(Music)

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

Margaret Flinter: And I am Margret Flinter.

Mark Masselli: Well Margaret, two and a half million and counting, the number of Americans who signed up for coverage by mid December on the federal marketplaces.

Margaret Flinter: It should be noted that about half of those who signed up during the second enrollment are returning customers, and many of them shopped around for plans that might better suit their budgets and their family needs. But the important thing is it does show that there is a very robust interaction beginning to happen with the online portals this time around, and everything seems much smoother.

Mark Masselli: There are still some issues. The volume is quite high in the federal exchanges, which is handling the insurance needs of about 37 states. So people seeking help from insurance navigators on the phone are being asked to leave their names and numbers, and they must wait for counselors to call them back with such high volume. Those callbacks are taking a few weeks to get back in some cases.

Margaret Flinter: So about half a million people phoned into HealthCare.gov to try and make the December 15th deadline for coverage to begin on January 1st. Kevin Counihan who heads up the exchange says that everyone who calls by midnight on December 15th will see their coverage begin January 1st even if the counselors couldn't get back to them right away. So I would say he is doing a terrific job at the helm of HealthCare.gov, Mark.

Mark Masselli: These new insurance marketplaces are also bringing differently structured health plans. The growing trend in high deductible plans require some analysis for families who must calculate a slew of out-of-pocket expenses. It really is important to shop around.

Margaret Flinter: And we had been watching another approach to the problem of covering the uninsured in America and also of controlling cost. Vermont was on track to become the first state to launch a single payer system by 2017.

Mark Masselli: Governor Shumlin made the recent announcement that after crunching the numbers every which way there simply was no way to pay for the significant increases that would be in taxes.

Margaret Flinter: And proponents of single payer approaches were so disappointed because Vermont presented the best hope, maybe the only hope

right now in the United States for success, but that payment piece simply proved too challenging.

Mark Masselli: The idea is simply going to take some time to take root which is unlikely in the current political climate.

Margaret Flinter: Well, our guest today is someone who has a pretty global view of the current political climate and health care in this country and the importance of looking at health reform from a non-partisan angle. Alan Weil is the Editor-in-Chief of the peer-reviewed publication Health Affairs.

Mark Masselli: Lori Robertson, Managing Editor of FactCheck.org looks at 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.chcradio.com.

Margaret Flinter: And if you have comments, don't forget to e-mail us at CHC Radio at www.chcradio1.com or find us on Facebook, LinkedIn, Twitter or Google+; we love hearing from you. Now we will get to our interview with Alan Weil 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. And the numbers keep rising. Numbers of Americans who have signed up for health coverage on the federal and the state exchanges has risen dramatically in the last couple of weeks of December. According to the Department of Health and Human Services, 6.4 million Americans were able to sign up for coverage on both the federal and state exchanges up from 2.5 million just a couple of weeks ago. HHS Secretary Sylvia Mathews Burwell is hoping for 9.1 million enrollees by the end of the 2015. But what about the cost? The survey of Americans shows more are grappling with health care costs than they were a year ago, a combination of paying for insurance where they might not have before, higher insurance rates due to some of the mandated coverage items under the Affordable Care Act, and largely the increased out-of-pocket expenses from plans with much higher deductibles.

Meantime, the date's been set. The nation's High Court will hear arguments on the tax subsidies for those buying insurance on the federal health exchange. The case is based on language taken literally from the original bill. The FDA is lifting a decade's long ban on a homosexual men donating blood. It was put in place in the earlier days of the AIDS epidemic. It is however continuing a ban on blood donations if a gay person has had sex with another person in the past year. 50,000 new AIDS cases per year are still happening in this country, and

the numbers are highest among young gay men of color, many of whom don't know they are infected at that early age.

Meanwhile, when do you think is the best time to enter the ER if you have got a critical cardiac event? If you answered when all the top cardiologists are away at a medical convention you would be right. A recent Harvard study looked at outcomes from patients who entered the ER with cardiac arrest or an incident related to congestive heart failure when the top docs were all away, patients did about 10% better with a 70% survival rate after 30 days rather than a 60% survival rate when the top docs were in town. The study finds that fill-in docs are less likely to do invasive interventions that could yield more deadly side effects.

