(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, Thanksgiving is behind us, Hanukkah is underway and Christmas is around the corner. We are officially in the holiday season.

Margaret Flinter: Well Mark it's probably not all that festive with the White House. They fixed much of the trouble with Federal Exchange www.healthcare.gov but you know, there are still a lot of problems to be worked out and I think that November 30th target date may look a little bit ambitious for a problem so layered and complex. They have come a long way since the initial trouble drove out there.

Mark Masselli: Well Margaret, the pace of insurance customers being able to sign up on the Federal Exchange has accelerated dramatically. A few weeks ago, only 27,000 customers were able to complete the process on the Federal site www.healthcare.gov, the next week the number had doubled and as these issues with the website continue to be hammered out, there should be a dramatic increase in business through December.

Margaret Flinter: Well the irony of this of course, business on the state exchanges has been going quite smoothly and been quite robust and if all states had gone that route, this might have been a smoother rollout. And we are seeing that pace accelerate as more folks become familiar with the idea of buying insurance in the online marketplaces and have done their sort of self-education and comparisons.

Mark Masselli: A number of state insurance commissioners are still milling over whether folks whose insurance plans were cancelled by the end of the year will be able to keep those plans. Some news though out of California, they said, "No, you can't keep your plan". Our exchange has been up and running and I think that bodes well for the way the country might head.

Margaret Flinter: So once again, something that will be decided on a state-by-state basis, Mark, and we wish everybody well in their decision making. But it does beg the question why are people so eager to hang on to plans that really don't protect them all that much. I think it's one of those situation where people aren't sure what they are paying for, or as somebody recently said, as long as you don't get sick you think it's good insurance.

Mark Masselli: Insurance is complex and that's something our guest today can speak to. Cathy Schoen is the Senior Vice President at the Commonwealth Fund. She just completed a study of 11 wealthy nations, including the United

States, comparing our respective insurance industries, and you can imagine the US didn't stack up as well in terms of affordability or efficiency.

Margaret Flinter: And for those who are interested, that study was published in this month's edition of Health Affairs.

Mark Masselli: Lori Robertson, Managing Editor of FactCheck.org will be stopping by to shine a spotlight on misstatements about health policies spoken in the public domain

Margaret Flinter: And no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Mark Masselli: And as always, if you have comments, please contact us at www.chcradio.com or find us on Facebook or Twitter; we would love hearing from you.

Margaret Flinter: Now we will get to our interview with Cathy Schoen in just a moment.

Mark Masselli: But first, here's our producer Marianne O'Hare with this week's Headline News.

(Music)

Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. Well November 30th has come and gone and there are still some sticking points on the Federal Health Exchange. Analysts had predicted the problems with the site were simply too complex to fix in so grand a scale and in such a short period of time. Experts say the amount of information coursing through www.healthcare.gov dwarfs that of any other government website, making it more similar to a high traffic eCommerce operation like Amazon or eBay. Just days before the October launch date, the www.healthcare.gov site failed to handle even 500 test customers logging on at the same time. But looking at the long view, analysts also predict the site will ultimately be running smoothly because "it has to".

Meanwhile, states are weighing in differently on the President's fix for the cancelled health insurance policy, telling folks they can keep their plan for another year. Well state insurance commissioners in California and Vermont, among others, say they won't allow insurers to offer those cancelled plans back to customers. They say it will undermine their robust state-based insurance exchanges and rate and benefit controls for their state's residents. Meanwhile, the President has insisted that all letters of renewal to those cancelled customers must come with a clear warning that the policies they are reinstating don't protect the consumers against discrimination for gender, preexisting conditions, which

lead to higher rates. Most of those canceled policies don't cover the Health Care Law's 10 essential benefits.

And the guy who became a billionaire creating Microsoft is now taking his innovations skills from the bathroom to the bedroom. The Bill & Melinda Gates Foundation has already launched a competition to build a better toilet, now they are turning their attention to reducing unwanted pregnancies and reducing the spread of STDs by building a better condom. Some of the more inventive solutions among the 800 plus entries into this competition include condoms made from cow's tendon or fish skin with the key ingredient collagen being called from those sources. Others of the polyurethane variety will come in one size fits all mode with antibacterial nanoparticles to fight the spread of STDs. Winners of the first round of the competition received 100,000 bucks to continue their research.

I am Marianne O'Hare with these Health Care Headlines.

