Dr. Zack Cooper:
What it takes to reform the health care system is actually quite different than what it would take, say, to really improve health care and, let's say, the developing world. You really need three prongs. First, you need communication, shape a narrative, get word out about what's happening. Second, you need to, frankly, lobby and form a constituency for efficiency. The third is really getting under the hood on the policy making side and sort of saying, look, here's literally what you could do. Two of the papers we've done have been featured on the front page lead story at the *Times*, and that gets legislators attention.

Ellen Kelsay:
That's Dr. Zack Cooper, Associate Professor of Public Health and of Economics at Yale University, where he also serves as Director of Health Policy at the school's Institution for Social and Policy Studies. An award-winning researcher focused on competition in government policy in health care and health insurance markets, Zack is a co-director of the 1% Steps for Health Care Reform project, an initiative that identifies problems in the U.S. health care system that increased spending and offers evidence-based recommendations on how to fix them.

I'm Ellen Kelsey and this is a Business Group on Health podcast, conversations with experts on the most important health and well-being issues facing employers today. My guest is Zach Cooper and our topic is lowering health care costs in the U.S. through incremental change.

Zach, welcome. We're delighted to have you today.

Dr. Zack Cooper:
Thanks so much for having me.

Ellen Kelsay:
We're so thrilled to have you. I know you have presented to some of our members before in some past forums and we're delighted to share you on a broader stage and really eager to share with our audience more about your 1% Steps for Health Care Reform project. Can you tell us about that?

Dr. Zack Cooper:
Yes, the project is really about identifying concrete ways to lower health care spending in the U.S. I think most of us can agree that the U.S. health system relative to other countries isn't efficient. I think where we get into trouble is sort of what you then want to do about it. From my perspective, a lot of the discourse around health care reform really occurred at a level of abstraction that sort of wasn't useful in practice. So people would talk about things like payment reform, and that sounds really good until you sort of say, well, how do I do payment reform? Well, what does that actually mean? It turns out it just means different things to different people. I reached out to a bunch of my colleagues in the academy, folks who I thought were the sort of smartest economists in the nation, and said look, from your research, can you identify discrete evidence-based interventions which if put into practice would lower health care spending by a percent or two. It turns out when you have a health system that if it were a country would be the fourth largest country in the world. The U.S. health system is just enormous. When you get 15 incremental improvements, it gets you hundreds of billions of dollars. So we put together these 16 proposals, they add up to about 10% of health care spending annually, and now we're pushing to get a bunch of them implemented.

Ellen Kelsay:
That's really amazing on so many levels. When you use like the payment reform as an example of something that's abstract, and it's almost so massive that people are right out of the gate stymied with where to begin, and sometimes, you know, smaller baby steps to solving a bigger problem is more effective in the long run, although it's not as splashy, it's not a silver bullet. You said these are 16 incremental improvements that in total would save 10%. Can you give some examples of what are some of the 16 things that you have among your recommendations?

Dr. Zack Cooper:
Absolutely. They range. One of them that I think is really promising is actually increasing the supply of kidneys for donation. One of the things we know is when folks get kidney transplants, not only did they live longer, better lives, it actually saves a significant amount of money for the Medicare program, because Medicare spends so much each year on dialysis. One of the briefs talks about ways you could do that. There's another brief related to kidney donation that talks about how you match up donors and recipients more efficiently. So we've got work there. We've got some work thinking about home health fraud. It turns out there's pretty significant amount of fraud across the U.S. health system, but in home health in particular. This is a brief that is working with some folks who used to be at Department of Justice, thinking about, well, if we really wanted to reduce it, what would we do? So we've got some work on that. We've got a bunch of work on making the markets that sort of underpin the health system, so the markets for physicians and the markets for hospitals, are more competitive. One of the things that we've seen over the last 20 or 30 years is a pretty significant consolidation in the hospital industry first, and now increasingly in the physician space with hospitals increasingly buying physician groups. Not only does that affect quality, but it also raises prices. So we talked about some concrete steps, in this case, that Congress could take that would make these markets a little more dynamic.

