Episode 4 — Buoy

So we're saving about $174 every single time someone uses Buoy when you compare pre versus post.

Welcome to "The Cure for the Common Company," a podcast series looking at innovations in the world of employee health and well-being. Steve Blumenfield and Lindsey Conon from Willis Towers Watson's health and benefits practice are talking to entrepreneurs and industry leaders who break new ground to meet the needs of today's workforce and deliver benefit solutions that can separate great employers from the pack.

[MUSIC PLAYING]

Welcome back to another edition of "Cure for the Common Company." We're joined here today by Andrew Le, founder and CEO of Buoy Health. Welcome, Andrew.

Thanks for having me, Steven, Lindsey.

Why is Buoy Health called Buoy health?

So when we are asking people what it was like to Google their symptoms, they said it felt like they are drowning in information. So Buoy as a verb, you know, to keep someone afloat. And then as a noun, it keeps things, you know, keeps boats from going astray. So it's also like guidance.

All right. Cool. And so now it's B-U-O-Y.

Correct.

Not B-O-U-Y.

Which would just be the misspelling of the English word.

Yeah. Which I see about half the time in emails. I see it typed is B-O-U-Y. And rather than never check, 'cause you never know.

What, why, check the facts.

I just kind of look up — well, the frequency distribution. And it turns out it's about equal. So thank you for telling me how to spell bouy.

I actually had checked the facts, and I found a great blog article that I think you had written when the company first went on. And you related it to your parents' marriage, or migration? Yes?

It was like a rocky, really bumpy marriage. Went up and down, like a buoy.

It was actually a very beautiful piece.

Thanks.

I can't remember it. I just remember it being very beautiful and then relating back to why you are calling it Buoy.

Oh, thanks. So that's not why we call it Buoy Health. But to me, it was interesting that buoy is nautical in theme, and that my parents actually met on a boat, escaping from Vietnam after the war. And so it was basically a blog post linking how their big risk was, let's escape from our home country with nothing and just go make it work, and then they met each other and fell in love, and all these serendipitous events happened so that they could have kids and all that stuff.

And then I relate it back to like, how I decided to start the company and not — I mean, they had a 50% chance of dying. So I would say, relatively speaking, this is a pretty safe bet.

Yeah.

Yeah.

Yeah, the chances of dying from entrepreneurial failure are lower.

Lower than 50%. Yeah, so I was like, you know, I'm coming out ahead, dad.

[LAUGHTER]

Do you want to talk maybe a little bit about why you started Buoy?

Sure, I mean, it was a very family-oriented reason. I was in my last year of medical school at Harvard. I was going to go be a surgeon. That was my life's dream. My last rotation was in the emergency room at MGH up in Boston. I was seeing all these patients who were googling their symptoms, reading something online and doing something inappropriate.

So one night, at 2:00 AM, I saw a jammed finger followed by someone who had an ulcer on their foot from a history of uncontrolled diabetes, we had to amputate his leg that night.

Wow.

And when I told the first person, you know, you shouldn't be here, she pulled out these pronouns from WebMD telling me why she was there. When I told the second person, sir, I'm so sorry, how didn't you come in two days ago? We could have done something better for you. He also pulled out pronouns from the internet telling us why he had waited and why he thought we shouldn't amputate.

And then right around then, I mean, that was obviously a very jarring experience. And then my dad had a mini stroke on his employer's treadmill. And like, he worked for a big Fortune 500 company. Collapsed and didn't go to the doctor. And when I asked him later hey, you know, why didn't you call me? Or I have two younger sisters who are book docs, he said, you guys are both work — you guys are all working. OK. Why didn't you Google it? And he said, I don't trust what I'd find on Google.

So for me that was this emotional tipping point. I ended up leaving school three months before graduating. A joke in the family is that when I told my parents, they had a second — my dad had a second stroke. But just became obsessed with this idea of fixing the first step in care, which we define as that moment that you're sick or injured, and you had really no idea what to do.

And can we intervene at that moment? Help you understand what's most likely going on clinically, and then match that to, well, basing your benefit design, this is the perfect service for you, this is a perfect doctor, is the perfect urgent care telemedicine vendor, et cetera. So yeah, that's how the company got started.

Do you ever miss being a surgeon? That was your lifetime dream.

It was. And actually, I took this sabbatical for about 3 and 1/2 years and then the school basically said, either you come back or you're — we're going to kick you out. And I still remember when I left my mom gave me her blessing, but said that if I didn't finish, that I wouldn't have grandchildren. Oh, she — I'm sorry. She said —

How does that work?

No, she said, and she wouldn't have grandchildren. And I thought about for a second, was like, I don't really get what you mean. And then I kind of put that on my kids would be her grandchildren. So if I

don't graduate and she doesn't have grandchildren, that means that she's going to do something to me that'll keep me from having children.

So that is, oh, mom, there's a physical threat. Yes.

The pronoun there was really confusing.

It was. I was confused, too, and then I clarified with her, and she confirmed. And so I went back to school. Yes, at 3 and 1/2 years for graduating, or after taking a sabbatical, I snuck back into school for three months, did my last rotations, graduated.

Good for you.

Then went back to —

Made your mommy happy.

