The Powers Report Podcast

Episode 15

Health Care's Option 3: The Market Option

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 i-Tunes 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.

I can't think of any American who likes dealing with a health insurance company. I could spend an entire show talking about how maddening it is to pay so much and get so little back – even when certain drugs or surgeries are covered. The insurance industry literally makes people sick because for all the good it's supposed to provide us, we somehow always feel screwed.

Maybe that's because health insurers make so much money. UnitedHealthcare Group, the country's largest health insurer, earned $17.3 billion from operations in 2018 (1). That's about half the GDP of the entire state of Vermont (2). One company.

Alas, if you beat up on the insurance industry in favor of public health, there are a few things to know. First off, the government underpays providers for care. Medicare payments don't cover the cost of care for most hospitals, which means that a hospital loses money every time a Medicare patient walks through the door. Given that Medicare is the largest payer for most hospitals, that's a problem.

Reimbursement from Medicaid isn't any better.

This is a major reason why over 100 rural hospitals have closed since 2010 (3, 4). Populations continue to move to urban areas making it harder for small hospitals to fill up their beds – and when they have patients, more often than not they're on government programs which don't pay enough to cover costs.

Some in the health care industry argue that the cost structure in hospitals is simply too high, and that hospitals should do a better job of reducing expenses so they can stay in business. In part, I agree with this, especially with regards to the high fixed costs and overhead that characterize many hospitals. (For more on this topic, please listen to Part Two of my podcast series, "Let's Find out about the Hospital" (5).)

Yet there's something very wrong about cutting off access to people in rural communities while hospitals in urban areas have alternative means to make up the losses from cuts in government pay.

And one of those alternative means is: payments from private insurance companies. Yes, the health insurance companies we love to hate overpay providers. This overpayment subsidizes the payments from the government. So if you like your government-funded health care system, you can't keep your government-funded health care system without private insurance companies.

Further, the government outsources the administration of a growing sector of its Medicare and Medicaid programs to: private insurance companies. These are programs where private insurers take payment from the government and then turn around and enroll people in programs where the insurance company gets to modify some terms of access and coverage. Most of Medicaid is now outsourced and is considered "Medicaid Managed Care." A third of Medicare enrollees are on Medicare Part C, or Medicare Advantage. With regular Medicare, you get to see any doctor you wish. Only doctors on your Medicare Advantage plan are available to you and at the terms specified by the insurer. But people seem to like Medicare Advantage because it typically covers more services than Medicare and apparently, is easier to use. And that's really important because, according to a recent poll, 72% of Americans don't understand how Medicare works (6). I think that number is totally understated, by the way.

Should we keep the private system or just go for a full-on public health one? It's like flipping a coin. On one side, there's the government, and that can't work alone. And on the other side we have private insurers, and they don't always have the best interest of patients in mind.

Well, life isn't always about flipping coins. We don't have to take the lesser of two evils when it comes to our health care system because we now have an Option 3: The Market Option.

Industry folks have been talking about the "consumerization" of health care for literally decades. As insurance companies have become bigger and they've started to cover more stuff, there has been a realization that consumers might want a say in all of this. So this idea that individuals would take their spending power and make an impact on the growing health care industry seemed to make a lot of sense.

Except that we have learned the hard way about the ridiculous level of price opacity in the industry. We can't make informed decisions about what to buy when we don't know exactly what we're getting. People typically shop for insurance (or choose an insurance plan offered by their employer) based on the monthly premiums, the deductible level and whether a key doctor or drug is covered. The rest of the terms – co-pays, other doctors, referral requirements, duration of coverage, access restrictions, out of network pricing, non-covered add-ons for equipment, devices, transportation – it's impracticable to think the average American can make a fully informed comparison about health insurance options.

More importantly, the more that's covered under health insurance plans, the less we as consumers can shop around to buy. This is one of the problems with the Affordable Care Act. It mandated that Ten Essential Benefits be covered by insurers. All kinds of stuff got shoved under the umbrella whether you wanted them or not, including coverage for rehab, mental health services and even birth control pills.

I'm not saying that coverage for a lot of things isn't good for a lot of people. And many employer-sponsored plans already covered these services anyway. The problem is that when the vast majority of health care goods and services are jumbled together in a market basket, then consumers aren't paying for individual goods and services. They pay their premiums and co-pays but these charges don't necessary relate to the actual cost of the goods and services. If you can't discern what you're buying and how much it costs, then you can't have consumerization in health care.

