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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, now that Health Care Reform is the law of the land, the baton has been passed on to the states to implement some of the key components. The first is the process that involves the states setting up their own high-risk pools, a temporary way to cover adults with preexisting health conditions who lack health insurance.

Margaret Flinter: This is to going to be such welcome relief for people who have really suffered from not being able to get insurance because of those preexisting conditions. But, of course, there are lots of unanswered questions about exactly how the states are going to do this, how much it will cost, and how many people would be included in the pools. The Department of Health and Human Services got the ball rolling last week when they reached out to the individual states to start learning about their plans for setting up these pools. What is known, these high-risk pools have to be up and running by July 1st of this year, just a few short months away. Then by 2014, the law replaces these state-run plans with new insurance exchanges.

Mark Masselli: You know, Margaret, that's a very tight timetable, 90 days from the signing of the bill. We also know that different states have different options for setting up the pools, since some states, I think 35 already have high-risk pools. Those states can add a new pool. States can also build on their existing programs. But if a state opts out HHS, will take over and carry on its own program in that state, it sounds like a public option to me.

Margaret Flinter: It does. And one concern that it really answers is how quickly can we make something happen. So, that July timeframe really is tight. And of course, there are some concerns out there. Former HHS Secretary Dr. Donna Shalala from the Clinton Administration said it's going to be hard to implement this kind of thing but it has been done before there is precedent. The states have implemented the prescription drug benefit, welfare reform and the children's health insurance program working in collaboration with the Federal Government. And the Department of HHS, they are very used to doing waivers and working directly with the states to make these kinds of changes.

Mark Masselli: They have got some great leaders there at HHS, but there is still no administrator for the Center for Medicare and Medicaid, a critical area in the department that needs that leadership. We announced last week that Don Berwick was going to get the seat, but apparently, we have to wait for the White House and the President to make it official. Hopefully, that announcement will come in the next few weeks as there is a lot of important work to be done.

Margaret Flinter: And Mark, I have to say that if there is one decision in health care that so far seems to have unanimous agreement is that Don Berwick would make a fantastic leader for the Center for Medicare and Medicaid Studies.

Mark Masselli: That he will.

Margaret Flinter: At the end of the day, it's all about investing and making health care better and setting up these high-risk pools is just one piece of it. We have got a leading health care economist with us today to help sort through some of these bigger questions with the new legislation, Dr. Stuart Altman, Professor of National Health Policy at Brandeis University. He has been involved in designing Health Reform as far back as the 1970s and just in the last few years was instrumental in helping to design the Massachusetts Health Care Plan. We are happy to have him speak with us today.

Mark Masselli: No matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you would like to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Now, before we speak with Professor Altman, let's check in with our producer Loren Bonner with our headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. Medicare is on a lot of people's minds this week starting with lawmakers who are back in Congress, trying to resolve a provision and a bill separate from the reform that just passed to reduce Medicare reimbursement rates to doctors. Physicians face a 21% cut in their Medicare payments, unless the center approves legislation to stop the schedule reduction. In a more positive light, the Center for Medicare and Medicaid Services has launched a new website offering researchers access to data on the cost and operation of health care services around the country. It's part of the administration's open government directive and will help decision-makers quickly compare utilization rates of hospitals in each state so that ways to improve efficiency in health care can be more easily accessed. CMS launched its own video to explain --

Imaging what this could do for our healthcare system as we think about delivering better healthcare across the country. Imagine if you are able to go online and compare the cost of a knee surgery whether it's in Seattle or in Boston, whether it's in Los Angeles or in North Carolina, democratizing data and shining white on the operation of CMS is going to allow the American people to engage in seeing where their tax-per-dollar is being spent and what types of results they are producing.

Loren Bonner: To learn more, visit Cms.gov\dashboard. Let's turn now to a group of consumers that will be dealing with an immediate benefit of Health Care Reform young adults. By September, insurers must allow children to stay on or return to their parents' insurance plans until age 26. This will allow an estimated two million young adults coverage by their parents' policies and assure to help out many college students who graduate and lose their insurance before they find a job. I went to the campus of Wesleyan University right here in Middletown to get some reaction.

