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Obamacare Pummels Blue Cross Blue Shield Of NC--What Can We Learn From This?

By Chris Conover, Forbes Contributor

Blue Cross and Blue Shield of NC is expecting to lose more than $400 million on its first two years of Obamacare business. According to this morning's News and Observer, "The dramatic deterioration in Blue Cross' ACA business is causing increasing alarm among agents and public health officials." In response to its bleak experience with the Obamacare exchange, the company has decided to eliminate sales commissions for agents, terminate advertising of Obamacare policies, and stop accepting applications on-line through a web link that provides insurance price quotes–all moves calculated to limited Obamacare enrollment.

What can we learn from North Carolina's experience?

Obamacare Losses Made the Entire Company Unprofitable in 2014

First, these are not nickel and dime losses. BCBSNC reported an operating loss of $50.6 million in 2014– the first such loss in 15 years. Why? Because its Obamacare policies lost $123 million *despite* $343 million in various insurer bailouts (the so-called "Three R's"–risk adjustment, reinsurance, and risk corridors).

What makes this shocking is that BCBSNC is the state's dominant insurer, covering 72% of the large group market. If a deep-pocketed insurer such as this cannot make a go of Obamacare, that does not bode well for many smaller carriers who do not have large profits on other lines of business with which to absorb whatever losses are generated by policies sold on the Obamacare exchanges. Indeed, part of the explanation for why over half of the Obamacare co-ops have already failed is that they lacked the deep pockets of the largest and most experienced insurers in the business.

The fact that one of the nation's largest insurers, United Healthcare, also has raised doubts about its ability to carry plans on the healthcare law's exchanges beyond 2016 makes clear that this problem is not unique to North Carolina.

The Problem is Getting Worse, Not Better

A large carrier such as BCBSNC can afford to absorb a temporary hit to its profits. But the evidence in NC is that Obamacare losses are growing over time rather than shrinking–a clearly unsustainable business model. It may just be a matter of time before BCBSNC too abandons its Obamacare policies as a line of business.

Obamacare losses were $123 million in 2014. Year-end final figures for 2015 may not be announced until late February. But the most recent news suggests they will be at least double the losses experienced in 2014. This mirrors the experience of UnitedHealth, which recently announced it expects to lose more than $500 million on the Obamacare exchanges in 2016 — after already losing $475 million in 2015.

Because of its enormous losses, BCBSNC was able to convince the state's insurance commissioner to allow a 32.5% average increase in its rates for the 2016 Obamacare policies now being sold. It remains to be seen how effective this is in forestalling future losses. However, as shown below, it should be obvious that higher premiums is going to limit the willingness of at least some Obamacare plan members to secure or maintain their coverage.

Special Enrollment Period Enrollees Are a Problem

One other thing made clear by the recent news is that BCBSNC is facing the same problem being experienced all across the country. People who buy their coverage during these special enrollment periods cost twice as much as Obamacare customers who secure their coverage during open enrollment (which this year lasted from November 1-January 31).

The special enrollment period is open to people whose circumstances have changed, such as getting married, having children, losing/changing jobs or similar situations. However, many such individuals evidently are staying insured only for several months, generating a lot of medical bills and then discontinuing their coverage.

Again, this is not unique to NC: earlier this month, in response to complaints by insurance companies, Obamacare administrators eliminated six additional conditions that allowed people to sign up for health coverage outside of the general enrollment period. According to UPI, these steps will "make it more difficult for persons without health coverage to financially manipulate or abuse the Affordable Care Act."

These steps presumably will be good news for the bottom line of insurers such as BCBSNC. But they by no means eliminate various ways in which people have figured out to game the system. More importantly, they clearly do not bode well for the future of Obamacare. Enrollment has been rather anemic. To the degree that Obamacare plan membership was artificially boosted by people willing to pay its high premiums just for a few months until their immediate medical needs were taken care of, any efforts to stem such abuse will inevitably result in even more anemic enrollment numbers.

