(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, here we are, the first days of August. The traditional dog days of summer are behind us.

Margaret Flinter: And we have had plenty of those already this year Mark, which I have to say I love. Also, maybe a good time to slow the pace down a little, take some time to relax away from the daily stresses and recharge your creative batteries.

Mark Masselli: Absolutely. Stress, as we know, can take over, and we know that one negative impact it can have is on your health. So take a little vacation time if you can get it and take care of yourself.

Margaret Flinter: Well I hope you take your own advice. But a recent study out there shows that these days people aren't taking much opportunity to leave the office behind, and majority people who do go on vacation, remain in continued contact with their work worlds via their electronic devices.

Mark Masselli: That they do. They have become a valuable tool in the modern world but it's a good idea to just disconnect for little time if you can get it.

Margaret Flinter: Well I will tell you one thing that I am going to stay connected to Mark and that's the Olympics, so much exciting competition and prowess to watch.

Mark Masselli: It is. It's inspiring stories too. I think what makes the Olympics so magical for people, so many of those athletes have stories of perseverance and overcoming adversity to get where they are. It's a great microcosm of the best of the human experience.

Margaret Flinter: That's right. And our guest today can speak to that. Dr. Gerard Anderson is a health economist at John Hopkins University School of Public Health and he has done extensive work studying how to live well with chronic disease.

Mark Masselli: He will be talking about how health care reform is going to improve care for those with chronic illness.

Margaret Flinter: And FactCheck.org's Lori Robertson will have another campaign claim to try and dig out the truth.

Mark Masselli: But no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Margaret Flinter: And don't forget, please email us at www.chcradio.com; we love to hear from you.

Mark Masselli: And we will get to Dr. Gerard Anderson in just a moment 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 this Headline News. The check is in the mail. This is the week checks start to arrive in people's mailboxes from the companies that insure them. About 13 million Americans will either be getting a check in the mail or a rebate notice thanks to the medical loss ratio portion of the Affordable Care Act, which states that insurance companies who spend more than 20%-25% of their income, they have to pay a penalty to their customers. This affects mostly the self-insured but employers who insure their employees would see rebates as well, which then have to be passed on to the employees, either with reductions in their contributions to their health plans or in other paybacks.

In other news related to the Affordable Care Act, the Catholic company owner in Colorado is getting a reprieve from the federal court in that state to be allowed to ignore the provision in the Affordable Care Act, providing mandatory birth control coverage. Judge John Kane in this case ruled that Hercules Industries in Colorado is being allowed a three month reprieve. It's the first time a federal court has ruled against the mandatory birth control ruling that came as a result of reforms in the health care law.

Meanwhile, another federal court ruling has upheld the Obama Administration's efforts to levy punishments against pharmaceutical company executives connected to wrongdoing. While companies like Purdue Pharma L.P. were levied fines for misleading the public about the dangers of OxyContin, the Department of Health and Human Services wants to exclude those companies from ever doing business with Medicaid or Medicare again, a far more costly penalty.

Meanwhile, our eyes are on the Olympics of course. And what kind of health insurance do our nation's elite athletes carry? Plenty it would seem. Many athletes carry more than one health policy due to their risk for injury. The US Olympic Committee is double covering the athletes in this year's games with plans that offer high deductibles but a solid base level of preventive coverage. I am Marianne O'Hare with this Headline News.

(Music)

Mark Masselli: We are speaking today with economist Dr. Gerard Anderson, Director of the Johns Hopkins Center for Hospital Finance. Dr. Anderson is the Professor at the Bloomberg School of Public Health and the School of Medicine at Johns Hopkins University, where he has served for almost 30 years. Dr. Anderson has conducted extensive research on health care payment reform and recently stepped down as National Program Director of the Robert Wood Johnson Foundation Program on living better with chronic disease. He has conducted an in-depth study of health systems around the world. He has authored two books on health care payment policy and he has written over 200 peer review articles. Dr. Anderson, welcome to Conversations on Health Care.

Dr. Gerard Anderson: Well I am pleased to be here and part of this conversation.

Mark Masselli: Dr. Anderson, as a health economist, you have spent a considerable part of your career analyzing health care spending and cost. Now that the Affordable Care Act has been upheld, we should see some meaningful reforms in place that could ultimately impact the cost of care delivery in this country. Let's start by putting health care spending into perspective. How does health care spending here stack up with that of other countries and how are we doing in terms of value that we receive for our health care spending?

