# US insurers discourage the sick from enrolling in health plans

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The Affordable Care Act (ACA), signed into law by President Obama in March 2010, prohibits insurance companies from denying coverage for people with preexisting medical conditions. Insurers, however, have devised ways to discourage sicker customers, particularly those with expensive medical conditions, from enrolling for coverage.

With about three months to go before the ACA exchanges begin open enrollment for 2015, the strategies employed by private insurers to keep less healthy people out of their insurance pools expose the pro-corporate character of the health care overhaul, commonly known as Obamacare. Many of the ACA regulations touted by the White House as groundbreaking protections for consumers are merely window dressing for a law that serves to boost the profits of the insurance industry.

More than 300 patient advocacy groups recently wrote a letter to Health and Human Services (HHS) Secretary Sylvia Burwell complaining about insurance company tactics, saying that they "are highly discriminatory against patients with chronic health conditions and may…violate the (law's) nondiscrimination provisions."

Included among the letter's signers are the AIDS Institute, the American Lung Association, the Epilepsy Foundation, the Leukemia & Lymphoma Society, the National Alliance on Mental Illness, the National Kidney Foundation, and United Cerebral Palsy, all organizations that supported the health care legislation.

One of the main complaints of patient advocates is the lack of upfront knowledge of details of the plans offered for sale on the Obamacare exchanges. It is extremely difficult if not impossible in some cases to obtain crucial details about the plans, including what prescription drugs are covered, exact co-payment and other potential out-of-pocket costs, and which doctors and hospitals are in a particular network.

One of the main ways insurers can avoid having to cover patients with expensive medical conditions such as cancer and autism is to limit the number of doctors and hospitals in their coverage networks. As the WSWS reported earlier this year, the majority of ACA policies cover only a narrow range of doctors or hospitals, or charge exorbitant premiums for the right to go to any provider.

For example, an Associated Press survey this spring of the nation's top cancer centers found that the MD Anderson Cancer Center, a prestigious research and comprehensive treatment center, is included in the networks of less than half of the plans sold on the public insurance exchange in the Houston, Texas area, where the center is located.

Plans with narrower networks, and lower premiums, tend to attract younger and healthier people, who are more concerned about price and are gambling on not having to utilize expensive treatment. Those with preexisting conditions, on the other hand, which require specialized care and costly drug treatments, are steered toward the plans with steeper premiums and out-of-pocket costs.

Some of the ACA plans require patients to initially pay 30 percent or more of the cost for drugs that can often run to several thousand dollars a month. Medications for the treatment of HIV and conditions such as multiple sclerosis are among these. While the ACA caps the annual amounts patients can be required to pay up front for these medications, this is cold comfort for patients and their families who do not have the cash or credit on hand to cover costs that can run into the thousands of dollars.

Another way that private insurers are skirting the

ACA regulations is to stay away from the insurance exchanges, or to participate in them in only a limited capacity. UnitedHealth Group Inc., the nation's largest health insurer, sold plans on only four of the ACA exchanges in 2014. They plan on selling individual coverage on 24 exchanges in 2015.

AP quotes Bob Laszewki, a former insurance executive turned industry consultant, who says that UnitedHealth's strategy may allow it to avoid the sickest patients, who moved quickly to sign up in the initial year of the health care overhaul. Laszewski reasons that this could free UnitedHealth to enter the exchanges and sign up healthier people after other insurers have "taken the bullet" during the first year of the ACA.

The efforts of the private insurers to game the Obamacare system are hardly surprising, given the structure of the health care overhaul. The central component of the ACA, the individual mandate, requires individuals without health coverage from their employer or a government program such as Medicare or Medicaid to obtain insurance or pay a tax penalty.

The insurance exchanges offer coverage for sale by private insurance companies, who stand to profit from the influx of new cash-paying customers. The standards on what constitutes "nondiscriminatory" coverage are deliberately loose, and in many cases these regulations are still being worked out. What is clear, however, is that the private insurers' participation in the ACA is not an altruistic exercise, but is aimed at defending their bottom line and securing the highest profit margin possible.

While the federal government runs the ACA exchanges in 36 states, state insurance regulators are still in charge of consumer protection, and some states are refusing to enforce any aspect of the law. The Obama administration claims that in 2015 it will identify plans that require unusually high patient cost-sharing in those states where the federal government is running the exchanges.