



The End Game
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One day, soon, we'll no longer have health insurance.

Most of us think of health insurance as a fixture, above the line in everybody's budget. And since the 1930's, it's always been there, even weathering the nihilism of managed care. That's over seventy five years; and over fifty years since employers jumped in to help pay for it. In fact, most of us can't remember a time without health insurance. So, as the consumers of health care we assume the reforms now being floated in Washington are focused on our needs: better and more affordable coverage, plenty of drugs, all the new stuff, cheaper, open to all providers, no paperwork, no hassles.

As jaded consumers, of course, we aren't naive enough to think we'll ever get all of that, or even most of it. We listen warily to insinuating words about health care from the Congress and the White House. At the same time, our doctors are depressed; hospitals howl about losses, Medicaid coverage shrivels, everyone's coverage shrivels, hang-nails are pre-existing conditions, drug costs are way beyond sticker shock, and the number of uninsured mounts. To add insult, our employers earnestly tell us that they have had it, and are fixated on getting more value for the abundant sums they pay for our insurance coverage.

We should be comforted by our politicians' reassurances that there is no crisis in health care. But we're not; we're only comforted because we know they're lying to us. So, vigilantly, good citizens, we take the job on ourselves: we study our health and its causes; we shop intensely for good insurance policies, and ply our frowning children with veggies. Yet while we do all of this, we read headlines about soaring and unsustainable national deficits, made worse by the crisis in our health care system with runaway costs, dangerous prescription drugs, unaffordable insurance, and wrenching stories of care out of reach, or gone awry. Still, at the end of the day, in spite of political chicanery and neglect, we think we'll keep on having pretty comprehensive coverage, though we also recognize that it'll cost us a little more out-of-pocket.

We can't afford that system anymore.

Entropy

For years, neither the buyers nor sellers of health insurance cared as much about restraining the overall growth of our medical care system, as long as managed care appeared to be slowing the rate of increase. After all, buyers and sellers both prefer more choices. We consumers sure do, enough to fiercely and successfully resist the efforts to limit choices imposed by those bottom-line fanatics at managed care companies. And insurance companies prefer more rather than less to insure, except when they can't manage profitably at the margins of risk, which is what began to happen in the last ten years and even more evidently over the past few years. Employers, generally, worry about aggregate growth only to a point, but care a great deal about "their" costs.

They, however, count those costs against productivity, and increasingly as opportunity costs as well, and so they are finding health care an ever more dubious investment.

Today, the bullish growth of our health care system has everybody alarmed. Lately, we've seen a slight slowdown in cost escalation, but everyone knows that's a blip, more a function of insurance business cycles than an enduring adjustment. And, as yet, we haven't experienced any of the costs of the most expensive entitlement program in over forty years. The Medicare drug coverage program will pour another \$ 700-800 billion in new costs onto the pyre over just the next ten years. We seem to have run out of tools and gambits to slow its growth. As a result, our politicians, insurance carriers and employers are now pleading with us to help them save the system that they so have generously supported through decades of double-digit inflation. We're told that without our help soon we won't have enough money to keep it from crashing, causing the poor, lame and halt to spill out of our ER's, over-run our sidewalks, and camp-out in our parks. What they want us to do, after giving us back some of our money (not paid in wages), is to exercise discipline in buying the same health care services they couldn't stop themselves from buying. And so, licked by those conniving providers pushing care---and us, weak-kneed impressionable, consumers, lapping it up---they've grudgingly turned to us for help with Plan B. Frustrated, even deflated, in their attempts to curb growth and costs in medical care, they are telling us that they need our help doing what we do best---that no one else on earth can do as well---be the shoppers we were born to be, with skills we have honed since birth.

Plan B: Citizen or Investor?

Plan B arrives with fancy nomenclature: consumer-directed health (CDH), Health Security Accounts (HSA's), Medical Savings Accounts, personal health plans. Plan B promises to put us in the driver's seat of our own health, bristling with empowerment, enjoying greased access (getting all those rules and administrators out of the way), and hoping for that ultimate payoff---a well lit and easy path to better health.

There is also some distinct and formidable ideology underlying this Plan: the "ownership society" model. The key premise of this model is empowerment of citizens with ownership and assets---to get our "skin" in the game---and not inflexible entitlements that commit the Treasury to promises it can't keep. We get to be in charge and we get ownership---it's our money embedded in an instrument, an asset---to buy the health care we decide we need and want. In this system, we purchase the health care products we need and want from markets with our personal assets. Coverage in this world isn't an insurance policy to protect against the unexpected, but is rather what you choose to buy with your tax approved health care accounts. Health insurance is no longer a viable business---anymore than auto insurance would be if the policy forced you to pick in advance the accidents, damages and injuries you expect to have in the future.