Ellen Kelsay:
Yes, I definitely want to come back to that hospital consolidation point in just a minute. You had mentioned in your introductory remark relative to these 16 proposals, that some of them are in various phases of implementation now. How are you implementing? With whom are you working? Are you working with health systems? Are you working with hospital systems, health plans? Can you share a little bit more about how is that going? How's the rollout going?

Dr. Zack Cooper:
A lot of the idea for the project actually came from our experience with surprise billing. We put out some work, I guess initially in 2016 and then in 2017, on surprise billing that got a lot of traction on the Hill. One paper was categorizing how often it occurs, showing that basically one in five patients at the time were going to an in-network hospital and getting treated by an out-of-network physician. Then a second paper that was showing that it actually was two really big physician staffing companies, one called EmCare and one called Team Health, that were frankly just using out-of-network billing as a business strategy. Then we tested some reforms that New York put into place. What was really cool is you got the chance to present that at most of the federal agencies and a lot of legislators, I think, became pretty engaged in the issue and ultimately we saw surprise billing protections passed into law December of 2020. I think that became a sort of template for how we want to engage. I think there are some of the proposals where we could see firms themselves take action, but I think one of the things that's so critical to understand in the U.S. health care system is, because there is so much regulation involvement in federal government, it's really almost impossible to do these sort of big programs without involving sort of policy changes. A lot of what we've done is work with federal agencies on how you might put these into place. There are a couple of states now that we're partnering with to talk through how they would implement some of these reforms. We're speaking to a bunch of legislators on both sides of the isle about how you'd introduce some of these into actual legislative packages.

Ellen Kelsay:
There is so much I want to ask you about just in that one response, but I would imagine where you started with surprise billing, that in and of itself is probably more than just 1%. Have you quantified if we could solve for that and do justice in the area of surprise billing, what that might equate to? It's got to be more than 1%.

Dr. Zack Cooper:
My guesstimate was that it was about 5% of commercial spending, about 2% of total health care costs in the U.S., and that's pretty close to what the Congressional Budget Office estimated. I think they estimated sort of 3% of commercial spending, maybe like 1.2% of total health care costs. It’s cool. The bill that became a law in December, I think, actually had a lot of good that was in it. We had spent a tremendous amount of time, my colleagues and I, working with legislators on crafting it and trying to get it so that it was as good for patients

and as good for the health care service system as we could, and I think learned a lot from that process. Now, I think the Biden administration is working on implementing the surprise billing reforms. When thinking about how you turn broad legislative language into the specific rules that structure how health care providers can behave and what they can and can't do, a lot of this we'll see how it plays out over time, sort of as the rubber hits the road.

Ellen Kelsay:
Kudos to you and your team, because surprise billing has been a very big pain point for so many patients, families, employers, everybody who's involved. That work right there is just so impressive and we're glad to see that it's getting some traction and that we do have legislation now and all eyes are on that. We had a couple bad actors, as you said, in those two companies. So, thank you for your work in that one area alone.

Dr. Zack Cooper:
Yes, we had an interesting meeting last week with some of the leading philanthropists in the country to sort of think about what you'd want to do, or what they could do, and how you could make progress reforming the health care system. I think in many ways, from my perspective, what it takes to reform the health care system is actually quite different than what it would take, say to truly improve health care in, let's say, the developing world. I think in the U.S., because there's such a large role for government, you really need three prongs. First, you need communication. You need to sort of shape a narrative, get word out about what's happening. Second, you need to, frankly, lobby and form really a constituency for efficiency. I think one of the challenges in the U.S. is there are a lot of firms who don't want to see their revenue cut. So there are lots of constituencies for doing more, there are very few unified constituencies for doing things more efficiently. We sort of have to lobby on that behalf. Then I think the third is it's really getting under the hood on the policy making side and sort of saying, look, here's literally what you could do. From our experience, we've been fortunate where, for example, two of the papers we've done have been featured in the front-page lead story at the *Times*, and that gets legislators attention and it can show them what an issue looks like and hopefully how to fix it. From there it's convincing them that this is a front burner issue that affects people's day-to-day lives and then showing them, in an ideal world, how you go about fixing the problem.

