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Goodman, Part II: Obamacare Exchanges, Medicaid Expansion Degrade Health Care Quality

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Last year, I sat down with Goodman in the Cato Institute's Hayek Auditorium to discuss his latest book on health reform: A Better Choice: Healthcare Solutions for America(Independent Institute, 2015). Video of the event is availablehere.

This is part two of a (lightly edited) transcript of our conversation. Click here for parts one and three.

MICHAEL F. CANNON: Thank you, John.

I've got a lot of things I want to ask you about the book and your views on health policy more broadly. I enjoyed the book. It makes a lot of very important points. I think your discussion of third-party payment in the book, the problems of third-party payments is one of the best I've read. I expect no less.

Let's start with questions about ObamaCare itself and the problems with ObamaCare. You already mentioned one of the things that I want to ask you about, which is how ObamaCare threatens access to care and quality of care for the sick by creating these perverse incentives that you're discussing.

How does a person with a high-cost illness experience that? If I've got diabetes, if I get cystic fibrosis, if I've got MS, what does it look like for me in ObamaCare Exchanges? How am I going to experience that dynamic you discussed?

JOHN C. GOODMAN: What people are finding out all over the country is that the narrow networks really are narrow and that they leave out the best doctors and the best hospitals. If you have diabetes, the number of doctors that are skilled at treating the problem are few. You may have to travel 50 miles down the road to find one. A woman in New York who had a broken ankle had to go to Connecticut to find a doctor who would treat her because of a plan that she bought in the ObamaCare Exchange. It really is a race to the bottom and the narrow network is one clue.

Another clue is the very high out of pocket payments required of people who need specialty drugs. Specialty drugs are primarily cancer drugs. They're very expensive. What the plans are doing is saying, that, if you need one of these expensive cancer drugs you have to pay a huge portion of the cost until you hit your out of pocket limit, which is a little over $6,000. So if you have AIDS or if you have cancer and you go into the Exchange, you're probably in a plan that's going to require you to pay $6,000 for lifesaving drugs that you need. That's the race the bottom.

Now, what would be the alternative to that? The alternative to that is that when people move from plan to plan, they don't move at a community-rated price. If you go silver plan to silver plan, the price that the enrollee pays will be the same as what all other enrollees are paying. But the plan you leave would make an additional payment to the plan that receives you. So the total premium the plan that receives you gets, would be actuarially fair.

And how do we get that? We start out with the formula that Medicare Advantage uses. We can even use the apparatus of Health and Human Services to do this—to get to the risk scores. And then the health plans are free to negotiate better ways of risk adjustment. Now I've set up a mechanism where the health plans are not running away from sick people anymore. In the Medicare Advantage program basically the healthy are just as attractive as the sick. There's no economic difference. You have special needs plans and they get $60,000 or more for enrolling seniors that have lots of health problems. In Medicare Advantage, it's Medicare that's doing the risk adjustment.

I'm willing to start with that, but then I want to evolve into free-market risk adjustment. With that you could have an insurance market that really works because plans get a premium that reflects the full actuarial value of the people they enroll.

CANNON: But in Medicare Advantage, that all depends on Medicare getting the prices exactly right. If Medicare's prices—the amount that they pay to the private plan that cover Medicare Advantage enrollees—are a little too high or a little too low, then you are creating these perverse incentives again, where they have an incentive to deny care to the sick or to buy gym memberships to attract the healthy, where they're making their money. Or the maybe-apocryphal story of having the sign-up for a Medicare Advantage plan on the fourth floor of a building with no elevators, so you keep all the disabled people out of your health plan that way.

GOODMAN: Medicare doesn't have to get it exactly right. It's a very imperfect system, but it uses seventy variables and it's not easy to game. It's a starting point and with that starting point, the private sector would be free to improve. So if I'm running a health plan, it doesn't matter that Medicare isn't getting it exactly right. As long as I can better predict the cost of the healthy and the sick, I can't game the system.

CANNON: You also mention in the book you discuss something that I think is very important for understanding ObamaCare, which is the Oregon Health Insurance Experiment.

Can you tell us a little bit about that? What does it mean for ObamaCare's Medicaid expansion and ObamaCare more broadly? And also, please comment on one of the lead investigator's subsequent work, Amy Finkelstein of MIT, her subsequent work about the value of Medicaid for enrollees.

GOODMAN: What happened in Oregon is something that never happened before.

We have lots and lots of studies about what a difference Medicaid makes and some found that, you know, people are actually worse off in Medicaid than if they are uninsured. But there were always questions and criticisms of the studies.

What happened in Oregon is that they took people who applied to be part of the Medicaid expansion and they assigned them by lottery. Some were admitted to Medicaid and some were not. They were otherwise very similar. So we were able to do the first controlled experiment to see what difference Medicaid really made and the bottom line conclusion was it had no real effect on health, certainly not physical health. That was shocking to lots of people. Some people say, you didn't have enough experience and as time goes on we will see an effect. But it looks like the results will hold up. Being on Medicaid just does not seem to affect people's health.

Amy Finkelstein, one of the authors of this of the study, did a subsequent study where she used some complicated mathematics and even tried to estimate what value the recipients placed on Medicaid. For a poor person who is enrolled in Medicaid, it's free to that person. But if they had to pay to enroll, how much would they pay. That is, what is it really worth to them? She found its worth between 20 and 40 cents on the dollar. So we taxpayers are spending a dollar and the value to the recipient can be as low as 20 cents.That's not, that's not a good exchange.

