(Music)

Mark Masselli: Welcome to Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, it's round 2 for the open enrolment under the Affordable Care Act, and so far roughly a 100,000 Americans were able to sign up for coverage on the online insurance marketplaces during the first weekend of open enrolment.

Margaret Flinter: Well indeed. The Federal Exchange, HealthCare.gov which had so many problems last year, ran quite smoothly Mark, accommodating half a million customers in the first weekend of open enrolment, and there is really pretty good news from the state exchanges as well. The handful of states that forged ahead with their own insurance marketplaces experienced few of the problems that they encountered last year.

Mark Masselli: Maryland has since adopted the system so successfully used in Connecticut last year, and Massachusetts brought in a new contractor for their exchange.

Margaret Flinter: The State of Washington experienced on issue on the first day of enrolment and had to shut the system down for a while, but the problem was quickly corrected and I think they were back up and running on day two, which is impressive.

Mark Masselli: But on the whole the road seemed far smoother in the second round of open enrolment.

Margaret Flinter: Well some 20 million Americans remain uninsured after the first open enrolment, and still so many Americans are not fully informed or just don't understand their rights and options under the law. And of course we have to note Mark that enrolment, that's only the first step. We have millions of newly insured customers, or Americans, who gained coverage under the Medicaid expansion, and the question remains how will they learn to access and navigate the health system for more proactive health care.

Mark Masselli: And that's something our guest today is quite informed about. Dr. Benjamin Sommers is an expert on Medicaid health reform and the impact of coverage on the uninsured. He has been analyzing data and has some unique insights into the effects of gaining coverage.

Margaret Flinter: Lori Robertson, the managing editor of Factcheck.org will look at some more false claims spoken about health policy in the public domain, but

no matter what the topic you can hear all of our shows by going to www.chc.radio.com.

Mark Masselli: And as always, if you have comments, please email us at chcradio@chc1.com, or find us on Facebook or Twitter. At CHC Radio we love hearing from you.

Margaret Flinter: We will get to our interview with Dr. Benjamin Sommers in just a moment.

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

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Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. What a difference a year makes since the second round of open enrolment on the federal and state-run exchanges began November 15th. There have been relatively few glitches to report. Half million people were able to log on to HealthCare.gov, the federal site on the first weekend alone. The 15 state-run exchanges including the District of Columbia also launched portals with few troubles to report. The challenge this time around is the need to reach more urban minorities who are most likely to be uninsured and least likely to be aware of the options they have under the Affordable Care Act. Next year the penalty increases to $325 per adult or 2% of income; in 2016 it will be the greater of $695 or 2.5% of income. Meanwhile more states are considering expanding Medicaid in spite of original opposition. Even in Texas, stalwart opponent Governor Rick Perry commissioned an independent study to advice on whether the state should expand Medicaid under the increased inclusion under the Affordable Care Act. The commission strongly recommended doing so.

If you want to know if he loves you so, it's in his kiss. Researchers in The Netherlands conducted a detailed study to examine how intimate partners share their microbiomes. There are about 80 million or so bacteria shared across the lips during the average French kissing session. Couples who kissed at least nine times a day were more likely to have similar saliva microbes. There are a number of studies that show it's healthy to have a high diversity of microorganisms in your mouth, and they say "Hey, it might be fun to try."

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

(Music)

Mark Masselli: We are speaking today with Dr. Benjamin Sommers, health economist, internist and Professor of Health Policy and Economics at the Harvard School of Public Health. Dr. Sommers' research is focused in on the

uninsured, Medicaid and national health reform. Dr. Sommers has won numerous awards for his work including the national Dissertation Award by the AcademyHealth as well as the 2010 Best Resident and Fellow at Harvard Medical School. He graduated cum laude from the Harvard Medical School where he earned his MD. Dr. Sommers, welcome to Conversations on Health Care.

Dr. Benjamin Sommers: Thanks so much for having me.