I mean I personally feel okay with it because I have a job and they are going to cover me health care wise which is nice and not the situation for most people. I think that it's definitely an improvement because I know that a lot of mine friends before health care reform were like supposed to begin enactment were worried that like, or there is just kind of this stigma that like there is this post collegiate like I want to have health care and I am a young healthy person and I can like be fine without it until like I am older and can afford it. And that's something that it was definitely not a safe approach and I think that the way that this works to help people get health care for younger people is definitely beneficial and safer and more fair.

Well, I mean obviously the health _____ 6:59 justice for it.

Well, I thought it would be a benefit because we can stay on our parents' health care insurance longer till we are 26. But overall, I thought it would benefit everyone as a whole.

Loren Bonner: We will continue to follow how reform is enacted in the coming months. For now, let's listen to the interview with today's guest to learn more about this Health Care Reform's overall goals for the future.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with the Stuart Altman, Health Care Economist and Professor of National Health Policy at Brandeis University. Welcome, Professor Altman. With the passage of National Health Reform, we expect new pressures upon the health care system, particularly in the primary care field, as up to the 30 million Americans will be coming into the system. You were involved in the Massachusetts Reform Effort and they experienced considerable pressure on their primary care infrastructure. But it seems to me that the difference in the federal reform effort is the plan to invest $11 billion over the next five years in building the capacity at community health centers, a major source of primary care for the uninsured. Do you think this investment will mitigate the problems? And if not, what are some of the strategies to help address the primary care shortage problem?

Stuart Altman: We did, in Massachusetts, witness not problems, not across the whole state. As a matter of fact, those areas where they had expensive amounts of community health center, the pressure was much less. But out in more rural

areas in the western part of the state where there are both few primary care physicians and few health centers, that's where we saw the biggest problem. Now, when we get to the federal level, the Federal Government realizes this and so they have made major investments in several areas. One, you mentioned, which is to expand the number of community health centers, particularly in rural areas where they have traditionally not been and where we are likely to see big increases in demand. But the more fundamental problem is how do we both get more providers into primary care and how do we restructure primary care so that the number of providers that are in it can do a better job. And I think in both fronts, the legislation tries to deal with it.

Margaret Flinter: Mr. Altman, let's focus on Massachusetts for just a minute more if you will allow us. You co-chaired the Massachusetts' Health Care Task Force for a number of years and ultimately Massachusetts was able to enact major health reform several years before President Obama tackled it. Many people have compared the Massachusetts' process with the National Health Reform process, but there is one really compelling difference and that's the bipartisan support that the Massachusetts' effort received really right up until the enactment of Commonwealth Care. Can you share with us what was fundamentally different that such a level of bipartisan support was possible in Massachusetts and that we just didn't see that on the national level? And has that bipartisan support remained constant in these first years of implementation?

Stuart Altman: Remember, we had a Republican Governor Mitt Romney, who actually was very much involved and was really much of the force that got this going. So, from the very beginning, we had Republican support. Second, Massachusetts was in a different place. It already had a very expensive insured population. So, the lift, if you will, to go from where we were to where we want to be is much smaller than nationally. And then third, and most people don't realize it, we had a rich uncle that helped us make the Massachusetts plan work and that's the Federal Government which helps support the Massachusetts reform.

Mark Masselli: Professor Altman, the role of health care economist is a little large during that Health Care Reform today. We were pleased to interview some of your colleagues, including Dr. Davis and Dr. Reinhart here on Conversations. It seems the question to the economists have not just been what it will cost but how would people behave post Health Reform? How can we motivate people to behave differently as in using primary or preventative services more? And how can we change our financial incentives to reward better health outcomes, not just doing more procedures?

Stuart Altman: So there is no question that we, as patients and as consumers, could do a better job. On the other hand, most economists, that I know of, do not believe that at least in the short run, prevention could really fundamentally change the cost curves. Over long period of time, no question about it, but we are talking about decades. Even if we were to change and change our eating

habits and our exercise, it's a long-term process. And unfortunately, a lot of us get sick from things that have nothing to do with our own conditions. And it's when we get sick that we spend most of our money. So again, we need to look to much better understanding of what motivates people to change. Economics has a role. I think incentives make a difference, financial and otherwise. But I would not expect that even if we do change the cost curves by themselves will bend that much. And in the short run, they probably won't bend at all.

