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The demand for health insurance among uninsured Americans: Results of a survey experiment and implications for policy[☆]

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ABSTRACT

Most existing work on the demand for health insurance focuses on employees' decisions to enroll in employer-provided plans. Yet any attempt to achieve universal coverage must focus on the uninsured, the vast majority of whom are not offered employer-sponsored insurance. In the summer of 2008, we conducted a survey experiment to assess the willingness to pay for a health plan among a large sample of uninsured Americans. The experiment yields price elasticities of around one, substantially greater than those found in most previous studies. We use these results to estimate coverage expansion under the Affordable Care Act, with and without an individual mandate. We estimate that 35 million uninsured individuals would gain coverage and find limited evidence of adverse selection.

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1. Introduction

Expanding coverage to the roughly 50 million Americans who lack health insurance has long been a key public policy concern, and one that has received enormous attention in recent years.¹ Most notably, the Affordable Care Act of 2010 (ACA) attempts to cover these individuals via a combination of an expansion of Medicaid and subsidies to purchase private insurance on state-run health insurance exchanges, as well as a mandate for most individuals to obtain coverage.²

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¹ See <http://www.census.gov/prod/2011pubs/p60-239.pdf> for the most recent Census estimates of the number of uninsured Americans.

² The Kaiser Family Foundation summarizes the Act at <http://www.kff.org/healthreform/upload/8061.pdf>.

Relying on existing research to predict the effects of such a fundamental reform on the currently uninsured is potentially problematic, because existing work generally focuses on the decision to enroll in employer-sponsored health insurance. The currently uninsured are rarely offered the opportunity to purchase insurance through an employer (Kaiser Family Foundation, 2004), calling into question the utility of existing estimates for understanding insurance demand of this population. Not only are uninsured individuals substantially poorer than the average worker offered employer insurance, but the decision to, say, purchase subsidized insurance from a state exchange might fundamentally differ from the decision to enroll in an employer-sponsored health plan, which takes place in the context of co-workers, an employer and potentially benefits counselors.

To address these concerns, we devised survey questions specifically designed to elicit the expressed willingness to pay among the uninsured for a comprehensive health plan. Existing data on the uninsured are generally limited in part because many respondents must be screened in order to yield a sample of uninsured people large enough to generate precise estimates, given that more than 80 percent of Americans are covered by some form of health insurance. Fortunately, for a two-week period during the summer of 2008, the Gallup Poll included our questions in their ongoing survey of 1000 individuals a day. We asked respondents whether they would

purchase a comprehensive health plan for a given monthly premium, and then lowered the price in several stages for those who initially said they would not purchase it. To the best of our knowledge, our dataset is the first to elicit self-reported willingness-to-pay for health insurance among a large sample of uninsured Americans.

Our results suggest that subsidizing the purchase of insurance plans would significantly reduce the population of the uninsured. For example, we estimate that about 60 percent of the uninsured would voluntarily enroll for an annual premium of \$2000. Under the current specification of subsidies in the ACA, we estimate that between 33 and 35 million uninsured individuals would gain coverage by 2016 as a result of the law. We also estimate that stripping the individual mandate from the law—the constitutionality of which has been challenged in federal court—would lead to between six and eleven million fewer individuals gaining coverage.

The Gallup data include extensive information on health status, and thus allow us to gauge the extent of implied adverse selection for a given subsidy schedule. We find, consistent with past literature, that less healthy individuals have lower price elasticities of demand.³ However, when we calculate the prices individuals would actually face under the ACA subsidy schedule, we find no evidence that less healthy individuals would be more likely to enroll, with or without a mandate. As enrollment is a function of both elasticities and the price points individuals face, other subsidy schedules may well lead to adverse selection; indeed Chandra et al. (2011) find that the individual mandate was important in limiting adverse selection under Massachusetts' 2006 health reform, which, as we discuss, mirrors the ACA in important respects. With or without a mandate, we find no evidence that those predicted to take-up private insurance are less healthy than those who are already privately insured, suggesting premiums for the latter group should not increase due to a change in the composition of the private insurance pool.

