John Marchica:

Welcome to health care rounds. I'm your host, John Marchica Mark, CEO of Darwin Research Group and faculty associate at the Arizona State University college of health solutions. 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. Please send your questions, comments, or ideas for Healthcare Rounds to podcast@darwinresearch.com. And if you like what you hear, please don't forget to rate and review us wherever you get your podcasts. Let's get started.

Kimberly Asciutto:

This is an encore presentation of healthcare routes. Today, we are rebroadcasting a conversation with Christopher Robertson, associate Dean for research and innovation and professor of law at the University of Arizona. This episode was originally uploaded on March 19th of 2020.

John Marchica:

Chris is Associate Dean for research and innovation and professor of law at the University of Arizona. He is also research director for the health law and monitoring committee of the uniform law commission, and a principal with Hugo Analytics, a provider of scientific services to litigators. In 2019, Harvard University press published his book, Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done about It.

Robertson has co-edited two prior books, Nudging Health, behavioral economics and health law, in 2016, and Blinding as a Solution to Bias: Strengthening Biomedical Science, Forensic Science, and Law, also in 2016. Robertson graduated Magna cum laude from Harvard law school and earned a doctorate in philosophy at Washington University in St. Louis. He has taught at Harvard law school, NYU law, and the London school of economics. He will join Boston University in the fall 2020.

Chris, thank you so much for joining me today. I appreciate your time. Chris Robertson is the author of Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done about It. So, I will have already read in your bio, Chris, through the magic of podcast. But in your words, just maybe orient our audience. Tell us a little bit about your background before we get into things.

Chris:

Sure. I've been working on health policy and health insurance for about a decade, bringing both a bioethics and a health law and health policy perspective, originally starting researching how medical problems were leading to bankruptcies and foreclosures, doing some litigation around hospitals overcharging uninsured patients, and more recently, a series of research studies about health insurance and how we ended up with the healthcare system that we have here in the United States.

John Marchica:

Right. Great. The big question... I think I've thought of this originally as an easy question, but I think it's a big question, and that is, explain to me how health insurance works in this country and what you see are the major design flaws.

Chris:

Sure. Even to begin to answer the question about health insurance, it really has to start from a recognition that it's fragmented in the US. We've divided up the 330 million Americans into the older Americans that are getting care through the public system called Medicare, working age Americans, most of whom are getting insurance through their employers. And others that are working for smaller employers, or are self-employed, or unemployed, are getting care and health insurance coverage from the individual markets. And finally, we have poorer Americans getting care with your Medicaid. Even that system varies state by state as to whether they've expanded it, et cetera.

And then, there are a series of other health insurance programs for native Americans or military families, et cetera. But once you see that we have this fragmentation of health insurance coverage, you can then look at the types of plans that we have. And one of the striking features of American health insurance is huge cost exposures. By cost exposures, I mean co-pays, deductibles, and other things that are sometimes called out-of-pocket payments, although even that's a euphemism sometimes because patients simply don't have money in their pockets to pay large portions of their care.

So, in my view, that's the primary design flaw, is that we've actually made health insurance incomplete. It doesn't actually cover all of our needs reliably or predictably.

John Marchica:

So, explain to me the logic, or maybe the definition. You had mentioned, I think, deductibles, co-payments, co-insurance. I saw, in your book, there was the George Loewenstein study of people who thought they were very educated about these terms and turns out not so. So, maybe give us a little lesson on what those things are and what their purpose is in our insurance system.

Chris:

Sure. Well, I like to think of it as three zones of insurance, where, in any given year, even if you have health insurance, if you have a deductible in your policy, that means the first X amount of money... Let's say $3,000 for a family would be quite common. That first 3000 of spending comes completely out of pocket, which actually means you don't have insurance coverage for that first $3,000 of care. So, that's his zone one, no insurance. Once you've met that amount out of pocket, you move into what I call zone two, which is some insurance. And typically, in this second zone, when you go incur medical costs, the insurer is going to pay about 80% of them, and you're going to pay about 20% of them. And the actual ratio is varied, because we have both copays, which are fixed dollar amounts, like $450 per day in the hospital, or $50 to go to specialist physician.

