Episode 28 – Bind: A personalized health plan with clarity on price and quality

[MUSIC PLAYING]

DAVE DICKEY: Bind, the name, is an acronym.

STEVE BLUMENFIELD: Yes.

DAVE DICKEY: Because Insurance Needs Differ.

STEVE BLUMENFIELD: Because Insurance Needs Differ.

DAVE DICKEY: And you need something more personal, and that's what Bind is able to deliver for you.

NARRATOR: 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.

STEVE BLUMENFIELD: Hey, Dave.

DAVE DICKEY: Steve. Thanks for having me.

STEVE BLUMENFIELD: Hi, everybody, and welcome to Cure for the Common Co podcast. This is Steve Blumenfield, Head of Strategy and Innovation for Willis Towers Watson's health and benefits practice in North America. Today, I'm excited to talk about Bind Health, an innovative personalized health plan with price and quality clarity. Welcome, co-founder Dave Dickey, to the pod.

DAVE DICKEY: Thanks a lot, Steve. I really do appreciate you doing this for a bunch of entrepreneurs and including us in it.

STEVE BLUMENFIELD: Aw. Thanks so much, Dave. I'm also joined by our North American Head of Wellbeing who also happens to live and work in that rarefied Minneapolis air along with Dave, Regina Ihrke. Welcome, Regina.

REGINA IHRKE: Thanks, Steve. So glad to be here and being able to share the Bind story with all of our listeners.

STEVE BLUMENFIELD: Absolutely. I'm looking forward to digging in. So Dave, let's get started. Tell our listeners a little bit about yourself and what led you and your co-founders to start Bind Health.

DAVE DICKEY: Yeah, we call it unfinished business. There's a group of us that started a company back in the internet era in '99 that invented the account that could roll over, now known as the consumer-driven healthcare movement, and we noticed that there were some wrongs that we wanted to write. And specifically around--

STEVE BLUMENFIELD: What?

DAVE DICKEY: I know.

STEVE BLUMENFIELD: You made a mistake? An entrepreneur admitted to a mistake. You heard it here in the podcast. Entrepreneur made a mistake. OK. Sorry.

DAVE DICKEY: It's a first. So we called it unfinished business. And it was personal for me, too. In 2014, my wife was diagnosed with melanoma, and we ran to the local clinic, and they said this is bad and you need to go to the Mayo Clinic, which is not far for us here in the Twin Cities. And called the insurance company and went down there.

She had three surgeries. And then I found out six months later that the Mayo Clinic was not included in the network. So here I am, health insurance expert doing what I thought was right, and at the end, paying nearly six figures for a mistake.

And so I realized at that time that health insurance is really important to people and it's really important when you're sick. And the current solutions today and the remedies for those current solutions today just don't actually work for Americans. If you think about the alternatives, it's big deductibles and narrow networks, and neither of those are good for you and me, but they do save money. And so the group of us, we wanted to get together and innovate around the idea of insurance not around the periphery, not around care delivery, not around member experience, but really innovate insurance, and that's what we ended up doing.

STEVE BLUMENFIELD: Wow. That's a heartbreaking story. Thanks for sharing that. Can you say a little bit about what Bind is? Maybe describe it for our listeners?

DAVE DICKEY: Absolutely. Bind is, as you mentioned, this clarity in cost and coverage. And that clarity delivers savings for not only you, the employee, but also the plan sponsor. And it does so by getting rid of much of the stuff that causes some of the confusion in employee benefits today. Things like deductibles, co-insurance, co-insurance limits, and the like.

And instead, it puts a price on everything. A price on all the treatments, all the providers. And you're able to know that before you go and therefore, you can consume things that are of value for not only you, but also for the plan.

REGINA IHRKE: So it seems to me like that's the biggest-- one of the biggest challenges is really how do these insurance plans work for most individuals, right? They kind of see that deductible. They don't really understand the co-insurance, the out-of-pocket piece. How have you been able to really help these members understand what they pay for versus the plan so that it's more clear?

