Curbside Consult: The State of Obamacare (Part 1)

Harold Pollack: Jonathan Cohn, great to talk to you again.

Jonathan Cohn: Hey, good to be on again.

Harold Pollack: So maybe we should start by introducing ourselves. Tell me what you do for a living and stuff.

Jonathan Cohn: I'm Jonathan Cohn. I make my living as a journalist. I'm a senior editor at The New Republic where I've been for a long time, writing about domestic policy with a particular focus on healthcare. I once wrote a book on the subject called Sick.

Harold Pollack: Why don't you grab your book from behind you and hold it up so people can see it.

Jonathan Cohn: Oh, this is advertising, is it? Okay. Where is my book? You can see it, so it must be ...

Harold Pollack: Look to the left. Look to your left.

Jonathan Cohn: Oh, up here?

Harold Pollack: Yes, there you go.

Jonathan Cohn: Oh, yeah. There you go. I just toppled over my whole bookcase, but there's the book.

Harold Pollack: That is one of the essential sources, and it's one that includes quite a bit on Chicago.

Jonathan Cohn: You saw that. In fact, the first reporting I did when I started the research was in Chicago about hospitals in Chicago and what they were charging [inaudible] and the efforts I went to to collect bills after people went to the hospital. It was sort of harrowing, some of these stories. It was amazing how even some faith based hospitals, religious hospitals which, you know, had a mission to be social, do social good, and the uninsured came in and couldn't pay their bills, they would farm out the bills to some pretty cutthroat collection agencies. Some of those stories were pretty startling.

Harold Pollack: Yes, I think as people start to buy their bronze plans and start going and using services, we're going to discover some of those stories are going to come up again because there are going to be people who just can't pay their high co-pays and things like that.

Jonathan Cohn: Yes, yes. No, we've had ... it's funny, you and I both, I don't think our positions on the Affordable Care Act are great secrets. We support the law. We both think it will do a lot of good. One of the difficulties in this environment is that I know I do, I know you do. We're both very well aware of the flaws and the shortcomings of the law. I could talk for hours about everything I don't like in it, things I wish were different, things that I know are not going to turn out well.

I still think the balance is overwhelmingly on the positive side, but there's a lot I don't like. One of the things I don't like is I think there's a lot of people, like you say, who are going to end up with higher deductibles than they realize or higher co-payments. A lot of people I think are going to discover, I've read a little bit about, that deductibles are structured differently than they were in the past sometimes.

You're going to see plans where it used to be you had kind of a separate drug deductible and office visit deductible, for example, and you're going to see plans where they're unified. Now this is true of everybody, the employer market as well, but I think what we're seeing with the exchanges is in part because they really want to drive the price down, and they think that's where the market is. They're doing it [inaudible] there.

Harold Pollack: Can you just repeat that? There was a glitch in the ... can you just repeat that?

Jonathan Cohn: Oh, sure, sure. There are a lot of changes that have been coming to health insurance of all kinds, private health insurance, ways that insurance companies are figuring out to hold down the cost of insurance, and these were happening already and were going to happen, but I think we are seeing a lot of them happen more quickly now inside the plans that are being sold in these exchanges for a number of reasons. It's a new market, which is kind of good.

It's an easy opportunity to introduce something new [inaudible]. You can do many changes. Some of it is they've done market research, and I think they believe, probably correctly although we're not sure, that the market is going to shop on price first. There was an interview ... I've certainly heard that. If you read Sarah Kliff, and if you're watching this you should be reading Sarah Kliff because we all read Sarah Kliff in the Washington Post.

She had a great interview with the CEO, I think of WellPoint if I'm not confusing the interview, in which she said "They did a lot of market research and it was very clear that the number one thing people were going to shop on was the price of the plan," so the plans are being very aggressive. They're a little nervous about who they're going to attract to the plans, but I think they're going to get a lot of sick people, and this is a chance to make changes so they're introducing a lot of these new payment and these new insurance models more quickly in the exchanges and I guess to some extent testing them out, but that's why [inaudible] see are these new kinds of deductibles.

