John Marchica:

Welcome to season four of Health Care Rounds. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care and attaining joy in work. I'm John Marchica, host of Health Care Rounds. I'm also the CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Please, don't forget to rate and review us wherever you get your podcasts and send your questions, comments, or ideas for Health Care Rounds to podcast@darwinresearch.com. Let's get started.

Kim Asciutto:

Our guest today is Dan Pelino, well-known thought leader, author and cofounder of Everyone Matters, Incorporated. He is a regular contributor to the discussion on healthcare, citizen based services and smarter cities. Having appeared on CNN, Bloomberg and other media outlets, he serves as a moderator and host to the current healthcare debate and is a professor lecturing on leadership at Western Kentucky University. He has worked for IBM for 36 years, leading its global healthcare and life sciences business for 10. Now cofounder with Anne Altman of Everyone Matters, Incorporated, Dan has served on the executive committee for the Patient Centered Primary Care Collaborative and on the board of directors of the Healthcare Executive Network.

John Marchica:

Dan, thanks for taking the time to talk today. Really appreciate your setting aside 30 minutes or so. When we first met and I asked about your background, you gave me an interesting answer. You said that you're a community builder and not a community owner. What did you mean by that?

Dan Pelino:

Well, within the world of healthcare, most people define themselves as I work at a hospital or I'm CEO of a hospital or system, or they say they're a doctor. People that are in the health insurance business work for an insurance company. People that work in pharma work for a pharma company. Those that work in the health government aspect are government employees, whether it's in the United States around the world, they work for a government in the world of health. I'm none of these. I'm none of those.

But I work with all of them in trying to help them build the best healthcare systems that could possibly be. I had a chance to work with these great leaders around the world, see what they were trying to accomplish, ask them questions about why they were doing what they were doing, see the results that they were able to post. But you see, I'm not an owner of that PNL. I'm not an owner of that result. I may be an influencer on the idea, but I'm really not the owner of the idea. I was an enabler. I was a community builder. I brought people together. I believe that healthcare is a concentric circle that is made up of hospital systems, made up of insurance companies, made up a pharma, and of course, government with the patient in the middle, patient centered healthcare.

I, along with the people that work with me around the world, we built that idea forward in something called the patient centered medical home. Then we help with the integration of healthcare systems, which continues to happen every day. We helped insurance companies move from providing insurance to be more of a health company. We help pharma be more active within not only trials, but then how they would do outreach into patients, into that patient centered medical home. We help governments look at best approaches of government spending and involvement. So you see I'm a community builder.

John Marchica:

Got it.

Dan Pelino:

I built a community made up of all of the stakeholders in support of the patient. Someone was, I didn't make that name up, someone bestowed it upon me. Just like my friend, Dr. Paul Grundy was bestowed upon the godfather of the medical home, patient centered medical home, people would say, "You want to talk to Dan, because he's, he's a community builder. He doesn't have a dog in the fight, but he's seen the best. He works with the top leaders in government, healthcare, all aspects. He's got some interesting opinions about what's worked and what hasn't worked, so he's worth having the conversation with." Hence I'm community builder versus an owner.

John Marchica:

Got it. Got it. I didn't want to bring this up so early, but I'm going to. About halfway through, a third of the way through your book, Trusted Healers, a lot of authors come on, Health Care Rounds. I always ask them the same question. What was the motivation behind writing the book? What drove you to write this and then with your collaborator, is it Bud Ramey?

Dan Pelino:

Yeah. Well, I want to give you three points that are of value. When IBM asked me to take on the responsibilities I did, it was first time they didn't put a doctor in that position. You see I'm a behavioral science guy. In my career at IBM, even though IBM's a significant technology company, IBM also likes to chase after grand challenges. I would be one of those people, because of my background in looking for value that they would put me in those leadership roles to look, to create value and solve, or at least try and advance, some of those challenges. Sam Palmisano, at the time, was chairman. He asked me to step into the healthcare, rural healthcare, life sciences, and try and tackle this.

