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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, it's hard to believe we're coming up on a year since the Obama Health Reform Initiative began. It's been a rocky road over the past few weeks with Health Care Reform efforts and it doesn't seem to begin any smoother.

Margaret Flinter: Yeah, it certainly doesn't, Mark. And the President has now set a meeting with Congressional opponents for February 25th for a televised health care summit. But leading House Republicans say they might refuse the offer if the White House doesn't choose to start over again with the fresh Health Care Bill. Republicans also seem hesitant to participate for a fear of winding up looking like props in a White House show by partitionship, although this effort is part of President Obama's plan to live up to that campaign promise of making the negotiations more public.

Mark Masselli: The republicans don't want a rerun of the last encounter with the President at their retreat in Baltimore as they know that president will be speaking past his immediate guest and directly to the American people. In poll show, they are opposed to Health Care Reform as it's currently framed in large numbers. The results are stark reversal from early summer when Americans were supportive of the effort. The Democrats have never recovered from those town hall meetings and the President knows he needs to turn public sentiment around.

Margaret Flinter: Those poll figures were startling. And a real contrast to Massachusetts where the poll showed the overwhelming majority of people are very satisfied with their own health care reform system. I heard several Congressional staffs speak at a meeting this week in Washington and I will tell you Mark there is a sense of rawness and bitterness there, but the President is vowing to stick by his promise of passing comprehensive reform and there is a strategy in place for how it could happen using the reconciliation process though even the experts agree that is really tricky from a parliamentarian point of view.

Mark Masselli: But there is some good news coming out of Washington in terms of health initiatives. The First Lady Michelle Obama unveiled a campaign to fight childhood obesity by improving childhood nutrition and physical activity.

According to the National Center for Health Statistics, about two-thirds of all Americans are counted as either overweighed or obese and the government still lacks an effective strategy to tackle the issue.

Margaret Flinter: I was very happy to hear about the obesity campaign. I think it's been about 10 years now, hasn't it?

Mark Masselli: I think it has.

Margaret Flinter: Since we started our first obesity initiatives here at our Community Health Center, and at the time, it seemed we were the only people in health care talking about this. Now it's a major national issue as it should be and I am very glad to see some of our initiatives are being recommended.

Mark Masselli: The issue of health care spending continues to dominate the news. Last week, actuaries at the Centers for Medicare & Medicaid Services reported that U.S. health spending reached $2.5 trillion in 2009 and that health care share of the economy continues to grow. Next year, government programs will account for more than half of all U.S. health care spending as the weak economy since more people entered the Medicaid program.

Margaret Flinter: Dr. Gail Wilensky who was on our show last week and is a health care economist was quoted the other day in the Wall Street Journal in response to that report and she said it's going to be a desperate issue 5 to 10 years out. The report predicts that by 2020, about $1 in $5 spent in the U.S. will go to health care, a proportion that is way beyond any other industrialized nation. Dr. Wilensky went on to say that the U.S. will have to decide soon between raising revenue to pay for Medicare or reducing benefits.

Mark Masselli: Our guest this week, Dr. Robert Berenson, a fellow at the Urban Institute, is here to give us some more perspective on health care. Dr. Berenson is a health policy expert as well as a physician and advocates a national solution for Health Care Reform versus a state-by-state solution. Dr. Berenson says it would be too much of a financial burden for states to take on and acting their own solutions.

Margaret Flinter: And no matter what the story, you can hear all of our shows at our website Chcradio.com. You can subscribe now to iTunes to get our show regularly downloaded. Or if you want to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And speaking at every word, as always, if you have feedback, send us an e-mail right online at Chcradio.com, we would love to hear from you. Before we speak with Dr. Berenson, let's check in with our producer Loren Bonner for headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. Health Care Legislation is still stalled in Congress but President Obama is making every effort to save it from dying. This week, he is engaging his critics through a bipartition approach to Health Care Reform. In an interview with CBS Evening News, he told Katie Couric that he is inviting Republicans to give him their suggestions on Health Reform.
President Obama: How do you guys want to lower costs, how do you guys intend to reform the insurance market so people with preexisting conditions for example can get health care, how do you want to make sure that the 30 million people who don't have health insurance can get.

