Paul Keckley
I think we've got a lot of folks that are understandably playing the fast second card that are large employers like your members that can wield a much greater influence on the future of the system than they have in the past and I think it's necessary. I really, really, really believe that.

Ellen Kelsay
That's Paul Keckley, managing editor of *The Keckley Report*, a weekly newsletter providing insights and special reports on health care. Paul is a health care policy analyst and widely known industry expert who has dedicated his career to understanding and advising on health care trends, policy issues, and growth strategies. In addition to *The Keckley Report*, Paul has published three books and 250 articles.

I'm Ellen Kelsay, and this is a Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

In the face of rising health care costs, Paul Keckley and I explore his provocative question - are employers ready to move from the back bench in U.S. health care? We discuss what he believes employers need to do differently to address the projected 8% health care cost trend in 2025 and what it means for other constituents and stakeholders.

Paul, welcome to the podcast. We're thrilled to have you on today.

Paul Keckley
Thank you. Thank you. Thank you.

Ellen Kelsay
All right. You are such a fascinating individual. I've known you for a while now. Every time I talk to you, I learn so much, but for our audience who might not be familiar with you, give us a rundown on who you are, what's your background, what have you done?

Paul Keckley
Well, of consequence, I've found myself at the intersection of health policy and health industry and trying to arbitrate between the two, both of which have strong views about the other, rarely based in fact. And along the way, academics, startups, was in the White House working on the Affordable Care Act and stuff like that. I'm just a journeyman health care guy.

Ellen Kelsay
Well, you've journeyed through a lot. You've seen a lot and you've contributed a ton. I want to talk about a lot of that in our conversation today, but really grounded in a lot of your work today and how it manifests itself is in part through your report called *The Keckley Report*. For our readers who are not familiar with it, we will definitely want to encourage you all to go out and check out Paul's report. It's always really covering some very intriguing topics. So Paul, I want to ask you, how do you even select the topics that you end up writing about in *The Keckley Report*?

Paul Keckley
Well, I kind of go through in my head everything that I've read and heard that week and studies that have come out and I sort through it. Then by Friday night, I get to a point where I think this is something important and I should zero in on that. I've been doing this 25 years. Honestly, the reason was I needed a systematic way to understand the industry in an objective, data-driven, unbiased way. You've got folks that live in the delivery system world that think the world revolves around that. So the information you get about employers or payers or anything else is very

subordinated and very incomplete. So I kind of constructed my own way of surveilling health care in 5 zones of activity - clinical innovations, technologies, capital market flows, consumer actions and views, and then the regulatory/policy environments. I track lag and lead indicators in those 5 buckets of activity. Consider it outside health care as well as inside health care. I look at how we might predict some of health care's future from industries like financial services to determine at what point fundamentally structures change or capital flows reverse course. That's been a habit and I just keep doing it.

Ellen Kelsay
A weekly newsletter for 25 years, you're probably...

Paul Keckley
It's a freebie too.

Ellen Kelsay
Yeah, it's great. It's awesome. So prolific, very expansive in terms of the range of things you've covered and written about. Often in your true style, very thoughtfully, but provocatively all based in, as you said, data. What are you hoping to achieve? Are you trying to educate, inform your audience? Are you trying to spur people to action? Are you trying to get them to think and act differently? What's your goal?

Paul Keckley
That's such a good question. Two things. One, I think informing is a critical element of this whole journey, but informing based on fact rather than talking heads, based on facts that are collected and interpreted in a way that doesn't reflect a foregone conclusion, which is what health care is prone to do. We typically do a study to prove our point instead of asking an honest question. I think we have to assemble that kind of data to ask and answer honest questions. But then second, I believe we have to prompt a discussion about the system's future and I think that's urgent. I really didn't see it as clearly even when I was pulled into the White House on the ACA stuff, as I do now. I think we're at the tipping point of answering the question of what's the future of the system. The incumbent players all tend to have answers about what piece of legislation they want to change in the 119th Congress or how the FDA ought to accelerate approval of this or that, but the things that impact us longer term don't get a lot of discussion. The boards and their compensation committees don't expect that of their C-Suites. I'm finding myself in the vortex of let's ask the question, what's the future of the system? Then let's begin modeling scenarios about that that can be dissected, criticized, but let's not run from that. Let's embrace that. If we don't, the U.S. system then collapses. It becomes a commodity and that becomes a recipe for some other unintended results. I think we have to educate, but I also think we have to prompt the discussion about the future of the system.

