# Primary Care Cures

# Episode 73: Rachel Means and Charlie Cano

Ron Barshop:

Most problems in healthcare are fixed already. Primary care has already cured, on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance, that squeezes the docs, and it's totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with us. Ron Barshop of Beacon Clinics. That's me.

Ron Barshop:

All right. What happens when a town like Temple, Texas or Spartanburg, South Carolina go 100% corporate medicine? Well, unlike a Walmart retail displacement, prices only rise instead of dropped when a big city monopoly buys every independent in the town and that's happened in hundreds of towns in America.

Ron Barshop:

So now the big system can now feed patients into what I'll call the meat of their sausage factory. Is that a big deal and does it really matter? Well, let me answer the question with a question. Why are our national outcomes rank below Croatia but a slightly better than Cuba when we spend almost double what the Swiss spend? They're the number two rank in spending per capita. It's embarrassing.

Ron Barshop:

So here's exactly what happens at the stroke of midnight the day an independent doctor sells. Sell isn't the word, it's more like a shotgun wedding because they're forced to sell. Every pressure that's brought to bear on them makes them have to leave in the independent practice from every direction.

Ron Barshop:

Well, here's what happens at the stroke of midnight. Prices double or triple or quadruple, in fact, infinity is the accurate word. And your insurance pays for it so you don't really see it, you feel it though because you have to go through your deductible. Everything just went up in double and your doctor's burnout only increases. We know it never decreases when they go work for the man. Why? Because they work for the man.

Ron Barshop:

Errors increase. We know this too. Medical errors are the number three cause of death after cancer and cardiac. We lost my wife's mom because of a medical error. Maybe somebody you loved was lost through a medical error too and maybe you didn't even know it was a medical error because maybe it was hidden.

Ron Barshop:

Okay, now there's more imaging when the doctor gets purchased by the system. Every 13 seconds, a worthless test is ordered in America and there's more hospital referrals, of course, because papa needs

more meat and to the factory. So I'm not anti-hospital. Nobody I know is anti-hospital. Tyler, Texas has a saying. They say them's good people. Hospital people are good people. They just work in a really crummy model and now with this pandemic and Marshall Plan, it gives every system a double strategic fund.

Ron Barshop:

In fact, the top 20 systems for those of us in the show know has 105 billion to match the 100 plus million they collected from the Marshall Plan. They didn't need a Marshall Plan bailout. They needed a number of a good stockbroker and a bonds salesman and a venture capital guy and a private equity people on Wall Street. They also need a number of the local country club because they're swimming in cash right now.

Ron Barshop:

Now, the bigs can finally finish what they started and by all the rest of the independent hardscrabble primary care physicians left, which is about 30% of the doctors out there. The 45% specialists that they don't own, they can finish them off to and make them part of the system because they got to have more meat.

Ron Barshop:

Independence got slaughtered by this pandemic. For the last nine to 10 weeks, they've had zombie patient volume, whether you're a specialist or whether you're an independent primary care physician and now, there's a ton of shotgun weddings being planned by these delighted hospital wedding planners that are acquiring.

Ron Barshop:

Yay! That's not a future where everyone wins guys. And today, I introduce you to the future where everyone wins. I, too, am delighted like the hospital wedding planner to introduce you because they may be, in my judgment, my important show I've done in 75 shows because my guest and her client represents a refreshing new way to buy health care and it's called Go Direct.

Ron Barshop:

So if you've been reading what I write on LinkedIn, I talk about direct contracting. You're going to learn all about that today from people that know exactly what they're talking about. You skip the middles, the waste, the administration, the hidden games, the hat tricks, and now you're playing ball directly with the providers that are delivering services without a bunch of middlemen. And it has a name, Direct Contracting.

Ron Barshop:

Direct contracting with imaging, with medications, with docs, with labs, all of it. You can direct contract with every player in that ecosystem. It makes the employer the hero and you're going to meet one of the today. And now the employee is the alpha consumer and we're all that. And the doctors are now happy prosperous and gets back to the well care, not the sick care model, gets away from factory medicine back to true care and no more machinery, feeling like you're a piece of meat if you're a patient, a doctor, or an employer even.

Ron Barshop:

So you can't do these best practices doing direct without a visionary architect, engineer and general contractor all rolled into one. You're going to meet that person today too. But first, meet a happy client, Charlie Cano started as the engineer but led now for the last 14 years as CEO of the local Wi-Fi and cable

provider called Etex. And they have a 3,700 square mile radius in North East Texas where they provide 5G digital revolution, which is Wi-Fi for your home and cable for your home. And he's been there since the fiber wars and now he's doing the 5G Wars.

