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HEALTH DEBATE REALITY CHECK: THE ROLE OF INDIVIDUAL REQUIREMENTS

By Jonathan Gruber, Ph.D., Len M. Nichols, Ph.D., and Mark V. Pauly, Ph.D.

The good news is that presidential candidates in both parties are talking about making health insurance and care more affordable in lots of ways. The inevitable bad news is that a few key points have become confused in escalating campaign combat. We three health economists, not affiliated with any specific campaign, feel compelled to clarify what health policy research does and does not have to say about an issue central to current campaign debates, the role of an individual requirement to purchase insurance.

An individual requirement to buy or acquire health insurance is a necessary element of any proposal that aims to cover all Americans. A large share of the uninsured in the U.S. today are offered insurance at low or zero explicit premiums, either at the workplace or through public insurance programs, but they forgo these opportunities for a bargain. Sometimes but not always they do so because the cost is obviously too high relative to the income they have available for other needed consumption.

In particular, a sizeable share of the uninsured are higher income individuals who could afford to pay the full cost of a health insurance plan, or any fraction of it, but choose not to. As a result, any plan to increase insurance coverage in the U.S. that does not include a requirement to purchase or acquire insurance will not result in universal health insurance coverage. Recent estimates suggest that a plan with uniform generous subsidies but without a mandate would cover no more than one-half of the uninsured in the U.S. Even with other cost-saving measures and a child mandate, we think that it is very likely that at least 15 million Americans would remain uninsured.

When individuals remain "voluntarily uninsured," it imposes three costs, both on the uninsured and on those who are insured. First, these individuals do use medical care, to the tune of roughly $30 billion per year in unpaid hospital bills, and those costs get passed on to the insured. Second, the ability of those in better health to opt out of risk pools may mean (depending on how insurance is priced) that premiums rise for those in poorer health, and an "adverse selection" spiral that prices almost everyone out of the market. Finally, many of these "voluntarily uninsured" may not appreciate the actual health risks they face, and the value of at least holding catastrophic insurance coverage against these risks. In our view, therefore, an individual requirement should be a key part of fundamental health care reform in the U.S.

Of course, an individual requirement is not enough—it is only one of the three elements central to universal coverage. The second is subsidies to ensure that the required insurance is affordable for all. The third is a reformed insurance marketplace where individuals can meet this requirement through improved markets, with competitive insurance rates and a range of insurance options. These essential

Jonathan Gruber, Ph.D., is a Professor of Economics at MIT and a member of the Massachusetts Connector Board, Len M. Nichols, Ph.D., is Director of the Health Policy Program at the New America Foundation, and Mark V. Pauly, Ph.D., is a Professor of Health Care Systems at the Wharton School of the University of Pennsylvania.

insurance reforms will be much harder to implement unless insurers are confident that all—the healthy as well as the sick, the irresponsible as well as the responsible—are going to be in the risk pool.

Moreover, individual requirements will not be effective if they are not enforced. Contrary to some claims, however, considerable experience suggests that mandates are indeed enforceable. The Netherlands and Switzerland reach 98–99 percent compliance with their individual health insurance purchase requirements. American states that use information sharing smartly have reached 98 percent compliance with auto insurance mandates as well. Recent research by Sherry Glied and colleagues at Columbia suggests some key lessons about mandate enforcement. Penalties for non-compliance must be serious but not so high as to be unenforceable politically, and the probability of being detected if non-compliant must be high. This can be greatly aided if data about enrollment is shared among multiple entities (e.g., employers, schools, providers, insurers, insurance market administrators), and if recurrent checks of available data are made electronically. Auto-enrollment under certain circumstances can be a powerful tool abetting compliance. The tax system can be an effective way of reaching all households in which someone earns taxable income, which includes the vast majority of the uninsured. We expect most uninsured to comply willingly, once subsidies make insurance affordable, but the continued existence of a minority of free riders will taint (and perhaps destabilize) that achievement.

Some have pointed to the state of affairs in Massachusetts, which in 2006 passed an ambitious health reform plan, as indicting the role of the mandate. In fact, the opposite is true. Starting in late 2006, the government has provided heavily subsidized insurance for low income groups and a reformed insurance market for others. In addition, by the end of 2007, individuals in Massachusetts are required to have health insurance or to pay a small tax penalty; in 2008, the penalty becomes substantial. The voluntary system in place thus far in Massachusetts has been highly successful, with as many as half of the uninsured gaining coverage through late in 2007, but it has been far from universal. Yet this should not be surprising since the mandate is not yet in place! Far than showing a failure of a (not yet existent) mandate, the experience in Massachusetts shows the key role that must be played by a mandate: the state has covered less than half of the uninsured and those enrolled are the least healthy uninsured. To move to full coverage and to avoid this “adverse selection”, a mandate must be in place.

On the whole, we veterans of past health reform wars are heartened by the effort most candidates in both parties have put into their health proposals and discussions this year. What is striking is how closely all proposals from serious candidates incorporate choices in markets and means testing of financing, raising the hope of compromise and political action. Compared to past presidential campaigns, we are particularly impressed with the greater realism that comes from attention devoted to the need to increase the efficiency of the health care delivery system as much as possible, and accept the higher cost of highly valuable care as worth paying for. We welcome this more balanced approach to achieving the goal of universal coverage as far more likely to attract the bi-partisan support any health reform proposal will need to be successful in 2009–10, when getting the details right will really matter.