[00:00:01.320] Announcer:

Welcome to APG on American Healthcare, the official podcast of America's Physician Groups, where we discuss current issues in the healthcare value movement. APG members are at the forefront of national healthcare reform, practicing at risk based prospective payment and other population-based payment models, the very models described by federal legislation for the entire nation. And now for an inspiring and educational look at the transformation of America's healthcare delivery system. Here's your host, APG President and CEO, Don Crane.

[00:00:36.540] Don Crane:

I am delighted today to have as my guest, Ian Morrison, well known, I think, to many of the listeners of this podcast. Ian is an internationally known author, consultant and important for our purposes, I think, a futurist. He holds a PhD in urban studies and MA degree in geography and a graduate degree in urban planning, all of which beautifully prepared him for a career in health policy, as you'll soon hear; author of a number of books, one of which The Second Curve: Managing the Velocity of Change was a New York Times Business bestseller and a Business Week best seller published in seven languages.

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But I think for our purposes, more importantly, pretty much required reading for any student of healthcare policy. He is the Past President of the Institute for the Future; spoken at APG conferences a number of times. All of that is what the bio reflects. What I would add, sort of on a personal note is that, of course, as you'll soon hear in a minute, he's got a great sense of humor. But he's also, I think, like a lot of us, invested in the improvement of American healthcare.

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So, while he is not as knowledgeable as anybody else, one gets the sense that he is truly sincere in his interest that we transform this system, from something where it is now to something much better in the future. So, with that. Ian, welcome. Great to have you. How are you today?

[00:02:06.660] Ian Morrison:

I am terrific, Don, and thank you for that very kind introduction. It's a real pleasure to be here. And, in distinguished company.

[00:02:14.340]

Well, very, very good. So, well, here we are, September 2020. We could not, of course, have a conversation about healthcare without plenty of conversation about our COVID pandemic which is upon us at the moment in big ways. Where I think I'd start, Ian, is with our value movement. So, as you well know, the mission of APG is to proliferate risk-based, coordinated care. So that is what we are all about.

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We have, you know, three hundred forty-five members that are all committed to that very thing in terms of taking risk-based contracts and the like. And so, I think the leading question for so many of us is, what do you think, Ian, the impact of this epidemic will have on the value movement?

[00:03:00.630] Ian Morrison:

Well, I think that's a key question, Don, and I think there are signals and signs in both directions, both positively and negatively.

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I mean, let me just start by saying that if you were committed to value and particularly had delegated risk, talking particularly your members who are physician groups, then you weather the storm a lot better than those people who were dependent on fee-for-service and folk turning up, especially if you had made the investments in telehealth and other kinds of digital enablement to serve patients so that money flowed and the care can flow. And it proved out, I think for many the resilience of the value model.

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And it sort of reflected in our friends at Kaiser Permanente who, unlike other health delivery systems, didn't see the same financial shock of loss of electives and so forth.

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And there are other positive signs like, you know, I think in North Carolina, we saw a fairly significant shift to support practices using kind of at-risk ACOs using the outdated model, you know, to take this moment of uncertainty for physicians to advance, you know, the value-based care model.

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And that's on the positive side. Now is also on the positive side I think the market has responded to things like, OK(?), IPO, you know, so there are signals of positivity out there.

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On the other hand, though, I worry a little bit that the mainstream health delivery system, particularly large hospital systems, even if they have significant medical groups and are taking some risk either in ACOs or Medicare Advantage in various forms. I worry a little bit that the job one for them is going to be the return to normalcy of fee-for-service volumes. And I've been sort of joking in the last year or two, pre-COVID that we're not moving from volume to value.

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We're moving from volume to volume, you know, replacing inpatient volume with outpatient volume. And I worry a little bit that the mainstream health system will revert to that volume-to-volume story in response to the hammering they got economically in the early part of the year.

[00:05:39.950] Don Crane:

So interesting for you to draw this dichotomy between those that are already in risk and those are not in risk. Those not in risk may need to double down on fee-for-service to, you know, resume that volume and bring back those revenues. And that being a kind of backwardising kind of a trend. As I think, though, about and we've seen a little of that, frankly, Ian, already among some of our members that are frankly within integrated systems.