Ron Barshop:

Now meet Rachel Means. She is that architect, engineer and contractor who strips out the middlemen and provides lean optimized health benefits. Consulting with a super neat little hat-trick of her own, she discloses 100% of her fees for delivering this high-value care plan. And she'll drop the costs for you very quickly 30% and as much as 60% over time below the old school plans that people are used to. Every client, yep.

Ron Barshop:

So she's a 16-year veteran who was trained in Houston, Texas at the big advisors in the Shell game maneuverings, and she worked for those large consultants and learned how to play those games. And it disgusted her. All the many, many hidden commissions weren't right in her book. So a former Gallagher guy told me that there's 17 to 20 different hidden fees built in and disclosed into the average health benefit.

Ron Barshop:

I don't know if you heard that, so I'm going to repeat it, 17 to 20 different commissions and fees are built into every employee health benefit for the broker. I didn't know that. So disgusted Rachel Means moved to bustling Tyler, Texas to set up her own shop and now she helps employers with 30 to 100,000 lives insured across all over the southern united states with Texas as Rachel's heart.

Ron Barshop:

I'm super honored to have you both on this very important show. How are you all doing today?

Rachel Means:

We're great. How are you, Ron?

Ron Barshop:

Well, after all that, are you still great? Did I overstate it?

Rachel Means:

I'm fantastic. No. You did great. You understated it in my opinion.

Ron Barshop:

Okay. Well, so why don't we start Charlie with you and how did you meet Rachel and what was your problems and your issues you were dealing with at the time before you met with her? And what's been solved since you've met Rachel?

Charlie Cano:

Well, I meet Rachel through, I guess, a new employee for her that was familiar with our company and the previous third-party administrators that were handling or consulting for us. So there was an introduction made and during a lunch hour, me being an engineer and know all about telecommunications and engineering, I like to study the details. And in that one hour, I realized that I had zero knowledge on the health care model and like you mentioned, all the hidden fees and all the lack of transparency.

Charlie Cano:

So it was very eye-opening for me to have somebody sitting across the table and being 100% transparent, telling me where all the hitting hidden formulas and tricks were, and helping me identify where we could save a lot of money and be more educated and help our employees at the same time.

Ron Barshop:

When you started the first year, you've been with Rachel now three years or four years?

Charlie Cano:

Going on four years.

Ron Barshop:

So when you started with Rachel, she initially did what to help you save on your health care spend?

Charlie Cano:

Well, the number one thing was to change PBM, so we would have a more transparent model. And for us to realize what the spin was just on medications, those are those averages are typically going to be very consistent. There's some big dollar medications out there but we just had no knowledge. We thought that we had to pay and didn't realize that there was opportunities for us to negotiate that, find some better price points.

Charlie Cano:

So that was the number one thing that she brought to the table is educating us on saving money just on the pharmaceutical side.

Ron Barshop:

Okay, so PBM is a pharmacy benefit manager in case people don't know. So we switched to pharmacy and we were able to bring costs down by roughly how much? Do you have a sense of that Rachel?

Rachel Means:

Oh, 50% immediately. One of the biggest outliers with Charlie's plan on the pharmacy side is they had no idea the high cost drugs they were spending money on. It's typical in a self-funded plan. You get the invoice. You pay it. You don't have any data and nobody tells you otherwise. So when Charlie let me look at their plan, the first piece of low-hanging fruit was that the PBM and the spend. So immediately same drugs, same access, same pharmacies, actually lower co-pays, immediately saved them 50%. And we do that year-over-year on the pharmacy plan.

Ron Barshop:

So Rachel let me ask you this. One of the strategies and I know you've got a ton of them up your sleeve to use a local pharmacy, so you can support the local Tyler community while you're bringing costs down for Etex.

Rachel Means:

Yes. So most of the time, we do a big hybrid. The big goal is to cut the middlemen out between the consumer and who ultimately pays the bill, which is the employer group. So we go to our local pharmacies. We let them price for us. Sometimes they're not competitive on the higher cost drugs and we

have to use a different avenue to source those. But absolutely, local pharmacies are dying because of the DIR fees that they have to pay to these PBMs.

Rachel Means:

So realistically, the PBMs have taken the money from these pharmacies and they can't survive. So anytime you can partner with the local pharmacy owner to deliver lower co-pays and lower costs to the company, it's a win-win for the community.

Ron Barshop:

So I don't want to denigrate PBMs but my understanding, I don't understand some of the PBMs and you do understand them. The three biggest in the country are owned by upstream and downstream people they're supposed to be negotiating with. How in the world are you supposed to negotiate with the pharmacy you're buying it from, the pharmacy you're delivering it to, the middleman you're sourcing it from? They own so many layers of this non-transparent chain, you're basically negotiating with your boss for discounts. That doesn't make any sense to me. Am I smoking dope or am I on top of this?

