Progressive-Conservative Pundits on hope for Bipartisan consensus on health policy

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Marianne O'Hare: Welcome to Conversations on Health Care. This week we continue our health care on the ballot series, opposing views on the outcome of the midterm election and the impact on health policy moving forward with former Obama CMS Administrator Don Berwick.

Dr. Donald Berwick: We can find a way to move money where health can be preserved, we may see some progress.

Marianne O'Hare: And Jim Capretta of the Conservative American Enterprise Institute.

Jim Capretta: Medicare's HI Trust Fund is expected to be depleted in five years or so.

Marianne O'Hare: FactCheck.org's Managing Editor Lori Robertson checks in, and we end with a bright idea. Now, here are your hosts Mark Masselli and Margaret Flinter.

Mark Masselli: Roughly 112 million Americans voted in the recent midterm elections and the candidates and issues they voted on will have profound implications for health care policy in the states at the national level and ultimately in all of our lives. We're following up on our series called Health Care on the Ballot with the discussion focusing in on the results and what they mean.

Margaret Flinter: Our guests today are Dr. Donald Berwick, who helped shape the Affordable Care Act during the Obama administration, and the co-founder and president emeritus of the Institute for Health Care Improvement. Also joining us today is Jim Capretta, a senior fellow with the American Enterprise Institute. He is also the author of a new book US Health Policy and Market Reforms".

Mark Masselli: Well, welcome to both of you in Conversations on Health Care. Let's start with a question to each of you, it was widely predicted that the midterms would really trim the sails on the Biden administration's plan for Democrats in the States and yet the Democrats hold the majority in the Senate are barely in the minority in the house and saw many wins for their governors and state lawmakers. What is your view of how these surprising results will influence health policy in the next few years? Let's ask Dr. Berwick to respond first and then go to James.

Dr. Donald Berwick: I sure have no crystal ball. We still have a problem passing legislation given that the house is going to be in Republican hands. I suspect the elections signal that there's some public will for some moderation in this highly polarized climate that we're in. I think people want action. They know there are problems. They appeared relatively intolerant of people taking very, very extreme positions.

I hope against hope, perhaps that this means that there'll be some opportunity for some progress kind of in the center for things that everyone cares about. Everyone's very worried about drug prices. Everyone knows that the Medicare Trust Fund is threatened. Everyone knows that there are people left out of the system now who need to be included. I'm hopeful there'll be some progress.

The Biden administration did pass some very, very important legislation during the past couple of years. I also suspect that the positive benefits of some of that legislation will become more apparent to people as the Affordable Care Act has been. There'll be some more wind in the sails of some of the reforms that we need.

Mark Masselli: Yeah, some of those policies come into effect in January, so we'll see if they come to fruition as they planned. James, your thoughts?

Jim Capretta: Well, I think the secret of the 2021/2022 term, there was a pretty big group of senators, bipartisan group of senators in the Senate that got a fair amount of legislation through to President Biden. They wanted to make clear to the country that they thought a working Senate was very important, a working Congress was very important. They're not going to pass legislation that is highly partisan from an even a democratic point of view, I think. Something like the Inflation Reduction Act, which passed only with Democratic votes wouldn't happen this time around, but things in the middle still could pass. Things that are bite size that can get some bipartisan support could still pass. Things like mental health improvements, substance abuse questions, improvements even to the FDA and CDC. Those are possibilities even in this new Congress it's coming in.

I think the big action might be in some of the states, actually, as you sort of hinted that with your question. A lot of states are still with lots of so many initiatives like the public option plans, trying to do price limitations on certain providers and drugs. Some of that action could shift to the states.

Margaret Flinter: Well, Jim, you're well aware, and we appreciate your pointing out some of those areas where there does actually seemed to be some agreement. The country heard not to have it on the crisis, mental health, substance abuse and where we might see some agreement. But Dr. Berwick, you are a veteran of many Washington battles, and I know we still have Congress's lame duck session to tackle.

The thing that always surprises me is when I see that we're set for something like a decrease in Medicare payments. All providers looking at a 4% cut unless Congress acts. We hear Medicare so often talked about as the third rail something that you can't touch. What do you think is going to happen in that arena this year?

