

March 31, 2014

Dear Readers,

Attached please find a very preliminary and incomplete draft Essay on some thoughts I have been pondering related to the potential evolution of health care reform. I apologize that I have not been able to fully express many of these thoughts in this draft. I am uncertain whether this is a project worth developing further, and I will look forward to hearing your thoughts and reactions.

Thank you for your consideration,

David Gamage

## **The Evolution of Health Care Reform: Should Risk Adjustment Become the Heart of Obamacare?**

By David Gamage<sup>1</sup>

What is the heart of Obamacare? At a basic level, most everyone knows that “Obamacare” is the colloquial term commonly used to describe the Affordable Care Act and its accompanying legislative and administrative reforms to the American health care system. Yet it is hard to pin down the essence of Obamacare. Even the best of the favorably inclined explanations of Obamacare tend to sound more like long lists of loosely connected provisions than a cohesive vision.<sup>2</sup>

Of course, the opponents of Obamacare do not struggle to describe its essence: as a big government or socialist, freedom-destroying, at best misguided or at worst malicious, attempt at micromanaging the American healthcare system. Critics of Obamacare thus regularly quote Nancy Pelosi’s remark that “we have to pass the [health care] bill so that you can find out what’s in it...”<sup>3</sup> To its conservative critics, then, Obamacare has no heart. Rather, Obamacare is conceived of as a mass of tentacles reaching across American society to impose costs and to restrict liberty.

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<sup>2</sup> E.g., <http://kff.org/health-reform/video/health-reform-hits-main-street/>. See also Allison Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PENN. L. REV. 101 (2011).

<sup>3</sup> See [http://www.washingtonpost.com/blogs/post-partisan/post/pelosi-defends-her-infamous-health-care-remark/2012/06/20/gJQAqch6qV\\_blog.html](http://www.washingtonpost.com/blogs/post-partisan/post/pelosi-defends-her-infamous-health-care-remark/2012/06/20/gJQAqch6qV_blog.html)

This critical vision of Obamacare gained prominence through the individual mandate becoming the focus of the Supreme Court litigation challenging Obamacare (which culminated in the 2012 decision of *NFIB v. Sebelius*). The individual mandate was always one of the least popular aspects of Obamacare's reforms. That the Supreme Court litigation focused on the individual mandate thus helped to make Obamacare's costs and restrictions to liberty more salient. At the same time, that many of the major benefits to be provided by Obamacare did not roll out until the beginning of 2014, and that the rollout of these benefits has since been plagued by serious implementation problems, has led to these benefits becoming less salient to the voting public.

If its opponents view the heart of Obamacare as a manifestation of "government overreach and arrogance",<sup>4</sup> how then do the supporters of Obamacare conceive of its reforms? Typically, Obamacare's supporters focus on perceived problems with the American healthcare system prior to Obamacare. Though this lens, Obamacare's provisions are thought of as solutions to troubling problems.<sup>5</sup> Yet this conception does not justify Obamacare's particular provisions: why *these* reforms? Even granting that solutions to problems were needed, why *these particular* solutions?

What is probably the most coherent justification for Obamacare's specific regulatory provisions is based on a vision of shared social responsibility amongst employers, the government, and individuals. Under this vision, employers are thought to have the social responsibility to offer affordable health insurance to their employees; the government is then

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<sup>4</sup> *Id.*

<sup>5</sup> I will admit that I have justified my support for Obamacare along these lines.

thought to have the social responsibility of offering affordable health insurance to those who lack good employer-based options; with individuals then having the social responsibility of actually obtaining health insurance and of paying reasonable individual contribution amounts. This vision is often articulated based on a notion of private and public actors voluntarily coming together to fulfill their social responsibilities, with Obamacare's framework designed to prescribe and facilitate each actor's role. Thus, many of Obamacare's regulatory provisions are often understood under this vision as a series of carrots and sticks designed to deter the shirking of social responsibilities.

