THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS
1750 Ocean Park Boulevard, #200, Santa Monica, CA 90405 - 4938
Tel: 310-392-0522 · Fax: 310-392-8874 · Net: consumerwatchdog.org

Overview

In his January 2008 discussion paper, *Covering the Uninsured in the U.S.*, prepared for the Journal of Economic Literature, Jonathan Gruber of MIT defends the proposition that the solution to the health care affordability crisis is to require all Americans to buy private insurance policies, or face steep fines and garnished wages, without limiting what insurers can charge.

The following analysis illustrates the major faults of Gruber's argument in favor of mandatory purchase of insurance. Generally, the Gruber analysis:

- ✓ Relies on a 30-year old RAND experiment to conclude that most people are "over-insured," utilizing too much health care unless they face punitive co-pays and deductibles. However, this study is both out-of-date and flawed by the unrepresentatively low out-of-pocket costs of the experimental policies. Today, yearly premiums for a family of four top $12,000 annually, and over the past six years, the amount families pay out-of-pocket each year for their share of premiums has increased by about $1,500.[1]

- ✓ Relies on an out-of-date health insurance profit and overhead figure of 12%, and avoids discussing the explosion in insurer profitability since 2000. Some experts say that up to 50% of overall health spending goes to clinical and insurer administrative waste, inflated prices, and fraud by providers.[2]

- ✓ Relies on unsubstantiated notions, originated by insurers themselves, that requiring Americans to buy unaffordable and poor quality health insurance policies is a necessary component of reform.

- ✓ Assumes that the insurance market is highly competitive, ignoring extreme market consolidation that will inevitably lead to higher prices and skimpier benefits, as the Massachusetts experience is already demonstrating.

[1] Press Release announcing the Kaiser Family Foundation 2007 Employer Health Benefits Survey: http://kff.org/insurance/ehbs091107nr.cfm
[2] *Health Costs Absorb One-Quarter of Economic Growth, 2000-2005*, Alan Sager, Ph.D. and Deborah Socolar M.P.H., Boston University School of Public Health, February, 2005

Analysis

The "over-insurance" claim. Gruber claims that most people who are insured are over-insured, resulting in "excess medical consumption."

- ➢ Gruber's chief evidence is the RAND Health Insurance Experiment, completed in 1977, which "randomly assigned different levels of patient coinsurance and deductibles" and found a small decrease in medical utilization at higher consumer cost levels for copays and deductibles (price elasticity was -0.2).

- ➢ What Gruber does not immediately reveal is that the RAND participants, no matter what their deductible, faced out-of-pocket costs of no more than $1,000 (about $3,650 in today's dollars) and often much less, ranging between 5% to 15% of family income. There is no mention at all of a premium in the experimental plan design. The plans also covered dental. Furthermore, the families that participated in the experiment were paid *in cash* the difference, if any, between the value of their old insurance plan and the experimental plan.

- ➢ The study is simply no longer related to the real world of health insurance—or the reality of degraded health insurance policies that depend on $2,500 deductibles, 30% copays *and* $7,500 to $15,000 out-of-pocket limits in addition to monthly premiums costs. (These were the parameters of a "mid-level" policy in a proposed California mandatory purchase plan)**.**

  - ⇒ Nearly one out of four Americans under the age of 65—61.6 million people—is in a family that will spend more than 10% of its pre-tax income on health care costs in 2008. And 17.8 million non-elderly Americans—more than three-quarters of whom have health insurance—are in families that will spend more than 25% of their pre-tax income on health care costs in 2008.[3]

  - ⇒ Between 2000 and 2008, the number of people who are in families that spend more than 10% of their pre-tax income on health care will have increased by nearly 19.9 million. Over that same period, the number of people in families that spend more than 25% of their pre-tax income on health care will have increased by nearly 6.2 million.[4]

Policy degradation. In fact, mandatory purchase of private insurance will lead only to more high-deductible, bare-bones policies:

- ➢ Unregulated mandatory private insurance regimes have only one method of suppressing premium prices: selling higher deductible policies that provide

[3] *Too Great a Burden: America's Families at Risk*, FamiliesUSA, December 20, 2007: http://familiesusa.org/resources/publications/reports/too-great-a-burden.html
[4] *Id*.

less coverage. Studies show that very high out-of-pocket costs ultimately force people to delay care until conditions become chronic or life-threatening, when treatment is more expensive, and good health outcomes less likely.[5] Such manipulation is already evident, even without a mandate.

