Part I

The Current Situation

As many of us have experienced in our professional lives, great opportunities often come from adversity, problems, and setbacks. While it's hardly breaking news that there are problems in health care, the extent of the collateral damage that is a direct byproduct of these problems is less well known. This part of the book goes beyond the visible parts of our present situation to explore the underlying dynamics and incentives behind many of these problems and the extent of collateral damage.

Most people have a fundamental misunderstanding of the pressures that drive the health care industry. Those pressures have a profoundly negative financial and health impact on your organization and employees. However, there is good news in our current situation. Despite what you've heard, unit prices are flat in most of health care. Plus, millennials are now the largest chunk of the workforce and are changing their world in ways that hold great promise for health care.

CHAPTER 1

AMERICA HAS GONE TO WAR FOR FAR LESS

One definition of an economic depression is two or more years of income decline. Since the middle class has seen wages decline over the last 20 years after adjusting for inflation (see Figure 2), they have been experiencing a depression for nearly twenty years. Here's why.

Employers spend more on payroll than ever, yet virtually the entire increase has gone to health care costs, as Rand concluded in their report, *How Does Growth in Health Care Costs Affect the American Family?*[13] In many cases those costs have literally taken all of the payroll increases for middle class employees. In Mobile, Alabama last year, the Public Education Employees Health Insurance Plan board voted to raise health care insurance premiums for families, from $177/month to $307/month. This promptly ate up the state-approved 4 percent pay raise for employees that make less than $75,000 a year.[14]

Both employees and employers (public and private) bear the burden of these huge premium increases.

Accurate Box Co. CEO Lisa Hirsh said that 25 years ago health care benefits were 5 percent of an employee's total compensation at her company. Today, that cost can be 30, 40, or even 50 percent of total compensation. "When family health care costs

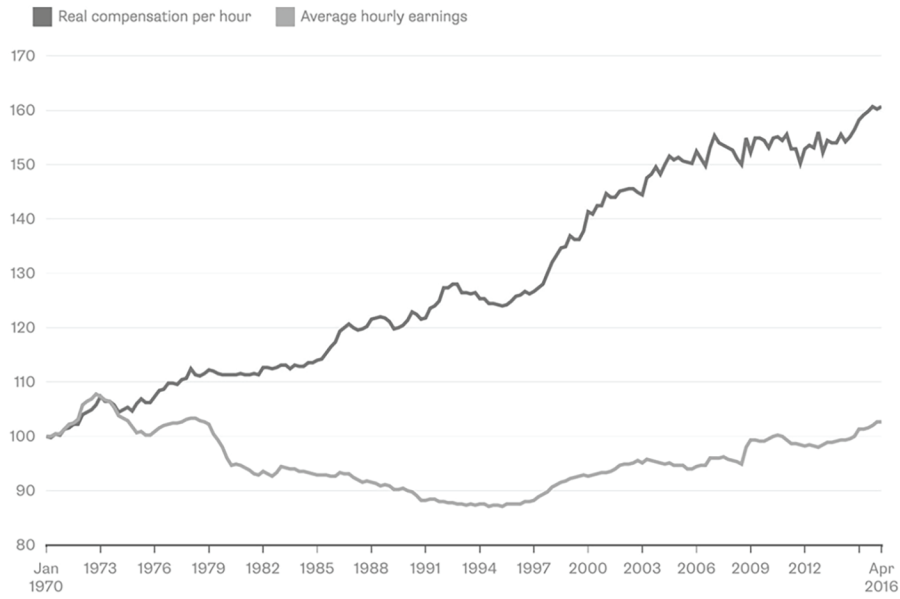

Figure 2. Compensation, including Benefits, Versus Take-HomePay. Includes benefits, indexed to 100, and adjusted for inflation. Source: Barry Ritholtz, "Health-Care Costs Ate Your Pay Raises," [16]

are $30,000 a year and the person is making $30,000, their total package could be $60,000, but they're not seeing it."[15]

A Sneak Attack

Imagine if a foreign country were causing this kind of collateral damage on our economy. We'd go to war in a second. Yet, we haven't. Evidence of the industry's "sneak attack" on the U.S. is clear. To wit…

Household income has been devastated by health care costs.

