TECHONOMYHEALTH

How Do We Redesign Healthcare?

Speakers:

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(Transcription by RA Fisher Ink)

David Kirkpatrick: …Dan Munro, who you're about to hear from, wrote one of my favorite articles in here [the magazine]…the lead article in it is Dan's, because he has such a compelling point of view on the architecture of the American system and he wrote a book called *Casino Healthcare,* which is an excellent, scathing indictment of our system, which he may summarize, in 10 minutes.

Dan Munro: Thank you very much, and I look forward to the opportunity to talk to you today. I thought I'd try and frame this a little bit relative to my background, the book, the article, and then what I wanted to do was kind of a short story on patient identification, in part because patient identification I think represents a great short story looking through the lens of technology, innovation, and policy. And it starts with another companion book that I strongly recommend, which is by Dr. Bob Wachter, who wrote *The Digital Doctor*. If you haven't read that, that is an excellent book on the evolution of the electronic health records system. He works as a clinician at the University of California, San Francisco, which is I believe an Epic shop, and his lens into the entire electronic health records system is phenomenal. And one of the first things he identifies, which is what I'm keying off with patient identification, is that the first thing that we have to do in the healthcare system is we have to figure out who the hell you are. [LAUGHS] And that comes back to patient identification and how we do that today.

So how we do it today is typically by name. We use social security number, we use a birth date, we may use an address, and then we cram all of those numbers into an algorithm that then tries to do what's called patient matching, in the sense that any hospital system has a thousand John Does, has a thousand Mary Smiths. We'll get into that in a little bit, but the algorithms are what are used to do patient matching and mismatching so that we begin the process of understanding who you are.

The problem with all of those fields and all of those numbers is that they aren't ANSI-recognized and they're not ISO-certified. So there's no standardization around those that we

can really apply to, so they aren't really intelligent numbers. There's nothing intelligent behind them. And what do I mean by that? So the patient mismatching problem that we wind up with as a result of that is that in a large enough hospital system, they're going to lose about $17 million a year on denied claims just on patient mismatching. Intermountain Healthcare in Utah spends about $5 million a year just on patient matching. Kaiser Permanente has about 10,000 Maria Gonzalezes in their database. And there's a facility in Houston that has over 250 of the same name with the same birthdate. So when you see the size and scope of this, you begin to understand it. About 8–14% of all medical records have incorrect data. So the cost to correct this in the system represents hundreds of millions of dollars a year.

Anybody know what this number is? I wouldn't expect you to. It's actually what's called the Tire Identification Number. This is a number that the National Highway Transportation Safety Administration dictated that the tire industry use for every passenger vehicle tire. And it's been in use since 1971. Why is that important? It's important as a consumer if there's a recall on that tire, you can do it by that identification number. And it's an ISO-certified number that is represented by that as well.

Anybody know what this number is? This one's a little bit more common. VIN, excellent. So yes, it's a number that's been applied to—and there's a huge history behind this, in part because each of the auto manufacturers in the US established their own vehicle identification numbers starting in about 1954. The problem was that they weren't unified. And so again, in 1981, the National Highway Transportation Safety Administration dictated that all of the manufacturers use a standard number that is ISO-certified. And the beauty of a technology like Carfax isn't the fact that we can do that on a mobile phone, which we can, but that it's predicated on a VIN number that can be looked up for recall information to see if that vehicle has been stolen, to see if it was a part of a flood. So vehicle identification number is another example of identification.

The more recent example is probably through the TSA. How many people here have a known traveler number? Wow. Great example, right? And you have to pay into that system, because you recognize that there is a value in exchange for that. We haven't found that yet in healthcare, but we're getting there. And we started to try and recognize that with a legislation back in 1996 called HIPAA. Anybody know what the P stands for?

Audience: Portability.

Munro: Great. I don't often get that. In any event, it's mandated through Health and Human Services, but it's regulated by HealthIT.gov, which is also ONC. And before we go any further, I do want to dissuade everybody from the idea that there's a HIPAA compliance. Nobody is HIPAA-compliant. There's no certifying governing body out there that says you're HIPAA-compliant. HHS doesn't do that. ONC doesn't do that.