--having a company.

But do you miss being a surgeon?

Sorry, that was a really long winded way of not answering a question.

It's OK. I just want to tell you it's OK.

Steve, you should have been a doctor.

Your mom called.

The empathy that you just gave me there —

This is not the emotional health podcast.

We already had that one. Check out episode number 1.

OK, that was a good call-back. I don't miss. Because when I went back for three months, I went from like loving patient care, everything about it, to when I went back, I felt how un-scalable it was relative to what we were trying to do.

Unscalable. Say more about that.

I mean, at Buoy, we see a patient every 13

--every 13 seconds, like —

Wow.

--soup to nuts.

The same patient?

[LAUGHS] Yeah, it's the same hypochondriac in New Jersey just like —

6 million times —

Hitting the site.

--right?

Yes. Yeah, exactly. [LAUGHS] But that speed of impact is massive. So any new feature we release, any new model that we create, anything like that, it's like one to many.

And while I loved patient care, when I was dealing with a lot of this stuff that doctors have to deal with — they really are patient saints. They have to go through so much to see a person from a documentation perspective, from a billing perspective, from a — oh, god, coordinating the person's care. It's really, really hard. Once I had seen the other side, it was hard for me to go back. So I don't miss it.

But my sisters, they still see patients. And when I talk to them, it's interesting that our worlds have diverged so much. Yeah.

Wow.

So can you tell me a little bit about exactly how Buoy does what it does? How is it scalable in a way that a physician is not?

So what Buoy does is it interviews patients like a doctor. And after a two- or three-minute interview, it narrows the world of diagnoses down to a maximum of three different matches, reasons for and against each. And then by understanding who they work for or who their health plan is, we can navigate them into the right service within the set of services that their employer or their health plan has curated.

It took us about four years to build Buoy itself. And when we started, just found that the current technology was mostly rules-based decision trees — basically, hard-coded questionnaires. And the new approach was to take a bunch of electronic medical record data and do some fancy machine learning on top of that. We found both approaches had a lot of weaknesses. On the decision tree side, it was too hard-coded to be flexible enough to help a lot of different types of people. And then on electronic medical record side, there's a huge problem of selection bias. Most people don't go to the doctor, for instance, when they're sick. So if you train on only people who go, you're going to make everyone look sicker.

So we basically said we're going to go back to the source. And we ended up reading thousands of clinical papers — basically, papers that would go into a medical textbook that a doctor would read to then understand medicine. And we taught the program the statistics that underlie medical training. For instance, if you have a fever, you're more likely to have a bacterial than a viral infection. If you're a smoker, the chances of you having a lung infection or lung issues is much higher than someone who doesn't smoke.

So can I just break this down a little bit?

Sure.

What I think I'm hearing you say is that where the prior approaches were essentially taking the decisions a doctor would make and automating those decisions — putting aside the machine learning piece of the other option — you went back further and said the components that make doctors smart and knowledgeable about those decisions were where you wanted to start, so you could create the code and the decision-making around those smaller pieces of decisions that would lead in a direction without going to the kind of assumption level that this physician made above that. Is that about right?

Yeah, that's a really good way of putting it, Steve. Exactly. The decision tree would basically be almost like taking a transcript of how a doctor would talk to a patient with this particular situation. If you had a cough, then you take a right and you would ask this question. If you have a fever, take a left and you'd ask this question. But what's missing is the underlying logic. And the logic is not rules-based.

So doctors don't think like trees. A physician isn't sitting across me and thinking, OK, after I ask this question, depending what Steve says, I'm going to either turn left or right. It's not like that. They're really thinking about it from a statistical approach of saying, OK, well, based on everything I know about you, what's the most likely thing going on? And then based on all the things I don't know, which one is going to help me the most statistically with what is most likely going on?

Very cool.

So we tried to replicate how they think in a way that's really defensible and understandable by a physician. And then the machine learning comes in, because you see a lot of people, people use the product all the time. And if you understand what ended up happening to them, you can learn. It's almost like a doctor read all these papers, memorized the stats, and was now using them in real time in talking.

Yeah.

And then just like a physician who's had 40 years of experience — basically, he has 40 years of patient encounters — each one has taught that physician to understand medicine a little bit more. Similarly, every time we see a patient, we can understand medicine a little bit more and get better and better and better. So when we talk about a patient every 13 seconds, the best doctors see 40 patients a day. We see many more than that.

So if Buoy were an animal, what would it be?

OK, so thinking this through in real time, we're Buoy, so it has to be nautical, so it's got to be in the ocean. I feel like people at Buoy are really kind and generous, and so it'd have to be kind of cuddly. But at the same time, we're super competitive. So I'd probably say something like a killer whale or an orca. Did you guys see recently about the killer whales that have been found to kill great white sharks? And they just go in and literally just eat their liver like it was foie gras or something. And yet they're so cute.

So you're the cute animal that will eat livers out.

Right, if the liver were the complexity of health care.

[LAUGHS]

Yeah, that's a great white.

OK, there you are.

And then we're the orca.

You're the orca —

Yeah.

--cutting out the liver — the dysfunctional liver of health care in America.

Exactly. Exactly.

