Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Weeks of April 4th - 11th

**U.S. Uninsured Rate at 11.0%, Lowest in Eight-Year Trend**

Gallup

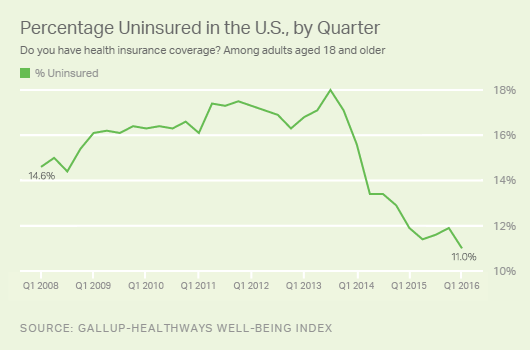
In the first quarter of 2016, the uninsured rate among all U.S. adults was 11.0%, down from 11.9% in the fourth quarter of 2015. This marks a record low since Gallup and Healthways began tracking the uninsured rate in 2008. The uninsured rate has declined 6.1 percentage points since the fourth quarter of 2013, which was right before the individual mandate provision of the Affordable Care Act took effect in early 2014 that required Americans to carry health insurance.

Results for the first quarter are based on nearly 45,000 interviews with U.S. adults aged 18 and older, from Jan. 2 to March 31, 2016, conducted as part of the Gallup-Healthways Well-Being Index. Gallup and Healthways ask 500 U.S. adults each day whether they have health insurance, which, on an aggregated basis, allows for precise and ongoing measurement of the percentage of U.S. adults with and without health insurance and the net change in the uninsured rate over time.

The uninsured rate for the first quarter accounts for interviews conducted both before and after the Jan. 31 deadline to purchase a 2016 health plan from government insurance exchanges. The percentage without health insurance in the second quarter of 2016 may decline slightly, as it will be the first quarterly measurement this year to reflect interviews that were all conducted after the exchanges closed.

Uninsured Rate Declines Most Sharply Among Hispanics and Blacks

Across key subgroups, blacks and Hispanics have experienced the largest declines in their uninsured rates since the fourth quarter of 2013. The rate among Hispanics was 28.3% in the first quarter of 2016, still significantly higher than for all U.S. adults, but down 10.4 points from the fourth quarter of 2013. Similarly, the uninsured rate has declined 9.5 points among blacks over this same period to its current 11.4%. These larger declines for blacks and Hispanics partly reflect higher uninsured rates among those demographic groups relative to whites before the implementation of the new healthcare law.



The uninsured rate has declined significantly for all age groups below age 65 since late 2013. Seniors, most of whom were already covered by Medicare before the recent changes in health insurance took place, continue to almost universally report being insured.

**Percentage of Uninsured U.S. Adults, by Subgroup**

*Do you have health insurance coverage?*

|  | Q4 2013% | Q1 2016% | Net change (pct. pts.) |
| --- | --- | --- | --- |
| National adults | 17.1 | 11.0 | 6.1 |
| 18 to 25 | 23.5 | 14.8 | 8.7 |
| 26 to 34 | 28.2 | 18.5 | 9.7 |
| 35 to 64 | 18.0 | 10.7 | 7.3 |
| 65+ | 2.0 | 1.6 | 0.4 |
| Whites | 11.9 | 6.4 | 5.5 |
| Blacks | 20.9 | 11.4 | 9.5 |
| Hispanics | 38.7 | 28.3 | 10.4 |
| Less than $36,000 | 30.7 | 20.0 | 10.7 |
| $36,000 to $89,999 | 11.7 | 8.2 | 3.5 |
| $90,000+ | 5.8 | 2.9 | 2.9 |
| Gallup-Healthways Well-Being Index | | | |

**Percentage of Uninsured U.S. Adults, by Subgroup**

*Do you have health insurance coverage?*

|  | Q4 2013% | Q1 2016% | Net change (pct. pts.) |
| --- | --- | --- | --- |
| National adults | 17.1 | 11.0 | 6.1 |
| 18 to 25 | 23.5 | 14.8 | 8.7 |
| 26 to 34 | 28.2 | 18.5 | 9.7 |
| 35 to 64 | 18.0 | 10.7 | 7.3 |
| 65+ | 2.0 | 1.6 | 0.4 |
| Whites | 11.9 | 6.4 | 5.5 |
| Blacks | 20.9 | 11.4 | 9.5 |
| Hispanics | 38.7 | 28.3 | 10.4 |
| Less than $36,000 | 30.7 | 20.0 | 10.7 |
| $36,000 to $89,999 | 11.7 | 8.2 | 3.5 |
| $90,000+ | 5.8 | 2.9 | 2.9 |
| Gallup-Healthways Well-Being Index | | | |

More Americans Have Self-Paid and Medicaid Insurance Plans

Gallup and Healthways focus on adults aged 18 to 64 because nearly all Americans 65 and older have Medicare. Compared with the fourth quarter of 2013, the largest increase in insurance type has occurred among those paying for a plan themselves. In the first quarter of 2016, 21.8% of U.S. adults aged 18 to 64 had a plan fully paid for by themselves or a family member, up 4.2 percentage points from the fourth quarter of 2013. The percentage of U.S. adults with Medicaid has also increased to 9.4% in the first quarter of 2016, up 2.5 points from the fourth quarter of 2013.

