The Medical Debt Wealth Transfer

4sight Health Roundup Podcast Transcript
Feb 8, 2024

David Burda:
Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers, count and value rules. Hello again, everyone. This is Dave Burda, news editor of 4sight Health. It is Thursday, February 8th. Puxatawney Phil did see his shadow as I predicted, and we're gonna have an early spring this year. I mean, we might hit 60 degrees here outside of Chicago today, so it was really a no-brainer. Speaking of shadows, one dark shadow over healthcare is medical debt, patients getting hit with expensive and overpriced medical bills that they can't pay, and then all sorts of bad things happen. We're gonna talk about two solutions to medical debt on today's show to tell us whether they're really solutions or part of the problem are Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson partner at Transformation Capital. Hi Dave. Hi, Julie. How are you guys doing this morning, Dave?

David W. Johnson:
I'm doing great. Dave. Terry and I are in Rochester at the Mayo Clinic, and it's just a remarkable experience to participate in coordinated patient-centric team-based care. What we love about Mayo is that our healthcare treatment regimens reflect a uniform Mayo standard of care. They're not dependent on finding the exactly right doctor. It's fantastic.

Burda:
Yeah, it can happen. A real life example. That's great, Dave. Thank you. Julie, how are you?

Julie Murchinson:
I'm well. I'm in Dallas. I've spent some time this week with a number of clinical leaders from health systems listening to, you know, what they're doing with digital. And Dave, we, we could talk for hours, <laugh> about the experience, but a lot of good intention out there.

Burda:
That's the beauty of the show. You guys are always on the front line. Thank you. Now before we talk about solving the medical debt crisis, let's talk about another crisis waiting to happen if you're not prepared. And that's Valentine's Day, which is next week. Dave, without giving us too much information are you ready?

Johnson:
Yep. Valentine's Day. You know, like so many American traditions, this one started in, in Great Britain when they reduced postage traits in the 1840s people started sending Valentine's Day cards to one another. Then Cadbury got in the act, and so we've got greeting cards and chocolates and flowers and everything else. Evidently they're like a billion cards sent in the US each day. A lot of those coming in from schools and the average spend is 150 bucks. But the answer to your specific question, not ready at all, gonna be scrambling this year. <Laugh>,

Burda:
It's great that you have a dollar amount. I, I, I gotta reflect on what I'm doing. Thank you Julie, how are you? Are, are you Valentine's Day ready?

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Murchinson:
I was actually in a CVS earlier over the weekend buying my kids each a little Valentine's Day bag. So I was seeing them and I was shocked of what you can buy candy wise, and it just said a lot to me about society. Like you can buy a bag of just red gummy bears. You can buy heart shaped starburst, heart shaped sour patch kids. Of course you can buy your old Whitman's box and all that, which is super cute. Reminds me of my childhood, but I mean, we are, we are over the top on the candy front for Valentine's Day here.

Burda:
<Laugh>, personalization, <laugh> crazy. It's great. Well, I thought I was ready until I heard what Dave said. I'll be back at the store after this <laugh> podcast. Thanks Dave.

Johnson:
That's the average spending, Dave, in the country. So you know, you gotta set your sights higher.

Burda:
Right? Yeah. We must be above average. So but my wife also is doing something called Galentine's Day, which is February 13th. I don't know anything about it other than I'm not involved, and I think that's good. <Laugh>.

Murchinson:
That is good. <Laugh>.

Burda:
That is very good. Speaking of involved, and there's your transition. Let's talk about medical debt in two ways. Others are getting involved to solve the problem. The first way others are getting involved is by friends, family, coworkers, and even strangers donating to a patient's GoFundMe account to help pay off their unpaid medical bills. A study published in the American Journal of Public Health in 2022 said, medical crowdfunding campaigns raised more than $2 billion from 21.7 million donations from 2016 through 2020, but only 12% of those campaigns met their crowdfunding amount goals. The second way others are getting involved is a not-for-profit organization, like rest in peace, medical debt paying off a patient's outstanding medical bills owed to debt collection agencies or even healthcare providers themselves. Such organizations take in charitable donations, then turn around and use that money to wipe out medical debt, rest in peace. Medical debt says it's paid down more than $10 billion in medical debt for more than 7 million families so far. The question is, are these two approaches the solution to healthcare affordability or part of the problem? Dave, you get crowdfunding. What are the pros and cons of this approach? And does it do anything to make medical care more affordable?

Johnson:
There's something uniquely American and awe-inspiring about the way that everyday citizens come together to help those in need, often strangers. It really grew out of westward expansion when communities were starting faster than governments were able to, to provide governance.

