Law professor sees trouble brewing along the HIX horizon, but is the sky falling?

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What will happen across Main Street and Corporate America if public health insurance exchange (HIX) enrollment for 2014 ends up being about 2 million instead of the projected – and hoped for – 7 million mark? A University of Houston law professor offers a sobering outlook. But it’s still anyone’s guess as to whether the nation is in store for a health care reform hangover.

Seth J. Chandler recently outlined the possible consequences of this scenario in a provocative analysis published by The Health Care Blog, which major media outlets have described as a leading industry authority and insider voice.

Among his predictions:

Chandler arrived at the 2 million sweet spot with the help of predictions for the federally-run Pre-Existing Condition Insurance Plan that ran from 2010 to 2013 and served as the basis for modeling estimated signups for the individual exchanges.

“We’re just not seeing the kind of numbers that were projected to occur by now,” he told EBN, noting that they’re actually less than a quarter of that initial projection.

Even with allowances for procrastination and a surge of interest, he’s convinced that HIX enrollment numbers will be substantially lower than expected for 2014. The fact that the deadline to enroll keeps being extended “is an indication that enrollment is not going as initially hoped for,” he adds.

However, it may be far too early to think the world is ending when viewing the emerging HIX marketplace within a larger context or longer time horizon. It’s not unusual for a new initiative to falter before it becomes successful or popular. Some benefits industry observers point to the Medicare Part D prescription drug program as one example.

A spokeswoman for the U.S. Centers for Medicare and Medicaid Services, who agreed to provide background information only, noted that the public exchanges are still barely “half way through a six-month-long open enrollment period” and that November enrollment “was more than four times greater” than the previous month. “Additionally,” she says, “we will continue to
conduct robust outreach and education to the uninsured to ensure they know of their new health insurance options.”

The stakes are certainly high, with risk being the operative word. “This is all about risk allocation and who joins, and when they join the exchanges,” says John Rother, president and CEO of the National Coalition on Health Care, a nonprofit and non-partisan group of more than 70 organizations representing about 150 million Americans. He believes that individuals with more health issues will be the most motivated to initially enroll in the exchanges, sparking concern about adverse selection and higher costs.

Nonetheless, Rother points out that eventually there will be a more balanced mix of healthy and less-healthy enrollees in the exchanges. The factors the will drive that outcome include a stronger desire for coverage, lack of alternatives and much higher penalties after the first year.

And there could be much more to the professor’s predictions than meets the eye. “I would think there would be other issues,” says Paul Fronstin, director of the Employee Benefit Research Institute’s Health Research and Education Program. “Fewer people with coverage – in other words, more uninsured individuals – impacts overall use of medical devices and drugs, both of which have taxes associated with them, that would translate into lower tax revenue.”

Assessing SHOP exchanges

Chandler recently began studying the impact of scenarios referenced in his blog on the scope, quality and future of employer-provided health benefits coverage. He’s particularly concerned how SHOP exchanges will function, particularly for the smallest employers that will be eligible for tax credits.

His sense is that SHOP will draw mostly unhealthy employee populations, which will turn the exchange into a high-risk pool that will scare away small firms with healthy workers that will instead choose to negotiate lower rates with existing carriers along the road to complying with essential health benefits requirements.

“If the individual exchanges become dysfunctional because there aren’t enough people in them and therefore there are price pressures, that alternative is less appealing to some employers,” he surmises. “To think that everything will play out in a linear model that the Congressional Budget Office used is pretty unrealistic.”

Chandler is curious about what is happening with state-run SHOP exchanges, referencing a dearth of information on this part of the HIX equation in contrast to an endless stream of reports about the federally facilitated marketplace’s technical difficulties. There could be “50 different narratives” on how implementation of the Affordable Care Act will unfold with experiences varying from one state to the next, he says.
For example, Oregon’s HIX enrollment is, in his opinion, “a disaster” with just 44 people enrolled by the end of 2013. Not only is the state’s website not working, but there also are problems with processing paper-based applications. Given the state’s middle-of-the-road demographic mix and liberal leanings in its urban areas, “you would not expect it to be acting like Texas or some of the very conservative states where a lot of people just won’t participate on principle,” he adds. Chandler cites Texas and Maryland as states with low enrollment in the early stages of the HIX rollout.

In contrast, he says state-run exchanges in California, New York and Connecticut are “doing okay,” though two unknowns are how many reluctant consumers will come around and sign up as well as pay their premiums.

Do size and money matter in the SHOP exchanges? Absolutely, according to Rother.

“The impact is going to vary, depending on the size and wage level of the employer,” he explains. For example, he says there will be strong incentives for lower-paid employees of small businesses to join the public exchanges with the possibility of an employer contribution toward that coverage. This scenario is likely because these firms lack the leverage of larger companies to negotiate deep group discounts. His belief is that most of those employees will be better off with HIX coverage.

On the other hand, he says higher wage environments such as a law firms will not qualify for HIX subsidies and more than likely will prefer to keep their workplace plan. Employers “probably won’t have the option to walk away without facing some pretty severe financial penalties,” he notes.

Rother doesn’t believe there will be any significant disparities between SHOP exchanges run by federal government versus individual states, but he sees “regional variations in health care costs” – a phenomenon that the exchanges will make more visible. “I don’t think it’s a function of how well the exchange runs,” he says, adding that most high-cost areas are being served by federally facilitated exchanges.

Next battleground issues

After making such bold predictions, Chandler cautions the readers of his blog by explaining that his thinking could be proven wrong by a host of unforeseen events. For example, HIX enrollment could swell if the federal government decides in 2015 to substantially raise the penalty for not having health insurance coverage to $295 per individual or 2% of household income (whichever is greater) from $95 per person or 1% of household income (again, whichever is greater).
He also points to the potential actions of other key stakeholders – from a decline in free transitional reinsurance for HIX insurers putting pressure on premiums, to employers deciding to pare full-time payrolls or maintain coverage.

A few wild cards were also tossed into his conclusion. These included events such as a major security breach in Healthcare.gov’s security that compromises personal information, continuation of serious technical malfunctions for online enrollment and the public HIX payment system for insurers, drastic reductions in HIX medical providers or a sea change in legislative power.

And with some ACA supporters arguing that the main goal of health care reform is to have an actuarially sound pool rather than reduce the number of uninsured individuals per se, Chandler says it’s “damage control in high gear.” He says one indication of this is the federal government’s refusal to release the age-distribution of public HIX plan enrollees.

The narrowing of provider networks could be the next big battleground in terms of consumer resistance to the ACA, according to Chandler – especially if friends or family members share their tales of woe. He says another scenario that soon will play out involves pricing associated with early catastrophic claims spiking rate requests that must be filed by May or some insurers deciding to pull out, altogether. With people already griping about sticker shock, he calls this a serious problem that could deepen consumer skepticism and renew calls for repeal of the ACA.