But then, we also have co-insurance, which is a percent of charges after adjustment. So, we have those two features in the zone two, some insurance. And then, there's a third zone called full insurance, once you've passed what's called your out-of-pocket maximum. Now, before the affordable care act known as Obamacare, not all plans even had an out-of-pocket maximum. And in fact, in Medicare, there is no out-of-pocket maximum. You can keep paying that 20% forever. But in employer-based plans and plans on the individual market, there's a cap on how much you can be forced to pay in a given year until full insurance kicks in. And that out-of-pocket cap ends up being really important. The Affordable Care Act allows it to be as high as $16,300 a year for a family, which is still a devastating amount of exposure, but that's at least where the cap starts.

Now, the second part of your question is, "Well, what's the purpose of having all these exposures, instead of making insurance complete?" And it really goes back to an economic theory from the 1960s and seventies called moral hazard. And this is the theory that insurance is actually a problem.

Insurance actually allows us to spend other people's money, OPM, so that when you go to the hospital, you might consume healthcare that's not really very valuable, because you shrug your shoulders and say, "Well, I'm not paying for the care. The insurance pool is paying for it."

And so, the thought is that insurance is actually a huge driver of wasteful spending. This is a theory we can talk about. So, the antidote to this huge waste cost to insurance that's been theorized is to instead give patients some skin in the game, make them pay at least 20% of the costs, so they'll feel, and thereby make better cost benefit trade offs. So, we can talk more about the validity of that theory, but that's really the motivation as to why the US has over and over embraced incomplete insurance, which leaves people exposed to huge costs.

John Marchica:

But isn't the moral hazard... Isn't that with that first... the first zone that you talked about. Isn't that where, at least so the theory would go is, is that you know that all of what you are doing up until this certain point will cost you money personally, that maybe you're not going to go to the doctor if you're feeling just the sniffles, or you're going to think twice about having care, because you know...

Just like your car. If you get in a fender bender, and then you take it in to the shop, and they say, "Well, it's going to cost 400 to fix." And then, you think about, and you say, "Well, if I report this as an insurance claim, then my insurance is going to go up. And I've got a thousand dollars deductible, so I might as well just pay this out of pocket." Isn't that kind of like the same theory?

Chris:

That's exactly right. But the limitation of this theory is that, if you look at aggregate health spending in the US, if you look at where most dollars are spent, it's not on the thousand dollar course of care, or the $50 specialist visit, or filling that statin to keep your heart attack from happening. It's actually on the lung transplants, and the patented cancer drugs, and the huge catastrophic costs. Health spending is hugely concentrated. So, giving people all this exposure to low dollar care, causing them not to fill their prescription for that statin, can actually backfire because it causes them to have more high-dollar care, which is going to be fully covered by insurance anyway.

So, this is really the fallacy of using cost exposure to manage health spending, is it puts the pressure on exactly the role costs. We actually want people getting preventative care. We want them filling their prescriptions to prevent heart attacks. But when they do have the heart attack and need that stent installed, there's no way we could expose them to a substantial portion of those costs because it's just too much. No family could bear it out of pocket.

John Marchica:

And I'm sure you have this buried in your book, which by the way, from what I have read, I haven't read the whole thing, it is outstanding. It's extremely well-written. Some of these kinds of books, I mean, it's like a slog to get through them. I really have enjoyed reading, so far, what I've read. So, congratulations on that.

Chris:

Well, thank you. I had some good editors. They went through and took out all the worst of the jargon. And there's no equations. So, I had some good non scholars keeping me clear.

John Marchica:

Yeah. Well, they served you well. So, anyone who is interested in this topic is going to find this to be a very well-researched and fascinating read. But anyway, back to... The question is, "Does the existence of copays actually end up costing us more money in the long run? Have you researched that? Is there research on that?"

