Primary Care Cures

Episode 136: David Contorno

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 the Heritage Foundation has issued an important report on direct primary care just this week, July 4th week. Here are a few of its highlights. A family of four can save on average $17,000+ with cost-sharing plan paired with it. Cost-sharing plan be like Sedera like a previous guest we've had. So America is fueled by hourly workers and two-thirds are one medical bill away from ruin, according to Gallup polls, so thank you high deductible healthcare, but if you're looking at one medical bill away from ruin, that means that these folks are what we call functionally uninsured. And I did a little bit of math and we have I think somewhere between 130 and 150 million functionally uninsured Americans.

Ron Barshop:

I didn't take the two-thirds number of all the 185 million workers. I just took half and then I added to that the uninsured population which has been 30 million forever. And then I also added in the 10 million unemployed. And if you can't find a job in this economy, you can't find a job. But if you take those numbers, and you throw in Medicare and Medicaid populations which is about 124 million and throw in another 19 or 20 million for Veterans and Defense, you're looking at basically somewhere between 40 and 60 million of us are in wealth care and the rest of America seems to be this, what I call this 130 million in poor care or sick care or transaction care and so they are functionally uninsured. Well, what is the answer? You know what the answer is going to be because we're going to talk about it today.

Ron Barshop:

So let's get back to the Heritage report because it had some other interesting things. DPC, direct primary care, was associated with reduced ER department utilization by 40% because the DPC model leads to more primary care face time. Well, if you got more face time with your doc, that's like wearing a seatbelt or giving up cigarettes, we know. So again just DPC being a subscription model, you're not paying copays or deductibles anymore, you now have a lot more face time with the doc. And then they threw in a case study by a former guest of ours Carl Schuessler who walked us through the DeSoto Memorial Hospital which achieved a 54% reduction in their

health plan spending which is over a million or two, your one, it was 1,600,000, year two, while eliminating all the copays and all the deductibles, as I said earlier, for an employee. And their out of pocket costs basically went to nothing. And it lowered the employee premiums by 20%.

Ron Barshop:

So remember, when we set up these plans with direct primary care, we don't always have a pure rip-the-Band-Aid-off approach. Sometimes they'll keep in the old PPO or the old HMO, so not everybody switches over all at once. They do it slowly. So these savings were achieved in a population that has the slowest second lowest median family income in the state of Florida. And again as I said, a previous guest walked us through the numbers here, but what they did essentially from 20,000 feet is DeSoto was a rural hospital about to close. They were just financially bankrupted essentially. But by contracting with the local county and the city, the school district, the local pharmacy, they were able to direct contract and save the hospital by getting out the middlemen, the BUCAs.

Ron Barshop:

And 50 million Americans live in rural areas, and if we can save our hospitals in all of these rural areas, that saves the rural economy, it serves a county and saves a region because when the hospital closes, that's pillar one of a three pillar crash. So basically getting back to the Heritage Foundation, Congress should allow ... This is a recommendation. They had a lot of good ones, but this is my favorite one. Congress should allow DPC practices to contract directly with Medicare recipients without needing to opt out of Medicare. So Maine has addressed this issue by allowing this, but what they're saying is if you have a Medicare or a TRICARE or a Medicaid patient and you also have them on a subscription model, you might be tempted to double dip, so you just got to opt out of this federal largess by saying, "I'm not going to see any of those patients."

Ron Barshop:

Well, again, it's a real burden for some DPC because they also moonlight in the evenings and do some medical directorships and they do some other ... Maybe they work at the VA, but they can't do that if they have to opt out. They're basically giving up their ability to bill. So it's a good rule. It's a good recommendation. I'm really glad to see this Heritage Foundation come out. It's been taking years to get this going and Dr. Gross was on our show. The DPC Coalition put it all together, and of course, he was involved with the DeSoto Memorial story, so he had firsthand. But anyway, our today's guest is of that genre. He's a benefits engineer who's basically really not only rebuilding primary care where all his clients live, but he's rebuilding the whole healthcare ecosystem with the foundation of primary care. So I want to welcome an award-winning benefits engineer to our show, David Contorno.

Dave Contorno:

Thank you, Ron. Happy to be here.

Ron Barshop:

There's so much to talk about. Where do you want to get started? I'm going to let you go because you've seen this from every angle. What type of employers are you starting to find are waking up to this new model?

Dave Contorno:

I got to tell you, the employers that have embraced this the most and it doesn't work any better in this environment, I think it's the mindset of the employer that recognizes the pain point is just too high in the current environment tends to be smaller, a few 100 employees, blue or gray collar and family-owned. And the reason I think those metrics buy in to a different way of doing things the most is I think, as an organization, those companies tend to run on tighter profit margins. I think if each employee maintained their own P&L and we know most people aren't sophisticated enough to do that, they too would be running on tighter margins than the average American.

Dave Contorno:

And I think third and I think probably most importantly is, in those family-owned businesses, the owners, the decisionmakers are not sitting in a perch in an ivory tower somewhere. They're down in the fields. Maybe they were working the trenches alongside the other guys and gals at one point and maybe it was the son and now he's running it, but he knows the employees' names. He was one of the employees. He knows their spouses and their children. That really has been the metric of employer that has just said, "Enough is enough of the status quo and I'm going to be brave enough to try something different."

