

**Sent:** Mon, 29 Apr 2013 09:21:58 -0400  
**From:** DMCOS <dmcos@who.eop.gov>  
**To:** [REDACTED]  
**Subject:** FW: TNR (Cohn): Why Obamacare Is Not a 'Train Wreck' (Again)

P6/b(6)

Sir,

This is worth a read.

DM

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**From:** Velz, Peter  
**Sent:** Monday, April 29, 2013 8:21 AM  
**To:** DL-WHO-Press; DL-WHO-Healthcare  
**Subject:** TNR (Cohn): Why Obamacare Is Not a 'Train Wreck' (Again)

<http://www.newrepublic.com/article/113049/obamacare-implementation-2013-busting-myths#>

## Why Obamacare Is Not a 'Train Wreck' (Again)

**JONATHAN COHN**

Max Baucus thinks it might be a “train wreck.” David Brooks is predicting chaos. And Democratic senators are telling the White House they are panicked. They’re all talking about Obamacare and what happens next year, when it starts making insurance coverage available to nearly all Americans.

Believe it or not, the conversation represents progress. Instead of talking about whether we should have a health care reform law, we’re talking about how well (or not well) the law is going to work. So let me spoil the surprise for you: It’s not going to work as well as many of us would like, and the initial adjustment may not be easy. The whole enterprise is going to be a work in progress. And that’ll be ok—because it will still do a lot of good and make life better for most people, particularly with the passage of time.

As even Obamacare’s most ardent defenders have said from the start, the law is far from ideal. The architects of reform had to make all sorts of compromises, just to get the law past lobbyists and obstructionist Republicans. And then, after finally enacting the historic legislation in early 2010, they had to spend most of the next three years fighting repeal. In Washington, Republican congressional leadership has repeatedly blocked funding for implementing the law. At the state level, conservative officials are at best indifferent to its success and at worse outright hostile to it. This last part is no small thing, given the leeway state officials have over the law’s implementation. In states like Florida and Texas, officials have already indicated they won’t be expanding

eligibility for their Medicaid programs—depriving millions of health insurance.

This helps explain why even supporters of the law are nervous about what happens this fall, when the new insurance “exchanges” are supposed to open for business. The exchanges are the new online marketplaces through which people without employer insurance can buy insurance directly and, depending on their incomes, qualify for tax credits that offset the cost. The idea is to make them pretty simple: You go online, enter in some financial information about you and your family, and learn what kind of insurance you can get. If you’re poor, you’ll be instructed to enroll in Medicaid, assuming your state makes it available. If you’re not poor, then you’ll get to choose from among a set of regulated plans—each with a comprehensive set of benefits, and priced in ways that you can make real apples-to-apples comparisons. And if your income is less than four times the poverty line, or about \$94,000 a year for a family of four, you’ll learn about tax credits to offset the cost of the premiums—the less money you make, the bigger the tax credits you get will be.

But constructing such a system is complicated. It requires, among other things, collecting a lot of information. A [prototype form](#) that the federal government released in March ago had [21 pages](#), although it would seem like less online and not everybody would have to fill out the whole thing. A well-functioning exchange also requires seamless, near-instant communication between the federal government (which is in charge of the tax credits) and the states (which run Medicaid and, in at least some states, will be running the exchanges). That’s a substantial information technology challenge, particularly since the security needs to be ironclad. Even the states most committed to the new law, and with the best resources for doing so, have struggled with this. In conversations over the last year, I’ve heard the phrase “white knuckles” more than once. You can imagine what it’s like in states where officials are ambivalent.

Other challenges have nothing to do with logistics—and everything to do with the inevitable complications of trying to fix a broken insurance market. A good example of this is all the talk about “[sticker shock](#).” Come the fall, when people start shopping for coverage on the exchanges, some of them will see higher prices than they’ve seen before. Partly that’s because people with lousy insurance will finally be getting decent insurance; the price will be higher but the coverage will be more comprehensive. The other source of sticker shock will be the end of discrimination based on medical condition. That will mean lower premiums for people who suffer under this system—namely, the old and the sick. But it will also mean higher premiums for people who benefit under this system—the young and the healthy.

Insurers are just starting to submit their bids for next year. And some of the numbers you’re hearing sound scary. Last week, for example, CareFirst in Maryland requested rate increases that will average 25 percent. The danger of high rates isn’t simply that they would be difficult for many people to pay. It’s that they would keep healthy people—particularly, young healthy men<sup>2</sup>—from buying insurance. These folks might opt instead to pay the penalty for carrying no coverage, thereby causing higher rates for everybody else.



After canvassing officials and experts, Brooks concluded that the most likely outcome is that "we're probably in for a few years of shambolic messiness, during which time everybody will scramble and adjust, and eventually we will settle down to a new normal." I've certainly heard similar things, even from supporters of the law. Nobody really knows for sure: There's just so much variation from state to state, so much unknown information. But chances are good you're going to hear stories about people who went online to get insurance—and got sent, electronically, to the wrong place. You're probably hear about people frustrated that the electronic forms are so complicated to fill out. You're going to hear about employers confused about what the law requires—and, in some cases, trying to game the new system. And you're going to hear about more insurance bids like the one in Maryland, particularly from states that have no existing regulations on pricing.