DAVE DICKEY: Yeah, we think the role of the plan is to help the consumer understand the different places that are going to be helpful for them and the plan. And so behind the scenes, there's a lot of different data sources that are being combined and using pattern recognition. So here's your AI startup guy saying something about AI to actually come up with and stratify them. Who's good, bad, and ugly?

And all that information is known by the health plan because all those claims come only to the health plan. And so when that's the source of truth, you're able to get a real clear picture of who's doing good quality, who's doing bad quality, who's efficient, who's inefficient.

And so what we end up doing is we take all that information and then we set prices based on the most-- the highest quality, most efficient providers and treatments, those become the lowest price tags for employees

to consume. And the most inefficient and poorest quality that are still in the network are ranked at the other end, and those are the ones that employees will pay more for. And it's all bundled in something that we use every day, and that is our smartphone. It's in an app that's available on demand when you need it. It's known before you go.

STEVE BLUMENFIELD: OK, so I'm the member and I need to go to a doctor. What happens? I guess the pieces that are in my head to unpack here. So it takes some time to do this, Dave. So we can do this in pieces.

When I sign up for this, what does that mean that I've got to pick? And how do I know where to start? Do I have to use this app? What if I don't like apps or I forget my password or whatnot? Just maybe start to break this down a little bit for us.

DAVE DICKEY: Sure. So it depends on what kind of consumer you want to be. If you don't want to do anything, this is still a health benefit for you. There's coverage for the things that were covered previously. They just have different price tags.

And so if, in fact, you wanted to pick a plan and you didn't want to use the app, you don't have to. There is still an ID card, and it's recognized at the counter, and people can still get access benefits doing it. But the majority, it's about 80% of our consumers, what they end up doing is during enrollment, they pick the plan and they also go through a process during enrollment to test drive the plan. So we have a pre-member experience that actually shows the price tags of all the different providers, all the different treatments that would be in place. And so it actually starts the learning before you even become a member.

Once they enroll, they get an app from us. That app is relevant and special and unique to them. And inside that app is a lot of information that can be beneficial to them around the two fundamental questions that consumers have around their benefits. And those two questions are, is what I have covered? And, how much will I pay for it?

If you think about that, that's what insurance should be, and no insurance and company in America can do that except Bind, before you go. Why? It's because we've got deductibles. We've got co-insurance. We have co-insurance limits.

And those numbers are amorphous. By getting rid of those things and putting price tags, what you and I would call co-pays, what we talk to the marketplace about in terms of price tags, you know before you go what opportunities for savings are in place. And like I said, you don't have to use the app in order to access care, but if you do, there's tremendous savings opportunities for you, the employee, and therefore, the plan sponsor.

REGINA IHRKE: So usually when we are working with employers and they're looking at what are the options that they want to offer, right? And they see a lot of, actually, people overinsure, right? So they see a lot of people tend to overinsure. Does this kind of have-- what have you seen from a result perspective of, do you see that they're buying smarter because they have the right tools?

And then maybe the other piece of the question would be is-- always the biggest challenge is we don't want to have people lose their docs, right? They don't want to lose their doctors in all of this. That even though it's disruption, there is this challenge of how we communicate that to these members.

DAVE DICKEY: Yeah, I'll take that first one first.

REGINA IHRKE: Yeah.

DAVE DICKEY: What are some of the results that we're starting to see as a result of giving people this information? And the first thing is they do use it. Why? Because it's beneficial to them.

There's money saving capabilities for employees in the use of this app. And inside of that use of the app, there are recommendations for switching, as you mentioned. And the switches that are in place that yield the savings, it's not as much on the overinsurance as more efficient purchasing, I would say, of care.

