Episode 26 – Centering the health plan around primary care with Centivo

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ASHOK SUBRAMANIAN: We're actually really focused on getting the folks who are the high utilizers, getting them into this effective primary care centered model. That's what brings cost down over time.

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ANNOUNCER: Welcome to the Cure for the Common Company, a podcast series looking at innovations in the world of employee health and wellbeing. Steve Blumenfield and other experts from Willis Towers Watson's health and benefits practice are talking to entrepreneurs and industry leaders who break ground to meet the needs of today's workforce and deliver benefit solutions that can separate employers from the pack.

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STEVE BLUMENFIELD: Hey, Ashok.

ASHOK SUBRAMANIAN: Hey, Steve. How are you?

STEVE BLUMENFIELD: Great. Hi, everyone, and welcome to the Cure for the Common Co podcast. This is Steve Blumenfield, Head of Strategy and Innovation for Willis Towers Watson's Health and Benefits, North America. Today I'm excited to talk about a primary care centric health plan innovator that's bringing affordable care and better outcomes to members and employers. Welcome, Ashok Subramanian, CEO of Centivo, to the podcast.

ASHOK SUBRAMANIAN: Great to be here, and thanks for having me.

STEVE BLUMENFIELD: Well, we are delighted to have you here as well. I'm also joined by Willis Towers Watson's Head of Health Care Delivery and a deep expert on this space, Drew Hodgson. Also a man with an enviable accent. Welcome, Drew.

[LAUGHTER]

DREW HODGSON: Thanks, Steve. Thanks for having me.

STEVE BLUMENFIELD: All right. Let's get into it, Ashok tell us a little bit about yourself and what led you to found Centivo.

ASHOK SUBRAMANIAN: Absolutely, Steve. So, you know, I like to joke. I made the wrong turn at the college career fair and have ended up on this employer side of the health care business for -- going on over

15 years now. I started a company in 2007 called Liazon, and I was a colleague of yours, Steve, for a few years at the firm after -- we all joined forces.

But ultimately, as I was thinking about what's the next chapter here -- I do think we have this sort of generational issue which is, in 1980, the average American spent 250 bucks out of their pocket, per year, for health care. That number is now $2,000. Open enrollment has pretty much become the announcement of the annual pay cut all across companies in America, and we can do better. And I think we've found a good mousetrap to help drive better quality, lower cost, and I look forward to sharing that with you.

STEVE BLUMENFIELD: Boy, that's just a sobering statistic to bring back to mind. The 10-times magnitude, and frankly, if you're in a consumer-driven health plan today, you're not even through your deductible, right, at that point, if you've got a family, not even close. So that is very, very sobering. So tell us a little bit about the model. Give us a quick thumbnail sketch of Centivo.

ASHOK SUBRAMANIAN: Yeah. So the short strokes of it is, employees select a network that is driven by a leading health system on a market by market basis, and it's a health system that has done the work over the last 10 to 15 years to truly deliver value. So what that means is, number one, it means that this is a health system that has proven itself to perform better when their money is on the line, Medicare programs, commercial programs, where there's real risk. And number two, these are health systems that have organized themselves to cover what a family needs, cradle to grave, routine to complex.

And that's really been driven over the last 10 or 15 years of the impetus from whether it's a Medicare space, the Medicaid space, or others, saying, we want to control more of these assets together and really deliver coordinated care. So those partners are the basis of our network. And then we add to that a primary care centered front end because what we found is, and a lot of research has shown, people are really bad at shopping the health care system. They do what their doctor tells you to do.

So by basically trading, you get the richest benefits that you've seen since 1980 in exchange for, you've got to stay in your lane led by the guidance of your primary care physician. That's what gets us to that win-win, a better quality, lower cost, but being able to get that member that affordable benefit -- the likes of which they haven't seen again in 35 years.

STEVE BLUMENFIELD: There's a lot to unpack there, and I'm sure Drew is loading up some questions here. But I'm going to start with one maybe -- that might be on the minds of folks hearing that model. It sounds a little bit like HMOs of old, but then again, it's kind of centered around best practices. It gets the consumer engaged in different ways. So just help us draw that line, what's different now from then-- and how you do it?

DREW HODGSON: If I can piggyback on that a little bit around the primary care is -- you talk about the HMO days of old, right, and the gatekeeper approach, and there was such pushback against that back then. And that's part of the reason why we have these ridiculous, broad networks today. And it does feel like the gatekeeper being the insurance company versus the gatekeeper being the primary care physician. So I'm curious to know your take on how we move employers to really think differently about what that gatekeeper term actually means.

ASHOK SUBRAMANIAN: It's a set of great questions. So let me try to be uber macro and kind of, really in-the-weeds micro at the same time. So on the uber macro side, it's important to note, you're right for all of the 1990s backlash, if you will, on HMOs being shoved down people's throats. Let's also step back and realize that most health plans in America have a negative NPS score, a negative net promoter score. The few plans that actually people really do like and have a positive score are plans like Kaiser, plans like SelectHealth in Utah, plans like Geisinger in Pennsylvania.

