

Three Inconvenient Truths: The Future of Health Plans in a Connected World

*Speech by Matthew Holt, Author, The Health Care Blog
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Hello my name is Matthew Holt and I'm here to tell you the truth. Now I know that you are a bunch of senior executives at health insurance companies, so you may not be very used to that....

I also understand that the person I'm replacing as a speaker here is Governor Arnold Schwarzenegger, who starred in some famous movies involving the end of the world and invasions by aliens, predators and terminators-- -- something which might seem metaphorical to you after you've heard my talk.

I'm here today to tell you three potentially inconvenient truths.

First, you've done very, very well for the past several years. But the chances that you will be able to keep running your businesses in the same manner in a decade or so are very low. In fact if you keep running your businesses the same way the chances are good that you won't be in business. That may not matter to those of you close to retirement, but it probably does matter to everybody else.

Second the world is changing under your feet, and if you intend to be a health insurance company that contributes value to society, you have to understand the changes that are happening in that wider society. I'm not just talking about American Idol and the ability to track minute by minute developments in the life of Lindsay Lohan, although of course that's a crucial component of societal change. I'm talking about the significant advances in technology and business leading to significant changes in the way we purchase, consume and—yes--produce health-care services.

Third, I'll tell you some potentially good news. Although I'm essentially on the same speaking circuit as the Liberals who think that Hillary Clinton is too right wing, I'm here to tell you that there is a role for an intermediary between the consumer and the healthcare system, and that intermediary need not be the government. That's because, if the right incentives are created, healthcare organizations -- on both sides of the payor - provider divide -- can substantially add value to society, by improving the healthcare delivered and the health outcomes produced at a substantially lower cost. **But** this is only good news if you're prepared to fundamentally change your organizations, so that, when society finally demands better performance from its healthcare system, you are ready.

So first, why do your businesses need to change? To be fair, it's by no means guaranteed that I am right. The naysayers and the doom merchants have been saying that the American health care system was on an unsustainable course for a couple of decades now, and if I look around the room I see plenty of executives running very profitable companies -- albeit most of them officially non-profit -- using the same old techniques of underwriting, price discrimination, and aggressive provider contract negotiations, that served your predecessors well 20 and 30 years ago.

The problem is that with a brief exception of the Phantom managed-care quote unquote "revolution" in the mid-1990s, it's been completely unnecessary for health insurers to attempt to systematically change the behavior of the providers who service their members. And make no mistake, that's a very, very hard thing to do. So here's the result...

This is the chart of the increase in health care costs as a share of GDP over the past few decades. Back in the mid-1990s at IFTF, we created this complex econometric model which explains the growth curve this chart shows, and here it is.

Of course in the past few years, the slope of that chart has got worse. And that has been during a time when the economy as a whole has been growing. This hasn't mattered a whole lot to the health insurance industry, and it's even managed to keep a bigger chunk of that increase! (You call that reducing your MLR). But there were two signal events at the biggest for-profit health insurance company United Healthgroup that symbolized what happened to the health insurance business after the failure of the Phantom managed-care revolution.

The first was in 2001 when United Healthcare gave up its policy of utilization review. That was a signal to the provider community that health insurers were simply going to turn round and pass on costs to employers, and to the government.

The second was in late 2003 and concerned this character, Patrick Rooney, the founder of Golden Rule insurance company. Rooney may not be the worst example—in fact I think Mega Life and Health whose CEO sits on the AHIP board may be worse—but Rooney is the biggest symbol of how to run an extremely profitable insurance company by making sure that you don't sell health insurance to anyone who might actually need it. While many of you in this room over the years have been opposed to some of what Rooney and his cohorts have been up to, that didn't stop United Healthgroup making him almost a billionaire when they bought Golden Rule in 2003.

And of course the man behind both those decisions, Bill McGuire, may well be joining several other CEOs at Club Fed due to his backdating of stock options—another symbol of greed run amok.

So the leaders of health insurance today are a gang of billionaires whose major interest is in avoiding covering the care of sick people while looking out only for themselves. And they've been successfully characterized as that by Michael Moore.

We don't have to argue the merits or the veracity of Moore's analysis to understand that there'll be little sympathy for health insurance companies or their executives in the future.

So what does that future going to be like? Insurers have traditionally had big and small employers as customers. The problem is that the workforce has changed-- fewer and fewer Americans are receiving insurance at work. And as the cost of care skyrockets the insurance they are receiving is costing them more and covering less.

The remarkable thing is that unlike in the 1990s when insurance coverage at work increased as the economy boomed and labor force increased, since 2001 the absolute number of Americans covered by employer health insurance has gone down as the numbers in the workforce has gone up.

There are two results from this. First the number of un- and underinsured has increased, and more people had been forced into the absolute gong show that it is the individual health insurance market. And despite what your consultants may tell you, they are not happy.

Second, the number of un and underinsured has not increased dramatically more only because of expansions in Medicaid and now re-famous S-CHIP programs.

There are two consequences from this general trend.

First the number of middle income Americans who experience some discontinuity of health insurance coverage has gone up dramatically. When the CEO of Safeway can't get insurance for his son, you know this has reached up well into the middle class. That has obvious political implications.

But it also has *less* obvious political implications. That's because the major protection that health insurers, the healthcare system, drug companies and the rest of corporate America have been afforded by the last 30-odd years of *laissez-faire* government, have largely been the result of a strange coalition between upper income business interests and the lower-middle-class religiously motivated voters who are the core of the Republican vote.

If, as one drug company CEO mentioned to me, your best bet is to hope the Republicans keep the White House in perpetuity -- even ignoring the morass the present occupants of the White House have created in Iraq -- the demographics of the issue do not favor Republicans. That's because the baby boomers are

getting older, while their employment and their health insurance are getting less secure. So those core Republican voters who are middle-income white males in the South are now *becoming* those people in their 50s who are more and more concerned about their health.

