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Mark Masselli: This is Conversation on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret after a very rocky start with the Health Insurance Exchanges the first open enrolment period under the Affordable Care Act exceeded the administrations expectation signing up over 7 million Americans for health coverage.

Margaret Flinter: Well, all in all it's been a huge learning curve for everyone watching all these advance unfold and the deem days of early January when nothings seem to be working now seem far behind this.

Mark Masselli: A recent poll show some 50% of the nation things favorably about the health care law now that's up from 40% just a few short months ago in spite of all the snafus with the online portals.

Margaret Flinter: Well, at the same time a poll of doctors around the country shows up pretty unfavorable view of congress. Well, there was a bipartisan deal to fix the sustainable growth rate formula for reimbursing practices for Medicare patients. Congress ended up passing another emergency funding measure instead, this is the 17th time congress has passed an emergency bill to keep the reimbursement rates intact but Mark it's just not a solution and it's getting kind of old.

Mark Masselli: Congress simply couldn't agree on where that money would come from. But it's an extremely important issue Margaret 10,000 Americans per day turn 65 add into the Medicare patient load. So, it's time to repeal the flawed SGR and find a permanent solution.

Margaret Flinter: And we're still looking a solution to the Health Care cost issue, at close to 20% of the nation's GDP it's a crippling weight on family finances and our future growth in our economy. And our guest today heads an organization that seeking meaningful payment reform in health care as one approach to containing health care cost.

Mark Masselli: François de Brantes is Director of the Health Care Incentive Improvement Institute and his organization just released a report cart on health pricing transparency and 45 states across the country got a failing grade. We have much work to do there.

Margaret Flinter: Lori Roberson, Managing Editor of FactCheck.org will look at another false claim spoken about health policy in the public domain and no matter what the topic you can hear all of our shows by going to CHC Radio.

Mark Masselli: And as always if you have comments you can email us at chcradio.com or find us on Facebook or Twitter, we'd love hearing from you.

Margaret Flinter: Now, we'll get to our interview with François de Brantes in just moment.

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

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Marianne O'Hare: I'm Marianne O'Hare, with these Health Care Headlines. 7.1 million and counting the last minute push leading up to the March 31st open enrolment deadline on the insurance exchanges. So, a business really amp up, continued problems with the federal exchanges which serves 36 states around the country looked to derail that number. And a number of states with their own exchange were also having some serious issues including Oregon who sight never really work properly and Maryland as well that states is decided to scrape their system entirely. And adopt a system develop by access held CT CEO Kevin Counihan in Connecticut that system worked essentially flawlessly and needed very little retro fitting. Kevin Counihan expects other states will seek to adopt the Connecticut exchange design as well.

Meanwhile, there are millions more newly insured Americans who are hiding in plain sight according to a report at a New York Times. Millions of customers opted to purchase insurance on their own through private insurers instead of the exchanges. Big insurers like WellPoint and Highmark say they a significant business privately off of the insurance exchanges. Meanwhile, no doc fix this year though there was a much loaded bipartisan plan in place to replace the sustainable growth rate formula for Medicare reimbursement for practices serving seniors, there was no agreement on how to fund the fix so it's been delayed for another year. And so we have plans for the ICD-10 switch it was supposed to happen in October of this year, the house manage to get a one year delay into the SGR bill which passed in the senate as well a number of medical groups are opposed to being forced to switch. I'm Marianne O'Hare with these Health Care Headlines.

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Mark Masselli: We are speaking today with health economist François de Brantes Executive Director of the Health Care Incentive Improvement Institute not for profit organization focusing on improving health care to target models of payment reform previously Mr. De Brantes was the program leader for various health care initiatives at GE Corporate Healthcare Programs. And Mr. De Brantes has spoken and written extensively on health economics in numerous publications including health affairs in his recent eBook it's the incentive stupid why rotten incentive continue to screw up healthcare. He earned his master's in financial economic at University of Paris and

earned his MBA at the Tuck School of Business Administration at Dartmouth College. Mr. De Brantes welcome to Conversations of Health Care.

François de Brantes: Thank you.

Mark Masselli: François, your organization released a pretty demy report on the state of price transparency in the health care in this country. Ranking 45 out 50 states with failing grades and -- and you call this lack of price transparency in health care one of the most overlook consumer protection measures we face. So, why is transparency so important and well we want to hear about the states that are failing tell us about also the states that have been doing well on it.