Ron Barshop:

Through the miracle of the microphone, I've discovered that what you said I thought was true blue and gray collar is actually turning into more white collar because there are companies that have large patient bases like Premise Health have 11 million, Medici has 13 million. There's several that have a million like Crossover Health. They've got LinkedIn. There's one medical that has Apple. Facebook's in the game now. Google's in the game. Amazon, the mighty Amazon now is using their fulfillment centers with Crossover Health clinics.

Ron Barshop:

So these direct primary care really are now scaling with a corporate backbone, still often run by doctors which is the right way to do it, but they're scaling with these large tech companies that can't retain employees. Talk about retention and attraction once you have this model in place.

Dave Contorno:

Well, I will tell you that when we've put this model in place for employers, we typically offer to the employee population, a plan where you have to go through the DPC home for everything except emergencies, of course, and then what we call an open network plan where you can really see any provider and the first metric that surprised me as we did this was the percentage of people that willingly chose the DPC plan. Because in a lot of ways, we set it up like a gated HMO plan to steer people through the DPC. And everyone has to change doctors if they choose that plan, but on average, the first year we do that type of setup, we typically get between 40 and 60% of people to take the DPC plan.

Ron Barshop:

Because that's free. There's no copay, no premium, no deductible.

Dave Contorno:

Exactly, exactly, but that number only goes up in subsequent years. And the reason is because the ... Listen, healthcare I think is probably one of the few industries that has net promoter scores worse than cable companies. So let's admit that the bar of impressing people in healthcare should be pretty low, but the overwhelmingly positive feedback we get from those patients, once they engage with the direct primary care provider is off the charts. They are amazed at how much time a doctor is willing to spend with them. They are amazed that they're not just sending them out the door with a script and a referral to a high cost specialist. They are amazed when they sit down and talk with them about their nutrition.

Dave Contorno:

I know when I had my intake with my DPC, he spent two hours. Now I tell you one question that he asked me that I found very interesting that no other doctor has ever asked before, and the second he asked that, I was like, "That makes sense. It's something that my doctor should know." And it was, "Do you have any guns in the house?" That question surprised me, but then when I thought about it, you dramatically increase the likelihood of being shot if you have a gun in the house statistically. It's a good thing for your doctor to know just in cases if it were to occur. So little things like that and it just that the-

Ron Barshop:

[inaudible 00:08:44] juvenile delinquent. They're targeting you, man.

Dave Contorno:

That's right. That's right.

Ron Barshop:

I asked about retention and attraction. Is anyone target tracking those numbers? Because my retention went 200%. Nobody wants to leave a company with free healthcare. My attraction, I used to have to interview dozens of people to find a good MA and now I can do it with one interview, two interviews because the best people want free healthcare.

Dave Contorno:

We do track turnover with some of our clients, not all. Now some of them were in the restaurant business where they had 140% turnover every year and now they're at 50 or 60%, which for some industries, that would be awful. But for them, that was really fantastic. We had a municipality that had zero turnover on the DPC plan, not on the other plan interestingly enough. So yeah, we definitely see a big uptick in that and their ability to ... So one of the things that DPC does, and you mentioned this in the opening, is it lowers costs and definitely we need to talk about that.

Dave Contorno:

I do want to talk at some point though about the improvement in clinical state of the employee, the patient also because that is really important, but when we're able to build that plan and have it up and running for a couple of years and all of a sudden, the member has no out-of-pocket, and on top of that, we've heard Use total cost by so much that the employer can now pick up a much larger percentage of the cost or sometimes even 100%, it gets employers to the point where they can say, "We not only offer a plan where you have no out-of-pocket when you use it, but you also have nothing coming out of your paycheck when you're enrolled in it." And that's just unheard of in today's environment. Even in unions, even in teachers jobs, where they expect high level of benefits because the pay is not as great, this still beats those.

Ron Barshop:

I'm going to challenge you to think a little differently about what you just said. I love everything you said by the way, but you said sometimes they choose to pay some of it, sometimes they choose all of it. You're sort of the employer's doctor. You're diagnosing the problem, you're putting a prescription together to fix it with this reassembled plan. I think you should insist as their engineers, their doctor and their engineer. You pay 100%. You'll recover this every time. There's nobody that has not recovered that cost, but you should pay 100%.

Dave Contorno:

I've become close to that. I'd say, "Pay 95%," and the reason I think there should be a little bit of skin in the game is for two reasons. One is I think people value stuff they paid for a little bit. And secondly, I don't want, let's say, a husband and wife and both of them work in a full-time job at two different companies. Both, they are offered health insurance. Why should one employer carry the weight of the other spouse when the spouse has a plan available to them to their job? And some employees will double dip and that makes things confusing and actually makes coverage more difficult. So I think just having a little bit is a good idea, but certainly a much higher percentage than what most employers are doing today.

