

Turning the Exchanges into Real Markets

The Obamacare exchanges are highly regulated markets in which every buyer and every seller faces the wrong price. As a result, every buyer and every seller faces perverse incentives.

On the seller side there is an obvious race to the bottom, as insurers try to attract the healthy and avoid the sick. After enrollment, the insurers have a perverse incentive to over-provide to the healthy (to keep the ones they have and attract more of them) and under-provide to the sick (to encourage the exodus of the ones they have and discourage enrollment by any more of them). It appears that the health plans are actively trying to dump their most costly enrollees on other plans.

On the buyer side, individuals face perverse incentives to wait until they get sick to buy insurance and then to drop their coverage once the medical bills are paid. When they do obtain insurance, their incentive is to choose low-cost plans with skimpy benefits and skimpy networks while they are healthy and then switch to very generous plans after they get sick. Every time an individual games the system in this way, he pushes up

costs for everyone else.

Fortunately there is a better way. The health insurance exchanges should be deregulated and denationalized and turned into genuinely free markets.

Exchanges Without Mandates

The first things that need to go are the individual and employer mandates. As far as getting people insured, the employer mandate appears to have a negligible effect

anyway, and it's very bad for the job market. Although the individual mandate may have some

impact, even under the best estimates most of the uninsured will still be uninsured after Obamacare is fully phased in.

Plus, the mandate forces people to buy a product designed by politicians, rather than ones that meet individual and family needs. What woman would willingly choose to buy health insurance that offers free mammograms while she is healthy but makes

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her pay full price if there is a symptom of something wrong? That's only one of the many needlessly wasteful and expensive consequences of letting health insurance benefits be determined by the political system.

But don't we need mandates in order to keep people from gaming the system? We have found better ways in Medicare Part B, Medicare Part D and with Medigap. In those markets, if you don't buy when you are eligible, you can face penalties. In most places, if you don't sign up for Medigap insurance when you are first eligible, you can be individually underwritten.

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Does getting rid of the mandates mean we have to give up on the idea of universal coverage? Not necessarily. We have already seen that when people are offered a tax credit to purchase health insurance, millions of people will turn down the offer. What should we do with the unclaimed tax credits? If they are sent to safety net institutions in the communities where the uninsured live, money would follow people. If everyone in a community opted to be insured, the tax credits would help pay for private insurance. If everyone elected to be uninsured, the money would go to a local safety institution as a backstop in case patients cannot pay their medical bills.

That's probably as close to universal coverage as we are ever going to get.

Exchanges without artificial prices.

Obamacare regulations are inducing insurers to choose narrow networks in order to keep costs down and premiums low. They are doing that on the theory that only sick people pay attention to networks and the healthy buy on price; and they are clearly trying to attract the healthy and avoid the sick. The perverse incentives that are causing these perverse results have one and only one cause: When individuals enter a health plan, the premium the insurer receives is different from the enrollee's expected medical costs.

Precisely the opposite happens in the Medicare Advantage program, where Medicare makes a significant effort to pay insurers actuarially fair premiums. The enrollees themselves all pay the same premium, but Medicare adds an additional sum, depending on the enrollee's expected costs. For example, some special needs plans are paid as much as \$60,000 or more per enrollee. Under this system, all enrollees are financially attractive to insurers, regardless of health status.

Exchanges without government risk adjustment.

What we call “health status risk adjustment” would begin with the Medicare Advantage risk adjustment formulas. However, the extra premium adjustments would be paid by insurers to each other — not by Medicare. Further, the insurers would be able to improve on Medicare's formulas as they learn of better methods of adjustment. They would also be able to use “look back” techniques to adjust the payments through time when they discover the original estimated expense was too high or too low. The risk adjustment we



are describing here is adjustment produced by the marketplace, not by a bureaucracy.

Exchanges without limited enrollment periods.

Outside of the open enrollment period, no one in the United States can buy individual or family coverage unless they experience a qualifying event (divorce, loss of a job, etc.). The next opportunity will be in November, and even then you will only be able to buy insurance that becomes effective the following January. These limited enrollment periods exist in order to keep people from switching plans as their health condition

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changes. And the reason that is viewed as undesirable is that people would take advantage of the system – paying low premiums for skimpy coverage when they are healthy and then choosing a rich plan after they need serious medical care.

But it is actually good for people to switch plans after they get sick. Don't we want to fit the right plan to the right patient when health conditions change? The only reason plan switching is viewed as a problem is because none of the premiums are actuarially fair. In a rational insurance market, people would be able to buy insurance at any time, night or

day. And they would be able to continuously move from plan to plan.

Exchanges without perverse incentives.

In the reformed marketplace described here, the healthy and the sick would be equally attractive to the insurers. That's because every insurer would receive an actuarially fair premium for any new enrollee. Obamacare's promise to end discrimination against those with pre-existing conditions was bait and switch. Insurers cannot exclude the chronically ill or charge them a higher premium, but they are free to discriminate in other ways – by excluding the best doctors and the best facilities from their networks and by charging exorbitant out-of-pocket fees for life saving specialty drugs.

In the reformed market we envision, health plans would compete to enroll the sick – just as special needs plans do in the Medicare Advantage program. In all likelihood, health plans would specialize in expensive-to-treat conditions. Cancer Treatment Centers of America, for example, might actively recruit cancer patients from other health plans.

On the buyer side, individuals would no longer be able to game the system by waiting to insure until they get sick. Individuals would be free to switch health plans all year round, 24/7. But they would have to pay the full actuarially fair price of any upgrade and they would receive the full actuarially fair discount for any downgrade.

A version of this document was originally posted by John Goodman at *Forbes*.



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