(Music)

Mark Masselli: We are speaking today with Cathy Schoen, Senior Vice President for Policy, Research and Evaluation at the Commonwealth Fund in New York. Ms. Schoen is the Former Research Director of the Fund's Commission on a High Performance Health System. She has taught health economics at the University of Massachusetts' School of Public Health. Prior to that, Ms. Schoen served on President Carter's National Health Insurance Task Force. She has authored numerous publications on health policy issues including a recent Health Affairs report on health insurance cost and complexities in 11 countries including the United States and is co-author of the book Health and the War on Poverty. Ms. Schoen, welcome to Conversations on Health Care.

Cathy Schoen: Thank you for inviting me. I am glad to join you.

Mark Masselli: Cathy, to say that this has been tumultuous times for the Affordable Care Act and that the American public is learning about the complexities of the health insurance system with the online marketplaces having really an inconsistent rollout, some great successes in certain states, and the Federal system still not ready for prime time but they are working on it. So we thought this would be a good time though to look at the insurance industry itself. Your recent report published in Heath Affairs compared insurance complexities in our country with 10 other wealthy nations. So how did the US insurance industry stack up in your findings against with those other countries?

Cathy Schoen: We stacked up very poorly actually, despite spending far more than any of the other 10 countries in the study. And this included Germany, France, United Kingdom, Sweden, Norway, Canada. The US stands out for far more negative experiences based on reports of what American adults are

experiencing on virtually all our measures of affordable access, burdens paying medical bills, time-consuming insurance complexity, Americans fare poorly.

Margaret Flinter: Cathy, I know that at a fundamental level, these two areas, affordability and access are so critical and so basic and your report noted that the lack of affordability really had the most profound impact on primary care and of course if people can't afford it then they have issues with access to care. So, we know that that leads people to forego care longer, to defer seeking care when they need it and then seeking care in the emergency room. What's the real cost been according to your study to our nation's health as a direct result of this insurance system and can you quantify how you think this is going to change once the Health Care Law is fully deployed?

Cathy Schoen: When you hear that nearly 40% of adults, so not just sicker adults, 40% said that they went without care because of cost. They didn't get recommended care, they didn't fill a prescription, they didn't go to a specialist, compared to 4% and 6% in some of the other countries. We pay a lot out of pocket, a $100,000 or more even when we have insurance, Affordable Act says is a key part of our concerns. If you can't get in, you are not going to get quality care. As you noted, we more often wait for primary care and 1 out of 4 say they waited six days or more. This is all part of root causes going back to an insurance system where we often have much higher deductibles, much higher cost sharing and we have huge numbers of people who have no insurance altogether. So the only place whose doors are open is the emergency room, where people with a high deductible avoid going to see the doctor but they know in the middle of the night if they get really sick the emergency room door is open. So we are really distorting our health care systems, building emergency rooms and we are not investing in primary care and comprehensive care for people with chronic disease to avoid complications. We really can do much better if we keep our eyes on the price.

Mark Masselli: Let's get down in the weeds a little. And your report focuses on the administrative cost of insurance in America, and part of the Affordable Care Act limits the percentage of premium cost that can be spent on non-medical expenditures. How much do these administrative issues impact health care cost in this country and what can we learn from other countries?

Cathy Schoen: The Institute of Medicine estimated that we spend in excess of $300 billion a year, much of it wasted on administrative costs. And those insurer administrative costs are just the tip of the iceberg. Inside a doctor's office, there is anywhere from one to two extra people in terms of time, of nurses, doctors, administrative staff dealing with paperwork and it's partly because we just never have standardized, we have different reporting forms, things change all the time, no two carriers do things the same way and we don't see this in other countries, even countries like Switzerland and Netherlands and Germany which have competing private insurance plans, just the way they have reached near

universal coverage, they do much more standardization than we do and the result is less time for doctors, patients, hospitals and I might add, a lot less administrative cost.

Mark Masselli: Cathy, would that be true for Medicare in this country?

Cathy Schoen: Absolutely. Our Medicare system operates at much lower administrative cost, much lower administrative cost.

Mark Masselli: That's right. Is that more comparable to what you see in the countries that you looked at?

Cathy Schoen: Much more comparable. And if you talk to senior citizens who have been on Medicare for a while, it doesn't change every year, so they know more what to expect. Even if it's complicated when they first get in, it's going to be that way next year. So this notion of insurance surprises doesn't happen as much, where you thought the plan was going to pay and you get your bill and oh, for some reason you didn't do the right thing, you didn't make a phone call. It's very unusual that that would ever happen in another country and it doesn't happen for most Medicare beneficiaries.

Margaret Flinter: Well Cathy, you have certainly been looking at the American health care system and health insurance issues since going back all the way to your days working in the Carter Administration, where you served on the President's National Health Insurance Task Force. Taking that long view, I would be curious of your thoughts about the role that lack of transparency may have played and what it will play going forward and how much it has the potential to change things.

