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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret tomorrow at 8:00 a.m., the Senate will take their final vote on their Health Reform Bill and we will for the first time in our history have key reform bills passed in both chambers.

Margaret Flinter: It's a very exciting moment and it's been a drama played out on the national stage, it's still not over. The next step for the legislation will be a joint conference committee which will work to reconcile the difference into a final bill that can pass both chambers, then on to President Obama for his signature.

Mark Masselli: The President has once again been the conductor behind the scene. He clearly expressed his wishes to get the Senate Bill done before the Christmas break.

Margaret Flinter: Christmas Eve counts and the President has requested that the conference committee act so that the final legislation gets passed before his State of the Union address on January 21st. It's a very tight time frame, but the President is persistent.

Mark Masselli: The high wire act continues and there is quite a difference between the two bills, but Senator Reid has been very clear as he is needed to make enormous compromises to get the 60 votes for cloture and it doesn't appear there will be much maneuver room in conference for the House language.

Margaret Flinter: Well, I think that's true but there are a number of very difficult issues to negotiate, and the first is the abortion issue. The House language is more restrictive and that was needed by Speaker Pelosi to ensure her narrow vote margin.

Mark Masselli: And another issue is who gets taxed the Senate Bill curbs cost by taxing so called "Cadillac Plans," high deductible insurance plans, but the House on the other hand does not include a tax on the Cadillac Plans but it does impose an income tax on the very wealthy.

Margaret Flinter: And the big health care policy difference between the two bills still will be over the public option. The senate plan does not include the option of a government-run insurance plan as Democratic

leaders did away with that provision in order to appease lawmakers such as Senator Nelson and Independent Senator Joe Lieberman of Connecticut.

Mark Masselli: The House Health Care Bill however includes a public option where the government would negotiate rates with insurance companies instead of setting fees as it does in Medicare.

Margaret Flinter: And at least 50 Democrats in the House are on the record of saying they will not vote for a bill without the option, while Nelson and Lieberman have refused to support a bill that does include a public option.

Mark Masselli: We will keep you informed as the debate continues, but this week's Conversation on Health Care interviews Dr. Karen Davis, one of the country's leading health economists, and currently serves as president of the Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues.

Margaret Flinter: It is very timely to have her on our show. Dr. Davis is published extensively in the field of health and social policy issues, including the landmark books Health Care Cost Containment, Medicare Policy, National Health Insurance: Benefits, Costs, and Consequences, and her first book Health and the War on Poverty. She was elected to the Institute of Medicine in 1975, and among her many appointments, she serves as an advisor to the Congressional Budget Office.

Mark Masselli: No matter what the story, you can hear all of our shows on our website Chcradio.com. You can now subscribe to iTunes to get our show regularly downloaded. Or if you'd like to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Margaret Flinter: And as always, if you have feedback, email us at Conversations@chc1.com, we'd love to hear from you.

Margaret Flinter: The Commonwealth Fund has been informing Health Policy for decades but their recent studies are particularly pertinent now as the proposed bills have lurched forward with public option in and out, Medicare buy-in at 55 in and out, concepts like the patient-centric medical home, health insurance exchange becoming almost household words. Today, Conversations on Health Care welcomes Dr. Karen Davis, the economist and president of The Commonwealth Fund, one of the few

charitable organizations established by a woman. It was founded in 1918 by Anna Harkness charged with "doing something for the welfare of mankind." So today, we thought a good time for Conversations to take a look at a few of The Commonwealth Fund studies in light of the Health Reform Legislation that's emerging. The Fund recently released a study that assessed the impact of the Reform Bills, then under consideration, this was October. So here they are with a look at how they have faired in surviving to the final bill. First, changing the insurance market, most of these provisions are in, creating a health insurance exchange or exchanges with the choice of plan, this innovation shifts insurers from competing for healthier enrollees to competing on value and greater transparency. The Fund estimated that the insurance exchange would lower administrative overhead and that it would be effective over the long term in blunting the rise in premiums and cost to employers and households. Along with that was the creation of medical loss ratio standards for insurance plans. The second key thing they looked at was the public plan. Now, that's out. Back in October, it still had legs as one of the options that would be offered in the exchange and it's worth taking a moment to look back and remember why. The Fund reported then that the Congressional Budget Office estimated the plan would have lower administrative costs, and while it would track sicker individuals, it would only have a slightly higher premium than those of private plans. Still in Instituting Provider Payment Reform, both the House and Senate bills would establish Medicare and Medicaid Payment Innovation Centers with broad authority to test innovative payment methods for medical homes and accountable care organizations, incentivizing primary care and prevention also still in and that's been an issue of central concern to The Commonwealth Fund over the years. You could counter the impending surety to primary care providers and lay the groundwork for more fundamental payment reforms. The Commonwealth Funds released last week a report titled How Germany and the Netherlands Harness Insurance Markets for the Public Interest. Broad and optimistic note as supportive as the fund had been of the public option, this report said hey, other countries have achieved universal coverage, quality, care, cost control and systems that are based on private plans, so what can the U.S. learn from them. Both Germany and the Netherlands provide universal coverage within systems that rely on competing insurance plans and largely private delivery systems to ensure that markets and competition work in the public interest. These countries have developed rules of the game, responsibility for which lie with quasi governmental authorities with relative independence from their respective health ministries. Efforts focus on three key areas, Ensuring Access and Fair Competition in the Insurance Markets, Adopting Payment and Pricing Policies to Drive