What are the characteristics of those plans? Number one, they control the assets of the health care providers. Number two, they require primary care at the front end. So interestingly, you're right, that while poorly-executed HMOs have been disliked and there's been a backlash, well-executed ones actually are favorable, and people like them, and have really good scores.

STEVE BLUMENFIELD: If I could just pull that out for a second. I mean, I love the distinction that you're making here, which is the health plan doing it to you, saying, you've got to do this with this doctor, really hands off at that point. Go here. They decide for you. We're telling you have to do this. As opposed to we've built a best care team and if you stay within this care team, you're going to get the best care and it's care that you trust with a great system. And I love that you use the 'K' word there, you use Kaiser because everyone will resonate and they'll go, oh, OK. That's what's different. So yeah. Keep going.

ASHOK SUBRAMANIAN: Yeah, no. Just to build on-- We had a call with an employer a couple of days ago who said, this really sounds like Kaiser, and our people love Kaiser, we can't get them out of Kaiser. Now, here are the two things, now going really in the weeds. First thing, the question about, is the health plan going to deny care, the gatekeeper? We actually have a really interesting approach to this, which is we auto-approve every single referral.

So the message is not that we are sitting there, the big bad health plan, trying to adjudicate, is the doctor making the right decision? All we're forcing the referral for is that a person is actually using their guide, their trusted partner, their primary care team, to help them determine where to go as opposed to picking it up off a neighbor, a billboard, yelp, whatever the random act might be.

So that's kind of a really in the weeds point around how care gets approved, which is 100% of the time. And I think that's a big difference between the HMO saying you didn't let me go to doctor ABC. This is completely different from some of that old baggage.

DREW HODGSON: You brought the Kaiser. You know, I've often used Kaiser as an example of the likes of Centivo with employers in those situations, but one of the pushback we get a lot from clients is disruption. And that drives me nuts because I think disruption should not be a bad word, ever. You have to disrupt, right? If you don't change the claims, you're not going to do anything valuable or improve outcomes.

So -- you see employers all the time argue, saying I can't disrupt my employees that much. I can't narrow the network. We're on a single system. Yet all at the same time having Kaiser in California -- and trying to get that message across. How did you get employers over that hesitancy?

ASHOK SUBRAMANIAN: Yeah. I think there's an answer which is a general one, and then I think we're at an interesting point in time with the American workforce, the challenges we're having attracting and retaining people. And so the message that we're looking to promote, and that's really resonated with a number of employers, is not the negative of disruption but the positive of empowerment. Let's give people an option. Let people vote with their feet. What we find is when you get that option, whether you're a mid-market company or a large Fortune 500 company, anywhere from 25% to 40% of people are voting with their feet and choosing that.

And so that's an interesting juxtaposition to the disruption, which is, if there is a well-built, truly, affordable, 1980-style benefit, now the conversation moves to well, how could you withhold that as an option from your workforce, especially if your competitors for talent might be offering plans with free primary care, with no deductible, with really low predictable co-pays?

So what we found is interestingly, the tightening of the workforce, the labor market that we're seeing over the last few months, has moved the conversation away from hey, we don't want to change anything because it's a tight labor market to we need to find more opportunities to promote, empower and personalize people's health coverage. And this fits really well in that kind of a message.

STEVE BLUMENFIELD: So for both of you to, maybe, clarify that one a little bit for some of our listeners who might not be as deep in-- disruption and plan design and member selection and open enrollment, I think what I hear you say, Ashok, is, we're going to put Centivo in alongside other options and let members who want this, see this as a benefit. And if they have to be disrupted from a physician relationship, which by the way half of them probably don't have, right? If they have to be disrupted, that can be their choice. Is that what I'm hearing you say?

ASHOK SUBRAMANIAN: Yeah. So there's a bunch of interesting things there. The first is that exactly what we're saying. So let people have the option. If they want to stick with a broad network, a traditional plan, a Blue Cross, let them do that. But make sure this is available as an option because it is, sort of, rich, drives good quality, et cetera.

You make an interesting point though, Steve. I don't think most people know this. 40% of Americans are what are considered medically homeless, don't have a primary care physician, use urgent care, telemedicine or emergency room as basically their source of primary care. That is -- Let's just all be blunt here. That is an unmitigated disaster. That is not something we see in other countries and other wealthy countries. And Drew, you can probably speak to that from your own experience. But that we have built a system where half of America doesn't even have a relationship with a doctor that they've used more than once is completely absurd.

DREW HODGSON: And an interesting point, though, around that is -- I'd like to pick your brain a little bit on how you feel about the future of primary care, right? Primary care has been in a free fall, if you like, for quite some time in this country ever since the HMO days, right? The lack of primary care -- And I really do believe that some of those HMO days is what's caused the reason why we have a lack of primary care physicians. And the virtual world is so taken off now. Right, now we see it's amazing how quickly we could switch to virtual when they had to and got it up and running really easily.