I call one of my best friends, Dr. Chris Dangler. I grew up with Chris. He's just a terrific leader on his own right. He said, "Dan, if us doctors are so smart, we wouldn't be in this problem that we're in. We need someone like you, that you don't have a dog in the fight, that you can bring us together to the table, and you can work with a company like IBM, where you have a pretty strong balance sheet. You're widely respected on solving grand challenges. You put a man on the moon for God's sake, so you should do this."

I gathered a bunch of people together, actually 137 people for a week. We put together work plans and things that we would do as you normally do when you're running a big portion of the business, [inaudible 00:07:01] fortunate to do that. At the end of the week, these people had presented back to me, things to do, and including this integration around the patient of hospital systems, insurance companies, and pharma. Nobody before had really spent a lot of time trying to connect those dots in support of the patient. They gave themselves a standing ovation. I told them at that time, "This work is so terrific that someday someone's going to write a book about what you've done in support of the patient center medical home, what you've created." Little, did I know that it would be me that would do that.

When I retired from IBM, people came up and said, "Dan, you have to write the book. You've done this. You've been with these people for over 15 years. You've created this value." At IBM, we had a pretty strong record of financial returns as well. I bought $4 billion for the company within that period of time, supported through the organization, continue to create value. Then I would, at the end of all of my speeches, when we would continue to go forward, I would ask people in the audience, "Why do we do

what we do?" They'd look at me with the stare of the Wisconsin dairy cow. You know? "What's he saying." The answer is why do we do what we do? It's because everyone matters, because everyone matters.

The idea of creating this continuum of care, what Paul Grundy talks about with the patient centered medical home and this intersection is in support of the patient and in support that everyone matters, everyone should be entitled to this type of healthcare.

To answer your question, I was fortunate that IBM asked me to get in the middle of a grand challenge, supported me with acquisition, a terrific team. We had a great run. The reason I wrote the book was because upon retirement, the team, my clients, people in the media said, "You have to write the book." Patrick Kennedy wrote the forward, as you know. My friend, Patrick Kennedy is just a strong, significant voice in mental and behavioral health. Never thought I'd be on the Dr. Oz Show, never thought I'd do over 150 podcasts, never thought that I would find a voice in support of all the people that are doing terrific work and supportive of better healthcare system. That's how we got here today.

John Marchica:

You write a lot about, at least where I am in the book, about Dr. Paul Grundy. Tell me about your relationship with him and why he's the centerpiece of the book.

Dan Pelino:

Well, Grundy's an interesting person. He did work for me for IBM. Before that, he had worked in many organizations. He worked for four sitting presidents. He's a Quaker by background. His parents were Quakers. He worked with Nelson Mandela. He was ambassador to Denmark, knighted in the UK. He is around the world recognized as one of the strongest leaders and the voice of the patient centered medical home. He's one of the most interesting people you've ever met in your life. He's tremendous at what he's been able to do to influence and bring community together, including supporting the primary care docs, the RNs, the PAs, et cetera, the continuum of care, understanding how specialty works within that. He has been really the galvanizing force in how you should think about the continuum of care.

Of course, the example that I love to use is the fact that in the past, many of us would go see our doctor. We'd fill out the obligatory information on the clipboard. We'd turn it back in, go into a file folder. We would be put outside a door. There'd be a rustle outside the door. There'd be a knock. A doc would come in or someone would come in. They would have read our information. Five, 10, 15 minutes later, we walked out of there with a prescription to go fill. Then they were gone and we may never see that person again, kind of like a cowboy or cowgirl riding into town and then riding out.

Well, in the world today, we are more like a race car, a formula one car on NASCAR. We are in the race of our life. What you and I want out of our healthcare system is a pit crew where everyone in there is wearing our colors, an RN, the PA, primary care docs, specialty, as we need them, mental behavioral health, if we need. They call us in. They say, "Hey, it's time to come in and change the tires. It's time to come and get your flu shot. By the way, your blood pressure's a little high. You run a little hot. We've got to pay attention to that. Maybe we need to sideline you for a little bit and get you back out after you get ready." We are in the race of our lives. We are that NASCAR. We are that formula one car. What we need and what we want and what we deserve is a pit crew of professionals that help us be the best we can be.