Rachel Means:

No. You're smoking the weed. Yeah. So that's correct. There are actually five to six layers between the drug manufacturer to the employer group who pays the invoice. And so you're right. Actually, it's the four biggest now. One actually just bought an insurance company, perverse incentives much. And then you get into the whole rebate game, Ron. When I met Charlie and his team, they had no idea 30% of their spend was supposed to be given back to them every year. No clue.

Rachel Means:

And so we start digging, where are the rebates, who's keeping the rebates? And that was another big discussion, just an education of what is a pharmacy rebate, why do we have pharmacy rebates? Why can't we just have lower cost up front? So ultimately, it's a lot of education and we spent a lot of time on pharmacy with Charlie's company just because that was just the lowest hanging fruit immediately.

Rachel Means:

And so once we got that fixed, we started moving onto our other initiatives but you're correct. You're correct. You cannot negotiate with the big PBM because it's the cartel in my opinion.

Ron Barshop:

So we had Vijay Patel, he's not part of the cartel. He was on our show. He has what he calls a transparent PBM where he says, "I'm going to take 10% from this side, 10% from that side. It's all going to be fully disclosed and there's no more rebate games, no more hat tricks, no more shell games." So do you feel sometimes like ... He made it pretty clear on the show that episode that it's kind of a game of three-card Monty. They're hiding the card from you that you think you're going to get. If you think you're getting the 30% rebate, Mr. Cano, maybe you're not getting it. You weren't even told you should be getting it. Were you a little upset when you found out there's something you should be getting you weren't getting?

Charlie Cano:

Well, definitely, definitely upset but also, a lot of shame on me for not doing the research that I needed to. I had the confidence on the engineering side but I never did study the health benefit side, which was the second highest fan that we have as a corporation. So definitely upset that there was that trust that was violated with our consultant at the time, our broker at the time. But now knowing better, which is why I love being on these kinds of conversations, when I educate all the other executives out there that your

number one or number two spending in your company needs to get the same level of attention as what your skill sets are.

Ron Barshop:

It's interesting, everybody has a senior vice-president of HR director, VP of HR. They have somebody that's in charge of the people part, which is labor is almost always going to be the biggest spend. But there's no real title, I guess CFO would come closest to it, for somebody who should really be managing this giant division called health care spend. There almost should be a chief of health care spend, shouldn't there?

Charlie Cano:

Oh, I agree with that and when-

Rachel Means:

And Charlie's become that.

Charlie Cano:

Between me and my CFO, we are the co-chiefs of health care spend because we focus a lot, and again, we owe it all to Rachel and her team to educate us on that but we definitely pay a lot of attention to that every month.

Ron Barshop:

Okay. Well, let's have some fun with my favorite subject, which is direct primary care. Rachel, when you started this idea of going direct contracting, you didn't really have what you needed. And so you've helped create a company that you don't have ownership in that is direct primary care clinics in northeast Texas, so Lufkin, in Longview and in Tyler. You now have some terrific partners there. Tell us what that's meant to you to have a direct primary care relationship that you can scale in that area.

Rachel Means:

So yeah, 75% of my self-funded block of business out in the East Texas area in northeast Texas utilizes direct primary care. And we are going on four years in that model. The number one, yes, it saves a ton of money but to me, it's the patient experience. When you have a sick child, you don't want to go sit in an urgent care clinic for an hour and a half of people coughing everywhere when you can get on the spruce at virtual. You can go into the brick-and-mortar. It costs you zero dollars.

Rachel Means:

If your child has to get an x-ray, you're immediately referred to the local imaging clinic that we have direct agreements with. It's a $35 x-ray instead of a $350 x-ray and you don't have to pay for that. The member has zero out-of-pocket costs for anything sourced through the DPC clinic, whereas prior an Etex employee that maybe has a $35,000 a year paycheck, they go and they're having to spend 100 bucks on an x-ray for their child.

Rachel Means:

And so to me, having happier clients with their employees when you walk in at their Christmas party and they hug you and tell you how great their health experience is. I don't know many people that say, "Man, I really love my health insurance plan these days." So to me and my team especially, it's a very gratifying

experience. Number one, to be able to save the client a ton of money but number two, bring the health care experience back to the consumer. That's been the biggest thing for us.

Ron Barshop:

Yeah, so let's take this now to the employee level, Charlie. The employees have no copay, no deductible, no premium. So everybody who was paying 300 or 400 bucks a month just got a raise, didn't they?

