



WHAT DOES AN IDEAL SOLUTION TO THE HEALTH INSURANCE CRISIS LOOK LIKE?

Principles for policymakers when crafting a federal waiver application

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SUMMARY

When it comes to public policy, the best option is often found in figuring out how to harness the natural forces of free markets for societal gain. This holds true for the health insurance industry as well. The experiences of Switzerland and the Netherlands are evidence to that fact.

Risk Equalization is an innovative policy that answers the interrelated problems of cream skinning, adverse selection, and pre-existing conditions. It spreads risk across the entire population as insurance is supposed to work.

Competition drives prices down while enhancing quality as suppliers vie against each other to offer better and innovative products. The consumers are the winners.

Insurance companies earn reasonable but not unsightly profits. In economic lingo, they make accounting profits needed to stay in business but not economic profits.

Everyone purchases insurance on private markets, and legislation guarantees that they do not lose coverage by changing jobs. The Insurance Commissioner checks for actuarial soundness, and the companies are bound by truth-in-advertising laws.

The safety net is redesigned to subsidize the consumer, which will not distort market pricing, and to eliminate welfare cliffs and marriage penalties. The redesign helps those unable to purchase insurance on their own and is run through the Georgia Gateway.

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INTRODUCTION

The political stars may be aligned for Georgia to adopt meaningful health insurance reform.

The Trump Administration is encouraging states to come up with their own solutions to health care through federal waiver application processes that will give states flexibility under federal law. It may also provide states with revenue streams. Eager to make a positive impact for those caught in the health care crisis, the new governor and legislative leaders have expressed a keen interest in tackling this monumental task and the timing is perfect.

More than 13 percent of Georgians are without health coverage, and prices in the individual health insurance market have more than doubled since the enactment of the Affordable Care Act.¹

Luckily, the Affordable Care Act, a.k.a, ObamaCare, provides for a waiver process, that is, the Section 1332 waiver, that allows states to redesign health systems and capture some of the money set aside for the federal

government to pay for the system. Last Fall, the Trump Administration rewrote the federal guidelines to be far more favorable to the states and perhaps more in the spirit of the law than the Obama Administration's narrow and restrictive guidelines. Additionally, the Administration is encouraging states to seek changes to Medicaid, allowing for even more improvement of the health care system.

Given the enthusiasm over this opportunity, this briefing gives my take on what consumers really want when it comes to health insurance coverage, lists the obstacles that policymakers need to consider, and offers what I see as the best solutions to overcome those obstacles. The opinions expressed here are based on my research and readings over the last three years. **In my prior publications for the Georgia Center for Opportunity, I concluded that the best solution lies with a consumer-directed market system coupled with a reformed safety net program, and this commentary reflects that belief.**

1. *Reforming America's Healthcare System Through Choice and Competition*, U.S. Departments of Health and Human Services, Treasury, and Labor, Report to the U.S. President in response to Executive Order 13813, 2018, p. 4

WHAT DO PEOPLE REALLY WANT?

FREEDOM TO CHOOSE THEIR PROVIDERS AND CARE

Consumers don't want insurance companies or the government telling them which medical doctors to use or what health care facilities are allowed. They want the freedom to choose whomever they trust and whomever they believe will give them the best care.

People want the right to hire their own doctors and switch doctors when they believe they are not getting the care they need and deserve.

ABILITY TO SHOP FOR INSURANCE

Consumers don't like being restricted in how they shop for insurance. They don't like being forced to purchase insurance through a government-run exchange or told they can only enroll during certain times of the year.

Unless they have an employer that offers excellent coverage with little cost to them, they do not like being limited to health insurance plans offered by their employer.

Consumers don't like being forced to buy coverage they don't want or won't need.

Shopping for health insurance should be no different than shopping for auto insurance, homeowners' insurance, or life insurance. Being able to shop for insurance implies that consumers should be able to easily identify what coverage is being offered and its price so they can easily compare what other companies are offering and charging.

Consumers want to be able to switch plans or insurance companies whenever they feel they need to or whenever they find an offer they like better.

PORTABILITY OF PLANS

Consumers don't like to feel trapped in a job because of health care, knowing that if they quit their job, they can lose their coverage.

People prefer policies to follow them wherever they go and want to have the ability to keep a policy long after they leave a place of employment. They like making the decision when to terminate a policy.

THE RIGHT COVERAGE WHEN NEEDED

It is important for health insurance to cover health needs when they arise. Nothing can be more frustrating than discovering a health plan does not cover treatment for a recent diagnosis.





QUALITY CARE

When someone does need the services of a health professional, quality of care is extremely important, whether it is for a broken bone or cancer treatment or just needing stitches. Generally, people just want to be well, and the quicker they can get there, the better. Therefore, in order to maintain quality, it is important that health insurance is accepted by the best doctors and by the best treatment facilities.

