(Music)

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margret Flinter.

Mark Masselli: Well Margaret, it is a new year, and it's also flu season. It turns out this one is reaching epidemic proportions in many parts of the country.

Margaret Flinter: Well that's right, Mark, and in spite of an aggressive flu vaccine campaign as we have every year, many folks have not heeded the warning. It just seems no matter how much we emphasize the need for that annual flu shock, millions of Americans just opt out, and that leads to more flu coinfection, and this year's strain is particularly virulent.

Mark Masselli: The Centers for Disease Control report that the flu strain H3N2 has dominated over the H1N1 strain which the vaccine was targeting. So even some who received the flu vaccine may not have gained the full protection hoped for.

Margaret Flinter: The vaccine is produced earlier in the year based on projections of which strain of flu virus will dominate in the coming flu season, but the fact remains the flu vaccine is the best viable line of defense, and this year's vaccine will mitigate the symptoms of flu.

Mark Masselli: We should put this in context against the Ebola epidemic, Margaret, which frightened so many people in this country with only handful of cases here fortunately. Conversely, the flu has already killed several thousand in this country, and the flu season is only just getting underway. Already 43 states are reporting widespread outbreaks, and the death toll is rising.

Margaret Flinter: Well, one thing that we do have now is of course so many new electronic tools at our disposal to track the spread of flu. The CDC's FluView is available on their website; Google has a flu tracker; you can see in real time and real numbers where outbreaks are at their worst. And I think in the future, it won't be uncommon for folks to get alerts on their smartphones when they are entering an area with a higher incidence of contagious diseases.

Mark Masselli: If you haven't gotten your flu shot, it's still not too late, and for those who have gained health coverage for the first time on the Affordable Care Act, the flu shot is completely covered, one of many health benefits of expanded coverage under the health law.

Margaret Flinter: And that's something our guest today knows quite a bit about. Dr. Uwe Reinhardt, a long-time Professor of Economics at Princeton University, is one of the nation's leading health economists.

Mark Masselli: He is an expert on health reform, Medicare funding, physician compensation, a whole host of issues impacting the cost of delivery of heath care in this country and around the world. He will be sharing his views on the Affordable Care Act and the changing landscape of expanded coverage for millions of Americans.

Margaret Flinter: Lori Robertson, Managing Editor of Factcheck.org stops by. She is always on the hunt for misstatements spoken about health policy in the public domain. But no matter what the topic, you can hear all of our shows by going to www.chc.radio.com.

Mark Masselli: And always, if you have comments, please email us at CHC Radio at www.chc1.com, or find us on Facebook at Conversations on Health Care, or on Twitter at CHC Radio, we love hearing from you.

Margaret Flinter: We will get to our interview with Dr. Reinhardt in just a moment.

Mark Masselli: But first, here is our producer, Marianne O'Hare with this week's Headline News.

(Music)

Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. What a difference a year makes. Things continue to run rather effortlessly on the Federal Insurance Exchange, HealthCare.gov, with millions of new customers signing up for coverage before the turn of the year, some 1.9 million for the first time with close to five million Americans re-enrolling in a health plan for the second year in a row all before the turn of 2015. Enrollment closes February 15th, and experts on both the state and federal exchanges feel they will exceed their targets for sign up this time around.

Looking at some of the states that had enormous problems with their state-based exchanges during the first open enrollment, again, we see a different scenario from last year. Maryland, whose program was so dysfunctional, people had to sing up by hand, scrapped their system and adopted the one used by Connecticut so effectively in the first open enrollment. They have since signed up more than 160,000 customers in Maryland with little or no complaints.

Meanwhile, uncertainty is clouding the future as a Supreme Court decision looms this spring on the legality of the tax subsidies for those buying insurance on the federal exchanges in those 37 states where no state exchange was created. The case King v. Burwell is set to be heard on March 4th. Meanwhile, HHS Secretary Sylvia Burwell is saying she believes that the subsidies will be held up by the Supreme Court. About 87% of those who purchased insurance on the exchanges so far have qualified for some kind of subsidy.