**Type of Health Insurance Coverage in the U.S., Among Adults Aged 18 to 64**

*Is your health insurance coverage through a current or former employer, a union, Medicare, Medicaid, military or veteran's coverage or a plan fully paid for by you or a family member? Primary and secondary insurance combined*

|  | Q4 2013% | Q1 2016% | Net change (pct. pts.) |
| --- | --- | --- | --- |
| Current or former employer | 44.2 | 43.4 | -0.8 |
| Plan fully paid for by self or family member | 17.6 | 21.8 | 4.2 |
| Medicaid | 6.9 | 9.4 | 2.5 |
| Medicare | 6.1 | 7.6 | 1.5 |
| Military/Veteran's | 4.6 | 5.2 | 0.6 |
| A union | 2.5 | 2.6 | 0.1 |
| (Something else) | 3.5 | 4.4 | 0.9 |
| No insurance | 20.8 | 12.9 | -7.9 |
| Gallup-Healthways Well-Being Index | | | |

Implications

The uninsured rate has dropped considerably since the fourth quarter of 2013 when the key provision of the new healthcare law requiring U.S. adults to obtain health insurance took effect. After declining significantly in earlier quarters, the rate of uninsured U.S. adults leveled off in 2015. Most healthcare policy watchers had anticipated this, as those who remain uninsured are among the most difficult to insure. The drop in the first quarter of 2016 suggests that the rate may continue to decline in future years, although less markedly and maybe only in the first quarter of each year as U.S. adults continue to make use of the exchanges to obtain health insurance.

The open enrollment period concluded on Jan. 31, 2016, meaning slight changes are expected in the second quarter of 2016 when the totality of interviews are conducted after the exchanges have closed, but further significant changes to the uninsured rate are unlikely until the first quarter of 2017.

http://www.gallup.com/poll/190484/uninsured-rate-lowest-eight-year-trend.aspx?tr=y&auid=16612036

**Study finds surprising reason why more black, Latino children aren’t insured**

Washington Post

Medicaid and the Children’s Health Insurance Program (CHIP) were developed to give society’s most vulnerable kids a chance at health care. But there’s a catch: In many states, parents must sign their kids up for the programs to receive coverage. And to sign their kids up, parents must know that their kids are eligible in the first place.

A new study published in the [International Journal for Equity in Health](http://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0331-y) found a distressing information gap among parents of uninsured Latino and African American kids. More than half didn’t realize that they were eligible for free or low-cost health insurance — a situation that forced families to make hard health-care decisions and pay for them on their own.

It tells us that this system is not designed to keep kids on insurance,” says Glenn Flores, a health-policy researcher and pediatrician at Medica Research Institute and the Mayo Clinic, who led the study.

During the study, which was conducted between 2011 and 2014 in Dallas, researchers went to 97 sites in areas with low-income residents and recruited parents at Goodwill stores, laundromats, public libraries, food banks and other community centers. They were looking for kids who shared three characteristics: They were up to 18 years of age and lacked health insurance; were identified by their parents as Latino, Hispanic, African American or black; and were eligible for either CHIP or Medicaid. After screening more than 49,000 caregivers, the team found a group of 267 uninsured children to study. They asked their parents a barrage of questions, including one about whether they were aware that their children qualified for subsidized insurance.

Forty-nine percent of the parents studied were unaware that their children were eligible for Medicaid or CHIP — although 95 percent of all children studied had been insured in the past. Parents who were unaware that their children qualified for insurance had higher incomes, and Latino parents were more likely to be unaware than African American ones (57 percent vs. 40 percent). That racial difference disappeared when results were adjusted for income and the duration that children had gone without insurance.

Parents with uninsured kids cited a number of factors for lapses in insurance. Thirty percent of parents had lost coverage and never reapplied. Other reasons included applications that never received a reply (9 percent of respondents), missing paperwork (8 percent of respondents), fathers who were supposed to cover their children (4 percent). Other reasons included being dropped from insurance coverage because of late payment of premiums and language and citizenship barriers (1 percent each).

Even more worrisome, Flores says, are the disadvantages faced by kids who go without insurance. Two-thirds of the uninsured children in the study had special health-care needs such as eczema, allergies and asthma, and 40 percent had no usual source of preventive care. Thirty-five percent of parents had financial problems that they attributed to their kids’ health.

Although kids were not insured, they didn’t necessarily stop receiving health care. On average, the uninsured children visited a physician three times a year and went to an emergency room once. About 0.1 percent of children were hospitalized each year. Parents shouldered an average of $593 per hospitalization and $47 per preventive visit. Three-quarters of parents interviewed had delayed care for their kids, and more than four in five parents said they worry more about their children’s health than other people do.

