4sight Health Roundup Podcast
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What Are the Best Options to Reduce Healthcare Administrative Costs?

David Burda:
Welcome to the 4sight Health Roundup podcast, 4sight Health podcast series for healthcare revolutionaries, outcomes matter customers, count and value rules. Hello everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, April 17th. Yesterday, April 16th was my 65th birthday. I am officially a Medicare beneficiary after reporting on living through with older friends and relatives and reading about the horrors of Medicare Advantage. I have traditional Medicare with a separate Part D drug benefit, and a Medicare supplemental plan that covers vision and dental. Take that Dr. Oz. One of the reasons Medicare Advantage is a horror is the administrative hassle for both members and providers. We're gonna talk about healthcare administrative costs and what to do about them on today's show with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
Well, I'm doing great. You know, my wife Terry has had kidney disease since she was a kid and now qualifies for a transplant. And we went to a screening with the Northwestern Transplant Village on Tuesday of a new film called Abundant, which was like a series of TED talks with what they call non-directed donors. These are people who give away a kidney to strangers.

Burda:
Mm-Hmm <affirmative>.

Johnson:
And it was just a remarkable experience. And to the individual who had made the donation you know, where do these people come from? They had this sort of enormous sense of purpose and, and gratitude for the experience. So I'm feeling full this morning.

Burda:
Yeah. Well, good, good luck with that process, and please let us know how we can help. Best wishes to you and Terry. Thanks, Steve. Yeah. Julie, how are you?

Julie Murchinson:
I am, I think much less fulfilled by anything inspiring, but we've had a lot of sun this week and just been nice to be home, so I'm in a good place.

Burda:
Good, good. Good to hear. Okay, before we talk about healthcare administrative costs, let's talk about Easter candy, which has nothing to do with our topic today. Easter is this Sunday, and these shelves have been full of Easter candy for baskets and Easter egg hunts since Valentine's Day, I think Dave, I know you're not a big candy person with a few notable exceptions, like a Payday bar <laugh>, right?

Johnson:
You know me so well.

Burda:
Yeah. But, do you have a favorite Easter candy?

Johnson:
I sort of do, and I don't, I'm mesmerized by these Peeps, chicks, and bunnies, you know, those marshmallow and sugar concoctions. I don't like to eat them, but the color, shapes, and textures are just so weird. It's almost like they're mutant candies of some kind or another. I can't get 'em outta my head.

Burda:
<Laugh> Good marketing. Yeah, they got you. Julie, how about you? What candy do you want in your Easter basket?

Murchinson:
I prefer the much less nightmarish peanut butter eggs. That's all I need is a good Reese's peanut butter egg.

Burda:
<Laugh>. Yeah, that's a, that was a great idea too. I have to go with the Fannie Mae Easter egg you know, chocolate on the outside, buttercream on the inside.

Murchinson:
Mm-Hmm <affirmative>.

Burda:
You take one bite and it's so sweet, like your teeth hurt, and you, you say that that's enough, and then the next thing, it's gone. Right. Gone, you eat the whole thing. <Laugh> <laugh>, and you regret it immediately. So I'm looking forward to that. Okay. Let's talk about healthcare administrative costs, but we're gonna do something different on today's show. You're gonna comment on someone else's commentary. I don't think we've done that before, so I'm not sure how this is gonna go. We'll see. Michael Chernew published a lengthy forefront blog post in Health Affairs earlier this month called Implications of the Healthcare Systems Design for Administrative Costs. He chairs the Medicare Payment Advisory Commission or MedPAC. He's also a health policy professor at Harvard and director of its healthcare markets and regulation lab. Let's hope he keeps his job. Both jobs. In his piece, Chernew argues that our system's high administrative costs are a direct result of how the system is structured. He cited things like decentralization of care delivery, lack of standardization, the value placed on autonomy and innovation, and how health insurance works as the culprits. And there's not much you can do about them unless you change the system. He offered what he called three broad strategies to change the system with the goal of reducing administrative costs. One, replace the current system with a government run single payer system. Two, go hard on technology, specifically AI to make all transactions and decisions in healthcare as efficient as possible. And three, go hard on targeted regulation to standardize, simplify, and set guardrails on all transactions and decisions. Ultimately, he settled on option three, targeted regulation as the best option. Dave, what do you

think about Chernew's premise his three solutions and his preferred option, and what option would you propose?