Thankfully, that's starting to change.

The Market Option, which is a phrase I am officially coining, describes the rise in legitimate consumer power resulting from an increasing shift in health care costs to patients. In other words, insurers and employers are covering less, forcing patients to pay more. And patients are starting to get pretty savvy about the whole situation.

The main driver behind the Market Option is the rise in high deductible health plans, or HDHPs. An HDHP is an insurance plan that charges a lower monthly premium, but a higher deductible. (Hence the name.) The IRS considers a plan to be an HDHP if the deductible is at least $1,350 for an individual and $2,800 for a family (7). Those are rates for 2020.

Looking at adults with employer-sponsored coverage, only 14.8% of them had a HDHP in 2007 (8). That number jumped to over 43% in 2017. And the figure is expected to increase. A separate report that included not only the folks getting insurance from their employer, but also through the health insurance marketplace, identified that 47% of adults were enrolled in a HDHP in the first quarter of 2018 (9).

One of the best parts about a HDHP as far as its role in bringing about the consumerization of health care is how it helps promote price transparency. Let's say you need carpal tunnel surgery. It's an outpatient surgery that doesn't cost a lot of money, maybe $3 – 4,000 – at least compared to something like a total hysterectomy, which is in the range of $15,000 (10).

If you have a high deductible, you may wind up paying for that surgery out of pocket, because the cost of it could be less than your deductible. As a result, you don't need to have the surgery done by one of the doctors in your plan. You can compare the prices of covered doctors with those of so-called out-of-network doctors. You can negotiate a better rate, in some cases, if you pay cash.

Note that some insurance plans may view your out-of-network payment differently when it comes to satisfying your deductible. The plan may have a higher deductible for these out-of-

network payments because it wants you to use the doctors in its plan. However, if it's the end of the calendar year, it won't matter as much. Your deductible will get re-set in January and you'll have to start paying for everything all over again, so if you think the quality is comparable and the price is lower, you can go with an out-of-network provider.

In any case, it pays to shop around, especially for some of the more commoditized health care services like X-Rays and lab work. When folks with HDHPs ask for prices, that benefits everyone. When providers are forced to give prices to the market, the prices become more publicly known, which should increase competition. It's a jolt to the system and everyone can agree that the health care system needs quite a few jolts to get it where it needs to be.

HDHPs are ideal for people who are relatively healthy and aren't planning to use a lot of health care services. HDHP enrollees benefit from paying lower premiums and since they're not going to use a lot of care, they're not worried about maxing out their deductible. So if the deductible is high, it works for them.

Some folks argue that those with limited "health care literacy" – which one could argue is, like, everyone – can get stung when enrolling in one of these plans. Obviously, the low premium payment is a draw for anyone on a budget. Folks may not realize that in order to gain access to the health care services they need – like paying for certain drugs or seeing certain doctors – they may have to pay out of pocket for these services first. If you're in a family HDHP, that means you'll have to cough up at least $2,800 (as of 2020) before your care gets covered. And even then, you're still responsible for co-pays and other miscellaneous charges.

HDHPs are also contributing to high medical debt for some people for a number of reasons. As noted, many folks simply may not understand what it means to have to satisfy their deductible and doing so could drive them into financial risk. A more concerning issue is that some people are foregoing treatment as a means to save money (11). This is particularly frustrating for those who skip necessary preventive care – like mammographies and colonoscopies – because these tests are automatically covered under plans that satisfy ACA regulations. Foregoing preventive care and screenings can result in sickness and even death.

Some folks with conditions like diabetes who are on HDHPs have to satisfy their deductible and pay out of pocket for drugs, like insulin, before their insurance coverage kicks in. This has caused many patients to skip dosages, reduce their intake, or look for off-market alternatives. The short-term savings for patients is causing longer term high costs for employers and insurers.

In an effort to better incent some chronically ill patients to take their meds, the IRS has stepped up with a new guideline. In July the IRS declared that it will allow insurance companies to cover selected health care expenses for chronic diseases for certain HDHP enrollees without the member having to satisfy the deductible requirement to access them (12). This guidance applies specifically to HDHPs that are accompanied by a Health Savings Account or an HSA (13). It goes into effect in 2020.

