TCNtalks Transcript: Redesigning Healthcare: A Path to Value-Based Care

Melody King: 0:01
Welcome to TCNtalks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host, Chris Comeaux.

Chris Comeaux: 0:23
I'm excited. Rita Numerof is with us today. She is the co-founder and president of Numerof and Associates. Welcome, Rita. Good to have you.

Rita Numerof: 0:31
Good to be here, Chris.

Chris Comeaux: 0:33
I'm going to read from your bio, Rita. Rita is an internationally recognized consultant. She's an author with over 30 years of experience in the field of strategy, development, and execution, business model design, and market analysis. Her work across the entire healthcare spectrum gives her a unique perspective on the challenges of pharmaceutical and medical device manufacturers, healthcare delivery institutions, payers, physicians, suppliers, in other words, the whole value chain. Dr. Numerof has served as an advisor to Congress on issues related to health care reform. She wrote the Heritage Foundation's policy paper, Why Accountability Care Organizations Won't Deliver Better Health Care and Market Innovation Will. She's the author of six books, including Bringing Value to Health Care, Practical Steps for Getting to a Market-Based Model. One of my favorite ones is the Bringing Value to Health Care. I have it here. The book outlines a market-based model in health care focused on transparency and cost, quality, and payment connected to outcomes that matter. These themes are reflected in her bi-weekly column. If you've not seen Thank you. across global healthcare ecosystem from pharmaceutical, medical device manufacturers, the healthcare institutions, payers, physicians, and suppliers. So, Rita, it is an honor to have you on our show. Is there anything I left off that would be important?

Rita Numerof: 2:05
Oh, I think that was more than enough, Chris. Thank you so much for the gracious intro. I appreciate that.

Chris Comeaux: 2:11

I've really been looking forward to this show. You know, we're living at such interesting times. I remember I first got to meet you as at a, what was at the time, National Hospice Workgroup meeting many moons ago, probably 2010, may have been 2008. It's been a while. And now I think where we are in healthcare, very interesting times, changes afoot in so many segments of our economy, but and it seems though, at the same time, healthcare maybe is at an inflection point. I think of like the assassination of the CEO of UnitedHealthcare at the end of last year, just tragedy. But yet half our country cheered. And the United States has always been looked to as kind of a setter of moral standards throughout most of history. So, for me, it seems like that's a wake-up call for us in healthcare. We rank very low internationally in healthcare outcomes, yet we spend more than any other country. So, you've written extensive and how to redesign healthcare based upon value, common sense, and just good market principles. So, I basically have two questions for you. How do we get so screwed up? Why is it screwed up? And really the ultimate question is how do we fix this?

Rita Numerof: 3:22

That's a great set of questions, and we'll begin to, I think, understand it and put various pieces of the puzzle together today, Chris, and there is so much more behind it, but hopefully we'll be able to paint a picture so that listeners will be able to really get a handle on how did we get here, what's wrong, and what's the path forward to be able to fix it, because I think just criticizing where we are and why we got here isn't going to to help anybody. But if we don't understand what the journey has been that we've been on, where we got sidetracked and how we need to get back on a main road, we're not going to be able to get to a different future. And we all desperately need that. I think the easiest way to answer your two questions is that we have a fundamentally broken business model. What we pay for, how we pay for it, drives what we get. And so we are getting exactly what we're paying for and how we're paying for it. So, nobody should be surprised that it's broken. The good news is that more people are recognizing that we're not getting value commensurate with what we pay. The bad news is this has been going on for a long time. At least 40 years, the Centers for Medicare and Medicaid Services have been trying to bend the proverbial cost curve. And I will say that there are a lot of industry players, industry stalwarts, names that would be familiar to most of your listeners. are committed to maintaining the status quo. Even though behind closed doors, they will say it's not working, it's broken. But what they do, very interestingly, is they point the proverbial fingers at some other part of the segment. And you mentioned my last book, Bringing Value to Healthcare. My co-author and I took on every segment of the healthcare industry. And wrote about how they got to where they are, what was wrong with where they were, and what needed to be changed. I've been interviewed a lot. People have asked. That book is several years old. What, if anything, would you do differently? What

