Primary Care Cures

Episode 151: Andy Schoonover

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:

The Reserve Board says 40% of us are illiquid, which means under 400 bucks in the bank. The Bureau of Labor Statistics says 40% of us are in high-deductible plans, so if you have a $1,500 deductible and under 400 bucks in the bank liquid, do you really even have insurance? Well, that's a hat tipped to Dutch Rojas, he came up with that quote. But this is basically a functionally uninsured dilemma, and insured are just under 30 million Americans. And we hear a lot about that in politics and campaigns, the uninsured, the uninsured. The functionally uninsured are a much larger population, more than double. So, it's half of all workers. We have 151 million workers, so at least 75 million folks, are functionally uninsured. But to add insult to injury, over 85 million carry at least some medical debt today, according to Debt.com.

Ron Barshop:

Six weeks ago, Ford came out. And by the way, half of those 85 million carry at least a thousand, so 85 million Americans are carrying debt from a medical bill, and 75 million, which is half, have basically high-deductible insurance, and they're functionally uninsured. We've got a problem, don't we? And just to put 85 million in context, that's about how many watched the Super Bowl last year. So, employers have been pressured by these ever-spiraling healthcare costs, ever on increase, ever on increase, and for decades now. And they're squeezing their employees by that choice because they have to, into these high-deductible plans. And the Department of Labor defines a high-deductible plan as anything over $1,500, and boy, some of them get really high, way past 5,000. They get up to 8,000, 10,000.

Ron Barshop:

So, they've had to shift risks to their hourly workers, and America's primarily an hourly working economy, that's the backbone of American economy. Guess what percent make under 30 bucks an hour? That would be 81% of us. 51% make under 20 bucks an hour. So, we are a wealthy nation, an economist at the Federal Reserve told me a couple of years ago, because really our poor still have dishwashers, and they have washing machines, and they have televisions, and they have cell phones. So, related to the poor in the rest of the world, who survive on two to $4 a

day, our poor are doing pretty good. But, if you've ever been to Europe or Asia and stayed with a friend, or stayed in a house, they don't have dishwashers in a lot of these houses, and they don't have washing machines in a lot of the upper middle-class houses.

Ron Barshop:

So, we're actually okay, but I digress. That's called my monkey brain at work. So, America's an hourly worker economy, this is largely the makeup of the great resignation that's in the headlines. The hourly guy who works his shifts at Walgreen's, or your server at the diner who just gets up and they're done, an Amazon delivery person, 20% of hospital workers even have quit this pandemic. They've just opted out of working, but supposedly this hourly worker backbone that I'm talking about that is part of this resignation. Because, I believe, there was a time when a good job meant a good healthcare plant that not only protected your finances, and it protected your health. So, today's healthcare plans do neither, for undeniably half of all Americans, so the benefit no longer retains good people because over half of us are functionally uninsured.

Ron Barshop:

You got it? You can't use it, it's a non-benefit. There is another road or two, and this show is dedicated to making sure you're aware there is hope, especially for our hourly workers or self-employed contractors like realtors. Or actually, anybody not on Medicare. You can opt out of your non-usable plan, your, "Non-benefit benefit," in air quotes. It's an empty promise, these benefits today. So, you opt in to direct contracts, or direct payment models like our guest today, you're going to learn a lot about a new way of thinking about a direct payment model to take care of your health costs. So, we've had dozens of guests and direct contracting connect with you about primary care, and specialists, and surgery centers, and labs, and imaging. You can get even your medication to Benazepril.

Ron Barshop:

I love that our guests' from Wembley Scripto, so we had Zack talk about that if you want to listed to that episode. We really don't need middle men, these bigs really just get in the way and add only complexity and friction and bureaucracy and cost. Did you know that docs only get eight to 18 cents per dollar that they bill? Eight pennies. If they work for a big, more like 18 cents, if they're independent. But, the bigs and the admins needed to please the bigs with ICB10 codes and ICB11 codes, and CPD codes. They feed off the medical exam to the tune of 82 to 92%, so that doctor that should be making a lot more can, if they go direct, they get a raise, and they have less volume. Typically five to 800 patients, versus 1,500 to 2,500.

