Introduction to the healthcare puzzle

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It is asynchronous care. If you don't have a belly button in your office, there's not a code to submit. So. Getting the primary care, we're willing to crawl, walk, and run it into, but we do come to the point with an employer where we say, yeah, the ask here is that you change your doctor.

Now there's, we don't fully take away the element of choice in our plans where people could have a copay to go somewhere else, but that copay is going to be a lot higher than what they're used to.

This is Dr. Talks. Hey guys, thanks for joining us again on My EMD Unscripted. We're very excited to kind of go a little bit away from the nuts and bolts of longevity and health and move really more into what makes all that possible.

You know, I cannot wait to introduce JD Osment to you, but I'm probably going to start with a question that says, why does healthcare in this country seem like the unsolvable puzzle?

And what if you or your employer has a lot more control than they think? It's just everyone, when it comes to re-enrollment time, just, oh, it's just like, oh, I have to go to that meeting.

JD Osmentu2019s background in employer insurance

I have to do all of that stuff. And then I'm going to have a bunch of stuff I don't get. I don't understand. It's going to be expensive. And the only time everybody would rather be at work is when they're at a re-enrollment meeting.

So JD, welcome to the show. Tell us a little bit about yourself and how we got here, man. Dr. Carter, thanks for having me. We got here through a mutual client that we both serve that we work with in Tyler, Texas, state nursing home there, state veterans nursing home, and yeah, in the employer sponsored health insurance space.

It's a bit of a deep track, but some big industry, as you know, big business, and it's a great big pain for most people that are dealing with it. Oh, it's awful.

Yeah. The only bigger insurance industry, I guess, is probably when the government's involved. So that's the only worst one there. That's right. Medicare.

So employer sponsored, you know, how you could say one out of every two insured Americans has their health insurance through their employer. So it's a, it's a big space.

Well, okay. So we're going to get to the good part. I'm not going to throw the punchline out there about why you're on this podcast and not a bunch of other sort of Blue Cross Blue Shield brokers, but get me started on how we got here, your story, what's going on.

Sure. Yeah. You know, right after school, I finished college, I got hired to be a health insurance salesperson, health insurance broker for a firm in South Carolina.

And I was kind of tasked with focusing on the self-funded employer space. So self-funded is just referring to employers that are big enough to be their own insurance companies, which Nowadays it's just about any size employer.

But when I started out, I was focused on businesses with a hundred or more employees for the most part, you know, calling and my job was sales. I was selling anything that I could sell.

So whether it be Blue Cross, United, Cigna, whatever product was out there that an employer wanted. And really the whole industry is kind of, it's a relationship business, but the actual nuts and bolts of the job are just recycling logos year after year.

You're going to go from Blues for a couple of years, over to United for a couple of years. They were to try, see Etna out, try that on for a little while, let all your people get upset about it.

And then go right back to Blue or United, one of the big companies.

Why traditional brokerage incentives fail

But it's, you know, it sounds a little bit maddening and it is, but it's designed to be that way from the traditional brokerage side of the table on, you know, the traditional brokers are paid for new business.

Primarily you're paid more in the first year of a sale and you're paid more, you know, when you're changing a logo. So there's. all sorts of misaligned incentives and I got really tired of doing it.

I'm the type of person that read all the contracts for the things I was selling and, you know, it doesn't take long to get deep into the weeds to see a lot of stuff that doesn't feel really good.

But my moment was, I remember vividly meeting with a client of mine. It was a nursing home. I was talking to a group set up in their conference room for open enrollment.

I had a group of CNAs around the table with me, and I'm explaining how the adaptables are going up. The employer's charging a little bit more per paycheck this coming year.

And I'm looking around the room for people that are doing an extremely difficult job for not enough money. And just realizing all of these people would be better off without this health insurance.

Like truly, that they're stuck with a $4,000 deductible that they can't pay. And by having health insurance, they're not automatically just going to get shuffled into financial assistance that they all would qualify for when they have health insurance.

And then they get stuck with, you know, collections notices, credit impairments, because they can't meet their out of pocket. And I just didn't believe it anymore.

Wanted to get out of the industry entirely, but instead got me and my business partner met up and decided to start a new firm that attacks the same problem in a different way.

