Following Recent Trends In Affordable Care Act Insurance

By Anita Chawla and Keziah Cook; Analysis Group, Inc.

Law360, New York (September 9, 2016, 11:49 AM ET)

Anita Chawla

Keziah Cook

Health insurers offering Affordable Care Act (ACA) plans must walk a fine line to offer mandated covered services while remaining profitable. Although ACA included design features intended to protect plans that insure unhealthy individuals from large financial losses, these features have proven to be insufficient in light of actual plan enrollment. Some insurers are choosing to exit ACA marketplaces, while others are experimenting with more restrictive plan designs. Both actions reduce choice for consumers, and the latter may leave insurers vulnerable to lawsuits alleging discrimination.

ACA Coverage Expansion and Adverse Selection

The Affordable Care Act created healthcare marketplaces, also known as exchanges, to expand insurance coverage to Americans who are ineligible for public insurance programs and who lack employer-provided health insurance. The introduction of marketplaces was combined with an individual insurance mandate and premium subsidies to encourage high enrollment. However, adverse selection problems have plagued the marketplaces as enrollment in ACA plans has included fewer healthy — and more chronically ill — adults than anticipated.

For the first three years of ACA plans (2014-2016), risk corridors were intended to provide further protection against insurer losses if plans substantially underestimated

medical spending when setting premiums. However, the risk corridor program was underfunded and only 12.6 percent of payments were made to unprofitable plans in 2014[1].

Some insurers are choosing to exit ACA marketplaces entirely rather than face losses. For instance, nonprofit consumer cooperative plans are going out of business and major insurers including Humana Inc[2]., United Healthcare Inc[3]., and Aetna Inc[4]. have announced their intent to withdraw from the marketplaces. Others, however, are looking for creative solutions to manage profitability, including exploring alternative plan designs.

ACA Regulations and Plan Design: A Limited Set of Options

The ACA requires that plans cover certain essential health benefits and forbids explicit exclusion from coverage of individuals with pre-existing health conditions. As a result, plans must attract a mix of individuals with varying health risks so that an average premium still allows them to remain profitable. Risk adjustment was intended to address the financial consequences of an insurer attracting disproportionately unhealthy individuals in the marketplace. In that scenario, the insurer would face losses in the absence of a premium increase. In contrast, if plans attracted relatively healthy individuals, risk adjustment would lower premiums to prevent plans from reaping financial gains. However, there are known shortcomings with the current ACA risk-adjustment model. For instance, it may especially underestimate costs associated with individuals who have chronic conditions that prevent full-time employment because it was calibrated using claims from employer-sponsored insurance[5]. In light of insufficient risk adjustment, plans are vulnerable to large losses if unhealthy individuals are disproportionately represented.

Consider HIV patients, for example. The current risk-adjustment mechanism does not properly compensate plans for known HIV patients nor does it always correctly identify such patients. These patients are likely to predictably and consistently have medical expenses that exceed their premiums; medical care for such patients can cost upwards of $20,000 per year[6]. The current ACA risk-adjustment model fails to identify up to 37 percent of patients on HIV anti-retroviral therapy regimens as having HIV[7]. Without proper risk adjustments in place, plans with a disproportionate number of HIV patients may face financial losses.

The ACA permits plans to incorporate patient cost-sharing, narrow provider networks, limits on nonessential services, and restrictive formularies into plan design. Such features are ways for plans to contain healthcare spending while, at the same time, accepting all applicants during open-enrollment periods and continuing beneficiary insurance coverage (except in cases of failure to pay premiums). For example, plans may impose high cost-sharing for specialty drugs or choose to apply a single high deductible to both medical and pharmaceutical benefits. These plans may be less affordable for individuals with chronic conditions, thereby resulting in the choice of other plans. Limited benefit plans, therefore, improve profitability directly, not only by limiting the medical services each

member can consume but also via selection of healthier individuals. If the pool of individuals remaining in plans with full benefits is sicker on average, insurers will choose to either exit or limit benefits. Full benefit plans that remain will be forced to raise premiums to avoid large losses.

In the absence of modifications to the risk-adjustment process, this spiral will continue to push ACA insurers to offer only plans with limited benefit designs. This will have the unintended consequence of ACA plans that are detrimental to those with costly chronic conditions and/or increasing litigation risk for insurers.

Litigation Risks

Insurers offering limited benefit plans face two types of litigation risk. The first is that plan enrollees may allege that they were misled with regard to the benefits included in the plan. For example, enrollees may believe that a larger range of providers are included in the network when choosing a plan and only discover the limitations in the network after experiencing a health event that requires specialist care. Similarly, limited benefit plans that imposed restrictive conditions on certain types of treatment may be charged with violating policy terms that are framed in the context of medically acceptable treatment. In this situation, plan enrollees that required access to the excluded providers or treatments could claim they were harmed (e.g., Andre v. Blue Cross of California).

Claims of discrimination point to a second type of litigation risk. Limited benefit plans may be perceived as discriminatory towards individuals with chronic illnesses due to the higher cost burden experienced by these individuals. Regulations regarding discrimination as defined in Section 1557 of the ACA (which includes discrimination on the basis of age, sex, race and disability) went into effect July 18, 2016 and provide a private right of action[8], allowing members of a protected class to sue insurers if plan design discriminates against them, even if they chose not to enroll in the specified plan. Accordingly, damages assessed under such discrimination suits could potentially exceed the associated medical costs, but no clear precedent has been set yet. Recent cases in Florida, brought under state law, resulted in agreements from insurers to modify benefit design, but they did not result in significant penalties. For example, Florida Blue recently settled a class action lawsuit by agreeing to provide Harvoni to all of its members, but it did not agree to pay any damages to patients with hepatitis C who chose other insurers or remained uninsured. (Oakes v. Blue Cross & Blue Shield of Florida).

What's Next?

The Section 1557 regulations specify that changes in plan design to avoid discrimination against protected groups must be implemented for the 2017 plan year. These requirements potentially elevate the risk of litigation for limited benefit plans, especially for plans structured in a manner that shifts costs to individuals represented by

advocacy groups that provide cost-sharing assistance to underinsured individuals. However, the Centers for Medicare and Medicaid Services recently announced that it intends to modify the risk-adjustment program, including by incorporating prescription drug utilization data into the risk-adjustment model, beginning in 2018[9]. This change may more appropriately compensate plans that cover individuals with high prescription drug costs, reducing the incentive to offer limited benefits that may be perceived as discriminatory.

Profitability may be especially challenging in 2017, because there will be fewer options for acceptable benefit designs and modifications to risk adjustment will not yet be in place. Insurers that can remain in the marketplace until 2018 when new regulations are in place may then again be able to profitably offer full benefit plans. In the meantime, insurers must balance the risk of discrimination lawsuits against the increased profitability of limited benefit plans. If it becomes harder to manage this balance, additional insurers may choose to exit the marketplaces.

Endnotes

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7 Table 4.4 in HHS-Operated Risk Adjustment Methodology Meeting

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