Mark Masselli: We are right in the midst of the second round of the Affordable Care Act, particularly the Medicaid expansion and the addition of young adults who have been able to stay on their plan has been significant. Can you tell us a little bit about in this sort of short period of time what the impact has been thus far on population health, if you can?

Dr. Benjamin Sommers: Sure. The impact of expanding health insurance really fall into a couple of different categories, and they play out over different time periods, but the first and most immediate impact is that you increase people's access to health care services, and you reduce their financial risk of catastrophe if they have anything serious happen and they have large medical cost will they be able to pay for it. When you look at the features of coverage expansion under the Affordable Care Act, the very first one that took effect that impacted large numbers of people was the provision that let young adults stay on their parents' plans through their 26th birthday. This took effect starting in September of 2010, and the results from that expansion were quite impressive and actually larger than most of the original projections had been. Somewhere close to three million young adults signed up who were otherwise uninsured, and got coverage to their parents' plans.

And we see reduced issues of paying bills in the emergency department, we see people more likely to have a primary care source that they can go to, more likely to say that they can afford their needed medical care without any cost-related barriers. And perhaps most exciting from the perspective of population health is that even in a fairly health age group we have seen people describe their overall health status has having improved significantly since this policy went into effect, and that's a change that we haven't seen for slightly older adults who were not affected by this policy,

Margaret Flinter: We so often see that there are still the disadvantages in lower income groups or minority groups, and I am wondering if we saw the kind of success across the population for the group under 26 being able to stay on their parents was it really limited to a more affluent group. Could you tell you a little bit about that?

Dr. Benjamin Sommers: The way that the policy is set up is that to benefit from it you have to have a parent that A, that you have an ongoing relationship with and

is willing to add you to a plan, and B, that they themselves have private insurance that they can add you to. So on the one hand you would think that those features in particular would be more common in higher socioeconomic groups, but there is a counterbalancing factor here which is that if you look by income and education that the number of uninsured young adults was higher, and so you kind of have this tradeoff and it may be that there are more parents with private coverage who are in higher income groups, but many of their young adult children already had coverage.

The challenge is that this provision affects a lot of young adults who don't live at home, and so when you are talking about say a 24-year-old who is working on a Master's degree, we don't know if they are from high income families, lower income families, but we do see that there are certain features that are pretty strongly associated with bigger benefits from this law. So for instance, young adults who're not in school, and young adults who're single were much more likely to benefit from this provision, and the reason for that is because a lot of people were already able to stay on their parents' plans. At least they were age 23 if they were in school full time, but a lot of non-students didn't have that option. And then the other factor is if you are married you essentially double your chances that you yourself have a way of getting health insurance without your parents, and so it was really kind of single people, non-students who were particularly likely to benefit from this provision.

Mark Masselli: Dr. Sommers, when the Supreme Court upheld the legality of the ACA but ruled against Medicaid expansion many states opted out, and I think you and your colleagues have conducted a number of studies that demonstrate the public health impact when Medicaid is expanded within a state, and you have also analyzed what happens when the designation is broadened. You have analyzed some long term data from states like New York and Maine. What have the data on Medicaid expansion in those states shown us?

Dr. Benjamin Sommers: We studied three states that essentially they expanded eligibility to anyone whose income was under the federal poverty level, and it no longer was a requirement that they have a child at home at a disability or be pregnant, and what we found in studying five years before and five years after these Medicaid expansions were a bunch of significant changes that were positive. We found that coverage rates went up, the uninsured rates declined not surprisingly. People said they had an easier time getting the care they needed. They were less likely to have costs interfering with their medical care. They said they felt better. Much like with the young adults we found that coverage led people to rate their own health more highly, and then probably most importantly, we found that there was a significant decline in the mortality rate for adults in the 20 to 64 year old age group, who are really mostly the target audience for this expansion. And these were declined mortality that we were not seeing in similar states that are nearby that did not expand Medicaid.

