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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we look at Healthcare on the Ballot from two sides of the coin, with Emily Gee from the progressive Center for American Progress, and Joseph Antos from the conservative American Enterprise Institute.

Emily Gee: Most people in America support -- you know, women in America support a right to choose, but that doesn't mean that legislatures won't go the other way. We've already seen some really draconian bans on abortion.

Marianne O'Hare: Lori Robertson checks in from FactCheck.org, and we end with a bright idea improving health and wellbeing in everyday lives. Now, here are your hosts, Mark Masselli and Margaret Flinter.

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Mark Masselli: Early voting has already started in some parts of the United States as Americans make important decisions about who they want to represent them. The polls show that health-related issues are some of the most important ones to voters this year. Joining us to discuss Healthcare on the Ballot are policy experts from two prominent Washington D.C. think tanks.

Margaret Flinter: Emily Gee, PhD, is the Vice President and Coordinator for Health Policy at the Center for American Progress. Gee has worked on the implementation of the Affordable Care Act. And she was an economist on the staff of the Council of Economic Advisers in the Obama White House. And Joseph Antos, PhD, is a senior fellow at the American Enterprise Institute. He served in high level positions at the White House, for Congress, and at the agency level.

Mark Masselli: Well, welcome to both of you to Conversations on Health Care.

Joseph Antos: Thank you.

Emily Gee: Thank you.

Mark Masselli: Well, let's start with Joe. The Republicans have released their policy agenda called Commitment to America. And it includes wording about personalized care and lowering prices through transparency, choice and competition. But it's a bit vague on details. But it does -- I'm wondering if it aligns with your thinking, and tell us why.

Joseph Antos: It's not surprising that Republicans for the midterm are not being very specific about health policy. Health policy, really I think for Republicans, is really not high on their agenda right now. But the other factor, which I think is often overlooked, is that they don't want to get ahead of whoever their candidate is going to be in 2024. That said, yeah, the idea of promoting an efficient health care system,

working off of the current system that we have today which is a mixed public-private system with regulation, that makes a lot of sense. And to try to create those efficiencies, I think there are several key components. One clearly is that consumers, patients, and their doctors need to have a better idea about not only what things cost, but also how effective the treatments are likely to be and whether there are alternatives. I think that's really critically important. But what really matters is health care. And what people care about is, am I going to get the care I want at the time I need it, will it be good care, and will I be able to afford it. I think those are the big issues.

Margaret Flinter: Well, thank you for those comments, Joe. And Emily, let me turn to you. Your think tank has the word 'progress' right in its name, and CAP is known for its progressive stance. As you say on your website, your mission is focused on improving the lives of all Americans with bold and progressive ideas, as well as strong leadership and action. So, maybe tell us where does CAP stand on health policy and any points of difference from what we heard from Joe.

Emily Gee: So, I think when I think about health policy, and in particular health equity, there it's more than just the health care system. And there are a variety of ways in which we try to approach this issue. One piece of health equity is of course health care system itself. The Inflation Reduction Act which passed back in August, is a big step toward those goals, helping decrease the cost of coverage for millions of Americans, giving seniors protection they didn't previously have against out-of-pocket costs for drugs in Medicare. But also, that together with a couple of the other big pieces of legislation that passed in the last couple of years, the Infrastructure Investment and Jobs Act, the CHIPS Bill, aren't necessarily health care bills per se, but they do advance health because they take care of what we call social determinants of health, or the factors that influence what goes into health.

Part of achieving health is getting the health care that we need having health coverage, but a large part of it is about the environment that we live in. Do you have access to clean water and clean food? Do you live in a safe neighborhood? And so, in particular the Inflation Reduction Act and the Infrastructure Investment and Jobs Act, do affect our environment and help address climate change, making historic investments, not just addressing climate change, but making sure that money goes to underserved communities. And so, you know, our hope is with equitable distribution of the funding available in those bills, we can prevent situations like we just had in Jackson, Mississippi, where a predominantly Black community with very outdated water infrastructure didn't have access to clean water for two weeks. That has knock-on effects to the ability of businesses to operate, the ability for kids to go to school. And so taking care of both our built and natural environment, is really a key component for

health.

