David Goldhill, The Catastrophic Care Approach to Healthcare Delivery

Transcription By Isaiah Mudge

The problems I've been looking at in healthcare are in great part, frankly, intellectual. Which is, we have this view of healthcare that it is fundamentally different than everything else, and in some ways that's right. Healthcare is one of the small handful of services for which we have a direct safety net. It's something where intervention in markets has been assumed to be the correct policy for a very, very long time. It is something with [certain] unique characteristics obviously. There's not much you can do being a customer when you're unconscious and you have something that's a genuine emergency. Many people are born with things that will assure that their entire lives are unhealthy lives. Societies have tried to address that in a variety of ways. But one of the things that's most interesting to me is that the debates about healthcare fundamentally have not changed since the mid twentieth century. That's fascinating if you think about it, because everything else has.

We had a debate about how healthcare should be properly financed and governed and managed at a time when most care was episodic, when most of the expensive care was major and unanticipated. And one could argue that the systems we set up all around the developed world, fundamentally insurance-based, reactive, and with central authorities acting not just as financiers of care, but essentially as the customer of care, might have made sense in those days.

What's interesting is it's seventy, eighty years later, and for the most part we're still having the same debates. We're still having the same discussion. If you listen to the political rhetoric in the United States, many people say, [well], look around the world, and the US is the only country without. Without a universal safety net, without universal insurance, or without care being provided for everybody. Without price controls, without supply controls. And that's right. The question I've been asking is does that mean the United States is behind or the United States is ahead?

Something interesting happened to healthcare between the time the NHS was founded in Britain in the late forties and today. Healthcare became something that was primarily episodic, to something that is overwhelmingly chronic. In the US somewhere around eighty percent of spending on healthcare is on conditions that last more than a year. That would have been unthought of when we established our first efforts and safety nets and national health systems. The percentage of GDP spent on healthcare, particularly on disposable income, all around the world makes it one of the one or two top industries. [And] of course, the third thing, [the thing] that has changed absolutely everything in the economy, is the information balance between seller and buyer has changed because of the internet.

Health Affairs published just this month yet another appreciation of Kenneth Arrow's article, which made the key argument calling for governments, for insurers, or strong central authorities to act as the consumer in healthcare. And that argument is "we can't be consumers of healthcare." Why? We just don't know enough. We're in a situation, to use in economist terms, where a seller could say to us, "buy my stuff or you'll die." That's a very strong pitch. And Arrow's point was that there was no way for consumers to evaluate that claim to push back against it. And that the amount of emotional anxiety and lack of information and superior

knowledge that the seller had, meant relying on normal consumer markets in healthcare was impossible.

That is the most influential article in health economics. It's justified a lot of what had already occurred in other developed countries and what was going to occur today, and people refer to it today still as an intellectually foundational argument for what we do in healthcare.

Here's the problem: That piece is sixty years old. And in any other industry, if Arrow had written about almost anything else, any other industry, we would say "yeah, but a lot has changed." Only in healthcare, and I think it says more about the field of health economics than [it does] about healthcare itself, do people still refer to something that people wrote pre-internet, as if it is the final word on the relationship between sellers and buyers. And again if you live in the world of health economists, nobody says what I just said, which is "things change." But things really change.

Let's look at the conventional wisdom in healthcare. One is, without insurance very few people can afford care. It's almost impossible to afford. Who do we think is paying for that insurance? When Ezekiel Emmanuel wrote his book about the Affordable Care Act, he started as every single healthcare writer does, with a story. And his story was about a single mom in her early forties, who develops breast cancer, and thank God she has insurance because the cost of her treatment was seventy-five thousand dollars. Well, Zeke's a responsible academic so of course he's got footnotes, and if you go to the footnotes what you find is that this woman was paying fifteen thousand dollars a year for health insurance, with a five-thousand-dollar deductible. Which basically means every five years she pays for the cost of breast cancer treatment. Now try to imagine if you own a home, if your homeowner's insurance policy was priced in such a way so that every five years you paid for the price of the house, that's not insurance. And again, this is somebody who desperately needed insurance at the time. And the mistake in that, and it's a very common mistake, was that all that matters is what happens at the point of purchase. The fact that this woman is going to shell out a hundred fifty thousand dollars out of pocket over ten years so that she gets reimbursed seventy-five thousand dollars once, in any other industry would obviously be bad math and bad consumer math. It's not in healthcare. I'm going to come back to that.

Another part of the conventional wisdom is that technology pushes up the cost for care, and I like to joke that that line is written on an eight-hundred-dollar laptop. You know if you look at healthcare in 1965 when Medicare was passed, the average cost of healthcare... per American was somewhere around two-hundred and fifty bucks….