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So, I agree with that concern. But I also hear, I mean, loud and clear the call for a doubling down on value. So you were alluding this repeat what you pretty much already said with the reduction in elective procedures, services, with the fear that patients have to visit their physicians, primary care physicians, but really all physicians, you know, the visits dried up, the work dried up, the revenues dried up.

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And, all of a sudden, we have, you know, droves of physicians, lots of them primary care physicians, which is an important footnote in terms of what we need to take care of our people. But all of a sudden and we have examples of, you know, these physicians closing their doors, Ian. And so the unmasking of the you know, the inadequacies of fee-for-service as a payment model have been observed, you know, in spades producing a I think a call; I'd like to say a clamor for, you know, incentives or mandates or something to pull the Band-Aid off and try and move physicians across the country from volume to value, away from fee-for-service into some kind of prospective payment.

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Have you been observing that same thing as well? And do you think that might take hold?

[00:07:28.220] Ian Morrison:

Yeah, I do. And I think that there's a great logic to it. And as I say, it depends who's driving the bus for those physicians, whether it be the groups themselves or whether they are part of an affiliation with larger entities who may have a slightly different set of priorities economically going forward. I mean, I talked to a lot of health system leaders across the country. And, you know, I genuinely take them at their word that

they are, despite the obvious incentives that still exist in a hybrid mode where they've got both fee-for-service and some form of at-risk provider arrangements that they want to move towards value.

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And I take them at their word on that. But I do come back to this harsh reality that there's a lot of revenue to be made up in the interim. I think the lever here, there are two levers, I think, to be pulled. One is whatever may happen going forward with health policy on both Medicare and Medicaid to encourage value-based payment going forward. On the one hand and I know we're going to get to this later on, but also really reaching out to self-insured employers to engage more directly in the value movement.

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But I would ask you, Don, because you're, you know, you're close to your membership.

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One could imagine that a lot of people out there who are in medical groups, whether they are sort of on the road to value, but maybe still immersed in hybrid practice both fee for service and so forth.

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I mean, are you seeing them determined to double down on value as a result of this covid experience?

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Or are is there some reticence given, you know, their history and the markets they're in because you're all over the country? I mean, this isn't just a California phenomenon.

[00:09:24.170] Don Crane:

No, it's across the country. And in no uncertain terms, those that are in risk are very, very happy they're there.

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So, these prospective payments, telling you what you already know, have continued in spite of the pandemic. Right? Prospective payment, making that money available for the treatment for both COVID patients and non-COVID patients without missing a beat. So, our members are extremely thankful for that very thing. And, you know, frankly, interestingly, I'm both a little bit of a victim and a beneficiary of this prospective payment. So we think about our conference business, for example, Well, it's in trouble because of COVID, and yet our member dues revenue has continued unabated because they've got the revenue and they haven't lost the revenue as fee-for-service groups.

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So, you know, that's what I'm seeing across my membership. And, you know, frankly, we're sort of hoping this is the big disruptor, Ian, that will motivate Congress, motivate state houses. And then, as you say here, and we'll talk about it in a minute, employers to make a big move into value because it's not just important for pandemics. And I think we know that this is not the last pandemic we'll ever see. But it's also important for the treatment of patients with multiple chronic diseases, which represents, I think, you know, 80 percent of the spend nationally and 90 percent among seniors.

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So that's my answer to that. It's, you know, prospective payment is a Godsend at the moment.

[00:10:56.740] Ian Morrison:

Right. Right. No, I agree. And, you know, we are of the same mind that that is something we should be encouraging. And I just think we have to be realistic that there are other forces tamping down our enthusiasm for that, you know, migration.

[00:11:13.070] Don Crane:

I guess it's never easy to transform this system. So apart from the value movement, let me ask more generally, how do you think this will impact the healthcare system? I mean, how does it affect different players mode of practice?

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What do you think?

[00:11:33.920] Ian Morrison:

In terms of the whole COVID pandemic?

