Catching Up With ....

Emily Friedman

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- Independent health policy and ethics analyst
- Areas of interest include trends in healthcare; healthcare reform; healthcare quality improvement initiatives; the social ethics of healthcare; disaster preparedness; leadership in healthcare; health policy and how it works (or doesn't); the impact of demographic change on healthcare; insurance and coverage issues; lessons from international health systems; and the relationship of the public and society with the healthcare system
- Adjunct Assistant Professor at the Boston University School of Public Health, repeatedly honored as one of the school's best teachers
- Honorary life member of both the American Hospital Association and the American Medical Association
- Prolific lecturer and writer
- Writes a regular column for *Hospitals and Health Networks Daily*
- Author or editor of several books on ethics, healthcare history and other topics
- Other publications include an examination of minority participation in clinical trials; an analysis of the impact of population change on all aspects of healthcare; and a report on the increasing trend of organized armed violence against hospitals around the world
- Since 2007, studying, speaking and writing about the rebuilding of the Cambodian healthcare system, which was almost totally destroyed between 1969 and 1979
- Named one of the "100 Most Powerful People in Health Care" and one of the "Top 25 Women in Health Care" by *Modern Healthcare* magazine
- In 2011, 2012 and 2014, named one of the "top five" health care speakers in the United States by Speaking.com

Health Insurance Marketplace News: *How has the concept or definition of health insurance Exchanges changed over time? What has changed most about them?*

Emily Friedman: Things are in flux, to put it mildly. The original concept of an Exchange was the Massachusetts Connector, which was part of that state's effort to make insurance easier to obtain. It was also designed to foment price and benefits competition among insurers. The Connector served as the playbook for that aspect of the ACA. It was an interesting idea, because competition among insurers had not been based on price or benefits packages very often; for the most part, competition focused on how to avoid covering people who were not well. Although the ACA has a lot of stupid provisions, the reason, in the end, that I supported it is it sought to end discrimination against the sick -- the most deplorable aspect of our insurance system.

There's an old joke that you don't want to see public policy or sausage being made. The ACA is a product of more deals than the Kansas-Nebraska Act; it's a gigantic compromise. And that will continue to haunt it. The problem is not new. The situation always is -- and this is a huge issue with the Exchanges – that the feds want to have all the power but want the states to fund whatever the program is, and the states want all the power but want the feds to fund it. Given that truth, it's a rather screwball idea that a state and the feds can run an Exchange together or that the feds can run a state Exchange. I suspect that over time, more states will hand their Exchanges over to the feds.

Some of the Exchanges just belly flopped, including Hawaii and Maryland (surprisingly in the latter case, because the state usually has pretty competent health policy officials) -- and a number of others didn't work very well. But other Exchanges have been quite successful at doing what they were supposed to do, which is to say, "Hey, insurers, if you want to be part of this, if you want to cover people who are going to be subsidized, you have to follow these rules. You can't discriminate against sick people, and you can't charge more than what the Exchange allows you to charge." But the insurers apparently thought, "How do we avoid sick people now? I've got it! We fiddle with the pharmacy formulary." And that's what they've done. They place drugs for AIDS, MS, Parkinson's and severe cancers in the top tier of the formulary with 40% cost sharing. That's how you get rid of sick people. It's a classic case of the law of unintended consequences. I thought it was a golden opportunity for insurers to move from risk aversion to risk management, but they didn't see it that way. It's appalling that we have an industry that seems determined not to care for the people who need insurance the most.

HIMN: *What will Exchanges look like five years from now? Will public or private Exchanges dominate?*

EF: Hell if I know. If a Republican is elected president, he or she is going to do the best he or she can to repeal the ACA, but by then it's going to be useless to try to do so; most of it is going to be set in stone.

(continued on page 11)

Catching Up With... Emily Friedman...*continued from back page*

We're talking 18 months from now, when the law will have been in effect for seven years. The future of both public and private Exchanges is going to depend – and I'm not trying to sound simplistic – on how well they work. The second factor is what the overall political landscape is going to be. If there is a large Republican majority in both houses and a Republican president, some provisions of the ACA could be repealed. If there is a Democratic president whose veto can be overridden, the future of the ACA Exchanges will depend on how far the Republicans would be willing to go to break up the law. My guess is by then they're not going to go that far. Taking away the subsidies and allowing insurers to go back to discriminating against the sick and cutting Medicaid so that 17 million to 20 million Americans are disenfranchised? I just don't see it. I just don't see it.