And that's what we do at Calvary Partners. So your partner, what's his name? His name is Parker Ariel. Parker Ariel. I looked, I looked at your site, looked good.

It's super exciting to, you know, my story is a mirror of yours in my industry, right? So, you know, I burned out trying to be a ER doc in the current system and mostly people just needed access to their doctors.

And then pretty soon I was like, I don't want to be a doctor anymore. So, um, and then, and then me and a buddy of mine, Dr. Jeremy Smith, you know, he had started a year before me and was like, well, let's do it a different way.

There's gotta be a better way. So introducing direct primary care, it wasn't called that then. That's kind of how we solved our side of the problem. What did you guys do differently at Calvary?

Yeah. So, I mean, the most basic difference and like really where we started was let's at least work for the right people. So let's get paid in the way that we should start.

So we really started, we were fortunate to get plugged into basically a multi-family office that owns a couple of companies. and we started with one of their portfolio companies, large company with a couple thousand employees, and we set it up to where we're just going to work for you.

So we contractualized it right from the start with our first agreements with client number one, where, and this is true for all of our ongoing agreements now with any employer, is we are contractually prohibited from taking any compensation from any vendors in the health insurance stack.

So, none of the TPAs, none of the stop-loss, we don't take compensation. Not the PBM, nobody. So we work off a fee from the employer and that's it. So that's like the simplest way to boil it down is aligning the incentives from the start.

We want to work for our clients. And we want to make that really easy. I'm not that smart. So it gets really complicated. If I have revenue sources where there's competing interests, that's really hard for me to wrap my head around.

So having just aligned incentives that keep us in a very focused lane where we get to go to the employer and say, okay, what do you want to accomplish here?

Everybody wants to save money. Sure. But. Saving money is not the hard part. Saving money in a sustainable way is the hard part. Saving money in a way that's not just disruptive to the end user is the hard part.

Saving money and still producing quality.

Building Calvary Partners with aligned incentives

So what's your secret? What's your secret, man? How are you doing all that? Yeah, so we started in 2020 and we tried a bunch of stuff out. You've heard all kinds of things like reference-based pricing in the industry.

There's all kinds of widgets out there, wellness, people chase all sorts of threads trying to find the thing that's going to solve their problem of continuously increasing costs.

continuously increasing deductibles. And the thing that we've, after five years of trial and error, the thing that we've settled on is a combination of everybody needs primary care.

So direct primary care is foundational to all the plans that we build now. We don't go anywhere without it. And number two is paying cash for services.

It's simple as that. And that sounds a little bit you know, reductive, but we pay cash at the time of service for 98 plus percent of all the claims activity on our plans.

That same day payment to provider. And so, you know, for the folks listening out there, that's like, 180 degrees paradigm shift from the way that the billing works in the medical industry, right?

For insurance, how does it get? Yeah, people would think, you know, if they have the Blue Cross logo on their card, people assume that health insurance works the same way that their car insurance works.

where, you know, if something bad happens to my car, they're going to pay me for the car. But health insurance doesn't work that way at all. So health insurance, you pay your premiums and then that gives you the chance to

get, you know, whoever's logos on your card, you get access to their network of physicians and you get access to their quote unquote discounted rates with those providers.

A large portion of the industry is built on something called float where, you know, premium dollars get deposited into an interest bearing account. All that money just gets to float for a while before claims actually get adjudicated.

So in the traditional model, the way you used to practice medicine and fee for service, there's a huge burden on doctors and your mid-levels and the staff to code that service.

You've got to take detailed notes, which is important, but then you've got to code that service and that particular carrier's language, which they're not all the same.

To be clear, detailed notes in this time and age are almost complete. They're 90% detailed for the insurance company, they're 5% detailed for the lawyers, and 5% of that detail actually matters for the patient care.

In the system, if you don't detail for the insurance company, you go out of business. And they decide, they decide all of those things. So keep going.

Sorry. Sorry. So, you know, it's on a burden to just, it's not the burdens on the physician to, you know, to get paid anything. They have to chart a visit in a very specific way.

