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Marianne O'Hare: Welcome to Conversations on Health Care 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 health care of the future. This week Mark and Margaret speak with Timothy Jost, Professor Emeritus at the College of the Washington and Lee University School of Law. He is a coauthor of the casebook Health Law, one of the most widely used health law textbooks in the country, and has been one of the most prolific analysts and writers about the Affordable Care Act. He talks about the election, the new configuration of the Supreme Court and what it means for health reform.

Lori Robertson also checks in, the Managing Editor of FactCheck.org she looks at misstatements spoken about health policy in the public domain, separating the fake from the facts, and we end with a bright idea that's improving health and wellbeing in everyday lives. If you have comments please e-mail us at chcradio@chcone.com or find us on Facebook, Twitter, or wherever you listen to Podcast and you can also hear us by asking Alexa to play the program. Now stay tuned for our interview with health law expert Timothy Jost here on Conversations on Health Care.

Mark Masselli: We're speaking today with Timothy Jost Professor Emeritus at the Washington and Lee University School of Law. He is a coauthor of the casebook Health Law, one of the most widely used health law textbooks in the country. He is author of Health Care at Risk: A Critique of the Consumer-Driven Movement,

Margaret Flinter: A renowned scholar on American Health Law, Dr. Jost has published extensively on the Affordable Care Act. He's been a significant contributor to the Health Affairs blog series "Following the ACA" and written over 600 articles since the ACA's implementation. Professor Jost, welcome back to Conversations on Health Care.

Professor Jost: Thank you. Good to be here.

Mark Masselli: Well, Professor, you joined us the last time it was 2017. The nation was adjusting to the Trump administration who would really campaign does, you know, on repealing the Affordable Care Act, which they came fairly close to doing. But the health law survived for many more days. And the country right now is on tenterhooks as we are awaiting the official results of the current presidential race. And obviously there are lots of sets of legal challenges that are being put forth. And still the ACA still remains in jeopardy. I wonder if you could

talk to our listeners about the impact of the 2020 election. And what do you think it bodes for the Affordable Care Act and health reform in general?

Professor Jost: Well, it appears now that Vice President Biden is quite likely to be elected president, but that he will still need to work with the Republican Senate and a House controlled by Democrats but with a narrower margin. It also appears that Democrats did not gain much in the way of state legislatures and probably lost ground there.

Any chance of repealing the Affordable Care Act legislatively seems very remote at this point. But we have that case before the Supreme Court next week challenging the ACA, which poses some possibility that the law could be invalidated by the court. All of the actions therefore, to expand ACA protections or to reverse Trump administration actions undermining the law by the Biden administration will probably have to be accomplished through administrative regulation or guidance. Any dramatic moves by the Biden administration will be opposed by litigation, and many of those cases will be heard before the 220 judges appointed by President Trump, including possibly the supreme court now, which is completely dominated by conservatives and Trump appointees. There may be a few opportunities for bipartisan legislation, such as addressing surprise medical bills, or possibly pharmaceutical costs. But the ambitious agenda that the democrats proposed for reforming our healthcare system will probably now have to largely be shelved. Things like the public option, or major increases in ACA subsidies are unlikely to make it through a Republican Senate. So I think we're going to have a few more years of stalemate.

Professor Jost: Professor, this maybe is a little bit of looking back question for a moment. But I know you've said that the ACA was never designed to replace America's kind of patchwork quilt health system and that its primary purpose was to provide coverage to more people by expanding Medicaid and certainly subsidizing premiums for low-income Americans. You know, from where we sit in healthcare we can accomplish so much more through preventing denial for pre existing conditions the end of lifetime caps, letting our kids stay on our health insurance plans till they were 26. But when you look at the impact of the ACA on the healthcare landscape in America and the efforts to try and dismantle it almost from the beginning, how has that impacted consumers? We know the gains but what didn't happen because of the kind of constant efforts to dismantle it?

