The Powers Report Podcast

Episode 25

Consumerism in Health Care: Part I

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.

In this episode of The Powers Report Podcast, I will talk about the consumer's role in the health care landscape. This is going to be the beginning of the discussion. Talk of consumerism in health care will take place over the course of future podcasts because the subject is complicated. My company, Longitudinal Health Care is just getting started and we are squarely in this space. I've talked before about our mission, which is to eliminate health insurance. In prior episodes, I talked about different ways we were thinking about going after the problem. As we've investigated these ideas, we've tweaked them. But I've kept these shows up in the podcast sequence because it is interesting to see how the company has evolved. After a ton of customer interaction, investor commentary and guidance from our advisors, we've landed on something really cool: the Over/Under. I will talk about it later in the show.

But for now, let's talk about health care. It's close to a $4 trillion industry. It's almost 20% of our Gross Domestic Product, yet we, the American consumer, have very little direct control over the spending. In other words, health care hasn't been consumerized.

You might think it has been if you listen to the quotes from politicians over the last couple of months. Here are a couple:

- From Democratic Senator Ron Wyden who co-sponsored a bill to lower drug costs. "Chairman Grassley and I have worked for over a year on a drug pricing bill that would end price gouging, lower consumers' costs at the pharmacy counter, and save taxpayer dollars." (1)
- This one is from FDA Commissioner Dr. Stephen Hahn, about some recent Executive Orders signed by President Trump. "We remain committed to advancing the policies outlined in the Safe Importation Action Plan, as quickly as possible, as we continue our broader work to increase drug competition to benefit American consumers." (2)

Hmmmmmmmmm. Government health care and consumer. Kind of an oxymoron. One of the reasons that the American health care system has such a hard time getting consumerized is because the government controls about 45% of all the money that's spent (3). That's for programs like Medicare, Medicaid, health care for veterans, the Department of Defense, etc.

When politicians talk about lowering costs for consumers, they mean they are going to try to lower costs in their programs. That means that the government is buying, in the case of the quotes I just read, the drugs. If they're buying the drugs, the government is the consumer, not the American people. Lowering costs for the American people happens however the government decides to pass on whatever savings they can generate. Maybe it's a lower copay or a rebate. But since the government fixes that price to the people, it's not a free market situation that the word "consumer" implies.

Let's got private sector. Here's a quote from the CEO of Livongo, a care management company that just merged with telemedicine giant Teladoc. "It's the ability to bring together the health and care side by creating unique consumer-centric virtual care." (4)

Really? Have any of you personally bought care management from Livongo or Teladoc? Probably not. That's because these are not companies that sell their services direct to us, the consumer (5). They sell to employers and insurance companies. These parties are the consumers of Livongo's and Teladoc's product. The employer or insurer then offers these services to us. In order for the companies to maintain their contracts, they have to make sure the ultimate user of their product, we, the people, are satisfied. But the definition of consumer is someone who purchases goods and services for personal use. As with the government example, we're getting the services through a third party. That's not true consumerization.

You may be asking, Why do I care? I don't know what a diabetes care management program is and I wouldn't know how to shop for one. Nor do I have any idea about how to negotiate with Pfizer to get my Zoloft. True.

But with the skyrocketing costs in the American health care system, we have to start considering alternative models to what we already have. People obviously want consumerism. Politicians and business leaders wouldn't throw around the term so frequently if it didn't resonate with people.

Yet the people need to understand that what we're being told is different from what we're getting. And if we want consumerism in health care, we, the people, are going to need to make some changes too.

As you know, I like to talk about the money. Given how the health care system is structured today, how much of the money that is spent can actually be consumerized? And for this discussion, I am skipping government programs. I can't fix the government.

I am talking about the Americans who are on private insurance. That's around 55% of the population. In 2018 that was close to 180 million people. About 9 out of ten of these people get their insurance from their employer (6).