Margaret Flinter: Dr. Altman, your involvement in National and State Health Reform really goes back a long way. You were at the old Department of Health Education and Welfare in the early 70s, maybe with Dr. Davis, and many others who helped shape the legacy of community health centers and the other War on Poverty programs. I have read that you designed President Nixon's HMO Legislation and even drafted a plan to offer all Americans a federal health insurance option, something oh we might call a public option in today's world. But you did not support the Clinton Plan, as I understand it, because it called for a much too massive restructuring of the health care system. Help us understand, if you will, why this Health Reform Legislation we just passed one-year support, was it the right legislation or, as to paraphrase Winston Churchill, can you can't on the Americans do the right thing when we exhausted all other possible options?

Stuart Altman: The Clinton Plan really was a massive restructuring of the whole delivery system from the ground up. And well, it was ingenious and I am marveled at the ingenuity of it. I just felt that the American people were not willing to take that much of a radical change. It was much more than just financing. It was actual delivery, fundamental delivery reform. And my cautionary note to them, which they didn't listen at the time, was this is too much. You see the Obama people and the Hillary Clinton people when she was running learned the lesson that they needed to leave the delivery system alone, that this was to be a financing system. Now, many people have criticized the current legislation because it didn't do enough to control health care cost, and that's correct, they didn't. And from my point of view, they were absolutely right. Had we tried to fundamentally change the delivery system plus covered everybody, we would have run into the same set of problems that the Clintons ran into.

Mark Masselli: Today, we are speaking with Stuart Altman, Health Care Economist and Professor of National Health Policy at Brandeis University. I think we all heard the slogan of this summer "tell the government to keep their hands off my Medicare." You have devoted a lot of study to strategies to preserve and protect Medicare. You have also written about the need to reform the payment system in Medicare. I am not sure our listeners understand the ideas upon bundled payments and accountable care organizations or even the old DRGs are just so much jargoned to non-health policy people and health professionals alike. Can you make it simple for our listeners, how could change in the way we pay for improved care and save money?

Stuart Altman: When Medicare was set up, it became a cost-based system. If you spent the money as a hospital, you got paid for it. If a doctor could charge whatever they normally charged and the government would pay for it. Now, over the years, that system has been modified and substantially changed, so that now hospitals for example are paid a bundled payment. So if you, as a Medicare patient, go in and you have particular illness, that illness is categorized as a certain diagnosis and the hospital was paid a fixed amount of money for that whole stay. The government no longer pays the hospital just whatever their costs are and it doesn't pay the hospitals by each individual service. And as a result, hospitals have an incentive to try to find the most efficient way to provide the care. The problem is that that technique is only for inpatient care, it does not extend out to outpatient, day-to-day care from doctors before you go into the hospital, it doesn't extend out to long-term care or post acute care. So the idea is, can we develop a bundled payment which is more inclusive. Now, it could be based on a diagnosis. So if a patient is suffering from diabetes, there would be a certain amount of money that the providers who provide the care to the diabetic would receive a bundled and then there would be an allocation among the providers. Again, the hope is that by doing that, we would not see a lot of questionable care that's given, because let's face it, a lot of care that we receive really is the limited use.

Margaret Flinter: Professor, we talked a few minutes ago about the role of community health centers, particularly around accessing and meeting this surge and demand that we might see. But I would like to get your thoughts on and as a delivery system as well, the legislation, as Mark had mentioned, has an unprecedented investment in funding the growth and expansion of health centers. But they really represent a delivery system that's different than what exists as a dominant form in the United States which is still the small independently owned practice. And instead, it's a pre-model for the providers, it's a team model, certainly nurse, practitioners, physicians' assistants or primary care providers along with the physicians. And maybe even more than that, they have really embraced some of the concepts like planned care and the chronic care model. What are your thoughts about the health centers as a delivery system model in the United States? And do you think that that model is going to become the dominant paradigm in primary care?

