The Powers Report Podcast

Episode 5

The Longitudinal Health Care Plan

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. These are major themes that will be discussed in each podcast. 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.

In this show I will talk about why we need a big new idea in health care. I've spent a lot of time talking in previous podcasts about what doesn't work. I'm going to talk a bit more about the structural and financial imperatives that are driving the need for truly seismic change in health care. I think we have to get our heads around why small incremental solutions aren't going to do the job so we can embrace bold new ideas.

Bold new ideas like mine…

So here we are, several podcasts into the show and I haven't given an explanation of where I think health care will be in the next generation. Here's what I think. Health insurance will be obsolete. This is an inevitability, especially when you think about what we use health insurance for. As I discussed in an earlier show, having health insurance doesn't make us healthier. It's not a useful tool in engaging us in ways that improve our health. And since we are so unhealthy as a nation, we need mechanisms that are going to better motivate us, behavior-wise.

Health insurance provides financial security and we need that. We need to know that we'll be able to pay for our health care requirements. I think we can all agree that using health insurance as a mechanism to do so is inefficient. There's tons of waste in the system on both the public and private sides. Since health insurance today is inefficient and doesn't make us healthier, we have to find something else. The great part about this realization is that innovation is already helping to create an alternative to the current health insurance system in America.

I believe that very soon we are going to self-fund the majority of our own health care. In other words, we don't need to give our money to insurance companies or to the government. We should save it and invest it and then use it to pay providers directly for the vast majority of the care we need. And advancements in technology are enabling us to know more about just how much money we're going to need to set aside.

We are learning so much about what we're born with – our genetic profiles. We also know that the real drivers of health outcomes are the external determinants of health. These are the demographic, socio-

economic and behavioral attributes that affect how we live. We need to fuse this data so we can predict all the diseases and conditions an individual will develop over the course of his or her lifetime. Once we do that, health insurance will be obsolete.

With our health needs identified, we will be able to attach costs to paying for them. In simple terms, once we sum up all those costs, we can identify our lifetime health care expenses. My view is that we should put the money we need into our own health care accounts. I call these accounts Longitudinal Health Care Plans, or LHCPs.

This is a radical idea, fraught will implementation challenges. I know this. In fact, I wrote an entire book about it.

Many listeners may be aware that I recently published a book called *Health Care: Meet the American Dream*. The book came out in October of 2018 and it is an Amazon bestseller.

I'm proud of the book and I'm proud of the idea. It took me over three years to write the book and when I started, I didn't know I was going to develop an alternative payment model for the health care system. But I knew I wanted to do something besides simply critique the system because that's what the majority of health care books out there today do.

No doubt, we can use books that explain what's wrong with the industry that are written by people who are experts in the industry. It helps for a doctor to explain why the system makes it hard to provide what the patient needs and wants because insurers (private and public) dictate how care gets delivered. We as patients can totally relate to this!

There are books that deconstruct for Affordable Care Act, try to help you navigate the system, discuss how major policy machines operate, etc. Like I said, we need these books to help more people understand what's wrong.

But problem identification isn't getting us where we need to be because the health care system is too far gone for band-aid solutions. We simply can't just identify what's wrong and say, "Fix that." We can't complain about the patient/provider relationship and offer up a solution tantamount to, "We need a better patient/provider relationship." It doesn't do us much good to deconstruct the pharmaceutical industry and explain why pricing is totally opaque and then demand more price transparency for drugs.

Sure. We need more price transparency. Which means we have to eliminate the pharmacy benefit managers, or PBMs, which serve as the middlemen between the manufacturers and us, the drug takers. What's the replacement? Do pharmacies or the government or patient advocacy groups negotiate directly with multi-national pharmaceutical companies for products? And how do they pay for distribution?

We have to get prescriptive with the solutions and stop just doing problem identification.

