Senator Bill Cassidy

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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the healthcare of the future.

This week Mark and Margaret, welcome U.S. Senator Bill Cassidy, Louisiana's ranking republican and also a physician. He's co-sponsored a bipartisan bill addressing growing concerns around patient data protection. Citing tech companies like Google, now handling data for large health systems as well as their purchase of Fitbit now gaining access to huge amounts of personal health data. He talks about this smartwatch data bill aimed at protecting consumers.

Lori Robertson also checks in, the Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea. It's improving health and wellbeing in everyday lives.

If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcast. You can also ask Alexa to play the program Conversations on Health Care.

Now, stay tuned for our interview with Louisiana Senator Bill Cassidy here on Conversations on Health Care.

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Mark Masselli: Welcome to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: We're speaking today with the United States Senator Bill Cassidy, a Republican and Senior Senator from Louisiana. Previously, he was the U.S. Representative for Louisiana's sixth congressional district and before that, a member of the Louisiana State Senate. Senator Cassidy is also a gastroenterologist and founded the First Free Community Clinic in Baton Rouge to treat those lacking insurance and access to medical care. Senator Cassidy is a graduate of Louisiana State University and LSU School of Medicine. Senator Cassidy, welcome to Conversations on Health Care.

Bill Cassidy: Hey, thank you for having me. I'm very pleased to be with you.

Mark Masselli: Oh, that's great. I think it's fair to say that our country and its population are still trying to find this common ground, if you will, around health reform and health policy. There's plenty that divides us, but I think you have been trying to unite us in a bipartisan effort. You recently joined with Democratic Senator Jacky Rosen of Nevada submitting a bill aimed at protecting personal health data. You cite

Google's recent partnership with health system ascension as well as their acquisition of Fitbit. Examples that you're concerned about, I'm wondering if you could talk a little bit about your Smartwatch Data Act and what you're seeking to accomplish with it?

Bill Cassidy: Imagine that you have a smartwatch that gives a sense of how much you're walking every day, that's an app iCheck, but it also has the ability to see if you fall or if your gait the way you walk is shuffling or whether it's a good long stride. You can monetize that data. If you find that someone who happens to be, because you know this, 70 years old, has begun to fall more often, or maybe they're not walking at all, they are declaring themselves at risk for neurologic disease, maybe Parkinson's. If they have Parkinson's, you understand if you're a Medicare Advantage Program, yeah, I get a little extra for somebody who's 70 something years old, but maybe not enough for someone who's going to go into full blown Parkinson's. Maybe that's somebody I don't wish to have on my plan. That can be monetized. That is wrong. We need to have safeguards around our data been monetized in such a way unless we are aware of the implications of that data being monetized.

Margaret Flinter: Senator, it does feel sometimes like we're in the wild, wild, west with some of these issues, and it's really a lot of it is fairly recent. I'm not sure we could have anticipated not too many years ago, the explosion of platforms from the smartwatches gathering, real-time health metrics and here's your great example of maybe monitoring the gate of somebody who might be moving towards Parkinson's or in the early phases. We've got genomic companies like 23andMe, leveraging enormous amounts of data and also potentially profiting from that data. HIPAA now seems like almost the distant past when it was first created and we all had to master a new domain to learn about that. We understood was fundamentally to try and protect patient privacy. We don't know if it's fully equipped to help us govern these new areas of health data generation. If you could talk with us about how this bill might enhance health data privacy, and does it build upon HIPAA, is that still a strong foundation that we can build upon?

Bill Cassidy: I think HIPAA is a strong foundation, but HIPAA has limitations. As one example, these apps that would download your medical records, you say, okay, please download my medical records. Those are not HIPAA covered entities, and so that app can do whatever it wants to with your data. Now, people argue it's my data, so you can do something with it what you wish. I'm a physician and I know that in that history and physical is a family history.

Margaret Flinter: Right.

Bill Cassidy: I have a family history of a sister who had a difficult pregnancy. Oh, let's figure out who that sister is. She has a different last name, but

we know who she is and we know who she works for, that small group. Do we really want to ensure this particular small group, because we see that she still is in childbearing potential. In fact, we know from consumer data that we purchased that she recently purchased a pregnancy test. She's thinking of becoming pregnant again, but she had a high risk pregnancy once before. You see where I'm going with it.

Margaret Flinter: Absolutely.