Professor Jost: Well, there have been tremendous gains, we have expanded Medicaid to cover about 15 million more Americans. The marketplace has now covered about 10 million Americans. The majority of Americans are

covered by their jobs, of course, but as you said, they have new protections such as preventive services without cost sharing coverage of adult children up to age 26, the end of lifetime and annual limits. Almost everyone has benefited from the protections against preexisting condition exclusions, if only to the extent that if they lose their current coverage, and I think what we've seen in the last year is that it's not that difficult to lose your employer-sponsored coverage, you don't have to worry about whether you'll ever be able to get coverage anyplace else. The ACA also closed the Medicare drug coverage Doughnut Hole, offered Medicare beneficiaries new preventive services, and it dramatically changed the way in which Medicare pays for health care services, reducing costs and increasing value. It imposed taxes on wealthy Americans that have significantly expanded the lifespan of the Medicare trust fund. It also get things like creating new remedies for fraud and abuse, or giving the Food and Drug Administration authority to approve generic biologics for many people biologics have just been so incredibly expensive and generic biologics have the promise of bringing those costs down a bit. It contained many provisions to improve the health care workforce and also included things like privacy for nursing mothers, and nutritional information on fast food menus.

All of these changes now are baked into the American healthcare system. And it frankly, would not be possible to eliminate the ACA, without throwing our entire healthcare system into chaos. It's not just about preexisting conditions. It's about our entire healthcare system, and it would effect everybody in some way.

Professor Jost: You know, Professor, our good friend Don Berwick said of you that you are to the American healthcare policy what GPS is to a dark and unfamiliar road. And I think we're going to need that GPS, as the road ahead seems quite treacherous. And you talked a little earlier about the Supreme Court taking up in a week or so another challenge to the ACA. And you recently wrote about the death of justice Ruth Bader Ginsburg and the GOP’s elevation of Amy Coney Barrett to replace her. I think she noted she didn't really tip her hand in the confirmation hearing. Though she did in a moot court setting, she did vote to strike down the Affordable Care Act. And I'm wondering what are the various scenarios you see happening there in terms of the individual mandate, and how that might go and other legal challenges? You talked in broad general terms about 200 of the new Trump administration's appointees be a logjam to get through, maybe paint a detailed picture of what might lie ahead?

Professor Jost: Actually, Justice Barrett voted to preserve the ACA in that moot, although maybe that was just to make the students feel good. I'm not sure. The case raises three questions, really California vs Texas. One is

whether Texas and the individual plaintiffs have been injured by an unenforceable mandate sufficiently to have standing to challenge the statute. The second is whether the mandate itself is unconstitutional now that the tax that forced it has been zeroed out. And then the third and really biggest question is if the statute is found unconstitutional, how much of the rest of the ACA should be invalidated with it?

Justice Barrett, in her testimony suggested that severability was the key question and that's where other people think this question is to how much of the ACA should be invalidated? Two other Justices on the Court, Chief Justice Roberts and Justice Cavanaugh penned opinions earlier this year suggesting that severability should be presumed, which is to say that if a single provision of the statute is found unconstitutional, the rest of the statute should presumably be upheld. I think it'll be likely that the two of them will go the same way on this case with the three democratic appointees, and that will be enough to preserve the statute, whether or not Judge Barrett joins them or joins the other three republican-appointed judges who are more likely to rule to invalidate the ACA. There, of course, is a lot of litigation right now, pending most of it challenging Trump efforts to undermine the ACA, and there will be certainly a lot more litigation coming in once the Biden administration starts promulgating rules. So it's going to continue to be good times for lawyers, probably not good for the experts.

Margaret Flinter: Well, maybe this question, I'm not sure it's a good time for good question for lawyers or people who like to imagine the future. But it would seem that this pandemic that we are deep in the middle of is likely to have some profound effect on our healthcare system going forward. And certainly, it has laid bare some of the incredible health disparities by race and ethnicity. By income, it's laid bare some of the terrible inequalities perhaps and access to quality care in long term care and nursing homes for our elderly. It has probably created an entire major new class of pre existing conditions, and so I wonder, going forward, do you have a sense of what might be different? What have we learned from going through a pandemic that might impact our health policy discussions going forward?

Professor Jost: Well, that question depends on whether when really believes there is a pandemic and really believes that it's as serious as it actually seems to be. But Congress has already taken some steps to protect individuals from the costs of COVID tests and also the cost of COVID vaccines when one becomes available. Legislation passed last spring provided funding to support health care facilities to address the extra burdens, they were bearing because of COVID, not actually so much because of COVID itself. But because of all the other tests and

procedures that were cancelled because of COVID. I think we need further legislation to protect health care providers and also to protect state and local governments from the added costs that COVID has caused. And we should also be thinking about additional protections for consumers against costs caused by COVID, particularly for uninsured persons who contract the disease.

On the other hand, it's a little hard to justify paying for treatment for COVID when we don't pay for treatment for other equally serious or even more serious conditions for uninsured people, seems to me that the argument for covering people for the costs of COVID is essentially an argument for universal health care coverage. That's not where we seem to be going and given the makeup of the Senate for at least the next two years.

