Fixing Healthcare Podcast Transcript

Interview with George Halvorson

Jeremy Corr: Hello, and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular new books, medicine podcasts, and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of the Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, an author of the bestselling book, Mistreated: Why We Think We're Getting Good Healthcare and Why We're Usually Wrong. His new book Uncaring: How the Culture of Medicine Kills Doctors and Patients was published three months ago. All profits go to Doctors Without Borders. If you want more information on the book and a broad range of healthcare topics, you can visit his website, robertpearlmd.com. Together, we also host the biweekly Coronavirus, the Truth podcast.

Jeremy Corr: Our guest today is George Halverson. Mr. Halverson was the CEO of Health Partners in Minnesota for 17 years, CEO of the Kaiser health plan and hospitals for 12 years, and president of AHIP, America's Health Insurance Plans, chair of the First 5 California commission for children and families, and the current chair and CEO of Institute for InterGroup Understanding. He has published a dozen books on improving healthcare and four books in the area of racism and intergroup peace.

Robert Pearl: George, you've been a health plan leader for most of your career, including CEO of both Health Partners in Minnesota and Kaiser Foundation Health Plan based in California. From your perspective, how do you believe health plans can lead the nation to higher quality and lower costs?

George Halvorson: Well, I absolutely, totally believe that we have to become better purchasers of care as a country. Now we've been a payer. As a payer, we spend $4 trillion and we get inconsistent results, bad care in many settings, really inconsistent progress and care delivery. And when we buy care as a package, when we buy care from plans, and when we expect the plans to deliver the care, we have a whole different leverage for purchasing. That setting, we can expect quality to improvement. We can expect data to flow. We can expect teams to function. And so when we function as a buyer, not a payer, we end up with much better care. Both Kaiser and Health Partners are care settings and deliver care in addition to insure care. And because of that and you know the results, the outcomes, we have half as many people with hospital admissions, we have far lower people with asthma attacks.

George Halvorson: We end up with much better care because we can focus on the care and do a better job of care. And we can also keep up on the science. Because when you're a solo practice doctor, and you're just trying to keep up all by yourself, that's really hard. There's 1,000 medical journals out there. But when you have like a Health Partners or Permanente Medical Group, that group can keep up on

all of the science, can distill the science, and then can pass the best current science onto all of the people on the care team. So it's really problematic to try to keep up with medical science outside of a group setting. But in a group setting, because of Permanente, Health Partners, Mayo Clinic do a really good job of keeping up. So I much prefer the model. I just think it makes huge sense. And I think the whole country needs to move in that direction.

George Halvorson: And before I say that, I would like to mention quickly, I really enjoy your books. You write great books. They're insightful, they're clear, they're easy to read, they're inspirational. You bring a level of talent, and insight, and wisdom to the writing process that can only come from your unique background, not only running a major medical organization, but also doing it in a way that is focused on improving care. And then as a physician, your insights, your personal insights into that doctor-patient relationship that you embed in your books is just very powerful. So I think you're almost unique in the ability to write those books and you write them really well. So I'm a big fan, and I enjoy reading them, and I share them with people. We haven't talked for very long time, but I'd just like to say that to you. Well done.

Robert Pearl: Coming from someone like yourself, who's published over 20 books, that's high praise. So thank you so much, George. So let me go back to the question of the health plan role, though. In both of your roles you led, you were the CEO of not-for-profit health plans. What do you see is the difference between a not-for-profit and for-profit health plan through the lens of the patient and the lens of the purchaser?

George Halvorson: Well, I think the differences between the not-for-profit, the for-profits were significantly greater a couple decades ago than they are now. As a not-for-profit health plan, we can focus on the wellbeing of the patient. I used to be chair of AHIP years ago. I was chair a couple times of the National Association of Insurance Companies and Health Plans. And one of the things, when we went down the path of improving quality in that context, we initially had some of the for-profit companies resisting going down that path. And they resisted because they had shareholder lawsuits, literally saying, "As shareholders, that those health plans should not be improving quality. They should be optimizing profit." And they couldn't do some of the things. So as a trade association, we managed to get quality into the agenda, but actually Kaiser Permanente and Health Partners, both, in the market, proved that you could cut the number preterm births in half and cut the number of asthma attacks in half.