In 1965 the very first commercial mini-computer was sold by a company called Digital Equipment Corp., DEC, and the price of the very first mini-computer… was eighteen thousand dollars. So in 1965 the lowest level information technology was roughly eighty times the annual cost of healthcare.

So fast-forward fifty-five years later, and I think we all know where we are, which is that phone that you're all on is somewhere between three hundred dollars and a thousand dollars. And the average spending on healthcare is something closer to twelve thousand dollars. And to

argue that it is technology that has pushed up the cost of care, sometimes I think is intended to be irony, but it's not. One of the key arguments that Arrow made and a key part of the conventional wisdom, is that patients can't possibly have enough knowledge to be medical consumers. What's interesting about that is again that pre-internet understanding. Any doctor will tell you that the average patient shows up with the diagnosis that they've come up with online, and a variety of treatments. And for most doctors that's annoying because the patient's often wrong, but it doesn't matter. It's completely changed. And what's more important, even if you get away from patients [trying to be] their own doctors and trying to tell doctors how to be doctors, [is] the nature of care has changed. We went from a sort of auto-mechanic idea of change—you had a heart attack we need to fix you—to chronic care. Even for cancer now, almost invariably a patient has to make a choice as to the type of treatment, and a doctor is an advisor as to alternatives. That is not in the traditional model of care. If patients are required to make these kinds of decisions—and they are—then how is it we don't have a healthcare economy which is designed to assure greater patient understanding? How do we have [at] the foundation of the economy [the idea] that patients don't have enough knowledge, …[when] the reality of care in the 21st century… [is] patients needing to make decisions?

The conventional wisdom argues that only big intermediaries have enough expertise, enough market power, to drive prices, quality, and appropriateness. And I understand having that point of view when Arrow wrote in the early sixties. I don't understand retaining it today. We have sixty years of experience in which we've seen the very different ways in which CMS, state Medicaid organizations, and private insurers do the opposite, do a very poor job of driving prices and value, do a horrific job of driving appropriateness, and of course, as far as quality and safety goes… we still have somewhere between 175,000 and 250,000 deaths a year from medical errors. And by errors we don't mean incorrect diagnoses or incorrect treatments, we mean literally mistakes. I don't think one can fairly argue that quality has been well-driven in this system.

And then there are the classic things that people say against consumer healthcare, which is that when you have a heart attack, you can't shop around. That's true but so what. When you have a tire blow out on a highway you can't shop around, but it doesn't mean that when the tow truck comes you can ask for your net worth statement. We have markets not because they work in every circumstance, but because they work in many circumstances. And what I talk about the intellectual trap that we're in in healthcare, it's this either-or assumption. It's that because markets can't work in every situation, they can't work in many. The reality is that the way healthcare has changed, becoming much, much more integrated in the day-to-day life of many people, mostly about chronic conditions requiring patient decision-making. We must have market mechanisms in order to have the type of... care that is going to work in the 21st century. What we're really arguing about is a state of healthcare that existed in the mid 20th century, not where we're likely to go in the 21st century. And so as a result I do argue that most of the systems are designed to fail, because as care needs and technology become ever more targeted, ever more individual, ever more long-term, systems that are based on financing as if it's a car wreck are designed to fail not just here.

Why should you care? Well, we talk a lot about cost in healthcare, but I think we talk about it in very abstract terms. When I first started looking at healthcare—the first thing I did—

[I] was running a 500-person entertainment business in the U.S. And I looked at what somebody starting with us would contribute to the healthcare system over her lifetime. Now I should warn you, these numbers I first calculated in 2009, so they're out of date. But at the time if you looked at a young woman starting work at say $30,000 a year, and having the sort of normal three-percent growth in her income every year, and having a normal life, getting married at 30, having a couple kids, retiring at 65, going on Medicare. I actually [had] her divorcing at 65 because it made the math easier. But what was interesting is when you added up everything we took out of this woman's paycheck and everything she spent on healthcare, just how large that number is.

So what I did is I said, let's look at insurance premiums, our share [and] her share, because our share of costs is just our cost of employing her, it just affects the wages we pay her. But everything, what percent of her federal taxes funds healthcare, her Part A tax, her deductibles and out-of-pocket, the Medicare premiums she'll pay, the very large percent of her state income taxes that fund Medicaid. What I discovered is, assuming a zero-percent increase in the cost of healthcare over her lifetime, this working woman would put 1.2 million dollars into the healthcare system over her life. And I want to pause on that for a second because these are big abstract numbers, but of course this makes sense. If we're spending ten thousand dollars a person per year on healthcare, who do we think is ultimately paying for it? Where do we think it's coming from? And if only two-thirds of the population at any one time contributes, they're going to put in way more than their share. What's interesting is when you ask people how much they worry about spending on healthcare over their life, they worry that they're going to run up the bills to a hundred thousand, a hundred fifty thousand, two hundred thousand. If you [then] said to them "do you understand that you'll put into the system five or six times that over your life?" I suspect we would no longer have this system.

