CEO Leadership Series: Vol 15

Demystifying the strategy, opportunities and obstacles driving healthcare payers

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Key Takeaways

The government, and CMS specifically, continues to set the pace in the market.

- Approximately 50% of every healthcare dollar spent in the United States is actually funded by a government entity.
- With that, we are already a relatively socialized healthcare system where a lot of the hospitals, physicians and insurance companies are working directly or as agents of the government. And for the most part, it all boils up to and somehow gets controlled by CMS.
- The government has wanted to squeeze down the costs of the Medicare Advantage program. Ultimately, CMS doesn't want to be in the Medicare Program at all. The whole idea of launching Part C and D was to retire Parts A and B. However, that effort has been delayed by a decade at least.

Understanding payer strategic priorities

- Large payors look at the portfolio of business they engage in as a mutual fund. Typical line of business performance:
  - **High performing:** Medicare Advantage and medium-sized fully-insured groups.
  - **Mediocre:** Third-party administration, self-funded businesses and smaller groups.
  - **Low margin / money losing:** Medicaid, really micro groups and individual plans.
- The reason a lot of insurance companies love Medicare Advantage is that the government, for all intents and purposes, is guaranteeing 5-8% after tax margins (10%-15% pre-tax). The economic leverage on that is tremendous.
- Large insurance companies do not place heavy strategic priority on Third-Party Administrators ("TPAs"). TPA margins are very thin - approaching 1% on fees generated. That being said, there is margin in selling self-funded employers stop-loss insurance. Large insurance companies have dedicated arms that generate healthy margins selling stop-loss and managing general underwriters.
- Areas of permanent concern for payer CEOs:
  - New government regulations
  - On-going consolidation in the provider market
  - New highly expensive drugs

Making sense of the self-insured employer market

- The self-insured employer market is huge in terms of the number of employees, but it is small in terms of the number of companies. There are only so many companies that have 150+ thousand employees – there's approximately 100-200 of them in the United States.
- Brokers often communicate a message of a rapid march toward self-insurance across the market. However, this is a fallacy. Kaiser Family Foundation has done a study every year for decades and the percentage of employers who have been self-insured has remained rock solid at about 55% to 57% of the market. Users of self-insurance:
    - **Heavy:** Employer groups >2,000 employees
    - **Limited:** Employer groups <50 employees
- Self-insurance is generally not a fiscally responsible way to go for any employer that is below, say, 600, 800 employees. Brokers often talk of moving these sized employers to self-insurance to save them money. In reality, all that generally happens is that brokers churn the accounts and receive a commission every time they do it.

Key Trends & Innovation Emerging to Capitalize on Displeasure with Status Quo

- The market has historically been characterized by a pervasive zero sum us-versus-them type of mentality across key stakeholders – i.e., hospitals, payers, brokers, providers – fighting to optimize their interests. This has created a really difficult contract negotiation environment, and constrains partner-like coordination that will be essential to truly improving outcomes.
- New market trends and innovations are emerging in response and are seeking to capitalize on employer / consumer displeasure, as well as inefficiencies and silos associated with status quo.

Key Trends to Monitor

Coordinated Provider Networks

- Hospital systems and providers are collaborating more in terms of consolidation, partnerships, IPAs, MSOs and other types of organizations to try to bring together their buying power in the context of payer negotiations.
- A key risk is that the consumer loses in this scenario as an arms race between payers on the one hand and providers / hospital systems on the other hand drives up pricing.

Big Box Retailers

- Walgreens, CVS, Amazon are emerging as potential players to disintermediate the hospital-based environment.
- These big box retailers are building out an infrastructure that has the potential to be more readily accessible to more people in the matter of actually delivering preventative services and care management, or maintaining your health and wellbeing. Conversely, most hospital systems are structured to wait for you to get sick and come knock on their door.

A New Role For Insurance Companies as a Value Add Service Provider – More Intelligent Plan Design & Development of a Specialty Solutions Provider Network

- New entrants in the insurance market are seeking to delivery better service & products by bringing together a more holistic range of solutions from:
    - Overall integration between benefit plan design, incentives to the consumers, incentives to the physicians
    - Digital solutions
    - Care coordination
    - Technology and analytics-based infrastructure
- These players are targeting disgruntled mid-sized employers that represent a historically overpriced, underserved market and that generate high levels of margins for incumbent insurance companies.