Ellen Kelsay:
That's great. I think the point you've made about it, it is a multi-pronged approach. It's not any one thing, but many little things working in concert simultaneously over a sustained period of time that will ultimately bring about meaningful and sustained change. You mentioned lobbying, you mentioned getting under the hood with policy makers and profiling the issues publicly, in the media and otherwise. We feel the same. Often we work issues from a public policy and advocacy perspective, but then also from a market perspective and who are the players that we need to maybe profile or raise some heat to do things differently. I'm curious, you've mentioned earlier in our conversation about working with states and working with legislators, are you also working with the stakeholders kind of in the commercial market to implement some of these changes? Or if you're not directly working with them, are there things that you would say that employers could influence on the commercial side of things?

Dr. Zack Cooper:
A lot of the early stages of our work are just sort of understanding market dynamics. That involves lots of conversations with firms about what they're seeing and what they're experiencing. Once the research comes out, I have lots of conversations, in particularly with employers, about what they could do as firms. I think one of the challenges though, you know, missing the sense is what motivates the work. Take a look at, let's say adoption of biosimilars, something that a lot of firms out there want to see happen for their employees, it's a huge source of rising health care costs. In many instances because of public policy, the firms are actually pretty limited in what they can do. I think this is one of these challenges in the U.S. health care system, where the firms themselves, the employers, really I think are responsible for sort of the provision of the insurance or sort of arranging it for their policy holders. Individuals bear the costs of the health care they consume, although in many instances it comes out of their wages and they're not super aware. Then the levers for change rest with government. I think it's that sort of lack of sync up across those three groups that creates challenges. I sort of

see my role in saying to each of the groups, here's, I think, what needs to be done, here's how we sort of coordinate and then here's what we could do going forward. I think a lot of what I'm thinking about these days is how you create a constituency for efficiency. I think that's something that's missing, frankly, across a range of issues. What is the unified group that steps forward and says we have a health care system that's really putting the country financially under an immense amount of pressure, let's speak up for the need to improve it. I think what's hard is, you know, if I was the CEO of Home Depot, clearly it's an issue that matters to me, but it sort of doesn't quite matter as much as whatever home building policy or the issues that are really front and center for my business. So, I think the challenge is there's just no central group who's out there pushing this issue day in and day out.

Ellen Kelsay:
Yeah, it's so interesting because, obviously, our organization represents many of the largest employers around the world and for whom health and well-being investments is the second largest expenditure, organizationally. It’s a huge price tag issue for them organizationally, and obviously, as we've seen certainly in this past year and a half, that health and well-being of a workforce, truly really does matter and there is direct correlation on an organization's business and how they perform from a business context. I do think we're at this kind of interesting paradigm where matters of health and well-being investments in those programs are catching C-suite attention in ways that they never did before. But, you know, even with enlightened employers, many of whom we represent, it's no one stakeholder group can do it alone. I like your phrase of constituency for efficiency, right? Because you need all oars in the water rowing in the same direction and it's not just employers, it's not just policy makers, it's not just health plan executives, it's not just pharmacy executives. You can go down the list, it's all of them together really trying to do this. And you said it's a challenge because there are some deep rooted conflicts and some of those stakeholders may not want to see the change come forth that could impact their businesses, perhaps negatively, even if in the long run it's the right thing for society.

