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 Burta, news editor at 4sight Health. It is Thursday, January 22nd. One of my many New Year's resolutions was to get the RSAV vaccine to protect me from the respiratory syncytial virus, which can really screw up your respiratory system if you're old like me, or young like a baby, or anyone in between. I got the vaccine earlier this week at my local pharmacy. It was free and took all of about five minutes. It's one and done, and you never have to get it again. It's not a miracle. It's not political dogma. It's not online quackery. It's evidence-based medical science. It's how we promote health and avoid costly medical care. Health, not healthcare, as we like to say at 4sight Health. How we spend our healthcare dollars is what we're gonna talk about on today's show with Dave Johnson, founder and CEO of 4sight Health, and Julie Merchison, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

When I was eight years old, my mother took me to see the movie Dr. Shivago, and all I remember about it was it was really long. It actually had an intermission, and there was snow everywhere. <Laugh> And that's what it's like in Michigan right now.

Burda:

Thanks, Dave. Julie, how are you?

Julie Murchinson:

Well, it's been sunny in Seattle, like literally sunny and in the 30s and 40s, so I cannot complain compared to your weather.

Burda:

We're jealous. All right. Now, before we talk about national health spending, I wanted to ask you about your trip to the JP Morgan Healthcare Conference last week. You both were out in San Francisco while I was here minding the store. , Dave, what's your big, , takeaway from the meeting?

Johnson:

Well, I mean, there was a lot going on, per usual, but maybe the biggest takeaway was that the CMS leadership was out in force, really everywhere, you know, Oz and crew. And there's a sense that, under Dr. Oz, CMS is way outperforming expectations. And I'd say, there's real excitement, maybe even belief, that we're on the cusp of health data interoperability.

Burda:

Thanks, Dave. Julie, how about you? What opened your eyes or had, , you scratching your head from the meeting?

Murchinson:

Well, I'll say, you know, almost every health system presentation literally said we're back to pre-COVID levels. So it was kind of a very rosy back-end business picture, which is not what I hear on the daily basis. And, you know, everybody was talking about ChatGPT Health, but not as many people were talking about what Anthropic has done, which, you know, is arguably potentially a bigger, better contribution or business. So I was, you know, I found that curious.

Burda:

We'll keep an eye on that. While you two were out, I'm sure you heard CMS released its latest annual figures on national health expenditures. CMS and national health spending rose 7.2% 2024 to almost $5.3 trillion. That follows a 7.4% jump in 2023. We can talk about the numbers all day, but instead, I wanna get your reaction to a commentary

on the numbers by Michael Chernew published in Health Affairs. Chernew teaches health policy at Harvard, and he currently chairs MedPAC, the Medicare Payment Advisory Commission. After a six-year run, his term as MedPAC chair ends in April. He made a few interesting points in his commentary, and I wanted to get your reaction to them. First, he said prices and health insurer profits are not driving spending growth. Instead, he said the main driver of spending growth is greater volume and intensity of care. He was skeptical about the ability of AI to control spending, saying, quote, "The productivity gains from AI may free up resources to deliver services that would otherwise not be used," close quote. And he said a non-trivial driver of spending growth is the increased use of expensive products. Dave, what's your overall take on Chernew's commentary? , What did he swing and hit? What did he swing and miss? And if you were to add a bullet point to his commentary, what would it be?

Johnson:

Well, Mike Chernew is a great friend and a brilliant economist. I probably enjoy debating the great healthcare issues of the day with him as much as with anybody. In this particular analysis, Mike is both right and wrong. So it went out of the park and swung and miss. Where's he right? Obviously between 2023 and 2024, volumes and intensity of care drove expenditures higher. It wasn't prices. He had fun with the title, , rephrasing Uve Reinhardt's famous, It's The Price is Stupid. And in this case, it wasn't the prices. It was, it was volume and care intensity. So kudos to Mike on that. What his analysis misses is that prices are already too high, kudos to Uve Reinhardt, and that healthcare services are disproportionately delivered in centralized high cost hospital physician and treatment centric settings. So, you know, you're getting a higher number, you know, sort of a marginally higher number on an already artificially inflated base. You know, I went to the Harvard Kennedy School and maybe the most important policy lesson I learned, was where you stand depends on where you sit. The quintessential example was