There will be some people surprised when they go to the doctor. They'll be like, "Wait a minute, I have to pay for this out of pocket?" I think that's something ... I worry about some of those out of pocket expenses. I think they're too high. You and I both talked about this. This is “Things I Could Change in the Affordable Care Act,” that's right near the top of the list.

Harold Pollack: Again, this is Harold Pollack. I'm talking to Jonathan Cohn on another Curbside Consult at healthinsurance.org. By the way, there's one thing that I find very encouraging about even the criticisms that are going to come out about the new plans for the exchanges, which is we're talking about real stuff. This is really “how do you make health insurance work for people, and how do we manage the real tradeoffs that health insurance requires?”

It's not about death panels, it's not about what's going to be whatever. It's about what is the human experience of people. Even if some of the things that we see have to be changed or some of the critiques of ACA turn out to have some validity to them, we're in a reality-based discussion of something that's actually happening and that millions of people are now using, and I think that's a big step forward. It also means that those of us who were advocates for the law pretty much, for myself, putting myself in that category, we are now ... the terrain has shifted a bit and now the conversation is different.

It's really about how to make this work and make it successful and something that's imperfect but improving. That's sort of a change in mindset for many of us.

Jonathan Cohn: Yeah, I know. I mean it's real now, right? Now it's real and I agree completely. I'd much rather argue about real than imagined. I would say the footnote on that, the caveat here, and these are among the things I'd file under things “I didn't realize beforehand,” you know, “things I wish I had known.” Even though it's real now, it's happening, we don't necessarily know what's happening now. We saw this a lot early as the plan cancellation notices went out.

We have lots of anecdotes. They are supplied everywhere, by the news, on Twitter, whatever you hear from people, but when it comes to actually quantifying what's going on, we just don't have good information and we're not going to have it for awhile. When you look at these numbers the administration puts out on enrollment, there's a lot of hoopla over the two million number.

Now I thought that was an important number, and you tell me if you agree. I thought it was an important number primarily, number one, because it showed the system was working. It was processing a lot of people. We spent October and November not knowing if it was going to work, right?

Harold Pollack: Can you just explain what the two million number is for those of us who are not aficionados?

Jonathan Cohn: Yes, yes. Under the Affordable Care Act we have these exchanges, these marketplaces where you go to buy insurance or get a determination that you can get into Medicaid. They are for people who don't have insurance from their employers and are not on Medicare basically. That's who they're for. Every state has an exchange. About 15, 16 states are actually, and the District of Colombia, are running their own exchanges.

They set it up on their own, it's their own website, if you live in California, Connecticut, Kentucky, you're in one of those states. The rest of the states basically asked the federal government to run the website for them, and it's run through a website, HealthCare.gov, right? You don't have to go to one of these sites to get insurance, and that's important for reasons we’ll get to in a second, but that's where a large number of people will go to get it. The websites really didn't work very well, as you may have heard, in October and November.

Harold Pollack: Anyone who's gotten this far in the interview is well aware of ...

Jonathan Cohn: Yes, that's right. That's right, that's right. HHS, the Department of Health and Human Services, has been releasing numbers on enrollment, which says that as of the end of December ... in December, things really picked up. The website was working. It was getting to the deadline where if you wanted coverage January 1st, you had to sign up.

It really picked up, and they determined there were two million people had gotten all the way through the process and actually selected a private insurance plan in time, by the end of December. Then an additional ... I'm mixing my numbers up … was it four million Medicaid determinations?

Harold Pollack: That's my understanding, around that, maybe a little more now.

Jonathan Cohn: Right, a little more now, but now those numbers are real numbers. Those are actual people who went on the site and got their determinations or went on the state sites. Like I said, I think that was significant because it told us, okay, this thing ... and sure enough, the volume's ramping up and that's a kind of good reality check because we expected it to ramp up because it was real low for the first few months, partly because the websites were down, but even in the states like California, it was a little low where they always had a working website.

That was a really important number. What the number doesn't tell us, it doesn't tell us a lot of things, right? Let's face it, the administration, I think, as administrations are wont to do, didn't advertise this although they were honest about it. I mean they didn't hide it either. It was there in their statements. They didn't billboard it, but they were very honest about this.