Dr. Zack Cooper:
Yes, and I think there are a lot of tangible steps that employers can take. I think with the increasing availability and use of sort of analytics of claims data, a lot of these employers can say, look it turns out a really small group of folks are doing the lion's share of the spending. If we look at them, in many instances they have sort of the same conditions. When I talk to large employers, it depends a little bit on the industry, but often we're sort of talking about sort of subset of orthopedic procedures, baby deliveries, back pain and cancer. When you sort of break it down by who's sick and what they have, it makes it a little easier than just sort of boiling the ocean. I think what we're starting to see is some companies pop up that are helping in each of these domains individually, and then some employers are starting to say, look, there's this group of super high spenders, individuals who I think we can help with interventions that sound really, really heavily targeted. That is like, we're going to assign you a very specific nurse practitioner, a PCP, who's essentially going to just follow you around through the health care system. Even though you're spending a ton of money on that individual to help your employee, the returns from that from reducing health care spending can be absolutely enormous.

Ellen Kelsay:
I agree with you. Data, access to data, transparency of data, the utility of that data, is so critical. I’m so glad that you called that out as an example.

Dr. Zack Cooper:
I think one of the things we see and sort of a good example of how long a pathway needs to be, we were looking at data for a couple of really big firms and you'd see a person who was a couple standard deviations outside means, the really, really high spenders and these are folks who were spending millions of dollars annually. Who are they? What do they have in common? One thing that jumped out is they were often women who were delivering multiple babies, like septuplets, like five kids at a time or whatever the number was. When you sort of talked to the firm about it and looked at the genesis of some of these births, they were really around sort of family planning policies, so it was often firms that didn't have super generous family planning policies, mom was having trouble potentially having a kid, went to a place that wasn't as reputable for IVF and

ended up in a position where she was carrying a lot of embryos. Is there a pathway for you to say, look, we're going to help firms do everything from the sort of family planning side for their employees, all the way through the first year of life. I think it has benefits aside from health spending in terms of sort of healthier, happier kids and parents. Then it actually turns out to have huge returns from a health care spending perspective.

Ellen Kelsay:
Yeah, that's a great example, and certainly family planning and fertility are big areas of focus, both from a policy, as well as a coverage perspective, so great example there as well. I want to tie back to your remark earlier on consolidation. You specifically mentioned hospital consolidation and the impact that that has had on prices and spending. On the surface many would think, oh, well, consolidation drives efficiencies, but as we've seen that hasn't always borne out and in many cases it's driven an increase in pricing and overall spending. I would love for you to elaborate on that.

Dr. Zack Cooper:
Sure. I think take a step back and just say there's been a pretty extraordinary amount of consolidation in the 2000s. It's something on the order of 1400 transactions or about a hundred transactions a year, 1400 hospitals directly involved, which basically means that almost every hospital in the country was either involved in or a neighbor to a merger. So we've ended up in a universe where the level of concentration, sort of how much competition we have in hospital markets, is sort of over a threshold at the Department of Justice, of the Federal Trade Commission, would consider highly concentrated or sort of cause for concern. I don't want to say that all mergers are bad. They're not. I'm an economist. I think that firms competing and firms getting the chance to structure themselves in different and complicated ways makes sense, but I think what the empirical evidence bears out are sort of three key facts. First, in many instances, these mergers allow the hospitals themselves to raise prices, and when they do those prices show up in insurance premiums and then that shows up in wages, so that can have some challenges. Second, there's really no evidence that mergers allow hospitals, for the most part, to raise efficiency. I can think of a number of studies that show they don't and sort of one or two studies that show teeny, teeny, efficiency gains. I think you're seeing prices go up, no efficiency gains. And third is the impact on quality. Frankly, this is the one that actually concerns me the most. Two pieces of evidence here. One, there was some good work that came out last year in the *New England Journal of Medicine* that looked at a whole bunch of mergers and found that on average there were no quality effects. They did not raise quality. The only thing that I think we know very, very convincingly is that when hospitals are located in more competitive markets, they actually have better quality. I think you've seen this huge transformation of a large sector of the U.S. economy, the hospital sectors in 6 to 8% of GDP, with an evidence based that says those mergers on the whole have raised prices, haven't improved quality, and haven't really improved efficiency. I think it's not in the consumer's best interest.