However, to the extent that this vision of shared social responsibilities was intended to be the heart of Obamacare, the message has not been clearly communicated to the American public. The messaging and rollout of Obamacare stands in stark contrast to the Massachusetts experience with health care reform—an experience which Obamacare was designed to imitate. In Massachusetts, health care reform was passed as a joint project of a Republican Governor (Mitt Romney) and Democrats in the state legislature. In light of the political consensus surrounding the enactment of health care reform in Massachusetts, it was perhaps reasonable to expect that social norms might develop to support a vision of shared social responsibilities. Yet political consensus hardly describes the circumstances surrounding either the enactment of Obamacare or its implantation. Quite the contrary, most Republicans remain adamantly opposed to Obamacare and have attempted to fight against the successful implementation of the carrots and sticks offered to ensure compliance with Obamacare's shared social responsibility requirements. Republicans and conservatives are thus unlikely to voluntarily

comply with what Obamacare deems to be their social responsibilities or to aid in the development of social norms in support of compliance.

The health care times, “they are a-changin’,”<sup>6</sup> and rapidly so. Little can be said with confidence about what the political environment surrounding Obamacare will look like in a year, let alone several years. Yet there is reason to be skeptical of whether a vision of shared social responsibilities can successfully operate as the heart of Obamacare, at least in many states. For this vision to operate as intended, social norms must develop such that most individuals and employers will fulfill their assigned roles primarily based on compliance with these social norms—rather than primarily acting either in order to pursue Obamacare’s monetary carrots or to avoid its monetary sticks.

This Essay is based on skepticism as to whether social norms are likely to develop—at least in “red” states—to support the shared social responsibilities vision of Obamacare. Yet in the absence of the development of strong social norms, the outlook for Obamacare is troubling. At best, Obamacare’s various monetary carrots and sticks might then effectuate a costly balancing act—in which Obamacare’s regulatory framework sort of functions, but only in a heavy-handed, coercive fashion that imposes considerable, wasteful costs. Even more problematically, Obamacare’s regulatory framework might collapse under the weight of its loosely coordinated regulatory provisions. Even at great cost, then, the balancing act might prove impossible to maintain.

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<sup>6</sup> Bob Dylan

There may be a better way forward. This Essay ponders whether we might seek an alternative vision of the heart of Obamacare: a vision based on risk adjustment. Obamacare's regulatory framework contains several provisions designed to adjust for divergent health risk profiles in those seeking insurance from different sources. Although increased attention has recently been paid to some of Obamacare's risk-adjustment-related provisions, these provisions nevertheless remain surprisingly understudied. Yet it now appears that whether and to what extent Obamacare is seen as a success or a failure may largely depend on the operation of these risk-adjustment-related provisions.

Beyond evaluating the ad-hoc risk-adjustment-related provisions already becoming key to Obamacare's regulatory framework, this Essay considers whether a broader vision based on risk-adjustment might guide the future evolution of American health care reform. In other words, this Essay ponders where we should go from here. How should Obamacare evolve?

The answers to these questions will largely be determined by political constraints. At this point, it seems unlikely in light of political constraints that the U.S. will adopt anything resembling either a complete single-payer system or free-market system. Even if Obamacare is "repealed and replaced"—as Republicans are advocating—political constraints suggest that we are likely to retain a hybrid system with highly regulated markets for health insurance playing some substantial roles. But what precisely should be the roles that these regulated markets play?

The risk-adjustment vision explored in this Essay is based on the thought that markets should facilitate choice and competition in health insurance plans, but only with regard to

factors other than health risks. Prior to the passage of Obamacare, most commentators agreed that the individual market for health insurance was a disaster. The reasons were, first, that healthier individuals had incentives to forgo purchasing insurance or to purchase limited insurance, thus creating the adverse selection problem. And, second, that insurance companies had incentives to compete by attracting a healthier pool of insureds and by deterring or denying coverage to less healthy insureds. Choice and competition thus largely operated on health risk factor dimensions, rather than on the quality and cost of care.

In contrast, with a complete system of risk adjustment, insurance providers would be compensated to the extent that their insured populations ended up being more costly than average in terms of health status. Conversely, insurance providers would be required to pay into the risk adjustment system to the extent that their insured populations ended up being less costly than average in terms of health status. With a perfectly functioning risk adjustment system, then, insurance providers would face no incentives to compete in terms of health risk factors and neither would individuals face incentives to choose amongst insurance offerings (or whether to purchase any insurance) based on the individual's health risk factors. Instead, both competition and choice would be based on the quality and cost of covered care.

Of course, no real-world system of risk adjustment should be expected to operate perfectly. Undoubtedly, under any feasible system, some health risks would be mispriced, leading to some incentives for gaming by insurance providers and by individuals. Moreover, implementing a risk-adjustment system potentially involves significant administrative and compliance costs. Nevertheless, risk-adjustment might prove a better model for guiding

Obamacare's evolution than the shared social responsibility vision. Whether this might be so, is the primary question to be explored by this Essay.