Ellen Kelsay
That leads me to one of your more recent articles that you put out about prompting the future. That article is entitled, *Are Employers Ready to Move from the Backbench in U.S. Healthcare*?

Paul Keckley
I thought that would get your attention.

Ellen Kelsay
It did. That's why we're talking right now. What was going on? What was your thought process as you were writing about that?

Paul Keckley
In my mind for many years, I have felt that the large self-insured employer community could play an important role in defining that future state and needed to do that in an organized way, which is the reason Mary Jane England and other people that were in the business coalition world were relationships that I really, really cherished. There were 2 types of large employers. There was a type that was really driven by how the health benefits provided the employees and retirees needed to be structured and its impact on the P&L. Then there was another group that said, but we ought to look beyond that. That second group seemed to be a smaller group. When I was in the White House, I remember approaching the Business Roundtable, the Conference Board, U.S. Chamber of Commerce about being a participant in this formulation of what became the Affordable Care Act. I was very disappointed that the appetite for that was very low. The rationale from all was, first, you've got the insurance folks at the table, so you really don't need us. Second, we're such a broad-based, horizontal set of perspectives that we really will be better at reacting to what you come up with and helping to create that. That disappointed me. I remember a conversation with Ivan Seidenberg, who was CEO of Verizon at the time, who said, I really think we ought to be thinking about this future, but I don't want to make any big changes until Randall Stephens makes changes. He was at AT&T at the time. He used this phrase, never forgot it, he said, I just want to be a fast second. I don't want to be the bleed edge of any of this stuff, but I want to be a fast second. I think we've got a lot of folks that are understandably playing the fast second card that are large employers like your members that can wield a much greater influence on the future of the system than they have in the past, and I think it's necessary. I really, really, really believe that. I think we think in the world of health care that either the benefit consultants or the third-party insurers or the TPAs or others represent that voice. They don't. They represent a perspective on that voice, but that voice needs to be direct and it needs to be clear, and that's where I arrived at that theme. It's time to step up.

Ellen Kelsay
Let's talk about what does more look like? What else do employers need to be doing? What do they need to do differently from what they're doing today?

Paul Keckley
I kind of knew you'd go there. Having access to your own data is a pretty good start, but what most of the larger employers depend on is somebody to analyze their data, and that data is primarily around utilization and cost and not around clinical processes, and yet as an example, one of the biggest issues right now for your members is what are we going to do with these GLP-1s. This med didn't just come out of the blue 2 weeks ago. This has been in the pipeline for more than 9 years, so we need in becoming activists about the future of the system to be as astute about how care will be delivered and by whom and how as we are what it costs, and I think that's been a shortcoming for employers simply because that gets weird. The science changes fast. We've got 80 randomized control trial studies published every day that are in Tier 1 journals where you have to pay attention. I think that's Part A. We have to become as astute about clinical processes, diagnostics, therapeutics, ways to diagnose, treat, and mitigate health care issues and problems as we are spotting waste and cost variability and price lack of transparency and things like that, so that's kind of one big area. A lot of large self-insureds basically say, well, we've hired a medical director, and that's the role they play. Most of those folks get buried in benefit design and coverage for these marquee questions like obesity and GLP-1s and things like that, but the bulk of the spending and the bulk of the problems in health care are in areas that don't get the kind of spotlight that obesity has. I know mental health is getting more attention now, but my first assessment getting off the back bench is become as vocal and as predictive about the future of how care is delivered to whom, by whom, how and why as we are what it's going to cost and