Technology

- With the advent of technology and with every subsequent generation, as the baby boomers and soon the millennials continue to age up, I think you're going to see higher rates of technology-based adoption and home-based self-care.
- This will create interesting questions for regulatory bodies and plan design teams at payers – what is medical care versus quality of life?

Sifting Through What's Working vs. Not Working

- Ten years ago, there were maybe a few hundred innovators representing the entire landscape. Since then, it seems that every year there is a new subsection to those landscape splits and there are now thousands upon thousands upon thousands of companies included.
- The lack of transparency, the lack of true understanding about what all of these innovations will have in terms of impact, I think are a very real issue that causes a lot of people a lot of confusion. From an actuarial perspective, the cost benefit analysis around some of these innovations is very challenging and somewhat subjective.
- In that context, how do payers pick the winning solutions?
    - **No Way Around Commitment & Experimentation.** At some point, you basically have to just jump in the pool and say, "I'm going to take one and I'm going to implement it. And if it doesn't work, I'm going to rip it out and I'm going to try the next one."
    - **Value-Based Care.** When in doubt, pay on results. Payers to rely on heavy utilization of value-based care payments to partnered solutions providers – let payments for tangible results vet out the viable solutions.

- **Follow the Clinical Results.** Clinical trial results became table stakes. I would rather just focus on, "Do you have a clinical impact on a population level basis, yes or no? Prove it, and if you can prove that you have that kind of clinical impact, then the economic impact will follow." What it will be, we don't know because we don't know how many people will actually be impacted the way the patients in your trial were, but there will be a positive clinical impact if you've shown that in your clinical results.

Background

I'm an actuary. I've been in the healthcare space over three decades. I started with Aetna doing your traditional actuarial work, then moved into investment banking. From there I did some stints in consulting where I was a junior partner at a couple of The Big Four. Since 2017, I've had my own consulting platform. Additionally, since 2018, I've been the chief financial officer and chief actuary and co-founder of a startup health insurance company that sells a fully insured commercial product. We went through Y Combinator and launched in Dallas-Fort Worth area in 2022. In 2023, we expanded to Austin, San Antonio and Houston.

At a macro level, CVS Health, Centene, Humana, Cigna, Anthem generate a trillion dollars of annual revenues between them. How do they view the world when they look at the marketplace split between Medicare, Medicaid, Affordable Care Act marketplaces and the employer marketplace?

That's a lot to unpack. Let's start with the different markets. First, you have to really separate out companies that are multi-market such as the United's and CVS Aetna's, from the companies that are much more focused on a specific regional market or line of business. Humana is very focused on Medicare and Medicare Advantage, while Centene focuses on the Medicaid market and increasingly Medicare Advantage.

50% or thereabouts of every healthcare dollar spent in the United States is actually funded by a government entity. And with that we are already a relatively socialized healthcare system where a lot of the hospitals, physicians and insurance companies are working directly or as agents of the government.

And for the most part, it all boils up to and somehow gets controlled by CMS. There's the Medicare Advantage Program where CMS is directly influencing what kind of products, pricing and margins these companies will realize by virtue of how they manage that program and the bid process. On the Medicaid side, there is also direct and indirect control whether by virtue of the rules and regulations that are set up that states have to adhere to through HHS as part of their Medicaid structure in order to receive federal funding, or through other economic incentives embedded in how the Medicaid program is structured. There's sort of a loose sense of control and influence that CMS has by way of their financial influence.

It's a very complex mosaic of a lot of intricacies. The reason a lot of insurance companies love Medicare Advantage is that the government, for all intents and purposes, is guaranteeing 5-8% after tax margins. They will allow you to create a product that will in essence guarantee you that level of margin. So, you see a lot of companies such as Humana, and even United for that matter, as well as a lot of the startups and smaller players such as Devoted and Oscar aim to get into Medicare Advantage market.

The economic leverage on that is tremendous. Even if you only sign up 5,000 people, you're getting over a thousand dollars per member per month and you're being guaranteed 5-8% after tax margin. That's tremendous cash flow. Everybody who has the desire for that kind of cash flow will make the investment for the infrastructure to adhere to all the corresponding government regulations and oversight.

It's a cost plus revenue model? You send me your costs, we'll pay you back your costs plus the margin?

You have to put together your business model and show that you can actually achieve it, and then the government does a retrospective audit of your results to make sure that you did exactly what it is you said you were going to do.

But yes, for all intents and purposes, that's kind of how it works.