Rising Premiums Will Lead to Declining Exchange Enrollment

It's critical to remember that the reinsurance and risk corridor subsidies to insurers were only temporary programs designed to terminate at the end of this year. In the meantime, various taxes on insurers are continuing to be phased in. As a consequence, University of Minnesota economist Stephen Parente has calculated that the cost of the least expensive policies on the Obamacare exchanges will more than triple in NC between 2016 and 2017!

That is, the average premium for Bronze policies with very narrow provider networks (to make them affordable) will climb from $1,777 in 2016 to $4,336 in 2017. The average premium for Bronze catastrophic policies (i.e., very high deductibles, again to make them affordable) will grow from $783 in 2016 to $2,929 in 2017.

Dr. Parente's model shows that higher premiums are likely to result in a 2% decline in the number of people with non-group coverage in 2017 relative to 2016. The number of uninsured is likely to rise by 5%. This is not a temporary situation: nearly-identical numbers are projected in every year through 2024. In short, 2016 may well be the year of peak enrollment in Obamacare, with declining numbers going forward after this.

Bottom Line

In light of Obamacare's "crumbling facade" (as the Washington Examiner recently put it), Aetna recently sent a letter to the Obama administration warning the exchanges could collapse next year "unless some fundamental flaws are corrected." In light of the bleak news coming out of BCBSNC, N.C. Insurance Commissioner Wayne Goodwin likewise has indicated his intention to send a letter next week to DHHS Secretary Sylvia Burwell to express his concerns on "this matter of very high priority concern."

We will see if these pleas make any difference. Given the willingness of this administration to ignore strong public opposition to this misguided law at its inception and its continued insistence on implementing the law in the face of persistent opposition by a majority of the public, by various states and by a majority in Congress, I am not holding my breath.

Update #1: February 4, 2016

A reporter asked me whether I agreed with those who blame BCBSNC's situation on NC's decision not to expand Medicaid. For example, in the article I cited, the reporter stated: "Several insurance agents said one reason Blue Cross is getting pummeled by the ACA is because low-income people are signing up for steeply discounted coverage....Many of those people would have been eligible for Medicaid if state officials had expanded the federal health program for the poor under the ACA. "In North Carolina, the Affordable Care Act was not fully implemented," said Adam Linker, a policy analyst for the N.C. Justice Center, an advocacy group in Raleigh. "Obviously, that is not a sustainable way for insurance companies to operate."

My response was that I disagreed that the failure to expand Medicaid had anything to do with BCBSNC's plight:

- The failure to expand Medicaid opened up Exchange to people between 100-138% of poverty. But this had the effect of increasing the size of the pool (generally a good thing in insurance markets since it allows for more stable

rates). Yet there is almost no difference in the risk characteristics of this added Medicaid-expansion-eligible population and those on the Exchange (see Table 4 and its discussion).

- Moreover, even if actuaries wanted to conservatively assume that the expansion-eligible group was sicker than the rest of the pool, the fact that the state wasn't going to expand Medicaid was well-known to BCBSNC actuaries at the time they priced their 2014 policies in 2013 and their 2015 policies in 2014. The decision not to expand Medicaid was not some "surprise" action taken after those rates had been locked into place.
- The reality that the Exchange population has ended up sicker-than-expected has been observed all across the country—not just in states that failed to expand Medicaid. Unfortunately, none of the official statistics measure health status so we have to instead draw weaker inferences based on age.
    - In NC for the 2014 sign-up period, 28% of Exchange enrollees were in the desirable "young" age category of 18-34 vs. 24% who were age 55-64. Those figures are nearly identical to the national averages (Appendix Table A1): 28% age 18-34 and 25% age 55-64. That tells us NC's situation is far from unique.
    - More importantly in states that ran their own Exchanges (nearly all of which expanded Medicaid), the situation was no better: 27% age 18-34 and 26% in the age 55-64 category. In short, such states had a slightly WORSE health status profile in their Exchanges despite having expanded Medicaid. So Adam Linker's claim might sound good theoretically but it is not supported by empirical evidence.
- Finally, a private health insurance market with poor people is perfectly capable of operating in a stable manner. For example, the Swiss model provides universal coverage based entirely on a private health insurance model. The Swiss don't segregate the poor into a separate inferior public insurance plan like Medicaid while everyone else gets superior private coverage. Instead, their plan works much more like food stamps does in this country. Just as poor people shop in the same grocery stores as everyone else in America, poor people in Switzerland purchase the same kinds of health plans as their counterparts. But it is made