Dr. Donald Berwick: I'm not sure the lame duck hasn't got many breaths left. But I think some of the problems you cited the payment cuts will have to be I think they'll be moderated. I don't think that anything dramatic is going to happen at lame duck to cut back on payments. I think that there is some work that needs to be done to make sure that people have the coverage that they need, and perhaps we're going to see some of that. But as Jim said, I think a lot is going to shift to the states in terms of innovations.

For example, I would watch, not necessarily during the lame duck, but over the next year or two Medicaid waivers as an area of very interesting variation and novelty amongst states, there are some real will to get that done, and perhaps the administration then will be able through its administrative authorities to allow more variation amongst states in trying to do some creative things with financing.

Mark Masselli: Jim, let's stick with Medicare. Your book makes the case for what you call a vigorous and properly structured competition in health care that could deliver the same benefits seen elsewhere in the economy. In an ideal world, what do you think Congress should do about this Medicare payment reduction issue? Let it stand or make some modifications?

Jim Capretta: Well, I think the payment reductions that are scheduled to happen here in the next few weeks, if something isn't done, I think those need to be addressed and probably lessen. I don't know if they need to be gotten rid of all together. But some moderation of what's expected probably is an order, especially with inflation running at 7%. You have physician practices paying out a lot of expenses. If their fees also get cut, I mean, you're going to have a real pressure point building there that I think probably won't just be sustainable. Just to get through the next few months they probably should do something there.

Having said that, I think over the long run is your question indicates they need to kind of take a step back, Medicare's HI Trust Fund is expected to be depleted in five years or so. They need to look at the whole program, how to structure it better, simplify it, make the benefits more uniform and standardize and improve how beneficiaries interact with the program.

Margaret Flinter: Well Dr. Berwick, maybe I can pick up on what you were just referencing as we talk about innovation and Medicare. You were commenting that the states might actually be looking to do some real innovations in Medicaid through waivers. Would you like to highlight one or two states where you see some really interesting proposals there that you think might move us forward around Medicaid reform?

Dr. Donald Berwick: Yeah, Maryland's always interesting to watch. They're making continue to try to tweak and adjust their payer model. My home state

Massachusetts now is implementing a massive Medicaid waiver that I think to be highly significant, very important to watch it as we try to give an opportunity to move resources to social influences on health, which really is the secret here. If we can find a way to move money where health can be preserved we may see some progress against our deteriorating health status.

California is interesting, I think we're going to have it. Oregon would be good. There are some Midwestern states that I think to watch here, this may not just move in Medicaid reform. I'd say the basic reforms to watch are ones that move us toward global budgets and consolidated payment, allowing people to give care to use resources to meet many more kinds of needs of patients in Medicaid instead of just continuing to run a repair shop. That's what I've got my eye on right now. I hope all of that can happen.

At the federal level, there are some early steps. For example, in the ACO REACH program, there's a pretty dramatic change. It's small and it may not have immediate impact. But the willingness of Medicare to pay plans just a little bit extra for entering areas of geographic areas of deprivation. It's probably not enough to influence behavior much, but it's the first shank in payment that might allow us to move some payment toward the social deprivation indices as a way to allocate resources.

I must say the other thing that I've got my eye on but not much hope as Jim knows, I am very critical of where Medicare Advantage has gotten now. I think it's a tremendous problem. It's an enormous subsidy going to private insurers now without equivalent benefit at all. I don't think the administration will have the political chips to take that on, if ever. But there's an awful lot of reform needed there. I just wish it would happen.

Mark Masselli: I think you're right on that. That Mass 1115 waiver is certainly one we're keeping an eye on. Jim perhaps one of the silver linings from the pandemic has been really the loosening of regulations that have resulted in the greater use of telehealth. Americans in rural parts of the country have really embraced greater access to health care. It wasn't necessarily on your list earlier, but it is certainly had been a benefit for accessing specialist and yet the flexibility authorized during COVID-19 Public Health Emergency will expire soon. Do you see telehealth as part of this push for market reform?

Jim Capretta: I do I mean, I don't know people who are for it or -- or when I'll put on the label of market reformers. I think they probably are just saying it's a good potential supplement to existing ways of trying to help patients, and there's bipartisan interest in it. Now honestly, I think if there is a spending deal here, and the next before, the end of the year before the holidays I wouldn't be at all surprised if telehealth some fix

in telehealth is put in independently of the public health emergency to allow it to continue for a couple more years, get a real evaluation done of it. There are some concerns about just sort of adding on another service on top of other services without really making substitution and cutting costs. There's a little bit of question about what it does over time and how it affects patient's health. I would bet the Congress that will authorize it, if they get the opportunity. There'll be bipartisan support for that. Give it a couple of years and have an independent evaluation to see what it's doing to patient outcomes.