Mark Masselli: Well, let's make sure we're clear on where each of you are in relation to the candidates in the ballot. So, a question to both of you, generally would you agree, Republican candidates are linked to AEI support for what it calls pro-market solutions to our nation's health care issues, and that the Democrats are aligned with the Center for American Progress view of a shared prosperity model?

Joseph Antos: So, probably that's true. I think there is a general understanding about market-oriented principles and the need to create incentives that lead to a more efficient health care system. But, also as Emily said, we need to make sure that it is a fair system. We need to make sure that people who need the help, get the help.

Emily Gee: So, for CAP, I would say we are open to working with people, any and all political parties. But, our vision for what health care system would look like is universal coverage. It's a place where everybody has access to health care, and everybody has the ability to achieve their full health potential, both because they have good health care, but also a good environment and good nutrition and good access to education. All the other things are so important for a good start in life. And I think, you know, there are probably also areas where maybe Joe and I would agree. If I could go out on that limb, I do think there are places in health care where we do need better competition. One of them is among providers in health care, where because of consolidation in the market for health care providers and insurers, consumers are often not getting a good deal on the price of health care.

Margaret Flinter: A question for both of you on a little bit different thing. The Biden Administration has extended the COVID Public Health Emergency order for another 90 days. Emily, maybe let me ask you. You've supported this move. Why? What does it provide for? And, is it possible for this to continue when the President has said that COVID is over? How do we go forward with that?

Emily Gee: So, we are still dealing with the effects of the pandemic. I think we are entering a new phase in which, you know, fortunately, even as cases are up and may rise into the winter, we're not seeing that same spike in hospitalizations. And that is because vaccines work. We have the new bivalent vaccines that give us protection not only against the original strains of the virus, but against the Omicron variants. The government has ordered more than 100 million doses of that, so there's plenty to go around. And I think getting that vaccination will be important for maintaining our nation's health going into the winter. But continued preparedness and keeping up with new variants, will require sustained funding for public health. My hope is that Congress will provide funding for continued COVID readiness, as well as shoring up the public health system that has been so badly

battered by the pandemic.

Mark Masselli: The Supreme Court's Dobbs decision overturned Roe v. Wade earlier this year, and Senator Lindsey Graham has introduced a proposed national ban that would prohibit abortion after 15 weeks nationwide with only a few narrow exceptions. I'm wondering if you both agree that more limits to abortion will occur if Republicans take control of Congress and gain more power in state legislatures. Joe.

Joseph Antos: No, no. This is a very personal kind of an issue. I think both sides on this issue have tried to blow it up into public policy. I think this is not a topic that needs to be legislated on. It may well be the case that in some states, they will clamp down a bit more in terms of the period of time over which abortion is permitted. That is apparently their right under the Constitution. I'm not a lawyer; I couldn't tell you. But I think this is a very sensitive issue that is not going to be something that, at least Republicans will be talking about at the national level. The fact that Lindsey Graham introduced this proposal, doesn't mean that Republicans will go for it. In fact, there's been largely silence from the Republican party on this, and I think they are not willing to touch it at the national level.

Mark Masselli: Well, before Emily responds though, Joe, if the Republicans take control of Senate, is it that you don't believe whether it will be up or down, that Graham won't be able to get it on the floor for a vote?

Joseph Antos: That's right. This is something that you can only -- people will not view any action in this area as uniformly favorable .And every politician wants to do things that are favored by the constituents, rather than are controversial among their constituents. And this is a controversy that is true in every state and in every Congressional district.

Mark Masselli: Emily?