> affordable because the government subsidizes premiums to the extent they exceed 8% of family income. [Note that this is quite a contrast to Obamacare, where poor people are presumed to be able to afford nothing towards the cost of their own health care and therefore are given free Medicaid, while near-poor people are guaranteed that their premiums won't exceed 2% of income; families are not expected to contribute 8% of their income until it exceeds 250% of poverty. In short, the Swiss model relies far more heavily on personal responsibility and far less on taxpayers to subsidize care than Obamacare does. Contrast this with the attitude of Obamacare enthusiasts such as Timothy Jost. "Jost agrees that the ACA is flawed, but in his view, the law lacks ambition. “The basic problem with the law is it just isn’t generous enough,” Jost said. “The subsidies need to increase if we want health care to be affordable.”

Update #2: January 4, 2016

In a follow-up piece at the News and Observer, John Murawski reports "N.C. Insurance Commissioner Wayne Goodwin this week became the latest public official to warn of the harms wreaked by the Affordable Care Act, saying the federal insurance law has destabilized the state’s insurance market and now threatens to leave some residents without options for health insurance...

Goodwin, a Democrat up for re-election this year, warned that the ACA is driving up insurance costs, reducing consumer options and generating unsustainable financial losses for the insurers, with the potential risk that insurers will withdraw from the state altogether." [The letter is here].

ACA enthusiasts perceive Commissioner Goodwin’s letter as an overreaction. As I explained to Mr. Murawski, I disagree for the following reasons:

The Commissioner’s conclusion “Insurers cannot continue to have annual losses in the hundreds of millions and be expected to continue ‘business as usual,” Goodwin wrote. “I am highly concerned insurers may withdraw from the individual market in North Carolina altogether” seems pretty solid to me in light of the statistics he has already

provided (the number of insurers offering individual coverage here has decreased from 29 to 8, while those offering small group coverage dropped from 27 to 10. Total plans in the individual market have fallen from 1,700 to 683). After all, this has actually happened in the real world before:

- In the aftermath of health reform in Kentucky in the 1990's, all but 2 of its 40 insurers fled the non-group market.
- In 1993, the State of Washington reformed its individual insurance market by adopting the guaranteed issue and community rating requirements. Over the next three years, premiums rose by 78 percent and the number of people enrolled fell by 25 percent. By 1999, 17 of the State's 19 private insurers had left the market, and the remaining two had announced their intention to do so (p.3).
- In 1993, New York adopted the guaranteed issue and community rating requirements. Over the next few years, some major insurers in the individual market raised premiums by roughly 40 percent. By 1996, these reforms had "effectively eliminated the commercial individual indemnity market in New York with the largest individual health insurer exiting the market." L. Wachenheim & H. Leida, The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets 38 (2012) (p.3).

Admittedly, in those instances, the states didn't have an individual mandate or subsidies to help forestall the unravelling on their insurance markets, but the point is unwise regulation has led to situations where things can deteriorate in a hurry.

It's far better (and productive) for the Commissioner to be sounding an alarm in advance as opposed to hand-wringing after the fact etc.

READ CHRIS' BOOK, The American Health Economy Illustrated at Amazon and other major retailers. With generous support from the National Research Initiative at the American Enterprise Institute, an online version complete with downloadable Powerpoint slides and companion spreadsheets has been made available through the Medical Industry Institute's Open Education Hub at the University of Minnesota.

Footnotes

[1] As reported by the News and Observer's John Murawski, in the webinar held with hundreds of agents, Roy Watson Jr., the company's sales director for individual and small group markets, made clear that combined losses for 2014 and 2015 were expected to exceed $400 million. Subtracting the reported losses of $123 million for 2014 leaves at least $277 million in losses for 2015.makes clear that this problem is not unique to North Carolina.