

Curbside Consult: The State of Obamacare (Part 2)

Harold Pollack: Hold on one second. Let me just put a break into the conversation just to remind people that this is Curbside Consult, and I'm talking with Jonathan Cohn. We're now talking about the issue of how narrow networks should be in people's insurance. You wrote a piece about Cedar Sinai Hospital in Los Angeles and how many people were very disappointed to discover that their exchange plans didn't include that hospital. Maybe you could say a little bit about that.

Jonathan Cohn: Yes, so this is something that's happening in a lot of communities. Sinai in Los Angeles is a very well known hospital. It's in the sort of western side of Los Angeles. It's well known because it's the hospital of the stars, you know? Jodi Foster had her baby there. Madonna had her surgery. It's got a very wealthy, very generous donor base. It's massive. It's one of these very large hospitals. It's got its own art collection.

You know, a good hospital can attract ... and this is from any top hospital in the United States now. They do a brisk business in the sort of elite, and they will ... I don't know which specific hospitals are like this, but I would be willing to bet if you went down the list of Mass General, the Brigham in Boston, and Sloan-Kettering, and Hopkins in Baltimore, Northwestern in Chicago, MD Anderson in Houston, all the cancer hospitals, they all have wings and these are where the Saudi Princes were to get their care and whatever, and that's fine.

Hey, you know, look, if there's royalty overseas that wants to pay out of pocket billions of dollars and pour it into the American healthcare system, who's to object, right? The issue is ...

Harold Pollack: I should say, by the way, we have a new 700 million dollar pavilion in our shop as well, and it is quite beautiful, and it has a wonderful ... the next time you're in Chicago I'll take you up to the dining area up on the 7th floor, or the top floor actually.

Jonathan Cohn: I believe you've been to Ann Arbor recently. Perhaps you've seen the glistening new children's hospital at the University Of Michigan Medical Center. Look, these are very good hospitals, and they do some great work. Cedar's is no different, for the really high end stuff, you know, the most complicated cases, the cancers that don't respond to the normal protocols, the people that come in with four different very serious things.

The point you really need is sort of the people who do the most complicated cases and do them regularly, right? In medicine, that's the key thing, right? If you have a complicated case, you want to go to someone who's seen it before, who does these. You know, you get at transplant, you don't want someone who does three transplants a year. You want someone that does 50, and that's what those hospitals should be there for, and you want to go there, and we want them, and we want them to thrive and to drive research and do all that.

Cedar's, great hospital for all that stuff. Cedar's is really, really expensive. It's among the most expensive hospitals in the whole country, not just in southern California. Because of their reputation, they're able to basically say to insurance companies, "Hey, we don't have to put up with your discounts. You don't want to send your people here, fine, but people won't like it," and sure enough, they don't. The flip side is that, you know, the insurance companies then pick other hospitals.

Now the ACA, the Affordable Care Act, does have a kind of network adequacy requirement in it. Like every regulation in the law, it has not been written in a way that would be as strong as I personally would like it, but it does say you have to be able to ... I mean you have to have a children's hospital or a place that does pediatric specialties. In Los Angeles, for example, the insurance plans that don't cover Cedars, they will send you to either UCLA or USC, which are both excellent teaching hospitals, right, or you can go to Kaiser West, Kaiser Permanente.

Harold Pollack: Do they have a good art collection in those places?

Jonathan Cohn: They don't. They're cheaper. They are cheaper. You can get to see the [specials 00:30:38]. Now on the one hand when you think about it, most people are able to get to a provider, at least at the hospital level, that will provide the care they want. The flip is a lot of people don't worry about hospitals. They worry about their doctors, right? People want to go see the doctor they want to see.

Maybe they had a doctor before, and now the exchange plans don't include that doctor because these exchange plans are not paying a lot of money to the doctors. As somebody who pays by Public Health, someone who talks to interview people, like you, that's bad. That's not just bad because it makes these people ... it causes inconvenience, or not just bad because it makes them uncomfortable, but it's bad for care.