Ron Barshop:

That's if they go direct. But actually, every doctor is direct, every primary care doctor listening to this is direct, and I'll explain that. We'll explain that, it's all happening for 30 million strong. It's a movement with no name, no leader, no articles, few macro studies but plenty of evidence by these contractors that are directly involved in this by their company evidence. But we're learning that it saves 20 to 60% off the employer healthcare spend. Employees love it when it's executed well, and communities benefit. Check out the college matriculation rate to the poorest school district in Orlando, and how a portion of the 450 million in healthcare savings arose in hotels and resorts, saved a once crime-infested, hopeless district.

Ron Barshop:

So, they have 6,500 employees in 6,000 rooms, but they also have adopted not only a small school district called Tangelo Park, but a larger one next to it. These are the two poorest districts in Orlando, and the elementary school principal told us that he used to walk by the playground and collect syringes and needles from the junkies the night before. Well, no more. For 30 years, they've been helping the community matriculate from college at the same rate as the top 10% rich schools. Well, that's episodes 54 and 74 if you want to learn more about how community benefits from direct contracting. A second way to go direct I will learn about today with our guest, it's not a new idea but it's a fresh wrinkle on a new idea. How about if you crowdfund your healthcare?

Ron Barshop:

Kind of what health insurance was supposed to be a long time ago, but it's no longer. Today's guest is Andy Schoonover, the CEO of CrowdHealth, which, like direct contracting, says goodbye to deductibles, and co-phase, and billing, and in and out of network docs and coding and all of that, because his platform is paid out to the ecosystem on an all-cash basis. To the docks, to the imaging, to the meds, discount pharmacies, to the labs, all of it. Everyone who takes cash is in network, and that's pretty much everyone. Welcome, Andy, to the show, glad to have you.

Andy Schoonover:

Thanks for having me, appreciate it.

Ron Barshop:

Yeah. Any comments before we get going?

Andy Schoonover:

Man, you perfectly framed the picture, the mess that we are in. I would say that there's only one additional stat that I would throw out there that I didn't hear, and the one that breaks my heart and is really the mission of why we're doing this is, we had 250,000 families last year who had health insurance go bankrupt because of medical bills. And it is a perfect reflection of what you just said, which is, thanks to Dutch, if you don't have enough cash in the bank to pay for your deductible, you don't actually have health insurance. I mean, the whole point of insurance in general is if you have a large event that it won't put you into financial distress, and that's just not the case with health insurance.

Ron Barshop:

You know, for families making 35 or 50,000 a year, and they've got a $25,000 premium. So, that's a typical family that's paying 2,000 to 2,500 a month, and they've got an 80-20 co-pay for these big expenses, and they have deductibles that are five to 8,000. They're in it for 30, $40,000 before they ever have the insurance company have to tap their funds.

Andy Schoonover:

Yeah. I mean, and that's the reason why we... I can tell you a quick backstory of why we started CrowdHealth, but it was just perfectly along those lines. I was running a healthcare technology company, and we were doing remote patient monitoring, so we were monitoring blood sugars and blood pressure and things like that from folks with chronic conditions. And funny enough, we were selling into the big health plans. We sold that company, and after I got off of Cobra, which I think was $2,000 a month or something like that for me, my wife and my two girls, I jumped on Healthcare.gov, because I thought it was the only option. Got a health plan, and it worked until I actually had to use it, my little one who was one at the time was having recurring hear infections, and so went to the ear, nose and throat doctor who said she needs tubes in her ears, she had a perforated eardrum.

Andy Schoonover:

So, we went to the hospital, 15 minute procedure, got the bill. It was $8,000 for 15 minutes, and my health insurance company came back and said it was medically unnecessary and so they weren't going to pay for it. And so, it was one of those times where I was like, "Man, I've been fortunate, I can write an $8,000 check." But as you were talking about in your opening, the vast majority, I mean 90% of Americans don't have $8,000 in their bank account to pay for a pretty kind of innocuous thing, like ears, tubes in their ears. And so that was kind of the catalyst for me starting CrowdHealth. I called up my health insurance plan, I was like, "I quit. If you're not going to pay my bills, I'm not paying your bills," and my family and I have been uninsured ever since. And so, that's kind of the founding story of CrowdHealth.

