(Music)

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret another budget deadline in congress and another standoff.

Margaret Flinter: And another new word, sequester, the March 1st budget deadline looms large with the sequester about to kick in and the two parties disappointingly remaining true to form and trenched in their respective camps and this is a dangerous game Mark.

Mark Masselli: If there is no deal by March 1st, hundreds of billions of dollars in spending cuts go into effect immediately across multiple governmental agencies and that will generate some negative consequences, with funding from many programs at risk for being cut including health care.

Margaret Flinter: Well I saw the New York Times recently printed a very specific list of the children who will lose their positions and head start, the women who won't get mammograms and one area where that political recalcitrant does seem to be falling away those with the Medicaid expansion to include more people living close to the poverty line, called for under the Affordable Care Act but rendered optional by the Supreme Court decision just last summer.

Mark Masselli: Florida's governor has joined the growing list of states who were vehemently opposed to the health care law. Governor Rick Scott just announced that he's reversing his position and agreeing to expand Medicaid. Pressures from health care industry and consumer advocate groups impacted his decision.

Margaret Flinter: He joined states like Michigan, Arizona and Ohio who first opposed and now have agreed to the Medicaid expansion which will be covered entirely by the Federal Government for the first three years and I think a very pragmatic decision on their parts.

Mark Masselli: I think you are right, but the jury is still out, the legislatures of those states must approve expanding the Medicaid roles in some states like Florida with a republican majority in the legislature that may pose a challenge.

Margaret Flinter: Our guest today is an expert on the politics of health reform and in particular the challenges that remain somewhat of a threat to aspects of the Affordable Care Act.

Mark Masselli: Dr. Jonathan Oberlander is the professor of Social Medicine and Health Policy at the University of North Carolina-Chapel Hill. He writes extensively on health

care politics, author of several books on health care including the 'The Political Life of Medicare".

Margaret Flinter: And FactCheck.org's Lori Robertson uncovers yet another false claim about health reform.

Mark Masselli: No matter what the topic you can see all of our shows by googling CHC Radio.

Margaret Flinter: And as always if you have comments, email us at chcradio.com or find us on Facebook or Twitter because we love to hear from you.

Mark Masselli: We'll be getting to our interview with Jonathan Oberlander in just a moment but first here is our producer Marianne O'Hare with this week's headline news.

(Music)

Marianne O'Hare: I'm Marianne O'Hare with these the health care headlines. **(2:32 inaudible)** eleventh hour deal, it appears as though congress is unable or unwilling to head off illuming reduction in across the board federal spending. The so called sequester is slated to go into effect on March 1st and while there are some whispers from certain camps about willingness to compromise on certain budget issues, the leadership appears headed for a standoff. Conservative GOP leader is warning speaker John Boehner if he caves on the President's Call for Tax increases on the wealthiest Americans to address some of the budget deficit, he might lose the support needed to keep his job as speaker. Meanwhile other conservatives like Senator Lindsey Graham say, they are willing to compromise on some revenue increases as long as the president is flexible on spending on entitlement programs like Medicare and Medicaid.

The nation's governor state budget directors, hospital administrators and research scientists are all bracing for the impending cuts which are arbitrary and across the board and can seriously impact their ability to meet their obligation. Serve their patient populations or keep their research going if sequestration is allowed to proceed. And Russian President Vladimir Putin not often viewed as a **pay of** public health reform is taking a **(3:40 inaudible)** step forward. He's signed a measure into law this week banning smoking in most public places. 40% of Russians smoke costing the nation $50 billion a year in health cost. I'm Marianne O'Hare with these health care headlines.

(Music)

Mark Masselli: We're speaking today with Dr. Jonathan Oberlander, professor of Social Medicine and Health Policy & Management at the University of North Carolina-Chapel Hill. Dr. Oberlander is a leading expert on health care politics with the specific focus on the cost of health care and is author of several books including the 'The Political Life of Medicare" and 'The Social Medicine Reader". He's a contributor to the New England

Journal of Medicine and the Journal of Health Politics, Policy and Law. Dr. Oberlander is the Russell's Sage Foundation scholar and earned his PhD in Political Science at Yale University. Dr. Oberlander welcome to Conversations on Health Care.

