Margaret Flinter: Welcome to Conversations on Healthcare with Mark Masselli and Margaret Flinter. A show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the healthcare of the future.

This week, Mark and Margaret speak with Larry Levitt, Executive Vice President of the Kaiser Family Foundation. He has taken a deep dive into what Medicare for All actually means. He breaks down the various health reform proposals being talked about on the campaign trail and talks about the shift in the roll of insurance companies should any of them come to fruition.

Lori Robertson also checks in, Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with Bright Idea, that's improving health and wellbeing in everyday lives.

If you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter, we love hearing from you. You can find a show on www.chcradio.com or wherever you listen to podcast as well. And you can also hear us by asking Alexa to play the program Conversations on Healthcare. Now stay tuned for our interview with the Kaiser Family Foundation's Mr. Larry Levitt, here on Conversations on Healthcare.

Mark Masselli: We are speaking today with Larry Levitt, Executive Vice President for Health Policy at Kaiser Family Foundation, he previously served as Editor-in-Chief at kaisernetwork.org. Prior to his time at the foundation he was the Senior Health Policy Advisor to the White House under President Clinton. He holds a Bachelor's Degree in Economics from UC Berkeley and a Masters in Public Policy from Harvard Kennedy School of Government. Larry, welcome back to Conversations on Healthcare.

Larry Levitt: Thanks for having me.

Mark Maselli: Yeah, it's been seven years and we are in the throes of this presidential election with a very crowded field. I think crowded is an understatement. The Affordable Care Act, while it remains the Law of the Land. There is sort of a drumbeat of challenges, on the left you have what appears to be a whole group of people, I don't know if they are abandoning the Affordable Care Act, but they are moving on to a new iteration of health reform, namely some form of universal coverage. I am wondering if you could help our listeners understand the sort of nuance difference between Medicare-for-all, single payer, universal coverage and maybe put this in some historical context for us.

Larry Levitt: Yeah, I mean we have been having this debate for well over 50 years, certainly dating back to President Harry Truman, who proposed the first formal National Health Insurance plan. The basic contours of this idea of national health insurance or a single-payer health plan or Medicare-for-all, has been around since then. The terminology has change somewhat, we used to call it single-payer, now I think kind of latching on to the popularity of the Medicare program, is this idea of calling it Medicare-for-all. The idea that everyone is covered automatically; that the government is sponsoring health insurance, the government is not employing doctors or owning hospitals so it's not socialized medicine. But the government is serving as the insurer for everyone. Again, everyone is automatically covered by virtue of being a resident of the United States.

Margaret Flinter: Well, Larry, given some of the impassioned speeches referred during the debates and in-between them. There are some variations even among the candidates and what they really mean by Medicare-for-all and I agree with you, I have never heard Medicare spoken up with so much love and affection, as we have in this current season. Bernie Sanders generally is considered to be the most radically sort of far out there on the Medicare-for-All. And Elizabeth Warren is pretty closely aligned with this idea that you have got to take the insurance companies out of the equation. But on a practical basis, how would that work, in this country to really take the private insurance industry out of the equation altogether?

Larry Levitt: Yeah I mean, at one level it's very simple that everyone gets a Medicare card and everyone gets access to healthcare automatically, with no deductibles, no copays. At a practical level it's a really much more complicated than that. Like the every other high income country has universal coverage. The United States stands out as the exception, it's the only country that does not cover everyone. But the idea of Medicare-for-All as put forward by Senator Sanders or Senator Warren, in some ways would leapfrog all these other countries, by eliminating private insurance, eliminating premiums and deductibles and copays entirely. But all these other countries that have universal coverage still preserves some rule for private insurance, whether it's just supplement the benefits, which don't cover everything, in these other countries or to allow people to jump the queue, to get access to care more quickly or see other doctors or hospitals.

What Senator Sanders is proposing is really a much more expansive version of universal coverage than we see in any other country. It would certainly be simpler, it would certainly have lower administrative cost and profits, but the idea of eliminating an industry that employees tens of thousands of people and that is very profitable and very powerful, not only poses kind of difficult practical issues but also difficult political challenges as well.

Mark Masselli: Larry, obviously there are some variations on the theme of Medicare-for-All, Senator Kamala Harris has her own version of this, it obviously differs in some really significant ways, including a 10 year transition period. But maybe you could dissect her plan a little for us.