Efficiency and Stimulate Reforms, and Instituting Quality Information Systems that Support Innovation and Value Including Comparative Effectiveness. Just as the German and Dutch Government approaches have evolved with a unique, historical and cultural context, progress in U.S. will also need to reflect our own unique starting point and key concerns. Yet, these core elements are likely central to harnessing the United States markets for the public interest in an accessible, high quality, affordable and dynamic U.S. health care system.

Mark Masselli: Dr. Davis, welcome to Conversations on Health Care. Part of the first generation of health care economists in the United States along with people like Uwe Reinhardt that define the field, you had that front row seat at Health Reform Innovations as the Deputy Assistant Secretary in HHS in the late 70s through your current position as President of The Commonwealth Fund. You are regularly called up by Congress to testify on health issues. What's different about the Health Reform debate this time around?

Karen Davis: Well, it's true, we have been working on Health Reform in this country for almost a century and certainly I was involved in shaping President Jimmy Carter's Health Reform Bill in the late 1970s. So, here we are 30 years later. And first of all, there is just a lot more progress on Health Reform than there has been in the past. President Nixon, President Carter, President Clinton certainly never got a bill through the House or Senate, so I have to credit President Obama for a strategy that seems to be working to really advance Health Reform.

Margaret Flinter: And Dr. Davis, The Commonwealth Fund has invested heavily in understanding and in reducing racial and ethnic health disparities, I think you were one of the first to point out that when members of minority groups had access to what you called a high performance health system, those disparities could be substantially reduced or even eliminated. Can you elaborate on this for us?

Karen Davis: Yes. Our study showed, Closing the Divide, that there are two essential ways of eliminating racial and ethnic disparities in access to care and quality of care, and that's first of all having health insurance coverage. So Health Reform that would cover over 30 million uninsured people is very important to minority populations to ensure that they can get the services that they need. But what was particularly interesting about our Closing the Divide study is that if people are enrolled in a medical home, that is to say a physician practice that offers patient-centered accessible coordinated care, many racial and ethnic disparities,

the use of services, the ability to get needed care, preventive care, control of chronic conditions disappear. So, it all boils down to being able to get into the system by having insurance and then to have a doctor or a clinic or a health practice that is organized and knows you and has all of the attributes that make it easy to get accessible high quality care.

Mark Masselli: And speaking about those delivery vehicles for reducing racial and ethnic health disparities, certainly the Community Health Center Movement is part of that. Today, they are over 1000 health centers who have served 20 million people, but that was the goal the Federal Government set out in the early 1970s and certainly the Health Reform Bill calls for heavy investments in another round of expansion. How has your thinking evolved about meeting the needs of low-income people and populations in addition to the patient-centered care and community health centers? What else should we be looking at?

Karen Davis: Well, I am very excited about many of the provisions that would enhance the capacity to provide primary care to low-income populations. The Senate Bill has major new funding for Community Health Centers, $6 billion over five years. It also has provision for a program for community-based collaborative care networks that would link a hospital and the Federally Qualified Health Center to provide the whole continuum of comprehensive services for low-income population. So, on top of money, that was in the fiscal stimulus packaged called the American Recovery and Reinvestment Act that expands capacity, helps fund information technology, positions Community Health Centers to really fill the gap between now and when improved health insurance coverage kicks in, which may not be till 2013 or 2014. So, we are looking at three to five years before we have improved health insurance coverage and that's going to be a critical time period to make sure that the uninsured can get access to Community Health Centers. But it's also a critical time period for our Community Health Centers to restructure themselves to compete effectively in a world post reform and become a provider of choice of being able to perform services into an integrated health care delivery system where people not only have good access to primary care but they have relationships and access to specialty care and inpatient hospital care.