[00:11:36.280] Don Crane:

Yeah, it is a pandemic. We've seen telehealth, for example, where we're wondering about shifts in populations, those that all of a sudden are without a job and are therefore uninsured and moved from commercial into Medicaid. There's any number of ramifications. How do you see all of that?

[00:11:53.120] Ian Morrison:

Well, I've been sort of tracking this pretty closely with colleagues. And I have to say that let's start with the obvious, the disease where it crashed and is crashed now over almost every part of America one way or another.

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I mean, I'm giving a talk to Henry Ford in a couple of weeks and they are a physician group. And, you know, just listening to The Reprieve, I don't know if you saw it on NPR, which was This American Life documentary on the radio of the experience for four patients and providers in Detroit during and immediately after the pandemic. I mean, it was absolutely amazingly challenging for the New York's, the New Jersey's, the Louisiana's to respond to just the sheer weight of patients coming through and the agony and the difficulty of managing that.

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So we cannot forget just the burden that this placed, both emotionally and physically and economically on healthcare providers. And I think what we've learned is that the elective shutdown, you know, was even more damaging for people who didn't get exposed to that first wave that crashed over the country.

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And that's why in the second wave, if you like, you know, the July spike in Miami and Atlanta and Arizona, that many of those health systems actually didn't, you know, stop all electives but ran kind of two different hospitals. Right? And so I think and what I'm hearing and seeing across the country is that the hospital business is sort of coming back, you know, as is physician visits, you know, regardless of which market you're in, we're maybe down only 10 percent or so in terms of visit rates, according to some data estimates and down a little bit still on E.R. visits.

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But I think you alluded to what I've been sort of you know, I'm not a clinician, but what I've been watching is the sort of second order knock-on effects of all of this on the economy. And obviously, you know, the cascade that I've been kind of tracking is that, you know, job loss as a result of the pandemic will eventually lead to health insurance coverage loss, although there is a big lag in there and it's been mitigated, you know, over the last few months by employers not eliminating health insurance immediately.

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I think that shoe is about to fall in the next few weeks. And so, I worry a little bit about that. And then the cascade, obviously, of fewer commercial lives covered in the longer run, an increase in Medicaid concomitantly, although the studies show there's probably a seven-month lag between the height of unemployment and the height of Medicaid enrollment. So, I mean, that cascade is going on and that has

big implications on payer mix for provider systems of whether they be physicians or hospitals or both going forward.

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Because let's be honest, the lifeblood of American healthcare is commercial payment. Unless you're an at-risk group who really cut its chops on Medicare Advantage or Medicare choice or however you want to put it back in the day, you know, like our good friend Bob Margolis, you know, who had a preference for Medicare lives over commercial. I think unless you're in that category of pure play, you know, you're looking at the kind of the demise or not demise.

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But I mean, I've said that I believe that January 2020 was the height of private commercial coverage in America and will be for some considerable time. I'm happy to be proved wrong, but I do think that's a fair forecast.

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But, I mean, I'd be curious how your members are seeing this in the sense of, you know, do they worry about a commercial to Medicaid substitution going on as a result of this? And how are they preparing for it?

[00:16:24.330] Don Crane:

Well, they're worried, of course, because, as you said, indeed, the reimbursement is higher in commercial than it is in Medicaid. So, there's concern there. I think they're prepared for it because the nature of their business is, you know, taking care of populations for, you know, prepayment. I think they feel they can absorb it. Tougher, I think, for the fee-for-service world to move from commercial. Tougher most of all for hospitals where, you know, their commercial rates are sometimes two and three hundred percent of what the hospital rates.

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I think for my members, there's a level of durability and resilience that will allow them to do that. But I wonder who the other, you know, I know you do a lot of work with employers. Or how nervous are they about this shift and who are the other winners and losers you think emerge from this kind of shift from commercial to Medicaid?