Charlie Cano:

They did, and even before the money savings, that feel good part of that story, there's a lot of legwork that has to be done upfront and that is the trust factor with your employees to maybe leave the doctor that they've been used to all their lives. They thought that the normal was to go into a waiting room for an hour, an hour and a half. And it's hard to break them away from that comfort zone thinking that that's just the way things are.

Charlie Cano:

So getting the trust and allowing them to experiment and they can go just go try this at no cost, was one factor. The emotional trust that you get from the employees but yes, definitely they got a raise. I mean just the emotional raise, which is really more important to me than the numerical, the financial one is the fact that they feel good, the morale of having better attention, a quicker access in and out is definitely a bigger game for us than any kind of $100 or $200 raise.

Ron Barshop:

Let me tell you what you and I have in common Charlie is that we're both early adopters and we're a little bit crazy. And a lot of early adopters get pioneers when they're back because they're the pioneer. They got arrows in the pioneer back, but I started a direct primary care relationship two years ago and I want to hear if your experience is similar to mine. I used to have to interview 60 to 80 to get for A players on board that I needed in this past January. On the fifth interview, my team said, "We're done. We got our four A players." I'm like, "What? What about the other 54 you have lined up?" And they said, "We're done. We got our A players."

Ron Barshop:

What do we put in our ad? Free health care. Boy, does that attract a players. Does that help you with your recruitment to have this direct primary care relationship and this no health care costs model?

Charlie Cano:

Definitely. That's one of the key components that we use to recruit employees. We have very rich benefits. We're a high-tech telecommunications provider out in rural America. We live out here away from the big cities where there's not the big entertainment and then not the big salaries that you typically would see in a big city. So the benefits definitely compensate for that and so that's been an easy recruitment. In fact, we have lines and lines of people wanting to work for our company. We have very little churn, very little turnover on our employees, which is a good thing because we do our due diligence to hire good people. And we keep them for a very long time.

Charlie Cano:

So it's a good position to be is to not have to be looking for new employees all the time, but when we do, they realize that this is a company that takes care of the employees, not only with the benefits but just the culture as well.

Ron Barshop:

So Rachel, even if you weren't saving them 30 to 60%, your clients are something what Charlie just described as essentially low to no turnover as well. I had zero turnovers for the first time in my 30-plus year career as a CEO. I've never had zero turnover. Everybody wanted a job had a job, kept a job. Are you seeing that across the board for your ... You have 215,000 clients or employees I should say of hundreds of clients. What is your experience with turnover and retention and attraction with these planes you're creating?

Rachel Means:

Well, Ron, because I work in multiple different industries, a lot of them, one of the biggest compliments that I can or my team gets is that we definitely are helping recruit and retain. It's hard to leave a health care plan when you have zero dollar out-of-pocket, zero dollar RX co-pays if you go to the local pharmacies and no deductible when you have these certain procedures done. And then you have to go over to the corporate chain that has a location here and they have a $5,000 deductible and you're a $12 an hour employee.

Rachel Means:

It's been an evolving ... It's funny because you never think about being in my space, the recruiting and retention tool of everything that you put your heart and soul into. So that's been very gratifying the last few years. I do hear that a lot more so often, just because I think of the Covid madness and everything that's been happening the last few months definitely is a huge factor in recruiting and retention. And we hear that more and more daily.

Ron Barshop:

I got to tell you, there's a sort of a society benefit too and that most of my employees are single female Hispanic in Houston, San Antonio, throughout all of Texas. That's 99% of my MAs are that. And they were on Medicaid because you can have a baby for free on Medicaid. What do you do? That's terrific. It's a $7,000 procedure for nothing, but the problem is now that kid gets pinkeye or they get an ear infection or maybe they got a urine urinary tract infection themselves. And now they've got to go into a Medicaid clinic and they have to deal with basically extremely long waits, extremely long lines, hacking and coughing and crying babies all around you.

Ron Barshop:

And it's a time suck and some people are worried about losing their jobs because it's a half a day out to check your kid out of school and go do that. And frankly, I know people that can't afford their vaccines on Medicaid because they can't afford these co-pays. So we have gotten people off Medicaid onto these plans because they, again, have no cost, free access, immediate front door access to these doctors. What is a typical wait for Charlie, speaking as a patient? You as a patient, what's the longest wait you've ever had to see one of these primary care doctors?

Charlie Cano:

Well, I just walk in the door and don't even have a chance to sit down in the waiting room when they say, "Charlie, we're ready for you."

Ron Barshop:

Are you giving a clipboard or do you have a clipboard that you have to fill out a bunch of patient history?

