

The Powers Report Podcast

Episode 29

Need Versus Want: Learning to Self-Ration Our 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.

The coronavirus pandemic has upended our way of life. It's changed what we do every day and it's forced us to re-think what is normal. Things we enjoyed doing – throwing parties, going to the movies, traveling for a vacation – these things are luxuries now, things most people can't do at all. And now that the holidays are upon us, these restrictions will seem much more acute. We can't help but wonder what in our life we really need, and what is part our life that we simply want. Understanding the difference between need and want in health care is the subject of this 2020 holiday edition of The Powers Report Podcast.

It's easy to say that everyone "needs" health care. It's impossible to define what that means. One person's need is another person's want. Why is this worth discussing? Because of money. We have a hard time talking about rationing in health care because it means we have to put a limit on care. When we do that, there's a perception that we're denying someone of their human right to health care.

We have to be able to talk about rationing because we need it. Our health care costs are out of control and we have to entertain new ways to deal with the situation.

Rationing will never be 100% fair. We can point to Canada with their universal health care and to their long wait times for care. Or to France, where they've limited the number of inpatient beds as a rationing tool (1). This forces doctors to consider another way to treat patients. Is that rationing? Or is it just encouraging an alternative care path? It's both. Yet we can look at the

limited inpatient beds as a problem, now that we have a pandemic, and more and more people are being hospitalized with limited resources to treat them.

We have to have, dare I say, a rational discussion about rationing. That is why talking about need versus want is so important. When we ration, there will be limits on care which some people may object to and others will not. Some people will get everything they want and need. Most people will feel restrictions. Remember: we have restrictions and massive inequity in health outcomes and in who pays for health care today.

This discussion is not applicable to the Medicare population. Medicare is the public health program for individuals aged 65 and older. A lot of care is delivered towards the end of life, when, arguably, some of it isn't necessary. I'm talking about giving someone a double knee replacement when they are an 85-year-old obese diabetic with dementia. I know that describes someone's grandmother. I am sure she is a wonderful person.

Yet there is a point where the body can't work anymore. We need to accept this with grace. We can't treat human beings like science experiments. The elderly, many of whom are frail and afraid, aren't in the best position to challenge a doctor's recommendations. That's falling, increasingly, on the children of the elderly. They need to work with doctors to help ease their parents through a difficult, yet completely natural, transition – and do it with dignity.

The rationing changes I am talking about relate to those on private insurance and to those on Medicaid. Both insurance models. I think they should be managed similarly, except that one is funded by the employer and the other is funded by the government.

When we think about rationing, we have to acknowledge that there is a lot of subjectivity in health care. This subjectivity is a function of a number of factors, including the person's health status, their personal preferences, the doctor's skill, experience and care-giving philosophy, the insurance coverage and then the financial situation of the patient. I'll discuss all of these together.

Traditionally, we've relied on the doctor to tell us what we need. Many insurance plans require a doctor to authorize care before it can be scheduled. We can't get prescriptions without a doctor (or, depending on the drug, a nurse practitioner). Doctors order lab tests, imaging exams, perform surgery. When something's wrong, we ask them what to do.

Unfortunately, not all doctors do the same thing. And when they don't do the same things, there's cost variation. I like controlling costs. But I am also aware that things that may seem cheaper in the short term, like pills, can be more determinantal in the long-term, particularly if the pills don't solve the underlying problem or worse yet, if the pills cause unintended side effects.

Let's take this example. A depressed patient. Not someone who's bipolar, but someone who's having a tough time sleeping, getting their work done, finding meaning in life... One physician may prescribe medication, antidepressants. Another physician, looking at the exact same patient, may not prescribe medication. Rather this doctor believes that behavioral modifications like a structured schedule, focusing on meaningful relationships with friends and family, and therapy are necessary. Some doctors will prescribe drugs, therapy and recommend behavioral changes. Options abound. And so does the variability.

Which begs the question...if there is no one answer, if there is no agreed-upon course of clinical action, then does the patient need any of it? If we agree that something is needed, then shouldn't we start with the least invasive, least expensive option, which is behavioral modifications?

Well, this is where need and want get funky.

What if the patient wants medications? What if he tells the doctor he's tried everything. He didn't like his therapist. He's been unable to maintain friendships and can't hold down a job. Should he get the meds?

