The Powers Report Podcast

Episode 27

R.B.G.'s Immediate Legacy: An Uncertain Future for Health Insurance

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 your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

The passing of Supreme Court Justice Ruth Bader Ginsburg will have an impact on America for years to come. She was an inspiration to women and to men, a brilliant, principled, disciplined and positive personality. Her passing leaves uncertainty over the status of a number of landmark rulings, from *Roe v. Wade* and abortion rights to *Obergefell v. Hodges,* which confirms the Constitutional right for same-sex couples to marry. The issue many of us are concerned about with RGB gone is the fate of the Affordable Care Act.

The Supreme Court is set to hear yet another case about the Constitutionality of the ACA, *California v. Texas*, right after the election next month. Regardless of when you're listening to this, meaning, whether you're tuning in before or after the case was heard and adjudicated, there will be uncertainty. In this show, I will clarify some misunderstandings about healthcare buzzwords in an attempt to foster a better discussion in these uncertain times. I'll offer some alternative policy ideas too.

Before I get started, I'll give you a brief review of what the upcoming case, *California v. Texas,* is about (1). When the ACA was passed in 2010, it included a penalty for not having health insurance. It's referred to as the individual mandate. Congress is authorized to tax Americans, so the penalty for not complying with the ACA – for not having insurance – was via an individual's taxes. In other words, if you didn't pay the fee you were supposed to for not having insurance, the IRS would deduct what you should have paid from your refund. If you didn't get a refund…it was an accounting mess.

Congress's taxing power with regard to enforcing the individual mandate was affirmed in the prior Supreme Court case (*NFIB v. Sebelius*). Then the 2017 Tax Cuts and Jobs Act was passed. In that law, there is a provision that put the penalty for not having health insurance at zero dollars. So now we have a law on the books and the only way to enforce it is a penalty that's at

zero dollars, meaning the law is unenforceable. Several State Attorneys General are arguing that if there's a law on the books that can't be enforced, then the law itself is nullified.

Things could go a lot of ways. The whole law could be considered invalid. The individual mandate could be severed, leaving the rest of the law intact. Some of the law's elements, such as protections for those with pre-existing conditions, could be at risk if having the individual mandate is deemed essential to making that element of the law function. If the Democrats take over Congress, they could pass a law making the penalty a dollar. If no Supreme Court Justice is affirmed to replace Ginsburg's spot, then the Court could wind up in a tie. The prior ruling would be in place, but just for the jurisdictions covered where the ruling occurred (which was in Louisiana and that jurisdiction covers Texas and other adjacent states).

No matter what happens – there will be confusion.

Taking a step back, Americans are frustrated with Congress. We're angry at insurance companies. We're unnerved about the future. And we've become extremely divisive.

In health care, so many of the things Congress, the press and the public at large are fighting about are misunderstood and increasingly irrelevant.

Number one on that list is the term "pre-existing conditions." Protections against being denied coverage for pre-existing conditions is arguably the most popular aspect of the ACA. It's ridiculous that people who are sick can't get insurance because they're sick. It defies logic. But the term has evolved and our approach to dealing with pre-existing conditions must evolve too.

No one knows what a pre-existing condition is. There is no industry-wide definition. The Centers for Medicare and Medicaid Services has this helpful explanation. A "pre-existing condition" is a health condition that exists before someone applies for or enrolls in a new health insurance policy. Insurers generally define what constitutes a pre-existing condition." (2) If the insurer defines pre-existing condition, then a cold could disqualify someone from getting health insurance. We need an actual definition of the term so we can have an understanding of what it means.

That being said, we all have pre-existing conditions. Let's put this in context. The ACA was passed in 2010. 23andMe was founded on 2007. This is the popular over-the-counter genetic testing company that can tell customers whether they have selected genetic markers. Those are indicators of potential pre-existing conditions. Now this sort of thing wasn't on the radar when the ACA was passed. In fact, 23andMe was embroiled with legal issues about their product with the FDA in the early 2010s.

But here we are in 2020 and there have been over 25 million DNA tests done in the retail space (not just with 23and Me) (3). What happens if Aetna forms a partnership with 23andMe? The beginning of the end of all privacy, although that probably started already with Facebook.

Any insurance plan should cover pre-existing conditions, but the fact of the matter is that some of these conditions are somewhat inexpensive to manage, others aren't and others are just risks of getting something. We need to separate them out.

Psoriasis. It's basically a rash on different parts of the body that comes and goes. It's a chronic condition. It could be quite inexpensive to treat, given the patient. Some can respond to steroids. Some just manage it by staying out of the sun or covering flare-ups. Others need, or I should say are, prescribed super expensive biologics. They may or may not work. Is this disease debilitating, like HIV? No. I'm not minimizing its challenges. But in the grand scheme of illnesses, anyone who has HIV would swap with someone who has psoriasis.