would you say differently? And I'm here to tell you that the predictions that we made back then, the guidance that we put in still holds. And I want to talk through a little bit, Chris, why that is. One of the problems is that the magnitude of the problem has gotten increasingly worse. You've got horrific burnout among clinicians. Burnout is also associated with issues of morale and safety. So our healthcare delivery organizations are in some respects less safe than they were even 30, 40 years ago, not because clinicians want them to be less safe, but because of a way in which the cultures have evolved and the bureaucracy has been imposed and the way in which reimbursement has occurred, these forces have conspired, if you will, to create the conditions in which care is increasingly unsafe. I will tell you that probably about 20 years ago, one of our healthcare delivery clients, a very well-known major internationally recognized academic medical center, was a place where we were doing quite a bit of work. And one of the senior officers, essentially the equivalent of a chief operating officer, who had a PhD, clinician by training, said to me in conversation that if I ever needed healthcare services, this is about 20 years ago, to make sure that I had an able-bodied, smart advocate with me at all times who would be able to ask questions and navigate the system. 20 years later, things are worse. So, guidance, make sure if you're going to be in a system that you have somebody with you that is in a position to be able to help you navigate and understand what's going on. So, there are more R's. Our patients, consumers are certainly not happy with the experience they're getting. And the staff are also concerned about violence that they're experiencing. This used to be such a one-off kind of thing. But you read about this in some local paper almost every day, that there has been violence. So you add to that the issue of safety. creating more protection adds to the cost of delivering services, but it's not really delivering services. So, all of this, I think, needs to be seen as symptomatic of things clearly not working. And so, from a historical perspective, I mentioned before that we've been trying to bend the proverbial cost curve for over 40 years. So the Centers for Medicare and Medicaid Services, which pays for probably a little bit more than half of the coverage that Americans get through some non-employer based insurance has been trying to change this dynamic again for decades they introduced DRGs diagnostic related groups which i know you're quite familiar with as a way to reduce costs and move money away from the payment system that had been in place before. The payment system, without getting too technical, was known as usual and customary rates. It's a fancy way of saying that whatever your peer group charges for XYZ services in a given geography, as long as you're within that range, we will reimburse you when you submit the bill. It was kind of a retrospective payment. Services were delivered as long as it was within range. UCR ensured that you would get paid. And so, you separated out typically cost and quality. And we had clients at the time in the early 90s saying, we can't do cost and quality. Pick one. we can't do both. And so obviously, you know me, and that was obviously a point of challenge and discussion. When DRGs were introduced, it sent shockwaves through the industry. And at the time, I had just gotten my doctorate and

came to St. Louis from Philadelphia. I'm sure everybody has picked up the fact that I'm an X-E's coaster given my speech pattern. And I was on faculty teaching graduate studies students' health policy, and I had a contract to also write my first book. The one that you referenced, just FYI, is book number six, and we're playing around with the idea of doing book number seven. So public announcement today. At the time I was teaching, I predicted that DRGs were going to lead to poor outcomes, poor coordination, and higher costs, the exact opposite. of what CMS and conventional wisdom was basically saying. So most people thought that I had flown in from another planet at the time. And it was something that I had trouble getting my arms around because from where I sat, the alternative model that I was proposing was pretty straightforward and made common sense. It was a model that focused on transparency and cost and quality. It focused on accountability for care outcomes across the continuum. So not thinking in terms of episodic individual things that people would do to and for patients but rather look at it across the continuum and that we would connect payment to outcomes that really mattered. Oh, and by the way, they would be available, outcomes and costs would be available for people to comparison shop, much like we do in every other part of the economy. And so DRGs did none of this. At the same time, another historical point that I think is relevant to where we are today is that people were beginning to recognize that we had a sickness model in this country, not a health model. and wellness model, it was a sickness model, that people who were providing care and services were paid on a fee-for-service basis. So, every time you did something to someone, you got paid. And this practice drove up utilization and cost. So even though there was now a prospective payment system in place to replace the retrospective system, we still were driving up utilization. And at the same time, health maintenance organizations came into the picture. If we have a sickness model, then an alternative might be a health model. And if people could be reimbursed for keeping people well, wouldn't that be a good alternative? Well, logic says absolutely, that would be a good alternative. Except that with the HMO model, we had the same problem that we had with DRGs and fee for service. There was zero transparency in cost and quality. There was no connection between payment and outcomes. And in the HMO model, because of the way the payment was structured, as a provider, if you did less for your patients, you made more money. And so that's why I feel so strongly that unless and until we look at the underlying payment model, we are not going to be able to get out of the situation that we're in now.

