John Marchica:

Welcome to season four of Healthcare Rounds. Here, we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care and attaining joy in work. I'm John Marchica, host of Healthcare Rounds. I'm also the CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Please don't forget to rate and review us wherever you get your podcasts and send your questions, comments, or ideas for Healthcare Rounds to podcast@darwinresearch.com. Let's get started.

Today, I'm speaking with David Contorno a nationally recognized thought leader and author on disrupting health care and delivering better care at lower costs for employers and their employees. David spends a lot of his time educating the industry, including his competition, on how to bring these cost-effective healthcare solutions to the masses. In 2016, Forbes named David as one of America's most innovative benefits leaders.

So David, thank you so much for spending some time with me today. I appreciate it.

David Contorno:

Thank you for having me.

John Marchica:

So my first question for you is going to be a slam dunk, but I think a lot of people don't really understand this business. So I wanted you to talk to me about the benefits consulting business and what does your average broker do for an employer?

David Contorno:

I was, I guess, what you'd call the average broker for many years and really what they think they're doing and what they're actually doing can often be two different things.

When I was a traditional broker, I was coming to employers and I thought I was bringing the best in breed, comparing them, beating them up for the employer to get the insurance rates as low as possible, and then putting it together in a nice spreadsheet to present to the employer decision makers. And then once they decided upon the options that I gave them going to the employees and educating them on the products that they had decided upon.

And so really that's the flow of advice that employers are getting is the advisor is being solicited and coveted by the carriers, bringing the carriers to the employer and having them choose from this kind of boxed-in set of options and said, "Here are your options, which one do you feel is best for you going forward?" But there's a lot of minutia in that that I think sometimes the brokers aren't even aware of that affects what solutions they bring to that employer, that impacts the advice they give, whether they're conscious of it or not, and ultimately results in what employers have been doing for decades.

John Marchica:

So what are some of those things? Get into the weeds a little bit here. Because as I said, it was relatively recently that I even learned about the benefits consulting business and there's a couple of behemoths out there that have a large share of the market, but maybe dive in a little bit deeper. I think the folks would appreciate that understanding.

David Contorno:

Sure. Well, I use a lot of analogies in what we do. And could you imagine for a minute, if you were buying a home and you found out that the real estate agent that was representing you as the buyer, also represented the seller? You'd feel a little weird about that, right? Because you know as the sellers real estate agent, they want to get as high of a price as possible. As the buyer's real estate agent, they want to get as low as a price as possible. And now you have the same person sitting in that seat, right? Well, isn't that what most brokers do every day? Aren't we going into the employer and we're purporting to represent their interests, but we're being paid by the carrier, the third party, at least in part. And I say this, I mean, the majority of insurance is sold on commission basis.

So what I said is absolutely true, but even if an employer is paying their broker a fee, is there undisclosed compensation? And there often frequently is. It might be a trip to Ireland. I was given private cruises. When I was a traditional broker, I was really good. And I was given a lot of things that didn't have to necessarily be number one, directly monetary. And number two, although it often was, reportable to the client. So really that's what we've been doing is we were being paid by the carrier, but we're coming in purporting to represent the interests of our clients. And I believe at the end of the day and it depends how much in the weeds we get today, but you'll find out, I think at least from my opinion, that our healthcare system is working exactly as the financial incentives have designed them to work.

And what came first, the chicken or the egg? I don't know, did the system come first and they found a way to make it work financially or did the financial incentives come first and they just chase the financial incentives and capitalize upon it? It was probably a mixture of both, depending on what vertical we're actually talking about, but the system we have today, if you look at who makes money and when, and under what circumstances and what control we've given them over our healthcare, you'll find that they've organized this as a very carefully orchestrated chess game that is working exactly in their favor.

John Marchica:

Yeah. You said something like that to me in our pre-interview, and it struck me is, healthcare works exactly as it's supposed to work, exactly as it's been set up to work. So it's not like it's broken in that sense, right?

David Contorno:

Yep.

John Marchica:

So how so is that? Why is that? Where are the incentives and the misalignment or alignment of incentives that may not be in the consumer's benefit?

