The Powers Report Podcast

Episode 10

Transforming Philanthropy in Health Care

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

A funny thing happened at Morehouse College in May. A billionaire promised to pay off the student loans of the graduating class (1). While the rest of us are tinkering into summer, the recent graduates of Morehouse College and their families are probably still reeling from the surprise announcement. It has inspired me to think more about how philanthropy is changing, not just in education, but also in other fields. In this podcast, I will talk about the need to embrace new modes of philanthropy in health care, and how this Morehouse model can serve as a catalyst to make giving more targeted and more efficient.

Here's the re-cap. Austin-based billionaire Robert F. Smith delivered a commencement speech at Morehead College. Smith is the founder of Vista Equity Partners and is one of the wealthiest African Americans in the country. He's not a graduate of Morehouse, which has historically been a black, male college. Yet Smith is a proponent of using his wealth to support African American causes. He pledged $50 million to his alma mater, Cornell University, to support African Americans and women in chemical and biomolecular engineering programs. He gave $20 million to the National Museum of African American History and Culture in Washington, DC. And he's the founding director of Fund II Foundation, which focuses on promoting human rights, African American culture and other related causes.

But the Morehouse gift is different for Smith and it's different from what most philanthropists do. It's not a lump sum, broad-based gift. It is, ostensibly, a direct-to-student payment. It's efficient and it's immediate. And that's what I like about it. In fact, we need more of this type of thinking in the world of health care philanthropy.

Let's draw some comparisons.

Education and health care are often linked together. We all need an education and everyone uses health care services. When it comes to philanthropy, these are the two most popular areas to give money. The Chronicle of Philanthropy identified the top 100 charities in 2017 (2). Forty-one were colleges. Eight were medical centers and another 13 were for Health, which includes organizations like the American Cancer Society. Social Services and Community Foundations accounted for another 12, and many of the funds sent to these groups can help improve the health of millions of Americans. Those organizations collectively accounted for 74 of the top 100 charities.

Now let's talk about the money. In 2017, CMS estimated that about $239 billion of the $3.5 trillion spent on health care came from "Other Private Revenues." (3) These funds include several categories, including philanthropic support. That $239 billion represents almost 7% of the total spend. To put it in context, private business spent about 20% and federal, state and local governments spent over 45% of the $3.5 trillion.

Interesting factoid, Households paid over 28% of the money. Money paid by Households includes premium payments, out of pocket payments and Medicare payroll taxes. So philanthropists pay about a quarter of what all the Households pay into the health care system. Somewhere in all of this are the general taxes that philanthropists and the general public pay, and much of that gets routed to funding Medicare and Medicaid. In any case, that's how much money we're talking about. It's a lot.

Giving chunks of money to education or to health care organizations, especially medical centers, is great for donors for several reasons. First, there are tax benefits. I don't know specifically what they are because I'm not in the habit of giving away tens of millions of dollars to charity, but you can be sure that the tax upside is there. If getting a tax write off incents people to give money to help the under-served, then it's a win for everyone.

But more specific to what I want to talk about relates to the one-time, big splash, hands-off approach to giving away money. Donors in education and in health care will give tens, even hundreds of millions of dollars to institutions and they often get naming rights. Think about the names of the universities and colleges and graduate schools near you. I went to Yale. It was named after Elihu Yale, who donated a bunch of books, a portrait and some other stuff to a burgeoning college in Connecticut. It was subsequently named after him. My graduate alma mater is the University of Michigan. I got an MBA at the Ross School of Business. Real estate developer Stephen M. Ross has given the university $313 million (4). I got my Master of Architecture from the A. Alfred Taubman College of Architecture and Urban Planning. Taubman gave over $40 million to Michigan (5). You get the idea.

In health care, donors, depending on the size of the donation, may get an entire building or wing named after them. In Austin, where I live, we have the newly minted Dell Medical School, which is part of the University of Texas educational system. The Susan and Michael Dell Foundation gave $50 million towards the school (6). A smaller donation or a donation of that size in a larger market, like New York, might only garner the donor's name on an atrium. One of my former clients had a Gamma Knife, which is used to address brain conditions, named after a donor.

The point here is that the donor gets their name publicized into perpetuity. They solidify their legacy forever, so even when the money is gone, generations later, which it typically is, the family name will still be on a building façade, on promotional brochures, in video history. It's an attractive draw for donors seeking this sort of multi-generational fame.

Donations come with terms and are structured financially around how the donor wants to transfer the assets. Sometimes donors will give stock in his or her company as part of the donation. Money may come in over a period of time, in amounts that are smaller than the publicized total commitment. Donors may give stipulations about how the funds are supposed to be spent, and sometimes they don't. Some donors get on the board of an institution to kind of oversee what the administration winds up dong with their money. Other donors are more directed with how they want the money spent. Billionaire Michael Bloomberg recently committed $1.8 billion to his alma mater, Johns Hopkins (7). The

money is to be used for financial aid. So Robert Smith's Morehouse donation has a pretty beefy precedent.

