Mark Masselli: This is Conversation on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, we just recently observed World No Tobacco day. It's a global event launched by the World Health Organization to examine the impact tobacco is having on global health, as well as the global economy. Well, it is certainly seen a decline in this country, smoking is on the rise in other parts of the world.

Margaret Flinter: Well, the numbers do tell the story on this important health topic, Mark. Smoking is directly to some 7 million deaths per year globally and if smoking and tobacco consumption continue at this rate, the number will be 8 million global deaths by 2030.

Mark Masselli: Well, smoking rates in this country have dropped significantly in the past couple of decades, one-fifths of deaths are attributed to smoking or exposure to secondhand smoke. An estimated 450 thousand deaths per year in the United States; the World Health Organization is calling for a collective global action to curb the spread of tobacco, which is heavily marketed to vulnerable populations.

Margaret Flinter: Well, there is an economic toll as well Mark, the World Health Organization estimates 1.3 trillion dollars in productivity loss from smoking related health costs, as well as lost productivity due to sickness and absenteeism. It is exacting a huge toll on developing economies and adding 100s of billions of dollars to healthcare costs, all the way around, terrible.

Mark Masselli: Terrible and there are some public interventions that seem to be working, public smoking bans, higher taxes on tobacco products are helping to curb the problem, but a much larger global effort is needed and speaking of health costs, Margaret, it is all at the center of health policy discussions underway in Washington.

Margaret Flinter: The Senate is now grappling with the GOP Health Reform measure passed in the house to replace ObamaCare. The American Healthcare Act has taken a lot heat from entities across the healthcare spectrum and that is something our guest today has spent much of his career focused on.

Mark Masselli: Thomas Miller, Senior Fellow at the Conservative American Heritage Institute has done much research on market-based alternatives to the Affordable Care Act. He has some insights into what may happen with the Senate iteration of the GOP Health Reform Bill. It'll be interesting to hear what he has to say about some of those market driven alternatives to the Affordable Care Act.

Margaret Flinter: And Lori Robertson also stops by, the Managing Editor of FactCheck.org. She looks at misstatements spoken about health policy in the public domain, but no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Mark Masselli: And as always if you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter, because we love hearing from you.

Margaret Flinter: We'll get you our interview with Thomas Miller in just a moment.

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

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. July, at the latest, that's the timeline some Senate Republican insiders are putting on producing a replacement to the House GOP's American Healthcare Act on the books. Back from Memorial Day recess, many including GOP leadership went home over the holiday to some vociferous opposition to their plans to repeal and replace ObamaCare. Growing contingents with the GOP majority say they will not put their stamp on a Bill that kicks 10s of millions of Americans off their health insurance as the Congressional Budget Office estimates might happen. With no apparent healthcare deal in immediate sight, some in the Senate are looking at ways they might be able to make short-term solutions and improvements to the law to bolster the unstable insurance marketplaces. Opioid death rates appear to have skyrocketed in 2016 with some early statistics revealing death rates above the 50,000 mark last year as the epidemic continues to unfold, some State and local governments are taking their own action. Ohio, a hotspot for opioid overdoses has become the largest State to sue Purdue Pharma, Johnson & Johnson, Janssen Pharmaceuticals Unit, and the Teva Pharmaceutical, and Allergan, the lawsuit seeks to recover money the State and residents spent on unnecessary opioid prescriptions, as well as costs associated with addiction and treatment. The five companies are denying allegations. The White House is following through on a promise to rollback birth control coverage requirements in the Affordable Care Act under certain circumstances. Federal officials drafting a rule that would rollback the requirement that religious organizations must comply with the mandatory birth control coverage. The proposed rule could take effect immediately as an interim final rule. The typical process however is to open the rule to public comments before a final decision is made. It's being called the first in clinical cancer trials, an experimental gene therapy for patients with advanced multiple myeloma, a particular kind of blood cancer that is on the rise, shows all participants in a study showed noted improvement after the experimental treatment, though the sample was relatively small, just 35 patients; every single one responded favorably to the treatment in all but two were in remission within

two months. Experts say it's a first for multiple myeloma and rare for any cancer treatment to such early success. I am Marianne O'Hare with these Healthcare Headlines.

Mark Masselli: We are speaking today with Thomas P. Miller, Resident Fellow at the American Enterprise Institute, where he studies health policy and market based alternatives to the Affordable Care Act. Mr. Miller is a former senior health economist for the Joint Economic Committee in Congress, where his focus was private health markets, health information transparency, and market driven healthcare. Also, served in the National Advisory Council at the Agency for Healthcare Research and Quality, he earned his B.A. in Political Science from NYU, his JD from Duke University School of Law; Tom, welcome to Conversations on Healthcare.