[00:17:22.080] Ian Morrison:

Right. Well, you're right. I mean, I've been close to the Pacific Business Group on Health over the years, and I've been in contact with them and spoken and participated in their board meeting more recently in

the last couple of months. I mean, without telling tales out of school, I think they are…and Elizabeth Mitchell, the current CEO, has been very eloquent about this and in a number of different forums. But, you know, I think they are, first of all, concerned that while in the short run, you know, they've seen their per member, per month burden, if you like, go down because of the elective shutdown.

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I'm talking about self-insured here. You know, the burden obviously has gone down. You know, we've seen medical loss ratios basically drop, but it's cold comfort if you're United Airlines, you know, you're going to have to lay off half your people, right? I mean, it's the fact that your spend per capita went down. It's not exactly…not licking their chops at that. So, it's been a negative, you know, obviously for some industries who are, you know, just simply dealing with the massive reduction in demand and what do they do about the workforce.

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But to answer your point more specifically, I think they are very concerned about this relative cost shift that they may experience as a result of being the place where providers look to make up the elective loss of 2020. So, they're fearful for the future. The other thing is, I think and this is the good news potentially for you all, I think they have the sophisticated ones like PBGH have really learned about the importance of primary care in particular and the role that physician groups play in that, whether they have done enough to massify their firepower to support you is a whole

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other issue and one thing certainly I think we could gang up on them on. But I do think they recognize the importance of primary care. The other final strand of that and then I'd love to ask you some questions about what I'm seeing in terms of this issue of disaggregation of health insurance. The other strand is really around, you know, their overarching concern that the system is not working quite the way they need it right now.

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And they've been reaching out to a whole variety of point solutions, whether it be Livongo or, you know, telehealth for behavioral health, and they're cobbling together a lot of that. And I worry greatly that the sum of the point solutions is actually more expensive than sending a nice, you know, per member per month check to your members.

[00:20:21.170] Don Crane:

So, let me dwell on that for a minute. I mean, I have long wondered why employers here I think, you know, employer covered coverage, sponsored coverage is well over 50 percent of the healthcare in the United States. And so, you know, I thought, look, and they indeed complain about high costs. They do

implement some pretty good programs, reference pricing centers of excellence. But, you know, I've often wondered why they don't rise up a little bit more strongly. In other words, a lot more strongly, Ian, and basically demand the kind of improved system that I think they want and we're all talking about.

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I mean, do you see this situation COVID and the shifts we're talking about as precipitating, you know, a much larger effort by employers to pound on plans, pound on physician groups, pound on Congress?

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They've been passive in the past, I think. Will this make them active?

[00:21:23.330] Ian Morrison:

Yeah, well, I think that's the right question. And I do see signs amongst leaders like PBGH that they are stepping up and trying to put in place both policy and marketplace mechanisms to make their clout felt in the way you're talking about. And I encourage and support that. The real problem is that you've got a big distribution even amongst, let's say, as you correctly point out, you know, over half of the folks in America getting coverage through the private sector and over half of that half are really amongst these big jumbo, self-insured employers. You know who the group I've been, because I think you do have to make a distinction between the insured and the self-insured market.

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But I would say that, you know, the problem that all employers have, regardless of whether they're kind of more sophisticated, as in the PBGH members, or whether they're more the laggards and followers, is that there are a number of things. One is they all want to do their own thing for their own employees because they all figure they've got kind of a slightly different mix of humans, which I think is at one level maybe true, but is kind of goofy when you think about it.

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Right? And the other thing is, and this is where I think we have a problem, is that they don't have enough lives, any one of them in one place to really make a difference unless you're state local government or you're Disney and you got 100,000 people in the theme park in LA or South Florida. So that lack of firepower locally has frustrated them and, you know, having really impactful discussions directly with provider systems. They're not enough to change the game.

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And so, you default basically to say, well, have your plans do it. And then I'm constantly hearing from the plans, well, we try and put these narrow networks in place and then the employers don't have our back.

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You know, they emphasize, oh, well, you've got to have everybody in it. I'm like, well, wait a second, you know, how is that going to work? I mean, how are we using our firepower if everybody can go anywhere? And that's been, I think, the back and forth over the years where people have confused choice with quality. And, you know, I've been trying to encourage them to let's pick some provider partners and coordinate amongst yourselves to really drive both benefit design and funding and relationships towards those high value, high performing providers, many of whom I think would end up being your members.