David Contorno:

Yeah. So let me, I'll tell you the three entities that I view as it not working for. Number one are the employers who foot the bill for half of healthcare in the United States. Number two is the doctor, the provider of care, because they are generally being beat up. I'm talking about the actual doctor. I'm not talking about the healthcare system. I'm not talking about their executives. I'm talking about the actual doctor and then the third person. And I think the most important person that is not working for, is the patient. So let's look at the entities that we have entrusted to help advise and manage our healthcare. Number one, the broker. We spoke about that, the advisor. They're typically paid in a way where as costs go up, they make more money and they could again get commission. They could get some of the

spread pricing from a PBM. They could get stop-loss commissions and overrides. There's many, many ways.

Then let's go to the insurance carrier. So if you're fully insured, then you need to be acutely aware of a provision of the Affordable Care Act, called medical loss ratio provision. What it says is that every fully insured health insurance carrier in the United States must run at either an 80 or an 85% loss ratio. So 80 to 85 cents of every dollar they collect in premium must be spent on healthcare costs for the members on their plan. And that sounds like a good thing, because now they have to compress that 15 or 20% to cover their overhead and their profit. The problem is when you tie their overhead and profit to a percentage of claims, then the only way they can deliver on what their stated mission is, which is to drive shareholder value, especially for the publicly traded companies, is for medical costs to go up, because that's the only way they can raise the premium.

And that's the only way they can raise that 15 or 20% to be 15 or 20% of a bigger number, which results in a bigger number to them. So most people think the opposite. They think that if an insurance company keeps costs down, that they will make more profit and that's not true. They'd have to return profit. As a matter of fact, and this is pretty sad, but United Healthcare alone made around $7 billion in profit in the first quarter of the year. Now, because of... That's largely because of the reduction of the elective procedures and things like that, the COVID expenses are going to come behind it, but they're going to have to return not just United, but the entire healthcare industry is slated to return about $2 billion to members. Now think about that for a second. United Healthcare alone made over $7 billion and the entire industry is going to have to return around 2 billion at the end of the year.

It's going to be a pittance to each and every person because it's not in their interest to do that. So the second entity that benefits from costs going up is the fully insured health insurance carrier. Now, let's say you're in a self-funded plan. You might say that doesn't apply to me, because I'm in a self-funded plan, but the majority of employers have self-funded with the Blue Crosses, the United, the Cignas, the Aetnas, who they're riding on the same claims adjudication systems, the same PPO contracts, the same pharmacy benefit managers as where those things do apply. And now the carrier has even less incentive to really care about the money going out the door, because now it's completely not their money. Even though I argue that even in a fully insured world, you should be acutely aware of how much your carrier is paying for your members on your plan, because guess what?

That drives your renewal next year. This notion that we're fully insured so we're completely insulated from rising costs or big claims is ridiculous. You're not insulated. You pay for that on renewal. So the carrier benefits as healthcare costs go up, they're allowed to raise their premium. The only checks and balances they really want is to just make sure that their premiums don't go up faster than their competition. So, that's where they apply some pressure if they feel they're disadvantageous in the marketplace, they will try and right that ship. But that's about the extent of it. I could talk about pharmacy benefit managers for hours and hours, but let's just say the pharmacy benefit managers, which is for those of you that don't know, is an entity within every health plan that manages your pharmacy, your clinical, your costs, the three big ones are Optum, which is owned by United Healthcare.

You have Caremark, which is owned by CVS and you have Express Scripts, which is now owned by Cigna. So the PBMs are not held to a medical loss ratio, so they can inflate costs all they want. And of course, that adds to the loss ratio on the healthcare side. So, that's just a quick overview of a couple of entities that we trust to manage our healthcare costs, who benefit as costs go up. Even some of the health systems have gotten into either the network game, the insurance game, the TPA game, or the wellness game. There's another thing that boggles my mind. Imagine if you were to trust... Trusting a healthcare system, to tell you whether you need healthcare or not is truly the fox guarding the hen house, right? Now, we have a healthcare system who wants patients to come in.

I have a friend of mine who I shall not name, but he was CFO of a large hospital system out in the West. And his CFO came to him one day and he said, "We've had a really bad flu season this year." And the CEO said, "What do you mean? The vaccine worked this year." This was a few years ago. "The vaccine really worked this year. We've had so few admissions, so few emergency room visits. It's been a great year." And he goes, "No, no, that's bad for us because we lose all that revenue on those people who would otherwise be coming in to be helped."

John Marchica:

Right.

David Contorno:

And he quit at that point. He's like, "That's it. I'm done." And he went into a different area of healthcare called direct primary care. But that's the healthcare system. We don't have a healthcare system.