Chris Comeaux: 13:29

Wow. There's so many pearls in what you just said. Several quotes that are just maybe a way to just put a pin. I just came across, I'm always kind of a history buff, Rita. I knew Eisenhower, he said, be aware of the military industrial complex of people who will make war because war is profitable. But he also warned us against the healthcare industrial complex, the people who will be glad to have you sick because they make money the

sicker you are because it's a very perverse system. And then also there's another quote I actually used frequently is that every system is perfectly designed wink wink it's kind of a smart-ass way of saying perfectly designed to produce a result it produces exactly

Rita Numerof: 14:13
We're on the same page Chris.

Chris Comeaux: 14:21
Yeah so how do we fix it?

Rita Numerof: 14:26
So not by going back to the government to do more i think that they have brought us um to the situation that we're in now and we need more people to understand what the underlying issues are that you and I have been talking about. I think that armed with information, Chris, people can begin to take action on their own behalf. I think that having broad-based consumer information patient businesspeople across all walks of life and all industries across this nation being increasingly aware and sharing with a common voice that what we have isn't working and there is an alternative and it's going to be less expensive, more responsive, and it is there for us to take advantage of if we demand it. the power of the government shouldn't be understated. I think they do have a role to play in this. Don't forget, they pay for about 50% of the care that's delivered in this country. And what they've done is to try to bend the cost curve by continually squeezing and putting pressure and reducing reimbursement and creating complexities and more bureaucracy. We've done studies in different organizations, and we've come up with numbers that are somewhere between 30 and 40% of the time that is spent by clinicians and other administrators we can look at separately. is devoted to administrivia, not care delivery, but administrivia. And the more that individual physicians and nurses and other clinicians are fed up in their individual practices, you see them running for the so-called safety of care. employment or they're getting out of the business altogether and retiring. So, at the very point where we're seeing an aging population, often because the miracles of modern medicine, which is a good thing, we're also experiencing fewer responsive delivery systems and fewer responsive clinicians, which is very concerning because those numbers are going in the wrong directions. The last Trump administration put in place several measures to force, and I'm using the word force by design, to force transparency in cost and quality. And essentially, the idea was that we would take the top 300 shoppable procedures. So, we're not talking here about somebody gets hit in a you know, crossing the road or it gets run over going north on 95, we're talking about a shoppable service and that these procedures would be posted by insurer in a standard format that would be easily accessible by everyone all over the country as a starting point. They did not take on the issue of quality, which is the other half of this equation I feel really

strongly about. And the assumption was that we would have a bevy of code writers who would see this as an entrepreneurial opportunity to get code written so that hospitals would be able to post these 300 shoppable services and begin to put in place applications. the systems and data that would be user-friendly, consumer-friendly, again, standardized format, kind of like what we have with cars, what we have with refrigerators. This is not rocket science. And so, what's been interesting is that the hospitals led by the AHA, the American Hospital Association, fought this effort all the way to the Supreme Court, and they lost. The Supreme Court ruled in favor of of the administration.

Chris Comeaux: 18:42
And what case was this, Rita? Because I'm like scratching my head. Do you remember the name of the case?

Rita Numerof: 18:38
You can look it up. I don't remember the exact name, but it was Trump versus the AHA. And if you're having trouble looking for it, I can get you that information as a follow-up to today's call. And so what is striking to me is this went all the way up to the Supreme Court. They lost. The American Hospital Association lost. And basically, the industry said, that's nice, but we're going to continue business as usual. Thumb its nose at the Supreme Court. And they continued to be not transparent in cost. We're not even talking about quality here. We're talking about cost. Right. And the fines that were imposed were tepid. So, they didn't have a whole lot of clout behind them just in terms of the magnitude of the money. And what's more problematic is the extent to which the last administration held these institutions accountable, even for the paltry sums that were assigned for each infraction of the rule, basically didn't happen. So, you had non-enforcement of a rule that was put in place that was supported by the Supreme Court. And so, the simple requirement about basic transparency and cost was something that the industry would not It wasn't that they couldn't, they would not embrace. And so, what we need, I think, is clearly a market-based model that would allow transparency, would force transparency in cost and quality, accountability for outcomes across the continuum, with payment that would be specifically tied to outcomes that matter to us as consumers.

