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MANDATING EMPLOYER COVERAGE OF MENTAL HEALTH CARE

by Richard G. Frank and Thomas G. McGuire

Prologue: Roughly three-quarters of the estimated thirty-one million people who are uninsured in the United States work or are the dependents of employed persons. Given this and the fact that 64 percent of Americans currently receive their health insurance through their employer, the notion of requiring employers to provide insurance has become attractive to many policymakers. As legislators at the state and federal levels debate the benefits and problems of such a plan, one important aspect that bears discussing is the inclusion of mental health services. Here, economists Richard Frank and Thomas McGuire ask whether mental health care should be part of a broader health insurance mandate and look at the impact of such a requirement on the benefits and cost of coverage. Frank, who earned his doctorate in economics from Boston University, is an associate professor in the Department of Health Policy and Management at The Johns Hopkins University School of Hygiene and Public Health; a research associate at the National Bureau for Economic Research; and assistant director of the Johns Hopkins University–University of Maryland Center on Organization and Financing of Care for the Severely Mentally Ill. He also serves as a commissioner of the Maryland hospital rate-setting commission and is currently researching the public financing of mental health and the role of nonprofit organizations in funding care for the indigent. McGuire is a professor in the Department of Economics at Boston University. He received his doctorate in economics from Yale University. McGuire recently received a Research Scientist Award from the National Institute of Mental Health. His current research efforts include designing a model mental health benefits package and setting physician payment rates in psychiatry for a relative value scale.
Laws—both proposed and passed—that would require employers to provide insurance for both physical and mental health expenses have recently attracted much attention from both state and federal legislators and policymakers. Such laws aim to reduce the number of citizens without or with inadequate insurance against health expenses. Specific proposals at the national level include bills by Sens. Edward Kennedy (D-MA) and Lowell Weicker (R-CT) and Rep. Henry Waxman (D-CA) (S. 1265 of 1987 and a newer version, S. 768, and H.R. 2508). At the state level, Massachusetts recently passed legislation to provide universal health coverage. Hawaii recently enacted compulsory health insurance legislation, and other states are at various stages of considering a similar strategy.

Policymakers’ interest stems from a number of attractive features associated with tying health insurance to the employment contract. It is commonplace in this country for workers to rely on their employer to sponsor group health insurance. Roughly 64 percent of the U.S. population is covered by some type of employer-sponsored health insurance. Because an estimated 72 to 77 percent of the uninsured live in households where the household head is employed for at least part of the year, mandating employer insurance would appear to be an effective tool for reducing the number of uninsured. Requiring employers to insure workers is also attractive to legislatures because it requires few or no direct public expenditures. Costs of insurance for the working poor or near-poor are kept “off budget,” requiring no new taxes.

From the point of view of workers and firms affected by the legislation, however, compulsory employer-based insurance may be quite costly. It requires a minimum level of fringe benefit contribution by firms, increasing the total compensation paid to workers. The primary concern is distortion in labor market decisions, thus reducing demand for labor for just the set of low-wage workers the legislation is trying to assist. Furthermore, small firms in highly competitive markets may be particularly adversely affected by legislated increases in costs.

This article concerns the following problem: If some form of compulsory employer-based insurance is enacted, what should be the extent of the regulation? In particular, should mental health be a required component of coverage? Should there, in effect, be “a mandate within the mandate” requiring coverage of a service that might not otherwise be included in the minimum benefit package chosen by the firm? Specified mental health coverage could have important effects on the existence of mental health coverage for the working population, and on the cost and efficiency impacts of insurance legislation.
Three approaches to compulsory insurance that have been developed in detail include Senator Kennedy and Representative Waxman’s Minimum Health Benefits for All Workers Act, the Congressional Research Service’s (CRS’s) “tailored plan,” and the Commonwealth of Massachusetts’s program. The Kennedy-Waxman bill would require employers to provide all employees working more than 17.5 hours per week and their dependents, an insurance package that covers hospital care, physician services, diagnostic and screening tests, and pre- and postnatal care. Deductibles and copayments would be quite limited ($250 per person or $500 per family deductibles and 20 percent copayment rates). Employers would be required to pay at least 80 percent of the insurance premium and 100 percent for low-wage workers (those below $4.19 per hour). The bill would provide catastrophic coverage by limiting out-of-pocket family liabilities to $3,000 per year. The Kennedy-Waxman bill allows for some flexibility in the form of specific employers’ plans. The bill refers to the notion of “equivalence” in benefits and makes use of a scoring system developed by the American Academy of Actuaries. One mental health benefits package associated with this plan involves no specialty inpatient mental health coverage (in other words, reimbursement for general hospitals only) and outpatient coverage consisting of twenty-five visits with a 25 percent copayment and a $150 deductible.

