Primary Care Cures

Episode 126: Katy Talento III

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

So next May marks the 175th birthday of the venerable American Medical Association, which broadly claims to represent a third of all doctors, but half their membership are students and residents. And I believe it had its best days fighting Big Tobacco, but that was 1986. And here's why I think it's best days are sadly behind it because the AMA has sadly become irrelevant to most doctors. If you look at the actual numbers, about 88% of all doctors agree with my humble opinion by not belonging to the AMA, not a third, even in medical city, Houston, Texas, where I'm from, last I checked, the numbers were 11% of the local docs are AMA members. And remember, half of those are students and residents and they don't get a vote on membership. They got to join.

Ron Barshop:

A recent blue-ribbon panel of geniuses assembled by the AMA recommended seven changes to fix the fee-for-service model, declaring it broken. Now nobody listening to this show is really going to disagree unless you're with a big hospital or big insurance, because they rely on volume-centric transaction care to make their model work. But I digress. Okay. Seven changes by the geniuses to redo fee-for-service. And what the AMA suggests in this manifesto nicely describes direct contracting. You hear me talking about that all the time on this show. Their ideas never once interestingly mentioned the patient nor the employer who are paying for all these ideas, but any big fix to fee-for-service has to include doctors and payers, the employers, and the patients. Everybody has to win with a solution, or it is by definition, a patchwork, not an answer. It's wallpapering a rotted wall.

Ron Barshop:

Anyway, direct contracting makes winners of all three of those parties. And my personal experience is how great direct contracting is now four years old. As an employer and as a consumer, it's a true attraction and retention tool for me and my company. And it's not only the perfect tool, free healthcare, but it's so much bigger than my company culture that I used to think was so important because my team now feel safe first and foremost with free healthcare.

Ron Barshop:

Okay, let's go back to the seven recommendations. I'm digressing again. They're so dumb, I'm just going to read a couple of them. First of all, this was from the AMA, first of all, do not secretly reduce payments to PCPs. Well, that's cute. Are they paranoid much about the RUC, the RUC? Let's get right down to seven because that's kind of cute too. Seventh, financial considerations should not be the only factor. Most PCPs are driven by intrinsic motivations to deliver excellent care and help their patients live healthy lives.

Ron Barshop:

So the bottom line, guys, is the seven perfectly described direct primary care, direct contracting with surgery centers, with labs, with imaging, and with pharmacies. So just, they're not asking for more advice, but if I could be so bold as to offer some, quit making these lofty recommendations blue-ribbon panels and see what's under your nose, AMA, your big idea is already out there, just by the people on my show, that's 25 million to 30 million employees strong are enjoying this direct contracting digital first care. And that's just from the CEOs.

Ron Barshop:

As I said on this show, I'm betting there's a lot more than 30 million out there because I keep finding more. This monthly subscription model has an unstoppable future where everybody wins, the patient for sure, the doc for sure, the employer and outcomes, for sure, as our guest today will attest to, I can hear her head nodding in the air and the healthcare costs dropped like a lead balloon in the ocean for employers too when you skip the big middles that are in the way, bloating everything up. And every employee gets a significant raise overnight is my favorite feature.

Ron Barshop:

No more premiums or deductibles or copays. I took the Brookings Institute figures, and this is hard to do on the show, but I'm going to just walk you through some numbers very quickly. If you take 1,430 a month, that the average employee is paying for their healthcare by direct contracting and you put that in their pocket now, for every 1000 employees, this significant raise of 1,430 a month is a stimulus of $34 million for the local economy, because we know from economists, when you pet that kind of stimulus into a local economy, that's a 2X effect. Now if a 1000 people is 34 million into an economy, imagine what 25 or 30 million is. And we're talking somewhere between 850 billion and a trillion dollar stimulus with no new laws, no marches, no pitchforks, no lobbying, no petitions, no anything, just market forces sidestepping the bigs and their bloat as a middleman and chief preservationists of what we call transaction care, a $150 billion fricking annually.