Dragonfly Health / Ad: 20:46
Thank you to our Anatomy of Leadership sponsor, Dragonfly Health. Dragonfly Health is also the title sponsor for leadership immersion courses. Dragonfly Health is a leading care at home data, technology, and service platform. With a 20-year history, Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single efficient solution for caregivers, patients,

and their families. The company serves millions of patients annually across all 50 states. Thank you, Dragonfly Health, for all the great work that you do.

Rita Numerof: 21:34
And it would enable competition. One example of how that competition would be enabled is by posting services. You would think, Chris, that any business would want to talk about its outcomes and let the near world know about how good the quality and relative cost was. I'm not talking here about getting to the lowest cost, but it's an issue of how we... make decisions about value for myself. And so, I think the government does have a role to play in establishing expectations for transparency, for proof of outcomes, but that's only going to come if Joe and Sally Consumer really advocate for this alternative. But for the most part, as I mentioned before, bureaucracy has just added enormous burden, non-value add and has really destroyed innovation and access. Related to this, we need to be thinking about site-neutral payments, another thing that the administration has put in place that the industry has fought. And why? Because it is looking for every nickel... and dying can possibly get. And that gets back to the problem of reimbursement being squeezed so low. So those are some of the things that I think are going to be really important.

Chris Comeaux: 23:00
On that site, neutral reimbursement. So, I'm going to take a shot at it. You correct me if I'm wrong. Like, for instance, you could take, if I'm under a healthcare system, I could get a much higher reimbursement compared to, like, say, an imaging center that's under a healthcare system versus an independent imaging center that's out in the community. Same service. It just happens that one gets because it's part of this site. Is that it? Or would you say it differently? I

Rita Numerof: 23:25
Yeah I think that's a really good description. So, imagine I'm going to the to the Comeaux Clinic. And, you know, last week you were acquired by ABC Healthcare System. And so, I know what the fees have been. I know what my co-pay has been. I've been seeing you for years. Same clinic, same staff, same everything. You all know me by name. You know exactly what I'm going to come in for. And then all of a sudden... my copay is 20% higher than it was last week. And I asked you, why is that, Chris?

Chris Comeaux: 24:06
What's changed?

Rita Numerof: 24:10

I said, well, we're no longer an independent standalone facility. We're now part of ABC Healthcare System. And they are now able, in quotes, to charge a facility fee, which, of course, they do. You haven't moved. Your location isn't different from what it was before. All you've done is sell your practice to the system, and they now make more money. And part of the driver for buying up practices around the country is to be able to do just this.

Chris Comeaux: 24:40

I want to go back to several things you said, and I think all of this is kind of shaping where do we go. statistic I bumped into, and I can't remember. It was in a call. I get to do this, but I actually have a day job where I'm actually working in health care every day. And I think the statistic was before 2020, the mix was 90% was paid either through government funded commercial insurance, employer provided health care, 10% by individuals. But now today, that's something like 65-35. Does that square with the data that you have? That kind of blew me away. And I think it's through high deductible plans, HSAs, FSAs, that that much is coming out of people's pockets for health care, which I think is a trend in the direction of what you're poking on. Because historically, as Americans, like when I was the CEO of Four Seasons, we launched the company to retrofit people's homes to stay in the homes. Brilliant idea, too early, because people were not prepared to make those investments themselves. People paying directly for things related to their health and health care and well-being, I think it was early. And this was probably, I don't know, 2008, maybe 2009. But now it feels like it's headed more in that direction. So, do you want to respond?