The CRS developed several mandated employer benefit packages for congressional consideration, including a “tailored” plan and a “typical” plan. We focus on the tailored plan because it was argued that such a plan was “best suited” to meet the circumstances of the employed uninsured. This plan covers both inpatient and outpatient hospital care (inpatient care is limited to fourteen days per admission), physician services (inpatient and outpatient), pre- and postnatal care, screening, and diagnostic tests. There is no provision for catastrophic coverage. The tailored plan requires employers to pay 80 percent of premium costs for employees and 75 percent for dependents. Cost-sharing provisions under the tailored plan are minimal. Deductibles are $50 per person or $150 per family. Copayment rates are zero except for prescription drugs, which are set at two dollars per item.

The tailored plan calls for no specialty inpatient mental health coverage and no outpatient mental health coverage. This is a result of explicitly recognizing a trade-off between mental health coverage and other benefit design provisions. The “typical” plan, which applies to coverage by large employers, covers thirty days of specialty inpatient
mental health care and up to fifty mental health outpatient visits with a 50 percent copayment. To offer lower levels of overall cost sharing in the tailored plan compared to the typical plan, mental health coverage was eliminated from the latter.

The Massachusetts plan is more complicated than the federal proposals, in part because of the need to comply with Employment Retirement Income Security Act (ERISA) provisions. The state offers employers with at least five employees a choice between providing health insurance and paying a tax of roughly $1,680 per employee. A statewide insurance pool for small employers will be organized to help these employers provide coverage. If the employer offers insurance, the policy’s benefit structure must comply with existing health insurance mandates. Massachusetts currently has a mandated mental health statute that requires $500 of outpatient mental health coverage and sixty days of inpatient care. Employees of firms choosing to pay the tax rather than to provide coverage will be offered a state-sponsored insurance policy that also will meet the requirements dictated by state health insurance mandates—including that for mental health coverage. In general, any state relying on private insurers to supply the coverage in a compulsory employer insurance plan will de facto require the plan to include all applicable state mandates.

The Case For Mandated Mental Health Benefits

Legislation in thirty states, referred to as state mandates, requires sellers of insurance to provide coverage for a minimum level of mental health services. The specific form of legislation varies state by state. In some states, insurers are required only to offer certain levels of coverage. Other states specify a minimum required level of coverage. All states regulate group-purchased health insurance. Regulation sometimes extends to individual and health maintenance organization (HMO) contracts as well. ERISA prevents states from directly regulating employee benefits, exempting self-insured plans from mandate provisions.

The rationale for state-mandated mental health benefits has been made on the basis of shortcomings in the markets for insurance and for mental health services. These same arguments can be applied to the case of requiring mental health coverage in compulsory employer-based health insurance.

Coverage for mental health services generally is not offered or offered on a limited basis for a subset of the following reasons: (1) insurance coverage will attract high-cost enrollees to the plan; (2) coverage is unnecessary because of public programs; (3) enrollees are not interested in
mental health coverage; and (4) insurance coverage will expand demand and increase costs. A case for regulation of mental health benefits can be made on the basis of a divergence between private and public interest for each of these reasons, except the fourth.

**Adverse selection.** Employers or insurance plans are rightfully concerned about attracting bad risks. In a group plan, adverse selection can be as important as in individual plans. High-risk employees may choose employment on the basis of insurance coverage, or working spouses may select the family plan with better coverage instead of their own plan through work. Mental disorders are usually chronic, and users may be able to foresee their own service needs with some degree of accuracy. In these circumstances, adverse selection can present a threat to a private insurer.\(^7\)

Adverse selection does not create high costs or high-risk enrollees; it merely influences who pays for the care of these high-cost enrollees. In pursuit of shelter from high-cost users, plans vulnerable to selection effects may reduce otherwise beneficial mental health coverage below desirable levels. State regulation can reduce socially wasteful competition for good risks by specifying a minimum level of coverage to be offered by all plans.

**Public mental health programs.** Virtually all states directly provide inpatient mental health care and some community-based services to residents who cannot pay for care. Thus, private plans can limit mental health care to minimal amounts and not leave enrollees totally without recourse. State mental health systems thereby provide a form of catastrophic coverage for mental health care. When private plans do cover mental health services, private insurance generates revenues for state community-based providers.\(^8\) The argument for state regulation of insurance from this perspective is based on a position that public services should be made available to those who cannot pay because of inadequate resources, not to those whose insurance plan has chosen not to cover the services. This argument for mandated mental health benefits is probably stronger in the context of requiring employer insurance.

