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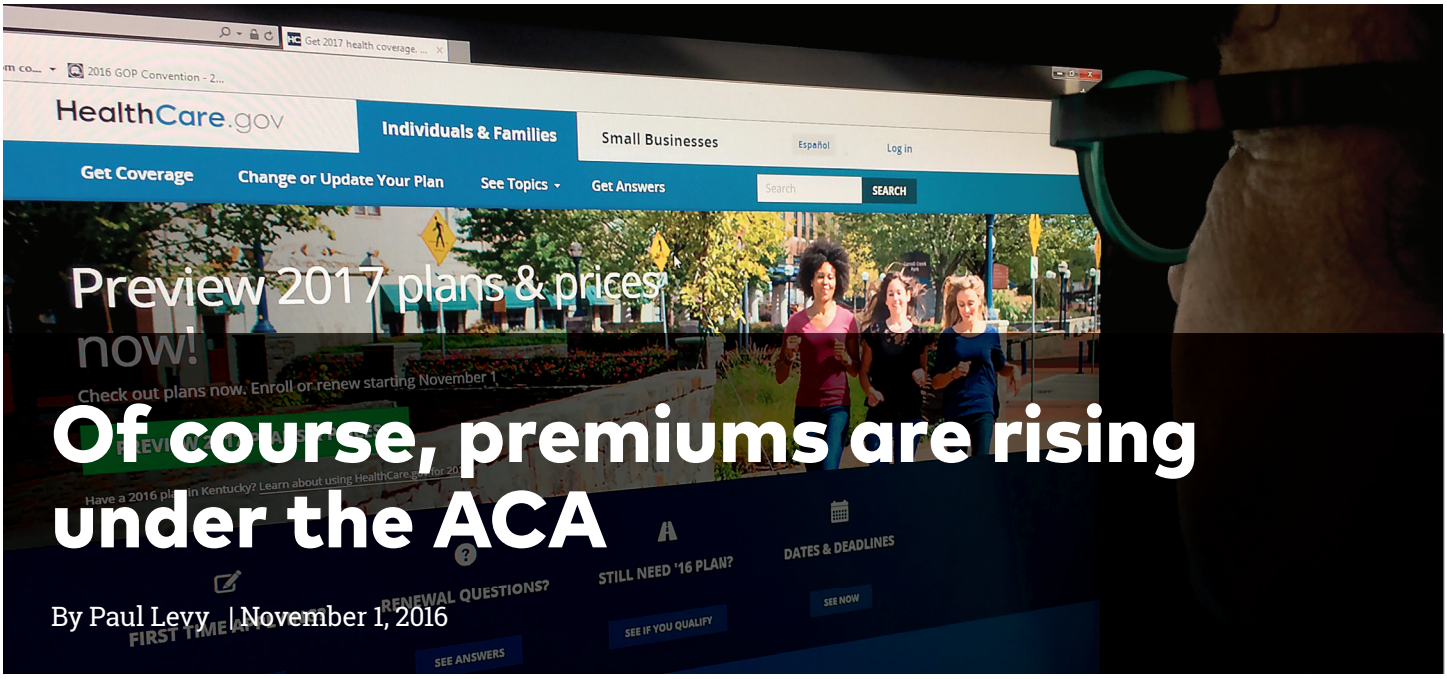

Of course, premiums are rising under the ACA

By Paul Levy | November 1, 2016

When President Barack Obama first promised that the Affordable Care Act would result in "access, lower costs, and choice," healthcare providers and insurers understood that, at best, you'd end up with two out of three.

So the news that health insurance premiums have risen under Obamacare comes as no surprise. The law's focus on access and choice — and the lack of government structures and market incentives to control costs in this context — practically guaranteed the situation we're in today.

Consider: There's simply no way that changes in insurance underwriting — elimination of pre-existing conditions, an end to lifetime coverage limits, and guaranteed issue of insurance to all subscribers — will do anything but create an actuarial guarantee of higher rates.

And providing a statutory allowance for insurance companies to keep 15 percent of the premium dollar for administrative costs and profit creates an incentive to raise, rather than lower premiums.

Meanwhile, government policies around pharmaceuticals — permitting direct-to-consumer advertising for drugs, prohibition of discount shopping by Medicare, and FDA actions that have allowed monopoly-like re-marketing of long-proven drugs — are a guarantee that drug prices will rise.

Likewise, medical device companies operate under a regime that approves their equipment based on safety. There is no provision in the FDA enabling legislation that requires showing that new, more expensive procedures are economically efficient compared to older ones. Here, too, direct-to-consumer marketing and company payments to surgeons have accelerated the use of technologies in search of markets.

Also, the government has been essentially silent on the concentration of market power by large insurance companies and large hospital systems, virtually eliminating the potential for price-based competition among both funders and providers. Employers respond with more and more high-deductible health plans so they can offer lower premiums to their workers, while shifting healthcare costs to those same workers.

All of this occurs amid shifting demographic trends: The elderly are living longer, Baby Boomers

are entering the stage of their lives requiring hospitalization, and there is an increasingly sedentary and overweight population among middle aged and young people. All of these contribute to both acute and chronic health problems.

Finally, of course, people who now have access to health insurance are using it. It is no surprise that emergency room visits have increased in some areas, especially those with shortages of primary care doctors.

Many advocates for Obamacare envisioned that so-called accountable care organizations would reduce costs by better managing people's health, and especially by keeping people out of the hospital. The results from the ACO pilot programs are mixed, though. ACOs operated by physician groups tend to do better than those controlled by high-fixed-costs hospital systems. The latter tend to operate as cost centers in search of revenue streams, with no real interest in controlling costs.

And there is very little useful transparency with regard to clinical outcomes. What data exists on federal websites is out of date and often not on point with regard to enhancing quality and safety. In the words of one wag, many ACOs are neither accountable, caring, nor organized to really reduce costs.

Policymakers in the next administration and Congress will need to put fixes in place to mitigate rises in insurance premiums and the healthcare costs that are driving those increases. But let's not throw the baby out with the bath water. We must acknowledge that the underlying purpose of the ACA — to provide access to insurance and relieve Americans of the fear of losing their employer-based plans when they change or lose jobs — is essential.

Also, it is wise to provide subsidies to those who are unable to afford insurance. Those steps are consistent with what most people consider as the right to healthcare.

Given society's demographic trends, the focus should be less on the design of insurance plans and more on encouraging competition among insurers and providers, requiring real-time transparency of clinical outcomes, giving Medicare the right to negotiate drug prices, requiring proof of economic efficacy of drugs and devices, and prohibiting hospital systems from dominating ACOs.

Paul F. Levy was CEO of Beth Israel Deaconess Medical Center in Boston from 2002 to 2011. He is the author of ***"Goal Play! Leadership Lessons from the Soccer Field."***