CAN THE FUTURE OF HEALTH BE AFFORDABLE?

Announcer 00:00:01

Please welcome Managing Director, Gallup, Ilana Ron-Levey.

[Applause]

Ilana Ron-Levey 00:00:12

Hi, everybody. It's great to be here. Since 1935, Gallup has been assessing the will of the American people to really help leaders make better decisions and improve their lives. And I think too often in health-care conversations, where we focus on policy and we focus on the changes that we need to make in the health-care system, we don't always understand how the American people are living and experiencing their health-care realities. So, what I wanted to do today was to do a short pulse of the American people and how they're feeling and experiencing their health-care realities. Probably the most important place to start is health-care affordability. Through the Gallup West Health Center on Healthcare in America, we've been tracking the percentage of Americans who say they're cost-secure enough to pay and afford health care. And what we've seen in the last year is that 2.8 million more Americans say they're unable to afford or pay for health care compared to the prior year. Oldest and youngest Americans are hardest hit. Both old and young Americans had the largest drops in how cost-secure they feel. So, what we're hearing, what we're reading, this is really reflected in the percentage of Americans who say they simply can no longer pay for or afford health care. We wanted to dive deeper and really understand what were the economic implications of this growing insecurity. And what we found is that one-third of Americans are making trade-offs to cover their rising health-care expenses. So, for example, and maybe most concerning, 15 percent of Americans—and that's 39 million Americans—are saying they're stretching out or prolonging their prescriptions, taking not the recommended dose, so they don't have to pay for another one. They're borrowing money. They're driving less. They're skipping a meal. And obviously, this has implications for the economy overall and the American dream. And perhaps most startling, 11 percent of American households earning $240,000 or more say they're also making these types of trade-offs. So, these trade-offs are not confined to only the lower-income quintiles. A lot of people wonder, "Is this really about uninsured versus insured Americans?" And you can see when you look at health-care affordability for those that are not insured, clearly, they're more likely to have to make these kinds of trade-offs. 62 percent in the last year without insurance say they've had to make this type of trade-off. But for those with health insurance, close to 30 percent say they too have had to make this type of economic trade-off to afford health care. So, I think it shows us that while insurance is some degree of mitigation and inoculation, the health-care

affordability crisis affects those with insurance at high levels. When we asked Americans who are insured how do their costs compare this year to the prior year, 67 percent of US adults with insurance say the cost of health insurance has gone up for them. And when we look by age, we see strong majorities of those age 30 and up experiencing rising insurance costs. And at the oldest American level, the Medicare age, we see 83 percent saying their costs have gone up. This is the same group that had an eight-point drop in cost security for health care in the last year. So, they're both more cost-insecure and reporting higher insurance costs. Milken is a global community, and so is Gallup, and we wanted to take a step back and think about are the issues affecting health care in America unique to this country, and where does gender fit in?

Ilana Ron-Levey 00:04:44

And through the Gallup World Poll, which is the world's largest annual study of the human condition, including experiences with health care, we see that women were more likely than men to report health problems and have lower satisfaction with the availability and quality of health care. And what's interesting in these sort of 57 countries with a pronounced gender gap, this spans both high-income and low-income countries. So, some of the gender-related concerns of increased health problems as well as lack of access to quality health care exist in other developed countries like the United States. This also mirrors when we looked at cost insecurity. There was a 15-point difference between men and women. So, all Americans are suffering from rising insecurity related to health care, but there was a 15-point difference in favor of men as compared to women, with more women experiencing cost insecurity around health care. So, in this backdrop of rising costs, affordability concerns, a gender gap, Americans are looking for alternatives. And we see that one in four Americans are turning to AI and chatbots for health information and advice. And in the last 30 days, of the 14 million US adults who said that they used AI for health information, 14 million of them said they did it because of cost factors, that they were unable to pay for a doctor's visit, so they used AI to replace the care that they might get. Now, surely, these other factors, like speed and access and quality, right now are more prominent, but cost is rising as a driver to using AI. We also wanted to understand, for those Americans who use AI for health-care information, what would make them more comfortable or less comfortable with AI-driven decision-making? And what we saw is the factor that would increase comfort the most was the ability to request a review by a health-care provider, knowing that a human and a medical professional could be in the loop on demand. And I think that this showcases the centrality of health-care providers to American experiences with the health-care system. And just in closing, going back to that role of primary care and why primary care is so important, seven in ten Americans—and this is a bright spot compared to, I think, everything else that I showed—seven in ten Americans say that their health-care provider ensures that they receive adequate preventative screenings and evaluations. And there's not a gender gap here. So, this is a strength of the American health-care system. You can see, though, that there is strong age differentiation, where younger Americans are less confident, less satisfied that they're receiving the preventative care that they require. So, in closing, we have a cost-insecure population with rising insecurity, more unaffordable care, a gender gap in quality and access, openness to using AI and experimentation, but wanting humans in the loop and increasingly looking for AI for cost reasons. We hope that as we continue to have conversations about how the health-care system can adapt, we can keep the lived experiences of Americans front and center, and we'll continue to track this information and report on progress. Thank you so much.

[Applause]

Announcer 00:08:51

Please welcome the panel on "Can the Future of Health Be Affordable?" Moderated by Esther Krofah, executive vice president, Health, Milken Institute.

[Music plays]

Esther Krofah 00:09:18

Well, this is—can everyone hear me? Yep, there we go. Okay. Hi, everyone. Well, this is the closing session of our conference, so we are extremely delighted to have an incredible group of leaders and CEOs that are with us on really the fundamental question that those who were voting last week were asking and wanting to see a response to, which is: Can my health, health care, or all parts of their engagement with the health-care system, can it be affordable? That is the question that we have at hand. Not an easy question, but I want you all to wrestle it down in the next 50 minutes. We're going to walk off the stage. You're going to tell us how to make health more affordable. Before we start, I want everyone just to go down the line, introduce yourself, help orient us in the part of the health ecosystem in which you work. So, let's start with you, John.

John Brooks 00:10:08

John Brooks, director of the Center for Medicare. So, we have 70 million beneficiaries, both in Medicare Advantage as well as in original Medicare fee-for-service.