[00:24:10.610] Don Crane:

So, what do you think is the level of appetite among self-insured employers to move out of, you know, they're more principally self-insured PPO, right? What's their appetite for moving into prospective payment capitation?

[00:24:26.210] Ian Morrison:

Well, I mean, if you look at you know, I've dealt with Kaiser over the years. If you think about Kaiser, I mean, they're the people who are getting like a prepayment in pure form. And, you know, the constant kibitzing from the self-insured employers to the Kaisers says, we want to look under the hood more. We'd like to see what's under there, because they believe if they could see under the hood, they could, you know, get a better deal.

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And there's a lot to-ing and fro-ing in that regard. I think they're, and this is what I wanted to raise with you and ask you about whether you're seeing this, I'm concerned that if we're going back to this point solution model is that we're actually seeing a reverse trend from the integrated capitated delegated model amongst employers.

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I'm seeing far lower levels of self-insurance. In other words, that smaller and smaller companies are going self-insured.

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I don't know if you saw this announcement in the last week or two, but this new venture that's been formed Coefficient is the name. This is a verily subsidiary from Google backed by Swiss Re, the reinsurance company that is aimed at self-funded employers bringing sort of sophisticated analytics to that marketplace.

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And they have some very serious people, you know, like Vivien Leigh, who I know and respect, who's chairman of the endeavor, and some ex-Anthem people and Tesla's former CFO. This seems like a serious endeavor here. And I do believe that there is this potential for a disaggregation of that self-insured market where employers cobble together a series of offerings from, you know, direct primary care relationships that they fund to the Livongos of the world for their chronic population to a at-risk reinsured carveout to minimize the very high cost, complex preemies and so forth that end up going to the children's hospitals.

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I mean, I could conceive of a way in which that starts to nibble away and further undermine, you know, the prepayment for chronic care management that's been the lifeblood really of, you know, a lot of your members.

[00:26:55.320] Don Crane:

Well, that's not a welcome, you know, story. There's obviously an awful lot of innovation going on and experimentation. So, it's not surprising. One would hope that the cream would float to the top somehow. And, you know, the sort of virtues and superiority of a prospectively-paid group would be the, you know, the emerging victor in terms of delivery models and payment models. But it'll be that as it may, and there probably shouldn't be any sacred cows.

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And I'm not so sure that what you've described in the way of cobbling together couldn't also include the cobbling of groups together to produce bigger network for national employers and the like. So maybe we're watching sort of the renaissance of some really, some new creativity that will emerge in the self-insured market. I hope so. Let me shift your gaze over to health plans for a minute. You know, Affordable Care Act signed in 2010. So, 10 years ago. MACRA occurred, I think, 2015.

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We had this value movement going for at least that long.

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Original Medicare through CMMI has been doing a really excellent job, in my personal opinion, in terms of experimentation with alternative payment models. There's much debate as to whether they really generated savings or not. But certainly there's been activity in the movement towards value in original Medicare. But it's in original Medicare almost exclusively. And that's where my question to you lies: Where are the health plans?

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OK, so why are they not pushing more risk-based contracting downstream in Medicare Advantage? Why are they not bringing more capitated products into commercial?

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Are they simply satisfied with fee for service and don't think it's not broke and do not think it's broke? Thus, why would we fix it? Do they're making so much money on Med Sup that they don't want to move away from that. Do they fear empowering physician groups?

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I mean, where are the health plans, do you think?

[00:29:01.130] Ian Morrison:

Well, I mean, my experience with the plans is that most of them, you know, I'm talking about the big nationals here, have committed pretty significantly to Medicare Advantage as one of their growth engines going forward. Some of them, many of them, in addition, are seeing managed Medicaid as certainly their upside.

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And I think the short answer to your question is they believe that they have some of the tools to emulate what your groups do in terms of steering patients to appropriate levels of care, if that makes sense, so that they, you know, rather than delegating with a premium and capitation payment, they believe they can pull together tools and processes and technologies that emulate that which would be done by a delegated capitated group. Now, having said that, you know, and there's not a lot of transparency about what's going on inside all of these plans in terms of the provider contractual relationships.