Investors are chomping at the bit to get a piece of the health care market. In the first eight months of 2018, health care start-ups had raised about $20 billion (1). But this problem-identification-fix-that approach plagues start-ups too. Billions have been poured into the industry with promise to be disruptive game-changers. No one's delivered yet. Many have failed. Some have failed miserably, like Theranos, the over-the-counter blood testing technology that turned out to be a massive fraud. Worth $9 billion one day (2), gone tomorrow…along with almost everyone's investment money.

Anyone working in the industry appreciates the challenging environment of onerous regulation and the powerful insurance industry. The drug industry is pretty powerful too, but drugs only represent ~10% of all health care spending (3). Some of the problems with start-ups is that they aim too low because they don't believe they can challenge these major forces. Some health tech start-ups just try to avoid the government as a payer altogether. These companies develop solutions that are either marketed directly to consumers, or they're marketed for employers or insurers.

Here's an example and I have seen ideas like this presented at health tech events over the years. We're supposed to look for so-called "pain points" to fix. So here's one. Right now, most people don't have a running tally of how much has been spent towards satisfying their deductible. And lots of people have high deductible health plans. Wouldn't it be great to know the progress you've made towards maxing out your deductible for the year?

Let's say it's July. You need to have an elective knee replacement at some point, or maybe you need a preventive colonoscopy. No one wants a colonoscopy and having to pay it for because you haven't satisfied your deductible doesn't make it any more appealing. So if you knew you wouldn't have to pay for a colonoscopy or a knee replacement out of pocket because you had satisfied your deductible, perhaps you'd be more inclined to go ahead and schedule it.

But developing a solution like the running deductible tally just adds a layer of complexity on top of an already too-complex system. Tactically, let's consider what it would take to implement something like this. A start-up would need a connection to a broad range of insurance companies so it could get plan information and terms on as many insurance plans as it could. That way, it could expand reach to more customers. That's crazy ambitious so let's just say the start-up lands one insurer to start.

The start-up would have to connect to providers and/or claims gateways so it could track how much a customer or patient had spent based on the terms of their plan. Alternatively, the start-up could try to get the data from the insurance company, but they're not giving it up without a fee, you can be sure of that. So maybe the start-up just markets the idea to the insurance company since they hold the majority of the data. But then who pays for it?

Imagine you're the patient. Someone's going to charge you money so you can find out how much money you've spent? I don't think so. Nice idea. Really challenging implementation.

Now, I'm not trying to bash ideas. We can use small ideas and incremental fixes and we probably need a lot of band-aids to get us where we need to go. Radical change doesn't happen overnight. It will take years, decades, even a generation.

I started in this industry as a consultant in 1995. I think it's taken that long to get familiar enough with the industry to understand it probably more than most people. That said, there's one rule of thumb that is applicable to solving big enterprise problems regardless of industry: follow the money.

If you look at who spends the money in health care, well, it's no surprise. It's the government and private insurers. CMS puts out figures for national health expenditures every year. When you hear people say, "America spent $3.5 trillion in health care in 2017" they're referring to the National Health Expenditure data.

Looking at the figures (4), you can get an idea how much the government spent. You can lump together the dollars for Medicare, Medicaid, CHIP, which is the Children's Health Insurance Program, and Veterans Affairs and Department of Defense programs. That spending is about 41% of the total dollars. But the government spends more.

There's another category called "Other Third Party Payers" which is over half a trillion dollars. The way the data was released for 2016, the year before, that half a trillion dollars was broken out more and a huge chunk, about $150 billion, was identified as Investment. That's not investments made by private companies, it's more government-related. So those dollars, which are wrapped up in the 2017 half a trillion dollar figure, have to get added into the government spending total. And there are other programs too, like "Indian Health Service" and "Other federal programs" that are lumped into this half a trillion dollar category. So government spending is probably at least 45% of the $3.5 trillion, or roughly half of the health care spending in the U.S.

The estimate for private insurance is a lot easier. That's 34%, or a third of the spending.