This Essay proceeds in three Parts. Part I analyzes some of the political constraints restricting the options for how Obamacare and, more generally, the American system for health care finance might evolve over the coming years. Part II then analyses reasons for skepticism about whether the shared social responsibilities vision can operate successfully as the heart of Obamacare, and suggests that following this vision is likely to lead to Obamacare either operating as a costly balancing act or else collapsing under the weight of its poorly integrated regulatory provisions. Finally, Part III considers whether a vision based on risk adjustment might be a superior model for guiding the evolution of Obamacare and the American system of health care finance going forward.

## **I. The Political Constraints on the Evolution of American Health Care Finance**

The advocates of health care reform are often motivated either by an ideal of a free-market system or a single-payer system. Yet nothing resembling either of these ideals is likely to be implemented in the U.S. in the foreseeable future. Instead, the U.S. will almost certainly retain some form of a hybrid system with significant roles played by highly regulated markets for health insurance.

Looking first to the free-market ideal, it is widely agreed that for most goods and services that markets are superior to direct government provision. Markets facilitate choice

and competition and thereby effectuate a dynamic matching between consumer's preferences and systems of production for efficiently meeting those preferences. Yet health care differs from most other goods and services, especially due to the politics of health care provision.

Health care expenses can be exceedingly large as compared to individual's annual budgets, and many individuals thus rationally seek to insure against future health care expenses. This in and of itself might not be a problem. Free markets for insurance (or at least relatively lightly regulated markets) can offer the traditional advantages of market provision so long as insurance providers can underwrite their offerings so as to price based on insureds' risk factors and so long as providers can turn away individuals who do not purchase insurance in advance and who cannot afford to pay without insurance. But for health care, the majority view amongst the voting public appears to be that individuals should not be denied care because they cannot afford to pay. This majority view especially seems motivated by concerns about individuals who develop expensive health conditions prior to purchasing insurance or to having the opportunity to purchase insurance—the pre-existing condition problem. The bans on insurance providers denying coverage or charging higher premiums to those with pre-existing conditions are thus amongst the most popular of Obamacare's provisions, enjoying overwhelming majority support. But if insurance providers are not permitted to deny coverage or to charge more to those with pre-existing conditions, then what is the incentive for individuals to purchase health insurance prior to developing expensive health conditions? There is thus a fundamental tension between providing health insurance through markets and the popular notion that individuals with pre-existing conditions should not be denied care.

Moreover, even to the extent that the public would be willing to abandon restrictions on insurance providers denying coverage or charging more to those with pre-existing conditions, allowing competition and choice based on health risk factors can undermine the advantages of market provision. There is evidence that—in the absence of substantial regulation—markets for individual health insurance result in insurance providers competing largely based on the goal of selecting healthier populations of insureds and in individuals making insurance choices largely based on information about their own health risk factors. These factors threaten the twin problems of adverse selection (which can result in market death spirals) and of health risk selection (which can dramatically increase administrative costs). Many analysts have thus concluded that market provision of individual health insurance is highly inefficient.<sup>7</sup>

What about the single-payer ideal? If market provision of health insurance is (arguably) inefficient, why not just have the government finance health care? Many analysts argue that market competition is needed in order for better forms of health care provision to evolve over time. Other analysts worry about centralizing too much power over health care in the government's hands, thereby denying individual choice. Regardless of the reason, if there was not sufficient political support for the adoption of a single-payer system during the initial years of the Obama administration when Democrats controlled a supermajority of both legislative chambers and the Presidency, it seems unlikely that the political environment will become more favorable to the single-payer ideal in the foreseeable future.

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<sup>7</sup> Markets for employer-provided health insurance potentially solve these problems, but only because employers design the insurance options offered to employees so as to deter employees from selecting based on health risk factors and to deter (or outright ban) the insurance providers from selecting based on employee's health risk factors.

*[Add discussion of the role of ESI and the tax exclusion in leading to most Americans not understanding the true cost of their existing health insurance policies. Possibly also add discussion of interest group politics.]*

Thus, due to political constraints, it seems virtually certain that the American system of health-care finance will remain a hybrid system involving highly regulated markets, at least for the foreseeable future. There are numerous conservative reform proposals that would involve loosening the regulation of health insurance markets from the Obamacare framework, but few Republicans advocate returning to the system in place prior to Obamacare. The call is almost always for “repeal and replace”, rather than just for “repeal.” Notably, most conservative reform proposals would maintain significant restrictions on insurance providers’ ability to deny coverage to those with preexisting conditions or to charge higher premiums, even if the proposed reforms would loosen these restrictions as compared to Obamacare.