So my question for you is like, what is the role of the primary care physician in the future? Are we heading towards these primary care patient-centered virtual medical homes? Is the younger generations really wanting to have a relationship with a primary care physician? Or are they looking to be in that medical home dealing more with nurse practitioners? It's a huge question, I know, but I'm curious to hear your thoughts about that.

STEVE BLUMENFIELD: Great question, Drew.

[LAUGHTER]

STEVE BLUMENFIELD: Oh yeah. Come on, Ashok. Answer this for, everyone wants the answer.

ASHOK SUBRAMANIAN: 45 seconds. 45 seconds or less to--

[LAUGHTER]

ASHOK SUBRAMANIAN: -- answer that question. Yeah. So here's how I would answer it. My sister's a primary care clinician. My uncle is a primary care clinician. The last-- as you say, 25 years of lower compensation, especially relative to specialists, a lot of aggravation, a ton of paperwork, patients who yell at you, it's been a very difficult time for primary care. That is changing. I think a couple of things have driven the change.

The first is the recognition in Medicare and in the employer world that we need to start compensating primary care, independent of when you see a person. This idea of you have a 7-minute visit and you've got to kick someone out of the office to see the next 7-minute visit, instead moving to, whether it's a per member per month, a capitated model, there's all kinds of funny words. But the fact that you get paid independent of the visit is now becoming accepted as a normal practice.

Virtual has sped that up. How do you define a visit if you're texting back and forth with your doctor? How are you defining a visit if you're communicating through a patient platform? So moving to 50% or more of compensation based on, you're in charge of the patient, you're the quarterback, you're the coordinator, but not necessarily having to see the person face to face. That realignment of incentives is a big part of it.

The second part of it though, and I think this is really interesting, there's been an emergence of what's called direct primary care. If we cut through the words, what about half of direct primary care is, is basically a doctor saying, I would have a much better lifestyle if I could make the same amount of money seeing 500

patients as I do seeing 2,500 patients. And the way I do that is by charging a flat fee, call it concierge medicine, direct primary care, whatever you want.

What I think this is going to move towards, Drew -- going to the basis of your question -- we're going to see primary care not take that approach of being the uber-concierge doc. I think we're going to see primary care really being leaders of teams, panels going not from 2,500 to 500 but going from 2,500 to 10,000, but having a situation where what's known in the industry is each member of that team is practicing at the top of their license, a health coach, a licensed clinical social worker for mental health issues, a nurse practitioner, a PA, and the primary care physician, all working together on behalf of that much larger panel.

That's how we'll bring costs down and make sure people get the attention they need. You don't need a doctor to answer a phone call at 2:00 in the morning. You actually need a team of people who can serve all of your family's needs at an appropriate time.

STEVE BLUMENFIELD: It's a very inspiring view of the future. And -- I would add that there's a possibility that won't just be the primary care physician. That there are models now that are -- creating hubs that are geographically-located, that might be in retail centers, there are virtual versions. Let's talk about virtual. And -- at time of this recording, we're still in the midst of -- the grips of COVID, the Delta variant at the time of this recording, so, how has that impacted member utilization of services in the way that your people do business?

ASHOK SUBRAMANIAN: Yeah, it's a really great question. So a couple of things. First of all, we believe, our Chief Medical Officer believes, folks that we have in our orbit, that 80% to 85% of primary care can be delivered virtually. And so the interesting part of how do you fit that in to a coordinated care model is in a traditional health care view. It's very linear. You have PCP. You have a specialist. You have a second-level specialist, a -level specialist. And the minute the PCP refers out to that specialist, you've lost the patient. There's very little interaction back and forth.

In a new age model, especially in a virtual-first model, we see the team as really being much more hub-and-spoke as opposed to that linear bow chart or flow chart, where the PCP is in the middle and you have multiple specialists, but the specialists are reporting back to the PCP. And a really good example of an enabling technology for this is, there's a company, but there's others in the market, called RubiconMD. RubiconMD is known as an e-consult platform.

Primary care is in many cases not even shipping the patient physically to the specialist, but rather actually getting the consult or the guidance from the specialist behind the scenes for a cardiovascular issue, a GI issue, an ortho issue, whatever it may be. But the patient interaction stays at that primary care level.

That's a good example. I'll give you a couple other examples later as we go deeper, but I think that's a good example of the hub-and-spoke as opposed to, you see the primary care doc for seven minutes, you get the referral, and I'm done. I never see the primary care doc ever again.

STEVE BLUMENFIELD: I love that description because I think empowering that primary care physician in many cases who are-- they're the trusted advisor given the tools to advise, and they make it happen behind the scenes. We see a lot of examples of that. We had someone on recently from AccessHope, similar model. But -- virtual care, is that's something that your folks are using as a tool?

ASHOK SUBRAMANIAN: We are. So -- there are tens, if not hundreds, of startups and incumbent large companies, health systems themselves who have definitely said we now do virtual. What we've looked to do is partner in specific areas, such as virtual urgent care, 3:00 in the morning, ER redirection, filling a script on a weekend. That's being done very well by the open market. We have partners who do that.