In other words, at least four out of every five dollars spent on health care are controlled by two major constituencies. Any idea in health care that doesn't take control of the dollars away from the government and from private insurers cannot radically change the system. That is the black and white of the situation. It's why change in the industry is so hard.

There are a few things to do. Nothing, modify the current system, do something totally different. Let's discuss each of these.

1. We can maintain the status quo and not care. That works for a lot of people. I'm thinking it doesn't work for you, because you're listening to this podcast. And it sure as heck doesn't work for me. So that's out.

2. Try to tweak the system. Since we're talking about money, we could consolidate most of the spending one player. That way, we at least don't have competing payment systems. If we go this route and we shift control to the government, we're looking at the single payer or Medicare-for-All plan. In Podcast #3, I talked about why a single payer system would be ineffective in America. That doesn't mean we won't do it. It will just be outrageously expensive and inefficient if we do.

   We could, alternatively, put the majority of control of health care dollars in the hands of for-profit health insurance companies. Terrible incentives there, at least if you consider how the industry is structured now. But we should appreciate that the government basically outsources the administration of a lot of Medicaid and Medicare to private insurers right now. So although the government is footing the bill, they are taking that money and paying private insurance companies to administer the care.

   A great example of this is the Medicare Advantage program (5, 6). And about a third of Medicare enrollees (7) opt to join a Medicare Advantage plan and the numbers are growing. Advantage plans are an alternative to traditional Medicare coverage. The plans are offered by private insurance companies that consolidate some of the services offered through Medicare and then can add other services that Medicare doesn't cover. Like vision and dental. Advantage plans can also provide prescription medication coverage.

Medicare pays the insurance company a fixed fee per beneficiary and then the company makes sure that it spends less on you than the amount they've been given. Unlike regular Medicare, you can only see the providers contracted under the plan, and there are other restrictions and pricing differences.

Medicare Advantage is good for some people. It simplifies things by rolling a lot of what Medicare does and doesn't offer into a one-stop-shop. Given the rise in dementia among the elderly, anything we can do to simplify things is a plus.

Advantage plans are also good for the government because it makes what they have to manage a lot smaller. And given how massive the Medicare program is, the more we can reduce the size to control spending, the better.

Medicare Advantage programs are probably the best for the insurers. The plans are growing and they contribute to the positive bottom lines of insurers. Now I am all for innovation, but Medicare Advantage plans are taking advantage of the American people. I mean, if we're going to have private health insurance companies provide services for Medicare, then why don't we just give the elderly the opportunity to simply opt out of Medicare altogether? Think of the money we'd save! We'd avoid the administrative costs of routing money through the Medicare program to the private insurers who have to then route it to providers to pay for care. This is so inefficient. I think about this stuff and I get more and more encouraged to pursue option 3.

3. Which is … Do something completely different. That's where my plan comes in. This is the Longitudinal Health Care Plan that requires people to opt out of both private insurance AND Medicare so they can save the money in their own accounts to pay for their own care. It is a long term plan, for sure. Figuring out how to opt out of Medicare will require individuals to get a payment from the government commensurate with what is being spent on other enrollees and that won't be easy. But starting with opting out of private insurance is a little more doable. The challenge there is getting people to believe that they can actually fund their own care. That's a huge leap of faith.

   But think about it. If you're not paying for your health care, then who is? YOU are paying for it. The vast majority of us are doing it right now. We just have no idea where our money goes and that needs to stop.

   I strongly believe that we need a payment system that optimizes efficiency while motivating us to be well. That is exactly what an LHCP does. Since we're spending our own money, we're incented to be healthy. We can see how our behavior today impacts our long term health. We can project not only when we'll get sick, but how much it will cost. And the best part? We can take corrective action now to prevent or forestall the development of some of the diseases and conditions we're supposed to develop. I'll talk more about this in future podcasts, but the LHCP is the plan that can help all of us be as healthy as we can be.

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