The government has wanted to squeeze that program down so the costs of Medicare Advantage are equal to the cost of the AB Program. Ultimately CMS doesn't want to be in the Medicare Program at all. The whole idea of launching Part C and D was to retire A and B, but they've obviously delayed that by a decade at least.

When you think about the other markets, these large commercial payors look at the portfolio of business they engage in as a mutual fund. There are some areas that perform really well such as Medicare Advantage and medium-sized fully-insured groups. There are other areas that perform mediocre such as third-party administration, self-funded businesses and smaller groups. And then there are parts that perform abysmally such as Medicaid, really micro groups and individual plans. As a result, you get this balance of business and you say, "At the end of the day, I am looking for a global corporate strategy." And you're going to manage your book of business and focus on markets that you believe will generate the kind of cash flow and margins that you expect to achieve ultimately to achieve that long-term strategy. The insurers manage their portfolio as a mutual fund of opportunity and they mutualize the gains and losses from one block of business against the other block of business, one market

against another market. When they lose money in New York, they're making money in Cleveland. You get the idea. It's more a matter of, "How do I manage all the moving pieces and, at the end of the day, end up cashflow positive?"

Large payors used to worry about large health systems capturing market share and being able to dictate pricing. Is that still the case today? What are the top three greatest external concerns for the CEO of United, Andrew Witty? In terms of players in the marketplace, are the large payors worried about Third Party Administrators (TPAs) or they don't view that space from that perspective? Are they worried about provider groups capturing too much market share and starting to behave like large health systems? Are they worried about big box retailers, CVS and so forth going out there and bullying their way into their market? What do they think about in terms of new up and comers?

Hospital competitive dynamics can still play a key role in determining payor strategy for a particular market. One of the reasons we launched our insurance offering in the Dallas market was because there are five competing hospital systems to do business with. Picking up one or two of those hospitals who are willing participants to shake up the dynamics of the market is easier. If you go into a market where there's only one dominant hospital, you pretty much say "I have this much money, can I do business with you?" And the hospital will say, "Yes, I'll take all your money."

The CEO of United has both Optum and the UnitedHealth Group, and then within Optum and UnitedHealth Group, he's got countless subsidiaries each with their myriad of issues. At a global level he's probably permanently worried about new government regulations, ongoing consolidation in the provider market, and about new highly expensive drugs. You get one drug that costs a million dollars for one dose, that becomes a major concern when multiplied across his network.

The large insurance companies are not worried about TPAs. TPA margins are approaching 1% on fees generated. It's really a razor thin business. Where all the money is made on third-party administration is in stop-loss, the provision of capital on the backend that every self-insured employer needs. And the smaller you are, the higher the margins are. Companies such as United and Aetna have dedicated arms - that aren't labeled United and Aetna but rather have their own distinct company names – that are generating healthy margins selling stop-loss to these third-party administrators and managing general underwriters. The TPAs and managing general underwritings are quote unquote, selling, through their brokerages the solution to employers saying, "We're going to save you money." I've quoted the business on the other side, and I can tell you that on a fully insured basis, it can actually be cheaper to be fully insured once you drop below 800 employees, but it all depends on who your reinsurer is and how much they're charging you for that cost of capital. The costs out there that I've seen are bordering on usury in terms of the level of charges that are being levied for the amount of capital coverage that they're giving people in the stop-loss.

When Anthem looks at the self-insured marketplace, meaning employers providing balance sheet protection, is that a threat to them? It's a huge market. There's a lot of usage?

It's a huge market in terms of the number of employees, but not a huge market in terms of the number of companies. There's only so many American Airlines and Home Depot's and Walmart's out there where they have 150, 200,000 employees. It's literally a worldwide market that is numbered in the thousands as opposed to the hundreds of thousands. There's a 100 or so, maybe 200 of them in the United States. Anthem, of course, wants to be part of the story for American Airlines. I'm using American Airlines as just a generic example - I have no idea if they have Anthem/Elevance or not. But the idea being that the insurer initially wants the business with American Airlines to have a lot of membership in a specific market so that they can then take that membership and say, "Okay, this is how we're going to leverage that membership in terms of better contracts. We're going to be able to go to the hospital system and say, 'I've got 10,000 employees who are going to use your hospital, you're going to give me better rates.'" The reason that they were so focused on having these large employers in their portfolio was focused strictly with the idea of leverage in terms of negotiating power with the larger hospitals.