That didn’t surprise Genevieve Kenney, an economist who is senior fellow and co-director of the Health Policy Center at the Urban Institute. “The parents of children who are uninsured are much less likely to feel confident that their children can get the care they need,” says Kenney, who specializes in Medicaid, CHIP and health-care coverage issues. “We’re learning more and more that those kinds of worries and anxieties have adverse effects on families.”

The study has its limitations — a small sample size, a focus on only one subset of racial diversity and its location in Dallas. Texas has long had the highest uninsured rate in the nation. In 2014, when the study ended, 6.2 percent of children nationally were uninsured. But the number was as high as 11 percent in Texas and even higher in Dallas County, where 15.9 percent of children went without health insurance.

“Dallas County is among the worst in Texas, and so it seemed like a natural place for one to conduct the study,” Flores says.

But do those numbers translate to the larger population? After all, other states, such as Louisiana and Alabama, have had better luck keeping kids on Medicaid, receiving multiple performance bonuses for retention and adopting strategies such as more-streamlined applications and electronic payments. Nor is the effect of the Affordable Care Act, which was implemented only during the last month of the study, clear, although parents who were questioned during the study’s last month about how the ACA affected their awareness of Medicaid and CHIP enrollment for their children told researchers that it did not have an effect.

What the study does illustrate is a disconnect between available programs and awareness, Flores says. “We need to do a much better job with outreach,” he says. In a companion study, his team may have come up with a solution. It conducted a [randomized, controlled trial](http://pediatrics.aappublications.org/content/early/2016/03/16/peds.2015-3519) that paired parent mentors — people trained on the importance of health insurance and how to get coverage for kids and whose own children had been enrolled in Medicaid or CHIP for a year — with families identified in the first study.

Ninety-five percent of kids whose parents worked with mentors were enrolled in insurance by the end of the study vs. 68 percent of controls, resulting in lower out-of-pocket costs, greater access to care and greater satisfaction among parents. Perhaps pairing people with peers who have been there before can help ensure that fewer parents shoulder the burden of paying for their children’s health care alone.

<https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/study-finds-surprising-reason-why-more-black-latino-children-arent-insured/>

Florida Agrees to Improve Poor Children’s Access to Health Care, Settling Suit

Florida health officials, in a settlement announced Tuesday, agreed to improve access to health care for poor children, ending a long-running class-action lawsuit that had accused the state of shortchanging doctors and leaving low-income families to trek long distances to visit specialists.

The state reimbursed doctors so little for [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier) services that many doctors refused to treat the patients, lawyers argued in a suit filed in 2005 by pediatric doctors on behalf of nine plaintiffs. Hundreds of thousands of children who were on [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier) never received checkups, and for years, 80 percent of the children never saw a dentist, the worst rate in the nation.

Doctors were being paid about half of what they received from the[Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) program, so parents whose children required specialists were forced to travel long distances or wait months to find a physician who would accept the insurance for low-income people.

One child was unable to be tested for [lead poisoning](http://health.nytimes.com/health/guides/nutrition/lead-nutritional-considerations/overview.html?inline=nyt-classifier) because the laboratory was a three-hour round-trip bus ride away. A Fort Myers boy who needed his ear drained was referred to a specialist in Sarasota — almost two hours away.

“They would tell you, ‘You have to wait another month,’ ” said Rita Gorenflo, a retired nurse in Palm Beach Gardens who adopted seven special-needs children who received Medicaid benefits. “My son would get a referral for a pulmonologist, but he couldn’t get seen for three or four months. I have seen so many children at the clinic going without what they need.”

As a plaintiff, Ms. Gorenflo testified for more than two hours at a 90-day trial that ended in 2012. In December 2014, a Federal District Court judge ruled that Florida violated federal law, and ordered mediation.

After the ruling, the state had argued in court papers that the judge’s decision was moot because so many improvements had been made to the Medicaid program.

“The Medicaid program, as it presently exists, bears no resemblance to the program described through testimony during the trial,” an assistant attorney general, Stephanie A. Daniel, wrote in a court filing. “Plaintiffs have searched for and found only a very small number of anecdotes which they argue, without evidentiary support, are representative of an ongoing controversy.”

Despite the state’s argument that the lawsuit was stale, the three health agencies named in the suit signed a settlement agreeing to take important steps that would improve care. Among the steps, according to settlement documents, was an incentive plan that would eventually pay doctors who meet certain criteria at rates equivalent to the federal[Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) program.

“Ultimately, what this is going to do is provide additional reimbursements to doctors who provide quality care and meet quality care objectives,” said Stuart H. Singer, the lead counsel for the plaintiffs. “They will take steps to begin to get Florida to national norms in terms of the percent of children who receive [preventive health care](http://health.nytimes.com/health/guides/specialtopic/preventive-health-care/overview.html?inline=nyt-classifier)and [dental care](http://health.nytimes.com/health/guides/specialtopic/dental-care-adult/overview.html?inline=nyt-classifier).”

The Florida Agency for Health Care Administration also agreed to meet national benchmarks for the percentage of children on Medicaid receiving preventive care by 2019 and the norms for dental care by 2021, Mr. Singer said.