Margaret Flinter: Well I think it's really helpful for our listeners to hear about what the impact of several years of expanded coverage has been on the health of the people of your state.

Dr. Benjamin Sommers: Sure. What we found in some ways was very similar to the Medicaid findings, which was that we found people were gaining coverage; they were less likely to have trouble paying for their care. We were able to look at some additional outcomes and found that people were more likely to have a preventive health visit. If you looked at the types of cause of death, it really fit in with the framework of health care making a positive impact. We found that there were bigger declines for things like heart disease, diabetes, blood pressure management, infections and cancer, which are conditions that we think early detection, early treatment and chronic disease management with health insurance are likely to be much more beneficial than for say things like car crashes.

The evidence really does suggest that giving people health insurance makes a positive impact both in terms of access and perceptions of health, but also important population measures like mortality. I will add that we do have to think about the political context too though that Massachusetts had a pretty united bipartisan approach to this health reform. It was passed by then Governor Mitt Romney. Obviously nationally, things are quite contentious, and we see a lot of states that are really reluctant to expand Medicaid that are trying to slow down the implementation of the coverage expansion. If the laws aren't implemented as well because there is opposition, that may very well play out in the benefit on the general population.

Mark Masselli: We are speaking today with Dr. Benjamin Sommers, health economist, primary care practitioner and Professor of Health Policy and Economics at Harvard School of Public Health. I want to pull the thread a little on sort of the political observation and just wondering what the role has been of the research that you have done about the outcomes on those states that have been reticent to expand their Medicaid program.

Dr. Benjamin Sommers: The Medicaid expansion decision is interesting though from the political perspective, in that it doesn't quite fit into the traditional partisan divide in the way that lot of the other features of health reform seem to. And the reason for that is the Medicaid expansion is there for the taking, and the federal dollars, which are quite generous are also there for the taking. For the new Medicaid expansion under the ACA, states don't pay anything for the first three years, and only pay 10% in the long run. So you have a lot of vested interest in the states that want to see that federal money brought into the system. You have physician and other provider groups, you have the business community that says this is positive revenue that could come into our state economy, and then of course you have the advocates for people who would gain coverage through the expansion.

So you have a lot of groups that maybe traditionally aren't huge fans of federal programs saying "This is a little bit different though because the money has already been required in the law, the question is whether our state is going to miss out on it." And so that argument has actually been fairly effective in several states with Republican governors who have put their support behind the expansion. I have been encouraged that there has been I think a reasonable debate about what the expansion coverage would mean for people's lives. There have been for a long time some studies that suggest that people with Medicaid might do worse than others, but typically those are our studies that are really subject to the flaw that people who are in Medicaid look entirely different than those who are not.

Fortunately, there are some other studies including ours that take another approach which is to follow longitudinally with either natural experiments, or in one case in Oregon a randomized trial where people will have their names picked off a lottery list to get offered Medicaid, and that's offered pretty clear evidence that you don't harm people by giving them Medicaid. Our study found that mortality impact; the Oregon study didn't find any blood pressure or cholesterol changes within 18 months of getting coverage, but overall I think we have hopefully added some meaningful data to the debate that's made it clear that giving people Medicaid coverage when they were uninsured certainly has a positive impact and ought to be taken into account.

Margaret Flinter: I was so interested to see you were quoted in a study recently published in Health Affairs that found a very high degree of satisfaction among the country's Medicaid recipients, and I look at so much that's changed, certainly the expansion of the community health centers across the country. But what do you attribute this to? Do you think we have really made progress?