Dr. Jonathan Oberlander: Thanks so much for having me on.

Mark Masselli: You know, you've been analyzing the politics of health care reform in this country dating back to the start of the last century, in your recent article in the New England Journal of Medicine, the future of Obama Care, you state that the passage of the Affordable Care Act was a landmark achievement for President Obama and his reelection sealed its fate but you say that frets the law far from over in the opponents of health care law are deploying tactics to delay and to fund this law. Tell us what you see as some of the most vulnerable aspects of the Affordable Care Act.

Dr. Jonathan Oberlander: Well I think it's important to emphasize that the a lot really has crossed a threshold since 2010 but the threat of **(5:17 repeal)** really has receded given the ruling by the Supreme Court upholding the constitutionality. So at this point, if we're looking for vulnerable parts of the law maybe some that have escaped detention we might start first with the IPAB that would not be the iPad which is not vulnerable. But the IPABM the Independent Payment Advisory Board which is a commission of 15 experts that if Medicare spending exceeds a specified threshold, they would have the power to make recommendations to slow down Medicare spending that would go to congress and if congress didn't do anything, those recommendations would go in the law. It's been very controversial from the beginning and actually not one person has been confirmed to the panel yet and it's not clear to me if anybody is going to be confirmed if they can get the necessary votes and the senate. So I think we'll expect we'll hear a lot about that because I think that institution is in some ways overrated and not essential to containing cost as we've been led to believe.

Another area that I think is vulnerable that we have not heard about is the employer mandate, the requirements in the Affordable Care Act that firms with 50 or more employees that don't provide health insurance that are workers and the workers wind up getting subsidized coverage from the government that they have to pay a penalty. I think that's actually a substantial political **(6:41 Inaudible)** feel, we haven't heard more about it but if the American economy is still struggling next year and I hope it's not but if it is I think you'll see republicans really target the employer mandate and say we can't afford to impose any call center employers when we're trying to climb out of this economic hole. I don't know if they'll be able to do anything about it given that they don't control the senate but I do think you will hear a lot of debate about the employer requirements.

Margaret Flinter: Jonathan there's been some interesting shifts and changes in innovation already for one thing that's going forward that just as it seems to be on the radar of most Americans is this co-op plan option. I understand that a number of the co-op health plans have now been approved which should really be member owned and

governed. Can you maybe sure with us a little bit about your thoughts on the status of those plans and what impact they are likely to have?

Dr. Jonathan Oberlander: Yeah I don't it's going to have much impact actually. So the co-op was sort of a consolation price to liberals who didn't get the Medicare like public option that they wanted so badly out of healthcare reform, didn't get a national health insurance exchange which was another consolation price and didn't get a Medicare buying and expansion in Medicare for folks who are age 62 to 65. So this you know if you are scoring at **how may** Olympics, they don't give medals for fourth place and that was sort of fourth place and so the co-ops are supposed to be nonprofit ways of delivering health care, structuring and so forth. So that they sound good and in fact we have funded some co-ops but actually much of the money that was left has been resented already. And you know a lot of changes have happened to the Affordable Care Act and that already it is very much a living lawn and one of the changes is they actually have resented the funding, that would have expanded the co-op program and so I think in most parts of the country it's going to be a very negligible impact and I don't think it's realistic to believe that new nonprofit organizations are going to be able to compete with the behemoth of American health insurance.

Mark Masselli: Jonathan, I want to pull the thread a little more on some of those vulnerable areas of the health care law that are soon about to take center stage and one of them that we've been following is the development of the online insurance exchanges. What do you think in terms of the significant savings that we'll see from and what troubles you as you think about the execution on this very important element of the Affordable Care Act?