Charlie Cano:

No. Once we get onboarded, you're ready to just talk to the doctor, the nurse checks you out, does whatever she needs to do. And the doctor is in there within minutes. So it's been an amazing ... It's almost like being part of a private group that you feel like a VIP. So a $10, $12 an hour employee or 100 plus an hour employee is treated the same. They come in and have the same level of zero to a couple minutes wait. And they come back feeling really good about their experience.

Ron Barshop:

Okay. So you walk straight in, you get to see the doc right away. They do the pulse ox, the blood pressure, they maybe check your height, your weight, your vision and then you're talking to a doctor. And how long are you in with the doctor typically? Is it 15 minutes and he or she is typing into their computer ignoring you the whole time? Or are they giving you eye contact?

Charlie Cano:

Definitely, there's no computer in that room. They take their notes after you leave. Input all of that. So it's nothing but 100% focus on the patient. So I haven't seen any of that take place.

Ron Barshop:

[crosstalk 00:22:36] hey, move on. I got another couple of behind you today. You're fully scheduled, double booked today.

Charlie Cano:

No.

Rachel Means:

Ron, the biggest thing is have you ever had your physician just reach out to you via text on your app saying, "Hey, just checking in, make sure you got in to see your back injection guy okay. Everything fine. Do you need me?" I don't know about you but my normal physician and God love her, she's amazing but I call her at 8:30 in the morning and I get a return phone call between 4:45 and 5:00. But I'm not sitting there waiting by the phone. I have to wait a full another 24 hours to get access to that physician.

Rachel Means:

And so breaking away from that model and seeing the patient satisfaction and just the attention and bringing it back to the patient and the physician has just have been an incredible experience for me and my team. And I know Charlie and his employees truly appreciate it.

Ron Barshop:

So I'm just here to tell you having done this show now for a year and a half, that this is the consumer experience everybody that's in direct primary care finds as a patient. I can speak as an employer, as Charlie can. I can't speak as a patient as Charlie can. And it's exactly the same everywhere I am as everywhere Charlie is. And it's everywhere across the country like this. We're not describing some new whiz-bang idea. This has been around for 20 years, folks.

Ron Barshop:

So let's talk a little bit about the hospital experience. Now it's time to go see a specialist. You got to have a baby. Let's make it labor and delivery, that's the most common surgery out there. What does one of your employees have to go through now to go get that handled with Rachel, your model?

Rachel Means:

Well, deliveries are treated a little bit differently. Can we move to maybe a personal experience that Charlie had, maybe talk about like in [inaudible 00:24:19] and then talk about how we facilitated the appointments and you didn't have to go through the normal system?

Charlie Cano:

Yeah. So definitely my personal experience is not through labor, but it's been through some back problems and having back problems requires a lot of an MRI and having to schedule that. Obviously, the cost, that's ridiculous when you don't have these predetermined plans and costs. It's amazing how much the price changes but just being able to coordinate through this primary care and saying, "Hey, go to this location. Tell them that you're with us." And whenever they're ready to charge, they call that a primary care physician and they take care of that behind the scenes.

Charlie Cano:

So it's just a matter of me showing up. "Hey, I'm here for my MRI." I go through that normal weight of that facility because that's a different facility but once I go in, they take care of the MRI, everything sent back to the doctor. I mean it's almost automatic. So it's a much more pleasant experience other than having to go through the back pain.

Ron Barshop:

Well, it sounds to me like you've condensed the steps. Actually with my partner, [inaudible 00:25:35] broken down to go see a specialist in America today under the traditional old school plans. It's a 51-step, two-step. So we have a Texas two-step, now we have a 51-step, specialist two-step and that 51 steps, it starts with a fax 1973 technology. And it ends with you actually getting that back handled.

Ron Barshop:

And all the 51 steps in the middle have to do with co-pays and waiting and driving and waiting some more and driving some more and seeing people. And then it's no wonder that only 50% of our referrals actually happened in care today because it's just too much trouble. It's a gigantic time suck. So Rachel, how has that been condensed now? Can you give us a quick overview from your perspective? How does that handoff happen now to go see the ... was it in this case, an orthopedist?

Rachel Means:

Yeah, so I mean in East Texas, we know all the providers. Somebody text me, "Hey, I need my shoulder surgery repaired." I know exactly who I'm going to send them to. I know exactly how to get a hold and I say I, my team, the mouse in my pocket obviously. But if Charlie or if one of his employees needs any type of care, they know that with the direct primary care model, our team in the DPC team are 100% on board all day long back and forth.