Mark Masselli: We're speaking today with Timothy Jose, Professor Emeritus at Washington and Lee University School of Law, significant contributor to Health Affair's Blog series Following the ACA." You know Professor, this recent presidential campaign, you know, broad health discussion, in some ways beyond the ACA, most of the Democratic presidential hopefuls, of course, wanted some kind of universal coverage, or Medicare for all, but if elected, the Biden administration would take them probably a much more measured approach. They've been really focused in on how to reduce Medicare age to 60. And some other changes, but not, not Medicare for all, as you mentioned, but the republicans controlling, the Senate will see a lot more pushback in advance. So I'd really like to know the trajectory for the next iteration of health reform and assuming it's a 48/52. In Biden, having been a longtime senate member of whether or not you see any scenario where some compromise can be found with some of the more moderate Republicans?

Professor Jost: Well, I think there are some things that Congress might be able to do like dealing with surprise medical bills, or doing something about pharmaceutical costs. But I think largely Biden is going to be limited to doing what President Trump has been doing for the last four years, which is executive orders and regulations. And these can expand coverage at the margins, he can do things like increase the open enrollment period for the exchanges. Doing a lot more advertising, Trump administration cut that by 90% funding more navigators probably rolling back on some Trump rules like the rules allowing short term limited duration coverage that is not subject to ACA protections.

Mark Masselli: Can you push a little more on what the executive orders really could do? I mean, advertisements, probably not an executive order. But what are the -- what's the force and the power of an executive order?

Professor Jost: Well, frankly, an executive order doesn't really have any force on its own. Trump has proved the master of putting out executive orders that are essentially meaningless. But what an executive order does is essentially directs an administrative agency to do what it can to deal with the particular issue of problem. I think rolling back on some of the new Trump regulations, expanding birth control coverage, expanding protection for LGBTQ individuals, expanding access to special enrollment periods to the exchanges.

So there are some things that are not insignificant that the administration can do. Probably one of the biggest things is to change the guidance on waivers, so that Medicaid work requirements would not be permitted, or that you couldn't do what Georgia has done in the last couple of weeks of getting rid of the federal exchange. And all of that can be done administratively. Now, probably anything he does administratively that significant is going to be challenged in court. But that's been true with the Trump administration, too. And some of these rules have held that.

Margaret Flinter: Now Professor, I'm glad you raised the issue about Georgia, which has been much in the news in recent days, this issue of getting the waiver from CMS to allow it to opt out of the federal health insurance exchange altogether. And instead having a collection of payment options for insurance coverage for low income residents. Can you talk about that move, I don't see how that works. Given the protections that are in place for the health insurance exchanges, what will Georgia be allowed to do? Why are they doing it? And will others try and follow up course with that, do you think?

Professor Jost: Well, Georgia has cut back on what it's asked to do. So what's proposing right now is less ambitious anyone who's proposing earlier. But basically, what it's proposing now, is that they be allowed to opt out of the federal exchange and all coverage would be marketed through insurance agents and brokers. And predictions are that tens of thousands of people would lose coverage if they do that. It's a little unclear why they want to do it. It was put out for public comments. And I hope about 1800 comments were submitted opposing it. Five were submitted supporting it. It was put out for public comments and I hope about 1800 comments were submitted opposing it, five were submitted supporting it. Even the agents and brokers whom it's supposed to benefit, don't seem that excited about it. It's the kind of thing that where the Trump Administration is trying to come up with an alternative to the ACA, and it doesn't seem like there's much there that could actually help consumers. It's unclear who it would help at all. But that kind of thing, which is permitted under the current waiver guidance of the Trump Administration, I think, is going to be dramatically reversed. That's not even a rule that's just guidance that

Biden Administration could change that guidance, its first day in office, although whether they could revoke the Georgia Waiver or not, which doesn't go into effect for a couple of years, probably not, but at least they can monitor it very closely to see if it's working.

Mark Masselli: Professor, you've spent a lifetime analyzing American Health Policy but in this past decade, we've seen all these rapid changes technology is advancing, Telehealth, Remote Monitoring, Genomics, Predictive Medicine, all moving really at a rapid pace, and we're seeing a growing trend of consumer driven healthcare. I'm wondering if you look forward, what's your vision of the kind of health system we'll see evolve in the country over the decade ahead and what kind of laws will be required to protect health consumers?