We have a sick care system. We have a system that benefits when you're sick and use the plan. Everyone benefits that you're trusting to do it. And I find it so odd how we think of health insurance versus other types of insurance, because most people would go out of their way to not file a claim on their auto insurance. Even if they had a small fender bender above their deductible, they might say, "Yeah, I'll just cover it, because I don't want my rates to go up." They certainly don't want to file a claim on their life insurance or disability insurance, right? We go out of our way to prevent using those insurances. And yet when it comes to health insurance, we have this expectation that it should pay for everything every day in every way. And the rates shouldn't go up when they do. It's again, nonsensical.

What I really try to do is get people to center back on, let's think about what insurance really is. First of all, health insurance and healthcare are two different things and not the same. We confuse those things in healthcare, but not in other areas. We don't confuse Geico with Ford, but we confuse Blue Cross and Blue Shield with a provider of health care. Blue Cross and Blue Shield doesn't provide any healthcare at all. And so I think we start to intermingle these things and therefore it becomes a scary proposition to make substantial changes to your health insurance, when you presume that that's going to substantially change your health care. And again, I understand why we feel that way, because we've relinquished so much control to these carriers over the years. But it doesn't have to be that way.

John Marchica:

So at a very basic level, what has... Probably going to laugh when I ask this question, but I think a lot of people want to know the answer to this.

What has been driving premiums up year, over year, over year? What's the root cause behind that, or causes?

David Contorno:

So the root cause is that it goes back to those financial incentives. It benefits the healthcare system, the health insurance system, so they've allowed it to happen, but it depends on who you ask. If you ask the health system, why are your costs going up? They'd say, "Well, the cost of goods are going up. The cost to pay for doctors are going up. We're writing off more and more bad debt. We're getting lower and lower reimbursements from the entities that control it. And the costs are just going up. Costs are going up everywhere." But if you look at healthcare costs and you compare them to how much other things have inflated, you'll find that food costs and car costs and home costs have actually, when you adjust them for inflation, have actually gone down over the last 20 years.

Healthcare and college tuition are the two noticeable exceptions to that. And I would argue that they actually kind of have gone up for the same reasons. If you think of the average 17-year-old student, who's getting ready to go to college, let's go back a whole bunch of decades when college costs $10,000 for your entire school, for the four years. Okay? The whole thing. Well, at that time, there was really no government funded programs for funding tuition. And so they had to come up with the money on their own, which was a check and balance. If the college charged more than the average American could come up with for their child's education, they weren't going to have any students. But as soon as the government made it easy to finance your tuition, well, if you're a 17 year old, $10,000 is an unfathomable amount of money, right?

Is 25,000 any more unfathomable? I don't think so. Not to a 17-year-old and if 25,000 is similar to 10,000, is a hundred thousand any different or 200,000. And if I'm able to easily get this money to fund and pay for this care, I'm sorry, tuition, why am I going to care about the costs, until later? And that's what health insurance has done for healthcare. It has put us in a situation, particularly when HMOs first came out where the cost of care is irrelevant to us, certainly at the time of service. And then we don't link it to, "Oh shoot. Now my rates are going up. My benefits are getting worse," even though there's a direct correlation. So I believe that it was the removal of that consumerism, where you had to pony up the money. Back in the day when I was born in the seventies and for most of the healthcare's history, before that in the U.S., you had to pay out of pocket for the birth of your child for whatever, and then submit a claim and get reimbursed.

So again, there was another check and balance in there which doesn't exist today. And then the Affordable Care Act, which lifted lifetime limits on healthcare costs from insurance carriers. You know, there's a drug that was just approved by the FDA earlier this year, that's for children, of course. And it's going to cost $2.1 million. It's the most expensive drug ever made. If we have the old $5 million caps on lifetime care, those drugs would not be possible because you chew through half a person's lifetime care on a child in one fill. But when the Affordable Care Act lifted, the lifetime limits barrier went away completely.

John Marchica:

So I've got a couple of things. One, I think one of the reasons why college tuition has been going up consistently, is in part due to competition. And what I mean by that is that they're trying to attract the talent of those 17-year-olds by building stadiums, building new complexes, having new facilities, better dorms, better food, all of the ways that they try to woo these a spoiled 17 and 18-year-old kids, this arms race going on among competing colleges and make themselves more competitive. But specifically as it relates to premiums, does it just come down to the fact that these large healthcare entities, these large carriers are publicly traded entities that need to deliver a consistent shareholder return?