who's going to do it. That's not something that has been a core competency for a lot of large employers. Second, I think we have to think large-scale. We operate a system of health or human services, which I find odd. When you look at other systems of the world, the integration of social services with their health care system is much more clear and direct. It is the large employer who has borne the brunt of the cost of the system, of its ineffectiveness, and we keep passing that through to you and hope you don't figure it out, but a big part of that is our system doesn't address social services as an integral part of health care. Even in a lot of the on-site, near-site primary care clinics that a lot of the large employers have adopted, the kinds of data being collected on the social circumstances for which individual employees and households are exposed is missing. So that's a second broad area. If we were really about fixing the system, reducing demand, improving its effectiveness, reducing its net cost, and allowing us to fund other things in our society that are also going to need more attention, like the climate or like education and things, it seems like we ought to be spending less in health care and more in some other areas, and that's a key area. We cannot address demand in the system without addressing this connection of health and social services, so why do we operate these dual systems? Why is the public health world completely foreign to what happens when you're at a medical staff meeting at a big health system that's talking about population health? That's a second big area. At a community level where employers operate and have huge impact, where we ought to be prompting some of that discussion, how are we integrating these things?

And a third area is at a federal policy level, which is I think we have to elevate the voice of the employer as a unique voice in defining the system of health. When you go to all these meetings, like you go to and I go to, and you'd think that the insurance folks are the surrogate for employers, and they would like to play that role, but I think that's not just misleading, I think it's harmful. I think employers have to be the direct voice. I think we need to be pulling you, for instance, into congressional testimony on a variety of issues where the employer has huge latitude, and the great part of this is we have to listen. The system has to listen to employers. If the RAND data is anywhere near accurate, if we are forcing you to pay 254% of what Medicare pays us for the same widget, I guess we ought to be paying attention. But what's happened is at the national level and at the state level, there's a lot of tension between insurers and health systems, but that tension is over 340B eligibility and site neutral payments and prior authorization on all the things that are around the business practices that everybody's gotten accustomed to, and no one's asking the question, what's the future? For me, that's a necessary part of the future, that employers are at the table. I tell people, if I'm going to put a whiteboard up and create a future state, I've got to have three players at the table. I've got to have the employer, I've got to have the public health community, and I've got to have the delivery system people at the table. So for me, those three things, I've got to have a voice, I've got to design a system that looks at the community level and then up from that, health and social services so that I'm getting out ahead on some of this stuff, and I really believe it's possible. The problem is we can't wait too long.

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Ellen Kelsay
If all of that happens, if employers step up and focus on those three things that you just did such a great job of talking about, what does that mean for everybody else? What does that mean for the system?

Paul Keckley
It means we'll probably rationalize the funds in the system much differently than we do today. Most of the way capital is deployed and operating costs are allocated is to protect yesterday's health system. It's incrementalism. So if we have a voice of the employer, we probably start

spending money very differently than we do today. We're probably putting some of our more expensive types of services for the 1 to 5%, depending on how you define it, into very targeted types of programs that have a very clear clinical pathway and an accepted way of early-stage diagnostics, aggressive intervention and management, and very transparent sharing of data and results. There's plenty of money in the system. That's the irony of all this. It's just spent in the wrong places and in the wrong ways, protecting ways that we made EBITDA and exec comp deals for yesterday's delivery system, not about the way it ought to be designed for the future. If I had an employer at the table, I imagine they'd say, you know, this is not a bucket that has endless funds flowing. It's a bucket that needs to be finite. Interesting, in every other system of the world gets a better result than we do at a third or less the unit cost. They have a very, very aggressive front door of the system that puts primary preventive health, social services, prophylactic dentistry, mental and physical medicine, they integrate all that, and it's a designated front door. You can't get to the rest of the system unless you participate in that front door. The second thing, all those other systems have a finite budget for their health care system. And then third, they all have a mechanism for defining the clinical process so that the evidence of what works best, when, how, and why is the basis upon which care is delivered instead of, in the U.S., we talk about quality of care like it's just a given. Well, it isn't, and the variability is so wide, but we run from the notion that you'd want to eliminate variation and standardize care where the evidence is clear this works better than that. Those three attributes would be easy for employers to embrace. It's the basis for everything about business. We can't let everybody do their own thing. There has to be an approach to things. I don't think employers have been schooled perhaps enough in what alternative systems of health might be. What would be alternatives to begin putting on the radar so that lawmakers, again, I'm looking for that stronger voice, so that lawmakers say, these folks are thinking about that. They're looking at a longer-term view.