John Marchica:

Who's doing this well? If you can name names, obviously, I'm sure you've seen. I'm wondering if you have a domestic example and then maybe an example from another country. Who's got this patient centeredness and the patient center medical home. Who's doing this well? Who's got it right.

Dan Pelino:

Let me start with your second question first, because around the world, we see that the countries that are performing best spend 14% to 20% of their first dollar on preventative care, well care. We in the US only spend 5% of our first dollar on well care. We spend more on sick care. We've all heard the debates. We don't need sick care. We need well care. Sure enough, Denmark, Sweden, many of the other countries that perform far better than we do in the World Health Organization, and longevity, and spend far less, they are far more aggressive upfront.

Now here's what people would say to me. I've worked with these countries and help them build out their system. I'll just pick on Denmark for a minute, because they're usually right at the top if not always the top. At 5.5 million people, that's a fraction of 330 million people.

John Marchica:

Of course.

Dan Pelino:

For instance, when Blumenthal came in as head of health and human services, he said, "Dan, where should I go?" I sent him to Denmark. He came back and he said, "Dan, there are only 5.5 million people. How can I take this out to the rest of the country?" I said, "Well, the reason you can," and I'll just use you as an example. You're in Arizona.

John Marchica:

Right.

Dan Pelino:

You're in the Phoenix proper area. Let's say there's 5.5 million people within that area proper. How many people go outside of the area for their healthcare? Not many.

John Marchica:

Right.

Dan Pelino:

90% of the care that the people, that 5.5 million people, so when you start to look at them, the dominant healthcare systems like Banner and Mayo, et cetera, they can take those ideas like they have in Denmark and apply them into an integrated care model, into a primary care extension continuum of care, et cetera. That's what they do. Banner's pretty good. Mayo is obviously May. May is two mops. One specialty, you go up to Rochester, Minnesota, when you might have a serious concern. Mayo, what they build out your area's very good with the continuum of care and that expansion.

That's why we're seeing this consolidation of healthcare systems, because they want to put together that continuum within the organization that they built. That becomes in network. You and I know that as in network today. When we see the idea of the best performing systems, many of these ideas came from these countries that were able to have better feedback from their patients that are outreach into

their communities, more around preventative care, well care models, et cetera. That's where we are. We need to do more with the US than we do. We just need to. We've always been specialty.

From Flexner Report, 1911, where we built specialty care and docs came in and they studied. Then they went out into an internship and rotation. Most of them wanted to go into some kind of specialty. More money was there. Primary care was thought of something that just a family doctor does. I wasn't perceived as the most important part of care, the front door care. It wasn't thought of as well care. We now know that we can't leave this problem, the doorstep of the emergency room and the specialist want us to be able to be well, so when we come to them, they can do what they know they need to do.

It becomes important, this continuum here that we talk about. This patient centered care starts with preventative care. and that's what we write about the book. We bring those ideas and questions you should ask your doctor and things you should think about into the idea of preventative care, primary care, work with RNs, PAs, that primary care doc upfront. That keeps you out of the emergency room, keeps you out of the hospital, helps you spend significantly less in out of pocket on your healthcare costs. It is the answer to what our country needs to do in order to lower costs of healthcare. It will be far less expensive.

John Marchica:

Dan, how do we align incentives? Because if I'm going to be, I'll be skeptical of what you're saying and say, well, Banner, they make money on procedures. They're out. They just acquired, if I remember from getting the right health system, they just acquired another hospital. They've got the Banner MD Anderson Cancer Center. They've got the Neuro Institute, they've got all these things that are based on doing things, doing procedures, fee for service, right? How does a Banner, how do you align the incentives to get a Banner, which gets paid predominantly for doing things to align on what you're talking about?

Dan Pelino:

Well, let's just start with the elevator conversation with the CEO of Banner. Here's the three things that he or she wants to talk about. First of all, help me get my costs in line, so I'm not out of control of my costs. Second, how do I keep my referral patterns within my network, within my hospital?

John Marchica:

Right, no leakage.