And that, you know, then submit all those codes to the insurance company and then he gets. basically any amount of time to get around to adjudicating that and saying, here's what we pay for X, Y, and Z.

Oh, and this is a 99212. So this is low level visits. So you can actually bill for this to get this up to a 99214. Here's some things that have to be present.

And you know, you know this well, there's so many, you know, it's just on doctors to get into a habit of. coding things in a way that gets their business owners to it.

It's a game. Every business exists to make money. In the meantime, this process may take the fastest that an insurance provider is gonna pay a doctor for a service.

And this is just, let's say you just walk into a primary care office, fastest turnaround is maybe 30 days. And then that's fast. Oh, that's crazy. That almost never happens.

That almost never happens. So really, you might be looking at 90 days before you're getting paid for a service you did. But in the meantime, the buck doesn't stop for the end user.

The patient gets left like the patients have hardly ever talked about in the insurance industry, you know, by a margin. So what's happening if you're going to, you know, the ER she used to work at, you're at UT, you're at any hospital.

Direct primary care and cash-pay claims model

Epic, the backend system for all hospitals that are on Epic, or there's other EMRs out there, the bills are auto-generated. So the patient shows up. They got seen a bill is going to get issued automatically from the system for the services as soon as those services are entered.

It's not going to have time to account for what insurance that person had. Somebody might not have had the time to enter that in yet. So end user has insurance.

They're all of a sudden getting a bill saying insurance paid zero. You owe this amount of money. And it's just, you know, unless you know that, you know, insurance hasn't had time to adjudicate this yet.

It's like a first pitch. You don't have to swing at the first bill you get. That's right. You got to keep waiting, but then you keep waiting. And then all of a sudden, after 30 or 60 days, Epic is going to automatically generate a collection notice.

Now it's not a bill anymore. Now you're getting sent to collections. Even though your insurance hadn't had a chance to pay for it yet. So you magnify this issue.

You take this issue and what the end user is feeling, which is what We've tried to move away from focusing on the price. That's the easy thing. We want to focus on the end user experience, but you take that experience and how bad that feels to be paying per paycheck for health insurance, then to go need to use that health insurance, which nobody wants to do.

Nobody wants to be sick and have to go use the health insurance. But now I used it and I'm getting all collections notices. I'm getting an EOB that says insurance has paid nothing.

It's just because it hasn't adjudicated yet. So the end users just left in this way. I guess I just need pay this to go away or people that can't afford to pay it.

And they can't afford it being on their credit. We're so far removed now from caring about, you know, the customer service side of healthcare in the traditional setting that it doesn't even get brought up.

It doesn't even get brought up. It's a non-issue because there's so many other bigger things that seem like the issue, but for us, it's an important issue.

We want the end user to feel like they have benefits that actually work for them. Well, it's not, it's kind of like what I say. It's like what we do here with direct primary care is low hanging fruit.

It's not hard. It's just not how it's done. That's right. Right. So all you have to do is push all that other crap to the side and say, what do we actually need to take care of people?

What do we actually need to do to get this patient access to that service? Right. And you guys, you guys take the handle. So the difference between what's going on with, uh, say the big EMR medical record systems, auto generating bills and collection notices.

How have you guys set it up differently on your end? Yeah. So we think of it in, you know, there's like the outside the box and this it's somewhat of a new box.

So that not to sound and that sounds a little bit corny, but the status quo says what employers are told you need a night worker doctors. then you need the insurance company to do all that negotiating for you because it's big and scary and hospitals are going to bill you a fortune and there's no way that you can handle all this.

And what about the big scary claims? There's no way that you can handle the cost of those for your population when those pop up without the insurance in network discounts.

And we kind of just take in the, there's this huge, huge industry, this middle between doctors and patients and between, you know, employers and that the federal government says you have to offer affordable health insurance to your staff.

If you have more than 50 employees that just told all the businesses, guess what? You're an insurance company now as well. And they're, they're tasked with that.

And then they're tasked with on the other end of the spectrum. I want to hire people and keep people and make sure they feel cared for. And this solution in the middle continuously makes that hard.

This giant middle that you cram at this problem, this, all right, let's just go buy something from Blue Cross or let's

just go buy something from United.