According to an article in the *Annals of Family Medicine*, from 2000 to 2009 the average annual increase in insurance premiums was 8 percent. During the same time frame, household incomes

rose an average of 2.1 percent. If health insurance premiums and national wages continue to grow at these rates, the average cost of a family health insurance premium will equal 50 percent of all household income by 2021—and exceed 100 percent of household income by 2033.[17] This is at least partly to blame for the fact that *nearly seven in 10 Americans have less than $1,000 in savings*.[18]

Illness or medical bills contributed to 62 percent of all bankruptcies in 2007.

This is up from 46 percent in 2001.[19] In 2013, more than 1.5 million Americans lived in households that experienced a health-related bankruptcy. More than three-quarters of those people had insurance.[20] Some say medical bills may also be the top cause of homelessness. Nearly half of all GoFundMe crowdfunding campaigns are to pay for medical related expenses.[21]

State-level data demonstrate that health care is choking other budgets such as education.

Massachusetts is a cautionary tale. Its move to almost universal health care insurance in 2006 became the model for reform nationwide, the Affordable Care Act. While the state did see coverage increases, Figure 3 shows this came at a 37 percent increase in health care costs. As a result, funding in education decreased by 12.2 percent, mental health by 22.2 percent, and local aid by 50.5 percent. Frequently in education, what used to be paid for by taxes has been cut entirely and parents or teachers have to raise money to ensure their children get core school programs. In other words, we're stealing our kids' future.

Massachusetts was also forced to cut infrastructure spending, which dropped 14 percent. And Massachusetts is hardly alone. At both the state and federal level, trains are literally going off the tracks and bridges are falling into rivers as health care costs have starved budgets of infrastructure investment.

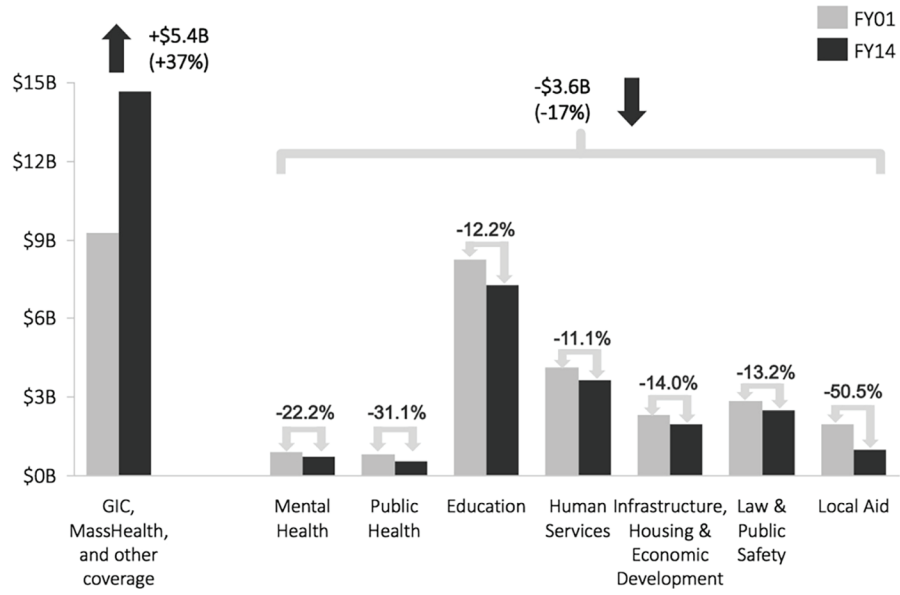

Figure 3. Source: Health Policy Commission, "List of Figures in 2013 Cost Trends Report by the Health Policy Commission." [22]

