Opinion: What's ailing the ACA—insurers or Congress?

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Since the Affordable Care Act – or what many call Obamacare – has been labeled a failure since the day it started, according to some political types, it's difficult to know if the recent defections by large insurance companies are really a death knell or just growing pains.

Aetna dropped a bombshell Aug. 15 when it announced that it was pulling back dramatically in the individual market, dropping coverage in about two-thirds of the 778 counties throughout the U.S. in which it has offered coverage. UnitedHealthcare announced in April it was pulling out of most Affordable Care Act marketplaces that offer health insurance plans, mostly where there were few enrollees or their market share was very low.

This has led critics and even those who support the ACA to wonder if this could be the beginning of the end for the ACA.

The answer is: We don't know yet, but reports of its demise are greatly exaggerated.

As someone who has spent years researching health insurance and who has testified before Congress, as well as being CEO of a health insurance company, I hope I can offer some insights that may not have surfaced in recent discussions. Here's what explains theses defections and what I think all Americans should know about the debate.

In addition to insurers backing out, Congress has failed to support the

law in ways that could help insurers. Congress is supposed to help insurers cover their losses and thus be more likely to stay in the market.

A new – and complicated – insurance landscape

Insurers file preliminary premium and plan design proposals with federal and state governments in May of each year for the coming year's open enrollment. They have until Oct. 1 to finalize these.

The facts are that almost all insurers on the ACA exchanges pull some of their plans by the October deadline. UnitedHealthcare and Aetna are just more public and extreme than most. This is because insurers have almost no information in May from the current year's enrollment to know how to set premium prices for the next year.

The companies state that they end up pulling back because of major losses on some of their plans. That is true. But every company lists more plans in the spring than they intend to offer in November enrollment. This is because of the lack of data in May.

In other words, as experience reveals actual costs, each company will cut some losing plans. More promising ones survive. This culling is a normal reaction to timing problems imposed by government deadlines. That said, there are also more serious problems behind withdrawals.

Riskier business

The fact is that Obamacare is forcing insurers to take on far more risk than they previously did. They must offer insurance to more people who didn't have health insurance previously. They must cover pre-existing conditions, and they must offer less of a differential among premiums for individuals than ever before.

Most insurance in the U.S. has been offered through employers, Medicare or Medicaid. Having large numbers of people within a group plan allows insurers to spread the risk among a large group of people. The switch to covering millions of people individually is unprecedented.

This creates a new landscape for insurance companies, who survive by the balancing of risk among large groups. It is an entirely new business model.

Think of past experiences in areas devastated by floods or hurricanes, where insurers drop coverage or raise rates. Or, consider your homeowner's insurance, and the increase in premiums you are charged if you file too many claims.

A big problem: Congress has not kept its bargain

There's another problem that is not often discussed when the insurance companies announce their premiums and their coverage areas. Obamacare offers payments to insurers to offset their losses in covering high-risk individuals. Congress is not living up to this part of the law.

These payments, called premium stabilization features, are part of the law.

Republicans in Congress who are opposed to Obamacare, however, last year allowed only 12 percent of the compensation for early losses promised by the ACA.

The ACA law says insurers are due the full amount, but the courts say any shortfalls must be appropriated by Congress, rather than just taken from other funds. This was adjudicated in the courts after the ACA was passed, and initial premiums were set based on this safety net.

Because Congress has only allowed 12 percent of the amount due to insurance companies, the premium stabilization features have been insufficient to limit losses as the law envisioned.

This gap was not anticipated in prior year rates by insurers, but it is built into the premiums this year. That's part of the reason for the increases.

This higher risk coupled with enrollment that was less than anticipated and biased toward those with poorer health resulted in much higher than anticipated costs for insurers. Although insurers are in the business of managing risk, it is the unexpected nature of these changes that have made them much more cautious.

The nature of the insurance market for individuals and the requirement that no one can be turned away creates large and ongoing insurance challenges. Historically, people who posed too high a risk were routinely turned away. Without the ACA, premiums for these previously uninsured people would have to rise to outrageous levels to cover their costs.

What is affordable, anyway?

But having everyone in the pool and reducing out-of-pocket costs to "affordable" levels via sliding scale subsidies allows differences in net premiums to vary only by income levels, not age or other normal factors insurers use.

The "affordable" in the ACA is not based on the gross premiums that are bandied around in the press but net costs after subsidies, as a fixed percentage of income. Net premiums that enrollees actually pay are the objective of the law.

Affordable premiums range from 2 percent of income at the bottom to

9.5 percent at the top. Subsidies are varied to reach these objectives. Thus, the higher premiums being sought now will result in larger subsidies for most out-of-pocket expenses relative to income.

The problem is that not all people receive these variable subsidies. Young people have low premiums to begin with since they use little health care and thus have low subsidies, while those in higher age brackets benefit greatly. The problem is that insurance company premiums must rise to reflect the overall risk of the population rather than the lower level for some groups.

Those with higher incomes not receiving subsidies at all see a net rise in cost. Thus, while most in the market benefit, it is undeniable that some pay more – and they are not happy about it.

But that's what insurance is supposed to be all about – sharing the risk across everyone in the insured population. It's just that we didn't do that prior to the ACA.

And all the good things that people actually do like (guaranteed insurability and fixed premiums regardless of age or gender, no preexisting conditions, etc.) aren't possible unless everyone is in the pool together.

Are we in this together, or going it alone?

Fundamentally, this is a clash between the rugged individualist view of self-sufficiency and a collaborative view of the responsibility of the group for shared objectives. You can't have both, although the ACA tries to balance the two. We have to share the risk, but we still have choice of plans.

But the balancing act fails when it appears there will not be enough

players to provide the choices promised. This is why the loss of choice of plans in many areas of the country is a serious challenge, although a dominant insurer actually may be able to negotiate lower payments from providers and pass it on in lower premiums, as is the case in several states.

So is the sky falling on the Affordable Care Act or not? Making this model work in all areas of the country has always been a challenge, especially where there is a single hospital or dominant provider system or where one insurer has an overwhelming market share. This is where a "public option" or "Medicare for All" might help keep everyone honest.

As Medicare is more aggressive about fostering change and efficiency, it may be that the most innovative payer is the government. On the other hand, competition has worked well in most sectors of the economy, although it is less clear the marketing and administrative overhead that comes with it here is worth the gain. This should be the debate – whether we want to provide access to insurance for all – rather than knee-jerk political responses.

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