François de Brantes: So, why is it an important? Well, principally because the percentage of consumers who are paying the significant percentage of medical expenses out of pocket has risen dramatically over the past decade and it's scheduled to continue to rise over the next high deductible health plans and other consumer directed health plans proliferate. So as a result of which I think there's been a growing disconnect between the role the consumers have assumed and managing health care expenses and the lack of information about the prices of health care services. So, where as in pretty much on the other purchase you get to know the price of a good before product before you buy it today in health care that's simply not the case. And unfortunately unless states take very proactive action to assemble data so that they can offer this information free of charge to individuals it's unlikely that they are going to get it any other way. So, the states that have been doing a really jobs are the ones who have has legislation enabling what are called all pair clients databases which collect information from all the health plans operating in that state. But beyond an acting legislation you have to implement it and here the example last year was New Hampshire unfortunately this year they got a failing grade because they change vendors some point last year and their website has been down since then and it just really what we're trying to do now is look at health care information and what's available through the consumer's eyes and unfortunately through that lens there is no state in the country that actually does a model job.

Margaret Flinter: Well I'm look at the work that you're doing and we think about Steven Brill's work who we had on the show who wrote Bitter Pill why health care cost are killing, really outline this gross lack of price transparency and the wildly different prices that are paid. I guess the question is beyond knowledge what do we see in terms of action do we have any evidence to suggest as we look at the states where there has been more transparency of the two states with a passing grade is there any evidence to suggest that it makes a difference?

François de Brantes: The prove at this early evidence from New Hampshire's work suggest that variability in prices does decrease when you have pricing transparency and that shouldn't surprise us a whole heck of a lot. Because if you're an outlier if you're really expensive relative to your peers you are going to have a lot of more questions to answer than if no one knows about it. And so invariably price transparency has that

effect. But again it's only a partial solution because ultimately the manner in which you can help reduce overall variability is by changing the way providers are paid in the way consumers incentives work in accessing medical care. And so, you know, as the -- not too subtle title of the book suggest. Rotten incentives actually do screw up the health care and that's priority number one and transparency is one of it. So I think we are on the pathway there but we still have a lot work to do in the other areas.

Mark Masselli: You know, pick up on the threat that health care cost are really strangling the country -- people having to make a very difficult choices. And the health care law's hopefully starting to shift some focus from fee for service model towards rewarding better outcomes but I think we had for Massachusetts governor noted that that in their first round of legislation that really was about access and it only recently have they started to look at cost control is that true in the federal model?

François de Brantes: Unfortunately the Affordable Care Act legislation provided the Federal Government with incredible leeway and testing new payment model and then broadly disseminating them throughout Medicare. And the center for Medicare innovation has unequal powers in that respect and it has chosen at least to date to take a relatively modest approach, they have a primary care initiative, they have accountable care organization initiative, they certainly have a bundle payment initiative. And so all those are ongoing it's progress but the latest calculations that we did put to combine effect of all of these implementations at most 15% of all Medicare spent. So, there is a long, long way to go.

Margaret Flinter: Well, François beyond ACA there is ACO the Accountable Care Organizations care delivery system that's supposed to reduce cost by better coordinating care and then we have the patient centered medical homes and the focus on coordination within primary care. But, you've said that both of these models put the cart before the horse. So, I guess the question where is payment system reform happening at a scale that's significant enough to shift towards this none fee for service system?

François de Brantes: Well, there are few. And it's actually the better news is that it's a mixture of both public and private initiatives much has been said and written about the efforts of Arkansas but they have been followed by similar efforts in Tennessee and now in Ohio where the governor's office directly right, because we think that from what we seen that what's you need. You need the leadership from the governor's office and so from the governor's office down there's a very clear stated objective to move away from fee for service and to use the purchasing power of the state thought the state employee benefit plan and through Medicaid to effect that change. So, that right off the bat usually the largest employer in the state. So, the state as an employer and Medicaid combined really do represent a significant purchasing power that can be used to modify payment at a scaled level for providers. So, those states are doing a great job and they're continuing to experiment and grow and push on the pure private sector sites some health plans have really embrace to the concept of -- and the implementation of different payment models and they have very clear strategies to move aggressively

away from fee for service and they're doing it throughout their enterprise and throughout their network. So, it's happening but it's not happening if you add all of these up you're still on the fringes initially of what constitute anything close to a critical mess.