If we are going to keep the ACA around, even in modified form, then the Exchanges, if we can make them easier to use, will be a very, very useful tool for people seeking coverage. But they must become more user-friendly; the average person is not a healthcare rocket scientist. If costs continue to rise, expect employers to send more employees to Exchanges, especially pre-65, pre-Medicare early retirees. A lot of companies will send them to Exchanges, because they can be a pretty expensive crowd. I'd expect some very large employers, for administrative reasons, to set up their own little Exchanges and invite insurers to compete for their employees. At companies with 40,000 or 50,000 employees, I dare you to find an HR professional in this country who wants to deal with health insurance. The temptation for an employer to get out from under providing health insurance is very strong, so early retirees and employees of mid-sized and smaller firms are liable to be sent to Exchanges -- which is not necessarily a bad thing. They could be better off as long as they can afford the coverage.

That's the other thing that has developed with the Exchanges. The most commonly chosen plan is Silver, but most Silver plans have pretty whopping deductibles. So we've created a new class of egregiously underinsured people. Even though out-of-pocket spending is limited under the ACA, someone making $20,000 a year can't make the copay to, say, have a baby. And the providers pay the price. Because of what hospitals are eating in unpaid deductibles, I have been told that they've become the second-largest source of "health insurance" in Tennessee. And that is happening in other states. If people can only afford a Silver or Bronze plan, that's what they're going to purchase -- and the provider ends up eating the unpaid costs. I'd like to think that if we have Exchanges in five years, we will have established a floor below which people cannot be allowed to fall.

HIMN: *Tell us about you: What path did you take to your present position? Was it the path you envisioned when you started?*

EF: I was doomed to be a policy wonk. My birthday is July 28, the date that Public Law 89-97 was passed by the US Senate, creating Medicaid and Medicare. My father was a hospital-based pathologist and my mother was a medical writer, so I grew up in a hospital in Los Angeles. I'd go over there after school and I later worked there one summer. I went to the University of California at Berkeley in the 1960s, where I was a minor sort of hippie; I worked my way through college, so being a full-time hippie wasn't really an option. I moved to Wisconsin to go to graduate school, but working and going to school full-time were more than I could handle. And I was going to Chicago on weekends. I'd done a fellowship there at the University of Chicago, and had fallen in love with the city. On one of those weekends, I met a man and fell in love with him, too, so I moved to Chicago to be with him. I took a job at Encyclopedia Britannica and worked my way up through the ranks. I ended up running the *Compton Yearbook*, the annual supplement to the *Compton Encyclopedia*. That kind of work makes you a journalistic omnivore. I did everything: proofreading, writing, obituaries, paste up, captions and photos. You name it, I did it. Then, because I was unhappy with my work situation, I went looking for another job. The American Hospital Association needed a book editor, and I got that post, and two years later I became the chief writer for all of the Association's journals, running around the country doing interviews and research for stories. I went freelance in 1985 and I've been freelance ever since.

HIMN: *What occupies a typical day for you? What functions, activities and workload are you typically engaged in?*

EF: I don't have a typical day. I do have many days when, like everybody else, I just sit there lashed to the computer. I'm a research writer, and I take my research very seriously. But I also could be on an airplane, off to speak in California or Greece or wherever. I do volunteer work in Cambodia once or twice a year. Most people don't know that the Cambodian healthcare system was utterly destroyed during its holocaust, and almost all the physicians were murdered or fled. But the most common cause of death during that calamity wasn't murder; it was starvation and disease. I have tried to tell the story of what happened to their healthcare system, and I continue to do research and chronicle their attempts to rebuild it. They still have a long way to go; the most common cause of death for kids under five is diarrhea, which is a treatable disease.

In the last two years, I've spent a lot of time overseas and on the phone studying organized armed violence against hospitals. Most hospitals are prepared to deal with "lone wolf" attacks, and there is information readily available on how they can protect their staff and patients. But if, say, the Friends of ISIS decide to pay a visit, that's a more severe problem, and it's not being taken seriously enough. And this work has changed me; I had to step away from it at one point because I was so angry. Who thinks it's okay to slaughter unarmed nurses and patients?

I have a thing about people being treated unjustly. I've been able to get through this work because I think it's important that people not be silent about horrible behavior. I had a wonderful experience a couple of days ago. In July, I was walking a friend to her cab when I tripped and bashed my face on the curb. I have spent weeks looking like the Bride of Frankenstein. One day in a store, this poor woman took a look at me, and she was just stricken. She said, "Can I help you? Are you alright?" This is what I mean about not keeping quiet. She thought I was a victim of domestic violence. If I saw someone walking around with an injury like I had, I'd do the same thing. If we stay silent, it's going to keep on happening. If I have to blow most of my savings on trying to warn the world's hospitals that they're soft targets and need to take their security more seriously, I'm just going to keep on trucking.

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