Between 2004 and 2014, officials in the little town of China, Maine, saw health insurance costs go up 141 percent to $200,000 per year for 11 municipal employees; the cost for just one of those employees with dependents equals the town's entire parks and recreation budget or the operating budget for one of its three volunteer fire departments. Instead of repaving roads, China is patching budgets. Beyond these microcosms, there are hundreds of millions of dollars in unfunded pension commitments around the country.[23]

More than 210,000 people die each year from preventable medical error in hospitals and other health care settings.[24]

It's the fifth leading cause of death in the U.S. after respiratory disease, accidents, stroke, and Alzheimer's.[25] Note that this is more than the number of soldiers killed in WWII.[26]

These deaths are primarily due to infections, along with errors in prescribing and administering drugs, mistaken diagnoses, botched surgeries and procedures, falls, and communication lapses from one care provider to another. The number of preventable adverse events associated with hospital care every day is 10,000—the medical equivalent of "friendly fire" happening seven times per minute. As with most cases of friendly fire, it's leadership and design that are most often at fault, rather than individuals. For detailed information on this subject, check out Sarah Kliff's powerful exposé on the flawed medical culture, "Do No Harm,"[27] and Dr. Marty Makary's book, *Unaccountable*,[28] which brings these statistics to life in devastating detail.

Hyperinflating health care costs have significantly reduced retirement savings.

I did some very rough, back-of-envelope calculations on what could be put into people's retirement plans if not for hyperinflating health care costs. I used historical rates of inflation, S&P growth, and health care premiums. Over 30 years, the average American household would have around $1,000,000 in their retirement account (assuming growth in an S&P index fund).[29] As things stand, the majority of Americans have next to no retirement savings and 68 percent of millennials aren't participating in a job-related retirement plan.[30]

There are unprecedented levels of dissatisfaction and burnout by doctors.

According to a Doctors Company survey of 5,000 physicians, 9 out of 10 physician respondents indicated an unwillingness to recommend health care as a profession.[31] A major reason is the layering of more and more bureaucracy. A recent study found that for every hour physicians see patients, they spend nearly two additional hours on recordkeeping.[32] Another reason is they're forced to see too many patients too fast, robbing them and

patients of the ability to effectively diagnose or of any sense of connection or satisfaction.[33] Sadly, doctors have the highest rate of suicide of any profession.[34]

The High Cost of Poor Care

Dying is a good example of how we overspend on care we shouldn't be receiving in the first place. As renowned physician, policy analyst, and author Atul Gawande covered in his book *Being Mortal: Medicine and What Matters in the End*, the U.S. does a horrendous job dealing with end-of-life issues. This often leads, as Ken Murray, MD put it, to "misery we would not inflict on a terrorist" for our loved ones.[35] It also squanders billions of dollars. Approximately 30 percent of all Medicare spending is in the last six months of life, most of it unnecessary and much of it harmful.

Knowing the limits of medicine and what impacts quality of life, many doctors die differently than the rest of us, said Murray, meaning they die with much less intervention (and cost). People in La Crosse, Wisconsin, happily for them, are not like the rest of us: 96 percent of residents have advance directives saying how they wish to be treated at the end of life—and those wishes are respected. Now look at the cost differential: $18,000 for care in the last two years of life in La Crosse vs. a national average of $26,000. At one hospital in New York City, this is more than $75,000.[36]

Musculoskeletal (MSK) procedures, primarily surgeries such as knee replacements and spinal fusions, are another example of our overspending on care we don't want or need. The *Atlantic* reported in "When Evidence Says No, but Doctors Say Yes" how pervasive overtreatment is in areas such as stents and musculoskeletal procedures.[37] In fact, benefits expert Brian Klepper, formerly CEO of the National Alliance of Health Care Purchaser Coalitions, estimates that 2 percent of the entire U.S. economy (not just health care) is wasted on non-evidence-based MSK procedures that add no value. How can that be? Health care spending is nearly 20 percent of the national economy, MSK procedures

are typically 20 percent of healthcare spending, and only 50 percent of MSK procedures are evidence-based.[38]