The ownership model is diametric to an entitlement philosophy that frames insurance as a social good essential for community, welfare and productivity, and, in fact, the model upon which all of our education, welfare, health and social service systems have been based for over fifty years. Under the entitlement model, health insurance is a business model, but one that also serves social objectives, primarily widening access through the pooling effects of the group insurance model.

Under an ownership model, however, insurance is just a product and will only survive until better products come along.

And now they have, the argument goes, with consumer directed health.

Doing Nothing?

What if we do nothing? First, the chorus of complaints about the system will continue and become even shriller as frustrations mount. One of those major frustrations will be a further 25-30% decline over the next five years in the purchasing power of a private health insurance policy. Health insurance will then be administered as automobile insurance is: one one-time pass---good until you have a claim and then you can never afford it again.

Ironically, at the same time stories will abound about significant biomedical breakthroughs offering the prospect of vitality and health forever, a veritable medical renaissance. Yet, the potential to empower medicine through genomics depends on our ability to finance that potential through the steady growth of our health care sector. And this at a time when the health care sector is declining in productivity and narrowing in access. Over the next five years, as the purchasing power of health insurance declines further, markets will shrink and returns on investment will sour. This, in turn, will lead to steady erosion in the confidence our citizens and health care stakeholders have in our system. The policy response will be erratic policy tinkering, more uninsured, a lot of hand-waving, valiantly conceived regional risk pooling models for the poor and truly sick, and steadily thinning insurance coverage for the middle class in spite of legislatively inspired finger-plugging of some of the biggest holes in the dike.

Among the consequences will be the undernourishment of molecular medicine as those downward pricing pressures and slow absorption of new services and products into mainstream care stifle the development of a broad biomedicine culture and sector. In short, in an already bloated health care system with unsustainable financing, we can't afford the towering costs of genomic medicine. And this is, in turn, why we will build consumer markets to drive medicine into the future. This new Plan B medicine will revel in the powers of the biotechnologies as a fully articulated molecular medicine slowly but steadily arrives. This will be a medicine once financed unevenly, now endowed generously and reliably, and given fresh license to expand, even into the nether territories of human enhancement.

The Costs of Innovation

Innovation is ultimately funded by taxpayers and consumers, and, in the case of medical care, those funds must substantially flow from patient revenues. But the prospect for sufficient and ample growth is poor. Against a backdrop of intensifying cost controls, thinning reimbursement and a groaning burden of chronic ill health in our population, productivity in relation to improving health is declining in medical care. That's another way of saying that our entire health care system is less cost-effective over time. Prove it you say, and I say, I can't, inarguably, but how much will you bet that productivity is increasing?

In this torpid environment, patient care revenues won't be sufficient to support levels of services already provided *and* finance an explosion of new health technologies.

Making Plan B happen will take a lot more muscle than today's dysfunctional health care delivery system can muster, even given the enormous resources poured into it. Health care is nearly a \$ 2 trillion industry, by far the largest single non-governmental sector in the world. About \$800 billion of those dollars flows through commercial insurance companies. Health insurance, like any insurance product, has typically been sold as a hedge against unexpected and untoward events. Unexpected events were the predominant risks when the private insurance model first appeared in the 1930's and 40's. Today, the threats to our health are different. Health care practice is far more focused on the treatment and maintenance of patients with known conditions than on its response to the unexpected. Our risks are mostly known and the consequences for failing to heed that knowledge should not be, but often are, unexpected. In our genetics, we all have pre-existing conditions. In fact, today, by combining the unfunded truths of public health with the increasingly more granular genetic risk data, we are very close to knowing more about our risks than we don't know. In a genomics medicine, the capacity to model and assess risks will increase enormously. Definitive health risk data is the master gear that can make prevention finally go. If these data become sufficiently definitive, markets can be wrapped around good risk pools as well as bad ones, and every thing in between.

Insurance is the wrong business model for today for an evolving medicine. It continues to shackle medical care to a practice model diminishing in impact as our health needs have changed, slowing the arrival of a new more potent genomics medicine. In a private insurance model risk data are either useless or radioactive. They must either be embargoed, or if used, defanged, because adverse selection would swiftly become intolerable and the risks of liability unacceptable. On the other hand, in consumer health markets, risk data are exceptionally valuable and can be leveraged as an asset leading to personalized product lines priced to match to demonstrable risk profiles.