Regulation of insurance can serve as a substitute for tax-supported care for the uninsured. Insurance regulation differs from direct tax support in a number of ways, including the distributional implications. While a “user fee” has some attractive features, it is fundamentally a regressive tax, falling roughly equally on high- and low-wage workers. We consider the argument for financing mental health services by insurance regulation in more detail below.

**Enrollee interest.** Lack of enrollee interest in mental health coverage can be the result of denial, underestimation of the effectiveness of mental
health services, stigma associated with mental illness, or undervaluing benefits of service use that may accrue to wider populations. For purposes of a policy discussion, these complex factors all lead to the same effect: demand for mental health insurance that is “too low” from a social point of view. Public intervention may be justified to require some minimum level of coverage.

**Demand response.** Finally, demand response or moral hazard—when the presence of insurance affects the quantity of services demanded—should be recognized as a legitimate reason for limiting mental health service coverage and, therefore, respecting the low coverage emerging from private markets. Demand response creates new use and social costs. Too great a demand response can mean that having insurance coverage can reduce consumer welfare. This is the primary reason that mandated benefits in private insurance are set at low levels of coverage.

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**Paying For Mandated Mental Health Coverage**

In the health services research literature, the “cost of mandated mental health benefits” has been estimated to be the extra cost to a payer of the added coverage. Empirical studies conducted at the state level have found utilization increases on the order of 10–20 percent of mental health costs. Thus, the cost depends on demand response, and there is no reason to think the extra costs created by requiring mental health coverage in compulsory employer insurance would differ from costs of mental health coverage in the current voluntary private health insurance plans.

We are concerned here, however, with “cost” in another sense. Financing compulsory insurance will create efficiency costs in labor markets, and, in this sense, the costs of adding the same mental health coverage in two different situations will differ, even if demand response is the same. As we argue here, the “efficiency costs” associated with the financing mechanism are likely to be very small in the case of state-mandated mental health benefits for voluntary insurance, but they are not likely to be small in the case of mandated mental health benefits within compulsory employer insurance.

It may be helpful to illustrate this argument by referring to another form of regulation of the labor market that finances a social goal through regulation of employee compensation. The minimum wage increases the wage compensation that firms must pay some workers. What is the “cost” of an increase in the minimum wage? In one sense, it is the extra compensation that must be paid by the firm. But this cost is exactly offset by a benefit, the extra wages received by the worker. The efficiency cost of the minimum wage is the change in hiring practices that decreases the
welfare of firms and/or workers. An increase in the minimum wage will prevent some firms from hiring workers willing to work at a lower wage. Some workers and firms therefore are harmed by such an increase. The benefits of an increase in the minimum wage must be weighed against the efficiency costs created. The first one-dollar increase in the minimum wage above the market wage may distort labor hiring practices only slightly, but a second one-dollar increase will be more costly in an efficiency sense. Similarly, the cost of an “extra” benefit in compulsory employer insurance depends on how deeply it is already disrupting patterns of compensation for affected workers.

Mandated mental health benefits, alone and in combination with universally required employer insurance, are financed by regulation of the compensation agreement between workers and employers. By forcing the contract to take a form other than would be agreed upon voluntarily by the two parties, the regulation may change the behavior of either the firm or the worker, distorting the functioning of the labor market.

The efficiency costs of regulating fringe benefits can take two forms. One is to distort the wage/fringe benefit choice of the firm, forcing the firm to compensate the worker in an inefficient manner. The second is to increase the cost to the firm of hiring certain types of labor (those covered by the mandatory insurance plan). This will alter the choice of inputs in production. The magnitude of these effects depends on the substitutability of wages and benefits in the preferences of the workers, and the degree of substitution of inputs in production. Furthermore, the distortionary effects depend on the size of the mandate. Our main conclusion is that if the regulated fringe benefit is small, the extra efficiency costs imposed by the required benefit are themselves small. The same increase in the required fringes (as might be required by addition of a special coverage feature) in the presence of other regulated benefits can cause much higher efficiency losses.