Cathy Schoen: Well it certainly will help you to have prices that you are going to face as a patient or as a physician when you are about to recommend treatment be a secret, is not the way any market works very well. We need to know what things are going to cost us before we get the service not afterwards when people can't explain it. We are an amazingly non-transparent system right now. So it's a starting point. But I think we need to start asking why are prices so high in the United States and why does the same thing cost five times as much in one place as another place, and that's where transparency will help us start to ask those questions and start to direct our energy on making a much more coherent system, not just transparent but one that makes more sense.

Mark Masselli: We are speaking today with Cathy Schoen, Senior Vice President for Policy, Research and Evaluation at the Commonwealth Fund in New York. She served on the Carter Administration's National Health Insurance Task Force. Cathy, let's look at the online insurance marketplaces and they are still working out the flaws in the Federal Exchange www.healthcare.gov and clearly we are seeing mixed realties with these new online insurance public marketplaces but

this is sort of a new experience for Americans. So what has your research at the Commonwealth Fund shown about the public's perception of these public or private marketplaces and how will that change overtime?

Cathy Schoen: We are clearly at the very early stages. The good news is kind of an interesting piece of news. People are not aware there are reforms in place. Some people, before this happened, thought the Affordable Care Act had been repealed.

Mark Masselli: Well that's good news.

Cathy Schoen: And part of the initial problem on Federal Exchanges where the Federal government is now running in far more states than expected to, millions of people tried to get on. They had not expected that kind of turnout in the first few weeks and the flaws in the web became quickly available as it just couldn't handle the volume. So we think that's going to be there. People, when we surveyed them, if they had tried to enroll or find information, were frustrated, were intending on coming back. There is a real eagerness in the United States to have decent insurance. If you are uninsured, you want a policy, and for the first time it's being offered at fairly affordable rates, and if you have awful insurance, you would like it to be better. We have a lot of people who have policies that just fail them when they need them. They hit a thousand dollar cap on a drug benefit; they run out altogether of an insurance benefit. (14:26 inaudible) define insurance the way every other country says, and you shouldn't be surprised. Insurance should be giving you access and protecting you when you get sick. They don't all look alike; they didn't agree let's just make this simple. So the complexity is still there of our private insurance system so we think it's going to iron itself out; we hope it will iron itself out.

Margaret Flinter: Well I want to go back to this issue of what is a high performing health system and high performance primary care. And we talked about accessibility and affordability but Cathy, maybe share with our listeners what are some of the other characteristics of high performance health care and how do those characteristics make a difference on some of our most vexing issues like health disparities.

Cathy Schoen: We spend by far the most, nearly 50% more than the next highest country. So it's not that we are not spending enough. We have a wealth of resources but we have never really invested in primary care. And when you think of what is primary care, that's the place you go first when you have a concern. Hopefully you can stay with that practice over time if it's a place you like and they get to know you and your medical history. When you need more complicated care and specialist care, they help you navigate the care system. If you have a chronic disease, along with nurses increasingly, remind you on what medications you are taking. So when primary care is working well, it's at the hub, and if you call someone, you can get in quickly. We often wait. More than half of

the Americans in our survey said last time they needed care, they couldn't get in the first or the second day, and a quarter of them said they waited six days or more before they could be seen. If you call at 10 o'clock at night, that's considered after hours care. It's not after hours care for being sick, but you are told just go to the emergency room. There are other countries that have said that shouldn't happen. There is an always an after hours care system. The vision should be you can get in quickly, including by phone, we know it works, emergency room use goes down, people get to specialists when they need to but you don't bounce around the care system as much and the management of chronic disease improves, outcomes improve.

Mark Masselli: I wanted to take a look at the regulations and our comparison against other countries because we have the lowest number of insurance regulations against the 11 countries that you polled and I want you to tell us about this lack of regulation in the American system. Is there a difference between the counties that you studied, that might have had a Federal system where we really have 50 state insurance commissioners and maybe other entities that really pose lots of problems? Tell us a little more about the lack of regulation here.