Ron Barshop:

And here's the cool thing. It's evergreen. It keeps popping up year after year after year. So it's the first to raise healthcare costs and inflation hasn't stolen from what Dave Chase calls the stolen American Dream for most workers. Imagine our economy, if everyone got a raise via free healthcare. AMA, your membership is a 12% of all docs for good reason. The membership is only 10% of your revenues of your 2020 annual report. I dug into it. Your chief revenue source is creating 12,000 CPT codes and licensing it out. Name one other greater source of misery for the

very doctors you represent. They're now becoming code slinging EHR mandated secretaries with white coats.

Ron Barshop:

And you offer burnout seminars. Burnout only goes away when you get rid of CPT codes, not with resiliency seminars, because the moment your meditation or your belly button staring or your counseling session ends, you're back in the coal mine again, slugging it out with your EHR system that makes you a lot of money, AMA. The burnout will go away when we throw this cash cow where it belongs in the circular file and replace it with direct contracted care.

Ron Barshop:

Now remember, this new way of care doesn't need to build and code or pre-authorize the thing, it's based on monthly subscriptions paid by employers. So AMA for or against direct contracting, which dumps codes in the trash of history. Okay, AMA, I'll lay it up a little bit, but I just want to say, as an outsider, I can call you what you are, which is a dinosaur completely out of touch with your mission to promote the art and science of medicine, and so public health improves. Direct care actually does both of those things. Join our movement to see real change in fee-for-service.

Ron Barshop:

Okay. You're not supposed to have a favorite child or in my case today, a favorite guest, but Katy Talento was definitely on my short list. And that is why this is her third invite in 18 months. And when I say shortlist, I don't mean in tiding people because she is tiny people, but because she's mostly mighty, mighty, mighty in this field of direct primary care and direct care and changing everything. The talented Ms. Talento is a former nun and is a Harvard-trained epidemiologist and later worked for five different Senate staffs on the healthcare policy bill, and HHS, just as an aside, is the only agency on the planet that spends a $100 billion a month. So there's no peer in the world for spending power in the US for sure.

Ron Barshop:

And for our last president, Katy was in the inner circle White House health policy as an advisor, she put the transparency bug and more in our last president's ear because he was the first one not owned by the bigs. It didn't exactly help his reelection. All the past presidents needed that reelection payola and could never push the bigs around. But Katy was in the right place at the right time with the right leader, and now hospitals are forced into transparent pricing and it's all the rage to read about it. It's just fascinating stuff. And in six months, it's going to be even more interesting because the big insurers are in that same awful bind. The bigs are not happy about all this transparency breaking out everywhere. She's extremely modest about being the spark and turning over this opaque applecart. But yes, it's on Katy. We love this guest.

Ron Barshop:

So today, Katy is a transparent and Uber Creative Benefit Advisor partnering with another favorite child of mine, Rachel Means, two human spitfires every employer should have in their corner. Only if you enjoy uncovering meaningful, buried treasure inside your second largest spend, should you call them. Okay. Welcome back, Katy.

Katy Talento:

Hi, Ron. Thanks so much for having me back. I'm glad to be your favorite horse in the stable.

Ron Barshop:

Yeah. Well, horse in the stable. Well, you're more like a Arabian, a rare Arabian champion. That's what I would, you're not just like any horse.

Katy Talento:

Okay. If you say so. Thanks.

Ron Barshop:

Hey, Katy. There's a lot going on right now. First of all, do you have anything you want to comment on what we talked about here?

Katy Talento:

Oh my gosh. Well, one of my favorites is how they use the word resiliency when they try to talk you out of your burnout, like you're just not resilient enough. If only you were more resilient, then you would love, love, love those EHRs and all that time spent billing and chasing patients for surprise bills. I mean, really, it's so outrageous. I think that direct contracting, as you say, is the future. And if I never see another CPT code, it'll be too soon. So you've got it right on. We're going to get rid of all these middlemen.

Ron Barshop:

It's life enhancing when you just can, and in fact, you get to forget all these acronyms, you've had to remember as MACRA, and well, you don't have to forget HIPAA, but you get to forget a lot of acronyms that are basically created by this middleman that says we have to learn how to be more efficient at being giving crap care.

Katy Talento:

Exactly. RVUs and CMS. And yeah, it's true. This is the future. And I love all these sort of trade associations and the associations of the middlemen, the PCMA is the PBM Association. And then the Blues all have their own federation and AHEP and the insurers, all these guys, they don't know what to do with themselves. I mean, I don't know how they justify themselves to their members because they're losing everywhere, which is kind of awesome, kind of fun to watch from the outside.

