Goodman Institute
Turning Ideas Into Policy

How Obamacare Made Things Worse for Patients With Preexisting Conditions

What would the individual health insurance marketplace look like if it were designed to meet consumer needs aas well as other markets?

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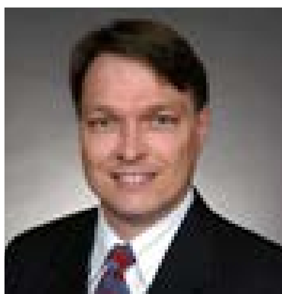

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One of the strange features of the national health care conversation is how it has evolved.

What is often referred to as Obamacare began as an attempt to insure the uninsured. In fact, the initial Congressional Budget Office estimates predicted the Affordable Care Act would be largely successful in doing just that.

Yet it was the Senate's Democratic leader, Chuck Schumer of New York, who identified the political problem with that goal early on. About 95% of those who vote already have insurance, Schumer noted. So Obamacare was promising to spend a great deal of money on people who don't vote.

Perhaps for that reason, the public case for health reform underwent a dramatic shift. On the eve of its passage, virtually every advocate who went on national TV to advocate for the Affordable Care Act had nothing to say about insuring the uninsured.

Instead, their message focused on protecting sick people from abuses by insurance companies. More often than not, that meant protecting people who migrated from an employer plan to the individual market with a preexisting condition.

That message has continued. Virtually every Republican proposal to reform Obamacare has been attacked by opponents as weakening protections for those with preexisting conditions.

The message is not aimed at voters who have individual insurance. It is aimed at voters with employer coverage who fear they may end up in the individual market and be mistreated.

So what has been the result of health care reform under Obamacare? Have things gotten better for people with preexisting or chronic health care problems? Or have they gotten worse?

The Market Before Obamacare

Wharton economist Mark Pauly and his colleagues conducted an extensive study of the individual market in the pre-Obamacare era. They found that less than 1% of the population was both uninsured and uninsurable because of a preexisting condition.

What happened to those Americans? Prior to Obamacare,

those with preexisting conditions were protected under the federal Health Insurance Portability and Accountability Act (1996), which required states to enact measures to protect such people.

Most states complied by setting up risk pools, which provided subsidized insurance. The insurance typically resembled a standard Blue Cross plan and the premium enrollees paid was often 50% to 100% higher than the premium paid for comparable coverage in the individual market.

This arrangement was not perfect. In some states there were waiting lists, for example. And there often was a waiting period for coverage of preexisting conditions. But the vast majority were handled in this way.

The Affordable Care Act introduced a temporary program, effective in 2010-2014, prior to the full phase-in of the law, stipulating that people who were denied coverage in the individual market were able to enroll in a federally funded risk pool. They would pay a premium no higher than the average premium charged to healthy people in the individual market.

Over a three-year period, roughly 135,000 people took up this offer.

Significantly, at the end of this period, virtually no one in the country was forced to be uninsured because of a health condition.

Despite this reality, Obamacare went on to impose massive changes to the market, in the form of a major new Washington-designed program that created heavily regulated "exchanges" to sell insurance products on the individual or small group market.

Many of the country's top hospitals today are off limits to patients covered by Obamacare's current plans.

The Promise of Obamacare

When the Affordable Care Act was enacted, many advocates probably imagined it would look like a typical employer plan or a standard Blue Cross individual policy. And in many markets, that's how it started out.

When Blue Cross of Texas first entered the Dallas exchange in 2014, for example, its plan looked a lot like the plans it sold to employers. The coverage extended to virtually every hospital in the Dallas-Fort Worth area, including the prestigious University of Texas Southwestern Medical Center.

But after sustaining huge financial losses, the insurer retreated the following year to a more restrictive plan that treated UT Southwestern as an out-of-network hospital. That meant patients faced steep out-of-pocket expenses on top of an already large deductible. The following year, UT Southwestern was excluded entirely.

Today, not a single exchange plan in Texas covers UT Southwestern. The same process has been repeated across the country.

Reality: Plans That Look Like Medicaid, With a High Deductible

Many of the country's top hospitals today are off limits to patients covered by Obamacare's current plans. Take Houston's MD Anderson Cancer Center, which was named America's best cancer-care hospital by U.S. News & World Report in 13 of the past 16 years.

