

The New York Times

Economix

Explaining the Science of Everyday Life

JUNE 25, 2010, 6:00 AM

Nudging People to Buy Health Insurance

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I have argued (in [last week's post](#), in [January](#) and [last year](#)) that if Americans want a private health insurance system that does not base the price of individually sold policies on that individual's health status and that does not allow an insurer to refuse to sell a policy because of an individual's health issues, then they should accept a mandate that all Americans purchase at least a minimum package of health insurance. That, in turn, requires that lower-income families be publicly subsidized to enable them to afford the insurance.

The current, vehement opposition from Republicans to the mandate stuns me. After all, there was a time, in the 1990s, when prominent health-policy analysts allied with Republicans in Congress fully endorsed the idea of the mandate, as did the officeholders whom they advised. For example, in "[A Plan for 'Responsible National Health Insurance,'](#)" a seminal paper published in 1991 by a group of politically conservative economists led by Mark Pauly of the [University of Pennsylvania](#), made the mandate a cornerstone of its proposal.

"In our scheme, every person would be required to obtain basic coverage, through either an individual or a family insurance plan," they wrote. "All basic plans would be required to cover specified health services; plans could, however, offer more generous benefits or supplemental policies. The maximum out-of-pocket expense (stop-loss) permitted would be geared to income, with more complete coverage required for lower-income people, to ensure that no one faced the risk of out-of-pocket expenses that were catastrophic, given their income."

As a matter of principle, these authors did not call for strict [community rating](#) by insurers, but they also recognized that it is not administratively practical to base public subsidies on actuarially expected costs for each individual. Therefore, as a practical matter, they were prepared to accept a move toward community rating.

Similarly, in his [testimony](#) before the Senate Special Committee on Aging on March 10, 2003, the economist Stuart Butler of the [Heritage Foundation](#), said, "Today there is a legal

and moral obligation on society to provide some level of health care to those who become ill,” adding: “It is also reasonable to expect residents of the society who can do so to contribute an appropriate amount to their own health care. This translates into a requirement on individuals to enroll themselves and their dependents in at least a basic health plan — one that at the minimum should protect the rest of society from large and unexpected medical costs incurred by the family. And as any social contract, there would also be an obligation on society. To the extent that the family cannot reasonably afford reasonable basic coverage, the rest of society, via government, should take responsibility for financing that minimum coverage.”

During the 1990s, prominent Republican members of Congress readily accepted this advice. As Julie Rovner [reported on National Public Radio](#) on Feb. 15, 2010: “John Chafee of Rhode Island, along with 20 other G.O.P. senators and Representative [Bill Thomas](#) of California, introduced legislation that featured an individual mandate.” She noted that four Republican co-sponsors — [Robert Bennett](#) and [Orrin Hatch](#) of Utah, [Charles Grassley](#) of Iowa, and [Christopher Bond](#) of Missouri — remain in the Senate today.

Ms. Rovner concluded that a “summary of the Republican bill from the Clinton era and the Democratic bills that passed the House and Senate over the past few months are startlingly alike.”

In sum, then, there is something more than a bit ironic in that what was once quite popular among Republicans and may even have originated with them would now ignite among them such strong opposition, including from those who a decade ago embraced the idea.

But perhaps the entire brouhaha over the mandate — including [the legal challenge](#) to it on constitutional grounds — could be sidestepped by cobbling together ideas from both the right and the left of the ideological spectrum.

In his “[Patients’ Choice Act](#)” (S.1099), introduced in May 2009, Senator [Tom Coburn](#), Republican of Oklahoma, advocated strictures on health insurers that appear [quite similar](#) to those in the health overhaul law. He coupled them not with an outright mandate to be insured but with what he called “auto-enrollment” of individuals in an insurance plan.

Under that arrangement, individuals without health insurance presumably would be automatically assigned to a health plan, but they could either change to another plan or opt out of insurance altogether by explicitly requesting to do so. It is an [application](#) of what has come to be called [libertarian paternalism](#) or simply “[nudging](#).”

In this case, the nudging preserves the individual’s freedom not be insured and merely changes the default option from “remaining uninsured” to “purchasing health insurance.” The idea is to preserve people’s freedom to choose but also to influence their choices by the way they are structured — that is, to nudge them in the direction of being insured.

In “[Averting a Health-Care Backlash](#),” published in December in the left-of-center American Prospect, Paul Starr, a sociologist at Princeton, proposed to couple this relatively mild form of nudging with requiring people who opt out of their automatic enrollment to acknowledge formally that they will forfeit for a number of years the right to purchase health insurance on the terms provided for in the recent legislation. Professor Starr proposed a five-year period.

Those who choose to opt out would then find themselves for at least five years (and possibly longer) in [today’s insurance market](#) — without guaranteed issue, without community rating, without public subsidies and with very rapidly rising premiums.

This augmented libertarian paternalism strikes me as a workable alternative to an outright mandate to be insured, although the number of years may have to be raised above five years to make it work.

Professor Reinhardt serves on the board of Amerigroup Inc., a Medicaid managed-care company that does not operate in the small-group market, but in a market regulated by the states, with premiums negotiated with the state governments that pay those premiums.