Rachel Means:

"Hey, we have a new diabetic or hey, this guy did this, what incentive are we going to give them?" So to me when Charlie shows up and he needs a specialist, we reach out with the DPC clinic, Charlie's not on the phone or his assistant's not on the phone or his wife isn't on the phone, trying to get the record to make sure they made it there. And waiting a week to be seen by an orthopedic guy who needs to give him his back injections.

Rachel Means:

He shows up like he said, I text him most of the time and say, "Hey, just show up at 10:00 a.m. Here's where you go." He goes in and gets the care and get back to work and you're done. And so I think you're right. Those 50, I actually consider it about 150 steps if you knew everything that went behind the scenes leading up to that visit have now been condensed into one. Charlie showing up to get the care that he needs and then going back to work.

Ron Barshop:

And there's no more surprise bills. There's no more out-of-network billing because there is no coding and there's no billing with the primary care side. But on this other side, that's all paid by the employer. So the contracts are negotiated ahead of time even when the complications to negotiated ahead of time. So you're not going to have pay $76 for an aspirin or $120 for a piece of toilet paper. You're going to basically be getting everything you need ahead of time contracted.

Ron Barshop:

So this direct contracting and not only close to the doctors and the pharmacy, we've talked about already but it flows to these surgeons and the hospitals too, doesn't it?

Rachel Means:

Correct.

Charlie Cano:

Well, and even when there is let's just say again, we're dealing with these other clinics, these other employees and there's going to be human error on that side of it because they're having to manage so many different plans. Even when there is human error and they do code it incorrectly, and there is some over billing, it isn't the experience that now that's on me, that's on my family. We get turned into collections. It's addressed. We give it back to our consultant Rachel and her team and they go in there and they reeducate that administrator on this is the way you need it coded. This is the way you need to turn in.

Charlie Cano:

And along that, it follows the proper procedures and it gets taken care of. So it's not this headache of oh my gosh, we're in [inaudible 00:29:00].

Ron Barshop:

So Charlie, 70% of your employees and my employees, in fact, all of America are making less than $20 an hour. And these are folks that can afford maybe a $400 premium but they can't afford a deductible or a copay. And so really only 80% of Americans are functionally uninsured. The other 20% are in what I call the Country Club of Karen and it's a good life. But the 80% that can't afford to go see a doctor, it's a shame. Are now more of your employees able to afford to go see a doctor because they don't have any premium copay or deductible?

Charlie Cano:

Yes. 100% of my employees are able to do that and we don't segregate, we don't separate the plan. We don't make it a VIP version for me and my executive team versus the others. We all are on the same plan. They all get the same level of care and again, I designed everything with my lowest paid employee in mind because we want them to feel that they're taken care of.

Charlie Cano:

Now regardless, they're eventually going to grow and evolve in the company and make more money. But when they first start out, they are going to be a $12, $15 employee and it takes some steps to get on get on up but they're all going to get, what I would consider, a VIP health care plan.

Ron Barshop:

So folks, there's nothing that grates my teeth more than when I see really brilliant people in health care talking about we need to, we got or we have to. And Rachel, I know you feel the same but we don't need to have more transparency. We need more Rachel Means out there because there is transparency when you bring a broker and adviser, a contractor, an engineer and architect all in one human body, that can transparently not only price the care out there but they're on fees.

Ron Barshop:

We don't less burnout for doctors. We don't got to have to have more burn out. We have less burn out with direct primary care in Tyler, Texas and throughout the rest of the country with about 2,000 doctors and it's growing fast. We don't need to got to have to have less surprise billing. We have no surprise billing with this model. So Rachel, do you agree with me that a lot of the things people think we need to got to have to have are solved by you and your solution? And Charlie, would you agree with her?

Rachel Means:

Yeah, Ron. I think you're right. We've all been waiting on some type of solution to come to the market for a long time. And when you get tired of that model, that just is a vicious cycle of insanity, let's increase deductibles to lower our cost. It doesn't work. So when you jump ship and you start digging through the actual data and you can find the transparency yourself, it's only going to help your block of business and your clients as well. So I think you're right. I think we can't sit around and wait for a government solution for health care. We're not there and I don't foresee it's getting there anytime soon. So I absolutely agree with that statement.

Charlie Cano:

Well, and the obvious answer is I would agree with Rachel, but I'd also like to add as a CEO, you have to be engaged. You have to be all in on this model and communicate to your employees. A lot of CEOs, they just kind of categorize some of their expenses as out of sight out of mind. I'm not worried about that. I think that the CEOs that are truly operating on taking care of their employees and looking at the bottom line, they're going to have to be engaged in this in order to partner with somebody like Rachel.