Mark Masselli: We're speaking today with Health Economist François de Brantes the Executive Director of the Health Care Incentive Improvement Institute not for profit organization focusing on improving health care through targeted models payment reform. François we've talked a little bit about the pair, now we'll talk about the people and you've said that the largest untapped resources are the consumers themselves and increasingly consumers shouldering larger responsibilities for choices regarding their health care coverage in their shopping online for health insurance plans, they're paying higher deductibles. And you say to generate real transformation in health care systems we need to unleash the consumers as a true agent and you say price transparency is one important step what are the other tools in their tool kit and how do you feel the social media's playing a role in that, how our people really getting this information in ways that they can digest it.

François de Brantes: So, first off the industry is in its infancy compare to every single other industry consumer based industry and the rest of the economy. Think about the lack of engagement of any real robust social media round whether it's opinions on different providers or the only area where that has had an affected aid is for treatments and very specific diseases where you have a very, very powerful social media effect in brining parents of patients or patients themselves together. So that's one aspect of consumers and but ultimately what this consumer is in other industries means, it means that as a purchaser you're making a conscious decision, and you're making that conscious decision because you're paying out of pockets some more portion and you have information about quality. So, you're accessing value some of it is objective because it's information that's provided by a third party that you respect and trust and some of it is subjective comments by other consumers who have had an experience. it's unvarnished and it gives you a sense of what was their true experience with that particular supplier. And I know that physicians and other clinicians and hospitals don't necessarily like to think about themselves as suppliers but that's what they are they're supplying a service and that service happens to be health care to 300 million consumers. And we've taken the consumer out of the equation by either shielding them from the information only providing them with partial information and we removing their sensitivity to the purchase or giving them full sensitivity where it doesn't matter and no sensitivity when it does.

And I'll give you an example. So, in many consumer directed health plans, high deductible health plans chronic care is paid out a pocket as part of the deductible expense. And a friend of my has a child with type-1 diabetes so obviously he need insulin in order to live. That's expense that's paid out of pocket all the way thought the deductible, I don't think any would argue that, that makes any sense whatsoever. On the flipside preventive care which has marginally utility for that particular person is covered in full. So, we are giving no price sensitivity where it doesn't really matter and when creating price sensitivity where we shouldn't and then it that person actually

needs a significant operation they will go to their deductible and then they will be completely insensitive as to whether or not you're getting it done in a high value location where both of you have, you know, competitive pricing and high quality or a low value location where you have high price and potentially low quality. So, it just bad, you know, it's badly designed and it can and should change unfortunately I don't see that happening anytime soon because there's no one really out there doing a lot of innovative work around employee benefit designs. So this is a big issue because I think we can in fact and there's lots of evidence and when you do put the consumer in charge of a lot of decisions with the right information markets work, and it's messy and it's not always right but it works and we constantly, constantly try to prevented that from happening in health care and we just have to find a way to get it done.

Margaret Flinter: Well, François you do see some bright spots on the horizon in your writings in spite of the paucity of available health care pricing and performance data around the country. And I know that you've reference the Robert Wood Johnson Foundations aligning forces for quality effort which keeps remains one of the few bright spots across the United States and providing transparent quality information to consumers which is equally as important and maybe more than the pricing information test about that pilot program and what might we learn from their success.

François de Brantes: So, it's a great reference and yes it's one of the few bright spots because you have publicly available information on quality of health care. For the most part that is highly centered around primary care it only represents at most 20 to 25% of all health care delivered in the country. And so we need to do a better job collectively at going beyond information on primary care services and delving into what is the same for specialty care and so for when a patient has an advance chronic condition they need specialist. And we need to sometimes try to ignore that and say well the primary care facility or the primary care practice's going to take care of it. Not always, they shouldn't always take care of it and in fact they should work collaboratively with specialist in the management of those patients, but again it usually highly, highly contain to one specialty a couple of specialties mostly primary care and we have to go far beyond that.

Mark Masselli: You know François I want to get your thought on payment reform we talk about sort of achieving an Affordable Health Care you say that we would have to remain at our current levels spending for probably a decade. And that maybe doable given the last couple of years but certainly not over the trend line if you look back over the last couple of decades. And I wonder obviously there is a big shift trying to move from volume to value but sort of underpinning all of these is, it's 17% of the GDP and it supports a lot of people. Tell me there what your thought is about one -- on one hand how to control it and the other hand the politics of a such a large share of the GDP and the political realities of dealing with that.