That's what people want that this huge middle comes at number one, a ginormous cost. And it delivers the horrible end user experience that we just laid out.

So the simplistic way to think about what we do is we just eliminate the middle and it's not like. It's a full set, like fully take the whole middle out, take the network out, which is a big scary thing to get over the hurdle with an employer to not have a network logo on your card.

We have plenty of data to say you don't need it, but that's gone. We throw the whole network out. You don't need it. We'll pay the doctors cash. Like with the transparency act, we know that hospitals have to post their cash pay prices.

So we pretty much work off of that. and we're going to try to get fair prices the best way we can in real time by instead of the claim submission process that we outlined earlier, we're going to do it all.

We call it pre-adjudication, but this only works with practices like yours, which we're doing this already. So this is not theory. This is reality. We're doing this for a bunch of patients of yours already.

Where we piggyback on your referrals for our members. You say, Hey, I'm sending JD out for an MRI on his knee. He's got knee pain. Might be time to look at a knee surgery that comes to my office.

Eliminating the insurance middleman

We call the provider that you're sending that. sending me to, we find out what the cash price is, and then we put that money on a digital credit card for the member.

We text it to them the day of their appointment. They show up and they don't have to worry about what network they have on their card. Is this a network or out of network?

What's the deductible? It's fully paid for up front. They just walk in and say, I'm paying cash for this. And the user experience goes from walking into a provider's office, not knowing what's going to happen, not knowing how much any of it's going to cost, not even thinking that asking the question is a possibility, to knowing what I'm going in for, how much it's going to cost, and they get to see the real dollar amount every single time of the benefit that their employer is providing them.

And this is not just for the little one-offs for imaging. We're doing this for large swaths of oncology claims. We're doing this for people that are delivering babies.

We're doing this for all kinds of major surgeries where paying cash Gives the employer, our clients a fair price because we're paying cash in real time.

We're able to deliver an end user experience that's truly unparalleled in that there's not this limbo of waiting for the bills, waiting for the shoe to drop.

Everything's paid for upfront. And it's actually been something that we didn't anticipate. is how interested hospitals are now with talking with us. They want to do it.

I live in South Carolina. We've now met with every single hospital in our state. Every single hospital system in our state has reached out, and we've sat down with all their leadership.

And we have some hospitals that are very interested in pursuing our product that's called the Direct Help Plan as an outward-facing product to go talk to employers about.

Well, you know, if you've ever been to a jewelry store when they were having a sale, they're having a 40% off sale.

But had you gone to that jewelry store the week before, the listed price would have looked different, right?

Right. You're going to inflate the price to get a 40% discount. And that's all that the insurance companies have been doing for the last, you know, gradually in the practice of trying to make all this work to everyone's benefit, but the patient.

the prices have been artificially inflated so that… the insurance companies can give a discount. And I think the temptation is there to vilify the insurance companies and the hospitals for allowing this to go on, but the goal of any business is to make money.

They're not evil people. They have to run their business. It's a slow trickle, man. It's been doing this since, what, the 50s is really when we got going with this.

And then the Affordable Care Act poured gasoline on it. It did. It did not help. No, it didn't help. It's made sure that doctors haven't gotten a raise in a good long time, but the premiums of health insurance and family premiums up to over $30,000 on average.

The cost is going up and the reimbursement to the medical side of things is going down. reimbursement to the admin, to that middle that we talked about, you know, stock prices are looking great.

Yeah, those are looking okay. Big carriers, those are looking pretty good. So we get the middle out, and as it turns out, the hospital's actually happy with that cash price, right?

Like, that's really all they ever wanted. So the new stats are coming out and I talked to a hospital leadership team about this last week. It's now up to 47% of patients that come into a hospital pay all of their bill.

The other 53% pay none of it. Wow, man. Having money upfront is truly like found money. Now, and to employers that may be listening to this, like the too good to be true problem that we have is a real one.

And it's Like I don't have a good answer for you. If you're going to listen to this and say, this sounds way too good to be true. There's no way it can be this simple.

I don't have a good answer for you, but I would encourage you to just reach out to a hospital next time you need something done, the surgery or someone, you know, the surgery coming up in your population and just say, I'll pay you cash for it right now.

