Katherine Baicker

Mark Masselli: This is Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret it's hard to believe six years have passed since the President signed the Affordable Care Act into law truly has proven to be a watershed moment for much needed reform of the American healthcare system.

Margaret Flinter: When the President signed the law in 2010 and estimated 50 million Americans were uninsured, now 20 million Americans have gained coverage and that's a signature achievement. Of course the health reform journey continues but we note the progress.

Mark Masselli: The uninsured rate for African Americans has dropped 53%, dropped just under 30% for Hispanic population, many of those close to the poverty line gained coverage under the Medicaid expansion portion of the law as well.

Margaret Flinter: The Supreme Court do not uphold [PH] the Medicaid expansion law with the result that 20 states have yet to approve Medicaid expansion. And that leaves many of their most vulnerable residents still uninsured and without access to care or the resources to pay for it. That reminds of a comment that was made by Harvard School of Public Health, John McDonough "Because of this people will die".

Mark Masselli: And our guest today is one of Dr. McDonough's Harvard colleagues, Katherine Baicker

Margaret Flinter: She is renowned health economist who has been analyzing data for years on the impact of gaining health insurance coverage on health outcomes as well as on reducing personal financial burdens.

Mark Masselli: Also we will be hearing from Lori Robertson, the managing editor of FactCheck.org, is always on the hunt for misstatements spoken about health policy in the public domain but no matter what the topic, you can hear all of our shows by going to chcradio.com.

Margaret Flinter: And remember if you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter because we love to hear from you. Now we will get to our interview with Dr. Katherine Baicker 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 healthcare headlines. On the sixth anniversary of the signing of the Affordable Care Act one of the more contentious aspects of the law found itself under review at the Supreme Court again, the mandate requiring all employers providing health coverage to offer birth control services as part of that mandate and issue the controversial requirement that most health insurance plans provide women with access to contraceptives at no additional out-of-pocket cost. Challengers say it's still violates a federal law protecting the free exercise of religion, the Supreme Court still [Inaudible 00:02:37] since the death of Antonin Scalia Supreme Court observer say, the court seems evenly split.

An estimated 86 million Americans, about 1 in 3 adults are believed to be pre-diabetic setting a stage for a tsunami of diabetes cases down the line. Health and Human Services Secretary, Sylvia Mathews Burwell announced plans to expand a pilot program launched at the YMCA that puts at risk patients into diabetes prevention programs. The program uses group meetings, exercise and diet counseling and other methods to help pre-diabetics gain control of their condition and according to early results the program appears to be working. It's the first prevention pilot program to become eligible for expanded funding under Medicare.

The FDA is stepping up action in the wake of a rising tide of opioid addiction and overdose deaths in this country. FDA issuing new rules for so called the Black Box Warnings to be placed on all opioid labels about risk including risk for abuse, addiction as well as overdose and death. Overdose is now the leading cause of accidental death in this country with 47,000 opioid deaths reported in 2014 alone.

And chocolate, the wonder drug it's been getting a lot of great praise [PH] lately as a heart healthy, brain healthy super food according to, another recent study it may also be a potent performance enhancer. A study just published in the Journal of the International Society of Sports Medicine found that just a few days of ingesting dark chocolate increased the production of nitric oxide in cycling athletes. Every athlete in the study performed better after ingesting dark chocolate versus a control group eating the white stuff. I am Marianne O'Hare with these healthcare headlines.

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Mark Masselli: We are speaking today with Katherine Baicker, PhD and the C Boyden Gray Professor of Health Economics and recent Chair of the Department of Health Policy and Management at the Harvard T H Chan School of Public Health. Professor Baicker serves as a Commissioner on the Medicare Payment Advisory Commission, as Chair of the Massachusetts Group Insurance Commission and on the Congressional Budget Office Panel of Health Advisers. Dr. Baicker's work has been widely published and she serves on the Editorial Boards of Health Affairs and the Journal of Health Economics. She earned her BA from Yale and her PhD in economics from Harvard. Professor Baicker, welcome to Conversations on Healthcare.

Katherine Baicker: Thank you for having me.

Mark Masselli: Well Katherine you have earned the reputation of being one of the nation's leading health economist and you focused much of your research on the effects of health reform and we are six years out from the passage of the Affordable Care Act and the impact of which you really spent a lot of time focusing on. So maybe you could share with our listeners how the ACA has lived up or fallen short of the expectations both in terms of coverage as well as the economic impact on consumers.