Emily Gee: So, my colleagues and I certainly believe, you know, this is a deeply personal issue for women and should be something that they choose, and something they are allowed to consult with their physicians on. It's also, you know, most people in America support -- women in America support a right to choose. But that doesn't mean that legislatures won't go the other way. We've already seen some really draconian bans on abortion, preventing it at the very early stages where women may not even know they're pregnant, and, you know, laws that don't have exceptions for cases like rape or incest or life of the mother.

So, I'm very fearful of what could happen if Conservatives take stronger control of state legislatures. Right after the Dobbs case, the Dobbs decision was handed down, we saw a handful of states enact so-called trigger bans or pre-existing bans on abortion, and they were

very eager to put those into effect as soon as the court decision came out.

Mark Masselli: But Emily, we also saw Kansas, which I believe is a pretty Conservative state, actually turn it down. What's your sense of that didn't seem to break on party lines there?

Emily Gee: So, I think that that is hopefully part of a trend, of voters either rejecting bans, or hopefully adopting constitutional amendments that would protect a woman's right to abortion at the state level.

Margaret Flinter: Well, I think we are all in for an interesting time watching the returns as the election arrives on our doorstep. But, certainly a group of very engaged voters, usually our senior population, and certainly a population that we're all concerned about, and Joseph, I wonder if you can comment, Bloomberg is reporting that House Republicans will enact Social Security and Medicare eligibility changes, maybe spending caps, and Safety Net work requirements if they win the majority. Kind of had thought of those as classic third rail that people wouldn't touch, such popular programs. Do you think that's likely? Should seniors be worried?

Joseph Antos: Well, let's distinguish between the programs. I think you've mixed a couple of programs up. No politician in his right mind, or her right mind, would announce that they're going to cut Social Security benefits. There may be a need to address Social Security funding; that's not the same thing as cutting the benefits. On Medicare, I think the same is absolutely true. And there's obviously a need, given that the Part A Trust Fund, Medicare Trust Fund that covers the cost of hospital services and other inpatient services, the Part A Trust Fund will become insolvent in the next few years, probably sooner, sooner than later, because the assumptions that went into that estimate are we're overly optimistic about how the economy is going.

We're clearly in a recession. We're clearly in a high inflation time. These were not taken fully into account in the latest trustees' report. So, things are going to happen, are going to have to happen. But, touching benefits is really very difficult for a politician. It's much easier to do what they've always done traditionally, which is to cut payments to providers and hope that that doesn't restrict access in any serious way. I think that's probably where it's going to be going. Now, what you did refer to, which I think is an issue for Republicans, has to do with the expansion of Medicaid eligibility, and whether there is a social compact with people on Medicaid, or on welfare programs in general. Do they have some obligation if they are able to, and if the opportunity is given to them, to give back to the community? I think that's the question. That was certainly an issue during the last administration. I think it will be an issue in the future as well.

The Biden Administration has made it perfectly clear by reversing all the approvals for states that wanted to try something different with their Medicaid programs over the past few years. They've reversed all of those waivers. So, I'm sure that our Republicans will be talking about this over the next two years, but that won't change the Biden Administration's position on it. I think there is a legitimate question, given that we have similar requirements for social responsibility for welfare programs, that where a beneficiary in Medicaid program is able, and where the opportunity is available, the idea that there should be some social responsibility requirement, I think resonates very well with a lot of people, and certainly resonates very much with Republicans.

Mark Masselli: You know, Emily, I think--

Margaret Flinter: Thank you. And I should have clarified -- sorry Mark, go ahead.

Mark Masselli: No. Emily, I wanted to sort of pick up on Joe's comments about benefits. Because you've written about, a lot about the Inflation Reduction Act, how it will save families thousands of dollars including health care costs. But I'm wondering if it impacts the election, because getting to the insulin at $35 goes into January, past the election. Is this something that's really resonating right now? Are people connecting that these are on their way? And is it translating, do you think, into opportunities for Democrats? Or, is it show me, I'm from Missouri, show me it in my paycheck or in my Social Security benefits but until then I don't believe you?