Chris:

So there's a couple of different ways to approach. And of course, it's a very fragmented system. There's lots of different courses of care. It's going to have different effects in different places. But there's been a body of research that suggest that adding copays and exposure does reduce healthcare consumption. But the problem is there's also been a lot of research that suggests that the reductions in consumptions are indiscriminate. People reduce consumption for high value care and low value care alike. So, it's almost like rolling a die, and if the die comes up six saying, "Okay, you don't get that healthcare."

Because in fact, people aren't very good at judging what is high value or low value care in the first place. That's why we go to doctors who are supposed to be the experts. So, the second thought... The second way to get at that question is to look internationally. In the US, we have some of the highest levels of cost exposures, the biggest deductibles and copays. Other countries have entire sectors of the healthcare that have no cost exposures. But in the US, we sure are not getting a lot of value for what we spend. By that, I mean we're spending overall twice as much as other developed countries on our healthcare, even though we have these huge cost exposures that drive people into bankruptcies and foreclosures, and cause them not to take their heart medicines.

So, it does not seem that costs exposures... if you look at all the evidence together, that cost exposure is really good tool for reducing wasteful health spending.

John Marchica:

So, if the problem is that the way that we've structured these incentives isn't getting us what we want, what do the behavioral economists, or what does Chris Robertson, say about how to properly align incentives to get people to not seek low value care, but to ensure that they're taking their meds, that they're doing the right things, and that they're accessing healthcare in the right way? Maybe I'm not asking that question exactly how I wanted to ask it, but you get the gist of what I'm getting at.

Chris:

Well first, I think from a policy perspective, you're trying to set up incentives, like you said. From a policy maker perspective, we often don't really know what's high value or low value care for a particular patient. Even at a policy perspective, we're relying on the FDA to approve a drug or device is safe and effective. We're relying on a physician to figure out which drug or device is appropriate for which patient. And so, it's really hard for us from a policy perspective to say, "Even though the FDA has approved this, even though your physician has recommended it for you, we want to create a system that's designed for you to not do what your physician says." Right? So, I guess another way to put this is, behaviorally, we've already set up at least these two gateways on a lot of health spending, the FDA and physicians. And then, we also set up a third gateway, which is payers. Right?

Not all healthcare is covered by insurance. So, when we said, "It is covered. Your doctor's recommended it, and the FDA has approved it, but we still don't want you to consume it," that's a pretty tricky sort of moment to be in as a policy maker. Now, there are some areas, I think, where the research

suggests we should be nudging people away from certain care, for example, imaging for low back pain, or antibiotics for what's probably a viral infection. And in areas like that, maybe there is a targeted role for a cost exposure to cause a patient to get a second opinion. And an example of that would be in pharmaceuticals. I don't mind having a cost exposure to nudge patients towards taking the generic, rather than the patented brand name drug, or the original innovator drug. Because as far as we know, they're chemically identical.

So, that's a great place where a cost exposure can nudge someone to higher value, lower priced care that's otherwise identical. But more generally, I think cost exposure puts the pressure on the wrong actor in the system, because patients are not in the position to really assess value. The physicians are. So, I would put a lot more pressure on adjusting physicians' incentives to make sure they're driving towards high-value care. And for that purpose, I like salaries, I like management, some of the same tools we use in the rest of the world to make sure that our agents are reflecting the values in their own goals. So, I would put a lot more pressure on physician conflicts of interest, relationships with the drug and device industries, fee for service payments, that are really driving up care prices and costs in the US. Now, that would be one of the main levers rather than focusing on patients' cost exposure across the board.

John Marchica:

So you mentioned... I want to go back to something that you just said about generics versus brand name. I think, at least these days... I mean, 20 years ago, the pharma companies would fight it out to continue to have their brand name prescribed, even in the face of the generic. But I think that managed care in the nineties kind of took away a lot of that problem. I can't imagine a doctor writing for an antibiotic and saying dispense is written.