Mr. Singer said he and Carl Goldfarb, his co-counsel at Boies, Schiller & Flexner in Fort Lauderdale, and lawyers at the [Public Interest Law Center](http://www.pilcop.org/#sthash.ww7Joef5.dpbs) in Philadelphia spent “tens of thousands” of hours on the lawsuit. The lawyers took the case pro bono but will be reimbursed for about 60 percent of their normal fees, Mr. Singer said. The case had been brought by the Florida Chapter of the American Academy of Pediatrics and the Florida Academy of Pediatric [Dentistry](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/teeth_and_dentistry/index.html?inline=nyt-classifier).

Jane Perkins, the legal director of the [National Health Law Program](http://www.healthlaw.org/), an organization that handles similar cases around the country, said Florida had one of the worst records in the nation when it came to Medicaid fees paid to doctors and the number of eligible children who actually received health care. But cases like these are unusual, she said, because they are so costly and time-consuming.

In a statement, the Florida Agency for Health Care Administration said that over the last two years, the state had had a 13 percent increase in Medicaid eligible children receiving preventive dental services.

State contracts now require the companies that participate in the Medicaid programs to maintain networks of medical and dental providers at levels sufficient to eliminate problems with access to care, the statement said.

“We are in a new era of working collaboratively with the members of the Florida Pediatric Society and the Florida Academy of Pediatric Dentistry to achieve our mutual goal: achieving the best possible health outcomes for the children served by Florida Medicaid,” said the agency secretary, Elizabeth Dudek.

http://www.nytimes.com/2016/04/06/us/florida-agrees-to-improve-poor-childrens-access-to-health-care-settling-suit.html?mabReward=A6&action=click&pgtype=Homepage&region=CColumn&module=Recommendation&src=rechp&WT.nav=RecEngine&\_r=0

**Insurers Warn Losses from Obamacare are Unsustainable**

The Hill

Health insurance companies are amplifying their warnings about the financial sustainability of the ObamaCare marketplaces as they seek approval for premium increases next year.

Insurers say they are losing money on their ObamaCare plans at a rapid rate, and some have begun to talk about dropping out of the marketplaces altogether.

“Something has to give,” said Larry Levitt, an expert on the health law at the Kaiser Family Foundation. “Either insurers will drop out or insurers will raise premiums.”

While analysts expect the market to stabilize once premiums rise and more young, healthy people sign up, some observers have not ruled out the possibility of a collapse of the market, known in insurance parlance as a “death spiral.”

In the short term, there is a growing likelihood that insurers will push for substantial premium increases, creating a political problem for Democrats in an election year.

Insurers have been pounding the drum about problems with ObamaCare pricing.

The Blue Cross Blue Shield Association released a widely publicized report last month that said new enrollees under ObamaCare had 22 percent higher medical costs than people who received coverage from employers.

And a [report from](http://healthcare.mckinsey.com/2014-individual-market-post-3r-financial-performance) McKinsey & Company found that in the individual market, which includes the ObamaCare marketplaces, insurers lost money in 41 states in 2014, and were only profitable in 9 states.

“We continue to have serious concerns about the sustainability of the public exchanges,” Mark Bertolini, the CEO of Aetna, [said](http://thehill.com/policy/healthcare/267740-aetna-serious-concerns-on-obamacare-sustainability%20) in February.

The Aetna CEO noted concerns about the “risk pool,” which refers to the balance of healthy and sick enrollees in a plan. The makeup of the ObamaCare risk pools has been sicker and costlier than insurers hoped.

The clearest remedy for the losses is for insurers to raise premiums, perhaps by large amounts — something Republicans have long warned would happen under the healthcare law, known as the Affordable Care Act (ACA).

“The industry is clearly setting the stage for bigger premium increases in 2017,” said Levitt of the Kaiser Family Foundation.

Insurers will begin filing their proposed premium increases for 2017 soon. State regulators will review those proposals and then can either accept or reject them.

Michael Taggart, a consultant with S&P Dow Jones Indices, pointed to data from his firm showing per capita costs for insurers are spiking in the ObamaCare marketplaces.

“We made a significant change in the rules with the ACA, and we're still working through the process to see how that market stabilizes,” Taggart said at a panel on Wednesday. “Is [a death spiral] a possibility? Sure it's a possibility. I wouldn't attempt to put a probability on it, because I think there are a lot of things going on.”

One factor helping to prevent a death spiral is ObamaCare's tax credits, which cushion the impact of premium increases on consumers.

“What we're likely to see is more of a market correction than any kind of death spiral,” Levitt said. “There are enough people enrolled at this point that the market is sustainable. The premiums were just too low.”

Dr. Mandy Cohen, the chief operating officer of the Centers for Medicare and Medicaid Services (CMS), said in an interview that there is “absolutely not” a risk of a death spiral or collapse in the ObamaCare marketplaces.

While acknowledging that “companies are needing to adjust” to the new system, she pointed to the 12.7 million people who signed up this year, 5 million of whom were new customers, as a sign of success.

“What brings us the most confidence about the long term stability and health of the marketplace is its growth,” Cohen said.

Another risk, should regulators reject large premium increases, is that insurers could simply decide to cut their losses and drop off the exchanges altogether.