Bill Cassidy: Now, this example is not outlandish. It is certainly within the scope of what people can do now with third party data. The fact that I am downloading my history in physical, which includes a family history, which can then be monetized, sold without my permission, and specifically without my sister's permission, is a brave new frontier. Now, that's before we begin to talk about genetic data.

Margaret Flinter: Right.

Mark Masselli: Right.

Bill Cassidy: Genetic data, which has the code for everybody to whom I'm related. My sister didn't get permission for that genetic data to be posted and yet, they know pretty much -- they know a lot about her, because of my decision to so post. We just have to think this through.

Mark Masselli: Well, and I really appreciate how you've described this in ways that I think people can get their heads around. I also think, in addition to those concerning trends, we also have the data breaches that are happening all across the country and really all across the world. You've got that on one side, you've got people tapping into your data as you've actually described in using it for ways that aren't about improving outcomes. Then, you have sort of the corporate group who are entering the healthcare business, the CVSs, the Walmart's, Walgreens. On one hand, those are great for our consumers, but it also is a point of vulnerability in terms of, as you've described earlier about how this might be utilized. What do you think the right set of protections are at the state level, the federal government's responsibility? Where do you see this responsibility for protection lie?

Bill Cassidy: Well, let me just kind of accentuate something that you mentioned, but just to also show. I've been showing the risk of having our privacy sacrificed, but you mentioned there's the potential for great benefits. There's a friend of mine whose son has a rare form of inflammatory bowel disease, which does not respond to the normal drugs like Humira that are used to treat it. There is enough of a data set that they've been able to realize that he is one of a very small number of people that have this particular genetic profile, and although this drug doesn't work, this one does.

Mark Masselli: Yes.

Bill Cassidy: We can also see that there is a promise in the ability to amalgamate. What is the potential? What is the -- where do we need to be? One, I'm not sure that answer is entirely there, but if something is going to be monetized, I kind of would like to directly benefit. If I have the gene, somebody researches me and I live to be 110 years old, and I don't have Alzheimer's and I don't have arthritis, I don't have diabetes, and someone says, let's go through his genetic code and find out the longevity gene. Maybe I should know they are using my genetic code for such a gene, maybe I should benefit. By the way, as an aside, the United States does not require permission for someone's DNA to be tested. Meaning that someone could sneak up to that 110-year-old, clip off a little bit of their hair and send it off without their permission and their genetic code could be so isolated. Whenever I see a pop up ad, how do you know somebody is cheating on you? I bet you they're trying to get somebody to send off, I've never clicked on it. I suspect they're trying to get you to send off that long hair you found on their coat, because they would like to expand their data set of genetic code.

I think we just need to have a very full conversation about it and we have to realize what is that stake, not just for the individual, but everyone to whom he or she is related to and/or is given information about, and then try and find the resolution of that tension. By the way, I also think that you should only be able to get DNA testing on somebody with their explicit permission, unless that person is a minor, in which case the parent could be the agent for them. That is something I feel strongly about.

Margaret Flinter: Senator, I think it's fair to say that you've been a vocal opponent of the Affordable Care Act, but you have been offering and advocating for other approaches that you think would help reform the health care system, and you've promoted a number of bills, which really get right to the heart of the issue that's on everybody's mind, which is the cost of health care in America. Your bills are seeking to promote transparency and health delivery costs, and particularly in drug costs, it is astonishing to look at the price of some of the drugs that we need to treat conditions today. Talk about some of the noteworthy aspects of your legislative proposals, and also if you could maybe share with us some of the highlights of the white paper that you produced on reducing healthcare costs. I think that was just released last year.

Bill Cassidy: Yeah. You go on our website, cassidy.senate.gov, and we have a little bar you can click making healthcare affordable again. Let me just say that all the bills we've proposed have been bipartisan. I'm not saying it's solely a republican concern. I think it's just a recognition that healthcare has become unaffordable. I'll say the administration is also

bought into this. The president is all about price transparency as a market mechanism to get to lower prices. Would it be great if somebody ordered a CT scan on your daughter and you could scan her barcode for the certain type of scan they wanted your daughter to have. They told you that you could go right now down the hallway, and get that CT scan for $2,500. You could go Thursday at midnight and get it for $250 across town. You look down at your daughter and you would say, you always wanted to stay up until midnight, you're going to get to, and you would take her Thursday at midnight. That would be a market force responding to the fact that you are having an elective procedure.