Ellen Kelsay
All right. Well, you've given us a lot to think about, and like you said, time is now. We don't have much time to waste, and the current state's clearly not working. When we think about the employer market in the United States, we have a whole slew of employers of all different sizes, some operating in every state, in many countries outside of the U.S., and others who are maybe more geographically focused. The employer market is not a monolith, right? How do different employers think about this?

Paul Keckley
Well, I start with my data. When I start with BLS data and I start breaking it down into the 11 major buckets of industry they have, then I recognize that the least likely to change to keep the status quo in place are government, education, and health care. Those three industries just push back from anything like this, and then you've got this subset of light manufacturing, retail, transportation, hospitality that are at another end of the scale. Well, I need to do the minimum toward playing a role, but this is something bigger than my organization, and since most of my people are hourly and churn is high, this and that, it's a bigger question. We're going to have to let the government solve it. And then you've got everything in between. To me, the reason the voice of the employer is going to have to be central to a suitable solution to the future of the system is the workforce upon which all industries depend, see health care is important. They define what accessing health care means differently based on their experiences, but what we know is we're reaching a point at which even the most change-resistant industries like higher education or like health care have determined that they can't afford the health care for their own employees and they're going to have to do something different. They're like Ivan Seidenberg said, they don't want to be the first guy. They don't want to be the page one story in the *Wall Street Journal*, so I think that's what you have to do. You have to lead that. We have to give some political cover to CEOs to

begin asking these questions, studying the options, and bringing some policy discussions to the table that we've been afraid of.

Ellen Kelsay
You've mentioned policy. You've mentioned the White House. I'm curious your thoughts on, we have an upcoming election, what are your thoughts about what we might see and implications on health care issues?

Paul Keckley
Well, I don't know who's going to pull it out at the presidential ticket level, but I do know two things that are inevitable, and one is more and more of the tougher decisions are going to be at the state level, not at the federal level, because not just the Dobbs decision on abortion, but a series of other decisions have basically given governors a lot more latitude through executive orders, administrative actions, and on matters of public ballot referenda or even legislative votes. We've basically got states playing the role of defining the future. That makes life for your members awful if you've got to deal with 100 different ways of doing things. The second thing that's pretty clear is that Congress is going to be dysfunctional, which to the private market, the private capital market, is a great result because they love to be on TV and talk, but if nothing substantively changes, it means that the momentum toward too big to fail and consolidation is going to continue rather than slow down, it'll take some hits, and it means in health care, which is troubling, the playbook is going to be not anything longer term. It's going to be consolidate for scale, scale more than innovation, scale more than anything else, and you're seeing that the insurance companies do well and the health systems do well when they are one of two choices in a market, and that hurts employers.

Ellen Kelsay
Yeah, I was going to ask you about the FTC activity, and you know, with Lina there, they've got quite a focus on some of those behaviors and markets, so what are your thoughts?