The hospital's website suggests that it takes even garden-variety Medicaid, but it doesn't accept a single private health insurance plan sold on the individual market in Texas.

Since Blue Cross of Minnesota withdrew from the individual market in 2016, the state's Mayo Clinic—once cited by President Barack Obama

as a model for the nation—has been off limits to many Minnesotans covered by Obamacare exchange plans.

For instance, most of the 170,000 people with Obamacare who live in the Twin Cities do not have access to the Mayo Clinic. Likewise, Memorial Sloan Kettering appears out of bounds for every exchange plan in New York. Both of these hospitals are open to some Medicaid patients, although Mayo's chief executive predicted publicly that Medicaid patients eventually may have to queue behind their privately insured peers.

Unlike Texas Blue Cross, many established insurance titans such as Aetna, Humana, and UnitedHealth Group have retreated from market after market. Meanwhile, the remaining insurers are offering products that look a lot like Medicaid.

Centene, a Medicaid contractor, stepped in to pick up more than half the U.S. counties that had no insurer for 2018. In fact, Centene now supplies about 1 in every 5 Obamacare plans in the country.

Centene's core business is Medicaid managed care. About 90% of its exchange enrollees were eligible for premium subsidies as of 2016, and many rotate in and out of its Medicaid plans.

In a controversial 2014 decision, a Centene health plan refused to pay for a child patient's emergency brain surgery at Children's Medical Center in Houston. The hospital said its success rate for the surgery was close to 90%, while hospitals nationwide average only 47%. The insurer claimed the hospital was out of its network for the patient's plan, but relented after its decision was criticized in media reports.

Not much is known about the care of seriously ill patients under either Obamacare or Medicaid. But after conducting a yearlong investigation into the Texas Medicaid program, The Dallas Morning News uncovered hundreds of cases in which "essential medical care was delayed, denied or not delivered to people with critical health needs."

Many of the insurers that provide Medicaid plans in Texas offer similar coverage in the Obamacare exchanges. One of Centene's subsidiaries has the state's highest rate of appeals for denials of care under Medicaid. It offers similar coverage to exchange enrollees.

Narrow Networks

As noted, when the Affordable Care Act was enacted many people (especially Obamacare supporters) thought insurance in the individual market would look very much like employer plans. In fact, the employer mandate and the individual market regulations included the same essential benefits. Yet with the passage of time, the two markets have diverged radically.

> *...Obamacare plans typically contract with one-third fewer doctors and hospitals, on the average, than commercial plans.*

One survey, for example, found nearly three-quarters of insurers (72%) feature narrow networks in the plans offered through the federally managed exchanges (HealthCare.gov). This is in stark contrast to 5% to 7% of employer plans that limit worker choices to a narrow network of physicians and hospitals.

A report by health consulting firm Avalere found Obamacare plans typically contract with one-third fewer doctors and hospitals, on the average, than commercial plans. This equates to 42% fewer heart specialists and cancer doctors, one-third fewer mental health and primary care providers, and one-quarter fewer hospitals.

The main reason Obamacare plans have narrow networks is to hold down costs. That leads to lower premiums and makes the plans more attractive to buyers—especially buyers who don't have any health problems. A 2017 study in the journal Health Affairs found premiums for narrow network plans in the exchange were about 16% lower than plans with broader networks.

Shunning the Top Hospitals

As the Obamacare exchanges were enrolling their first members, Watchdog.org contacted 18 hospitals ranked the highest by U.S. News & World Report. It found that only one plan in all of Ohio (Medical Mutual of Ohio) included the Cleveland Clinic in its network.

In California, the premier Cedars-Sinai Medical Center was in only one Obamacare plan network. Nationwide, 61% of the top hospitals were covered by only one or two Obamacare plans.

In 2018, USA Today reported that Vanderbilt University Medical Center was not covered under any Obamacare plan in the Nashville, Tennessee, area. Vanderbilt is an academic medical center. Patients who relied on specialty care at Vanderbilt had to buy coverage off the exchange and forgo subsidies.

Time and time again, consumers who enrolled in Obamacare plans heard a common refrain when they tried to see a doctor. "We don't take Obamacare."

Shunning the Top Doctors

Poor access to specialty care also has been a problem from the very beginning. Time and time again, consumers who enrolled in Obamacare plans heard a common refrain when they tried to see a doctor: "We don't take Obamacare."