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And so you see examples of this all the time, community-based organizations that rise up to solve local needs, and particularly come about in times of crisis. You know police stations and fire departments passing the hat when one of their comrades gets hurt in the line of duty. When I was in high school friend of mine, Bob Dyer's younger brother, had leukemia, and Bob gave a, a bone marrow transplant, and we did all kinds of activities to support the family. I, I think it's as American as apple pie. It's really one of the better things about America. I mean, here's a and then GoFundMe came about in 2010 part of the fourth industrial revolution you know, connectivity, the internet apps and so on. I am writing about GoFundMe and I think, Dave, you gave me the the title GoFundMe Healthcare in the new book. I can't go a week without mentioning it, but in the funding fatigue chapter I take a deeper look at this, and there's an example from the later days of the Trump administration where the director of White House Security, a guy named Creed Bailey caught covid and had a bad case and ended up losing part of it one leg, and, and part of the foot, the other foot. And a friend of his, without his knowledge, started to GoFundMe campaign, and it was largely stalling. And then Bloomberg did a news story on it, and then it just took off and ultimately raised more than $80,000; much of which went to redesigning his home so that they could put in ramps and so on.

But it just was telling to me that someone with White House Insurance didn't have the resources when crisis struck to, to handle a disease. And that's, that's where GoFundMe comes in. It's this collision between individuals that are desperate and need to fund the high cost of healthcare. And without other resources, they go on this longstanding American tradition and ask the community. But as you outlined so well Dave, the, the practice is both expansive, over 250,000 campaigns a year, and most of the time doesn't work. In fact, the average campaign only raises 40% of its its goal. So we force people to reveal the most intimate details of their disease or injury. And it doesn't work. It, it actually, it actually feels cruel. Rob Solomon, the founder of GoFundMe, did an interview with Kaiser Health News in 2019, where he talked about this phenomenon that a third of their campaigns go to fund medical need.

And he said, you know, we didn't build the platform to focus on medical expenses, and that it actually saddens him that this is a reality. He emphasized in this interview that he'd like to see nothing more than for medical not to be a category on, on GoFundMe. You know, he feels good that their platform is there for people when they need it, but also thinks it reflects the reality that Americans die when they can't pay for healthcare services. And here's, here's a direct quote from him that just is a stinging criticism of the US healthcare system. The system is terrible. It needs to be rethought and retooled. Politicians are failing us. Healthcare companies are failing us. Those are realities. I don't want to mince words here.

We are facing a huge potential tragedy. We, meaning GoFundMe provide relief for a lot of people, but there are people who are not getting relief from us or from the institutions that are supposed to be there. We shouldn't be the solution to a complex set of systematic problems. They should be solved by the government working properly and by healthcare companies working with their constituents. We firmly believe that access to comprehensive healthcare is a right, and things have to be fixed at the local, state, and federal levels of government to make this a reality." So I'll just finish up by saying I think that GoFundMe healthcare really reflects the

cruel underbelly of us healthcare, and it's just profound failure to meet the everyday needs of people in their most desperate times. And I can't say it any better than Rob Solomon did, but I'm hoping for the day when we don't need these campaigns anymore.

Burda:
Yeah. Here, here. Thanks Dave. Julie, any questions for Dave?

Murchinson:
Dave, you've written in the past about the principal first do no harm. Do you think at this point GoFundMe is actually doing harm?

Johnson:
You know, it's, that's a really interesting question. One of the things that I find, again, uniquely American and depressing, is that many hospitals now have divisions that help people set up GoFundMe campaigns when they can't pay their hospital bills, <laugh>. And it just feels like a way of pouring gasoline on a raging fire that we give people kind of false hope rather than substantive solutions for addressing these challenges. And, you know, most Americans are probably one medical crisis away of facing bankruptcy. So there's a whole lot of harm that that's happening here. I, you know, GoFundMe I think is more a symptom than a cause but the disease is profound.

Burda:
Thanks, Dave. Julie, you get charitable organizations paying someone else's unpaid medical bills either from collection agencies or providers. What are the pros and cons of this approach? And does it do anything to make medical care more affordable?

Murchinson:
Yeah, I mean, similar issues, honestly, and it's tough for me. On one hand, I believe in this theory that alleviating financial burden can make room for individuals and families to actually manage, you know, more complex things like health in a preventative way. Of course, <laugh> it's a thing. I mean, there's data to support the thesis and the approach, honestly, could be a really key component to actually transitioning people to health versus healthcare, which is what, you know, we're all we're trying to do. But you know, when you step back and look at it, it's truly just a wealth transfer from very generous people to innovators, nonprofits, and hospitals. It does help people in the end, but is that really the goal to make those organizations wealthier? No, I don't think so. So I'm very torn, you know, with these models.