Ron Barshop:

It's great to watch from the front row of this show. So Katy, here are the hospitals playing games already with their mandate. We had Leon Wisniewski on and he'll be on the show in a couple of weeks after this show airs. And he said that in, I don't remember it's Rhode Island or New Hampshire, in Texas, we don't pay attention to states that are smaller than our counties, but one of those states had a hospital in it that was 21 million lines of Excel spreadsheet code to basically mask the information so that the average person couldn't get the hospital rates. Are they starting to gain the system by, A, not participating, and B, playing games with their transparency rules?

Katy Talento:

So I think the vast majority of hospitals are not complying with the regs right now. I know that I have filed complaints to CMS about a number of them in my local area, but, and I encourage everyone to do that. So if you see noncompliance, we should flood that complaint line and just make them too busy. But I do think that most of them are not complying. And probably one of the main reasons is that the enforcement authority is sort of a joke. So if they get taken down by HHS, taken down means I have to pay 300 bucks a day for being out of compliance. I mean, that's basically what they pay for band-aids in a day.

Katy Talento:

So I think that that's a huge problem and that's one of the things I was hoping looking for in the recent executive order from President Biden, I was really hoping that he would give direction to HHS to beef up those enforcement authorities, but he did not. So I'm not sure that we're going to see a lot of change, although I'm just hopeful that the momentum of price transparency and the movement of it toward greater compliance in the insurer space because they have to start complying come January 1, the hospitals had to comply with their rule this past January. Insurers have to comply with their rule this coming January. And the insurers are under a more stiff penalty. And so they actually are kind of compliant I believe, and they will out the hospital's negotiated rates. And that's the big secret sauce at hospitals, I thought. I guess they thought they could, if they hit it for a year, they'd gain something.

Katy Talento:

With respect to the spreadsheets and files that they're dumping on their websites, I actually think that's fine. Your average consumer, your patient out there, who's trying to figure out their price with their plan, they're not the main audience for those spreadsheets, for those machine-readable files. And I actually would rather have a bigger, more complex file that has more information, even if that hospital is trying to confuse me with too much information, I assure them they are not going to succeed at confusing us with too much information. There are all these really interesting vendors out there, either vendors that used to exist and that now have been empowered to grow even more with this new data, or vendors that are springing up to consume this new data, scrape it off all these websites and assign artificial intelligence and other tools to read it all out of these very complex spreadsheets. I don't think these hospitals are going to dump the vendors and they're creating these beautiful consumer tools and employer tools for self-funded employers to help steer patients and steer volume. And that was the purpose.

Katy Talento:

So just because there is a consumer tool that's required out there to be created by the insurers that, and I think that will be helpful for consumers. But really, most consumers are going where their plan directs them through its network, where a doctor refers them. And so that's why it's really important that the DPC practices that are steering patients and other primary care practitioners that are steering patients and employers that are steering patients, they have access to these machine-readable files. No matter how complex they are, I think it's great that they have it. And I would urge hospitals to dump all the data they want, they're not going to stump anyone. And so I think it's better to have more than less. I'm worried about the hospitals that aren't doing

anything and that are not putting out any information or substandard information more than the ones that are putting out too much.

Ron Barshop:

Yeah, there's a 2,500 in Wisniewski's database that he's been able to find, and he's been able to shame dozens more into giving the information by saying, everybody in your municipality is doing a bit, you want to be all alone out there. So he said, "They are out of shame starting to jump into the compliance." But I look at Keith Smith, who was one of our first guests and he has hundreds of surgical procedures that are plainly priced, complications, anesthesia facility, it's all in there. It's a one bundled price deal, and he's been doing it since 1994. And so this isn't so complicated where you can't do it if you're a hospital, but what are the new regulations for the insurance companies if the hospitals have 300 different procedures they have to present? What does that look on the insurance side, which has got, my gosh, tens of thousands?