Casper Weinberger. In the Nixon administration, he was head of OMB and they literally called him Cap the Knife because he was such a vicious cost cutter. <Laugh> And then during Reagan, , he moved over to defense and he outdualed, then OMB director, David Stockman and, and pushed through massive increases in defense, in defense spending. So was he Cap the Knife or Cap the Spender? I, you know, he was both, depended on where he sat. So at MedPAC and as an economist, Mike lives in the land of incremental policy levers, tweaked this payment model for a better outcome, ratchet down this payment code to reduce waste. This way of viewing regulatory systems and market, operations is entirely rational, but completely misses disruptive innovation and exponential, transformational change. I mean, that's why Clay Christensen's work has, has been so important. People don't see, disruptive innovation coming. So, as you mentioned, Dave, Julie and I were both at JPM. For, for me, it was the first time I'd been there since January 2020, the superspreader event. And the biggest difference on the streets was the ubiquity of driverless Waymo cars. - <Laugh> They're everywhere. The city of San Francisco is on the verge of allowing them to travel on highways, which will mean…

Murchinson:
They're on. ...

Johnson:
... Oh, they already are on highways? Okay.

Murchinson:
Yes. I saw one of the way the airport. Yeah.

Johnson:
Okay.

Burda:
Oh, Man.

Johnson:
Yeah, man. Waymo trips to the airport back and forth, and they're clean.

Murchinson:
They're beautiful.

Johnson:
They operate 24/7, they're cheaper, they're safe. And I kinda look at that and say, "Will we even have Lyft or Uber drivers in five more years?" That's disruptive transformational change, not incremental change. You know, there's that famous William Gibson quote, the science fiction writer, the future is already here, it's just unevenly distributed. So I sit here at a moment like JPM and think about what will be the equivalent, transformational changes, disruptive innovations in healthcare. I'll give you two. Cleveland Clinic is creating an app that offers a $10 AI-based primary care visit. You know, for the most part, your annual visit, the doctor doesn't accomplish much anyway. So imagine you get a $10 visit fully plugged into your data, that can really find, things to work on and obviously give you a clean bill of health quickly if that's what you deserve. If something like that catches fire, it could rewire the entire industry's supply demand dynamics for how we receive care at the most basic fundamental levels. Mayo Clinic's platform, which, you both heard me talk about is now up and operating in eight countries. It's EHR agnostic. They have four EHRs. They're part of an international, organization that has created a uniform lexicon, so they've standardized the EHR data. They're running over 200 algorithms to improve diagnostics and treatment, on their platform. And they expect to have over a thousand, AI-driven agents on the platform by the end of the year. Again, imagine if that catches fire. So paraphrasing William Gibson,

healthcare's future is already here. It's just unevenly distributed. So here's my message to Mike. Keep up the great work of understanding the incremental drivers of behavior within the healthcare marketplace. Make sure we pull the levers the right way. Just don't be blinded by them.

Burda:

Interesting. you know, while you're talking, the, the image that appeared in my head was the scene from the movie Total Recall with Arnold Schwarzenegger when he's calling in the Johnny Cab. Right? And he's telling the Johnny Cab to chase the bad guys and, I don't know if, if the, what, what, what are these things called in San Francisco? Waymos?

Murchinson:

Waymo.

Burda:

Yeah. All right. That's gonna change movies too, right? How do you tell the Waymo chase that Waymo in front of you?

Murchinson:

Yeah, yeah. You know someone's gonna take over the Waymo network, for sure.

Burda:

Sure. Oh, yeah, that'll be a plot. Absolutely. Yeah. All right. Thanks, Dave. Julie, any help? AI will write it. AI will write it. There you go. There you go. <Laugh> All right. <Laugh> All right, Julie, any healthcare questions for Dave?

Murchinson:

Well, Dave, you know, Chernew highlights a handful of CMS programs and you highlighted Oz earlier, that could really make an impact here, Wiser, Globe, Generous, Guard. And I know that we haven't unpacked

all these, but do you have a favorite coming out of this report or is there another program you would design?

