Psychology Today

The Market for Healthcare Risk

By: John C. Goodman **August 6, 2012**

In 1980, Census Bureau statistics showed that less than 1 percent of the population had been denied health insurance because of a health condition. Moreover, this was a period of time when there were few legislative remedies. Even so, this 1 percent was a politically vocal group and, in many cases, they evoked understandable sympathy. However, rather than deal with this group directly (for instance, by creating risk pools or offering direct subsidies), politicians through the years have imposed unwise restrictions on the other 99 percent of the people.

Destroying the Market for Risk

As is discussed in my new book *Priceless: Curing the Healthcare Crisis*, a proliferation of state laws has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring insurers to take all applicants, regardless of health status) and community rating regulations (requiring insurers to charge the same premium to all enrollees, regardless of health status) are a free rider's heaven.

They encourage everyone to remain uninsured while healthy, confident they will always be able to obtain insurance once they get sick. Moreover, as healthy people respond to these incentives by electing to be uninsured, the premium that must be charged to cover costs for those who remain in insurance pools rises. These higher premiums, in turn, encourage even more healthy people to drop their coverage.

Federal legislation has also made it increasingly easy to obtain insurance after one gets sick. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 had a noble intent: to guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. However, a side effect of pursuing this desirable goal is a provision that allows any small business to obtain insurance regardless of the health status of its employees. This means that a small mom-and-pop operation can save money by remaining uninsured until a family member gets sick.

Individuals also can opt out of an employer's plan and re-enroll after they get sick. They are entitled to full coverage for a pre-existing condition after an 18-month waiting period. A group health plan can apply pre-existing condition exclusions for no more than 12 months, except in the case of late enrollees, to whom exclusions can apply for 18 months.

Under ACA ("ObamaCare"), the perverse incentives to remain uninsured until you get sick will intensify. Basically, anyone who is uninsured will be able to obtain insurance for the same premium as a healthy individual, regardless of how long or why the person is uninsured. As in Massachusetts today, there will be fines for being uninsured, but the tax penalty will be small compared to the cost of insurance. And it may be weakly enforced, even at that.

Consequences of Unwise Regulation

By far, the worst consequence of government regulation of the market for risk is the unintended harm done to the very people the laws were intended to help. Precisely because the premium attached to high-risk individuals is much lower than their expected healthcare costs, insurers seek to avoid enrolling them in the first place. Precisely because payments to providers also do not reflect expected costs, they, too, have an incentive to avoid attracting the hard cases, especially among the chronically ill.

If healthcare markets worked the way normal markets do, health insurers and providers would vigorously compete for the business of the sick. In normal markets, entrepreneurs make profits by figuring out how to better solve other people's problems. In healthcare, by contrast, entrepreneurs run from other people's problems.