Number one, you had no idea with the private insurance plans how many people had actually paid their premiums. Of course, to get health insurance you don't have to just sign up for a claim, you actually have to pay for it. Now I think the assumption is most people will pay eventually. A lot of them are going to wait till they get a bill from their insurer. They may wait till the second notice from the insurer comes.

Lord knows, when I did our household bills, I'm amazed at ... I am one of those people who when I was a single guy before I got married, the power, I got the little red letters. I would pay the bill when the little red notice, "We're about to turn off your power," right, I paid my bills.

Harold Pollack: (laughs) Weren't you the person that they modeled, whatever that show is that Charlie Sheen was the star of?

Jonathan Cohn: Right, right.

Harold Pollack: That was you, wasn't it?

Jonathan Cohn: Yes. You know what? I really like a little index card to tell me how to manage my financial life, but that's what I really need. Maybe you can help me with that later.

Harold Pollack: Yes, maybe so. Again, this is Harold Pollack having a conversation with Jonathan Cohn about his personal finances on healthinsurance.org. I should say that Jonathan's wife has somewhat greater expertise when it comes to some of these matters.

Jonathan Cohn: Yes. She's a professor of engineering with an advanced degree in applied mathematics, very organized, so we yin and yang well. The more important figure that's not in those numbers is we don't know how many of those people didn't have insurance before, what their status was, so presumably some of the people buying insurance on the exchanges had insurance before.

A lot of the people getting Medicaid had Medicaid before. They were just renewing, so you can't simply look at that six million number and say, "Oh, we just cut the number of uninsured by six million." That doesn't make the number insignificant, right, because first of all, we know that people buying in the exchanges are able for the first time to get insurance, not having to deal with pre-existing condition exclusions.

We can assume a lot of the private plans were people who didn't have insurance before. With Medicaid, you would expect it to ramp up over time, so I mean on the one hand the numbers don't tell us a lot. On the other hand, I don't worry too much about where the numbers are so much as at the trend line. One last thing, and this never seems to get mentioned because, again, if you made it this long in the interview, you're probably somewhat aware of the debate going on.

I have seen a lot of people say, "Look, a lot of those private insurance numbers are people who had insurance before." That's almost certainly true. The flip side of that is that number does not include people who re-upped, got insurance directly from an insurance company. A lot of the people, quite possibly the majority of people, who had insurance already and were not eligible for financial assistance or maybe even were and didn't know it, they just picked up the phone and called, let's say, Blue Cross and said, "Hey, just renew my plan."

The plans are very aggressive about getting these people, so we have no idea how many. It could be a lot, it could be a little. We don't know, and I guess that's the sort of point here is we don't know, and it's frustrating as a defender of the law because I'd like to be able to get up and say, "Hey, it's definitely working. It's definitely doing these things," and I don't feel like I can do that.

I can look at these numbers and say this is consistent with what I would expect if things are working, but I can't say it's definitely working because we don't know. It's a little draining, I find and I'll get off my soapbox. I think the other side of the debate sometimes is more than willing to take those tentative numbers and draw a very definitive conclusion that it's not working, evidence to the contrary that, you know, past predictions of doom actually haven't been borne out, so there you go. I'll get off my proverbial soapbox now.

Harold Pollack: No, that is ... if you know that the law's a failure by definition, then you can find some number that you can cite that confirms that. I must say, one of the things that I worry about is people's ability to not only get on the website and so on but to actually make good decisions about what kind of insurance they should get, like I wonder how many of the people were just re-upping their old plan or even checking to know what are their options.

It's so complicated, and because the website was initially nonfunctional and is now just forbidding for people, I wonder how many people are really checking out, "Am I eligible for a subsidy?" "How do I know?" "Do I know enough to understand how to distinguish between plans?" I think a lot of us until we get sick really just have no idea what insurance is all about, and we have a big job to do just to help people make good decisions given their personal circumstances.

Jonathan Cohn: Yes, that's the reality of health insurance, right? I mean this has always been the problem is that people, most people don't really think about this. Look, I have some sense of my health insurance plan because I do health policy. You know, we actually got ... if I had to like go through a serious medical episode, I couldn't tell you without checking pretty carefully exactly what is covered.