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

(Music)

Mark Masselli: We are speaking today with Alan Weil, newly installed Editor-in-Chief of Health Affairs, a leading peer-reviewed journal on health, health care and policy. Before that Mr. Weil was the Executive Director of the National Academy for State Health Policy. Mr. Weil, an attorney, was director of the New Federalism Project at the Urban Institute. A frequent speaker and author on health reform policy, Mr. Weil co-authored several books including Federalism and Health Policy, and served on President Clinton's Consumer Commission on the Quality in Health Care Industry, co-authoring the Patients' Bill of Rights. He earned his Master's in Public Policy and his law degree from Harvard. Alan, welcome back to Conversations on Health Care.

Alan Weil: It's nice to be back, thank you.

Mark Masselli: Yeah. And it's been since 2011 when we discussed the Affordable Care Act, and lots has happened since then. Eight billion Americans enrolled on and received coverage on the exchange, and five million accessed coverage to Medicaid expansion, only about half of the states choosing to expand Medicaid. What's your assessment of the outcomes from state to state and is that what you envision would happen?

Alan Weil: I don't think anyone anticipated the country splitting quite the way it has, and two elements were certainly not foreseeable by me. The first I think I have a lot of company on which is the Supreme Court after all is responsible for having made the Medicaid expansion something that states could choose to participate in or not as the law was written. All states were to expand Medicaid, and we were going to have a uniform national platform of coverage. Now with the court's rewriting of the statute they said the federal government cannot tell states that if they fail to expand Medicaid they will lose their base funding for the program, and we have what you just described. I truly don't know a single person who thought that was where we were going to be at this point.

What I didn't foresee was how much states would become a place where even after the law was enacted and signed that there would be such a division about whether or not implementing the law was something states were willing to participate in at all, and so you have the significant element within the Republican Party that basically said, "Anything you do that is involved in implementation of the law is an (inaudible 07:50)." That is a big factor I think in the division today and certainly not one that I expected.

Margaret Flinter: Well certainly, Alan, you obviously are a long time health policy advocate and expert, you have contributed frequently to Health Affairs, and now you are the Editor-in-Chief of what we think of as the peer-reviewed journal for Health Policy. For our listeners, maybe tell us a little more about the journal's history, who the major participants and contributors are, and if there is any new directions that you are planning for the publication.

Alan Weil: So we started with the luminaries in the field, and I would say we still have them. We call upon a broad cross section of health services, researchers, physicians and economists and sociologists and statisticians. We cover the range of issues in health care as they relate to the policy environment in which we operate in. As for new directions, you know, mostly I will say I take the helm of this terrific journal that is so strong, I don't need to layout a big plan of transformation. But I do think we are in an era of faster information where the traditional peer-reviewed journal is coming under fire both from the time that it takes and the resources it takes as well as the many distribution channels that are available to those who don't want to subject their work to peer-review and want to get the message out much more quickly, and I think navigating that changing environment really is my top priority.

Mark Masselli: So in this ever-changing world of how readers consume news, sort of where that audience is not so much on the content side but on the delivery side, thoughts about that, even in the state position that Health Affairs is, you have others who are quite anxious about the transformation and what it might necessitate for organizations like yourself?

Alan Weil: Well, we occupy a unique space, and one thing I think we all have to remember is there is not one typical reader. Particularly for the policy work we do, we are reaching CEOs of organizations, we are reaching young staff members on Capitol Hill, we are reaching practicing clinicians around the country and indeed around the world, and I think we all know with the pace of change in how information is distributed and disseminated those different audiences are looking to different sources. It's making sure that as we think about our audiences we have appropriate distribution channels for the range of mechanisms that they are accustomed to. Our core asset is credibility and non-partisanship is a very important part of that. Our peer-review process and as long as we build from that core, some people will be Googling a topic and they

will find it, some people will read a blog entry, some people will read a tweet, and as long as we retain the quality of our content I think we can reach people the way they are used to gaining access to information.

Margaret Flinter: Let me take a quick look back if I can Alan, and you were in the health policy trenches back in 1990 when the Clinton Administration took its shot at passing comprehensive health reform, and you have noted that the conventional thinking back then was that the three pillars of reform improving access, improving quality and containing costs were actually competing interests and couldn't it be simultaneously achieved. But you have more recently said that the Affordable Care Act has shifted that landscape on these three goals, and perhaps the ACA has made it possible to envision the three pillars of access, quality and cost to actually reinforcing one another. What do you mean by that? Expand on that thought some for our listeners.