So what is it that they do do? So there's basically three principal rules associated with HIPAA: the privacy rule, the security rule, and the breach notification rule. They simply issue that as a rule that organizations have to abide by. But it's up to the organizations to prove that they've done that individually, which they typically do through an audit. And those audits are third-party-generated, they cost a lot of money, and they're done annually. And so most companies can't afford to do that, or they simply don't do that and simply indicate that they're HIPAA-compliant. And the fact is they're not. And more recently, HIPAA came out with a cloud computing guidance which is equally critical.

Buried underneath the legislation in 1996 were two other pieces of HIPAA that were long forgotten. One was the national patient identifier and the other was the national provider identifier. So two years after they implemented HIPAA, or after the legislation passed, in 1998, Congress stepped in, defunded the national patient identifier and said in effect, "HHS, you are prohibited from spending any money on developing a national patient identifier." But we do have to this day a national provider identifier. So every doctor in the system has in effect a national provider identifier.

So the reason that they argued against that, and the reason they said they wanted to defund it, was because of security and privacy. That argument falls by the wayside today in light of the breaches that we're seeing relative to healthcare generally. This is simply for one year, and these are the top ten breaches, and it's over 111 million records for just 2015. And we're seeing more of that of course as the years go on. So these are the organizations that have lobbied heavily for the government to step back in and provide a National Patient Identifier. Not surprisingly, one of the lead organizations that's lobbying heavily is HL7, which is the standards organization for the healthcare industry. But there are other groups as well. HIMSS, CHIME, AHIMA, all of these organizations have lobbied Congress heavily, saying, "We need a national patient identifier. Please give us a national patient identifier." But there's another group behind that, and I don't want to say that these people are anti-national patient identifier as much as they're silent relative to the need for a national patient identifier. So it's not that they're lobbying against one, it's that they're not lobbying for one. And I think until we get more industry involvement in that, it's not likely to happen.

The reason why is partly the basis of the article and then also of the book, which is the idea that what we have isn't a dysfunctional government but a lot of regulatory capture. So these companies in effect are working collectively with Congress, with legislative organizations, to protect their interest and naturally set barriers for these kinds of events to happen.

Munro: The revenue that's associated with keeping it that way is enormous, and that's how we get to $3.5 trillion a year.

Kirkpatrick: We'll come back to some of the other scathing points you make about the system, Dan. But let's just quickly introduce the other two people up here. Steve Krein is a CEO and co-founder of StartUp Health, which runs what he likes to say is an army of health transformers. It's basically a community of startups, which is, what, about 200 health tech startups in which you invest, but more importantly you coach, you mentor, you network them together, you help them figure out ways to intersect with the system broadly. Based in New York, which we're very happy about as New Yorkers.

Andrew Cohen is vice president of the healthcare vertical at Cognizant and very involved in healthcare, and he's been doing healthcare for an awfully long time and has worked for a lot of different parties in the system. Just talk about some of the different parts of the healthcare system you've worked in.

Andrew Cohen: Thanks. I started my career actually at Kaiser Permanente, and I was part of Kaiser's national expansion group where we came up into the northeast and other parts of the country to try and get the Kaiser model up and running. You know, one of the things that really impressed me about Kaiser was that when we sat around and really started to run the business, it was really about getting the physicians, the insurance folks, the finance folks, the actuaries, everybody together in the same room to have a conversation and to build consensus around how we were going to take care of people, how we were going to finance things, how we were going to run the business, pay claims, do operations. I thought it was brilliant at the time, and I said why isn't this everywhere? And again, that was early 1990s.

From there, I went to Health Net and Cigna and then spent about ten years at United Healthcare, doing network strategy and a lot of product development, so developing a lot of United's value-based insurance plans, all of their private exchange products and things like that. And then the last five years I've spent really focused around financial and strategic advisory work on the provider side, so really helping providers understand what's behind the black curtain at big health insurance plans and trying to figure out how I could be a marriage counselor, so to speak, between the different parties and try to bring the conversation together for formerly sort of adversarial roles. And now as we we're kind of moving back to that Kaiser model or to an ACO model or more collaborative model, things are coming full circle 25 years later.