Awesome.

[MUSIC PLAYING]

Maybe two questions here. One, have you done studies around how accurate you are compared to physicians? Employers are really concerned about the clinical aspects of what you're doing. But then I know something else we had touched upon is you're not only a doctor in a pocket, you're a benefits manager in a pocket, which I think for many employers out there is super appealing to have both. So can you talk a little bit about your clinical data as well as sort of the other side that makes this type of product really meaningful for employers?

For sure. So before I dive into each section, thinking about the problem, I think it's insane that people when they are sick have to all of a sudden morph into both a doctor and an insurance expert or a benefits expert at the same time.

I live both lives. And I was pre-med, so automatically —

So you got both.

--you assume I'm a doctor, and of course, a career in benefits.

Right. Right. But not everyone can be Lindsey.

No.

So —

[SIGHS LOUDLY]

[LAUGHTER]

So if you just took the average person, the idea that they would be that at the moment of illness, when their decision-making is probably not at their best to begin with, is such a tall order. So how do you take the clinical component and then mesh it with the benefits component into one offering that just naturally feeds one into the other, so that the person doesn't have to make these really difficult calls, it's just like laid out for them?

So from a clinical perspective, when we started the company, it took us about two years to build something testable. We first tested it in an urgent care setting, where we saw patients in the waiting room and then compared what the doctor said with what we had said. So we saw them beforehand. And we overlapped with the doctor —

How many did you lose in that process?

None, luckily.

[LAUGHS] He is a doctor by the way.

I like to air quote when I say doctor, because I can't write a script for anyone. I'm completely useless. If I get sick, I have to call my sister.

[LAUGHTER]

It's really embarrassing. It's like, hey —

It's embarrassing.

--can you write for me a — you know.

But anyway, sorry. We looked at the overlap. And we overlapped with them about 90.9% of the time.

But the interesting thing about machine learning and AI and just improvement in general is that every single time you push something new, it basically makes your research old, you know what I mean? So we're constantly trying to figure out how do we continually improve but then measure success, because you can't just continue to run studies in a urgent care every time you push a new piece of code.

So what we ended up doing is asking people what they were diagnosed with and whether they agreed with what we had said compared to what the physician had said at scale. So we call that a patient-reported outcome.

And then in 2020, we're looking to beef that up with real claims and EMR data to further understand what is the truth, because it's really hard to say what is the right answer. The patient has a view. The doctor, as coded in the EMR, has a view. But we all know what's put in the electronic medical record can be more for billing purposes. And then the claim data is even an extrapolation of that. So that's also really for more billing purposes.

Andrew, a couple of times you've used that phrase "we ask." And the experience is through an app, right? Am I thinking of that the right way? Could you just describe for our listeners exactly what that member experience looks like? Is someone calling up through a phone? Are they interacting through an app? Are they on their computer? Just go through that for us.

Sure. So Buoy is a chatbot that exists as a website and exists as what's called a progressive web app, which enables you to download an app-like version of Buoy directly from a website. So you don't have to go through the App Store. And it looks and feels exactly like a native app, it's just not technically an app.

The reason we went that route is that people at a moment of illness have very little patience for going to an App Store, finding whatever it is they're looking for, downloading, putting in their credentials to then start using something.

For that user experience, am I, as a user, typing an answer? Am I speaking into my device? What is that customer experience like?

Great question. So the chatbot is — it feels like you're actually texting with someone. We actually have a really large portion of our user base that's over the age of 60. And we did some interesting user testing with them. And one woman said back to us, how is that doctor texting me back so quick? [LAUGHS] Which was really —

Aw —

--endearing.

--sweet.

Yeah, it was very sweet. But it looks like you're texting, except instead of having to do a free response every time, you have choices to allow you to text faster, if that makes sense.

Great. Thank you.

And after two or three minutes of this back and forth feeling like you're texting with someone, it narrows the world of diagnoses down to a max of three different matches. And the matches are presented to you such that you can understand why we said these three are possible. And then within each match, it shows you the level of care, like, telemedicine versus primary care versus urgent care versus going to the ER. And then with a partner — in other words, an employer or health plan — they can specify, OK, well, here's the telemedicine vendor I've purchased, here's the diabetes management solution I've purchased. So taking the curated services that an employer has so carefully put together and then naturally matching them to our endpoints.

We take into account other things, too, like, what's the time of day. So knowing the time of day, you know certain things are open, other things are closed. Taking into account their location. A lot of people would rather travel a shorter distance. Then we can show them the services in order of distance. Of course, they're like, what's in or out of network for them, what point solutions they're eligible for.

So I have a question. So I'm thinking through almost using Buoy as sort of something to triage my symptoms in an acute situation. But you had mentioned some of the point solutions that employer offers are more focused on a, say, chronic condition. So you had mentioned diabetes. So can you help me understand how you can take someone from I'm in, around an acute diagnosis and then you're delivering content around a chronic diagnosis or something like that. That's just interesting to me.

For sure. And when you use Buoy, I think it's not obvious that there's really great opportunities for engagement for kind of more chronic disease management-type solutions.

Our whole belief is that people in general don't really care about their health unless they're actively sick. So we see the acute episode as a beachhead into the patient's entire wellness.