George Halvorson: And by making that a market model, we made it then something that the for-profit companies could do as part of their agenda. And so we literally forced them, and enabled them, and supported them in their change of direction by getting it right on the care side. But what was fascinating to me was a couple of my peers and I said, "Why in the hell are you not supporting us in this?" And they said, "We can't because the shareholder lawsuits." So you have to make it a market imperative and then we can follow because it'll be a market issue, not a do good issue." So that was fascinating, but very true.

George Halvorson: And today they have figured out that ... Optum right now is trying really hard. Their self image is that they're going to deliver great and continuously improving care. That's part of what they're trying to push in their culture. And that's also part of their market model. So they have gone far down that road. And I know for a fact that the folks at Optum have studied Kaiser Permanente, studied stuff that you had invented. They're moving it into their setting. But they're doing it with the belief that they will thrive over time by being best in care and not just best on underwriting and risk selection.

Robert Pearl: George, you've been a proponent of Medicare Advantage. You've written about it extensively. For listeners, can you explain how it differs from traditional Medicare and why you are so bullish on its potential?

George Halvorson: Yeah. The Medicare Advantage is, as you know, the voluntary program for Medicare. People who are in Medicare can choose to join a Medicare Advantage plan and they then get their care, their coverage from the plan. Standard Medicare is paid by the fee. So it is paid entirely by the piece. You file a claim with Medicare and they pay the claim. Actually they don't pay the claim. They have intermediaries that they hire, insurance companies, who pay the claim. Medicare doesn't pay its own claims, but the model is to pay by the piece. The Medicare plan Advantage plan pays by the month. Medicare Advantage is a capitation model. And so you end up with a monthly payment per member. And the plans then have to work with that monthly amount of money to figure out how to improve care and deliver care. And the Medicare Advantage model also has a five star program. And the five star program is quality of care.

George Halvorson: So the quality, there are 44 measures of quality of care that are measured by the five star plan for the Medicare Advantage plans. And so the plans who do better on the five star scoring can get up to 5% more dollars per month than the plans who do badly in that space. And so what that does is that's the first program in the world to actually pay more for quality. And it steers quality in the right direction. And it also encourages team care because when you're trying to figure out how to use that monthly amount of money, you get to use every member of the team.

George Halvorson: You can use the social workers, you can use the nurses, you can use each level of specialty care and you put together teams. And you can also, to make the program work, you look at issues like chronic conditions, and diabetes, and hypertension, all of the classic. And if you're paid by the month, you have a strong incentive to deliver better care for the patients because it costs a lot less. As you know, well, it costs a lot less to do it right. Half as many asthma admissions to the hospital, if you are paid by the month. And if you're paid by the piece, you really want as many, asthma attacks as you can get. And so the model works very badly on the P side works really well on the care side.

Robert Pearl: George, you were very active in helping to shape the Affordable Care Act. A decade later, how do you view this legislation and what do you wish had been different?

George Halvorson: The Affordable Care Act is really good and important work. It really, number one is, it did insure a lot of people that wouldn't have been insured otherwise. And we should not be the only industrialized country in the world that does not insure its population. So the Affordable Care Act got us part way there. It didn't get us all the way there, but it got us much further than we would've been without it. My absolute favorite part of the Affordable Care Act is actually the Medicaid expansion. Because what that did was it got Medicaid out to almost twice as many people. And Medicaid recipients are broke. They have no money. These are people who have medical needs and no money. And the Affordable Care Act expanded access to Medicaid in a major way.