Peter Kolchinsky 00:10:17

I'm Peter Kolchinsky. I'm a scientist by training, and I've been an investor my whole career. I run a firm called RA Capital Management that's one of the larger life science investment firms in the world. And we invest in a lot of development of novel medicines, diagnostics, medical devices. And for a little over 10 years now, I've also been somewhat of a health-care reform advocate and writer trying to study how our whole ecosystem works and how it all gets paid for.

Amy Perry 00:10:47

Sounds good. I'm Amy Perry. I'm the CEO of Banner Health. We serve about four million people in six states. We have pretty much the entire ecosystem within our organization, from acute care, rural, community, urban, academic, all the outpatient services, pharmacy, and we own a health insurance company.

Steve Nelson 00:11:11

Steve Nelson. I lead Aetna. I think I work for John Brooks, actually. *[Laughter]* No, just kidding. But we serve Medicare, Medicaid, and commercial lives, and look forward to the conversation about how do we solve this very easy problem, Esther.

Esther Krofah 00:11:28

Okay. We can do it.

Glen Tullman 00:11:30

Great, and I'm Glen Tullman. I'm the chief executive officer of Transcarent. Our focus is putting all of your health and care in one place—that's right here on your phone—and how do we make it easier for people to access high-quality, affordable health and care, primarily using technology and AI tools.

Esther Krofah 00:11:51

I'm actually going to start with you, Glen, and then I want to go back down this way. What do you see as the affordability challenge?

Glen Tullman 00:12:00

Well, I think all of us just had a lesson in the affordability challenge in the elections, and that was—the entire country, I think, as individuals and clearly as businesses, are feeling that health care is too confusing, too complex, and too costly. And I think the general consensus is it's getting worse and not better. So, people are striving for a solution. And at least our perspective is, the best way to do that is the way we've done it in every other industry—and that's use technology to make the process more efficient, which would allow us to take a lot of the frustrations that all of us feel in health care out of health care. And so, that's really our view of where we are today, and I'm not sure there's another way to do it than trying to make it more efficient.

Esther Krofah 00:12:55

But can technology really compress the cost? When I think about affordability, I'm thinking about my out-of-pocket cost, my cost for health insurance, any co-pays that I have, what I need to pay for medicines. Where does technology help us alleviate those burdens for patients?

Glen Tullman 00:13:12

So, I think first and foremost, what technology can do is—health care is very unique because the end consumer isn't really a consumer, doesn't understand cost, can't cost shop. So, whether we're talking about, first and foremost, getting people information on whether they might need a surgery to begin with. So, back surgeries, the estimates are a third of them shouldn't be done, and if you just gave people the right information, they could make those judgments rather than having somebody tell them they shouldn't make those judgments. So, more informed consumers. Similarly, when you're looking at drug costs, there is a very big range of drug costs from everywhere, from branded drugs to generic drugs to biosimilars. And if people were actually paying for more of those, or understood the cost and had the right incentives, they could make better decisions about that. And last but not least, selecting physicians, they could make better decisions about where they go. Do they go to a hospital? Do they go to an ambulatory surgery center? Which is better for them? So, all of that, you know, our view is if you give consumers more choice, you'll get ultimately a better cost and better decisions made. But you have to give them the right information to make those decisions, and I think, for the first time, AI is giving us that capability. In many other industries, I think AI represents a threat. I think in health care, AI represents a potential for abundance because we don't have enough doctors, we don't have enough nurses, we don't have enough therapists. That's driving up the cost of all those, and there's a tremendous amount of dissatisfaction. I'm sure Amy could school us on that, about how challenging it is for doctors just to be doctors. Not to fight about billing and not to fight with a variety of people. And so, the idea is we could make that process much better using smart technology. The last thing I'll say is, we've always talked about "Are people engaged in their health care?" And if you Google it, you'll find that a billion times a day—I was just with somebody on stage yesterday

from OpenAI—they get 30 to 50 million questions a week on health care. And so, people want to know. They just don't know where to go for their information and what to trust. And if we could give them that, I think we'd have a much more efficient system.

Esther Krofah 00:15:47

Yeah. Steve, to you, where do you see this affordability challenge? And is it about empowering the consumer to understand what the true health-care costs are? Because our system is not really designed for consumers to have transparency around where the costs truly are and, certainly, many of them have challenges navigating their health insurance. They don't even know which numbers to call for what. How are you solving that?

Steve Nelson 00:16:11

Yeah. So, I agree with everything Glen said. I think navigation, we talk about navigation a lot, actually, that it is one key. And so, there's really, in my mind, two: navigation, the complexity, the frustration, and then there's partnerships. And I have Amy to my right, which we've actually had a lot of great conversations about how payers and providers need to partner differently. So, those are two things right now that are in the way and, I think, creating and contributing to the affordability crisis, if you will, and I really do think it is sort of that level. But just a couple quick examples of how we're using technology and how we're thinking about partnerships. So, to your point about getting people to the right area, we've been innovating around, and we've got a couple of really cool tools right now, part of our award-winning app, Aetna Health app. If you put in, "I'm trying to figure this out," it'll analyze like 18,000 different services, take your clinical background, your data, some preferences you might put in, and will lead you to the highest-quality providers, and we will incentivize you to go there. And if you do that, prior auth, sometimes, almost all the time, not every time, but a lot of times, goes away.

Esther Krofah 00:17:48

Yeah.

Steve Nelson 00:17:49

And you end up saving your co-pays or whatever out-of-pocket expenses you'd have, and you get better quality, better experience, and lower costs. So, we've had NPS scores going up 29 points just on that experience alone, and they'll save personally between $300 and $3,000. And that's not even counting what it's saving the system. So, that's an example, and we have numerous things that are like that. On the partnership side, I don't know, I've been doing this for a long time. I've been on both sides of this conversation, so I have empathy for both parts of the conversation. But if we do not figure out how to partner better with—across the health system, this thing does not get solved. And right now, everyone's pointing fingers and, you know, no one seems to be accountable. But when we have conversations to say, "Let's figure this out," it's incredible how quickly we can solve something. And then friction starts going away. Prior auth becomes not an issue. Claims payment, all those things get to a place where you can start establishing trust. And then our members, your patients, you know, get better health care. And that actually drives lower costs, too. So, that's kind of how we're thinking about it. Those are two really complex things, but actually, at the high level, they're just common sense.