Why is it so expensive? Well… I think a major part of this, which we don't really appreciate is that intermediaries massively increase the cost of care. The theory—and this is another one of those theories [that] I think is way out of date—is that they have market power, so they should be able to drive down that gap. Well, has that worked? Even before something like the ACA's extraordinarily poorly thought-out provision that essentially said to sharers "you get paid fifteen percent of what you spend," there's never been a ton of incentive in private insurance to keep down the cost of spending because what are you doing? You're [just] marking it up, that's what your job is as an insurer. There's very little true risk in the health insurance business, which is why as the cost of care has exploded, their profits have exploded.

One of the things that makes America unique though, is that we don't have one single type of intermediary, we have several. We don't just have insurance; we [also] have CMS governing Medicare and Medicaid. And I want to talk about Medicare for just a moment, because I think it's important to understand that an intermediary is not a neutral customer… One of the big assumptions in healthcare economics is that intermediaries are just neutral, that their policies don't drive care. And much of what I've written about is [how] that's the exact opposite of what's true, that an intermediary's economic incentives drive how healthcare is delivered. CMS is a great example of this. [So] if you're CMS you're an organization responsible to Congress, and what do you want to show Congress? That you pay the lowest possible prices for things. And that seniors get all the care they could possibly need. So when you compare Medicare to private insurance, what do you see? You see that visible prices are much lower, but

you also see an extraordinary problem of overtreatment. You see massive amounts of uncoordinated care. The statistics on just the number of seniors who are taking contraindicated drugs is extraordinary. You see an enormous amount of accidental death and death from error. You see literally no governance of the system. All the time I hear from supporters of Medicare For All that Medicare is really cheap to run. I've never been, until recently, in the healthcare business… and you recognize… that [it] comes from a nonprofit perspective: "our foundation has only 5% expenses and the other 95% is given out to the poor." That is not what you want in a business. You can always run a bank without security guards.... It's not good for business though. We don't judge businesses [just] by their cost of administration; we judge them by their efficiency. The fact that Medicare only costs two or three percent of beneficiary spending to administer, isn't necessarily a good thing. If it fails to actually govern the healthcare system, fails to reign in excess, fails to protect its beneficiaries.

So private insurers who pay a much higher price per care have a different set of incentives. They need to show their customer, which is primarily companies, that they're sensible in how they administer. But because they're also marking up the cost of care, they have more of an incentive to allow less care at higher prices. CMS has more of an incentive to have a lot of care at really low prices. Neither are neutrals.

Where do we go? How do we get out of the traps we're in? You know, as I've mentioned, a big part of the trap is intellectual. And if we look at what that's about, it's about understanding healthcare the way we did sixty and seventy years ago as if it hasn't changed, understand the role of the patient as if it hasn't changed, and the doctor as if it hasn't changed. The first thing we do is to get out of that trap and understand that 21st century healthcare is likely to have a lot of care spending for which consumers can consider what they want, what's best for them, how they need, and that we want to encourage sellers to reach them and innovate on that basis. That's the first step. I would argue the second step is to abolish healthcare all together, by which I don't mean care itself. But I mean this idea that this thing with… tens of thousands of skews is a thing that needs to be solved as a thing. Nobody argues that making sure that our least well-off citizens don't starve is the same issue as how we regulate hygiene at restaurants. And yet, calling all of this healthcare in a way limits us intellectually. What we need is a 21st century economy of healthcare. What does that mean? That means we do want a safety net, because I think most of us believe that we would like to make sure that every one of our fellow citizens has access to essential care. We want to use that safety net for those things though, those things that we know people must have to lead healthy lives.

The second thing is we probably need some insurance because there are some things that are truly unexpected in the way that your home burning down is unexpected. Some of these are congenital, some of these are accidents, some of these will affect you for the rest of your life. So the idea of an insurance system like the one we have today based on your employment or your status in life probably doesn't work. There probably needs to be some insurance that follows you over your entire life, whether that needs to be government-provisioned isn't clear to me. But it's also clear that the less we cover by insurance, the less healthcare is going to cost. The more we can expose to a genuine market, the better a chance we have of keeping the cost of healthcare down, of reducing the amount of unnecessary care, and of creating—in terms of information,

technology, customer service—the type of information a consumer's going to need to make the choices they're required to make anyway.