So, a lot of that swap is practically, for all practical purposes, automatic. But what I'm wondering is how effective, in a formulary, are those different tiers to cover when you've got, let's say, $10 for a generic, and then maybe $50, not for the brand of that generic, but maybe for a newer drug that's in the class, but isn't an identical copy? So, are formularies... or have you seen... Are they effective in being able to keep costs down for the system?

Chris:

Yeah. My physician friends tell me that sometimes there are actually differences between the almost a dozen Statens that are on the market. But sometimes, it does make sense to rotate your patient through them until you find the one with the best side effect profile for them. And so, in my view, it's important for physicians and doctors to be able to have that discretion. And so, they do compete, especially when they're not identical chemical compounds, on quality factors like side effects.

So, I worry about narrow formularies that are kind of crude in limiting options available to patients and their providers, or creating huge, what I call rationing through inconvenience, huge barriers that the physician can get that other drug, but would have to spend an hour on the phone advocating for the patient that he's not going to get reimbursed for. So again, I would much rather see physicians working on salary and having population-wide metrics of efficiency, rather than saying, "You can never use drug a for your patient, unless you spend an hour on the phone fighting for it."

John Marchica:

Yeah. Well unfortunately, the way that we have things set up today, a lot of those drugs get put into different positions because of the rebates that they... and the deals that they struck with the PBMs when the...

Chris:

Yeah. And a lot of that has nothing to do with value for the patient. Right?

John Marchica:

Right.

Chris:

It's really just another fragmentation of our healthcare system.

John Marchica:

Yeah. So, given that we're talking on a Monday, amidst the insanity of this coronavirus escalating, what does your research suggest that we should be... And maybe it doesn't suggest anything, but I was thinking about this before we got on this morning... that we should be doing in the face of the coronavirus, or maybe the way...

Maybe talk to the way that we're...Maybe it's not an insurance question. I'm just curious about... I'm sure this has crossed your mind, as it is every American. Is there something that we should be doing differently?

Chris:

Sure. I think when you think about it from this economic personal finance lens, some of the advice is that if you are likely to be suffering from COVID, but you are at an age range where you're... and don't have complications, you might well just ride it out at home. And that's probably good for infectious disease and the health care system. And I have no fight with that. But when it is time for a patient to get care, I really want them focused on doing whatever their physician recommends. So, if the physician does say, on the phone, "It's time to get you to the emergency room," I want that patient to show up. And I want that patient to get the care. And so, the cost exposures associated with showing up in the emergency room can really distort the decisions a patient makes.

So, there's this amazing exchange by congressmen, Katie Porter and the head of the CDC, who was really parsing president Trump's claim that, "Oh, tests are free for everybody," which wasn't true in our fragmented healthcare system, and sure didn't account for the difficulties of showing up in an emergency room and having to pay those bills. The second big concern I have, aside from the insurance cost exposure, is our lack of insurance for lost income. Because the amazing thing that I think we haven't paid enough attention to is that, when you're sick, you're often also not earning income. And so, it's a perfect storm of time when you have healthcare costs, but you have reduced income because you're staying home, or you're flat on your back in a hospital bed. So, I think we've got to get... If we're going to continue having substantial cost exposures, we definitely also need paid time off in the United States, which 50 million Americans don't have.

And so, that really also makes me worry. Even aside from that interaction between costs exposures and lost income, that lack of coverage for paid time off I worry is keeping phlebotomists, or cooks, or childcare workers who are making about minimum wage anyway, to go into work on those

marginal days when they really would rather stay home, when they may be having a fever, they're nonetheless facing a huge economic pressure to show up at work, to literally put food on the table. And so, I think our country's failure to invest and to require paid time off is another huge failing that's going to... that's frankly going to spread disease more than it should in the United States.