And, you know, you're standing ground in Chicago, Cook County Health, who I think Dave, we actually even talked about last week. So they're becoming a <laugh> a mainstay in our discussion. You know, it funds its own hospital and health system like a lot of public systems do to provide care to residents regardless of income. And it's their mission to make sure that people can get care regardless of their ability to pay. But this mission is costing them $9.3 billion a year. And with this nonprofit today, the county is spending $12 million. That's a tiny portion of its budget to retire a billion dollars worth of hospital bills for residents. So I'd actually say this

nonprofit model is working for Cook County. Like, you know, it, it's now gonna be part of their business model. And in the year and a half since Cook County announced its program with the nonprofit, seven other local governments have followed suit, Akron, Cleveland, and Toledo, Ohio, New Orleans, Wayne County Michigan, Washington, DC, and now New York City. So you're seeing other public health systems align with this nonprofit to pay pennies on the dollar for their own debt, basically. The debt they're creating, really, so I went on to the site and get this, there's…. it really made me laugh actually, because I've spent a long time in Lake Tahoe as a California resident. There's a real estate agent in Lake Tahoe who started one of these campaigns. And it's a $10,000 campaign. So this real estate agent, I don't know what the agent's personal interest is, but it looks like a marketing campaign for her, right. <Laugh> or to the agency. Wow. So when you see things like that, you start to really wonder, oh my gosh, like, how are we using these things? So I'm, I'm torn for sure.

Burda:
you mentioned wealth transfer, I get that same feeling when the kids knock on the door and they wanna raise money for the high school football team, right? Part of me is like, isn't isn't that what my taxes are paying for? But yet you wanna help the, the kids buy safe helmets. So yeah, it happens at all different levels. Thanks, Julie. Dave, any questions for Julie?

Johnson:
What does it say about healthcare prices and the way we impose them on people and the absolute disconnection between actual costs and what, what prices get, get charged that third parties can acquire unpaid medical bills for pennies on the dollars. You know, wouldn't providers like Cook County benefit by going to standardized global treatment prices for commercially insured customers or even dare I say it all, payer prices? Of course, as that question's coming outta my mouth, I'm thinking Cook County has very few commercial payers, which is part of the problem. But wouldn't we just do better by having more standardized prices for routine care delivery instead, all this price discrepancy and back and forth with the revenue cycle. I mean, the amount of money spent trying to collect medical debt is just gargantuan. What do you think?

Murchinson:
Yeah, we cut out a lot of middlemen if we did that that would be helpful. You know, I think the reality is this is how the system works, but what I can definitely see coming, you know, when you look at what's happening on the drug price side, look at all the attention going to price transparency and the models that are being used for pricing. And, you know, we're seeing change happening in that space now after years and years of discussing it. And I can see healthcare prices going in the same direction. I mean, they get to the point where no one knows what they're paying for. The cost basis is varied. I'm not even sure the hospitals really have ever figured out their cost basis for these things. So you know, we might be headed towards a train wreck on transparency, finally, hopefully someday.

Burda:
<Laugh>. Thanks, Julie. Yeah. Train wreck. It is, that's for sure. I think both approaches are band-aids that help patients but don't do really anything to make care more affordable. You

know, I'd rather donate blood or bone marrow, a kidney or even part of a liver to help someone rather than giving them money. You know, as long as I don't get a medical bill for the donation that I can't pay for. Now let's talk about other big news that happened this past week. Julie, what else happened that we should be talking about?

Murchinson:
Well, I saw a great article about how at least 19 states are now directing money from their health insurance program for low income people into housing and housing aid, and, you know, addressing homelessness this way. And it's feeling this, you know, fascinating philosophical debate about whether healthcare funds apply to housing, whether housing is healthcare. So, you know, another angle on all this that we're talking about, California alone is by the way, directing $12 billion of its healthcare, health insurance money into housing 12 billion.

Burda:
Wow. social determinants, or what do you call 'em, Dave Health? Healthy multipliers.

Johnson:
Yep. Health multipliers.

Burda:
Yeah. That's a good trend. Dave, what other healthcare news blipped on your radar this week?

Johnson:
Well, I've got two quick items. The first, I'm not sure whether to be impressed or depressed, but my friend Dave Burton, who's from Cincinnati, was home last weekend and was in a bar. And it turns out the Department of Health for Hamilton County is handing out little kits that enable people to tell whether or not there's fentanyl in their heroin <laugh>. Is that a good thing or not? <Laugh>?

Burda:
My goodness.

Johnson:
Okay. And then the second one, and it, it gets to the point Julie was just discussing on transparency in drug pricing. My friend Hal Andrews wrote a brilliant piece this week on Mark Cuban's cost plus drug company. And rather than celebrate Cuban's business model as the antidote to the drug industry's blatant profiteering, as so many of us do, in including me, Hal reminds us that cost plus reimbursement is how healthcare got into the current financial mess. Cost plus is still fee for service, and it doesn't always correlate with values. So back to first principles. Way to go. Hal.

Burda:
Thanks Dave, and thanks, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sitehealth.com. And

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