Health care is a $3 trillion dollar industry and 30 cents of every one of those dollars spent on health care is wasted, according to the Institute of Medicine. In 2009, that was $750 billion. Imagine what we could do with that money.[39]

- Send every 17- and 18-year-old to a state university for four years
- Fund the Department of Defense for a year
- Cover all hospital and medical care for veterans for 51 years
- Pay for all U.S. economic aid to foreign countries for 36 years (and still have $14 billion left over)
- Cover all annual health care costs for the uninsured six times over

Yet, despite all this waste and devastation, and despite employers spending huge sums to keep up with hyperinflating costs, the reality is status quo health benefits are a horrible value proposition for employers and individuals.

For example, flawed reimbursement incentives have made primary care a "loss leader," like milk in the back of the grocery store (i.e., a low-margin item designed to get customers to purchase high margin items). The result is rushed appointments, unnecessary referrals to specialty care, and lower pay, making the discipline increasingly unappealing to physicians. Unsurprisingly, this has led to a primary care shortage. This leads to long wait times to see a primary care physician or no access at all, which can cause small health care fires to become 5-alarm medical infernos. In short, undervaluing primary care is the root cause of medically unnecessary office appointments, clogged waiting rooms, and unconscionable delays in care for people who truly need a face-to-face encounter.

Not surprisingly, Figure 4 shows that Net Promoter Scores, a common measure of customer satisfaction, shows the health insurance industry is lower than even cable companies.

Health Insurance: Lowest Customer Satisfaction of Any Industry

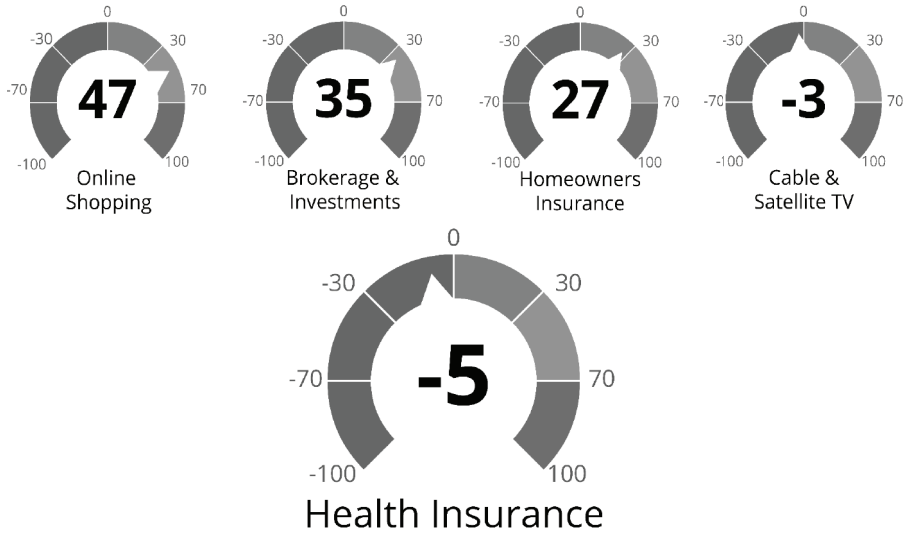

Figure 4. Note that some industries have so many detractors that the score becomes negative.[40]

A Way Out

While the status quo "preservatives" squabble in DC, forward-leaning individuals and organizations aren't waiting around. They see the threat for what it is and are creating examples for all of us to follow. There is a budding partnership between clinicians dissatisfied with the status quo, citizens who realize they have more power than they'd imagined, and employers no longer willing to passively accept further theft of the American dream.

Jeffrey Brenner, MD—executive director of The Camden Coalition of Health Care Providers and MacArthur Genius Award winner for his work using data to identify and improve the care of high-cost, high-need patients—put it succinctly in a *Freakonomics* interview: "There comes a point in a democracy when the public's had enough and they stand up."[41] For many across all segments of health care and all political persuasions, that time is now.

