[Music]

Mark Masselli: This is Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margret, open enrolment for this year's health insurance market place has come to an end. While billions of Americans enrolled for health coverage in the coming year it ended with more of a whimper than a bang, the close of the year's open enrolment numbers down by a couple of hundred thousand enrollees from the year before.

Margaret Flinter: Well you know Mark I have to think that that's an example of just how disruptive uncertainty can be in the health marketplace. Early in the enrolment season enrolment was running ahead of 2016's numbers but then in the final two weeks the numbers really dropped off, something to think about.

Mark Masselli: Absolutely yes, that uncertainty of course has come with strong redirect from the White House and the leadership in congress. As they plan to repeal the health care law consumers aren't certain they'll be panelized with a tax penalty now for not having coverage as stipulated in the Affordable Care Act. The bad news is those who didn't sign up for coverage remain uninsured.

Margaret Flinter: And I think also important to note Mark that enrollment did remain robust in the states that had formed their own individual marketplace exchanges and there is some evidence that in those states, with their individual marketplace exchange, consumers were empowered to seek affordable coverage and they learnt to navigate the portals early on, so for them the reenrollment process was a lot easier. It looks like people actually got used to it and figured out how to do it.

Mark Masselli: We're in uncharted waters at the moment Margaret and to get some clarity we thought we'd bring back a guest to the show who has been on the frontlines of health policy for several decades. Dr. Gail Wilensky is a renowned health economist and senior fellow at the Centre for Health Affairs at Project HOPE.

Margaret Flinter: Dr. Wilensky served as the administrator of CMS under Bush 41 and has significant experience promoting national health policies. She has some strong ideas about how reform should work moving forward and we really look forward to hearing her expert perspective.

Mark Masselli: And speaking of strong ideas, Lori Robertson, Managing Editor of FactCheck.org also stops by always on the hunt for misstatements spoken about health policy in the public domain.

Margaret Flinter: And to no matter what the topic, you can hear all of our shows by going to chcradio.com and as always no matter what the topic you can email us at chcradio@chc1.com or find us on Facebook or Twitter, we love to hear from you. We'll get to our interview with Dr. Gail Wilensky in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with these week's Headline News.

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. President Trump has shifted redirect on his plans for full repeal and replacement of the healthcare law. He is now saying the full repeal and replacement plan for the Affordable Care Act may not even be formulated until early next year saying it's a complex thing to accomplish. The President did vow that he would eventually come up with something "better than the ACA."

Meanwhile, House Speaker Paul Ryan continuing to point to a March deadline for his plan to come up with a replacement to the health care law, his plans have been more transparent stripping Medicaid expansion in favor of Medicaid block grants incentivizing health consumers to build up health savings accounts, high risk pools for those with preexisting conditions and even those living at the lower end of the economic spectrum will have to pay more making consumers more accountable for their own health choices.

However at the recent GOP leadership meeting in Philadelphia concerns were raised about potential political backlash if the law is replaced too soon jeopardizing coverage for millions of constituents or consumers learning that the GOP replacement will not really help them realize significant savings on their health costs.

Tennessee Senator Lamar Alexander says a more prudent course of action would be to repair parts of the Law that aren't working. Meanwhile the request from Vice President Mike Pence's home state of Indiana to please not touch the Medicaid expansion there, the Medicaid expansion provided federal dollars to states who expanded their Medicaid eligibility that expansion covered by the Federal Government for the first three years. All democratic led states expanded Medicaid and were able to expand coverage to millions of Americans and a number of republican led states followed suit, but some like Indiana put forth their own Medicaid expansion that provided funds for those living closer to the poverty line. Indiana's experiment proved quite successful leading to coverage for some 350,000 residents. Indiana's new Governor Holcomb has issued a request to leave the Medicaid expanded funding in place for 2018 for that state which would mean billions of dollars to continue the program.