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But I do think that, generally speaking, you know, I don't think you can effectively manage care without groups.

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And I don't think you could do it without delegating risk. But I think there is a sense that they believe they can pull some of this off without necessarily writing you guys a check and that they can do it with tools and support mechanisms. But having said that, there also I mean, United continues to add care delivery

assets across the food chain. And I think the other thing to watch is whether those care delivery assets mean increasingly not just include primary care, but include specialty delivery models.

[00:30:57.040] Don Crane:

Well, I suspect you're right. I discern a certain gap between walk and talk. The United CMO, I think just yesterday, Dr. Migliore, talked about the virtues of capitation and how it spawned prevention and so forth and seems to be strongly there. But our experience, if you look at the data that the land generates and the reports and issues, there's very little population-based payment even within Medicare Advantage, Ian. Essentially a kind of an HMO-like product (be)cause its capitated at the top.

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And so, we have a frustration there. And I think your explanation about them wanting to do it on their own has some merit to it. We know that they make the argument that groups around the country aren't ready to accept capitation. Groups on the other side of the table say, well, the plan's not giving it to us and they're not ready. So, there's sort of a readiness face off, it seems.

[00:31:56.620] Ian Morrison:

I mean, one question that I ask you Don in that regard. I mean, is, has there been a discernable chilling effect post-COIVD about the risks? Because I don't think clinically, I mean, I'm not a clinician, I'm a geography major. But I don't think clinically we know what the ongoing chronic care burden is of COVID patients and whether or not that uncertainty has a chilling effect on the willingness of your members to take risk going forward. I mean, but it sounds like you're saying we'd do it, you know, particularly the sophisticated ones.

[00:32:30.460] Don Crane:

We'd do it, but they're not given us the chance at it.

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Well, so it depends if this is risk adjusted. So if we look at, say, Medicare Advantage, we are indeed concerned that COVID is sort of the new chronic disease. That's not known yet, but you're seeing all the sequelae and these residual problems people are having and clearly that generates a lot of cost. Now, provided that's, you know, a risk adjusted such that the you know, the capitated payment covers that, I think we would welcome that, frankly.

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But that's an unknown, that picture. Now, for those that are not in risk-adjusted capitation, take commercial, for example. This is a problem. I mean, the higher the acuity, you know, you're going to have

to negotiate a higher cap rate and you can get stuck on that. So indeed, that might deter groups moving into, say, commercial capitated products.

[00:33:25.560] Ian Morrison:

And that's actually why there may be a potential positive upside by groups like this new, you know, fairly joint venture we talked about, because it may provide a sort of trimming of the tail of liabilities so that you can manage that which you have some control over. But I think you and I, you know, I mean, we go way back. Bob Margolis taught me this 30 years ago, you know, if you can take risk and influence the things you can influence, you should have responsibility and payment for that.

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And I still believe that to be true. But you're absolutely right. If you look, you know, I'm an adviser to Leavitt partners. And Governor Leavitt, you know, is very articulate about this move towards value. But if you look at the engine of value at the planned level, it's been Medicare Advantage and to a lesser extent managed Medicaid. It hasn't been commercial. And what you're saying is even at the delegated level, it looks more like fee-for-service arrangements than it does true delegated capitation.

[00:34:35.470] Don Crane:

Depends on who you're talking to. So, in California, for example, most all the Medicare Advantage is fully delegated and there's a lot of it outside of California. There's not a lot of downstream risk in Medicare Advantage. Some, but not a lot. And we've been complaining and advocating around that quite a bit. You know, we are big fans of Medicare Advantage. I think, I know you are. So maybe it's a year ago or so in a podcast you did with Robbie, our friend Robbie Pearl, his sort of, you know, how to fix American healthcare series.

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And I think his question to you was, how do we do this? And if I heard you right, it's been a long time, but I think you sort of surmise that maybe the model of the future is not Medicare for all, not original Medicare for all, but Medicare Advantage for all. You feel that way. Do you still feel that way?