- In addition to dramatic premium increases, many individuals and families already face unaffordable out-of-pocket costs in the form of deductibles of $2,000 to $5,000 a year or more, and physician and prescription co-pays. 95% of workers face additional costs for hospital admissions, such as separate hospital deductibles, co-pays and per diem charges.[6]

- The number of workers whose policies provide no out-of-pocket limit increased to 29%.[7] Without caps on out-of-pocket costs, regulators do not have the tools they need to prevent cases like that of Playa Del Rey resident Dana Christensen, who unknowingly bought a junk no-limit policy and was left with $450,000 in medical bills when her husband, Doug, died of cancer.[8]

- In many policies that do have out-of-pocket caps, not all services count toward the out-of-pocket limit, requiring workers to spend more before insurance coverage kicks in. For example, 32% of workers enrolled in PPOs are in plans that do not count the annual deductible towards the out-of-pocket limit. 79% of workers in PPOs are in plans that do not count prescription drug cost sharing toward the out-of-pocket limit.[9]

- Such reductions in benefits will only increase under mandatory purchase of private health insurance. In Massachusetts, the "cheapest" plans carry $2,000 individual deductibles, co-pays of up to 35% for most health services, separate deductibles for prescription drugs and up to 50% drug co-pays.[10]

Health care costs. In briefly examining the rise in U.S. health care costs, which run above the rate of inflation, Gruber says "the general conclusion [of health economists] is

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[5] *High-Deductible Health Plans and the New Risks of Consumer-Driven Health Insurance* Products, American Academy of Pediatrics, March, 2007: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;119/3/622#R17; *Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, Commonwealth Fund, December 8, 2005: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=326359

[6] *Employer Health Benefits 2007 Annual Survey*, Kaiser Family Foundation, Health Research & Educational Trust: http://kff.org/insurance/7672/index.cfm

[7] *Id.*

[8] http://www.consumerwatchdog.org/healthcare/st/?postId=5795&pageTitle=Dana+%26+Doug+Christensen

[9] *Employer Health Benefits 2007 Annual Survey*, Kaiser Family Foundation, Health Research & Educational Trust: http://kff.org/insurance/7672/index.cfm

[10] Commonwealth Connector, http://www.mahealthconnector.org/portal/site/connector/

a simple one: "the rapid rise in health care costs has been driven by quality-improving technological change." This sweeping and solitary claim fails to consider that private health insurance rates (including premium) have risen at 2-3 times the rate of overall health care inflation.[11]

- ➢ Massachusetts' experience with mandatory purchase of private insurance offers the most striking indicator of what may happen to Americans under a mandatory purchase regime. Proponents of the Massachusetts plan, including Gruber and former Governor Mitt Romney, predicted that comprehensive health insurance under Massachusetts reforms would cost about $200 a month,[12] but for many the cost is twice or more that amount.[13] Insurers in Massachusetts have signaled their intention to seek double-digit price increases next year,[14] and due to its failure to regulate costs, the Massachusetts program's projected annual budget is expected to double in three years.[15]

  - ⇒ John Kingsdale, executive director of the Massachusetts Insurance Connector Authority overseeing the mandatory purchase program, has acknowledged that unconstrained cost increases could doom the program. "The sustainability of reform depends on our ability to restrain or constrain or moderate the increase in costs. That's going to take a huge concerted effort by all players in the health care area."[16]

  - ⇒ Opinion leaders agree that the lack of cost controls is the biggest threat to the Massachusetts program:

> The financial problems are mostly because of underestimating the number of uninsured and the rate at which they would sign up for subsidized coverage. As a result, the state, which had originally expected to spend $472 million on subsidized insurance this fiscal year, now expects to spend about $150 million more than that. It anticipates spending almost $870 million next year.[17] *New York Times Editorial.*

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[11] Consumer Price Index, Bureau of Labor Studies: http://www.bls.gov/news.release/cpi.t02.htm
[12] Julie Appleby, "Mass. residents face required coverage," *USA Today*. April 4, 2006.
[13] Commonwealth Connector, http://www.mahealthconnector.org/portal/site/connector/
[14] Commonwealth Connector staff report, Dec. 12, 2007
[15] Alice Dembner, "Subsidized care plan's cost to double," *Boston Globe*, February 3, 2008
[16] Steve LeBlanc, "Reining in costs top worry for year two of health care law," *Associated Press*, January 6, 2008
[17] "Growing Pains of Universal Coverage," *New York Times*, Editorial, February 9, 2008: http://www.nytimes.com/2008/02/09/opinion/09sat1.html?_r=1&oref=slogin

> The state needs continued federal support for the plan. To seek this aid, it has to make three-year cost estimates. Much is uncertain about healthcare economics over the next few years, so it is wise not to panic about imprecise forecasts - in this case a $1.35 billion cost in 2011. Instead, providers, insurers, consumers, businesses, labor, and the government need to unite around a campaign to control costs.[18]
> *Boston Globe Editorial.*
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> [T]here's one way the industry can get everyone to buy its product: Have a law passed requiring it. That way the insurance companies can collect premiums from everyone - including the young and healthy, who are the most profitable customers. …
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> It works out well for the insurance companies, and perhaps the hospitals, which will collect more from insured patients than the state's "free care pool."[19]
> *Waltham Daily News Tribune Editorial.*

- At $12,000 a year on average for comprehensive family coverage, mandatory purchase of private insurance is unaffordable – particularly without regulation of what insurers can charge.[20]

- Many predict, and the Massachusetts experiment corroborates, that under a national mandatory purchase regime, families would be required to spend up to 10% of their income on health insurance. Assuming that there was some subsidization of cost for families under 300% of the federal poverty level, a family of four just above that cut-off[21] earning $63,600 would be required to pay $6,360 on health insurance.

- Middle-income families, saddled with monthly mortgage payments, would not be able to afford such an expensive monthly insurance premium. Nonetheless, Gruber has proposed levying large fines against families that cannot afford coverage. "The mandate has to be enforced," through higher penalties, Gruber

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[18] "The health law is working," *Boston Globe*, Editorial, February 10, 2008: http://www.boston.com/bostonglobe/editorial_opinion/editorials/articles/2008/02/10/the_health_law_is_working/

[19] "Cost Control and Health Care Reform," *Waltham Daily News Tribune,* Editorial, February 10, 2008: http://www.dailynewstribune.com/opinion/x2050487093

[20] *Employer Health Benefits 2007 Annual Survey*, Kaiser Family Foundation, Health Research & Educational Trust: http://kff.org/insurance/7672/index.cfm

[21] http://aspe.hhs.gov/poverty/08poverty.shtml

argued in Massachusetts, saying that "[w]e need to think beyond what looks mean and do what's right."[22]

- Gruber also fails to consider out of whack and uncontrolled pharmaceutical pricing in the U.S., as compared to other developed nations, which could be partly controlled by a simple purchasing pool. For example, if the U.S. paid Canadian prices for brand name prescription drugs in 2004, some $60 billion would have been saved.[23]

The 12% overhead cost claim. Gruber, citing data from 1999 – a low point in insurer profitability – concludes that overhead (administrative costs and profit) for private insurer is 12%.[24]

- However, beginning in 2000, health insurers experienced an explosion in profitability. In fact, between 2000 and 2004, profits increased 345%.[25] In 2003, health insurance industry profits along with the cost of administering public and private coverage, became the fastest rising component of health care spending.[26]