Ron Barshop:

Well, let's define uninsured. You've been uninsured by bigs, but you have been covered by this new model, so you have protection, you have an umbrella.

Andy Schoonover:

I do have protection, and I actually feel more secure in my protection than I ever have been. If you look at the Healthcare.gov plans, they... This is Kaiser Family Foundation data, one in six claims are denied by Healthcare.gov plans. So, you have a one in six chance. If you live in Tennessee it's one in three, if you live in Texas it's one in five. You've got to be doing a 17 to 50% chance of not getting your medical bill paid, and so people are saying, "Wow, how can you survive without health insurance?" And I'm saying, "A lot of times, health insurance isn't paying." So, yeah, we do our covered... We do have a group of people that are committed to helping us if we have a big healthcare bill, and we're committed to helping them if they have a big healthcare bill. And like you said in your opening, it's the way we've been doing it for thousands of years.

Andy Schoonover:

And it wasn't until into the '70s and '80s for the most part that the middle men stepped in, and really kind of stole our ability to be generous to our community members away from us, because we're no longer the buyers of healthcare, the insurance plan is.

Ron Barshop:

Yes. Well, I want to get into the mechanics of how it works-

Andy Schoonover:

Sure.

Ron Barshop:

... because I think it's fascinating, what you put together here. I kind of think of it like if the Uber ratings system had a love child with GoFundMe, that that would turn into your company. Because, the innovation I think you've done that's really creative, besides... We'll talk about the other innovations, but there's a rating on both sides, not only for the donor... Well, for the person who joins the fund, and we'll talk about how all that works. So, they're rated. Are they contributing regularly, or somewhat to other people's needs? And then there's also, are you shopping properly for the right kind of care at the right location that's lower cost than, say, going to a... I mean, you can get an expensive MRI for 4,000, you can get one for three or $400, depends on the place of service.

Andy Schoonover:

Mm-hmm (affirmative), mm-hmm (affirmative), yeah. As we were building the model, I think there was two problems that came up. One is, how do we keep people from going to the mayo clinic for a flu? There has been no incentive in the past for folks to shop for healthcare, I think there are still significant barriers for people to actually be able to actually be able to shop for healthcare, even though there is increased transparency we wanted to be able to help them shop for healthcare. And so, what we've done is put in a rating system that basically says, "Hey, are you a good shopper, are you actually going and shopping for your healthcare, or are you just taking whatever price the hospital or the orthopedic surgeon or whatever gives you? Are you allowing us to help you shop, or not?"

Andy Schoonover:

And so you have a shopper score as a part of our system, and the other problem, and we can talk about the mechanics of how this works, and I think it probably will make a bit more sense. But if you think about crowd health as being a crowdfunding platform not too dissimilar to GoFundMe, what is the incentive for people to actually help me, especially if it's a run of the mill procedure? I mean, I understand GoFundMe when somebody gets... Their kid gets leukemia or whatever, and it ends up being there's an emotional play here, that people just want to help, that there's just a sincere desire to help. If I'm getting a knee replacement, there's not quite that emotional tie to be able to help me. And so, how do we incentivize that?

Andy Schoonover:

And basically, what we do is, every month we reach out to our members and we ask, "Hey, here's a list of things that your community members need help to pay for. Are you willing to help them?" So, it's 100% voluntary. If you do help them, 100% of those bills, then you get 100% generosity score. If you help them with 50% of the bills, you get a 50% generosity score. And ultimately, what that does is creates a level of reciprocity where if you are generous, then if you have a bill others will see that you're generous, and will help you out. If you are stingy-

Ron Barshop:

Wait a minute, I'm a little confused, sorry to interrupt here.

Andy Schoonover:

Sure.