The more lives they have under contract, the more lives they have to insure, the more they're able to actually get better rates at these hospitals. It is a very much us-versus-them type of scenario.

And unfortunately, that pervasiveness in terms of mentality spread throughout the market and has created a really difficult contract negotiation environment today, because there's a lot of jaded individuals on the hospital side who expect an insurance company not to be their partner in terms of how to identify higher quality levels of care or to work with them in terms of better data management or better community-based issues or population health-based issues, which would lift and benefit everybody. But instead we get into these one-on-one kind of battles, where unfortunately the mentality on both sides, especially the larger companies, tends to be one more of, "I have leverage over you. This is the rate you're going to give me." As a result, hospital systems and providers are collaborating more in terms of consolidation, partnerships, IPAs, MSOs and other types of organizations to try to bring together their buying power and they're going to bring that power back to the insurance

companies and say, "No, no, no, you don't have market power here. We coordinated providers and health systems have market power. This is what you're going to pay us." And the only person who loses in this scenario is the consumer because as a result of both of these going at each other, they're just driving prices up in this arms race.

If you're a large payer, you view the self-insured marketplace, which I know to be available to employers at every stage of every size, not just American Airlines, but all the way down to 20, 50 and 100 FTEs. These TPAs offer micro versions of the self-insured product. If you're a large insurer and the entire employer landscape is moving towards self-insured, as it has over many decades, are you viewing that as a threat because you make great margin using your balance sheet?

No, the brokers love to tell the story, but it's a fallacy. There is not a tidal wave of groups moving to self-insurance. Kaiser Family Foundation has done this study every year for decades. The percentage of employers who have been self-insured has remained rock solid at about 55% to 57% of the market. And you can think of it this way, there's groups that are over, let's say, 2,000 employees – close to one hundred percent of that market is self-insured. And if you weight it in terms of number of employees, that's a tremendous number of employees. Then you get a tremendous number of companies who have less than 50 employees, and almost all of them are either not offering health insurance at all and pushing their employees onto the exchanges, or they're fully insured. The brokers love to talk the talk of moving to self-insurance to save money, achieve savings, bypass the insurance company's margins, but in reality, all that really happens is they churn the accounts and they get a commission every time they do it. And, in my perspective, it's generally not a fiscally responsible way to go, for any employer that is below, say, 600, 800 employees.

We lived through the churning, it was amazing, my last company. The last company we ran and owned was self-insured and every year was a brand-new solution to avoid significant premium increase. So that's very interesting that you say that because that was my own personal experience.

So at the end of the day, what's the broker really doing? They're just moving the account around. They just keep achieving a new commission every time they do it. But they're not really looking at, "Well, you need to have a new solution which integrates musculoskeletal-based care management with psychiatric-based mental health services to help reduce or address this cost issue you have in your high-stress work environment." No, they're just saying, "All right, your claims were here. We're going to move you over here and we're going to change your deductible and your copay, and, Mr. Employer, we're going to help reduce your cost by doing these things."

Earlier, you were asking about companies like Walgreens. When you think about some of these retailers and what they're doing, I actually think that it's very interesting to see Amazon do its thing and Walgreens do its thing, and even CVS, as a retail company and drug company, do its thing because the way that they are addressing the market, I see it as being more of a disintermediation of the hospital-based environment. I see what they're doing as really building out an infrastructure which is going to be more accessible to more people in the matter of actually delivering preventative services and care management, or maintaining your health and wellbeing. Whereas a hospital system, the way most hospital systems are structured, they wait for you to get sick and come knock on their door. I think that sitting back on your heels waiting for the market to come into your front door and need you in terms of care, is an antiquated model, which has had its time. But with the advent of technology and with every subsequent generation, as the baby boomers and soon the millennials continue to age up, I think you're going to see higher rates of technology-based adoption and home-based self-care, where these types of business models really set up for a more successful future. I actually think Walgreens is setting themselves up for more success than what the stock market and what analysts are giving them credit for.

So what is Evry Health?

Evry Health is a brand-new health insurance company for the larger group employer, fully insured market. A large group employer from a statutory perspective in Texas means any group above 50 employees. Our sweet spot is more in the 200 to 300 employees, but you get the idea. We're getting a couple of quotes that are in the 1,000 or 2,000 employee range, but for the most part, on average, our business model is to serve employers that are in a 200 to 300 life range.