John Marchica:

So, I hear these arguments from the talking heads in the last couple of weeks. I'm not saying that I disagree with them, but I'm wondering, how could you... They've passed this $8 billion bill that addressed very specific things. But how could you execute a policy tomorrow? How could they write something in the house, and then... or put something together in the Senate and send it over to the house, that could really address this problem that, in the moment, that that person who is wondering, "Do I go to work today? If I don't go to work today, well, I'm out 200 bucks and $250, whatever the case is. And then, if this happens on successive days, then I'm not going to be able to make my rent."

How do you execute a paid time off program that can have an immediate effect? What would that look like?

Chris:

I'm in favor of using the federal treasury, rather than pressing mandates onto employers. In part, because employers... There are small employers, a lot of them. It's a wonderful thing about the US economy is it's based on substantial number of mom and pop businesses, or businesses with 10 employees. And pushing those costs on them might just do more damage. We're just really moving the deck chairs from one person to another. The beauty of using the federal treasury is that we have a relatively progressive tax system, and thus the burdens can fall on the progressive tax payers. And so, in the past, after the financial crisis, 2008, we used the TARP fund. Hundreds of billions of dollars went to banks to bail them out. So, I think we can similarly bail out workers who are staying home. And when they stay home, they're actually doing a lot of good for the public health.

They're actually saving us from having the rash in respirators that would otherwise be used in the hospital. And so, I think the treasury is the place to look. And I think then we just need to figure out the actual payment mechanism, whether that's through the IRS, whether it's by pushing money into the state unemployment systems, whether it's through instant tax rebates.

I think there are a few mechanisms to actually get the transfers out. But again, I wouldn't wait on the transfers until next April 15th or something. We need partly that money to go out right away as a way to stimulate the economy. And that'd be the other benefit of this approach, is dumping money into billionaires who really can't spend anymore tomorrow is not going to have the same stimulus effect as sending money to the individuals who are really living at the margin, and can either put in that next grocery order or not.

John Marchica:

Yeah, I mean, it would... To me, it would have to be something that would be instantaneous, where you can register for something online. You say, "I have a sick day." And, I don't know, again, the mechanisms exactly how to have that transfer happen. But if you're out 200 bucks, 250 bucks, you're out a thousand dollars for the week, whatever the case may be, you should be able to... For the policy to be effective, it can't just be through the tax system. It has to be something that cash is available today.

Chris:

And we've done this before. We've done advanceable instant tax credits, the mechanisms do just for the...

John Marchica:

Okay, good to know. So, I saw... And my last question round this, and maybe one of our last questions for today. I saw that a Gilead drug, antiviral drug, remdesivir, is being tested as a possible treatment for COVID-19. I saw where one patient sent to intravenous antiviral, and where they'd given him a, compassionate use to one patient and that patient had gotten better. With my understanding, is that now they're undergoing some sort of clinical trials, RCTs, to ensure whether this drug works. My question for you is maybe the ethical side of this. If this drug is successful, what are the implications for the pricing?

Chris:

So, you mentioned compassionate use. I just want to flag that this is a program that the FDA has had for decades now. And it's been a remarkable example of regulatory flexibility, where the FDA can, within days, or in some cases hours, approve access to drugs that are not yet open for the market generally.

So then, flipping to the other side of your question, what's the valuation of a drug like this? I'm reminded of a few companies that they came out with the hepatitis C drugs a couple of years ago. And they were priced up in close to a hundred thousand dollars for a course of treatment. But that was a rational valuation in my book, because the cost of liver transplants and other treatments for that disease would be even higher. And so, as horrible as drug pricing can seem sometimes, when you look at the value of what they provide, when it is a truly high value drug, I think we should be prepared to pay it. In contrast, there have been other cancer drugs that have come on the market at that same a hundred thousand dollars for a course of treatment, when they haven't even been proven to extend life by a single day for cancer patients.