Johnson:
Well, I know Mike pretty well, a great guy. We're both part of Amitabh Chandra's egghead Group at Harvard, the Healthcare Policy Leadership Council, which is mostly economists like Mike, and then a few weirdos like me. You know, before he became the chair of MedPAC, he had jet black hair. Now he's totally gray, very distinguished looking <laugh>.

Burda:
There's a warning for you.

Johnson:
Yeah. Tells you what government service will do for you. So, you know, I love being part of the HPLC but it's filled with economists, as I said the dismal science. And when they're saying economists, they're talking about microeconomics, right? Not macroeconomics. And, you know, down deep, all traditional economists, like Mike, believe there is a market clearing price for all products and services. They believe in rational actors and the power of incentives. Why? That's why behavioral economics drives them so crazy. They use terms like externalities and friction to describe market imperfections. And you saw that in Mike's piece,. The phrase 'at the margin' sums up their worldview. How do we make adjustments at the intersection between supply and demand curves to improve market performance? So that's why Mike is hyper-focused on standardization and regulatory guardrails. You know, option three, the preferred option. From his perspective, that's the way to make the machine run more efficiently. It won't surprise you to learn that Mike's part of Zach Cooper's group. Zach is the Yale economist, healthcare economists called the 1% Initiative. And basically their approach is find and aggregate enough 1% solutions. And pretty soon you're talking real money. So, here's a sentence from near the end of Mike's article that I think sums up his worldview; "Moderate guardrails are important policy levers as they do not fundamentally alter the structure and delivery of the US healthcare system, but instead serve to foster small changes in a quantifiable manner." You know, and Mike and I have had this debate, so you, you <laugh> and you can both, you probably guess where I'm going on with this mm-hmm <affirmative>. <Laugh> you know, but that's the problem. I mean, Mike is the embodiment of incrementalist thinking. And that doesn't work when you've got a fundamentally broken system where we need to actually alter the structure and delivery of American healthcare. As far as, you know, as long as we're doing fee for service medicine and a SO contracting we can't solve the fundamental dilemma that payers want to pay less and providers wanna receive more. In normal markets based on price elasticity, you know, how much price affects supply and demand. You know, there are clearing prices, there are largely rational actors and, and, and you can improve things at the margin. But in healthcare you know, the actors operate within an artificial market riddled with perverse incentives, transfer payments, and players with monopoly and monopsony pricing power. You know, we're not gonna fix us healthcare until we address that issue, which fundamentally gets to payment. And so as I've said before, we're not gonna change the way we deliver care until we change the way we pay for care. We're not gonna get better balance between health and healthcare. Honestly, if we did like other countries, we'd spend more on health, and so we wouldn't need to spend as much on healthcare.

All the tinkering at the margins isn't gonna address this fundamental dilemma. And that's where traditional economists like Mike, just kind of run into a brick wall.

Burda:
Yeah. Yeah. So it's like tinkering with a car, right? You really never get it running.

Johnson:
<Laugh>

Burda:
You just spend your time tinkering with it in your garage. Great. great analysis. Thanks, Dave. Julie, any questions for Dave?

Murchinson:
Dave, it's just like the eternal dilemma. <Laugh>, <laugh>. What's I trying to do here? Like, can we truly preserve our autonomy and innovation while imposing standardization, like you talk about? Or are we just delaying the hard choice, you know, between wanting our freedom and having the most efficient system?