I've got a credit card ready to go swipe it. What, what price am I going to get? And then just look back at claim historical claims that and see what you've paid in the past for similar services.

It proves itself. It sounds too good to be true. Like it can't be this simple. It's on us. It's on my firm to build the ACA compliant, ERISA compliant box around the health insurance, which we've done.

And health insurance can't have limits. It has to pay for all the preventative stuff at a hundred percent.

How the Direct Help Plan works for members

Our plans do that. But what we provide back to the employer is the leverage of that real time payment that insurance companies have every reason to keep from you because they want your money up front so that they can collect interest on it.

Correct. And, you know, pay it out eventually and, you know, get all manner of, I'm not going to use the word kickbacks, I don't want to accuse anybody of breaking the law, but they're doing very well by abiding by the law of the land and, you know, getting paid handsomely for that effort.

Yep. Yep. And the hospital not only is okay with the cash price, but to get it at the time of service. and not have a

coding, you're saving money on the coders and the billers and the collections.

Even if they get their money 90 days later, they've paid multiple employees to do a bunch of things to try to make that happen. So they're already, best case scenario, gonna keep 50, 60% of the bill.

That's right. after the discount. So if you can just give them that bill upfront, they really, they make money compared to what they would get with the insurance game.

That's right. Because the insurance companies are like, no, you forgot to dot that I and cross that T. So we get to make interest on your money for another three weeks during this turnaround process.

Exactly. And that adds up to an almost infinite amount of money over time. Now it makes me kind of like- Yes. The only thing that gets more… I was listening to a talk recently.

When you look at the way that people get paid, ideally, one thing that direct primary care has got going for it is membership is good. Knowing that you're going to get paid this month and not having to start at zero every month is a cool way to- Cash flow is good.

Cash flow. But better than that is insurance, where people pay you every month, but you may or may not even have to give them anything. Yeah. And then when you do, you can delay it and wait because you already have the money.

And then the only thing better than that is tithing, right? Like you pay every month to God and you just, you know, it looks like, you know, sort of the church, which I'm a big fan of and believe strongly in tithing.

I think that's how God set it up for a reason. And that one's fine. It's the one in the middle, the insurance company where they're like, Yeah, we'll take your money, but we really don't approve that procedure.

That's really where you get- Yeah, prior all said yes, but you know, upon clinical review, it seems like, have you tried therapy? Well, no, I had a surgery last week.

Oh, dude. I love it. So, okay. So let's take a step backwards then. So you're presenting this plan to an employer. Okay. And so right now that employer's on a Blue Cross Blue Shield plan is people have $6,000 deductibles and they're looking at a rate increase.

And so, you know, they've got a relatively bad product at a super expensive price. They have confused. not that grateful employees, right? This benefit doesn't feel very beneficial.

And then you walk in and say, oh, we're going to solve all your problems. Every time you need something, you'll go to your direct primary care doctor and then he'll let us know if you need, if your people need anything.

You say, well, but my people don't want to change their doctor. And, and what if this, you know, and so there's, this is obviously, it's a paradigm shift.

Um, so take us to that conversation a little bit and how, how does, how does that go from, you know, you're selling snake oil to this might actually work.

Yeah, it's a great question. And it's a long sale cycle. It's a big decision for a business owner to make. As a business owner myself, we didn't start out this way, but in doing what we're preaching, we now do direct primary care and a cost share for all of our folks.

We pay a hundred percent for those things. But even that, it's a difficult decision to make because you want to make sure that you're not You know, ripping the rug out from somebody that the 20% of people in an employer that do have ongoing and serious medical concerns.

It's always a concern to take care of those people. And we're really passionate about that too. So we go in the education burden that we have is high and that we got to explain what the market really looks like.

How did we get here? And then we got to go to all the end user. We got to go to the patient and say the ask with this plan. And we, we, we prefer to crawl, walk and run an employer into this.

So what we'd like to do is, you know, take a stepped approach year over year and start with, we're just going to add direct primary care to what you have.

Hospitals, cash pricing, and upfront payment

And that doesn't solve the, well, my people have doctor cause this doesn't provide any, you know, guard rails or any carrot or stick to get people to participate with your practice.

