(Music)

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

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Although, we are a show about health care I think we would be remiss if we didn't congratulate the Green Bay Packers on their Super Bowl victory on Sunday, what a game with 31:25 win over the Pittsburgh Steelers. It was a great game but I really love that Volkswagen Commercial, Margaret.

Margaret Flinter: Well, I hear it was a great game and I continued my lifelong tradition of not watching it but I did enjoy reading about it and hearing about those commercials. And Mark, there was even health care news at the Super Bowl. The winner of the NFL's PLAY 60 contest was announced. PLAY 60 was launched by the NFL in 2007 to challenge kids to get active for at least 60 minutes a day and that really ties into our major concern with getting everyone to step up in the fight against childhood obesity.

Mark Masselli: Well, and here at the Community Health Center, we launched our Recess Rocks video contest back in September which asked students about how they think childhood obesity should be dealt with. This year's winners were just announced and as we suspected these kids really offered up some great creative solutions about how to resolve and solve the childhood obesity epidemic. You can catch that on our Recess Rocks' website at www.recessrocks.com.

Margaret Flinter: They certainly did and I think we have got to give a shout out to the O'Neill Elementary School in O'Neill, Nebraska, a first prize winner, the Macdonough School right here in Connecticut second place and the Cobblestone Elementary School in Rocklin, California. We were just blown away by the energy and creativity in the ideas that they offered up on how to solve the obesity epidemic and how they presented it. We are in good hands with this generation of kids.

Mark Masselli: We really are. And First Lady Michelle Obama will make it her goal during the second year of her Let's Move Campaign to get everyone out not just in schools but businesses and corporations. We are glad to be part of that and speaking of ongoing battles, Margaret.

Margaret Flinter: Yeah. We could never get away from the ongoing battle of the fight over health care reform which of course is far from over now that we are coming up on a year since the legislation was actually signed.

Mark Masselli: We are.

Margaret Flinter. And as expected, an amendment in the senate to repeal the Affordable Care Act failed. So the focus goes back to the budget process in the courts especially following and paying attention to the implications of Judge Vinson's ruling. Some GOP Governors are seeking to opt out of implementing the law altogether because of the ruling which struck down the entire the health care law again going back to that issue of severability that we talked about last week.

Mark Masselli: We certainly did. And some senators are saying forget repeal, let's use the ruling as a way to stop the implementation. Bills have recently been introduced in the senate to stop the enactment of the law until all the lawsuits are resolved and to allow states to opt out of the laws individual mandate, employer mandate and Medicaid expansion.

Margaret Flinter: And Senator Lindsey Graham introduced a piece of legislation that would give states the ability to opt out. He said his goal in introducing the legislation was to take down the entire health reform law because if you take half the states out of the individual mandate then health care reform falls.

Mark Masselli: Our guest, today can help clarify the issues and options for health care reform particularly around the individual mandate. We are happy that Dr. Mark Pauly is here with us today. Dr. Pauly is a leading health care economist at the University of Pennsylvania Wharton School. He is also credited with helping to develop the concept of the individual mandate on working with the team of academics who advised President George H. W. Bush on health policy.

Margaret Flinter: And no matter what the story, you can hear all of our shows on our website www.chcradio.com, subscribe to iTunes to get our show regularly downloaded or if you like to hang on to our every word and read a transcript of one of our shows, visit us at www.chcradio.com. And don't forget, you can become a fan of Conversations on Health Care on Facebook and follow us on Twitter.

Mark Masselli: Speaking of fans, this week, we welcome our new friends in Richmond, Virginia. WRIR 97.3 FM joins a growing list of stations carrying Conversations. They broadcast Monday at 12:30 p.m., welcome Virginia.

Margaret Flinter: Welcome Virginia, glad to have you and as always, to our listeners, if you have feedback, e-mail us at www.chcradio.com we love to hear from you. Now before we speak with Dr. Pauly let's check in with our producer Loren Bonner for the Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. The Florida court ruling involving a multi-state lawsuit against President Obama's health care overhaul has left some stage pushing back against health care reform implementation. The decision by Judge Roger Vinson to strike down the entire