Kirkpatrick: Well, I'm glad you say you think we're moving back to a Kaiser model, because I just want to quickly say one or two things about Kaiser, and the reason you were so excited about it way back then—for anybody that doesn't understand, Kaiser is both the insurer and the provider. So basically, they have—what, how many? Is John in the room? How many people do you have, 10 million?

John: Eleven million.

Kirkpatrick: Eleven million, okay. Kaiser basically has a huge incentive to keep people healthy because they are also the insurer. So that's frankly the system we need to have and the system more or less that every other country has nationwide. So it's just worth keeping in mind, it does exist in microcosm in the United States, and there are a few other examples of that that exist at smaller scale. Cleveland Clinic has elements of that and are going to be on stage later, but they're not quite the same, because they're not an insurer.

But it is interesting, when you say we're moving toward that—let me just ambush you right now. Why do you say we're moving—and quickly, one more thing, with Phillips, I did a thing at Davos the year before last with Zeke Emanuel, who's one of the Emanuel brothers and a big philosopher of healthcare, and he says we are heading toward the Kaiser-ization of American healthcare, which is a very optimistic statement. I'm glad that he thinks that. Do you think that?

Cohen: I think we're trying to get there. When I think about how we're financing healthcare or how we're looking to finance healthcare. We talk about value-based reimbursement today and value-based purchasing, to the extent that we really haven't fully adopted that. Even though all the major health plans are saying 85% of our physicians are reimbursed in a value-based arrangement and 80% of our members are taken care of under value-based care delivery models, the reality is it's just sugar-coated fee-for-service. I think that's really where we still are today. So I think everybody kind of wants to get there, but there's intense pressure and barriers not to get there, and I think that's one of the biggest challenges we're trying to solve now. And technology and data, I think, can help accelerate that, but we've got a long way to go before we get there.

Kirkpatrick: Okay, in a second, I want you to answer the question does everybody really want to get there? But Steve, I wanted to ask you to talk a little bit more about the perspective of the startup, which you're so conversant with. I mean, we've heard a couple of great startups today on the stage today, quite a few, and Katelyn, what she was doing with Eligible, I think maybe we'll talk about that specifically. But how do startups look at this opportunity and how optimistic are they allowed to be in the United States?

Steven Krein: [LAUGHS] Well, it's a great question, and I want to just kind of remove the word startup and replace it with entrepreneur, because behind all these organizations are people. And what we're seeing, not just here in the US, but globally, through this global army that we've built that are out every day talking to payers and providers and pharmaceutical companies and patients, is that the mindset of the leaders of these organizations is the biggest stumbling block to moving forward. So they are as optimistic as entrepreneurs in any other sector, but in this sector, the stakes not only are higher, but the barriers and the stagnation-minded leadership of the organizations they need to collaborate with are so difficult to

overcome that we're trying to get them to lock arms with not only each other but batteries-included leaders of organizations so that we can begin to move forward. Because when you talk about an organization, whether it's a hospital or a startup, look to the leadership and see where their mindset is. And that is what we're trying to decode, which is who's batteries-included, leaning into help, support, figure out, validate, iterate, experiment, and who's not and is locked with their heels in the ground, unwilling to move forward?

Kirkpatrick: Well, since I know your companies interact with pretty much every major player in American healthcare, of the large institutions in American healthcare, which includes hospital systems, insurers, the whole gamut, what percentage would you just roughly say are leaning into the kind of change you think is necessary?

Krein: Not enough, but there are plenty of examples of—and it's not big nationals, it's a lot of local, although large for their state. There's a hospital in Wisconsin, Aurora Health Care, run by Nick Turkal—CEO mindset is we have to do this now, we have to do it this decade, not a decade or two from now, and we're committed to figuring out and working with entrepreneurs and startups to validate and commercialize and figure out how to almost disrupt ourselves and lower cost and improve access to their local community. It's the largest employer in Wisconsin, but they're actually working and collaborating today with entrepreneurs and startups. The same thing's happening in Denver, Colorado. UCHealth Children's Colorado, two institutions run by CEOs who believe it's urgent that we move the ball forward. But there's not enough of them. So we're trying to create this model where we show other hospitals and other pharmaceutical companies and other insurance companies how to actually build the leadership team and build the mindset and culture so that the entrepreneurs with a decision maker who says, "Let's do it," but then the actual administrators or clinicians who say we don't want to or can't.

