Primary Care Cures

Episode 75: Dr. Lee Gross

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:

Well, we all know that high deductible health insurance has forced 80% of Americans into the functionally uninsured category. They may not have $450 even in savings, the vast majority of them. So a $5,000 deductible plan looks like a million dollar deductible plan. So it feels like to these folks, the majority of Americans that are in under $20 an hour, like the rest of us are in a country club. There's a 20% club of those that are in the care net, and there's 80% that are out. So it feels like a tree house of care, a have or have not. And I think some of the anger on the streets that we're seeing in the headlines has something to do with the have and the have not, and it's not a good thing. So not the case with employers who direct contract with primary care, with imaging, with whole field pharmacy, with specialists like surgeons and labor and delivery and with labs.

Ron Barshop:

Everyone above has a cash pay rate. That's why navigators exist to get people through this cornfield crazy maze called the American healthcare system. Who wins with direct contracts? Well, employers will say 30 to 60% and now have control of retention, engagement, and attraction of good people, and benefits like healthcare are no longer a painful out-of-control burden, but a toolkit to get and keep the best of the best. Ask anybody who direct contracts with primary care or any of these other pieces of the ecosystem if they'll ever go back to Legacy middleman heavy healthcare. We talked to the CEO of Etex, which is the utility in Tyler, Texas on a couple of shows ago. And he laughed when I asked that question. We talked to Cole Johnson of PJD Drywall a few episodes ago, and he laughed when I asked that question.

Ron Barshop:

Once you go direct, you can never go back. It's like asking a kid to give up her game controller. So if you have a daughter or son and you say, "Give up your game controller." They're going to look at you like you're nuts. That's the vibe I get when people think about losing their direct contracts. So, "Over my dead body." Well, so adios handcuffed HR Mavens, I have zero turnover now once I've got all my team on board with direct primary care, a subset of this direct

contracting we're talking about today with the larger health ecosystem. Employees eliminate friction like time sucks, like deductibles and copays and waits to see for weeks or months or hours in a gross crowded Medicaid waiting room. Adios DMV experience, hello app. They get the most meds now by telephone or by app. They get their tests by telephone and by app. It all gets set up nice and elegantly for them and it's just a beautiful thing.

Ron Barshop:

So the most important thing that really has happened though is what I call a sacred trust. A sacred pact that's between the doctor and the patient. That exam is sacred and was before high deductible healthcare got in the way. And the absolute backbone of a good health care is a great doctor-patient exam with time to do the proper questions. And the second sacred promise is the employer-employee promise that with good insurance once upon a time, your finances were safe. With good insurance once upon a time, your health was safe. And now with surprise bills and 70% of the medically bankrupt having health insurance, it's not safe anymore. So those two sacred pacts are restored when you direct contract. And the third person that's the winner, so we talked about the employer, we talked about the employee, now we're talking about the doctors. So I call this the golden triangle.

Ron Barshop:

The doctors now eliminate burnout. Direct primary care conventions are the happiest conventions in America according to four of our guests that have been on this show. EHR mandates adios, modern day equivalence of coal mine gigs, adios. So instead of getting black lung in a modern day coal mine called a hospital, now the risk is white lung. You get fibrosis from C19 and it looks like a snowdrift under an X Ray. It's terrible. No one knows more about direct primary care than our guest today. He's a buckeye in a case Western reserve University of School of Madison graduate. He was elected Chief Resident of his family medicine residency program at university hospitals in Cleveland. I'm sorry about that, Dr. Gross. You have to live in Cleveland. Oh my gosh.

Ron Barshop:

So Lee gross is a pioneer and thought leader in the direct primary care movement. He's testified at the US Senate. He's been at The Heritage Foundation speaking, he's conducted meetings with the leadership of CMS, HHS, labor, treasury, white house, it goes on and on. And he serves as the President of Docs for Patient Care Foundation, a national health policy think tank of practicing physicians who are committed to the establishment of an American healthcare economy, which reserves the sanctity of that sacred doctor-patient relationship. So D4PCF is the nickname, is the leading educator of DPC physicians around the country. It has trained over 1000 in the Direct Primary Care model. And Dr. Gross serves on the board of trustees for an HCA hospital where he lives near Arcadia, Florida. And he's also a delegate to the Florida Medical Association, and is a recipient of HGA's very first Humanitarian Frist Award, named after Senator Frist. Some of you follow him in his podcast.