Dr. Jonathan Oberlander: I think the key is to understand the exchanges are upfront in a broader war over Obama Care that has not ended. Another thing over republic and congress voted for the Affordable Care Act and there was and is a tremendous partisan divide. Exchanges actually were an idea that had originally a lot of conservative and republican support because if you think about what they are they are really clearing houses for a private health insurance and one of the basic theories behind an exchange is we should have more competition and so republicans of all different stripes including Paul Ryan have endorsed different forms of an exchange in their own health plans and if you look back at the public opinion data the exchange idea was the most popular idea of any in the Affordable Care Act and so you are quite right and about half the states so far had said no thanks we're not going to do it and not all of them but most of them would map onto states that John McCain and Mitt Romney won red states. And then I think at this point there are couple of questions of the exchanges. One question is how ready is the federal government going to be to run exchanges in a couple of dozen states which is a much bigger task and I think people anticipate it.

In the long run having more of a federal exchange might actually be simpler and more efficient but in the short run how ready are they going to be. Second question is how ready are the states going to be and a lot of states were simply hoping that the law would be overturned by the Supreme Court and they are not prepared, so there's a real

question and even in the states that are gung-ho about this, this is you know a difficult task and not an easy thing to set up. And I think a question that sort of is above all of that is how many of the eligible folks are we going to enroll, the people who are eligible for subsidies in the health insurance exchange were eligible for Medicaid, how many of them are we actually going to get. You know Massachusetts has done a great job in enrolling people in their health plan which was the model for the Affordable Care Act but this was a Bipartisan Law in Massachusetts with governor Romney supporting it, it passed almost unanimously in the state legislature and a real question I have is how this is going to play out in states where there is not bipartisan support and we know already that there's tremendous state variation and signing up eligible people from Medicaid. Now, it'll be interesting to see how that plays out both in Medicaid and the exchanges in the coming years.

Margaret Flinter: Well Jonathan you just at the end of your comment there, we're speaking to Medicaid expansion which certainly seems to be one of the vulnerable aspects of the healthcare law and not just finding people but actually figuring out how across the country are we going to resolve this sort of patchwork quilt of Medicaid expansion. How do you see this planning out politically at the state level and the federal level, will there ultimately be about practicality and the reality that their health care of hospitals and institutions can do much better by taking advantage of the federal support for the increased expansion?

Dr. Jonathan Oberlander: I hope so but I am worried that at least in the short run ideology is going to trump pragmatism. Nobody envisioned that the Supreme Court was going to rule that the Medicaid expansion was essentially optional for the states. That came as a shock to a lot of legal scholars and people who follow Medicaid, it certainly came as a shock to the people who wrote the Affordable Care Act because the way the act was **written**, people up to about $14,000 or so are eligible for Medicaid nationally across the country regardless of their demographic category which is a breakthrough in Medicaid policy. And above that up to about four times the federal poverty line, people would get subsidies in the exchange. But there's no provision in the law that says that if you are in a state that doesn't do the Medicaid expansion, that you will be eligible for subsidies to go in the exchange, in other words, if you are living in a state like Texas or a state like Louisiana or maybe a state like my own and North Carolina which may not take the Medicaid expansion and you are very low income and your state does not do the Medicaid expansion, you are not eligible for subsidies to go in the exchange, you are going to remain uninsured. So there's a terrible gap here because of the Supreme Court decision that's going to leave millions of low income Americans uninsured.

Let's be clear that the Medicaid expansion is a tremendous deal for the states. A 100% paid for by the federal government at the beginning after a few years, 90% that's a much better deal than they get from the federal government. Now on Medicaid we know that Medicaid expansion is good for state economies because if you insure low income people they have more money left over to purchase other goods and services which is good for economic growth. We know that Medicaid expansion is good for health outcomes, saves lives and we know that Medicaid expansion will be good for

hospitals and other medical providers. So there's a compelling case for states to do the Medicaid expansion but again this is even more politicized than the exchange issue and given the ideological nature of debates over health reform and over Medicaid and given that 25 states **and nor** do the exchanges. I think quite a few states are going to say no at the beginning to Medicaid. Now there are hospital lobbies, you are right are going to pressure them to say yes but I think a lot of them at the beginning are going to say no but in the short run, I think the real significance of this is a lot of low income Americans are going to be caught in a rather gaping hole in the Affordable Care Act safety net.