As an inverse example, Medicaid is notorious for bad health outcomes. It underpays doctors, and many doctors refuse to take Medicaid patients. **Practically any other health coverage is better than Medicaid.**

INNOVATION

Consumers want to see the continuation of innovation and improvement that has been nothing short of remarkable in the health care industry, providing better treatments, extending life, enhancing the quality of life, and eradicating diseases that were once commonplace. Conversely, no one wants to see any public policy solution that would slow down, inhibit, or block innovation in the industry.

COVERAGE FOR ROUTINE SCREENING AND PREVENTATIVE CARE

As a general rule, people don't like to see doctors and visit hospitals unless they must. It is easy to put off annual check-ups and routine screenings. For example, who likes getting a colonoscopy? Therefore, consumers like having policies that encourage them to have check-ups and routine screenings. **Likewise, they like policies that incentivize healthy behaviors.**

AFFORDABILITY

The best health insurance and the most advanced health care system are worthless to consumers if they are unaffordable. Prices need to be affordable for individuals, employers, and don't forget the taxpayers who underwrite the cost of expensive health-related government programs.

CONTINUANCE OF COVERAGE

People want freedom from worrying about losing coverage after developing a serious illness or condition.

OBSTACLES AND SOLUTIONS

The health insurance industry faces numerous problems that prevent the market from functioning properly. The public policy approach should be to address those obstacles so the market can work its magic. Once we get a market system to work the way it is supposed to, with a well-defined and limited but important role for government, it will give us the best overall result for consumers and the state of Georgia. To paraphrase economist Walter Williams, those areas of American society where markets are allowed to function and people are the most motivated to pursue their self-interest, “are the areas that we’re the most satisfied with.”²

Below are descriptions of some of the more daunting obstacles along with my recommended solutions.

CREAM SKIMMING

The Problem — The price of insurance is based mostly on the projected cost of claims. If an insurance company could be selective in choosing its customers by disallowing those persons with higher costs, that is, the high-risk population, then it could undercut its competition with lower rates. However, this practice distorts the actuarial costs for other companies, causing their prices to increase. Consequently, the high-risk population ends up worse off because they are charged higher prices that could be unaffordable to them. The insurance industry is particularly susceptible to cream skimming because of the cost disparities between high-risk and low-risk clients.

The Solution — Adopting a Risk Equalization mechanism spreads the insurable risk across the entire population, which is the way insurance is supposed to work. This happens on the backside of the industry, so consumers do not even know that it is happening. Consumers benefit because it keeps their shopping experience simple. They do not need to know everything that goes on behind the scenes.

ADVERSE SELECTION

The Problem — Adverse selection is the opposite of cream skimming. Its ugly head surfaced with the ObamaCare exchanges. Those with more health care needs—the high-risk population—tend to seek coverage more regularly than those with little health care needs. Subsequently, prices on the exchanges rose even higher to accommodate the higher costs. As prices spiral higher, low-risk individuals are more discouraged from obtaining insurance, making the situation worse.

The Solution — Risk Equalization also solves the problem of adverse selection for the very same reason described above.



According to a poll, **91%** believe Americans should have more choices for their health care.

For more information see addendum on page 9

PREEXISTING CONDITIONS

The Problem — Health insurance differs from other major forms of insurance because it covers more than major losses and catastrophic events. The reason? The cost of current usage—including pre-existing conditions—must be incorporated into the price structure. In response, insurance companies revise their pricing strategies by imposing and adjusting any combination of higher premium costs, higher deductibles, higher co-insurance payments, and higher copays.

Because persons with pre-existing conditions have predictable costs, those costs can be incorporated into the premium structure. However, the marginal cost of adding a high-risk client to an insurance portfolio can lead to a marginal loss for the company because it is difficult to charge enough of a premium to cover that additional cost. From the point of view of the individual, those higher premium costs for pre-existing conditions can be prohibitively expensive.

The Solution — Risk Equalization also solves the problem of pre-existing conditions. These three obstacles—cream skimming, adverse selection, and preexisting conditions—are interrelated. If Risk Equalization is designed properly, it will encourage insurance companies to seek persons with pre-existing conditions because they will be compensated for having a higher risk portfolio—not through higher premiums by the high-risk clients but by payments from the Risk Equalization Fund that works to spread costs across the entire population. Furthermore, a likely consequence would be insurance companies who specialize in certain pre-existing conditions, providing specialized services.

DIFFERENT COVERAGE FOR MEMBERS OF THE SAME FAMILY

The Problem — It is not uncommon for Georgian families to have different coverage for members of the same family, especially if the family is low income. For example, one child could be on Medicaid, a second child could be on PeachCare, and the mom could have coverage through her employer or none at all. Add a dad to the family, and the family can have a fourth form of coverage.