Dr. Benjamin Sommers: You know, it's really interesting because Medicaid often gets a bad rep in general discourse, but if you look at the general population it's a pretty popular program. For instance, a survey that was done during some of the budget negotiations over the past several years, people were asked whether they supported major cuts in Medicaid to help reduce the deficit, and if you believed that Medicaid was a terrible program that seems like a pretty reasonable approach, but the majority opposed any cuts; they liked it as it was. When you ask people if they know someone in their own lives who has been impacted by Medicaid, more than 50% of Americans have at this point either a friend or a family member who has been in Medicaid, and that will only increase under the ACA. And then when you look at the people who have the most familiarity with it, which is what we were doing in this three state survey that you mentioned, we asked people in three fairly conservative states, Arkansas, Kentucky and Texas to describe their general perceptions of Medicaid, and 80% of people supported expanding Medicaid. And when we asked people to compare having Medicaid to

having private insurance, the majority said Medicaid would be as good or better for their overall health care quality, which is really kind of striking.

So the people who have incomes that get them into Medicaid and have experience with it generally are positive about it, but I think as many of us who had private insurance probably can relate to there are challenges of having private insurance as well, and we have all had to run into it various times I imagine. There are major issues. When we know that doctors are less likely to see a new Medicaid patient than they are to take a new Medicare or privately-insured patient, a lot of that is related to how much they get paid to do so. And the bureaucracy of interacting with the state Medicaid office isn't always easy for providers, and that's another factor that state and federal leaders could focus on in trying to make sure that the Medicaid benefit does remain valuable and high quality.

Mark Masselli: Dr. Sommers, you also did a recent analysis of the makeup of the newly insured since the first round of open enrolment, and there was a percentage of Americans who gained coverage through their employers. The unemployment rates obviously improved, and so it stands to reason that there are more people who are picking up insurance through their employers. What's the picture look like for employee health coverage as more employees are thinking about creative ways to provide coverage for their companies? I know there is a new round of projections by CMS. It turns out that not a lot of people shed their health coverage to send people into the ACA, so a couple of questions there.

Dr. Benjamin Sommers: This is an area that I think the general public and policymakers are really interested in for the simple reason that even with all the changes going on with the ACA with Medicaid expansion, with the new marketplaces, the majority of Americans still get their coverage through work, and most Americans are generally happy with that coverage and don't want to see dramatic changes to it. So that was really the underlying premise of a lot of the decisions made for the ACA, both when it was being written as law and then implemented by the Department of Health and Human Services, trying to keep people in coverage that they like without disrupting it. And I think we all remember the controversy from last year when people were getting cancellation notices, and the president was being held accountable for the statement "If you like your health plan you can keep it."

That turned out to not really be much about the employer side; that was really about people who were buying plans directly from insurers. On the employer side, it's a little too early to say for sure because we don't have the really high quality federal surveys that tell us about employer coverage. We don't have that yet for 2014 because things come out on a little bit of a time lag. What we do have are some data sources like the Gallup tracking poll, and that's what we used in the study in The New England Journal of Medicine that you mentioned.

And what we found there was across all different types of coverage that about 10 million more adults had insurance in 2014 after the first open enrolment period compared to the baseline trend before that open enrolment period, and that took into account that the unemployment rate and income and other measures that could potentially throw off the estimates.

So we were trying to kind of filter out the economic recovery from our results, and we still found a major change in the insured rate. The survey doesn't really have that high quality measurement of the type of insurance, and we will have to wait for that, but what we can look to is the experience in Massachusetts which is pretty informative again because the law in Massachusetts was setup in some ways similarly to the national law. And what we found in Massachusetts, and what has been shown in previous work by several economists that have studied it is that if anything, employer coverage seemed to go up in the state after the health reform, and there are couple of reasons for that. There are really two big reasons, one is that the Massachusetts law like the federal law includes incentives to employers to offer insurance.

In particular if you are a large employer and you don't offer coverage to all your workers, or if any of them go on the marketplace and get a tax credit, you pay a penalty for that. And so this has been referred to as the Employer Mandate, and it's designed to make sure that large employers are offering insurance, which the vast majority already do, but to try to shore that up. The other reason that we can see a positive change in employer coverage is actually the individual mandate, and so this is the requirement that all individuals have health insurance, or they pay a tax penalty at the end of the year. And this seemed to have the impact in Massachusetts of encouraging workers to go to their employers if they weren't getting insurance and saying "I want it. I am going to be on the hook for a penalty; I want you to offer me insurance." And if the employer offered it to them, some people used to say no, that now say "Well wait, if I don't take this I am going to get hit with that penalty." So we saw more workers actually accepting the offer when it was made to them. So there is good reason I think we might see some of the similar dynamics playing out nationally, but it s a bit too early to say for sure.