Loren Bonner: The half-day bipartition health care session at the White House which will be televised live later this month is also an effort by the President to live up to his campaign pledge that negotiations would be more out in the open. The White House hopes that the public process would boost support and help Congressional Democrats pass the bill through a budget reconciliation procedure, requiring just 51 senate votes instead of 60. Republicans have expressed reservations with the bipartition summit going as far as saying they may refuse to participate if the White House doesn't start from scratch with a Reform Bill. Health and Human Services Secretary Kathleen Sebelius responded that President Obama is willing to add various elements suggested by Republicans but will definitely not draft a new bill. Meanwhile, First Lady Michelle Obama is building her own campaign around health. She's unveiled a comprehensive approach to fighting childhood obesity called the "Let's Move" campaign. On Tuesday morning, President Obama signed the memorandum that is certain to be the First Lady's legacy.

President Obama: I am so proud of the work that the First Lady along with the cabinet secretaries behind me have done in trying to tackle one of the most urgent health issues that we face in this country.

Loren Bonner: The First Lady plans to tackle the problem through improved nutrition and physical education in schools, promoting physical activity in community planning, making healthier foods more available, and introducing front

of the package labeling. Today, we are happy to have Dr. Robert Berenson as a guest on our show. Dr. Berenson is a fellow at the Urban Institute and an expert in health care policy, particularly Medicare. He was in-charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services, from 1998 to 2000. Before that, in 1993, he co-chaired two working groups as part of the Clinton White House Taskforce on Health Care Reform. Dr. Berenson also spent three years on the Carter White House Domestic Policy Staff working on National Health Policy issues. Dr. Berenson's current research with the Urban Institute has informed the Health Care Reform debate in Congress. A recent policy paper he co-authored with the Urban Institute helped Democrats find a compromise on the public option debate. The paper argued for a much stronger public option that would kick in automatically if the health care industry didn't meet its promise to slow medical spending. Dr. Berenson is also a board-certified internist who practiced for 12 years in a Washington, D.C. group practice.

Mark Masselli: This is Conversations on Health Care. We are speaking today with Dr. Robert Berenson, a senior fellow at the Urban Institute. Thank you for joining us today. Dr. Berenson, last week, the Centers for Medicare & Medicaid reported the health care expenditures consumed 17.3% of the GDP but it was also accompanied by an equally startling figure that for the first time ever government programs next year will account for more than half of all U.S. health spending. This is even before the cost of baby-boomer generation kicks in in 2011. Do you think this figure will motivate the american public and politicians or like that we need to take action now?

Dr. Robert Berenson: Well, I'd say two points about that. One is, that is the good thing we have some government programs because a lot of that increase in federal spending was from people who became unemployed and could fall back on to Medicaid even though. The states are pretty hard pressed, those public programs have been a major function. And on your major point, is this going to produce, will the world do something, I am skeptical. Everybody's second choice is to do nothing. If somebody's first choice results in cuts in payment to somebody, then there is concerted opposition to change. I have been doing this about 30 years and every time I think there is going to be a breakthrough, it doesn't happen.

Margaret Flinter: Well, I think we have a lot in common there. Dr. Berenson, maybe it's the recent blizzard or the loss of the Massachusetts Senate seat but we just aren't hearing a lot out of Washington on Health Reform now. We have

gotten further down the road this time than any time in recent history, but it is possible we'll again fail to enact Health Reform. The Urban Institute is very aware of the consequences of the do-nothing option and you have modeled that up and you had some pretty striking results. Can you share with Conversations the cost to the U.S. of doing nothing about Health Reform at this point?

Robert Berenson: The basic point is that every year, there are increasing numbers of uninsured. That will increase in the future if we don't do Health Reform as small employers give up providing insurance to their workers under financial pressures from an ongoing poor economy. We have no control over health care cost so people with insurance will see their premiums rising far more than the cost of living and then that report from CMS projects that we're going to be close to 20% of the gross domestic product in 10 years left to the normal course of events.

Mark Masselli: Dr. Berenson, you are quoted as saying we only need to reduce health care spending by 1.5% per year to bend the cost curve. That number sounds reasonable but every dollar is one taken away from someone's income or revenue somewhere, what's the best strategy to achieve that 1.5% reduction?