Should a patient be denied insurance because they have psoriasis? No. Should their insurance cover unlimited treatment options? No. There needs to be a sort of self-rationing of the funds.

Now what about someone with multiple sclerosis? They shouldn't be denied coverage either. Yet treatments for MS are expensive and could bankrupt a small employer who's legally required to provide health insurance for their employees. In these cases, where the employer has just a small group of people over which to spread the risk, having one or two people with serious medical issues can be financially devastating. What to do?

Well, we have to start thinking about alternative funding options. I think we need to have a basic payment that covers the majority of an individual's needs and if there are conditions that are very expensive to cover, alternative funding should be provided.

What does that mean? Well, there are numerous multiple sclerosis foundations out there. They advocate for research and to make sure MS is covered under insurance plans. What if they put a chunk of all that money towards an investment fund just for MS patients? What if that fund was set up like an annuity, where it spun out a certain amount of money each year in payments, but didn't deplete its principal? That money could go towards paying for treatments for MS sufferers. It could supplement the coverage these folks would get through insurance, while keeping rates more affordable for everyone else.

And for those individuals who have very serious issues, like cerebral palsy. These folks need to be pulled out of the insurance pool altogether and funded separately. There are public funds available to help these individuals which is great. Yet having them in an insurance pool with everyone else jacks up rates. There's no need to "insure" these folks. We know they have disease. Insurers are insuring against whether someone with cerebral palsy will sign up for their insurance program. We need to remove that from the risk pool altogether.

Those are my views on pre-existing conditions.

Onto the next thing, which is price transparency. This is a great one. Everyone wants price transparency. The Trump administration has made numerous attempts to get providers and pharmaceutical companies to post prices. Hospitals, insurers and pharma have pushed back for both good and bad reasons.

The major problem is that the so-called prices that hospitals and pharmaceutical companies start with are not the prices that everyone pays. Hospitals have charge master prices. These are list prices that are used to start negotiations with insurers. Depending on the negotiating party, the hospital may be paid a percentage of a charge master price. They may group multiple charges together for a price, depending on the procedure.

Moreover, if you're on insurance, you're not going to pay that full price, especially for a hospital visit, because the hospital visit will cost more than your deductible. And if you're going to the hospitals, it's hard to estimate exactly what's going to happen, so having the price so you can do a percent of charges that you might be responsible for…almost no one can do that. Nor should they.

As for pharma, drug prices are a nightmare, for all the same reasons that hospital prices are. But there are even more intermediaries – the pharmacy benefit managers – aside from the insurers, and there are rebates and all kinds of nonsense.

The most reasonable place to start to get pricing is in the outpatient environment. This is what consumers should care about the most, because this is where they're going to spend their out of pocket costs. If you've got an $8,000 deductible and you need something like carpal tunnel surgery, which should be less than $8,000, you should be able to shop around. There are some tools to provide ranges of prices. But that's where the problem lies.

One price does not fit all. Consider the knee replacement example. You can go to a website and find a price that can range over, I am not joking, $30,000. Like, one place will put it at around $20K and another has it at $50K. Why? Well, a lot of it has to do with the patient. If you're Joe, and you're 32 and fit with no health issues and a commitment to rehabilitation, you'll be approved to get your procedure done in an outpatient environment like an ambulatory surgery center. The procedure should have nominal complications and recovery should be as reasonable as can be expected. In other words, Joe's knee replacement is going to be towards the $20,000 range, assuming he goes to a facility that will charge that.

Then there's Max. He's 53, a smoker, obese, has high blood pressure and recently had a mild heart attack. He's too much of a risk to have his procedure done in the outpatient environment, at least in one that's not attached to a hospital. Right there, the price probably doubled. Then throw in that the procedure will take longer, will require more medication, will have a longer rehab…now you can understand why one price doesn't fit all.

My company, Longitudinal Health Care, is really pushing the consumerization of health care. One of the biggest challenges is that patients don't have the tools – yet – to be good health care consumers. We're working on a pricing offering that addresses the issue. We want to show local market cash prices that are customized to the individual. That way, folks have a better understanding of what the cost of care, in the outpatient environment, will be for them before they engage in it.

Another worrisome issue? The poor health status of Americans and the need to improve health outcomes. Well, the people on private insurance are, by and large, not the group that has serious chronic care problems. This is a really important fact that is not hammered home anywhere near as often as it should.

If you were to look at the health care spending of all Americans and put it in a line. Let's say one end has the person who spends the most on health care and at the other end is the person who spends the least. If you looked at the high spenders, the top 5% of them are responsible for 50% of all health care costs. At the other end of the spectrum, the bottom 50% of people are only responsible for 3% of costs (4). That means there is a massive subsidization of the high spenders going on by everyone else.