*[Add discussion of some of the major conservative reform proposals, to explain how they would retain restrictions on insurance providers’ ability to deny coverage or to charge more to those with pre-existing conditions or else would include alternative offerings for those effectively denied coverage—such as high-risk pools—thereby creating the same fundamental tensions, albeit possibly to a lesser degree.]*

To a large extent, then, Obamacare’s regulatory framework strips the traditional “insurance” function from what we label as “health insurance plans”, as would most conservative reform proposals, albeit often to a lesser extent. To understand this, we must recognize that health insurance plans in the American system had evolved to play two different

roles prior to the passage of Obamacare. The first of these roles corresponds with the traditional definition of “insurance” as offering individuals a financial product through which they can prepay based on expected future health risks so as to be protected in case their actual future health costs end up being larger than expected. In contrast, the second role that health insurance plans had evolved to play is as a mechanism for managing payments from insured individuals to health care providers.

To elaborate on this second role, it is important to understand that the norms of American health care are that health care providers rarely convey clear pricing information to individuals prior to the provision of health care services. Thus, neither individual patients nor doctors or other health care professionals are generally expected to make cost-benefit decisions about possible treatments based on prices. Instead, cost-benefit decisions and most other decisions regarding prices are made through individuals selecting amongst health insurance plans and then through these plans negotiating with health care service providers about what services will be covered and at what price. In effect, through this second role, health insurance plans act as intermediaries between individual insureds and potential health care providers, with respect to determining what services will be offered and what prices will be charged.<sup>8</sup>

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<sup>8</sup> Many analysts lament these norms and call for greater price transparency. (*E.g.*, John Goodman, [Priceless](#) (2012)). But it seems unlikely—in light of political constraints—that these norms will be changed through government action, anytime soon. Instead, if these norms are to change, the likely mechanism would be the development of new forms of “health insurance plans” that innovate in ways that force greater price transparency. The risk-adjustment vision elaborated in this Essay is thus compatible with view that health care pricing should be made more transparent.

Because political constraints suggest that market selection of health insurance plans will play only a very limited role with respect to the first traditional function of health insurance plans as financial products for protecting against future risks, the potential for markets is likely to be much greater with respect to the second function of health insurance plans as cost-benefit intermediaries. For this second function, markets can facilitate individuals exercising choice and insurance providers competing so as effectuate a better matching of individual preferences and the organization of health care provision over time.

A potential answer to the question of what roles should be played by markets, then, is that market mechanisms should govern individual choice and insurance-provider competition with respect to the role of health insurance plans as cost-benefit intermediaries. This is the essence of the risk-adjustment vision that will be elaborated further in Part III of this Essay. But first, Part II will explain why the shared social responsibilities vision of Obamacare's reforms is likely to (at best) devolve into a costly balancing act, at least in many "red" states.

## **II. Obamacare as a Costly Balancing Act**

To better understand the shared social responsibilities vision of Obamacare's regulatory framework, it is helpful to further examine the problems that Obamacare was designed to address. A primary motivation for the passage of Obamacare was the concern that many individuals were effectively being left out of the health care system. For those with preexisting conditions whose only option for purchasing health insurance was from the individual market, often the only obtainable health insurance plans were either prohibitively expensive or else

offered only minimal coverage. Similarly, the employers of many low-income workers offered only health insurance plans that provided minimal benefits—in the eyes of many of the proponents of Obamacare’s reforms, unacceptably minimal benefits.

Thus, Obamacare was designed to address what many considered to be gaps in the prior system for health care finance. The notion was that every American—regardless of health status—should be able to purchase an affordable health insurance plan providing coverage deemed to be adequate. To fulfill this notion, Obamacare was drafted to establish: Exchanges from which individuals could purchase health insurance plans; premium tax credits to make insurance plans purchased from the Exchanges affordable; bans on insurance providers denying coverage or charging more to those with preexisting conditions in order to ensure that no one would be priced out of being able to afford health coverage on account of health risk factors; various regulations requiring that the health insurance plans offered on the Exchanges provide at least a minimally acceptable level of coverage benefits;<sup>9</sup> and a number of other related provisions.