The three most trusted professions in the U.S. are nurses, doctors, and pharmacists. A key reason I love working in the health care industry is the great people I've gotten to know. However, great people inside a flawed system will always underperform those in a great system.

While it will take clinicians and others of all stripes to lead the movement, doctors have a unique role to play. In fact, some doctors are leading the revolution. Here are just two examples.

Rushika Fernandopulle, MD

Rushika is a practicing physician and cofounder and CEO of Iora Health, a health care services firm based in Boston. He was also the first executive director of the Harvard Interfaculty Program for Health Systems Improvement, and managing director of the Clinical Initiatives Center at the Advisory Board Company. Fernandopulle was among the first to understand that caring for the care team is foundational to achieving the best outcomes and reducing unnecessary costs and treatment. His work was featured in The New Yorker article "Hot Spotters," which highlighted the best ways to care for the sickest patients in our cities.[42]

Iora's mission is to build a radically new primary care model that improves quality and service, while reducing overall costs. It has opened successful practices in a wide variety of clinic settings, serving casino union workers, university employees, freelancers, undocumented workers, and Medicare recipients.

Rajaie Batniji, MD

Rajaie and his cofounder Ali Diab started Collective Health to help employees receive better care and coverage than the typical health plan. To tackle this challenge, they pulled together a team that could come at it from all angles—design, engineering, finance, law, medicine, product development, and operations. What they came up with is a smarter, more flexible alternative that connects a company's medical, pharmaceutical, dental, and vision plans on a single platform.

The impetus for Collective Health was Diab's horrible expe-

rience battling an insurance company that did not want to pay his massive medical bills following emergency abdominal surgery. The insurer claimed some of his surgical and hospital charges were experimental or the result of physician error, leaving Diab holding the bag for a shockingly large portion of the bill.

As a physician and political economist, Batniji had seen this scenario play out many times before: individuals left to advocate for themselves in a system where all of the economic incentives are misaligned and where getting answers about costs is impossible. Enter Collective Health, which was designed specifically for self-insured employers, two-thirds of the employer-provided health care market.

For these health care revolutionaries, it's what Ronald Reagan called Morning in America.

Rosie the Restorer

In family discussions about the need to fix health care, I explained to my son how every now and then the country is able to really pull together. I used Rosie the Riveter as a symbol from WWII. We decided we needed a new symbol of someone who was truly heroic and could get the job—any job—done. My son knew instantly who it should be: mom! Rosie the Restorer here is a mashup of a superhero, a mom, and Rosie the Riveter. [Courtesy of Cameron Chase, age 12]

CASE STUDY

PITTSBURGH (ALLEGHENY COUNTY) SCHOOLS

Bucking old habits that are devastating education funding elsewhere, forward-looking teacher union and school board leaders in Allegheny County, Pennsylvania are proving that it's not really so difficult to slay the health care cost beast and save their kids' future—even in an expensive and contentious health care market. Understandably, unions want their members to be fairly compensated and keep schools from being decimated. Recognizing that they share the same goals, the school board decided to take a new approach.

Assuming the current trend continues, kindergartners entering Pittsburgh area schools will collectively have $2 billion more available to invest in education and services over the course of their school years than their counterparts across the state in Philadelphia. In Philadelphia, schools pay $8,815 per member for teacher health benefits. The Allegheny County Schools Health Insurance Consortium (ACSHIC), with 48,000 covered lives, pays $4,661 per member—$199 million less per year. Class sizes in Pittsburgh are 30 percent smaller, teachers are paid better with better benefits, and there are four times as many librarians.