Emily Gee: I think these reforms will make a big difference. You know, there are multiple components of the drug reforms that run Inflation Reduction Act. One is allowing Medicare to negotiate lower prices for drugs, which is a wildly popular proposal [inaudible 00:17:09] across not just Democrats, but Republicans, and in voters of all affiliations. And it also stopped our companies from hiking prices. The law will force the companies to pay rebates back to the Medicare program if they raise the prices above the rate of inflation. But even less abstract, you know, are these parts that will protect seniors from high out-of-pocket costs. And I do think many people are eager to see those go into place, and they are very tangible, very understandable benefits for people who have high drug costs. That $35 cap on out-of-pocket costs for insulin goes into place just two and a half months from now. The $2,000 cap on drug spending in both Medicare Advantage and Part D standalone drug plans, will take a couple more years to implement, but that too is something that seniors will see. I think it will be very real to [inaudible 00:18:03] families.

Margaret Flinter: Well Emily, CAP recently published a report that stated that the Federal public option would improve health equity across the United States. But Joseph, I think you've written that Federal public option is

unlikely to deliver the market transformation that some advocates predict. I wonder if Joe, could you explain your perspective, and then Emily, if we have time, we would like you to comment as well.

Joseph Antos: Well, first of all, I don't believe that anybody's really talking about a Federal public option. A number of states have attempted to create a so-called public option, Colorado being the first one that comes to mind. And the states that have tried to do this, actually have been highly unsuccessful. I mean in many people's minds, a public option is something -- is a health plan that's run by a government, state or Federal possibly. In the case of the states that have attempted this, none of them have taken on the task of having the state government run a health plan. They're not good at it for one thing. Instead, their strategy has been to try to impose requirements on existing private health plans, and more importantly, a requirement on providers, especially hospitals, to participate in what are essentially discount plans, where the provider is required in some states to accept much lower payment rates than they typically get from commercial insurers.

That hasn't worked out well for Colorado, that hasn't worked out for other states as well. The fact is that there is a public option already since in the Federal government. The ACA created it. It's called the Exchange Plans. And if you're eligible for it, then there's your public option, and the fact is that only about six million people in this country, six million citizens of this country are not insured. Maybe it's about eight million now. I'm not sure what the exact number is. But it's a relatively low number, compared to the 350 million people we have in this country. And most of those people who aren't covered, have options that they could pursue, and for some reason they haven't pursued them. So, I think we're largely covered on this. I would argue that the ACA has largely solved the coverage problem. It did not solve the cost problem, but it solved the coverage problem, and you know, three cheers for that.

Mark Masselli: Emily, response?

Margaret Flinter: Emily, anything -- sorry, Emily, did you want to comment or respond to that?

Emily Gee: Yes. So I will say that the exchanges are working. I mean, they were not designed to substitute for employer-sponsored insurance or existing public programs. They're designed to fill a gap for people who didn't have either an employer or a public program option like Medicare and Medicaid. Prior to the ACA, people faced higher premiums if they had a pre-existing condition, or for being a woman, or for being older, with no limit. And so what these changes were designed to do, with the ACA plans or Obamacare, whatever we like to call them, is fill that gap. And they've been very successful. It's actually 14.5 million people, a record high, who are enrolled in

marketplace coverage this year. And the ACA marketplaces, in addition to Medicaid policy, have helped the U.S. weather the pandemic. Even though there was a lot of job loss, income loss during the pandemic, the uninsurance rate in the country held steady because those affordable options were available out there for coverage.

Joseph Antos: Can I make one other comment about the public option? If Democrats were to try to push through a Federal public option, the first plans that would be hit by it would of course be the ACA Exchange Plans, unless of course, the public option wasn't a better deal. So, this is not a shrewd political idea, and it's not very good policy.

Mark Masselli: Emily Gee with CAP, and Joe Antos with AEI, thank you both for your insights. We look forward to your future writings and ideas. Thank you to our audience for being here. And you can learn more about Conversations on Health Care and sign up for our emails, updates at www.chcradio.com. Thank you both again.