Robert Berenson: Well, that's exactly right. So we have an example right now where the Centers for Medicare & Medicaid Services put out a new regulation or every year they actually have to put out a new fee schedule for physicians in Medicare. And using new data, they decided that cardiologist, one specialty, could absorb a 13% reduction over four years in their net revenues from Medicare by reducing the reimbursement for some overpriced nuclear imaging studies and related services. And what does that produce? The cardiologists are going around trying to kill that regulation and going to the courts, going to Congress, going to public opinion claiming that cardiologists won't be able to survive that cut, well cardiologists are earning about $450,000. And the sad part is that they might be successful. So, that does raise the issue of the governance. Can congress actually make these decisions? Or are they too responsive to sort of special interest pleading and should we set up a new governance structure in Medicare? That's one of the issues that has been part of the Health Reform debate. One other related issue that gets no attention and yet has to be addressed if we're serious about health care cost is the fact that providers generally, and I am speaking now in particular about hospitals, have figured out how to get extraordinary leverage in their negotiations with health insurers. I am no big lover of health insurance companies, but when hospitals when they get 200% or 225% of Medicare as their basic reimbursement and are able to put

aside, these are in many case not-for-profit hospital, or 100 or $150 million a year in excess revenues that they can just put aside in their bank accounts, we have got a problem that needs to be addressed and yet you didn't hear anybody talking about that in Health Reform. So our prices are all screwed up. And we also have over the longer term need to move away from the current fee-for-service payment system that rewards imprudent decision making, but that is to try to get some control over the volume of services. But in the short term, we need to deal with just the prices that are excessive.

Margaret Flinter: Dr. Berenson, a fair criticism I think about the Health Reform Bill as they work their way through the Senate in particular is that they became much more about health insurance reform than Health Care Reform. You are an expert on Medicare and Medicare has certainly tried to improve health care through some of the elements of the Medicare Modernization Act. We haven't seen any slowing of cost but do you think the emphasis on prevention in chronic disease management that's now embedded in Medicare has a chance with helping to bend the cost curve through healthier enrollees?

Robert Berenson: Probably, sort of paradoxically, the debate that came about health insurance reform and that's what probably will not survive this year unless the President is able to do some political magic over the next few months. What can survive and I think has a good chance would be an expansion of some of the innovation in Medicare which not only affects Medicare but in fact a lot of what Medicare does is emulated by private insurers. So the Medicare Modernization Act which you referred to one of the major negatives in that legislation, was the overpayments to Medicare advantage private health insurance companies which are paid about 10% more than Medicare. And so, that has led to an increase in health care cost. But some of the other provisions which could be extended, new payment models, new organization models related to chronic care management, disease management I think do offer some hope.

Mark Masselli: We have been speaking with Dr. Robert Berenson, senior fellow with the Urban Institute. Dr. Berenson, we may not see the public option survive but tell us your thoughts on it. Would the public option spell the end of the private insurance industry as some people have suggested? Or would it simply provide a necessary element of competition for people buying their own health insurance coverage?

Robert Berenson: I think there has been some misunderstanding about the public option. The way the compromise was working out in the House and the

Senate for a public option would have produced the public option that wasn't going to be able to do anything. The value of what Medicare does and what a public option needs to be able to do is essentially not have to negotiate payment rates with providers who develop local monopolies where the purchaser really doesn't have any leverage, but in fact just to set reasonable rates related to the provider's underlying cost of producing the services. That's what the public option needs to be constructed as, and it wasn't in the debate. It was going to be a Pyrrhic victory for those who were supporting the public option because it wasn't going to have that ability. If we are serious about cost containment, we should have a public option.

Margaret Flinter: Dr. Berenson, we mentioned the need for payment methodology reform that seems to have two purposes, one to focus more on outcomes than just on the volume of fee-for-service procedures, but the other is to try and really pay more to primary care and you have recommended I think the geriatrician. Is there any hard evidence to suggest that this will improve things?

Robert Berenson: Many of the systems in Europe already are much cheaper, less expensive than the U.S. and produce the same level of quality, are also trying to promote more primary care. Especially as patients develop multiple chronic conditions, some of the data that I have been using for example show that 20% of Medicare beneficiaries with five or more chronic conditions see 14 different physicians a year and get over 50 prescriptions a year. Somebody needs to be sorting out all of the contradictory prescriptions that may have drug interactions, all of the different diagnoses that are in many cases incompatible with each other. That is really what some of us envision as the role of primary care is to really take the much large role in coordinating across the whole health system on behalf of the patient and with the patient. And I would point out that we don't have to adopt new payment models to make primary care more desirable. We could simply do what I was suggesting earlier, address overpriced procedures and tests which Medicare and other payers too generously reward and reimburse all physicians, but in particular primary care physicians, for spending more time with patients.

Mark Masselli: Dr. Berenson, you are also the Nation Program Director of a program funded by the Robert Wood Johnson Foundation called Improving Malpractice Prevention and Compensation Systems. Tort Reform was kept to something of a footnote in the Health Reform Bills with calls for pilot projects to study alternatives to the current system. More recently, President Obama has indicated a willingness to engage in discussions of Tort Reform. What are your

thoughts on the degree to which Tort Reform has the potential to have a significant impact on cost?