Stuart Altman: I think we need to separate this out. The health centers have been and probably will continue to be an important component of care, primarily in lower-income areas, primarily in areas that are very hard to serve. They will not be the dominant delivery system for the majority of Americans. The reason why there was an expansion of primary care in these areas is that many of the uninsured live in these areas. So it made sense to build up the delivery system in those parts of the country and those components even with all parts of the country where the uninsured are going to live. However, we have a primary care problem for all of us. And what we need to do is to change the delivery system in

the community hospitals, in the physicians' offices, in the clinics where we, the majority of Americans live, because this problem is not unique to the uninsured.

Mark Masselli: I've been concerned a great deal about the character and the quality of the next person who runs the center for Medicaid and Medicare Services, CMS. What are your thoughts on the name being flooded by the White House, Dr. Don Berwick, who currently heads the Institute for Health Improvement?

Stuart Altman: Well, I've known Don a very long time and I have tremendous respect for him. So I don't know any other American that has had the impact on our health care system that Don Berwick has had. I mean he created IHI, the Institute for Healthcare Improvement, to focus primarily on the increasing safety and the quality of care. And according to many estimates, as a result of the work that he and his staff have done, more than 100,000 Americans a year are alive as a result of the delivery system becoming more concern with safety and with improving the basic level of cares so the quality improves. Now, with that said, he is going to have a very tough job. Medicare is critical for change in the delivery system, not only for Medicare recipients, what most people don't realize is that we are so intertwined. So for those of us who are not on Medicare, how Medicare pays, what it doesn't pay for, what kind of incentives it sets out affects us all.

Margaret Flinter: Well, it's an exciting nomination and we will be following that one closely. Professor Altman, we like to ask this question of our guests who have such a great pulse on what is going on. When you look around the country and the world, what do you see that excites you in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Stuart Altman: What I am excited about is innovating in the community and making our community-based system work better. And one thing that's in the legislation that I hope works, and Don Berwick will have a lot to say about this, is that Innovation Center in Medicare that will allow Medicare to sort of behave in a different way than it's done in the past and be much more experimental in moving these unique delivery systems out to the community.

Mark Masselli: Today, we have been speaking with Stuart Altman, a Health Care Economist and Professor of National Health Policy at Brandeis University. Thank you for joining us. Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Margaret Flinter: This week's bright idea takes a look at our very own Wesleyan University and the change in the dining hall that's saving the school money and improving student health. Last fall, Wesleyan's main dining hall in the campus center did away with its plastic food service trays joining scores of other

universities that have made this move. One student, senior Sid Berkman, who's experienced the change, thinks it's a good thing.

The main reason that is given I think is to save water and like keep from cleaning in things, but I think it's more beneficial health wise because you can't carry as much food without it so you are not like feeling the necessity to like finish everything you crammed on to your tray.

The change was spearheaded by the Wesleyan Student Assembly Dining Committee with help from the Environmental Organizers Network after ARAMARK Higher Education Food Services released a study on the benefits of going trayless. The study of 186,000 trayless meals at 25 Colleges and universities found that traylessness reduced food waste by 25% to 30%. Going trayless also eliminates the half gallon of heated water needed to wash each tray after use. In one semester, the average school saved up to 200,000 gallons of water. While the Trayless Initiative was first supported for these environmental and economic reasons, the health benefits of eliminating trays also abound. First, traylessness makes it easier for students to make healthy choices about their portion sizes. Instead of piling different plates and bowls and cups of food and drinks on their trays without much thought, students are now more conscious of what food they chose. This means they are less likely to overeat making the threat of the Freshman Fifteen a little less problematic. The money that dining service saves through reduced waste and water energy use also helps ensure that schools can afford to continue providing students with a wide variety of healthy food options, including fresh locally grown produce. Wesleyan's decision to do away with trays is part of a larger nationwide movement. Middlebury College in Vermont led the way in 2006 and was closely followed by Skidmore College and Brown University as well as many more. Over 100 schools have now made the change and colleges and Universities are not the only places going trayless. Last month, New York City Public Schools announced trayless Tuesdays, a once-a-week experiment with traylessness. Although some students at Wesleyan and elsewhere initially bogged at losing the convenience of trays, they have since settled into a new healthier routine. Reducing waste and improving student health, now that's a bright idea.

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

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

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