Rita Numerof: 25:56

Sure. There are a number of things there that I think we can unpack. One is the issue of care in the home. I am a proponent of of being able to have people receive services at the place where they are, wherever that might be, bringing services to them. So, the notion of being able to use technology, which wasn't here 20 years ago, but being able to use technology to make it more convenient to people to be able to stay in their home is a good thing. We should all want that. And if we had a very different payment system, then there'd be a willingness on the part of healthcare systems, as an example, to invest in this new technology, to make it available because that would add to their competitive position. They're more convenient. They get the same outcomes. You don't have to stand in line. You don't have to go through a bureaucratic labyrinth of confusing hallways that's not set up to be patient. consumer friendly, and so forth. So, the idea of using technology to bring care and services closer to where people are makes a ton of sense. That's one separate domain, okay? New companies that are trying to bring real innovation, Chris, in a wide range of therapeutic areas are having a lot of difficulty bringing their products to market because healthcare systems that might be the adopters of this don't want to spend the additional money. And they have a vested interest, as we said before, to keep

their beds filled and their offices filled to bring people back into the edifices that have been built. over years. And by the way, these organizations don't pay taxes. They are considered nonprofit for the general good and welfare going back to laws that were put in place years and years and years ago. So the other piece that you were talking about had to do with not just the payment for these things and the use of the technology, But where it gets used again, the notion of site-neutral payment would allow new technology, which would improve efficiency, to get the healthcare institutions to actually make more money because they could deliver the same services in a much lower cost structure. But because we don't have that in the system today, you've got these headwinds against real innovation. And this can all be fixed. This is not rocket science.

Chris Comeaux: 28:54
But do you also think that the customers, the users of healthcare at the place where we're okay more and more paying for it? Because isn't part of the problem, it's not really free market when the customer itself is not directly paying. Like I'm paying through a third-party payer for a service, I'm removed from it. And that seems like that's been part of the problem. It's a major part of the problem.

Rita Numerof: 29:18
I want everything that's available if it's free. If I'm not paying for it. And this goes back, interestingly, to government intervention. It goes back to World War II. And what happened back then was that the government did not want employers to increase people's salaries during the war. They wanted to keep them flat. And as a benefit, quote-unquote... employers began to offer healthcare. And at the time, life expectancy wasn't nearly what it is today. And so, it wasn't either expensive and it was for not first dollar coverage back then, but for more catastrophic stuff. I remember as a kid going to a pediatrician's office and all of that was out of pocket. That was not covered by insurance. And so, one of the things that the government has tried to do, again, to bend the cost curve is to say, consumer, you need to have skin in the game and we're going to move to high deductible health plans if you were an employer, for example. And the government has done that as well with various kinds of co-pays, which have gone up and up and up. And if you think about this in contrast to other industries, typically you get more and more technology at less and less cost. Moore's law. In healthcare, it doesn't work like that. And part of it is the misalignment of incentives and how we pay for things.

Chris Comeaux: 30:56
What about the uninsured problem? So, we had T.R. Reid on our podcast. He went and researched healthcare systems all over the world and this debate about, but healthcare is a fundamental right. So, if you end up with a large part of the population that's just uninsured, how do you fix that issue? Are you saying, hey, free market will fix it, just like

we don't guarantee everybody has a TV or a cell phone, but yet people figure out how to make that work within whatever budget they have?

Rita Numerof: 31:25
Yeah. I think it's problematic when we look to other countries for solutions here. We are a very unique and diverse country for all the good and some would say for all the ill. And so, the system that we have today really is not a market-based system. If we really had a market-based, it's a government overlay system. with lots of problems associated with it. So, to call it a market-based system today is absolutely a misnomer. My guidance is we need to build a market-based system that is centered on the patient consumer. Looking at other models in other countries, it is difficult and extrapolating from those because they have different social systems. They've got different social programs. There are different requirements. for access. Years ago, when we were doing this work, looking at, at the time, the UK as an alternative model, people were arguing we should just adopt what the United Kingdom has done and create that. That will not work in the US. Yeah, I argued against that. And one of the examples that really stuck in my mind is one of our colleagues from the UK said, talked about really needing a knee replacement. And he had lots of money and position of power. And he basically was given a cane and Tylenol and put in a waiting list that would take somewhere between two and two and a half years before he would get that. So, we have become accustomed in this country to getting what we want when we want it and somebody else to your point before has typically paid. And so we as a society need to have a conversation and I'd love to be part of it. about what is a baseline legitimate right, if you will, for everybody. I have a personal view that a good society is in part marked by how well it takes care of the people that can't take care of themselves.

Chris Comeaux: 33:48
Amen. You know, actually, there's historical backup for that. I'm a bit of a history geek and Tolstoy researched every civilization in mankind. That was the number one indicator whether that civilization survived.