“Given that most carriers have experienced losses in the exchanges, often large losses, it only makes sense that most exchange insurers will request significant rate increases for 2017,” said Michael Adelberg, a former CMS official under President Obama and now a consultant at FaegreBD.

“Market exits are not out of the question if an insurer is looking at consecutive years of losses and regulators are unable to approve rates that get the insurer to break-even.”

The most prominent insurer eyeing the exits is UnitedHealth, which [made waves](http://thehill.com/policy/healthcare/260758-unitedhealthcare-may-exit-obamacare-exchanges) in November by saying it was considering whether to leave ObamaCare in 2017 because of financial losses. The company last week announced that it is dropping its ObamaCare plans in Arkansas and Georgia, and more states could follow.

The Department of Health and Human Services argues that the attention on UnitedHealth is overblown, given that the insurer is actually a fairly small player in the marketplaces.

It’s more important to watch what happens with Blue Cross Blue Shield plans, which are the backbone of the ObamaCare marketplaces.

There have been some rumblings of discontent from Blue Cross plans. The plan in New Mexico already dropped off the marketplace there last year after it lost money and state regulators rejected a proposed 51.6 percent premium increase. Now, Blue Cross Blue Shield of North Carolina says that it might drop out of the marketplace because of its losses.

Blue Cross of North Carolina CEO Brad Wilson said in an interview that the company had lost $400 million due to its ObamaCare business.

“We're not alone, and I think that that also is evidence to suggest that there are systemic and fundamental challenges that we all need to have a civilized conversation about,” Wilson said.

He said a key factor in the decision on whether to stay in the market next year will be whether regulators approve whatever premium increase the company ends up proposing so as to try to make up for its losses.

Asked about the risk of a death spiral, Wilson said he is not worried about that happening “tomorrow,” but has concerns if the situation does not change over time.

“There’s not going to be something magical happen that will cause this to turn around,” Wilson said. He is pressing for changes like further tightening up extra sign up periods that insurers say people use to game the system and repealing the Health Insurance Tax, which could help lower premiums.

Cohen of the CMS said that her agency is in close touch with insurers and Blue Cross Blue Shield of North Carolina in particular. But she pushed back on talk of Blue Cross of North Carolina dropping out of the marketplace, stating flatly, “I have no concerns about them leaving the market.”

She referred to [problems](http://thehill.com/policy/healthcare/%20http:/www.newsobserver.com/news/business/article54895100.html%20) the company has had with its computer systems that have led to some people being enrolled in the wrong plan, along with other issues that have added to the company’s administrative costs.

http://thehill.com/policy/healthcare/276366-insurers-warn-losses-from-obamacare-are-unsustainable?tr=y&auid=16631202

**New About Obamacare Had Been Bad Lately. How Bad?**

The New York Times

Ever since passage of the Affordable Care Act, a fierce debate has been waged over whether the law would work as advertised. While advocates promised that the design of new insurance markets would transform the way consumers buy health insurance, critics warned that the new market would never succeed. Reed Abelson and Margot Sanger-Katz have had front-row seats to the debate, and the two reporters took a few minutes to discuss when — and if — the market would stabilize.

Margot: It’s been a few weeks of bad news about the Obamacare marketplaces. On Friday, we learned that UnitedHealth has decided to [pull out of Obamacare marketplaces in two states](http://www.bloomberg.com/news/articles/2016-04-08/unitedhealth-quitting-obamacare-markets-in-georgia-arkansas). The week before, the Blue Cross and Blue Shield Association put out a paper offering [not-too-subtle hints](http://www.nytimes.com/2016/04/01/upshot/new-health-insurance-customers-are-sicker-should-we-be-surprised.html?ref=topics)that some members were losing money. Reed, you wrote recently about how [surprising stasis in the employer insurance market](http://www.nytimes.com/2016/04/05/business/employers-keep-health-insurance-despite-affordable-care-act.html) means we can look forward to much smaller Obamacare marketplaces than most people expected when the health law passed. And the parade of struggling start-up insurer companies [has extended to Maine’s Community Health Options](http://www.modernhealthcare.com/article/20151209/NEWS/151209860), one of the co-ops that had long been held up as one of the most successful. Health insurers need to submit their rates to regulators in the next few weeks — or decide to exit markets. Should we be worried about a health insurance apocalypse?

Reed: I think people have a tendency to catastrophize, especially when it comes to Obamacare. UnitedHealth, which is one of the nation’s largest health insurers, has only reluctantly embraced the new market, and the company is always held up as an example of why the sky is falling and why Obamacare is going to crash and burn: If United can’t make it, no one can.

United has only a small fraction of the individual market, but some of the Blues are also struggling. What is most troubling is the fact that many [insurers are losing money](http://healthcare.mckinsey.com/2014-individual-market-post-3r-financial-performance). You may not sympathize much with the insurance companies — and no one does — but they have to make enough money to pay claims. Do you think those losses are temporary — or a sign that the market is fundamentally unstable and potentially unsustainable?