Flu is reaching epidemic proportions in some states, 43 states across the country reporting extensive flu outbreaks statewide. The CDC warns not enough Americans are protecting themselves with flu shots. This year's strain is expected to lead to more hospitalizations and deaths than in years past.

Meanwhile, 2015 may turn out to be the year of the wearable device. The Consumer Electronics Show in Las Vegas showed a vast array of medical apps and wearable devices that do all kinds of data tracking, extensive kinds of diagnostics that can determine things like ear infections, do EKGs on your smartphone, and track your sleep patterns, a quantified patient movement getting more tools to keep track of all that personal health data. Last year, 47 million Americans used some kind of tracking device to log exercise, completed miles run, calories consumed, all of which is expected to positively impact health over time. And need to lose 100 pounds or so? Study shows a positive health impact of bariatric surgery can linger for decades as morbidly obese achieve normal weight after the gastric bypass surgery. Study shows it extends the length of life significantly in many patients over time.

I am Marianne O'Hare with these Health Care Headlines.

(Music)

Mark Masselli: We are speaking today with Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University. Professor Reinhardt is considered one of the nation's leading experts on health care economics. He has been a member of the Institute of Medicine since 1978. Professor Reinhardt is a trustee of Duke University and Duke University Health Systems, and is a member of numerous editorial boards including Health Affairs, the New England Journal of Medicine, and the Journal of American Medical Association. He earned his PhD in economics from Yale. Dr. Reinhardt, welcome back to Conversations on Health Care.

Dr. Uwe Reinhardt: Pleased to be back.

Mark Masselli: So lots of good things have been happening with the Affordable Care Act, and certainly the online portals, and yet the landscape is fraught with change. There both sort of political and potential legal problems loom large on the horizon. We have many states who are still refusing to expand the Medicaid and setup the stand-based insurances, and we certainly have the Supreme Court soon to take another crack at the ACA. As a leading health economist, you have been able to analyze the ACA from a uniquely informed vantage point. So how do you think it's going overall?

Dr. Uwe Reinhardt: After the first rough introduction in 2013, I think it's running much more smoothly, in many ways reaching its intended objective which was very simple, to give the peace of mind and access to health care that comes with having health insurance which is enjoyed by 85% of the population as a matter almost of right, and only 15% or 50 million were excluded from that social contract. So in that regard, I think it's doing what it was supposed to do.

Margaret Flinter: Well Dr. Reinhardt, you have described the Affordable Care Act as maybe the best we could have done under the circumstances. But contrary to public opinion, you have also said you think it's a surprisingly simple law perhaps relative to just how complex the American health care system is, and I think you have gone on to say that at best it's a band-aid on a broken health care system. Can you elaborate for us on just what makes this task of health reform in this country so utterly challenging, and what didn't the ACA accomplish?

Dr. Uwe Reinhardt: Well long before there was talk of President Obama or ACA, I remember giving a talk at a Congressional retreat, where I showed them the complexity of the American health insurance system. So we have a single payer system for the elderly, except the 25% of those who choose to go into private health care plans. We have 50 state Medicaid programs, they are also single payer government-run programs like Canada's. We have purely socialized medicine. We have that reserved for the American veterans. It's called the Veterans Administration system, and most Americans don't realize that it is the most socialized approach to health care you could have, and that's where we have put the veterans. And then we have a complete mismatch of systems under the private employment-based health system, then we have the individual market, and then there is QMB, Qualified Medicare Benefits, SLMB, Special Medicare Benefits and so on, and it looked like a Mondrian painting.

Now I asked these Congressmen "If you want to reform any piece of this patchwork, you are going to touch all the other patches, and you have to in your legislation think how does the 'no proposal' link to all these other," and that is why every single health reform plan is a huge mess, why, because the system is a huge mess. The entire American health insurance system by international standards is a huge bewildering, incomprehensible mess, and to try to fix it without touching all these pieces, you can't. And therefore, any bill, other than the bill that doesn't do anything which has been the alternative so far, will be complicated, and in that sense, the ACA is actually simpler than the existing system.