[00:35:27.610] Ian Morrison:

I do. I mean, I have to say, you know, if I was I thinking the way Robbie set it up, which was kind of a fun exercise saying you're in charge, you know, and that's a frightening concept I went through.

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But I mean, absolutely. And no, I think you characterized my view.

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In fact, funnily enough, George Halvorson, our old friend who ran Kaiser, wrote a piece a couple of months ago now and the healthcare blog about, you know, his proposal for, you know, a 20 percent payroll tax to support analogously that Medicare Advantage for all model. I wrote a similar thing back in a book 20 years ago arguing that that was if I had control, that would be a preferred migratory path.

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And I do think, the way to do it is and it may be a pathway we could see through a Biden administration and expansion of Medicare is to incrementally more of a Medicare Advantage for all.

[00:36:32.800]

And then the other lever we might have is the deductibility of employer sponsored coverage, because I think that could be seen in the long run as a mechanism to induce more people to move towards a tax financed benefit, because that's essentially what Halvorson's arguing is that you would replace premiums with payroll taxes, employer and employee, you know, that was tied more to income of employees rather than on a premium basis. And, you know, I have high respect for George and he and I are corresponding in this thing periodically.

[00:37:15.050]

But I do believe there would be resistance in the current environment by the Apples and the Facebook and the young guns who are making a quarter of a million dollars a year, that they are just going to simply write 20 percent of their income over to the federal government so that old people like me can get health insurance. But I think there will be some pushback on that. But I do. I mean, your basic question, I think is right, that if you were to conceive of an inherently American solution, it would look something like Medicare Advantage, which had preservation of choice.

[00:37:51.400]

And I think Alain Enthoven got it right all those years ago and that would be one way to pull it off. I mean, do you think it's a viable solution and certainly one that would favor your members it would seem to me.

[00:38:03.910] Don Crane:

So I think I do. Should this transpire it will be a fascinating path. I mean, so at the end, the Biden camp is talking all about, you know, expansion of coverage, extending the age of Medicare, public option. But Kamala and others have talked about Medicare Advantage for all.

[00:38:24.660]

I just have this sort of, you know, hunch that as the world starts looking at original Medicare, should the Bidens…should Biden become president. They look to, you know, you crunch the numbers on original Medicare. Anybody…my personal opinion here…anybody who knows about original Medicare knows that it's probably you know, despite my earlier comments about all the good work being done by CMMI, which I stick to, it is perhaps the weakest of all of the products or programs in the country.

[00:38:54.790]

I mean, it's the wild, wild West. It's fee-for-service and on and on and on.

[00:38:58.120]

So would this would be a leap of faith? But as we moved towards Medicare for all you know, wise minds would rise to the top and go, look, we can't do that, but we could do Medicare Advantage and that could be a winning argument. But then I think what would need to be done at some point is much, much, much more select sort of Germany or Switzerland, where I think they have, you know, basically insurance plans is sort of the mainstay within their systems, but highly regulated.

[00:39:31.270]

So, we're at Medicare Advantage, where it was utter laissez faire with the health plans.

[00:39:36.580]

I don't think that's something that would look good, but a Medicare Advantage for all with delegated capitated groups in a, you know, a fairly well-designed and well-regulated program. To me, that might very well be the answer.

[00:39:52.300] Ian Morrison:

Yeah, I agree with that. And I agree with your point about regulation. I mean, I don't know if you've been watching this PBS, you know, the news hour has done a nice series with Ashish Jha visiting various countries and they were in Switzerland last night, I guess, and that they're going to go to the UK and, you know, I thought it was a pretty balanced view. And models from around the world would suggest that you could conceive of something like this where there was elements of competition amongst plans and consumer choice.