Kirkpatrick: Andrew, any thoughts on that?

Cohen: Yes, I love the Aurora example. I think Aurora is really changing the paradigm. They're going direct to employers. They're putting full-page ads in local newspapers and trade journals, saying, "We don't just promise better and more cost-effective healthcare, we guarantee it." They're actually putting their money where their mouth is, and they're actually underwriting some of the risk in partnering up with 15, 16 different hospitals, 3,000 different physicians in that market, and they're going direct, using large insurers in the background to do the administrative stuff because they don't want to do that, but then they're going directly to the employers and marketing directly to the employers and saying if you contain your employees' healthcare or if your employees choose to contain their healthcare within the Aurora network, guess what? It's lower out-of-pocket expenses, no paycheck deductions, lower premiums, things like that.

Kirkpatrick: Well, the topic of this here is how do we redesign healthcare, and I think we've heard—I mean, certainly throughout the day, I have expressed repeated frustration. I think

we've heard a lot of different forms of frustration with the existing system. One of the questions that I have, particularly for you two and maybe especially for you, Andrew, is do you think that the parties in the system recognize the emergent—I mean, I don't think the frustration is at the level it's going to get to, because we're very distracted by the Obamacare debate frankly, in my opinion, which is really not the main issue, but I think we are heading towards pretty serious frustration. Do you think the industry looks at it that way?

Cohen: Yes, I think we're already frustrated. I mean, there's no question about it. Hospitals are frustrated, I work a lot of with them, a lot of large and small hospital systems around the country. The payers themselves are frustrated, employers are frustrated, consumers are frustrated, brokers are frustrated—I mean, all of the different stakeholders are absolutely frustrated. Everybody's thinking and trying to figure out a better way to do it. How do we build that better mousetrap? I feel like all the pieces are there, we just haven't figured out how to assemble them in the right way in order to get better performance.

Krein: So in what other industry does the industry look to incumbents to reimagine their industry? The taxi commission didn't get together and reinvent their industry, the entertainment business or the financial services business didn't sit as big organizations trying to do it. It's entrepreneurs for literally as long as history goes who have been the ones to reinvent and reimagine. Now, doing it in collaboration in healthcare is critical. It's obviously important for the entrepreneurs and these large organizations to work together; no other industry has that. But in order to change this industry, we have to change our mindset and get the mindset of the leaders of these organizations, and from top-down and bottom-up, to literally shift.

Kirkpatrick: But then let's go back to your article, the main theme of which ultimately was there is not going to be an Uber of healthcare. What do you mean by that, and why do you feel that so strongly?

Munro: So part of the reason is because in order to make the kinds of systemic changes that are necessary, you have to be disconnected from the profit motive. And we've lost that in the sense that originally if you look at the real innovation of the internet, it was DARPA, it was the government. It was the federal government that funded those initial exercises. It was the government that gave us GPS, on which in effect a lot of these technologies and a lot of this innovation reside today and we've leveraged commercially. But if you look at the underpinnings, where did that happen? It happened inside, initially big, big companies like Bell Labs. And today we have Google, as probably another example of a company that can afford to make a huge investment disconnected from a profit incentive.

Krein: There doesn't need to be an Uber in healthcare. There's going to be thousands of them around the world. In the US it's what, $3 trillion? But globally, it's obviously significantly larger. There are thousands of entrepreneurs all around the world, in every region and every country and every city in the United States, trying to reimagine and reinvent healthcare in very narrow

areas. So much so that we had to organize them into ten buckets where we said there's kind of ten big health moon shots in categories that entrepreneurs are working in.

Kirkpatrick: Can you remember what all ten of them are?

Krein: Absolutely. Access to care, cost to zero, cure disease, end of cancer, brain health, women's health, children's health, mental health and wellbeing, longevity—am I at ten yet? I have one more?

Kirkpatrick: Oh, that's pretty good. That's a good list.

Krein: But when you actually talk to entrepreneurs—how many entrepreneurs are in the room today? Raise your hand if you're an entrepreneur.

Kirkpatrick: Oh, nice.