Ron Barshop:

He's also received the Free Market Medical Association's Beacon award, they were on our show a couple of weeks ago, for his leadership in the healthcare market reforms. And he's president, if that's not enough, of his County Medical Society. Welcome to the show Dr. Lee Gross.

Dr. Lee Gross:

Well, thank you very much for having me. That's quite the introduction.

Ron Barshop:

Yeah. I'm out of breath. So I'm kind of done. Thank you for being on the show. We don't have any time left now.

Dr. Lee Gross:

Yeah, that's right. It's been a pleasure. I enjoyed it.

Ron Barshop:

Well actually your name is not new to this show because Carl Schuessler was on three shows ago and Carl talked about Acadia Florida and how you brought them in and how they saved a 1,200,000 for what was a four-star, but not failing hospital, but one was on the brink of disaster. And how the two of you together necessitated that hospital back to health with direct contract. Do you want to just talk about that a little bit and tell us your piece of that?

Dr. Lee Gross:

Yeah. So my piece of that is I've been working with DeSoto Memorial Hospital, which is a rural hospital in South Central Florida. It's a 49-bed hospital that happens to be in the county that is the sixth poorest County in the state of Florida. So a community that has a 50% uninsured rate, migrant farm worker population, and essentially a place where a lot of people sort of left to get their healthcare. And what we have done with them is started working with them to bring surgeons from out of the area to do cash based surgeries in their facility and charging lump sums and bundle surgical pricing. So we actually had one of the first hospitals in the country where you could have a cash bundle for hip replacements, knee replacements and so forth. And we started bringing patients to that hospital from all over the state of Florida to have procedures done, uninsured patients, self-funded patients, health sharing ministry patients were coming from out of the community to have stuff done there.

Dr. Lee Gross:

And so we developed quite the relationship with the hospital, with the administration. They were very familiar with our general practice model which was price transparency and direct primary care. And when we sat down and started talking, we realized that they were just wasting a ton of money in their health plan. They were self-funded, but they were self-funded through one of the large industry players that basically really just charges a whole lot of money for not a whole lot of value add, and said, "We really need to reconsider how you guys are doing your employee health benefits." And that's where we had the opportunity to bring Carl in, and together we deconstructed and reconstructed a very consumer-friendly and physician-friendly, employee-friendly health plan, that as you mentioned in the first year alone, going from self-funded to self-funded, we saved them $1.2 million.

Dr. Lee Gross:

So that was a 54% reduction in the first year in their health spend. We're now almost six months into our second year of that project, and the numbers we just ran were astronomical. Because we still have patients that are on the direct primary care side and the patients that choose not to participate in direct primary care. And the medical claims on the direct primary care side are still about 50% lower, even when you factor in the cost of the direct primary care. It's just been a spectacular experiment for us.

Ron Barshop:

I can do the math. It looks like a $41,000 savings per bed at a hospital. I think any hospital would take those kinds of savings for just rethinking how they engage the local community.

Dr. Lee Gross:

Yeah. It's been spectacular, and in essence what we've completely done, you had mentioned in your introduction about reducing deductibles, so what Carl and I did was we eliminated deductibles. There are zero deductibles if you have anything done as an employee of this hospital. So if you go to the hospital and have surgery, if you have an MRI, if you have a CT scan, if you have blood work, there's zero out-of-pocket cost. If I as a physician order any tests, I had zero requirement for getting prior authorizations and approvals. Why pay a nurse to oversee the doctor? Trust your doctors. And so we built the plan around trusting the doctors to be doctors, and incentivizing and encouraging the employees to get their care locally. And what we did was we switched almost the complete outbound foreign medical spend to about 80% domestic spend, which essentially for this particular employer, as being a hospital, it's essentially their right pocket paying their left pocket to have the care done.

Dr. Lee Gross:

It has been an astronomical change for this community. And when you now in a rural hospital see all of the employees in the hospital getting their care at that hospital, you see patients from around the state coming to that hospital to have care done. It completely changes the perception. That's what I would tell you is that last year, despite the fact that hundreds of rural hospitals around the country are shuttering their doors, last year was the best financial year that this hospital had ever had.

Ron Barshop:

Wonderful news. Every 10 days a rural hospital is closing its doors and a majority of those or a disproportionate share of those are in Texas. We have over 50 counties with no doctors, which means we have over 50 counties with no hospitals, no clinics. So we have another 50 counties with maybe one rural doctor. He's probably the local vet too, for all I know, but it's not healthy for a county when a hospital shutters. That's one of the reasons that counties go dry of people is because it takes too long for you to have a baby or get care if you break a leg, it's just, it doesn't make sense to live in that county anymore and people just eventually move.