Katy Talento:

Yes. You're right. The insurers have three machine-readable files that they have to dump monthly onto a public website. One of them is, it's basically their negotiated rates. So all the rates that they've negotiated with every healthcare provider, every hospital, every doctor's practice, every radiology facility, every lab, all of it. And so whatever they've contracted with, anyone they've contracted with, those contracted rates have to be posted. So that includes every employer self-funded plan that counts as a plan that has to put this information out.

Katy Talento:

So we have the carriers, if your carrier is your administering entity for a self-funded plan, which I don't recommend by the way, folks, don't do that, but if that's the kind of plan you have, their carrier is going to have to put out that information. If you're an individual patient and you're insured, let's say, on an exchange plan or in the small group market, the carrier is going to be putting out this information. And if you're a self-funded plan that uses a third-party administrator and independent third-party administrator, which is certainly what would I prefer to do when I'm building plans for clients, those third-party administrators, those TPAs are the ones that are putting together that tool and that file. They know what they're paying, what their negotiated rates are. It's a little complicated when you get into a reference-based pricing plan that gets very complicated quickly, but these TPAs that work with sort of Medicare-based prices on their plans, they're doing a great job of coming up with innovative ways to comply with this. So that's the first file, all your negotiated rates.

Katy Talento:

The second file is your out-of-network payments, the average that you've paid out-of-network to every provider. So if you are a big, let's say you're UnitedHealth Group. So for all the doctors and facilities that you don't have a contract with, they're not in-network, then you're still paying them. You're paying them an out-of-network allowed amount. And so this is called the allowed amounts file. Well, you can't have a specific allowed amount. You don't always have the same one. Sometimes it depends on the city that the doctor is in, sometimes it depends on the size of the group. It could depend on many, many things. So you may pay 270 different allowed amounts to the same doctor or the same imaging center over a course of a year.

Katy Talento:

And so what this file does is it says you have to tell us what did you actually pay on average to that doctor? And if you didn't see that doctor, if you didn't pay that doctor very often, like let's say someone that you haven't paid for very many patients, you only made five payments to this doctor as a carrier, as a health plan. That's fine. You have to list those five then. So you just, you either put your average or you put your last 10 payments, just historical claim data is really what this is. It's historical payments, what did I pay to this guy? And that isn't perfect because it doesn't necessarily mean you're going to pay that in the future, but it gives you a good idea of what the range is. So that's machine-readable file number two.

Katy Talento:

And the last file has to do with all the net prices that were paid for prescription drugs. This is really, really important and disruptive. And I think it was a little unexpected. It wasn't actually in the proposed rule when it came out from the Trump administration, and it came out in the final rule, this third file of drug prices, net of rebates, discounts, and all of the secret sauce that you these PBMs, Pharmaceutical Benefit Managers, and pharma companies and carriers all cook up together so that everyone gets paid well and they keep raising list prices on patients so that their cost sharing is more and more. This will be extremely helpful for innovative self-funded employers and their benefits advisors to really find out who's getting the best deal and how to steer volume to the best pharmacies, the best PBMs, and the best drugs, if there are choices clinically.

Ron Barshop:

Katy, I'm trying to imagine you sitting in the room when Trump was first elected and saying, if you want to do the right thing by healthcare, there's a lot you can do a transparency. And I would imagine that he's going to say since you're the only doctor in the room, "Well, what are your ideas." And I know that you like to give credit to all the regulators and all the downstream people that maybe you started the ball rolling and maybe they made all this happen in such an intelligent way, but did you, from the early days, get everything you wanted on the transparency side with what you're seeing rollout now?

Katy Talento:

No. I think we got a lot done and truly, truly it took a village, honestly, within the administration. It is true that the White House staff have the ability to start things rolling, but we don't actually do work. I mean, who are we kidding? We berate and beat down the agencies and make them do the work. But we had a really willing agency. I think there were all the usual arguments that are raised against price transparency by all the smartest people, oh, it's going to raise prices if everyone can see their prices, or patients don't shop. So we shouldn't do this. So you get all the usual arguments against, and we heard them all. We heard them from agency staff, we heard them from outside trade associations, we heard them from some of the economic advisors in the White House. All the smartest people in the room came at us arguing against price transparency.