If only you could read their thoughts – well scientists have unwilled a system that may actually allow completely paralyzed people to communicate their thoughts. It's a brain computer interface that measures blood oxygen levels in different parts of the brain when the person is being questioned. In a trial of the system in 4 patients with complete locked-in syndrome, that is incapable of moving even their eyes to communicate, it helped them use their thought waves to respond yes or no to spoken questions. All 4 original participants of the study reported being happy despite their complete paralysis. Scientists working on the project at Switzerland's WYSS center say the technology holds promise for those suffering from ALS or Lou Gehrig's disease and other classes of locked-in syndrome

I am Marianne O'Hare with these Healthcare Headlines.

Mark Masselli: We're speaking with Gail Wilensky, Ph.D., economist and senior fellow at the Center for Health Affairs at Project HOPE, and the international foundation focused in on improving health care worldwide. She served as the administrator of the Health Care Financing Administration precursor to the Center for Medicare and Medicaid Services under President George H.W. Bush. Dr. Wilensky recently served as president of the Defense Health Board, an advisory board of the secretary of defense, was a commissioner on the World Health Organization's Commission on Social Determinants of Health and co-chaired the Department of Defense Task Force on the Future of Military Health. Dr. Wilensky is an elected member of the Institute of Medicine; she received a bachelor's degree in psychology, a Ph.D. in economics at the University of Michigan.

Dr. Wilensky, welcome back to Conversations on Health Care.

Dr. Gail Wilensky: Delighted to be with you again.

Mark Masselli: You joined us back in 2011 when the Affordable Care Act was getting underway, the landscape seems to be shifting rapidly again and you served under President George Bush 41 as administrator to the precursor to CMS so you understand the importance of clear policy directives in health care. I wonder if you could share with our listeners your advice that you might have for the Trump administration.

Dr. Gail Wilensky: People are feeling uneasy now. They have not as a country liked the Affordable Care Act, more had an unfavorable opinion than had a favorable opinion but they are getting very uneasy because they understand what the Affordable Care Act does and they don't know what's coming next to people who have received coverage, people who have preexisting conditions. So the best thing that can happen is to have a clear indication as soon as possible about what is going to succeed the Affordable Care Act. Up until now the focus has been on repeal and replace, that has been the mantra of the Republican Party. We're beginning to hear the notion of repair and reform, people seem to be much more responsive to the notion of repairing it and there is a lot of agreement that parts of it didn't work as intended but it makes people uneasy to not know what comes next.

Margaret Flinter: But Dr. Wilensky in a recent op-ed piece you noted that the Republicans and Congress heads spent the last 6 years attempting to repeal the Affordable Care Act but they knew the efforts would be vetoed. As you know there is a reality shift as leadership learns it's not going to be so easy to deliver on that promise without disruption to the health care industry and without threatening the status quo for all the people who gained coverage help our listeners understand how the political imperatives may collide with policy as your opted title suggests and what you think is most likely to happen in the coming months?

Dr. Gail Wilensky: Because Republicans have focused so much on the language of repealing the Affordable Care Act they would miss the opportunity to do something that might be much easier and where they possibly could gain democratic support which is not just good policy and politics in general but maybe absolutely key to being successful. Well, Republicans control both Houses of Congress and the White

House, the control on the Senate is by a very small margin 52 to 48, they will need Democrats to get to 60 votes.

There's a process budget reconciliation which allows the Senate to vote on budget related measures with only a simple majority but anything else, and many of the insurance reforms are believed to probably fall into the anything else bucket, would require 60 votes. That means that they are going to require some support from the Democrats which means how they do this could become very important. In order to repeal that whole mammoth, 2,000 plus page piece of legislation, you would definitely need your 60 votes. What they can affectively do is remove the funding for almost all of the subsidies and other aspects that are funded by the various excise taxes with simple majority but the replacement may require a vote of 60 supporters. It's something that the Parliamentarian of the Senate decides whether or not a bill needs only a simple majority or requires the normal vote that the center requires to get around filibuster and of course you can count on some democrats wanting to filibuster any removal of the Affordable Care Act.

Mark Masselli: You know Dr. Wilensky a number of well known GOP strategists have been analyzing the kind of policies that are most likely to be part of whatever comes next and as Dr. Mark McClone, who was recently on our show, said that the reforms are going to have a distinctive Republican flavor have savings accounts, tax credits instead of tax penalties, what other types of things you might see emerge with the new Congress and new President all aligned?