Dr. Lee Gross:

Yep. You are absolutely correct.

Ron Barshop:

So let's talk about DPC, our favorite subject. I discovered this show started out as a challenge to find is there a holistic solution that takes care of the doctor, the patient and the employer in one fell swoop? And I can't find anything out there, Lee Gross, other than direct primary care is that answer. Do you disagree with me?

Dr. Lee Gross:

I think we built the perfect mouse trap, quite frankly. So I don't disagree with you one bit.

Ron Barshop:

Here's what I don't understand though. I don't understand that direct primary care has a couple of thousand doctors according to the DPC coalition, which you're involved with, but out of those 2000, the only couple of doctors that I can find that are scaling this for employers, primarily employers, because it appears just when I had people like Josh [inaudible 00:11:30] who's a supporter of yours on our show, it appears that the average DPC has 80% local social media, we'll call it business to consumer, and then the other 20% is business to business. So they're selling the local plumber, the local roofer, et cetera, the local church.

Ron Barshop:

But we also had Clint Flanagan on the show and he has 80% of his members in Colorado are employers. So I wonder if DPC can scale better from zero to 2000 over 20 years. And I wonder if it could have been 20,000 if we were more focused on scalable employer based models like the Colorado model. What do you think about that?

Dr. Lee Gross:

Yeah, I have mixed feelings about that. First of all, I would tell you that it took Starbucks 17 years to get to 17 stores. So for us to go from essentially a handful of practices to well over a thousand practices in 10 years is a fairly scalable process, especially into a very, very strong headwind of healthcare reform and affordable care act when people are penalized as they sign up for these programs. So I'm not sure I will completely fold my hand on the fact that it's not scaling as it is.

Dr. Lee Gross:

And then when you consider the tax considerations of this as well as it has also sort of faced a strong headwind. But unless the DPC practices embrace employer-sponsored healthcare, I think they're going to have a really hard time making this the primary care delivery model. I agree with you on that. The challenges that you have in this market space is that DPC doctors by nature are shunning third parties. The DPC movement is born in getting out of networks and dropping third parties in the middle of it. And so when you are trying to scale this through a large entity, you are essentially putting another third party right back into it, and ineffectively, you're asking these primary care doctors to sign capitation agreements. And before you know it, if it's not done properly, you've just basically recreated Kaiser Permanente, you've recreated the next generation HMOs, and essentially you're getting right back to the same problems that we left behind.

Dr. Lee Gross:

So it needs to be done thoughtfully and it needs to be done in a way that does not insert a new third party entity in the middle of that, that's determining everything.

Ron Barshop:

Capitation, I think, is dangerous. When I've had my value based care guests on, they all pretty much agree that letting a stranger set your capitation rates is just your road to disaster because eventually they'll capitate you down to zero. I mean, you look at MRI reimbursements, one of my business partners was getting 1600 outside the hospital, and now she's getting two or $300 for an MRI outside the hospital. So she just got capitated down to death basically, and you and I can both name dozens of verticals in healthcare that have been capitated to death.

Dr. Lee Gross:

Right. Yeah, but as you mentioned, if you're setting your own rates, and those rates make sense I know plenty of imaging centers around my community that if they had an option to be paid $500 by a commercial carrier or $250 by the patient cash at the time of service, they'd take the 250 all day every day.

Ron Barshop:

What is it about this... I'm going to call it almost like a religious fervor about cost savings to pass onto the patients. I get from speaking to all my guests that have been on the show, there's been five DPC docs, that they all have a fervor to find wholesale rates for this, and I'm thinking of pharmacy, the best possible rates for imaging and pass that on to all of their members. Where did that fervor start? Is that just sort of a natural outgrowth of a libertarian movement? What birthed that? You've been around for a long time, what created that?

Dr. Lee Gross:

What created that was it was driven out of pure need. So you can imagine that this business model that charges a small flat monthly fee, like Netflix, attracts a lot of uninsured patients. And when you're left as a physician having an uninsured patient that needs something done, you are forced to solve that problem for them or the patient's going to go without. So you realize that as a primary care doctor, what are you going to need to take care of this uninsured patient? You need access to affordable labs, affordable imaging services, affordable physical therapy services. And those are sort of the first logical things that we did. So when we approached the national laboratory and said, "Hey, if we could collect the money upfront when we order the lab, and then you sent me one bill for 500 patients, instead of you sending 500 patients bills and trying to collect from them, what could you collect? What could you [inaudible 00:16:15] the labs for?