What we are right now incubating, and we're piloting with our first client actually, in Florida, is a virtual primary care practice that is built for purpose, that is built for that team-based model that we talked about, that includes NPs, PAs, a health coach, and is truly built for an experience of a plan where we have special local referral relationships with well-built health care systems.

So a really good example -- Every virtual care practice hopes to be able to say, I can refer to a subset of doctors that are better than the average bear. What we're able to do, because we build the health plan around a partner in a market, example, Orlando Health in Orlando, is we work directly with the physician leaders there to say, who should we be referring to? Let's use your data. Let's not guess based on Medicare data or third party data that's scrubbed with all kinds of issues.

You might guess and say, hey, that doctor has results that look a little bit worse. But how do you know that doctor is not the one who's the ringer? Getting the toughest patients? And of course, their results might be a little bit worse. You get that insight when you're partnering very deeply and closely with local health care providers.

So we are going to increasingly look to roll this out. It's not meant to be at the expense of other solutions in the market. But we do believe the gap in the market is a truly advanced primary care practice that's built to be virtual first and that can curate in partnership with these local partners, how do you refer downstream the right way and not simply be guessing?

DREW HODGSON: To just pivot a little bit off of the whole primary care, let's talk more about the member a little bit here. A lot of employers out there today are very concerned about the member experience. They've not been thrilled with some of the major health plans, and the way they're treated, and some navigation services, and the changes are happening again. But that's been a major focus for a lot of employers.

So when I think about this model and I think about you're required to register with a primary care physician when you enroll, all the referrals have to go through the PCP et cetera, that can sometimes make people a little afraid of, what does that mean for the member? Am I going to get a lot of noise from this? Can you talk a little bit about how the member experience is different with Centivo?

ASHOK SUBRAMANIAN: Yeah, so I'll step back and let's take an analogy that we can all relate to, the airline industry. So if we --

STEVE BLUMENFIELD: Sure, it's a really low bar. Yeah. All right.

[LAUGHTER]

ASHOK SUBRAMANIAN: That's exactly right. Well same kinds of NPS scores as traditional --

STEVE BLUMENFIELD: To all of our airline clients, I'm sorry.

[LAUGHTER]

ASHOK SUBRAMANIAN: -- including one that we work on together. So we're fans of that. But the -- look.

So when JetBlue came to market, they basically said we want to inspire a better member experience, but it was enabled by some strategic choices around, what I'm going to call, their product architecture. Examples, we're not going to have a hub and spoke model. We're going to fly point to point. We are going to have a single aircraft, an Airbus A320. We're going to have a standardized set of training and parts, and materials. We're not going to have two cabins. But -- there's other things they did.

With those product choices, that enabled them to have a better member experience than an airline that has to, by definition, serve really small markets, really large markets, fly across the world, have multiple planes, have multiple pilots. That analogy is a really important one, Drew, to answer your question. I'm going to make a point to -- help out some of the broad insurance carrier networks.

It is impossible. It is by definition impossible to have a great member experience if the threshold is that that great member experience needs to include every single doctor in America, in the provider directory. It is impossible. And the navigators that are trying to do better on that have the same issue because there is no

quality assurance for a well-integrated health system, and Dr. Jones, who happens to just be in the directory, because they signed a network contract.

So the main piece of that Centivo experience, to answer your question, Drew, is when we work with a single partner per market or a small number of partners to fill out geography or clinical needs, the conversation starts with, you need to abide by standards that matter for self-funded employers. You need to make access available, same day for primary care, within a week for specialists. You need to operate on a common platform. You need to have automated scheduling. You need to have a service that we can get people to if they have a situation that needs some navigation.

There are standards that we can make people sign up to upfront that completely change the patient experience because you're cutting the network down by 80%. That is the key source of how you can actually drive to that better experience.

STEVE BLUMENFIELD: That was a huge statement, right. that you threw in the end there, cutting the network down by 80%. So -- getting to the top with a standardized, best practice version of a solution. And you used the airline example to show how that's possible when you're more targeted.

Let's drill down a little further in the member experience. Let's say I signed up for Centivo, how does my experience start? What does that look like? What do I do first?

ASHOK SUBRAMANIAN: It's a really great question. I disclosed at the top of this podcast, Steve, that I was a former colleague. And so when I left the firm, I joined the Cobra plan. And the Cobra plan, I won't name the carrier, was with a well-known national carrier. I signed up for Cobra. I paid my bill every month. I never heard from the health plan. I had no reason to, knock on wood, but I literally never heard from the health plan.

In the Centivo experience, it's very different. It starts with, let's not talk to the person when they're sick, let's start by engaging them to use the right front door of health care, which, as we've talked about for half an hour, is primary care. So the initial step is communication through a combination of digital app, phone call, email, whatever people sort of self-select that they want to be communicated with. But the first step is, you need to designate that advanced primary care team.

Our stats show that we get 80% engagement within the first month and about 90% engagement within the first two months. Interestingly, as we move into more virtualized models, we're looking at opportunities to say at the end of 30 days, we might default you into that virtual practice. You can change it any time. There's no issues there. But this idea of, let's make sure that everybody has someone who's looking out for them is the front end of the plan experience.