David Contorno:

That's part of it, but I find that the same incentives apply even in the few remaining nonprofit health insurance companies that are left, and most large health systems are "nonprofit." Or at the end of the day, I think that the difference becomes instead of having shareholders to turn to, they have Board of Directors they have to provide financials to. You look at how much money some of these healthcare systems make, and especially if they're nonprofit, they're partially subsidized by tax-payer dollars. And they get a lot of benefit from the community. And yet they tend to extract value from that community at the same time. So, then it seems to go to executives and to building new buildings and increasing capacity, even though there wasn't a shortage of capacity to begin with. That's where the money seems

to go in the nonprofit, but they don't seem to be any less profit driven or revenue driven than a for-profit entity.

John Marchica:

Yeah. I would agree with that. I would agree with that. They have to run their operations like a business, and they've got to be able to year over year, show a "profit," even though that they're not-for-profit. So you touched on this in the beginning, but I just wanted to... I think it's more like the framework for this discussion before we get into your company. And that is, in your view, what's wrong with healthcare benefits.

David Contorno:

You know, I think at the end of the day, it's an employer mindset that needs to be changed first. And Warren Buffet said it best. He said General Motors is a health and welfare company with an auto unit attached to it because it spends more on healthcare than it does on steel for its cars. So the first thing an employer needs to do... I've seen employers who, before we come into the picture, are more acutely aware of their paperclip costs under their office supply line item, than they are any costs under their healthcare line item, which is far higher up the P and L. In most companies, it's two, three, four or five on the P and L usually behind payroll and cost of goods if you're a manufacturer. So I think they need to get into the mindset of saying, "Wait a second, I don't care what the incentives are. I don't care if everything David said is true about why it's occurring. I want to understand how and why it's occurring in my plan."

And I find that most employers say, "Well, I don't want to get involved in the health care of my employees." Well guess what? You probably don't want to be involved in telling your employees where to sleep at night or what kind of car to drive, but I'd be willing to bet that most employers that allow for business travel, tell their employees exactly that when they're traveling on the company dime, and that's the same thing here. And luckily, the beautiful thing about healthcare is that for the most part, cost and quality are inversely related to each other. When you look at the higher quality facilities and providers of a particular procedure, they tend to be at the lower end of the price spectrum.

So what we have in healthcare is a true win-win scenario, where we can get better pricing, better quality. And actually under our plans, we have the employers cover that care better, lower out of pocket, zero out of pocket often, to encourage them to go to the place where it's... My partner, for example, in both life and business, her name is Emma. And she had a hysterectomy done early last year. And had she gone to her normal OB GYN for the hysterectomy, who by the way only does eight or nine or 10 hysterectomies a year. That's what the average OB GYN does. She likely would have had it done at the local hospital in an open environment, because that's what the doctors are used to, where she would have needed pain medication, opioids probably, would have been out of work for two weeks. And the cost would have been about $38,000.

But instead we have a relationship with a women's gynecological surgical center in Portland, Oregon, and we have relationships like this all over the country, thousands of them for thousands of different things. But our top specialty for hysterectomies happens to be where we're based in Portland, Oregon. And she went to a guy who does 400 hysterectomies a year, has a 97% laparoscopic rate. They were so confident in their work that they gave us the entire surgery on a USB drive. You find me a doctor or health system willing to do that. Not often. And the prenegotiated, prearranged price was $11,000. And because he did it in a laparoscopic setting, she was in and out in an hour and 27 minutes. She took no opioids whatsoever. And she was out of work for two days and then back to work.

So the outcomes were way better. The cost was one third and we went to a specialist who does almost nothing but hysterectomies. And, it's those types of relationships that we look to capitalize upon and make patients aware of and bring a little bit of responsibility as a consumer of healthcare, which is what a patient really is, back to caring about cost and quality. And I think the HMOs and the PPO networks took that away from them.

John Marchica:

Is that what your company does? Do you provide plans that have these networks of doctors that are specialists in certain areas that you can guide the employers when people need things? Or is this just your personal experience? Tell me about E Powered benefits.

David Contorno:

Sure. So as I've sort of relayed, I was a traditional broker for many, many years, and it wasn't until I switched fully, but it was a transition where I'm now in the model that I described.