Dr. Lee Gross:

And we were seeing 95% reductions in their charges, because from a lab's perspective, if you ask them what is the most costly thing they do, they would tell you the most expensive thing is human labor to track down claims and to get paid. The actual performance in the lab test is dirt cheap, so they can give those away for practically free. And then the next logical step from that is now that you have affordable labs, affordable imaging, affordable pharmacy services, affordable therapy, these patients eventually are going to need a stress test, they're going to need a surgery, there may even need a hospitalization. And so over the last decade, we've essentially

built an entire cash-based economy in healthcare here in Southwest Florida. There's very little except for an acute care extended hospitalization that I don't have a cash price on.

Ron Barshop:

We've had two gigantic announcements in the last seven days, here we are in the end of June. And the first one was the IRS is now seriously taking a look at deducting direct primary care membership fees just like you would health insurance. And they're also doing the same for these sharing arrangements like Siddhartha Health. So that's a pretty good move, and I think you've been working hard on that for a long time, haven't you?

Dr. Lee Gross:

Yeah. We've been working with the White House, with the Treasury Department, with Health and Human Services. We've been there for many, many, many years. We've been going back and forth with them. And on June 24th, one year ago, almost to the day to day, I was standing next to the president as his guest, as he signed the executive order that put this in motion. I can tell you that it probably took at least a dozen meetings with the white house prior to that, to make that a possibility. And the rules just released basically last week, it was not perfect, but boy, it was a monumental step in the right direction.

Ron Barshop:

The other big announcement this week was that and Dr. Marty Makary was on our show this past month. And he's standing right next to the president as he's announcing this transparency victory in the courts, the federal judge ruled that the hospitals indeed have to actually get their Excel spreadsheets out to the public. They can now have to see what their pricing looks like. Now they pushed back in their press release and said, "Well, there's hundreds of thousands of cells. How are the people going to read and understand it?" Well, how about you post your price? Just post your dang price. You're all in... Right? Not that hard.

Dr. Lee Gross:

And what they're not expecting the hospitals to do and patients to do is shop around for their heart attack. What the administration is essentially doing is saying, "Look, give us 30 to 50 of your shoppable services and your MRIs or X-rays or lab work. Tell us what a hernia surgery costs, and face it to the public. And, Oh, by the way, we want to know what the insurance companies are paying for those services, not what you're charging for them."

Ron Barshop:

I don't mean to get political here, but this seems to be a very DPC friendly, libertarian friendly, freedom friendly, transparency friendly administration, both from the regulatory perspective and from the office of the White House. And I'm not smoking dope, am I?

Dr. Lee Gross:

No, I think you're dead on, and if you look at the people that the White House has working in creating these rules and coming up with policies, their background isn't exactly that political sphere.

Ron Barshop:

It is interesting that... So Katy Talento again was on our show a few months ago, and she said that now the chiefs of staff have not worked together on a common bill for so long that they don't know how to do anything but carpet each other. So they literally have no training for Congress to get stuff done, other than to give away our tax money to the hospitals or with a pandemic. But they do not know how to craft legislation that is DPC friendly or libertarian friendly or free market friendly. So it almost had to come from the regulatory authorities and it had to come from the white house. You can't get stuff done in Congress anymore it seems.

Dr. Lee Gross:

It's almost impossible, and obviously this is such a supercharged issue with so many third parties that have gross financial mis-incentives to not do the right thing in this, that even a good bill turns into a bad bill very quickly, because people want to put restraints on things. Direct primary care is not a popular thing within the general insurance community. Even people that you would think would be putting forward friendly legislation, put forward pieces of legislation when you actually read the bills and track down the references within these codes, is quite harmful to the direct primary care movement.

Ron Barshop:

Also folks, while you're doing your summer reading and enjoying your delicious novels by the swimming pool, this gentleman is reading tax bills and legislative bills-

Dr. Lee Gross:

You have no idea.

Ron Barshop:

Oh my God, how many pages have you read Dr. Gross? This has got to be ridiculous.

Dr. Lee Gross:

Thousands. I mean it's thousands and thousands of pages. And just to track all this stuff is just... Things look so innocuous when you just look at the bill. And your eyes just skim over the tax code that it's referencing. And when you look into the tax code and you realize that the bill that's... Specifically I'll point to Senator Cassidy's bill. He's a very big supporter of direct primary care, and I appreciate his support over the years. But the bill that he's promoting, basically codifies direct primary care as health plan. And you have 28 States that have passed legislation that says that direct primary care is not a health plan, and it's not going to be regulated to as a health insurance product. Well, when the federal government passed legislation that says it is a health plan and it's codified in the tax code as a health plan, that creates conflict between state and federal law.