In fact, for Georgians under the age of 18 living in a family at 138% of the poverty level or less, 60% have different coverage from their mother, and 70% have different coverage from their father.³

The reason is simple. The system is fragmented. People obtain insurance coverage through employment, individual markets, government programs, such as Medicaid, PeachCare, Medicare, TriCare, VA services, and government-run exchanges. And the rules for eligibility are all different.

The fragmentation complicates the situation for a family. **Low-income families typically get stuck navigating multiple plans instead of a single plan for the family.**

The Solution — Individuals and families get to shop for insurance on the private market. They get to decide what policies best suit their needs. The market responds because insurance firms—even if they are “nonprofit”—want to maximize their profits. In a true competitive market, competition drives prices down and that minimizes economic profit, benefiting the consumer with lower prices and better quality.

Low-income individuals and families who cannot afford to purchase insurance on the private market receive subsidies from the government to help them purchase such insurance. Eligibility is means-tested by an eligibility engine designed to eliminate welfare cliffs and marriage penalties. The program is run by the Georgia Gateway with all the benefits of program integrity to ensure that only those in need receive the benefits.

All government health care programs are (eventually) integrated into this single program. This integration eliminates market distortions from those programs, helping ensure that the health insurance industry is functioning efficiently.

3 Data estimates calculated by the author using microdata of the American Community Survey of the U.S. Census Bureau for 2017, made available by the University of Minnesota Population Center: Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas, and Matthew Sobek. IPUMS USA: Version 8.0 [dataset]. Minneapolis, MN: IPUMS, 2018. <https://doi.org/10.18128/D010/V8.0>



90%

According to a poll, believe patients should choose how health care is provided.

For more information see addendum on page 9

THIRD-PARTY PAYORS

The Problem — Third party payor systems separate consumers from providers. Often consumers do not know the true cost of services they receive because they are only responsible for paying a copay irrespective of the price. This practice undermines market forces that bring discipline to an industry.

Third party payor systems mean that insurance companies market policies to employers and not employees, the ultimate consumer. Not all employees of a business firm have the same needs. Therefore, there can be and often is a disparity between the needs of an employer and that of its employees.

The Solution — Requiring convertibility of all policies to individuals if they leave their employers will address the third-party payor problem and help stabilize the system. Additionally, Risk Equalization will change the market dynamics to help with an easy conversion to a system where insurance companies are not penalized to offer policies directly to consumers. Ultimately, employers will change how they offer health benefits to their employees. Instead of having employees contribute to their plans, employers will be contributing to the plans of their employees.

OPAQUE PRICING

The Problem — Health prices are not real. People often pay different prices for the same service at the same facility. Across facilities, they can pay vastly different prices.

There are two reasons for this. First, insurance companies negotiate prices directly with providers. Government programs, like Medicare, has its own list of prices it will pay. Consequently, providers end up receiving different payments from different payors for the same service.

Second, because of all the backdoor negotiating and the lack of transparent pricing, there is no market discipline to bring prices to equilibria, which is how markets normally work. Consider the example of shopping for gasoline. You can drive past gas stations where they prominently advertise their prices. You often have multiple choices on where to fill up your car. This transparency of pricing brings competition, which works as a force to push prices down.

The Solution — Government plays its proper role of referee, making sure that prices are advertised truthfully and readily available, and that competition exists. However, government does not get mixed up in the actual supply of the service or competing with insurance companies directly. It lets the private insurance market determine the true actuarial prices that underlay the prices being offered to consumers. Competition drives down prices that in turn minimizes economic profits, making for a more efficient market.

LARGE PUBLIC PROGRAMS DISTORTING PRICES

The Problem — Medicaid and to a lesser extent Medicare notoriously underpay for services, which, because of the size of those programs, distorts prices for everyone else, exacerbating the problem of opaqueness.

Moving off government programs can be clumsy. For example, fluctuations in income can mean being on Medicaid, and then off, and perhaps on again. Additionally, employers can be tempted to push their low-paid employees onto government programs, like Medicaid. The losers are both the employee being pushed off onto Medicaid and the taxpayer.

The Solution — All government programs are integrated into a single means-tested program that provides subsidies to consumers to help them afford insurance on the private insurance market. This eliminates market distortions by these large government programs, allowing for the market to provide true prices while minimizing profit. It also eliminates the possibility of the transition problem—when someone moves off a government program—because all persons are in the private market. Finally, the incentive for employers to push employees onto government programs is eliminated because there are no government programs. The subsidies are provided directly to the individuals based on means testing.

LIMITED PROVIDER NETWORKS

The Problem — One strategy insurance companies use to control costs is to limit coverage to providers in a network or require higher out-of-pocket costs if a customer receives services outside the network.