By the way, it is not necessarily the insurance company that will negotiate that best price for you, because the insurance company will pay for both. You can't really rely upon them to do anything more than to pay 80% of the cost. I picked those two numbers, because about five years ago, there was a survey done in Los Angeles for the cash price of a CT scan, and that was the difference in the cash price then, wouldn't it be great if the consumer knew, and wouldn't it be even better if she had bought searching for that better value. We think that once you begin to mandate price transparency, the market will respond.

Now, I say that because more and more folks are moving to Health Savings Accounts, in which they're responsible for the first part of their deductible, so this makes that Health Savings Account more useful and hopefully more used, because you now have the ability to find that good price. That's one of the ideas that we've been pushing for, but one thing we are big about is direct primary care, in which the patient contracts with a primary care physician $50 to $100 a month, and they get everything cared for on an outpatient basis within that scope of practice. I call it a Blue Collar Concierge Practice. If you have a headache Friday afternoon, the doc doesn't send you to the ER to wait overnight to finally get your headache treated. If he does that, you're going to cancel your contract with him. It's a month to month contract. He's going to have some sort of follow up, so you're going to be seen, it's not going to cost you anything out of pocket, you're going to be seen and you're going to have your problem addressed, then maybe even making a house call, because that would be more convenient for you, and you're more likely to keep that contract going with him. That’s another example of what's already being done, but which can lower costs for folks and make healthcare more convenient for them.

Mark Masselli: We're speaking today with U.S. Senator Bill Cassidy, the Senior Senator from Louisiana. He previously was their representative from Louisiana, sixth congressional district. Senator as a physician, and also is someone who worked in a free clinic caring for the most

economically challenged patients and also your region has a very high rate of uninsured residents. I'm wondering how that informed your thoughts of how we might improve access to primary care? You talked a little bit about the HSA. I know you've got a new bill coming out, you've ways that that might be allowed people to use that for primary care as you were indicating. I also know you've been a supporter of Community Health Centers in Louisiana, but what's your larger thinking about this access? You've got the working man's or working woman's package that you have. I say working class and below economically, are you contemplating?

Bill Cassidy: Think about the way many health insurance plans are structured. They can have a $6,000 deductible. 95% of families will never get to $6,000 in health expenses per year. Now, that plan may work for somebody who is better off, who understands that if they go into the hospital uninsured that they have assets that the hospital will come after suing them if they don't pay their bill. What if they're working person and the hospital is not going to get the money out of them, because they don't have any money. These sorts of policies, $6,000 deductibles, are more for the benefit of the insurance company and for the hospital and for those selling high priced drugs and medical equipment than it is for the patient. For the patient, she really needs first dollar coverage, so that when her daughter has an earache, she can take her to the Urgent Care Center and get both her visit as well as the antibiotic for her daughter. That's really what she needs.

Now, she still wants that high end policy, where her child has leukemia, she gets it covered. I think what we really need to think about doing is restructuring these policies, so it actually helps that working family that has maybe $2,000 in their savings account, but doesn't want to spend it on a single ER visit, and they get a bill for $5,000. My practice was actually in the Louisiana's Charity Hospital System. About 90% of my practice for those on Medicaid are those who were uninsured. I no longer practice. Those are folks who are working two jobs to pay their rent, and for them to pay a $6,000 deductible is ridiculous.

Mark Masselli: Yeah.

Bill Cassidy: Now frankly, the hospital will lose a little bit, because maybe the threshold, by which -- above which everything is covered will be higher than it was before. More importantly, the patient will gain, because she now has the first dollar covered for her daughter's earache and for the antibiotic, which her daughter needs.

Margaret Flinter: Well, Senator, we want to thank you so much for the service and the care that you provided over a career in the charity hospital system, and the free clinics, and for your support of community health centers. We've had memorable guests from Louisiana on our show.

Your state's health secretary Dr. Rebekah joined us not too long ago, describing one of the impacts of Hurricane Katrina that you all lived through. You didn't hear so much at the time compared with the human suffering, but this was the destruction of tens of thousands of paper medical records, which of course, were always vulnerable, but Hurricane Katrina really brought that issue to light in a way that no other natural disaster had. Your state launched an effective electronic health record system and its aftermath. Talk with us about what has made the Louisiana's record system more robust, and what the rest of the country might learn from Louisiana?