Dr. Lee Gross:

And it also, the states that have not passed direct primary care protection now look to the federal law and say, "Well, we need to regulate this as an insurance product." It's quite harmful. And then they go on to put in caps on how much the practice is going to charge. So you talk about a

third party that's setting your capitation rates. What if the third party is the federal government? That would be the first time ever in recent history that the federal government would cap how much a doctor could charge for their own services.

Dr. Lee Gross:

So those are the types of scary things that sort of keep me up at night, because once we introduce those precedents into... If you're taking the most affordable thing in the country, the shiniest potential future solution to healthcare, and the first thing you do in response to that is you cap how much they can charge for that, that just blows my mind that that could happen, but we are very close to that happening.

Ron Barshop:

So that's in the IRS proposals, is the cap?

Dr. Lee Gross:

No, that is in a bill introduced in the US Senate and has also passed the United States House. It was also bundled into one of the COVID relief packages, but was stripped out the last second.

Ron Barshop:

Does it have a leg, since it's something that might pass?

Dr. Lee Gross:

Anything's possible right now with these must-pass pieces of legislation. So, that's something that could go into a COVID release package, it's something that could go into a budget bill. But frankly with this internal revenue service rule that just came out once that's finalized, we only really need one line of legislation to make this entirely perfect. And that one line of legislation just needs to say direct primary care is not a health plan. I will tell you that the Internal Revenue Service rule that came out, it does make reference to direct primary care being a health plan, which does create challenges with contributing funds to your health savings account. But it opens up opportunities with health reimbursement arrangements, flexible spending accounts, Medicare savings accounts, general tax deductability. So it moves the ball 99 yards, but it doesn't take it across that goal line. We just need that designation that it's not a health plan to clear up the HSA issue.

Ron Barshop:

Well, one thing I noticed about DPC on this COVID crisis is that the numbers held fairly steady people. I think over 88% of DPCs have [inaudible 00:24:19] or some other apps that you can text or have a secure way to reach your doctor by telehealth. The vast majority of members didn't go away in this crisis, whereas a fee for service just completely got decimated. I know because I'm in that world with my allergy clinics, but it seems like value based care and DPC were the big winners on primary care front with this crisis. Does that resonate with you?

Dr. Lee Gross:

It absolutely does. And I sort of describe it as right now, we feel like we have survivors guilt. We are in this pandemic that decimated all of our friends' practices. It decimated the primary care practices. Half the primary care practices in the country are near insolvency right now, because they're in a fee-for-service model, and we're in a growth mode. We continue to grow. We lost 12 patients last month and added 22 in the midst of a pandemic. Even when patients lost their jobs, they still maintain their memberships in our practice. They didn't lose. And we're adding two more physicians to our practice in the next several months.

Dr. Lee Gross:

Again, we are at capacity and needing to grow to accommodate the demand for the practice. If you look at our work that we did with this rural hospital, frankly, they lost so much money from shutting down of elective procedures and people being afraid to come to the hospital, that had we not saved them that $1.2 million, that hospital would also be boarded up right now. And the ability to do that telemedicine with a rural population has been fantastic.

Ron Barshop:

So do you think that we would have more DPC docs jump into this new arena if they didn't have to get a whole new load of debt? I mean, they're sitting on, if they're a new resident, maybe 250,000 or less of debt, and now they've got to take on maybe another 50 or 100,000 to start a DPC practice. Is that the hitch they get along for DPC transitions or is it something else?

Dr. Lee Gross:

No, I think it's just general fear, and that this is an insurance based society and people are addicted to their insurance and they want to use their insurance for their healthcare. DPC practice says, "We're not going to take any insurance. It's difficult, and so I think we have to overcome the fear of that. There's a lot of education that's going to be involved, but I think fortunately or unfortunately we're at a perfect storm right now where we have 32 million Americans that are out of work. Those 32 million Americans oftentimes got their health benefits through their employer, and now we have half the primary care practices in the country near insolvency. So if you've got docs that need to reinvent their practices and patients that need access to affordable healthcare, that is the perfect match. And we should be doing our best to flip all of these primary care practices to DPC practices in the next year or two.

Ron Barshop:

So do you think that this is a movement that is going to start increasing dramatically and we'll see a lot more movement, much faster growth in maybe 200 practices a year?

