

Gail R. Wilensky

Nov. 30 has passed—so now what?

On Nov. 30, the Obama administration declared it had met its commitment that HealthCare.gov would work “for most people.”

Although some have questioned whether “most” should mean “80 percent,” which is what the administration has decided it should mean, or something more, the more relevant question is, Where does the country stand now with implementation of the Affordable Care Act (ACA)? Based on almost daily articles on the subject, the answer is that there are still clearly challenges with the enrollment process.

Continuing Challenges

Despite the administration's Nov. 30 declaration of its accomplishment, in mid-December, people were continuing to report difficulty in getting through the enrollment process, although far fewer than during October and November.

In what some of their constituents may regard as “only appropriate,” members of Congress, who will be required to get their insurance in the D.C. health insurance exchange rather than through the Federal Employees Health Benefits Plan, were reporting the same mix of experiences as the rest of the country. Politico recently quoted Rep. Chuck Fleischmann (R-Tenn.) as having experienced three website crashes during the first week of December; when he was able to obtain information regarding plan options, he found he will pay almost twice monthly what he currently pays for family coverage. Rep. Phil Roe (R-Tenn.), one of 16 physicians in the U.S. House, said it took him at least seven tries to access information through the site; when he did, he found he would face a 75 percent increase in

premiums for his family of two, and he was unable to determine which physicians and hospitals go with which insurance plan. He said he would refuse to sign up until he could do so.

In contrast with these negative experiences, Sen. Brian Schatz (D-Hawaii) said it took him just an hour to get coverage for his family of four and that it will not be “significantly” more or less expensive than his family's existing plan.

Although supporters seem to be reporting fewer negative experiences, political affiliation is not always a good predictor of experiences. Rep. Joe Garcia (D-Fla.) reported encountering problems and being asked to call back.

At the state exchanges, some states continued to report success in mid-December—Kentucky, New York, and California, for example—but even some of these states were beginning to report encountering “back-end” issues in transferring information from their exchanges to the insurance carriers. Other states that are running their own exchanges continued to report challenges—Maryland and Oregon prominently among them.

The problems encountered in both Maryland and Oregon are surprising because their governors and legislatures were early supporters of the legislation and because both states have been regarded as leaders in healthcare reform activities in the past. After two months, Maryland was reportedly able to sign up only around 3,000 individuals for private insurance. In mid-December, the Oregon exchange reportedly remained basically nonfunctional. There are a variety of explanations, but some attributes of both states' exchanges seem

hauntingly similar to the causes that have been attributed to the federal exchange woes: complex websites that were supposed to be “state of the art,” an inability to browse without creating an account, and inadequate amount of time allotted for end-to-end testing of the system.

New Challenges

Not surprisingly, as some of the earlier problems encountered with HealthCare.gov were being remedied, other problems that were not obvious when the system kept crashing or sending error messages began to be identified. Two types of problems have caused both consternation and frustration: errors in the information being sent from the federal exchange to the insurance carriers chosen by the person during the enrollment process, and erroneous determinations of Medicaid eligibility for individuals whose incomes clearly make them ineligible.

The first of these problems (so-called “back-end errors”) has been reported since mid-October. The errors include not notifying insurers that people have enrolled online, misidentifying the relationships between individuals in a household, and incorrectly specifying the household’s income information. People are being told to expect to receive insurance information and cards once they have enrolled and to contact the government if they have problems or questions—which so far has not proven to be a recipe for success. People also are expected to pay the premiums before they are actually enrolled, another step that does not seem to be well understood.

The second problem, where individuals with incomes upward of \$50,000 a year or more have been incorrectly determined to be eligible for Medicaid, is another recently reported cause for consternation. Such a determination bars these individuals from obtaining subsidies to purchase private insurance, even though they may be eligible to do so. Their only recourse is to file an appeal with the federal exchange and wait until the case gets resolved, which leaves them stuck in an “insurance limbo.”

The U.S. Department of Health and Human Services (HHS) was initially supposed to begin sending Medicaid application files to appropriate states in early November, but as of early December, it was unable to do so, and the federal exchange website could not provide states with the information they needed to determine eligibility. This transfer of information was to have started by mid-December. HHS has assured the states that they will not be held responsible for people who are enrolled in Medicaid by error, but this promise does not clear up the problem for people who are stuck in insurance limbo because of an initial error in Medicaid determination.

And Now, Issues About the Coverage ...

Reactions to the coverage opportunities have varied. After years of paying high premiums for limited coverage, being told they were uninsurable, or being unable to pay the premiums required for their age or health status, some people happily report being able to purchase similar or better insurance for lower monthly payments or gain eligibility for the expanded Medicaid program. Others, including some who support the ACA, are discontentedly reporting that the plans available to them in the exchanges require higher premiums for similar or worse coverage, or that their existing plans are being continued for substantially higher premiums.

The ACA clearly will provide important benefits for some people who have been historically shut out of affordable coverage, but the notion that “we will all be better off” is not true for everyone in the individual or small-group market, and it is likely to be even less true for those who have been reasonably satisfied with the group insurance plans. Overpromising on new legislation to win passage is a high-risk strategy that can easily backfire. It is too early to know whether that will be the fate of the ACA. ●

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