Ron Barshop:

Now you said you got to give up your doctor. Do you get a lot of pushback from the employees on that?

Dave Contorno:

We do, and listen, my whole approach with employers and to a lesser extent but still to some extent employees is to make them uncomfortable because I believe that people don't change until the pain of staying the same becomes greater than the pain of change. And I remember one time when we launch a direct primary care plan, we actually bring the doctor to the open enrollment meetings. And that's a really important thing. And so I had this doctor there, he was able to talk about how credential T is he's been a professor at Tufts University. And this one situation, I'm thinking of very entrenched in the community, been a primary care doctor for 30 years. And she said one in place, "Well, who are you going to refer me to?" and I stepped in and I said, "Well, I need to know your age, your gender, your comorbidities exactly what you're going to because we don't just refer you to an orthopedist. We forward you to the right orthopedist for you based on your situation time."

Dave Contorno:

And she says, "Well, who is that going to be? How do I know they're good?" and I said, "That's a really good question. How do you know the doctors are going to on your own are good?" And her response was, "Well, I go to their website." I said, "Okay, so you look at their self-reported bio. If they graduated last in medical school, do you think that's going to be on their self-reported bio?" I said, "I don't think that's a really good judge of quality." And I started to tell them how we look at quality. I think that the point I'm trying to make is most people judge a doctor's quality on bedside manner and not on actually how good of a doctor they are.

Dave Contorno:

And when you start to look at the quality doctors and really the doctors that have been brave enough to step out of the traditional fee-for-service space where they have basically income-guaranteed patients, they come to them, they don't need to look for them, they don't need to talk about money or cost, it takes a really brave bold type of provider and doctor to do that. And the difference in the type of care that they give is just night and day different. And so when we talk about this to the employees and they start to wake up to the fact that they can actually be doing in healthcare what they do everywhere else which is compare cost and quality and find wherever that value intersection is, I think it speaks to a lot of people and I think that's why people are so willing to go with a doctor that was at their employee open enrollment meeting which is uncommon. Now they have a face and they can build a real relationship with someone who's much more available to them than the traditional primary care doctor.

Ron Barshop:

So we've talked about the [inaudible 00:13:46] these patients are definitely happier. They're not going to leave once they joined this movement. We also know that the employers are happy because no employer of yours has ever gone backwards and said, "I can't wait to get back with Blue Cross." And then the third party would be the doctors. We don't have data on this, but we know from DPC conferences that they're the happiest conferences in America in primary care, because everybody's free of EHR. They're free of lost autonomy. They're free of burnout. Let's talk about outcomes and cost, which you mentioned earlier. What can you tell us about, first of all outcomes, then we'll get to cost?

Dave Contorno:

There's just story after story, but I can tell you of people who have had multiple back surgeries, and of course, the primary care, normal primary care just incentivizes them to get out of the office as quick as possible and refer them to ... And I don't know if you've spoken on this on prior podcast, Ron, but I think it's important to understand how the traditional doctor is compensated financially for their work. And there's, of course, a bunch of metrics, but one of the ones that I think is really damaging is known as an RVU or a relative value unit which is a measurement of how much revenue that doctor is generating in other parts of the healthcare system that he works for or his healthcare system is partnered with.

Dave Contorno:

So they maximize their own income by getting you out of the office as quick as possible, so they can see as many patients in a day as possible and sending you to where the highest cost care is

most likely to occur. And the problem with that is that's typically not in the interest of the patient, either financially or clinically. And so when you have a primary care doctor that doesn't have those incentives and your back is hurting and so they send you to a proper physical therapist first because there is no financial incentive, that's why we see back surgeries go down so dramatically. We see people who are taking the number one revenue drug in the country is the Humiras of the world and that's largely counteracting what it is that we're putting into our own body.

Dave Contorno:

And when you have a doctor that can take the time to learn that patient, understand why they're struggling with their diet or with nutrition and make suggestions and monitor them and followup and check in with them, they often can get off of those medications. I've seen people get off of migraine medications and opioids and diabetes medications. The list goes on and on and on to where ... I think the biggest value that a DPC doctor has to offer their patients is time.

Ron Barshop:

So if you all are listening to all of my shows, you heard Cathryn Jakobson Ramin who wrote the authoritative book on backs, the back, it's really a scam, but the industry, that 95% of back fusions are unnecessary. Your back resolves itself in time. And then you also heard that Al Lewis say the same number from Quizify that 95% of all back surgeries are largely unnecessary. They resolve themselves in time. So what you're saying is utilization goes down. Overuse, overtesting, expensive testing, hospital internal testing, all that goes down because the DPC doctor doesn't see or have an incentive or really the pressure for their RVUs. Well, let's talk about the cost. If you're going instead to the hospital imaging or the hospital lab, instead you're going to an independent lab or a direct contracted imaging, you're going to save a little bit of money, aren't you?