Bill Cassidy: There was an effort within the charity hospital system, which is largest hospitals in New Orleans, to get things in an environment where you could log on and see everything you needed. A lot of the other progress has been subsequent to the Obama administration's effort to promote the use of Electronic Medical Records. Our hospitals still have the same problem that every hospital does. You may both be on Epic, but you still have systems that don't communicate very well. A friend of mine who's at one hospital with Epic says, if he gets records from another hospital with Epic, it comes over unstructured, meaning that is not as in your labs all lined up, so here's the date and here's the lab, but rather it’s just a mass of paper, and then we flip through and see what it shows, but that could be in Louisiana we hear that or it could be in Iowa or Maine or New York. I think we have a long ways to go to before we have an EHR system, which is as seamless as tax payers were promised, and which is why taxpayers put a billions of dollars to achieve.

Mark Masselli: Louisiana has a large rural population and I know that you're concerned about how you access and deliver care there. Certainly, Telehealth Telemedicine is one of those force multipliers, if you will. As you think about tapping the potential of Telehealth, what's on your mind in terms of supporting legislation that might be helpful?

Bill Cassidy: There are several issues there. There's one the financial issue, the regulatory issue, as well as the technical issue. The financial issue, is it paid for? The administration has recently come out with some rules saying that if you are in an at risk plan, say, a Medicare Advantage Program, they really have begun to melt away all the restrictions upon the use of Telehealth, which is fantastic. That way you're not going to have some doc ripping off the system living in Montana practicing across the nation, but really doing nothing to value, because now, it's a capitated program, and you have somebody kind of making sure that it's done correctly. I think we're evolving to models where it can be used.

Speaking of the technical, some of it can be far simpler. Again, my daughter had a rash the other night, and so I have a friend who's a

dermatologist, I FaceTime Harry, I said what a great name for a dermatologist. I say, Harry, my daughter's got a rash. He goes, hey, Bill, I think this is what it is. I'll call her prescription, pick it up, and she'll be okay. By the next morning, we were on our pathway to things being done. I think the technical is a little bit further along, although we have a ways to go. Then the regulatory, I think that we have issues such as, can you cross state lines, but certainly within a state, there's not a reason why a group within my state could not help somebody in a rural area. That said, you could also imagine somebody in Philadelphia doing tele mental health across the nation, and I do think we have to figure out the regulatory environment that allows that to be done.

Margaret Flinter: We've been speaking today with U.S. Senator Bill Cassidy of Louisiana. You can learn more about his policy initiatives by going to cassidy.senate.gov or follow him on Twitter at @SenatorBillCassidy. Senator Cassidy, we want to thank you for your commitment to care, to public service and for joining us today on Conversations on Health Care.

Bill Cassidy: Thank you both very much for having me.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about 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 U.S. politics. Lori, what have you got for us this week?

Lori Robertson: In the last Democratic presidential debate, former Vice President Joe Biden made the dubious claim that, "right now the vast majority of Democrats do not support Medicare for All". The opposite is true according to a poll published earlier the same day Biden made the claim. The poll of 1,205 adults found that 77% of Democrats and 53% of all adult Americans regardless of party said they favored Medicare for All. That's what they said when asked, "do you favor or oppose having a national health plan, sometimes called Medicare for All, in which all Americans would get their insurance from a single government plan?"

An earlier KFF poll published in January found that overall support for the idea plunged by 23 points when voters, regardless of party, were told it would require most Americans to pay more in taxes, and by 21 point when told it would eliminate private health insurance companies. CNN reported in July that its own poll showed among potential Democrats and Democratic-leaning Independent only 31% supported Medicare for All when given the alternative of a public

option favored by 48%. That's a government run insurance plan that would compete with, but not replace private insurance. CNN said 12% didn't want a national health care plan at all.

That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and as a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

[**Music**]

Margaret Flinter: Each week Conversation 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 Queens University in Belfast, Ireland, there's 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 are exposed to music therapy in addition to traditional therapies had far better outcomes than those children in a control group that offer traditional therapy without music therapy.

Dr. Sam Porter: It is not a matter of them being given music or choosing music, they actually make music. 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 the mood in children and adolescents as well as adults, but his study revealed just how effective the music therapy was.

Dr. Sam Porter: There were two very interesting secondary outcomes, levels of depression and levels of self esteem. In the secondary outcomes, we find a statistically significant difference between the control group and the intervention group.

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

Dr. Sam Porter: I mean, that's one of the marvelous things about music therapy is the things that is not, there are no side effects. It is not a dangerous therapy to get kids involved and it is such a good way and a harmless way of doing things.

Margaret Flinter: 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**]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and Health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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