Talking to The New York Times, small business owner Amy Moses, described Obamacare as a "two-tier" system. Although their insurance cards may look the same as other Americans who have employer coverage, many enrollees discover their plans are not accepted by the same number of doctors and hospitals. Some describe feeling like "second-class citizens."

Notably, lack of access to specialists may be worse for children than for adults. Studies have found that pediatric specialties are harder to access than adult specialties in Obamacare plans. In a survey of 1,836 silver plan networks in 2017, researchers found two-thirds had a narrow network in the pediatric specialties compared to roughly one-third in the adult specialties.

Cancer Care

Cancer patients in New York have discovered none of the typical gold, silver, or bronze individual plans on the New York exchange have Memorial Sloan Kettering Cancer Center in their networks. Sloan Kettering is considered one of the premier cancer centers in the country.

This is not uncommon. Nationwide, one-quarter of the cancer centers designated by the National Cancer Institute participated in no Obamacare plans. Many of the top cancer centers reported being in-network in at least one but not all exchange plans in their respective states.

Many of these placed the cancer care center in a higher-cost sharing tier. Not being treated initially at an NCI-designated cancer center increases the likelihood of dying from the disease by 20% to 50% for various cancers, according to a recent study.

Cost of Specialty Drugs

Another problem for seriously ill Obamacare enrollees is sticker shock for those who require costly specialty drugs. These are expensive drugs that cost anywhere from $1,500 to $30,000 a month or more.

Obamacare enrollees often find plans cover fewer high-cost drugs or have higher cost-sharing compared to employee health plans. Higher cost-sharing for expensive drugs is a means to steer members to cheaper drugs.

For instance, generic drugs may be free or available for nominal fees. Specialty medications costing thousands per month may require patients to pay one-third of the cost.

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One company, HealthPocket, found the cost-sharing for expensive specialty drugs in Obamacare plans in 2017 was far more than most patients could afford. Patients with a bronze plan who were prescribed Copaxone (for multiple sclerosis), the Humira Pen (an immunosuppressive drug for arthritis, Crohn's disease, and ulcerative colitis) or Enbrel (rheumatoid arthritis) had to pay about $2,000 a month. The drug Tecfidera, used to treat psoriasis and multiple sclerosis, required cost-sharing of nearly $3,000.

Patients with silver or gold plans faced out-of-pocket costs almost that high. Academic research from Harvard found the use of formulary cost-sharing often is used as a method to discourage high-cost enrollees who would be unprofitable.

Primary Care

Seeing primary care physicians is not always easy for Obamacare enrollees. In an interview with CNBC's "Squawk Box," health care executive Alan Miller explained that providers tend to prioritize appointments—giving favorable access to patients with employer plans that pay higher fees.

Miller is CEO of Universal Health Services, which owns hospitals and ambulatory care centers in Utah. He says low reimbursements are a primary reason emergency department visits did not go down under Obamacare.

Evidence certainly supports this theory. Research going back a few years found that Medicaid enrollees considered it more difficult to schedule timely appointments than patients with Medicare or private insurance or even the uninsured willing to pay cash.

This difference is due to Medicaid's low reimbursements and has persisted over time. It appears that where a patient stands in the queue depends on how generous is the fee paid by his health insurer.

One study found that the fee that Medicaid pays doctors has a significant effect on the ability of patients to see them.

Why a Race to the Bottom on Quality, Access to Care?

Why does Obamacare insurance look so different than what we were promised? The problem starts with community rating, which requires insurers to charge the same premium to all comers regardless of health status. This gives insurers an incentive to seek healthy buyers and avoid sick ones.

Since healthy people tend to pick the cheapest

plan, and sick buyers are much likelier to look carefully at coverage details, plans with low premiums and narrow coverage networks are suited to attract the healthy buyers insurers want.

Additionally, the law provided much larger subsidies for Obamacare coverage than for alternative markets, thus encouraging people with health conditions to choose the Obamacare market whenever they had the option.

For example, sick people who qualified for retiree coverage from their employer, or for employer continuation coverage after leaving an employer plan, or disabled people who qualified for Medicare coverage, or AIDS patients being treated at federally subsidized Ryan White clinics. The net result: a pool in which enrollment skewed older and sicker.

So having attracted higher-cost enrollees, Obamacare then failed to handle their risk adequately. The statute provided for states to create risk adjustment programs to transfer funds from plans with healthier enrollees to plans with sicker ones.