Margaret Flinter: Certainly on the ground we're certainly seeing telehealth is something that contributes to access, especially in that all important area of behavioral health. Now maybe some better ways to make it more available for substance abuse treatment as well. We certainly are keeping an eye on that. It may be a little bit outside of the policy realm, but what will captivate the public's attention and has in many ways is upcoming, we hear Republican leaders really want to subpoena Dr. Anthony Fauci bring him forward for hearings in the house and also talk of Hearings about federal waste in the COVID relief programs.

Dr. Berwick, you certainly went before Congress many times when you were running the Centers for Medicare and Medicaid Services. Do you think these hearings actually serve a role and might be a way of continuing to educate the country about what the entire COVID pandemic and response was about? Are they needed or not so much?

Dr. Donald Berwick: We certainly need a period of national reflection on what we learned from COVID about preparedness, about pandemic response, about public health response to the strengthened the public health system of public communication, educating the public. There's a tremendous amount of learning that we need to gather and then map it into policy. I just must say to take an American hero like Dr. Fauci who is just as good as it gets both in science and in public leadership and subject him to gaming in testimony. It's a waste of time, and I wish they would just give it a rest. But we do need to learn, and hopefully, there'll be a period of reflection in Congress and the executive branch about what this tells us about how to be a more prepared country.

We were clearly not prepared, our performance was probably about third worst in the world, and we didn't have to lose a million Americans to this disease. We got to be smarter than that. The other preparedness -- I can't help mentioning this is the recent attacks on the grid are not trivial matters. This is as dire a threat for this country as the public health emergency was in COVID. We are definitely not prepared there. I hope Congress is going to take this extremely seriously. It would be not just a health issue, but certainly a health issue if we can't secure our grid.

Margaret Flinter: Well, we've heard from so many guests that this isn't the last pandemic that we're going to face so we really need to be prepared. Jim, of course, Dr. Berwick was a key architect of what we know is Obamacare. We saw some interesting election results in South Dakota where voters approved a ballot measure to expand the state's Medicaid program under the Affordable Care Act, opening up coverage to additional 40,000 residents. But we also saw that earlier, Oklahoma and Arkansas, very conservative states, is the fight against Obamacare really over, what does it mean for the future market reforms that you advocate for?

Jim Capretta: I do think that the question of Medicaid expansion is largely settled. The reason is that the Affordable Care Act sort of set up a structure where it's easy now for a state to be presented with a yes or a no question. We either expand Medicaid according to the ACA's stipulations, or it's going to be very difficult for you to get coverage to that population, but you can't undo the rest of the structure of the ACA and go in a wholly different direction.

Given that the ACA is in place has been for over a decade, and the only way to get coverage to that very vulnerable population below the poverty line is to provide Medicaid coverage at this point. Then, yeah, I think that states are wise to just take it because you're not going to get coverage to that population in any other way, so they should adopt it. But remember, when President Obama passed the Affordable Care Act he called it a market based reform. Remember, it's competition on the exchange, it's choice amongst private plans. It's a Medicaid expansion to be sure, but its central feature was competition amongst insurance plans on the exchanges for the individual market. In some ways it is a market reform. The question for America is how to make very complicated, fragmented, uncoordinated and not so well designed system of public and private work a little bit better together?

Margaret Flinter: A question that maybe both of you would like to respond to. But Dr. Berwick, let me start with you, whether it's in the exam room or town halls or legislative assemblies, few things get people talking like drug prices. You've noted that there are actions President Biden could take now to lower drug prices including the Most Favored Nations drug pricing for a number of drugs. Take us through your thinking on the topic about what needs to be done in this area. Jim, we welcome your comments after Dr. Berwick as well.

Dr. Donald Berwick: It's a very bad problem and continuing to worsen mostly. It's not one problem, though, their drug prices depends on which tier of drugs we're talking about. The high end or the extremely expensive biologics and biosimilars, we are seeing very, very little discipline exercised by the companies themselves and the market forces are not

working. I'd love to hear Jim's comments about it. I can't wait to read his book. I'm personally seeing no alternative, but some very aggressive administrative pricing of drugs. I just don't see a way to get that under control there. The prices are obscene, and they don't have rationale in my book.