- Even if the 12% figure for pure insurer overhead and profit were up to date, it fails to capture the cost of clinical and administrative waste, inflated prices, and fraud by providers and insurers. Administrative waste is substantial for doctors and hospitals that must determine whether a patient is insured, what services, providers, and medications are covered, the need to file different forms for different payers, and the need to track patients' spending towards deductibles. Some experts estimate that the total of non-health related spending may be as high as 50%.[27]

- 3.2 million people, 27.3% of those employed in health care, work in administrative settings.[28]

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[22] Alice Dembner, "Health insurance penalties too low, panel official says," *Boston Globe*, January 11, 2008
[23] *Affidavit Supporting Illinois Governor Blagojevich's Petition to the FDA to Permit Prescription Drug Importing*, Alan Sager, April 8, 2004
[24] *Health Spending growth up in 1999: faster growth expected in the future*, Heffler S, Levit K Smith S, et. al., *Health Affairs*, 2001
[25] Weiss Ratings; news releases: http://www.weissratings.com/News/Ins_HMO/
[26] "Health Spending Grows At Slowest Pace In Seven Years," press release, *Health Affairs*, January 11, 2005: http://www.healthaffairs.org/press/janfeb0501.htm
[27] *Health Costs Absorb One-Quarter of Economic Growth, 2000-2005*, Alan Sager, Ph.D. and Deborah Socolar M.P.H., Boston University School of Public Health, February, 2005
[28] *Cost of Health Care Administrative in the United States and Canada*, Steffie Woolhandler, H.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D., *New England Journal of Medicine*, August 21, 2003

Strange New Math. *New York Times* columnist Paul Krugman recently cited Gruber's finding that a plan without a mandatory purchase requirement costs almost as much – $102 billion – as a plan with a mandate – $124 billion – but covers many fewer people at a far higher per-person cost. However, this analysis obscures the fact that Gruber divides total cost under the mandate plan by the total number of uninsured, even though many of those people won't receive a dime of subsidy from a mandate plan.

- Claiming that a mandate plan only costs $2,700 per person, versus $4,400 per person under a non-mandate plan, infers that the subsidies will be shared by all of the uninsured when many will simply be pushed into the private insurance market without a helping hand. A more accurate cost comparison would divide total cost by individuals receiving subsidies.

- In addition, part of Gruber's calculation is that the mandate will sweep in 97% of the uninsured. Though the Massachusetts plan that is similar to his model has not yet applied its full punishment to those who decline to purchase insurance, the percentage of the unsubsidized uninsured who have signed up is far smaller than expected: *less than 10% of the newly insured are in the unsubsidized category*.[29] Thus the mandate is failing at its chief task, pushing the unsubsidized into the insured pool.

The Gruber analysis relies on an unsubstantiated notion, proposed and pushed by health insurers, that mandatory purchase of health insurance is a necessary element of reform. The argument goes that uninsured Americans would largely refuse to buy insurance even if it were affordable, waiting until they get sick to seek insurance. However, there is no large-scale study or firm factual basis for this assertion (as even Gruber acknowledges in his paper), much less under conditions in which premium costs are made more affordable through regulation.

- 34.7% of Americans (89 million people) under the age of 65 did not have health insurance at some point during 2006 but were insured for some part of the year.[30] (Gruber acknowledges this broad "partial-uninsurance" in "Part I, The Uninsured"). The data indicates not a widespread refusal, but that Americans often seek insurance, but move in and out of coverage because they can't afford it.

- Even if the arguments of the self-serving health insurers were to be believed, there are alternative, and far less draconian, methods for incentivizing Americans to seek coverage. For example, an insurance mandate could require an opt-out, rather than an opt-in, a system that has been shown to increase participation in 401K retirement plans. As a penalty for joining late, higher premiums and/or delays for coverage of pre-existing conditions could be imposed. Though the penalty would be punitive, these measures achieve the

[29] Commonwealth Care/Commonwealth Choice Progress Reports, January 10, 2008
[30] *Wrong Direction: One Out of Three Americans Are Uninsured*, FamiliesUSA, September 2007

same outcome that proponents of the mandatory purchase regime call for, but by less onerous means.

