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Intelligent Money

Current thinking from Haven Financial Advisors

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Special Notes of Interest:

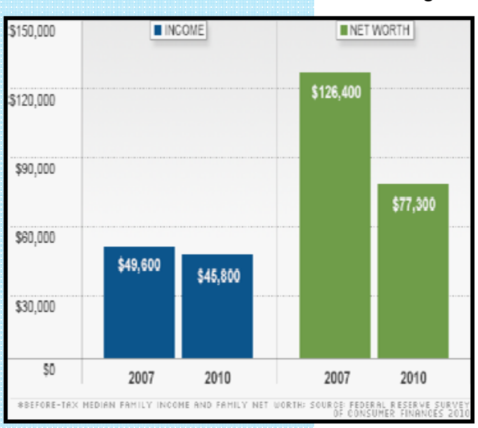
The average American family's net worth dropped almost 40% between 2007 and 2010, according to a triennial study released Monday by the Federal Reserve.

Health Insurance Mandates

A great deal of media coverage has been devoted to a federal rule requiring many employers — including religiously affiliated hospitals and universities — to provide contraception coverage in employee health plans. This rule is one example of a government mandate in health care. There are many more and they are an important cost component to health insurance premiums.

The press often focuses on federal health care mandates such as the one above. Most notably, the Affordable Care Act of 2010 (aka “Obamacare”) would enact several federal requirements such as the one compelling individuals to purchase health insurance. The regulation of health insurance is most intense at the state level, however. This article will focus on primarily on state insurance mandates.

In 1965, there were only 7 mandated health insurance benefit laws enacted among the 50 states. There were 860 by 1996. Today there are well over 2000 state rules requiring various kinds of health insurance coverage. Most of these laws affect only small group and individual policyholders. Large companies typically self insure and are thus exempt from state mandates. They are instead regulated at the federal level. And, indeed, there is some major federal legislation affecting large group insurers.



Besides the Affordable Care Act, oft cited legislation such as COBRA, ADA, and the Family and Medical Leave Act are major examples. These laws require larger insurers to extend coverage to the recently unemployed, disabled, and new parents.

This article surveys the context of mandated health care coverages at the state level and discusses their associated costs and benefits. Let’s start with Texas.

While republicans often criticize government regulation, the conservative state of Texas is among the most heavily regulated health insurance markets in the country. There are nearly 60 separate mandates. These require coverage for services such as in vitro fertilization, marriage and occupational therapists, and drug and alcohol rehabilitation.

Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, and lifetime and annual limits.

In reading through these mandates, there is no one item that provokes opposition. Most will find a sympathetic audience. The Texas Department of Insurance conducted a study of the administrative and claims costs of required benefits in 2005 and 2006. The research yielded estimates that premiums were increased by 5% to 6% as a result of the mandates then in place. However, William Congdon at the Brookings Institution and Michael New from the Heritage Foundation have separately done studies that suggest that 40 of the costliest state mandates in the country add as much as 20% to the cost of basic insurance coverage.

The large number of benefit mandates suggests that health insurance policy design is politicized. Let’s face it, passing health care mandates is a nearly irresistible way for legislators to increase consumer benefits without explicitly raising taxes. Manufacturers of anti-cholesterol drugs would certainly benefit if a CT scan was freely available to Texans at risk for heart attacks. Wouldn’t they spend their lobbying dollars to compel insurers to subsidize heart scans? In 2009, Governor Rick Perry signed just such a mandate into law.

The contraception mandate has been polarizing. Many voters expressed strong opinions on this issue based on their religious beliefs. However, there is an economic basis to question contraceptive coverage that has nothing to do with morality. Artificial contraception just doesn’t meet the criteria of an insurable risk. It’s a voluntary activity with comparatively low cost that is undertaken by a fairly large segment of the population.

More controversial perhaps is coverage of in vitro

fertilization. This is clearly an expensive procedure – albeit a voluntary one. Should an insured group be required to underwrite a voluntary procedure for a plan participant that can cost well over $10,000? How many attempts should be subsidized by the group? These are difficult questions to answer.

In additional to mandating benefits, states regulate insurance rates. One key form of regulation is known as community rating. States attempt to narrow the range of premiums that insurers can offer to various plan participants. Intuitively, it seems that such regulation serves a useful social purpose in that actuarially healthy plan participants subsidize the less healthy. Sounds goods in theory but state experimentation in this area has had unexpected results.

Younger and healthier plan participants have an incentive to leave the insurance market as they find their premiums are too high relative to the expected benefits of the policy. The healthy tend to leave the system thereby driving up average premiums for those that remain. States such as New York with strong community rating laws have seem premiums increase dramatically.

The Affordable Care Act attempts to squeeze the law of unintended consequences out of the system at the federal level by coupling an individual health care mandate with a nationwide community rating system. The young and healthy can only exit the system by paying a fine. Of course, as this article is written, the Supreme Court will be handing down an opinion on the constitutionality of that individual mandate.

While the majority of Americans believe that all adults should have a will or estate planning documents in place, only 44 percent report that they currently have any such documents.

Guest Column: Organizing for End-of-Life

Many of us are not organized for end-of-life. We don't intend to leave a mess, but unless we get organized that is what will happen. You won't leave a scavenger hunt for your heirs if you follow these steps.

Simplify. Consolidate or close accounts you do not use. Shred out-of-date records. They serve only to confuse matters. It's difficult to find the needle in the haystack because there is too much hay!

Organize. Keep important documents and financial records in one place. The best place for important documents is in a safe deposit box. Keep copies at home for convenient reference. Label your files clearly and keep your important records in one place, preferably a single file drawer, but at least in the same room of the house.

Plan. Decide whether you prefer burial or cremation. If you opt for cremation—an increasingly popular choice—be sure you designate final disposition of your ashes. Decide whether you want to be an organ donor. Make a record of your choices.

Communicate. Discuss your plans with your family. They will have to implement your last wishes. This will be easier for them to do if they understand your decisions. Also, people sometimes change their minds after learning how their family feels about their wishes. Write a Letter of Instruction for your executor listing your assets and accounts and any other pertinent information.

Review. Life is not static. Review your records whenever you have a life event—birth, marriage, divorce, job change or loss, house move, or death—or at least once a year.
Hint: You may want to consult your financial planner.

Bonus. If you follow these steps, you will not only leave an ordered legacy for your family, you will find your affairs easier to manage yourself!

Amy Praskac is a professional organizer who specializes in records organizing and end-of-life planning. Contact her at 512 371 3624 or at On the Record Advance Planning.