Larry Levitt: I think what Senator Kamala Harris is proposing is a plan that tries to capture the improved access to care and insurance that Medicare-for-All would bring, but without some of the political landmines involved. Really kind of two big differences in Senator Harris's plan, one is the 10 year transition as you mentioned. But I think what Senator Harris is putting forward is that, people wouldn't have to wait 10 years, they would immediately get access to Medicare on an optional basis, the voluntary basis. It would really allow people to kind of see what this Medicare-for-All plan would look like before being required to join in.

And then the second is keeping private insurers in the mix, currently in Medicare today about a third of beneficiaries have private insurance plan, they are called Medicare Advantage plans. What Senator Harris would do is keep those Medicare Advantage plans as part of Medicare. It allows the private insurance industry to compete with the government plan and give people the choice.

Margaret Flinter: Well, Larry, so we have talked about a few people but when you think about what Vice President Joe Biden has been saying. He is pretty emphatic that he wants to see the Affordable Care Act improved upon and strengthened. But some people say that doesn't really address the cost of healthcare and that will still remain a problem. Of course we still see some people who are uninsured. Others like Colorado, Senator Michael Bennet who authored Medicare-X in Congress are calling for a similar approach. What's the hallmark of these more moderate proposals in your view?

Larry Levitt: Yeah, I mean these proposals are being called moderate but they go way further than anyone could have imagined, when the Affordable Care Act was passed over 9 years ago. These proposals have a few things in common, one is, they build on the Affordable Care Act by filling in some of the big holes that still exist in the ACA. One of those is Affordability for middle-class people, small business owners, self-employed people, farmers, early retirees, aren't eligible for any subsidies, any help under the Affordable Care Act and they have been feeling the brunt of big premium increase, it's really taking it on the chin. These proposals would expand the subsidies to these middle-class people whose incomes are more than four times the poverty level.

The second thing they would do is fill-in what's called the Medicaid coverage gap. When the Supreme Court decided that the Medicaid expansion is part of the ACA was optional for states a number of states still have not taken up the expansion, particularly states in the south. Vice President Biden's plan would extend coverage to poor people in those states who don't have access to anything today.

Then the final is this idea of a public option so trying to capture the cost containment promise of Medicare-for-All, the simplification, but making it voluntary for people so giving people the option of joining Medicare but not necessarily requiring or making it mandatory for everyone.

Mark Masselli: We are speaking today with Larry Levitt, Executive Vice President for Health Policy at the Kaiser Family Foundation, he previously served as Editor-in-Chief at kaisernetwork.org, the foundations online health policy, news and information service. Hey, Larry, lots of conversations about the cost of healthcare and there is another side that doesn't get discussed as much that obviously, this is an enormous part of our economy up to 20% of our GDP. On one hand you have people who are talking about the efficiencies that currently exists in the Medicare program in terms of the administrative cost that we could lower those. Others are talking about a larger expenditure, maybe financing some of the additional expansion. I am wondering what kind of impact to the GDP would be felt and I know you have done some work on this, if health companies were taken out of the equation, would we be willing if we got the results that they get in Western Europe, in terms of outcomes, pay what we are paying now. Would we see a benefit to our society, because what we are seeing in the European countries, what appears to be better outcomes at a reduced cost. I still don't believe that you can really reduce cost with the health industrial complex without a huge struggle.

Mark Masselli: Yeah, well you hear a lot that Medicare-for-All that we can't afford Medicare-for-All. I think that confuses a lot of definitions of affordability and cost. Certainly Medicare-for-All would result in much higher government expenditures for healthcare, I mean that's a feature, not a bug of Medicare-for-All, the ideas to eliminate deductibles, eliminate copays, eliminate premiums, but you still have to pay for healthcare and the way we would pay for it is through taxes. It would be a shift from paying through premiums and deductibles, to paying for it through taxes. Certainly government spending on healthcare would go up dramatically, but what people spend out of their own pockets and what employers spend would go down.

Now whether we as a nation can afford that, is really more a question of how overall health spending, regardless of where it comes from changes, under Medicare-for-All. And that depends on the details, Medicare-for-All would pay doctors and hospitals and drug companies less and that would save money. We would see administrative efficiencies from not having insurance companies in the mix, it cost about 3% overhead to administer Medicare compared to upwards of 10% for private insurance. That would all help to reduce healthcare spending.

On the other hand we would have universal coverage, so the 10% of our population that doesn't have any health insurance. Now we would have coverage and they would use more healthcare that's the point of giving people health insurance. And eliminating deductibles and copays would lead people to use more healthcare and that would boost health spending as well. Most of the estimates suggest that you know if Medicare-for-all were implemented in Senator Sander's bill, we would spend about the same as we do now on healthcare as a country. So you can't really say that we can't afford it, we would just be paying for it, very differently.