Ron Barshop:

So I had Paul Johnson on my show many shows ago who was a drywall contractor working in this model in Arizona. And he has about 1,000 or 2,000 employees depending on the seasonality of the home building. I'm asking you the same question, Charlie, could you ever see yourself going back to the old model again for any reason whatsoever?

Charlie Cano:

No, not at all. I can never see myself going back to that. You have the ultimate control under this model. Why would you want to give that up?

Rachel Means:

Well, and I think, Ron, there's a saying that I've had a couple of clients, it's funny. When you know what you know, what it's hard to un-know it. And once you figure out the shenanigans that happen behind the scenes and where all the money is buried between the ultimate payer, which is not an insurance company,

the payer is the employer group. And once you open their eyes to that and show them the transparency that they can have, how are you supposed to go back to being put the blindfold on? I think it's impossible.

Ron Barshop:

Yeah. You can't unmake that bed. I'm going to make a statement, Rachel. I can tell you, Clint Flanagan who's been on the show with NextEra health has 100% renewal rate. He's the largest DPC in the country with 60 locations and well over 100 docs. He's scaling this with school districts, with high tech employers, municipalities and school districts. And I know that your renewal rate is not as 100%, it's more like a 105% because again, once you get in with Rachel, it's hard to go back to the old. In fact, it's impossible to go back to old. That's why Charlie you laughed, it's because I can't imagine ever trying to hire an employee again with $500 deductible and a giant co-pay and a ridiculous amount of care that gets pre-authorized and gets basically shifted to the risk it shifted away from the insurance company. I can't see that but it's almost like getting served old turkey at Thanksgiving. Nobody wants that anymore, it's old. That doesn't taste good. That didn't smell good.

Ron Barshop:

So let's talk about this new, super exciting ... I don't know if we're making an announcement on the air or not but I think there's something being created that has never been created in America before that I'm aware of. And we're going to call this a community health plan and this is where the local businesses in Tyler and the county and the city are all getting together to build and own their own care center, their own hospital. Am I right, Rachel?

Rachel Means:

Yeah, something to that effect. We're not quite there yet but the first step is getting the employer groups locally to communicate and talk about the transparency and health care. It's amazing to me how a community with all these local private owned employer groups, government funded groups. They communicate about roads and bridges and fiber and water, but they don't communicate about their health care plan. It was incredible when I moved out here.

Rachel Means:

And so really, getting everybody to where they're communicating, "Hey, what are you doing in your health care plan? Hey, what are you doing?" And Charlie, they're in Gilmer, Texas out in Upshur County. And I was introduced to the county out here that was just hemorrhaging money on their self-funded plan. And so really getting Etex, the county, the city, everybody just onboard to just have a discussion about, "Hey, bringing local community health care back here is what's going to save the employer groups."

Rachel Means:

And we've been very successful for the last couple of years at opening the door to even discussing that, and getting everybody semi on the same model. It's just been very eye-opening that again, communities don't have these discussions between the largest employers. So I think that's really important to look at community by community and especially in our state of Texas that is very local friendly and keep it local type of mentality.

Ron Barshop:

You and I were on the phone call yesterday morning with the gentleman who's a very wise and savvy businessman. And we were in his family wealth office and he said, "Well, this is a great idea but it'll probably only work in small town America. This isn't going to work from the big city." What do you think about that?

Rachel Means:

I think small town America is very easy because you do have that locally owned mentality. I think when you get into major metropolitan areas Houston, Dallas, essentially in Houston. I lived there for 16 years. You can drive 90 minutes and still be in Houston. So it's doable. I think you'd have to have a couple of the large employer groups pull together first and talk about the locality, the geography of where you put a deep clinic but it's doable. There are people doing it in the smaller suburbs of the big metroplexes. I just think that the more local communities that support local are susceptible to that model and plus, let's think about it. Rural America, they're the ones that are hurting the most when it comes to health care.

Rachel Means:

When you have a $28,000 to $35,000 in your employee that has a $3,500 to $6,000 deductible, they're effectively insured. So I just think the easiest model would be in the smaller communities in [inaudible 00:37:31].

Ron Barshop:

So can you imagine Charlie, you're sitting in a room with a CEO with a company with not 100, not 1,000 but 100,000 employees. Is there any reason they should not go to this type of a plan? Is there some hitch in the get along we're not talking about that they should be aware of?

Charlie Cano:

No, there's no reason why they shouldn't go to this type of a plan. Again, I think that sometimes those executives may have a lot more blurred vision because their focus is elsewhere. But if they really pull back the curtain and see what the opportunities are, there's no reason why they shouldn't move forward with this type of plan.