George Halvorson: And it's really sad that some of the states, for political reasons, have not gone down that path, but the ones that have, have done really good work. And 10 years ago, Medicaid, as you know well, had some major flaws and inconsistencies in a lot of settings. And now Medicaid is almost entirely purchased through plans and it's almost all capitated in its own way. And the NCQA does measurements of the Medicaid population in ways that did not exist a decade ago. So we now have better care. I was pushing for the Medicare Advantage. I told members of Congress if they lost everything but Medicaid expansion, they should keep that. They should vote for the plan for that.

George Halvorson: On the other side, the exchanges are a really good idea because they keep plans in local markets functioning, and they give people choice, and they've expanded coverage. And I think one of the very best things that the Biden administration has done has been to expand, is to make the exchanges more affordable and channel money down that path. Because that's a really smart thing to do, because that's, again, good care, good quality and moving in the right direction. So I'm happy with the plan, the law is directionally correct. I strongly urged a mandate at the time. And we didn't, it did not end up with a full mandate. But I'm fine with partial mandate because we're moving in directionally correct ways. Europe uses mandates. And if you go to the Netherlands, if you go to Switzerland, if you go to Germany, there are no Canadian single payer programs in any of those countries. What they have in every one of those countries is health plans.

George Halvorson: And there's a mandate for people to join the plan. So every single person in the Netherlands must join a health plan and they have dozens of competing plans who do a good job. And they're all capitated. So the real model for most of Europe is a capitated model. And a historical point, a Bismarck invented that because he wanted to unify Germany and he wanted something that would be everywhere. And he wanted health coverage to be everywhere. And he really, he was anti-socialist, he did not want a government program. So he invented health plans. He called them sickness funds. And he put over 400 sickness funds in place in Germany. And they're still there. If you go to Germany, you still must enroll through a sickness fund. They don't have one single person that has a government program in those particular countries. It's all capitated health plans.

Robert Pearl: You and I both agree that the right access, the correct access is between fee for service and capitation, not whether the dollars first come out of an employer or the government.

George Halvorson: Yes, exactly. And in those countries, they all use a payroll tax, just like social security. They use a payroll tax to fund the capitation. And the reason they use a payroll tax is they don't want that money going through the overall funding of the states. They don't want that money to compete with streets, and roads, and schools, and military, and everything else. So they designate a separate funding stream. And it's always based on the employer. Each employer must pay half of your premium and the employees pay the other half. And that actually funds the program. And they have managed to keep those costs very low because it's capitation model. And so they control it at the aggregate capitation level and not at the piece.

Jeremy Corr: So I'm a small business owner, and there really are not affordable or cost effective options for employee benefits that are competitive with much larger businesses. And there's really not really any affordable options out there I've seen for myself that don't have insanely high deductibles. I need to be competitive in terms of both salary and benefits to get the best talent. What is your advice for people in my situation? And what should be done to improve this problem as it would likely inspire a lot more people to try to become entrepreneurs?

George Halvorson: That's a really good question. I think we should use the exchanges as the very intentional vehicle for small employers, and add a small employer wing, if you will, to the foundation of the exchanges. Because the exchanges are, in most settings, they've got relatively affordable care. And then we should make sure that the benefits, to your point, should not have insanely high deductibles at the wing of the exchange that's supporting the small business should have that option. And I also believe on those exchanges that they should add a feature that is the equivalent of the old union accumulated benefit, the credit pool. The old days, if you were a union member and you worked 10 different union jobs, you actually accumulated credits against your benefit package. And you could tap into that when the credits got to a certain level, and there was a shared process.

George Halvorson: I think what we need to do is we need to create something like that for every one of the jobs that are the piece work jobs and have all the piece work employers put a couple percent into the exchange pool. And so those people can get credit in that pool and have coverage at the pool, and then also decide, we can fund it at a level so those people can both pay part of the premium, buy in themselves, and then have it subsidized. And so that, because we got many, many, many people who are working with several employers, part-time job, piecework stuff, and that whole infrastructure is way overdue for support. And we should make that happen with that model because small employers should have it for themselves and for their employees,

Robert Pearl: George, you were an early proponent of electronic health records. How do you see the current generation and what do you believe is in the future?