Margaret Flinter: Dr. Davis, Conversations on Health Care focuses on issues of both Health Reform, also innovations in health care, and a few weeks ago, we tacked issues of aging, we delved into reform, particularly the class, community living, assistance services and support provisions in the Health Reform Bills that would pay for community-based services, we

looked at the green nursing home project and talked with Jennie Chin Hansen from AARP who said "We are the only first-world country with a medical model of caring for the elderly." We'd like to hear your thoughts as an economist and the health policy specialist on the class provisions and the impact that aging will have on this reformed health care system and cost in the United States.

Karen Davis: Well, the biggest surprise to me is the fact that there is a provision in both the House in the Senate bill, called the CLASS Act for Community Living Assistance and it's voluntary but people would contribute early on in their lives a certain monthly amount. And then if they become disabled or frail, they would get a certain monthly amount for services to help them maintain their independence at home, they would have assistance with that. There would be a third party that would actually pay a home aid and collect the payroll taxes and make sure that various labor laws are met. But a person would be able to pick their own age and have the funds available to them to provide those services or other kinds of modifications to their home that make it possible to live independently. So I think that's a very important provision that would improve the quality of life for many older Americans.

Mark Masselli: Dr. Davis, on the other end of the age spectrum, here we sit at the campus of Wesleyan University surrounded by the next generation of health care consumers. Your recent report on the specific issues of the young, especially the 20-somethings, tells us that up to half of these individuals are likely to be uninsured at some point during the next year and they want Health Reform and help in getting insurance. One model is to extend the age we keep them on our policies as parents. But more interesting to us, we see this generation as wanting to get their care in different ways, not just to make an appointment and have that face-to-face visit most of us grew up with. What do you have to say that next generation coming up about the health care system?

Karen Davis: Well, again, I think Health Reform is very important to young adults. We did release that survey of young adults, ages 19 to 29, last week and we found that they are very supportive of Health Reform. So certainly, the provisions in the House and Senate that would raise the age of eligibility under parents policy up to age 27 in the House bill and up to age 26 in the Senate bill would be very important to young adults. But I think you are right, we need a modern system of health care delivery for young adults, that is geared toward their needs and works for them. Obviously, young adults are very computer-savvy. They like getting information over the internet. So, moving to a model of care where

people are enrolled in say accountable care organization that the organization has a lot of flexibility for meeting their needs can do that through e-mail visits, can do that through group visits, can do that through simply providing consultation to specialists, to the primary care physician to manage their conditions. For example, Massachusetts has a very interesting system of providing mental health services. Their state has funded a model where there is a psychiatrist, psychiatric social worker available to primary care physicians that are taking care of children or adolescents or young adults, and can help them, for example prescribe appropriate medications, monitor those medications, alter the dose if that's appropriate. That's a very different approach than today where we pay on a fee-per-service basis, physician really only gets paid if they see the patient directly. Once you move toward systems of care, high-performance systems of care that are really patient-centered, they can work out ways of tailoring services to meet the needs of different population groups. And I think you are right, young adults do require different strategy.

Margaret Flinter: Dr. Davis, back to the Health Reform Bill, the public option went down hard and that Medicare early buy-in equally hard over these last few weeks and I took some comfort in The Commonwealth Fund's reporting on the experience of Germany and the Netherlands in achieving goals for a new universal coverage good benefits, especially good primary care and they do it, you said, entirely through private insurance plans, albeit regulated private insurance plans, that compete with each other on quality and access and value. We think our listeners will be very interested in hearing more about that, especially in light of how the Health Reform Bill has evolved. And do you think the U.S. can get there with the current Health Reform Bill?

Karen Davis: Well, I think the key word there is "regulation". Germany, the Netherlands, Switzerland have health insurance for all, but they do it through competing private plans that are tightly regulated to make sure they are acting in the public interest. So you are right, the public plan is no longer an option in the Senate bill. They briefly consider the buy-in to Medicare for young adults. But in its place, there are much different requirements for private health insurance. Both the House and the Senate set a minimum on what's called the "medical loss ratio," another way of saying that is to make sure that most of the premium goes for medical care, and not for insurance company, profits or administrative overhead. In the Senate, that's set at 80% for individuals and small businesses, and 85% for large groups. In the House, there is 85% minimum requirement. But there are other standards on private

insurance companies. There are standards even in the early years for eliminating preexisting conditions. They put out a warning signal that if insurance companies jack up their premiums between now and the time the exchanges start in 2013 or 2014, they will be excluded from participating their patient protection, including choice of doctors and access to emergency care, as well as some provisions that have been there all along that require them to offer health insurance to everyone, they renew that insurance even if somebody gets cancer, they may now be dropped, they can't do that, they can't what's called recession, they can't go back in the medical record after they have been paying premiums for five years and say "Hey, you didn't tell us you had acne, you're not covered," and drop somebody they have a serious problem. So, same premium, they can't discriminate against people on the basis of health status. They can charge older adults a bit more than younger adults, but they can't charge sicker people higher premiums or exclude them. So, very tightly regulated to make sure that they live up to what we expect out of them.