Thomas Miller: Pleasure to be with you.

Mark Masselli: You know, you've been a vocal critic of the Affordable Care Act, but you also warned opponents of the ACA to get to work on replacement and here we are, four years later, watching the GOP replacement for ObamaCare, the American Healthcare Act take shape and I am wondering if you could share with our listeners what you think that current version of the law and what's really going to happen, and is going on behind the scenes?

Thomas Miller: The Affordable Care Act put in place a set of benefits to people and they don't want to let go off them. The AACA is a reaction to that overreach. Now, the problem with moving from criticizing what's in place to replacing it has now begun to confront difficulties of the Republicans. They may be a little surprised that the majorities they got after the November 26th elections including the White House and you know, like the ultimate thing in professional sports is , you play like you practice. They didn't practice enough and so they want it ready on day one to have a fully fledged out legislative vehicle. So it has been a turnaround in attitudes where people are reacting more to what they are concerned about and disrupting what they already know and the unknowns ahead of this various types of replacement legislation. Moving over to the Senate after some of the difficulties in the House involves changing what was done in the House to some degree, mostly reactions of Senators to make the rollbacks in the Medicaid expansion coverage was on risk. There is also reaction that moving to the type of subsidies, the Republicans have advocated for health insurance, moving into being so income sensitive to being a little bit flatter with some age adjustments may be too much of a stretch too quickly. And then the just the normal problems of what you do, what's called Budget Reconciliation tried to do some things, but not everything and it is difficult for the Senate to figure out where they are going to get 50 Republican votes plus the Vice President, but that's what they are committed to as they stare into the deep dark abyss of the alternative being a total failure.

Margaret Flinter: Tom, we've had a number of guests on the show recently, who've shared their thoughts about how best to retool American healthcare and American health reforms, specifically with a more market-based and consumer driven focus. We'd really love you to share with us what you see as the essential hallmarks of this approach, the market-based consumer driver focus.

Thomas Miller: Sure, we need to readjust our rhetoric and what we promised on consumer driven care to what we can actually put in place in the speed at which it goes about. We need a better way of usable and actionable information and we've fallen short on that and we made some progress on that front. Yet, we changed the incentive structure, so that people are rewarded for making better decisions and have a few negatives inside just to make them involve the networks on both the provider's side, the payer's side, and the patient's side and that leads to a type of bilateral accountability. It's not a one-way directional, but you are responsible for the decisions and choices you make. We found out that there are people who actually are more involved in decision making, ultimately, better patients would end up with better health. You need to also un-bundle a lot of complex integrated benefits that is possibly one side fits all and serves everyone, but don't actually match the leads in the coverage and the uniqueness is you learn more about how well patients are very different. Safety net has been matter though if you are going to train people used to make more decisions, not everyone is going to want to do that, but also lot of people will fall through and need special help and if you don't invest there, you don't have the political support or the credibility to offer wider choices and more responsibilities to everyone else in a freer environment. So the language here gets a little overstated. You know, saying everybody is going to have the most wonderful care possible at the lowest cost overstates it. What we can try to credibly promise is that people can improve their situation if they are willing to make the decisions and tricky choices on their own. You can't promise the best to everyone at all times with no cost whatsoever. That's simply a critical exercise which defies the reality of what actually happens. You want to try to have people for however much they want to spend their own money, as well as what they can get from other people, to maximize their value. That's not the same thing as saying just go away and we hopefully will request more.

Mark Masselli: You know, its not a muscle that Americans have exercised much in this sort of very complex disjointed American health system. It's not like it doesn't seem to operate like the auto industry and where consumers are really price sensitive and aware of that, you know, when you go into the emergency room, there is real lack of transparency about what the price is and not sure if you are thinking about it at that moment, but and I wonder what you are getting to a market-driven health system is going to work through the issues of this institutional resistance to get information about pricing out there, so consumers can make some choice and what's your sense of how that's going to work in your ideal vision?

Thomas Miller: Well, we all resist accountability and transparency if we are on the other end of it and certainly all those a bit little apprehensive in trying to have you know the equivalent of menu boards of the itemized prices and sometimes it doesn't mean much to people in terms of the decisions they need to make. You want to know, you know, what are my all-in costs going to be when I go to start over here, but what's my diagnosis and what's it going to produce when everybody throws the bills down and everybody gets involved in the multiple stages of care. Now, certainly there are extreme circumstances where you are totally unconscious, lifesaving reason, you are not about to be an active decision maker, but you can plan in through a whole lot more, I mean you know right away in sense of the insurance that you choose if you pay more attention to it, who is in your provider directory and what you know about what that plan offers in as a general rule and if you invest a little bit more, you might know that some doctors are better at some things than other things. Now, we can include those tools, but those are your decisions. Also, people are not usually you know, in life we get instantaneous situations. Even people with chronic illnesses become much more knowledgeable about their health condition and their care, so we need to deepen the accounts to which people can find out more about what matters to them and be able to make better more meaningful choices along the way. It's not an only nothing situation, you just really need to think about ways to reach caregivers and other type of intermediary resources, where other people can take care of those, who can manage things for themselves. We need to invest more in that than sometimes the benefits themselves, so the more as we get people having more interested in their health, would improve what would be a true market-driven approach.