Katy Talento:

And it was always so silly because I knew that the president would totally go for this. So everyone was going to lose that argument as soon as he put his foot down, which he eventually

did. And I mean, it really came down to a very simple message, healthcare is very, very complicated and healthcare financing is even more complicated. But ending secret healthcare prices is a winning message. And anyone who is against that just sounds corrupt. And so there's no way around that. And the president saw it immediately. The very first time he heard about the idea, he was totally sold. So he really drove it. And at times, we had to go back to him and make him drive it again, remind him that, hey, we're getting some obstruction, could you just put your foot down again? And he would put his foot down again and pick up the phone. And so he really drove it himself.

Ron Barshop:

Yeah, that's a great story. Is there a possibility that past presidents were so in the pockets of the lobby called big healthcare that they would never dream of taking these guys on?

Katy Talento:

Well, what really happens in sort of the healthcare swampy and policy circles in DC is that we are totally focused on government and government spending and government healthcare programs, Medicare, Medicaid, exchanges, we're very focused on that. But honestly, there's a lot that can be done with the Medicare and the Medicaid programs. Medicaid, it's a little bit hard because it's administered by the states and there's a lot that you have to do in 50 different states. So Medicaid policy can be a little challenging. Medicare, of course, you can achieve a lot in the Medicare space, but it's very slow. It's a slow program. And that's probably appropriate because it affects so many people and it's such a huge market actor, you have to be very careful.

Katy Talento:

But with employer-sponsored care, nobody ever paid attention to that. I can tell you about it. I'm always shocked at how much basic education I have to do with Hill staffers or even members of Congress, or very senior political officials. And it's not because I'm so special or because I know so much, it's just, I started reading and learning and I wanted to pass that on what I was learning and I wanted to share it. I mean, we passed Marty Makary's book around the White House and HHS. And honest to God, it wasn't until after everyone read that book, I literally sent them the free version and made everyone read it, that we started winning this argument and folks started getting on board because they got out of their sort of DC swampeon, the industry says this and that industry says that, that kind of mentality, and started seeing it from the employers and the patient's perspective and taking their side.

Katy Talento:

Everyone gets into government because they want to make a difference, they really want to help people, but we get so, I guess, distracted by how complicated everything is that we start to think that we can't change anything and that everything has to be done on the margins. And this Medicare demonstration project is the only way to change policy. No, there are things that we can do with ERISA, which is the federal law that governs employer health plans, and then in the regular individual and small group insurance market now, because the ACA put all that into HHS's purview.

Katy Talento:

So there are things that we can do in these commercial markets that we could never achieve in the larger Medicaid or Medicare space, but it requires knowing how employer-sponsored care works and how, looking under the hood of your typical off-the-shelf carrier plan, which frankly, most policy wonks in DC never have done. They don't really know it. So we had to really learn and teach ourselves and bring in experts and have big companies come tell us their problems and small companies tell us their problems and innovative benefits advisors and Health Rosetta like Dave Chase came and talked to us and told us, "Hey, you really need to focus on ERISA." So this was all a learning curve for everybody.

Ron Barshop:

That's amazing. Marty Makary has a new residence in Texas now, so we've got two centers of gravity, Maryland, and Austin now for him. Glad to have him down here. So let's talk for a second about what President Biden just did this week, which is a 72 point presidential executive order that talks about FTC and justice getting their act together so they can start breaking up some of these, not exactly breaking up, but they're saying these monopolies are too big, very few companies are representing a force of the healthcare economy. It's not right. And it looks like he is actually joining in the chorus line of what you started. So how do you feel about that? Is he going far enough? Is he going too far? Are you shocked? Are you happy?

Katy Talento:

Well, it's a huge relief, I'll say that. I was certainly worried that the industry pressure would get to the Biden administration the way it gets to most administrations and most politicians. Most members of Congress are very susceptible to this pressure. And as we say in Washington, your local hospital is usually the biggest employer in any congressional district. So it's no surprise that most politicians are scared to take on the hospital lobby. And so I was worried that this administration would fall prey to those pressures, but I shouldn't have been as worried as I was because we really did identify something that is so totally nonpartisan. And again, like I said earlier, if you're for secret prices, you are corrupt.