Dr. Lee Gross:

I do. I mean the rate at which it's growing right now is astronomical. I hate to sort of get into the politics, but I think one of the things that sped up the growth of our practice very rapidly was elimination of the individual mandate penalty for patients not buying an insurance product they couldn't afford. And so once they did that, patients signed up in droves because they could afford us. If that penalty gets reintroduced back into this mix and you penalize patients for signing up for our practices, so they can either afford their insurance plan or they can afford their care, but they can't afford both.

Dr. Lee Gross:

They were having to choose between an insurance product that didn't cover anything or the actual care they needed, and they were getting penalized for not doing it. So if that comes back, I think DPC is going to have a very difficult time in the next few years, but we shall see how that goes. And now if we continue to work with the employer-sponsored health plans and continue particularly with the self-funded community, the ARISTA plans and the flexibility that those have, I think the sky's the limit.

Ron Barshop:

Here's my concern about self-insured plans, is they're mostly 300-plus employers there. So you're talking about maybe a thousand lives with the kids and their spouses. They can't afford to go to a DPC who might have two or three locations in Houston or Dallas or Austin. They need somebody that can go state-wide. They need someone that can go Texas-wide, Florida-wide, Georgia-wide. And most DPCs, I call it kind of the lemonade stand mentality, they have a practice. Maybe they have an alliance with a couple of practices, but it's not a consistent offering, it's not a consistent pricing. Employers don't want to have to cobble something together. They want something turn-key.

Dr. Lee Gross:

We are working on that turn-key solution for you that keeps all the independent doctors independent, but also allows them to all function as one cohesive unit for inclusion into an employee-sponsored health plan or employer-sponsored health plan. So stay tuned for that one.

Ron Barshop:

So, that looks like some kind of an Alliance? Is that an announcement that we can expect soon? Or what does that look like?

Dr. Lee Gross:

That looks like a combination of all sorts of things, but it's definitely a technology platform and a way to... You imagine sort of a bee colony where every bee basically performs its own individual function, but cohesively they all sort of work together towards a common cause. They don't necessarily know that they're doing it, but they are. And so we are working on the platform that has the ability to incorporate all the price transparency, the independent practices. And because when you're trying to get all these independent DPC docs into a health plan, they all have to perform the same services, they all have to charge the same amount, they all have to have set hours, they have to set services, set ages, and you're just not going to get that out of a thousand independent practices.

Dr. Lee Gross:

You have to have them have the individuality, and it's the market forces and the competition and the quality as determined by the patient that really makes that magic happen. And that's really where your cost savings are going to be. And so we're trying to harness all those things. And again, empowering the patient in this entire process to be the end consumer and purchaser of these services.

Ron Barshop:

You have [inaudible 00:30:48] in Florida, so you've got a good technologist there who understands the benefits side and you have urgent cares he's signing up left and right. I guess it's going to come out of Florida. It seems like a lot of innovation happens there. So yeah, it wouldn't be surprising if it was birthed out of Florida.

Dr. Lee Gross:

We will have a few markets we're starting up and Florida is one of them.

Ron Barshop:

Terrific. Anytime soon that we can expect something in Texas or this part of the country?

Dr. Lee Gross:

It wouldn't surprise me if we looked at Michigan as a good launching site and perhaps even Pennsylvania.

Ron Barshop:

So there's too much more to talk about and we've run out of time and we promised you a limited amount. So let's kind of wrap up this talk and we can do another one soon as we have more exciting things happening in DPC, which it seems like, gosh, a lot. But let's talk about you, how do people find you if they want to reach you and connect with you.

Dr. Lee Gross:

Yeah. So they can follow me on Twitter. It's @drleegross, D-R-L-E-E-G-R-O-S-S. They can go to my practice webpage it's epiphanyhealth.org. E-P-I-P-H-A-N-Y health.org. And then if they want to make a generous contribution, tax-free contributions to the work of Docs 4 Patient Care Foundation, where we do all of this policy work to make these things happen. We've been pushing at this for a decade now, it's D-4-P-Cfoundation.org.

Ron Barshop:

Well thank you. And if you could fly a banner over America with one single message for all Americans to read, what would that say?

Dr. Lee Gross:

Health insurance is not healthcare.

Ron Barshop:

Yeah, that's true. It used to be, but that's not true today for sure. Well, thank you for your time, and I can't tell you how much I enjoyed this, and it's great to have somebody who's a living legend, and that would be Dr. Lee Gross. And we look forward to doing this again soon.

Dr. Lee Gross:

Appreciate you having me.

Ron Barshop:

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