US health insurers seek huge rate increases for 2016

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Health insurance companies across the US are seeking rate increases of 20 percent to 40 percent and more, according to filings by the insurers with state insurance commissions. Insurance companies cite a larger than expected pool of unhealthy enrollees, high drug prices, and diminishing profits as contributing factors requiring the premium hikes.

The rate increase requests are the latest demonstration of the pro-corporate character of the Affordable Care Act (ACA), commonly known as Obamacare. The news follows the US Supreme Court's 5-4 ruling June 25, which upheld government tax subsidies, a critical component of the law that provides tax credits to those purchasing insurance coverage on all the exchanges set up under the ACA.

Under Obamacare's "individual mandate," uninsured individuals and families must obtain insurance or face a tax penalty. The premiums for plans purchased on the ACA exchanges go directly into the coffers of the private insurers.

Blue Cross and Blue Shield, one of the nation's largest insurers, is seeking double-digit increases in many states, including a 23 percent hike in Illinois, 25 percent in North Carolina, 31 percent in Oklahoma, 36 percent in Tennessee, and 54 percent in Minnesota.

The ACA, signed into law in 2010, requires insurance companies to disclose large proposed increases in premiums, and increases of 10 percent or more must be made public and are subject to review under federal law. However, there is no mechanism to rein in the rate hikes if state insurance commissions approve them.

In cynical comments made last week in an appearance in Tennessee, Barack Obama said consumers should put pressure on state insurance regulators to examine the rate requests carefully. "My expectation," he said, "is that they'll come in significantly lower than what's being requested."

In one example of the opposite result, Oregon Insurance Commissioner Laura N. Cali has just approved rate increases for companies that cover more than 220,000 people. Moda Health Plan, with the state's largest enrollment, received a 25 percent increase; LifeWise, the second-largest Oregon plan, received a 33 percent hike.

In some cases, state insurance commissions have already granted insurance hikes in excess of those requested by the insurers. In Oregon, Health Net requested increases averaging 9 percent and was granted increases averaging 34.8 percent. Another insurer in the state, Health Co-op, requested a 5.3 percent increase and the state approved a 19.9 percent hike.

Insurers cite the fact that new customers enrolling in ACA plans have turned out to be sicker than expected, which leaves the insurers with a more unhealthy pool of insured customers, requiring them to increase premiums. This is hardly a shocking development, as significant numbers of younger, healthier people have chosen to remain uninsured and risk the cost of getting sick and needing medical care that would have to be paid out-of-pocket.

However, these young people are not simply paying Russian roulette with their health. The driving force behind the decision of many not to enroll in coverage—including the so-called young invincibles, and many workers—is the economic reality that they cannot afford the premiums. To add injury to insult, they face the prospect of being both uninsured and paying tax penalties under the Affordable Care act. For individuals, these penalties for the uninsured were $95 in 2014, rose to $325 in 2015, and will increase to $695 in 2016.

Another factor contributing to the increased pool of unhealthy customers is a policy adopted by the Obama administration in late 2013 that allowed people to keep insurance plans that did not meet new federal standards, including a set of required coverage, including wellness checks and some screenings. The exemption was a political move on the president's part to make good on his earlier statements that "If you like your plan, you can keep it."

Customers may also be required to switch plans in order to keep premium costs down. The Kaiser Family Foundation analyzed 2016 premium changes in 10 states and the District of Columbia where the group found complete data for all insurers for the lowest- and second-lowest cost "silver" plans.

For example, Kaiser found that in Seattle, Washington, an unsubsidized person enrolled in the second-lowest silver plan offered by BridgeSpan in 2015 would see a 12.6 percent premium increase if the individual stayed in the same plan, but would pay 10.1 percent less if the person switched to a similar plan offered by Ambetter.

Kaiser found that those switching plans to save money would potentially have to switch doctors and hospitals as well, and that staying with one's plan also did not guarantee maintaining a provider network. The entire framework of the ACA is thus skewed to the whims of the insurers, and customers are required to scramble each year to determine their selection.

Health and Human Services (HHS) Secretary Sylvia Burwell told the *Times*, "You have a marketplace where there is competition and people can shop for the plan that best meets their needs in terms of quality and price."

The HHS secretary did not mention that the most affordable "bronze" plans come with deductibles in excess of $5,000, which means that coverage for all but "essential" medical services do not kick in until the deductible is paid out-of-pocket. This means that despite being insured, many people will go without health care for themselves or their children, resulting in needless suffering and deaths.

Some of the premium increase requests by the private insurers are staggering. Blue Cross and Blue Shield of New Mexico has requested rate hikes averaging 51 percent for its 33,000 enrollees. Scott & White Health Plan in Texas is seeking a 32 percent rate increase. In a ludicrous statement to the *New York Times*, Scott & White's CEO Marinan R. Williams said that the rate hike requests show that "there was a real need for the Affordable Care Act."

Arches Health Plan, which covers about a quarter of the people insured through Obamacare in Utah, says it collected premiums of $39.7 million in 2014, but had claims of $56.3 million in 2014. The insurer has requested rate increases averaging 45 percent for 2016.

The Obama administration has touted a provision of Obamacare that requires insurers to spend at least 80 percent of premiums on medical care and related activities. How this works out in reality, however, is that if the profit margins are not to the insurers' liking, they request premium increases to generate the revenue to pay stockholder dividends and the bloated salaries of insurance company executives.

The CEOs of the top five for-profit health insurance companies—Aetna, Anthem, Cigna, Humana and UnitedHealth—all took home at least $10 million in 2014, according to filings with the Securities and Exchange Commission. Executive compensation ranged from $10.1 million for Humana CEO Bruce D. Broussard to more than $15 million for Aetna CEO Mark Bertolini.

In the latest round of mergers as a byproduct of Obamacare, Aetna Inc. and Humana Inc. announced last week they had reached a deal to merge, creating an insurance company valued at $37 billion. If approved by the government and carried through, the insurer would become the nation's second largest, covering more than 10 percent of the US population.