Margot: I think some of both. It seems clear that some insurers just made pricing mistakes. I’d include a lot of the nonprofit co-op plans that [have gone belly up](http://www.nytimes.com/2015/10/26/business/health-care-co-op-closings-narrow-consumers-choices.html) in that category. United may fall in that category, too, in some places. That doesn’t seem to me like a permanent problem. If everyone priced too low, they can just raise their prices in future years, and it’ll be O.K. That’s not great for middle-class people who pay their own premiums, but most people in the exchanges won’t notice a difference because of the way the subsidies work.

These markets also turned out to be more complicated than some insurers expected. Some regulatory choices didn’t go their way. And it does look as if more customers than you might expect are [staying enrolled in plans for only part of the yea](http://rwjf.ws/1S6R2cG)r, which makes it hard for the insurers to collect premiums.

But I think they’ll probably figure it out.

Reed: But isn’t it a vicious cycle? The big players won’t stay in markets unless they can attract enough customers to make it worth their while. Those who say Obamacare is doomed argue that the premiums are just too high for people who don’t qualify for a subsidy. If you are insured and relatively healthy, you may not feel as if the coverage is a good deal. The deductibles are steep, meaning you end up paying for a lot of your care before you see the first dollar of coverage, and you can’t always see your choice of doctor.

The result is that the market could be too small and therefore too volatile to attract mainstream insurers like United.

How do you solve that?

Margot: Well, it seems clear that you need some competition in every market to keep prices low. But maybe we don’t need the big carriers to play everywhere. As you noted, United barely showed up in the exchanges in the first place, and customers in most markets still have a lot of choices. The Medicaid-managed care plans seem to be having some success in this market, so maybe they will be a big part of the exchange mix.

I also think it’s worth looking at the states where things are going well and the insurers *are*making money: California, Vermont, Washington. Those state exchanges made some different regulatory choices early on that got more people into the new markets right away, so their markets stabilized more quickly.

Reed: You’re right that you may not need the established players for the market to work. The market may not look the way we thought it would, with the same insurers and same characteristics as the employer market. But one of the reasons insurers are leaving is because of the market’s instability. [There’s tremendous churn in this market](http://avalere.com/expertise/managed-care/insights/only-33-percent-of-exchange-enrollees-in-2016-kept-their-same-plan-from-201), with most people switching plans every year to try to find a cheaper alternative.

I’m not sure I know what the business model is for an insurer, if the expectation is that you’re going to keep your customers for only a year. It makes achieving long-term goals like keeping people healthier and focusing on preventive measures much harder because there may be no payoff for the insurer.

Margot: Yes, I think this is one of the contradictions of the Affordable Care Act’s design. The whole idea was that competition between the insurance companies would help to hold down prices, the way it does for, say, electronics or groceries. In order for that system to work, [you need people to actually switch plans](http://www.nytimes.com/2014/09/18/upshot/with-new-health-law-shopping-around-can-be-crucial.html) if their plan starts charging more than the competition. The fact that [people are actually switching](http://www.nytimes.com/2015/02/27/upshot/high-rate-of-shopping-and-switching-in-obamacare-plans-is-a-good-sign.html) seems like a sign that this market is functioning as it was designed. But as you point out, all that churn sure makes it hard for an insurer to make money by investing in its customers’ long-term health. But the individual market, pre-Obamacare, also had a lot of churn.

Reed: Yes, there’s always been churn, but the insurers got pretty good at figuring out which people they wanted to insure by turning away the people who were most likely to cost them the most money. They definitely figured out how to make money.

It’s easier to smooth all of this out if you insure more people. Do you think there’s opportunity to see the market increase in size? I know insurers in the early years suffered when some states allowed people to keep their existing plans. Those plans that were grandmothered, as it is called.

Margot: My sense from talking to folks in the industry is that the grandmothered plans really wrecked their early calculations. The Obama administration, responding to a political freakout about people whose plans were getting canceled in 2014,[let states keep them for a few more years](http://www.nytimes.com/2014/03/06/us/politics/obama-extends-renewal-period-for-noncompliant-insurance-policies.html). The result was that healthy people tended to hold onto their old, cheaper plans, while sick people went to the exchanges. You can see how that might make the exchange market unprofitable for new entrants.

I do think the market size is a bit of a chicken-or-egg question. [Your story last week](http://www.nytimes.com/2016/04/05/business/employers-keep-health-insurance-despite-affordable-care-act.html) on stability in the employer market did such a good job of laying this out. Everyone (including the Congressional Budget Office) expected that employers would start dropping coverage once the marketplaces were up and running. That didn’t happen. It means that Obamacare has been much less disruptive to the status quo than many people thought. But it also means that the exchange markets are smaller and probably more expensive than people thought, too. If prices keep going up, maybe they’ll never grow much. It certainly seems like everyone is [cutting down their long-term estimates](http://www.nytimes.com/2016/01/26/upshot/budget-office-lowers-its-forecast-for-obamacare-enrollment.html) for exchange enrollment.

Reed: The other possibility would be to expand the pool of people who qualify for subsidies. Is that a political nonstarter?