Mark Masselli: You know, as we look back at the sort of formation of the ACA, there were lot of chefs in the kitchen helping with its creation. One of the chefs was Dr. Jonathan Gruber, an MIT economist, who helped craft the Massachusetts Health Reform before advising the White House and the ACA, and you have lauded Dr. Gruber as one of the great minds in health economics. But he recently found himself in the (inaudible 10:59) if you will, for some of his

recent comments. Certainly the words ‘stupid’ and ‘Americans’ came together in that, and you were just talking about the real complexity I think even for the informed. But you took on this issue in the Health Affairs blog and tried to sort of look at the difference between maybe ignorance and stupidity, maybe you can inform our listeners what you were trying to get out in your blog.

Dr. Uwe Reinhardt: Before writing it, I actually looked it up in the dictionary, and stupid means unable to learn. That is decidedly not true of the American people. We are pretty quick learners. Ignorant means poorly informed, a lack of information, and there, I would say Americans cannot possibly say they are very well-informed because ask yourself who would have informed them. Do you think MSNBC informs people very well? Do you think Fox News informs people very well? It's very, very difficult to accurately inform any people about something as complicated as the Affordable Care Act, or for that matter, cap and trade or tax reform. To inform the voters properly is a monumental task, and therefore, ignorance isn’t a shameful thing. I am totally ignorant on climate control. I am not ashamed of that. Why? I don’t have time. I leave that to my colleagues at Princeton who specialize in climate control. The trouble with economics in general is that every cab driver think he is a fully trained economist. They are not, and that’s what I mean by ignorant. The American people are very poorly informed on the ACA, and Kaiser Family Foundation has run survey after survey showing that Americans are ill-informed.

Margaret Flinter: Well, you know, it's complicated for those of us who live and breathe health care reform all the time, but there were a few key areas that just ended up being points of confusion, and I think one of them was around this notion of choice, consumer-driven choice, and you have noted that in selling the idea of health care for all American people under the ACA. We needed that notion of consumer-driven choice. You have used a great example I think of high deductible plans that could in fact leave customers vulnerable to much more out-of-pocket or higher health care expenditures, and you use the term rationing by income. What do you mean by that?

Dr. Uwe Reinhardt: There has always been a fraction of ideological thinkers, but also among economists that says “You really want to have the patients’ financial skin in the game of health care because if you cover everything from the first dollar on, people will over-consumer health care because they think it's free.” So in particular, the economics profession has always argued people should feel fiscal pain as they consume health care. Now when you do that though, you have to realize you are basically saying that you want to ration part of health care by income class. Think of a family with $5,000 annual deductible. If that family has an annual income of $30,000, they will very often forego health care when they actually think they need it. If they are a family with $200,000 with $5,000 deductible, wouldn’t be fazed at all; their behavior in health care wouldn’t be changed at all. When we want to go to doctor, we go. Deductible doesn’t deter us at all. But it would deter a waitress. So therefore, instead of saying

consumer-driven health care empowers you, that's such deceptive language. Why don't you just speak English and say, "Yeah, we want to control health care cost in part by rationing by income class, and that's what we are going to do, and rich people, yes, will have better access to health care than poor people."

Mark Masselli: We are speaking today with Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University. Professor Reinhardt is considered one of the nation's leading experts on health care economics. And let's talk for a moment about the ultimate goals of health reform, or at least one of them bottom-line would be cost containment. And you are a firm believer that physician compensation should be directly tied to performance and quality of care, and now we are starting to see a shift in the landscape moving towards compensating providers and physicians for value not for volume. What needs to be done to incentivize and accomplish real value in health care?

Dr. Uwe Reinhardt: One of them is to control the annual national health spending, the spending on health care. The other issue is getting better value for the dollar, reduced spend, and those actually are separate issues. To get better value for the dollar, if you look back in the last 40 years, we paid for a lot of junk, a lot of unnecessary care that really should never have been purchased, for example, MRIs that were really not needed, operations that were not needed, and we should no longer pay for those. So that is what we now mean by value-based health care. Actually, a better term would be not paying for junk anymore or for unnecessary stuff anymore. That is one issue, so that when we do pay money for health care, we actually get something that makes a clinical benefit in return. I think that's a reasonable thing to ask, no matter how much you spend on health care.