Dan Pelino:

No leakage. And three, can you help me think about other services that I should provide that are specialty that I can get into. It could be breast cancer, could be prostate cancer, could be GERD, but the specialty that you might not have today that end up giving you advantage of scale, because you have an in network and then the specialties that communities need attention.

Where we need to go is value based care. Value based care is where you're managing a population and you're managing them to be well. You get paid for managing them to be well. We have found working with Cleveland Clinic and many of the other systems that have gone forward, that if you can get people to the right aspect of their life with BMI and glucose levels and no nicotine, and the six plus two that I talked about in the book, the chances are that these people are going to be healthy and spend less money in the system, but you should be incented to keep them healthy. That's where we're going today. Value based care models. Now, one of the challenges is you're scoring a non event. You're paying someone to keep them well.

John Marchica:

What do you mean by that?

Dan Pelino:

Well, today, as you said, everything's really based on some type of episode of care, so there's some level of episode of care. What you and I want is we want someone to keep us well, make sure that we are as best as we can be, back on that racetrack of life that we talked about earlier. Does it make sense that you pay someone to manage a population so they're healthy? That's the only way you would get away from the episode of care payers is to move towards a value based care system. You should incent the individuals that are in your healthcare system, pay people to be well, pay them to get to the right BMI levels, pay them to get to the right glucose levels. We have found that roughly $1,000 to $1,200 a year is an incentive to be able to get these people there. I'll give you another example of how this plays out. Do you know that 40% of the produce in the US is sold through a Walmart?

John Marchica:

No, but it doesn't necessarily surprise me, because it's a big retailer.

Dan Pelino:

Would you know that roughly 40% of the people that have come into Walmart cash their check there?

John Marchica:

That I did not know.

Dan Pelino:

When you start to think about reaching the demographics of the people that are served by a Walmart, what does it look like if you have primary care that might be connected to Banner, but at the Walmart and you create an incentive where somebody comes in that might be driving the drugs, got a gun on the back, might be a little bit overweight, might have a little issue with their glucose level, but you say, "I'll tell you what, if you can get to these levels by, let's say six months, you see that 55 inch television set over there? That can be yours." Create an incentive system. It doesn't necessarily have to always be money. It can be other ways, depending on the demographics.

We have to have care meet people where the people are instead of having the guy with the F-150 and the gun rack having to drive to the hospital system or a doc, why can't we have these extensions at places like Walmart? Walmart's starting to do this. They have them connected on the front end with RNs and PAs and maybe a primary care doc connected through to Banner. You see, we then start to be, and we can have the conversation where the individuals are towards wellness, towards preventative care and stop diabetes, stop this poor individual potentially from having to do an amputation or become diabetic.

John Marchica:

Is Walmart thinking that way? I haven't had [crosstalk 00:21:25].

Dan Pelino:

Yeah, absolutely. Yeah, yeah, absolutely. I helped them think about many of these things stayed a little while, but they're definitely going no way. These are the fundamental changes that we need to have

within our society in the US to have healthcare meet people where people are. Then we can get them to be able to do preventative care. Right now, today, wherever you go, I can almost guarantee that if you look at it, your listeners right now are listening to you and me, count how many signs, "Free Flu Shot Today." You can get a free flu shot at CVS, Walgreens ...

John Marchica:

Walmart.

Dan Pelino:

... Walmart, depending what grocery stores. Here, I'm on the East coast, Wegmans, free flu shots. You see what I'm talking about? It's this idea of being able to meet people in this world of preventative care, where they are. Then we get a chance to keep them out of laying this problem at the doorstep of the emergency room when they get really sick or potentially using the emergency room as their primary care door.

John Marchica:

Right, right. It's interesting, the example that you gave. There was the thing about ACOs, right?

Dan Pelino:

Yep.