The idea behind the business model is bringing digital solutions and care coordination and a level of overall integration between benefit plan design, incentives to the consumers, incentives to the physicians and such, with a technology and analytics-based infrastructure, that is a level of service and integration that these employers don't get from the traditional insurance companies.

The idea being that this is an overpriced, underserved market with high levels of margins within the larger insurance companies. Since it's our only focus, we're looking to be also cashflow positive, but to do so through smarter use of the analytics, better coordination of care, better integration of digital solutions with brick and mortar solutions, and bringing about a much more comprehensive universe, consumer-based universe, where the experience then for the individual member is one much more akin to a guided journey as opposed to throw them in the deep end and hope they can swim.

So you've had great experience working with the largest insurers and entering the space as a new entrant. What's it like from a barriers-to-entry standpoint to offer a new fully insured solution? What are the biggest obstacles? Is it a balance sheet obstacle? "Where am I raising capital to take on this underwriting risk?" Is it an administrative obstacle? Is it an expertise obstacle? Is it a marketing obstacle? How do you compete with billions of dollars spent on brand awareness by these combined trillion-dollar-revenue asset class? And, where are you seeing the most resistance for the new entry? By the way, I have to tell you, you are brave to take on these giants. There are a few companies that are larger than these in the world. And now you have Amazon to compete with as well.

It's interesting. You have to have a deep level of industry knowledge in order to be able to appease the regulators that you're going to be bringing a market solution out that is going to be responsibly managed and capital preservation will be part of your story. So there's a lot of knowledge and experience that has to go into going through that regulatory hurdles. There are a lot of nuances in minutiae associated with just the running of one of these companies and the level of documentation, and all the specifics that go into even just paying a claim can be mind-numbing for the less initiated.

It's mastery over some of those details, having an understanding of the regulatory environment, let's call these table stakes. You're not going to start down this path if you don't have some knowledge of what it takes to run a company and you don't have some knowledge of what it takes to get through the regulatory environment. Let's also assume for table stakes purposes that you've got some financial backers who are willing to put some money behind you and give you the amount of capital you'll need in order to satisfy the regulators, and to invest in all the infrastructure you need to get things off the ground. All right, you're out to the market. You've overcome all of those roadblocks or speed bumps. Let's call them speed bumps because you get over them eventually, right? You go around them or you get over them, you avoid the potholes, you get to the starting line, you're ready to go, and the first thing the physicians say to you is, "Well, who are you? I've never heard of you before. How many members do you have?" And so you have to get through, remember what I was saying before, the us-versus-them kind of thing. They're so used to the Blue Cross Blue Shield plans and the United's of the world coming to the table and saying, "I've got 10,000 members in your market. Do you want a piece of this? If so, here are the rates I'm willing to pay you," versus actually finding somebody that they're willing to collaborate with around better care for the patient.

Better care for the patient has been a door opener at a lot of physician offices because they literally have said to me, "Oh my God, I've been waiting 30 years for somebody to come in my office and talk to me like this. Finally, we're having the right conversation."

So there's that. We get past that. Then the employer's like, "Well, talk to my broker." Okay, so then you call their broker. They're basically like shopkeepers, they have shelf space, and you say to the broker, "I'd like to be on your shelf space." And they're like, "Okay, how much commission are you paying?" First question. They don't care about your product. They don't care about what you're doing differently. First question.

This is like trying to enter the marketplace with a new beverage and realizing that the entire beverage industry is controlled by five wholesalers that look at you and say, "Why should I do business with you when I have Coke and Pepsi? " It's not easy.

So buying shelf space with the brokers is the next game that you have to play. Then you have to be really diligent on the underwriting on the back end because although they'll say they'll put you on their shelf, they may only direct the worst cases to you, as opposed to giving you a true opportunity to bid on a market representation of what's actually out there. Say, "Oh, this is a problem client for mine, I'm going to send them to the new company."

Bad credits for some reason... what makes a bad client from a broker's perspective other than poor credit?