Margaret Flinter: Tom, you've wrote recently that in addition to the rollback of government regulations, getting rid of the individual mandate requiring the purchase of insurance, whatever version of the new healthcare or TrumpCare if you want to call that, we end up with needs to significantly slow the growth of Medicaid moving forward and certainly that advice would seem to have been heeded in the ACHA, which makes dramatic cuts to Medicaid as does the President's Budget. You know, we certainly think as a Safety net in terms of community health centers, which is the system of care that we are so familiar with. So what does that Safety net look like if Medicaid is significantly reduced and if the patient's with preexisting conditions choose to go uninsured?

Thomas Miller: On the Safety net, there is very little kind of too tight to populate, we sometimes board them together. There are individuals who have short-term financial emergencies, who are lower income in general and they may need some ways to get out of that, low income problem. On the other hand, when we are willing to best to invest side of the Safety net, such as the Medicaid expansion, we tend to give a shorter shift to the people who have much more serious and longer term illnesses or disabilities and then treat them as well. So, we need to invest more in the people who truly can't help themselves on a longer term basis while trying to mainstream the other low income population into better

jobs as opposed to making their status on a longer term basis. You mentioned community health centers, who tend to do a much better job worth the dollars because they tend to be more accessible, less complex, less expensive as a general rule, that can actually deliver the care that people need in many of those circumstances. In addition though there are just many other ways in which we can improve the health of the vulnerable population, the low income population and that may involve ways in which by investing earlier in their lives giving them the tools, the business skills they need, the educational factors that they wouldn't have those type of problems that knowing the patients can been better mange the rise in the healthcare and economic system. So if we could invest earlier in delaying the onset of these chronic conditions. There's plenty of research on that front, we sometimes wrapped up in the idea of social determinacy, how we can actually get better help over a longer period of time and they got expensive system as fewer customers coming into it at least in the earlier stage.

Mark Masselli: We are speaking today with Thomas P. Miller, Resident Fellow at the American Enterprise Institute, where he studies health policy and market-based alternatives to the Affordable Care Act and Tom, you know, I would like to take a look at the national discussion that is going around health reform now and what we are seeing now is a deeply divided public perception about the Bill that came out of the House. I am wondering how the Senate sort of builds public trust or what's your view of the polling data right now, which did show in the Affordable Care Act was not liked that they were pretty accurate in that. Again, it is showing that they've got off to a bad start and so what's your thought about how do you think they'll be able to close that divide in terms of public perception?

Thomas Miller: Well, it's a serious case of risk conversion. There were some over-promises as well or contradictory promises, which came out more from President Trump. I think it's hard to regenerate some type of these non-extreme bipartisan committee. We've just got a long history as to where we've been on healthcare and you are not going to put that egg back together at least in the short term. That's why the Republicans are going it alone, the same way did the democrats and that's just the underlying political reality. With the narrow margins they have it oncoming, they got in toward to exercise to use the tools they have to deliver something although they didn't know what that was going to be. Looking ahead, we are likely to see some desperate moves later on as we enter the end of this year, early next year to move more toward a broader short-term set of intermediate fixes and then rescue efforts, particularly as some of these markets begin melting down; that's is bailing water out of the boat, but we will eventually go through that exercise if necessary. I would like to be more optimistic on this front that I tend to adopt the perspective of the Miracle Max in the Princess Bride, I've seen worse than is most here.

Margaret Flinter: Well, I am going to give you a chance to be a little bit optimistic perhaps, because one of the tenets we live by is we should always be looking around the country to see who is doing innovative work, who is not just had a

good idea, but is implementing it, innovating, and has some results to show for, so when you look around the country, what States do you see that have really made some positive strides in health reform; we'd love to hear your take on that.