Dr. Gail Wilensky: Well people have been taking about the need to protect individuals who've preexisting conditions and Republicans understand that but the mechanism they use is likely to be different. In the Affordable Care Act there is a law that says that insurers cannot make any distinction according to the health status of an individual, those of us who have employer sponsored insurance through the HIPAA law that was passed in 1996 and it basically says if you maintain, continue this coverage then you won't the placing any exclusions when you change jobs or get new insurance.

In the 1990's people would be stuck in a job because if they changed jobs and got a new insurance and they or somebody in their family had a preexisting medical condition they would face a 6-month exclusion from coverage for that preexisting medical condition, the HIPAA Legislation would not have to be subject to a preexisting condition exclusion. Republicans have talked about this as a way to provide a strong incentive to be continuously covered. There is a lot to talk about removing the mandate on individuals. I and others have talked about whether the Congress shouldn't take a page from Medicare to do what Medicare does which is to say that for the voluntary part, part B the physician coverage and part D, if sometime later you decide you want that insurance you will pay a penalty for every month you delayed after that first year because they want to avoid at their selection having people wait.

I was disappointed in 2009 that they didn't give this strategy a try, so that's another kind of thing. In general, Republicans try to use less regulation and try to put in strong incentives to encourage you to do something that they think is appropriate and the Affordable Care Act – the amount that a premium was allowed to vary

because of age was 3:1 and the youngest adult males were being asked to pay more than would have been actuarially calculated so that the pre-Medicare population could pay less. Except that we know that the youngest adults are the hardest to convince to go buy insurance so unless you had almost all of the insurance paid for it made it even less likely that we could get this young healthy population to buy in and of course you want them in because they help your risk pool and what you require to buy is probably going to be determined by the states. So those are the kinds of changes that I would expect to see with the Republican package, 6 years after its passage the majority to people in the country had an unfavorable opinion of the Affordable Care Act. It's only right now when they're being threatened with losing it and they don't know what's coming in its place that people are starting to be more favorable in their attitude.

Margaret Flinter: I'd like to thither a bit to another area where there is lots of concern, interest and debate right now and that of course is Medicaid. Lot of concern among the states' Medicaid directors who've adopted their policies and budgets to accept the Medicaid expansion in their states, but the talk coming from GOP leaders like Speaker Ryan and Senator McConnell seem to indicate elimination of the Medicaid expansion is on their agenda but also a fundamental change to the Medicaid program and moving it to block grant status. Could you talk about how that might impact some of the recent coverage gains under Medicaid expansion and how you think state Medicaid directors will prepare for what's coming next?

Dr. Gail Wilensky: There are two kinds of block grants, one is just a fixed amount of money which would put the state at great jeopardy and the other is called the per capita block grant. They would be eligible to receive an amount of money for every person if you get more people under the poverty line for example because you have a recession. The state would automatically receive more money than if times were good and so my advice to governors is only consider a per capita Medicaid block grant.

The second issue is how the governors feel about this change. They want more flexibility and block grants provide a lot of flexibility of the Hyde Amendment which prevents having federal money go for – abortions would probably be attached to that language. Medicaid can provide a lot of flexibility but frequently they have to ask permission in order to get a waiver to do it their way. If the majority of at least Republican governors don't want to go on this direction, the Republican congress would think wrong and hard about whether they do it anyway.

Mark Masselli: We are speaking today with Gail Wilensky, Ph.D., economist, and senior fellow at the Center for Health Affairs at Project HOPE. She served as administrator of the Health Care Financing Administration and co-chaired the Department of Defense Task Force on the Future of Military Health Care. I want to get back at this issue of trying to find common ground, one area that we know where there's been bipartisan support has been the support for community health centers maybe you could address both of those.

Dr. Gail Wilensky: Fortunately, for the country the very close division in the Senate requires cooperation to do at least some of the changes that you would like to have associated with the next round of health care reform and that is going to pressure

Congress to find ways to work together. It's always better to get bipartisan support, you are much more likely to get abeyant and stability over time. Republicans aren't going to have much choice, for some things they can go alone but for many pieces of legislation they are going to need to have some bipartisan support. The question is whether the Democrats and the Senate will want to provide that, some may not but there are a lot of Democrats who are up for election in 2018 and there are people particularly who are middle of the road politically that if the Legislation is something they can me made comfortable with might well support it. This will be much better for the country.

