What's Up with the Insurance Markets?

Questions and answers on why costs keep going up and what can be done

In August 2016, after the insurance giant Aetna announced it would pull out of most of health insurance marketplaces across the country, a national debate erupted over "market instability" and what could be done. Here's a quick primer from Put People First! PA and the National Economic and Social Rights Initiative on what happened and why.

Why is Aetna leaving the marketplaces?

Aetna has lost money in the marketplaces that were set up by the Affordable Care Act (ACA). The reasons the company cited include that there are more sick people than anticipated that have signed up for plans and that prescription drug costs are high.

Wait a minute - more sick people? Isn't that the point of healthcare?

It's ironic, right? People who haven't had access to care for a long time tend to have more health challenges, a greater need for care and more chronic conditions. Under the law companies aren't allowed to reject people with pre-existing conditions (although they are still figuring out ways around that). Additionally, plans are priced so high that 1) younger people and people with less of a need to access care are purchasing the plans with the lowest monthly costs and the highest deductibles and 2) a number of people are opting out of the ACA altogether and taking the fine. These factors combined with the administrative, lobbying and advertising overhead of insurance companies result in losses for them.

What does this mean for the ACA? Is it in danger?

The ACA got more people access to insurance by mandating with federal law that everyone buy insurance. Then the government subsidizes the insurance companies (with money collected through our taxes) to help offset our costs. What Aetna's and other companies' behavior is showing us is that a healthcare system based on insurance companies is not designed to meet our needs - it's designed to make profit. When making profit comes into conflict with giving people coverage, the insurers opt-out. Right now, experts are predicting that the ACA is not in any immediate danger. But what you can see is that the way things are going, premiums continue to rise across the country to keep the insurance companies in business.

What does this mean for people on ACA insurance plans?

In some places where Aetna and other insurance companies pull out, there will be fewer insurers left, which could result in those companies having more power to increase premiums even more. For individuals and families this is a catch-22. Despite rates we already can't afford, companies are threatening to leaving the market if they're not given

the go-ahead to fleece us even more. Everyday people are the biggest losers in this equation.

What do I do when people use what's happening with the ACA to attack "government-run healthcare"?

The fact of the matter is that the ACA is in no way "government run". It would be better described as a government-subsidized private insurance system. The ACA keeps private corporations at the center of our healthcare system. Insurance corporations determine who gets care, when, how, and how much.

So what's the solution?

The best way to cover everyone is to get rid of the "middle man" altogether - the insurance companies. They don't produce anything of value. What they do is take our money and then ration our healthcare. A system in which everyone is automatically covered when they are born where we put in what we can and get what we need would take care of the current issues that the ACA is facing. For instance:

- Everyone would automatically be enrolled in the system - including youth, people who don't need as much care, etc.
- Because everyone would be in the system from birth, people could access care without fear of cost whenever they needed to - not just in an emergency. That means preventative care could catch issues before they become chronic, putting less stress on the system overall.
- By getting rid of insurance companies, we would save the money that they typically spend on administration (including lobbying and advertising). Traditional Medicare (run by the government) has an overhead rate of 2%, whereas the average private insurance company has a rate of 12-14% and it's projected that the ACA's overhead due to insurance mega mergers will reach 22.5% over the next eight years.
- The other advantage of having a 'single payer' as opposed to a complicated system of different payers (the insurance companies) is economies of scale. So one comprehensive system would mean that the system could set prices for prescription drugs, medical equipment, and hospital care at a reasonable level.