And the two places that we end up getting switches are around provider choice, and I'll define that more because I would agree that there's a lot of skepticism of will people actually change. But the two places are provider choice and then treatment choice. And what we've been able to see in terms of provider choice, while many people say there's no way I'm changing my pediatrician. There's no way I'm changing my OB-GYN. What we do see is different types of provider switching.

So we have a funny saying in our family, the healthcare experience starts with getting in the minivan. And one thing that actually doesn't require getting in the minivan is using virtual care. And that is a provider switch that is available.

And we've seen three and a half times the number of uses on virtual care than other book of business platforms of other commercial vendors. And the reason is because they're on the app, they can just click and then use virtual care. It's that simple.

Where we also see switches on the provider side is instead of going inpatient-- we do give the prices of inpatient. We give the prices of outpatient. We give the prices of ASCs. That's ambulatory surgery centers for those of us that may not know the acronym.

And again, we see the switches. Same surgeons still doing the work, but the setting has changed, the provider setting has changed. And it's still the same treatment, but there's a significant, as you know, cost difference from moving from inpatient to an ASC.

STEVE BLUMENFIELD: What is that like for the member? I'm trying to imagine a member asking a doctor to use a different ASC or-- just unpack that a little bit.

DAVE DICKEY: Yeah, absolutely. Sadly, I lost my wife three years ago. So now I am dating, and one of the women I started to date was a doctor.

I asked her, what do you do? And she's like, well, I'm a doctor. And she asked me, what do you do? And I'm like, well, I'm in health insurance. And I'm like, this is not going to go very well.

[LAUGHTER]

She's like, which one? And I said, well, it's a new one. It's called Bind. And she took off her glasses and she looked at me and she said, you're with Bind. And I said, yeah.

She's like, they pull out their app in the examining room and tell me where to send the drugs. So we've talked a long time about this shared decision support, right? I mean, there's vendors all over the place that are advocating this sort of construct.

But, really, the best shared decision support is when the consumer has information and the doctor has information. And so these are things that, as part of the course of plannable treatments when you're scheduling surgeries, they can pull it out and say, can we move this to this other location because it's going to save me some money? And what we've seen is, with a high regularity, consumers are doing that and there is switching.

STEVE BLUMENFIELD: Dave, once again, thank you so much for sharing something personal, and our hearts go out to you for what you have been through. I don't know how you move from that to-- well, I don't know, but you did. And to have a first date with someone and tell them that you're from health insurance when they're a doctor, there's a sitcom right there, right?

[LAUGHTER]

DAVE DICKEY: Sadly, I'm afraid so. The whole, actually, dating situation is a sitcom, but that's another podcast, Steve.

[LAUGHTER]

STEVE BLUMENFIELD: That's right. And now we're launching Dave Dickey on relationships.

[LAUGHTER]

So what you're describing here, it's a little bit complicated. I'm trying to follow the thread for a typical employer trying to think when do they put in Bind and what is it like? Is this coming alongside other plan designs?

Is this something I'm replacing like I did a full replacement for a CHP? When do I pick this? How do I use this?

DAVE DICKEY: Yeah. So it depends on the market segment, but the majority of our large employers do hang this alongside consumer-driven healthcare options or PPO plan designs, and we become an option, and it becomes a solution for the employees that are interested in a new kind of design that answers those two fundamental questions of, is it covered? And, how much is it going to cost me?

For middle market, it's a little different. And Bind has grown substantially in its market coverage. Initially, we started working with Fortune 500 employers only on a self-insured basis and only on an option basis.

Once it got into the middle market and you had to deal with stop-loss coverage, that's when full replace for Bind came out. And we now go down to 100 lives for coverage on a full replacement self-insured product. And then now, in a few states, about 10, Bind is available on a fully insured basis for small groups, 50 and above. So check--

STEVE BLUMENFIELD: Really?

DAVE DICKEY: Check local listings. Yes. So the opportunity for this chassis to go into different market segments is there, and that was the intent all along, is to have something that would actually be personalized and relevant for the individual.