We calculate elasticities of take-up with respect to premium price of around 1.0, significantly larger than those typically found in past studies. There are several reasons why our estimated demand curve may differ from those found in past studies. First, as mentioned earlier, almost all past work is based on individuals' decisions to join employer-provided health plans, a decision few of the uninsured actually face. In fact, our elasticities are quite similar to those found among another group of individuals not offered employer-provided insurance, the self-employed (Gruber and Poterba, 1994).

Second, past studies generally need to impute prices for those who do not have insurance or cannot recall their premium price, which likely downwardly biases estimated price sensitivities. Given that in the current environment, prices can be undefined (e.g., insurance companies can deny coverage to applicants with pre-existing conditions), assuming that each individual faces a finite going price can lead to underestimates of consumer demand as some individuals will be assumed to be turning down an offer when in fact they were denied coverage. We find that uninsured individuals are more likely to have been denied coverage in the past, suggesting that the bias induced by assuming that the going price applies to everyone could be especially important in estimating demand among the currently uninsured.

Finally, even if the researcher can correctly determine the plan's price, plan features (e.g., deductibles, copayments, provider networks) can vary extensively and in ways the researcher cannot

always observe. Thus, an individual who chooses not to purchase health insurance at a relatively low price may appear to have low demand, whereas she may in fact be reacting to the low quality of the offered plan. Even some employer plans can initially exclude coverage for a pre-existing condition, so an individual who chooses not to enroll could be viewed by the researcher as having limited demand when she in fact could have very high demand for a more comprehensive insurance plan.

We designed our survey experiment in an attempt to address these and other challenges faced by past studies. First, our sampling frame allows us to gather a large group of uninsured individuals in order to directly elicit their willingness to pay for health insurance. Second, we present individuals with a specific, comprehensive insurance product, so that plan quality does not vary across individuals. Third, we offer hypothetical premiums to respondents and vary them exogenously, so there is no need to impute prices. Finally, our survey experiment permits us to estimate a range for each uninsured individual's willingness to pay for health insurance, which enables a more textured analysis of the characteristics of individuals who would likely take up health insurance under reforms such as the Affordable Care Act than is possible with an aggregate demand elasticity. Overall, our results suggest that using the demand curves estimated in much past work may under-estimate the effect of policies to extend coverage to the uninsured.

Of course, using survey data on people's self-reported decisions in hypothetical choices entails its own set of serious concerns, such as anchoring bias (the tendency of individuals to choose a valuation close to the first price the survey suggests). We make an effort to address anchoring bias by randomly varying the initial prices we offer respondents and find no significant effect of the initial offer on respondents' final valuation. Moreover, our survey differs from contingent valuation (CV) studies, which typically ask respondents to value a public good, such as an environmental project, with which they have little personal experience. We instead ask about a private good that most people would have experience with: given the well-documented "churning" in health-insurance status (see, e.g., Klein et al., 2005), many uninsured individuals would have purchased insurance in the recent past. Indeed, past work on take-up decisions for employer-provided insurance has shown that hypothetical-choice surveys and actual field data yield very similar demand elasticities (Royalty and Hagens, 2005). However, other potential biases related to hypothetical valuation are more difficult to address and we later discuss how they might affect our estimates. At a minimum, our simulations of the effects of the ACA provide a benchmark with which to compare the eventual enrollment patterns once the law's provisions are fully implemented and thus will allow researchers to further gauge the utility of using survey data on health insurance demand.

The remainder of the paper is organized as follows. Section 2 reviews past work on the demand for health insurance. Section 3 describes the Gallup Daily Poll as well as the questions we added to it. Section 4 presents data analysis on uninsured individuals' decisions to buy into a subsidized health plan, estimating aggregate price elasticities, predicting individual reservation prices, and testing for the presence of adverse selection. Section 4 also discusses how shortcomings of hypothetical evaluation might bias our estimates. Section 5 uses the results in the previous sections to estimate the effects of the Affordable Care Act. Section 6 offers concluding remarks.

2. Review of related literature on insurance demand

This section reviews studies on three topics related to our question: employees' price elasticity of demand for employer insurance,

³ See, for example, Strombom et al. (2002), who find that older and sicker individuals appear less sensitive to premium price in their decisions among different health plans.

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