Krein: There we go. I know we have a bunch of our companies here. Stand up if you're a health transformer. Because I just want to use this as an example. There are thousands of these entrepreneurs, 200 of these entrepreneurs are in the startup health ecosystem, this army around the world. These are entrepreneurs literally within their little slice, working within the system to try to change this little narrow segment they're working in. Some are working in children's health or women's health or mental health and wellbeing or longevity, but what they need is a) a runway, b) to work with people who have the right mindset. Because literally, if you look on one side of the wall, are solutions, technologies and data and other things being literally brought into the hospital, to the insurance company, to the pharmaceutical company, but leadership is not embracing, slowing it down.

Kirkpatrick: But I'm confused. You sound so excited about what they can do, but then you say but leadership is slowing it down.

Krein: Leadership of the big organizations. I talk about payers, providers—

Kirkpatrick: Yes. Is this how we're going to redesign healthcare or not, I guess is the question. And maybe a secondary question, after you answer that, is are we going to end up redesigning healthcare in other countries first and then have to retrofit ours once we see what's really possible elsewhere?

Krein: Yes, so our thesis is that innovation in other countries will inform entrepreneurs and innovation here in the US and vice versa. Part of our model is to have this global army connected together so that Aurora in Wisconsin can work with a technology out of Helsinki, Finland that never would have been in its region or pitching Aurora Health Care, Nick Turkal's

team. And so the idea of educating, the idea of coaching even teams within these organizations on how to work with entrepreneurs and startups, a) so they manage expectations, b) so they validate and actually work on collecting the data, and stand by and next to these startups and entrepreneurs as they build their case, as they actually prove that what they have works. And it's that collaboration that's required. They cannot do it alone. By the way, both—the entrepreneurs can't do it alone, but these hospital systems, these pharmaceutical companies,

and the insurance companies can't do it without innovation either. And it's not going to come from within.

Cohen: Just thinking about the innovation, I think you're dead on. I think the innovation is definitely the key to really making the change. I think about big insurance companies now, and they need to think about what are the things that truly differentiate them. And paying claims, and doing customer service and doing underwriting and pricing and things like that, those are not differentiators. So I think a lot of what we're seeing now is insurance companies starting to outsource that type of stuff and start to say, okay, what are we going to focus on to really make a difference and to change the paradigm?

Kirkpatrick: So the differentiator will be, like this Aurora example, actually keeping people healthier? Is that what you think the competitive basis will become?

Cohen: Well, I think models that support that. So you look at what Aetna's doing with their federation of ACOs. So now they're going out—and ACOs tend to be a very local thing—

Kirkpatrick: What does ACO mean?

Cohen: Accountable care organization. So accountable care organizations is just hopefully bringing doctors and hospitals and other care providers together in a more organized way to get them to manage care across the continuum, ideally. It started with Medicare and the MSSP ACOs and it's expanded out to kind of think more about the Kaiser model. How do we create an integrated health experience? And companies like Aetna, who insure a lot of big national companies that have people across many, many states, that model doesn't necessarily fit with an ACO that's localized like the Cleveland Clinic or Northwell Health out here on Long Island. So what Aetna's doing is saying we're going to have a federation, so if you're an employer that has employees across many different states, you can come to Aetna and you can say we like the ACO model, and they've got 30 or 40 of these ACOs all strung together and starting to build plan designs those high-performing narrower networks.

Kirkpatrick: So I would love to set up a little debate between Andrew and Dan, but when you look at that sort of thing happening, are we going to sort of short circuit—do you think we can

make enough progress with that kind of stuff to really improve the healthcare system to the degree we need to long-term? I guess that's the key question.

Munro: So far, the evidence that we've seen on ACOs is encouraging but nominal, and it goes to the heart of the larger issue, which is that it's innovation around the edges, it's not at the core. My background is as a systems engineer, and I actually have a degree in computer science, I did software development for a number of years, infrastructure software, which is very low-level. That gave me insight into the system design element, which I've seen in healthcare and we're not getting to the core of healthcare. We're dancing sort of around the edges. Meanwhile, every year, cost goes up. The Milliman Medical Index, which is the index that's published every year, came out today for this year. The average annual cost for a family of four in America for PPO coverage through their employer is now almost $28,000 a year.