Both Smith and Bloomberg are making the lives of specific people a whole lot easier by addressing one of the plagues facing Millennials: mounting student debt. Instead of giving the money to a university's administration and allowing it to spend time and resources to allocate the funds – which of course dilutes some of the value of the donation because they have to spend money to figure out how to spend the money – these two billionaires want the money to go to the kids. Simple, direct, efficient.

Now, while I like the simplicity of these types of donations, there's a huge problem with them. And that is that by giving money away to cover the cost of skyrocketing debt, the donors aren't addressing the root cause of the problem: skyrocketing tuition and fees. There's a mind-blowing graphic provided by the College Board that shows how tuition and fees have increased over the last 30 years (8). At private, nonprofit four-year colleges, tuition and fees went from a little over $17,000 a year in the 1988-89 academic year to, get this, $35,830 a year. And that's adjusted for inflation.

In three decades, the cost of private college doubled. Mr. Smith's magnanimous donation to Morehouse College grads is a life saver because the average student graduates with somewhere between $35 to $40,000 of debt. Maybe, if Morehouse's tuition were lower, then the students wouldn't have so much debt. Smith's donation could go a lot farther than rescuing one class of students.

What has been a culprit in the rise in tuition? One major factor is ballooning administrative costs (9). There are more administrators overseeing more people doing more stuff, providing kids with more help and more programs and services. Here's what I mean.

I went to Yale in the late 1980s. Back then, there were just a few noted oversees programs. You could do Yale in London, which was a curated semester or year in the UK. And then there was a summer program, Yale in China. That was exotic and parents had to put up a chunk of cash. Now, travel has become cheaper and much more accessible, making something like Yale in China not all that groundbreaking anymore. Nonetheless, Yale now offers an incredible array of international opportunities for students. According to the university, two out of every three undergraduates participate in an international program (10). You can see how administrative costs can explode – and that's just one example of one type of programming at one school.

Now tack on all the new amenities being built (11). Like water parks and lazy rivers at colleges across America. Give me a break. And then there's been the addition of new majors at schools trying to attract students. According to one report, 41,446 new degree or certificate programs have been added to schools across the country since 2012 (12)! What is the result? More administrative bloat.

Now, the health care industry is also plagued by excessive administrative costs. One estimate indicates that about 30% of costs in health care go towards administrative expenses (13). In an earlier podcast, I drew a comparison between how much more efficiently for-profit hospitals operated when compared to not-for-profits (14). Most hospitals in America are not-for-profit, like most institutions of higher learning. They just do not run efficiently as for-profit business, and most have high operating costs.

Of course, the entire health care system in America is convoluted, contributing to the high administrative costs. The fee-for-service system drives up utilization oftentimes without associated value. Americans are increasingly unhealthy, which makes the cost of care higher and the

pharmaceutical industry has nonsensical pricing. About half of health care is funded by the government, which means bureaucracy, which means high administrative costs. We all know the health care industry is a mess.

I guess the question is, how can donors in health care give money that doesn't perpetuate the industry's problems? The Smith plan of repaying loans doesn't fix skyrocketing tuition problems. If you're a health care donor and you give money to a family that needs help paying their high deductible, you're not doing anything about getting rid of the high deductible itself, which is the root case of the need for the gift.

I think one of the biggest problems philanthropists have in giving money direct to patients relates to discerning who "deserves" it. That's a much easier call in education, although there is some debatable unfairness in the Smith/Morehouse donation. Consider the families that saved and sacrificed over the years so they could put money towards funding their child's education. Some of their kids didn't need to take out a loan to go to Morehouse because the families had saved to pay for their children's education. Those families lose out on getting a financial hand-out from Mr. Smith. No doubt many of them are grumbling about what went on.

The analogy in health care relates to paying for health care services for individuals with high health care costs that are a result of their own poor behavior. It's one thing to fund the care for an infant born with cystic fibrosis. That's a genetic condition, and you can't help having it. It's quite another thing to pay for someone's bariatric surgery. As a donor, you can't tell if the patient needs the surgery, which is used to combat obesity, due to circumstances out of the patient's control, or because he or she simply ate too much and drank too much and didn't exercise.

So how do we get money to patients who deserve it the most without perpetuating our bloated health care system? Well, the first thing we have to do is ditch the bloated health care system. That is my view, and that is why my company, Longitudinal Health Care, is offering up an alternative way to fund health care. To make the system work for more and more people, we'll need the support of forward-thinking philanthropists.

Longitudinal Health Care is bringing a new kind of product to the market called a Longitudinal Health Care Plan, or LHCP. Our goal is to eliminate traditional health insurance because it is an outmoded way to fund health care. We incorporate genetic testing and predictive analytics in a decentralized model that enables our customers to save their money to pay for their care directly to providers through the course of their lives. That's a mouthful. Please listen to my podcast about the LHCP for detailed information about the program (15).