Esther Krofah 00:19:20

Yeah. And are you thinking about cost to patients? One of the questions we talked about during the prep call was “affordability to whom?”

Steve Nelson 00:19:29

Yeah.

Esther Krofah 00:19:29

Is it affordability and lack of friction between the partners that you’re pulling together—you and a health system—or is it about creating a frictionless experience for that patient who can navigate perhaps through that app that you talked about, and they better understand what they are potentially going to have to pay for a particular service or intervention, you know? Who are we talking about?

Steve Nelson 00:19:53

Yeah, I think I would be disingenuous if I said it was anyone but the end consumer. You know, I mean, ultimately, whether it’s taxes or direct costs or whatever. But I think a really big stakeholder in the affordability conversation is whoever’s the fiduciary. You know, whether it’s CMS or it’s, you know, an employer, or it’s, you know, an individual, or a state, you know? And so, those are all folks that we have a lot of frustrating conversations with about “What are we doing about it?” And the expectations for us to deliver and do something different are very, very high. And, you know, I guess the—I would say—dissatisfaction, you know, when we can’t make progress there. I mean, this environment right now over the past, I’d say, even year or so, we’re seeing trends that, you know, we haven’t seen before. And it’s not sustainable. So, anyway, there’s a lot of angst around that. So, I think it’s depending on, you know, how you score it, a lot of noise coming from both parties, you know, the individual and whoever’s paying the bill.

Esther Krofah 00:21:15

Yeah. And Amy, from a health system, can you tell us a little bit about how you think of affordability? We had a great conversation earlier this morning, and you made it just so real what’s happening within your hospital systems in terms of patients that are likely going to be coming in to your ER, they’re uninsured. How are you planning for that? What does affordability mean for you?

Amy Perry 00:21:38

I think that you asked the right question earlier in “affordability for who?”

Esther Krofah 00:21:45

Mm-hmm.

Amy Perry 00:21:45

And I think that that is sometimes, especially in a large forum like we have at the Milken Institute, and a lot of different perspectives both in the audience and on stage, we hear things differently depending on the lane that we’re swimming in. But what I would like to point out with regard to affordability is that the less

people that have access to health care, have access to coverage, the more pressure it's putting on the commercial payers. And we see that in a lot of places, right? I mean, right now, we don't provide care as efficiently as we need to. So, you know, if it's a Medicare patient, basically we're selling dollars for 95 cents, and without the Medicaid supplemental payments, we're going to sell dollars for 60 cents. Okay, this is just very rough math, right? So, now we have to make up 45 cents. Where am I going to make it up? I'm calling Steve. You know? It's like, how do we then—and then the public, which I'm sure you all in this audience have health insurance, probably. It's very likely you have health insurance. So, you're seeing these incredible increases—and they're coming from a lot of places. They're coming from, you know, drug advancements, they're coming from good reasons, right? I think that, though, probably the most difficult place that they're coming from is having to cross-subsidize some of the public health that I believe this country wants to provide everyone. But I also think that there's a reality check here in that we talk about in the United States, and one of the reasons I think we have this challenge is we try to provide this extraordinary level of services for everyone, and we do at Banner. We're here for everyone. You come in, it doesn't matter if you have insurance or not. You know? But is that sustainable? And I think that the answer is reimbursement alignment, because owning a health plan and partnering with Steve on our commercial work, I know that when we keep people well, everybody wins. We reduce the cost. The patient is better. The community's healthier. We have less expense. So, my sense is that one of the most important solutions that we all figure out is we need to match the reimbursement to wellness, and our health system is not built for that, but it can be.

Esther Krofah 00:24:29

And you're an IDN, an integrated delivery network. So, you're both a health system, but you're also a plan. You're an insurer. That enables you to have a different philosophy in terms of keeping people well. Is that helping you with lowering costs?

Amy Perry 00:24:47

Incredibly helpful.

Esther Krofah 00:24:49

Mm-hmm.

Amy Perry 00:24:49

I can't tell you how important it is and how quickly we're trying to expand that because that alignment of care, of health, instead of only getting paid if someone's sick, drives a business strategy that we all have to face. We all have to face the reality of our revenue streams. And so, in a system like Banner, where we treat four million people, we have only about a little over a million that we insure, so we get the premium dollar for those million. So, that means 25 percent—we have complete alignment. It's like music, right? You get the premium, you make the right investments, you give insulin, you're not waiting for the limb amputation. There's this huge benefit. But it's really hard to get that 75 percent into an alignment system. And we've done a lot with CMMI. We're going to be in the LEAD program. Anytime CMS comes out with a demonstration, innovation, we're in because we know that the more we move that pendulum into an alignment for health, the easier it is to win at this for everyone. I mean, win for the families, the communities, the affordability, the health system.

Esther Krofah 00:26:14

And Peter, you have a particular point of view on this question. In our prep call, he didn't want me to talk about the negatives. He said, "So, let's talk about what is working for America." But as you think about the sets of challenges that are coming up, you talked about some of the issues with drug pricing and the increase in cost for innovative medicines. How do we make this more affordable for individuals that say, "I can't afford a $100 copay for a new medicine"? "Although we want a cure, we can't afford to pay for it." How do the two things balance?