Johnson:
You know, the thing is, Julie, most American consumers are willing to trade off freedom for lower prices. I mean, you see that all the time. The rush to Medicare Advantage demonstrates that the trouble is the consumers don't really know what they're buying. And I actually believe part of the way out of our dilemma is, is to empower consumers by giving them more transparent purchasing options that they can tailor to their, their own needs. Like, one of the policies I like a lot, I think I've mentioned it before, is allowing self-insured employers to keep the to keep the tax deduction for funding health insurance. And then just giving that payment to their employees as much as they want. And then the employees go onto the exchange and buy an approved plan. And there's probably a lot people like Mike could do to improve the selection process of the plans that are on the exchanges. But to the extent, let's say a company gives an employee $25,000 and they can find a plan for $20,000, they would get to keep the $5,000 additional dollars as taxable income. And I start to think about what it would be like to have really robust exchanges where the insurers would have to play, and having consumers with the ability to make real value-based decisions about the level of care they receive and then the incremental income they could get back. So I, you know, again, I think until we fundamentally change the way we pay for care, we're not gonna change the way we deliver it. And right now we've got this system that you know, is fundamentally broken and people like Mike are just playing at the margins. See what I did there?

Burda:
Nice. <laugh>. Yeah. And it's true. Consumers can get pretty smart pretty quickly when their own money is at risk, right?

Johnson:
Can you imagine? Yeah. Can you imagine five grand more?

Burda:
Oh, yeah. Signing up. Exactly. Thanks, Dave. Julie, it's your turn. What's your critique of Chernow commentary? Do you agree or disagree with his premise and solutions? And do you have a silver bullet to reduce healthcare administrative costs?

Murchinson:
Dave, you know, there is no silver bullet <laugh>.

Burda:
I know.

Murchinson:
So, no.

Burda:
<Laugh>, yes,

Murchinson:
But listen, I'll argue for technology innovation all day long, and I've four reasons. So first, I think we all talk about this. Technology addresses our root problem, which is really complexity, and it does so without undermining our whole foundation around our autonomy and a competitive market and an innovative market. And Chernow's right that, you know, are uniquely decentralized and complex system creates a lot of burden. But tech can standardize processes without centralizing control, like AI powered prior auth, which is, you know, becoming a thing today can cut friction in major ways, and LP and LLMs can simplify all the payer provider communication documentation, a bunch of redundancy. So it can do a lot around complexity. Number two is look at all the industries tech already powers, and it helps manage complexity in all these industries without totally overhauling it. You don't need to overhaul to implement things like machine learning, power, revenue cycle tools, like we're doing that today. So what if we actually shifted from reactive to proactive tech, and not just managing administrative burden, but eliminating it with simplification through technology? It's possible. Number three is, and this is where I can see Chernow's you know, selected a path, a good one married with technology because guardrails and innovation are kind of the sweet spot. And in his middle ground, you know, modest standardization, regulatory simplification, all that, there's a space for tech to work because tech thrives under smart guardrails. So with more data interoperability and clearer standards tech could actually unlock a lot more efficiency and frankly, value than it even is looking like it can today. And four and final <laugh> tech really is the only way we preserve our capitalistic healthcare system. And I mean, especially in today's day and age, Americans won't stand for anything else. So, you know, we can get our lower cost, we can get higher efficiency, we can simplify our processes, and it's not just a tool, but paired with thoughtful policy, it can become more of a competitive advantage. So, you know, I think it's really the most sustainable path forward. But I like a bit of a combination, I guess, of two and three.

Burda:

Yeah. Yeah. Tech thrives under smart guardrails. I'm gonna, I'm gonna steal that <laugh>. I like that. Thanks Julie. Dave, any questions for Julie?