Ron Barshop:

Andy, do you have... Labor and delivery is the most common surgery in America, [inaudible 00:14:34] C-section, it's six, 7,000 bucks typically, application. So, you have 7,000... Let's say you have 7,000 members, which you don't yet, because you're brand-new. But, you have 7,000 members. That means if everybody kicks in a buck, they've got that covered. Is that how that works? Of course you have the $550 the member has to pay, so maybe we should get into the mechanics of what each member pays.

Andy Schoonover:

Sure, yeah, let me start from the beginning. So, if you are between the ages of six and 54, it's 175 bucks a month, a little bit more if you're older or a little bit more if you're younger. You put that money into an account, $25 of the 175 comes to us, that's how we make our money, it's a subscription fee model. The 150 stays in that account, that is your account. And then that account builds up over time, but you'll use the money in that account to help others with their medical needs. So, everybody think about it as, we have 2,000 bank accounts out there, and everybody has money in that bank account, and you're putting money in there every single month. And then we're asking you on a monthly basis to contribute to the medical bills of other people in that community, and so you're using the money out of that account to help other people.

Ron Barshop:

So, like a health savings account where I have my 2,500 bucks, or 2,400 bucks at the end of the year, minus your admin fee, call it $2,000. If I haven't used my 2,000, what you're saying is now I can donate 200 of that towards that labor and delivery, or $2, whatever I choose, right?

Andy Schoonover:

Exactly, exactly. And at the end of the day, if you need crowd help, the money is yours so we give it back to you. That's significantly different than the way your health insurance plan would work.

Ron Barshop:

Okay. So, you got funded by $6 million initially back in April a year ago. Do you have enough to take care of the cancers, and... I mean, cancer's obviously going to be less than 1% for your population. Do you cut off age? I know you cut off 300 pounds, and you cut off smokers. But, do you cut off any other age limitations other than Medicare age-eligible?

Andy Schoonover:

Only Medicare age, yes. If you're eligible for Medicare, then we recommend you go to Medicare.

Ron Barshop:

Okay. Now, I want to dispel a myth too, because a lot of... You only pay the medications for 120 days, and a lot of older folks have co-morbidities, and they have lots of medications they're on.

But, you have a prescription discount that gets them their medications, a pennys a pill, as opposed to the ridiculous rates that they'll pay at a typical retail store.

Andy Schoonover:

Yeah. We're working with a company that's similar to GoodRx, it's not GoodRx but it's similar, based upon a similar platform. And so, we're getting similar prices to GoodRx, which oftentimes, especially on the generics, are 70, 80% less than what is billed by your health plan. So, a lot of the folks that we have, and there are no kind of pre-existing requirements for us, and so if you have a pre-existing condition, we ask you to be responsible for those, or kind of commit to paying for those, that pre-existing condition in the first year. And then some of the bills are eligible, so up to $25,000 of the bills are eligible in year two, 50,000 in year three, and then 100,000 in year four and beyond, they're eligible to be funded by the community.

Andy Schoonover:

But what we're seeing is lots of folks with hypertension, high cholesterol, those types of things. But those drugs are not that expensive, I mean, those drugs all have generic equivalents. They're 10, 20, 30 bucks a month, and so we think we're saving people on average around 6,000, six-ish, six to $7,000 a year. So, when I show them the math that they're paying maybe an extra 30 or 50 bucks a month for their prescription drugs, you're still in the black there.

Ron Barshop:

Yeah, people tend to get nervous thinking about how I'm going to pay for drugs, but the truth is, again, generics are, at least for one of our guests, Scripto, literally 85% of their drugs are pennys a pill, and they charge 150 bucks a year to access those pennys a pill drugs. And the 15% that aren't pennies and pill, or maybe one of them actually is a dollar a pill. So, pennys a pill is 90 cents at the end of 90 days. I mean, it's not even a dollar. So, it's sometimes $2.70, but you're not paying a lot for the drugs if you know how to get them wholesale, and you can use Scripto, or you can use All Service, which is the GoodRx mob.

Andy Schoonover:

Yeah, exactly.

Ron Barshop:

So either way... Now, the medication that scared people though is, "What about the drip I'm going to have to take when I have cancer? What about that chemo?" That's the stuff that scares them, is the specialty drugs.

