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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret open enrolment has come to a close on the online insurance market places created by the Affordable Care Act and in the few assured months millions of Americans have gained insurance coverage, a rocky start but much more promise than people expected.

Margaret Flinter: And business was brisk during the final days of open enrolment up 20% per day in the final week here in our home state of Connecticut and I think that was the experience all around the country though of course lagging in states like Texas that actively engage in trying to block the promotion of the health care law.

Mark Masselli: The Department Of Health And Human Services did grant a small reprieve Margaret as long as the person started the enrolment process by March 31st deadline they would grant a grace period for a couple of weeks to make sure they could iron it out all the difficulties they might have encountered. They won't be hit with the tax penalty for not having an insurance by the end of March.

Margaret Flinter: Well we should know Mark that there are lots of opportunities for lessons learnt here. I don't know when we will get another big impact program like this but the administration could have done the better job of messaging. A recent Kaiser Family Foundation poll show that 50% of Americans just had no idea when open enrolment was coming to a close. Many of them thought enrolment had already ended.

Mark Masselli: There are simply so much complexity to health care law and all of the changes to health care surrounding it. I think it's going to take some time to process such a dramatic see change and in fact the law envisions over the next few years of enrolling all of the people they set out to do.

Margaret Flinter: And speaking of change another poll shows that by two to one margin a majority of Americans feels the health care law should be kept in place and fixed over time rather than repealed or replaced. So it seems like Americans are beginning to understand the benefits of Obama Care or the Affordable Care Act in ensuring access to health care for all citizens.

Mark Masselli: Meanwhile legal challenges to the law continue a private company has sued against the mandate requiring free contraception coverage through employee insurance plans. The Supreme Court heard the case recently and there has been no decision yet but the analyst are saying that with the courts conservative leaning on this issue the mandate could be in jeopardy.

Margaret Flinter: Well the health care law definitely has an emphasis on prevention and an emphasis on women's health and on parity and of course we would like to see that mandate appalled for those reasons.

Mark Masselli: It's about creating an opportunity for equal access to preventative health services including birth control and it was important minority populations tend to be impacted higher numbers in this country and that's something our guest today knows quite a bit about.

Margaret Flinter: Dr. Gary Puckrein is the Founder and CEO of the National Minority Quality Forum and he sees the health care law as a game changer in terms of reducing health disparities in this country.

Mark Masselli: Lori Robertson will also be stopping by the managing editor of FactCheck.org as always on the hunt for misstatements about health policy spoken in the public domain.

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

Mark Masselli: And as always if you have comments please email us at CHC Radio or find us on Facebook or Twitter because we'd love hearing from you.

Margaret Flinter: We will get to your interview with Dr. Gary Puckrein in just a moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

Marianne O'Hare: I am Marianne O'Hare with these health care headlines. Uninsured and staying that way and assessment of the millions of Americans who are still uninsured after open enrollment on the insurance exchanges under the Affordable Care Act has drawn to a close. It shows many are choosing to remain uninsured even though they have options both on and off the exchanges. A Kaiser Family Foundation Poll showed 50% of adults under age 65 who still lack coverage plan to remain without insurance while 40% they do signup by the deadline at month's end and only four out of ten of the uninsured knew that March 31st was the deadline to sign up for coverage. A majority of the public 53% is tired of hearing fights over the health care law, 42% believe the debate should continue.

Meanwhile of the 5 million folks who require insurance in the federal exchanges a vast majority qualified for tax subsidies do offset the cost of the health plans. Without those subsidies many families would find insurance unaffordable for the largely low and moderate income people acquiring the insurance and appeals court challenge is posing a threat to those subsidies the corner stone of the healthcare laws and insurance mandate. The case heard Tuesday began with a lawsuit filed by the residents of West Virginia and several other states who object to being required to buy insurance even with subsidies. Meanwhile the Supreme Court heard arguments last week regarding a privately owned four profit company rejecting the health laws mandate supplying free contraception to insured women. The hobby lobby case in which a company owner cited religious beliefs for his rejection of the mandate was presented to before the conservative leaning High Court, decision yet to be handed down.