Katherine Baicker: Sure. I think there were two main goals of health insurance and healthcare reform. One was to expand coverage to people who didn't have insurance or didn't have adequate access to care. And the second was to improve the value that we get from the healthcare system as well as spending growth for both public programs and for health insurance premiums for people buying it in private markets.

I think we have succeeded better on the first goal than we have to date on the second, and that's because the second goal is harder. As a profession we have a pretty good idea about how to expand insurance for different populations but it's a problem that we understand pretty well. Getting higher value out of the healthcare systems, stopping spending a lot of money on things that don't improve health while maintaining access to life saving care, that is a much harder question and I don't think we have the answer yet.

Margaret Flinter: Well Katherine as an economist, of course your focus in on analyzing cost benefit analysis of policy decisions that we make, and there are so many items right now that drive the cost side of the equation I have been thinking about the, certainly the ongoing Medicaid expansion debate but also the public health crisis that arrive on our horizons needing money for research on the zika virus or battling the opioid crisis. We would really like to hear your thoughts as a member of the

Congressional Budget Office Panel of Health Advisors this idea of intrinsic value and how that comes into play when people are round the table informing policy decisions.

Katherine Baicker: People like to say, well you can't put a price on health, as an economist I can put a price on anything. And I think that it's important to put a price on health because we have so many competing public policy priorities; health, and food, and housing, and education and transportation. So if you are not willing to think carefully about, is this money creating the most good world by devoting it to healthcare, I think you are going to end up with a really distorted use of resources.

And we see that when we think about spending on healthcare that produces very small health benefits at enormous cost. I think we haven't wrestled [PH] carefully enough with how we want to make those decisions. Those are very tough decisions to make but if you are not willing to engage on what's the value that I am getting out of this healthcare spending, there is no way to devote those resources to where they are doing the most good.

It's much easier when you identify care that is not improving people's health at all and there is an alarming quantity of that, conceptually I think we all agree, the much more difficult ones are treatments that might extend patients' lives by a matter of week at a cost of millions of dollars and the human being in all of us, I think has the same reaction, well of course you want to do whatever you can, but that may not be the right answer when there are all sorts of other things you could use those resources for that would improve people's lives by more, and that's the tradeoff.

Mark Masselli: Katherine, you gained quite of a bit of attention for a research study you conducted, it was the so called Oregon Medicaid Experiment which offered uninsured Oregonians a chance to win Medicaid coverage in a state wide lottery. And you had the sort of perfect scenario for a randomized clinical trial with a control and the intervention group, could you tell us what you studied in the Oregon experiment and why it was so interesting and how you were able to mine it for such a rich datasets.

Katherine Baicker: This is I think one of the most important studies I have had the opportunity to work on. Oregon as you mentioned had a waiting list for its Medicaid programs. And they decided that the most fair thing to do would be to draw names from the waiting list by chance, and the most fair way to allocate the limited spots that was available was by lottery. So it was born off necessity and scarce resources but it then created this unprecedented opportunity to really assess the effects of expanding Medicaid on healthcare used, on financial wellbeing a whole range outcome. And that's because people who are on Medicaid and the uninsured look different in lots of ways,

being poor or having a disabling health condition are both independently bad for your health.

People on Medicaid have a higher mortality rate. It might be tempting to naively conclude that Medicaid is killing them they have a mortality rate, what a terrible program, but of course that's not a valid conclusion from that fact pattern. People on Medicaid have higher mortality rates for lots of other reasons. So with the Oregon context we had this unprecedented opportunity to have an actual randomized control group. You would never accept information about whether a drug worked or not without a randomized control trial but we are frequently forced to do that for public policies because there is no randomized control trial, but here, born out of necessity in Oregon there was one. And so we were able to launch a massive data collection effort to study the people who got Medicaid because of the lottery and the people who remained on the lottery list but didn't get access to the program. And I think we have found a lot of interesting things people wouldn't have expected.

Margaret Flinter: Well Katherine I am going to ask you to maybe stick with that because I think the results were very fascinating and participants who got coverage reported feeling healthier. There is a 30% improvement in self-assessment of mental health or reduction of depression, coverage led to a great use of specialists in hospitals services which actually increase the cost of care without markedly improving their health maybe you could address some of these interesting findings, how do they inform your broader understanding of the impact of gaining coverage?

