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Crass Market

How ObamaCare's exchanges undermine quality health care.

Peter Suderman | September 30, 2010

When Barack Obama pitched his health care overhaul last year, he declared, "My guiding principle is...that consumers do better when there is choice and competition." But judging by the legislation he signed into law, his idea of a competitive marketplace is one that's run by the government.

ObamaCare calls for each and every state to set up a "health exchange," a highly regulated, government-run marketplace where individuals can shop for health insurance, by 2014. Each state is required to either show progress on building an exchange by 2013 or make way for the federal government to build and manage one directly.

These exchanges are the chief method by which the federal government will exert control over the insurance marketplace. Despite being operated at the state level (provided they choose to set up the exchange), state governments won't entirely be in charge. The Department of Health and Human Services will have the authority to determine minimum health insurance requirements for most medical services and providers as well as cost-sharing details for plans offered through the exchanges. By the end of the decade, the Congressional Budget Office estimates that 24 million individuals will be served by these exchanges.

In theory, they will expose health insurance customers to greater competition while protecting them through regulation. Insurers participating in the exchanges, for example, will face strict limits on how they can price their premiums according to individual risk factors. In practice, they will likely prove difficult to design and implement, and may ultimately undermine the country's quality of care. No matter what, there is little doubt that the exchanges will fundamentally alter the health insurance landscape across the states.

Already, some state insurance regulators—including the head of the National Association of Insurance Commissioners' exchange task force—are openly advocating banning insurance companies from selling individual policies outside the exchanges, leaving the state-run exchanges as the sole market for individual health insurance.

Others simply propose applying exchange regulations to all health insurers, even if they operate outside the exchanges. The effect of both policies would be the same: to get rid of individual insurance sales outside the purview of the exchanges and their rules.

States tasked with building the exchanges can expect the process to be tricky at best. Because the

exchanges will be the vehicle through which individuals receive ObamaCare's new health insurance subsidies, they will be expected to quickly and accurately determine an individual's eligibility. That will require the exchanges to rapidly verify such variables as family size, location, smoking status, and income.

Income verification will be the biggest challenge of all, as eligibility is based on family income—a major problem for dual income homes. Will states ask employed women to provide their husband's tax returns? What if she's separated but not divorced?

Meanwhile, there's evidence that the sort of government-managed competition fostered by exchanges does little to prevent adverse selection. Indeed, because insurers will be limited in terms of how they can charge based on health risk factors, the new rules may encourage plan providers to avoid investing in resources that help the sick.

For example, a 1997 *New England Journal of Medicine* study looked at billing records for elderly Americans participating in Medicare HMOs in Florida. The study found that, despite exchange-like regulations guaranteeing access to any HMO plan and prohibiting insurer cherry picking (or "medlining," as it's sometimes called), insurance companies managed to lure in the healthiest—and cheapest—patients, while leaving the sickest, most expensive patients on publicly funded Medicare.

Individuals enrolled in the HMOs used two-thirds less care than those on traditional Medicare. And those who eventually rejoined the publicly funded Medicare rolls went on to use 180 percent once back on the public program. In other words, despite rules that were designed to ensure equality, private insurers had still managed to attract the healthiest, cheapest patients while pushing the sickest, most expensive patients away.

But how do they do this? As John Goodman, president of the National Center for Policy Analysis, explained in his book *Lives at Risk*, plan providers in managed care environments offer benefits likely to attract healthy people, like sports club memberships, but avoid or dump services that will attract sick and expensive individuals.

In 1998, for example, the Kaiser Family Foundation released a study suggesting that Medicare HMOs tailored their advertising to "target physically and socially active seniors, rather than beneficiaries in poor health." That same year *The Washington Post* reported on one health plan in Minnesota that offered easy access to obstetricians, but quickly dropped the service after it lost millions by attracting too many pregnant women. Another health plan in California quit dealing with a university hospital that had developed a reputation for pursuing complex, expensive treatments.

Or look at the case of Shelby Rogers, as noted by the Cato Institute's director of health policy studies, Michael Cannon. In 2008, *The Washington Post* reported on the story of the 13-year-old with muscular atrophy whose private duty nurse was initially paid for by her family's federally-provided insurance. Eventually, though, the insurer tried to back out. Why? According to a representative, the reason was because coverage for private duty nurses made the plan too likely to attract patients with similar maladies as Shelby's.

ObamaCare's defenders will likely argue that such practices merely prove the need to get tough with insurers. The ominous warnings against insurers from Health and Human Services

Secretary Sebelius surely count. But in ObamaCare's exchanges, which force insurers to take all comers and charge equal prices regardless of health history, pressure to avoid the sick by any means will be fierce. Squeezed by federally-required regulations, insurers will certainly compete—but only to avoid the sick.

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