I mean, you know, if you've got a longstanding relationship with a physician, you want to keep that because it's good for your health, and sometimes you really are even in a big place like Los Angeles, there may only be a few providers who are really, you know, know what you want. As a public health expert, I'm willing to say ... I'm not a public health expert.

As someone who talks to public health experts like you, I am willing to say confidently that most people who think their doctor is indispensable are probably wrong. I say that as the son of a doctor who I think is fantastic. I went to college with one, and lots of [inaudible 00:32:01] are doctors.

Harold Pollack: We like doctors.

Jonathan Cohn: I like doctors. I really do, but they're not as indispensable ... everybody thinks their physician is like the greatest in the world. They're probably not, but there are some people and they tend to be the ones with a chronic illness who a lot of them have found their way to the people who are best, and you don't want them to have to lose it. This is one of the areas where I think about improving the law.

I can say analytically, well, this happening already. Physicians go on and off networks all the time. We may see some acceleration again on the exchange side, but this is happening already. There are other ways to do it though. One of the more interesting things looking forward is, at least at the hospital level, you know who's not having a problem with narrow networks is the state of Maryland, and why doesn't the state of Maryland have a problem?

Because they tell every hospital ... they just set the fees. They just say, "Hospitals, here's what you're making if you're in the state of Maryland," so insurers don't compete. The government sets the prices. Now any free marketers [seeing this call 00:33:02] have just, their heads have exploded. You know, that's socialism. It is government price setting, but yet it's in Maryland. It works pretty well in Maryland. Johns Hopkins is in Maryland. Great hospital, but they seem to do just fine with it.

Harold Pollack: Just reminding folks this is Curbside Consult. I'm Harold Pollack interviewing Jonathan Cohn, and we just mentioned Maryland's new system, which basically sets the prices of hospitals. What's interesting about Maryland from that perspective is it does have one gigantic really prestigious hospital that is probably dominant in that. Therefore, you have ... in order to set up a scheme like that, you basically have one entity to negotiate with. I think it would be ... if New York State tried to do that, it would be a fundamentally different enterprise.

Jonathan Cohn: It would be.

Harold Pollack: Just the complexity of it would be so much greater, but the places that hold down costs are the places where government sets prices. Even if you look across the different wealthy democracies, that all have universal coverage in different ways. The ones that really have the most discipline cost experiences are the ones where the government is most able to set aggressive prices.

There's a lot of reasons to be worried about that, but that is the way that countries have basically held costs down, and everything else that people talk about like comparative effectiveness resurge, and preventative care, and having lots of uninsured people who just can't access care. Everything else that people talk about as ways to keep costs down are much less effective. In the U.S., we've tried the "well, we'll just allow a lot of people to go uninsured" strategy and clearly, we don't ...

Jonathan Cohn: Worked out well, didn't it? Great.

Harold Pollack: Yes, we've succeeded in actually executing the thing that you needed to do to see if it worked we did, but it didn't work.

Jonathan Cohn: It didn't work.

Harold Pollack: Now one of the things that you mentioned about people's connections with doctors reminds me of something that an unknown that I'm concerned about, which is what will happen with people? You look at the segment of people who live with disabilities who have chronic illnesses or who have loved ones who have those issues. I don't think that we've really tested out how well, certainly how well the new exchanges are going to work, and it's partly can you see the doctor that you want to see, but it's also there are all of these ways that the current health system sort of has evolved.

I'm a worker. I earn \$70,000 a year. I have a child with cerebral palsy, and my child has a supplemental Medicaid plan that covers a bunch of things that private insurance doesn't deal with. Maybe it's school based services. Maybe it's complicated assistive technologies that I need that are sort of beyond the level that private insurance typically does.

If you go into the new exchange and you say, "Well, now with that income I could actually get an income subsidy and buy a silver plan or whatever," you actually can't get a supplemental Medicaid plan the way that you could with your employer. There's a series of really complicated issues like that, that nobody's even thought about yet because we just haven't had enough people going down those paths.