And the first thing is, is that I talked about how brokers get paid being a misaligned incentive. We get paid in a very clear way. On our smaller clients, we just charge a flat fee. We contractually prohibit ourselves from being allowed to take revenue from any other source, except the client. We are firmly rooted in the client's side of the equation, but for slightly larger clients, and it doesn't even have to be that large, but a couple hundred employees and above, we will tie performance incentives from the client to our revenue so that we are fully aligned with reaching their goals, which is usually lowering costs. Although we have had a few clients that have looked for other markers. And typically, we'll create this bonus threshold where we save you this, you give us this. We save you that, you give us that, and fully align ourselves on the side of the client.

So the number one thing that's really important is how we get paid is fundamentally different across our entire book of business. When I started to change that, before I even really had the solution sets that we have today, I had to find solutions that would allow me to achieve that because going back to the same well of what I'd been doing for the prior 15 or 18 years, wasn't going to deliver the results that I was now aligned with financially. So really, and I alluded to this earlier, I don't think there's any broker or many brokers out there who are intentionally giving bad advice. Just like I don't think there are doctors out there who were intentionally giving bad medical care, but the financial incentives align themselves so that as costs go up, the brokers make more, as quality of care goes down, the health systems make more, the doctors make more.

That's eventually what's going to win out in aggregate and you again, might have a few doctors pushing up-stream, but I promise you they're beaten up and sick and tired of it pushing against those immense forces. So now I have to deliver on what I am now tied to financially. And so our plans, we don't utilize networks at all. We don't have a network for anything else we buy. Imagine if we bought cars the way we buy healthcare. We call up Geico and say, "Hey, I'm thinking about buying a new car. Can you tell me what dealership I can go to, what kind of car I can get, what options I can get and what it's going to cost me?" That's crazy. I just bought a new car a week ago. I went and bought the car and then I told Geico what I was doing.

It wasn't the other way around. I told them what I needed them to insure, not the other way. So we started to build health plans that didn't have a network. See, in my opinion, the network is what has created or allowed for the most dysfunction in our system when even a self-funded employer, if they use a network like United or Blue Cross or Cigna in their self-funded health plan, this is... Think about how crazy this is for a second. They sign a single piece of paper that is contractually obligating them to the costs of tens of thousands of other pieces of paper, the actual contract between Aetna and the

doctor or Aetna and the health system, right? They sign this one document that obligates them to tens of thousands of other contracts. And if the employer is even smart enough to say, "Whoa, wait a second. I'm not signing this contract, which obligates me to those contracts until I see those contracts."

If an employer even thought to do that, they would be told, "Sorry, those are proprietary and confidential. You can't see those." But let me tell you what's in those contracts. And again, they vary. So this isn't absolute, but number one, it says, "Whatever you charge, you have to agree to a discount off that charge." Now, whatever you charge, you have to agree to a discount off that charge. So imagine for a second, if you walked into Kohl's and it said, "This thing is 30% off, and this thing is 60% off, which one do you want?" And they're both about the same. You'd probably gravitate towards the 60% off one, right?

John Marchica:

Sure, of course.

David Contorno:

There's going to be a bigger discount. But what if that 60% off item had a starting price that was 500% higher than the other item, that was a lesser discount.

John Marchica:

Right, I see where you're going with this.

David Contorno:

When all you contractually obligate yourself to is a discount, then the carrier wants the biggest discount possible, because that's how they're selling their network services. So I might say to a health system, "Hey, raise my discount by 10%, but raise your starting price by 20%, I get to say, I have a bigger discount. You get more money net. We're all happy." Those are the types of backdoor deals that go on all the time. And then, here's another backwards incentive. For anyone listening to this, think of the local large health system in your nearest city. There's always one or two that are the big behemoths in the cities. And think for a minute, if you're an employer of a few hundred employees, if you left your insurance carrier, do you think your insurance carrier would even see it on their balance sheet?

No-

John Marchica:

Of course not.

David Contorno:

One employer is not going to impact an insurance carrier, right? But what if that large local health system went out of network for that insurance carrier. Then every employer in the area is going to ditch that insurance. "I can't go where UMass isn't taken or where Sloan Kettering isn't taken. I can't put my employees in that plan." So the hospital systems are far more the customer of the insurance companies than the employers and patients are, because not only are they in bed with them financially and aligned financially with the health systems, but they're aligned in really every other way and really at the mercy of the health systems. So the other thing that often goes into those PPO contracts is a no audit provision or a limited audit provision. And there's a great link. It was just a couple of days ago.