François de Brantes: Well, look so this is why I am so adamant about unleashing the consumer because nothing can stand in the way of 300 million people. And I actually think that it's the reason why there isn't as much consumer is in health care is because the level of threat that it represents to the incumbents. Lots of question would have to

be answered from lots of people who either haven't done their job well, fail to do what they should have been doing. And until you get to that point it's unclear that the forces of the status quo can be changed. For every dollar that spent that mean it's going into someone's pocket and those people aren't going to give it up willingly. So, the hypothesis that you could maintain current trend rates or current spent per capita at its current level for decade I don't it's a unreasonable hypothesis at all. The only way that's ever going to happen however is if you truly unleash the consumer and that's not going to happen unless there's full price transparency and full quality transparency and on that respect they all fail. I mean if you actually have that and it was recognized in each state as truly an unbiased source at that point first of all, all of the health plans would probably default to that information as opposed to whatever they can lean internally which is highly and precise. And from that point value decisions can be made with consumers the solution itself is not particularly complicated like the politics are and ultimately it will take the leadership of several governors across the country looking at their own liability to stay, you know what we continue to subsidies the few incumbents at the expense of every single tax payer in the stats or we flip this on its head.

Margaret Flinter: We've been speaking today with Health Economist François de Brantes, Executive Director of the Health Care Incentives Improvement Institute and not for profit organization is focus on improving health care through targeted models of payment reform you can learn more about his work by going to hci3.org. François thank you so much for joining us on Conversations on Health Care today.

François de Brantes: Well, thank you.

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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 non-partisan and nonprofit consumer advocate for voters that aim to reduce the level of deception in US politic, Lori what have you got for us this week.

Lori Robertson: Well, we've seen a lot of viral emails about the Affordable Care Act the latest to hit our inbox is one claiming that the law requires Medicare beneficiaries over age 75 to be admitted to the hospital by their primary care physicians. It's not true the email wrongly claims that an emergency room doctor can't admit a senior to the hospital and have the cost covered as a hospitals stay that a primary care physician would have to be the admitting doctor. But there is nothing in the law that says that, we spoke with the non-partisan center for Medicare advocacy and a policy attorney there told us without hesitation that the claim is false and that there is no such requirement in the law.

The Centers for Medicare and Medicate Services also confirm that the law says no such thing. Medicare part A covers hospitals services when a doctor makes an order for treatment it doesn't require a primary care physician to do so. We are not sure how this particular viral claim came about, but we do know that this anonymous messages often

refuse to die. The version we've received from readers is an anonymous message that includes old bogus claims from 2009 including the false said that seniors age 76 wouldn't be eligible for cancer treatment, that claim can be trace to now 5 year old letter to the editor from a former judge in Texas who misread a health care bill in the house. Even the judge had said that his letter isn't accurate and he wishes the viral version of it would just die. We too advice a healthy use of the delete key and reading your inbox of such claims and that's my fact check for this week, I am Lori Robertson Managing Editor of FactCheck.org.

Margaret Flinter: FactChek.org is committed a factual accuracy from the countries 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 chcradio.com we'll have FactCheck.org 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 to everyday lives. The flu doesn't just exact a toll on public health impacts a meaningful punch on the economy every year as well. Comprehensive vaccination programs have had an impact on curtailing flu outbreaks but there is still a lot of room from improvement. In 2011 an estimated 100 million work days and close to 7 billion dollars and loss wages were attributed to the flue. Largely because many employees without paid sick leave are more incline to work while sick. An estimated 80% of those who come down with flu like symptoms ignore doctor's orders and go to work, leading tomorrow widespread co-infections. And a first of its kind study researchers at the University of Pittsburg School of Public Health decided to analyze the impact on flu outbreaks in the work place and to ask what would the difference be if there were universal access to paid sick leave.

Lead researcher Dr. Supriya Kumar says their study showed a pretty dramatic link between access to paid sick leave and reduction in flu outbreak in the work place, they also created another option what if there were a new sick leave category focusing just on flu days. Their model show that if those worker specifically diagnose with flu we guarantee just one pay day off to recuperate there would be a 25% reduction in the spread of flu. And when worker were guaranteed two paid days off the numbers went up to a 40% reduction in co-infection. A universal paid leave program for all workers that has the potential to greatly reduce flu co-infection in the work place positively impacting both public health while saving billions of dollars in the overall economy now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care, I'm 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 Centre.