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Mark Masselli: This is Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret 2017 is drawing to a close, it's been a tumultuous one for healthcare. The year is marked by several attempts to repeal the Affordable Care Act under the new administration of President Trump and while those efforts failed, congress has found other avenues that could compromise and weaken parts of the law.

Margaret Flinter: The legislation removes the ACA's individual mandate which requires all Americans to buy insurance or pay a tax penalty. Removing that incentive that's expected to lead to millions of Americans not having coverage in the coming years.

Mark Masselli: And of course no surprise those most likely to opt out of purchasing coverage are expected to be young healthy when their group stays away from the insurance pool the price goes up to cover the sicker members in the insurance pool. The congressional budget offers another analyst all concur that it's going to lead to significantly higher premium cost and higher out of pocket expenses for those purchasing insurance.

Margaret Flinter: And it's also expected that congress will have to cut a number of social programs in the coming years to make up for the 1.5 trillion dollars in tax cuts to help address the deficits that will grow in the wake of this tax bill. So it appears that a lot of vulnerable people could end up on the losing side of this equation Mark.

Mark Masselli: We lost something very important Margaret last year renowned health economist Uwe Reinhardt passed away in 2017. His theories underscored much of the affordable Care Act and his brilliance will be missed.

Margaret Flinter: He has been a guest on the show Mark as you know a number of times over the years. Most recently in 2015 so we thought this would be a good time to revisit that conversation with an old friend and colleague and reflect on the great contribution that he made to the broader understanding of health economics.

Mark Masselli: Really looking forward to revisiting that interview Margaret.

Margaret Flinter: And Lori Robertson will stop by, the Managing Editor of FactCheck.org.

Mark Masselli: But no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Margaret Flinter: We will get to our interview with Dr. Uwe Reinhardt the Late Dr. Uwe Reinhardt in just a 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 am Marianne O'Hare with these Healthcare Headlines. Insurance companies are bracing themselves for what could be a significant shift in the landscape if the congressional tax reform bill goes through as it's written. Part of the 1.5 trillion dollar tax cut involves removing the individual mandate requiring all Americans to purchase health insurance. Insurers are viewing this development with some trepidation already scrambling to adopt rate estimates upward next year to accommodate what is likely to be a sicker pool of customers on the exchange. An estimated 13 million Americans are expected to be without insurance coverage over the next 10 years, some will chose not to be covered while the increased rates will price many others who are sicker out of the insurance market places.

Meanwhile Congress's failure to reauthorize the Children's Health Insurance Programs since it expired at the end of September is putting health coverage for the nation's children in jeopardy, and the state of Alabama seems to be leading the charge. They announce that on January 1st coverage for at least 7,000 children will not be renewed and that they will suspend any new signups for health coverage under the program. Nine million mostly poor and vulnerable children are covered by the Chip program. Preemies and ADHD a recent study showed babies born at 32 weeks gestation were twice as likely to develop Attention Deficit Hyper Activity Disorder, and babies born before 28 weeks were four times as likely to develop the condition. Researchers are viewing these findings as an important benchmark for understanding at least some of the causes for developing attention Deficit Hyperactivity Disorder.

There's been an uproar surrounding these seven dirty words now ban from use at the Centers for Disease Control and Prevention it was reported that the Trump Administration has cast an edict that seven words or phrases are no longer allowed to be used in policy discussions especially those are vulnerable entitlement, diversity, transgender, fetus, evidence based and science based. The CDC Director under Trump Dr. Brenda Fitzgerald did not deny the word ban exist but insist that the CDC is still committed to applying scientific rigor to their agenda. I am Marianne O'Hare with these Healthcare Headlines.

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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 healthcare economics. Professor Reinhardt is a member of numerous editorial boards including Heath Affairs and the Journal of American Medical Association. He earned his PhD in Economics from Yale. Dr. Reinhardt welcome back to Conversations on Healthcare.

Dr. Uwe Reinhardt: Pleased to be back.

Mark Masselli: Lots of good things have been happening with the Affordable Care Act, and yet the landscape is fraught with change. 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 that comes with having health insurance which is enjoyed by 85% of the population as a matter almost of right and only 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 relative to just how complex the American health care system is. Can you elaborate for us on just what makes this task of health reform in this country so utterly challenging?