Katherine Baicker: I think we learned a lot about how health insurance affect healthcare use, health and wellbeing from the study. As you noted, we saw a substantial increase in healthcare use. When people gained access to Medicaid, they went to the doctor more, they got more preventive care, they use more prescription medications. I think all of those lined up with the expectations of policy makers and stakeholders part of the goal of expanding insurance was to expand access to those services and we also saw an increase in hospitalization. On the other hand the population was probably substantially underserved there were probably a lot of conditions that needed to be addressed in the hospital and we saw a substantial increase in use for those kinds of services.

The very surprising thing was that we also saw about a 40% increase in Emergency Department use, and I don't think was expected by most people, they had really hoped that getting people access to primary care we would keep them out of the Emergency Department and that maybe less surprising to economist, when insurance makes the Emergency Department free, people go more often. They were more likely to go in

situations we might think of a somewhat more discretionary, and once people had insurance they were much likely to opt to go to the Emergency Department in those circumstances.

The second set of findings was to think about financial well-beings, and that is under-appreciated in my view. Insurance is supposed to get you access to care but it's also supposed to keep you from getting evicted from your apartment because you paid your hospital bill instead of your rent. And we saw it succeeding very well for new Medicaid beneficiaries in those circumstances. There was a dramatic reduction in bills being sent to collection, the incidents of catastrophic out-of-pocket medical expenses vanished when people had Medicaid relative to being uninsured.

But then the third set of outcomes that you pointed to is health outcomes and there is a stories much more nuanced, we saw this big reduction in clinical measures of depression there was a 30% drop in assessing people as having a clinical depressive episode when we interviewed them in person. And this is a dramatic improvement, the physical health outcomes were a little more mixed, people reported being in much better health but we didn't detect improvement in things like cholesterol, diabetic blood sugar control or high blood pressure. So our estimates [PH] were consistent with some modest improvements in those measures but any changes in them were not big enough to be statistically detectable in our sample.

Mark Masselli: We are speaking today with Katherine Baicker, PhD and C Boyden Professor of Health Economics and recent Chair of the Department of Health Policy and Management at the Harvard T H Chan School of Public Health. You know Katherine I was thinking as you were talking about the Oregon experience, that you have another set of opportunities and many states have chosen not to opt into the Medicaid expansion program, are you picking up similar types of dataset examples as you did in the Oregon experience?

Katherine Baicker: It's harder to compare across states. There is something different about the states that are choosing to expand from those aren't so it's not a perfect apples to apples comparison. That said, I think that there is still a lot to learn by looking at states that expand versus those that don't, before they expand versus afterwards. I would love to see more information about, what's really working well in insurance expansion and what works less well in terms of the type of insurance whether it's public or private, how heavily managed it is, how far beyond the siloed walls of the healthcare system it reaches. There are some really interesting experiments going on in some states – Oregon included – looking at reaching out into the community to try to provide

more flexible Medicaid benefits or some states are experimenting with providing health insurance on the exchange instead of Medicaid benefits.

One of the lessons that I think we learned from Oregon is that expanding a traditional Medicaid managed care plan to a population with complicated healthcare needs, is probably not sufficient to dramatically improve management of chronic conditions like diabetes or high blood pressure. And I think that there is a lot less for us to learn about the provider side of things and the insurer side of things in terms of designing insurance products that really work for these populations.

Margaret Flinter: Well Katherine we all turn our eyes towards the state of Massachusetts which has had new universal coverage for I think almost a decade now, in the years following the passage of health reform usage and cost went up, but the death rate actually dropped indicating some things were working, what can we learn from the long view in Massachusetts still out-of-pocket cost is a big issue lot of people.

Katherine Baicker: Understanding the effect of a system wide expansion of health insurance maybe very different from a narrow expansion because there maybe more of a strain on capacity, there may not be enough primary care providers to go around when you suddenly ensure millions of people across the country. But if the payment system and incentives are right, their provider system can adjust to accommodate an influx of new people and you raised the issue of co-pay nuance cost sharing can be an important component of a sustainable healthcare system.

It has to be designed in a way to maintain access to high value care but to not spend a lot of money on care of questionable value. But at the same time we do know that if there is some cost sharing people will think twice about whether the care has enough value for them. You can't expect me as a non-clinician to be able to make incredibly nuance decisions about the best course of healthcare for me some kinds of preventive care, some things that are of questionable value that second MRI, antibiotics when they are not needed maybe they should come with high cost sharing so the patients are less likely to use them. And higher income people are exposed to a little bit more cost sharing and lower income people don't face barriers to accessing high value care that higher cost sharing might bring. I think that's a necessary component of a sustainable healthcare system.

