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OPINION / COMMENTARY

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ObamaCare Can Be Worse Than Medicaid

No exchange plan covers care at the MD Anderson Cancer Center in Texas or Mayo Clinic in Minnesota.

This year will be the last in which uninsured Americans are forced to pay ObamaCare's penalty for lack of coverage. The change—part of the GOP's tax reform—comes as relief on the demand side of health insurance. Yet nothing has changed on the market's supply side. Without additional reforms to ObamaCare's restrictions on insurers, millions of Americans will continue to choose from a limited range of lackluster plans.

Many of the country's top hospitals are off limits to patients covered by ObamaCare's current plans. Take Houston's MD Anderson Cancer Center, which was named America's best cancer-care hospital by U.S. News & World Report in 13 of the past 16 years. The hospital's website suggests that it takes even Medicaid, but it doesn't accept a single private health-insurance plan sold on the individual market in Texas.

Since Blue Cross of Minnesota withdrew from the individual market in 2016, the state's Mayo Clinic—once cited by President Obama as a model for the nation—has been off limits to Minnesotans covered by ObamaCare exchange plans. Memorial Sloan Kettering appears out of bounds for every exchange plan in New York. Both of these hospitals are open to some Medicaid patients, though Mayo's chief executive has predicted publicly that Medicaid patients may eventually have to queue behind their privately insured peers.

Think about these developments. When Mr. Obama promised to insure the uninsured, what kind of insurance was he talking about? Most people, and maybe even the president himself, imagined it would look like a typical employer plan or a standard Blue Cross individual policy. Who imagined that the only products available would be more limited than Medicaid?

When Blue Cross of Texas first entered the Dallas exchange in 2014, its plan looked a lot like the plans it sold to employers. The coverage extended to virtually every hospital in the Dallas-Fort Worth area, including the prestigious University of Texas Southwestern Medical Center. But after sustaining huge financial losses, the insurer retreated the following year to a more restrictive plan that treated UT Southwestern as an out-of-network hospital. That meant patients faced steep out-of-pocket expenses on top of an already large deductible. The following year UT Southwestern was excluded entirely. The same process has repeated across the country, as insurance titans like Aetna , Humana and UnitedHealth Group have retreated from market after market.

Meanwhile, the remaining insurers are offering products that look a lot like Medicaid. Centene, a Medicaid contractor, stepped in to pick up more than half the U.S. counties that had no insurer for 2018. Medicaid contractors like this may be the only insurers that can survive in the ObamaCare exchanges.

Centene's core product is Medicaid managed care. About 90% of its exchange enrollees get premium subsidies, and many rotate in and out of its Medicaid plans.

In a controversial 2014 decision, a Centene health plan canceled a child patient's emergency brain surgery at Houston's Children's Medical Center. The hospital said its success rate for the surgery was close to 90%, while hospitals nationwide average only 47%. The insurer claimed the hospital was out of its network for the patient's plan but relented after its decision was criticized in the media.

Anecdotes like this one account for much of what's known about the care of seriously ill patients under ObamaCare. But this month the Dallas Morning News published the results of a yearlong investigation into Medicaid in Texas. The paper uncovered hundreds of cases in which "essential medical care was delayed, denied or not delivered to people with critical health needs."

Many of the insurers that provide Texas' Medicaid plans offer similar coverage in the ObamaCare exchanges. One of Centene's subsidiaries has the state's highest rate of appeals for denials of care under Medicaid, but it offers plans with similar coverage to exchange enrollees.

What's driving this race to the bottom? The problem starts with the community rating system, which requires insurers to charge the same premium to all comers regardless of health status. This gives insurers an incentive to seek healthy buyers and avoid sick ones. Since healthy people tend to pick the cheapest plan, and sick buyers are much likelier to look carefully at coverage details, plans with low premiums and narrow coverage networks are suited to attract the healthy buyers insurers want.

What about risk adjustment, the ObamaCare mechanism that is supposed to transfer funds from plans with healthier enrollees to plans with sicker ones? The program's administrators don't always assess risk properly. When ObamaCare's risk adjustment undercompensated insurers, they passed along the cost to certain patients through higher out-of-pocket charges, according to a 2016 study by Harvard and University of Texas economists. Insurers also have an incentive to spend not a penny more on the plans than the risk-adjusted compensation they get for enrollees, meaning such plans tend to offer restrictive coverage.

Problems on the buyer side of the market also hamper risk adjustment. Since the mandate to buy insurance has dozens of loopholes and has been enforced weakly, millions of healthy people choose to remain uninsured. When they get sick, however, they often enroll and choose the gold and platinum plans with the most generous coverage. These latecomers usually cause insurers to pay out much more in coverage than the insurers receive in premiums and subsidies. Companies like Centene have a solution to that kind of buyer behavior: They don't offer gold or platinum plans.

Congress should be examining these kinds of problems—rather than searching for ways to bail out the insurance companies that helped create this broken system.

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