Dr. Uwe Reinhardt: 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, we have 50 state Medicaid programs, we have purely socialized medicine. We have that reserved for the American 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's quimby-slimby special Medicare benefits and so on, and it look like a Mondrian painting. Now I ask these Congressmen if you want to reform any piece of this patchwork, you are going to touch all the other patches and that is why every single health reform plan is a huge mess because the system is a huge mess. And therefore any bill, other than the bill that doesn't do anything it 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, one of the chefs was Dr. Jonathan Gruber

an MIT economist. You have lauded Dr. Gruber as one of the great minds in health economics. But he recently found himself in the woodshed if you will for some of his recent comments. 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: 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 Americans cannot possibly say they are very well-informed. It's very, very difficult to accurately inform any people about something as complicated as the Affordable Care Act to inform the voters properly is a monumental task. I am totally ignorant on climate control why? I don't have time. The trouble with economics in general is that every cab driver thinks 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: So 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 consumer driven choice and you have noted that in selling the idea of health care for all American people we needed that notion of consumer-driven choice. You've 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 affection 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-consume health care because they think it's free. 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 a family with $200,000 with a $5,000 deductible wouldn't be fazed at all their behavior in health care wouldn't be changed at all. 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 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 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: 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, MRI's 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. It's 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're 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 say well if I had one more MRI, it could marginally change my diagnosis but the probability is quite low. 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 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 a kind of upper echelon that will increasingly seek boutique-like coverage and more concierge care. Is it three tiers all with equal potential for quality?

Dr. Uwe Reinhardt: No, it's a 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 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, 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? 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?

Margaret Flinter: So let me use the example you just raised of Hepatitis C 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 it's 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 [PH 17:03]** 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. And I have to say so far to my amazement American society has said we are willing to pay it even someone in jail is worth it to us. On the other hand you could also ask, is it really necessary to pay Sovaldi a $1000 a pill? 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 we will pay you 700 a pill and you'll still make out like bandits, you know, 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 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 we're willing to spend that already why complain about us? And that's Gilead Sciences point of view and this 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, you know, and I have a PhD which is great for a mission, I don't know.

Mark Masselli: We have been speaking 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: The Head of the House Science committee made a false claim about funding of graduate students from the National Science Foundation. Representative Lamar Smith Chairman of the House Committee on Science Space and Technology said that the NSF funds quote more than twice as many graduate students in the Social and Behavioral Sciences as in computer science Mathematics or Material Science. In fact 21.5% of the 22,821 graduate students funded by the NSF in 2015 were in math, computer science and Material Engineering according to the latest data. That's more than three times the number of psychology and Social Science Students. Smith made his claim in an op-ed published in the newspaper Roll Call, he claimed the NSF is funding too much low priority research in the Social and Behavioral Sciences including Sociology and Psychology and not enough research in quote feels most likely to yield scientific breakthroughs, technological innovations, and economic growth such as computer science. Smith has a right to view some scientific fields as more important than others but he is wrong about NSF funding for graduate students. His office urged us to reach out to NSF for specific numbers so we did. And NSF spokesperson told us that Smith's statement only focuses on a single program and therefore is inaccurate. If we look at NSF funding for graduate students across the agency, NSF funded the most graduate students in the physical sciences including physics and chemistry, literally 18% of the 22,821 graduate students with NSF funding. These numbers are for 2015 the most recent available, in second place was computer science one of the fields that Smith highlighted. 14% of the students were in that field when we add in math and statistics students and material engineering 21.5% of the graduate students funded were in the field this mention, psychology and social science students meanwhile made up only 5.9%. You can see more on the breakdown of the National Science Foundation graduate student funding on our website at FactCheck.org. 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.

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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 a 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. 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, 380 of them so far.

Dr. Robert Zarr: How to get there, parking, is parking available, if someone is going to drive? Bike racks?

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 ask 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 the things they are willing to do.

Margaret Flinter: He wants to make the prescription for outdoor activity adaptable for all of his patients and adaptable for pediatricians around the country. He's plan 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.