Dave Contorno:

Not a little bit in many cases. So the way most of our plans are set up is that if you choose the DPC plan and DPC refers you or even the open access plan and you allow our concierge team to help guide you to where the quality is high and the price is reasonable, then we waive out-of-pockets for the members. They pay nothing, no deductible, no copay, nothing, where the plan is bearing the full cost of that MRI, for example. And you can get an MRI. At the Sutter Health System out in California, I've seen MRIs $12,000, or $14,000. I would say the average hospital based is probably between 1,800 and maybe 4,000, 4,200, but we have a network of independent radiology centers across the country and our average MRI price is 250 to 400 bucks. So even with deductible and coinsurance thrown in there, it's still in the employer's advantage to pay 100% of it.

Ron Barshop:

If you liked what you just heard, Cristin Dickerson, who has been on the show, she regularly publishes Green Imaging if you want to follow them on LinkedIn, case studies and you can see these numbers are true. It's ridiculous. And let's talk about surgery. So if you get referred in the network to surgery, you're going to have the same numbers saved, right?

Dave Contorno:

It's even bigger on surgery, at least dollar-wise because the dollars are typically bigger. And I'll give you an example. My wife who some people in the industry know as well because she's also my business partner, her name is Emma and she needed a hysterectomy. And I find this to be a really fascinating example because the average ... There's 550,000 hysterectomy done in the US each year. There's 58,000 OB/GYNs. That means that the average OB does eight or nine hysterectomy a year. Now I'm not a big sports guy and this is a little bit of a dated analogy, but Tiger Woods, he won the Masters last year, right? I asked people, "Do you think he practiced eight or nine times a year to get back to the top of professional sports?" Of course, not. Eight or nine times a week, he practice, right?

Dave Contorno:

So the problem with the normal OB/GYN is because they do so few, they rely on the techniques they learned in medical school which is typically open. Open is obviously higher infection rates, longer recovery times, typically requires opioids. The alternative to that is a laparoscopic surgery. Laparoscopic surgery is far less time under the knife, far smaller incisions. Generally no opioids needed. It's an outpatient procedure, but think about this dynamic for a second. If the average OB/GYN even wanted to do laparoscopic, they have to invest dozens and dozens of hours of training, hundreds of thousands of dollars in additional equipment and then the normal insurance plan sees that as a less invasive procedure, so their reimbursement is lower. Why would they go through all that for eight or nine times a year? They wouldn't.

Dave Contorno:

So we have a network of gynecological surgeons, each of whom do 300 or 400 hysterectomies a year. They all have 95-plus percent laparoscopic rates and we have a prearranged, pre-negotiated price of $11,000, all bundled. So if there's a mistake and readmission, it's on them versus the national average of $38,000 for hysterectomy.

Ron Barshop:

I asked Keith Smith of surgery center of Oklahoma on the show, "What kind of complications do you have?" He goes, "Why would I ever have complications if I know what I'm doing?"

Dave Contorno:

And you're talking to a patient of Dr. Keith Smith. I had my inguinal hernia repair there a few years ago. And at the time, I had BlueCross and BlueShield. I don't anymore, but it was cheaper for me to push my BlueCross and BlueShield card aside, pay for cash, pay for travel than my deductible and out-of-pocket alone would have been had I had it done locally.

Ron Barshop:

I love hearing those stories. So you're invited on the show, David, anytime, anyplace, if you ever want to bring one of your clients, 300-person employer on board and tell their side of the story because, of course, they're not going to sing your praises, but they're going to say, "I'll never go back." We've had three guests including the famous Rosen Hotel. So we had those folks on telling us their amazing story, how they use the dividend to not only grow debt-free, but to turn around the worst crime-ridden drug-infested neighborhood surrounding their hotel in Orlando.

And now they have a matriculation rate for college in that neighborhood equal to the highest 10% quartile incomes in neighborhoods in America. And they adopted a neighborhood five times that size.

Dave Contorno:

Well, and I got to tell you, I had the privilege of maybe five or six years ago to go down and visit with Harris Rosen and his team. And he was one of the people that put in my head that the employer that really cares about their employees are the ones that willing to do this and I'll tell you why. He was, at the time, 82 or maybe 84 years old. And we walked through the lobby of his flagship hotel which is called Shingle Creek. And there was a woman who was sweeping the floor in front of the elevator and he walked up to her and goes, "Maria, how are you doing today? How's your husband Jose? How's Little Johnny?" like he knew their whole family and I was just beside myself.

Ron Barshop:

Because of that turnover. You had 17%, the industry has 75. He does know them. I went to a bartender, I was staying there and there's this magazine on my dresser I checked in the hotel. I didn't know anything about Rosen Hotels. And it has this picture of this, I thought, egotistical bastard and it turns out, no. I started reading his story and he's done amazing things for the local community and poured the dividends he's received from this model into a ... They used to have to collect needles in the parking lot, in the playground of the elementary school there because that's where all the people are shooting up after buying their drugs and none of that stuff ... They don't have any gangs there anymore. Crime is negligible. It's just you talk about a turnaround.

Ron Barshop:

And then they're now on second and third generation employees of people that started working there. So if you're not losing your employees, of course, you're going to know Maria's name sweeping the floor.