Margaret Flinter: Well Dr. Wilensky I think there is one issue I've noted that's emerged from the administration that seems to have actually resonated with people on both sides of the aisle and that's getting a handle on reducing the exorbitant cost of pharmaceuticals. You recently wrote that the high cost of prescription drugs is much more than a political issue, President Trump has promised to incentivize the pharmaceutical industry to reduce the cost of drugs to consumers but also to reduce the role of the FDA and drug approvals to accelerate the pace of competitive drugs entering the market place. What policies do you think might actually lead to making pharmaceuticals more affordable for consumers?

Dr. Gail Wilensky: The pharmaceutical industry is different from other aspects of health care when it comes to regulating the prices or trying to control spending the way we do in Medicare. Generally in Medicare the Centers for Medicare and Medicaid Services set a price that they'll reimburse hospitals, if you miss on pricing for most services you get a pushback right away hospitals will threaten not to participate or will have trouble staying in business of getting participation in Medicaid is a problem in many states because of low fee schedules.

In pharmaceuticals, it's a little different, there is a very long lean time while drugs are being developed in the laboratory and then go through clinical testing, go to the FDA for approval for safety and efficacy, and finally get to market. But also a lot of drugs that look promising at various stages don't make it through that whole process or by the time they make it through there may be a lot of other drugs that are already on the market. Once you actually get through that process, the cost of producing the drug is not usually that high. The high cost is in the whole development process and the likelihood that a drug that starts to look promising and never makes it through that whole process but it may not be worth it for the company to try to do that again for the next product because they have to absorb all of those costs. So the concern is that unlike a physician where if you're not paying enough you'll know pretty quickly because physicians will refuse to see certain patients as happens in Medicaid.

In the pharmaceutical world you won't feel that impact for many years to come because of this long production process. I think the best thing we can do is try to expedite the review of expensive specialty drugs because we've seen that some of the large buyers can play one drug off another if there are competitive drugs in the specialty area, we saw that with Hepatitis C drugs, there was a big drop in price once there was competition to Sovaldi and Harvoni the price dropped significantly. So, there are other things you can do but one of the things we can do is to try to help by providing enough resources for the FDA, we don't want them to skimp on their

process, we just want to give them the resources so they can do this as expeditiously as possible.

Mark Masselli: You know you've dedicated a good portion of your carrier to improving the plight and the health of American veterans. What are your observations on the new administration's call for more privatization of the VA? Dr. Shulkin is the nominee who faces enormous amount of challenges as Secretary for Veterans' Affairs. What are your views at how best to make the necessary improvements to fix the current system?

Dr. Gail Wilensky: There are a number of things that need to happen and we owe this to our veterans to get it right. Having options outside of the VA for individuals who either live in an area where there are not the kind of resources available within the VA to see them in an appropriate and timely manner makes complete sense particularly when it comes to providing regular health care that can be provided easily through the private sector and that option is actually not new to the choice program, it's just been expanded and it makes a lot of sense.

We do ultimately need to decide what role we see in the future, 10 years down, for the veterans' administration. Do we see them providing all of the health care needs? Most veterans actually don't receive their health care at the VA, there are some 22-23 million veterans, there are 6 million or so regular users, and 1 or 2 million occasional users of the VA. But another way to think about the VA would be to have it focus on providing the health care that specializes in the needs of war and have regular routine care be provided by the private sector. So you could imagine a VA that focuses on PTSD, and prosthetics, and the multiple injury support that we have seen following the wars that we've been in in Iraq and Afghanistan and of course other wars as well and so have this very specialized focus for the VA which it does very well.