I am nervous that ... I actually think Medicaid, for people with really complicated problems, Medicaid is probably better than private insurance for a lot of people because Medicaid just had the responsibility to do it for a long time. A lot of states are really hoping that the new exchanges will be able to assume these types of tasks, and it's just completely unproven what this is going to look like and how that's going to work.

I suspect that as things move forward that there's going to have to be some sort of real modifications to deal with these issues. That's going to require Congress to actually do some stuff, and it's not clear that Congress is able to do some stuff. When CHIP, for example, at Children's Health Insurance Program is reauthorized, I think there'll be a real question about how do you make this work with ACA? I think a lot of people thought that you didn't so much need CHIP once ACA were fully up and running, and that's really not going to be the case for a variety of reasons.

I want to shift gears a little bit so we'll be efficient with your time. I appreciate you're willing to come on my program. This is Curbside Consultant and Harold Pollack talking with Jonathan Cohn. Let's shift to what to look for in 2014. One basic question I want to ask you is this death spiral potential issue. How worried are you that we're just going to find that the mix of people who have signed up for insurance is going to include too many sick people and not enough young and healthy people?

Jonathan Cohn: Right. I think there's two questions here, which is are we worried that the risk pool won't look good, right, and then are we [inaudible 00:38:32] if it doesn't look good? Let's separate those two, right? The first question, are we going to get a good risk pool. Again, my answer is I can't be sure. I don't know. If I had to guess, looking at the information we have now, I think it will be good enough in most places.

That's a very wishy-washy statement, but let me explain what that means. [Anybody who knows anything 00:39:01] about insurance, and if you're on this call, certainly you've made it to minute whatever we're in, you know this. You need healthy people, a lot of healthy people paying premiums so you have enough money to cover the cost of the sick. That's insurance 101, right? Just because that's the case, it doesn't mean there's some magic number and either you hit it or you don't and if you hit it, you're fine and if you don't hit it, the whole thing falls apart.

That's not the way these things work. What's happening is insurance companies have set up premiums. Now when they set the premiums, each insurance company made a guess. Where do we think? What kind of people do we think we're going to get? Every insurance company does it a little differently. They made a guess, and then they're going to get people and they're going to look at who they got. We don't yet know.

We know that so far, we don't have as many young people as you could have, you know, if you had a good representation. If everybody signed up who was in the market, there would be many more proportionately. We'd see many more young. The estimate running around, about 40% is a good enough proxy. The number isn't what people think it means, but let's use that, and we're at like 25% now so we're a good bit under that, but you know, the insurance companies presumably didn't think they were going to get to 40% and they set their prices accordingly.

Insurance companies live year to year, but they understand that this is a long term project. I thought it was interesting, Sarah Kliff, who's been out at the meetings from the J.P. Morgan investment conference where all the insurers were. It sounds like mostly, not all, you know, Humana last week had said, "It looks a little worse than we thought. We're getting more sick people," but then Cigna and WellPoint I think, no Aetna and WellPoint both said, "No, it looks okay to us." You know, whatever.

They're talking to investors. Maybe they're putting a good spin on it. Who knows? It doesn't sound like ... I'm not hearing, myself, in conversation, I'm not hearing a lot of panic about this. I mean if it was really bad, I think you'd be hearing a lot of panic, so that tells me that it's probably okay. One thing to remember though is it's 50 different states plus the District of Columbia, 50 different sets of risk pools.

I feel pretty good about what it's going to look like in California, New York, the big states, the ones where we know they're going to get a lot of enrollment. What's going to happen in a small rural state that hasn't really pushed this hard, you know, just the numbers aren't very big in those places so you wonder what's going to go on there.

Harold Pollack: [They originally looked for more variability 00:41:36].

Jonathan Cohn: A lot more variability, right. You just figure the law of averages, right, between the Dakotas and a few places like that. You're going to get some places that are ... you're going to get some weird of numbers. That's the question of whether you get the mix or not, but now we get to so what happens then?