I know it's from a large employer. I happen to know it's a generous employer. It's a large university system. Those tend to be pretty reliable, so I don't think there's any surprises in there, but I haven't checked, and it's a big problem. Now this is one of these give and take things in the law, right, which is I think the instinct of progressives, a lot of health policy experts, is to protect people, right?

I mean that's why we have these regulations, right? We say, "Look, we're not going to let them sell you an insurance policy that has this huge gap that doesn't cover rehabilitation after a hospitalization," right, so you know, before you can buy a policy and you go to the hospital. Maybe it will pay for you to get your, you know, you get in a car accident, it will pay for the resetting of your bones that were broken but then it doesn't cover the time you have to spend in rehab, okay?

Now to me, that's the same as selling me a car with a wheel that's going to fall off. That's a defective product, so I don't want to sell that anymore, and I think it's fine to outlaw that. I think it's fine they sort of set very clear standards. Obviously, that's the premise behind the law, right? It does have a sort of set of essential benefits, right, and it sort of sets a floor on how much [inaudible] cover, right?

You have to at least cover 60% of the typical person's medical bills, which is a kind of a fungible number but at least sets a standard. The flip side is there are a lot of people, and they tend to be more conservative, who think they want choice. People should be able to choose their risks, and the law goes pretty far away in that direction, right, because those essential health benefits are there, but they're pretty loose. They don't get very specific.

There's regulation [inaudible] obviously, but there's some leeway there. The floor, 60% of your medical costs, that's not a lot of money. If you're buying one of those bronze plans and you get really sick, you are going to, you know, you're going to spend a lot of money. Of course, you know, some of the silver plans, one thing I discovered, and now we're really getting into the weeds here, but it's interesting.

It's not clear to me that if you know you're going to have high medical bills you're actually so much worse off with a bronze plan because they have the same maximum out of pocket costs. It's just a question of how quickly you get there. If you know you're going to blow through it anyway, it's basically you concentrate the spending in the earlier part of the year, but you're not actually out of pocket more over the course of the year.

It really depends on the individual policy, so it's a funny calculus people will do, but obviously the flip side is the silver plans, you can get extra help with the cost sharing if you qualify. Now we're really so far in the weeds, you and I are like ...

Harold Pollack: Well, no. Let's talk about that in a moment. Again, this is Curbside Consult. This is Harold Pollack talking to Jonathan Cohn. If you get a silver plan, you're eligible for more assistance than if you get a bronze plan. Can you just explain that a little bit?

Jonathan Cohn: Yes. When we talk about insurance, right, and we talk about some of the financial side here, okay, there's sort of two issues you look at, right? You look at the premium you pay. That's what you pay every month to get your coverage, right? Then you look at the out of pocket expenses, okay. “What do I pay?” “What's my co-pay if I go buy a prescription?” “What do I pay if I go to the doctor's office?”

Plans all have deductibles now, right, where they say basically, "All right, you know, you pay the first so many dollars of your medical care in every category or certain categories before insurance even pays a dime." For example, if I had $100 deductible on prescriptions, my insurance doesn't cover my drug cost until I've spent $100 over the course of a year. Then at that point, right, then they start to cover it, so there's out of pocket costs and there's premiums.

The law provides ... as you know, it sells insurance and the plans like ... these are standard features of all insurance plans, but the law says if you're buying coverage on your own, depending on your income you'll get some assistance. What's complicated, and I know a lot of people probably don't know this unless they've actually gone through the exercise of shopping for one of these policies, is that there's two forms of assistance.

There's the assistance on the front end, on the premium. The way that works, it's based on your income, and the amount of assistance is a formula that has to do with how expensive insurance, the typical plan in your area, and you basically ... it's like a credit and you can sort of apply that to whatever plan you buy. You buy a cheaper plan, the same credit applies.

Actually, in some places, if you qualify for one of these, you can actually get a bronze plan for free and you pay no premium on it because the tax credit is so high. In addition to that, the law also says ... those out of pocket expenses, they can get pretty burdensome. Anyone who's on medical, you know, been to the doctor, they get big and they get fast.

The law says, "We will also help you with your out of pocket expenses but with two conditions. Number one, it's scaled on income like the premiums are, but it doesn't go as high." In other words, not as many people qualify for those. If you want the numbers, the assistance on the premiums, you're eligible for at least some money until you get to about four times the poverty line, which for a family of four is actually like $96,000 a year.