So it's still, you're still going to get some people in that don't have a strong relationship with the doctor. And those people end up being our sales force.

Like, you know, this so much business is word of mouth. And the people that come into your office and are like, wow, I walked right in and I didn't wait in a waiting room for 30 minutes.

And I got, you know, somebody spent real time with me and asked me questions and they weren't staring at a computer screen the whole time. Like it's such a different service from what people are used to that people talk about it because it feels like we're getting away with something.

So yeah. That experience feels so revolutionary and just then be able to text your office and actually get a response. The little things like that, that seems like low hanging fruit.

That's not possible in a fee for service situation. Like a doctor does not get paid for a phone call. It is asynchronous care. If you don't have a belly button in your office, there's not a code to submit.

So. Getting the primary care, we're willing to crawl, walk and run it into, but we do come to the point with an employer where we say, yeah, the ask here is that you change your doctor.

Now there there's, we don't fully take away the element of choice in our plans where people could have a copay to go somewhere else, but that copay is going to be a lot higher than what they're used to.

And that's the, that's the carrot and the stick. But we have to do that because it saves, you know, if you're, if you work for a business, what the decisions you make from on the healthcare front do trickle up into what comes out of your paycheck every, every two weeks.

So it matters. When you're, when you're doing the crawl, walk, run process with these businesses, it's opportunities to, to sit with the employees every year, if not more often.

It's okay. More often. The rates are going up because, and we're going to try to get around that by. And let's get you the best product. Who here has used the direct primary care doctor here?

Yeah, yeah, yeah, yeah. I've been in some of those meetings and it's been really great. And all of the plans that we've been a part of, because obviously we do this with you.

We have a couple other brokers that do it differently. I love what you're doing. We're like, how do we get more groups with JD? This is healthcare done right.

But the conversations in those rooms is, hey, you know, the next year, hey, we don't have an increase on our healthcare this year. And that's now because of y'all's decisions as well.

So thank you very much, give yourselves a round of applause, good job, da da da da. But now who's used the direct firmware care in here? And like most of the hands go up because they've drank the Kool-Aid, if you will.

It's such- a positive reinforcement for what we do. Absolutely. And with a business that's big enough to not make a wholesale shift. So if we're talking to a business with 25 people on the plan, we don't have the scale to say, offer your people a Blue Cross plan and offer the direct help plan alongside that comes with it.

There's just, from a stop loss perspective, it isn't possible. But when we're talking to a business with, you know, 500 or more employees, we can likely get away with that where we can keep a more traditional plan up and running and offer this alongside of it.

And we might get 30 participation in the first year, but we've consistently seen that jump to 80 plus percent in the second year. That's cool. The plan has no deductible and everybody that's experiencing direct primary care talks about how great it is.

And I really do think we skimmed over that part, but when you were saying that if the direct primary care doctor says they need hip surgery and they go pay that hip surgery with that card, what's the patient's deductible in that scenario?

The plans that we build on the direct health plan platform, so around direct primary care, they don't have a deductible. So it's a zero deductible plan as long as your direct primary care doctor thinks you need it.

That's right. So the traditional planes that people have have an in-network and out-of-network tier. We don't do that because we don't use the networks in the first place because that's where a lot of the value generation for all the wrong people happens.

So we build plans on a coordinated and uncoordinated tier. So coordinated means You started with primary care, you started with Dr. Carter, and that can be as simple as, hey, I have an existing specialist relationship, you know.

What we see more times than not on the people who have chronic stuff, where they're going to specialists every month for either medication or going to a specialist every quarter for a check-in, they're running labs.

Employer adoption and the DPC rollout strategy

You could run the same labs and just coordinate with their doctor. Now you know that people on our plan are qualified buyers, so it doesn't feel like you're asking for a favor when you call up one of your peers that's a specialist and says, hey, will you see one of my people?

No, I don't really know what their insurance is going to pay you. You know when you're calling up a provider that you want to get one of our members into, but it's good business for them to take.

So you don't feel like you're bending over backwards. So the peer to peer gets easier. Yeah. I hope it gets easier for you to make those calls and say, Hey, I do want to work with you on this patient that I think we can work together on.