STEVE BLUMENFIELD: Fully insured. So are you the health plan in that case yourself? Do you have a TPA relationship? I'm just curious about that. I didn't expect that to come out.

DAVE DICKEY: Yeah. So one of our early investors was UnitedHealthcare, and they've been a great partner with us, and they obviously have a lot of resources as it relates to paper, and they're the backing behind it.

STEVE BLUMENFIELD: So clearly, there are some results here.

DAVE DICKEY: There are some results here. The true north for Bind always has been the product. Straight up.

Can we actually help this really big problem in America? And that really big problem in America is cost and satisfaction. And so over multiple years, we have seen a reduction in cost for not only the plan sponsor, which you both know can be easily done by shifting costs--

REGINA IHRKE: Yeah.

DAVE DICKEY: --but it's not just the plan sponsor. Actually, the employees are saving half. OK, let me hit this one hard because this is really important for your audience. The plan sponsors save money and employees save money to the tune of half of other national benchmarks, and here's why.

If you have this much waste that we have publicized in healthcare where there's been poor quality and inefficiencies and you actually navigate people to those right places, those places of high value, we could get rid of this waste and thereby start to see health insurance premiums go down and coverage improve. Why? Because there's that much in it.

REGINA IHRKE: So Dave, you kind of answered-- my next question was going to be-- you answered two pieces of it, which is when we're working with employers, they usually have three objectives, I would say. There is affordability on both the employer and the employee that you've addressed. There's steerage to higher quality, which we then know has a byproduct of savings. And then the new piece that is really continuing to come up and, obviously, I think was much more of a focus since COVID, the Black Lives Matters movement was really around health equity. And so maybe can you talk about that piece because that seems to be the next additional focus we're seeing employers say as, how can a plan solve for that?

DAVE DICKEY: Yeah, in America it's unconscionable, our outcomes. And we're here in the Twin Cities, the epicenter of George Floyd's murder and the reckoning they're in. And as we started to study the inequities, we said, let's do something about it. We've got a plan design that's in place that doesn't have these ranges of co-pays depending on where you go and what you get for certain treatments and conditions that tilt toward people of color.

What we have done is we have made it the lowest end of the co-pay range in order to get more access and care for some of these conditions. And you guys know the conditions that we're talking about. But we're a health plan and the next chapter for us is to make no delineation on conditions that tilt toward the BIPOC community and instead give more coverage for care in these areas so that we can get after this disparity that is just, as I mentioned, unconscionable.

STEVE BLUMENFIELD: So essentially, differential benefit.

DAVE DICKEY: That's right. Our customers have-- it's up to them to decide how they want to communicate it. What we've done behind the scenes is, again, we have the data. We understand what the conditions are. And what we end up doing is then setting those co-pays, just like we set co-pays for everything else, at the lower end of the scale so that there isn't at least a financial barrier from getting access to care for these issues.

Now let's say you're Dave, a white person having one of these conditions. They still get the lower end of the scale, but our idea was let's get after this remedy and follow the data and the science to go to those areas where the disparity is the greatest and actually help them along with respect to coverage amounts. I mean, at the end of the day, that's what health plans do.

Are you going to pay for stuff? And if so, how are you going to pay for it? And we're going to cover more of it at the lower end of the range if that makes sense.

REGINA IHRKE: Wow. It really seems like that would be a differentiator, right? Because I think that's a piece that employers are struggling with, how to help that population out right now. I think everyone's looking into it, but we can't figure out what the right thing solutions are.

DAVE DICKEY: And that's the problem with the deductible and co-insurance, straight up. You can't identify conditions inside of a deductible co-insurance. It's all thrown in. And so that's again why this personally relevant plan design starts to come in to show how unique and special it can be.

STEVE BLUMENFIELD: OK, so it's a different plan design. It's not a HDHP. And you mentioned that you learned quite a bit from those initial implementations. But those things were learned in retrospect, right? So what are the anticipated unintended consequences that for the next thing you design, Dave, we'll be sitting here saying, oh, yeah, I learned this one, too.