Provider networks are a consequence of the third-party payor system and the opaque pricing mechanisms. It limits the choices of consumers and does not solve the fundamental challenges of the health care system.

The Solution — By getting the market to function properly, insurance companies will innovate with plans to attract consumers. These plans may still include provider networks, but they will be for reasons to attract consumers. Ultimately, consumers will be the winners. In the long run, provider networks may disappear, but no one can predict with certainty what innovations will arise out of markets once they are allowed to function properly.

NON-PORTABILITY OF POLICIES

The Problem — Consumers can get trapped in a job, knowing that if they quit they can lose their health insurance.

The Solution — Federal law allows employees who lose a job and who had coverage to get the same coverage at the full cost for up to 18 months. This is a partial solution but not the whole solution.

Georgia law should require permanent convertibility so that the health policy can follow the individual wherever they choose to go without limitation.

Risk Equalization also plays a role in the solution. By equalizing risk among all insurance policies, the convertibility will become a non-issue.



GOVERNMENT-RUN EXCHANGES

The Problem — Although insurance companies offer plans through the ObamaCare exchanges, these exchanges are not the same thing as a true market. The products and manner by which they can be offered are prescribed by federal law and regulations.

Furthermore, the exchanges divert people to government run programs, like Medicaid and PeachCare. Also, the exchanges impose a nationwide enrollment period. Regulations prevent individuals from signing up outside the enrollment period unless they can prove to the government they had a “qualifying event.” Contrast that to shopping for an auto insurance policy where you can enroll any time of the year, or shopping for practically any other good or service.

The Solution — The exchanges are eliminated. Consumers are free to shop as they will, and suppliers are free to market their products as they please, providing they adhere to truth-in-advertising standards and their policies are checked for actuarial soundness, as they currently are.

LACK OF ANY COVERAGE FOR MANY

The Problem — 13.3 % of Georgians lack any health insurance. The reason is chiefly affordability.

The Solution — Consumer-directed market solutions coupled with a safety net achieve universal coverage. As I noted in my other writings, the systems in Switzerland and the Netherlands that have consumer-directed market health care have achieved universal coverage. As long as Georgia gets its markets to function properly along with a single subsidy program checked for welfare cliffs and marriage penalties run through the Gateway, Georgia, too, will achieve universal coverage.

ADDENDUM

The section on “What do people really want?” is a compilation based on a confluence of factors from research, opinion polls, personal experience, and sentiments of the author’s associates, friends, and family. For example, consider a recent survey conducted by the Heritage Foundation⁴ that found overwhelming support for the following statements:

- “A healthy America is a strong America. Our health care system should be the best in the world. It should offer more personal choice, more access to doctors, lower costs, higher-quality care, protections for people with pre-existing conditions, and open avenues for innovation.” (97 percent of those polled agreed.)
- “Health care policy should empower people—not government bureaucrats or insurance companies—to make the best decisions for their families.” (94 percent of those polled agreed.)
- “Americans should have more choices for their health care.” (91 percent of those polled agreed.)
- “Patients—not bureaucrats—should choose how health care is provided.” (90 percent of those polled agreed.)
- “Health care plans should remove health care decision-making from Washington, D.C., bureaucrats and insurance company executives and give it to the states, small businesses, nonprofits, and families.” (84 percent of those polled agreed.)

Consider, too, the words of the late Warner V. Slack, M.D., of the Harvard Medical School:

Once consumer-driven health care is in place, physicians will welcome their liberation from the

parsimonious personnel working for third- and fourth-party payers. And they will be free of much of the offensive, ill-advised, financially driven intrusion of bureaucracy into their relationship with their patients. Employers should also welcome consumer-driven health care, which will free them from the administrative and litigious responsibilities associated with reimbursement. Third-party payers may object at first because consumer-driven health care will entail fundamental corporate changes. Yet they too will be relieved of many administrative and litigious responsibilities that now accompany reimbursement for routine care. But most important, the patient and prospective patient will be the principal beneficiaries.⁵

As a final example, consider research conducted by the Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine for the National Academies. It lists five principles to guide the extension of health insurance coverage to more Americans as follows:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.⁶

4 Elizabeth Fender and Marie Fishpaw, “Public Opinion on Health Care Policy,” The Heritage Foundation, April 23, 2019: <https://www.heritage.org/health-care-reform/report/public-opinion-health-care-policy>.
5 Warner V. Slack, “The Patient’s Right to Decide,” Chapter 28, in Regina E. Herzlinger, editor, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*, San Francisco: Jossey-Bass: A Wiley Imprint, 2004, p. 379.

6 Institute of Medicine, *Insuring America’s Health: Principles and Recommendations*. Washington, DC: The National Academies Press, 2004, pp. 8-10: <https://doi.org/10.17226/10874>.



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