Rita Numerof: 34:01
So, I'm glad I'm on the right side of history on that one, Chris, and that we're on the same page. And I feel very strongly about it. And I think it's also rooted in religious values and practices and so forth. But then what does that mean? You know, I... need transportation. So, do I have a bicycle? Do I walk? Do I go by public transportation? Can I afford a car? What kind of a car am I going to buy? And so, there are different kinds of things. And we can get into other aspects of our economy in terms of access to internet and a variety of other things that are really critical from a security standpoint. And I think the pandemic, which should have been a wake-up call to the healthcare industry in terms of we need a

different model here, boys and girls. And I was hopeful that they would move more to a population-based accountable for care across a continuum model. But the government bailed them out and gave them funding so that they could continue to do what they were doing before. And so... We are looking now at closures in rural hospitals all across America, which is very concerning. And I'm not saying we need to have a tertiary care facility in every rural community around the country. That would not make any sense from a cost standpoint, but it wouldn't make any sense from a clinical quality standpoint either. If you're not using these services and providing and doing these procedures in a regular way, you're not going to have the same kind of quality outcomes that you would if you're doing it all the time, every day. So, you could use technology to enable care to be delivered remotely. You can have certain kinds of clinical settings within these communities for patients' immersion care. I'm a farmer. I ran into a problem with my tractor and my finger needs to be put back in place. And the list goes on and on and on. And you have to have those kinds of services available where people are. And so, there are lots of different ways to meeting the needs we have. We just need a different model, a conceptual framework. And most people have trouble conceptualizing it.

Chris Comeaux: 36:41

Let me pick on the insurance companies for a little bit. I think I had shared this with you in some of the pre-notes. Medicare has about 3% of administrative costs. I've not forgotten your quote earlier about how much time they spend in things that are non-value added. But from an administration of the program, Medicare is 3%. The commercial insurance companies are 20%. So that's one reason why we spend so much is it gets sucked into... what was on that bullet, deny, depose, defend. And so how do you respond to that? Like my personal feeling is what value do they add to the system today? If you look at like PBMs or other aspects that, do they really add any value? So, you're just creating more complexity and things are a sucking value, making it one of my first nurse mentors, Rita, she was a nurse in the finance department, and I couldn't understand why they put a nurse in the finance department. And she told me this story. She goes, yeah, finance and clinical don't communicate. So, we came up with a great solution. We put a nurse in the finance department. I'm sitting there going, What the heck? And she goes, you see, Chris, that's an ambulance and a curve. And she told me this parable about this horrible curve. The town couldn't fix the curve, so they came up with a great solution. They put an ambulance and a curve. So, to this day, we use that parable that that's healthcare. We don't ever fix the issue. We just kind of throw an ambulance and a curve. So, it feels like insurance companies, the whole prior authorization, all those processes just create friction that aren't really solving the problem.

Rita Numerof: 38:10

Well, I think there's a lot of truth in what you're saying. And when I talk about changing the business model in healthcare, it's not just for healthcare delivery. It's changing the entire ecosystem and all of the segments that feed into the problems. We as consumers need to take more accountability for our health. We are also responsible for the outcomes that we get or don't get. And so, we need to stop pointing fingers at all the different segments and say, I'm doing fine. Thank you very much. If you would change, we'd have a much better system. It really has to be comprehensive, integrated redefinition of who's doing what and changing the underlying payment. We have enough money to provide the level of care we need to for people in this country. We're just going about it. It's just misallocated. And so, I think your point about the value add and the problem of insurance companies, you're not alone in this. And the example of Brian Thompson's horrific killing is just an illustration of how crazy and how far things have come. And my concern even more is the applause that Mancini got on the back end of that. The insurers since 2010, and don't forget, they were the segment that actually got the vote over the finish line. to be able to pass the Affordable Care Act.

Chris Comeaux: 39:46
I did not know that.

