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Race to the Bottom: Competition in the Exchanges

Insurers rush to attract the healthy and avoid the sick, then narrow the networks to the point of inefficient delivery.

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The news isn't good for the ObamaCare exchanges. Most buyers this year are facing higher premiums, higher deductibles and narrower networks than last year and we are seeing more people drop their coverage as the months go by. That last fact is the most alarming. Last year, 1.3 million people dropped out of the exchanges after having signed up in the open enrollment period. In general, those who drop their coverage tend to be healthy. But, if the only ones who remain are the old and the sick, the prospect of a death spiral looms larger.

Don't blame the insurers. They are doing the best they can, given the incentives created by ObamaCare rules and regulations. President Obama promised a new health insurance market place – one in which health insurers would no longer discriminate against chronic patients with pre-existing conditions. What we have is worse discrimination than we had before.

At the time of enrollment, insurers face perverse incentives to attract the healthy and avoid the sick. The conventional wisdom in the industry is that healthy people buy on price. Only the sick spend time looking to see what doctors and facilities are in the health plan's network. Only the sick pay close attention to copays and deductibles – especially for medications for chronic conditions.

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After enrollment, the insurers have a perverse incentive to over-provide to the healthy (to keep the ones they have and attract more of them) and under-provide to the sick (to encourage the exodus of the ones they have and discourage enrollment by any more of them). They are acting on those incentives.

A study by researchers at Emory University finds that out-of-pocket expenses for medications in a typical Silver plan are twice as high as they are in the average employer-sponsored plan. For example, patients in a mid-priced Silver plan with at least one chronic condition such as diabetes or asthma pay $621 out of pocket for prescriptions, on the average. That compares to $304 for those

with employer coverage. The result: fewer prescriptions are being filled and refilled.

This practice is shortsighted, says health economist Ken Thorpe, one of the researchers who produced the study. The cost of drugs known to prevent illnesses, such as Metformin for diabetics, is much less than the cost of treating advanced diabetes. Discouraging the drug through high out-of-pocket charges is "penny wise and pound foolish," he adds.

Thorpe would be correct if the insurer planned to keep the patient around for many years. But that isn't their intention. The insurers don't want diabetics in the first place! They would be delighted if all their diabetics left and joined some other plan!

Another of President Obama's promises was that health reform would usher in a new era of coordinated, integrated care in which providers work in teams to insure high quality and efficient delivery. Yet the opposite is happening. According to a study funded by the Robert Wood Johnson Foundation, health plans are trying to keep premiums down by paying low provider fees – even lower than Medicaid pays in some cases – and including in their networks only the providers who will accept those low fees. In other words, narrow networks are the result of economics, not the result of the desire to have better coordinated care.

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A study by Avalere finds that the average exchange plan network includes one-third fewer providers than non-exchange plans (such as employer-sponsored plans), with even larger shortcomings in such specialties as oncology and cardiology. Specifically, the analysis finds that exchange plan networks include 42 percent fewer oncology and cardiology specialists; 32 percent fewer mental health and primary care providers; and 24 percent fewer hospitals.

Researchers at the Leonard David Institute of Health Economics approached the same issue in a different way. They categorized network size into five groups: x-small (fewer than 10% of the providers are participating), small (10% to 25% are participating), medium (25% to 40%), large (40% to 60%), and x-large (more than 60%).

Given those categories, the researchers found that more than 40% of networks can be considered small or x-small, including 55% of networks in HMOs and 25% of PPO networks.

Networks can also be evaluated by specialty. The researchers found that 36% of primary care networks were small or x-small, compared to 23% of internal medicine subspecialty networks and 59% of oncology networks.

Commenting on the Avalere study, Robert Book notes that:

Narrow networks are a major impediment to care coordination, since it makes it much more difficult for patients to assemble a care team that is both in network and able to coordinate care with each other....

There are numerous reported examples of patients facing these issues, including cases in which a network includes both surgeons and hospitals, but where the none of the in-network surgeons have privileges at the in-

network hospitals.

And here is something that is catching a lot of patients by surprise. If a doctor or facility is "out-of-network," the patient is responsible for 100% of the bill.

Take the case of Robert Martin, an 18-year-old Los Angeles resident who hurt his ankle playing football. Before taking him to the emergency room, his mother was careful to make sure that the hospital was in her insurance plan network. But after paying the required co-payment, she received an additional $1,400 bill from the doctor. Even though the hospital was in-network, the doctor wasn't!

If a patient goes to an in-network hospital but sees an out-of-network doctor, the patient is responsible for 100% of the doctor's bill.

The White House is defending the experience of the exchanges by claiming that competition works. Where there are more insurers competing in a market, says Richard G. Frank, an assistant secretary of Health and Human Services, premiums are lower. True, but if the way insurers keep premiums down is by forming networks of those doctors who will accept the lowest fees, that isn't necessarily a good thing.

Some exchange plans are paying doctors less than Medicaid pays. Blue Cross in Dallas, for example, pays some doctors 10% less than Medicaid's fee. If insurance buyers were forewarned, that would be one thing. But no exchange plan is advertising that access will be worse than it is for Medicaid patients.

Some people (including some health economists on the right) are defending these outcomes by claiming that narrow networks are actually good. Integrated providers at such places as Kaiser Permanente or the Mayo Clinic, they say, are better able to provide coordinated care – raising quality and lowering costs. But that is not how the exchange plans are forming their networks. The ObamaCare plans aren't grouping together doctors who know each other and practice together. They are simply throwing out a low price and taking every physician who will accept it.

As Robert Book explains in a blog post at Forbes:

A patient who has heart disease and diabetes needs a primary care physician, a cardiologist, and an endocrinologist – and needs them to know each other and be used to communicating with each other to coordinate care. They also must have privileges at the same hospital, so they can all consult when hospital care is needed. If that patient has a narrow network plan, she is much less likely to find all of those physicians who both know each other and are in the same insurance network – not to mention that there might not be an in-network hospital at which all have privileges.

Meanwhile, yet another bait and switch is underway. Health plans are managing to avoid sky high spikes in premiums by increasing their deductibles instead.

An analysis at Yahoo Finance explains it this way:

Customers who choose Ambetter's $6,500 deductible plan in Indianapolis will get limited benefits such as primary-care visits at a cost of $30, specialist visits for $60 and generic

drugs for $15, along with free preventative care such as vaccines. But big-ticket items like diagnostic testing, MRIs, specialty drugs, emergency-room visits and surgical procedures aren't covered until after a patient racks up $6,500 in in-network bills...

And there is a down side to artificially low premiums:

By offering the two lowest-cost Silver plans in the Indianapolis market with ultra-high deductibles, the insurer is driving down the subsidies available to purchase either more comprehensive coverage or lower-cost bronze coverage. That's because the size of exchange subsidies depends on the price of the second-cheapest Silver plan in each market. Largely because two Ambetter plans are priced so low, the subsidy available to 30-year-olds earning 250% of the poverty level in Indianapolis-area Marion County will fall from $1,140 this year to $809 in 2016. That will hike after-subsidy premiums for the cheapest Bronze plan by 25% to $1,914 a year.

In a previous post, I reported on anecdotal evidence that the U.S. is headed toward a two-tier health care system, with many patients being denied access to the best doctors and the best facilities. Scholarly studies are now confirming that observation.

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