In the middle ground there I think competition can do a lot. I think Part D, remember came in a lot cheaper than anyone thought it would. There is room for competition. To do that you have to be able to open up competition, there are some patent laws that need to be changed. There are some awful stories around the defects in the drug patent laws that allow capture of medications as old as a pyramid and then on this high pricing.

I'm also a fan of some of the new stuff that's going on in competition the generic market. I was an advisor to Civica Rx, which is a very, very interesting move by healthcare providers to make their own drugs, and I suspect we might see some more of that. It's not one size fits all. I am a fan of Medicare negotiating prices, but we have yet to see really whether that's going to work. I'm going to follow the changes in recent legislation with great interest as kind of an early trial, whether that using that market power can help. But, again, I say the lack of discipline is shocking. In fact, the nearly fraudulent or nearly not quite illegal activities around drug pricing need to be brought under control.

There are some FDA reforms that would help. I hope there are some bipartisan thought about that because we are a little slow in terms of helping important drugs emerge, and I'd be happy to see that happen as well.

Margaret Flinter: Jim.

Jim Capretta: Well, my perspective basically is that inevitably in the drug space, and the drug pricing space, you're balancing two conflicting objectives which is you want research and innovation to bring new products into the market that are better therapeutics than what is currently available. At the same time you want to make all of the therapeutics priced at a level that they're affordable and accessible for the whole country, everybody equally, and those are difficult to reconcile. I think the big missing piece here is really a much more vigorous and publicly run and publicly initiated effort to figure out which drugs coming online are actually valuable, and which ones aren't.

If we have things coming online with very high and elevated price, that don't deliver therapeutic benefits, they shouldn't be priced high. The big part is deciding what is the clinical value of a new product? I think we could do a much better job of identifying that. Frankly, Germany does a better job than we do in that regard, and trying to price according to value rather than just letting the drug companies

decide what the value is. There should be a much more public effort. My view is around identifying those things that are coming online that really are beneficial and those things that are not. The things that are not, they should be priced at generic level.

Dr. Donald Berwick: I'm also wondering about another need that I'd love to hear Jim's thought about at some point. There actually is not an awful lot of correlation between what might call the social need for a drug, that if you could pick the top 10 drugs to create what would they be, and the research investments and being induced by the current market forces or whatever forces are there. I'm wondering if there's a possible policy initiative, which would change that which would sweeten interest in producing the drugs which we need most for the health of the public and decrease interest in the others. I've not explored that to the extent, I want to, but I think that would be a very interesting avenue of policy research.

Mark Masselli: Well, in that spirit of the season we want to end on a positive note. Where do you see the opportunity for progressives and conservatives that come together in 2023 on health care issues? Not crickets.

Dr. Donald Berwick: No, I think we've already hit on some -- there's no -- there should be bipartisan interest in a strong public health infrastructure. It doesn't matter how you vote you're going to pay the price if we don't have one, and that's got to be government. You can't -- there's no private sector public health defense. We did talk about drugs, I think we're all worried about it, we have different solutions. My solutions are certainly different from Jim's, but we're concerned enough we ought to find our way to some answers. The mental health and substance misuse arena is desperate killing tens of thousands of Americans and we have not yet formulated strong public policy on that and I think we probably could find a bipartisan route there. On markets and the ACA, we will continue to disagree. I don't have much faith that market solutions are going to be the ones that work, but then again I haven't studied Jim's book yet. Maybe I'll change my mind.

Jim Capretta: Well, I think on this question of mental health and substance abuse, it's really bordering on really a crisis in United States at this point. It really needs to be attended to by both parties because it's affecting so many aspects of our society. I think there is great interest in both parties and being just much more aggressive and putting together a national strategy to really get the problems that are out there a little bit better under control and directed and treated. I'm hopeful that that it could be one big area where there could be a lot of bipartisan agreement and movement.

Then on these other things some of them are by necessity. They're going to have to do Medicare probably on a bipartisan basis because neither party probably has enough political capital to do it on its own.

Some Medicare solvency will probably be bipartisan. I wouldn't anticipate that right away, but over time that'll probably happen.

Margaret Flinter: When all else fails, bipartisanship possibly may win the day. Thank you both, Don and Jim for joining us today for sharing your insights for your work. Thank you to our audience for joining us. You can learn more about Conversations on Health Care, and sign up to keep updated with hearing from us at www.chcradio.com. Thank you so much. Best wishes to both of you.

