CHAPTER 3

AMERICA HAS GONE TO WAR FOR FAR LESS

"Health is worth more than learning." – Thomas Jefferson

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?*[32] 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.[33] 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 five 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 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."[34]

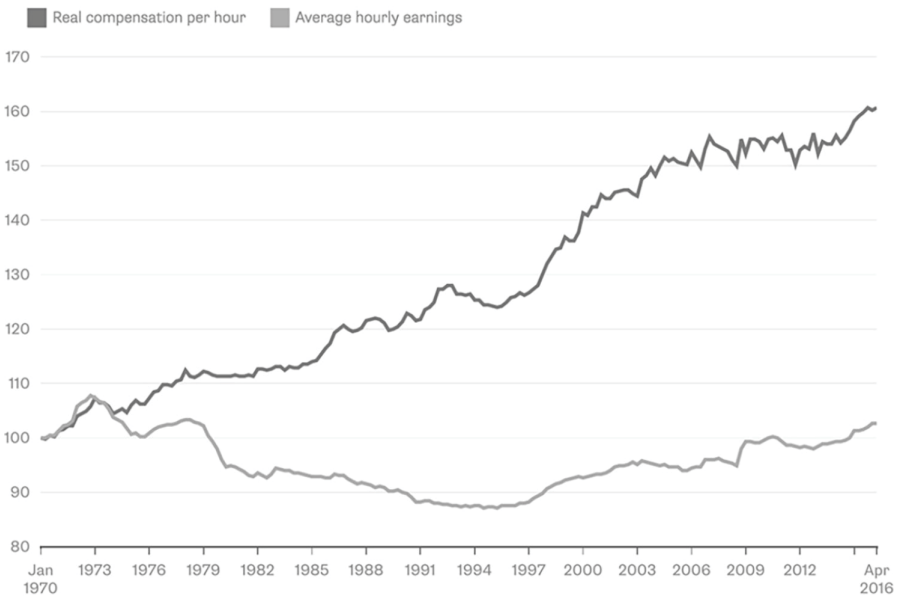


Figure 2. Compensation, including Benefits, versus Take-Home Pay. Includes benefits, indexed to 100, and adjusted for inflation. Source: Barry Ritholtz, "Health Care Costs Ate Your Pay Raises."[35]

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…

The greatest public health crisis in 100 years is a crisis created entirely by health care industry dysfunction

As we saw in Chapter 1, the opioid crisis is a predictable outcome of a profoundly broken health care system. Every two weeks, as many people as died on 9/11 die from overdoses— and overdoses are underreported due to stigma. Last year, more people died of opioid overdoses than Americans killed during the Vietnam War.[36] The vast majority of opioid use disorders begin with a patient following doctor's orders. Many high-function individuals are able to hide their addiction from their friends and co-workers. For example, Kristin Labott's nurse colleagues didn't find out until she was cuffed and taken away to jail;[37] fortunately, she has been in recovery for over a decade. However, while I was writing Chapter 1, a leader in the public health department of one of the biggest cities in America died of an opioid overdose. Her friends knew the cause of death, but her husband wanted it reported as a heart attack to protect her reputation or perhaps a life insurance policy that limits payouts related to drug-related deaths.

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 eight percent. During the same timeframe, 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 its household income by 2021—and exceed 100 percent of household income by 2033.[38] This is at least partly to blame for the fact that nearly seven in 10 Americans have less than $1,000 in savings.[39]

Illness or medical bills are a major contributor to bankruptcies

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.[40] 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.[41]

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 the local, state, and federal level, drinking water has become unsafe, trains are literally going off the tracks, and bridges are falling into rivers as health care costs have starved budgets of infrastructure investment.

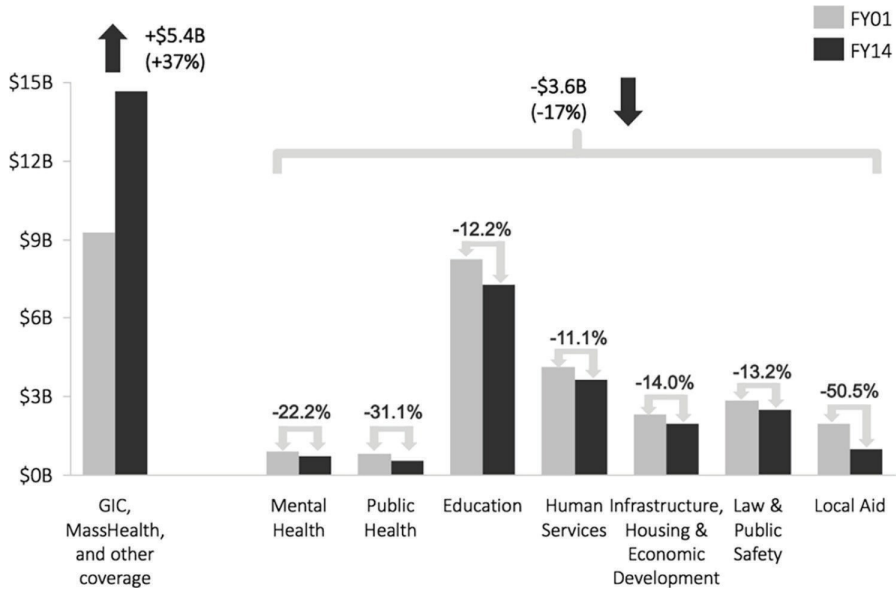


Figure 3. Source: Health Policy Commission, "List of Figures in 2013 Cost Trends Report by the Health Policy Commission."[42]