What's the carrot? So the carrot, to be clear, and I think we may have rolled over this, but weren't very explicit about it. The Centivo plans, in almost every case, there's a couple of employers who have done a little bit differently, all primary care is free. Not simply the well visits but also the sick visits. So the ear infection if you're a kid, whatever it might be, are all covered at 100%. And that happens, that qualification for the highest level of benefit is contingent on that process of activation, which is the selection of that primary care doctor.

So there's a carrot in terms of the rich benefits. There's a set of nudges that we engage people on digitally as well as telephonically. But ultimately, the stick is, you're not going to get that full level of coverage unless you go through that process of activation, and that really does drive the levels of engagement I referenced.

STEVE BLUMENFIELD: Ashok, one of the things that you mentioned here is that the employees pay nothing for these visits. Who's paying?

ASHOK SUBRAMANIAN: Steve, it's a great question. So ultimately, it is the employer paying the bills for the coverage. But the math, which we'll keep really simple for this podcast -- And a good actuary, and we know at least one on this phone call who can help us with that, can do the math on basically saying, primary care

today represents about 5% of a typical commercial employer spend. If you increase your primary care spend even by as much as 40%, so say 5% to 7%, that pays itself off substantially on the rest of the 95%, the pharmacy, the inpatient, the outpatient, the emergency room utilization that goes down.

And what we're finding and what we're basically explaining is like 12 years ago when employers adopted free preventive care after the ACA, there was a little bit of an extra increase. But think of that as an investment, not an expense. It drives better downstream results.

STEVE BLUMENFIELD: Excellent. Thank you.

DREW HODGSON: Let's pivot a little bit here, maybe, around -- I'm curious, though, who you think your competitors in the market are, right? This is a model that has sort of been developing a little bit, not identical to yours, but the concept of the carve-out, right? I think the people like Imagine Health come to mind, Employers Health Network comes to mind, Bind comes to mind, which I know we can have a conversation.

That you sometimes get compared to all these different solutions in the market, I hear consultants say it, and I hear employers say it. Even comparing to Kaiser, as you mentioned, the whole concept, what do you consider as your competitors? And what differentiates you from those ones I just mentioned?

ASHOK SUBRAMANIAN: Yeah. So I think there are certainly, with respect to Imagine Health and EHN, as examples, there is a commonality in that we're looking at network as a source of value. If you cut the network down, if you focus on ones who meet certain standards, our model is primary care centered, their models are not. But those differences notwithstanding, there's clearly similarity and sort of the supply side of health care. The idea that better doctors, getting people there, getting better rates, getting better contracts -- is a major driver of restoring affordability. So definitely a commonality there.

The Bind model, we do get some employers and consultants who compare us to them. And I'm not an expert on their model. But honestly, I think it's completely different. It could not be more different. It is taking a very broad network and seeing if at the point of any individual episode of care or service, we can use benefit design and nudges to sort of drive you there. That's really the opposite of saying I'm going to have my journey completely driven by a guide, who's your primary care physician.

But to answer your question, so there's a lot of upstarts, the biggest competitor in our minds is not any one company, but is a theory. And the theory is, can I keep the big fat book of doctors in the broad network? And can I use a series of apparatuses? Whether it's a navigator, whether it's an incentive program, whether it's a transparency tool, whether it's a analytics tool that highlights the best doctors, and you guys are probably thinking of the types of companies I'm referring to here.

But it's a theory of the case of, can I avoid the perceived dissatisfaction of cutting the network down and use of an amalgam of overlays to get people to the same outcome? That is really the biggest difference. And look, from my experience, it just doesn't work. That's not how people access their health care.

DREW HODGSON: It's funny you bring it up that way because that is -- you've hit the nail right on the head there with how employers, and other consultants, weigh this up. It's the navigation, transparency side of things, how do we keep it in the broader network versus do we do the full narrow network. And that is sort of the battle that goes back and forth with a lot of -- And I certainly land on the side of narrowing the network down as being a more effective and more approach and creating that EPO-type model. So I think that makes a lot of sense.

ASHOK SUBRAMANIAN: Just to add to that real quick. I think the key is, when you're looking at your benefits buyer being an employer, then you think of, I can only have one monolithic solution and you want to so-called avoid disruption. If instead you think of the buyer as ultimately being a financier of benefits and somebody who is trying to offer an array of options to a diverse workforce, well, then the idea of having open access models, EPO models, PCP-centered models, just starts to fit a much better narrative.

And that's I think why, Steve, you mentioned and you clarified earlier, we always recommend that this should be a side by side choice. You should never force people into something like this. But when you give them the option and give them the tools to navigate those options, you get, as we talked about earlier, 25% to 50% of people choosing.

DREW HODGSON: I want to bring up a little bit around price transparency, too, with the regulations that have come through already with the hospital systems and the incoming 1122. One of the biggest selling points that you've always said around, Centivo is the dual peak feeling of higher quality, lower cost, right? And the ability, when you steer to a single system, you'd be able to negotiate a lower cost, right? Once those price transparency regulations come out, how does that impact you? Did you think there's an impact to your success in being able to negotiate those prices?