John Marchica:

Very much so in line with what you're talking about, so all the things that they're trying to track at least, and they're not without their faults, but just the general concept is let's look for those markers where people are sick, and let's focus on preventative care, right? One of the things that is a problem, I think with the ACO model and what docs will say is, "Well hey, I'm accountable. What about patient accountability?" Right? Well, the example that you gave with the 55 inch TV, which today probably costs Walmart 50 bucks to buy, maybe less. Now, you're giving people an incentive beyond just, "Yeah, I know I should stop smoking," or "Yeah, I know I should stop eating all these sugary foods." Now you're giving them something that's more likely to have an effect rather than just a cash payment, 25 bucks or something, right? I think that's interesting.

I wanted to get the question about behavioral health, because Patrick Kennedy did write the forward. We know he's been a champion of behavioral health issues for some time. What are we getting so wrong about behavioral health? What is it that we're getting and how do we raise these concerns and bring behavioral health issues more into the forefront?

Dan Pelino:

Well, first of all, the stigma has been around mental and behavioral health for a long time. People didn't want to talk about it. I got a chance to be with Dr. Oz and with Patrick on this exact point that you're bringing up. We're on show last October, October 28th or so. We got into the conversation of checkup from the neck up and know your rights and things that you should think about. People just haven't talked about these things.

The first thing is you have to have that conversation. The second is that Patrick and I worked on a lot of the infrastructure. Given your background, you can appreciate this. First of all, the primary care docs did not necessarily have the mental behavioral specialists within their network. They didn't really want to

refer out, even though they were more checkup from the neck down as opposed to checkup from the neck up. Oftentimes, if they did refer out, they didn't get the patient back because it wasn't connected to the system. The electronic medical records today have the ability to capture that information in structured data, so you can pass it back and forth.

Also, the incentive systems have changed. The incentive systems to ensure that the primary care doc gets paid for referring out and being able to be recognized within that process. All of that may sound disingenuous, it's important because that's their livelihood. They should get paid for doing the right thing, et cetera. The last is the insurance companies didn't spend a lot of time on this. In the past, it was difficult to get reimbursed. There was a very significant ruling, Wit versus United Health Group that the Supreme Court ruled on where the Supreme Court ruled in favor of the family saying that United could have done much more to help and in the reimbursement model.

Now you see ads on TV in the last year or so about checkup from the neck up. It's amazing how this has turned because the Supreme Court said, "No, people are paying into those healthcare benefits for a top to bottom, from head to toe. You have to pay attention to that." You have voices like Patrick Kennedy talking about the challenges that he's had. We're smarter, by the way. We're smarter.

We've had issues that have just accelerated this, Oxycontin for instance, pain killers that people use brought out in the late 1990s. That was under, "Do no harm," and doctors thought that they were not addictive. They would prescribe 30, 60 pills of that. Well guess what? Addictive. These people were cut off, and then they started going to heroin. That's when the heroin epidemic was there. Then people started to say, "Hey, this heroin stuff, get out of here, catch them," all that. Now they're on fentanyl. It's like China doll and it's China powder. You don't even know where this stuff's coming from, but just a fraction, a fraction, a small coating could kill on fentanyl.

Here we are 30 plus years since we started with a Do no Harm, that it causes tremendous harm. It just exasperates. Much of what's been done is awareness, a lot around infrastructure and payment reform that's been significant, and the others stepping up to the issues that have gone before us that need to be addressed.

With that, as your listeners are listening, don't let your kids vape. That's on the front end of some of these problems. We're starting to see issues on this vaping. I'm not saying it's good, bad, but definitely pay attention to it, pay attention because there's aspects of that vaping that are not good at all. They could be under the same thinking of other things that have happened to us in the past. Does history repeat itself? I would say yes.

John Marchica:

Yeah, I went through that, the whole fight with my three kids as they were going through 14, 15, 16 year old that, and it's everywhere. It's everywhere, especially at that age and even younger. My youngest was facing these issues in middle school.

Dan Pelino:

They have mental behavioral aspects of it, right? It's not just, there's underlying, there's peer pressure, there's other aspects, as you know, when you're living through it, as you did this, maybe you do. This is important. The most important thing that we can do as elders in our society is health care literacy. The good book, the Bible, talks about 40 years, it's referenced to 146 times. Why does it reference 40 years? It's because it's a generation. I don't know about you, but I'm not sure I received a lot of healthcare literacy when I was a young boy. I had the appropriate birds and the bees conversations, but I didn't have others about what you should eat and what you should do and how you should exercise, et cetera.