Let's say you're talking to your doctor. And you said, oh, I'm here for my sinus pain. And they're asking you questions that any doctor would ask, which would include what's your past medical history, what's your family history, what else is going on at home. If they find out that you have a history of diabetes, or you're a smoker, or you are overweight or obese, they might spend five minutes of that 15-minute visit helping you with your sinus pain — OK, it looks like you have sinusitis, here's what we're going to do for the sinusitis — but with those big gaps, you know there's a large impact to the person's well-being if you can help them along these very serious, very costly other axes. So can you then take the last 10 minutes and say, OK, let's coach you on your diabetes or let's talk about your smoking. Have you thought about quitting?

So similarly, when you're looking at Buoy, we're in this acute episode. This person's extremely activated around their health. We're interviewing them. We find out all kinds of things. 7% of our users have a history of diabetes. 45% are overweight or obese. 21% are smokers.

If we're figuring that out in the context of the interview, why would we not tell them, hey, so that sinusitis looks like you should go to the retail clinic down the street, but by the way, did you know that your employer also purchased Livongo for you? Because I see that you have a history of diabetes. Oh, looks like you have high blood pressure. How about Hello Heart, which your employer has already

purchased? And so the navigation isn't just for that acute point of care, but also for solutions that really fill a gap in care that's more chronic.

Those two companies you just mentioned are examples of point solutions — for those who might not know and that are listening to the pod, those point solutions are solutions specifically hired on or bought by the employer for the people to address a certain specific condition —

Right.

--or another interest area the employer might have if it's not a condition.

Right.

OK, so in short, what you're doing, Andrew, here is helping people to figure out exactly what's wrong with them and then find the right care at the right price at the right time.

[MUSIC PLAYING]

Exactly.

Have you found that your employers that you work with are receptive to that? I know I work with a few employers that would almost get a bit of the heebie-jeebies around people being targeted outside of the benefits ecosystem. How do you do it in a way that isn't creepy, that isn't —

Totally.

--breaking the HIPAA barriers or whatever other infosec stuff that our employers are worried about?

At the end of the day, the currency that we're playing with is the person's trust, because they have to trust us to use it. They have to trust us in terms of what offerings are available to them. And then they're going to make a decision based on what we — hopefully, they're going to change their decision, which is showing even more trust.

So in order to create and maintain that trust and fight the heebie-jeebies, everything that the person does is an opt-in in terms of telling — they tell us who they work for. We don't get a list of your employees and say, let's go find him and hit him with — it's not going to be like you're going to go on Buoy, and then all of a sudden, you go onto Amazon, and it's going to be like, wanna check your symptom again?

[LAUGHTER]

Hey, don't you work for?

Yeah, exactly.

I'm right behind you.

Right.

(WHISPERING) Telemedicine.

Yeah. We're not going to target them in that way.

Got it.

Everything is going to be opt-in. And you can remain anonymous all the way until you actually consume care. So there's no authentication. You don't have to give us your Social Security number, so you can figure out what benefits you have.

Because you're right. I think it would be jarring for someone to be targeted. But if we lay out a fishing net, and they run into it, and then we'll enable them to opt in. They're making that choice themselves.

Oh, yeah, laying out a fishing net is a lot less scary. We're just going to put a hook in your mouth now.

How does an employer fit you into a category that they're looking for? How do you describe yourself to an employer?

I think that's actually remains to be a challenge. We don't fit into a predefined market as of yet.

Well, if you can define the market, what would you call it? And where would you place it relative to others?

I would say that we're in the clinical navigation —

Clinical navigation.

--space. And the clinical navigation — different employers, depending on what they've already purchased, will think about Buoy differently when they're selling it to their superiors. So sometimes they'll say, you know what? I'm going to replace NurseLine, because no one uses NurseLine, and most people who use NurseLine get told to go to the ER anyways.

That's been my experience.

And so then they'll pitch it to their bosses and say, we're going to replace NurseLine with something that's digital first. It's going to be more accessible to people. The younger generations much prefer using something on their phone than calling somebody. And on top of that, don't forget that the NurseLine doesn't know my benefits at all. That's one approach.

Another one is thinking about kind of the advocate space. I think advocacy is extremely high touch. Does a lot of good for a lot of people. However, we think that a lot of the phone calls that go into advocacy don't necessarily require a human. It would be nice to have a self-service component.

For the most part, when you log on to your bank, you kind of don't want to talk to someone. It's kind of worst-case scenario that you gotta call the bank. Same thing with travel. I'd rather book my flight digitally than call someone and go through that whole rigmarole.

So giving someone the option to self-navigate into your benefits without having to call Sue on the other line is nice. And we don't think that that is a one-to-one replacement at all. We think it's complementary. We think that some people are going to want to call, some people are going to want to use the digital experience. So that's a second bucket.

And third, sorry, Steve.

Big buckets. Didn't expect a third bucket.

We're already at a clinical navigation advocacy. So what's the —

The third bucket.

There's a third bucket.

So the third bucket, which is really the idea of a single place, like a hub. I know there are a lot of hubs in health care.

CAH. My wife's initials, CAH.