The other one is cost control really means saying "We are spending 17% of our GDP on health care. No other country spends more than 11%, so we should somehow manage to get by with spending only 15% on health care." That's sort of spending control, and that's a different issue where sometimes you might say you might want to forego even clinical intervention that has some benefit, but those benefits aren't worth the cost of the intervention. For example, where a doctor says "Well if I had one more MRI, it could marginally change my diagnosis, but the probability is quite low, but having an extra MRI could sharpen it a bit." May be in that case, the extra $1000 that MRI costs isn't worth it. That is cost control, which means you sometimes withhold even clinically beneficial services, but they are only marginally beneficial.

Margaret Flinter: Dr. Reinhardt, you have sort of synthesized to say we are heading towards a three tier system in health care with a third of the nation covered by Medicare or Medicaid, a third that will wake up and wish they were Canadian, which has a single payer approach to health care, and then a third

tier, kind of upper echelon that will increasingly seek boutique-like coverage and more concierge care, and is it three tiers all with equal potential for quality?

Dr. Uwe Reinhardt: No, it's different degrees of quality. I am really thinking, just like housing, we have housing for very rich people, we have sort of middle class housing, and we have housing for the poor, and I think our health system is lumbering towards this sort of arrangement where the quality of the health care experience that people have in America will vary by income class. If you are very poor, you will get health care, but it may be in very sparsely equipped facilities. If you work for a corporation, it depends how rich your paycheck is. Then of course, if you are rich, and there is a growing number of fairly well-to-do people, you can have boutique medicine Disneyland, immediate access, where you have 24 hours per day access by cellular phone to some primary care physician, and they will arrange stuff for you.

Mark Masselli: Dr. Reinhardt, I wonder what happens to our larger economics if we have a dramatic reduction in the amount that we spend on health care? What if we were at 17% but actually got great value, would you have any problem with it?

Dr. Uwe Reinhardt: You know, you are raising one of the most sophisticated questions in health care that rarely is ever put. Health care is actually part of GDP. I remember the very first speech I ever gave was in 1976 on the imperative of cost containment. I showed it to my wife. She looked at it, and said, “It is elegant but trash,” and I said “well, what do you mean by that,” and she says “you take it as a premise that we have to control health care cost,” but she says “have you ever worried how much money America spends on trucks,’ and I said “no, I haven’t.” She said, “So why pick on health care?” “Health care is part of the GDP,” she says, “the real issue though, an economist would tell you, is if the health care you produce is really unnecessary, then that is not good job creating.” But I personally believe that a lot of health care is actually highly valuable. I mean you look at sale value. Everyone hammers around a $1000 pill, but don’t tell me that isn’t a high value product. If all of a sudden we spent a whole lot less on health care, there would be a lot of unemployed people, and the question then is what else would they do. But what you just asked me is rarely ever asked, and yet it is an important issue.

Margaret Flinter: So let me use the example you just raised of Hepatitis C and Sovaldi of where are patients with Hepatitis C most likely to be found in terms of their insurer. I bet many people have raised this to you since that whole debate unfolded, and what do you say to these state governments and health care systems about the need to make an expensive investment in curing a disease that otherwise is highly likely to lead to long term disability and premature death?

Dr. Uwe Reinhardt: Well, I think you could teach a whole university course just about Sovaldi because it raises all these economic, political and ethical issues.

We are basically being challenged by Sovaldi to say how much is the life of someone in jail with Hepatitis C worth to you, the church or synagogue-going taxpayer. Right? That's an extremely naughty thing for Sovaldi or Gilead Sciences to do, but they confronted us with that question, and I have to say so far, to my amazement, American society has said "We are willing to pay it. The life of even someone in jail is worth it to us." One would have to say that it's quite admirable for those who have that ethical bend.