Dave Contorno:

That's right. That's right. And I'm going to give you a little data on the cost because the first time we did a direct primary care plan was for a 2,200-employee municipality in South Carolina. The doctor involved there was Dr. Shane Purcell, and his partner, Amy Cianciolo. And at the end of the first year, we had reduced their total spend by 22%. Now in that model, we offered both a DPC-only plan and an any-provider plan to all the employees and we had about 48% choose the DPC plan. Now, for any of you on this that know how health plans are built, then what you should understand is that if you look at those two plan options, the DPC plan and the open access plan both have a similar set of fixed costs. Both have administration fees. Both have stop loss premiums that are the same, both have to pay claims.

Dave Contorno:

But on top of that, the DPC plan has to pay another 50, 60, 70, 80 bucks a month per person per bellybutton for the DPC membership fee. And this was in rural South Carolina, so it's a little less expensive. In some urban areas, it could be 100 or 150 bucks, but that's what it was there. So in order for me to just break even for this client, I have to reduce claims by at least the amount of

that membership fee on the DPC plan. But not only was total spend down 22%., but even with that additional fee, even though the direct primary care plan people were paying zero out-of-pocket, the total cost was still 16% less than the other people.

Ron Barshop:

Do you use national partners for pharmacy? I want to talk about medication cost too or do you use local partners. How do you do that?

Dave Contorno:

We do both. So the first thing is we got to talk about the evil pharmacy benefit managers and they are just ... Gosh, we talked about how doctors are paid on this, we talked about how hospitals make money, how insurance are going to make money, but all of that pales in comparison, I think to the ugliness that goes on of the PBM side. And so the first thing is you got to get the right PBM. And we believe it's one that is 100% transparent on 100% of their book of business. So they're prohibited from spread pricing. And I don't know the level of people listening to this, but that is the biggest reason why drugs costs so much is spread pricing. They're prohibited from taking any of the rebates. They're prohibited from club acts and some of those gains. That's the first thing.

Dave Contorno:

The second thing is how do they get paid? Most PBMs get paid not only with those backend things that I just mentioned but also with a per-script fee. And the problem with the per-script fee is that they're incentivized to fill medications. We don't want them to be incentivized. We want them to be incentivized to help us get to the lowest cost, most appropriate medication. The PBMs that we work with charge a per employee or per minute per month, no matter how many drugs they fill. So now I know they don't have the financial incentive to fill drugs. So then I need them to notify me when certain drugs are requested to be filled because I want to go into action.

Dave Contorno:

So let me tell you the trick that we use whenever we can that saves the most amount of money. If you've ever heard at the end of a drug commercial, it says, "If you cannot afford your medication, AstraZeneca may be of help," and they say it really fast and really low. Now, this gets a little confusing, because there's two large umbrellas of programs out there that drug manufacturers do. One is called copay assistance. That is not what I'm talking about here. Copay assistance is when you have coverage of the drug, you have to have coverage of the drug. And their goal is to cover your out-of-pocket, so that they get to the point where you're a health plan aka your employer aka you the next year when your rates go up is paying for that drug at 100%. That's the point of a copay coupon.

Dave Contorno:

It's not to save you money, it's to make sure that you keep taking their drug and that your deductible isn't an obstacle to the drug company getting to the point where the plan pays 100%. That's not what I'm talking about though. I'm talking about a program called a PAP, a patient assistance program or an FAP, a financial service program or an MAP, a manufacturer assistance program. And that is specifically when you don't have coverage for the drug.

Dave Contorno:

And the second metric in most plans and it differs from drug to drug is you have to make a certain percentage above the federal poverty level, but those levels can be pretty high and cover most of America. So when we see a high-cost drug pop up, we get notified before it gets filled or approved. And I go and see, "How much money does this employee make and is there a financial assistance program available?" Assuming there is, we then instruct the PBM to remove the drug from the formulary? Now, if your Express Scripts or Caremark and you're making $1,000, $5,000 $20,000 every time that drug is filled, are you going to remove that drug? Of course not and they refuse to, but the PBMs that make money differently have no problem doing.

Dave Contorno:

So we make sure the person qualifies. We remove the drug from the formulary. We apply for the program. The drug manufacturer calls the plan and says, "Hey, is this drug covered?" Now they get a no and then they ship the drug, the manufacturer directly to the employee or to the doctor if it's an infusion at no cost to the employer or the employee. Now it doesn't work on every drug, but that's the first thing we go to because that obviously reduces the cost the most. And I want to say one thing that I know, we're really not going to get into, but one of the reasons why I'm so dedicated to this is when I changed from being a traditional broker that's commission-based which means as my clients rates went up, so too did how much money I made, the first thing I changed was how I get paid and I changed my payment to where I charge a transparent fee that is contractually the only revenue I can get and I get a bonus for my client tied to doing what they want me to do, which in most cases is lowering costs, so I have a strong incentive.