Dr. Gerard Anderson: We are spending about twice as much as most other industrialized countries. So we spend about $8500 a year per person in United States; countries like Japan, France, England spend less than $4000. So we are spending twice as much as they are. Now I don't mind spending twice as much on something if I am getting twice as much value from twice as good outcomes. The problem is that there are certain areas where United States does incredibly well; there are also unfortunately certain areas where the United States does very poorly. And overall, we sort of do about average, little less than average in most of our health care indicators, things like life expectancy. We are just not doing very well on the value equation these days.

Margaret Flinter: Dr. Anderson, I think that hospital financing is a fairly mysterious area. When you look at Medicare and ambulatory care or outpatient care, it's kind of pretty well-defined. There is a board that sets prices. We see so much more variation in hospital price, and you have used the example of five patients, five different hospitals having the same gallbladder surgery might have wildly different fees. Tell us a little bit about what drives this great variation in pricing.

Dr. Gerard Anderson: Hospitals represent about 35% of our health care spending and the thing is that for the Medicare program, the program for the elderly and the disabled, there is a very nice formula, and Medicare basically pays hospitals their cost. The private sector basically Aetna Credential, all the other private insurers, they pay anything that they want, there is no standard for

that. So, when one insurer might pay twice as much as another insurer, and it's particularly bad if you are uninsured, then you have nobody negotiating on your behalf, and in that case, you are going to pay three to five times what somebody with insurance is going to pay for exactly the same thing. And so as we move towards the Affordable Care Act and getting a lot of people into health insurance, those people are going to pay a lot less for exactly the same services they had because now 30 million Americans will have health insurance.

Mark Masselli: So is that the only incentive built into the Affordable Care Act to address the issue of reducing cost which is just purchasing power, or are there other incentives built in to help realign the payment structure?

Dr. Gerard Anderson: Well there are but the first thing for the public to understand is that the Affordable Care Act really wasn't intended as a cost containment activity. Its real intention was to get the 30 million Americans health, insurance, and to pay for it, it needed to have some cost containment activities. But the real goal of the Affordable Care Act was really to cover 30 million additional people in Affordable Care Act.

If you are an elderly person and you need preventive services, you are now going to get them free and that's going to save you a great deal of money. We all know that if you have a child who is under 26, they are going to get services for free. There is something called IPAB which is a way for the government to negotiate if industry is charging too much. And finally, what we see is right now private insurers are taking a lot of cost in terms of administrative costs and what the government is doing as part of the Affordable Care Act is really clamping down on how much administrative cost private insurers can do. So yes, there are a number of things in the legislation that are going to save money but it's important to recognize that that wasn't the primary purpose of the Affordable Care Act.

Margaret Flinter: But maybe we could look a little bit at what is the role of hospitals and the acute care setting. And we see a shift from people who are uninsured and requiring uncompensated care because as you note, the uninsured person might be charged five times the amount of the insured person for that gallbladder surgery but it's not likely they have the money to pay it. If they had the money to pay it, they probably would be insured in the first place, right. So one could at least hypothesize that hospitals will see a great reduction in the number of uninsured people and that might free up resources for investments in other areas. How do you see this really affecting hospital finances and how are all of you in the hospital financing and future planning world looking at that?

Dr. Gerard Anderson: Well I think you are correct that they are going to see a lot more people that are going to walk into the hospital with an insurance card. And that means that all of us don't have to pay those charges for somebody

uninsured. Because essentially when somebody goes to the hospital, doesn't have insurance, they still get care, they still get the same level of care that anybody else does, and it's expensive. And what it means is that we all, who have insurance, have been paying those bills. Really the big difference that we will see is for a person who has private health insurance who has been paying the bulk of the cost for the uninsured their premiums are in fact going to go down because they are not any longer going to have to pay the cost of an uninsured. So, all of us who do have health insurance, about 170 million of us through the private insurance system, we are going to see a substantial reduction in the price when we go to a hospital. And I think that's just going to be very good for all of us.

Mark Masselli: We are speaking today with Dr. Gerard Anderson, Director of the John Hopkins Center for Hospital Finance. Dr. Anderson is a professor at the Bloomberg School of Public Health as well as the School of Medicine at John Hopkins. He's recently stepped down as the National Program Director of the Robert Wood Johnson Foundation Program on living better with chronic disease. Now, I want to go back to the Affordable Care Act because one of the provisions in there is around Accountable Care Organizations. And the Department of Health and Human Services recently announced that there are now more than 150 Accountable Care Organizations and these physician groups and hospitals are forming ACOs to streamline process share cost primarily for the Medicare population. How do you see these ACOs impacting the bottom line cost in health care across the board and are ACOs poised to change the game significantly?