Ellen Kelsay:
All of that is so spot on. Another thing we hear, anecdotally, is that many providers and physicians aren't happy practicing for big systems, or they've lost autonomy, or they're encouraged to refer to the in-patient versus the out-patient setting. There are unintended byproducts of poor physician delivery, and then, therefore, poor patient experience. In addition to the quality and the pricing concerns, I think we have consumer experience challenges and then providers who are becoming increasingly disgruntled practicing that way as well.

Dr. Zack Cooper:
You raise a really good point about what I'd refer to as vertical integration and that's sort of hospitals buying physician groups. I think, again, a couple of really important policy issues and then sort of how it plays out for folks today. We've seen a lot of it occur over the last 15 years. What's really interesting is that most of these deals are under what's called the Hart-Scott-Rodino reporting thresholds. That's sort of the threshold at which you have to notify antitrust authorities that you're completing a transaction. Most of these deals haven't gotten any scrutiny from regulators. What we've seen is huge increases, sort of 20-30% increases or higher probably, in the share of physicians who are working in practices owned by hospitals. Now, what are the challenges? You described them. Physicians often that are frustrated, there's pressure on where they refer patients. There are some things that are at times more convenient, maybe like big IT systems, but part of the

question is why is this happening? I think it's a really good example of unintended consequences of public policy. There are two Medicare programs which I think we can look at that really directly have led to a lot of the consolidation we've seen. The first is historically Medicare has paid more for the same service, if it was delivered in the hospital or a hospital owned practice. If I were an orthopedic surgeon, the same patient visit or the same procedure is literally going to get more generously reimbursed, even if I'm in the same office, if I'm in a practice that's owned by a hospital. That sort of nudged a lot of these providers to move over and enter into these vertical deals to get acquired by hospitals.

The second, for example, is the 340B Program which offers discounts to certain hospitals for purchasing physician administered, infused drugs. So, if I'm an oncologist and I was previously in a physician-owned practice and I join a hospital, in many instances there are pretty steep discounts that I can get for the price of those infused drugs and there was just sort of no way for some of these groups to compete. These sort of policies that were introduced on the Medicare side, with frankly the best of intentions, created all of these into unintended consequences that affected how providers practice medicine and how patients receive care.

Ellen Kelsay:
You definitely hit a nerve on 340B. We hear that quite a bit. You're point on the Medicare payments being twice as much in an in-patient setting is a great example, as you said, of well-intended policies that have some pretty severe unintended consequences. You had mentioned earlier that you're working with steps or made some recommendations to Congress on steps they could take to address some of the negative effects of hospital consolidation. Are those two examples that you just shared among those recommendations or are you also recommending that the threshold for reporting be lower? If you can share any insights there, that'd be wonderful.

Dr. Zack Cooper:
I think antitrust reform across the economy, but also in particular in health care, is one of these areas where actually I think we will see action. On the hospital front, we have a couple of recommendations. The first is literally just more money for antitrust enforcement. What's sort of amazing is when you look at the number of filings over the last decade or so, those have gone up by about 50%. So the regulators are having to assess and analyze more deals, but we've actually seen the enforcement budget at the FTC and the DOJ go down in real terms. The first thing we've recommended is just fixing that. You just need to give the folks working on making the market work as dynamically as possible, the resources they need.

The second is related to what we just talked about, site neutral billing. I think that needs to happen. The third is the reporting thresholds. You don't want to have huge bureaucracy so that small deals, like my local hardware store merges with a store nearby, they've got to like go through the FTC, but you sort of want something that allows the FTC to be aware of some of these transactions and take action if they think that they're anti-competitive. The other is really a change in, and it's going to get into the weeds a little bit, but about antitrust law. Senator Klobuchar is actually is out with a bill that has a lot in there. She actually really studied antitrust law pretty carefully. I think it's about, sort of, what the standards for a case have to be. Do you have to show competitive harm or threat to harm? Sort of small changes in the legalese around our antitrust statutes could have big effects.