Rita Numerof: 39:48
Yeah, it was really close. I was watching it very carefully, and I wasn't making any bets. It could go one way or the other. And there was an announcement that one of the major insurers in California had just upped their rates 39% or 43%, just some crazy number over the year before. The number actually turned out not to be correct. But it was enough to say, we need to pass this. Of course, we hadn't read the bill yet, but we need to pass this bill to be able to control, so to speak, the insurers. Because that was, at the time, the segment that everybody loved to hate. Well, you know, fast forward 15 years, they've moved into other lines of business to ensure their continued growth. They've got to be concerned about MLR. you know, medical loss ratios. And knowing that the insurance side wasn't going to continue to be profitable, the three mega insurers have each developed a slightly different business model to ensure their profitability and continued growth going forward. The FTC and Congress have finally said, you know what, maybe we should be looking at all this consolidation and hopefully all the consolidation that's transpired also on the healthcare delivery side, and take a look at the value in fact that they do bring. And as part of my view of a different model, this has to be part of what we scrutinize. How we use insurance has been perverted from how it's used in other sectors. You wouldn't fill your car with your car insurance You pay out of pocket for that. But every little thing that we do from a health care delivery standpoint, we somehow want to use our insurance as though we're not somehow paying for it on the back end with those copays and increased premiums and the list goes on. So they are under pressure. How this is going to

evolve under the current administration, I've got some ideas, but I think we need to see it unfold a little bit more. They have been incentive to scrutinize payments as an antidote, if you will, to the upcoding and up charging on the delivery side. And they have supported not the consumer member, but historically their customer has been the employer, the commercial employer. And so, they have acknowledged more recently the burden of prior authorization, which is a good thing. It took them too long, but it's a good thing. And some are introducing programs that will allow certain clinicians who pass certain thresholds would be able to bypass prior authorization. And here again, I think more consumer voice will help to drive and accelerate that.

Chris Comeaux: 42:53
Can I ask, so two things occurred to me really listening to you, and I think you were the first one to say that, and I'm like, oh my gosh, that just sticks in my brain. Thinking about health insurance like I think about automobile insurance. So, my automobile insurance is really for catastrophe situations. repositioning that. I think most Americans would get that. So that is a brilliant way of going, hey, if we look at it that way, it's more for catastrophic situations, which is interesting because my own personal family, we've moved more to a high deductible plan. So, in many respects, and then I'm putting my money in an HSA, which I get to deduct pre-tax, and I actually don't lose it from year to year. So, and it may have been a conversation through you, but this is the first year I'm kind of moving in that direction. And I go, you know, that makes a whole lot of sense to me philosophically. I'm taking care of myself. My family's taking care of ourselves. That's much better kind of alignment kind of across the thing. So that's just one thing that occurs to me listening to you. I think, I might be wrong, but I've seen some early data. I wonder if we're not going to find ourselves in that exact situation during 2010. A lot of the early renewals, because healthcare costs are going to the roof again, we're going to get all those renewals later this year. Is that going to be an interesting opening again to go, we got to do something about this? Do you get a sense of the same thing, or am I overreading some of the data?

Rita Numerof: 44:15
Yeah. I think there's going to be more pressure to do something about it. We're doing some work in our firm to get coalitions together, very selectively, very focused, individual leaders to test out some ideas that would support a fundamentally different business model. I think it would be hugely problematic to go about making changes legislatively and otherwise that are more band-aids and that we continue to play whack-a-mole. We've got to have holistic, systemic solutions. And I think using the broad dissatisfaction with the status quo and creating real problems teeth and clarity about an alternative model that really does reflect the market-based principles that you and I are talking about is the solution. And if we don't get there soon, I'm concerned things will get even worse.

Chris Comeaux: 45:19
I wonder too, it wasn't lost upon me, I forgot how you put it earlier, but we've always created constipation of innovation in healthcare. One small example is like the, you know, the innovation of really having x-rays in physician offices is, it has been low-cost technology for a long time, but yet, you know, hospitals fight it because of all the capital costs they've put into their own infrastructure. So, you give multiple examples where we have literally created constipation of innovation, but I wonder... AI is moving at such a breakneck pace. And at some point, innovation, we can look throughout history, always seems to create like this inflection point. So, I wonder if that's also another thing that's coming to a head that's going to, we got to do it. And you can't fight the innovation anymore. So, I don't know if you have a comment about that.