Peter Kolchinsky 00:26:48

So, whenever I hear anybody say that drug prices are too high, I actually, like, ask, "To whom?" And odds are that person's a member of the public, and what they really mean is too high to the patient at the pharmacy counter. In which case, if they have insurance, that's a function of insurance design. That may be a novel drug that has a high price and the person has to pay the list price out of their deductible, which is a uniquely American thing, or it may be a generic drug that has been marked up and the patient's being milked for their rebate. As Mark Cuban has shown you, some of these drugs cost like 20 bucks, but the person's being charged, you know, 2,000 or whatever. It's an insurance design thing. And I think my industry has been absolutely terrible at acknowledging, like, that's not right. You know, we didn't invent these medicines for even one person to be denied. Instead, my industry goes immediately into defensive mode. "Aren't these expensive and risky?" Because it assumes that the person's saying, therefore, we must price-control new medicines. So, for starters, I would hope that we continue to have these kinds of dialogues where we've got people who are concerned about the payer side of things, and then people like me that are doing the investing and focused on the R&D. We are part of one whole. You know, innovation and affordability go together. There is no innovation without proper insurance. I would wish the world to appreciate that all novel medicines essentially, you know, add up to about 1 percent of the GDP of all developed countries, right? So, in the US, you can keep funding all this innovation. You can keep driving incentives. You can both afford these medicines for the patients who need them today and keep driving incentives for all the R&D that gives us hope of better and better. But the question is, "How do you spread that 1 percent of, you know, OECD GDP across everyone?" Well, in the US, it's more like 1.4 percent of GDP, and in Europe and other countries, it's less. But then in the US, actually, it's not, like, spread evenly, you know? Medicaid is less, you know, commercial is more, Medicare in the middle, you know. And so, if you don't spread it in the right way, if you try to, you know, get fewer and fewer and fewer people to pay way more than others, then when those people break, and this is kind of maybe what we're dealing with, where commercial insurance is saying, like, we're reaching a breaking point, then everyone loses out. But we can absolutely afford to spread that 1 percent, you know, across everybody, and certainly not dump it on patients in the form of high out-of-pocket costs.

Peter Kolchinsky 00:29:33

And then one final comment I'd make is that medicines are the only things that really go generic in health care. Hospitals don't. And, you know, Alzheimer's is probably going to cost the US something like $40 trillion over a century, right? You could do the math in all kinds of ways, but it's, like, a monstrous number if you need nursing homes and hospitalizations and, you know, caregivers. And, you know, $40 trillion is such a huge number that if you really grappled with it, you'd be like, "Oh my God, I would totally give the drug industry, like, $10 trillion if they would just solve it, solve Alzheimer's." Like, you don't have to give the drug industry $10 trillion to solve it. You just need to not freak out when they launch an Alzheimer's

drug, you know, at the prices that they do. You should do the math and realize, "Wow, for what they're charging, if they kept making progress at this rate, we might not even end up paying, like, $5 or $6 trillion." Like, "Wow, what a bargain." You got to look at the cost of all these things in the greater context of "What will this disease cost us if we don't invent our way out of it?" And so, I don't think the question is, "Can we afford novel medicines?" Which a lot of people ask, especially when it's dumped on them as a high out-of-pocket cost. I think the question is, given the cost of disease, "Can we afford not to incentivize the development of novel medicines by paying for them?" Because they are readily affordable. If we spread it right, it's just 9 percent of all US health-care spending. $4 per American per day pays for all the innovation that we get.

Esther Krofah 00:31:15

So, John, I'm sure you're running the numbers in your head. As Peter's saying, let's pay for all new innovative medicines, and it's only 1 percent on average of GDP, though the US pays more. So, when we talk about affordability from a Medicare perspective, what does that mean for you as the largest public payer? Oftentimes, you're left with the purse string. Are you thinking about affordability relative to taxpayers or those beneficiaries that are within the program?

John Brooks 00:31:45

It's a great question. First, I just want to acknowledge folks who are here listening to a conversation about affordability at 5:20 on a Friday.

Amy Perry 00:31:51

Amazing.

[Laughter]

John Brooks 00:31:51

So, I just want to recognize everyone. We see you. I appreciate it. We think about both. The Medicare program has to balance responsibilities to taxpayers, as well as very significant responsibilities to beneficiaries. We have 70 million beneficiaries, 20 percent of whom are disabled, and the other 80 percent who are above the age of 65 plus and may also be disabled in addition to being 65 plus. And, so these are a lot of folks. The average Medicare beneficiary, as they hit Medicare, has two and a half chronic conditions, and that number could be going up over the next several years. And so, these are programs that are vital to American families, and we need to make sure that we protect affordability there. And there are a couple of different aspects of that. We have seen some, you know, challenging trends over the past, you know, 5 to 10 years. We've seen original Medicare get more and more expensive over time, and that has meant that Medicare Advantage is a more and more attractive option. As the Part B premium in traditional Medicare has gone up, more and more lower-income beneficiaries have migrated to Medicare Advantage because of the supplemental benefits, dental, vision, and some of the other benefits of those products. That is a good news story in a certain way, in that beneficiaries are getting additional access, and there's a lot of value and coordination of care that's happening there. We also have seen in the ACO program, where we have providers coordinating significant improvements in the quality of care, as well as some of the incentives that Amy was speaking to, where we're going to be rolling out a new ACO lead model over the next 10 years, which is going to basically allow ACO participants to enter and maybe not adjust their

benchmarks for five or even 10 years as they invest in beneficiaries and generate additional savings. So, when I think about affordability from program standpoint, we've got a lot of beneficiaries that have financial challenges. We're also headed towards a Medicare trustee cliff in 2032, where the trust fund is slated to run out or estimated to run out at this point in time. We also are headed towards a cliff in our Medicare Part D program, where we've got significant increases in cost as a result of the Inflation Reduction Act and some of the changes to the benefit there that we're going to need to fund. So, from a beneficiary experience perspective, I think we're still seeing, for the most part, beneficiaries are getting access to the services that they need, and that they're in a decent place with some places where we can and need to improve. From a taxpayer perspective, we're facing significant fiscal challenges. To some of the points about longitudinal care, I mentioned LEAD and some of our investments there. We're also doubling down on program integrity, addressing fraud. We had products like skin substitutes, which grew from $250 million in spending to $15 billion in spending in a five-year timeframe. You know, we're making those reforms to make sure that we minimize waste and abuse. And then we are also going to be making investments in technology. I think the first promise—you know, the promise of artificial intelligence is real, as was mentioned earlier. I think the first wave of artificial intelligence hitting the health-care system is just turbocharging it with existing incentives. And so, the use case that's been most readily at hand has been revenue cycle management.