My company, Longitudinal Health Care, is going to market with a cost calculator called the Over/Under, or O/U. The O/U will tell you if you are overpaying for your health care or underpaying. One of the key aspects of the O/U is to educate you on ALL your health care costs and help you understand comprehensively how the money is spent. We can't consumerize health care until we start from the top and get an understanding of what can be consumerized and what can't. The O/U helps determine that.

Here's what I mean.

There are two parts to the O/U. I'll talk first about how much money is paid into the system and then I'll discuss the second part, how much is spent on you, the patient, every year. Both of these expenditure buckets are called costs, which is confusing, but hey, it wouldn't be American health care if it weren't confusing.

The money that goes into the system is what you and your employer contribute. The biggest component of this is what your employer pays for your health insurance. (If you're part of the one in ten who don't get insurance through your employer and have to buy it yourself, then this obviously doesn't apply.) To keep this simple, let's assume you have individual and not family insurance. In 2019, the total amount contributed by your employer and you, on average, was about $7,190 (7). Your employer pays about 83% of these costs. You pay about $1,240 in premiums every year.

Do you shop for this health insurance? Certainly not. That's because our health insurance is not just insurance. I think we all need insurance to protect us from catastrophic events, just like we need car insurance. But we are paying into a system that provides insurance and coverage. All kinds of coverage given at rates and prices we don't understand. Further, we don't know if we're going to need any of this stuff, so we're really not shopping at all. We're putting money into the system hoping, at some point, we'll get value out of it.

Let's say your employer provides your insurance for you. If so, odds are there's one or maybe two different insurance companies to choose from. If you're lucky. But small employers offer one. Big companies just self-insure, meaning they have enough employees to set up their own health insurance structure so again, you don't get to choose from all the insurance companies offering plans in your community.

Your employer may give you options for a high deductible health plan or not. You're probably aware that if you're relatively healthy and don't expect to have any major health care episodes, it's better to opt for a plan that has lower premiums. The risk is that if something does happen, you'll be on the hook for more money out of pocket to satisfy your deductible.

That right there is about the biggest element of consumerization that exists for the bulk of your health care expenses. Whether you chose a plan with a high deductible or not. And many people don't even get that choice.

If you're one of the one in ten who buy on the open exchange, you really don't get to shop for much of anything. Just like folks who get insurance from their employer, you don't get to pick the services covered by the plans. The Affordable Care Act mandates that a selected group of services are covered under every plan. You're paying for this stuff whether you want it or not. Mandating that people have to buy things they do not want or need violates the free market ethos that drives consumerism.

There are other examples of how "shopping" for health insurance is not true shopping, but I think you get the point.

So we've got about $7,910 going into the health care system to pay for health insurance. There's another chunk of money that goes into the system via your out of pocket, or OOP costs. All the money you personally paid out of pocket for your insurance-based coverage – outside of the premiums – needs to be included too. I'm talking about co-pays, or your payment when you have a doctor visit. If you get hospitalized or have a major procedure or go to the ER, there's usually a coinsurance fee. That's the percent of the charges that you have to pay before you hit your deductible.

According to data from the Health Care Cost Institute, which I've analyzed to get into these buckets, the OOP costs for a male, aged between 26 and 44 are about $680, a year (8). That's an average. Add that to the $7,190 contributed by you and your employer and the amount put in is about $7,870.

You also may pay OOP for stuff not on your insurance, like acupuncture or maybe to see a chiropractor. For simplicity, I'm going to exclude those costs and just stick to the premiums, employer contributions and your OOP costs. The $7,870.

So here's the question. If health care were consumerized, you, the consumer, should get $7,870 in value from the system every year because that's what has been contributed. Where does all that money go? Well, that's why we're helping people calculate their O/U!

Now we'll talk about how much money is given to providers and drug companies for your care. These are also health care "costs." This is the other side of the O/U. There's the $7,870 that goes into the system. How much do you get out?

This figure has two categories. One is how much your doctor and other providers get paid from the insurer (which is usually an insurance company but could be your employer, depending on how the relationship is structured). That's the so-called "contracted rate" that we never see. These, by the way, are the rates the Trump administration is trying to get made public. If hospitals had to disclose what rates they had with all the different insurance companies with whom they contract for care, we'd have more price transparency. We consumers want that!