ASHOK SUBRAMANIAN: Yeah. I think there's an interesting push and a pull. The positive is, so all three of us are in the, or at least have been historically, in the New York market, there are seven or eight academic medical centers in any broad network in the New York market. If you ask the typical, no offense to your colleagues, benefit consultant, typical benefit broker, typical employer purchaser, they have no idea that New York Presbyterian is extremely expensive, that Mount Sinai is a high-quality, high-value player, that Atlantic Health is a high-quality, high-value player, that Yale New Haven is very expensive. These are things that people just don't know.

And so transparency, in terms of shining the light on those entities that are structurally more cost effective than others, is a huge boon to a business model like ours because the believability around some of that is something that, right now, is not clear, and not open, and not published on a website. So that's a huge positive.

I think where it starts to get interesting is, now when you get inside of those systems, the level of transparency around a maternity episode, a knee scope, a cancer episode. And I think what's interesting is going to be, there is a narrative that transparency at the code level or the episode level will inevitably lower cost. I'm not convinced of that.

DREW HODGSON: I'm not either.

[LAUGHTER]

ASHOK SUBRAMANIAN: And I think that's a great thread. I'd love to hear why, Drew, you're not either. But -- my short answer and I'll pause is -- I think for commoditized, competitive, low friction, low acuity stuff, sure. You can get a lab test cheaper, an X-ray cheaper, an MRI cheaper. But the reality is, when it becomes clear, that payer A is paying more than payer B for something that is not commoditized, I think price goes up rather than going down.

DREW HODGSON: And that's exactly where I'm coming from. I feel like once prices are exposed between -- I always use the analogy with the television sales in Walmart and how Sony TV versus a Samsung TV, we don't know how much they paid for those televisions.

[LAUGHTER]

DREW HODGSON: If we did, then every single company would be -- getting them for the same price, right?

So I do feel like when Aetna finds out what UHC is paying -- it is basically a reversion to the mean, right, is what ends up happening in the overall -- to your point to those particular costs, and then potentially even increasing prices down the line.

STEVE BLUMENFIELD: Excellent. All right. Let's get a little tangible here. Where can someone use Centivo today? And what type of company wants to use Centivo or you think is a good fit?

ASHOK SUBRAMANIAN: Yeah, no. It's a great question. So the ultimate answer is, ask your consultant and they can certainly guide you to the right solution. But we are available today in about 16 MSAs, that's up from five or six at this time last year. There's some significant developments on the horizon, you know markets like North Texas, markets like Colorado, the Pacific Northwest. So I know, Drew, you're chomping on the bit to get that in your analytical tools. Well -- just bear with us. We'll get that to you.

But there's a lot of acceleration of momentum on the buildout from a market perspective. So that's from a geography side. But we're in places today like New York, and LA, and Florida, and so on. From a size and company profile perspective, what we found is the best employers are already self-funded. So companies that are fully insured today, we ought to be a great fit for, but they have more things they have to get through, in terms of their benefit strategy. So organizations that are already self-funded, organizations that typically have at least 500 or so employees in a given market, where we have an overlap.

And I think the last part is, interestingly, cost always matters. Let's be clear. But employers are bombarded with, you can save money doing this, doing that, negotiate your PBM contract, et cetera, et cetera. We have found that those employers that are really looking to reinvest the efficiency of a program like ours into the workforce through benefit design, we have an employer who's done it to introduce and expand a 401(K) match. We've had employers who've done it for other workforce initiatives, those types of employers have tended to be the ones who've resonated and gravitated most to our model, as opposed to one saying I need to save 40% and drop every last penny into my EBITDA.

[LAUGHTER]

DREW HODGSON: So Ashok, we were talking a little bit about your geographic footprint, how you're expanding across the markets. And a lot of employers out there struggle, I think sometimes to, and consultants to a certain extent, to evaluate the markets they're looking at to whether Centivo is a really good fit. Now, obviously our approach at Willis Towers Watson through our Scout tool has been very effective in doing that. I'm just curious to know what your thoughts are on how employers should be thinking about this?

ASHOK SUBRAMANIAN: Drew, I think it's critical for employers to have advisors who understand local health care delivery. At the end of the day, it's intuitive that all health care is local. We all know if we move from Boston to San Francisco, we need to change a doctor, we need to change things that we do as people access health care.

But look, let's just be blunt about it. Over the last 25 to 30 years, we have moved to consolidated national PPOs. The height of localization is a best in market-type strategy that only the largest of large employers deploy. And we've really moved away from this idea of having multiple entities in local markets be offered as options.

And without a consulting or evaluative methodology to help sort that for employers, it will lead to value that could be out there for members, for affordability, for quality, that just simply doesn't get matched to the right kinds of employers. So I applaud the work that Willis Towers Watson has done in this area. I know there's others who are trying to do similar, but you've definitely taken a leadership position on this.