Andy Schoonover:

Let's add some market forces into play here, right? The reason why those pharmaceutical companies can get those from health insurance plans is your health insurance plans are not negotiating on your behalf. We think that they are, they are not. They have no incentive to, even with the whole ECA, Obamacare that worsened it, because it gave the health insurance an incentive to actually have premiums go up as opposed to premiums go down.

Ron Barshop:

Actually, yeah, the pharmacy got a waiver to ever have to negotiate their pricing again with Medicare, with Medicaid or Medicare. So, federal government cannot negotiate drug prices on any type of medication, specialty, generic, fill in the blank, because of 2009.

Andy Schoonover:

Yeah, exactly. And so it really has perverse incentives, and so what we're doing is we are negotiating with these hospitals, we are negotiating with these pharmaceutical companies, and you can negotiate, I always say that. I've got more negotiating power as an individual than United Healthcare does against my local hospital.

Ron Barshop:

Okay. Where I might be, let's say I have the labor and delivery, I'm going to have three kids over the next six years, okay?

Andy Schoonover:

Mm-hmm (affirmative).

Ron Barshop:

So, we're going to have 18,000 and... What happens if somebody doesn't fund the full six grand, or seven grand? What happens if there's a complication and it's really 12 grand? What happens when the community can't step up for the full amount that's needed to take care of it?

Andy Schoonover:

Yeah, I mean, we think we have the systems and processes in place where the community can do that. We do no believe, and we've kind of backed this up because everybody at Crowd Health is a part of Crowd Health, we are all members of Crowd Health, we don't have any other insurance, Crowd Health is what we use. So, we put our money where our mouth is, and we believe we have the systems and processes that we, between negotiating those bills, which is significant, we post-negotiate all of those hospital bills, we can get those bills down by about 60%. Oftentimes the hospitals, given that you are an individual, you're not a part of the CrowdHealth plan. You are an individual that is using CrowdHealth as a platform to help you crowdfund for some of these bills.

Andy Schoonover:

And therefore, the hospitals, the pharmaceutical companies, all these people will... Or, all these organizations will negotiate with you, and we do that on your behalf. So, it's one of the services that we provide you, is we will negotiate with the hospital and the pharmaceutical companies.

Ron Barshop:

And you'll navigate for the best care, the cheapest care is not the best care. Actually, the best providers in primary care and surgery and specialist tend to be lower-cost, they're not higher-cost. It's not like buying a car, where you get a really nice car for more money. In healthcare, it's the almost opposite.

Andy Schoonover:

Yeah, they're inversely related, quality and cost, often, oftentimes. I mean, if you think about this as the orthopedic surgeon, I talked to one in Austen, the best in Austen I think, he does six or seven knee replacements every day. And so, if you think about six or seven knee replacements every day as opposed to six or seven knee replacements every month or every year, the guy who can do them every day, he's seen every complication in the book dozens of times, they can do it faster, they can do it more effectively, they don't have to come back for redos. Knee replacement is one of those where you have to come back for a redo fairly often, and so if you do lots of them and are better at them, you're typically lower-cost. This is not the Ritz Carlton or the Ferrari, this is actually the opposite of that. It's, you get the best doctor typically at the lowest cost.

Ron Barshop:

We had Keith Smith on the show early on, and he said... I said, "What do you do with complications at the Surgery Center of Oklahoma?" And he goes, "Why would I ever have a complication, Rod?" And he's right, they have lower infection rates, less complications, because they do it right with professionals that know exactly what they're doing and do tons of them. So, every surgeon's a specialist today, there is no such thing as a general orthopedist, a general radiologist even. They're all narrow-casted specialists, because they have to be good at something because otherwise it's too complex.

Andy Schoonover:

Right. And that's why I said, this guy I talked to is just knees, that's all he does, he just does knee replacements, and he does six or seven a day. And so, he's excellent at it, and he is dying to go into an all-cash pay system, because I think his practice had 10 doctors in it, I think they have a hundred people working for them with 10 doctors. A big chunk of them are billing people, and those billing people are trying to get funds from health insurance plans, and the doc would love to go and cash.