[LAUGHTER]

DAVE DICKEY: Yeah, so we have learned a ton. We have two main products. We came out with one that was called On Demand. We have another one that gets rid of On Demand feature and we call it Bind Basic. All of this was based on employer feedback.

So the foundation of what you've heard me talk about today is all in place in both designs, which basically says everything has a price. All treatments and providers have different price tags. Because of some employer feedback, they liked having everything covered next year the same as what they covered last year.

So we don't include things like gastric bypass or something like that today. I don't want to cover it tomorrow. And so that Bind Basic plan sets price tags for everything, all the treatments, and all the providers.

This Bind On Demand thing is a second product that we offer that allows consumers to flex coverage on demand. So there were 45 procedures that were set to the side and allowed people to buy on demand. Things like hips, knees, backs, very plannable procedures. And those would be things that you would buy coverage for on demand when you need it. That, too, has its place in the marketplace, but I would say that was probably the fundamental lesson learned in the marketplace.

I would also say that consumers have said to us that they're very interested in even more money saving tips. So in those on demand situations, they want to actually start to shrink the coverage even more and have more things beyond demand because there's an ability to save money in terms of premiums as a result of that. There's also interest to have other notifications around money saving tips.

What we've got in the app today are money saving tips around treatments. So instead of having a surgery, we advertise chiropractic and physical therapy. And then we also advertise different doctors that would be treating these different conditions.

REGINA IHRKE: So your app, does it then connect to if an employer has a digital physical therapy or some kind of cognitive behavioral therapy-- does it connect in those tips, pieces there? Steve's doing these podcasts all the time and it's about-- the biggest thing is how do we connect the ecosystem better for these innovations that are out there?

DAVE DICKEY: That's right. Yeah. So that's exactly what our app does.

There are tiles available for employer specific solutions that would be advertising. And honestly, that's why we get such great virtual care penetration. It's because when you're looking for money saving tips and it says $0 for virtual care, click here, it's right there.

STEVE BLUMENFIELD: So let's talk about the change over time. If folks listen to some other podcasts, we've had the topic of disruption before. And Drew Hodgson, one of our folks, made the argument that disruption isn't always bad. If you're taking someone, forcing them to make a decision away from a poor experience with low quality for a high price, that's good disruption, and sometimes, that has to happen. I'm curious what happens over time.

Let's say in a situation where it's a full replacement. So everyone who is getting insurance from this company has to now use Bind if they wanted to get insurance from the employer. Do we see a difference in behavior year over year as people learn?

Let's say they start not engaging. Do they learn over time? Or do they end up not learning? What are the percentages there? Do they end up footing just a higher bill? Or do we see a migration?

DAVE DICKEY: You do see actually a migration. And we do see a consistency between full replace and option enrollment in terms of the plan performance. Again, adjusted for risk, which is really important, as you guys know. But it is the same sort of performance for full replace and slice based on full replace versus slice.

But we do see a higher take rate in year two in those option environments because one of the big reasons that people don't want to join Bind is because it's new. It's a different name. It's a different ID card.

And I get it. I mean, we want our insurance companies to have marble in the front lobby and we want them to have all sorts of name recognition. And yet, that marble and name recognition has continued to take from your out-of-pockets and take from your paychecks and not in an efficient way.

REGINA IHRKE: So Dave, it seems like you've learned a lot, right? And you've got a lot going on your roadmap. If we were looking out five years from now, what would you want to be saying in any big news press or on TV about what Bind is doing?

DAVE DICKEY: I want big, big font because I think it's possible. Healthcare premiums cut in half.

STEVE BLUMENFIELD: That's awesome. That would be great. We'd all--

DAVE DICKEY: Wouldn't that be great?

STEVE BLUMENFIELD: Yeah.