Dave Contorno:

If I was the average broker and I even knew how to do these things and I put you with a plan in which I could do these things because you can't do them with the BUCAs or the large PBMs, why would I do it? If I actually save you 500 grand in premium and that lowers your rates by 10%, I make less money. That's the whole ... If you want to know why our health care system, one of the things I say is our health care system isn't broken. Many people think it is, but it's actually working exactly as it was designed to work. It just wasn't designed by employers, doctors or patients. So it's not working well for those three groups, but it's working really well for a lot of people and brokers is one of those groups.

Ron Barshop:

And shareholders and large big corporate account the bigs. Let's go back to the Heritage Foundation, at the top of the findings, 17,280 in savings per family, which is it squares with the average family premium or contribution to implore [inaudible 00:28:42] is about 21 grand and it's about five grand if you're talking about singles. So 17,000 sounds about right to me. If you have a $17,000 raise, meaning you no longer have premiums, copays or deductibles of that much, that $14,100 a month buys you a nicer, a new home. It buys you a nicer school district. It can get rid of credit card debt.

Ron Barshop:

For a lot of my employees that have never had a first vacation because they're working poor, the average hourly worker makes under $20 an hour in America. Morgan Stanley says well over

half. So if you have never had a vacation before, that's pretty sweet. So can you talk about the employees and the reaction that you get when they suddenly get an overnight benefit rates, a cash raise?

Dave Contorno:

Well, I will give you a story and you actually almost touched on it a second ago, but we have a client up in Wisconsin, Central Wisconsin and they are a chain of Subway restaurants and retail automotive parts. So you're talking hourly people, right? That's their whole population except for a few managers in the corporate office. And we put in a program in which for medications, if you allow us to source it outside of the pharmacy with the manufacturer assistance program, I just gave you as one example, we also import drugs safely and legally internationally. That's another way we save about 60 or 70% when we do that. If the member allows us to do that, then we waive their out-of-pocket.

Dave Contorno:

And I just want to point as a sidenote and you said it earlier, Ron, I believe that HSA or HSA-compatible health plans are the single most damaging strategy that my industry has ever unleashed on the unsuspecting American public. And I can't overstate that because it's an avoidance to care, number one, and number two, I can't do what we do which is waive the out-of-pocket because you can't have dollar one coverage. So you literally can't make it as affordable as possible for people to get the right care. So anyway, this woman was on an HSA plan. She had a $6,600 out-of-pocket every year before her plan picked up 100%. And she knew that just with the medication, she meets that $6,600 every year.

Dave Contorno:

And I'll tell you, most employees don't listen fully at the time of the employee meetings. That's why we do several of them. When she went to fill her drug for the first time under the new plan and it costs nothing, she went into the owner the next day and he tells the story amazingly. But she walked in and said, "Tim, there has to be some mistake. I just filled my drug for the first time under the new plan and it didn't cost me anything." And he looked at her and said, "No, you did the right thing and so I'm paying for it 100%." And she started crying right on the spot and literally said, "For the first time since I've been diagnosed with this disease 10 years ago, my family is going to be able to take a family vacation this year."

Dave Contorno:

That's how powerful this is and that's just a piece of how much she's saving. Forget about the fact that after the end of the first year, we save so much money overall that typically what comes out of employees paychecks goes down. And then like Harris Rosen, we often require employers to do a dividend. And we really want that dividend to be in line with their culture. So it could be ... One of our clients took all their employees to Vail, Colorado on a team building trip for four or five days. And now here's a good story. Another client of ours is a car dealership and I don't know if you've noticed, but where the mechanics work, where the lifts are, it's usually not heated or cooled. They kind of open the doors during the summer and put space heaters in when it gets really cold in the winter. Well, this client put in heating and air conditioning and all the mechanic bays and said to them, "Your health plan paid for this." That's pretty powerful stuff.

Ron Barshop:

I just did some math, if you take the savings, the average savings Heritage Foundation says that we deliver with these new plans and you multiply it times the number of months in a year and then you multiply that times 1,000 employees, that's about $17 million that goes into the economy. But it's a lot more than that because we know through federal economic stimulus, although economic studies say it's a 2x benefit, meaning if you're saving 17 million in the economy with a stimulus, it's really 34 million. So every time you're putting a plan and it's 1,000 employees, you're putting 34 million into mostly local economy, which is really ... We didn't even talk about that enough in our industry.

Dave Contorno:

And I want to put the numbers into perspective for any employers or even brokers that are listening to this that follow this. The Kaiser Family Foundation, if you take the total spent by a company on healthcare and divide it by the average number of employees, so this is blending together singles and families and spouses and children, the Kaiser Family Foundation is saying that the average employer spends right around $16,000 per employee per year on healthcare. Our plans, and I believe firmly that while enhancing and improving primary care is foundational, it's not all that needs to be done. And there needs to be a comprehensive holistic approach to, "What happens when they need outside primary care? What happens they need medication? What happens they need radiology?" all that needs to be addressed.

Dave Contorno:

But if you do it, I want to put into perspective where our per employee per year costs are, our clients range from $3,300 to $7,700 per employee per year. So our worst-performing client is about half of the national average. And the reason I want to put those numbers out there and sometimes I hesitate because some people are like, "No way, there's just no way," but there is so much bloat and fat in the healthcare system that when you change the incentives to remove those instead of increased those, it's not hard to say ... I tell people all the time, "I didn't graduate college and the college I did go to was majoring in photographic technology, but I think that I learned everything I needed to learn to fix healthcare by ninth grade economics. It's really not that hard if you know where to look and you start demanding info and questions and answers just most employers demand in every other part of their business."