STEVE BLUMENFIELD: Well, thanks for saying that, Ashok. That's very thoughtful. But to maybe translate down from some of the deep technical elements of what you're saying, my simple way of looking at that is, I think you're threatening that the days of taking that peanut butter approach -- we talked about peanut butter and jelly in the prep comments -- that peanut butter approach across the entire population leaves a lot of spaces where it's just not evenly spread. And you can do better by taking a more rigorous look at local markets. We have the tools now to do that, and Centivo is one of the tools.

ASHOK SUBRAMANIAN: I think that's exactly right. And again, it's not that anybody is doing anything wrong, it's that the world has changed. So the broad carrier networks, there are overlaps, 97, 98, 99%, in terms of provider access. From a discount perspective? Yes. There are some markets where certain carriers have certain advantages. But the reality is, companies are typically evaluating differences of less than 2% when it comes to network differentiation.

So the basis of the analytical frameworks around national PPO consolidation, which is network size, overlap, and discount, simply are irrelevant. And we need to move to more relevant vectors to make these evaluations and those local dynamics are really the ones that are emerging.

DREW HODGSON: Question for you. We're going to go -- kind of wrap this up a little bit, I think, at this point. Right, Steve? So let's say that Centivo was just a massive success, right? So five years from now. And you were on the front cover of a periodical, what would the headline be? What would you want the headline to be?

ASHOK SUBRAMANIAN: Affordability restored.

STEVE BLUMENFIELD: Pithy. I think you've won the pithy headline award.

[LAUGHTER]

STEVE BLUMENFIELD: Very nice. Affordabilty restored.

ASHOK SUBRAMANIAN: Again, the lens that we bring, and I appreciate your five years from now, successful -- But if Centivo was successful is a business or not, yeah, the chips will fall where they may. But -- the core of what we're doing is -- I don't believe there's another health plan in America that wakes up in the morning and goes to sleep at night focused on, how can we make sure that our members are spending as little as possible without compromising on quality and while enabling our employer purchasers to make sure their numbers are going around the block? That is the moral compass of the company, health care affordability at the level of the patient.

STEVE BLUMENFIELD: All right. Love it. Let's keep growing in that direction. Let's say Centivo were a mythological creature, a Greek god or goddess, what would you think it is?

ASHOK SUBRAMANIAN: The Sphinx comes to mind but not Greek. So I've gone offscope here, Steve. Yeah --

STEVE BLUMENFIELD: You can be -- That's OK. It doesn't have to be Greek. That was an example. Sphinx is OK.

ASHOK SUBRAMANIAN: Yeah. I think there's certainly a lot of the excitement, and the enthusiasm, and the passion for what we're doing that comes through conversations like this. But let's also be real. There is a David versus Goliath type of mentality that comes in a business like this. We do work with very large organizations. There are built in assumptions that there is no way to be more cost effective than those large organizations.

It's the kind of things that, as we talked about earlier, the airlines, the telecoms company, others that have big massive competitors certainly have to deal with. So the riddle of the Sphinx, the David versus Goliath, I think there's a number of good analogies there.

STEVE BLUMENFIELD: All right. So let's hear more about the Sphinx. You got me curious.

[LAUGHING]

ASHOK SUBRAMANIAN: Well. You know, I think the riddle of the Sphinx is, how do you lower cost, advance quality, and make members pay less all at the same time. Those three things are generally viewed as completely incompatible in health care. We have experienced a generational arc of cost shifting, bad news, and take a wild flip through the provider directory, and maybe, maybe not, you'll get a doctor who can do things the right way. So it is really that structural building of all three of those things. I think of the riddle of the Sphinx and the three aspects of that. That's what made me think of that.

STEVE BLUMENFIELD: Very nice. Two unique answers. All right.

DREW HODGSON: I have one more question to ask you because you mentioned that David versus Goliath, and it's kind of going back to a bit more of a serious question I suppose on the BUCA. And I'm curious to know, as Centivo grows, and your growth has been pretty rapid, over the last couple of years. BUCA is going to have -- it's paying attention. What do you think their reaction is?

STEVE BLUMENFIELD: Just explain BUCA for those who might not know.

DREW HODGSON: It's the Blue Cross, UnitedHealthCare, Cigna, and Aetna, the big four insurance carriers, right, is BUCA, sorry. And we use so many acronyms, don't we? But they're going to react, or they have already started to react as Centivo continues to grow and get attention. What is your fear from them? And what do you think their reaction will be over time -- in challenge to you?

ASHOK SUBRAMANIAN: Yeah, it's obviously a great question. The main line carrier is being buffeted by a number of forces. We've touched on that today. So obviously, there's what Centivo does. But they've adapted over time on navigators, on second opinion services, on various other pieces of the puzzle, PBM carve-outs, there's a lot that's changed in their world.

So I think it's first important to realize that none of this has been monolithic. It's been a very fluid environment in this delivery of health care and health insurance over the last 20 years.