Ron Barshop:

I've been in hundreds of primary care clinics, here's the setup labor-wise. You have a front desk, they're collecting your clipboard and entering the data in for the insurance company, EHR system. It's not yours, you don't get the data from that EHR. The doctor doesn't really get much either, they have to do it to get paid. Then you have the outtake, same thing happening, you're now paying your co-pay. Then you have the referral coordinator, that's not a caregiver. Then you have the person who's handling all of the billing and coding and collecting, there's literally seven people for every doctor that's in primary care. And of all those people, only one is rooming you, taking your blood pressure, cuffing you, taking your eyesight if you're a kid, giving you your vaccines.

Ron Barshop:

There's a shot nurse, usually. So, one to one and a half people are caregivers, and the rest of them went to medical assistant's school to learn how to basically deal with transactions.

Andy Schoonover:

Mm-hmm (affirmative). Add on top of that the cost of your EMR, which is doing your billing for you, and they're taking six, seven, 8% off the top of everything, versus Visa, which is how we would do it, which is a percent and a half or 2%, right?

Ron Barshop:

Mm-hmm (affirmative).

Andy Schoonover:

And so, there's six or 7% right there that can be eliminated if you transition to a cash pay system. And so, that's what we're really utilizing, and the doctors love it. We are absolutely pro-physician, and every physician I talk to is like, "Wow, if we could go to all cash, my life would be easier, I would want to do medicine a lot more, my passion is taking care of the patients, and 30% of my time is spent dealing with health insurance plans, which is the bane of my existence." So, we are just getting incredible feedback from physicians that would love for us to succeed.

Ron Barshop:

And we had the folks of Texas Medical Management on our show a couple of weeks ago, and they told us that the surgeons make two to four times what they would make through insurance pay, versus cash pay, because of the lack of middle men that are needed, you know, that fluff.

Andy Schoonover:

Exactly.

Ron Barshop:

So, let's change the subject, I want to allay people's fears about this concept of crowdsourcing your health. Because, everybody worries about the cancer, car accident, or cardio incident. You can have a heart attack, and boom, you're in for 20 grand. It's not as scary as y'all think, I did the math for a previous show, and the number of Americans that are working Americans under 65 and children that have any of those three incidents, the scary ones, the car, the cancer and the cardio, it's one and a half percent, and one percent of that one and a half is cancer. And if you catch it at stage one, it's not quite as scary, or costly, or threatening. So, at one and a half percent, that means there's a 98 and a half percent chance you're going to be okay throughout most of your working life.

Andy Schoonover:

Yeah, and this is a different structure, people have to get comfortable with it. But as I said earlier, you already have the health insurance plans denying claims, and these are significant claims. These are, in my situation, an $8,000 claim. And so, what is riskier? You have a one and a half percent chance of having a large, catastrophic event in which we can negotiate that down, the community actually allowed the hospitals to finance some of that for us, and so there's not a large upfront cost for the community. And so, we are very, very comfortable with a brain hemorrhage that we had three or four weeks ago from one of our members, it's probably going to be a $200,000 bill. We're very, very comfortable with the ability of the community to come up and fund something like that.

Ron Barshop:

What number of members do you need to have to have actual coverage for scary things like that? Because I know the six million is to help you get your operations going, but is some of that going to cover these early, scary things that are sort of one in a million situations until you get your numbers up, and get your community up?

Andy Schoonover:

Well, given that we can reduce the typical ER bill by about 60%, given that we can finance these over a period of time, and when I say finance these let me make sure that the audience understands this is... We had actually an investor of ours that had a cardiac arrest, it was a $500,000 bill. It was negotiated with the hospital down to 100,000, that bill was paid out over 24 months, so let's just say $4000 over 24 months. A couple thousand people in the community, that's $2 per month for a huge, catastrophic cardiac arrest where a person had to have like a, I think it was a triple bypass. That is a big, catastrophic one, where for you it would be two bucks a month. And so, that's the way that this works, we don't have to have the huge pile of cash on the back end to be able to do this.