Margot: It’s such an interesting question. Every time I write a story about the health law, I get comments and emails from people just above the income cutoff for subsidies. These are the people who have been most hurt by the health law. Plans on the exchanges are just really expensive for them, and often come with big deductibles, too. And if premiums keep rising, they’ll keep getting squeezed. Analysts from the Urban Institute [have done the math](http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000328-After-King-v.-Burwell-Next-Steps-for-the-Affordable-Care-Act.pdf) and found that some of them are paying more than 25 percent of their income on health care now. Still, it is awfully hard to imagine Congress approving massive new spending to make Obamacare more generous. [Hillary Clinton has some proposals](https://www.hillaryclinton.com/briefing/factsheets/2015/09/23/clinton-plan-to-lower-out-of-pocket-health-care-costs/) about affordability, but they don’t include expanding subsidies.

Reed: One of the strengths of the law, and its main weakness, is its emphasis on keeping the status quo. While President Obama may have overpromised when he said you can keep your plan if you like it, the insurance isn’t radically different. The only way companies can seem to bring down prices is by narrowing networks of hospitals and doctors or hiking deductibles. While Bernie Sanders seems to be offering the most dramatic change by proposing that everyone switch to a government plan like Medicare, I’m still looking for a market response — some real change in how care is delivered that is much less expensive or at least more effective.

**Margot**: This is the thing I say whenever anyone asks me what I think about the health law. It basically baked in all of the complexity and dysfunction of the pre-existing American health care system.

**Reed**: We’re heading into the season when insurers and state regulators start talking about next year. Any thoughts on what we might expect?

Margot: I’m expecting them to ask for rate increases! The insurance companies are doing everything they can to [broadcast their intentions to charge more](http://www.nytimes.com/2016/04/01/upshot/new-health-insurance-customers-are-sicker-should-we-be-surprised.html?ref=topics). There are reasons we should expect the plans to do so even if the markets were already stable. Some of the early training-wheel programs set up by the law expire, which means the plans have to pay out more claims for really expensive patients. Last week, I heard Peter Lee, who runs Covered California, the most stable market of all, say he’s expecting bigger rate hikes next year than the last two. The Department of Health and Human Services has even signaled it expects rates to go up. This week, it put out [a research paper to remind the public](http://1.usa.gov/1RSfUrW) that requests to hike rates don’t always matter for individual consumers.

What will you be keeping your eyes open for to shape your thinking about how these markets will do long term?

Reed: We should keep watching for the exits.

But we should also look at what happens with some of the newer players, like Oscar, the for-profit company in New York that has a lot of capital. And I know that some of the big health systems —

I’m thinking of another hometown player, Northwell Health, formerly North Shore-LIJ Health System — have started offering plans. Some of these systems, like Northwell, have had some success in attracting customers and think they can make a go of it.

And we should watch the Department of Justice. If it approves some of those big health insurance mergers like Anthem and Cigna and Aetna and Humana, my guess is those companies will not be leaving the marketplaces anytime soon.

<http://www.nytimes.com/2016/04/14/upshot/news-about-obamacare-has-been-bad-lately-how-bad.html?mabReward=A3&action=click&pgtype=Homepage&region=CColumn&module=Recommendation&src=rechp&WT.nav=RecEngine&_r=0>

**HHS Study Shows Benefits of Shopping and Subsidies, but Costs Still a Concern**

Georgetown University Health Policy Institute

As insurers selling on the Affordable Care Act’s (ACA) Marketplaces begin to file their 2017 rates with the Department of Health and Human Services (HHS), concerns over proposed increases will once again emerge. But a report released by the HHS Assistant Secretary for Planning and Evaluation (ASPE) demonstrates that behind the headlines about rate hikes, consumers are likely to see much more modest premiums after they have shopped around for the best deal and after subsidies are taken into account. Nonetheless, additional research released this week reminds us of more longstanding trends towards higher out-of-pocket costs that pose challenges for consumers, even as state and federal Marketplaces work to address these challenges.

Premiums, Shopping, and Subsidies

Data suggesting that those seeking coverage through the ACA’s Marketplaces [have higher medical costs than those who had coverage prior to the ACA](http://www.nytimes.com/2016/03/30/us/politics/newest-policyholders-under-health-law-are-sicker-and-costlier-to-insurers.html?_r=2&utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=27840980&_hsenc=p2ANqtz-9z7k0aja2kYvUR3bFwt_FuE4Y1edtwuPidXvH5OI5tcD-Pc31ScIMYexNfB_FZOv0gin4EyqlMCDwHh8kP5PPWf5KRTA&_hsmi=27840980) has once again [fostered concerns](http://www.wsj.com/articles/affordable-care-act-enrollee-spending-is-increasing-1459310462) about premium increases for Marketplace coverage. Of course, none of this is news, as the need to provide a path to coverage for those who were previously locked out of health insurance was [the main rationale](https://twitter.com/SabrinaCorlette/status/715165247204679680) for the ACA’s market reforms. Still, increasing premiums certainly pose a challenge for consumers and policymakers alike. But this week’s ASPE report demonstrates that proposed rate increases are only part of the story.