The Stealth Strategy

This is not tinkering. It is also a stealthy and seductive model of change---most of the enabling mechanisms are subtle. This scale of change is typically very slow to come. Institutional inertia is certain and the degree of behavioral change needed seems impossibly challenging, especially among physicians whose resistance to change is legendary. Acceleration, however, will be sought through a series of congruent and supportive public policy initiatives, including a much more robust and deployed IT infrastructure, including many decision-support tools for patients and consumers, and especially, if the electronic medical record model that emerges is accessible to consumers, as an electronic bazaar of health care products and services.

It will also be critical to move two other assets to consumers to empower them to manage their own health: real money in their pockets (which is what HSAs are all about), and relevant health information through technology that can provide consumers with their entire human genome on a chip for less than \$100. A supportive public policy must then interdigitate health care policy with tax, financial services and retirement policy. All of these changes will facilitate trading health care services as currency. And that, to these reformers, is the missing part for their

engine; the enticements of fat and happy markets for big money players with Wall Street, not Main Street, addresses. The political ideology and troops are lined up, and big business is desperate for an exit strategy. What's been missing is the financial community. Today, we use a crisscrossing, cross-wired array of incentives to prod providers and health care workers to paltry and inconsequential results. Plan B, on the other hand, is premised upon putting consumers and providers into dis-intermediated markets in order to finally move supply to meet demand, or, in the case special case of medical markets, move demand to the supply it "thinks" it's choosing.

Patching the Safety Net

Even fully and successfully implemented, Plan B can't solve every one of the crises in health care. A full roll-out of Plan B tomorrow would still leave us with 50 million without insurance, many millions more underinsured who can't afford Plan B, and still others who are so sick, disabled, or otherwise compromised that their needs are far greater than even a stretched Plan B can accommodate without diluting its impact. And this is why you we find Newt Gingrich and Hillary Clinton on the same dais on health care. Political opposition will dictate coupling Plan B with a thin, just short of threadbare, catastrophic plan---a single payer plan for those who really need one. The Plan will be inspired by the elegant simplicity of Medicare but fashioned out of baser stuff. Such a plan will be pretty comprehensive if you are severely disabled, frail, or unequivocally and chronically compromised. But beyond these intensive levels of care (needed by around 5 % of us at any given time), the rest of us will have to make do with less, measured against what has been typically covered over the last 20-30 years. If conservatives hold sway on its design, most of the financing, at a bit less than 50% of comprehensive coverage, will be secured from a combination of tax credits and deferrals, highly flexible spending criteria, subsidies, and tweaks to address inequities; in other words, health care policy becomes tax and welfare policy. If liberals are the architects, health care policy stays health care policy. That means there will be a more Medicare-like plan for everybody with a somewhat larger scope of coverage, and mostly funded from general revenues. Both ways we will get less for our public dollars, and in neither case, will be much private health insurance left behind.

Bringing in the Banks

Market mechanisms like the HSA lure Wall Street and entrepreneurs into the financing side of health care---a target of theirs for a long time---almost 20 % of the economy, a nearly \$ 2 trillion sector. There will also be a much smaller but thriving private insurance market marketing niche coverage tied to the odds of serious disease, such as stroke. Beyond that for a few, for anything health related we may want or need we will own financial products and instruments, the use of which we can direct for our health needs. Often, these products will be tied to other financial products such as annuities, long-term care, retirement, and investment accounts. We consumers won't pay be paying premiums but we will contribute to health savings accounts. And, rather than paying fees for services, we will be paying money management fees and credit costs. Financial service companies will move into health care banking service business lines, and major health insurance carriers, like Aetna, United Health Care, Anthem, and many Blues plans, seizing the opportunity to shed low margin comprehensive health insurance products, will also create new non-insurance service lines of business. Eventually, these same companies that now sell insurance (after all, they're just "brands" with virtually no solid proprietary assets) may

either merge with, be acquired by, or joint venture with financial service companies. (In these transactions each of us as a member of a Health Plan has a dollar value---you may own your healthcare account, but as a member of your health plan, you can be bought and sold like a rented goalie).

What this all means is that we consumers will first be given back our money (not paid in wages) as if a gift, and then be asked to pay fees to these subsidiaries of our old carriers. First, there'll be fees for managing our money and, then fees to another subsidiary, an info-mediary, to sell us information about our health we couldn't get from them before.