On the other hand you could also ask, is it really necessary to pay Sovaldi a $1000 a pill to get innovation in health care, and there I would say well actually not really, because Sovaldi bought the company that invented the drug for 11 billion. Producing the drug is not that expensive, but the revenue they expect from it is something like $270 billion. I think if they made only $150 billion, they would still be very richly rewarded. So you can at that plane also say "You know, what, we will pay you $700 a pill, and you still make out like band-aid, and think of the tax payer too because we have schools to pay for, we have police to pay for, fire brigades to pay for, and you have to help us manage our budget too." So you could see this as an issue where there isn't a clear answer. I could see Solvadi saying "Look, given what you have already spent on Hep C for interferon and for transplant, what we are offering you is no more expensive," which is true, "and so we are really just shadow pricing, we saw what you were willing to spend, we will charge you a little bit less, and given you were willing to spend that already, why complain about us?" And that's Gilead Sciences' point of view. And this I point out to my students, "As you become an adult, you will realize some things don't have crisp answers. May be the Pope knows it, but I sure as hell don't." And I have a PhD, which is great for a mission, I don't know. I would say one of the nice things you can learn at Princeton is how many of life's questions don't have a simple answer.

Mark Masselli: That's right. We have been speaking today with Dr. Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University. You can learn more about his work by going to www.princeton.edu/~reinhard. Dr. Reinhardt, thank you so much for joining us on Conversations on Health Care.

Dr. Uwe Reinhardt: It's been a real pleasure.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Well do retiring members of Congress get free medical care for life? No, they don't. A chain e-mail about House Minority Leader Nancy Pelosi makes that false claim, and also greatly exaggerates what Pelosi could receive as a pension. We will stick with the health care claim. Members of Congress don't receive free health care while they are in office or upon retirement. Under the Affordable Care Act beginning in 2014, insurance coverage for members of Congress switched from the Federal Employees Health Benefits Program, that's the government's employer-sponsored private insurance market for federal employees, to the health care marketplaces created by the law. Under both systems, workers and the government both pay for insurance coverage. Like most employer-sponsored plans, the government pays a certain percentage of premiums, in this case 72%, and the workers pay the rest.

That's still the case for Congressional retirees. They don't get free insurance; they pay the same share of premiums as active federal employees. According to the Office of Personnel Management, retirees will be eligible to purchase insurance through the Federal Employees Health Benefits Program if they meet certain criteria. They must be eligible for retirement, and they must have been continuously enrolled in one of the governments' employer-sponsored health plans for five years before retirement. And that's my fact check for this week. I am Lori Robertson, Managing Editor of FactCheck.org.

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Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. It's a known fact that the current generation of American children is more obese than any previous generation, and at Washington DC Community Health Center, Unity Healthcare, a pediatrician was in a quandary over how to tackle this growing health scourge. He began with a unique solution targeted to a teen patient whose Body Mass Index or BMI had already landed her in the obese category. What he did was write a prescription for getting off the bus one stop earlier on her way to school, which made her walk the equivalent of one mile a day. Dr. Robert Zarr of Unity Community Health Center understood that without motivation to move, more kids just might not do it. The patient complied with the prescription and has moved from the obese down to the overweight category, certainly an improvement. He then decided to expand this program by working with the DC Parks Department,

mapping out all the potential walks and play area kids have within the city's parks, mapping 380 of them so far.

Dr. Robert Zarr: How to get there? Parking, is parking available if someone is going to drive? Bike racks, there is a section on pets, park safety.

Margaret Flinter: Dr. Zarr writes park prescriptions on a special prescription pad in English and Spanish with the words Rx for outdoor activity and a schedule slot that asks when and where will you play outside this week?

Dr. Robert Zarr: I like to listen and find out what it is my patients like to do and then gauge the parks I prescribe based on their interests, based on their schedule, based on the things they are willing to do.

Margaret Flinter: Ultimately, Dr. Zarr says with some 40% of his patient population grappling with overweight or obesity, he wants to make the prescription for outdoor activity adaptable for all of his patients, and adaptable for pediatricians around the country. He is planning to create an app for his parks database where providers and patients alike can use it, and one day he would like to be able to track his patients' activities in the parks. Rx for outdoor activity, partnering clinicians, park administrators, patients and families to move more yielding fitter, healthier young people, now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.