You now have real reason to do that. And that other provider has real reason to take the call because this is good business. The direct primary care dots job and mid-level provider, whoever's in charge, who has this relationship with the patient, is they're also that patient's navigator.

They're like, oh, you need knee surgery. Let me tell you who I think is the best at knee surgery in this group over here. And guess what? That group takes cash.

So we're going to be okay. Had that person gone to their hospital-based primary care doctor, they probably would have also said that you need knee surgery, but they would have said you need to go to the hospital system that I work in, Doc, who may or may not be the best, right?

It may not be aligned and there's going to be a lot of people getting their hands in your pockets along the way because the primary care doctors don't actually make money for that hospital network.

They're just feeding the system. when he said in a previous conversation that our motives are aligned with the patient's motives, which are aligned with the plan.

Yeah. Yeah. It's like, yeah, that was like sort of, yeah, of course they are. It was, I don't know why I had never thought of it. The employer is like, if you want primary care to be primary, when there's easy to get every CEO to think, yeah, I wish everybody went to primary care first and not an ER.

That's a super easy math to do. That's low hanging fruit. The real reason that you want your people to go to a DPC is because right off the bat, his incentives are aligned.

You're going to pay him the same amount of money every month for everybody that's on this plan. He not like you, guess what? You got some hypochondriacs that work here.

I guarantee it. And now that they have access to Dr. Carter and they know I don't have to pay anything when I go and I can call them anytime. You could then be stuck with patients that are just going to call you every day.

Your incentive is I want to get everybody to feel so good that they don't need to call me. So incentives are aligned right from the start. If you lived in a vacuum and you got to build your own world, this is exactly how you'd want to pay your physician.

Where I want them to be incentivized for me to not have to use them. If I feel great, I don't feel like I need to go to the doctor. And that's great for Dr.

Carter and it's great for the patient. There's a not insignificant percentage of my practice that when I call them to come in for their annual, they're like, well, why?

I'm doing fine. And I'm like, no, you gotta come in, man. I gotta keep you rolling. Like we're in the business of avoiding the future potholes. Just come get your labs, bro.

And they're like, oh, okay, okay. But they've just gotten- It's not gonna cost you anything. Just come on. It's not gonna cost. Just come on in. Yeah.

Yeah. Yeah. This will cost you a little time, but guess what? A hundred percent of that time is going to be used on you. Not in the waiting room. Not.

Yeah. Our guarantee. We won't waste your time. That's what we try to take out of the DPCs is we don't want to waste the DPCs time either. And like, When an employer bolts DPC onto an existing plan, a status quo type plan, you still have the risk of saying, hey, it is time to get this knee looked at.

But if that person is on a high deductible plan with a $4,000 deductible, they might not go get the MRI because they can't afford to. That turns into an ER visit down the road, and you're going to get blamed for it to some degree.

When renewal comes around, Dr. Carter is an easy way to save $100 per person. We don't want to bolt it on. It has to be integrated for it to stick. If we're in order for us to save the employer, the amount of money that we want to, and to give the level of care that we want to, it's just, we've helped people on a Blue Cross Blue Shield plan, not have an increase the next year because we were able to avoid a bunch of ER visits and we were able to step in and make significant improvement in some people's quality of life because we happen to get a reasonable amount of utilization of that group.

But the problem is, there's only so much money I can save you, right? Because the middle man still exists and they're siphoning off their piece. But okay, man.

Gosh, like we said before we started, it was like, you know, just in case, we won't get stuck. But I think more likely we're going to have to cut ourselves off because people are going to get tired of hearing about insurance soon enough.

Okay, let's talk about- Len, let me give Miami Select their flowers real quick, because we work with a bunch of DPCs all over the country, and Miami Select stands out as a practice that's grown up a lot, that sees a lot of patients, and does that well.

Scaling is really hard in DPC and not every DPC doc wants to. DPC can just be a quality of life play. I'm going to see less people and make the same amount of money, but employers need it.

Scaling the model for smaller groups

Employers is the market and employers is risk to a DPC practice because you could get fired. Just the families that come in, the retail business for lack of a better term is sticky and isn't going to leave very often.