Rita Numerof: 46:05
So, I think that fighting innovation, if I don't get a fee-for-service payment, is kind of built into the DNA right now of a lot of executives in healthcare delivery. And many of them are hanging on for dear life in terms of the margins that they're not making. It is a very difficult business. There are so many things that need to be addressed. And at the same time, we as a nation need to have a reliable healthcare system. The issue of technology is an interesting one. In most organizations, Chris, companies across industries, leading companies have invested in technology to improve efficiency and effectiveness, right? I want to be able to lower my overhead costs, get the product out the door in a more reliable, efficient way. Sometimes that's meant loss of individual jobs. Sometimes it's meant repurposing. Sometimes it's supported, you know, greater growth. The use of technology other than medical technology to do x-rays or to perform surgical procedures and diagnostic procedures, the list goes on. But the use of technology and AI to improve core processes across the board and create new standards has not been employed in most healthcare delivery organizations. This is fascinating to me. So, if they haven't done that, what have they used technology for? Well, when tech was introduced at an organizational level, it's interesting you mentioned finance before in healthcare. It was introduced in the electronic health record, not to improve the patient experience, not to improve outcomes, not to improve the workflow of clinicians. It was designed to improve payment. Exactly, exactly. And so, if we are focused on maximizing payment in the current model and we have all this investment in the status quo, I am concerned that like the innovation you tried to bring to market years ago, that the use of that will be stymied. because the fundamental model hasn't been changed. And until we address that, I think we're still going to fight innovation.

Chris Comeaux: 48:48
This is incredible. You and I could keep going back and forth, but I want to give you an opportunity to kind of land the plane. via Amazon. And then if he needs his prescription,

just like our typical interaction with Amazon, it paints a beautiful picture. And so I'm curious what your thoughts are about that. And that might be an interesting segue to let you land the plane on like, how do we fix this? Like the more you talk, I'm thinking, God, this feels like Mission Impossible.

Rita Numerof: 49:37
So, I am very optimistic. I am not giving up on this. It is a daunting challenge. And I think that we have more opportunity, Chris, to address these underlying problems than we ever have in the last 40 years, because more and more body politic have come to the conclusion that this isn't working. And there are alternatives. I think the one medical example of what you should and could expect from a healthcare system is a great example of what's possible. And I think there are more and more of those out there. We need the legislation, the payment models to catch up with where technology and innovation are.

Chris Comeaux: 50:22
So, if Rita was queen for a day and they came to you and said, Rita, just basically write the slate that would fix it all, what would you do?

Rita Numerof: 50:30
Do we have time for another show, Chris?

Chris Comeaux: 50:33
We could actually totally do one. I'd love to do a part two. You want to leave a teaser?

Rita Numerof: 50:38
All right. We can do that. What I would say is I would love everybody to read my Forbes articles. Comment on them. You don't have to like them. You don't have to agree. But let's have conversation. Forward them on. Send them on. You showed my last book, Bringing Value to Healthcare Practical Steps for Getting to a Market-Based Model. The elements of what we need to do differently there, Chris, are outlined there. We have a solution, we're working on a blueprint, and we're getting key people in coalitions to begin to understand it in the same way and to stop piecemeal solutions.

Chris Comeaux: 51:19
All right. Well, what we're going to do, we're going to include a link to those Forbes in the actual show notes so folks can actually go to it. I've actually signed up after you and I reconnected. And so, we're going to connect with your team and we're going to get you

booked for a part two, maybe shoot for a summertime earring somewhere along those lines. How's that sound?

Rita Numerof: 52:19
Sounds good. It was a pleasure, Chris.

Chris Comeaux: 52:21
It's always a pleasure to be around you. You make me think, you push my thinking, and I always learn something new. So, I so appreciate you. So, to our listeners at the end of each episode we share a quote - a visual, possibly might create a Brain Bookmark a thought prodder about our podcast subject to further your learning and growth, what we are going for is like a brain tattoo, Thank you so much. And maybe even more importantly, this podcast, what we are going for is like a brain tattoo. Anatomy of Leadership. You know, it's easy to rail against the world, be frustrated by things. Let's be the change we wish to see in the world. And gosh, healthcare is a critical part of our lives and also where we spend a whole bunch of our economy goes towards healthcare. So, thanks for listening to Anatomy of Leadership. And here's our Brain Bookmark to close today's

Jeff Haffner / Brain Bookmark: 52:36
“Unless and until... We look at the underlying payment model. We are not going to be able to get out of the situation we are in.” By Rita Numerof