Thomas Miller: States have been, newer things happens a small degree, you can pull out particular reference on whether there would be no managed care in Medicaid or small pockets of individual provider groups trying to do things differently and having some, we tend to know about the excellent examples, the problem is how the broad-base them and still them up and they tend to have a certain organic nature to it. The same people who had been before yet again they definitely try to give you an answer to it. With the Affordable Care Act, we increasingly treated the States as the equivalent like a large employer, salary plan that are for administrative services only, but we also stunted what might have been the more evolutionary bottom up development of things working and other people saying, hey that works and you think what if you do it, so lets do more of it, because we put things into a little bit more of a cookie cutter arrangement and so to be able to use the word innovation, I don't want innovation, I want something that works and if something that works well, it should work on kind of a larger scale and people should do it, so it needs to be tested by what results are actually produced. If we get into a more results oriented approach, which doesn't measure whether you've hit the check marks in the various set of potential healthcare inputs, by that measurement, that actually produces better life expectancy or less upsetting consequences to your injuries and improves your health, that's what I want to know, but I also want to know how much it costs and that's a balancing act between the cost and the outcome side as to which side you would prefer and they call that value.

Mark Masselli: We have been speaking today with Thomas P. Miller, Resident Fellow at the American Enterprise Institute, where he studies health policy and market-based alternatives to the Affordable Care Act. You can learn more about his work by going to aei.org. Tom, thank you so much for joining us on Conversations on Healthcare today.

Thomas Miller: You are very welcome.

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a 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: Our readers have asked us whether have scientists have confirmed that E-cigarettes cause an incurable respiratory disease called popcorn lung. The answer is no. The vapor of some E-cigarettes contains a chemical associated with popcorn lung, but there's not enough evidence to

conclude they cause the disease. Electronic cigarettes or E-cigarettes were introduced into the U.S. market in 2007. They deliver nicotine flavorings and other chemicals to users in the form of a vapor and they are often promoted as safer than traditional cigarettes. Online articles on E-cigarettes and popcorn lung have been circulating on social media. Popcorn lung or bronchiolitis obliterans is an incurable disease characterized by the scarring of the smallest airways in the lung. That scarring limits the passage of air. If the disease becomes severe enough, the only treatment option may be a lung transplant. Researchers have associated the inhalation of popcorn flavoring chemicals with popcorn lung in workers at microwave popcorn factories. A December 2015 study conducted by scientists at the Harvard School of Public Health found at least one of three chemicals associated with popcorn lung in 47 of these 51 E-cigarette vapors studied, but the study didn't confirm that E-cigarettes definitely cause popcorn lung. Previous research on exposure to diacetyl suggests it might not be that chemical alone that can cause respiratory issues. While it's unclear whether E-cigarettes can cause popcorn, what is certain is that they aren't harmless; they contain nicotine, which poses health risks, especially to children in teens. And that's my Factcheck for this week. I am 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 www.chcradio.com, we will have FactCheck.org's, Lori Robertson, check it out for you, here on Conversations on Healthcare.

Mark Masselli: Each week conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Fitness trackers have become all the rage, especially among upwardly mobile fitness conscious people seeking to monitor their own health and fitness goals. But another trend has emerged in the age of wearable devices; after a few months, about a third of users simply stop using them, leaving a lot of costly devices sitting in the shelf and not in use. The reality capture the imagination of Tufts University School of Medicine, Professor Dr. Lisa Gualtieri.

Dr. Lisa Gualtieri: And I thought what if you could take all of these abandoned trackers and give them to the people who could benefit most from them.

Mark Masselli: So in 2015, she launched her nonprofit enterprise, Recycle Health, an online social media campaign which seeks donated wearable devices to provide these expensive devices for free to those in need.

Dr. Lisa Gualtieri: People are excited about the potential how these devices help them leave healthcare alive. At the same time, there are many-many barriers. So we found a lot of people, who never downloaded an App to their smartphone. So how do you get the package, get the device working on your wrist.

Mark Masselli: She partnered with organizations working with adults in wellness programs, seniors in fall prevention programs and veterans as well. Her goal is to start collecting vital data on the deployment of these devices and the impact they may be having on behavior change in vulnerable populations.

Dr. Lisa Gualtieri: One of our dreams would be to make it really easy for organizations that have money, say for instance in short to say the money that we spend on giving people trackers is going to save us so much more than that in reduced healthcare costs. We are working with a number of senior centers in the Greater Boston area. We really see a lot of potential with populations who are not the ones that the vendors are targeting.

Mark Masselli: She is hoping to expand their data collection on health outcomes for vulnerable populations, who gain access to these wearables.

Dr. Lisa Gualtieri: These are devices that people weren't using, people no longer want and other people are being helped by it. It's about a low-cost intervention we could possibly have.

Mark Masselli: Recycle Health, a simple repurposing of personalized wearables, providing these tools to vulnerable populations, empowering them to engage in activities that can improve their own health, now that is a bright idea.

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

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

Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University, streaming live at wesufm.org and brought to you by the community health center.