There was a hearing in the state of Tennessee, over the state of Tennessee health plan for the state employees. And what they found was that, and you can Google this, it's on YouTube, that Cigna over the last year and Blue Cross over the year before that had erroneously processed 96,000 claims, only on doctor claims only. That was all that they had audited. They didn't audit pharmacy. They didn't audit facility claims. But they audited doctor claims. 96,000 claims and $17.5 million of overpayments. They found 96,000 times that the insurance carrier demanded the employer, because they're self-funded, pay more than the billed amount. So forget about this notion of a discount. Employers are so blind to what is going on within their health plan, that for several years, this cash-strapped state was not only not getting the discount that they were supposed to get, but they were paying, because it was self-funded.

So they're paying more than the amount the doctor asked for.

John Marchica:

Wow.

David Contorno:

Completely absurd.

John Marchica:

So this has been a fascinating discussion. I just wanted to get to one last point, which is, you said you don't use networks. So if you were to come in, we're under 50 employees and we want to offer health insurance. If you were to come in, what would our conversation sound like?

David Contorno:

So, first thing I do is I talk about the problems. I talk about how you're getting this, what is by design. And if you stay on the path you're on, I can tell you why and how you're going to continue to get the same results, but do I even really need to, because you've been getting those results for decades. What more do I have to do to prove to you that you are in an unsustainable environment than for you to look back the next 20 years, project out the next 20 years, and tell me if you can afford that.

I don't think... I shouldn't have to do any more than that. So we build a health plan that has no network of providers. And we allow the members of our plans to literally see any provider they want to see, as long as that provider is licensed to practice medical care, and is willing to accept money as a form of payment, then you can go and see that provider. But every one of our plans has a care navigation team engaged, and that care navigation team has access to cost and quality, first of all, at every provider across the United States. And secondly, access to prearranged and prenegotiated pricing at thousands and thousands of facilities around the country that are... A great example. Surgery center of Oklahoma in Oklahoma City, Dr. Keith Smith. He opened this facility up in 1993 and from day one, he's never taken insurance, Medicare, Medicaid. He posts all of his pricing and quality metrics, right on the homepage of his website.

I encourage you to go check out Surgery Center of Oklahoma and all of his pricing is right up front. And when I talk about how we make this a win, win, win situation, I'll tell you the example of my own hernia surgery that I had done at the Surgery Center of Oklahoma. At the time, this was back a bunch of years ago, I was covered by Blue Cross and Blue Shield. I was on a high deductible health plan where I had a $14,000 out-of-pocket to meet before the plan would cover a hundred percent. And I was living in Charlotte, North Carolina at the time. So I called the four hospitals near me and I said, "I have Blue Cross and Blue Shield. I need a hernia repair, just an inguinal hernia. I'd like to know what the cost is." And they were like, "Well, what's your deductible?"

I said, "That shouldn't be relevant. I want to know what the total cost is going to be." So they're like, "Oh, I don't know. Let me look." And I get put on hold, I get bounced around. Finally, they come back with a number and I go, "Great. Is that the full price?" And they said, "Oh no, no, no, no. You have to call the surgeon and you have to call the anesthesiologist." I mean, could you imagine if you want to fly somewhere and American Airlines says, "Oh, that's just to get your butt over there, but you have to get your luggage there. And you have to call in advance and have food delivered to you on the plane. And, your bathroom time has to be scheduled." Could you imagine that that was like the way, like, "No, just go do the other components yourself."

So anyway, here was, after the Blue Cross Blue Shield discount, the price range for this hernia surgery was $8,900 at the low end, $49,500 at the high end, after the Blue Cross and Blue Shield discount.

John Marchica:

What?

David Contorno:

Yeah. Now there's massive variations in the cost of care, even within a single health system, but the high end place, which everyone in Charlotte thinks is one of the healthier, better healthcare systems, actually had the highest infection rates. They had some of the worst outcomes and they notably had four times higher incidents of items left in patient after surgery than the surrounding hospitals. Now, as I mentioned, I went to Surgery Center of Oklahoma. The total cost at Surgery Center of Oklahoma was $3,060. Now it gets even better than that. I asked the surgeon now, Dr. Keith Smith, who owns the Surgery Center of Oklahoma, he's an anesthesiologist. So he connected me with a local surgeon in Oklahoma City.