And the stethoscope as smoking gun something to consider. A recent study conducted in Switzerland showed one out of twenty patients leave a doctor's office with an illness causing germ after contact with their physician while hand washing protocols are strictly followed in many cases now. There is still a contact culprit, the stethoscope and the study conducted by the director of infection control at the University of Geneva hospital show the bacteria on the diaphragm of the stethoscope was much higher than on the palm or the back of the clinicians hand. Common sense dictating that reusable equipment should be wiped down after each use. I am Marianne O'Hare with these health care headlines.

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Mark Masselli: We are speaking today with Gary Puckrein PhD, President CEO of the National Minority Quality Forum an independent nonprofit research and education organization dedicated to improving health care for all populations. Dr. Puckrein writes extensively on health disparities and health reform for the Huffington Post and has published two successful magazines American Visions and Minority Health Today. He was awarded his doctorate from Brown University graduating Phi Beta Kappa. Dr. Puckrein welcome to conversations on healthcare.

Dr. Gary Puckrein: Well thank you very much.

Mark Masselli: And as our listeners may know that April is National Minority Health month. Your organization the National Minority Quality Forum is a offshoot of an earlier organization you found at the National Minority Health Month Foundation which sought to eliminate the disproportion number a burden of premature death and preventable illness in special populations. Health disparities really remain just an enormous problem for our country and while the Affordable Care Act is attempting to close the access gap we still have a long way to go before we see improved out comes and I really I would ask you to illuminate for our listeners how wide that gap of access and care and health outcomes really is?

Dr. Gary Puckrein: It's a great question you know if you think about it, if you go into a health care facility be it a hospital, a doctor's office or pharmacy the first thing you are asked to present before you have access to any services is your insurance card. And that insurance card tells a lot about what you can receive by way of products and services so what's happening in a lot of underserved communities we have somewhere around 52 million Americans who have not had an insurance card. So the result of that is they either get emergency care in hospitals or they get subsidized support from the federal government in which all of our taxes go for. Typically when they are providing that emergency care it's more expensive because it's a rescue care typically in the emergency room or because the patient has now progressed further in the disease then they ought to have given our ability to a risk of the development of that disease. It's hidden. We don't see them immediately come out of our pockets but when we go into a healthcare facility the cost of that rescue care or that charity care is built into a price it's worth and that's part of what ACA is doing. It's saying, well first of all it says we're already paying for it let's realizing but let's do it so that we are doing it in a way in which those people can have continuous healthcare so they are not getting rescue care anymore which is very expensive then not showing up in the emergency room which is very expensive. And we're making them

better able to be part of a work force because they now can go to work and so that's really what ACA is doing.

Margaret Flinter: Well Dr. Puckrein a sort of difference slant that i know you have been very concerned about is the disproportionate representation of minorities in clinical trials and you have a campaign the I'm In Campaign that looks to rectify that iniquity tell us about that. What are you hoping to accomplish and what's been the cost of that historic underrepresentation in clinical trials?

Dr. Gary Puckrein: One of the things that needs to be understood about clinical trials is that they are not only used to develop the new therapies but they are also used to help us understand what is actually the best therapy to provide an individual when they have a disease or disorder. And what we come to learn is that everyone's different. We are moving into the world of personalized health care in which we are trying to provide the right care to right moment, to the right individual. And in order to accomplish that we have to get to biodiversity, we have to have more diverse populations in clinical trials so that we can best understand what works and it's actually kind of a numbers game and what you want to try to do is get a good sample of the population that is most likely to be affected by disease and to get them into trial to see what appropriate therapy will work for them. The problem has been is that minority populations have not been represented in clinical trials in the past and so what we have done is it's really in the clinical setting after the drug or device is approved it's in use and practice where we come to find out how well it works in a particular patient population. So the idea is to bring a little bit more rigor to all of this by encouraging greater diversity in clinical trials and so that's what the I'm In Campaign is trying to do. You'll get to the issues of trust as well as to help everyone understand the value of participating in a clinical trial.