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.[43]

More than 210,000 people die each year from preventable medical error in hospitals and other health care settings.[44]

It's the fifth leading cause of death in the U.S. after respiratory disease, accidents, stroke, and Alzheimer's.[45] Note that this is approaches the number of soldiers killed in combat during WWII.[46]

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,"[47] and Dr. Marty Makary's book, *Unaccountable*,[48] which bring 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).[49] 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.[50]

There are unprecedented levels of dissatisfaction and burnout by doctors.

According to a Doctors Company survey of 5,000 physicians, nine out of 10 physician respondents indicated an unwillingness to recommend health care as a profession.[51] 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.[52] Another reason is that 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.[53] Sadly, doctors have the highest rate of suicide of any profession.[54]

The High Cost of Poor Care

Dying or end-of-life care 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.[55] 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 also 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.[56]

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. These unnecessary MSK procedures are one of the significant on-ramps to opioid use disorders. The *Atlantic* reported in "When Evidence Says No, but Doctors Say Yes" how pervasive overtreatment is in areas such as stents and musculoskeletal procedures.[57] In fact, benefits expert Brian Klepper, formerly CEO of the National Alliance of Health Care Purchaser Coalitions, estimates that two 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 health care spending, and only 50 percent of MSK procedures are evidence-based.[58]

Health care is a three-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:[59]

- 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 that 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, over-prescribing, 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

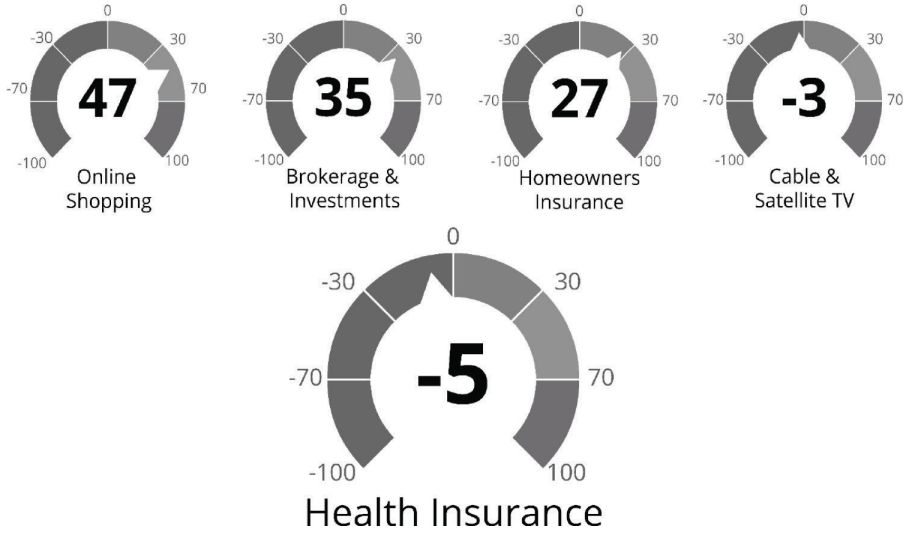


Figure 4. Note that some industries have so many detractors that the score becomes negative.[60]

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 communities 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."[61] 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 people 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

Fernandopulle 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.[62]

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.

Full disclosure: My parents are in a Medicare Advantage program that has Iora Health as a key primary care partner.

Dr. Mark Tomasulo, D.O.

With an ever-changing health care system and frustration among both doctors and patients, Tomasulo founded PeakMed Primary Care with a goal of redefining access and decreasing health care costs. He realized that the business of health care has rapidly changed over the last 15 years and, as a result, the doctor-patient relationship has suffered. Doctors are reluctant to enter the specialty of Family Medicine and senior mentoring physicians are retiring early.

The restructuring of the health care system has increased costs to the patient as well as to the employer, creating a barrier to true health care. PeakMed's disruptive approach in health care has created a platform allowing doctors and patients to communicate, manage, and collaborate individualized care plans without the constraints of a broken system. PeakMed has grown into one of the most successful Direct Primary Care organizations through their success working directly for individual patients as well as individuals sponsored by their employer.