Really?

So that's what you are. You're clinical and advocacy and hub. Yeah, there you go.

Clinical advocacy —

You're made for her.

What's her first name?

Cheryl.

Cheryl. I like that. A is?

Ann. Are you trying to get personal information now?

I'm going to go find her on Google.

[LAUGHTER]

So a hub.

So a hub. A lot of employers already purchase hubs. So we're good. If you already purchased a hub, we'll sit on your hub. We don't have to be someone else's. We don't have to replace that.

This term navigation that you used earlier has become usurped the way the term hub became usurped and platform. It seemed like as soon as there was a hub, everybody's a hub. And now everyone's a navigator! Like, everybody's a navigator now. And this is part of the challenge, because it's hard for an employer when this wellness vendor and this hub vendor and this expert medical opinion vendor are all now navigators, and they all claim to have some advocacy it muddies the water, and it makes it hard for a consultant to help an employer when they see one of these new companies come in and say, I'm this and I'm that, because the names become somewhat meaningless, unfortunately.

So you're describing clinical decision support — I'm going to use the word "decision support," that's not a word that you use there — and a level of member help. You said at the outset it's not really a category. That's why there are several that you fit into. How do you demonstrate value since it's such a murky area where you're playing?

The value measurement is actually the thing we're most excited about in terms of the fact that we've kind of proven it out on our consumer and health systems side first. So we moved into the employer space because when we measured how we were affecting people's decisions, the health systems were changing the way they were thinking about using Buoy. In other words, they didn't want us to talk to their patients anymore, they wanted us to go talk to their employees was their response when we started measuring what we were doing.

So from a value perspective, we ask patients or employees the second they start using the product, where are you headed? And so you have a sense for what they would have done.

Like, I'm about to go to the ER.

Exactly. You have a sense for how much this person would have cost had Buoy not intervened at all. And as opposed to other services that will ask post only, they will say, what would you have done? Nurse lines do this all the time, which is really biased, because I just told you, hey, you should stay home, but where would you have gone? That's kind of an odd phenomenon.

So we ask them upfront where they are going. That's a pre. So you kind of understand what the cost is for this person. After they use the product, we measure where they ended up clicking through or we measure where they say they're going next. And you can see a delta between what they came in and were going to do and what they ended up doing.

And if you've stratified a number of options like self-care — one of the concerns we have from employers that we hear about solutions like Buoy are, oh, we don't want to be telling people diagnoses and giving them treatments. But you're laying out the possibilities —

Possibilities.

--and the paths they can take to then get care.

Right.

So if you lay out those paths, you can then tell in the end — and just clarify this for me if I get some of this wrong — this percent went to telemedicine and this percent went to primary care or went to urgent care versus ER. Then you can stratify that against the population and compare that to, let's say, what the average member of the population did, and across the book, X percent go to these less expensive treatment sources, and Y percent in the other population went to the more expensive sources.

You could do it on average. Or what I'm —

You just do it compared to where they were going first, though, right?

Yeah, what I'm describing here is on the —

Well, agree. I'm wondering if you also — totally. I got that point. I'm wondering if you also then can do the pre post — sorry. The population A versus population B comparison.

That's true. You could also do that analysis.

So you haven't done that, or you're —

We haven't done that yet.

OK.

But on the pre versus post, the study that we did on the consumer side was the end of 350,000 people across the country. All kinds of different demographics. And what we saw was pretty significant shifts downward. So we're saving about $174 every single time someone used Buoy, when you compare pre versus post.

Pre versus post ends up being one of those things that — I have a market research background. I always go to this. And there's this thing called purchase intent. And it's very difficult to accurately correlate purchase intent with actual purchases. And so, it's one of those things where I do agree that pre is better than just post, pre post better than pre post. But it's even better to have actual hard numbers.

And of course, there's issues on this cohort versus that cohort, too. I'm not saying any of these are magic.

Right.

But it's probably useful to have both pieces of — types of data.

Totally. We also recognize that there are issues with measuring ROI in a single format. So we just finished a study with the University of California Merced, where they followed up with patients two weeks later, to look at whether there was a match on their post intent with what they ended up actually doing.

Um-hmm.

We don't have the raw data on that yet, but the early read from the PI, this is anecdotal, was that this is extremely positive, that there's a strong correlation between the post intent and what they ended up doing.

Just say what PI means.

Sorry, primary investigator. And on top of that, we're about to release features now that actively follow up with the person via text. So you can imagine going again, beyond the post intent, and actually confirming with this person, yeah, I ended up going to telemedicine, and this was what ended up happening.

2020 will be the year that we start to layer on claims and EMR data to further beef up the understanding of what our effect was on the decision. But to your first point, Steve, a lot of noise. How do you measure what is or is not successful?

We feel like this early mechanism is lightweight and gives a pretty good understanding of our cost savings, to the point where we actually offer up a dollar for dollar savings guarantee for our fee. So we put our fee fully at risk in that regard, based on our ability to shift people's behavior from more expensive sites of care to less expensive sites of care.

Was Buoy always about this whole spectrum of identifying — helping the member identify what's wrong with them, if you will, and then helping to steer them to the right care on the employer or health plan platform? Or did it start somewhere else? And how do you get to where you are today?

