United Cuts Ties with the Exchanges – But Who is to Blame?

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Late last year, UnitedHealth, the nation's largest health insurer, warned that in 2016 it may make the decision to pull out of the Obamacare health insurance exchanges completely, starting in 2017 (it had already cut its advertising on all ACA plans). Not surprisingly, this sparked a great deal of commentary among both supporters and critics of the ACA, some leveled and thoughtful, some bordering on panic. Now, approaching the halfway point of 2016, it is becoming clear that United will make good on those representations. Per more recent reports, United already has plans to withdraw from marketplaces in Michigan, Connecticut, Arkansas, and Georgia, and has maintained the possibility of leaving the exchange marketplaces completely in 2017.

Not surprisingly, the reason behind United's withdrawal from the exchanges is a lack of profitability. So, before discussing the likely effects on the exchanges, it is worthwhile to look at what has made them unprofitable for companies like United in the first place. A primary reason is the same reason self funding is so attractive to many employers, and has become even more attractive in recent years – the ACA stripped insurers of many of the methods they previously utilized to control how much risk they take on. The inability to place dollar limits on most services, the inability to deny coverage due to pre-existing conditions or increase premiums for older customers, the establishment of annual out of pocket maximums, however you feel about these regulatory requirements, there is no question that they result in significant added claim exposure for insurers. Add to this a marketplace where a large pool of previously uninsurable Americans are given the opportunity to enroll all at once, and the obvious result is a historic influx of high risk insureds.

But, are the exchanges truly unprofitable and unfriendly to insurers across the board, or just to insurers such as United? Other insurers are having more success, and it is quite possible that United has simply attempted to utilize an outdated model in a new landscape with different rules. Exchange customers tend to choose lower cost options, and United is rarely the most economical benefit option (and what it is, it is not by much). Commentators have posited that this could be because its plans tend to offer wide networks, providing for maximum flexibility in choosing between medical providers over a large geographical area, while other insurers have kept costs down despite the ACA with features such as narrow networks and other cost containment methods.

In addition to reasoned commentary suggesting that United's failure in the exchanges it at least partially the fault of United rather than the exchanges themselves, the actual impact on the exchanges of even a full withdrawal by the nation's largest insurer may not be as devastating as many might think. Despite being the nation's largest insurer, United's actual footprint in the exchanges, before any withdrawals, is not particularly large (it covers about 6 percent of all marketplace enrollees). A report released last month by the Kaiser Family Foundation concluded that without United, the cost of the exchanges most popular silver plans would increase by about 1% nationally. However, the loss of United could have a much more significant effect locally, particularly in parts of the south. Many areas have access to few insurers offering exchange plans, and if another did not step in to fill the gap, United's withdrawal would leave millions of

exchange enrollees with only one or two insurers to choose from. In an insurance market, a lack of competition is never a good thing for customers.

Even if the exchanges' loss of United likely doesn't mark the death knell for the ACA or the exchanges themselves, it will create some volatility, in some locations more than others, and it has become exceedingly clear that it will take longer than initially expected for the exchange markets to stabilize. A way around this problem for many employers, and the sometimes skyrocketing premiums associated with it, is self funding. Self funding allows an isolated group, an employer, to shoulder only its own risk, not the pooled risk of an entire marketplace. Recent reports have estimated the average annual cost of medical care for exchange enrollees at 22% higher than that of Americans enrolled in employer-sponsored healthcare ($559 per month in 2015, versus $457). Plan expenses reflect this, resulting in huge savings as compared to purchasing group coverage from a traditional insurer. Opponents of self funding might claim that the market needs low risk lives to balance out the influx of risk coming into fully insured plans, and point to the ability of a company to self fund, removing those lives from the general risk pool in the insurance market and assuming only the claims risk of its own healthy employees, as the source of an adverse-selective effect, with insurers and customers on the exchanges bearing the brunt of the cost. Managing claim risk is by no means the only reason to self fund, however, and many self funded employers carry numerous extremely high risk lives, and still enjoy significant savings versus insurance, while also enjoying the other benefits of self funding, such as unmatched flexibility in benefit offerings. Indeed, many self funded employers choose to offer robust benefits which the fully insured market can't begin to compete with, while doing it in a more cost-effective and creative fashion.

So, lawmakers can either wait for these markets to eventually stabilize themselves, or take action to help things along. Here are a few scenarios:

A Bailout of Health Insurers

This possibility may be determined more by the next election than by the healthcare marketplace, but it is a distinct possibility nonetheless. Any campaign promises aside, a "bailout" would likely come in the form of a restructuring of the ACA's "risk corridor" cost-shifting features rather than an actual "repeal" of the ACA (which would render millions of Americans immediately uninsured with no prospect of replacement coverage). In its current form, the risk corridors are budget-neutral, in that funds are shifted only from profitable insurers to unprofitable ones, thereby insulating participating insurers from some of the losses they may stand to incur by taking on additional claims risk. Introducing public funds into this system could bolster this insulation, making the ACA exchanges more attractive to insurers, with the ultimate cost of course falling onto taxpayers.

Self Funding in the Crosshairs

As discussed above, a significant pool of lives, along with their potential premium dollars, is safely insulated from the exchanges in self funded health plans. Herding these lives into the exchanges would immediately make the exchanges more attractive to insurers. Rather than taking aim at the ACA itself, or funneling more funds into the system, it is possible that self

funding could become a target, with policy attempting to reduce or eliminate its viability as an alternative to traditional health insurance. The most obvious way this would be accomplished is through changes to ERISA, but this could also be accomplished to an extent by implementing policy which would disassemble the structures supporting self funding, particularly stop-loss or reinsurance, which can be regulated at a state level without the need for federal action. In fact, many lawmakers at state and federal levels are already attempting to hyper-regulate stop loss and reinsurance carriers, openly stating that the purpose of such regulation is to cull self funding, thereby strengthening the exchanges.

But, perhaps both of these approaches are ignoring the real problem. Perhaps the real question is: why are we operating in a system where simply getting sick can likely result in complete financial ruin? If having hemophilia, or end stage renal disease, didn't require hundreds of thousands or even millions of dollars in medical care, the very reference point for what "high risk" means would shift. Whatever the eventual solution to this illness, self funded plans must find ways in the interim to manage the symptoms – this means innovating ways to manage costs at the plan level, finding new ways to incentivize individuals to take responsibility for their own healthcare spending, and of course combating legislative efforts to undermine the viability of self funding as a health coverage option.

For more information on how to stay ahead of the curve, contact info@phiagroup.com.