George Halvorson: I think electronic medical records make a massive, massive amount of sense. I have been an advocate. Health Partners in Minnesota was completely computerized in the clinics that we owned. We had electronic medical record. Back before that, I actually ran a tiny little senior health plan called Senior Health Plan. And we actually had an electronic medical record based on a geriatrics system from Regions Hospital, which you probably had never heard of about, but I absolutely loved electronic medical records. So when I got to Group Health and Health Partners, I brought that along, and then ended up transitioning from that original patient information system to a EPIC system because the EPIC system had better billing and some other issues. But I've been an advocate of that for a very long time. And when I did health plans in Uganda, we actually did laptop electronic medical records in each of the villages in Uganda, because we needed to keep the administrative cost under 10%. And the only way you could do that was by eliminating all paper.

George Halvorson: So I've been on that path for long. When I got to Kaiser Permanente, Kaiser was already thinking in really good ways, as you know well, because you were doing a lot of it, about how to use computers to optimize care and deliver care. And KP did a great job of putting a system in place that is standard across all of KP at the system level. And as a result of that, KP wins every HEDIS award, number one in Medicare quality, the number one on 60 measures of HEDIS quality. The Leapfrog Group says that the best care in hospitals in the country tends to be in Kaiser hospitals.

Robert Pearl: In both Minnesota and California, you worked incredibly well with the medical groups and the physicians in them. Why were you so successful where others have not been, and what can they learn from what you are able to accomplish working together?

George Halvorson: That's a good question. I think one of the issues is I absolutely, totally believe in win-win. I really believe that we are better, more creative, more effective, more productive, that life is better, when you create win-win outcomes for all the relevant parties. And my sense is that the medical groups in both of those settings had the same attitude, wanted to do the right thing for the patient, the right thing for the public, the right thing for the member. When you start with win-win, and then you say, "Okay, given that we want to do win-win, what does a win look like? And how do we get to the endpoint on that? And one of the wins is to have all of the information about all of the patients all of the time. Okay? If we all agree on that, what do we need to do here to make that happen?"

George Halvorson: You led that you, you know exactly what I'm talking about, and you were a genius and incredibly good at getting that to happen in the real world. And that was a win. So we had a win-win relationship on that, and it makes a lot of sense. A lot of people go into those settings and actually want to fight. I'm amazed at

how many people are tribal enough in their own emotions that they go into a setting and they would almost rather fight in the setting than get along. And some people actually feel energized, and charged, and even in ennobled, which is amazing to me, even ennobled by fighting for their side. And I think that's just flawed. And certainly it's flawed in a healthcare delivery setting because you really don't want to have that sort of thing happen. So, in the hospital, folks always are, there's a predisposition toward win-win dispositions there as well. I think that might have been a part of the issue. What do you think?

Robert Pearl: My sense is that people let their egos get in the way and they want to battle over who's going to be the big gorilla? And as you say, the real issue is going to be how together can each of the parts create synergy that is far greater than the whole being far greater than some of its parts? And you were brilliant to doing that, as I say, both in Minnesota and California. So you should feel really proud of what you've accomplished.

George Halvorson: Well, thank you. Well, I look back in that and I think that was really good. And it was clearly the right thing to do because those care sites are doing really, really good work for people. And they're feeling really good about doing it.

Robert Pearl: You're the immediate past chair of the First 5 California commission, what is it? And what have you accomplished during the time that you've led the program?