That's a great question. We started with a vision of the future where people would Buoy it when they're sick. They wouldn't Google it anymore, they would Buoy it. And once they Buoyed it, we would be fully aligned with the person at the end of the day, in helping them navigate care and ultimately consume what they needed, and not consume what they didn't.

OK. So it's really about helping that person get better.

Exactly. The person, at the end of the day, is the hero of our story.

Ahh.

Sweet.

And we're the guide. We're Obi Wan Kenobi. We're Hagrid, Dumbledore, you name it.

And when we tried to figure out, how do you make money, we realized that you're monetization strategy —

[LAUGHTER]

--can deeply affect your product and your relationship with who you ultimately think is the hero. Let's look at —

That's an excellent reality. Really, because there are lots of fantastic ideas that help lots of people, but don't go anywhere because there's no way to monetize them in our society. That's how you get ahead. We're capitalistic.

True. And then, even in choosing your monetization strategy, I feel like it can either continue alignment with who you're ultimately hoping to serve —

Absolutely.

--or it can create a divergence.

Yes.

And I think — let's just call out an ad model, where you're trying to sell something to somebody.

Advertising model.

An advertising model, I think immediately creates a divergence between the end user and how they make money. Right? Like, let's look at Facebook. Facebook is trying to keep you on their site, trying to keep you scrolling. And that has some ramifications that we —

Is that what they're trying to do?

Have you listened to The Great Hack yet? It's good.

Is it good?

It is good. Netflix documentary. I know you want to look at yourself as like the Netflix for healthcare. So you might want to check it out.

Yeah, I'm going to check that out. Yeah, thank you.

You're welcome.

Let's take a look at Facebook versus Netflix. And if Facebook's HR buyer is listening, I'm so sorry. I still want to do business with you.

[LAUGHTER]

I'm just kidding. No, I'm not kidding. But —

[LAUGHTER]

--but Facebook's incentives are to get people to stay on the sites. They can see more ads and they can make more money. Right? Well, Netflix basically says, I want a subscription service with the end person. And the better my content is, the more likely you're going to stay on Netflix. And more likely you're going to tell your friends, and they're going to get onto Netflix.

And so, when the person who's enjoying it is also the person who pays, there's a really nice alignment between the company and the person they're looking to serve. In the Facebook example, which is the same of any business that's selling ads, so not just throwing Facebook —

Sure, all media.

All media, right? The person who's consuming is not paying. Someone else is paying. And so, there's a misalignment of incentives between those who pay and those who are consuming.

Interesting.

Yeah. The employer space is someone who is, right? Usually it's the employer that's paying. But they usually — what I love about the employer space is that they usually are doing the right thing for the right purpose.

Exactly.

So even though they're paying, they really want what's best for their members, for their members and their families, for their employees, right? Because happy, healthy employees, at the end of day, are most likely doing better work than not happy and healthy employees.

Exactly. So when we started out, we were like, OK, how do we make money? When we looked at the ad world, or any model where we would make money off of handing off to a service — if we made money like Sock Doc makes money, by selling an eyeball to a health system, or we make money like WebMD, by selling it to pharma, it creates a misalignment of incentives between our hero and how we capitalize.

So what we realized, after selling to health systems for some time, was that that misalignment really comes to bear when you look at your KPIs, or your Key Performance Indicators. When we were looking at how we are affecting people's desire for care and we were asking people upfront, what kind of care you're looking for, they'd use Buoy. And after they'd use Buoy, we'd say great. What kind of care are you looking for now?

We saw a dramatic shift downwards in what people — what kind of care people were looking for. It's almost like — it turns out, in our belief, that health care decisions are largely driven by fear and uncertainty. And so, if you can take away some of that fear and take away some of that uncertainty, people are actually much more reasonable, in terms of when to go.

And when you saw that downward shift, the service provider is unhappy because they're making money off of the service that's being rendered, going back to the ad situation. So we basically said, oh, we're aligning ourselves with the wrong people in health. Who in health care cares that we are actually getting people to the right care at the right time, regardless of what the —

Those who are paying for that care.

Those who are paying for that care. And Netflix doesn't work in health care, one-to-one, because the person, at the end the day, largely is not paying for their care. It's usually their employer.

There are complications. That's why you've got to actually target both.

You're right, Steve. We're going after both because we feel that the employer and the person, at the end day, are fully aligned with each other. In terms of reaching the person, at the end of the day, you're right. There's one method that we — we go into an employer as a partner of ours, and with the help of the employer, market Buoy to all of their employees.

That is going to drive some amount of utilization that we think is going to be pretty good. But we also know the problem is that email that comes from HR, that hits the employee's mailbox, is probably not going to hit them at a moment when they're sick. And so, it's very unlikely that the person who gets the communication, whatever it may be, is actually ready to use Buoy at that moment.

And we also know that people love — people remember to use Buoy after they've used it once, the first time. Which sounds eerily similar to telemedicine, when you think about — Thomas and companies talk about it all the time. Like, once you use it, you really like it and you come back.