Yet rather than deferring to states, which have long experience regulating insurance, the Obama administration put in place a federal one-size-fits-all risk adjustment program where risk was poorly assessed.

The results? It drove some insurers bankrupt and other insurers with small market shares out of the market altogether. And some insurers passed along the cost to certain patients through higher out-of-pocket charges, according to a 2016 study by Harvard and University of Texas economists.

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Problems on the buyer side of the market also hamper risk adjustment. Since the mandate to buy insurance had dozens of loopholes and was enforced weakly, and since Obamacare drove up coverage costs, millions of healthy people choose to remain uninsured. Only when they get sick do they enroll, and then they tend to choose plans with the most generous subsidies and lowest out-of-pocket costs.

These latecomers often cause insurers to pay out much more in claims than they receive in premiums and subsidies. Companies such as Centene have a partial solution to that kind of buyer behavior: They limit enrollees to getting care only from providers that are willing to accept lower payment rates.

Why Are Premiums and Deductibles So High?

In the first four years of the Obamacare exchanges, the average premium doubled and some families saw their premium increase fivefold. The average deductible in exchanges is about three times the deductible in a typical employer plan.

Why is that?

Before Obamacare, the customers for individual market insurance were either self-employed or buying coverage between jobs. They were mainly seeking financial protection against potential future medical expenses.

Obamacare attracted a new set of customers responding to the law's offer of subsidized insurance to pay for their current medical expenses, including costly customers who migrated into the individual market from other

coverage. That skewed the individual market toward a risk pool disproportionately consisting of older, less healthy, and costlier-to-insure individuals. The resulting premium increases then prompted a growing exodus of unsubsidized customers.

Health insurance expert Robert Laszewski explains that we are in what some people would call a "death spiral" in the unsubsidized part of the individual market. Healthy people are dropping out of the market–making the rational decision to remain uninsured until they get sick.

But as the healthy leave, the cost of covering the remaining enrollees becomes that much more expensive. For example:

—Between March 2016 and March 2018, more than 1 of every 5 people (4.5 million) with individual insurance dropped out of the market.

—Among middle-income families who were not eligible for a subsidy, almost one-half (47%) dropped out of the market.

Both in the Medicaid expansion coverage and in the private insurance exchanges, the sick are enrolling and the healthy are not. In Medicaid, for example, the average cost of new enrollees is 50% more than the cost of the previously enrolled.

In the exchanges, Laszewski gives the example of a family of four in northern Virginia which is among the 40% of families who do not qualify for a subsidy:

—The family faces a premium of $19,484 plus a $6,500 deductible.

—In essence, the family will have to spend $25,984 before they can collect any meaningful benefits.

No wonder almost 29 million people have decided to avoid health insurance altogether.

Health Care Solutions

What would the individual health insurance marketplace look like if it were designed to meet consumer needs as well as other markets?

Instead of running away from sick people, health plans would compete to meet their needs. Cancer Treatment Centers of America, to take one example, would want to enter the individual market.

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The network of centers would advertise and actively seek enrollees who have cancer. It would do that because it could receive a premium for each patient that covers the expected cost of their care.

Could there be a real market for patients with cancer, diabetes, heart disease, and other chronic conditions? One already exists.

More than one-third of seniors on Medicare are participating In the Medicare Advantage program, which gives them access to private coverage–similar to the health plans employers offer. Seniors pay community-rated premiums, and no one can be penalized because of a health condition–just like Obamacare.

But unlike Obamacare, special-needs plans that attract high-cost enrollees receive risk-adjusted additions to the standard premium to cover the extra costs of their care.

Risk adjustment in Medicare Advantage is done by Medicare itself. And like all government programs, it is far from perfect.

However, economist John Cochrane has shown how we can have market-based risk adjustment without government involvement, and a Goodman Institute piece expands on how Congress can empower state governments to create genuinely free markets.

To enable those reforms, Congress should empower the states to carry out needed changes.

For example, the Health Care Choices Proposal, developed by the Health Policy Consensus Group and supported by dozens of policy leaders across the country, would convert Obamacare funds into grants to the states and give them wide discretion to reform individual health insurance markets.

These ideas, especially if combined with other changes to empower patients, could form the basis for real reform that helps sick patients access the care they need.

This Brief Analysis was originally published by The Heritage Foundation.

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