Ellen Kelsay:
Well, we all know that policy change can take some time. As you looked at your 16 recommendations and 1%, and hopefully getting to 10%, any forecast in your mind of like feasibility of implementation and by when we might realistically be able to see any of this truly coming to light?

Dr. Zack Cooper:
I think the antitrust reforms are going to probably happen. I think that's on the sort of one- to three-year timetable. I think there's a broad bipartisan consensus that something needs to happen. So, I think that's first. I think the second is really going to be around organ donation. There was actually a lot of work done in the Trump administration around dialysis and around organ donation. It was really positive. I think there's now a

bipartisan consensus on that moving forward. So, I think that's there. Then I think some of them, you know I sort of call plumbing, but sort of really technocratic stuff that states can do is sort of coming. One example of that is, it turns out and this isn't the Medicaid space, so Medicaid covers a ton of people, but it's also a huge financial pressure for states. A lot of states have moved to Medicaid managed care, that basically means private plans competing for Medicaid beneficiaries. A lot of enrollees don't make an active choice, right? They just get defaulted into one plan or another and there's a lot of variation in quality across insurance products. One of the things that some of my collaborators on this project pointed out is if you could actually steer folks into better Medicaid managed care plans for folks who don't make active choices, you can actually really lower the Medicaid spend nationally.

Ellen Kelsay:
It's optimistic. It sounds like it's not like decades away. It's perhaps a few years away, which is good. Good to hear.

Dr. Zack Cooper:
I'll give you the one that makes me a little pessimistic. Say I spend my day thinking about how I do research that motivates policy and then how it worked with policy makers. I think one of the fun things about my job is I can sort of look at whatever I want, and what sort of jumped out at me was the odd politics of health care reform. What I was sort of curious about is what are the incentives for elected officials? We sort of looked at what happened when legislators took steps that raised the amount of money that hospitals and their districts got by way of increasing the hospital's payments or is there something that clearly increases health care spending locally? It turns out politicians are pretty active in taking steps to increase benefits for their local hospitals. The sort of kicker was that after they do that, not only does that increase spending, you see campaign contributions to those members of Congress who took those actions go up, I think at a 50,000 foot level. What I think about is how we change the incentives for our elected officials. If they're really rewarded for us spending more as a country, that's ultimately I think what we're going to get. Whereas, again I go back to really where we started, if we created a constituency for efficiency that rewarded politicians for steps that made our health system more efficient, then we might get outcomes that I think are maybe a little closer to what a lot of us would hope to see.

Ellen Kelsay:
I agree. Well, I've got another question and I'm going to totally shift gears on you. You've talked a lot about things that we can do, your recommendations, but I also know in your research there are some things that you think we should just stop doing or give up on because they're not working.

Dr. Zack Cooper:
Yes, one of the things I talk about with legislators is there's a lot of stuff we sort of want to do that we think works that we believe in, but sort of thinking that it works or thinking that it's good, usually isn't enough to sort of support action. We then often find research which confirms our bias.

Ellen Kelsay:
I believe when you presented to our audience, you talked about MRIs as a specific example. Anything you could elaborate on relative to MRIs?

Dr. Zack Cooper:
We had some work, and this was actually really the project that planted the seed for the 1% Steps project, so this was around basically how people consume planned MRI scans. This is like an elective procedure or elective diagnostic procedure where quality really doesn't vary. We found this sort of amazing stat, which was that on average folks in employer sponsored health insurance drove past six cheaper locations between their home and where they got care. So, the question was sort of like, why are they doing that, what's leading them to make choices? For an economist, I often think it's price, right? That's like where my brain goes. Maybe it's folks who are over their deductible or who don't have cost sharing that are getting these expensive MRI scans. It

really wasn't. It turned out patients basically just go where their physicians tell them to go, which I think for any of us who consume care recently, sort of probably resonates.