So we're fearful that going the employer to employee route alone, putting Buoy on all of your platforms, putting it on your portals, messaging to them, is going to have some limited upside when it comes to engagement. The elephant in the room is that everybody Googles.

So going back to why we started the company, the front door of health, where all the patient engagement goes to die today, is WebMD, Healthline, and Everyday Health, which is the back end of Mayo Clinic. Because those are the content makers, where most eyeballs end up on. And those eyeballs end up getting sold to pharma ads. And that's the end of patient engagement.

There's no handoff between WebMD and my employer benefit page. There's none of that.

Well, WebMD usually ends up in cancer. I mean, that's my —

Right.

So are you trying to solve that? What do you do to combat that?

So to combat that, we actually go fight the battle on Google with all of those other companies. So we write content. We try to go find people when are searching for their symptoms or diagnoses. We know that it's a really long battle. It's going to be a war for a really long time.

But if we can find someone on there, when they're Googling, they find our content. They click over to use Buoy and we ask them who they work for. And that happens — that person happens to be working for a client of ours, that's an additional piece of engagement that they otherwise would not have gotten because they forgot to go to the portal. Right?

And so, as we become — as we pour more and more resources into this, this is all on the behalf of the person and the employer, at the end of the day, in terms of getting them to the right care at the right time.

[MUSIC PLAYING]

When a consultant or an employer asks you to come in, what's the pretence? They're asking you to come in because they saw you? Because they have a certain problem? How do you usually get invited in?

So we get invited in based on either a pre-recognition of the buckets that the employer has identified, they're looking to solve. Whether that be like a telephonic triage, a nurse line, navigation, or kind of all-in-one place to go. That's one bucket. I think — a bucket of buckets.

The second reason people are bringing us in is people are just really interested in AI and machine learning. Really big buzzwords. And so there's a bit of a shiny object mentality around us. And I think people bring us in for that. And we talk a lot about how AI is really just a means to an end. We should really think about what problem we're trying to solve.

And then last, is thinking about the problem itself. So this will be like I need a lift for the services I've already purchased. I want higher ROI from my telemedicine, or I want higher ROI for my advocate services, or whatever. So driving engagement of those. Or I have this huge problem with people over consuming emergency room visits. That's a really natural problem for us to sit-in to.

So you could potentially be a replacement for the mailer everybody talks about, for your fliers to the ER.

[LAUGHTER]

Mailer to the free — yeah. I feel like that should be the standard that we should be judged up against. So like, a lot of physicians will ask us, are you trying to replace doctors? I'm like nah, I'm trying to replace the mailer that comes in and tells you when you go to the emergency room.

Or worse, just like when you're reading Yahoo Answers. I literally — we did this really interesting study on what piece of content people will make decisions on. And Yahoo Answers is actually a very — helps people with decisions a significant proportion of the time. And we're like, this is a really big problem.

I was giving a talk, and this guy raised his hand. And he said he had caught his 14-year-old daughter on Yahoo Answers, answering health care questions as if she was a doctor.

Wow.

And we're just like, see? That's the problem. That's a problem right there. We got her. We got Gwyneth Paltrow on Goop. We've got Dr. Oz. It's just myths and misinformation abound. We're throwing all kinds of people under the bus in this podcast.

Wow. That is just crazy.

It's crazy.

Can you talk a little bit about what you're seeing in terms of — we've talked a little bit about engagement and sort of that's the Holy Grail, is if you can get people in. Sort of what you're seeing among your employer populations of people utilizing Buoy.

So we're live right now with two large employers. One is about 11,000. The other is 10. And then, we are about to launch today with our third. And I think we have close to eight more by the end of this year.

Congratulations.

Thanks a lot. Appreciate that. And in terms of engagement, in the first couple of months for the first two, I think we're at about 5% of the population using the product thus far. And that's out of two months. So we know that there's going to be some waxing and waning. But if you kind of play that out over the course of the year, it's really easy to use our product, in terms of there's no sign in. The barrier to entry is very low. So we're looking for that double digit engagement rate.

And going back to an earlier statement that we're looking to really disrupt the WebMDs of the world's hold on the first step. Eventually, we'll be able to go to an employer and say, we already have 10% of your population using the free version. Wouldn't it be great if we could start to measure how that's reducing cost for you? And get them all the way to the end, which is specific to their benefit design.

Right now, using our kind of direct consumer strategy, we reach about 10% to 12% of any geography. So you can roughly estimate how many people, for any given company, we've kind of touched already.

So we talked a little bit about, that you have a free product out there. And I just wanted to be really clear for our audience, that there are differences between your sort of enterprise product and your D-to-C product. So can you be maybe a little bit more explicit about what they are?

I've just seen this in the past, where sometimes they get confusing. And for value conscious employers, they're like, why would I pay for it if it's free? So you have some, I think, advantages to the enterprise product.

Right. So the free product is almost as if you had the physician, but that physician doesn't know anything about your benefits. So it goes through the interview and then helps you figure out, OK, looks like you might have sinusitis or a common cold. And here is the level of care that's appropriate for you. But that's where it stops.