CANNON: In the book you mention the cuts that ObamaCare made to Medicare. You refer to those cuts as draconian, but you just mentioned that AARP, hospitals, and others who had their Medicare payments cut are not asking for that back. Are ObamaCare's cuts to Medicare draconian? Or are they not a big deal, as evidenced by the fact that these folks don't want their money back? Well, we say "their" money, but what we mean is, they don't want to eliminate those cuts to the subsidies they are receiving through Medicare.

GOODMAN: Let me describe how big they are. Some of you may remember, before ObamaCare we used to get these scary, scary forecasts about how much unfunded liability there was in Medicare and these numbers come out of the trustees report. When Obama signed the Affordable Care Act we wiped out $52 trillion of unfunded liability in Medicare. So if you make Medicare grow forever at the rate of growth economy, while health care costs are growing at twice that rate, the amount the government saves is huge.

Now why haven't we seen a lot of pain and agony out there so far? Because the Obama administration has managed to circumvent some of these cuts. Medicare Advantage, for example, was supposed to endure some substantial cuts, but they went around that and they found ways of grading plans and giving them extra quality bonuses.

So we really haven't seen big cuts to the Medicare Advantage program and the big cuts on the hospital sector are a few years away. The pain is on down the road we haven't really experienced very much so far. But we're going to experience a lot of it if the government holds to flat-line spending for Medicare, while the rest of the health care system is growing at a much faster rate.

CANNON: A couple questions about health care generally. You've always been confident that cost conscious consumers can force prices down. Walk us through, if you could, the example what WellPoint did in California with knee and hip replacements and the effect on prices.

GOODMAN: What happened was incredible. WellPoint, which is called Anthem in most places, has the health insurance for CALPERS, which is the health plan for all the employees and

employees' families and retirees of the state of California. We're talking about, a huge pool of people. WellPoint got the state of California to agree to this experiment. For hip and knee replacements, they looked at all the hospitals throughout the state and they were able to identify about 46 hospitals where hip and knee replacements routinely were $30,000 or less. Everybody else was more. So what the state of California and WellPoint said to all of the employees is that you can go to any hospital you want, but all we're going to pay is $30,000. By the way here's 46 hospitals. If you go to these, you don't have to pay anything more than your normal out of pocket payments. But if you go outside the network and it's more than $30,000, you're going to have to pay the difference.

After about a year of this the out of network hospitals—the ones that were above $30,000 dropped their charges by over a third. Within two years the out of network hospitals were charging less than $30,000. Here's what is amazing about this is. All of you have heard that to successfully negotiate with hospitals you have to be big. You have to be the government or a big insurance company or a big employer. The individual patient has no bargaining power. What happened here is the prices came down and WellPoint didn't do anything. They didn't get on the phone. They didn't write a letter. They didn't negotiate with anybody. They just sent patients out to tell their doctors, "All I have to spend is $30,000." And that's all it took. Suddenly the market responded in a way that, I think, surprised everybody.

CANNON: And the price reductions were substantial, they're on the order of $10,000 per patient.

GOODMAN: Oh yes! Yes, when I said the out of network hospitals were above $30,000 I should have added that some were $50,000 or $60,000 or more. So this is huge.

CANNON: This is a little bit a little bit wonky, but the economist in me has to ask this question.

You mentioned in in the book that there are sometimes death spirals in unregulated markets with guaranteed renewability, which is where the insurance company says to you: We will underwrite you when you buy health insurance, but we won't underwrite you again. Then, even if you get cancer, your premiums will not go up more than for anyone else in the group. Your premiums are not going to spike because you got cancer. You argue in the book that in those unregulated markets a guaranteed renewability you sometimes get death spirals because in those pools, those blocks of business, the people who didn't get cancer leave to find a more affordable plan; whereas the people who did get cancer cannot leave those plans because they would face underwriting again.

Mark Pauly and Bradley Herring had an article in *The Journal of Health Economics* several years ago called—and this is where we get really wonky—"Incentive-Compatible, Guaranteed Renewable Health Insurance Premiums," where they make the case that the incentive-compatible part of that title means that, actually no, the healthy people in those pools don't have an incentive to defect to go find another health plan with a lower premium, because they would be charged a guaranteed-renewable premium that would be the same as they're being charged in the current plan.

Is that your understanding of Pauly and Herring?

GOODMAN: Now this is getting a little wonky, but actually what Michael's talking about is just another variation on the John Cochrane idea of how insurance markets could work.

Ideally, you want a long-term relationship between insured and insurer, and when people move and go to another plan they can't have perverse incentives. What used to happen is you'd have an insurance company that would have a pool that overtime is getting sicker and sicker and it would create a new plan, and attract all the healthy people over to the new plan. That means the sick people who remained behind had to pay higher and higher premiums. That isn't going to happen anymore and thinking about how we get from where we are now to good health care system, I think that people in this room ought to just accept the fact that we're not going to win the battle of allowing the market to price health risks the way it used to. I think the public demand for people not to be discriminated against for preexisting conditions is just too strong.

But I also want to say I think the reason for that is the government's past policy of encouraging us all to have group insurance and that just guarantees that when you leave your employer, you have to be rerated again when you find a new insurance company. It creates the problem of pre-existing conditions. So it's a problem that government created. People demand that government somehow solves that problem. The way I think that problem can be solved with the least government involvement is what I just described earlier where we have a risk-adjustment mechanism that eventually becomes market-based risk adjustment and that gets incentives right.

Michael F. Cannon is the Cato Institute's director of health policy studies.