The State of the ACA Exchanges Heading into Fourth Open Enrollment Season

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One of the key provisions of the Affordable Care Act was the establishment of online "Exchanges" where consumers could purchase individual or small group health insurance plans. The law included many provisions outlining requirements that any plan sold on the Exchanges must meet, including coverage of certain services, restrictions on variations in premium rates, guaranteed renewability, and a prohibition on medical underwriting. (Some of these requirements apply to all plans, regardless of whether they are offered through the Exchange or not.) Individuals who qualify for a premium tax credit must purchase a plan sold through the Exchange in order to receive the subsidy.

Coverage for plans sold through the Exchanges began in January 2014, and the fourth open enrollment season is quickly approaching. While it was to be expected that it would take some time to iron out the wrinkles of this new marketplace—as is the case with any new government program—it seems that even after three years, the problems persist and may be worsening. Some fear this may be the start of a "death spiral"—where rising premiums lead to only the sickest patients signing up, causing premiums to rise further, and so on until the market collapses.

When consumers begin shopping for health insurance coverage for 2017 this November, just a week before the elections, many will find the premiums have increased dramatically. Analysis of currently available data finds that the average premium rate request for the lowest-cost "Silver" plan among national carriers is an increase of 27 percent; this follows average premium increases of 10.8 percent last year. Shoppers in Tennessee will find premiums that have increased at least 44 percent and as much as 62 percent. But at least they will have options, right? Wrong. According to preliminary analysis, in 2017 consumers in roughly one third of the nation's counties (up from 7 percent in 2016) will have only a single insurer from which to purchase coverage; nearly two-thirds of the counties will be covered by no more than two insurers.

This reduction in choice across the country is largely the result of compounding factors. Many insurers have had to exit the market because they have suffered unsustainable financial losses. Nearly all of the 23 consumer operated and oriented plans (CO-OPs)—created under the ACA as an alternative health insurance option from the well-established insurers and a compromise for the

lack of a "public option"—have collapsed. The CO-OPs have been unable to cover costs—premium revenues have not been sufficient to cover medical claims—and, because the businesses were new and funded with loans from the federal government, they did not have capital reserves to weather the storm. For these CO-OPS, the Exchange business is their only business. More well-established insurers that were in the market prior to the ACA, on the other hand, have other lines of business. They can exit these unprofitable markets, absorb the losses, and continue operating elsewhere. And that is exactly what most of them are doing. While some may argue that the "Big Five" insurers (Aetna, Anthem, Cigna, Humana, and United) should have been able to make a profit in these markets, the fact that they have not underscores the extent of the problems. UnitedHealth Group is on track to lose more than $1 billion between 2015 and 2016 on its Exchange plans; Aetna is projected to lose $300 million in 2016 on its Exchange plans.

People are not just facing higher premiums and fewer choices each year; the continued increase in the number of people enrolled in high-deductible health plans (HDHPs) leaves many people feeling like the health insurance they have is worth less and less. More than 40 percent of individuals are now enrolled in high-deductible health plans (HDHPs), up from just 25 percent the year the ACA was signed into law. The average deductible for "Silver" plans is now $3,117 and the average out-of-pocket maximum is $6,110. For many people, these up-front costs pose a financial barrier to accessing care. Compounding the problem, 64 percent of provider networks in 2016 are deemed "narrow" (having a very limited number of physicians participating in the network), and this is expected to increase to 75 percent next year. Nearly 20 percent of plans offered on the Exchange last year were found to be "specialist-deficient" (covering fewer than six specialists in a particular field within 100 miles). Narrow networks further complicate people's ability to access care, particularly individuals with chronic conditions needing specialized and more regular treatments.

Additionally, roughly half of those enrolled in the individual market (or approximately 8 million people), are purchasing plans off the exchange. In setting premiums, insurers must consider people in the individual market, both on and off the exchange, to be in the same risk pool. If a plan is offered both on and off the exchange, it must have the same premium. Thus, when premiums for these plans increase, the individuals purchasing off-exchange bear the full cost of that increase because they are ineligible for the ACA subsidies as a result of not purchasing through the exchange.

The bad news for the ACA, the White House, and consumers continues day after day. While the uninsured rate has dropped significantly, those with insurance are facing higher premiums, higher deductibles, reduced choice, and reduced access to care. The next administration will find it still has many of the pre-ACA health insurance problems to solve, along with plenty of new ones.