Harold Pollack: Let me put a pause in again. This is Curbside Consult, and this is Harold Pollack talking with Jonathan Cohn. People sometimes talk about the three Rs of the Affordable Care Act in connection to the risk pool. Can you say a little bit about that and how that fits into how anxious I should be about the sort of possibility of a dead spiral of sort of sick people signing up, leading to increased premiums, leading to more sick people and fewer well people signing up, etcetera?

Jonathan Cohn: That's a spiral monster. By the way, as someone who has ... when we had the whole debate on the individual mandate, the argument for the individual mandate was you didn't want a death spiral, so I don't want to diminish this. I mean it's a real danger in any insurance system. I think it's easily exaggerated as something that's an on/off switch as an either/or when in fact it's more of a spectrum, you know?

The more that you have this effect, the worse the prices get and certainly, in the long term to manage a sustainable system, you really do [inaudible 00:43:01] of several years. You need to get to a place where you have a good balance of healthy people and sick people. You need that eventually. The question is how quickly do you need it and what happens if you don't get it right away?

The law ... when you design an insurance system, and this has been known for a long time, you can build protections into the system to protect both ... there's always a possibility some insurance companies will end up with really healthy people, and some won't, right? Partly it's [cooking 00:43:31] the system, right? I mean in the old days, this was very common. You're an insurance company and you want to get really healthy people. What do you do? You give really big discounts if you join a health club, right? That's not so much ...

Harold Pollack: I can't say I've seen too many ... free wheelchair. That was not something that insurance companies generally offered. We're basically saying we don't want them to have a business model that profits from the health mix of the people who sign up.

Jonathan Cohn: Correct, correct. You do want to guard against the fact that we are moving from a system that had a place where companies could pick and choose who they insured, largely in most places, to one where they can't, and we don't know the introduction, how quickly. Everyone knew it was going to be a couple years to phase in the enrollment, so you wanted to protect insurance companies.

You wanted to make sure that the ... you wanted to give them the confidence to offer low premiums without the fear that if they got it wrong they'd be on the hook, so you did three things. First of all, what you call the wants, you and me, people like us, we call it the three Rs. I have been calling them shock absorbers because I feel like that's a metaphor for what we're really talking about here to smooth out the transition.

The first is what's called risk adjustment. None of these were invented for the Affordable Care Act. They've been used before in various places. The most common is risk adjustment, and all that says is basically we're going to sort of look at who goes into the different plans, the plans that are getting the healthier people. We're going to take a little money from them and give them to the plans.

Then we'll get the more unhealthy people just so, you know, don't try to ... it's partly to prevent them from gaming the system, sort of warning them in advance, "Hey, you're not going to be able to make money that way" and partly to compensate if it happens anyway. It's interesting. Countries that do this included the Netherlands. I'm studying that system over there.

One of the interesting things I heard was that their risk adjustment worked so well, they actually overcompensated, so there were insurance companies competing to enroll the diabetics because you actually work out pretty well.

Harold Pollack: If it's properly risk adjusted and you feel that you're good at managing the care of people with diabetes, then that becomes a profit opportunity. Now one of the uncertainties is always within the diabetics there are the people, maybe the people that have certain characteristics I can manage well, and the people who have sort of significant socioeconomic challenges I'm less successful with those people, so within the diabetics I might play games about who I really want to attract and who not, and there's always that level of how effectively can I truly risk adjustment.

In principle, if you really could handle this problem and we really could pay companies more if they had more cancer patients, some of them will decide, hey, we could make money by taking the most complicated patients and caring for them in a more economical way.

Jonathan Cohn: Right, and like all of these things, you can imagine a sort of worst case scenario and you can imagine a best case scenario. The one you just described to me is a win/win, right, because we're providing the care for less money. It's probably better care or at least as good care, right? That's good, you know, but there's a worst case scenario, right, which you discussed, so that's risk adjustment.