Consider first how required fringe benefits affect compensation costs. For the first unit of a required benefit, the trade-off for the worker between fringes and wages is one-to-one. If labor markets are competitive, and the firm must offer workers a wage/fringe package competitive with other employment, the firm can reduce wages about dollar-for-dollar for the first small, mandated fringe. (This is the justification for neglect of the efficiency cost of a mandate in earlier research on the cost of mandated mental health benefits.) However, as the level of mandated fringe benefits increases, fringes will become relatively less attractive to workers, and the firm may decrease wages less than dollar-for-dollar for subsequent increases in required fringes. With conventional assumptions about a worker’s trade-off between wages and fringe benefits (convexity
of preferences), the ability of a firm to reduce wages deteriorates as the required fringes loom larger and larger as a share of total compensation.

The increase in compensation costs has another effect: the firm, in response to the increase in compensation costs for the workers affected by mandatory insurance, will seek to substitute other productive inputs, including other forms of labor, for these workers. An accounting of the distortionary effect of requiring firms to buy mental health coverage for these workers must take into account this effect as well.

Production cost increases attributable to mandatory insurance will depend on the degree to which the firm is free to substitute other inputs for workers affected by the legislated insurance plan. In the extreme, if there is a perfect substitute at the original relative price, the mandated fringe will cause the firm to drop all affected labor. In this case, there would be no effect on production costs, but the legislation will have changed insurance coverage for no one! In general, however, some—but not perfect—substitutability should be expected. Some distortion will be manifest in displaced workers (who would have to move to some less favorable employment) and in inefficient compensation for workers. So long as the substitutability among inputs is not infinite, there will always be an increasing efficiency cost of increasing the level of mandated fringe benefits.\textsuperscript{14}

\begin{center}
\textbf{Mental Health Coverage And Other State Expenditures}
\end{center}

The user fee argument for inclusion of mental health coverage in compulsory employer-based insurance is based on an offset of other public expenditures used to support state community and institutional mental health services. If this offset were high—in the extreme, if every dollar financed through insurance regulation reduced tax-financed expenditures by a dollar—the inefficiencies introduced in the labor market analyzed above would themselves be largely offset by the reduced distortions made possible by less state reliance on tax finance. The more evidence there is for an offset, therefore, the less serious is the problem of inefficiencies introduced by the revenue-raising device.

Several studies support the proposition that mental health coverage as part of mandatory employer health insurance would reduce direct state expenditures. Linda Frisman, Thomas McGuire, and Margo Rosenbach examined budgets of state-supported facilities before and after Massachusetts mandated mental health services and noted a decrease in direct state support.\textsuperscript{15} Legislative discussion in Massachusetts anticipated this effect. In a political economy model of states' decisions to mandate mental health coverage, David Lambert and Thomas McGuire found
evidence that states with greater potential to shift costs to private insurance because of high mental health budgets were more likely to pass a mandate. Richard Frank tested for such an effect and found that presence of a mandate in a state reduced direct state expenditures on mental hospitals by about 11 percent.

Private insurance can decrease state expenditures by cost shifting for patients served in state facilities, or by providing the means for these patients to seek care elsewhere. The image of state facilities as a provider of last resort implies that those who could pay for care would prefer to be seen in a private facility. Recent research by Nancy Wolff and Mark Stone provides some empirical support for this long-held idea. Thus, inclusion of mental health coverage in legislation to require employer health insurance likely would reduce states’ direct expenditures for mental health significantly.

**Consequences Of Compulsory Mental Health Coverage**

Compulsory employer-based insurance represents a method of financing the expansion of health insurance to a substantial portion of the uninsured and underinsured that avoids direct taxation. While this approach has obvious political appeal compared to a tax-financed social insurance system, little attention has been devoted to the economic efficiency of such a plan. Prior research on mandated mental health benefits in private health insurance has made a case for such policies, based on the view that potential efficiency gains in the insurance and service market were significant, while the costs of increased utilization were modest. Many aspects of these arguments carry over to the question of required mental health coverage in legislated employer-based insurance. In particular, the prominent role of the state as a direct provider of mental health service for the affected population is a strong element in the case for including mental health in such legislation. Unfortunately, however, the stronger case for mandating employer-based mental health coverage must be considered in light of the likely higher efficiency costs of doing so in comparison to mandated mental health benefits within private voluntary insurance. Firms are forced to provide more fringe benefits than they and workers would have otherwise chosen; as a result, firms choose inefficient combinations of inputs due to the increased cost of the affected categories of labor.

The main consequence of the distortions in the labor market is that the efficiency cost of compulsory employer insurance increases nonlinearly with the size of the proposed plan. This suggests that the efficiency cost of a given level of mental health coverage will be greater when the mental
health benefit is accompanied by other benefits (as in a universal employer-mandated plan) than if the same mental health benefit is mandated without other benefits (as has usually been the case with state mandates).