There may have been the president's patch on fitness that you got at school if you could do pushups and sit ups and climb to the top of the gym in a short amount of time.

John Marchica:

We had that.

Dan Pelino:

It's not to say, right, we should leave a legacy of health care literacy. That will help more than anything else in every race, every population, every gender. It should be so important, because we've learned so much, we've seen what society is. We owe it to our kids to have that conversation on healthcare literacy.

John Marchica:

Now it's going to sound like I'm getting political. As folks who listen to the podcast know that I generally shy away from politics. It's bad for business. I will say this in the face of what you're talking about, we've had however many years of let's repeal Obamacare. Now we've got the ACA in front of the Supreme Court that probably is going to strike it down on a technicality. I think these are related. These issues of what you're talking about and understanding healthcare and understanding, taking responsibility, personal responsibility for yourself, for the things that you put in your mouth, how much sleep you get at night. All of those things is related. I know that fundamentally, I don't know if we talked about this previously, but this whole idea, this notion of prevention and the patient centered healthcare is at the core of the ACA. I mean, it's behind a lot of these things. Some, some of my professors were involved in helping give advice as well.

Dan Pelino:

Sure. I presented to the president on this, absolutely.

John Marchica:

President Obama?

Dan Pelino:

Yeah, and I presented to the 219 congressional leaders that voted in favor of it under Nancy Pelosi's leadership at the time, along with Mark McClendon. They asked us to come in and say, "All right, tell them what they just voted for." Not that they didn't know, but to be perfectly clear about this continuum of care, this front door care, this primary care aspect that was so important, why you needed to have your children on a plan and why you needed to have something that had no preexisting condition issues.

I'm aware of it. I've been right in the middle of it. I'm in the middle of it today. I have a chapter in the book, Right versus Privilege. I'm happy to have a conversation about it, because it's grounded in facts. The most impressive systems in our country today, practice what's in and define the Affordable Care Act.

John Marchica:

Why is it again, this is maybe where it does get political, why is it that you have 40% of the Congress, 50%, it depends on which, I guess, which area you're talking about, that doesn't understand this or that

doesn't prioritize this, or doesn't think that it's important and finds Obamacare like the evil that it is? Why is that?

Dan Pelino:

Right. Well, a couple of things. First people unfortunately, they don't really understand the importance of this. That's part of why I wrote the book, and I've done on over 150 podcasts on a lot of this health literacy, where you and I were talking about and how important the front door care is. We as a country are still well behind. We have ways to go.

The second piece is that there is a lot of influence through insurance companies and pharma to be more involved in the influence to get rid of the Affordable Care Act. The reason is, is because there's less reimbursement within that for different groups. It's not that they are greedy and they all want, but their business model. The business models have to change. Everyone is going to have to do something. We pay the most for care in the world for the worst care.

Part of that is because we offer choice for ways to pay for care, VA, Medicare, Medicaid, health insurance, and go alone where you have no insurance. Americans like to have choice. Now, do you think we pay for that choice? You bet we do. It creates a lot of the inefficiencies that we have, but people want choice. And so consequently, they don't like the idea that government says, "Well, we want you to do this and not that," or "We're trying to influence you to do this or not that." Truth of the matter is the best performing countries in the world in health, they provide more service to their citizens than we do. When we repeal, if it happens, then we're going to have to reset what that looks like. I'm hopeful that we will reset under the guiding principles of the patient centered medical home, and many of the things with the Affordable Care Act.

One of the small challenges we've had is if we had ever been able to move from Obamacare to the Affordable Care Act in name alone, we may not necessarily be putting it in front of the Supreme Court to appeal it. It's that political, because people think it's Obamacare as opposed to the Affordable Care Act. In order to have the Affordable Care Act approved, it wasn't the president signing it into law as much as it was the votes to support it. The people voted. People, associate his name with it because he was there the time. I think sometimes people get a little incented based on a previous party or a previous leader, regardless of the outcome.