Then we have a thing called reinsurance. Reinsurance, sort of a similar principle but operates in a different way, but it's really more on a person by person basis. It basically says to the insurance companies, when you get people who run up a lot of bills, we'll cover some of those costs. We'll create a pool of money that basically covers those costs. Now reinsurance is something, again, that exists in the market today, large employers who provide health insurance for their employees.

That's called self-insuring, right? Typically, they put ... what that means is they hire an insurance company to run the insurance, but the money's coming out of the corporate treasury basically. Now they don't want to be on ... they get nervous. Even if I'm a large company, I've got a couple people with transplants, that's a lot of money.

Transplants are sort of at the high end, right, or you get someone with a premature baby in the NICU. You think about places in the hospital where bills just boom, right? You're looking at ...

Harold Pollack: You'll get a six million dollar kid, you know, a six million dollar expense for something. There's some need even among the insurers to spread that load around.

Jonathan Cohn: Right, so they get reinsurance. It's insurance for insurers basically. It exists in the private market today. The basis of any exchange is the government provides it. Now it's important to remember reinsurance is literally an insurance program for the insurer, so this is designed the money paid into it is paid in by all insurers even though it's not ... even employer plans pay a reinsurance fee, and that money is then given to the plans in the exchange that have caught those people with the very high expenses.

Harold Pollack: Is it right to both the risk adjustment and the reinsurance are basically ways that insurers redistribute among themselves monies that are provided through premiums so there's no ... it's not as if the government is spending a lot of money doing these things. It's reallocating [inaudible 00:49:07].

Jonathan Cohn: It's reallocating, and I'm going to talk for a second about how you should think about that money because, you know, all money in the end does come from one place and, you know, there's no free lunches, but there's an important ... we'll get to it when I get past the third R. Then there's a ...

Harold Pollack: Sorry. Go ahead.

Jonathan Cohn: The third R is this thing called risk corridors. This is not something you see as much in the private sector, but it's something that exists in government programs. Medicare [inaudible 00:49:32] drug program had a risk corridor program built into it. Overseas, Netherlands and Switzerland, I'm like 99% sure both have risk corridor programs.

Basically what a risk corridor program says is that imagine it is sort of constructed like a corridor, and it basically says, "Look, to improve stability and to assure the insurance companies that they can survive in this, we're basically going say up to a certain range. You guys are guessing at premiums, and if the premiums turn out to be pretty much what you guessed give or take 3%, you're okay.

If they turn out to be way off by more than 3%, we will start to pick up half the cost or we'll take half the profits. Basically, we're going to share this with you," so you end up with ... it turns out that you get ... afterwards you look at the claims you paid out and it's like 5% higher than you thought. All right, that first 3%'s on you, but the second 2%, we the government, we'll absorb half of that, okay?

The flip side is if you end up to the good, right, you set your premiums and, whoa, no one used medical care and so you got this unexpected ... your expected claims, they were actually 5% lower than you thought. All right, 3%, good for you. You got lucky. You keep that money. After that, we're going to take about half of that money, and we're going to use ... basically that is [one page to the other 00:51:03.] As it get higher, you get about 8%. At the point, the government shares in 80%, not just ...

Harold Pollack: From a taxpayer perspective, that's a little scary. Doesn't it sound like we have a certain risk that we're really ... if it's way off, you know, if they set the premiums way too low that we'll be on the hook for a big bill?

Jonathan Cohn: Right. This gets right into the argument that you're hearing from the market. We're going to have this huge bailout of the insurance industry. Here are the three things to remember. First of all, again, it works both ways, right? It is a program that the government shares in the profits and in the losses. For that reason, the CBO, the Congressional Budget Office, when it estimated the impact of this, it didn't come up with a separate cost estimate. It said, "We think this will balance out. We think insurance companies, some are going to guess right, some are going to guess wrong. Of those who guess, some will guess too high, some will guess too low. More or less, it will even now."

Harold Pollack: So if insurance companies are good at their job, they won't wildly misprice their product.