Dr. Donald Berwick: Thanks, Happy Holidays to you.

Jim Capretta: Yeah, Happy Holidays. Thank you.

Mark Masselli: Take care.

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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 US politics. Lori, what have you got for us this week?

Lori Robertson: A randomized controlled trial and real world studies have found that for certain patients, PAXLOVID, Pfizer's COVID-19 antiviral pill reduces the risk of severe COVID-19 and death. The Food and Drug Administration authorize the drug for outpatients at high risk for progression to severe COVID-19 based on a randomized controlled trial that found the medication to be about 88% effective in preventing hospitalization and death in unvaccinated high risk adults with COVID-19.

High risk people with mild to moderate COVID-19 are eligible to take a five day course of PAXLOVID as long as they start the pills within five days of symptom onset. PAXLOVID consists of two sets of tablets that are taken together. One drug prevents replication of the Coronavirus and the other boost levels of the first drug in the blood. Several observational studies have subsequently found that PAXLOVID is effective in the real world, particularly for older high risk people and those who are unvaccinated. An online post being shared on social media; however, claims that the drug is a fraud and shouldn't be used. The real world Studies however have shown the medication is effective.

One study published in October in The Lancet found that in Hong Kong PAXLOVID was associated with a 66% lower risk of death and 24% lower risk of hospitalization among a mostly older 60 years and above, or unvaccinated population. An unpublished study of patients

50 years and older in Massachusetts in New Hampshire similarly found the risk of hospitalization after COVID-19 diagnosis during an Omicron wave was 45% lower among those prescribed PAXLOVID with greater reductions among those who are unvaccinated or obese. There have been cases of rebound with and without taking PAXLOVID. 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.chc.radio.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. When Indu Navar's husband was diagnosed with ALS, Amyotrophic Lateral Sclerosis, their experience was worsened by the medical establishment lack of swift testing protocols for diagnosis. Of the 30,000 Americans who suffer from this debilitating disease diagnosis is often the result of the process of elimination and it can take an average of 18 months to confirm.

Indu Navar: It took us two and a half years to get diagnosed. In that time, I saw him deteriorate every day.

Margaret Flinter: As ALS slowly overtook her husband, Navar founded a nonprofit to help others that are dealing with this paralyzing disease. She launched Everything ALS with a goal of developing artificial intelligence's interventions that might help clinicians diagnose the illness sooner. Noting the growing body of research looking at the voice as a new biomarker for neurological disease, a decline in speaking patterns often precedes more serious neurological symptoms. Working with engineers, she launched the Everything ALS Speech Research Study, an online volunteer voice bank in the hopes of building an algorithm that could detect subtle changes in voice expression.

Indu Navar: What people can do is they can actually donate their speech and also get involved in our research by going to www.everythingals.org. What we do is what that all that data, we actually apply machine learning and artificial intelligence to find patterns. For example, right now we're finding patterns in speaking rate and also changes in the lip. We will start finding many such biomarkers that will be implicated in progression tracking of the disease and also for early diagnosis of the disease.

Margaret Flinter: Vocal volunteers merely download a dedicated app speak into it for a few minutes once a week, and scientists continue to fine tune the algorithm detecting which patients are experiencing further decline. Their data is also Open Source so their findings can be shared broadly with researchers and pharmaceutical companies that are developing better diagnostics and treatments for this devastating disease.

Indu Nevarez: It's really bringing in open innovation. All the data that we collect is anonymized and then made available in an open innovation platform for thousands of researchers who can actually take a look at the data along with our own data science team. That's how we facilitate many clinicians, researchers and pharma companies who work with us to benefit from every second of the effort that you actually put in. To accelerate research we need to get involved in the research. That's why we've created a platform with citizen driven research and open innovation is a future of solving ALS and other neurodegenerative disease. This is really a force multiplier.

Margaret Flinter: A nonprofit hopes to expand their research and data offerings to those working on other neurological disorders like Alzheimer's and Parkinson's. The Everything ALS Speech Research Study, an open data algorithm building platform using vocal volunteers in collaboration with dedicated scientists, all motivated by seeking a swifter diagnosis, and hopefully one day a treatment or a cure for ALS. Now, 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 healthcare is a right not a privilege, www.chc1.com and www.chcradio.com.

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