Margaret Flinter: We have been speaking today with Dr. Benjamin Sommers, health economist, primary care provider, and Professor of Health Policy and Economics at the Harvard School of Public Health with the research focus on health reform and Medicaid expansion. You can learn more about his work by going to www.hsph.harvard.edu. Dr. Sommers, thank you so much for joining us on Conversations on Health Care today.

Dr. Benjamin Sommers: Thank you so much for having me.

(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 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 US politics. Lori, what have you got for us this week?

Lori Robertson: The most common questions we get from our readers are about viral emails, you know the frightening sounding messages that one relative always seems to be sending to his entire contact list. We have been debunking those types of messages for years including many about the Affordable Care Act, and while there may be a few chain emails floating around that are true, the vast majority we have researched are false. Sometimes they have a grain of truth; other times they are completely bogus. One email made 48 claims about the Health Care Bill when it was being debated in Congress. Only four of the 48 claims were accurate. We suggest a healthy use of the Delete key when dealing with these often anonymous messages riddled with exclamation points, capital letters and spelling errors and simply outrageous claims.

One email said an emergency room doctor in Tennessee said the Affordable Care Act was denying dialysis to some Medicare patients, and would deny care to those over 75. A hospital told us the account was fabricated by a guest in the doctor's home who wanted to further a political point. There are more hints for readers that an email is false. If an email claims a legitimate source backs up the claims, check it out. Often the source contradicts the email. Other times the sources (inaudible 21:27) satirical news story. One email claimed that Obamacare called for free gasoline service stations for low income people. Apparently not everyone understood that was a joke. Maybe the message challenges you to do the math. Break out the calculator; you may find the numbers simply don't add up. Our skepticism is also peaked whenever we see a message arguing that it isn't false. Urging us that this is not a hoax! makes us think that's exactly what this message is. 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. As the saying goes music soothes the savage beast, and according to a recent study conducted by Queen's University in Belfast, Ireland, there is some empirical data

to back that up. In a first of a kind longitudinal study, children suffering from a variety of behavioral and emotional conditions who were exposed to music therapy in addition to traditional therapies had far better outcomes than those children in a control group that offered traditional therapy without music therapy.

Dr. Sam Porter: It's not a matter of them being given music or choosing music; they actually make music along with music therapist assisting them. So the idea is for them to express themselves through music.

Margaret Flinter: Lead researcher Dr. Sam Porter said there has been anecdotal evidence that music improves mood in children and adolescents as well as adults, but his study revealed just how effective the music therapy was.

Dr. Sam Porter: An improvement in communication. Now there were two very interesting secondary outcomes, levels of depressions and levels of self-esteem, and in the secondary outcomes we found a statistically significant difference between the control group and the intervention group.

Margaret Flinter: Dr. Porter says in a group given musical therapy it showed overtime more interaction with their surroundings, and a better response to the traditional therapies as well, and he says the effects were sustained overtime.

Dr. Sam Porter: (Inaudible 23:54) marvelous things like music therapy as the things (inaudible). There are no side effects. It is not a dangerous therapy to get kids involved in. That is just such a good way and a harmless way of doing things.

Margaret Flinter: The study was conducted in conjunction with the Northern Ireland Music Therapy Trust which sees the promising findings as an incentive to incorporate this relatively low cost non-invasive therapy into standard protocols as an additional tool to enhance outcomes for the youth population which often suffers negative side effects from powerful medications. A simple targeted music therapy approach, age appropriate and showing great efficacy in improving outcomes for young patients with minimal side effects and lasting benefits, 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.