George Halvorson: Well, the commission is a taxpayer-funded commission that uses basically tobacco tax money to fund early development for children in the First 5 years of life. So First 5 commission, because it's zero to five, uses tobacco tax money as a separate revenue stream. And the commission is three members named by the governor, two by the speaker, and two by the majority leader. And those people serve typically four year terms. And I served two four year terms as chair. Jerry Brown named me chair. And then Gavin Newsom asked me to stay on when he came in on until, I just went off in January. We did a survey when I first got there and just got that 90% of the Medicaid mothers in California did not know or believe that they could influence their child's intelligence by almost anything that they did with the child. They thought that the cards that were dealt were the cards you had to play in that area.

George Halvorson: And what's true is that the first three months of life in the first three years of life are epigenetically wired so that we develop neurons by the billions and even trillions when we have the right interactions with each child. And when we don't have those interactions with each child, we end up with very, very few neuron connections happening. And those kids can't read. So 60% of the kids in school systems in this country can't read and they can't read because they didn't get, in the first three months, in the first three years of life, the interactions that made those neurons connect. The neurons actually change at age four. So when kids get to four, if the neurons haven't been connected, the body changes, purges itself of unused neurons and you can't do anything significant relative to that space. So before that, it's glorious, it's wonderful. You get a huge number of

neurons connected in those first couple years and they last for life. And if you don't do it, you're in trouble.

George Halvorson: So when you look at our prisons, when you look at who we imprison, we imprison more people than anybody in the world by a large margin. And we overwhelmingly imprison African American minority patients. But when you look at African American males who are in their 30s in California, and you look at the ones who have dropped out of high school, 60% are in jail, 60%. That number's true across the country, but it's also very true in California. So 60% are in jail. When you look at African American males who graduated from high school, 10% are in jail. Now, 10% is a really terrible number. 60 is worse. And we know with 80% accuracy by age three, which path they're on.

George Halvorson: So we know with 80% accuracy by age three whether or not they're on the path of going to jail or whether or not they're on the path of having the neuron strength they need to be able to read, and calculate, and do basic things. And it's true elsewhere. And Chicago right now has many murders. And when you look at the number of murders in Chicago, 90% of them are done by gang members. Nobody disputes that data. And this is what people often don't know. 90% of the gang members in Chicago are dropouts, high school dropouts. And we know with 90% accuracy by age three in Chicago, which kids are going to drop out. So it's the same thing. All murderers in Chicago, if we want to change those numbers, you got to go upstream and help kids in the first three months, in the first three years of life. With the neuron connections, they can work. And if we don't do that, we're in big trouble.

George Halvorson: So in California, we created the Talk, Read, Sing. I chaired the commission. Jerry Brown asked me to do it. We created the Talk, Read, Sing campaign. And when we started at 10% of the California mothers believed they could exercise the kids' brain and strengthen the brain. We got that up to 60%. Then we got that up to 70%. Then we got that up the 87%, two years before I had finished being chair. And so the mothers believed they could read to their kids and make a difference. And then what we tried to do was get books to the home. So in Los Angeles, we got books into the Medicaid homes through WIC, and we had the WIC program distributing the books. And they went from 40% of the kids in LA being learning ready up to over 70% just by getting books into homes, coaching the mothers, and helping them with the books. So we were on that program to do it for the entire state. Gavin Newsom was totally on board with it. Then COVID hit, and the whole program dies.

Robert Pearl: You've been a powerful voice against racism for as long as I've known you, and more specifically the impact that racism has in medicine. Can you tell listeners about the destructive impact that it has when it comes to people's health and what you see as the steps we need to take to achieve a solution?

George Halvorson: We are really wired instinctively to divide the world into us and them. We figure out who's an us, we figure out who is a them, and when someone is an us, we're supportive, we're enabling, we do good things for us. And when someone is a

them we're suspicious, paranoid, territorial, distrustful, we fire bomb them. We basically lynch them. When somebody is a them, those patterns of behavior are extremely powerful. And my Institute for any InterGroup Understanding works on that issue. How do we get as few people to be them as possible? And as many people to be us? And what do we do to bring people together? And how do we align people in the sense of being an us so they trust other people in the setting. In healthcare, we end up with all kinds of negative consequences, unintended consequences by many well-meaning people who diagnose differently, or treat differently, or prescribe differently, and also who literally don't trust ... The people who don't trust their caregivers because the caregivers are perceived to be them.