Prof Jost: It seems to me that the major concerns of health law are going to continue to be the traditional concerns of health law protecting privacy, protecting transparency and informed consent. I think Telehealth has some real promise, and I think it's generally believed that the COVID epidemic has shown what it can do, and that it is a useful technology and that can be money saving. On the other hand, I think many of the things that are being pursued right now are going to prove quite costly and then we're going to have to decide how that cost is going to be paid, and who's going to have access to those technologies, and those are all going to be difficult problems.

Consumer-Driven Healthcare, I think, we really need to see if that means anything more than increasing consumer costs because what it is often meant is just higher deductibles, higher cost sharing, with the idea that consumers will make better decisions if they have to pay a lot more for their care. I think most consumers at this point feel like they're already paying too much. We'll see where that goes. I think everybody thinks transparency is a good thing, except for maybe providers who have to be transparent, but we'll see.

Margaret Flinter: We've been speaking today with Timothy Jost, Professor Emeritus at Washington and Lee University School of Law, and one of the nation's leading scholars on American Health Policy and the Affordable Care Act. Professor Jost, we want to thank you for continuing to help us navigate the complex world of health policy in America and for joining us today on Conversations on Health Care.

Prof Jost: Thank you very much for inviting me and thank you for some great questions.

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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 healthcare 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: President Donald Trump has made the misleading boasts that the U.S. is in great shape because 97% of emergency room visits were for something other than COVID-19, but the number is not as impressive as it sounds. Trump was making that claim in late October campaign rallies as he falsely claimed the U.S. is, "Rounding the corner or rounding the turn on the pandemic". For instance, Trump said in Wisconsin on October 27, "Thanks to our relentless efforts, 97% of all current emergency room visits are for something other than the virus." The same day in Nebraska, he repeated this statistic adding, "We're in great shape". Trump's statistic is correct, but it's not the meaningful indicator he presents it as. Even during the pandemic's harrowing days in April, the percentage of ER visits due to a COVID like illness never went higher than 7%. The number while lower now has been on the rise.

Moreover, public health experts do not think that the U.S. is in great shape, and several metrics show that the pandemic is worsening. Trump's 97% figure likely comes from the CDC. According to the agency's data tracker, around 3% of ER visits in late October were due to a COVID like illness. That's an uptick from two months ago when the figure hovered around 2%. The CDC system monitors emergency department visits for COVID-19 like illness in a subset of hospitals in 47 states. The percentage of such visits each week peaked at 6.8% in April, and then hitting another peak of 4.2% in July. That's my FactCheck for this week. I'm 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'd like checked, email us at www.chcradio.com. We'll 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. Sub Saharan Africa leads the world in maternal and infant deaths each year. According to an annual report from Save the Children, an estimated 397,000 babies died at birth in that region in 2013, and some 550 mothers died per day as well. Most of the causes have to do with lack of access to medical care in these low-resource regions, and often the

local midwives lack formal medical training to prepare them to conduct interventions in the event of a life-threatening event like a hemorrhage or an infection.

Anna Frellsen: 90% of all the deaths that we see today could be prevented if the mother had access to this really basic skilled care during the childbirth.

Margaret Flinter: Anna Frellsen is CEO of the Maternity Foundation, a Copenhagen based nonprofit dedicated to eliminating maternal and infant death in the world. Their organization has created intervention for midwives living in low resource areas, if they just have access to a smartphone. It's called the Safe Delivery App, and it provides comprehensive training for midwives that teach them and guide them on what to do in the event of a birthing crisis.

Anna Frellsen: This is really a matter of building the skills of the health workers who are already out there and empower them to be able to better handle the emergencies that may occur during childbirth such as the woman starts bleeding or the newborn is not breathing and so forth as a matter of finding a way that we can reach to health workers and build their skills.

Margaret Flinter: Frellsen says the real promise of the Safe Delivery Application lies in its ability to provide ongoing obstetric and neonatal training so that local midwives can gain important clinical knowledge over time. The Safe Delivery App has been designed to be culturally relevant and easily understood, and it's received the United Nations approval for wider deployment, potentially impacting a million live births. A low cost culturally sensitive mobile app that offers immediate guidance and assistance to midwives and health workers, the backbone of the health care system and low-resource areas, empowering them with ongoing support and knowledge that can improve birth outcomes. Now that's a bright idea.

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Marianne O'Hare: You've been listening to Conversations on Health Care.

Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at

www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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