HealthAffairs Blog

Why Prices Matter Pt. 2

By: John Goodman **June 19, 2012**

In a previous post**,** I argued that the single biggest mistake in health policy is the belief that the best way to make health care accessible is to make it free at the point of delivery. In this post I will argue that the second biggest mistake is the belief that the best way to help people with chronic illness is to prohibit health insurance premiums from reflecting expected health care costs.

In my new book, Priceless: Curing the Healthcare Crisis, I show that in both cases we have completely suppressed the price system. So much so, that in this sector no one ever faces a real price for anything. In the market for medical care, no patient ever pays a real price for care. In the market for health insurance, no employee ever pays a real premium.

Yet in both cases, we end up harming the very people we are trying to help. Also, in both cases we have ignored the fact that there are other, more direct ways of helping the people we want to help, while leaving the price system intact.

How the Market for Health Insurance Is Different

Dennis Haysbert is the actor I remember best for playing the president of the United States in one of the Jack Bauer "24″ series. You probably know him better as a spokesman for Allstate. In one commercial he is standing in front of a town that looks like it has been devastated by a tornado. He begins by saying, "It only took two minutes for this town to be destroyed," and he ends by saying "Are you in good hands?" Allstate also has a "mayhem" series, featuring all kinds of things that can go wrong.

Allstate isn't alone. Nationwide has a clever commercial in which catastrophe is caused by a Dennis-the-Menace-type kid. In a State Farm ad, a baseball comes through a living room window. Nationwide's "life comes at you fast" series features all kinds of misadventures. And of course, the Aflac commercials are all about unexpected misery.

A print advertisement I like is sponsored by Chubb. It shows a man fishing in a small boat, with his back turned to a serious hazard. He is about to go over a waterfall that looks like Niagara Falls. Here's the caption: "Who insures you doesn't matter. Until it does."

By contrast, have you ever seen a commercial for health insurance that focused on why you actually need health insurance? That is, have you ever seen a health insurance commercial that

told you that you need a really good insurer in case you get cancer, heart disease, AIDS, etc.? My bet is that you haven't.

One place where a lot of people do see health insurance television and print ads, though, is Washington, D.C., in the late fall. This is the period of "open season" when federal employees have the opportunity to choose a new health plan. Once a year, members of the Federal Employee Health Benefits Program (FEHBP) can choose among a dozen or more competing health plans. At this time, participating insurers compete to lure new customers.

Unlike the casualty insurer commercials, however, the health insurance ads for federal employees are never focused on what can go wrong. They are all focused on what can go right. Instead of picturing victims of cancer or heart disease, for example, they show photos of young families with healthy children. The implicit message: if you look like the family in this photo, we want you.

The contrast could not be starker. Casualty insurers are trying to sell you insurance based on your need for their product. Their implicit message is: we know you don't think about insurance until something goes wrong, and that's when you are going to need us. Health insurers, on the other hand, never even talk about why you might actually need their product — unless by "need" you mean services that healthy people want (wellness checkups, preventive care, exercise facilities, etc.).

So what's going on?

The short answer is: the casualty insurance market is a real market in which real insurance is bought and sold. The health insurance market is an artificial market in which the product being exchanged is not real insurance at all. In fact, in many ways, it is prepayment for the consumption of health care.

Managed Competition

In the casualty market, each buyer pays a premium that reflects the expected cost (and risk) that the buyer brings to the insurance pool he is entering. Insurers compete to sell the *insurance features* of their product, because that is what buyers are buying. Federal employees, by contrast, never pay a premium that reflects their expected cost. What they are buying is the opportunity to consume care. As a result, health insurers compete to sell the *consumption features* of their product and they are only interested in selling to people who don't plan to consume very much.

Why is the Federal Employee Health Benefits Program so important? Because it is the "managed competition" model for how insurance will be bought and sold in health insurance exchanges under the Affordable Care Act (ObamaCare).

Under the model, insurers offer a product and charge a set premium that cannot vary by the buyer's health status. In the federal system, every buyer is charged the same premium. In the

Obama state-based exchanges, premiums will vary somewhat by age — but not enough to reflect the full expected cost differences that aging generates. Also, there will be some "risk adjustment," under which funds will be redistributed from plans that have healthier populations to plans that have sicker populations. But such risk adjustment is highly imperfect.

Bottom line: As in the federal employees' program, everyone who buys insurance will face the wrong price from the point of view of pricing risk and expected costs accurately. This will create perverse incentives on both sides of the market. On the buyer side, those who are undercharged will have an incentive to buy more generous insurance than they otherwise would, while those who are overcharged will buy less generous insurance. Put differently, the undercharged will over-insure and the overcharged will under-insure. These perverse incentives will have the unfortunate side effect of making everyone's premium higher than it would have been.

Bad as this is, it pales in comparison to the effects of perverse incentives on the seller side. You don't even have to be in the business to know intuitively that if everyone is charged essentially the same price, insurers will make profit on the healthy and incur losses on the sick.

So the first reaction of the insurers will be to try to attract the healthy and avoid the sick. But, the perverse incentives will not end after enrollment. Health plans will have strong incentives to overprovide to the healthy (to keep the ones they have and attract more) and underprovide to the sick (to discourage the arrival of new ones and the departure of the ones they already have).