Well, when you're dealing with, let's say, groups that are 75 to even up to 200 employees, everybody knows everybody and everybody knows everybody's business. As a result, the CFO or whoever is managing the benefit plan and going for the quote, knows that so-and-so just got diagnosed with lung cancer. And they're like, "Oh, well, they just got diagnosed. Blue Cross Blue Shield wants to raise the rates by 50%." I've literally seen quotes of rate increases of like 45, 50%, and when you do the math, you're like, "Okay, yeah, you've got one or two individuals who are going to have extremely high claims, which is typical. There's always one." There's only 2 to 5% of any given population who

have catastrophic experience, always, but the other 80% ... or 80% of the population have zero claims. At the end of the day, you have to be able to try to figure out, "Are there enough people in the population that you're quoting who will fit the programs of care coordination that we've designed?" For example, one of the things that we've spent a lot of time on as a company is thinking about how we can help people who are hypertensive or have heart-related issues and are either pre-diabetic or diabetic. Diabetes by itself is not a disease; it's a comorbidity that has great complications and cost implications for heart patients. If you have hypertension and you have diabetes, suddenly your risk for chronic kidney disease is quadrupled. But very few people who are hypertensive and diabetic are told by their primary-care physician to have a CKD test. They wait until they actually need dialysis and they say, "Oh yeah, by the way, hypertension and diabetes, we were just expecting you to have renal failure at some point." Why not manage that? Get in front of it. You could do so much more for a patient if they do have a home test kit.

It's the medicine of probabilities, which we're really only entering now. It's confusing for the mind because we have to think ahead.

We're pushing for people to be more aware of what their care needs will be, and to get tested and to be evaluated and to be ready now so they can start doing something. We had one person enroll in one of our digital solutions, gut biome type of stuff, genetic testing. Like 43-year-old woman. She said for the past 24 years, she's been going to a gastroenterologist and her primary-care doctor, one of them, at least, every month for the last 20 some odd years. She's been miserable, she hasn't been sleeping well, she's been taking all kinds of pills. She'd been moving through all kinds of diets. Nothing seemed to work, and she was depressed. She spent three months on our plan, she went through this program. The dieticians were able to work with her, she changed her diet, all her problems went away. She's off her drugs, she's sleeping well, she feels great. She's exercising. She's changed her life. That's a success story I will talk about all day long. To be honest with you, if nothing else comes out of this, if Evry is a complete failure and just flops, I will always be able to come back to this type of result... I have seven of these stories. I'll always be able to come back and say, "We made a difference in seven people's lives."

Our payer strategy team has worked with and for payers extensively. I'm very curious about the model of your Better Health program as it sounds like a sort of a value-based model. Can you talk about that? And then can you also talk about the CKD testing really sparked my curiosity because of the movement of end-stage renal disease patients at Medicare Advantage now and tools to manage them. So if you could speak on both of those, I'd very much appreciate it.

Sure. Let's go with first the value-based care model, including the digital health solutions, and how we approach the market. We've created a universe of digital solutions to address specific pain points within a population health-based environment. Think, for example, pain management for musculoskeletal-based bone joint type of issues, or diet and weight management for cancer patients who may also need mental health support for stress management and anxiety management. This is the type of mosaic that we've created and the type of vendors that we've gone out and talked with, every single one has got the exact same type of contract. "You're telling me you can deliver a clinical improvement? If you deliver that clinical improvement, you will get paid. If you don't deliver that clinical improvement, you won't get paid." So it's about 30% of fees that we pay as our baseline - I don't want to make these companies go bankrupt, I want them to continue. So administrative costs are kind of covered. And then the other 70% of their fees are completely at risk for delivering on these clinical improvements.

I'm not hiring dieticians and people to do gut biome genetic testing type stuff. There's all kinds of companies out there who have invested a lot of time and effort to become FDA approved, they've done all the clinical studies, they've done all the research, they're the experts. We just scan the market. We've put together our own little universe, and that's what we're leaning on. Our relationships with Quit, Genius, or Meru, and so on have been well publicized by our marketing team.

The idea of being able to coordinate the data and the patient experience with those digital solutions as part of our benefit plan, with their claims in pharma and lab data, and push that information back into the brick-and-mortar physician community, is unique.

Nobody else is doing this. I mean, literally there is no other insurance company out there doing this. That's powerful. And the physicians who are partnering with us recognize the importance of actually understanding what's happening with their patient at two o'clock in the morning when they dial into a digital solution on a Sunday, so that a Monday morning when they receive that update and they can update their electronic medical record with that information, next time that patient calls on Tuesday morning, they're armed with the information as to what kind of care that patient was seeking on Sunday morning, and they can work with them on what the next steps need to be. Physicians

love our transparency and our ease of working with them, and in fact, we often say to them, "We're API enabled, cloud enabled, our technology's on the cutting edge," because we're brand new, we don't have any of the legacy issues. We understand not everybody is ready for what we're able to offer, and we are willing to work with whoever comes to the table. That message of collaboration and partnership has a tremendous resonance.