health care law has led some GOP state governors to act on trying to halt implementation at least until an appeals court takes up the decision. But without knowing how the court will rule, GOP Governors are hedging; they have begun challenging the law on the administrative side as well. 21 Republican state governors wrote a letter to Health Secretary Kathleen Sebelius asking for certain changes to be made to implementing the state health exchanges things like more flexibility operating the exchanges and waiving the bill's costly mandates. They added that if their requests for modifications are not met then the US government should, "Begin making plans to run exchanges under its own auspices". Obama Administration officials continue to insist that Judge Vinson's decision was simply one opinion of one judge in one court and that implementation efforts will not be stalled. The National Coordinator for Health Information Technology announced he is stepping down to return to his teaching post at Harvard University. Dr. David Blumenthal was appointed by President Obama in 2008 to speed the health care system's switch from paper to electronic records. He is credited with developing many of the rules for health providers to qualify for $27 billion in incentive payments, to automate their records, money Congress made available in the 2009 economic stimulus package. Under Blumenthal's leadership the percentage of primary care physicians who have adopted an electronic health record system climbed from 19% to 29% and 41% of office based doctors and 81% of hospitals said at the end of 2010 they intended to take steps to qualify for higher Medicare payments made to those who meet the regulatory criteria for meaningful use. Blumenthal was a guest on Conversations in October of 2009; you can visit the archive section of our show page www.chcradio.com to listen to that interview.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Mark Pauly a leading health care economist. Dr. Pauly is a professor and Vice Dean at the Wharton School at the University of Pennsylvania and Chair of its Health Care Systems Department. He is also credited with helping to develop the concept of an individual mandate while working with the team of academics who advised President George H. W. Bush on health policy. Welcome Dr. Pauly.

Dr. Mark Pauly: Thank you.

Mark Masselli: Your health policy proposal to President Bush essentially aimed to keep the government out of the health care sector. At its core was the universal mandate which went on to gain support from congressional republicans and eventually Massachusetts Governor Romney. The individual mandate is now part of the Affordable Care Act. Can you explain to us what's different about the individual mandate you were involved with and the one that made its way into the Affordable Care Act?

Dr. Mark Pauly: I hate to date myself but the current individual mandate is not your grandfather's individual mandate. There are two differences, one is what it's

mandated to do and so our version of what was required in terms of the insurance was quite minimal. It was basically catastrophic coverage that could be sold at premiums that would be related to people's risk and was quite different from the pretty elaborate structure of insurance design of exchanges of rules and regulations that are envisioned in the legislation. So that was one. And then we did not envision that the central feature of the insurance that people would be required to have would be community rating. We didn't really take too strong a position on it but that was not a central feature. So the general idea was people would be required to get insurance at premiums that reflected the benefits that they would themselves collect and not be required as under a community rating in the current legislation in addition to paying for a premium that covers everything they would collect from insurance, pay an extra amount if they were below average risks to make transfers to above average risk. I guess the simplest way to say it is we viewed the primary goal of a mandate as one of kind of rounding up the stragglers, people who were facing insurance premiums that it ought have been rational for them to buy insurance but for some reason they didn't get up every morning and think about in addition to breakfast whether or not they should have health insurance. Whereas the current reform envisions mandating them to not only buy insurance for themselves but also at least as is true of the great majority of us, we are below average in terms of risk, mandate us to make a transfer to the above average risk. So that's an important difference.

Margaret Flinter: Dr. Pauly, Judge Roger Vinson in the latest court ruling on the Affordable Care Act struck down not just the individual mandate as Judge Henry Hudson had done before but really the entire law. So we now wait to hear what the Supreme Court decides. If it rules that mandating that Americans have to buy health insurance is unconstitutional, we are very curious what in this 2011 era would you propose to do moving forward. It seems the public generally understands now the concepts of shared risk and minimizing adverse selection but have the sense it's followed by not in my backyard. So, as an economist, what other strategy do you see to achieve the goal of universal coverage?

Mark Pauly: Yeah. So I think it's important to retain what I regard as the most important and positive feature of health reform which is a program of quite generous subsidies for people who can't afford health insurance to help them afford it, it goes up to 400% of the poverty line, is going to cost probably $100 billion or somewhere between $102 and a billion dollars a year or to put it in little more concrete context per tax paying household, it's probably $2000 to $4000 more in taxes but for that, you get a clean conscience, you don't have to worry about your fellow citizens not being able to afford health insurance. That part I hope remains. If I could control everything, I would throw the community rating overboard and just go with the subsidies and see whether we need a mandate at that point to close the gap.

Mark Masselli: So, talk to us a little bit about the community rating and sort of you obviously have had some concerns about that.