Alan Weil: I remember going to dozens of conferences a couple of decades ago where people said you can't have high quality affordable system for everyone. I really believe it's the practice of medicine and the evidence based behind that practice that's changed in these years along with some good thought leadership. We now understand that when people get access to appropriate care they actually stay healthier, and it costs us less certainly in the long run, and sometimes in the short run. We have also learned a lot about quality that was in its infancy a couple of decades ago, and understanding the problem of overuse. So there is now a framework in the Affordable Care Act. Obviously not everyone agrees with the approach it takes, but most of the attention goes to the elements of the Affordable Care Act designed to expand access to care through more health insurance. But there are major elements having to do with cost, particularly modifications to the Medicare program which is the biggest lever the federal government has, and major initiatives to improve quality, and the hope of course is that we can bring those together in a reinforcing way as opposed to a competitive way. I do think our thinking about those three elements has shifted fundamentally with a very positive sense of what's possible as opposed to what I remember which was sort of a resignation that well this is the best we can do.

Mark Masselli: We are speaking today with the Editor-in-Chief of Health Affairs, a leading peer-reviewed journal. Before that, Mr. Weil was Executive Director of the National Academy for State Health Policy, a non-partisan organization helping states achieve excellence in health policy and practice. You focus much of your efforts on improving population health on the state and local levels. Your work at NASHP and the Urban Institute centered on the importance of state policy directors being essential to improve population health, and what do you see in the states; what's exciting about population health?

Alan Weil: When I think about the Affordable Care Act, it creates a number of tools that states can use. The changes in Medicare payment are a catalyst for thinking about accountability in the health care system. So between state and

local there are opportunities to think more holistically about the health of the population, and so one of the most powerful efforts that I observe is when a community looks at its own population health statistics, and they say “We really need to focus here on children with asthma who are ending up in the hospital when with appropriate preventive services they wouldn’t have to do that,” then you cannot just generalize about population health you can harness the resources of the community to actually do something concrete.

Margaret Flinter: I think it ties to something that you have talked about this federalism and health care, and there has been this fierce debate on states’ rights that the Affordable Care Act precipitated. So maybe talk just a little bit about this new federalism, and also, do you see the possibility of increased regionalism coming into play around health care in the future?

Alan Weil: Well, we are certainly seeing regional differences in the response to the Affordable Care Act, and many of our largest cities sit on state borders and so certainly, the opportunity to work across state lines to try to solve problems is a practical necessity. I think it would be naïve to deny that the Affordable Care Act embraces an activist role for government in the health care sector. It says we have a market failure, we have lot of people who can't afford coverage, and we are going to solve that by giving resources to those who otherwise wouldn’t be able to afford it. And that broad conception of the word that the state has a primary role in addressing this social problem that not everyone agrees upon and we have regional differences in the view of that. So actually, much of the tension around the Affordable Care Act is just around public sector versus private sector and the role of government no matter what level.

Now what I have not seen is a serious effort to define an alternative pathway to achieving the goals of the Affordable Care Act. On the one hand, the state roles in implementing the law are many, and that’s been my focus for some time, but a national division over the role of government is a somewhat different discussion than division over whether it should be federal or state, and I actually think a lot of the opposition to the Affordable Care Act is much more about role of government than it is about federal versus state.

Mark Masselli: We want to spend a little time talking about payment reform. Massachusetts started off its initial reform and they have had some good outcomes in terms of their access issues, but talk a little bit about the landscape around payment reform.

Alan Weil: The Affordable Care Act was a catalyst. It's happening in the private sector as well as in the public sector. The term often used is Accountable Care Organizations, and the idea is to pay for the care of a population and to reward those who deliver care to that population. They can keep depending on the payment models some share of what they save by reallocating their resources so there is no question that this is a real phenomenon. Payment reform is a tool,

and then you can ask given the goal what kind of payment will support the goal and to then reimburse them, pay them for each thing that they do on the expectation and understanding that what they did was valuable. Well, we are now starting to understand, and many physicians would agree that a lot of what they do is not valuable. Interventions that help people live a healthier life tend not to be paid nearly as well as cutting someone open and fixing something inside their body or scanning them.

