Insight

Conflicting Messages from HHS

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Included in the Affordable Care Act (ACA)—otherwise known as "Obamacare"—was the establishment of health insurance exchanges—public online portals where people would be able to shop for either individual or small group health insurance plans offered by private insurers or by newly-created health insurance co-ops. These exchanges are designed to provide a marketplace for people, particularly individuals without employer-sponsored insurance, to shop for and easily compare insurance plans.

Theoretically, the exchanges are a good idea, but in practice there have been a number of challenges. Primarily, the numerous requirements and restrictions placed on insurers have increased the cost of doing business. Secondly, enrollment has been lower than projected and those that did sign-up for coverage were less healthy than expected. As a result, many insurers have had to pay out more for medical claims than they have received in premium revenue. In 2014, 70 percent of insurers sustained losses which amounted to $2.7 billion; initial analyses of 2015 data suggest that loss margins have nearly doubled and only a quarter of insurers reported earning a profit.[i] Consequently, many insurers have exited the marketplace, leaving millions of consumers with fewer options to choose from

Patients Should Shop Around to Save Money

Insurers who wish to offer plans on the exchange must first submit their plans and the premium rates they will charge to the state insurance commissioner. Each state reviews the filings and must give approval before an insurer may offer their plan on the exchange. Initial filings happen each Spring in advance of the upcoming open enrollment season for the following calendar year. For the last three years, these filings have been closely watched because they are a significant indicator of the wellbeing of the individual insurance market, and the exchanges that have become the "face" of Obamacare.

As the latest rate-filing season arrived in May, the Secretary of Health and Human Services (HHS) was already warning exchange enrollees not to worry. The initial premium increases requested by insurers are higher than what the premiums will ultimately be in the Fall when individuals are actually shopping for coverage for next year. Further, HHS assured, even if some rates do increase, consumers can shop around to find a lower price. It's the same song that was sung last year. And last year that message was somewhat true. Initial rate filings included premium increases of 36 and 51 percent, but the "average" increase—as HHS defined it—was *only* 8 percent.

What HHS fails to explain to the consumers reliant on the exchanges for health insurance, is that 1) premiums do not increase as much as insurers request because regulators refuse to allow it; 2) switching insurers may mean having to switch heath care providers; 3) some premiums will (as they did last year) rise by the amount requested; and 4) some insurers will exit the market (as some have already done) because premiums are insufficient to cover costs, which leaves customers with fewer (if any) options to shop around.

In Tennessee, the plan that enrolled 70 percent of individuals in the state's exchange in 2015 requested, and was approved for, a 36 percent increase for 2016. Oregon approved rate increases of 25 and 33 percent. In New

Mexico, a third of enrollees lost their coverage because Blue Cross and Blue Shield of New Mexico decided to not offer plans anymore after their request for a 51 percent increase was denied. Over half of the co-ops created by the ACA were shut down last year because of the large amounts of money they lost as a result of low premiums and high claims costs.

The situation in 2017 is likely to be even more tumultuous. Now, insurers not only have a second years' worth of claims data to analyze, but also a better understanding of how little they should expect from the federal government in supplemental payments intended to cover their losses. (Insurers did not find out until October 1, 2015, that they would only receive 12.6 percent of the value of their claims submitted under the risk corridors program for 2014). Armed with better information, insurers are able to make more realistic estimates of their expected costs for the upcoming year, which have been grossly underestimated in the past two years. Further, two of the three risk mitigation programs put in place by the ACA to help stabilize the markets will no longer exist in 2017, despite the markets being far from stable. The only risk program that will continue is the risk adjustment program, and CMS is mulling changes to the model which will introduce even more uncertainty for insurers.

The largest insurer in the country, UnitedHealthcare, recently announced they would stop offering plans next year in most state exchanges because of the $650 million they expect to lose from these plans in 2016, following their $475 million loss in 2015. The co-ops have continued to fail; only 7 remain and it is likely more will shut down by the end of the year. These exits will leave most consumers with only one or two insurers to choose from, and the initial rate requests are at least as troubling as those seen last year.

Premium requests for 2017 were made public in May, and the numbers reflect the better-understood reality and numerous problems that have plagued the Exchanges thus far. Plans in Oregon have again requested double-digit rate increases, which, if approved, will result in a two-year increase of up to 60 percent. Virginia is seeing an average weighted increase of 17.8 percent. Rate requests for Iowa would result in premiums increasing by 33 percent on average, and as high as 43 percent, and people in New York may see premiums increase as much as 82 percent. Premiums in Maine may increase by double digits for all costumers on the Exchange, and by as much as 22.8 percent for enrollees of Maine's CO-OP which was initially praised as the most promising CO-OP created under the ACA.

For Best Results, Patients Should Remain with the Same Provider

But even if consumers did have choices, or good choices, the message from HHS that people should shop around for insurance conflicts with the strategy employed in many of their payment model demonstrations setting the landscape for the future of health care delivery in the United States. There is good reason to believe that real savings are contingent upon individuals remaining with their insurer and provider long enough that they may reap the rewards of investments in preventive care along with the knowledge gained from a long-standing relationship with a patient.

Partially based on that premise, most of the models being developed by CMS are built on principles that hold doctors accountable for the patients they see, and patient attribution is typically contingent upon patients remaining with the same physician for some period of time. For example, Track 1 and Track 2 Accountable Care Organizations (ACOs) are accountable for patients that see a provider participating in the respective ACO for a plurality of their doctor visits in a year. Patient attribution will be a fundamental provision of physician payment models going forward. The Medicare and Chip Reauthorization Act (MACRA), which replaces Medicare's Sustainable Growth Rate (SGR) with a new payment mechanism, requires the development of

patient attribution codes. These codes will be used to define a patient's relationship with a particular provider so that payment can be adjusted according to the extent of the provider's responsibility for that patient's care.

So on one hand, the future of Medicare relies on patients remaining with the same provider for long periods of time, while on the other hand, the future of the exchanges relies on patients constantly switching insurers, which, more often than not, will likely require patients to switch providers.

[i] http://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20%28public%29_vF.pdf