Katy Talento:

And so the Biden team, they had a choice, are we going to be the ones that backpedal on secret pricing in healthcare? And so I was just really relieved that they doubled down on the Trump transparency rules and also on the Trump's surprise billing principles. They were required to do the surprise billing principles because Congress actually passed those in a law at the end of the year, I thought it was a Christmas miracle, banning surprise billing. So that was really great, and also requiring brokers to disclose their secret compensation stream. So there are really good things that happened in that bill that got no attention because everyone was focused on COVID and the post-election chaos. But I do think that it's really, it's a huge relief.

Katy Talento:

So team Biden this week implement, there were two things that came out, first was the executive order on competition in the American economy. And it goes through a bunch of industries like agriculture and transportation, a bunch of industries where there are anti-competitive practices, and it tries to tamp down on those in their unique sort of Biden-esque way. But one of the areas is healthcare, and they really double down saying, "Hey, I, Joe Biden direct HHS to double down

on the price transparency rules to give full-throated support to them and also to implement the surprise billing legislation that passed." So it doesn't say much more than that, and that was sort of the disappointment to me because they could have improved upon the transparency regs actually. But I was so relieved that they didn't weaken them in any way. And I'm really just saying, hey, we're for this too. It had to be a crushing blow to the industry interest that it hoped that they were going to have a more open ear in this new administration. So that's really great.

Katy Talento:

The second thing that the president did, President Biden did this week was come out with a surprise billing, one of the first surprise billing regulations that implements that law that Congress passed. And so it really just comes right out and it bans surprise billing in emergency settings and ancillary settings like out-of-network anesthesiologists at an in-network hospital or ambulatory surgery center, air ambulances. Of course, the ground ambulances, by the way, got out of this. They managed to weasel their way out of the law last December, which is a disgusting display of lobbying. And so they are not included in the surprise billing ban. So everyone needs to really be careful when you're taking an ambulance because you can't control who's coming to get you and where they're going to take you and they could surprise bill you badly. And there's no protection-

Ron Barshop:

You and I have a mutual friend, and I'm not going to say his name, but he's been a CEO of many hospitals. And he told me some of the games that are played with surprise billing. And he said, "One of the things most ER docs, most anesthesiologists don't work for that hospital. They're working for a private equity group and they can surprise bill all they want because they control the market in many cities. Same with ambulances, same with air ambulances, same with a lot of different verticals that have basically rolled up and controlled the supply of those doctors." So you think that doctor works for your emergency room, but he has nothing to do with it other than he's a contractor. And so he's out-of-network every time.

Katy Talento:

That's exactly right. And that is precisely the problem that this law, the No Surprises Act was trying to solve. And it bans surprise billing by those providers, the air ambulances, anesthesiologists, radiologists, pathologists, all those ologists that are out-of-network because they work for a private equity firm, or most of them actually don't work for private equity. It's just the private equity guys that surprise bill the most, but they may work for a separate staffing firm or their own practice of anesthesiologists. And they may have a monopoly and they forced their way into these hospitals because the hospitals have no other way to get anesthesiologist or whatever the ologist is. And part of their deal is that we're going to bill patients separately and we don't care what rates you've negotiated with their insurer. And so that practice is now illegal and that is starting in January. And that is the greatest news ever. I mean, it's really, really good.

Katy Talento:

9% of people who got surprise bills last year paid more than $400 for those bills. So when you think about how many people have $400 or less in their savings, this can really be catastrophic for people who are living paycheck to paycheck. I mean, 40% of ER visits, Ron, in the past year

resulted in an out-of-network bill. This is 40% of ER visits headed in-network hospital resulted in an out-of-network bill to one of these providers. So it's really-

Ron Barshop:

It was a gaming of the system. They literally were playing Three-card Monte with the patient and with the payer. There's no way you can know what you're getting into when you're sick and you're in distress and you're a high stress point in your life. You're not thinking to ask, are these guys going to screw me over or not? You don't know.

Katy Talento:

And even if you did ask and they say, yeah, not in-network, what are you going to do? And that's how it is at every hospital in your town. So it's not like you can do anything in that moment. And you would be shocked and somewhat scandalized by the doctors that lobbied me on this to not come after them for surprise billing.

Ron Barshop:

It's their business model. That's their business model to get 8X Medicare. They love it.

Katy Talento:

Yeah, totally.