Mark Masselli: Dr. Puckrein you use the word rigorous and it seems that sort of captures the diligence that your organization bring to the task in hand which is really about collecting health data from around the country and charting disparities and really looking at both ethnicity and drilling down the zip codes really to help shape a mosaic so that the health care population, the policy makers and their like understand the sort of scope and size of this health disparity. So talk to our listeners a little more about the most important and unexpected discoveries that you have mimed from this data.

Dr. Gary Puckrein: We have been collecting since about 1998 and we have a database now of well over 900 million patient records. We're on any random events when you look at populations down at the zip code level you can predict how many people in that population are going to the hospital because they have had a heart attack. How many of them will go on dialysis. How many new cases of diabetes you are likely to see in the year and I think that is perhaps the most important understanding that I walked away with. These are highly predictive events and so when you talk health disparities what you are really talking about is a pattern of essentially bad outcomes of that are occurring and reoccurring in certain communities. And any good scientist knows that when you see patterns those patterns are caused by set of variables out there and so the work is to try to understand those patterns and then how can we break

them and improve them and eliminate disparities when we see them and I think that sort of the lesson that I have learned over the years.

Margaret Flinter: Well Dr. Puckrein that of course would lead me to the next logical question about what do we do as people who have certainly hoped the access to a high performance health system would rise or both. So what are creative interventions, what's the kind of work that's going on this exciting new.

Dr. Gary Puckrein: So what do we want out of our health care system. There is a body of flown out there that suggests that people should only get the health care that they can afford and there is another body of flown out there that says that health care ought to be right. What I understand is this unlike the early part of the 20th century we now have choices. On the early part of the 20th century, you know, health care really couldn't intervene to save lives. And now we are developing the technology that can really control if not eradicate a disease. And so the question is do we want to apply that generally across the population? Now obviously I fall down on the side that health care ought to be covered but that's the work in the conversation that we need to have at the national level.

Mark Masselli: We are speaking today with Gary Puckrein PhD, President CEO of the National Minority Quality Forum independent nonprofit research in education organization dedicating to improving health care for all populations. Dr. Puckrein you have been supportive of the Affordable Care Act with one sort of caveat and that's the creation of the 15 Member Independent Payment Advisory Board or IPAB which was established to find ways to contain the cost in Medicare and your concern is that the panel yields too much power so tell us what you think the negative impact on the health of minority seniors and what your organization has done to try to change it.

Dr. Gary Puckrein: Consumer demand for health care is going to grow. We have an aging population. By 2030 a third of the US population will be on Medicare. You have minority population who have actually underused health care historically who are now going to be insistent that they have access to quality care. I think you build a very nice economy around providing health care services. I think a lot of the confusion around the value of health care is that we tend to only have a conversation about it of a cost proposition and I think there's a value proposition to health care both in terms of it's a largest sector in our economy and I am just not persuaded that in a market economy you want government price control to be extent at the iPad would seems to suggest. And so I just think that there are some real thought than needs to go into that.

Margaret Flinter: Well Dr. Puckrein we talked mostly about health care so far so I want to pivot a little bit and health but you know when we talk about the social determinants of health and poor health we talk about things like diet and living conditions but of course just being poor is a huge contributor to health disparities. Maybe you could share with us what is your data showing you about areas where the health of minority communities has been improved by targeted interventions and I would also perhaps ask you an opinion question as the push for increasing the minimum wage and trying to raise more people out of poverty takes hold in a country. What

is the impact from your viewpoint of increasing minimum wage and just raising people out of poverty on eliminating health disparities?

Dr. Gary Puckrein: So I think about it -- there's sort of an equilibrium as it were where human life survives better. And the question is if we're really about providing and insuring of that population has a great quality of life have opportunities for jobs, have a health care system that is responsive to their needs you kind of get to the social determinants of health which is that you can actually plot by geography where life expectancy in this country is greater and where it's less I mean people are doing that right now. And it's a function of the quality of air, the diet, the opportunities for exercise, the access to health care. And so as America becomes more diverse what we want to make sure is that our society is creating the best possible opportunity for everyone to have great quality of life. And so some of the environmental changer I think ACA is certainly an important part of those environmental changes. We are having conversations literally about the social determinants of health and lots of organizations are beginning to step in to look at issues about diet and here we're going to find a very complex story when we start to think about diet in diverse populations. And we also see this part of education and certainly we just are an important part of it. It is really not appropriate for people to work a full day at a job and not have a living wage. I don't understand a society in which the business model is that my business can't survive unless I provide someone wages that doesn't allow them to raise your family. There is something upside down about that model and I think that's what the conversation is about.