Jonathan Cohn: Right.

Harold Pollack: That's the assumption that the Congressional Budget Office is making.

Jonathan Cohn: That is correct. Now that was the assumption. Assumptions frequently turn out to be wrong, and obviously, you know, we have had some problems with the system. It's not clear yet whether that's going to affect the enrollment. This again goes back to something we discussed earlier. The insurance companies are saying things are looking roughly right, but you know, maybe, who knows?

Who knows what's going to happen in the next few months. Maybe they max out, and maybe no more healthy people will sign up and every sick person in America is going to go into an exchange, so who knows, right? What if they're wrong? You look at the numbers, and I'm going to tell you, I think I've spoken to every actuary in the United States at this point because I just wrote about this.

The great thing about actuaries is they know a lot. The terrible thing about actuaries is they refuse to put their name by something like they can certify as true, so I can't get anybody to give me a "this is what it will cost, this is what it won't cost." I will say this. If you, and I haven't written this yet, and I'm even allowed to say it on the air, but I'll just sort of say this, that in general, if you work with the numbers and you use what would be a realistic assumption of large losses and you [massage 00:53:25] the numbers, it's really hard to get a total payout in the first year that's [inaudible 00:53:32] a billion dollars, two billions dollars and that's ...

Harold Pollack: One or two billion dollars is the upper range, and to put that in context, how do we put that one or two billion dollars in context?

Jonathan Cohn: This is a trillion dollar bill. The money spent on the exchanges every year is 20, 30 billion dollars in subsidies, so that is not a lot of money. Here's the key part. This is sort of the [inaudible 00:53:02] puts this in perspective. This latest piece of news has gotten very little attention, and I blame myself because I really haven't written about it, so hopefully I'll write about it before the whole world sees this video and I won't scoop myself, although I did mention it in my last piece.

Harold Pollack: There you go.

Jonathan Cohn: If you think about it, why would there be a big payout? What would cause this to happen, right? What's the mechanism that causes a large risk corridor payout? It's the fact that the insurance companies set their premiums too low, right? If they have premiums high enough, it would account for the medical expenses. Now if you think about that, and whether you think that was the right thing to do or the wrong thing, whatever moral judgment you want, this is what's causing the payout.

Let's assume I'm wrong and actually you could get a payout of five billion dollars, seven billion dollars. Here's the thing. Again, I don't know why this hasn't gotten more attention. I blame myself. Those lower than expected premiums, those low premiums, they came in way below what the CBO projected. That means that the dollars that the government is spending on subsidies to help people buy insurance is going to be a lot lower, and the money the government is saving on those subsidies is bigger than the money that will go out in the risk corridors.

If you think of those two things as joined at the hip, which they really are because one causes the other. If you didn't have one, you wouldn't have the other. That's still a net gain to the taxpayer.

Harold Pollack: So it's possible that had ... suppose that it turns out things are more expensive. It may be that the government pays out less through the risk corridor mechanism than it would have paid out under this hypothetical if the premiums had been higher to match those costs.

Jonathan Cohn: Exactly.

Harold Pollack: The underlying question is how expensive are these people to take care of, not this risk corridor program.

Jonathan Cohn: Exactly, exactly. That's exactly ... that's actually a wonderful way to put it. In effect, that's a reality that's not going to change fundamentally, right? These people are so expensive to care for. We're all hoping this law changes the way we do medical care, and there's some signs that's starting to change, but that's a 10, 20 year process. Fundamentally, these people ... here's how much they cost to insure, and basically what we're trying ... that money's going to be spent by our healthcare system, and it's a question of whether it gets spent on the front end of insurance or on the back end, premiums versus risk corridors.

Frankly, unless I'm really wrong on the math, and like I said, don't anyone watching this quote because I'm still trying to figure this out. I'm pretty confident this is right but obviously not confident enough to put it in print. I think the way it's structured now, probably the taxpayer comes out to the good probably by quite a lot.