The cost sharing is only up to 250% of the poverty line. What is that, about 40-something? I want to say 40-something thousand per year for a family of four, maybe 50, somewhere in there. I'll have to check on that.

Harold Pollack: A little bit over 50, yes.

Jonathan Cohn: Yes, 40/50, right. That's the first thing. The second thing is ... this is interesting and actually may help explain some of the data we are seeing now from the exchanges. You only get those cost sharing subsidies if you buy a silver plan. You can't get them if you're a bronze plan, so if your income is below 250% of poverty, so again for a family of four $50,000 or below, there's a good chance that silver policy ... it may be more expensive … even with the credit on the front, even with the discounts … but if you have any kind of medical problems, the cost sharing subsidies kick in, and you actually will end up spending a lot less over the course of the year.

Harold Pollack: This is the kind of detail that I think ... first of all, many of the mechanics haven't really been ironed out, and also many people just don't understand it. I must say that I am conflicted when I think about these issues when I think about how to move forward on this law. I basically think that at some point, there has to be greater ... there's going to be some kind of bipartisanship in adjusting some of the details of the law at some point.

Basically, the Republicans have to realize this isn't November 2010, and the Democrats have to realize this isn't November 2008, and then the state waiver process, by the way, where governors and the Obama administration are negotiating some of the details I think will ... certainly the Medicaid program and also lopping into some other issues, I think that's where you're actually seeing some pragmatic problem solving around these issues.

I must say, I'm probably more willing than I was a couple of years ago to allow people to buy cheaper plans because it does seem to me that the public really demands that even though it makes me very nervous because that's insurance. A significant fraction of the people who are demanding that … if they had a really serious medical problem … would suddenly realize what they've given up, but it does seem to me that it's important to keep the premiums low so that we maintain public support for these things, and that means narrower networks than many people might want to see in terms of which providers they can see, and it means, you know, in other ways less generous insurance.

There's a real tradeoff there that people have to face. One of the challenges is to give people cheaper insurance but that protects them against some of the things they're not going to care about unless they're actually in that situation. It makes it ... if I'm a regulator, it's a very difficult balance because I don't want people to discover if they get in a car accident, "Well, I really will be devastated, and I didn't realize my cheap insurance doesn't work."

You want to prevent that, but it may be that, you know, if you're in Chicago that we allow some provider networks that are narrower than I'd like to see. You know, maybe you can't go to Northwestern or U. of C. if you get sick on this insurance, but as long as people understand that, that we'll have to have some give there so that people with modest incomes who really don't want to pay a huge amount for health insurance have options that are less generous than what Jonathan Cohn or Harold Pollack would want to do given our different life circumstances and preferences.

Jonathan Cohn: Yes, no. I think that's ... look, I mean this is, and this is the conservative ... you know, conservatives would say this is a weird thing, right, because I think conservatives would say, "This is a virtue." I think it's a bug, but we sort of both agree at this point we kind of got to go with it, which is, you know, a lot of people buy really skimpy insurance.

I think a lot of people, it's not going to serve people well. I think it will serve people better than nothing. I do, and I do think at some point we'll come to a happy medium on this and maybe we will see some state experimentation. You know, we'll see what happens. If I had my druthers, I think the one thing I would do ... well, there's a lot of things I would do, but you know, if I was going to think about how to tinker with this, maybe dialing up those subsidies on the cost sharing side would be an interesting idea.

That's something to play around with. I don't know.

The narrow network thing I have very mixed feelings about. I've written a lot about narrow networks. Narrow networks is what you were just talking about. You have a plan, but you can't get into all the hospitals. That's gotten a lot of attention. It's a big talking point for the law, the critics of the law, and I should say it's a weird talking point to hear from the right because, you know, it's basically how insurance companies hold down costs.

They bargain hard and they say, "Look, we're not going to pay. You have X dollars for procedures, for care, and they go to the hospitals and say, "Take it or leave it." The hospital says, "Leave it," and they're like, "Fine." This is how they negotiate. Again, it's something that's always happened in healthcare. It is now happening more, but it's been around, it's been a process for a long time, and I have mixed feelings about that.