So payment reform for what, to enable those who deliver care to think differently about the choices that they make. Our quality metrics are still fairly primitive particularly when it comes to people with complex health care needs. So I would say that the working out of the meaning of quality and the purpose of payment reform is something that is much better done locally or at the state level than nationally, that our efforts to change payment at the national level tend to be pretty clunky. They are directionally appropriate, but the details are complex, and they need to be worked out by people sitting around the table with trust who can say this is how we are going to measure quality, yes this is how patients view quality, this is how clinicians view quality, this is a payment model that will support that. From my perspective, that is by necessity a local discussion, and it's what ties all of these topics together.

Margaret Flinter: We have been speaking today with Alan Weil, Health Policy expert, and Editor-in-Chief of Health Affairs, the leading peer-reviewed journal on health policy. You can learn more about his work by going to www.healthaffairs.org, and you can follow him on Twitter by going to www.twitter.com/healthaffairs. Alan, thank you so much for joining us on Conversations on Healthcare today.

Alan Weil: It's been a pleasure.

(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 non-partisan, non-profit 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, in a new twist a Democratic group is attacking a Republican senate candidate for supporting “government-run health care.” That phrase has been a mantra for Republicans attacking the Affordable Care Act and those who support it, but neither this new Democratic attack nor the old Republican ones are true. The Democratic group senate majority pack is airing the ad attacking Representative Bill Cassidy, Louisiana Senator Mary Landrieu’s main GOP opponent. It says Cassidy wrote a plan that’s been called Obamacare

Lite. True, it was called that by an opinion columnist but it's not an accurate description. And the 2007 bill Cassidy wrote while a Louisiana State Senator wouldn't have created "government-run health care" adds claims with government bureaucrats making medical decisions. There is nothing like that in the bill which would have set up a state insurance exchange to serve as a clearinghouse for individuals and businesses by an insurance.

The proposal also was a far cry from the Federal Affordable Care Act which didn't exist at the time. Cassidy's bill didn't include subsidies for low income people, a mandate to have insurance or pay a fine or a set of essential health benefits that insurance had to cover like the ACA. The Louisiana bill called for state officials to come up with new health insurance proposals designed to reach universal coverage in the state, but that never happened. The bill died quietly in committee without even a public hearing. Cassidy meanwhile has aired an ad attacking the ACA saying he voted against it because it would lead to cancelled plans, expensive premiums, no guarantee that you could keep your doctor. But that was all true before the federal law was passed. 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, e-mail 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. According to Michigan Organic Farmer Michelle Lutz, health care spends too much time and money trying to fix the problems that are caused by a poor diet, (inaudible 22:39) be at the Henry Ford West Bloomfield Hospital agree with her. For years, she had offered organic food growing and cooking demonstrations at the health care facility just outside of Detroit, but when officials drew up plans to renovate the hospital three years ago, they decided to take it to the next level. A million dollar certified organic hydroponic greenhouse and garden were built and Lutz was hired away from her farm to run the operation.

Michelle Lutz: We really wanted to change the way that food culture was done in a health care setting. When you have the opportunity to heal someone it is very important that what they are eating becomes part of that plan.

Margaret Flinter: The facility now provides most of the nutritional organic greens, vegetables, fruits and herbs used in the food that is prepared there not just for patients who have come there to heal, but for their families and hospital staff as well.

Michelle Lutz: It's rather seasonal. In the wintertime and in the fall we change to more of a cold-tolerant crop, and then in the summertime like this time we are now transitioning to the point where we are picking cherry tomatoes, and we have sweet peppers and things like that that we will be supplying for the kitchen.

Margaret Flinter: Lutz says there is an educational component to the program that's ongoing and multi-generational.

Michelle Lutz: Right now, we are averaging 3,000 students per academic school year that go through our Healthy Habit program. We have a demonstration kitchen inside of our hospital, and then we have the greenhouse right behind the hospital. So we utilize those components to make sure that we press upon especially our youth and our community what does it take to have the foundation of healthy habits.

Margaret Flinter: And hospital chefs work to incorporate more super greens and medicinal herbs into their recipes, reducing the reliance on sugar and salt for flavors. The nation's first hospital-based year around certified organic hydroponic greenhouse, one that provides fresh fruits and vegetables to patients who are healing and the clinicians working to heal them, improving health and well-being for the system community-wide and teaching the next generation about the benefits of organic produce for a healthier diet.

Michelle Lutz: The idea of being just a hospital doesn't work anymore. You have to be a community center for wellness.

Margaret Flinter: 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