Who are those high spenders? Folks on Medicare and very sick individuals on Medicaid. Yes, there are some high cost outliers in the private market but most of these very sick people are on public insurance. The private insurance market needs to take care of itself and do a better job of explicitly articulating costs. It is really hard to do, given that both private and publicly funded patients are accessing care from the same providers. But Americans need to stop thinking that this chronic care issue affects so many people. *It affects so many dollars, not so many people.*

As a final topic, I'd like to discuss talk about the fact that not all insurance is the same. There's a lot of commentary about people not having health insurance, as if it were a binary thing. Many of you know that paying hundreds of dollars for a monthly premium and then having a $10,000 deductible is the equivalent of not having insurance.

The ACA tried to make all health insurance sort of "same-ish" by mandating that ACA-compliant plans had Ten Essential Benefits. Doing this made sure that everyone had somewhat equal access to the same things. But there are real problems with this approach.

Let's say you live in Texas, where I do, and you get cancer. You have insurance, so you're relieved. You want to go to the best cancer doctor out there because, you know, this is your life we're talking about. Your friend recommends you see someone at MD Anderson in Houston. But your insurance won't cover it. In fact, your insurance has what is called a narrow network. This is what a lot of insurance companies, especially newer or smaller ones, are using to enable them to offer cheaper rates. They go to a small group of providers and guarantee volume because they are the only provider that the folks on that plan will be able to see. The insurer gets a good rate and can pass that on to its customers in the form of a lower rate.

But who cares about that if you can't get to the provider you want? If you have to see a substandard provider, then you don't get the care you need, you're less healthy and ultimately, your health care is going to cost more.

There's another problem. I've seen this when I've pitched my company's insurance replacement product. Our master plan – and it is a ways out because the market isn't ready, but it is what

we'd like to see – our master plan is to have employers give their employees the money to buy whatever insurance they want. We'd like employees to buy our plan. We would spend the money in three ways. We'd get them catastrophic insurance in case anything crazy and unexpected happened. Then we'd create a custom budget for their health care – the outpatient stuff and generic drugs that the vast majority of people need and use. We'd utilize the pricing tool I mentioned to create the budget. Anything left over would go into an account to be saved for future health care expenses.

One question I get is whether people are going to be able to pay for their own care that way. Odds are, if the person has a serious condition, like multiple sclerosis, they're probably going to have to pay a supplement to the catastrophic coverage we offer. They'd have to do that until they could get access to supplemental funding options. But most people don't fall into that category.

Interestingly, depending on the employer, some people might be able to pay for their care through us. Generally speaking, large employers have more generous health plans. They spend more money on their employee healthcare costs as a perk to attract employees.

Many don't realize that individuals with conditions like MS, or Crohn's disease, are paying more out of pocket today simply because they access more care than normal. They have to pay deductibles and co-pays and coinsurance more than the average person.

It's even more of a problem if they are employed with a smaller company. That smaller company doesn't have a lot of other employees to share the cost of that MS employee.

Small employers, as discussed, are looking to provide the minimal amount of coverage necessary to ensure their employees get access to what they legally have to and of course, to basic necessities. There is an entire industry of brokers and small insurers and actuarials that set up small employer plans by estimating the health costs of employees and then pricing the plans accordingly. No wiggle room. That MS employee throws everything off and may not enable them to get access to the same low rates they had one year in the next year they contract for care.

These small employers can push costs down not only by providing the bare minimum of coverage but also by leveraging the narrow network of limited providers. Yes, their health care costs go down. But let's not forget that they've had to pay the broker to figure all of this out!

So… if someone can't afford to use our health care option, well, that's a function of their employer and the health status of the employees they work with.

All of this may sound very harsh. This pricing of an individual's care is coming, whether we like it or not. It should come. In a perfect world…well, in a perfect world Americans wouldn't be as sick as they are and health care costs wouldn't be as high.

But in that other perfect world, all employers would have to pay the same amount of money for their employees regardless of age and health status. That would mean that some employees would be paid more than they need and some would be paid less. I'd love to see that supplemental funding for those with pre-existing conditions caused by genetics. You don't get MS from over-eating and smoking (although those behaviors don't help). Others who wind up spending all of their allocation because of poor health behaviors…well, that is their choice.

No doubt those who are older have higher expenses. But if they saved the money they were allocated and didn't use when they were younger, they should have the money to pay for the care when they're older.

Given the coming wave of instability, we have to be open to new ideas about how to finance health care. One way to start is to be more aware and educated about buzzwords. In the end, the best thing we can do is to be as healthy as we 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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