However, the drafters of Obamacare recognized that establishing these provisions would threaten at least two major sets of problems without further reforms. First, if regulations would ensure that individuals could purchase affordable health coverage even after the individuals developed expensive health conditions, then what incentive would individuals have to purchase health insurance plans prior to developing expensive health conditions? To address this concern, Obamacare was further drafted to include what is commonly referred to

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<sup>9</sup> Many, but not all, of these regulations also apply to health insurance plans purchased outside of the Exchanges.

as the “individual mandate”, but which the text of the statute labels as the “Requirement to Maintain Minimum Essential Coverage” and its accompanying “Shared Responsibility Payment.”

Thus, whereas prior to Obamacare a primary motivation for individuals to purchase health insurance was the fear of being left without affordable coverage options if the individuals later developed expensive health conditions, Obamacare replaced this motivation with the bans on discriminating against those with preexisting conditions and with the individual mandate.<sup>10</sup> The individual mandate assesses a tax penalty on individuals who do not obtain minimum essential coverage (the statutory term for health insurance plans deemed to offer a sufficiently robust level of benefits) and who do not meet any of the exceptions to the individual mandate. However, according to most modeling, the tax penalty of the individual mandate was not set high enough to make it rational for many healthy individuals to purchase health insurance plans based on naked cost-benefit analysis. Instead, the models that predict that the individual mandate will incentivize a critical mass of healthy individuals to purchase insurance plans almost all assume that social norms will develop that individuals should obtain coverage and that these social norms will exert substantial pressure toward incentivizing healthy individuals to purchase coverage.

In light of the website difficulties and other implementation problems with rolling out Obamacare’s Exchange provisions, many analysts are currently expressing doubt about whether and to what extent the individual mandate’s tax penalty will actually be enforced. Because the individual mandate remains so controversial, many analysts doubt that the Obama administration will be willing to take the political heat that might result from vigorously

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<sup>10</sup> But note the enrollment period restrictions....

enforcing the tax penalty. There is already indication that the Obama administration might interpret the “hardship” exception to the individual mandate very broadly. For similar reasons, it seems highly unlikely that Congress will agree to raise the tax penalty if the current settings prove to not be high enough. Consequently, today there is even more reason to be skeptical about whether the tax penalty of the individual mandate will suffice to incentivize healthy individuals to purchase insurance plans, at least in “red” states where it seems unlikely that strong social norms will develop in support of the individual mandate.

At the time of this writing, we have only early hints as to whether sufficient numbers of healthy Americans are purchasing Exchange health insurance plans in the various states. It would thus be premature to make any strong predictions at this time. Nevertheless, there is reason to worry—that at least in some “red” states—that the individual mandate will not suffice to prevent serious adverse selection problems. As Part III will explain, these problems should be alleviated to some extent by Obamacare’s risk-adjustment-related provisions. But some of these provisions are only temporary, under current law.

Moreover, because the individual mandate requires that Americans purchase health insurance plans that provide “minimum essential coverage”, relying on the individual mandate to incentivize individuals to purchase health insurance necessitates regulations as to what constitutes minimum essential coverage. Among other regulations, the Department of Health and Human Services (HHS) has thus issued elaborate guidance on “essential health benefits” which must be offered to specified extents in order for a health insurance plans to be deemed as meeting the minimum essential coverage requirement. In other words, by designing a

regulatory framework around the individual mandate, Obamacare places substantial restrictions on the manner in which health insurance plans can function as cost-benefit intermediaries. These restrictions then limit individual choice as to options for health insurance plans and provider's ability to compete by innovating with respect to the organization of how care is offered.

Ultimately, then, although Obamacare's framework relies heavily on regulated markets for health insurance, it is not clear that these regulated markets can actually offer any of the advantages of markets as compared to government provision. By heavily restricting choice and competition, with respect to the both the traditional role of health insurance plans as financial products for protecting against future risks and the role of health insurance plans as cost-benefit intermediaries, Obamacare's regulatory framework may fail to obtain any of the advantages of market provision. In effect, the markets in Obamacare may operate as little more than an excessively complicated and costly form of a single-payer system.