They just have a proxy benefit on progression free survival or something. So, I do think we need to have a cold eyed look at the actual value they bring. And so here, I think a vaccine for COVID... I mean, there's literally trillions of dollars in economic loss that's happening right now as the US economy and the global economy is shut down. And so, I would not mind at all if Gilead makes humongous amounts of money on this drug, because it might well deliver that level of value. So, I guess you've seen the way I'm leading. Although I'm a big critic of patient cost exposure, and a critic of obscenely high drug prices that don't deliver value, when there's value there, we need to be prepared as a society to pay for it, just like we're prepared to pay for roads and billion dollar bomber planes, and other investments like that.

John Marchica:

Sure, sure. And the thing that I struggle with, Chris... And I totally agree with you, by the way. I'm aligned with where you're coming from. The thing that I struggle with is the polio vaccine. Right? I mean, effectively, it was given away, that it was seen as a benefit and such an important benefit to society. Now, we're going back a lot of years and I wasn't even born then, when it originated.

But I struggle with that because I think here is this altruistic move. And whoever... I guess that was Jonas Salk. But say a company had commercialized that in a big way. It could have been making a lot of money off of that, because the societal costs of having polio ripping through the country were starting to be astronomical. So, how do you wrestle with that, the ethics of that?

Chris:

So, if we were talking about distributing a COVID vaccine to Sub Saharan Africa, I'd say, "Well, let's adjust the price to a level that ensures that we can reach levels of immunity that are necessary. And so, in Sub Saharan Africa, the price needs to drop to nearly zero." But in a society like the United States, where we spend trillions of dollars on TVs and cars and washing machines and silly vacations, it would completely flip the incentives if we said, "Yeah. But for vaccines, we're not actually going to spend the money on it. We're going to force you to give those away for free."

I think we've got to respect that these pharmaceutical companies are our... They are our machines of innovation. And we've decided not to invest centrally. Maybe we should have 10 times larger NIH budgets and 10 times larger BARDA budgets. I'd support that, by the way. But to retroactively say, "Thank you for admitting the vaccine with your private investment. But no, we're not going to let you recoup the value," to me, completely, really undermines this powerful market-based mechanism we have created. So, we can talk about how to remake the market going forward, but refusing to pay for value that's been created seems really backwards to me. As long as they're not trying to charge such a high price that it becomes a barrier to us socially purchasing it, then I think we need to be prepared to pay the value of the product. But by then, I really... Just to emphasize, I'm saying we should be willing to pay for it collectively using our progressive tax system. We sure shouldn't be imposing it on the individuals who we want to create every incentive for them to get the vaccine.

So, that's why preventative services like vaccines should have no copays or no co exposures at all, because they're really getting the benefit, not just for themselves, but for the herd immunity that benefits the larger society.

John Marchica:

Well... And you could end up with a one-two punch. So, in this case, in the Gilead drug case, it's actually a treatment, not a vaccine. So, for the... I think, beyond just the symptoms. So, you could have a situation where you'd have an active treatment. And then, on the backend, when it's available in 18 months, whatever the timeline is these days, to vaccinate people on mass at that time. Interestingly, you may or may not remember this, but the Hep C example that you gave, Gilead was, I believe, first to market in that 80 to a hundred thousand dollar treatment range.

And then eventually, the prices... I think the rebated price for that category of drugs is somewhere between 40 and $50,000 today. So, it's come down.

Chris:

And that's partly because there are now at least two chemical compounds in that same space, sort of the system is working. We're getting a little bit of competition between different chemicals compounds.

John Marchica:

Right? Right. Exactly. But listen, I could keep going on with you, Chris. It's a fascinating conversation. But I want to thank you again for spending some time with me. Chris Robertson's book is Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done about It. I highly recommend it. So, it'll be a different type of read. There's a lot of books out there. And I've read a lot of them on criticizing our healthcare system and how to fix it, what to do about it.

This takes an entirely different approach though. I highly recommend it.

Chris:

I'm a big fan of the podcast. Happy to be here. Thank you.

John Marchica:

Thank you. Take care.

Kimberly Asciutto:

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