DAVE DICKEY: I think there will be more will needed from all of us on that front, but I think this is a first good start and it starts to address some of the issues that we're all struggling with, which is affordability and do people actually like it. I do want to talk about one other result that we haven't talked about, and that is, do people like what they have? When we started the company, we asked consumers what they wanted, and I told you the answer was, number one, is this thing I have covered? Number two, how much will I pay for it?

And then we found a study that reviewed what percentage of Americans can accurately define the terms deductible, co-insurance, co-insurance limit, and premium. So those four things, those four words. Guess, Regina, what percentage of Americans could accurately define deductible, co-insurance, co-insurance limit, and premium.

REGINA IHRKE: I would say less than 20%.

DAVE DICKEY: OK. Steve?

STEVE BLUMENFIELD: 5%.

DAVE DICKEY: Ding, ding, ding, ding. 4% of Americans could accurately define the stuff they have today. That means 96% don't know.

REGINA IHRKE: Yeah.

DAVE DICKEY: So let's get rid of it.

[LAUGHTER]

REGINA IHRKE: Yeah.

DAVE DICKEY: And so we did. And guess what? When you actually can talk and clear prices and show them what things cost in advance before they go, our net promoter score, which I know you get a lot of this on this podcast, our net promoter score is double.

I'm going to say it again. Double the very established health insurance companies that we all have insurance from. It's double that.

STEVE BLUMENFIELD: I don't believe that.

[LAUGHTER]

I don't because most of them are negative. So if you doubled that you'd be much worse.

[LAUGHTER]

DAVE DICKEY: Yeah, you nailed it. Usually, health insurance is right at the bottom with bad cable and big tobacco. At the very bottom of industries that people like. And we've been able to get after something that people actually like. And again, the only reason they like it is because they feel more in charge and empowered.

STEVE BLUMENFIELD: Let's say I'm an employer listening to this podcast. How do I know if Bind is for me? And this is a question that's not asking-- I'm not asking you to say-- it's for everybody, right?

DAVE DICKEY: Right.

STEVE BLUMENFIELD: Because that doesn't help that much. It's like, when is it especially right as an employer?

DAVE DICKEY: Yeah, we've had two use cases that seemingly-- one makes sense from probably what everyone is thinking about right now. So I would say the retailer, the manufacturer, the entities who have felt like they have cost shifted enough. So if you look at our client list, that's where a lot of our early adopters were. They were in those realms and that's where we have performed well.

The second use case is more recent. The second use case is, I use benefits as a retention strategy. I am not as worried about the cost structure, but I am very worried about the quality.

And I want a design that's actually going to incentivize better quality performance. So people get back quicker and have better, more productive lives. And, oh, by the way, I can enrich my very rich coverage already. So that would be the second group.

Ones that have not been fits, I would say are those that have cost shifted way-- they have cost shifted a ton. So think about if they're offering like mini med or a fixed indemnity or something that actually has not much premium and not much coverage in it. We can't save much from something that doesn't have much in it to actually make it worth their while. So that has been a struggle.

And then we have surveyed consumers around when they don't pick us, what were the issues? And I mentioned early we're new. So there is that constituent that wants a brand name and doesn't want to be a first mover. Although now we're in year three, so I guess it's a third year mover.

[LAUGHTER]

And then the second group is those that have committed to a strategy of funding HSAs for their employees. I'm not talking about moving to a CDH full replace but don't fund any account balances. I'm not talking about that. I'm talking about the Trojan horse of cost shifting where you're actually raising deductibles and saying, hey, you can open up one of these HSAs if you want. And as we all know, they don't.

REGINA IHRKE: Can you talk me through a little bit of-- I've gone to my PCP and he's seeing some numbers that he's concerned with and he wants me to go see a specialist. Or I've seen the specialist and now they want me to go have a surgery, et cetera. And really talk me through what does that member experience as they walk through that decision process from provider to what the members are being told to what they then go and do. Because we know the challenge is the member and the provider are having that conversation. Usually, even though we give them all of these great tools that are out there, none of them are ever used. I just called my friend Steve and Dave, and they tell me who they went to, and then, well, I'm off to the races.