Well, maybe the patient is lying. Maybe he doesn't want to pursue the harder things, like therapy, and just wants pills. Maybe the doctor doesn't want to argue and just writes a prescription.

Or maybe there really is something wrong and the patient's doctors are just not good at their jobs. Maybe this patient has acute anxiety or really is bipolar and has managed to mask the symptoms. It happens. There are bad doctors out there. As I like to say, someone got a C in medical school.

If we get back to the fact that I was talking about the need to control costs, you might think that none of this matters all that much. Pills are cheap. Therapy typically isn't, in comparison. But seeing a therapist even over the course of a year shouldn't cost tens of thousands of dollars. Nonetheless, small expenditures add up, especially when you have a population of 330 million people.

Of course, there is significant variation in clinical diagnoses for things that cost a lot more than a few thousand dollars. Joint replacements are a great example. One doctor may tell a tennis player with tendinitis that he needs surgery. Another will tell the guy to give up tennis for a while, and let the body heal. Someone else will prescribe medication. And/or physical therapy. What does the person really need? And what do they want?

Well, if they want to play tennis, they may think they need the surgery. But they don't *need* to play tennis – it's what they *want* to do.

Now someone playing tennis is going to be, arguably, healthier than someone that is not active and smokes two packs of cigarettes a day. That smoker wants to smoke. And when she gets cancer, she needs chemotherapy.

I think you get the point.

So where does this leave us? Here are some interim thoughts.

1. We'll never be able to figure out one definition of need versus want that fits everyone.
2. Everyone needs some sort of basic coverage for catastrophic events. And that includes the cancer the aforementioned smoker got.
3. We can't rely on doctors to make all the "need" decisions which means that
4. We have to ration another way. And that way would be through money.

So let me clarify point #3, we can't rely on doctors to make all the "need" decisions anymore. That's going to anger a lot of doctors. Here's what I have to say: If you are a good physician who works with your patients to prescribe a course of action that works for them, then you shouldn't have to worry.

The unfortunate reality is that one reason health care spending in the United States is so high is because of over-utilization. Half of Americans take at least one prescription medication every day (2). We take more medications, and we get more tests done than in other countries. Who orders this stuff? Doctors.

They can argue that the population needs it. We're more overweight and obese, we have higher rates of chronic disease here in America than in most other parts of the world. It makes sense, then, that we will need more health care.

Nonetheless, our fee-for-service world, where a doctor gets reimbursed for care that's delivered, has been a factor in driving up utilization. One study estimates that about \$430 billion in health care spending is attributed to over-utilization and is wasteful (3).

We have to have doctors involved in the process. I think they need to be at the front of the line, coordinating things. But they have to do it in conjunction with the patient and they can't have an unlimited amount of money to spend.

Which is how we get to point #4 – we have to ration using money.

What does that mean?

We have to set a dollar amount cap per person that's spent on health care each year. I'm going to throw out my perfect world example, knowing full well that it would require Congressional support. However, I think this idea could be doable for a large employer, or a set group of people as a trial. They can work out the kinks and then we can grow the program elsewhere.

First, every employer would contribute the same amount of money to health care for every employee. Small employers. Large employers. Same dollar amount, regardless of the employee's age or sex. That same set dollar amount would go towards every Medicaid enrollee too. It would just be funded by the government.

In this amount, there would be enough for a universal catastrophic care insurance coverage program. We'd have to get clear on what we mean by catastrophic. For simplicity, let's call any time someone is admitted to the hospital as catastrophic. Also important is that major cost outliers, like those with severe illnesses need to be taken out of the pool altogether. Their health care needs will not be able to be met in this model.

But the vast majority of individuals, especially because they are under age 65, do not have out of control health care expenses. I've quoted this statistic before on the show. Half of all the health care costs in America are spent by 5% of the population (4). On the other end of the spectrum, fifty percent of the population – half of the country – spends only 3% of health care costs. Right now that 50% of people is subsidizing the 5% of high spending people. That has to stop. We have to better manage the severely ill, the chronically ill and the elderly. The best way to do that is to separate the money that should be spent on them versus what everyone else needs.

Let's recap. Employers contribute the same amount per employee. Medicaid contributes the same per enrollee. Catastrophic care is covered.

What about everything that isn't catastrophic? And by that I'm talking about stuff below \$10,000. Stuff that today, many people have to pay cash for so they satisfy their deductible and then their coverage kicks in.