John Brooks 00:35:11

That's not the type of innovation that's really exciting us at the Centers for Medicare & Medicaid Services. But I think as we move forward, there are tremendous opportunities to close access gaps to help beneficiaries live healthier lives, to inform them on information that they need about how to get treatment, how to take better care of themselves in advance, and how to align the incentives of patients and beneficiaries and really empower them moving forward. And the great thing about AI is that it has the potential, if we get the incentives right, to actually be one of the first introductions of a deflationary technology into the health-care system. Most medical technology, frankly, increases cost. And there are a lot of benefits there. But AI, because of the low marginal cost and the power of these tools, creates the opportunity, if we get the incentives right, to be deflationary over time while closing access gaps. And so, we have a model, not coincidentally called ACCESS, that is basically encouraging technology-enabled care, which basically will reward technology-enabled care when we've got demonstrated patient outcomes. When we can actually see a patient's A1C being better managed. When we can actually see clinical outcomes, then the reimbursement will flow through to the technology-enabled care. And we've had enthusiastic support, not only from our traditional Medicare Advantage and Medicaid, you know, co-participants in terms of payers, but also across the commercial sector as we look to find ways to make new tools affordable and close some of the access gaps for patients.

Esther Krofah 00:36:47

John, you bring up an important point around aligning incentives, and Steve, you talked about partnerships are critical. And I wonder, as you went through all of those examples, do we need to go through this one at a time? Like, what is the biggest lever that we have for aligning incentives and for creating these partnerships? So, I wonder if each of you could kind of respond to that. Glen and Steve, we'll probably start with you. What is that biggest lever to align incentives? Because, Glen, you see employers, over 1,700, provide navigation services for 22 million, right, beneficiaries through your platform. Steve, certainly for you with the large health plan, and then we have a health system, and then we have an innovator and investor perspective here, and the public payer. What is the incentive that needs to be

aligned so that all of you will work together in a much more seamless way that will then result in that individual not having to face that really discrete encounter every single time that costs them more money? So, Glen, what incentive would you like to see aligned?

Glen Tullman 00:37:49

Well, I think employers are increasingly going to force us to work together. And it's interesting, this alignment, because there's something called Banner Aetna, which you two have partnered to work together, and we're supplying some of the technology for that. So, there are innovations that are happening, but I think we just need to kind of leap before we look, and we have to start to embrace some of these because it's really on fire now. And we have employers and the employed population and the insured population, but then we have a whole another piece of America that really is not insured at all. And they're functionally uninsured as well because if you have to hit $5,000 before your insurance kicks in, for most Americans, I think a third of Americans only have $400 in their bank account, in their savings account. So, you're functionally uninsured because if you get a $3,000 bill, which is not hard to do for virtually anything in health care today that requires hospitalization, then, you know, you're in a bankruptcy. And we know the number one cause of bankruptcy in the United States is health-care costs.

Esther Krofah 00:39:07

Mm-hmm.

Glen Tullman 00:39:07

So, we have to figure out a way to work together and to do what's best, ultimately, for the consumers. The fastest way to do that, I believe, is through employers because they organize large groups of insurers, and most employers above 1,000 now are self-insured. So, they're administered—at least the larger ones, they're administered by health plans—but they're self-insured, and so they have a very direct vested interest in managing the cost. And while I don't want this to be just cost-based, I think, as John was saying, that AI gives us the ability now, for the first time, to introduce deflationary technology. But we have to do that. Innovation begins by doing something, not by talking about it, but by doing something. So, that's the next step, I think, and we all have to jump in and start doing that at scale. And that's really the objective.

Esther Krofah 00:40:11

Yeah. Steve, your perspective?

Steve Nelson 00:40:13

Yeah. I think to your question, what's the biggest lever to—

Esther Krofah 00:40:17

Yeah.

Steve Nelson 00:40:18

—get us aligned? It's cost, you know? But it's enabled—I think the alignment is enabled by a couple of things that are under that. One is you have to adopt the mindset that there's not one single part of the system that can operate independently—that can get it done by themselves. And it's kind of ironic because obviously health plans who don't own provider groups—even if you do own provider groups—like, no one has the scale to take care of, you know, sort of like everyone in our country. And so, ironically, there's, you know, a lot of people walking around with, "Oh, I don't need you," or, "I don't want to…" The mindset has to switch. And so, that's one thing. The second thing is there is, I think, a driving force here that is the health-care system will be—well, it's already challenged by, I mean, you know, what happened in elections last week. The conversation about, do we blow this thing up, you know? And my position is, it is an incredible system to build on. It's not perfect, but we need to evolve it, not scrap it. So, I think—I'm not saying the lever is fear, but I think we could get thrown into a much worse scenario if we don't get it right. And so, I think there's a couple motivations there. And then the last one is we are all consumers of health care. We all feel it ourselves. We were talking about navigation earlier. I mean, I would consider myself a relative expert in health care, you know? It is challenging to navigate when you have a health—I had a family member who had a health issue in Arizona.

Esther Krofah 00:42:29

Did they try to get in?

Steve Nelson 00:42:31

Yeah, Arizona. And I called. No. I called—

Esther Krofah 00:42:35

Things like—

Steve Nelson 00:42:35

They sort of struggled for a couple hours, you know, and, like, what to do, where to go. It was actually very serious. And I called Amy and I said—and, you know, in the next hour, everything kind of worked out. If I didn't know Amy—

Amy Perry 00:42:50

I'll be giving my cell phone out.

Steve Nelson 00:42:52

No, I mean seriously.

[Crosstalk]

Esther Krofah 00:42:54

We don't all have an Amy to call.

Steve Nelson 00:42:57

But the fact that we needed the—*[Laughter]* Yeah. If you're ever in Arizona and you have a very serious health situation, call Amy. But it actually meant a lot to our family, and it probably saved my nephew's life. And so, it's just so frustrating that, you know, it has to be that way. And so—and then on your point about, I think, employers kind of rallying and helping us, I'm going to take a little bit of a contrarian point of view there. I'm talking employer large, you know, Fortune 100 all the time, including CVS Health.