In the model, our customers pay into their own financial accounts instead of paying an insurance company. They are incented to be well because they have clarity on how much they're spending, and how much they'll need to save. We give them advice about how to improve their long-term health and manage their predispositions so they can lead a healthy life. Data is power.

One of the great things about this model is that it separates out those who have high health care costs because of genetic issues (like the aforementioned baby with cystic fibrosis), and those who have high costs because of behavioral issues. Now one of the theoretical challenges to the program relates to its

perceived unfairness because some people cannot afford their health care simply due to genetics and/or trying socio-economic factors. My response to that is manifold.

First, we all have genetic predispositions. We are only now starting to understand what they are. And a predisposition to something doesn't guarantee that someone will develop it. In fact, knowing that you have a chance of getting prostate cancer should motivate you to engage in behaviors that lower your chance of getting it and should incent you to get the proper screening so it can be detected early if it does develop.

Second, most of us can actually afford to pay for our health care (assuming we get access to the employer-sponsored health insurance subsidy that half of us get). Ten percent of the population accounts for two-thirds of the costs (16). If those people are removed from the pool, the vast majority of everyone else should be able to cover their own cost of care.

Next. I'm not implying that we get rid of Medicaid. We're always going to need some public assistance for the poor. The LHCP is really a replacement for employer-sponsored and publicly purchased health insurance plans.

Finally, we have a major problem in health care that is not getting enough publicity, and that is the rationing issue. We've got tons of new drugs and therapies coming to the market and it's hard to determine who needs what. In an LHCP model, we'll be able to better direct funds to people who have made an effort to address their health situation, but for reasons out of their control, they can't afford their care. The reason that people in this category may not be able to afford their health care could come down to the cost of one drug. If people were able to get that drug cost subsidized, then they may be able to pay for their own care. Doing so keeps them out of the public health pool, giving them more control of their health care and a much more personalized experience. Here's what I mean.

Imagine you have an LHCP. You know your health profile and you're engaging in activities that help you manage your wellness. Then, you contract HIV-AIDS. Now you're saddled with a monthly drug bill that you can't completely afford. You risk losing access to your preferred provider and to the personalized health plan you've developed because you may be forced to go on Medicaid because you can't afford the drugs.

What I would like to do is engage philanthropists to fund part or all of the drug cost for individuals like this. It's a win for philanthropists because they are giving money directly to patients who, as some may view it, deserve it more than others. Doing so helps the entire health care ecosystem too, because now this person doesn't have to be part of the public health system. He or she doesn't become a tax burden to everyone else, and tax dollars aren't spend administering the care for this person.

That's how I see philanthropy in health care working.

And it wouldn't stop at subsidizing drugs. Let's say you have type 1 diabetes. Unlike type 2 diabetes, which can be mitigated or even cured through weight loss, type 1 diabetes is a serious medical condition. Individuals could have excellent health profiles and behavioral attributes yet still be unable to afford their heath care because of the condition.

Now, some philanthropists out there have type 1 diabetes or know someone who does and/or are sympathetic to the cause. They may seek to help pay for the type 1 diabetes related health care costs for

these individuals. Again, it's another direct-to-patient win. Patients get the customized care they need. Philanthropists get a high bang for the buck, knowing that their dollars have been used efficiently, to directly improve the life of another.

Philanthropy doesn't just have to come in the form of multi-million-dollar donations. It can come in small amounts, from lots of people. Just as campaign financing is changing with more, small donations coming from millions of people, we need to consider crowdsourcing to fund catastrophic costs for Americans.

Some of the most expensive care relates to individuals who have an extremely low chance of survival due to either birth defects or accidents. Oftentimes insurers will deny coverage for treatments it deems experimental. Yet the families of the sick are desperate and believe that the insurer should cover the cost. It is a difficult position, because the millions of dollars spent on a baby who's likely to die could be spent on preventive care for other babies who will survive to adulthood…or myriad other needy patients.

Crowdfunding enables people who support these families to put their money to work in a communal effort. In fact, a third of the money raised on the crowd-funding platform GoFundMe.com goes towards medical expenses (17).

Crowdfunding is even being used in China. Jack Ma, the billionaire behind Alibaba, is pulling in tiny contributions to cover catastrophic medical costs through his Ant Financial Services Group (18). Millions of people donate small amounts to be awarded to individuals with severe medical conditions. Why isn't Facebook doing this?

We have got to think about funding health care in novel ways. Many philanthropists have such good intentions when they give money to health care. Yet, because of how broken the system is, they may be throwing good money at a bad system. I'd like to encourage more organizations to embrace vehicles that work outside of the existing health care system. Models that reward good behavior and personal accountability ensure that the recipients of donor generosity will be best positioned to use the money effectively so they can be as healthy as they can be.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!

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