Ron Barshop:

Yeah. Well, you did give some good information last time. And it came from Al Lewis of Quizzify and you said, "If you keep your battlefield consent card in your wallet, and of course I do, says we're never going to pay anything more than two times Medicare for bill charges." That was really one of the best episodes ever just for that one little piece, because if you put that into the language and when you go, you're protected, but now that we don't even need that anymore because of this outlawing of this ridiculous practice.

Katy Talento:

Well, I would argue that we still do, because it's not the hospital that's doing that surprise billing. It's the provider, it's the doctor that's doing it usually. The hospital is price gouging, whether you're in-network or out-of-network, they're going to gouge you and overcharge you, they're going to upcode that ER visit to a level four or five for giving you a stitch or something. And so it's still really important to use that battlefield consent. We put it on all our members ID cards so that if they're in an ER, they don't have to think about it.

Ron Barshop:

Yeah. That's a great idea. Katy, what is the future of direct contracting hold? I got to tell you, I'm so excited. I just started doing the math a couple of months ago, and I realized that between maybe 15 of my guests, I've had CEOs on the show, we've got direct contracting is really scaling in the last couple of years. And we have certainly 25, but maybe closer to 30 or 35 million people that are direct contracting with these larger companies that are now in all 50 states. This

really, like DPC movement talks about 500,000 patients, but we're way bigger than 500,000. What should this movement be called? I don't have a name for it, do you?

Katy Talento:

Why don't you call it clean health plans, right? They're clean of corruption, of middlemen, of secrecy. You think about clean energy. So we could call it that, but you're right. It's kind of hard. They also call them high-performing health plans. So they are all those things. They are clean, they are high-performing, but the most important thing is that they create a really beautiful patient experience, like you were talking about at the beginning of the show.

Ron Barshop:

Yeah, the high-performing plan doesn't stick with me because you can have a high performing turtle in a race and he's not going to win it. But I like the idea of clean. That's a new idea that I haven't heard before, but I've heard digital-first. I've heard a lot of interesting thing. It's interesting we don't have an association, we don't have academics, we have lots of academic studies of the savings downstream, we don't have really anybody counting, head counting, how many people are in this movement. It's kind of happening on this show where we're figuring it out that this is really getting big. I mean, 25 million, that's some serious head count.

Katy Talento:

Yeah. It is exciting. And I think that the greatest thing is just getting out from under the billing code. And the doctors and the facilities that we talked to are happy to negotiate with us. Lots of them have never done anything like that before. We have to explain that, no, we don't use Blue Cross, or no, we don't use [inaudible 00:35:38]. We have to explain this to them.

Katy Talento:

And your average billing manager or office manager in a physician practice doesn't know anything about these health plans and bringing them into the movement and into the revolution is always kind of fun. Sometimes it's hard to educate them ad they're a little nervous, but as soon as you tell them, hey, you're going to get paid quickly. You're not going to have to chase patients for cost sharing, which is awesome. It's going to be free to them. We're going to steer people to you and they're going to have a great experience. So they really like it. We've had really good experience doing it.

Katy Talento:

There are some, I will say, it's not all a cakewalk. There are especially hospital systems, that for them to contract with an employer, if you think about like a dropdown menu in an electronic health record that has Blue Cross or Aetna, it's got all the carriers in there, think of all the places in their billing bureaucracy and in their EHR design where there's a dropdown and you have to pick the insurance plan. Every single one of those fields has to be recoded to add a new plan, like an employer plan that they've contracted with, because if you don't add them across the system, the IT system, then when that patient calls the main scheduling line for that hospital system and tries to make an appointment, they're told that they don't take their insurance.

Katy Talento:

So there's a lot of work that has to go on behind the scenes for hospitals to actually contract with an employer more than, I mean, I think that they make it harder than it has to be. I honestly think there are employers that would pay for the computer coders to fix their IT. But sometimes they put that up as a barrier. I just got that in a California health system a couple of weeks ago saying, oh, we can't contract with you because it doesn't matter how worthy a cause it is. And I know it's where the future of healthcare is going, but we can't do it for this small amount of patients. And so I don't want to oversell this as if it's so easy and it always happens because this is still very much a movement in progress. And it's going to take a while, but we can-

Ron Barshop:

I'm going to try something out on you and I'll see what you think of this idea. When you're talking to an employer for the first time, if they have a $10 million spend currently, and you start off the discussion with, if you had 2 million that you could count on in the next year, and the next year, and we're talking about maybe 4 million, and that could go as high as maybe 6 million that's coming back to your company. Would you put that in more benefits to retain and attract? Would you put that into your EBITDAS that you can perform for your investors? Or would you put that into the community, like some companies like RosenCare have done, and now turn around neighborhoods that are crime-ridden? What would you do with 2 million, 4 million or 6 million of found money?