What result would that have on the economy, on outcomes? We spend double of what the average, other high income countries spends on healthcare. We will not, in my lifetime I think get down to the level that other countries are spending on healthcare. These are the countries spend half of what we do and they get better outcomes, longer life expectancy, better health, lower mortality. Some of that is due to I think a better organized health system, greater emphasis on primary care. But frankly some of it's due to things these other countries do outside of the healthcare system. While we spend so much more than the rest of the world on healthcare, they spend a lot more than us on social services, things like housing and social supports. And if we could take some of that healthcare spending and shift it to social spending, we could probably get better health out of it, but that's a lot easier said than done.

Margaret Flinter: Well, Larry, one of the great services provided by the Kaiser Family Foundation which we really appreciate is regular polling of the American public on a whole variety of aspects of health policy. And the polls have shown pretty consistently that those with health coverage through their employers are really pretty darn satisfied with their coverage and with their healthcare, even though I think there is genuine concern and worry about the fact that copays and high-deductibles are chipping away, somewhat at that satisfaction. What's your sense of how consumers feel, generally about the possibility of a public option or a single-payer system, how does your data show that trending at this point?

Larry Levitt: Yeah I mean it's not like people love their health insurance, I mean you don't get into dinner conversations with people raving about their amazing insurance company. But generally people give their health insurance pretty good grades. But as you said there are a lot of problems, deductibles have tripled, in the last decade while wages have risen hardly at all. You know 40% of people we survey with employer-based insurance say, they or someone in their family has had some kind of problem affording healthcare in the last year. So people are not in love with their private insurance, but they are very anxious about the idea of losing it.

When we ask people do you support Medicare-for-All? Majority of people do support Medicare-for-All. But there is a lot of confusion about what that means, hopefully this show will help alleviate some of that confusion. For example, most people who support Medicare-for-All believe that they will be able to keep their current health insurance which is not the case. If we present people with the idea that private health insurance would be eliminated or the government would get more involved in healthcare or there might be longer waits for services, the kind of messages the opponents will use in this debate, support plummets in effect support shifts to opposition.

The idea of a public option gets significantly more support. We as Americans don't like to be told what to do, giving people the option of joining Medicare sounds a lot better than requiring them to join Medicare and give up their current health insurance and I think that's why you are seeing some of these ideas like from the transition that Senator Harris laid out or what Vice

President Biden has proposed, gain some traction, because it eliminates some of the anxiety and some of the political downsides of Medicare-for-All.

Mark Masselli: Speaking in sort of the political downsides, I just wonder after all the rhetoric, if the Democrats win, what do your poll show about what they should do? And I am sort of thinking about the struggle that President Obama had. He got through the Affordable Care Act but lost the Congress. In terms of sustaining this, we have not been able to do with Affordable Care Act, what we are able to do with Medicaid and Medicare, a good bill but not a perfect bill that over a number of years, we made important changes that strengthened and still do. The Affordable Care Act, we have never really been able to make the types of changes that would have improved an imperfect bill, which everyone knew it was imperfect. I am just wondering about the political calculus and where the public might be, to sort of think about past the election, past everything that people say, where is the right focal point for the government?

Larry Levitt: Our polling is very consistent, first that healthcare is a top issue for voters and second when they say healthcare is a top issue, they mean reducing the cost of healthcare and making it more affordable, that's what Americans wanted. Advocates of Medicare-for-All can certainly make the case that healthcare would be more affordable for many people and cost would come down. But all of these proposals have tradeoffs. At the bumper sticker level, healthcare reform idea sound great, once you start filling in the details, and the tradeoffs become clear and it becomes apparent that they are losers as well as winners, then they become quite controversial. I mean the Affordable Care Act was very popular at first and then as time went by, it became less popular and frankly the only thing that made the Affordable Care Act popular once again, was Republican efforts to repeal it.

In a campaign, candidates promising to lower healthcare cost and make care more affordable for people, those ideas will really resonate with voters, actually putting forward a big complex bill, that will have losers as well as winners, is probably not going to be a political winner for any incoming president, that's been the history that healthcare reform, at the talking point level is very attractive politically but the political capital necessary to get a bill passed, tends to hurt presidents.

Margaret Flinter: We have been speaking today with Larry Levitt, the Executive Vice President for Health Policy at the Kaiser Family Foundation. You can learn more about their very important work by going to www.kff.org or follow them on Twitter @kaiserfamfound or @larrylevitt, Larry, we want to thank you so much for your work, your dedication to keeping us informed about health policy and for joining us again on Conversations on Healthcare.