[Laughter]

Esther Krofah 00:43:35

Mm-hmm.

Steve Nelson 00:43:36

And the idea of employers having the intestinal fortitude to actually make really hard decisions—and I'm just going to pick on Arizona again. Do you really need the number of health systems you have in that market? You know, do you need Banner, Mayo, Ascension? Actually, I don't think so. And so, if you were able to really rank, stack quality outcomes, experience, all that, and go to an employer and say, "You will decrease your cost by 15 percent if you have the guts to take one of these systems out of your network," 99 percent of the time, it's "Can't do it." So, I think—

Glen Tullman 00:44:19

Do you not see that changing? Literally, I think in the last six to nine months, I think employers have run out of opportunities to cost shift, which they were doing.

Steve Nelson 00:44:30

Yeah.

Glen Tullman 00:44:30

And, I think, now they are, I see everything from dropping coverage from pretty large employers to cutting back on what's covered, to saying to people, "You can make your own decision as long as it's a smart decision, you get a second opinion," or those kinds of things.

Steve Nelson 00:44:49

No, it's—

Glen Tullman 00:44:49

I've seen a dramatic change.

Steve Nelson 00:44:50

—yeah, I think there's more appetite to do—I just was on the phone with a very large customer this morning, and their trend is they're just like, "We can't—do this." I said, "Well, are you willing to reconsider

the things that we put on the table earlier?" And they're like, "We are." So, I agree with you, but that is a recent development.

Glen Tullman 00:45:11

I agree.

Steve Nelson 00:45:12

And so, anyway, I think those are some of the levers that are moving—

Amy Perry 00:45:16

Yeah.

Steve Nelson 00:45:17

—us together and, frankly, it sounds like I'm kind of negative about it, but I'm optimistic because that's what has to happen, and that gives me hope, honestly.

Esther Krofah 00:45:28

Yeah. So, certainly the cost pressures at the employer level are driving change. They have to drive change because the large employers are seeing an average increase of what? Like 9.2 percent, the small about 35 percent.

Steve Nelson 00:45:41

Mm-hmm.

Esther Krofah 00:45:41

That's unaffordable, that's unsustainable. I can't imagine how a small employer can have year-over-year cost increases 35 percent for their carrier for their insurance alone. So, basically we're creating a little bit of two markets, the haves and the have-nots.

Amy Perry 00:45:54

Yeah.

Esther Krofah 00:45:56

You have, if you have insurance, maybe not even high-quality insurance depending on what you can pay for, and then those that fall out of the system, they're in the social safety net. So, Amy, can you just tell us a little bit about how you think about those two populations?

Amy Perry 00:46:10

Yeah. Boy, there's so many things that came up in my mind when we were talking about this.

Steve Nelson 00:46:15

Are you still trying to figure out which system you would cut out?

Amy Perry 00:46:17

Yeah. Well, we have. So, Steve and I have a narrow network, a preferred—

Steve Nelson 00:46:23

Right.

Amy Perry 00:46:23

—network in Arizona that's less expensive.

Steve Nelson 00:46:26

Yep.

Esther Krofah 00:46:27

Mm-hmm.

Amy Perry 00:46:27

So, that kind of concept, not everybody can come to the party if they're not willing to be at a reasonable value.

Steve Nelson 00:46:36

Right.

Amy Perry 00:46:36

So, I do think that seeing more shift to organizations that will try to be more affordable, that will lean into health, I think matters. But a really important point I want to make is capitalism requires a social contract. We need to make sure we have a functioning society. That means health. Health means people can go to work. Means they can graduate high school. We can have a functioning society. That requires a social contract. That requires investments. So, take the drug companies for a second. So, Banner Health has invested $400 million in a cure for Alzheimer's disease. And we've gotten a lot of work done and, in fact, contributed to a drug that's currently on the market that we get zero return on our investment. Our investment is the social contract. Because we're a nonprofit health system, our return is that, possibly, we can stop the $900 billion in spending annually on Alzheimer's care. We are investing in a stem cell treatment for Parkinson's disease. Our win is that we quit spending $90 billion a year in this country on Parkinson's. So, what I would suggest—because we have a little bit of a difference in terms of what's the end game—for me, if we win—and, by the way, we're investing a lot in cancer vaccines right now—if we win and we can possibly make any sort of profit on it, it gets reinvested into the social contract. Okay? And so, I would suggest that it could be a benefit if pharmaceutical companies, when they have a win, make

investments into the 70 percent of our country that has no access to health care or has limited access to health care. There are so many threads that we can pull to help make our society stronger so all our companies are stronger.

Esther Krofah 00:48:55

I just wonder if all of this is voluntary. So, you've made the decision at Banner Health to do this, right? Reinvesting in the community, reinvesting in medicine. If we think about systematic change, are we just going to say we're going to rely on one institution at a time to make that commitment? Is that what our future offers us? Can we think more holistically around larger levers and incentives where we can all align and say, "You know what? This is for the country." Maybe, John, you have the levers to do that more so than one institution. But are we making those trade—is that really where we are as a country, which is Aetna needs to make the right decision, and Banner needs to make the right decision, and, you know, Glen needs to make the right decision, all on their own? But can we incentivize all of us to do that at the same time? And then I'll come back to you, Peter, but I just wonder if you can react to that.