Texas being Texas, a lot of the market is on the fee-for-service based model, and we have talked with everybody. Our contract structure basically says, "We'll start where you're comfortable. Tell us what your revenue cycle platform is, what your administration capabilities are, we'll go with that. I'm not looking to make your life difficult. Whatever you can currently administer, that's the kind of contract we'll work on. And then we'll work with you on how to improve your systems and your analytics and your insight into your patient population so that you can get comfortable moving from that model to a more at-risk model." Some physicians and hospital systems are already ready and they're willing to take capitation and we've got a couple contracts along those lines. Some of them are eager to talk to us about bundled payments and a couple orthopedic-based surgical centers look great and we're contracted with them. Everybody's got a little bit slightly different perspective, but it always comes back to the lowest common denominator, the limiting factor in all those dialogues ultimately comes back to what can the physicians' revenue cycle management system actually handle? Because if it's an older system, it won't be able to handle anything too complicated and fee-for-service is where they're going to sit until they want to make the investment to change that system. So that's our limiting factor.

Can you elaborate on Early Stage Renal Disease and Medicare Advantage?

The prevalence of home-based test kits, Quest just got them, several other major lab companies have got them. It's more a matter of whether or not you're willing to pay for it and how well you're able to actually integrate the care that is going to be evolving as a result of it. If you just send a kit to someone's house without educating them as to why they're being sent that kit or what the results will be, or working with their physician on helping that patient through the journey, if you're just throwing something over the wall at them, that's not going to be effective.

Sort of like the three by five index cards that you get in the mail from your traditional insurance company, bombarding you with all their program announcements, "Sign up for the telehealth program at this other company. Sign up for this weight management program at this other company, sign up for this thing at this other company." It's never part of your experience with that one insurance company. If you just throw it over the wall, it'll never work, because the follow through and the integration with the benefits and the coordination of care with the physicians is all disjointed.

I think that if people were really going to be successful in managing chronic kidney disease, prevention and identification before it becomes a dialysis issue is critical. Once it becomes a dialysis issue, you're pretty much stuck with a very high annual budget. There's really not much you can do with it at that point. There's not much care management to be done. Now the only thing you can coordinate at that point is transportation services to and from the dialysis center. I'm a big fan of emerging technologies. I think that there are so many interesting things happening in the DME space, which includes nanotechnology to clear blockages for heart patients as an injection or the exoskeletons that remove the need for wheelchairs, walkers, and scooters. And this includes things like miniature dialysis units that literally bolt onto your belt and make you completely mobile, and able to wear and go and do whatever you want to do just by having this little thing bolted onto your belt, underneath your sweater or whatever.

The advances in this space are truly phenomenal, and I'm very excited for what that means in terms of reducing people's reliance on the healthcare system, specifically hospitals and brick-and-mortar type of agencies.

What is the next big thing in terms of DME technology for a payer to help manage risk?

There have just been so many interesting and exciting innovations. I am a big proponent of getting those solutions in the hand of the consumer as fast as possible. It is going to be a slow adoption rate, I feel, because if you think of a company like Humana, what's their willingness to suddenly add an extra $3,000 to an annual expense line to provide somebody with, let's say for example, let's go with something simple like the exoskeleton that bolts onto the back of your leg and basically provides motion assistance and spine support? Clearly it's a help for people who have some level of paraplegia, but the cost can be a steep hill to climb. It becomes a question of, "Is this lifestyle or is this healthcare? Is it necessary? Is it medically necessary, or can you get around in that scooter just fine?" I think the big change for me is going to be a shift in the philosophy of what it means to have quality of life. And I'm just going to leave it at that because when I think about the nanobots that have been created that you can inject in your arm, and they just sort of sit around in your system until they sense an arrhythmia in your heart and then they basically bolt onto your heart, give you a jolt and zoom around in your arteries and clear out the blockages to get you right-sided again, so that you can ambulatorily walk to your doctor's office

and say, "I think I just had a heart attack." And then you pee out the nanobots who basically just did their job. It's phenomenal, but the FDA doesn't know what to do with it. "Are they DME because they're physical nanobots or is it a drug because it gets injected?"

It sounds like benefit design will face a challenge keeping up with technology, and I'd liken that to when the hepatitis medications came out. These were curative medications, and I recall my clients just cringing when they had to pay and I said, "Let's weigh the cost benefit analysis of this med versus a liver transplant."