Emily Gee: Thank you.

Joseph Antos: Thank you.

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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 health care 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: The Centers for Disease Control and Prevention hosted an online seminar about the treatment of blood clots, which is expected to grow as the U.S. population ages and the obesity rate increases. But some vaccine opponents, misrepresented the webinar to falsely suggest that the projected rise in blood clots is related to the COVID-19 vaccines. It's not. Most of the people attending the webcast, were health care providers. But anti-vaccine campaigners, posted videos online about the CDC seminar highlighting a CDC synopsis of the event that said experts estimated the number of patients needing anticoagulant care to prevent blood clots would double by the year 2050. The post baselessly suggested this was related to COVID-19 vaccination. But the webinar explained that for several years before the COVID-19 pandemic, studies have said there will be an increased need for anticoagulant care. That's because two common medical conditions requiring blood thinners are expected to increase as the population gets older and obesity increases. The conditions are atrial fibrillation and venous thromboembolism or blood clots that start in a

vein.

The expert featured in the webinar, Allison Burnett, President of the Anticoagulation Forum, told us the expected increase in anticoagulant care has nothing to do with COVID-19 vaccination. In fact, she said a person is much more likely to get a blood clot after being infected with COVID-19 than they are to get a clot after being vaccinated.

And 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 is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. It's estimated that a majority of a person's lifelong health expenditures are often spent in the final months of life. But death is one of those topics that generates the least amount of conversation in the clinical setting in American health care. For folks who end up critically ill, are facing a terminal diagnosis, this can often lead to poorly communicated end of life wishes being discussed with the clinician who then often resorts to extreme interventions.

Dr. Manali Patel: In oncology, you know, there is a desire to want to provide patients with truth. However, there's this unspoken misconception that by having honest conversations about prognosis, that we are somehow removing the hope. And actually most studies that have evaluated this, have shown that when you provide honest prognostic information to patients, and allow patients to be part of the decision making about their goals of care, they are more appreciative of it.

Margaret Flinter: Dr. Manali Patel at Stanford University School of Medicine, sought to find interventions that might give clinicians and families a more useful tool to address this gap in communication. Her earlier research at Stanford, had yielded an interesting finding. Late stage cancer patients felt more comfortable talking about end of life issues with a layperson as opposed to a clinician. She and her fellow researchers followed patients at the Veterans Administration Palo Alto Health Care System after they were diagnosed with stage three or four or recurrent cancer. Half the people were randomly assigned to speak with a lay worker about the goals of care over a six month period, and the lay workers were given a rigorous 80 hour course and clinical

observations before being assigned to the study.

Dr. Manali Patel: She learned as she went, and then at the end, she came to that realization that these conversations really are not scary. We had hired her specifically because of her service orientation, and that's really the main crux of this intervention, was finding the right person who can engage in these conversations.

Margaret Flinter: 92% of the participants who received the layperson intervention, compared to only 18% of the control group, were likely to have end of life directives in their Electronic Health Record, often choosing hospice over emergency room interventions as their conditions deteriorated. The average cost of care for the intervention group in the last month of life was about $1,000 versus $23,000 for the control group.

Dr. Manali Patel: We found that the satisfaction scores went up for the patients in the intervention arm, but they went down for patients in the control arm.

Margaret Flinter: A low resource, compassionate patient-centered intervention that assists terminally ill patients, their families and their clinicians to have a frank discussion about end of life wishes, improving patient satisfaction at such a sensitive and challenging time, and saving significant costs as well, that's a bright idea.

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Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

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Marianne O'Hare: Conversations on Health Care is recorded in the Knowledge and Technology Center Studios in Middletown, Connecticut, and is brought to you by the Community Health Center, now celebrating 50 years of providing quality care to the underserved where health care is a right not a privilege, www.chc1.com and www.chcradio.com.

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