The enterprise version, now understanding who the person works for, will navigate them all the way into the right service, within the curated set of services that the employer has already purchased. And where those two things mix, is the fact that on our free site, we ask people who they worked for. And if they happen to work for a client of ours, we can now drive up the engagement of those end services appropriately, in a way that wouldn't have happened because that person forgot to go to their portal, or forgot to go to their hub, or call their nurse line, or whatever.

When you say, who do you work for, what about a spouse or a dependent? How do they respond to that? Or what is —

We actually clarify that, as well. It's not just who do you work for. But it includes like — or do you get your insurance through your partner? Or it narrows to that level.

And other beneficiaries. OK. Cool. So working with employers, you've got a couple under your belt. You have a few more. Any surprises, anything you've learned from working with them?

I think, going into it, I personally was really intimidated. You see these people who are taking care of tens of thousands of lives with these decisions that they're making. And you know that they are very busy. You hear they have a lot going on. They have all these different point solutions who are trying to pitch them. And it just seems really overwhelming.

I think the thing that we've really learned is that, at the end of the day, they're a person just like any other person who has been sick before. And so, the message that I feel like we can all just get behind is that, look. When you get sick, it's really, really hard to know what you have and how to fix it.

And if you just tell people how to fix it, it doesn't make sense because —

No context.

--there's no context around that, right? And then, explaining to them what they have but not telling them how to fix it is like giving someone — I don't know. I'm just going to skip the metaphor —

Oh, come on. We know you can do metaphors. Let's do it.

Giving them a hammer, but not giving them a nail. It really —

That's not bad.

Appreciate that.

It wasn't great, but it wasn't bad.

[LAUGHTER]

Text my English teacher. So if you can combine those two things, it's just such a — everyone understands. Everybody has been sick before. They've been alone, scared, confused. And that's where we can help.

So I guess I was expecting, on the employer side, to have to tell a story that was super — I guess, like jargon-y and full of benefit talk. Then it turns out, we're just humans and we all suffer from the same issues dealing with the complex beast that is health care. And wouldn't that be great if we could fix it?

All right. Cool.

Where do you think you're going from here?

We're going to continue to add more and more end points that naturally handoff from Buoy. So all the point solutions that we just talked about, working closely with them to make a really natural experience for someone who uses Buoy, and then ultimately needs a diabetes management solution, or needs a second opinion tool or needs, an advocate. And making that experience very seamless for that person.

Because we feel like that provides a ton of value for the employee, and of course, the employer, who ultimately has to pay. I think that's a more tactical answer, Lindsey, I think, when it comes to where we are going. I want to come back on the podcast in say, two years. Two years.

Season Three.

Season Three of Cure for the Common Company. And we will have a significant proportion of the U.S. population saying to Buoy it, when they're sick.

To Buoy it. Just Buoy it.

Just Buoy it. So if you had a — what's your favorite business magazine?

Well, that's tough. Um, my favorite business magazine. I guess Forbes.

In five years, when you're wildly successful, what will be the headline of the Forbes article on Buoy Health.

It would be very simple, and would just say, "How Buoy Fixed Health Care."

Nice. Very nice. All right. Let's get a little more esoteric here. If Buoy were a mythical creature, a god or goddess, someone from mythology, what would — who or what would Buoy be?

If it was a god or a goddess — this is really weird to say, but we would be Athena.

Athena? From The Who song?

[LAUGHTER]

You're not old enough for that.

I'm not — yeah. That was straight over my head.

[LAUGHTER]

We have a significant proportion of our leadership and our leadership team that are extremely powerful and impressive women. Actually, a lot of them got their training at Athena health, which is just down the road from us. And so, you know Lindsey, you talked about what would our Forbes article say? I had this dream of having a Forbes cover that the title is — or the big title is just, "The Women of Buoy."

And it's our entire population of female leaders on the team. Like, I would entrust my life to these women to no end. They're so incredible, each and every one of them. Yes, so I would say that if we were a goddess, we'd be Athena. And I'll just say publicly that my goal is to get them a cover of Forbes, talking about how incredible they are and how vital to our success they are.

That's awesome. Now Athena is the goddess of wisdom, courage, inspiration, civilization, law, and justice, strategic warfare —

Seems like all the women I know.

--mathematics, strength, strategy, the arts, crafts, and skill. That is a hell of a business card.

[LAUGHTER]

It's a lot. And that is how we should think about Buoy.

Why do you think users love you?

Um, I think they see that we have their best interests at heart. We're not trying to sell them anything. And it's pretty obvious, when you use the product, we're not trying to force you to do anything. So that kind of opt-in nature of it just creates a lot of trust. And people just feel like, you know what? This way better than me Googling 50 times and being told I have this crazy thing, and being showed all these ads.

It's just such a bad experience today, that just simply being aligned with the person, at the end of day, just goes a long way.

We've talked about your free product. And for our audience out there, is there a website where they go and access it, and give it a try for themselves?

Yes. It's www.buoyhealth.com.

And that's —

B-U-O-Y.

In case you spell like Steve.

[LAUGHTER]

Thank you for that, Andrew. And thanks for giving us a little bit more context on Buoy Health, and where you place yourselves in the numerous categories in which you play, and how you're trying to fix health care.

Thanks, Lindsey, thanks Steve. It was really fun.

[MUSIC PLAYING]

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