Andy Schoonover:

And while you'll have a amount of money in your account, that account is distributed over several thousand people. And so there is, from our perspective again, we are actually users of this, not just sellers of this. We truly believe that we have the modern-day finance structures to be able to pay a lot of these large, catastrophic bills. If we had five of those brain hemorrhages, I still would be very comfortable with it. So, that's the craziness of our system, is that United Healthcare would have to pay $500,000 for that cardiac arrest, but we're paying two bucks per month for a couple years. That's just a different financial model than what United Healthcare, Aetna or any of the other bigs have to deal with.

Ron Barshop:

Are there any that won't negotiate with you? I'm not MD Anderson in Houston won't negotiate with the cash pay, but most everybody else will pay cash.

Andy Schoonover:

Yeah, and even MD Anderson, they will negotiate with you in a cash pay. If they have a decision to make, you are a cash pay payer, and so they can look at you and say, "You have a $100,000 bill." They can put the Schoonovers into bankruptcy, or they can negotiate with you. What are they going to do? They are going to negotiate with you. So, I know for sure there are large bills from well-known hospitals like MD Anderson that have been negotiated down significantly, and in fact if you are a non-profit hospital there's actually a government mandate that you have to have charity care for anybody who is 400% of poverty level or lower. I believe it's, they have to give you 90% charity care. And that 400% poverty level, I think it's like $100,000 for a family of four. So, it is not a small number.

Ron Barshop:

Okay, so you've explained this well. Let me ask you, do you cover mental health, behavioral health, or is that a future offering?

Andy Schoonover:

It is, not yet. It is something that I'm passionate about, and we will do it at some point, but not right now.

Ron Barshop:

Chiropractic the same thing, you're not touching non-allopathic?

Andy Schoonover:

Yeah, not yet.

Ron Barshop:

No homeopathic, none of the... You can't go to a homeopathic doctor and get treated?

Andy Schoonover:

If it is, I think the way that we say it in our member guidelines, and everybody can go to Joincrowdhealth.com, member guidelines, they're right on the top. It's got a list of all the things that we are eligible for funding by the community, and those that are not. So, you can go and take a look there. It's not a huge list, so it's pretty easy to understand.

Ron Barshop:

But it's a DO, you can go see a DO-

Andy Schoonover:

Yes, yes.

Ron Barshop:

... and get your back cracked if you're having back problems?

Andy Schoonover:

Yes, absolutely. And Ron, one other thing with these negotiations, it is a federal law called Open Contract Law, and you probably know about this, is if you have a service that is provided to you and you have not agreed to what the price is going to be before the service is provided, you have to negotiate in good faith that service. So, your lawn mowing guy can't come and be like, "Oh, that's $5,000." It's like, "Hold on a second, you actually have to negotiate with me." And so hospitals are mandated by federal law to negotiate with people if they provide a service without providing the price to you first before providing that service. So, they have to negotiate with you.

Ron Barshop:

Mm-hmm (affirmative). I want to ask two more questions, because I know you're in open enrollment season, and this is your high tide busy time.

Andy Schoonover:

It is.

Ron Barshop:

Yeah, so congratulations, I hope it's going well for you. But, SDERAs, Iron, Liberty, the health-sharing ministries have been fighting for their oxygen to be alive, because the bigs are threatened by them and they're trying every way, through regulations and other state laws to close them down or call them insurance and basically denigrate them from their duty. Are you going to, or are you facing any of the same headwinds as a non-insurance insurance provider?

Andy Schoonover:

Yeah, what I would say is we've spent several hundred thousand dollars with attorneys to ensure that what we were doing is not considered insurance or being in the business of insurance, which are two different things. But look, we are a crowdfunding platform, we never touch the money. The account that you have is your money, and if you're going to try to shut us down you're going to have to shut down the healthcare piece of GoFundMe, which is I think the largest source of funds for GoFundMe, is their healthcare piece. And so, I think it would be very difficult for them to do that, but we are not naïve in the big health plans hating what we're doing, and they've got a lot of money. So, it's not a matter of if but when we have to engage in some of those conversations.