An HSA is a type of medical savings account that allows enrollees in an HDHP to put money aside to be used for health care expenses. Someone enrolled in an individual plan could put aside $3,550 per year and those with family coverage can put aside $7,100 a year. Again, these are 2020 figures.

Prior to the IRS guidance, HDHPs with an HSA could only cover preventive tests like the aforementioned mammography or colonoscopy. Individuals with a HDHP that had an HSA didn't have to take money out of the HSA to pay for those tests. Now, or at least in 2020, people with chronic diseases can get some of their medications and supplies covered pre-deductible too.

As noted, employers and insurers like this idea. Obviously, patients with chronic disease like the concept as well. I'm on the fence about it. On the one hand, it's great because individuals with chronic diseases who have an HDHP with an HSA have to pay much more out of pocket than others. It makes enrolling in this type of plan not all that financially appealing unless the meds they need for their chronic conditions are covered.

On the other hand, now that insurers are covering some costs for chronic illness, those costs will be shared by everyone – and that includes people who do NOT have chronic disease. Many chronic illnesses can be prevented (14). When blanket coverage is offered for medications to treat chronic disease, there's less of an incentive for people to better manage these conditions. This guidance just perpetuates one of the problems in health care today: we pay for treatment, not prevention.

More about this in a bit.

As noted, the guidance applies to people with a HDHP who have an HSA. Changing the access hurdle for HSAs by forcing insurers to cover more costs helps proliferate HSAs in the market. And there's a lot of upside about HSAs that more Americans should be aware of and take advantage of if they qualify and if it works for them.

HSAs are like Flexible Spending Accounts, or FSAs, in that money that goes into either account is tax-free. So it's like you're saving, depending on your income bracket, at least 30% on medical expenses because the money in either kind of account isn't subject to an income tax. That's a win for a lot of people – especially for people with high medical expenses.

The difference between a Flexible Spending Account and a Health Savings Account is that if you don't spend all the money you've set aside in an FSA in a given year, you lose it. You lose it, or you wind up trolling the aisles of Walgreens in December, buying up a lifetime supply of Band-Aids and heating pads. With an HSA, you get to keep the money you didn't spend. It rolls over in the account to the next year. That keeps happening until you turn 65. And all that time, you can keep contributing to the account.

When you turn 65, you can't contribute to the fund anymore, but you can still use it for medical expenses. You can use your HSA to pay for expenses that Medicare doesn't cover, like vision,

dental and long-term care. Given the skyrocketing costs in Medicare today, there's reason to believe that more and more costs for the elderly will be shifted to the elderly by the time Gen X ages into Medicare. Millennials and Gen Z may be in worse condition. So there's big upside to putting money into an HSA.

But it gets even better.

You're allowed to invest the money in your HSA and you don't get taxed on the gains. So here you've got this chunk of money and many people look at it like a 401K or an IRA. They see the tax benefits of putting the money away now because they can invest it and avoid taxes on the gains. Even when you turn 65, you can convert the money in your HSA to a traditional IRA. There are issues with taxes if you take early disbursements or if you don't use the money for medical expenses, but otherwise, it's a great deal.

All of this long-term savings stuff makes an HSA sound more like a retirement fund and less like a medical savings account. It makes people want to hoard the money and not spend it. Consider this scenario.

Let's say you wind up in an after-hours emergency clinic and get socked with a $300 bill. If you can max out the contribution to your HSA and still have another $300 on hand, it makes no sense to pay the clinic out of your HSA. You pay the clinic directly with the 300 bucks. That way, you don't lose the investment upside of removing $300 from your account. If you're relatively wealthy, the HSA becomes a long-term medical investment account that you can tap into in retirement.

Now, for some people, that's totally fine. We have a major problem in America in that people are not saving for retirement. One of the key expenses in retirement is health care. So if people use their HSA to save for these expenses, that's great.

In fact, there's even talk about increasing the contribution levels for HSAs, allowing people to save even more money.

The Health Savings Account Expansion Act of 2019 proposes to not only expand contribution levels to HSAs but also seeks to allow them to be offered to anyone – not just folks with a high deductible health plan. It would allow the funds to be used for more services than are allowed today (15). It is a move to put more power in the hands of consumers. I love that.