The easiest way to overprovide to the healthy is to offer services that healthy people consume: preventive care, wellness programs, free checkups, etc. The way to underprovide to the sick is to strictly follow evidenced-based protocols and be slow to approve expensive new drugs and other therapies.

Beyond that, a health plan can underprovide to the sick and discourage their enrollment by not having the best cardiologists, the best oncologists, etc.

What has been the experience of the federal employees program? There has been some evidence of backing away from expensive procedures, with the government's approval. But perverse incentives are held in check somewhat by the Office of Personnel Management (OPM), which operates like a large human relations department. Similarly, where managed competition has been implemented for state employees, for university employees and for employees of large corporations, the employer usually acts to try to prevent the worst abuses.

Managed Competition under the New Health Reform

What would happen, though, if the OPM went away and the FEHBP were opened up to everyone in Washington, D.C., in addition to the federal employees? What I would expect is a big mess — with insurers having perverse incentives to undertreat the sick and no one there to stop them from acting on those incentives.

Of course, there are countervailing forces: professional ethics, malpractice law, regulatory agencies. But each of these is highly imperfect. Would you want to eat at a restaurant that you know in advance does not want your business? You should think the same way about health plans.

With the advent of the Affordable Care Act, these perverse incentives will be set in place nationwide. Tens of thousands of employees will leave their employer plans and enter no man's land, where the healthy will be desirable and the sick will be vulnerable. Those with serious health problems will find they no longer have an employer who acts as protector and defender. Their problems will be made worse by the inexorable federal pressure on the health plans to keep premiums from rising, so as to contain the expense of the taxpayer-funded premium subsidies.

A Better Approach

After hail damages the roof of your house, your homeowner's insurance is supposed to pay for the repairs. But there is no requirement that you continue paying premiums while your roof is being repaired. And if you switch to a new insurer, the new insurer doesn't pay for damages incurred while the previous insurance was in force. These same principles apply to auto collision insurance and every other form of casualty insurance.

Yet health insurance is different. If you get sick, your insurer won't keep paying medical bills unless you keep paying premiums. If you are unable to switch plans (because your new pre-existing condition causes you to be rejected or face exorbitant premiums), you are stuck in a continuing relationship with your existing insurer — regardless of the quality of service or the premiums charged. If you are able to switch plans, the new insurer has to start paying your medical bills, even though the illness (and all the premiums paid up to that point) occurred while you were on some other plan. This is why the new insurer doesn't really want you and has no incentive to treat you well after you arrive.

To make matters worse, healthy people always have an incentive to leave a plan after some of its members get sick. The reason: the new plan formed by healthy people can charge much lower premiums. Meanwhile, premiums in the original plan (which now has only sick people) must rise to ever higher levels to keep paying the medical bills.

In a very real sense, health insurance isn't insurance at all. It's the artificial product of unwise tax and regulatory policies. A better approach has been proposed by University of Chicago Professor John Cochrane.

Cochrane proposes two premiums for two different kinds of insurance. The first premium is for, say, a year's worth of health insurance for a healthy person. The second premium covers the risk of changes in health status that potentially increase premiums in future years. Suppose that during year one you are diagnosed with a costly-to-treat medical condition. If you shop for a new health plan in year two, your premium will be higher than the rate healthy people pay, as a result.

But your health status insurance (which you purchased in year one) will pay the extra premium cost.

Cochrane's idea would in one simple step convert a completely dysfunctional market into a real market that solves real problems — for everyone.

Insurance for Pre-Existing Conditions. Instead of trying to force insurers to ignore them, the Cochrane approach allows everyone to insure against them. In the Cochrane world, you don't have to worry about the financial consequences of developing a pre-existing condition. Your health status insurance will pay those costs.

Premiums for Pre-Existing Conditions. In Cochrane's world, premiums for pre-existing conditions would be determined in the marketplace. This means that the cost of a year's worth of insurance for diabetics, asthmatics, cancer patients, heart patients, etc., would be transparent and competitively priced. By contrast, regulation in many insurance markets today tries to force insurers to ignore both the conditions and the cost of insuring them.

A Market for the Care of Pre-Existing Conditions. Once there is transparency and competition in the market for insuring for pre-existing conditions, a natural extension is a competitive market for efficient, high-quality care for those conditions. Providers who find ways to lower the cost of care will allow insurers to be able to lower the cost of insuring that care.

The Cost of this Proposal. Some might suppose that adding health status insurance to routine health insurance would be very expensive. But since the only purpose of insurance is to pay medical bills and since the medical bills would be basically the same as under the current system, there would likely be little, if any, increase in total insurance premiums. In fact, to the degree that this proposal leads to more efficient chronic care, total premium payments may actually decrease.

Choice of Health Plans. Although, in general, I think long-term relationships with health plans are better than short-term ones, there is no reason in principle why people could not choose a different health plan whenever they desire — and there is no reason to restrict such choices to an annual open season. The reason: Individuals (through premium payments made by them or on their behalf) would always pay an amount equal to the full expected cost they bring to any health plan they enter. No insurer would ever be forced to take an enrollee it did not want and no insured would ever be stuck in a plan he/she did not want to be in.

The Casualty Insurance Model. Cochrane's proposal is a clever way of introducing the casualty insurance model into the world of health insurance. My own proposal for ideal health insurance argues for incorporating other features of the casualty model as well. The proposal is also consistent with incentive-compatible health insurance, proposed by Brad Herring and Mark Pauly.