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BUSINESS

Insurers Move to Limit Options in Health-Care Exchange Plans

Losses on Affordable Care Act exchanges spur narrower choice of doctors, hospitals

A spokesman for the Department of Health and Human Services said that many surveys have shown exchange enrollees are satisfied with the array of health-care providers in their plans, and insurers are adjusting their offerings based on consumer demand. *PHOTO: GETTY IMAGES*

By ANNA WILDE MATHEWS

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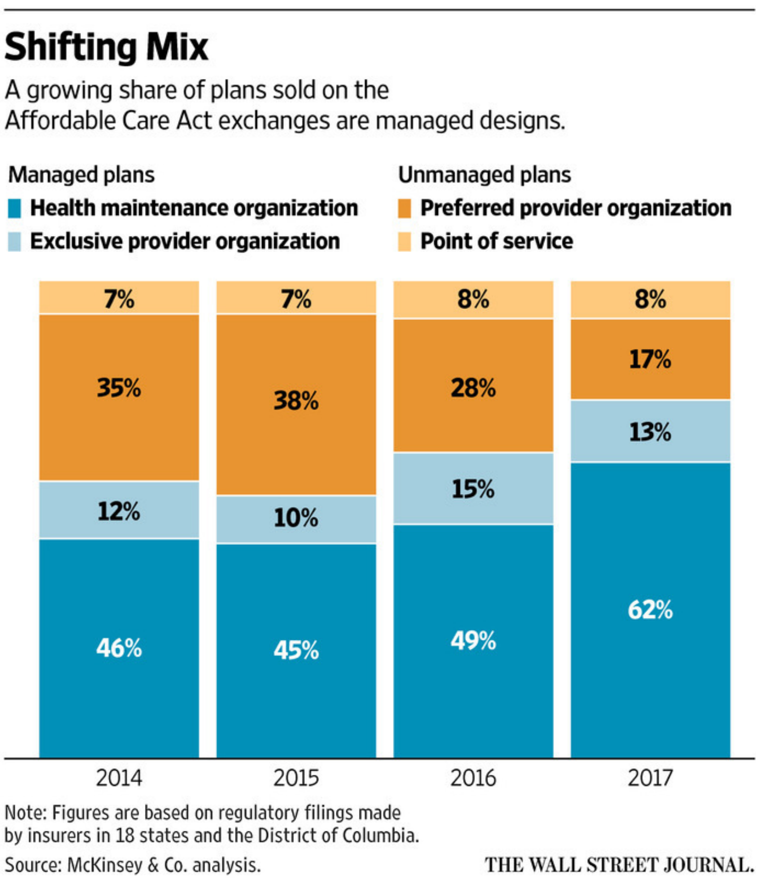
Under intense pressure to curb costs that have led to losses on the Affordable Care Act exchanges, insurers are accelerating their move toward plans that offer limited choices of doctors and hospitals.

A new McKinsey & Co. analysis of regulatory filings for 18 states and the District of Columbia found that 75% of the offerings on their exchanges in 2017 will likely be health-maintenance organizations or a similar plan design known as an exclusive provider organization, or EPO. Both typically require consumers to use an often-narrow network of health-care providers—in some cases, just one large hospital system and its affiliated facilities and doctors.



Only a quarter of the exchange plans next year would still be broader designs such as preferred-provider organizations, or PPOs, which generally offer larger selections of doctors and hospitals and include out-of-network coverage, the McKinsey analysis found.

Insurers offering HMO-style exchange plans "tend to have higher margins and lower rate increases," said Erica Coe, a McKinsey partner who leads the firm's health-reform research effort.

For consumers like Alexei Solcanu, a software engineer who lives in Matthews, N.C., a shift to a plan with a different network could mean changing health-care providers at a critical time. Mr. Solcanu's wife is pregnant, with a baby due in January. His current insurer, Aetna Inc., is exiting the state's ACA marketplace next year and he doesn't know whether the remaining choices will include his wife's doctor and hospital. "I'm worried," said Mr. Solcanu, 26. "That's my biggest concern." The details of 2017 exchange plans aren't expected to be available to consumers until October.

Across the states McKinsey examined, about 15% of exchange-eligible consumers are expected to have no PPOs to choose from. A spokesman for the Department of Health and Human Services said that many surveys have shown that exchange enrollees are satisfied with the array of health-care providers in their plans, and insurers are adjusting their offerings based on consumer demand. "Meanwhile, the large majority of consumers will still have a choice of multiple network types," he said.

Offering a smaller selection of health-care providers holds down costs, in part because hospitals and specialists with the highest reimbursement rates can be cut out. Insurers now increasingly strike special deals with providers that aim to incentivize more efficient and high-quality care. HMOs often also include hurdles to care, such as requiring a referral in order to see a specialist.

Since the ACA's first year, insurers have offered narrow-network plans on the exchanges to keep premiums down, but the trend appears set to jump. The HMO-style plans represented 64% of the exchange offerings in the McKinsey sampling of states in 2016, and 55% in 2015. The 18 states, which include Washington, Colorado and Indiana, represent around 40% of exchange-eligible consumers, and in the past changes in their plan-design mix have reflected national trends, McKinsey said.

In Washington, Premera Blue Cross said it will next year stop selling PPO plans that had enrolled 49,100 on the state's exchange. Instead, Premera will offer EPOs that don't include out-of-network coverage. Last year, Premera lost money on its Washington exchange plans. "We believe this will help lower costs for our members and improve quality," said Jim Havens, a Premera vice president. "We want to look at how we can be a sustainable model in the state."

A survey this year by eHealth Inc. of its customers found that a low monthly premium was the top priority of those who bought exchange plans, named by 54%. Only 12% cited access to their doctors, while another 1% flagged inclusion of a desired hospital. The survey drew responses from 324 ACA-plan purchasers.

"In the individual market, affordability is really important," said Bob Sheehy, chief executive of Bright Health Inc., a startup insurer that is teaming with a major Colorado health system to offer a plan built around its hospitals and affiliated providers. Colorado's exchange is expected to have just five PPO plans next year, out of more than 1,000 offerings, McKinsey found; in 2016, PPO plans represented 20% of the selection.

The shift in design mix on the exchanges is being sped up by the losses that many insurers experienced on their ACA business. Major players including Aetna and UnitedHealth Group Inc. are withdrawing from many state exchanges, in some cases taking PPO plans with them.

Others are retooling their offerings. Blue Cross and Blue Shield of Minnesota announced in June that it would stop selling PPO plans on the state's exchange amid losses on its individual business that it projected at more than $500 million over three years. The individual PPO plans had enrollment of 103,000.

Instead, the insurer will offer plans in each region of the state built around one major health-care provider, such as the Mayo Clinic. The exchange enrollees have proved less healthy, and thus more costly, than expected, and they are "going to require more coordinated care," said CEO Michael J. Guyette. "We believe it's going to help alleviate some of the pressures from the poor performance of the products."

Analysts say the trend against PPO plans will likely continue gaining momentum. That's partly because sicker enrollees may be more inclined to choose PPOs, so as the number of PPOs shrinks there is growing pressure for insurers to dump the remaining ones. "You don't want to be the last carrier standing with a PPO," said Sean Mullin, senior director at Leavitt Partners, a health-care consulting firm.

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