Yet it is clear that many people are not prepared to use these funds appropriately. Hence the issues with care avoidance. I joked earlier that practically all Americans are not "health care literate" and I cited a study that indicated that 72% of Americans don't understand how Medicare works. So we have an issue where we're health care illiterate in that we don't understand how the system works.

But we also have incredible *health* illiteracy. We don't understand what it means to be in good health. That's why we're such an unhealthy lot, which shockingly high rates of obesity, chronic

disease, dementia, etc. We'll never improve outcomes just by giving people more money to spend on health care through HSAs. Patients aren't doctors and they shouldn't behave that way.

We have to give people more spending power *and* we have to ensure that they appreciate how to use it. Improving health literacy will allow the Market Option to be a viable alternative to our current system.

How do we do it?

Well, we need more patient education. I've said time and again that I think annual primary care visits should be mandatory for all Americans. You can't get all your health guidance from the Mayo Clinic website. People need to have a consistent relationship with a qualified medical professional so they can get the tailored treatment they need.

A more radical idea is that people should understand the lifetime cost of their own medical care. No more sticking everyone in a giant insurance pool where no one person has any idea about the health care costs that they're utilizing. That model, the existing health insurance model, removes personal accountability for health and I am a big proponent of increasing personal accountability. We have to get more clarity on individual health care costs so we can start to take more responsibility for those costs.

I am advocating this through my company, Longitudinal Health Care. We are bringing a product to market that lets our customers know what their projected lifetime health care costs will be. We need to know this information so we can have an idea about how our behavior impacts not only our long-term health, but also, our pocketbooks.

Consider this. Let's take someone with Type 2 diabetes. Many patients can be cured of Type 2 diabetes through behavioral changes, proper medications and sometimes surgery. But our current health care system focuses on treatment, not prevention. So the patient will get access to the drugs he will need. He may be offered a cool app or newfangled gadget that can help manage glucose levels. The patient might be advised on ways to lower his risk, but the message has to be communicated in a way that makes the patient want to act. And that is clearly not happening right now as rates of Type 2 diabetes continue to climb.

Our company affords patients all of those opportunities to improve their health…but we also quantify how much it costs. And I'm not talking about the cost of one treatment. This is a comprehensive, longitudinal view on personal health care expenditures…what patients pay now, and what they'll be expected to need, based on their personal health situation.

A well-cited study indicates that if you're diagnosed with Type 2 diabetes at age 40, the lifetime excess costs to treat it are about $125,000 (16). That's using data from 10 years ago. Since then, insulin prices have shot up. Between 2012 and 2016, the cost for insulin has doubled (17). So the $125K lifetime cost to treat Type 2 diabetes is low. But let's stick with that number for the sake of this discussion.

Now, what if the guidance just issued by the IRS were reversed, and diabetics had to pay for their care out of pocket?

Let's do some simple math. You get diagnosed with diabetes at age 40. Let's say you live to age 75. (Average life expectancy in America is 78.6 years so if you have diabetes at age 40, odds are you're going to die earlier than the average person (18).) You'll have diabetes for 35 years. If you divide the $125,000 by 35, you'll have to spend about $3,570 on your diabetes care every year. That figure, by the way, is almost exactly what the individual HSA contribution limit is for 2020. That means that the cost for a Type 2 diabetic's annual medical care is comparable to the maximum amount they can put away in an HSA.

It makes you think a little differently about your health care costs and your behavior, doesn't it? I expect that the patient would much prefer to take steps to cure her diabetes than spend money that could be earning investment income in a vehicle like a Health Savings Account. I want to help these patients help themselves by providing an alternative motivation to act.

It's not just diabetes, of course. It's cancer and high blood pressure and the incidence of pretty much any disease. We need to get closer to understanding these costs so we can have a different conversation about spending. That said, we are a long way from shifting the financial responsibility of major medical expenses to the average American. But for a lot of things – especially outpatient surgeries, procedures and tests – we have to start taking more control.

I am thrilled that a third option, the Market Option, is developing in the American health care payment ecosystem. HDHPs and HSAs are an essential way to put more spending control in the hands of individuals. We must encourage a stronger patient/provider relationship that will give patients the education and tools they need to have better outcomes. This is how consumerization in health care through the Market Option can help more of us be as healthy as we can be.

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