George Halvorson: And so we've got that in the vaccine right now. We've got a lot of vaccine resistance and denial going on from people who just plain don't trust care system, because they think the care system has been them so many times in so many ways that have been so noticeable, that there's just not a trust level now. And the George Floyd thing, it was extremely powerful for this country to get a sense of what those kinds of situations were looking like. And the number of African Americans who looked at that and said, "Oh, that's different. I didn't know that was happening" was tiny, non-existent. But the number of white Americans who said, "Oh, what's that all about? I did not know that was happening." Is really high.

George Halvorson: And so what we have, actually, relative to instinctive behavior is I think we have a time of awakening right now that's really good for the country. I think that we have a sense. Because there's a lot of really well-meaning, good-hearted people, faith-based people, philosophy-based people who really want to do the right thing for people, who did not realize how many issues there were in that space and are now open to the thought of doing things. And social determinants of health is part of that. And the other thing that's equivalent is the Me Too movement, which has, I think done just really magnificent work on gender issues because we have a different attitude now than we had four years ago, relative to gender issues at a very major level. And it's because that's also become a different part of our culture.

George Halvorson: And we're looking, our expectations and values have changed in that space as well. And I've actually been writing about those issues. My Why We Discriminate Against Women stuff was some of the most widely read stuff that I did on the internet, that got a lot of exposure to a lot of people. Because I basically, "We instinctively do these sorts of things in male-female settings. And what we need to do is make sure that we enculturate along the gender lines as well as on the racial lines to get to the right direction."

Jeremy Corr: So a lot of the times when people discuss the social determinants of health, they tend to focus on underserved, poor inner city or minority communities. I come from rural Iowa. I grew up in an area where family farms were dying out to big corporate farms and small town businesses died out to Walmart, and even now, to Amazon. In many of these small towns, all that remains might be a bar, a

church or two, a gas station, convenience store, and a post office. Many of the rural folks do not even have access to high speed internet. There are a lot of poor, underserved Caucasian people in rural America who see all of the movements to help inner city communities or the massive public support for movements like Black Lives Matter. And they feel like there is so much being done now to help other groups in those communities, but they feel like they're completely forgotten or left behind.

Jeremy Corr: They feel like they're considered to have White privilege, even though they might have grown up dirt poor in a trailer park, surrounded by methamphetamines. They're called deplorables and things like that by politicians in the press. And they feel like they're dealt just as bad of a hand as an African American or Hispanic American who grew up in a similar situation in the inner city. I feel like a lot of rural folks have this feeling that they're left behind or that their problems are being ignored. And I think that's often leading to some of this resentment and thus furthering the terrifying amount of division we're seeing in the country today. What are your thoughts on this? What would you say to these people? and what can be done to help improve the social determinants of health in poor rural communities?

George Halvorson: That a really good question, and appropriate, and timely. There are clear social determinants of health challenges in rural communities. You mentioned the infrastructure issues are serious in a lot of communities. And my strong sense, and this might surprise you, is that I think we should look at the healthcare cash flow for the country as being a pump primer for those communities, for rural communities, and for social determinants of health. I really have a sense that we need to build out the internet infrastructure in those communities. We clearly need the WiFi everywhere to happen, but that doesn't cost that much money and we could do it. And so we can create a model where there's care everywhere and there is access to care everywhere and where there's internet everywhere, and we should make that happen.