Think about your health plan. Did you satisfy your deductible last year? The year before? Do you satisfy it every year? Probably not. Most people don't hit their deductible every year. They either spend a lot each year or they spend a little. On that year when you spend a lot, your care is getting subsidized by the people who spent very little. But you think to yourself...Gee. I've been putting all this money into the system all these other years. When I need it, I'm going to use it.

Well, again, I don't think we need to look to other people to do this subsidization. When you have a spike in health care spending, you need to be able to pay for that spike through this employer-funded account. Here's the trick.

You'd get the set amount each year. If you don't use it in one year, it would roll over. Like a health savings account. You'd have maybe five years of the costs rolling over. When you have a spike in care needs, you will have accrued enough money in the account to pay for it. The contribution level needs to be set where it's lower than the cost of a spike in care, because

people don't typically have high cost health events every year. But they do happen. People tear their ACL, need a hernia repair, may require an expensive but limited drug therapy. You'd have the money saved year over year, so you could be confident that your needs would be covered.

Then you get to year six. At this point, you're getting more money in from the employer. What you didn't use from year one should drop out of your account. Then you have the money from the next rolling five years. It's sort of a use-it-or-lose-it situation. This is better than an HSA because people have been known to hoard the health care dollars instead of spending them on the things they really need, like preventive care

Giving people a rolling account that's going to sort of expire allows them to be much more involved in what they need versus what they want. Again, they need to partner with a physician to make sure they're actually accessing the care that they need. But this is where doctors and patients can have discussions around whether or not they actually need that surgical procedure on their knee. Maybe they try physical therapy first. Maybe they engage in other athletic activities that don't aggravate their knee so much. Maybe they lose weight to reduce the strain.

I recognize that it is a leap to think that all patients will have the health care literacy to have these conversations with doctors. They won't. But some will. And we never know how well a model like this could work until we try it.

What we're asking people to do, in many ways, is self-ration. That requires them to have an ability to budget. Well, we know Americans are not good at saving and budgeting. Patient consumers are going to need help in making these decisions, and that help needs to come from not just the doctor. My company, Longitudinal Health Care, is designing tools to help people make better health care decisions. It's about time we put some of this information in the hands of the patients.

So let's talk about what happens after five years. At year six, you'll get more money in the account. What you had in year one drops out. Where does it go?

I think part of it should go to the individual as a reward for good health. The other part should go into a pool for health care overages, like a reinsurance pool for catastrophic events that weren't covered.

I also think that the amount of time that an individual can roll over the money should vary, based on their age. If you're young, your health care expenses are lower than if you're in your late 50s and early 60s. So a young person's account should roll over every three years, while an older person's should roll over every seven. That way they have a larger pool of money to use to cover their care. But they still have to ration.

One complexity I have not yet discussed is pricing. Patient consumers can't make decisions about how to spend the money in their health care accounts if they don't know how much anything costs. We would need to have articulated prices for care. We don't have that now.

The short answer is to use a multiple of Medicare's prices. Doing so is called reference-based pricing, or RBP. Medicare publishes their rates for care and these rates vary by location. It is a complex price list. But it's a price list. People are realizing that it's easier to tell a contracted party that they'll pay a multiple, like 130% or even 200% of Medicare's prices, instead of having to haggle on coming up with their own rates.

My company has spent a lot of time trying to get at market-based rates. I'd love for providers to publish one flat, non-Medicare rate that all people, including those on Medicaid, use to price care. If they can't come up with their own, the market should default to a set reference-based pricing rate and leave it at that.

I've got a few quick, final comments.

One of the great aspects of this idea is that it's portable. A person takes the account from employer to employer.

It lowers costs for the employers, because now they don't have to negotiate with an insurance company or a broker to set up a plan for their employees. Their health care costs have been stipulated. If a large employer wants to give more than the designated allotment, they can. It's what they do today.

And what about the people who don't get their insurance through an employer? Well, I think all of these employer contributions need to be taxed. They are not taxed now. These employee payments are a form of income, but they are not taxed as income. Those taxes should fund the standard minimum contribution of those who are self-employed or unemployed (assuming the unemployed are looking for jobs...there's a difference between being unemployed and not working!). Such an approach puts everyone, including Medicaid enrollees, on a much more level playing field.

I am confident that we can set a financial threshold that ensures coverage, but also pushes more people to talk about what they really need, and what they really want. In the end, if they are as healthy as they can be, I would expect they could have both.

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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