Dr. Gerard Anderson: Well I think they are poised to do it. So what we have now, we have a lot of people in managed care, and managed care is an insurance system. And what the doctors and hospitals have told us for years is if we could manage this care more effectively and really had control of it, we could in fact save a lot of money. Because we know that we are doing a lot of things that are unnecessary, we know that a lot of things just could change and so the Accountable Care Organizations are putting the control in the hands of doctors and hospitals instead of the hands of the insurance industry. And so, there is a great potential here with the Accountable Care Organizations. Now the challenge has been that they still don't really have any incentives to control cost; they really don't take very much risk and when they do take risk, they don't get very many savings. So I am not sure that it's going to really save a great deal of money but it's going to start transforming the health care system. We have also taken a look at things like Accountable Care Organizations over the past 10 years and so far we just haven't seen the saving.

Margaret Flinter: Well Dr. Anderson, I am still holding on to that idea that we are going to see our premiums go down as we go into this new era. Let me ask you to put your futurist hat on again for a moment, really talk about the future of hospitals and the hospital industry. Do you see fewer hospitals? Do you see the community general hospitals continuing in the large numbers they are today?

There is a lot going on I would imagine in the industry and share your thoughts on that with us.

Dr. Gerard Anderson: So I think what the hospitals are going to have to do is start thinking about population-based medicine. Hospitals are really based upon acute care model, which is a fine model but really a model for the 1970s and 1980s, where we wait until we get sick and then we get treatment. And the population model that's really coming in the 21st century is about care; we are keeping people out of a hospital. So the hospital industry has to be prepared for a lot less volume. We have seen it decline over the last 30 years. We used to have 6,000 hospitals, now we have 5,000 hospitals and that number will continue to drop. We will still need academic medical centers and we will still need hospitals but we are going to need hopefully fewer and fewer hospitals in the United States overtime.

Mark Masselli: Well Margaret asked you to put your futurist hat on; I am going to ask you to put your anthropological hat on. And it's sort of been an interesting civic lesson watching this whole health care reform debate unfold; there is so much acrimony and there are so many diverse points of view. Since you have compared systems around the world that provide health care to entire populations of countries, how is it that the benefit of improving our current health care system, making it more inclusive, more efficient, effective, elegant, less expensive has been lost on the country as a whole?

Dr. Gerard Anderson: Well if you look at other countries, one of the things that they have going for them is solidarity. Everybody sort of buys into the same model and the fact that everybody is in it for the greater good. In the United States, we are sort of more based upon individualism, the individual taking charge of their own health care.

Margaret Flinter: So Dr. Anderson, and I know you have just stepped down recently as the National Program Director of the Robert Wood Johnson Foundation Partnership for solutions, better lives for people with chronic conditions. Tell us about the four part framework that you and your group devised to try and tackle this area.

Dr. Gerard Anderson: Now chronic disease is the problem, at least the first half of the 21st Century. It's where the health care dollar is spent. And it really isn't just chronic disease but it's people with multiple chronic diseases, two, three, four. If you think of your mother, your grandmother, there are unfortunately a number of things wrong with many of the people. They have high blood pressure, they have diabetes, they might have beginning dementia and that's just a fairly common thing in the United States right now. The problem is that we have got a health care system oriented around acute illness not chronic disease and it starts with our research, what the NIH does and what the FDA does. And that is anybody who has multiple chronic condition is almost always excluded

from any clinical trial. So, we just don't have an evidence-based for taking care of the complex person. Then you move towards the educational system. And I teach at Johns Hopkins and we do a great job of training you body part by body part but we don't really train you to take care of the whole person, so we have got to change our educational system. The payment system is for an episode of care, a particular service that's being delivered that's called the fee-for-service system and it just doesn't provide any incentives or prevention, it doesn't provide any incentives to look at the person over a long period of time or to look at all the different problems they have. So the payment system has to change.

Mark Masselli: Dr. Anderson, the Affordable Care Act has survived its many legal challenges and health care reform is moving forward. But obviously, you have written in the past about your ideas of what should be in place. Walk us through the missing elements of the health care law and what should be done there.