George Halvorson: And then I think we should invest in local care sites because even though I think a lot of care is going to be electronic, a lot of care is going to be personal. And I personally think rather than trying to cut the percentage of healthcare in the economy from being 18%, that we should channel that 18% and put some of it in rural settings. And we should have clinics in those settings. And we should have hospitals, frankly, and nursing homes in those settings. And we should have a number of places where there are actual jobs. Healthcare jobs are about the best jobs in America. They're really good jobs, good paying jobs. People can aspire to them. People can train to get them. People who get them feel really good about them. And if you're a, a nurse, I've got a bunch of cousins who are nurses who absolutely, totally love and celebrate being nurses. And they're in rural settings. Those jobs are great, local jobs.

George Halvorson: KP invested in a lot of communities. Every community that KP and Health Partners, actually invested in several rural communities. Every time you go into a community and you help set up a care infrastructure, you make the

community stronger, you make the local people healthier, and you create good jobs. And so I actually think that building care sites in rural communities and building the electronic infrastructure is the right thing to do. And I think we will have better, less expensive and more local care. And we will be stronger as a nation when each of those communities has good jobs. So I think we should use healthcare to put good jobs into those settings. And we should do that in intentional and deliberate ways because it really does make a difference in a small town if there is, or is not a hospital. And if there is a hospital, it needs to be supported by the right infrastructure. And it needs to the right team on board for the actual delivery of care.

George Halvorson: But having those jobs with that distribution I think is really good for that setting. And that deals with some of the social determinants of health. And in our inner cities, again, the reason the majority of African American Medicare, people who join Medicare Advantage is the team care. It is the fact that Medicare Advantage teams work together with each other and the patient who comes in for care doesn't have a sense of being isolated. The average fee for service Medicare patient ends up with seven different doctors and the seven doctors have no coordination tools of any kind. So that's bad, but Medicare Advantage patients have a team and they have seven or more doctors, but they work with each other. They share information, they have common agendas. We need to have that in rural areas as well. We need the team care in rural areas at optimal levels. So I think is an answer to that. And it is to use the care resources appropriately to support that.

Jeremy Corr: Most people in America are not lucky enough to be a member of a capitation-based system like Kaiser Permanente. Many people have high deductible plans that make them reluctant to even use health insurance they have through their employer. And even paying up to their deductible is too much of an ask for many Americans as they just can't afford it.

George Halvorson: Oh yeah, absolutely.

Jeremy Corr: And they don't want to fall victim to bankruptcy. And this causes many Americans to not address health concerns or fears they have out of concerns about the cost, thus causing medical conditions they have, but aren't going to be seen for, to spiral out of control until the point where they need to go to the doctor and making it much more expensive and worse than had they addressed it sooner. So what are your thoughts on this and how do we as a nation solve this problem?

George Halvorson: One of the things that we should be doing is we should take advantage of the ability of the artificial intelligence mechanisms to come up with basically care plans and care strategies for each person. The internet access to that could be extremely cheap and each person could plug in their own data and their own information. And to the extent that there's diagnostic information, or blood sugar information, or whatever, plug it into the process and we should get

electronic support for care from that process. And then as you get it, that process could be a purchasing mechanism as well as an education model.

George Halvorson: And I think there's a purchasing model there for purchasing pieces of care that could be built. And again, that could even be attached to the exchanges. The exchanges could have validated, verified tools, units that do that provision of coaching and amalgamation for each person, because we should be able to figure out what the options are. And it's not that there's an infinite number of options and we can't do it. So the systems could do that, but we don't have any systems who are targeted right now to do that. But we could do that.

Robert Pearl: What advice you offer President Biden as he tries to address the vast array of problems that healthcare faces today?

George Halvorson: That's a good question. He should make the Medicaid part of his agenda really clear. And a lot of the people who are opposed to him, politically, a disproportionate number of them need Medicaid and need to have a sense of that he is helping, steering them in that direction. A federal Medicaid program that also got a lot of his ability would not be, I think the worst long-term thing for him to do. I think on the Medicare side, the pure classic Medicare for all model has some support with some elements in the party, but it does not have support with the vast majority of Democrats. Unions don't like it at all, because unions actually provide healthcare in good ways for their members.