I agree. I think that the whole idea of preventative care and lifestyle, quality of life is going to be, in my mind, the big change. Not unlike something as simple as we used to think 8-tracks and then it was VCRs, then it's DVD players, now we stream. It's the same idea. I see much the same type of technological advancements and speed to market and scale happening. Just kind of helping get to a point where everybody has got access to and is being favorably influenced by these types of things.

With all this innovation, can you speak to what controls are in place to understand what's working, what's not working? Is the marketplace organized and transparent enough that we should expect the markets to organically clear in favor of the best, most effective and most price efficient solutions?

CB Insights does a good job of trying to keep track of the market. Bessemer Ventures also publishes a similar lay of the landscape kind of thing. I always find these things fascinating because 10 years ago there were maybe a couple hundred companies that would fit into their landscape splits, and since then, every year it seems like they've got a new subsection to those landscape splits and they've got thousands upon thousands upon thousands of companies now that they're trying to figure out what bucket do they put them in and who should they be watching.

So much money being spent chasing after solutions that involve some level of technology or a biomedical type of innovation. One of the reasons why we spent the time as Evry Health to review the landscape, we reviewed something like 300, maybe closer to 400, vendors at this point. Clinical trial results became table stakes for us because to, perhaps where you're implying, there is not a lot of transparency about what the true impact can be from these programs. And as an actuary, I find some of the ROI type of calculations that people like to publish, quite frankly, they're a little made up to me.

I would rather just focus on, "Do you have a clinical impact on a population level basis, yes or no? Prove it, and if you can prove that you have that kind of clinical impact, then the economic impact will follow." What it will be, we don't know because we don't know how many people will actually be impacted the way the patients in your trial were, but there will be a positive clinical impact if you've shown that in your clinical results. And so I've gone more that route and said, "Let the chips fall where they may without worrying," because it's all on a value-based contracted basis, I'm not taking the risk for whether it succeeds or not. The lack of transparency, the lack of true understanding about what all of these innovations will have in terms of impact, I think are a very real issue that causes a lot of people a lot of confusion. I've talked with several hospital systems who've basically said, "We can't figure out which way to go because we have so many people who call us all the time and everybody says they've got the solution, and we end up spending six to nine months digging into their solution, and we end up just scratching our heads because we can't differentiate between seven of them as to which one is the best one for us to go with." At some point, you basically have to just jump in the pool and say, "I'm going to take one and I'm going to implement it. And if it doesn't work, I'm going to rip it out and I'm going to try the next one. And if that doesn't work then I'll take that out and I'll try the next one." And it is a little bit of a trial and error along those lines, which can be disruptive to the patient, but at the end of the day, I think we're all searching for the same thing. What's going to be clinically effective and actually help people achieve a higher quality life?

Has the cost benefit analysis around some of these innovations improved over the last 10 years? How about the actuarial work in forecasting into the future to quantify a lifetime benefit to a patient and in return the financial potential benefit to the various stakeholders, including the payer who's underwriting that risk?

It is a very difficult exercise because it is so subjective. Let's go back to the example I gave earlier about the gastro patient. How do you calculate the level of improvement that she's achieved in her life? She's got 50 additional years she's going to be living, roughly speaking, from an actuarial perspective, and the quality of those 50 years have dramatically improved because of four months she spent in the program that we sponsored. How do I calculate the benefit that she's achieved relative to the minor cost? It literally cost us $2,000 to have that program in place during those four months, for the entire population we served and we were able to have that kind of impact on one patient. To me, it seems that the cost benefit analysis was exceptional, but my perception of that exceptional cost benefit analysis and high ROI is really ephemeral because it's more based upon the emotional effect. Knowing that she's now going to live the next 50 years of her life having a better chance of having a higher quality of life, being happier, being more satisfied with herself, versus all the pain and agony and disruption that she was experiencing beforehand. Did I save $2,000 or did I create an improvement in the overall economy of millions? How do you want to measure it?

Sounds like there may need to be some more work done in the discipline of actuarialism in order to preempt more rapid adoption of lifetime value, lifestyle changes. It sounds like that may be the actual bottleneck.

Yeah. I don't know that the actuaries are necessarily driving the ROI conversation. I think the chief medical officers and MBAs in the finance department have more say in this regard than anybody else.

Special thanks to Mark Jamilkowski for his insights in this discussion.