Mark my words, if it gets repealed on the technicality, watch what comes back, watch what comes back. It's going to look remarkably similar. People are going to say, "Wait a second. He put preexisting conditions. I thought he didn't want preexisting. Oh, you're allowing children. I thought you wanted that off. Oh, you did with prescription medication. Oh, wait a second. Isn't that what was here before?" We've already seen some of the ideas for the next health plan. They look remarkably similar, but they don't have the name Obamacare. Remember, I'm a behavioral science guy. I'm a behavioral science guy.

John Marchica:

Yeah, yeah. Well, that's a very true. [crosstalk 00:36:19] question ...

Dan Pelino:

Some people will argue, by the way, the mandate. Some people will rightfully so argue the mandate, which was a cornerstone to have people that are healthy pay in this system to afford people that are not healthy the care that they deserve. Things have changed on some of that aspect. You can still have the principles of the Affordable Care Act without the mandate. We've proven that to be true. We've proven that to be true.

What I really believe in is let's drop the age for Medicare down to 55, so that people that are starting to get older, get the right kind of care. Many people that retire, they leave themselves without care until they are Medicare eligible. If you get past 57, so says Cleveland Clinic, without any significant conditions, any chronic diseases than par for par, you're going to live a really good life as long as you don't start doing things, you shouldn't do that are dangerous.

We need to catch these people into a primary care setting before they get too old, and we can capture some of these issues. Then on Medicaid, let's raise the poverty level, so the underserved in chance to have good care. Because of the challenge that we have on Medicaid, on how low the level is to qualify, there's many people that are underserved. If we raise that level, the poverty level will allow more people that are underserved to receive care. If we do it right, put these people in preventative care, it will cost us less money. Again, we score a non-event. We move towards preventative care. We move towards well care. These numbers, these whole, this is the mandate that we should accept, and we should work towards and celebrate.

Let's move towards well care, drop the age for Medicare, raise the poverty level, let Medicaid people get in. We don't need to have a Medicare for all. We could still have private insurance. We could still have choice. Let's allow preexisting conditions. If you want, we can call it whatever you want to call it.

John Marchica:

Does that mean that we're going to have to go to something national for Medicaid as well, because we tried the Medicaid expansion and some states opted in and some states didn't? You could argue, even the expansion states, the poverty level still is too low. I'm wondering, politically, how do you get that done?

Dan Pelino:

Well, a lot of people have offered Medicaid expansion. There's many states. By the way, it's okay to let states decide, because here's what states look at. The insurance commissioner has responsibility here. Let's just say, which is true, you're in Colorado. Let's just say in certain areas within Colorado, there's one health insurance company. You either have insurance through that company or you go alone, because it's too expensive, and because it's the only game in town. Are those prices too high? Should we not have an option for those people that'll look like Medicare products? Should there not be a government option when there looks like there's a monopoly? I think we say yes, there should be. Watch what happens. Free market. Those prices will come down. Now hospital systems are going to say, "Uh-oh, my reimbursements, et cetera."

Let me go back to what we said earlier. The CEO says, "Help me get my costs down. I don't want any leakage. Where can I bill the additional services so that I can add to my revenue line? How do I run this thing efficiently? What should I acquire next? How do I expand this, so I get the best care to my community." It works. It can happen.

John Marchica:

Well, Dan, we've run a little bit over, but I've really enjoyed this. I enjoyed the time talking to you, had a lot of other questions, but you kind of got to them. I hope that we stay in touch.

Dan Pelino:

My pleasure. Yeah, I'd love to.

John Marchica:

If there's a way that we can end up working together, your advocacy is strong, and your ideas are very strong as well.

Dan Pelino:

Thank you.

John Marchica:

Hopefully, we'll be able to find some common ground here in the future.

Dan Pelino:

Thanks for having me.

John Marchica:

Thanks, Dan.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Healthcare Rounds is produced by me, Kim Asciutto and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to health care executives. Our strategic focus is on healthcare delivery systems and the global shift for value based care. Find us at darwinresearch.com. See you next round.

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