Ron Barshop:

So just keep the math simple, Rachel. If somebody has $15,000 spend in their health care, which is pretty typical in America today for a single employee, a third of that is $5,000. Can they take their 1,000 employees times 5,000 and do the math that that's a $5 million savings? Is that about right?

Rachel Means:

Correct, yes. Exactly.

Ron Barshop:

Okay, all right. So if I have 10,000, that's obviously $50 million savings and $500 million savings if I have a 10x of that.

Rachel Means:

Well, Ron with that math, you can also add that you're putting extreme amounts of money back into your employees' pockets. I think that's one of the biggest pieces that I've learned that a CEO wants to hear is that, "Hey, we haven't had more than 2% to 5% raise in three or four years and now all of a sudden, we've got a bucket of money that we can share with the employees." Which is what Charlie does and that's why the culture at his company is just so incredible.

Rachel Means:

Again, when you show up to the Christmas party and people want to hug you because they're health care's so great, I just point to Charlie and make them go hug him because of Covid, you know.

Ron Barshop:

Charlie, leave me alone.

Charlie Cano:

[crosstalk 00:39:09]

Ron Barshop:

I got to tell you. So Commonwealth Fund did a study of the actual raises that people have got in the last, I don't if it was 11 or 17 years. I'm a little dyslexic on that number but I think the average employee has seen zero increase in their wages because health care and inflation has taken everything away from them, that they've got.

Rachel Means:

Yeah, correct. When you give them a 3% to 5% raise for the year but then their health care deductions have gone up 20% in their deductibles effectively going up 50% over three years. Do the math. It's very simple.

Ron Barshop:

Yeah. All right. Well, this was as I said, the most important interview I've ever done because this interview can literally change lives. It can get people raises. It can solve a lot of retention and attraction problems for us employers. But most importantly, this really saves America because it brings health care back to direct contracting. And it gets rid of all of the fluffy middle that's costing us about a trillion out of a $3.8 trillion spend, at least a trillion maybe more.

Ron Barshop:

Have you ever played with those numbers, Rachel and figured out how much money we're wasting in health care because of this gigantic administrative burden?

Rachel Means:

Are there any other states other than Texas, Ron? I don't know.

Ron Barshop:

Yeah, no.

Rachel Means:

I had played around with it definitely with the state of Texas, especially the government-funded health plans. That's a big deal in the waste. I'm not going to go into specifics but yes, I have played around within Texas. And on the government-funded municipality and school district health plan, there's about 40% over spend. And we're cost shifting to our teachers, which is, in my mind, a tragedy. You're shifting costs and not giving increases in wages to the people that are supposed to be educating our children and that's a problem.

Ron Barshop:

Yeah, this is bankrupting schools. It's bankrupting cities, counties, labor unions are upset. And I got to tell you, there's a lot of people marching on streets in America right now and maybe a week from now. And this post will still have people marching in America. I think the anger is this country club of haves and have-nots. It doesn't have to be that way.

Ron Barshop:

When you work for Etex or any of Rachel's employers, the country club is everyone, the CEO and the dock worker are in the same clinic getting their treatment. There's no special deals. That's the beauty of this whole model.

Ron Barshop:

So Rachel, we've invited you in a couple of more shows. We, like Saturday Night Live, give a bathrobe to someone who's been on three shows. And you'll be there in two weeks.

Rachel Means:

All right.

Ron Barshop:

So we have two guests that have hit in that number and we're looking forward to meeting some of your other friends that have done a really highly successful job in turning this machine. You've turned on into a new movement that's really changing America. Rachel, how can people find you if they want to get in touch?

Rachel Means:

Drive to Tyler, Texas. No, I'm kidding. You can go to my website, www.ebctx.com. All of our information is posted there and I'm on LinkedIn, Rachel Means. Follow me there. I've got some pretty good case studies I put out weekly.

Ron Barshop:

Yeah, Means, it's just like it sounds like. And then if you could fly a banner over America with one message, what would your message be?

Rachel Means:

Oh gosh, banner over America. Health care is not scarce and expensive. You just have to dig through it.

Ron Barshop:

Charlie, how about you? How's your banner looking?

Charlie Cano:

Man, the banner would be, "It's all about the employees." Just take care of your employees. And if that's what your focus is then you would migrate to somebody like Rachel.

Ron Barshop:

Very good. Thank you all very much.

Rachel Means:

Thanks Ron.

Ron Barshop:

Yeah, thank you Charlie and thank you Rachel. And we'll talk to you again very soon.

Charlie Cano:

Thank you.

Rachel Means:

All right, thanks.

Ron Barshop:

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