Kirkpatrick: Wait, so who's paying that? Is that the employer and the employee are both paying it in various pieces?

Munro: It's divided, but it's not an equal split. It's about a 60/40 split.

Kirkpatrick: The consumer's paying 60?

Munro: The consumer's about 40 and the employer is about 60, but—

Kirkpatrick: It feels like 60 when you're paying the copay.

Munro: The challenge on the road ahead is how much that variable is changing relative to the employer-employee contribution. It used to be 60/40. It's trending more and more towards 50/50, and I can see where over the course of the next five years that'll flip.

Kirkpatrick: Well, there was also that amazing statistic that somebody said this morning that inflation since 1999 has been roughly 41%, and healthcare costs to the ordinary American have been something like 240% increase. So that's a kind of untenable reality.

Munro: And so we talk about saving all of this money in healthcare, and we talk about the capacity for technology to do that, which I believe is there, but it's not having the kind of effect that we need it to have relative to these escalating costs every year.

Cohen: Not yet. And I think that's the challenge, because again, when we think about care delivery, ACO really—and if we talk about accountable care organizations, I concur, we're not seeing the benefits by any means whatsoever. But the problem is that ACOs are a way of delivering care differently. The other piece of that is financing that or paying for that

healthcare, and one of the things we don't see is that intersection between how healthcare's reimbursed and how healthcare is delivered. And without that synchronization of those two things, we're really not going to see the benefits. And that's part of the challenge. So everybody's set up these great ACOs, there are like 6,000 of them. At the end of the day, we haven't seen a lot of great performance or behavior change from providers, because again, they're still being paid essentially in a fee-for-service manner. So once you're paid—and I'm sure this part of your book—as you're paid in a fee-for-service manner, you're encouraged just to do more. That's all you're encouraged to do.

Munro: ACOs are effectively an overlay to a great big, huge billing engine, and the billing engine that we've had for the last 40 years has been based on fee-for-service**.** And we're not ripping that out. So in effect, everything that we do relative to ACOs and accountable care and value-based care, all of those are overlays to an underlying billing engine that's still fee-for-service.

Kirkpatrick: Well, and just to say something that came up at dinner last night that I thought was interesting. You know, we talk about Epic, and I was badmouthing it before, but you know, Epic is the sort of de facto employee health care record of America for the most part, and it was structured originally primarily just to do billing, not to do getting people healthier, right? Does that compound the problem?

Munro: Absolutely, in the sense that Judy Faulkner recognized early on that there was an opportunity in software to build a big billing engine, and so that's what they set out to do. And if you look at the underpinnings of what Epic is, it's a big huge transactional database that's able to handle literally millions of data inputs per second, right? Inside a hospital, when you have a patient that's in an ICU, that's strapped with 15 different monitors—

Kirkpatrick: Each one billable, is that what you're going to say?

Munro: Well, no, not each one billable, but each one generating data that has to go somewhere and that in some way does map back to a billing engine, then, yes, there is a correlation to being—

Kirkpatrick: I don't want to beat a dead horse, but would you say that this Epic structure, that by being so focused on billing—I guess it's the obvious point I already made but it can't really make us healthier in the aggregate the way we need to be made healthier?

Munro: In the same way that ACOs are an overlay, what we've tried to do is to overlay clinical care into the electronic health records system. And that's an equal challenge, because they're different systems. And so we're trying to overlay clinical care into a billing engine, and it's like trying to mix oil and water, the two don't necessarily mix. We'll get there, but at the end of the day, fee-for-service as a business model isn't broken. That's a misnomer. People love to say

that fee-for-service is broken and we need to get to this value-based care. No, fee-for-service works in every other industrialized country just fine. The problem that we've generated with it is fee-for-service for profit. And that's part of the challenge.

Kirkpatrick: Oh, you sound very non-contemporary.

[LAUGHTER]

Krein: Well, you asked about this Epic question, and it was started by an entrepreneur, but did a land grab, has installed inside of almost every large hospital system, controlling a big footprint. In any other industry, you'd have entrepreneurs and developers and startups able to work with these platforms. As closed as Apple is, they have a huge developer network of course building apps. Imagine if we relied on one company for every app on our iPhone or Android

device? Google, Facebook, even Salesforce.com have opened up their platforms for entrepreneurs to innovate. That is the biggest challenge today, entrepreneurs are literally being kept down, and I'm not saying woe is me—

Kirkpatrick: By what?

