. State mandates are laws which prescribe the content of employer coverage purchased from Blue Cross Blue Shield and commercial insurers. Mandates typically stipulate that certain benefits be included in a group plan, if one is offered. By making insurance more expensive, minimum coverage rules may price some firms out of the insurance market. Especially vulnerable are small firms that face much higher premiums to begin with (loading charges for firms with fewer than 10 employees are typically 60 - 70 percent more than for very large firms). The 1974 Employee Retirement Income and Security Act (ERISA) grants self-insured benefit plans exemption from all state insurance laws and taxation. Small firms, however, cannot viably self-insure as a means of circumventing mandated benefit requirements. Ironically, it is these very firms where coverage needs to be encouraged if we are to reduce the number of employed uninsured.

The collective number of state-mandated benefits across all 50 states more than doubled over the period mentioned above, up from 399 in 1979 to 827 in 1989 (Jensen 1992). These include requirements on the services or providers covered under the plan (about 80 percent of all mandates now in effect), rules governing entitlement to participate in an employer’s plan (15 percent), and the capability of separated workers and their dependents to convert former group coverage to self-paid individual coverage, regardless of health status (5 percent).

The public interest rationale for state-mandated benefits is that certain shortcomings exist in the market for employer health insurance, and to correct them the government must intervene. For example, insurers and purchasers may unknowingly undervalue the benefits of some types of care, such as chemical dependency treatment, resulting in a demand for coverage which is “too low” from a societal perspective. Also, without mandates, adverse selection might occur which drives up employers’ cost of particular coverages. This happens if individuals with chronic conditions tend to enroll in plans offering more extensive coverage, such as mental health benefits, and healthier individuals opt for low-benefit plans. Although they would prefer more, lower risk groups are unable to purchase insurance except at rates which are unfair to them (Rothschild and Stiglitz 1976). In this sense, adverse selection creates a market shortcoming, which a mandate may be able partially to correct.\(^1\)

An alternative view is that these laws simply serve the political interests of state legislators (Peltzman 1976). They do it in several ways. First, in an era of strained state budgets,