Mark Masselli: That's a great overview. Dr. Davis, you have a worldwide perspective on health care. What innovations do you see that really excite you and what should listeners at Conversations be keeping an eye on?

Karen Davis: Well, the most important thing to me is that people get health insurance coverage. We have about 45 to 50 million uninsured people. The Senate bill would cover about 31 million, the House bill about 36 million people. So it certainly makes a major step toward coverage and I think the expansions of the Medicare program for people below 30,000-33,000 income in the Senate and the House is very important. But in terms of innovation that I think is particularly exciting, I think both the Center for Payment Innovations in the House bill and the similar innovation center in the Senate bill, that would begin to test new models of care and new ways of rewarding team approaches to care that involve physicians but also nurse practitioners, pharmacists, other nutritionists, other professionals. So, the basic notion is to move away from fee-per-service towards what's called "bundle payment" or "global fees." And there are three different models that are to be tested by the Innovation Center. The first is the concept of Medical Home which would be the primary care base. It could be a Community Health Center, it could be a physician practice, it could be a public clinic. But that medical home would get bonuses if they do a good job of keeping people out of emergency rooms, giving them preventive services, controlling their chronic conditions. The second model is called Accountable Care

Organizations which would get shared savings if they really slow the growth in expenditures by for example making sure that people aren't readmitted to hospitals or get duplicate test. And then the third model is changing the way we would pay hospitals. They have a global fee for everything. You might call it surgery, whether wards. It's not only the hospital bill and the surgeon's bill and the anesthesiologist, but any care you might need for 30 days or 90 days is all one fee. And it really encourages the rehabilitation facilities to work well with the hospitals, the home health to work well with hospitals, the hospitals to reach out to the community of physicians to make sure that the transition out of the hospital to the rehab or to the skilled nursing facility or to the home goes smooth and people get appropriate follow-up care. So, all of those I think are very exciting innovations. In fact, I view this bill as really providing for an explosion of testing new innovative models of a care delivery and changing the incentive systems to really reward value, to reward outcomes. So that those that do a really great job taking care of patients, have much better clinical results, but also patient's experiences are better are all factored into holding these kinds of service delivery accountable.

Mark Masselli: Dr. Davis, thank you so much for joining us today. We really appreciate your time.

Margaret Flinter: Thank you Dr. Davis and thanks for the incredible work over the years.

Karen Davis: It's a pleasure.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. On this day, as people start thinking about their New Year resolutions, we turn our attention once more to the topic of ending tobacco use and how we could help our friends, neighbors and society get there. We looked at the State of Massachusetts and how they achieved a steep drop in the rate of smoking among low-income people enrolled in their Medicaid program. After years in which the rate of smoking in Massachusetts, like the rest of the country, hadn't budged the results, they have saved lives and millions of dollars. And for the first time in years, rates of smoking are dropping. Given the enormous toll that smoking takes, the largest preventable cause of death, you would think that if insurance covered treatment for anything, it would cover treatment both counseling and medication to help people quit smoking. But while counseling can be included in a visit with their provider, the medications have generally not

been covered by Medicaid. That's a huge barrier. Massachusetts looked at the research which showed that combining counseling and support with medication doubles the chance of a successful quit, and decided to cover the medications in its Medicaid program. They were astounded by the results. There was a rapid and steep drop in the rate of smoking among low-income people. When the program started in 2006, about 38% of people enrolled in Medicaid smoked, a much higher percentage than the national average of 20%. By 2008, the smoking rate for Medicaid enrollees had dropped to 28%, a drop of about 30,000 people. There are also indications that the drop has lowered rates of hospitalization for heart attacks in emergency room visits for asthma attacks. The outcomes to date have gotten the attention of policymakers who have introduced amendments to the Health Care Reform Bill that would require states to include treatment for tobacco addiction in their Medicaid programs. Smoking-related illness is estimated to cost the Medicaid Program $100 billion per year. As Senator Harkin said, this is one way we can actually bend the cost curve and keep people healthy. And just in case, you have lost the 800 number for the Smoking Quit Line that we gave you at Thanksgiving, here it is again, 1-800-784-8669. If you smoke, make quitting now the best gift of all to you and your family helping end tobacco use. Now, that's a bright idea.

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 Wesleyan University at WESU, streaming live at Wesufm.org and brought to you by the Community Health Center.