Mark Pauly: Well first of all if you make insurers sell insurance at the same premium as everybody else to high risk people, people everybody knows are high risk, one shouldn't imagine that it's going to come out of the insurer's pocket. Insurers will shift the costs of charging premiums that are below what the benefits would be for high risks to higher premiums for low risks. And the problem with that is that discourages low risks from buying insurance or from complying with a mandate if there is a mandate if the mandate isn't bullet proof. And in addition, many low risks are not well off people so it's not all that fair either. Compared to doing nothing at all for high risks, I probably favor community rating but there are better ways to help high risk people afford insurance, the most obvious one although not the only one being a high risk pool funded by general revenue taxation not by special levies on the people who happen to be low risks. So my preferred way forward would be to retain the subsidies, throw overboard the community rating and beef up what's already in place although it's still not working all that well but I think it could which is a system of high risk pools funded by federal general revenue taxation.

Margaret Flinter: This is Conversations on Health Care and today we are speaking with Dr. Mark Pauly, a leading health care economist who is credited with helping to develop the concept of an individual mandate while serving as an advisor to former President HW Bush. Dr. Pauly, I think you hit it on the head with the issue of the costs and how people are going to approach those costs and cost containment is obviously front and center in the law. We follow this very closely from the work of Dr. Gruber at MIT in Massachusetts and predicting and tracking cost outcomes of the Massachusetts plan to the Congressional Budget Office which has weighed in on its loss of how this bill actually slows the growth of cost. But we would like to ask you as an economist what's your predication about the Affordable Care Act's fiscal impact on America?

Mark Pauly: So there are sort of two definitions of costs, one is who pays what or what's the financing and the other is what real resources are used up. So the administration says and they are absolutely right that the bill when it's implemented will dramatically lower the price that a lot of Americans have to pay for health insurance. That's because of the subsidies that I just mentioned a few minutes ago. But of course a subsidy doesn't lower the real cost, it just shifts the cost from the people who would be getting the insurance directly, lower/middle income people for the most part and the rest of us taxpayers who as I said should expect pay more taxes in order to get a clean conscience. Some of that's already in the legislation with the increase in the Medicare tax for people above $200,000 a year. I believe there is lot more tax that will eventually fall on the taxpaying part of the public nevertheless. So there is the shift in cost and so certainly either in the legislation as planned or even in my idealized version of it, a large fraction of the population will be paying less than they are paying now. In

terms of reducing total amount of resources going into health care as a result of the legislation, I don't see too much there to do it. There are some interesting ideas. I guess the best way to characterize them is they might work but if there was an FDA of cost containment it wouldn't declare them to be either safe or effective so we would have to wait and see. And I wouldn't bet a whole lot of money on any of them as able to produce the kind of reduction in health care spending growth particularly in the public programs, Medicare and Medicaid, that we are going to need to keep the country, well I am not sure how fiscally sound it is but to get it back to fiscal soundness.

Mark Masselli: Dr. Pauly, speaking of Medicaid and Medicare, much of your work in health policy was focused in on the future of Medicare. You are also a former commissioner on the Physician Payment Review Commission which Congress established in 1985 to help Medicare payment system for physician services. The effort to curb entitlement spending has been a long element of the political debate in conversation but is rarely acted on because of the political volatility. The new Chairman of the House Budget Committee, Representative Paul Ryan has expressed his desire to revamp Medicare. You presented ideas about reforming Medicaid and Medicare in your plan for Responsible National Health Insurance in 1991; what are your thoughts now given the current environment about changes that could be made in Medicare and Medicaid?

Mark Pauly: Yeah. So Medicaid, what we thought then of course it was a difference fiscal environment, now is that this plan of mandated catastrophic coverage would incorporate low income people and therefore would replace Medicaid. I am probably less likely to think that's practical now given the substantial budgetary cost of the subsidies that are in the bill although a large part of those subsidies go to expanding Medicaid as well as providing credits for people to buy private insurance in the exchanges you know we were young and clearer eyed then and we thought of a nice tidy program of having all Americans in the same subsidy credit arrangement would make sense and I would still like to see us work towards that but there are lot of short-term impediments. On Medicare that's a much more serious problem. And my view is actually similar to Representative Ryan's there is just no way that I can multiply, divide or even take logarithms of the numbers on financing Medicare and come out with the conclusion that we can afford what we currently promise to seniors. And the reason for that is not so much because there will be more seniors relative to workers although there surely well but the reason is that Medicare like all health care grows in cost per person each year mostly because of new technology that's beneficial but costly. And so it's kind of like what my dad used to tease us with when we were kids, he would say kids it's not going to be such a great Christmas this year and that's kind of what we need to say to senior citizens I think or at least eventually need to say to someone that when you go on Medicare, you can't expect to get the rest of the taxpayers, your children and grandchildren mostly who are out there working to pay taxes to pay for new technology, a solution is to convert for the non-poor elderly. I wouldn't touch low

income elderly and I wouldn't touch today's elderly either but looking forward say 10 years and talking to people who are now in their 40s and tell them if you are lucky enough when you retire to be reasonably well off, you are going to have to pay for more of your health insurance than you are now and we will tell you right now how much the government will put towards your health insurance. It turns out that it's actually possible to put enough towards your health insurance that you could buy today's benefits when you do retire but if you want more benefits than that, if you want a fancier Christmas, you would have to pay your own money for that.