[00:40:23.630]

And that's the other thing I think we should acknowledge with the Medicare Advantage story is, you know, if you look at the history of growth of Medicare Advantage over the last 20 years, even though Democrats are not massive fans generally of Medicare Advantage, I mean, this sucker grew continuously through the Obama years, you know, on and on and through the Trump years. So, I mean, the consumers are

speaking now. I think as somebody who elected not to do Medicare Advantage, ironically, when I was eligible for Medicare, I'm not sure everyone understands that once you're in Advantage, you might not be able to go back to what you were doing on a fee-for-service with your supplementary without being medically underwritten, which, you know, for many is a cause for pause.

[00:41:16.310]

But I do think, you know, structurally and in terms of the marketplace, you're going to see Medicare Advantage just left to its own devices, get to 50 percent of Medicare recipients over the next few years, you know, holding all things constant without some major policy change. So in some senses, this, at least within the Medicare program, is sort of a shift that is inevitable. And the other thing to point out is with a bloody deficit.

[00:41:46.940]

I mean, I was just looking at the Congressional Budget Office forecast this morning. I mean, that the trust fund bankruptcy's coming in year by year.

[00:41:55.490]

So, no matter who's president, I'm sorry, this is going to be on their watch come January, that the deficit and the Medicare trust fund viability and Social Security is going to come into the into the conversation.

[00:42:10.190]

Lots of pressure, lots and lots of pressure. So let me kind of wind up here, Ian, and ask you. I mean, you and I have been doing this for a long time. The pace of change, it's been interesting for sure. But I think, generally speaking, slow. Are you optimistic about the future? Are you worried that we don't have the ability to govern ourselves wisely and efficiently enough to make the changes that need to be done?

[00:42:39.650]

I mean, what do you think?

[00:42:42.320] Ian Morrison:

Well, you know, if you get me on a good day and I'm actually quite optimistic. I mean, I talked to a lot of leaders like you who care about what they do.

[00:42:55.390]

And leaders of health systems and physicians who are really trying to do the best for their patients and for the people they serve. And I take them at their word. And I think there's a lot of hard work being done. I

think COVID, you know, was heroic in terms of just responses by a lot of folks. So on that level of just American ingenuity and leadership and willing to do mission, I think I don't lose heart and I am positive.

[00:43:25.930]

By the same token, I am concerned about national leadership and up and around this COVID epidemic. I mean, the latest…my latest anxiety is that we're moving towards vaccine chaos at warp speed. You know that we're going to have 20 vaccines released before the election. Surprise. And nobody will take them. I mean, according to the Gallup survey, a third of Americans won't take them and a majority of Republicans won't take them. A pretty significant plurality of people of color won't take them.

[00:43:54.670]

So, for all different reasons, but I just think this thing has been a complete bloody gong show from a policy point of view and could have been handled better.

[00:44:05.170]

So I despair a little bit about that, and I worry a little bit about what the deficit and that fiscal situation and residual unemployment does to, you know, the suite of problems that the next president, whether it's Trump or Biden, has to face. But look, on balance, you know, you have to be the other engine here.

[00:44:31.450]

Sorry, I should point to it. A positive point of view is technology. And, you know, even though most technology and healthcare has been cost increasing, I do think that digital shock wave that came across not just health, but the entire economy over the last six months has really been remarkable. And, you know, I'm still a guy who believes that the thing that distinguishes America from other places is just a passion and honoring of innovation.

[00:45:04.330]

And so I hope and pray that we're going to innovate our way out of these jams. And the combination of leadership and mission and honoring innovation and harnessing technology and science is going to get us not only through COVID, but to a better place in the long run.

[00:45:24.700]

So, I think it requires accountability of leaders, but that's why we need more people like you, leading us forward.

[00:45:33.850] Don Crane:

Well, thank you for that. Wish me luck. I wish all of us luck. I wholeheartedly agree with your sort of summation there. And I also thank you very, very much for doing this with us, Ian. We'll do it again soon, I hope. And with that, I think we need to wrap up they tell me, so thank you very much, Ian, and talk to you soon.

[00:45:53.440] Ian Morrison:

All right, Don. It was an honor and a pleasure. Thanks so much.

[00:45:56.890] Don Crane:

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[00:46:28.810]

And finally, please stay healthy and we look forward to seeing you again.

[00:46:34.000] - Announcer

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