Andy Schoonover:

And so, I'm actually looking forward to it, I'm looking forward to telling the world about what we're doing, and kind of getting back to the way we've done things for the last couple of thousand years, adding some technology and adding some modern-day finance. And I think people will look upon that, I've already had some conversations with state and federal legislative folks who are just blown away by what we're able to do, and see it as a potential path forward. So, we're looking forward to the conversations.

Ron Barshop:

Great. And my last question is, what's to prevent some jerk from dipping their toe into your pool and then pulling out the second that they've gotten funded before their burse?

Andy Schoonover:

Yeah, yeah. One of the limitations that we have is, you have to conceive after joining. And so, if you conceived three weeks ago when we joined, it's just math. We know that you've conceived before you've joined, so we're not going to do that. So, you have to be-

Ron Barshop:

Okay, well forget labor and delivery. How about for knee surgery, your example? What if they come in, get their knee surgery, and then they say, "Thank you, I've had a nice month here, I'm on my way."

Andy Schoonover:

Yeah, I mean, that's a pre-existing condition. We have access to your medical records, you give us that right upfront, and so we will see through those medical records that you've had knee issues in the past. We'll tell you it's a pre-existing condition, and so you're going to have to pay

for that. So, we've got some things built in there that protect us. And I think while we're not a health share, I think one of the things that the health shares have proved, at least some of them, not all of them, is that this is a viable thing to do over a big group of people, over a long period of time. And they have some of the same issues that we have, and they've been able to solve them. So, we have kind of looked at that model and say, "Okay, what are you all doing that can help us to keep some of these kind of adverse selection issues away from crowd health?" So yeah, we've used a bit of that member guideline content to help us.

Ron Barshop:

And you had some [inaudible 00:35:39] with smokers, if you stop smoking for what, 90 days, you're considered a non-smoker, so we'll take you, you can join our community?

Andy Schoonover:

Yeah, well you know, interestingly non-smoke... If you've smoked in the past, you're not eligible right now, and we may change that policy next year. But just, we've kind of looked at the data, and even if you stop smoking there is still a super high risk of some pretty costly events. And so, we're not allowing smokers now, but we're reevaluating that.

Ron Barshop:

Which includes vaping, correct?

Andy Schoonover:

Which includes vaping, yeah.

Ron Barshop:

Okay. So, if people want to find CrowdHealth and find you Andy, what's the best way?

Andy Schoonover:

Yeah, join Crowdhealth.com is our website, we're on all the major social media platforms, Facebook, Twitter, Instagram, at Joincrowdhealth is our handle.

Ron Barshop:

Okay, and there's some very nice videos of y'all explaining this, so if you didn't understand it from this interview you'll get a lot more clarity by going on their website. If you could fly a banner over America, what would that banner say?

Andy Schoonover:

Cancel health insurance.

Ron Barshop:

Yeah, I'm with you. That's what this show's about.

Andy Schoonover:

Yeah, and in our cancel culture, let's cancel something that really is hurting people in a big way, which is health insurance, from my perspective.

Ron Barshop:

Yeah, I love David Chase says that healthcare stole the American dream. It's really an apt saying, so very perfect way to end this show, and we'll keep up with you. How many members are you at now, and what do you hope to be in the next several years?

Andy Schoonover:

Yeah, we're going to be at around 1,500 here in the next week or two, and we're scheduled to be probably 15 to 20,000 by the end of next year. So, we're super excited about the trajectory, especially over the last, man, couple weeks with open enrollment has been pretty crazy.

Ron Barshop:

Do you think it's going to be employers signing up, or is it going to be individuals one-on-one? In other words, are you B to C, or B to B?

Andy Schoonover:

We're B to C.

Ron Barshop:

Got it.

Andy Schoonover:

Almost exclusively B to C, lots of 1099s out there. We have the great resignation, lots of people are looking for a way to pay for their health bills outside of their employer, more now than ever.

Ron Barshop:

Yes, I'd imagine. Well, good luck to you, and we'll stay in touch over the years, and it's exciting to have his new offering on the market. So, you take care of yourself.

Andy Schoonover:

Thank for having me.

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.