Anyway, for the male we're talking about in this example, that number that's aid via the insurer to providers and for drugs, is about $3,775.

The other piece is the OOP payments. We estimated that to be $680. We include the OOP costs on both sides. The first half of the O/U is what goes into the system. Basically what is paid by you and your employer. It's a money flow out from you. The other side of the O/U is how much the system itself uses. It gets paid by insurance companies to deliver care. And it also gets paid by you, directly, through these OOP costs. That's why the OOP figure is on both sides.

Technically, the OOP are a zero-sum as far as calculating your O/U. We're going to subtract what is used by what is put in so the OOP costs zero out and don't make an impact. However, they must be part of the discussion. And my next show will talk all about OOP costs because this is where the current ideology about sort of "lowering your health care costs" is centered around. Lowering your OOP costs. Again, much more on this in the next episode.

We were talking about making that estimate for all the costs spent on that male, aged between 26 and 44. $3,775 on stuff paid via the insurance company and $680 paid by the individual. That brings the total amount of health care spent on someone of this age is about $4,455.

The amount put in is $7,870. The difference is $3,415. It's an overpayment. For discussion purposes, let's just call is a $3,500 overpayment.

Let's take a moment to digest this.

First, we have to acknowledge that this overpayment is not just the consumer's money. Right? The employer puts in most of the dollars going into the system. So the young male shouldn't necessarily get a check cut for $3500 to use for his spending pleasure. If that were the case, employers would just contribute $3,500 less into the system.

But they don't, because they have to cover the costs for all of their employees.

If we do an O/U for someone much older, say a female between the ages of 55 and 64, she is underpaying by around the same amount the young male is overpaying. It evens out. Put another way, younger people are paying more into the system to subsidize the care for the older folks. Of course, old people were young at one point and did the same thing. So the older folks do have some justification in feeling like their care should be paid for by someone younger.

But when health care costs are going up every year, how do we know that the older person put enough into the system when they were young to cover the costs now that they're old? And how does the young person know that they'll put enough money into the system to cover themselves later? They don't. No one knows. No one is tracking this stuff on an individual basis. The money just gets sucked into the system and spent.

If health care were consumerized, really consumerized, then each of us would have our own lifetime health care account. When we put money in, we need to make sure that we're going to

be covered later. No one has that guarantee. Look at Medicare. The overspending is out of control. Younger generations don't have faith that there will be money for them by the time they hit 65. This is a justifiable concern!

As I'll talk about more in later shows, I'd like to move to a system where we each have one of these accounts. We have cool analytics tools. We can get a pretty good idea about what most people's future health care costs will be. Shouldn't we be telling people this stuff? Shouldn't we be explaining to a young smoker that their health care costs are going to skyrocket later because of their smoking now….and that those costs are going to be something they have to pay for?

That would be true consumerism in health care.

Well, some people have ethical problems with such a decentralized consumer model. We've got tremendous inequality in health care in America. Covid-19 is bringing this to the forefront. People with lower incomes who are less healthy are more likely to suffer from Covid-19 than others. And of course older people are more susceptible too. Who provides insurance for individuals who are older, low income and in many cases, less healthy than other Americas? The government, through its Medicaid and Medicare programs.

So here's a question. Do lower income people have worse health outcomes than others because they're on Medicaid or because they're poor? Is the Medicaid program broken or are poor people disadvantaged because of the lower levels of education they access and the types of neighborhoods where they can afford to live and the types of jobs they can get because of the lower level of education available to them? Well, yes. Yes to every single one of those factors.

I wish I had superpowers and could fix the entire health care system. As an entrepreneur, I can't boil the ocean. I have to pick my market. And when you're dealing with a $4 trillion industry, you need to whittle things down. So for us, we're looking at the those with private insurance. The O/U is something that anyone with private insurance should want to know. We're looking forward to helping you be as healthy as you can be so you can reap the benefits of this positive behavior.

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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