Trump administration seizes on Aetna pullout from ACA to push Republicans' health plan

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Insurance company Aetna announced May 10 that it will no longer offer insurance plans on the Affordable Care Act (ACA) exchanges in Nebraska or Delaware in 2018. Its withdrawal from these states will complete its exit from the Obamacare exchanges by the beginning of next year.

Aetna's exit will leave Delaware with Highmark Blue Cross/Blue Shield as the sole ACA-participating insurer. In Nebraska, Medica will remain as the sole exchange-participating insurer, but Medica's continued participation is not guaranteed; the company has previously hinted that may exit the exchange in Iowa, where it is the only insurer participating in the exchange.

The Trump administration has seized on Aetna's pullout from the ACA exchanges as proof that Obamacare is in a "death spiral" and that Congress must move to pass the House Republicans' American Health Care Act (AHCA) as soon as possible. It is convenient timing that Aetna's exit comes as Trump and the Republicans are pushing the US Senate to advance legislation to "repeal and replace" Obamacare.

Health and Human Services (HHS) Secretary Tom Price said of the Aetna exit: "Aetna's decision to completely withdraw from the Obamcare exchanges adds to the mountain of evidence that Obamacare has failed the American people. Repealing and replacing it with patient-centered solutions that stabilize the marketplace to bring down costs and increase choices is the only solution."

The reality it that the AHCA's "patient-centered solutions" will do nothing to expand coverage or lower costs in the insurance market. The bill's centerpiece is the gutting of Medicaid, the government health insurance program for the poor, and its effective termination as an entitlement program.

No longer would states be given Medicaid funding in accordance with Medicaid expenditures; instead, states would be given block grants based upon population, with yearly increases based upon medical inflation. It would allow states to force "able-bodied" Medicaid recipients into work programs.

The ACA's expansion of Medicaid availability to those with incomes 133 percent above the poverty level would be halted. This expansion currently allows about 10 million Americans to be insured. By January 1, 2020, all states that have chosen not to expand Medicaid under the ACA will lose the ability to do so.

In addition, the AHCA strips away the few protections of the ACA for those with preexisting conditions, and would allow insurers to offer barebones plans that do not cover essential services such as maternity care, emergency room services, and prescription drugs.

The AHCA, far from being "patient-centered," would do more openly what Obamacare aimed to do all along, cut the cost of health care for the government and corporations while shifting the burden of health even more heavily on the working class.

It slashes taxes for the wealthiest Americans, while penalizing the poor and destabilizing the finances of workers who are struggling to subsist. As with Obamacare, the provision of health care is subordinated to the profits of the health care industry as a whole, and the private insurance companies in particular.

Under the Obamacare "individual mandate," consumers have been forced to either purchase insurance or face tax penalties. While the AHCA removes the tax penalty for the uninsured, it allows insurers to charge those whose coverage has lapsed for 63 days or more, as commonly occurs when people change jobs or become unemployed, to impose a 30

percent hike in premiums when they purchase health insurance again.

In the meantime, insurers and pharmaceutical companies have shamelessly engaged in price gouging. If insurers are unable to make an adequate profit, they either hike their prices or pull out of the insurance market.

This is precisely what is taking place at Aetna. At the end of 2016, the company insured 964,000 individual commercial plan members. By the end of March 2017, that number had fallen to 255,000. The company projects losses of about $255 million in its exchange plan business profits this year; this follows losses of $700 million from 2014 to 2016.

The company cited "marketplace structural issues, that have led to co-op failures and carrier exits, and subsequent risk pool deterioration" as its rationale for the exit. Throughout the country, participation in the exchanges has consistently fallen since the ACA went into effect, at a rate of about 3.7 percent. In Delaware, exchange sign-ups fell 2.4 percent year-over-year in 2017. In Nebraska, sign-ups fell 3.9 percent, just slightly higher than the national decline.

After Humana pulled out of Tennessee in February, leaving 40,000 people with no insurance option, Blue Cross/Blue Shield said last week that it would step in, but only if certain conditions are met. Medica, the last insurer remaining in most of Iowa, has threatened to stop selling individual plans.

In an editorial penned earlier this month for CNBC, HHS Secretary Price claimed that the AHCA "will take the power out of Washington and give it back to patients and doctors, while providing tens of billions of dollars for patients with preexisting conditions," and would "provide a portable credit for Americans who don't get insurance through their job to buy their own plan, and empower states to run Medicaid in a way that ensures their most vulnerable citizens can access high-quality health care."

All of these claims are false. The "tens of billions of dollars" for preexisting conditions refer to the "high-risk pools" states could set up under the AHCA to offset insurance costs for people with preexisting conditions. The original House bill set aside $130 billion over 10 years for these pools, and an amendment added another $8 billion over five years.

Estimates from conservative analysts James C. Capretta and Tom Miller said the federal government would have to provide $15 billion to $20 billion annually to operate functional "high-risk pools" in all 50 states, leaving them woefully underfunded.

The "portable credits" referred to by Price would be much lower than the government subsidies under the ACA, and would be based on age, not income, with credits phasing out for those at higher incomes.

Finally, contrary to Price's claim that states would be empowered "to run Medicaid in a way that ensures their most vulnerable citizens can access high-quality health care," the ACA would result in millions of Medicaid recipients having their benefits slashed or being denied access to the program altogether.