Mark Masselli: We have a lot of corporations who have been grappling with their high cost healthcare and really trying to have them focusing on wellness, where do you see it being effective where some incentive might be good for these larger problems that we face?

Katherine Baicker: Working adult spend you know eight or more hours a day in their workplace and a lot of the behaviors that we are trying to help modify whether it's smoking or exercise or healthy eating or even medication adherence. The place where you are spending a lot of your time is going to have an important influence on your ability to follow through on the best of intentions. So there is a good reason to think that having employers as partners in promoting better health behaviors could be really valuable.

I think there is scanned evidence to date on how well they work. It's not that we know they don't work, we just don't know because it's very hard again without randomized control trial evidence to have a sense of whether it's just people who were already going to invest in better health behaviors. So having much better evidence I think would support both private investment and public investment in these kinds of activities. I am leading another effort to try to develop randomized control trial evidence on how well these programs work and if we find evidence that we do, that's a great public policy tools to use and it could be use in terms of, and hopefully we will soon have evidence about how well those might work.

Margaret Flinter: We have been speaking today with Katherine Baicker the C Boyden Gray Professor of Health Economics and Chair of the Department of Health Policy and Management at the Harvard T H Chan School of Public Health. You can learn more about Dr. Baicker and her team's work by going to @HarvardChanSPH, Dr. Baicker thank you so much for joining us on Conversations on Healthcare today.

Katherine Baicker: Thank you so much.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare 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: Alaska Senator, Lisa Murkowski says she opposes federal approval of genetically engineered salmon "for the health of both consumers and fisheries." but there is no scientific evidence that suggests GE salmon will pose a significant risk to either.

Scientists engineered GE salmon to grow faster than non-GE farm-raised salmon by inserting genes from two other fish into the genome of an Atlantic salmon. After these changes, the GE salmon remained nutritionally and physiologically comparable to non-GE salmon according to Food and Drug Administration's the scientific assessments.

The FDA approved GE salmon, marketed by AquaBounty Technologies in November 2015. The FDA says it can't establish with complete certainty the absolute harmlessness of any substance so it defines safe to eat as "a reasonable certainty in the minds of competent scientists". To start the FDA says that the growth hormone, the genetically engineered fish gains from genes from the Chinook salmon doesn't pose a risk to humans because it doesn't bind to mammalian growth hormone receptors.

There are elevated levels of another hormone in GE salmon compared with non-GE farm-raised salmon though the difference wasn't statistically significant. The FDA also found the nutritional profile of GE and non-GE salmon were similar. One difference was slightly elevated levels of vitamin B6. In extreme amounts vitamin B6 can be toxic.

In an address to the senate Murkowski implied that GE salmon can't provide the omega-3 fatty acids that are in wild species of salmon. But that the FDA found that the GE salmon's omega-3, omega-6 ratios were virtually identical to those of non-GE salmon. The GE salmon won't rich supermarkets for at least a few years and the FDA has to publish labeling guidelines before the salmon can be sold. 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 Healthcare.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Depression is extremely common among adolescents in this country but it's often hard to differentiate between typically teen angst and a clinical condition that requires a more immediate intervention. Suicide is the third leading cause of death among 10 to 24 year olds, a population that almost ubiquitously uses texting as a form of communication.

Nancy Lublin: So if you are someone who is in pain, you text us and then the counselor on the other side there are on screen that almost looks kind of like Facebook or Gmail.

Mark Masselli: Nancy Lublin is Founder and CEO of Crisis Text Line an instant texting service designed to encourage teens in crisis to reach out for help. All they have to do is text the numbers 741-741.

Nancy Lublin: When messages come in with certain keywords in them, they automatically get tagged as high risk. So we don't take them chronologically, if you are at risk for suicide you are automatically bumped up in the queue and you are like code red.

Mark Masselli: Since she founded Crisis Text the world has spread like wildfire. They receive an average of 15,000 texts per day from kids experiencing everything from typical teen dilemmas such as a fight with a boyfriend, to kids contemplating suicide those in most danger are encouraged to take action through a series of channels. Crisis Text Line, an instant age appropriate intervention, available free of charge and 24x7 to give kids in crisis a lifeline and lead them to help they need, now that's a bright idea.

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Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

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

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