Big Money; Small Government

If this sounds radical, it is---displacing health insurance with chits and securities is a pretty big change. This is why much of the support for this disruptive policy shift is muted. But, there is no mistaking the many reasons why it makes sense to the constituencies pushing it.

Employers will rejoice because that corroded bond between health care and employer financing will have finally been broken, although incrementally, one employee at a time as Plan B takes hold. And employers probably have the most compelling case---bolstering the competitiveness of American business by sloughing the burdens of paying for health insurance (though some of those dollars saved will be captured as tax revenues to support the catastrophic plan). Net savings should be considerable, even beyond the potential savings from reducing health care administrative costs. Another less obvious advantage for the business community is reduced exposure to liability for medical mishaps. As both resources and information moves to end users they bear the responsibility for their own health care decisions, and, as a consequence, that reduces the level of insurable risk to both carriers and employers from potential liability for deficient care, and, can further, significantly lower legal and capital reserve requirements.

Yet another reason is that the financial community sees the opportunity to manage substantial resources and the profitability that accompanies asset management, a business line with far more upside than health insurance. To paint the target: if just 10% of all payments for health care services were made by consumers with tax-favored health spending accounts (HSA-type), in today's dollars---a low ball estimate---those folks would be holding \$200 billion to spend on health care that insurance companies wouldn't be spending. That's the equivalent of launching an entirely new business sector the size of our electronics industry.

Suppliers and producers of all health care products will learn what the pharmaceutical industry has mastered---you can sell shoes to the cobbler with ads showing him barefoot. Lots of drugs are masterfully effective, the statins, for example. But the pharmaceutical sector has also mastered the arts of marketing medicine. Schering-Plough spent more in 2003 to advertise Claritin than Coca Cola spent to advertise its ubiquitous products, and given the results----selling over \$3B worth per year of a drug with just a little more chemical activity than vapor, who can blame them. Pill-pushers keep tantalizing men with new and better "get-it-up" elixirs, perversely to find the market flattening, notwithstanding, apparently right along with the users. Producers will also increasingly look overseas for fresh and growing markets for high-tech services, since US markets, even at the most robust, can't create enough demand.

Government will continue to support public health programs, though penuriously, subsidize special interest groups and services, as needed, regulate for safety, set practice guidelines and standards, provide glossy health education materials, militantly promote good health, lie to kids about sex and pot, assess technology, and, in a bit of real perversity, pay providers to practice the kind of evidence-based medicine we should have every right to expect from them without the bribery. Finally, government, in fulfilling its part of this historic bargain, will both expand and further strengthen stringent intellectual property enforcement, especially abroad as those markets expand.

Patients will have even less patience. Deeply wedded to lives of convenience and ease, as we are, and swayed by claims of easy---no gain, if pain---fixes, remedies, enhancers and elixirs, and now, with money of our own to wave in the air, we will want doctors who prescribe paths to frictionless good health. We won't have HMO's to blame anymore, though.

From Guild to Trade

Providers will get squeezed by both payers, now with heavier loads of "frequent flyers"---their endearing term payers call the really and truly sick---who are covered in the government financed low-end model, and more querulous, bargain hunting consumers with money in their pocketbooks looking for shortcuts to offset decadent diets, reckless drug and alcohol use, and sloth. In short, physicians and even hospitals must to learn to steadily reduce their reliance on third party revenue and learn to hustle retail and carry consumer debt. (Though, the "debt" problem may soon be solved by affinity credit cards tied to health savings accounts; Blue Cross/Blue Shield Association of America are already marketing such a card). They're also going to have to get over being above selling patients lots of new drugs, devices and gadgets to enhance, adorn, and empower, and even change them, but that's another story.

Our Role in the End Game

Many powerful industries gain from this policy shift and will expend lots of political capital to move the model along. All U.S. businesses, big and small will benefit; all producers will too, especially biotech and bioengineering firms, if not at first, as soon as markets form here and abroad; financial services companies and bankers get new skin in their game, and the advertising community will be gleeful.

While all of this maneuvering goes on, politicians will keep on making campaign promises offering more comprehensive coverage at affordable prices, saying not one word about the end-game underway in which they are wholly complicit.

The net effect of all of these congruent moves will vault the US health care industry over the next decade into first place as the largest industry in the world, exceeding the worldwide energy industries of all nations, combined, or about \$ 3 trillion.

The rest of us are the object of the end game----we're "demand."