Mark Masselli: Well said. We have been speaking today with Dr. Gary Puckrein, President and CEO of the National Minority Quality Forum. You could learn more about his work by going to nmqf.org. Dr. Puckrein thank you so much for joining us on conversations today.

Dr. Gary Puckrein: Well thank you for your time.

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

Lori Robertson: Well we recently heard President Obama jumbling his fax when asked about employer sponsored premiums. During a live online Q&A the interviewer relate a comment from Dan from Nevada. Dan works for a large corporation and said his insurance cost had "sky rocketed since the Affordable Care Act was passed" was the law to blame? Obama said no and he is correct that generally the law isn't to blame for sky rocketing work based premiums but then the President answered it a little fussy. He said the average premium was going up 15% a year before the ACA but that figure doesn't pertain to employers sponsor plans instead Obama was talking about the individual market which saw an average 15% premium increase the year before the law was passed. Employer plans the topic of the question haven't seen an annual increase close to that since 2002. Family premiums in the employer market increased about

4.8% per year on average in the 5 years prior to the law. In the 3 years since the average growth has been 5.9%.

We talked to experts back in 2011 when employer plans jumped up by 9% and they said the law's new requirements were responsible for about 1% to 3% increase. New requirements included allowing adult children's to stay on parents plan until age 26 covering preventive care without cost sharing, increasing annual coverage limits and covering children regardless of pre-existing conditions. The rest of that years increase as is normally the case was due to rising medical cost and that's why Obama also went a bit too far when he said on Web MD that the only impact on employer plans was a requirement to offer a minimum set of benefits. Large employer plans also have to spend 85% of premiums on medical cost and have an external appeal process for policy holders. Small group plans at companies with up to 50 workers are the ones that have to cover the law's essential health benefits. 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 to checked email us at chcradio.com we will have factcheck.org Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities and to everyday life's. Food labeling could be going one step further than simple calorie counts in the future. Public health researchers at the University of North Carolina has some pep in their step for another approach to getting consumers attention when pondering those food and beverage choices. There is a growing interest and a new approach to displaying calorie counts next menu items instead show the amount of exercise that would be required to burn off those calories consumed from drinking say 20 ounce cola. They developed an icon symbolizing a person walking and how far that person would have to walk to erase the calories they are just about to consume. They conducted a randomize study to determine what if any effect the measure would have on consumer choices.

Dr. Anthony Viera: And we showed them basically a full menu with all items and so one group was randomized to no information except the food items. Another one was a menu of pretty much every item exact same way and it had the calories. And then a third option had calories plus minutes to walk with our little figure and it had, you know, for example 91 minutes and then finally a forced menu that showed the same exact thing with the same exact figure with miles to walk so I might say 5.1 miles.

Margaret Flinter: Dr. Anthony Viera, Professor at the University of North Carolina Chapel Hill School of Public Health. He said the study showed quite clearly that when consumer saw the consuming the food or a drink item would require them to walk five miles to burn those calories off as opposed to just seeing the calories it had a direct impact on the choice.

Dr. Anthony Viera: So if you looked at total calories ordered when you are shown no label the average calories ordered will be 1020. When you are shown calories only which is a, you know, sort of the policy, the current policy the average order was 927 calories and we are showing calories plus miles the average total was 826 calories. So as you can see there was a definite decrease in calories when you are shown calories plus miles.

Margaret Flinter: The results of the initial study were so conclusive. They are now scaling up their research to test in restaurants. Restaurant food labeling showing a consumer how much exercise will be required to burn off the calories consumed, helping them comprehend the actual calorie value of the foods they choose and maybe that's positively impacting their intention to consume fewer calories more wisely. Now that's a bright idea.

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