Rewarding Wise Decisions

Jan Klein, ACSHIC's business manager, describes a model that is very consistent with the Health Rosetta blueprint. In a nutshell, they make smart decisions free or nearly free (e.g., primary care is free and going to high-quality care providers involves very low or no copays or deductibles) and poor decisions expensive (e.g., pay more to see higher cost, lower quality care providers). It's a much more subtle, yet more effective, strategy than blunt-instrument, high-deductible plans that often lead to deferred care, bankruptcies, reduced teacher compensation, fewer arts programs… the list goes on.

The consortium is managed by 24 trustees, equal parts labor and management. When consultants attend consortium meetings, they often can't tell who is who. Many times, union leaders are more aggressive in pushing forward new initiatives. While other employers have blithely accepted 5 to 20 percent annual health care cost increases, the consortium spent $233 million in annual claims in 2016—*down* from $241 million in 2014. The consortium is able to manage their costs without any stop loss insurance because they have control over what they call their benefit grid, a program that was defined and embraced by both union leaders and teachers.

They've accomplished this despite the fact that care provider organization consolidation in Western Pennsylvania has reduced competition and raised health care costs with little to no improvement in quality of care—and despite an ongoing war between the largest hospital, the University of Pittsburgh Medical Center (UPMC), and the largest local insurance carrier, Highmark.

Understanding that the best way to spend less is to improve health care quality, ACSHIC found that the path began with the following steps.

- Educating consortium trustees on quality rankings of hospitals, including sending them to a Pittsburgh Business Group on Health forum

- Retrieving hospital quality data through third-party data and tools (e.g., Imagine Health, CareChex, and Innovu)
- Validating vendor information by confirming it was not influenced by bias
- Selecting the most effective resources by identifying credible partners/vendors

Once educated, the trustees provided the following direction to the team developing the new school district health plan.

- Use quality measures from respected third-party sources
- Create tiered products so people are free to go wherever they want for care—but they pay more if they choose sites that have lower quality and value
- Focus on ease of access to regional clinics and hospitals
- Focus on the relationship between cost and quality (the former turned out not to be indicative of the latter)
- Educate members, especially about why the local academic medical center was placed in a high-cost tier (it wasn't the highest-quality facility for many kinds of care)
- Address member concerns (e.g., will this really save money?) through continuous communication

Spending Before Changes

(October 2013 - September 2014)

# 1 Hospital in the region	**# 32 Hospital in the region**
(highest-quality rating)	*(low-quality rating)*
33,352 Services*	31,047 Services*
293 Admits	362 Admits
$4,941,146 total	$15,089,972 total

Total spend: $20,031,118

**Services include imaging, lab test, outpatient procedures, etc.*

To improve value, ACSHIC implemented tiered benefit offerings tied to high-quality care providers.

- Enhanced tier has NO deductible and pays 100 percent of hospital charges
- Standard tier has a deductible and pays 80 percent of hospital charges
- Out-of-network care has a larger deductible and pays 50 percent of hospital charges
- Lower cost and higher quality is determined by independent third-party, benchmarks

Spending After Changes

(October 2015 - September 2016)

# 1 Hospital in the region	**# 32 Hospital in the region**
(highest-quality rating)	*(low-quality rating)*
40,046 Services* (+20%)	6,620 Services* (-79%)
328 Admits (+12%)	113 Admits (-69%)
$7,120,357 total (+44%)	$5,548,832 total (-63%)

Total spend: $12,669,189 (-36.8%)

In sum, the consortium reduced hospital spending by $7.36 million, a 36.8% reduction

**Services include imaging, lab test, outpatient procedures, etc.*

Going Forward

The consortium expects to continue enhancing benefits with only a very modest premium increase of 1.9 percent for members. Here are a few plan attributes going forward.

- The enhanced tier has no deductibles
- Primary care visits have no copay
- Specialist visits have a $10 copay
- An employee assistance program provider
- A second opinion service

Their determination to serve kids led education leaders in Pittsburgh to move past tired assumptions about labor and management being forever at odds over health benefits. With any luck, their steely resolve in the face of local challenges will inspire teachers' unions and school boards throughout the country to say NO to health care stealing our kids' future.