Larry Levitt: Thanks for having me.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, 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: In the latest democratic presidential debate, Senator Kamala Harris of California and former Vice President Joe Biden disagreed on aspects of their healthcare plans. Biden, initially said that his healthcare plan would cover the "vast, vast, vast majority of Americans" but when pushed by Harris, he later said, it would cover everyone. His own campaign website says otherwise. Biden's plan calls for among other things offering a Medicare style public health insurance option as a choice, an increasing tax credits for individual purchasing insurance on the Affordable Care Act exchanges. His website says his plan to build on the ACA will "insure more than an estimated 97% of Americans." Harris said as many as 10 million people wouldn't be covered under Biden's plan. Her campaign told us, she gets to that number by calculating 3% of the currently estimated U.S. population. That works out to 9.88 million people.

However that figure includes more than just Americans as Biden's campaign website said, because not everyone living in the U.S. is the citizen. Biden's campaign has reportedly said that under his plan, immigrants living in the U.S. illegally would be able to purchase insurance through the ACA exchanges which is not currently allowed. Those immigrants still wouldn't be eligible for federal subsidies as campaign explained.

Biden said that Harris's plan "Will require middle-class taxes to go up not down." Harris has proposed her own version of a Medicare-for-All plan that features an expanded Medicare system including private insurers and is spaced in over a 10 year period. But in a July 29th Medium post, Harris said her plan to pay for her proposal will "exempts households making below a $100,000 along with a higher income threshold for middle-class families living in high-cost areas." And that's my factcheck for this week. I am Lori Robertson, Managing Editor of FactCheck's.org.

Margarent 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 Healthcare.

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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 estimated that the majority of a person's lifelong health expenditures are often spent in the final months of life. But death is one of those topics that generates the least amount of conversation in the clinical setting in American healthcare. For folks who end up critically ill or facing a terminal diagnosis like late stage cancer, this can often lead to poorly communicated, end-of-life wishes being discussed with the clinician who then often resorts to extreme interventions.

Manali Patel: In oncology notoriously we are underprepared to have these conversations with patient. There is a desire to want to provide patients with truth however there is this unspoken misconception that by having honest conversations about prognosis that we are somehow removing the hope that patients are coming to us looking for. Actually most studies that I have evaluated this have shown that when you provide honest prognostic information to patients and allow patients to be part of the decision making about their goals of care, they are more appreciative of it and actually have more understanding of their disease process and better satisfaction with their care overall.

Margaret Flinter: Dr. Manali Patel is a clinical researcher at Stanford University School of Medicine. Her earlier research at Stanford yielded in an interesting finding, late stage cancer patients felt more comfortable talking about end-of-life issues with a lay person as opposed to a clinician. She and her fellow researchers followed patients at the Veterans Administration Palo Alto Health Care System for 15 months after they were diagnosed with Stage 3 or 4 or recurrent cancer. Half of the people were randomly assigned to speak with a late worker about the goals of care over six months period. The Control Group was given no such intervention.

Manali Patel: We found during the intervention was that she learned as she went and then at the end, she was completely proficient with having these conversations such that she came to that realization that these conversations really are not scary and shouldn't be scary and shouldn't be medicalized and maybe she didn't need all the training to begin with. And that's really the main crux of this intervention, was finding the right person who can engage in these conversations.

Margaret Flinter: 92% of the participants who receive the lay person intervention compared to only 18% of the Control Group were likely to have end-of-life directives in their electronic health record, often choosing hospice over emergency room interventions. The average cost of care for the intervention group in the last month of life, was about a $1,000 versus $23,000 for the Control Group.

Manali Patel: We found the satisfaction of course went up for the patients in the intervention arm that they went down for patients in the control arm. We found overwhelmingly that the patients in the intervention arm were very satisfied with the decisions that they had made regarding their medical treatments and regarding their life, but the patients in the control arms, really did not have much movement at all in terms of how satisfied they were.

Margaret Flinter: A low resource patient centered intervention, that assists terminallyill patients, their families and their clinicians to have a frank discussion about end-of-life wishes, improving patient satisfaction at such a sensitive and challenging time, that's a bright idea.

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Mark Masselli: You have been listening to Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Peace and health.

Moderator: Conversations on Healthcare is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes or whatever you listen to podcast. If you have comments please email us at www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. The show is brought to you by the Community Health Center.