But here's the interesting, I think, juxtaposition. When we hear anecdotally, or from consulting partners, broker partners, et cetera,

what do you hear from the carriers? What they usually say is, shrug of the shoulders, if we set our minds to it, we could do a primary care center plan too, we could build narrow networks too, we have bigger scale, we could get better rates, we don't do this because employers don't want it or employees don't want it. So that's often the typical shrug of the shoulders kind of dismissive answer.

What I have heard interestingly from alumni of those large insurance carriers, if I could use that term, people who've gone on to work in consulting, at employers or whatnot, is down deep they know that they have an Achilles heel. And their Achilles heel is the fact that they are so big that they have to serve the providers in their networks, in their Medicare business, in their Medicaid business, in their insured business.

And I go back to that example of New York Presbyterian, which I'm not saying anything that wasn't already reported by the Wall Street Journal, a large carrier knew that they could lower cost by building a network centered around Mount Sinai without some of those other players in the New York market. They ended up not being able to execute because of the terms of the conditions they had with players like New York Presbyterian.

That will become increasingly clear when organizations like ours that are built for this purpose are taking that message to the market. Whereas in the old days, in the large carrier world, it's like, OK. You don't like that product, I've got another product for you.

DREW HODGSON: Yeah.

STEVE BLUMENFIELD: Yeah. As in every industry, when you're remarkably successful, and let's not forget, those big four and many others, have been remarkably successful, when you get that big, you have to satisfy an enormous number of stakeholders. The things that you serve end up also being stakeholders of yours in some other way and necessary for your success. You become reliant and that becomes a weakness.

So, of course, innovators will find ways to fill those gaps. And then sometimes I mean, who knows, Centivo could be acquired or maybe you at some point acquire them. Maybe there's a different model that emerges out of this. So it's a truism of the way things grow and succeed.

ASHOK SUBRAMANIAN: It is, and look, the other reality, whether it's an innovator like us or other companies in the ecosystem, we have an advantage that the large companies don't have, which is, Drew, you mentioned our growth has been really rapid for two years, and it's been terrific. But, the expectations for what good growth is at Centivo is a whole lot different than at UnitedHealthCare. And that is an advantage for a new company in any market.

STEVE BLUMENFIELD: Absolutely. Yeah. Anything we didn't cover that you think folks should know about? Drew or Ashok?

ASHOK SUBRAMANIAN: No. I think we've covered it quite a bit. So Steve and Drew, there's been a lot of fun. I appreciate you inviting me and just the format of this has been great. I go back to, nobody knows how much health care really costs. People don't study their claim files with magnifying glasses. And even if they did, to back that out to providers and episodes, and controlling for risk, and all kinds of things --

STEVE BLUMENFIELD: After they wake up, right?

ASHOK SUBRAMANIAN: Exactly. It's a very difficult task. The variations in cost without correlation to quality is incredible, WTW and others have reported on this over time. But really the only effective way, that at least I've seen, to get people to act on that information is through a benefit design and a network that's built this way. And so it all starts from, the juice isn't worth the squeeze if it was 1%, 2%, 5%, but when you're talking 20, 30, 50%, it really moves the needle.

DREW HODGSON: I think it's important to understand how we get the enrollment, and how we get people to actually move from point A to point B. You know, they're so used to their broad networks, et cetera. I think the mistake that has been made in the past is that these plans a lot of times will have huge actuarial values, to your point, Ashok, you mentioned earlier, and therefore, really expensive, which makes it very difficult.

I think how you position a plan like Centivo is critical in making sure you are attracting the highest risk, the chronic conditions, into this plan that can get managed to care better. So pricing it at a point where people are willing to vote with their feet is really important as you go forward. Would you agree, Ashok?

ASHOK SUBRAMANIAN: I do, Drew. And I think there's even a deeper point there, which is we don't typically chase being the cheapest plan out of pay cheque. We want to be the richest plan when you need health care, which really helps us when offered as a side by side choice. So the consultant and the employer can feel comfortable that we're not just getting the young invincibles and taking them out of the plan, if anything, we'll get a few young invincibles, but we're actually really focused on getting the folks who are the high utilizers, getting them into this effective primary care centered model. That's what brings cost down over time.

STEVE BLUMENFIELD: All right. Well, Ashok, thank you. This has been educational. It's been fun. I've learned about the Sphinx today, didn't expect that. So --

[LAUGHTER]

STEVE BLUMENFIELD: Ashok, thank you so much for bringing insights about Centivo and the market to us today.

ASHOK SUBRAMANIAN: Great. Thanks for having me. Thanks for everything you guys do, and this is a great podcast series. Thank you.

STEVE BLUMENFIELD: Oh, thanks. Drew, it's always wonderful to talk with you. Thanks so much for sharing your insights and for spending time with us today.

DREW HODGSON: Yeah. Thanks for inviting me. I appreciate it, Steve.

STEVE BLUMENFIELD: I'm sure we'll do it again. And thanks mostly to you, our listeners, of the Cure for the Common Co podcast. We appreciate you listening. Thanks in advance for rating us, for sharing us with your friends, and have a great day.

[MUSIC PLAYING]

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