Dave Contorno:

And that's really what needs to be done is the intelligence and transparency in healthcare needs to be demanded by those that are paying for it. Just like they demand it in their office supplies or their logistics or whatever other procurements they might have in their business.

Ron Barshop:

Trig and calculus, but the screeching brakes on my grades, but I started finding algebra and math. Hey, so let's talk about the elephant in the room that if you're a first-time listener, listening to Primary Care Cure, you're saying to yourself, "These guys are smoking dope. They're not talking about the cancer, the car accident, the cardio that's going to cost you a million dollars. Screw them. Adios." So talk about catastrophic care, the Sederas of the world. How do you get through that problem?

Dave Contorno:

Well, within our plans, the problem with healthcare is just fundamentally how it is delivered and paid for. And so yes, we use Sedera sometimes. A matter of fact, I'm personally on Sedera, but it's not the only way to do it. What you need is to change how healthcare is paid for. And for those of you that don't know, let me tell you how healthcare is paid for in this country. It is where the insurance company and the provider, the health system usually, they go into a secretive backroom and everything they do back there is covered with nondisclosures across the board. Now, obviously, when you're a health system executive, CEO or CFO, you want your reimbursement rates to be as high as possible, right? Because the more money you bring in, the more money you make, right? That's the theory anywhere.

Dave Contorno:

But most people don't understand that insurance companies have the exact same motivation. Most people think that insurance companies make more money if they keep claims down and that is wholly untrue. For those of you that don't know, there's a provision of the Affordable Care Act called Medical Loss Ratios and it says that every insurance company must spend either 80 or 85¢ of every dollar they collect in premium on healthcare costs. That means they can keep 15 to 20% of that premium for their own overhead and profit. Well, 15 to 20% of a bigger number results in a bigger number. And the only way for that topline number to get bigger is for claims to go up.

Dave Contorno:

So while insurance companies certainly do deny claims and often they deny the wrong claims, they deny claims really for the purpose of getting you to where the incident of care is most likely to be the most expensive and so skipping over the physical therapy for the back pain and going right to the back surgeon as an example. So the way healthcare is paid for is these two entities go into a back secretive room where they know they're going to have no one looking at this and they negotiate but both of them want costs to go up. And the only thing that insurance company doesn't want is they don't want their cost to go up faster than their competitors because otherwise it prices them out of the market.

Dave Contorno:

And so healthcare, what they agree to in that back door among other things like no audit prohibitions, the main thing they agree on is the discount. And so the contract would say, "Okay, when a claim comes in from this health system, BlueCross has to give," I don't care, a 99% discount is irrelevant because what's not in that contract is the starting price. And so the provider can mark up that starting price as much as they want to get to the net price that they want. What other thing do we buy in this world in which not only the consumer but also the provider of that service or good neither party knows what the cost is going to be until after the services are rendered, the health system has incurred the cost, the member has incurred the liability or the health plans liquid liability, now the price is determined? That's just insane.

Dave Contorno:

So what really needs to change and this is why Sedera does it well on the individual and small group side, but it can be done in the mid and large group side which is what we specialize in is

changing how care is paid for, changing the incentives of the doctors when you can like the direct primary care doctor and putting in transparent and evidence-based partners, whether it's medical management, pharmacy benefit manager. So at the end of the day, every CFO, if you ask them, "How much does a box of paper cost?" they can tell you, but if you ask them, "How much does a knee surgery cost?" they don't know. And there's something that's really wrong with that and that's what we change within the health plan space is how the care is paid for.

Ron Barshop:

And this loss ratio, what they have to do if they don't hit their numbers, their 85 or 80% is they have to refund back to the employers and a dividend of the unused portion. Well, when's the last time you as an employer ever saw a dividend check from a BUCA? It doesn't happen. So I guess, I have a lot more questions and we've run out of time, but the most important question is, are you in all 50 states, Dave? Are you licensed everywhere?

Dave Contorno:

Yeah, we are. And we get business through two models. One is where we work with employers directly and we have probably 15 or 18 states just on that, but the other way that's given us a lot more reach is we've developed what we call our co-consulting program and we partner with brokers and consultants around the country, much like doctors who left the fee-for-service and might have looked to the Lee Gross or the Josh Amber for guidance. We try to be that guidance for brokers and consultants that want to build these nontraditional health plans for their clients.

Dave Contorno:

And so we partner with them on their first few cases to help get over the objections, to help build it properly, to help execute on it and to help report on it in a way that makes sense to everyone. So that allows us even a larger reach because we have consultants in many more states. So yeah, wherever they are and I want to also clarify the size group. We want to help any size employee that we possibly can. Now, I'm going to backtrack a second here when I say this, but you have to be self-funded or partially self-funded in order to do these types of plans, not because you actually have to be self-funded, but because the fully insured carriers that control the market won't let us do these things because it's contrary to their financial interests.