And I go in for the consult before the surgery. And I said, "Question for you. Of the $3,060 I'm going to pay Surgery Center of Oklahoma, how much of that do you get?" And he said, "1200 bucks." And I said, "Okay, that seems reasonable. Out of curiosity, you do surgery at places that charge 20, 30, $40,000 through the traditional plans as well, right?" And he said, "Yes." I said, "Out of curiosity, how much do you get out there when you do a hernia repair?" He said, "On average, I get about $800." He said, "On top of which the Surgery Center of Oklahoma is so efficiently run, that he can do four or 5 hernia repairs in the same amount of time that he'd only get one done in the traditional system. So he's getting a 50% higher reimbursement rate, four to five times the volume.

He loves this type of arrangement. So had I had my type of health plan back then, my health plan would have said, "David, you can go to the $49,000 place, and you're going to pay your full deductible and coinsurance and out of pocket of, at that time, it was $14,000. Or you can go to Surgery Center of Oklahoma. If it involves a flight, which it usually doesn't, the airfare and everything will be covered. And your plan will pay a hundred percent." Because if you're the employer, would you rather your employee go to the $49,000 place where they're going to pay 6,000 or 10,000 or whatever they're required to pay. And you're going to pay the $30,000 difference or $40,000 difference with worse outcomes statistically or instead, and I know one of the biggest pain points that health systems have been complaining about, is that as deductibles and out of pockets have gone up, health systems are writing off more and more of that patient debt.

So we're able to go to the health system and say, "We're going to pay you in full. We're going to pay you fast. You don't have to go after this member for money, that you won't ever get. And the employer gets to look like a hero because they pay a hundred percent of the care at a much lower price with a better outcome, where that employee will get back to work faster." It really is a win, win, win situation. So, that's the way our health plans work is we build this incentive to care about cost and quality, and they

can either self-research it and we can validate it. Or we prefer that they allow us to help them research it, show them why we researched it as we did and why we came to the conclusions we did. And then they make the choice.

They're never forced. We typically match the employer's current plan. And so we say, "Listen, if you go where you've always gone, you're going to pay what you've always paid. But if you come into this other point of entry for care, where cost and quality matter, you'll pay nothing." And we do it not just on planned outpatient procedures, like an inguinal hernia or a hysterectomy. We do it on planned inpatient procedures. We do it on medications. So maintenance medications, where we can source them for 50, 60, 70% less. And then we say to the member, "You'll get your monthly diabetes medication at no cost, if you order it from this source instead of this source." Because again, it's going to cost the employer less to even pay a hundred percent of it, then whatever their share would have been had they done it traditionally. So that's how he built it across the planet.

It's just injecting common sense. And the hardest part is helping employers understand that cost and quality are inversely related. We have the sense, especially I think in America, that as quality goes up, cost goes up and I agree to some extent, but even so, if you look at some of the ultra-luxury automobiles, there are some that are 200,000 and some that are a million. When you get up to that level, does it really vary that much? The quality from the 200,000 to the million, maybe from the $8,000 pre-owned to the $20,000 new, I can see that, right, but that's the same thing. We don't always send them to the lowest cost. If your knee replacement, if the lowest cost is 14,000, but the best quality provider is 18,000. I'd so much rather you'd go to $18,000 place where you're likely to get better outcomes and we don't have to pay for that surgery again in a year or six months or five years. I'd much rather do that.

John Marchica:

Sure, sure. Well, David, this has been a lesson, an interesting lesson in how insurance works and the rule of the benefits consultants. I appreciate your time and I'd encourage people to... What's your website? I'll give you a quick plug, here.

David Contorno:

Thank you. Yeah. epoweredbenefits.com. E as in Edward, powered benefits.com. But I will say that I put a lot of content out on LinkedIn, so I encourage anyone to connect with me on LinkedIn. David Contorno, I'm sure the spelling will be up in the show notes and stuff.

John Marchica:

Yeah, it will be. This was great. And look forward to staying in touch, David.

David Contorno:

Thank you so much.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Healthcare Rounds is produced by me, Kim Asciutto and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in- depth customer insights to health care executives. Our strategic focus is on healthcare delivery systems and the global shift for value based care. Find us at darwinresearch.com. See you next round.

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