ASPE’s data reminds us that the Marketplaces are structured to facilitate shopping around for the best value. In its analysis of the 38 states operating on the federal Marketplace platform, 43 percent of returning customers shopped around and selected a different plan.

In addition, consumers can also qualify for subsidies through the Marketplace, and 85 percent of those with Marketplace plans received premium tax credits to offset the cost of coverage. ASPE reports that when subsidies are accounted for, the average monthly net premium increased by four percent between 2015 and 2016. Since the average net monthly premium after subsidies was $102 in 2015, this represents an average monthly increase of $4, for an average monthly premium of $106 in 2016.

More than Premiums: Rising Out-of Pocket Costs Threaten the Value of Coverage

But while ASPE’s research provides a more complete view of the way in which consumers experience Marketplace coverage, additional research released this week reminds us that premiums are not the whole story. In addition to premiums, consumers face additional out-of-pocket costs in the form of copays and deductibles[. Recently released research from the Kaiser Family Foundation](http://files.kff.org/attachment/issue-brief-paying-for-health-coverage-the-challenge-of-affording-health-insurance-among-marketplace-enrollees) underscores the challenges that consumers face in affording their coverage even after the ACA’s market reforms. According to 2014 survey data, one third (33 percent) of those with Marketplace coverage reported having trouble paying for their premiums, compared with 17 percent of those with employer-sponsored coverage.

Kaiser’s survey data suggests that this difficulty in affording coverage stems from the interaction of premium costs with other expenses, some directly related to health care while others are the result of more general economic pressures on families with low and moderate incomes. For example, 49 percent of those reporting difficulty paying their premiums had dependent children in the home, compared with only 16 percent for those that did not report issues with their premium. Kaiser also finds that those with difficulty paying their premium were generally more likely to report facing financial challenges in other aspects of their lives.

Additional out-of pocket costs besides premiums also posed challenges for consumers. Kaiser reported that 36 percent of Marketplace consumers report dissatisfaction with their deductible. More generally, adults that reported trouble paying their premiums were more likely to use services (and thus more likely to face charges associated with their deductible). Further, as a result of these out-of-pocket charges, 38 percent of adults with difficulty paying their premium reported unmet need for care. This demonstrates that affordability challenges threaten access to core services, even for those with insurance.

Concerns about affordability are not a new phenomenon limited to the Marketplace. Rather, rising out-of-pocket costs have been a trend in the private insurance market. For example[, a recent study](http://www.healthsystemtracker.org/insight/payments-for-cost-sharing-increasing-rapidly-over-time/) of employer-sponsored coverage based on the Peterson-Kaiser Health System Tracker found that between 2004 and 2014, average payments by enrollees towards deductibles rose 256 percent, from $99 to $353. This led deductibles to go from representing a quarter of cost-sharing payments in 2004 to almost half in 2014. Buttressing these findings, the Commonwealth Fund [recently reported](http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/how-high-health-care-burden) that when total out-of-pocket costs are taken into account, including premiums, deductibles, and other cost sharing, a quarter of all adults with private insurance had unaffordable coverage.

Tools to Help Inform Consumer Choices

While these trends suggest that out-of-pocket costs will continue to be an issue for consumers looking for affordable coverage, HHS recently announced changes to Marketplace coverage that aim to assist consumers in finding a plan that is most affordable. This is important, as Kaiser’s recent report found that adults with difficulty affording their premiums were also more likely to report difficulty understanding aspects of their coverage. First, carriers selling through the FFM for the 2017 plan year [will be required](https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017) to offer a standard plan option with standardized in-network deductibles, cost-sharing limits, and copayments and coinsurance amounts. These standardized options will make it easier for consumers to compare benefits and costs across plans. These changes in the FFM build on efforts in state Marketplaces such as California, which [requires insurers to offer standardized plan designs](http://board.coveredca.com/meetings/2016/1-21/CoveredCA_comments_9937-P_Standard_Benefit12-21-15.pdf) that specify which services may be subject to a deductible and otherwise limiting out-of-pocket costs. California also recently announced [changes to their contracts with insurers](http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-5-2016_CLEAN_V3.pdf) that require plans to provide consumers with more tools to help consumers make informed choices when selecting plans and the costs of covered benefits.

In addition, HHS [has revised the template for the Summary of Benefits and Coverage](http://healthaffairs.org/blog/2016/04/07/cms-releases-final-summary-of-benefits-and-coverage-template-accompanying-materials/) that serves to inform consumers of the costs and benefits associated with their plan. These summaries will now contain more information on which services are covered before the deductible and other limitations such as situations where cost-sharing on a covered service does not count toward the consumer’s out-of-pocket limit, numerical or dollar limits on services, and prior authorization requirements.  While long term trends suggest that out-of-pocket costs will continue to pose challenges for affordability and access for consumers, these tools will allow them to make more informed decisions about their coverage.

http://ccf.georgetown.edu/all/hhs-study-shows-benefits-shopping-subsidies-costs-still-concern/

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at [kvanpelt@vitalysthealth.org](mailto:kvanpelt@vitalysthealth.org).