Dave Contorno:

But you don't have to be large. We've done it on companies as small as 14 or 15 employees as long as the state regulations allow us to do that and it does differ from state to state, but we talked about the Medical Loss Ratio for a second. I just want to bring one point home. A lot of employers that we meet would say, "Oh, well, we're self-insured, so the Medical Loss Ratio doesn't apply to us." And they're right, if they're self-insured, technically the Medical Loss Ratio doesn't apply, but let me tell you what they most likely did that doesn't make any sense to me. They most likely put themselves on a self-funded chassis with Blue Cross United, Cigna and Aetna on all the same claims administration platforms, on all the same PPO contracts, and all the same pharmacy contracts in which those metrics do exist.

Dave Contorno:

So they're being impacted by it anyway, but they've removed whatever risks the insurance company had from them and put it on their own shoulders. That makes no sense to me.

Ron Barshop:

So you're on the small end, 15 employees, what do you do on the large typically?

Dave Contorno:

So we've worked within companies that's actually as big as a little over a million, although that's very infrequent. We've had 55,000, 25,000, 10,000, but we really like that 50 employees to a couple thousand. That's really the where we can get in front of the right executives, they care about their company, their own employees and we can really do a lot of magic in that size.

Ron Barshop:

And I'm doing a head count because there is no association that tracks the direct contracting players of the world like the Premise Healths and like the Nexteras, but how many belly buttons do you guys have currently and what do you think you'll have three years from now?

Dave Contorno:

Between the direct business and the co-consulting business, the last check I had we were somewhere around approaching 100,000. And I don't know if you've had Dave Chase on. Have you Dave Chase on before?

Ron Barshop:

Of course. [crosstalk 00:41:46]

Dave Contorno:

Yeah, I figured. So I was the founding advisor within Health Rosetta, so I, next to Dave and Sean, helped to create the programs and a lot of these certifications. And so I consider myself to have influence among many other people too within that entire group. And we have, I think, over 2 million in the whole Health Rosetta between all the advisors. So listen, that's still a small little pittance, but the more we touch and-

Ron Barshop:

No, it's not small. It's got to start change somewhere, and again when you have happy doctor, happy patient, happy employer and then you have great outcomes and great cost reductions, that's the quintuple aim and that's way past the triple aim.

Dave Contorno:

I agree. We didn't really talk about it, but this these types of plans makes doctors lives better too and doctors have had one of the highest burnout and suicide rates of any profession for the last few years.

Ron Barshop:

You just say you show them the platform they got to operate on and they like go crazy with elation and I can't tell you how easy it is.

Dave Contorno:

And I'll say one last thing on doctor satisfaction, when we put in a DPC plan, I want everyone who might be a DPC to hear what I'm about to say. Even though there's "an insurance plan," it's not a traditional insurance plan, but what I want them to know is that every single DPC within our plans, they have no step therapy, no prior authorization, no precertification requirements. If they say it's medically necessary, they don't need to ask permission. It is automatically covered. Now, when they send the patient out back into the regular world, we then typically put some of those metrics back on the specialists but the DPC, they say it's covered. They say, "It's necessary. It's covered."

Ron Barshop:

By the way, I've invited as a guest, a cool new DPC model, I'm not sure you've heard it, but there's maybe a half a dozen to a dozen of these out there, but I call them Robinhood DPC where they charge $200 for the concierge red carpet care you get with direct primary care, no copay, no deductible, no premium, and then they take 100 of that or they take actually two-thirds of that and they buy two free DPC memberships for poor that couldn't afford it. So 200 basically buys you and your family and then it buys two other families access to the doctor. How about that?

Dave Contorno:

Love it. Love it. It's like TOMS shoes. When you buy a pair of TOMS shoes, they donate a pair of shoes.

Ron Barshop:

That's what they told me. When I talked to them, they said, "This is the TOMS shoe model. It's the Robinhood." Anyway, super cool. All right, Dave. We'll get you on again. I love talking to you and guys like you. And if you want to bring a guest on, you have a free carte blanche pass anytime to be on Primary Care Cure. So thanks for your time and if people want to find you what's the best way?

Dave Contorno:

I would LinkedIn David Contorno. Luckily, my name is unique enough that I'm really the only one that comes up, so follow me on LinkedIn, a great way to message me through there as well.

Ron Barshop:

And if you could find a banner over America with one message, what would that banner say?

Dave Contorno:

It would be two words, healthcare and then the does not equal signs health insurance or health insurance does not equal healthcare, either way. Those are two separate things. We understand the difference between cars and car insurance and homes and homeowner insurance, but we intermingle the words healthcare and health insurance as though they're one of the same.

Ron Barshop:

You hear often people say, "I've got good health insurance meaning I've got good healthcare," is not true. That person likely is functionally uninsured. All right, man. Well, you have a great Fourth of July remaining of your weekend and I'll talk to you soon, man.

Dave Contorno:

Thanks, Ron.

Ron Barshop:

Bye.

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.