Historically it's done very good post-stroke work but we have special injuries, IED in particular and PTSD following these wars and have a take on a much more specialized function that would help us structure where we go in the future and it makes a huge difference about whether we're going to think about having specialized support for the VA and using the regular health care system to provide the routine support, or whether we're going to continue trying to do what we've done. We have a problem, there is clearly a lack of accountability and appropriate incentives and structure, problems with the use of electronic scheduling and support that has not yet been dealt with, it's been noted as a problem by the GAO repeatedly, we got to get this going.

Margaret Flinter: We've been speaking today with Dr. Gail Wilensky, economist and senior fellow at the Center for Health Affairs at Project HOPE. You can learn more about her work by going to projecthope.org. Dr Wilensky I want to thank you so much for joining us today on Conversations on Health Care.

Dr. Gail Wilensky: You're very welcome, pleasure to be with you.

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 non-partisan, 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 an interview with ABP News, President Donald Trump questioned the estimate that 18 million Americans could lose insurance if the Affordable Care Act is repealed with no replacement. He said "nobody ever deducts all the people that have already lost their health insurance that liked it." In fact estimates from governmental organizations on how many have gained insurance under the ACA, or stand to lose it if the law is repealed, are net estimates. The Centers for Disease Control and Prevention publishes data on health insurance status from the National Health Interview Survey, the latest report shows an estimated 28.4 million Americans of all ages were uninsured for January through June 2016.

The number of the uninsured in 2010, the year the ACA was enacted, was 48.6 million – that's a decrease of 20 million people. In percentage terms 8.9 % of all US residents lacked insurance during the first half of 2016, the lowest uninsured rate on record. The rate was 16 % in 2010 and has been declining every year since. These are the total numbers for the uninsured in the country. The claim that millions lost their insurance is a longstanding talking point based on the fact that many with individual market plans received cancelation notices in 2013 when their plans no longer met minimum benefits standards required under the ACA, when those specific plans were discontinued policyholders weren't denied coverage.

Another study from the Ryan Corporation suggested that most of those who had their plans canceled found coverage elsewhere and remained insured. To be clear some who buy their own insurance on the individual market got a better deal before the ACA, were relatively young and healthy who also earned too much to qualify for subsidies under the health care law and there is evidence that some have lost or dropped their insurance coverage even as many more have gained coverage in recent years. As for the estimate that 18 million could lose their insurance if the ACA is repealed that comes from the non-partisan congressional budget office which said that the number of the uninsured would increase by that much in the first year following repeal of the individual mandate penalties. The number would be higher once tax subsidies and Medicaid expansion funding were eliminated, 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 would like checked, email us at chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

Each week conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Stanford based bio engineer Manu Prakash has a simple goal, he wants to create a portable medical lab small enough to fit in a backpack and he has already developed a tool that fits the bill. While sitting under a tree in Uganda he noticed that the local medical clinic's door was propped open by an expensive centrifuge machine, one that was reliant on electricity, now broken and no longer in use. He wondered how could he create a portable centrifuge that will be

inexpensive to make, easy to operate, and easy to replace. His inspiration came from a simple ancient childhood toy – the whirligig, a toy that functions by pulling two ends of a string threaded through a round object like a button

Manu Prakash: Before us nobody had actually understood how this toy works, so we spent a significant portion of this time truly understanding the mathematical phase for how you can convert linear motion into rotational motion and there is some beautiful mathematics hidden inside this object

Margaret Flinter: So he took this simple toy idea to another level creating a human power centrifuge made from simple components paper, twine and plastic. All together each paperfuge, as he calls it, can be constructed in under two minutes and costs only 20 cents and yet remarkably it works extremely efficiently.

Manu Prakash: With this set of principles we're able to essentially make a centrifuge that spins all the way to 120,000 rpm. In the lab we can separate and pull out malaria parasites from blood, separate blood plasma – it is an ultralow cost centrifuge.

Margaret Flinter: It's currently being tested for Malaria diagnosis but is being readied for far more complex diagnostic challenges.

Manu Prakash: This is a tool that requires no electricity, no infrastructure, you can carry them around in your pockets for a price point of 20 cents.

Margaret Flinter: The paperfuge, a cheap but highly effective feedthrough for clinicians providing a portable solution to diagnostic challenges creating a quicker pathway to diagnosis and treatment. Now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care, I'mMargaret Flinter.

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

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