Dr. Gerard Anderson: Well, the first thing is we have covered 30 million Americans but probably about 20 million Americans still won't have health insurance coverage, and these are people who are undocumented, who for whatever reason choose not to purchase health insurance. So, sooner or later, we have got to get these 20 million Americans into the health care system. You mentioned Medicare Party; Medicare Party is Medicare for everyone and it essentially is not the public option but it's a variant of the public option, which says that if you want to, you can buy into the Medicare Program at reasonable premium rates and you wouldn't essentially have an option of not going to Blue Cross or to Aetna but essentially, getting the same coverage with the same benefits as the Medicare beneficiary. And we could certainly add 20-30 million people to the Medicare **rows** at a small administrative cost; the Medicare Program only costs about three cents in administrative fees, most of the private insurers are about 20 cents, 25 cents in administrative fees. So you would get a lot more value for your dollar if you could buy into the Medicare Program and that's just a way to do it more effectively and to provide coverage for a large number of people.

Margaret Flinter: Well, I think there would have been a lot of support for that in many quarters. So Dr. Anderson, we like to ask all of our guests this final question. When you look around the country, and around the world, what do you see in terms of innovation that our listeners at Conversations should be keeping an eye on?

Dr. Gerard Anderson: Think of an older woman with dementia who falls. She is going to have a very difficult problem. And so the question that we are really struggling with right now is how to meld all the different services that she is going to need, maybe some long-term care services, some transportation problems that she has got. All the countries in the world are really trying to struggle with that particular type of person who has multiple needs, and right now, all the different systems are setup to work in silos. The silos work reasonably well but

the person has to deal with six or seven different silos, all of which are not coordinated and until we get the financing and the delivery systems in place, she is going to have to do all the coordination or her family member is going to have to do all the coordination themselves. And that's what I am hoping in the next 10 years we will be able to make it much, much better.

Mark Masselli: We have been speaking today with Dr. Gerard Anderson, Director of Hospital Finance and Management at Johns Hopkins School of Public Health. Dr. Anderson, thank you so much for joining us on Conversations on Health Care.

Dr. Gerard Anderson: Thank you for inviting me.

(Music)

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 US politics. Lori, what have you got for us this week?

Lori Robertson: Well, Mark and Margaret, there have been a lot of claims about the penalty in the health care law for not having insurance. So this week, we will take a look at how much that tax will be. Once the penalty is fully implemented in 2016, the minimum tax will be $695 per person for the year, up to a maximum per family of $2,085. These amounts however can be higher for people who make more money. When the penalty is first implemented in 2014, it's a lot lower. It starts out at only $95 per person, jumps the next year to $325 and then by 2016, we are at that $695 minimum. Children 18 and under are assessed half of the adult penalty. But the penalty will increase with income and here is where it gets complicated. It will either be that minimum amount of $695 or 2.5% of household income above the income tax filing threshold. So, for instance, a married couple that earns $100,000 a year would pay about $2,025 if they didn't have health insurance. The penalty also can't be more than the national average of the lowest cost plan on state insurance exchanges. And that's my fact check for this week. I am Lori Robertson, Managing Editor of FactCheck.org.

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.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. It's every working parent's nagging fear, what happens if your child comes down with an illness while you are at work and they are at daycare. A pilot program in Rochester, New York offers a glimpse into what could be a promising solution, Telemedicine. The federally funded grant between the University of Rochester, Medical Center and several urban daycare centers, equipped the daycare centers with diagnostic peripherals that could be attached to their cell phones and images sent to the pediatric clinic via the Internet. Usually when a child exhibits signs of a sore throat, urine infection or pink eye, the parents are immediately called, meaning the parents have to leave work and the child taken to the doctor's office. These daycare workers still call the parent but the next call is to the doctor's office for a live visit via teleconferencing.

Our telemedicine program is designed to make it easy for your child to be seen for an illness by one of our regular doctors. Most common problems can be cared for this way.

Mark Masselli: Daycare workers are trained to utilize diagnostic tools like the otoscope, the tool used to examine the ears, the images transmitted to the clinician and a diagnosis is made. In many cases, the telemedicine visit was sufficient for a clinician to diagnose a child's problem and recommending a treatment course. Working parents were able to retain four and a half hours of working time and the children's absenteeism was reduced by 63%. The pilot program has been so successful that local insurance companies are now getting onboard with covering these telemedicine visits. It's simple economics. A trip to the emergency room costs insurance companies a lot more than a teleconference visit. The program is already being rolled out in other daycare centers in the region and could provide an excellent model for daycare centers around the country. A safe, simple telemedicine solution to a logistics problem facing millions of working parents whose kids fall ill while at daycare, now that's a bright idea.

(Music)

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.