Paul Keckley
Well, I did a lot of work back in the day with the FTC and with the DOJ on some of the antitrust stuff. I think she's picked a couple of fights that she will regret. Going after tech right out of the gate, as much as people are frightened by that, that's a different world, and you're talking about companies that operate globally and have armies of attorneys, and FTC doesn't have an army of attorneys, so I think it would have been a better start to go after certain industries that were a little more confinable. It doesn't mean you didn't go after the Microsofts, but for instance, in health care, in the HIP world, the electronic health record world, we've basically got three players, Epic dominant, Cerner/Oracle second, and Meditech third, and that's it. That's pretty much it. So they're going after PBMs and they're going after some others. I think there's going to be some ways they can slow down some of the unintended negative consequence of consolidation, but do I think it's going to reduce the M&A activity and the combinations? No. I think it'll modify how some of those deals are valued. Here's an example. Could the hospitals that have consolidated on the promise that they were going to create a huge amount of synergy/reduce operating costs that would accrue to the benefit of the community, could hospitals be held accountable if they didn't produce those savings realized by the community to give up some of their tax exemptions? We've never tested that. I think that's where, if the Harris team is in place, and if they keep Khan and her expanded team, I think they'll be looking for ways to modify how consolidation is approved and evaluated rather than mitigate it because you can't access private capital, which drives a lot of the consolidation. You can't access those markets if you're saying, by the way, we're going to regulate you as a commodity. You have to let markets work. You have to access the private capital markets

to do it. But there may be ways to hold people more accountable when and after they do their deals. That's where they're going to go. I think Khan, for instance, she's sharp. I've been really impressed. I follow a lot of the working papers, and they're anticipating this. They're anticipating they're going to get a lot of pushback, and they're choosing their fights in health care. It's pretty interesting, for instance, that they are starting to raise these questions about the role of private equity and whether the real answer here is a carried interest differential in what the GPs in the private equity deals take home versus ordinary income tax. That's not just a little nip-tuck, but it's not saying we're not going to let private equity do a deal. They're saying we're going to maybe change the way you have to value those deals. I think you can expect more of that.

Ellen Kelsay
I'm curious. Are there any other areas that you're watching or that we might see you write about in the coming weeks? See what strikes you in that week?

Paul Keckley
Yeah, probably whatever hits me on midnight. No, I am very sincere. I worry about the future of the system, and I worry about the lack of attention to what it might be. I remember back in the White House days in August of 2009 when a very simple concept that was finding its way into the early stage Affordable Care Act, the House version of that law, had a provision where if a senior approached their internist, their family physician, about their health at the end of their life, their end of life options, there was a code to which that internist could bill an hour of time. It sounded like a pretty decent idea. When they went home in August of 2009 on their recess, that became death panels. Death panels became the tag put on the Affordable Care Act, among other things. It's government-run health care. It's this, it's that. The reason I think a lot about how you would initiate this process of defining the future state, looking at scenarios in which health care is more accessible, more affordable, more transparent, more balanced in where it spends its dollars, and more valued by its users. I think we've got to start that. I have to be very conscious of the fact that the minute you have that discussion, you've got some spin agents out there that are going to spin it in a way that it's not intended. I don't know what the future state of the system is going to be. I think there are things that we can observe in other systems that could be instructive, but I don't think you can cut and paste from any other system two hours. I think it's going to be a uniquely American mess. I think we've got to start. I want your members to be part of that. I want you at the table.

Ellen Kelsay
As always, you tell it like it is. You're so direct, insightful with your arguments. You're provocative with your suggestions and recommendations. You've certainly given us a lot to think about, certainly myself, as well as our audience and listeners. We need more of all of us to shift away from being the fast seconds to being bold firsts and have a stronger, more consistent voice at the policy level. Paul, always just so grateful for your time, your perspective, your insights, and look forward to having you back on again in the future and reading what comes out of your Keckley report in the coming weeks and months ahead.

Paul Keckley
You will have influenced it, I'm sure.

Ellen Kelsay
I've been speaking with Paul Keckley about his perspective on how employers can address growing health care trend. For further insights from Paul, listeners can subscribe to *The Keckley Report* by visiting https://paulkeckley.com/.

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