Mark Masselli: We're speaking today with Dr. Jonathan Oberlander, professor of Social Medicine and Health Policy & Management at the University of North Carolina-Chapel Hill. Dr. Oberlander is the author of several books including the 'The Political Life of Medicare" and "The Social Medicine Reader". Jonathan as I was listening to you, I was sort of harking back to an interview we did recently with David Gergen who also shares your concern that the Affordable Care Act was such a partisan divide in our country and I wonder how do you envision this Affordable Care Act ever recovering from this. Do you see any seam of opportunity to bring sides together that can slowly stitch the nation back together to understand the importance of this to individual constituents, what's the pathway politically to bring the country together?

Dr. Jonathan Oberlander: Well I am going to say something that is going to sound a bit morally obtuse but I think the main pathway is actually not to focus on what it does for low income Americans but to focus on what it does to protect Americans you have insurance, both private insurance and Medicare. This was the great feeling politically of health reformers in 2009 and 10 and actually stretching back from **(15:49inaudible)** 20th century as well. You know the uninsured are disproportionately low income, they don't get as much medical care as the rest of us. They die at a higher rate because they don't have health insurance but they are not politically powerful. They don't vote at a high level, they don't have a lot of money and so on. And so if you want to win a health reform debate, you have to persuade Americans who already have insurance which is about 83-84% of us that health reform is in their interest and I think if there's a path forward for the Affordable Care Act, it is people experiencing it and understanding that when you actually look at what its doing for me and for my family and for my friends, this is not too bad, this is not as scary as we thought.

The second path forward is to persuade folks with Medicare and folks with private insurance that this law is good for them and that it helps their children who are under age 26 stay on their coverage, that it expands their access if they are on Medicare to preventive services, that it has new rules on insurance plans that prohibit them from annual and lifetime limits on coverage that protect American families from going bankrupt. So I think that's the case that has to be made and you know there's a lot of controversy when Medicare was enacted in 1965 as well and of course in Medicare very quickly rose to become a popular program but the Affordable Care Act is different in at least two respects. One, the political environment is much more divided on partisan lines and it was in 1965, and second, Medicare is an easier program to understand and the Affordable Care Act is not a single program, it's a series of policies and subsidies

and regulations and programs that affect different groups of Americans in different ways at different times. And that makes it more difficult to explain to people and it makes more difficult to explain to folks what the benefits are. I mean I don't think most insured Americans understand what the Affordable Care Act will do for them.

Margaret Flinter: Well Jonathan, I'd like to ask you to speak to one of the areas of I know your great expertise in and that's the cost containment piece and you've written extensively about the inherent challenges of containing cost in a system that so many derive their revenue, their income and their profits from. You've said that the law only throws darts at cost containment, tell us what you mean by that and how would you like to expand those darts to a more comprehensive strategy.

Dr. Jonathan Oberlander: You know universal health coverage is a very difficult goal and it's something we've been fighting in this country about for a century and when Massachusetts passed their Health Reform Law in 2006, the national reformers had a model but the sub-sensitive model and a political model. When Massachusetts enacted their Health Reform Law, they said look, it's so hard politically just to expand coverage for the uninsured, we're not going to do health care cost really at the beginning and to a large extent that's what the Affordable Care Act, it is well now that there's no question that Affordable Care Act has more cost containment than in Massachusetts but nonetheless I think most of it is what I would call throwing darts and that what I mean by that is there are lots of ideas in the health policy research community, electronic medical records and patient centered medical home. And basically what the Affordable Care Act does in the theory behind in cost control is let's just throw all those ideas at the board at once like darts. And we don't really know which one are going to stick and let's just hope that one or two stick and so the proponents of this would say it's you know its stronger because it has a diverse strategy. And my response to that is I don't really care how many cost containment tools there are, I care how many are effective. To me it's not about how many strategies we have, it's about having effective strategies and well I completely sympathize with the political calculation and don't think that the Affordable Care Act would have passed with stronger cost control, I do think over time we're going to have to move to strengthen it.