Cathy Schoen: All of the other countries we are comparing ourselves to have either universal or near universal coverage. And where they have private insurance system and several of them do, years ago they said you cannot turn anyone away because they are sick, you cannot charge them more because they are sick or because they are female. They have everyone in. So people also know everyone will have insurance and understand it's there for a lifetime. So just at that starting point of how not so much we regulate the private insurance industry but the fact that we have a universal system or we are trying to aim for it, enables us to say let's change the rules of the game. Insurers can't turn you away anymore starting in 2014, they can't charge you more if you are sick, can't happen, can't ask you questions about your health when offering you insurance. So that basic change will mean that people who market and people who are actuaries, al these hidden people will have less to do. We have removed a layer that shouldn't really be necessary. And overtime, what you have pointed out, we 50 different states, they could be more similar; there is no reason not to be. Yes, there is no reason why we wouldn't have common standards for insurance across the United States.

Margaret Flinter: Cathy, you co-authored a book that was a very pivotal book I think for many of us in health care and community health, titled Health and the War on Poverty, and in it, you examine the impact of programs like Medicaid and Medicare on leveling out at least a piece of the health care playing field. How far have we come since that book was published back in the late '70s?

Cathy Schoen: When Medicare and Medicaid first came in, the book we wrote said let's look at those 10 years what did we get. We got dramatic improvements

in health outcomes. The Medicare program itself became an engine for innovation for the entire United States, investing in our academic health centers, building up clinical knowledge. It's been the innovator for us all. And the way hospitals are paid, doctors are paid, private insurers often wait for Medicare to act and then follow. So I think we had the opportunity to be innovative again looking forward particularly if we finally bring everybody in so that it's no longer going to be okay that the way you save money is just by not serving certain people. We have lagged behind other countries. They have improved faster than we have. That doesn't have to be the story. We ought to be able to do better.

Mark Masselli: We have been speaking today with Cathy Schoen, Senior Vice President for Policy, Research, and Evaluation at the Commonwealth Fund in New York. You can learn more about this report and their work by going to www.commonwealthfund.org. Cathy, thank you so much for joining us on Conversations on Health Care.

Cathy Schoen: Thank you for having me on.

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Well we recently looked at a claim from Kentucky Senator, Rand Paul, who said the Medicaid expansion in the Affordable Care Act may bankrupt rural hospitals in the state. But Kentucky health care leaders say the hospitals stand to benefit because the expansion would extend insurance to those who otherwise wouldn't be able to pay their hospital bills. Senator Paul has introduced legislation to repeal the Medicaid expansion. He said the state hospitals could be overwhelmed with new Medicaid patients and may go bankrupt, but state health care officials have supported the expansion partly because it would financially help the hospitals.

In addition to extending Medicaid to those earning up to 138% of the Federal poverty level the Affordable Care Act also slowly reduces Federal funding for uncompensated care that goes to hospitals. The uncompensated care payments will be cut by $18.1 billion over seven years nationwide to help pay for the Medicaid expansion. In Kentucky, the state estimates the Medicaid expansion would cover an additional 308,000 state residents. A past president of the Kentucky Hospital Association said that not expanding Medicaid would financially hurt hospitals and that the hospitals supported the expansion. The state Cabinet for Health and Family Services issued a report recommending expansion saying our hospitals will suffer without it. It estimated that the cut in uncompensated

care payments would total 287.5 million over eight years. And that's my fact check for this week. I am Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. An estimated 26 million Americans suffer from diabetes or pre-diabetes and that number is expected to triple in the coming decades. Diabetes is responsible for more deaths in this country than AIDS and breast cancer combined, but managing diabetes in such a large and diverse population remains one of the most pressing chronic health issues that face us. A pilot program launched by the American Pharmacists Association Foundation has indications for a new tool in the arsenal. Pharmacist, and Foundation Vice President Benjamin Bluml created a pilot program that was deployed in 25 communities and 17 states, all focused on the underserved population, those who are homeless living at or near the poverty line, the uninsured, people who often have the most difficult time complying with diabetes management directives. Pharmacists were deployed as front line monitors of the patients' A1C levels, blood pressure, cholesterol, BMI.

Benjamin Bluml: The patient often time sees their pharmacist as much or more than all of the other health care providers combined and so what a natural point of access in our health care delivery system.

Margaret Flinter: The initial results of the pilot program project IMPACT Diabetes showed some pretty significant improvements in the compliance, in diabetes management of more than 2000 participants.

Benjamin Bluml: So we asked each one of the communities to implement a collaborative care program that included pharmacists and we saw statistically significant improvements in A1Cs, in LDL cholesterol, in systolic blood pressures and in body mass index.

Margaret Flinter: Based on the success of the pilot program, the foundation plans to roll-out project IMPACT Diabetes to more communities around the country who are in need of better diabetes management. Pharmacists working in concert with a care team of clinicians, dieticians, medical providers, offering one more layer of intervention for patients who struggle to manage their chronic illness, helping to yield better health outcomes and a better quality of life, now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.