Furthermore, some analysts have argued that the restrictions that have been placed on the permissible forms of coverage that can be offered by Exchange plans have forced these plans to offer coverage that most individuals do not want, thereby exacerbating the potential for adverse selection problems. For instance, because health insurance plans are heavily restricted in what coverage benefits can be provided, many health insurance providers have designed plans with very narrow networks in order to limit costs. Some analysts have argued that many consumers would prefer plans with more limited coverage benefits and wider networks. Indeed, there have been some news reports that HHS or some states may attempt

to further regulate Exchange health plans so as to require more robust network, which would then further restrict choice and competition with respect to the quality and cost of covered care.

*[Discuss the second major problem: employers dumping their lower-income and/or less healthy employees on the Exchanges. Then discuss Obamacare's provisions designed to prevent these forms of dumping—e.g., the employer mandate, the nondiscrimination rules, and the limits on the availability of the premium tax credits—and the various gaming and other problems these provisions will in turn create. Maybe also discuss the reconciliation problems with the premium tax credits and the problems with integrating Medicaid and the premium tax credits. Finally, explain how the various provisions designed to address these problems will at best create a wasteful and costly balancing act.]*

### **III. An Alternative Vision Based on Risk Adjustment**

We can now turn to the question of whether a vision based on risk adjustment might offer a superior alternative for the heart of Obamacare as it evolves over the coming years. Importantly, risk-adjustment-related provisions already play key roles in Obamacare's regulatory framework, although these provisions have been understudied and underpublicized as compared to provisions like the individual and employer mandates.

Perhaps most importantly, Obamacare was drafted to include an extensive risk-adjustment system to be applied to individual and small group health insurance plans, both

inside and outside of the Exchanges. This risk-adjustment system will require payments from health insurance plans that attract a population of insured with disproportionately high health risk factors, and then will transfer these payments to compensate health insurance plans that attract healthier populations of insureds. This risk-adjustment system is designed similar to previously existing risk-adjustment systems in the Medicare Advantage program, in some States' Medicaid programs, and in the Massachusetts health insurance Connector.

In the absence of a risk-adjustment system, some research suggests that the healthier of the individuals seeking health insurance plans from the Exchanges would adversely select toward the cheapest health plans (those providing the least generous coverage) in a manner that could lead to a death spiral for all but the cheapest health insurance plans.<sup>11</sup> In other words, to the extent that the individual mandate successfully induces healthier individuals to purchase insurance, in the absence of a risk-adjustment system, these individuals might just purchase the cheapest insurance options available, leaving the more expensive (and robust) insurance plans with higher cost populations. This could then lead the higher cost plans to raise their prices, which could then lead more of the healthier insureds to opt for cheaper plans, with this process continuing until all insureds have switched to the cheapest available health insurance plan—the death spiral problem.

Obamacare's risk-adjustment system should solve this problem by alleviating the incentives for individuals to choose cheaper health plans and for health insurance providers to compete so as to attract healthier populations of insureds as compared to other health plans.

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<sup>11</sup> Ben Handel, Igal Hendel, & Michael D. Winston, *Equilibria in Health Exchanges: Averse Selection vs. Reclassification Risk*, at 42-44 (August 21, 2013).

However, Obamacare's risk-adjustment system is not currently designed to apply either to individuals who opt not to purchase any health insurance or to large employer plans. Instead, the individual and employer mandates and related regulatory provisions were drafted to apply to these populations.

In addition to the risk-adjustment system described above, Obamacare also includes two temporary programs similar to risk-adjustment provisions but that apply more broadly—the risk corridors and reinsurance programs. These two programs are to be funded by a tax assessed on all persons covered under health insurance plans, with a limit of \$25 billion to be spent on the two programs during the three-year transition period in which these programs are to be in effect. The risk corridors program will then use a portion of these funds to compensate health insurance plans that incorrectly estimate the average costs of providing care. The reinsurance program will use another portion of these funds to compensate health insurance plans for each insured individual covered who incurs extraordinarily high medical costs. A number of analysts have suggested that the risk corridors and reinsurance programs should together be enough to prevent Exchange plans from succumbing to adverse selection death spirals during the three-year transition period in which these programs will be in effect, even if the individual mandate ends up largely being a failure.

Taking a step back, we can see that Obamacare does not implement a complete risk-adjustment vision. This is because the permanent risk-adjustment program will not apply either to individuals who do not purchase any health insurance plans or to large employer plans. In a sense, the risk corridors and reinsurance programs will extend the risk-adjustment framework

to apply to large employer plans—as large employer plans will be subject to the tax assessed on all persons covered by health insurance plans, with the proceeds of this tax then used to subsidize Exchange plans that end up with high risk populations of insureds. But these programs are only designed to be temporary transition measures that are scheduled to expire after 2017.