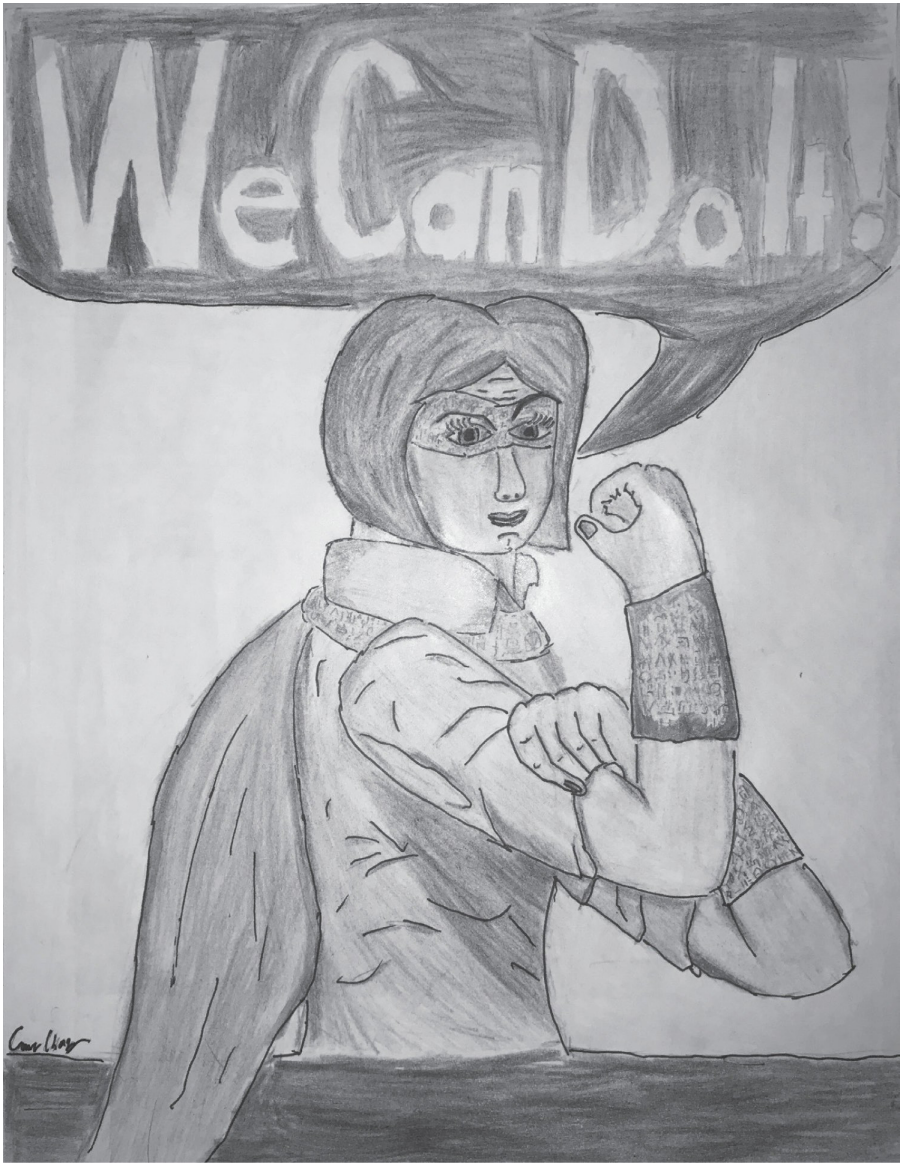
Tomasulo currently holds the title of Chief Medical Officer where he focuses on disruptive innovation and bending the curve of cost and access in health care. Tomasulo completed his medical training through the United States Army. He served eight years in the Army as one of the top officers in his field and was part of small unit deployments in support of Operation Iraqi Freedom.

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

Key Take-aways

- The health care system itself has become the greatest immediate threat to our freedom to pursue health and the American Dream. The opioid crisis serves as a wake-up call to the even broader crisis in health care.
- Health care has redistributed virtually all employer increased spending from employees to an under-performing health care system over the last 20 years creating an economic depression for the working and middle class.
- Health care is choking funding for education, public infrastructure, and social services.
- Despite spending far more than any country in the world, there are 10,000 instances per day of preventable medical mistakes, causing unnecessary suffering and spending.
- Physician leaders are proving there are ways to get twice the health care at half the cost.

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

Investing in Kids While Ensuring Teachers Receive Better Care

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 compensated fairly 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 five 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, even though 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.

Results

Health care purchasing before (October 2013 - September 2014)

# 1 Hospital in the region (highest quality rating)	#23 Hospital in the region (low quality rating)
33,352 Services*	31,047 Services
293 Admits	362 Admits
$4,941,146 in total costs	$15,089,972 in total costs

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

Intervention to improve value: tiered benefit offerings

- The enhanced tier has NO deductible and pays 100% of hospital charges.
- The standard tier has a deductible and pays 80% of hospital charges.
- Out-of-network care has a larger deductible and pays 50% of hospital charges.
- Lower cost and higher quality is determined by third-party, independent benchmarks.

Health care purchasing after (October 2015 - September 2016)

#1 Hospital in the region (highest quality rating)	#23 Hospital in the region (low quality rating!)
40,046 Services (up 20%)	6,620 Services (down 79%)
328 Admits (up 12%)	113 Admits (down 69%)
$7,170,357 in total costs (up 45%)	$5,548,832 in total costs (down 63%)

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. Imagine how much better schools would be if every school district replicated Pittsburgh's approach. If you are a parent or community member, share (www.healthrosetta.org/schools) with leaders in your local schools for this and other examples of success. You can find calculators on how avoiding wasted health care bureaucracy can allow for health and well-being in our future and kids.