Margaret Flinter: Dr. Pauly I think part of the world of an economist is thinking about how people will change their behavior in response to some of these decisions that go on in the legislative arena or the financial reason arena. And it seems that the Affordable Care Act is filled with incentives to get people to change their behavior and not just in the traditional ways. There is increased payments, reimbursements to primary care providers for instance for primary care services something people looked for, for a long time and reimbursements to providers who are willing to change their behavior and jump into the digital age and have electronic health records. There are incentives for medical students and dentists and nursing students to choose to work with underserved populations through all the loan reimbursement and scholarships, there are incentives of course for individuals to buy insurance and even incentives for elders to do a little bit of what you are just talking about around this class act and being able to buy insurance where they can pay for community services. I guess sort of the global question is do you think that behavioral change across the board is likely to result from anything within the Affordable Care Act or have we really just made it too easy for everybody?

Mark Pauly: Well I don't know but I do know nobody else does either. That's kind of one of the points I was making a few minutes ago. As an economist I am programmed to believe that incentives are a good thing but whether these particular programs will be effective is a matter of faith. Now we really don't have very much in the way of empirical evidence particularly about the effective incentives on physician behavior to suggest that they would be highly effective. In fact what we have got so far suggests most of the time they have fairly minimum effects. Even sometimes the problem is if you pay doctors less they do more and if you pay them more they do more so it's kind of hard to get them to do less. At least that's what the empirical evidence shows. So actually I am somewhat seriously concerned about this that our understanding of how physicians respond to incentives is really very primitive. That doesn't mean we oughtn't to try a lot of things but it does mean that I and a CBO, the people there have a hard job but if I was working there I would have laid awake nights worrying about those cost reduction estimates and whether they are really credible.

Mark Masselli: Dr. Pauly, we always like to ask all of our guests this question. When you look around the country and the world what do you see in terms of innovations and who should our listeners at Conversations be keeping an eye on?

Dr. Mark Pauly: Yeah. Well we know a lot of things that don't work that's mostly what we see around the world or at least don't work all that well or have downsides. So most countries keep their health spending low compared to us by just paying people less. They pay their doctors less, they pay their nurses less. So there is something that's worked for other countries to hold their spending down and they make smaller transfers from the general public to health professionals than we do in the US but I don't see that working here. I am going to have to say I think that there really isn't a model elsewhere in the world that would work for the US. There are models that work fine for the Swedes and reasonably well for the British but they would be a disaster if we tried them here.

Margaret Flinter: Today, we have been speaking with Dr. Mark Pauly, a leading health care economist and Vice Dean at the Wharton School of the University of Pennsylvania. Dr. Pauly, thank you so much for joining us today on Conversations on Health Care.

Dr. Mark Pauly: Sure.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Margaret Flinter: This week's bright idea focuses on an innovative program that's using technology to bring health care to rural areas. Dr. Sanjeev Arora from the University of New Mexico Hospital created the Extension for Community Healthcare Outcomes Project or Project ECHO in 2003 to address the acute shortage of specialists practicing medicine in rural and underserved areas of New Mexico. Specifically, project ECHO seeks to teach primary care providers in rural clinics how to best treat their large patient populations with Hepatitis C, a common infection in many communities. Educating providers through telemedicine is at the core of the program. The University of New Mexico, School of Medicine connects with community health care providers through video technology. Physicians, nurses, pharmacists from around the state come together to learn about Hepatitis C treatment and about best practices to treat the disease. The providers engage in direct case based learning that lets them care for their patients in their communities. And the benefits go beyond bringing better care to underserved population. Patients get expert treatment from the local primary care providers they know and trust while saving money on costly referrals and travel. Project ECHO has quickly become a rural health care reform model for the treatment of many chronic and complex illnesses. This year, the University of Washington launched a replication of Project ECHO and many supporters of the project such as the Commonwealth Fund and the Robert

Wood Johnson Foundation are confident that project ECHO can serve as a national model for health care delivery and continuing education particularly in rural areas. An innovated project in New Mexico using telemedicine, case based learning and disease management techniques to expand access to care for patients, now that's a bright idea.

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

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

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