The last element, which a lot of market people don't talk about, but I do, is we need the government to be the government. One of the difficulties I see in the patient safety movement is that the government is compromised: it's the partner of the healthcare industry, it can't be anything other, it spends almost half the money spent in healthcare, it's the partner of the hospitals. My interest in healthcare started with my father's death from a medical error in a hospital. In part because I like to think of what I and others wrote, this became an issue that the Obama administration started paying attention to, started attaching penalties to those types of errors, and that's terrific. But the reality is that there's only so much that CMS can penalize the hospital—it's got to keep the hospitals in business, it's their business partner. And part of the reason that you don't see the type of effective regulation in something like healthcare that we see in aviation, is that in aviation the government's role is strictly as a regulator. In healthcare it must be a business partner. And I think those of us who believe in markets need to talk about how compromised the government is in that role when we expect it also to be the provider of care. We're not going to get there quickly, and I think a lot of the things that we hope to accomplish through policy are less likely to work than we think. Let me give an example: many of us—and I include myself—believe strongly in high deductible plans, and in HSAs, and the logic there is that it does sort of what I said, it takes some of your care away from the insurance system into what could be a market. But that hasn't worked, and the WHY it hasn't worked really is interesting. [So] if you have a high deductible insurance plan, what you've probably noticed is that your insurer keeps the same in-network and out-of-network rules, and approval rules for spending your own money as they do for spending their money. So how does that create any competition? How does that create any need for you to shop around? Or hope that providers will come to you with innovative and interesting offerings? [So] if your concern is diabetes and some entrepreneurial provider says, "I've got a great pre-diabetes package to help you avoid diabetes even though it's in your family history," you can't spend your money on that and have it count against your deductible. It's not in your insurance plan. If you want telemedicine, you have to use telemedicine that your insurance agreed to, even though you're paying for it out of pocket. So the system—and I don't necessarily want to accuse insurers of doing this on purpose—but the whole high deductible system has been hijacked by keeping network and insurance design in place and making, as a result, sort of the worst of both worlds. Now you have a high deductible, you have to spend a high amount of money out of pocket. And your insurer won't recognize it against your deductible if you spend it on anything other than the exact same structure we have today.

I got frustrated after a decade of writing about these things, and so in the last year and a half I've started a company called Sesame, which really in some ways after a beta test in Kansas City last year, just opened for telemedicine nationally and for physical medicine in New York and Houston three weeks ago. What Sesame is the simplest idea in the internet, but incredibly complex in healthcare. It's a cash-based marketplace for care. Doctors, nurse practitioners, clinics, surgical centers, list cash prices, and you can lock-in the cash price by pre-paying. You basically buy your appointment, you buy your service, and what we've seen is extraordinary interest from a wide range of providers in doing that, and utterly massive discounts. Discounts well below the prices that you can achieve through your insurer's discount. We really designed

sesame for people who were either uninsured or high deductible and had figured it out. What I mean by figured it out is that in any given year around 15% of American families bust through their deductible. Most of those families know they're going to bust through their deductible on January 1st because there's a serious chronic issue, for example diabetes, which you know you're going to spend more than your deductible. The percentage of families who don't know they're going to bust through their deductible and do in any given year is small single digits. Which means if you've got a five-thousand-dollar deductible, you are a self-paid patient with catastrophic insurance. you actually have the type of plan I wish we would adopt on a national basis, but you may not know it yet. So for people like this, if they're told they need an MRI, and they have a five-thousand-dollar deductible, they can… go to a hospital, and any hospital can quote them $2100, $2200 for an MRI, and your insurance discount may bring that down to $1100 or 1000, sometimes 900, 950. On Sesame I don't think we've ever sold an MRI for more than $450. You literally save 4, 5, 600 dollars off the insurance price. Most primary care appointments are in the 40-50-dollar range for physical appointments, 20-35-dollar range for virtual appointments. We have everything. I heard Dan mention Keith Smith: Keith lists his surgeries on Sesame; we've actually sold a couple in just our three weeks of business.