But employers can in theory come and go. We haven't had an employer change a DPC yet, but it could happen. So we were really appreciative of My MD Select as being a consistently great service provider, but also a partner in growth and that they want to grow and they want to go to where the employers are.

And that's really, really additive to our business. And we hope to continue to be additive to yours. Man, you guys are awesome. Thanks for the, thanks for the compliment.

The thing is we just don't, we don't do it different. The difference is, is we've been called, we feel like we've been called by God to grow this thing in a way that not just gives me a better quality of life and gives my patients better care and gives my staff a better quality of life, but I want more patients, more doctors, more staff, more receptionists for goodness sake.

to get to experience healthcare this way. And I want to shift, we, you and I are trying to shift this insurance game towards the patient for all the right reasons.

And so that's why we were like, JD, where else do you want to go? How can we help you get there? Tell me about, so, cause you were saying Calvary in the past had mostly been pretty big groups so that they could, self insurer that could get rid of the insurance behind all of this and be their own insurance company, which just gave palpitations to every business owner out there listening to those words.

But you're also figuring out ways to successfully bring this down to say groups of 25 ish, like Yeah, if we have 25 people on the plan, yeah. So if we've got 25 people on the plan, we can try.

I'm gonna say we don't bat a hunt, we're not gonna bat a thousand in the under 50 space. It's really tough from a stop loss perspective. We're gonna get better at that as we grow, because we're gonna have more scale and be able to either create our own captive or park business in that space in a captive, which we are near approved by multiple captives.

So we have those options right off the start. But yeah, if you're a business with a hundred employees on your plan, it's a note like absolutely we can help you right away.

We haven't missed on one yet. Not to say that we can't, but we haven't yet. But if you're less than that, but you're growing, you know, you just want to learn about it, dip your toe in the water.

I'm not going to, I can't guarantee you that we're going to save anybody money. but we're gonna do our best and we've been successful at it so far. Our average cost per employee per year is about 40% less than national average for a plan with no deductible.

It's crazy. It is truly low-hanging fruit. Now, it's a lot of work. You're having to call ahead, get the cash prize, send

the card. I mean, on your end, it's a lot of work.

We're the only insurance brokerage in the country that puts our phone number on the front and center of the insurance card. Yeah. It's not a 1-800 number.

You're not calling the TPA. You're not calling the BBM. All calls come through us. So we staff aggressively for that reason. But the only way that we can provide any solutions is to have line of sight into the issues.

So if people are having a bad experience, we need to know about it. And even paying those folks to help you out, you're 40% cheaper per employee than the national average.

And the patients have no deductible. They get hour-long direct primary care visits. They get no wait. They get 24-7 access. They get all of the direct primary care goodies, which in and of themselves seem, quote unquote, too good to be true.

And there's no deductible, and it's no deductible, and it's cheaper, which is of course too good to be true. It's a call to find out more. That's right.

Now that we've half angered, half confused everyone out there with, is this even real?

Closing remarks and contact information

Holler at us. JD, we'll get your contact stuff. in the show notes, what's the best way if they were to want to, if someone listed right now. Yeah, so they can check out our website, directhelpplan.com and then Calvary Partners LLC.com.

So Calvary Partners is the brokerage side of business consulting arm. The direct health plan is, you know, our health insurance chassis, our health insurance product.

Nice. We are dabbling in letting other people sell. So if you're a broker and are interested in talking to employers about that solution, reach out. My email is JD at cav.partners.

That's C-A-V dot partners. I love it. Find me on LinkedIn and we'll put other content in the show notes. And we'll get all that in the show notes so that you can just be one click away.

But JD, man, thank you so much. I know you're on the East coast. This is family time right now. I appreciate it. This is great. Yeah, it was, it was great.

I, when we first met, I was like, I have to get him on the app to get him out there. So, um, thanks for the time and thanks for what you do. And, uh, thanks for letting mine deselect be a part of it.

And we, uh, we look forward to doing our part to change healthcare for the better. So good time here. All right, brother. Thanks a lot. You have a great one.

You too. Bye bye. Thank you for tuning into Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health. Each day is a new opportunity to make choices that empower your well-being.

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