Mark Masselli: We've been speaking today with Dr. Jonathan Oberlander, professor of Social Medicine and Health Policy & Management at the University of North Carolina-Chapel Hill. Dr. Oberlander is the author of several books including the 'The Political Life of Medicare" and "The Social Medicine Reader". Thank you so much for your time today.

Dr. Jonathan Oberlander: Oh thanks for having me on, I really enjoyed it

(Music)

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: Well, Mark and Margaret we found some misleading tweets from house republicans including Speaker John Boehner who claim that the Obama administration was spending $1.2 million “paying people to play videogames” but the 1.2 million went to university research that studied how videogames can stimulate the cognitive abilities of seniors. This Twitter campaign started with House Majority Leader Eric Cantor who tweeted that “President Obama wants to raise your taxes so he can pay people $1.2 million to play World of Warcraft” and more GOP tweets were launched the following day. None mentioned that the videogames were part of a cognitive study of seniors. The project in question, doesn’t even use the World of Warcraft game that Cantor and others mentioned but it does use the Wii game Boom Blox. The $1.2 million was grant money awarded by the National Science Foundation to a project at North Carolina State University's games through gaming lab. The research that how video games can improve everyday abilities such as memory and reasoning and seniors can broadly sought together knowledge on how cognitive training can reduce the client as people age. We take no position on whether the government should have funded the project but the GRP tweets twist what the grants are all about. And that’s my fact check 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 liked checked e-mail us at chcradio.com, we’ll have Factcheck.org’s Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Margaret Flinter: Each week conversations highlight a bright idea about how to make wellness a part of our communities and everyday life’s. It’s no secret that baby boomers are ageing in large numbers and that means that those suffering from age related dementia around the rise as well. Four million Americans live with Alzheimer's disease and we know that number will double by 2025. No cure and few drugs that can stay off, its devastating effects. **(22:48 Daniel Cone)** has devised a tool that is improving the experience for these patients who’s quality of life declines along with the loss of brain function. He wondered what will happen if you provide iPads for patients in nursing homes that are loaded with their own personal playlist of the songs they loved when they were younger. In his first pilot program called Music and Memory, patients in a nursing home were given the iPads with their own personalized song list and the results instantly noticeable. Patients went from being non-communicative and disengaged to being animated and engaged. Patients like Henry featured in this documentary on the program called Alive inside.

(23:24 Video)

Do you like music?

Yeah, I am crazy about music, getting beautiful music, beautiful sound.

What was your favorite music when you were young?

I guess Cab Calloway my number one band.

What's your favorite Cab Calloway song?

(Singing)

(23:47 Video ends)

Margaret Flinter: **(23:47 inaudible)** explains one of the theories as to why this program works so well.

(23:52 Video)

See reality is because our memories of music are co-located in the brain with our autobiographical memories when you say a song that's familiar you are ticking off memories that you had.

Margaret Flinter: The results from the Music and Memory program were so impressive that **(24:07 Cowen's)** personalized iPad program is now being used in 50 nursing homes throughout North America and many more are lining up.

(24:14)

We've done some research and feedback from the front line from the nursing homes and from the staff is that their ability to provide care is facilitated and so that allow them to get their job done, to pay attention to all the residents as much as possible and that's been a big win as well.

Margaret Flinter: A simple personalized application for a readily available piece of technology that could dramatically impact the quality of dementia patient's lives, now that's a bright idea.

(Music)

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

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Health Care broadcast from the campus of WESU at Wesleyan University streaming live at wesufm.org and brought to you by the community health center.