Pollsters will tell you that most Americans think the Democrats are a better bet on healthcare than Republicans. In fact, many liberals are now quoting recent polling data which suggests the overall philosophy of the nation is now as liberal as it was during the Johnson administration. If this is true, at some point in the next decade you're likely to be facing a government which will not automatically espouse free-market solutions -- especially to a problem that the free market has yet to show it can cure.

The second consequence of this trend is that regardless of the political party in charge, more people and a greater share of the healthcare system are coming under the government's budget, and therefore being paid for by the taxpayer—or more accurately by the taxpayer and the Chinese central bank.

Roger Orzsag, the Congressional Budget Office director, has been walking around Washington, telling the story that on its current course the increased costs of Medicare and Medicaid are likely to take up essentially all discretionary spending (and much more) in the government budget within the foreseeable future.

As I just told you, health insurance companies have not seen significant growth in the employer market and instead have been looking to government programs, especially Medicaid and Medicare to increase their top & bottom lines. And we know how controversial that is. Well, if you believe the CBO, it is a reasonable assumption that at some point that spigot will have to be turned off. At some point society as a whole will become really concerned about the amount it's spending on health care--and with the baby boomers filling Medicare it may well be relatively soon. Perhaps coinciding with the next recession – when health care costs tend to grown much faster than the economy

But looking around the world no free-market solution has ever really reduced the cost of health care.

But government funded systems have. In both Japan and Canada in the 1990s the *absolute* dollars spent on health care went down. So it can be done—even it's not likely to be very pleasant. But even the American government can make cuts if it has to, as it did with defense spending in the early 1990s. If we get to that stage, more politicians may echo the cry of “what use are those insurance companies taking their 30% cut.” And it's not hard to see the electorate agreeing with them.

Okay. I'll agree that this is a bleak scenario. It is quite possible that instead we could muddle through and health insurers could keep doing what they've been doing. But on the other hand the demographics of the baby boom, and the relentless rise in the cost of health care are unlikely to change. And if health insurers can't prove their value to employers, the government and consumers, why should they be kept around? The industry as it now behaves is unsustainable. And as Herb Stein once said, if something is unsustainable, in the long run, it will end.

So now to my second point—the change in technology and society. This I am going to make very briefly. As the baby boom has aged, American households have got richer, better educated -- Mrs Robinson would have to get around twice the number of graduates if they remade the movie now-- and far more savvy about using information technology. There is generally a new type of consumer, and this of course is best illustrated by the incredible growth of the Internet, and more recently the use of online social networking -- -- that's all your kids on MySpace and Facebook

This consumer is already seeking healthcare information online voraciously, and is now expecting the same type of immediate self-service and gratification from the healthcare business that it gets from many others online. And frankly, many of you to this point have done a pretty lousy job in that regard.

The good news is that because healthcare is only an occasional problem for the majority of the younger baby boomers, and those below them, and because the decision maker on healthcare has been the employer, the government, and the provider -- not the end consumer -- health care organizations have got away with this so far. But the demographic trends are marching in this direction, and just as they are having increasing concerns about the security of their health coverage, those baby boomers are bringing their increased expectations to the healthcare system.

And then there's more, and this news gets worse. The combination of more drug and high-tech treatments, and increased diseases like diabetes & asthma particularly amongst the still significant numbers of lower income Americans means that both you're going to have to do more with less and answer to have higher expectations from those you're serving.

And to be clear, there's no real reason it has to be a health insurance company doing that "serving".

More than a decade ago my IFTF colleagues made this chart describing the five core functions of a health insurance plan. I won't go through all the functions, but you can see that many other kinds of organization can put together those

services. For example two weeks ago Microsoft announced that it was creating “HealthVault” in which consumers can store all their health information. You can be absolutely sure that Google and a host of others are right behind them, and I don't have to tell you how many more people go to their websites to run their daily lives, than go to yours. Not to mention the half trillion dollars in market cap that these non-healthcare companies bring to the table.

Later this morning you will have some examples of non-health insurers providing services which fit well into my five functions. And of course at some point the question is, why do you need a health insurance company to provide those services at all?

My third point is a call to action. There are significant problems with the healthcare system that I don't think the government or consumers by themselves can fix. In most things, you pay more, you get better quality!

The chart from Jack Wennberg's group at Dartmouth shows the regional variations in cost caused by the huge variations in clinical practice. And people outside the health wonkery realm are beginning to pick this up -- it's no accident that this subject has appeared in the New York Times several times this year and is the subject of Shannon Brownlee's new book *Overtreated*.

We also know that the treatment of Americans with chronic conditions is almost unbelievably inconsistent and that that poor care is responsible for a huge chunk of healthcare costs.

Sorting out this mess is your job.

That includes--the use of information technology and data to detect this waste, the development of new incentive systems for providers, and the creation from scratch of advisory and motivational systems for consumers

These are all needed to improve the care being delivered and the outcomes being produced.

To my mind, that is the **only** feasible long term role for health intermediaries.

No question, it is much easier to play pricing games, to avoid insuring sick people, and to stick the big increases to your customers. But if you can't do that any more, then you have to prove to your own customers – and society as a whole -- that your role as intermediary between consumers and providers is doing three things:

- a) saving money by reducing inappropriate care,
- b) improving healthcare process by promoting appropriate care, and

c) (eventually) improving overall health outcomes by helping to figure out what motivates people to improve their health decision making.

And I fully expect you to be scored on your performance in doing all three of these tasks

I wish you luck in pursuing our future, I hope to be back here in 10 or 15 years time to hear how your organizations rose to that challenge. Because if you fail, we may all be doing very different things in 15 years time.