John Brooks 00:49:48

Yeah. I think the fundamental point that, in order for people to have faith in markets and people to have faith in America, they need to understand that they have opportunities, and those opportunities need to seem like they're attainable and that the playing field is fair. So, I think that that's right, and I think that that is downstream of societal trust and of a million different decisions by different entities to make investments in America, whether it's through the social safety net, whether it's through, you know, drug development, whether it's through providing access to care. I mean, when I think about the larger conversation we're having around incentives, you know, it's very striking to me that CMS has been, you know, on the journey for value-based care post-Affordable Care Act, which gave CMS a lot more ability to experiment with new models, for about 15 years now. Most of those models have not saved money. And even more discouraging to me than that is that the uptake in the commercial market for many of the concepts that CMS has pursued around value-based care is practically nonexistent. There just has not—we have not cracked the code in terms of identifying a value-based construct that's a win-win from the payer and the provider perspective that's really spread. Now, I'm optimistic about ACOs and LEAD, where, you know, we have the ability for providers to journey with us on this 10-year journey. I'm optimistic that there could be additional constructs in Medicare Advantage, et cetera, which allow plans to make more investments in beneficiaries in preventive care that will pay off over time, so that we can have longitudinal care for the patient. But in terms of aligning the incentives for payers, for providers, and for patients so that everybody benefits long term when patients are healthier, I don't think we've cracked that code, and that's something that, you know, keeps me up at night and that we wake up every day trying to fix. And one of the reasons I'm excited about panels like this is because we have so many folks with diverse perspectives here that we can learn and hopefully crack that code.

Esther Krofah 00:51:57

Yeah. Absolutely. So, there are more solutions that we can offer here in, in this topic. Peter, your thoughts around what is the incentive that you would like to pull? What would have the most impact on the social contract that we just heard about?

Peter Kolchinsky 00:52:10

Yeah. Thank you. So, I'd love to get kind of specific, and maybe later we can debate some of the specifics in the remaining seconds we'll have left. But I think that we need to have proper community-rated insurance, which I think requires an insurance mandate. We have that in Massachusetts. We've got the lowest uninsurance rate in the entire country. Everybody has to pay in. I think that for that, you would probably need to have some premium subsidies that are means-tested. Some people can't afford to simply pay the same premium as everybody else. But get everybody pitching in, you know, what they can. It is affordable if we spread the costs widely and implement the efficiencies that we've just talked about. I think we should reexamine skin in the game. We should have, like—does anybody fake cancer to score chemo or fake diabetes to get insulin? Like, I don't think so, right? So, if we think that somebody just doesn't care and they're just refilling their script and not even taking the drug, we should come up with fixes for that. But there's a lot of people who can't afford appropriate care because we keep using high out-of-pocket costs to essentially deputize patients into second-guessing their physicians. Right? And that's just cruel, and it's leading to a lot of anger. So, I think I would prefer to see what I would call honest coverage or truth in insurance. Decide if you're going to cover a drug, a treatment, you know, and then if a physician prescribes it appropriately, cover it from the first dollar, maybe with a modest $5 copay. If you need to confirm if it's appropriate, use a prior auth, a real-time, electronic, digital prior auth, not something that grinds a physician into submission, right? And, you know, it has to be faxed or whatever it is. That may take some technological upgrades, but we should seek, you know, the truth of whether something is appropriately prescribed. And then if it is, cover it. That's the promise of insurance. We should keep getting a bargain from drugs. That means that all drugs have to go generic without undue delay. That is what I call the biotech social contract. You know, our industry makes medicines that will go generic without undue delay, and in exchange, society makes all appropriate medicines, branded or generic, affordable through proper insurance, which means, you know, low out-of-pocket costs. I think we need trade pressure on other countries to get them to pay their fair share, so that it's not just dumped on the US, but that's going to require much more finesse than just most-favored-nation. Other countries like to use really skimpy health economic math to claim drugs aren't worth their prices. They ignore that drugs go generic, that they benefit caregivers. You know, all kinds of values are stripped away just so they can say, "Oh, yeah, it's not really worth it." But there's a counter to that. It's a form of math called generalized cost-effectiveness analysis that shows that, guess what? The US has been rational all along. The prices we've been paying have been getting us a bargain, and, you know, everybody else is free-riding. And I would say if we made those kinds of changes, like bringing other countries into it, that would be a global biotech social contract. I could keep going, but I won't.

Esther Krofah 00:55:23

Yeah, well, we don't have time for you to keep going, but—

[Laughter]

Esther Krofah 00:55:27

—But that's a good list. That's a long list. In our final remaining minutes, just ending on a note of optimism, what is the one affordability solution that you would each offer? Where should we go as a country? We just came through the midterm elections. It was a number one concern of voters. We are hearing solutions around: Should we go Medicare for All? Should we start from scratch? Should we decrease the age or increase the age, depending on what programs we're talking about? What is the one solution we should really be debating as a country to get us to much more of a system-wide change across different types of

categories, whether you're Medicare, Medicaid, commercial, that gets us closer to affordability? And I would say our perspective ought to be affordability on behalf of patients. So, let's go just down the line. What would you want to see us move toward as a country, Glen?

Glen Tullman 00:56:21

There's a lot of people looking at me here.

[Laughter]

Glen Tullman 00:56:25

Well, I'm sorry to say, I don't think there's one solution to this.

Amy Perry 00:56:28

Okay.

Glen Tullman 00:56:29

I don't think it works for the country.

Steve Nelson 00:56:30

You're breaking her rule.

[Laughter]

Glen Tullman 00:56:32

Yeah. I mean I guess—The answer is, but I do think there are a lot of different solutions that people can bring to bear, and I think what we have to have is, to go back to the social contract, I think we have to have a commitment to say people have to stop blocking solutions that are reasonable. And I'm hoping that the message the voters sent, which was this was a victory, I think, for democracy, not for the Democrats and surely not for the Republicans. But what the voters said is, "We didn't like the last folks. We threw them out. We put new folks in. We didn't like what they're doing." And my message to the Democrats was, "In two years, you'll get thrown out, too, if you don't get to the middle and figure out things that work." And that's really what people want. And, I think, as each of us in our respective roles have to step to the table and say, "What can we do to make this better?" Because if not, I think frustrated voters will vote for all kinds of things we don't want. And I agree with you that scrapping the system, one, it's not viable. Two, we have the best system. So, we have the best doctors, best hospitals. You know, you can go down the line, best drug development, et cetera. What we haven't done is figure out a way to get everyone to take advantage of it, and that is the objective, and that's an affordability objective. And so, I think it's a collaborative. The one thing we have to do is collaborate and realize we're one country, and we got to get this fixed to make everything else work.

Esther Krofah 00:58:11

Steve?