Ron Barshop:

I think that like taking it from 20,000 feet and having a big picture discussion, and then you know, Katy, you can deliver that 20% blindfolded by just the pharmacy. You could deliver the 40% with the pharmacy and the primary care. And then you throw in all the other imaging and all the other labs and surgery. Now you're talking about the 60%. So you can, I mean, what Rachel and you call ripping the bandaid off, which is just go straight to 60 and don't pass go. You can pretty, I mean, there's no such thing as guarantees in life, but you can pretty much in your sleep, get them 20%, can't you?

Katy Talento:

Definitely in our sleep, we can get them 20% and we guarantee it. I mean, I think our biggest marketing challenge, certainly at AllBetter, and I think all the benefits advisors out there doing this type of plan, our biggest marketing challenge is convincing people, the HR directors or the C-suite that it's not too good to be true. They think we're trying to sell them something and get them to fire their broker or whatever. And they just think we're selling.

Ron Barshop:

Okay. So we need to start an association. We have to start an association, Katy, I'm sorry to interrupt you. If we have an association and we have all the enlightened HR directors and VPs, have all the enlightened CFOs sitting around a table with the Katy Talentos of the world and the others that are in this ecosystem and making a big difference. We have to get our act together. We're just all individual little molecules spinning and spinning, and we don't have organization right now. This could be the beginning of something.

Katy Talento:

I think that is right. I know that Health Rosetta is trying to be that as well and trying to create some credibility around these types of plans. It's also true that I think one thing that will really help, and I am working on this, I hope you'll have me back when we're ready to launch it, but there are patient groups that are considering how do we grade employer plans with respect to patient access, capability and experience giving employers the great PR and the recruiting competitive advantage to have this seal of approval from patient groups. And so there's nothing out there grading employer plans. They all think that they offer the gold standard because they have some insurer logo on their cards.

Ron Barshop:

Glassdoor for health employers, for the health plans. I love it. I love it. Well, this is always amazing. We could go all day I know, because this is how our minds work, but, Katy, we'll definitely bring you back. We've been on a six month schedule. So I'm tickling you for Christmas, and just cancel all your Christmas plans and we'll have this conversation again because it's interesting, it's always evolving what we talk about.

Katy Talento:

It is. It is exciting. And I'd love to be back again and talk about all this stuff.

Ron Barshop:

Yes. All right thank you. Well, it's again, I always offer you this opportunity, you can fly a banner overhead. I remember what your last one was. What is the banner going to look like now?

Katy Talento:

Well, I do think it's important to end the secret prices, make healthcare human again. And there are so many logos. And when it comes to healthcare, it's so bad, it's so bad that it's easy to demagogue, it's easy to come up with slogans, but the implementing really beautiful patient experience and employer experience is hard, hard work, but it's like the only thing I want to do, it's the only thing we're doing in healthcare these days.

Ron Barshop:

Yes. I'm going to tease the next show that we're going to have with Rachel, your partner, and that we're bringing a meat processing plant on that was the only one in the nation to not close one single moment during the pandemic. How did they do it? Using these techniques and strategies by having direct care on site. Beautiful story. Imagine what that would look like for meat processing around the country, for food processing around the country, for... fill in the blank, manufacturing around the country, nothing closed because they did this methodology. Beautiful story. Can't wait to share it with everybody on the show.

Katy Talento:

Great.

Ron Barshop:

All right. Well, thanks again. And we'll get you back on in a few months. Thanks, Katy.

Katy Talento:

Thank you so much, Ron. Appreciate it.

Ron Barshop:
Thank you for listening. You want to shake things up. There's two things you can do for us. One go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.