Our evaluation of the desirability of including mental health coverage within compulsory employer-based health insurance permits no firm conclusions at this time. In comparison to the case for mandated benefits for mental health in voluntary insurance—an issue controversial enough in its own right—the case for including mental health in a required insurance plan is in some ways weaker and in some ways stronger.

Some important areas for further research are suggested by our analysis. The first is a general issue concerned with the labor market impacts of requiring employer insurance coverage, especially for small firms and for workers who are on the boundary of qualifying for such plans. It is the behavior of workers and firms in this market that generates the inefficiencies of expanded coverage under a compulsory insurance plan. The second area is specific to mental health. A unique part of the case for inclusion of mental health coverage in compulsory employer insurance is based on the role of the state as a direct service provider. How much will mental health coverage offset direct state expenditures? Will the cost burden of mental health care for the indigent be distributed more equitably if mental health is included in a compulsory insurance plan? These are important topics for future work.

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NOTES

2. The U.S. General Accounting Office and others have studied the composition of the uninsured population. GAO, Health Insurance; and D. Chollet, Uninsured in the United States: The Non-Elderly without Health Insurance, EBRI T-51 (Washington, D.C.: Employee Benefits Research Institute, March 1987). According to these reports, at least 60 percent of the uninsured are in households where the head is employed for the entire year (52 percent full time and 8 percent part time), while another 15 to 20 percent of the uninsured either have spells of unemployment or move in and out of the labor force.
3. State and federal plans differ, in part, because states are constrained by Employment Retirement Income Security Act (ERISA) provisions that limit state regulation of the structure of employee compensation. Massachusetts works around the ERISA restrictions by requiring the employer to pay a tax equal to a certain amount per worker per
year, and then allows the firm a credit against this tax obligation dollar-for-dollar for any amount spent on health insurance for the worker up to the level of the tax obligation. In this way, Massachusetts is formally requiring that a “tax” be paid rather than a fringe benefit provided. Proposals are being developed to modify ERISA to make implementation of state-level mandated employer insurance easier. Congressional Research Service, *Insuring the Uninsured: Options and Analysis*, Education and Labor Serial 100-DD (Washington, DC.: CRS, October 1988).

The CRS developed two plans, the “typical” plan and the “tailored” plan. The typical plan represents the type of plan most often offered by employers who provide their employees with health insurance coverage. This is based on a survey conducted by Hay-Higgins Associates under contract to the federal government, as reported in the CRS literature cited here. The CRS believes that the tailored plan is better suited to the needs of the uninsured.


5. The other major differences between the typical and tailored plans in terms of type of benefits offered are: (1) no catastrophic care under the tailored plan, and (2) no coverage for alternatives to acute care hospitals (such as rehabilitation hospitals). The tailored plan includes screening and diagnostic tests, which are not in the typical plan.


7. The evidence for adverse selection on the basis of mental health coverage is reviewed in Frank, “Regulatory Policy and Information Deficiencies.”


9. These issues, and some evidence associated with them, are discussed in Frank, “Regulatory Policy and Information Deficiencies.”

10. Essentially, the argument is that insurance induces consumers to pay through premiums for services they would not have wanted had they had to pay out of pocket. Even if consumers are not paying premiums, social welfare can fall when the inefficiencies of overuse due to moral hazard exceed the benefits of insurance coverage. This argument of course relies heavily on consumers’ being able to assess the benefits of services. By explicitly considering this in reason three, we have covered this base.


13. This assumes the firm has chosen a wage/fringe combination that is best for workers and ignores issues introduced by the tax subsidy going to firm-paid health insurance benefits. The tax subsidy, it is usually argued, leads to an already overgenerous choice of health insurance as a fringe benefit payment. This complication does not affect our argument.

14. The mathematical expression for the full efficiency cost is quite complicated, depending in general on worker preferences, production functions, and even demand elasticities across final products. We have computed these costs in a simple simulation model of the labor market for affected workers. The efficiency cost of a mandated fringe is bounded from above by the imposed cost itself. Substitution possibilities always reduce these costs. Thus, when a full analysis is done, the result is that the inefficiency cost rises with an increase in the level of required fringe remains, but this cost actually rises at a decreasing rate, asymptotically approaching the imposed cost itself. More information about our analysis of the costs is available in R.G. Frank and T.G. McGuire, “The Efficiency Costs of Financing Health Insurance through Insurance Regulation” (Unpublished paper, 1989).

15. Frisman et al., “Costs of Mandates for Outpatient Mental Health Care.”