But when you hear these stories, it's important you hear all of the details. And in many recent accounts, you haven't. That's most obvious in the stories about insurance premiums—and the CareFirst story is a perfect example. The premium increase won't take effect unless state regulators approve it—and, if a [tough statement](#) from the state insurance commissioner is indicative, they may not. CareFirst officials say they are simply following the advice of their actuaries, who predict the influx of previously uninsured people with medical problems, will drive up costs. But, as [Sarah Kliff](#) reported in the *Washington Post*, other Maryland insurers like Kaiser Permanente requested only minor rate increases. And as an editorial from the *Baltimore Sun* pointed out, "The point of the insurance exchange is to foster competition. ... If people don't like what CareFirst is offering, they will have a choice."

More important, the premium isn't actually the price most people will pay. Remember, the federal government is providing tax credits that offset part or all of the premiums—and take care of some cost-sharing. In addition, the law will make a skimpier, cheaper plan available to young people, while allowing those under 26 to stay on their parents' plan. (That provision is already in effect.) As [Michelle Andrews](#) of Kaiser Health News recently explained, citing a study from the [Urban Institute](#):

Although premiums will be higher for many young people under the new rules, this increase will have very little impact on their out-of-pocket costs, the study found. The reason: The vast majority of young people will be eligible for subsidized coverage -- through the exchanges, Medicaid or their parents' health plans. On the health insurance exchanges, premium subsidies will be available to people with incomes up to 400 percent of the federal poverty level—\$45,960 for an individual in 2013.

Notice that the worries about implementation chaos apply strictly to people who would otherwise be uninsured or at the mercy of the existing individual insurance market, in which plans are inconsistently priced, full of coverage holes, and of unpredictable reliability—and in which financial assistance for buying private coverage is not available at all. Even if it takes these people a while to get insurance, and even if finding that coverage is a maddening experience, they're going to end up with

something they don't have now: Coverage that meets more of their needs and is available to them, with substantial financial assistance. Don't forget: Today, people with pre-existing medical conditions frequently cannot get *any* coverage on the individual market.

Meanwhile, the vast majority of Americans won't notice any of these changes directly, because they will continue to get insurance the same way they do today—through Medicare, through Medicaid, or through an employer. To the extent Obamacare affects these people in the short term, it will mostly be by adding protections such as prohibitions on lifetime limits or, in the case of seniors, extra prescription drug coverage. And those changes have already started taking effect.



Of course, Obamacare is supposed to help even the presently insured—not simply by providing a safety net in case they lose their jobs, but also by reducing the cost of health care overall. This is the other common complaint you hear about Obamacare: That it didn't "solve" the problem of higher health care costs. This is absolutely true, particularly given the many concessions the architects of reform made to the health care industry.

But it took many, many decades to create the problem of health care costs in America. It's bound to take at least a few years to solve it. And that may actually be [starting to happen](#). Health care spending has actually slowed down in the last few years. The recession obviously has a lot to do with that: When people have less money to spend, they get less health care. But most experts believe that other forces are also at work. The most intriguing, and promising, sign is new data on hospital readmissions—that is, people coming back into the hospital shortly after getting discharged. In the aggregate, readmissions are a sign of poor care, either in the hospital or during follow-up. Obamacare penalizes hospitals for readmissions and, sure enough, readmissions plummeted right after it became law.

While the data is far from conclusive, the timing does not seem to be pure coincidence. Just the other day, [Annie Lowrey](#), of the *New York Times* wrote about Advocate Health Care, a Chicago hospital network that has reduced admissions. One reason, though not the only one, appears to be Obamacare's payment incentives. Skeptics "may be right that no one thinks the law contains as much cost containment as it needs," says Alan Weil, executive director for the National Academy for State Health Policy and one of the most attentive followers of reform at the ground level. "But everywhere I go I find people are pleasantly surprised by how quickly and forcefully it has accelerated delivery system improvement." The progress is halting and, more than occasionally, frustrating. If you want an example of the latter, read [Ezra Klein](#)'s investigation of a promising initiative that Medicare is about to defund. But it seems to be progress all the same.

The last time government introduced a major new health care program was in 2006, when Medicare began offering a prescription drug benefit through what is called "Part

D.” It got off to a notoriously rough start, as seniors showed up at pharmacies only to discover they were enrolled in the wrong plans—or that their plans didn’t cover drugs like they did before. The Children’s Health Insurance Program, which became law in the late 1990s, was slow to attract enrollees. But things got better. As [Larry Levitt](#) of the Kaiser Family Foundation noted recently, the end result was that seniors got drug coverage and kids got insurance they never had before. Today, the programs are highly popular, even if they are not perfect.

The key, really, is expectations. On Friday, the [Commonweath Fund](#) released a report with two key findings. One was that more young people have health insurance, thanks to Obamacare’s requirement that insurers make coverage available to people under 26. That’s a reminder of benefits the law has already delivered, without the ill-effects critics had predicted. The other finding is that large numbers of Americans remain uninsured or under-insured—simply put, they can’t get health care when they need it, or they remain exposed to financial catastrophe when they get sick. These people may be a lot better off because of Obamacare or they may be only a little bit better off. Either way, they’ll be better off—and, over time, their situation will improve. That’s not bad for government work.