Robert Berenson: There is a need to do the Tort Reform but I don't think it will have a major impact in cost. It doesn't sound contradictory. There is no question there is a lot of defensive medicine going on. That doesn't mean that there is lot of costs associated with defensive medicine because some of the practices that physicians do to avoid, suits may actually save money. There has been a fair amount of research in recent years and there is increasingly a convergence in thinking that defensive medicine does exist but it may reflect about 1% or 2% of total health care spending. We should do malpractice reform but some of the Republicans who say that defensive medicine is responsible for 25% of health care cost, I have heard figures like that are just making it up, there is no basis for that. So we should do Tort Reform. It certainly would provide a basis for bipartisan moving forward but I don't think people should see Tort Reform as some kind of magic bullet around reducing costs.

Margaret Flinter: Dr. Berenson, the Urban Institute helps contribute some intellectual firepower to the development of our neighboring State of Massachusetts new universal health insurance plan and in retrospective, it really seems even more remarkable. They've got that passed and implemented. But with the chance for meaningful National Health Reform somewhat up for debate, the states might be back in the driver seat of innovation and change. We have read in New York Times that states are pushing back already against the possibility of being told to have to put an individual mandate in place. How might states approach Health Reform this time in the context of falling tax revenues? Are there any other models out there for them to embrace?

Dr. Robert Berenson: Very few other states have the commitment of financial well-being wherewithal to be able to do what Massachusetts did. You have states like Texas that have over 20% uninsured. They are not going to do that, and as it is, even though the Federal Government is picking, we wouldn't have picked up by far the large share of any expansion in Medicaid in the Health Reform. The states are still saying that the hit that they were going to take would make their finances that much more fragile. So my own view is we need a national solution, not a state-by-state solution.

Mark Masselli: Dr. Berenson, you are an internal medicine physician as well as a health policy expert. When you look around the country and the world, what do

you see that excites you in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. Robert Berenson: The New York Times had a profile of Brent James of Intermountain Healthcare. This was a profile of about three months ago where they make a, that's in Utah, it's an organization that makes a serious investment in trying to figure out how to improve quality at a reasonable cost and they do a great job but have basically pointed out that the reimbursement system penalizes them for doing the right thing. So if we could change the reimbursement system, we might get more progress. I think that in the area of end-of-life care, this became obviously a hot political item with Republicans, in particular certain prominent Republicans and talk show hosts accusing the Democrats of death panels and things like that, for simply promoting an opportunity for patients and their professional caregivers to discuss their options at the end of life. 27% of spending in Medicare occurs in the last year of life and half of that in the last month. And there is a lot of data demonstrating that patient's own wishes are not honored at the end of life. They are getting more care than they would choose if their wishes were honored. So there is an area where we could actually improve patient well being, honor their wishes and save money.

Mark Masselli: We've been speaking today with Dr. Robert Berenson, a senior fellow with the Urban Institute. Thank you for joining us today.

Dr. Robert Berenson: My pleasure.

Margaret Flinter: Thank you, Dr. Berenson.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. On past shows, we brought you stories about school gardens and urban farming. This week's bright idea focuses on another aspect of this local food's crusade, "the backyard chicken movement." The idea of raising poultry right at home is now catching on. The magazine Backyard Poultry now has over 100,000 subscribers. The progression from garden to chicken pan makes sense because the system is nearly self-sustainable. Raising chickens in your backyard is a healthy choice not simply because it aids garden cultivation. According to Elizabeth Kolbert's recent New Yorker article, chickens industrially raised for the eggs they lay live in cages so small, they cannot spread their wings, let alone walk around. And when their laying rates decrease, they are often starved up to two weeks to reset their biological clocks. Backyard chicken owners are trying to increase public

consciousness about the dangers of this system and the benefits of eating more locally. As the Washington Post reported last year, raising backyard poultry has suddenly become as chic as growing your own vegetables. It's all part of the back-to-the-land movement whose proponents want to save on grocery bills, take control of their food supply and reduce the carbon footprint of industrial agriculture. Owning chickens is relatively easy because they can live year round in outdoor coops. Listeners who are interested in learning more about "backyard chicken movement" and how to raise their own chickens can visit Poultryone.com or Backyardchickens.com for more information. Raising fresh, healthy food right in your own backyard, 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.

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