Johnson: (31:49):

There were 10. I mean, <laugh> 10 new payment models that came out of mostly CMMI, but also FDA in December. Six were, focused on delivery reform and, and four were focused on bringing down drug prices. What they share in common is they're easy to understand, so they're clear, they're big, they're longer term, they're outcomes driven, and they emphasize prevention, so evidence-based prevention. So collectively, and this is gonna be my article, next article for the HFM magazine, which will come out next week, plug for my commentary. But collectively, they could become a game changer, driving industry supply dynamics. So I'm big on the whole concept, but in terms of favorites, I'm gonna go back to the two that we did talk about, ACCESS and TEMPO, and please don't ask me what they stand for, what the acronyms- <laugh> That's gonna be a quiz. <Laugh> yeah. But what they do is they, they pay for outcomes. So if I'm a primary care doctor and I help, Dave lower his blood pressure, I get paid for doing that. And I just love the fact that they are bringing the health tech into the equation with TEMPO. So you've got both, you know, a treatment program married with health tech to help drive the better outcomes. Smart incentives, will lead to smart outcomes. It's really as simple as that.

Burda:

Well, Dave, I would pay you to lower my br- blood pressure, so we'll talk.

Murchinson:
No more Packers <laughs>.

Johnson:
Don’t watch games. <laughs>

Burda:

Yeah, it’s as simple as not watching football. That's great. All right, Julie, what did you think of Chernow's commentary? I'm most interested in your reaction to his comments on AI and expensive products, which is a world you play in. You know, isn't all this supposed to make care better and cheaper? And I think you once said on this show that one snowflake doesn't think it caused the avalanche, right? What do you think?

Murchinson:

Well, <laugh> we were in the middle of a blizzard. Yeah. <laugh> That's for sure. First, I'm obsessed with MedPAC and I worship Michael Chernow and I could pour through his commentary all day. So this, you know, it, it's good food for <laugh> good food for good thinking. So AI, you know, AI is playing very different roles and we're on a journey here. And to the extent that AI can actually control or ev- potentially decrease costs, I know that we don't really think that's ever possible. We have a long way to go to see how it shakes out. And when I look at his commentary on coding intensity, you know, AI is being used to identify unbilled codes to make hospital bills more complete in fee-for-service settings. Is that driving up costs? Yes. <laugh> And it's exactly what Turnout specifically references, but is it wrong? I don't think so. I mean, in many ways, it's right-sizing billing and taking us to some new normal. In other words, providers have been under billing for years and we're seeing pretty widespread billing correction of sorts. So I, by the way, just think this correction has just begun, so I think we're gonna see a lot more of this. Obviously, it needs to be appropriate. That's one of the biggest questions on everyone's mind. And every system I talk to has an access problem, or so they think, of course. And AI-driven efficiency will drive more throughput, but it's gonna take a long time. And the question is how much more vol- volume is truly sitting on the other side today or, tomorrow? And then I listed his commentary on AI-enabled services, medical services. And, you know, we are crawling down a

much longer road here. I think in the long run, once we get used to practicing in more the way that Dave and I talk about with preventative health versus this, you know, risk mitigation, physician liability way of practicing medicine, and we get better at triaging patients to the right, you know, point of care or next step, and we move into more of a continuous health monitoring, you know, diagnostics and AI-enabled medical services, as he calls them, will result in less costly care. Is that in the next few years? I would not run to PolyMarket and bet on that. <Laugh> That's for sure. <Laugh> So we're just in the middle of a tough bubble. And the use of expensive products I found really interesting given all the talk we have about GLPs. So, you know, the price has drastically dropped now since our first discussion, and the use has skyrocketed. So we're kind of on a similar journey here. We haven't seen the full downstream effect of their use, no, you know, and meaning how does it impact all the acute care, highly cost, high cost care. And we haven't seen what happens when they're taken earlier in any individual's life to control diabetes, as a preventative measure or, you know, all the other, comorbidities that come with it. So it seems like the same is true of other expensive, potentially game-changing products, that may be extending life. And I don't know, maybe we're a mile into this 1,000 mile journey. I'm not sure.

Burda:

If people listen to the show, , you were the first one to point out the impact of GLP-1s, you know, a couple years ago.

Murchinson:

Go me.

Burda:

Here you go. So, good job. Thanks, Julie. Dave, any, any questions for Julie?

Johnson:

We're way more than one year in one mile to a thousand mile journey. <Laugh> But, boom.

Burda:

There you go. There you go. <Laugh>

Johnson:

Anyway, Julie, I'm gonna journey right into the tough bubble that, , you mentioned. So implicit in turnout's Mike's analysis is the demographic reality that an aging population is also a sicker population, one that will require higher levels of healthcare services or greater levels of healthcare services to treat greater numbers of acute conditions. The six trillion dollar question for American society, and you touched on it, is whether the nation's service model can transform sufficiently and quickly enough to offset, perhaps, even mitigate the impact of negative demographic trends. So what's your take?