Johnson:
Julie, my friend David Meltzer a doctor and an economist, how's that for a combination? <Laugh> from the University of Chicago says we need the equivalent of the Manhattan Project to assess and price healthcare risk adjustment. So, thought experiment, imagine a healthcare marketplace for a moment where we get risk adjustment, right? What do you think that would do to administrative costs?

Murchinson:
Oh my gosh. If we could get risk adjustment right, it would definitely be transformative. I mean, there's no doubt about it. I mean, today, risk adjustment's so complex and opaque and totally gamed, and it just drives like layer upon layer of costly administration, like imaginative health plans and providers wouldn't need to over-invest in documentation just to protect their revenue. Like it would be a totally different world. And the gaming, again, I always mention our friend Jan Berger, the gaming if that could go away, we would engender more trust period, and plans could start to compete on care quality and efficiency in the way that I think a lot of today's, you know, measurement and policy is really trying to get them to do. But our reimbursement system has plans competing on their coding prowess, <laugh>. So, you know, we can't get past that. And I don't know, you know, the talent and resources that we focus on paperwork today could really be focused on patient care. And you could do a lot if data and AI could be focused on predicting care needs and improving outcomes instead of just navigating risk scores.

Burda:
You know, a coding came up in an episode of The Pit. You remember that Dave?

Johnson:
Yeah, I do. <Laugh>

Burda:
They were pushing for more EHR documentation, right? Thanks, Julie. Options one in three government run and more regulation only work when you have smart, well-intentioned people in charge. And we have the opposite of that right now. So I'd pull a lever for technology and the effective use of technology to simplify, you know, just basic administrative tasks to reduce spending. I mean, other industries do it, right? Like you said, why can't we?

Johnson:
Dave, I agree, there's one thing, and, and maybe you know the answer to this, but why do we have to renew our health insurance every year? Why can't we do longer term contracting? I think that state regulation, but imagine if you could actually contract for five years how that could change insurer behavior, provider behavior, and so on. Particularly if we move into risk-based contracting. Do you know why it is we have to change why it is every year that we have to?

Burda:

I have no idea. But that's, that's a very interesting question, right?

Murchinson:
Soc and Jane was just arguing that same thing on the HES stage last week, and Rushika Fernandopulle, when he was building Iora was always talking about kind of the tenure timeframe to bend ACOs curve. And you know, the one <laugh>, the one party that gets hurt in that whole game is the payer, because rates don't go up. So…

Burda:
Ah, Okay.

Murchinson:
I don't know. <Laugh>,

Burda:
I think we found the answer, Okay, let's talk about other healthcare news that happened this week. Was it all bad? Was it Julie, what else happened in healthcare that we should know about?

Murchinson:
Well, I could raise and discuss if I even understood the executive order on reducing drug prices this week.

Burda:
It's like the Rosetta Stone, right?

Murchinson:
Oh God.

Burda:
Well, maybe the opposite of the Rosetta Stone, right? <Laugh>. Yeah.

Murchinson:
But I'd rather celebrate Micky Tripathi's new role leading AI at Mayo. That is a score for Mayo.

Burda:
Yeah. Yeah. Him paired with I'm thinking John Halamka.

Murchinson:
John Halamka. Exactly.

Burda:
You know?

Murchinson:
The band's back together.

Burda:
Yeah.

Murchinson:
Move from Boston to Minneapolis. Or Rochester, I guess.

Burda:
<Laugh> Unstoppable. Thank you. Dave, what other healthcare news is worth mentioning?

Johnson:
Well, speaking of cutting edge technology companies, Transcarent closed its deal with Accolade this week, so congrats to Glen Tullman and his team. The acquisition more than quintuples the company's size. So imagine a world where, you know, one app covers the map and that you go just one place for all your health and care needs. And you know, Glen is setting up the kind of model that could actually change supply demand dynamics that even Michael Chernow would get excited about.

Burda:
<Laugh>. Yeah. Another, another good match. Thanks Dave and Julie, thank you. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening, I'm Dave Burda for 4sight Health.