$50 billion surplus promised to help offset cost to the middle-class will not materialize. Gruber bases the existence of this surplus on the faulty per-person costs above, and on reaping a negative: He argues that removing the employer tax credit for employee insurance will provide enough new revenue to pay for the mandate and subsidies.

- ➢ However, this "extra" revenue will be all but impossible to calculate exactly, and real-world politics would make it impossible to corral for use as a middle-class subsidy.

- ➢ Without subsidy, a family of four making $82,000 a year would be forced to pay $10,000 for its insurance premium according to Gruber with no apparent limit on deductibles or copays.

The Gruber analysis mischaracterizes Federal Employee Health Benefits. Gruber cites the higher-than-average premiums of federal employee health benefits as a reason why access without a mandate will not be affordable. He ignores two key points: the federal employee base skews older than the general population, and the federal plan is based entirely on private insurance products, with no true publicly administered alternative along the lines of Medicare.

The Gruber analysis misstates the history of health care reform. Gruber writes, "[T]he failed centerpiece of the early Clinton Presidency was a plan for universal coverage; 15 years later, each of the major Democratic candidates for President is proposing a plan for universal health coverage."

- ➢ President Clinton's health care plan was not universal health care. That plan proposed solving the heath care cost and availability crisis by injecting more competition in the health insurance market. The theory was that with more insurers offering coverage, more companies would be forced to compete for customers by lowering prices and offering better quality.

- ➢ Since the demise of the first Clinton health plan, insurance has become less, not more, competitive nationally. There have been more than 400[31] mergers of managed health care companies.[32] The nation's two largest health insurers, WellPoint and UnitedHealth, control 33 percent of the U.S. commercial health insurance market.[33] In 280 of the 294 markets surveyed, one health insurer accounts for at least 30 percent of the combined HMO/PPO market.[34]

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[31] *Competition in Health Insurance, A Comprehensive Study of U.S. Markets, 2005 Update*, American Medical Association, 2006
[32] *Id.*
[33] *Id.*
[34] *Competition in Health Insurance, A Comprehensive Study of U.S. Markets, 2005 Update*, American Medical Association, 2006

- A handful of remaining insurer super-conglomerates have a stranglehold on privately insured health care. Yet, mandatory purchase of private insurance embraces this oligopoly with its uncontrolled prices and overhead.

Gruber analysis ignores the only affordability reform with proven track record of success. Regulation of insurance rates is the only proven curb on insurance costs.

- In 1988 California voters passed the nation's most effective insurance regulation. Since 1988, property and casualty insurance rate regulation under Proposition 103 has saved California drivers $23 billion in premiums.[35] The nation's health insurers should be required to abide by the same strict oversight as auto and home insurers in California.

- Under Proposition 103, auto and property/casualty insurers must justify premium increases to the elected insurance commissioner and receive approval before raising rates.

- Our consumer group's premium challenges alone have saved Californians $800 million in auto, home, and medical malpractice premiums since 2003.[36]

- California auto insurance premiums have declined by 7% since voters approved Prop 103 in 1988, while rates nationally have increased 47%.

- In the fifteen years following the passage of Prop. 103, California fell from 2nd most expensive state for auto liability premiums in the country to 21st. At the same time, the stability of rate regulation has provided above-average profits for California insurers.[37]

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[35] *Why Not the Best? The Most Effective Auto Insurance Regulation in the Nation*, Consumer Federation of America, June 2001

[36] *Proposition 103's Impact On Auto Insurance Premiums in California*, *15 Years of Insurance Reform*: 1989-2004, Foundation for Taxpayer and Consumer Rights (FTCR), available at: http://www.consumerwatchdog.org/insurance/pr/?postId=8011

[37] *State Average Expenditures for Personal Automobile Insurance* 1993-2004, National Association of Insurance Commissioners.