Krein: By the mindset of these organizations that have made commitments and that are doing things within their organizations to not embrace entrepreneurs and innovation that wants to actually come help their patients—

Kirkpatrick: Specifically Epic, you're saying, is not—

Krein: You brought up Epic. I didn't bring up Epic as an example. It's just not an open platform where entrepreneurs can develop on. So there is a way to do it. It's very difficult, it's very taxing, it's very expensive, and there are entrepreneurs doing it. But ultimately, when you look in India, at consumerism much further ahead than the US, entrepreneurs are bringing things to market without some of the barriers they have here in the US.

Kirkpatrick: Okay. We've got some time. We've got another ten minutes after this, right? Anyway, I think we do. Because one thing that I—and maybe Esther could even shed light on this. I've been so confused reading the papers in the last few weeks. On top of all this other stuff, I look at this figure of withdrawing $880 billion from Medicaid, and I can't believe that that's really what I'm reading. How could that possibly be a legitimate proposal? Because that would be, on top of all the other problems we have, $880 billion less to spend on keeping Americans healthy. Am I reading that right?

Munro: Over 10 years.

Kirkpatrick: Okay, but still, only $88 billion a year less, okay. That's weird.

[LAUGHTER]

Dyson: The disconnect isn't just between who pays and what they pay for. It's short-term versus long-term thinking. And the reason fee-for-service is broken is because you're paying for something in the present, or often in the past, because it takes three months to bill.

Munro: It's transaction-oriented.

Dyson: Yes. What you should be paying for, and this is where big data comes in, is activities that 10 years from now are going to give you a huge return on that investment. So we need to start looking at healthcare as investment rather than spending. I mean, this is a budgeting problem, but if you go talk to somebody at the Congressional Budget Office and those kinds of people, they get it, but Congress never asks them the right questions.

Kirkpatrick: Okay, but wait—he's like down on profit. I mean, it sounds to me, if you really thought of it the way you just described, the profit per se wouldn't be a problem. You'd just be measuring it differently. Am I right?

Dyson: Yes, it's the way you invest in a startup. You put in millions of dollars in the hopes that later you'll get billions back. And you risk adjust it, you put in a discount factor and all kinds of things—

Krein: It's viewed as an investment, not a cost.

Dyson: Yes.

Kirkpatrick: But Andrew, are we moving in that direction?

Cohen: I think so, but the challenge is who makes that investment? I mean, is it the federal government, is it employers, is it big insurance companies? Because, you know, part of the resistance is, especially if you're an employer, why make an investment today for—

Dyson: Because they're going to leave.

Cohen: Yes, they're going to leave, right? They're going to be somebody else's benefit or problem later on.

Dyson: Right. And that's why Medicare Advantage works so well, because usually those people stay with you until they die, whereas Medicaid has a churn, every eight and a half months, somebody drops off Medicaid, then they get untreated for three months, then they come back sicker, but usually with a different payer provider arrangement. So the challenge is—and it's complicated—doing multiparty contracts, with the city or whoever benefits from the savings, which is partly the individual, but it's also the jail system, it's the schools, it's the police, it's the employers, it's the mayor who gets reelected. It's just like in advertising. We need to get better

at doing attribution, like who actually benefits from this money going in. Some people are working on it. I don't want to go on at length, but that's where we really need to be moving.

Kirkpatrick: It's very interesting what you've really learned getting so deep in these five communities. You're articulating it quite interestingly, so thank you for that.

Dyson: Thank you.

Kirkpatrick: But we're going to pass the mike to somebody else. Okay, let's get somebody new over here.

Audience: So Steve, I'll talk the same way you do, but—and thank God for the healthcare system being so screwed up if you're an entrepreneur because there are about 8,000 problems every day to look at to solve, and that's really pathetic. I don't want cut my own legs out from underneath me and the rest of the entrepreneurs, but is there really any solution other than single payer?