Steve Nelson 00:58:13

Can the future of health be affordable?

Esther Krofah 00:58:15

Yeah.

Steve Nelson 00:58:16

Yes.

Esther Krofah 00:58:16

Okay.

Steve Nelson 00:58:18

But let's evolve, not scrap.

Esther Krofah 00:58:21

Mm-hmm.

Steve Nelson 00:58:23

That's my pitch.

Esther Krofah 00:58:26

Okay. Let evolve—one more sentence. Let's evolve how?

[Laughter]

Steve Nelson 00:58:31

So, I think we should entertain evolutionary ideas, you know? So, whether it's, you know, extending Medicare coverage to a lower age group or things that we maybe traditionally would say, like, "No, no, no." You know? Like, in the spirit of we have a great system, let's build on it, let's work with it. We have an incredible program, Medicare Advantage. It's actually one of the purest forms of value-based care out there, John, right? It works. And so, when I give—And that's different than scrapping, you know, kind of single-payer, Medicare for All, sort of these scorched-earth kind of ideas, you know? I just think there's opportunities. That's just one example of let's embrace some of the uncomfortable conversations, and let's go figure it out.

Esther Krofah 00:59:27

Yeah. That's a great call to action, right? Let's move outside of the status quo. Let's recognize that something is broken.

Steve Nelson 00:59:32

Yeah.

Esther Krofah 00:59:32

And it's okay to evolve.

Steve Nelson 00:59:34

Right.

Esther Krofah 00:59:34

Right? I think, Glen, that's the point that you're making as well. Also let's do it together. Amy?

Amy Perry 00:59:39

So, my feeling is we need to support our communities. I think that the way to make health care affordable is a real grassroots, completely non-glamorous approach. We need our kids to graduate high school. We need to help them get jobs. We need to keep our communities safe. Those fundamental things matter. GLPs are not a panacea for saving us all, okay? I do believe we need to get into our communities, we need to find out what they need, and we need to support their action in providing a stronger, healthier America at the grassroots level, from our rural communities to our urban communities. It's going to take all of us working together. And I do think that America cares about each other, and we care about our neighbors, and we're going to see what happens over the next two years to see if we can lean into that.

Esther Krofah 01:00:34

Excellent. All right, let's move care out of hospitals. Let's move it back into community. That's part of the solution. Peter?

Peter Kolchinsky 01:00:43

I think we ought to get better at telling stories that allow America to understand what actually is working, how these pieces fit together. All this stuff is really complex, and it's super boring the way we talk about it. But we understand it, so, like, the jargon makes sense. But I really wish that we would, like, set up a funding agency for Hollywood to get the details right in its stories. And maybe over, like, five years or something, the public might understand a bit more about it, right? But we just—

Glen Tullman 01:01:14

But Peter, Hollywood's having so much fun picking on insurance companies.

[Laughter]

Peter Kolchinsky 01:01:17

I know. I know, man. We've just got to outbid whoever is—

Glen Tullman 01:01:20

Sells tickets, I guess.

Peter Kolchinsky 01:01:22

But in any case—

Esther Krofah 01:01:23

But if we need to hire Hollywood, haven't we made it too complicated?

Peter Kolchinsky 01:01:25

I just think—I just think you can't win hearts and minds without better storytelling. The facts don't do it.

Amy Perry 01:01:32

Yeah.

Peter Kolchinsky 01:01:32

I mean, I know I have tons of facts, and I am working on the storytelling part of it, not the facts. Because there's so much working, as Steve pointed out, and we have to evolve it so it works for more people, ideally all people. I started a nonprofit called No Patient Left Behind. Not fewer people left behind, like, no patient left behind. That should be our goal. So, if you guys are good at storytelling, if anybody's ever made a TikTok video that got a whole ton of views, come talk to me. Like, I need those skills.

Esther Krofah 01:02:00

All right. John, I'm going to let you close out our conference here. Can the future of health be affordable? What's your answer?

John Brooks 01:02:06

The future of health can be affordable. I don't think there's a single silver bullet. I do think if you think about prevention, though, and you think about individuals fundamentally wanting to be healthy. They want to know how to be healthy. They don't always know how to be healthy because we live in a very confusing information environment, and the competition for attention is intense. But I do think with the combination of new technology, including AI-enabled tools, which can provide people with much more specific and targeted information, as well as the widespread deployment of those and a focus on prevention, Americans can lead much healthier lives. That'll save our system a lot more money. That will make them more productive in their workforce, but also, it just enables all of us to live better lives. You know, as they say, healthy people have 1,000 dreams; a sick person has one. I think about the ESRD population. We have a lot of patients with end-stage renal disease. Medicare pays for almost all of those patients. Those patients are on dialysis, and end-stage renal disease is end-stage, so the trajectory there is very unfavorable without a transplant. A lot of those patients, if we had caught them five, 10 years before, if we had explained what their A1C was, what that meant, if they had had a tool that they could easily use that helped them understand that they were on a trajectory that was going to lead to a place that they

really didn't want to go, then—and you can—and we can understand human psychology better with these tools to provide the reinforcement mechanisms so that people can manage their health better. I do think there's a lot of reasons for optimism right now, and I think that has a lot of positive externalities in terms of affordability. But really, I think it's about leading more full lives, and I think that that's where I'm most optimistic.

Esther Krofah 01:03:55

Yeah. Well, the American people have spoken. And what they've said is that health is not affordable. And what I've heard from all of you today is that in each of the different sectors you represent, you're motivated to fix this problem, that you're committed to fixing the problem. It might take collaboration, it might take technology, it might take partnership, it might take thinking about the paradigm differently, Peter, from your perspective. And you can work on these solutions through demonstration programs, John, that you described. But unless we're putting those patients first, we're putting those families first, we're thinking upstream and prevention first, until we want to commit to evolve, we're going to be back here next year or in two years with the same question: Can the future of health be affordable? I hope that we work together. I hope that all of us work together, that this is not the conversation we're going to have in two years. Thank you so much for joining us. Thank you to all of you for being part of the Future of Health Summit.

[Applause]

Have a fantastic day. Thank you.

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