What if the risk-adjustment system was broadly extended to encompass both individuals who opt not to purchase any health insurance plans and to all large employer plans (including self-insured large employer plans)? Consider first how the risk-adjustment system might be applied to individuals who opt not to purchase any health insurance plans.

One approach would be to treat these individuals as though they had purchased a health insurance plan that provided zero coverage benefits in the plan year. The extended risk-adjustment system could then assess payments if (as is likely) this deemed zero-benefits health plan attracted an overall disproportionately healthy population of deemed insureds. Thus, these individuals could be required to pay risk-adjustment payments based on the amounts assessed as needed to compensate other health insurance plans that attract disproportionately costly populations of insureds. Requiring these individuals to remit risk-adjustment payments would be appropriate, because even though these individuals selected not to purchase a health insurance plan for the current year, these individuals would still be benefitting from the role of health insurance as protecting against future risks, as these individuals would be allowed to purchase health insurance plans in future years. In other words, because of Obamacare's bans on health insurance plans charging more or denying coverage to individuals who develop

expensive health conditions, even individuals who do not purchase health insurance plans in a given year still benefit from the overall health insurance system. Requiring these individuals to remit risk-adjustment payments would in effect be charging these individuals for only the cost of the health insurance function of protecting against future health risks and not for the health insurance function of operating as a cost-benefit intermediary, as the individuals would not be benefitting from this second function.

An alternative approach for extending the risk-adjustment system to include individuals who do not affirmatively purchase health insurance plans would be to treat these individuals as though they had purchased the least expensive health insurance plan available on the relevant Exchange as a default. There are of course numerous other possible alternatives. *[Maybe discuss alternatively assigning these individuals to a health plan as a default, but allowing the individuals to then affirmatively opt out (as a form of nudge). Perhaps discuss requiring the individuals who wish to opt out to post a bond (as with many state auto insurance programs) or making it so that by opting out these individuals would then be removed from the ban on insurance companies discriminating against preexisting conditions.]*

Extending the risk-adjustment system to include individuals who do not purchase health insurance plans potentially has several advantages over the individual mandate approach. First, as currently designed, the individual mandate is a fixed amount (or percentage of income) determined in advance by statute. In contrast, the risk-adjustment payments would be determined based on the risk profiles of the individuals signing up for the various health insurance plans as compared to the risk profiles of those not purchasing insurance. This is why

under the individual mandate approach the Exchanges must worry about attracting sufficient numbers of young and healthy insureds. If the individual mandate was replaced by extending the risk-adjustment system, and to the extent that the risk-adjustment system was successfully administered, there would be no need for the Exchanges to affirmatively seek to attract young and healthy insureds. Instead, the risk-adjustment system would compensate for any differences in risk profiles, thereby removing the incentives for individual adverse selection and for health insurance providers to design their plans to select for health risk factors.

A second potential advantage of extending risk adjustment as compared to the individual mandate approach would be to alleviate much of the need for regulating the benefits covered by health insurance plans. In particular, there should no longer be a need for minimum essential coverage provisions. Instead, individuals could be allowed to select from a range between plans offering no coverage whatsoever to plans offering extensive coverage benefits, with the risk-adjustment system pricing into all of these options the benefits that the bans on discriminating against preexisting conditions provide in terms of protecting all individuals against future health risks. Thus, as discussed previously, the market advantages of choice and competition could be unleashed with respect to the role of health insurance plans as cost-benefit intermediaries.

A third potential advantage of extending risk adjustment as compared to the individual mandate approach would be its political messaging. The individual mandate is extremely unpopular, partly because it makes salient coercion and costs without directly connecting these to benefits provided. In contrast, the risk-adjustment approach could more clearly connect

costs and benefits. This would especially be so if individuals were permitted to opt out of the risk-adjustment payments if they posted a sufficiently large bond or if they also opted out of the bans against health insurance plans discriminating against those with preexisting conditions.

*[Discuss extending risk adjustment to large employer plans. Also discuss options for addressing the problem of the disparity in subsidies. Maybe also discuss potential solutions to the problems of reconciling the premium tax credits and integrating the premium tax credits with Medicaid.]*