Munro: Yes. I'll dive in. In part because what you're focusing in on there is the payment mechanism, and what we need to focus on is the coverage mechanism. Because if you look at every other industrialized country, it has universal health coverage. How that's paid for can be either single payer, multi payer, employer-paid—there's a number of different ways to pay for it. So one of the things I try and do in the book is specifically that, to make the distinction between universal health coverage and single payer. Because we tend as a country to go straight from universal health coverage to single payer. And I'm not convinced that America's culturally a good fit for single payer, and we don't need to have it in order to get universal health coverage.

Kirkpatrick: Who would pay, or how would you—

Cohen: And I agree with that, because I think we had a single payer system. It was called Medicare, and guess what? It didn't work very well, and that's why we have Medicare Advantage, one of the fastest-growing components of the Medicare space.

Munro: [LAUGHS] On the one hand. On the other hand, the headline today is a whistleblower now claiming that United Healthcare has spent years gaming Medicare Advantage specifically for profit incentives.

Kirkpatrick: On the other hand, when Brian Donley comes up from Cleveland Clinic—you're a big fan of Medicare Advantage, right? We're just going to go straight to your session.

[LAUGHTER]

Donley: I think there are some advantages to it, and it does promote some good behavior from the provider.

Kirkpatrick: Yes. Okay, we'll get more detail in a minute, but thank you. Yes?

Audience: So Steve, building off something you said earlier around there'll probably be no one single Uber of healthcare. I'm with Johnson & Johnson, and I think we would agree with that, but we recognize there has to be this broader ecosystem of partnerships that does come together with startups, with existing people with knowledge around the regulatory frameworks, et cetera. So a question is what is one thing that existing players need to bring in to help fix it, and what is one thing that only startups or people outside the system could bring in that would help change the system?

Krein: Both the same thing, an open mind to collaborate and work together to figure it out. And here's the truth, nobody knows what's going to work and what's not going to work. All you can do is experiment and try to figure it out, using data and using time, and using enough data points in order to figure that out. So what we're seeing across—we have a single database of every stakeholder in the world that our entrepreneurs connect with every single day, every investor, payer provider, pharmaceutical, government agency—not the organizations alone, the people within these organizations. And I'll use—I don't know if anyone from Pfizer's here, but I'll just use Pfizer. There's literally 18 different doors to go into Pfizer if you're an entrepreneur or startup. Seventeen of them are the wrong one, maybe even 18 of them. One is the right one. It could be right next door to the one you went into. And so at the end of the day, it's how do you make it very transparent who the right people that have the commitment from the top all the way to the CEO to work and collaborate with these entrepreneurs and startups to figure it out. The entrepreneurs are more nimble, they're hungry.

I don't know how many entrepreneurs get bigger paychecks than anybody who's actually at these large organizations. I can tell you not very many, so the entrepreneurs need to be open with what they can do to collaborate and what they need, and the organizations need to do the same thing. If everybody can talk at the same time, at the same table, and exchange what the value exchange will be, what the value alignment that needs to be created is going to be, you can actually move the dial. We speak to organizations after they meet with startups and entrepreneurs, and they literally were either not listening or actually went right past it, or you talk to the entrepreneurs and they say, well, they were looking for something else. So these organizations go out looking for solutions, they don't share their problems they're trying to solve, and these startups going in with their solutions don't ask the right questions of these organizations. So ask more questions, better questions, and actually exchange that together.

Kirkpatrick: We've got to wrap, but Andrew, do you have any final thoughts?

Cohen: No, not on that point, particularly. I mean, I think we definitely have to get people working together more than they're working together now. The big problem has been that nobody really trusts each other. Data is really being seen as a currency, and people are

protecting that currency as much as they possibly can, which I think has really hindered the ability for people to share information and thus work together in a more collaborative way. So I certainly believe we need to do more of that, and I think that will be supported by entrepreneurs, that will be supported by data technology, there's a lot of things that are driving that, but we really have a long way to go, I think.

Kirkpatrick: Any final thoughts?

Munro: Final thought is, I agree 100% with Esther. I'm not anti-profit. What we've developed in the way of a system is quarterly-driven, and that's part of the problem.

Kirkpatrick: Okay. So thank you all, really great.