Burda:

Easy one for you there, Julie.

Murchinson:

You know, I was just at a large academic yesterday that's putting up a $5 billion new tower that will be stunning, state of the art, everything. You know, you saw in at least half, if not more of the presentations at JP Morgan that health systems are building new buildings, you know, just the building is everywhere. Like I said earlier, like, I don't know how much demand there is on the other side of the door today. I know there's a lot, but with a little bit of throughput work, which I know is very, very hard, we might be able to address most of that demand. So as the, as we hit this demographic cliff, you know, I think some health systems will be fine because they won't be making their bread and butter off, you know,

the highest complexity, craziest, most unique issues. Maybe it's, maybe the academics will be in a, a worse place than your run-of-the-mill health system, or maybe it'll be vice versa. I'm really not sure. We're gonna address so many of our, you know, chronic issues that lead to comorbidities, that lead to hospitalizations…we all think we're gonna be overbedded, right? But I don't know. I, I think it's gonna be shakeout differently for different, different kinds of institutions.

Burda:

When I go to the grocery store now, where is the line? The line is to get into the self-checkout area, right? <Laugh> And if you look to the right, there's four or five, you know, cashiers stations open and nobody's there, right? Is that the image of healthcare's future, right? Everybody's building new cashier stations, and everybody else wants to use the self-service line, so- Yeah.

Murchinson:

Yeah, so true.

Johnson:

I understand why all these new buildings are going up, but I still got Terry Shaw's, , observation in the back of my mind that healthcare has always been a cottage industry. It's just that we've turned the cottages into hotels. <Laugh> And I can't help ... Yeah, isn’t that a great line? I just can't help but thinking, these are, you know, the equivalent of building new buggy whip plants. You know, they aren't aligned with where the future's going. And so, we've got the ability to manufacture a lot of buggy whips when the demand won't require them.

Burda:

Yeah. It, it'll be interesting. Well, I'm gonna just keep beating the drum for vaccines and immunizations. You know, I can't think of a cheaper

and more effective way to keep us healthy, and none of this whole milk, raw milk ridiculousness, right? So hang on.

Johnson:

Well, Dave, my new best friend is Susan Menares. I met her and had a chance to get to know her in San Francisco. You know, she was the one that RFK fired, from the CDC. And I told her that the greatest irony ever would be Carolyn Kennedy awarding her the Profile In Courage Award at the Kennedy Museum in Austin, which I think should happen. As Edmund Burke said, the only thing necessary for evil to triumph is for enough good people to do nothing. And she and her team at CDC stood up for science, stood up for the American people. And, you know, this too shall pass, but I hope she gets that award and, she and Carolyn send a signed copy of it to RFK. Yeah.

Burda:

No, that'd be fantastic. Thanks, David. Now let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, you know, some of these companies are really making an impact on doctors specifically. Obviously, we, you know, we've been hearing so much about how Ambient has been such a gift to physicians, but y- you've heard of the company, Open Evidence, kind of the ChatGPT for doctors that, you know, -

Johnson:

Yeah, yeah.

Murchinson:

... crawls all of our research. It's just doubled in valuation now to $12 billion, which is crazy. But it's amazing to me that it's the one thing that

doctors are using that's doing so well. It's taking that 17-year gap down to, you know, nothing.

Burda:

It's impossible to keep up. That's great. Dave, what's your big healthcare news of the week?

Johnson:

Well, just before I get to my own news, I watched the first couple episodes of the second season of the Pit this week, and they had an ambient listening system in the Pit ER, and it got a diagnosis wrong, and one of the residents said, "AI, almost intelligent." so there you go. <Laugh>. But this wasn't an immediate story, but there's some shakeout happening in the drug wholesaler business. Optumrx, switched from Cardinal to McKesson, Mayo also just switched its provider. And I had a couple of conversations about what was going on, and it feels like, health systems are largely making the decision on which drug wholesaler to use based almost entirely on price, and they're looking for more and more transparency. And it feels like the drug wholesalers are going the way of the PBMs, you know, they, both sectors have used oligopoly pricing power to extract excessive profits from American society, and maybe the jig is up. I hope it is. Should be.

Burda:

That's why they're all diversifying into oncology, right? I think <laugh> maybe their old business model's dying. We'll see. 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 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.