George Halvorson: And so he's clearly not going to go down that ideological path, but he should go down the ideological path of taking the Medicare Advantage program, and strengthening it, and making the expectations, I think he should increase the expectations of the plans in Medicare Advantage to make sure that the plans are all providing electronic support to every member in ways that will be supported then by apps on the internet and a whole bunch of other approaches, so that we can improve care. So I think I would urge him to support that agenda, expand that agenda, support Medicaid.

Dr. Robert Pearl: For 30 years, you have been a proponent of our nation moving from fee for service to prepayment or capitation, however we want to label and to describe it. What's it going to take to get across the finish line? And when do you think it will happen?

George Halvorson: I think it depends a little bit on how the election balance happens. I think there's a likelihood that we're going to make some significant progress on the Medicare side this year. I think when you've got literally 60% of Hispanic Americans that are choosing Medicare Advantage, 50% African American choosing Medicare Advantage. And when that becomes visible, when the overwhelming majority of people of multiple comorbidities are in Medicare Advantage, and people hear that, when do you literally get to 80% of the people with three or more chronic conditions joining, there's nobody in the news media that knows that. There's nobody that has any understanding. They actually think there's some kind of risk skimming going on. But when they actually learn what the real proportions are

and why those proportions are what they are, I'm hoping that the public discussion will transform, and mature, and become more enlightened. And I'm hoping that because the data points are so overwhelmingly in favor of Medicare Advantage, and they're totally invisible. No one has really worked that pathway.

George Halvorson: So I'm hoping that that happens. And the other thing that's true is artificial intelligence is doing magnificent stuff. I've seen programs at Mayo, where they can, with almost 80% accuracy, look at some Fitbit data and figure out who's going to have a heart attack in the next year. There's a whole bunch of new tools that are coming out the public are going to want, love, appreciate, use. And I think the existence of those tools is going to create a demand for them. And one of the things that's true about it is those tools work best when you've got a financial stream, a stream of cash that pays for them, enables them, supports them, and they work worse when they're just paid for by the piece and individuals can't afford the pieces.

George Halvorson: And so I'm optimistic that the new world of systems in healthcare is going to help drive the financial model to team care. And I know that the people at HIMMS totally agree with that because the head of HIMMS and some of the other HIMMS people have now said that they finally understand that for HIMMS and for the systems to flourish, the payment model needs to change.

Jeremy Corr: Robbie, what do you think about what Mr. Halverson said?

Robert Pearl: Jeremy, I've had the opportunity to work with other health plan leaders and George is head and shoulders the best. He combines a strategic model, a deep compassion for people, and an unwavering courage. Where others perceive fear, he recognizes opportunity. Rather than promoting himself, he's committed to win-win. I concur with his views on so many subjects. Like him, I'm a firm advocate for a prepaid form of health coverage like capitation, which is far better than fee for service. I believe in the necessity of providing medical insurance for all Americans. And we both have been advocates of the electronic health record and overcoming racial inequities in medicine. His most recent work on the power of books and reading for families and the impact it can have for very young kids and his efforts to reduce the intergroup strife, these are groundbreaking actions. I hope elected officials and people overall will listen to him and learn from his perspectives. He's a true healthcare leader.

Jeremy Corr: We hope you enjoyed this podcast and we'll tell your friends and colleagues about it. If you want more information on both the system and culture of medicine, you can find it at robertpearlmd.com. Congratulations, Robbie, on the success of your recent book. I know it will stimulate intense discussion and debate and improve healthcare for all Americans. Please subscribe to the Fixing Healthcare podcast on Apple Podcasts or other podcast software. If you like the show, please rate at five stars, and leave a review, and visit our website at fixinghealthcarepodcast.com. Please follow us on LinkedIn, Facebook, and Twitter @fixinghcpodcast. Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.