The idea of a marketplace is not just about price. And this is where I want to part a little with those who claim that just price transparency is the answer. So in one of the first industries to have effective marketplaces was travel, and I served on the board of Expedia in… early 2000, I think until 2007. And one of the things we saw happen in the travel marketplace was really interesting. Airlines became fully price transparent to the customer. They also became fully transparent to each other. Which meant that no airline anymore ever offers a genuine special by which they're offering a price less than other airlines are. The reason—and some of it relates to the fact that there's no longer much competition in [the airline] business—is I know if I cut the price from Newark to LA… Delta and American are going to match my price immediately. I literally won't have more than a few seconds of price advantage, so I don't do it. There are different prices on those flights, the redeye is priced differently from the first price in the morning, etc.… but truly direct competition doesn't exist. If you are flying out of Newark in coach in the morning flight, and you both booked on the same day, you're both paying the same price regardless of what airline you go on. And that is because, in a noncompetitive industry, price transparency sets a floor; it doesn't actually drop competition. There was much more price competition in the airline business before marketplaces. But on the hotel side, what it created was massive differentiation as a way of competition. Let me give you an example. So you're going to LA on this flight, and one of you is going for a romantic weekend so you want a small hotel somewhere in a fun part of town, someone else… just cares about a great gym, someone just cares about night life… there's literally dozens and dozens of different forms of demand and so there is price competition because I have to charge correctly for each of those categories or somebody will say, "You know what, I can skip the gym for the night, the one hotel with a great gym is too expensive." And that's what was really interesting about price transparency in other industries. If you were in a competitive marketplace, you were likely to see real price competition persist but without competition you just created floors. And my fear in healthcare is that without creating genuine competition for the consumer dollar, all price transparency will do is create floors.

When I had my second child, I was uninsured. I walked into a hospital; I negotiated a deal. In a price transparent noncompetitive world, I'm not sure that deal is available. A lot of what we do on Sesame is those deals. It's a hospital chain that is losing out to the big merge chain that dominates its market, that's willing to try something innovative. It's a doctor who just so happened to have a cancellation the next hour that she wants to fill. But it's also innovation. When we launch Sesame one of the very first things that happened is a pediatrician in our beta market of Kansas City started listing late night hours at a two-times premium to her daytime hours. Now you might think to yourself, I just said that this would drive prices down, here's someone charging a premium, but for those of us who have been parents, we know that with a newborn something happens at ten o'clock at night, your choice is the emergency room. And at two times, that pediatrician is about an 80% discount from the emergency room. More importantly, there is no way for that pediatrician to sell a premium [service] in the reimbursement market. Why? Because from an insurance perspective from CMS perspective, 10 at night and 10 in the morning is the same use of resources; they should be reimbursed the same. There's no one selling the pre-diabetes package, etc.... except in the cash market. There's some corporate benefit stuff that's come up recently that I can talk about; but fundamentally, in healthcare, unlike any other industry, we say innovation on packaging, innovation on quality, innovation on price needs to come from the customer i.e.: the insurer, CMS, not the provider. And in doing so we've killed all the potential entrepreneurial energy that's driven change in other industries.

And that's where I'll finish. What our goal is in Sesame is to create low-cost healthcare reflecting low marginal cost across the broad spectrum, for those people who are very value-conscious. Either the uninsured, or people with high deductibles, who really have to think about each dollar. In doing so, though, in that small corner of healthcare—that small corner of healthcare by the way which, like every small corner of healthcare, is about 250 billion dollars a year in spending—in that small corner of healthcare, we think we can create something normal that starts to create normal market dynamics. To circle around to what I said at the end, that's what we need to think differently about healthcare. Some corner of healthcare in which we see markets are actually working so we can carve back insurance, we can carve back the safety net, to what works best. I wrote a piece in Forbes about three weeks ago about telemedicine that I think illustrates this really well. Telemedicine is… technology that grandparents have been using to talk to their grandkids for twelve, thirteen years now. The innovation was getting third party payers to reimburse it. But let's look at what that's done. Teladoc, which is the largest telemedicine company in the United States, and the only one public… did four million telemedicine visits in 2019. They paid the doctors roughly 25 dollars a visit: that's 100 million dollars. They had 533 million dollars of revenue from the companies and insurers who subscribe to Teladoc. So do the math, their revenues were about 130 dollars an appointment and they paid the doctors about 25 dollars an appointment, and they lost money. Why did they lose money? Because that's the cost of servicing third party payment. The difference between the 25 dollars you pay doctors and the 135 dollars they charge customers all goes to servicing third party payment systems. If you look at the national medical accounts, the entire 533 million is treated as medical service. But it's not. The bulk of it is admin cost and sales and marketing and all the clerical work you need to do to get something reimbursed. On Sesame a typical doctor lists their telemedicine cervices for 25 or 30 bucks, and that's what the patient pays. And fundamentally the more parts of the healthcare economy we can do that in, the more confidence we as a society

will have carving insurance back to where it is genuinely pulling risk and providing value, and not just adding massive costs to every single episode of healthcare we need. And when we can do that, when we can see that that's a possibility, we can start to build a healthcare system that really works for 21st century needs.