I think this dovetails with a lot of the emerging evidence on so-called consumer directed health care, sort of high deductible health care plans and an increase in cost sharing. I think what we're starting to see really come through in the literature is that patients really struggle when they're exposed to higher out-of-pocket costs. It can get them to broadly reduce their consumption of health care, but they reduce necessary and unnecessary services in parallel and most of the spending we see happen after people touch the health care system. Once they touch the health care system, there's not a whole lot that cost sharing can do, so you're basically like ratcheting up the pain without any meaningful improvements in the productivity of the health care that gets provisioned. I think a lot of what I'm doing these days is thinking with employers about how you'd want us to structure benefits for your employees and probably shift away increasingly from pro-consumer directed health care plans or high deductible plans.

Ellen Kelsay:
Yes, we've definitely seen that start to bear out in our own research findings as well. I wanted to kind of loop back, you started our conversation with talking about some abstractions and payment reform being one of them. Just to be clear, you're not saying that that's a lost cause and we shouldn't be focused on payment reform, but that's probably a longer slog and might take perhaps 5, 10 years to truly affect meaningful change, and so these 1% incremental changes are important and we might be able to realize them more swiftly, but it's not at the exclusion of focusing on things like payment form. Is that correct? Would you say that they're both important?

Dr. Zack Cooper:
Yes. I guess the way I think about it is if the U.S. health care system was a country, we'd be a country about the size of Germany. You think Germans pay a lot for a lot of stuff, and if you said we want to do payment reform to the German economy, people would look at you like you were crazy, like what in the world is that mean? That's kind of the way I think about payment reform in the U.S. health care system. Broadly there are a lot of services where we don't pay for things well, whether that's the way we pay primary care physicians, you probably want to move them towards capitation wherever possible. We definitely don't want to pay hospitals retrospectively based on their charges, but it's sort of taking this idea of payment reform and making it really, really specific to not only the setting, but probably the conditions that we're talking about. From my perspective, payment reform is kind of a buzz word that became a sort of thing people said when they wanted to sort of symbolize, they wanted it to take an action, but didn't really want to commit to doing something tangible. What I'm really sort of thinking about these days is like, what are the tangible steps? What's the specific payment reform that you could take in a specific setting, for a specific condition, that would make things better for us day to day.

Ellen Kelsay:
Yes, I like that framing. That makes perfect sense. I've got one last question for you. What is the top thing that you would like to see employers and their partners know about addressing health care costs in the United States?

Dr. Zack Cooper:
I think the first thing is that most people don't spend very much; in a small pocket, spend a tremendous amount. What can we do to help those folks who are spending a lot? Often they access health care when they're at their most vulnerable and I think the steps we take to make the health care, the access, easier and better, will actually know and make those folks happier, but lower health care spending. I think that's the first. I think the second is that not all care needs to be delivered locally and that in many instances, when you can get patients for really complicated conditions to travel farther, they can get access to much, much better facilities who in some instances offer less care. They don't do procedures; they get much better outcomes at much, much lower prices. I think this idea that you need to get all your care right next to your house, or right next to your firm is probably a pretty antiquated view of what health care in this country should look like.

Ellen Kelsay:
I love that. You're right. It is about improving efficiencies, lowering overall health care spend, especially for those who most acutely need it, which is a smaller proportion of the overall population. Your point around travel, I agree. It's been so interesting with this past year and a half of travel restrictions and people who might've used to travel to a travel center of excellence, as an example, were less apt to do so. Hopefully we'll see a resumption of those activities and willingness to do so as we emerge from the pandemic and hopefully not too far away from now, that we'll see. Zack, we really appreciate all of your insights, your time today, wonderful conversation, so much appreciate your time, and really respect the work that you're doing. Thanks again.

Dr. Zack Cooper:
I appreciate it. Thanks for having me and really appreciate all the work you're doing with employers on improving health care in this country.

Ellen Kelsay:
I've been speaking with Dr. Zack Cooper, co-director of the 1% Steps for Health Care Reform project. You can learn more about this project by visiting https://onepercentsteps.com/.

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