DAVE DICKEY: Right. First of all, the providers that you can see, it's a large national PPO network and you can see any doctor without a referral. So it's on a PPO chassis. And so that means that there are just different price tags for the entire marketplace.

But in your situation where you actually went to a primary care doctor, you would show your ID card. And at the counter, typically, what happens is they check it. They look on the back. It says UnitedHealthcare's network. It's in.

And then what they end up doing is submitting that bill to us. And we pay it. And then what comes to them in an explanation of benefits is, here's your co-pay. Now you could have been able to know what that co-pay price was and what other providers are available to you if you wanted to using the app, but you don't have to. So that is the primary care situation.

For specialists, again, it's an open access PPO plan. So you could go straight to a specialist. And let's say in this instance you're pregnant. We would actually show the entire package of pregnancy to you as you start having that discussions with your OB-GYN about delivery.

And there would be different price tags for all the different providers in your area. And it's a national network. So if you're traveling, there's still coverage for that.

STEVE BLUMENFIELD: Soup to nuts, the entire price? Or is that going to be the price just for that OB-GYN? Is that also going to include the facility? Is that going to include every specialist that you see along the way?

DAVE DICKEY: Yeah. This is where the health plan has all the information to be helpful, and up to this point, has not. We package it all together. So what you see on the app is the package price that you will pay, all the facility, all the professional services, the labs.

Let's say you actually have an emergency c-section when you were going in for a normal vaginal delivery. It's still the same co-pay. Why are we able to do this? Again, behind the scenes, we have pattern recognition to figure out the providers, the referral practices, the quality, all of that. And that's how we set those prices for the plan and that's why consumers in advance where they can go to find value.

REGINA IHRKE: So it sounds a little bit like what I think of as we have a relationship with our primary care doctor, our OB-GYN. We don't normally have a relationship with a hospital, right? Or a facility, right? So that's where you're kind of doing that steerage more than on that front and side of that provider that you're seeing as much.

DAVE DICKEY: That's right. And that's also, as you know, where the real money is.

REGINA IHRKE: Yeah.

DAVE DICKEY: And where the real savings opportunities are. And so when we talk about provider changes, that's where we've seen the biggest dent in where the savings really start to yield. And when you can start to get some of these bigger dollar savings, this is how you can also enrich coverage at the same time. By getting rid of deductibles and putting price tags to things, you're giving coverage right away, which means most people will fare better under a Bind plan than they will under a high deductible plan.

REGINA IHRKE: Got it. So Dave, I understand we're setting these prices based on different quality perspective. Are there providers that are just not covered at all? And one of the areas, I would say, the other big priority we hear a lot of is, what are we going to do about covering mental health services where we have so much out-of-network already today in a traditional health plan? So maybe covering a little bit of those and how that experience works would be really helpful.

DAVE DICKEY: Yeah. As I've mentioned before, we use UnitedHealthcare's network and inside of those claims that we're evaluating, there are network discounts. So as part of the calculations that I've talked about

and the pattern recognition of setting those prices of who's most efficient and best quality and setting those co-pays at the low end of the range for the consumer, all of that information is discounted care because there still is a network. Now--

STEVE BLUMENFIELD: OK, so you're using United's network. So then the flip side of that question, which is what I think where Regina was going was, what about out-of-network for that member?

REGINA IHRKE: Yeah.

DAVE DICKEY: Right. The simple answer is, there is out-of-network coverage for those plan sponsors that want to have out-of-network coverage. It's still a self-funded plan. And it's usually double the co-pay of the high end of the range.

STEVE BLUMENFIELD: It gets interesting, right? Because if I'm a member and I know that everything is priced, suddenly, someone's out-of-network. Am I going to see the final price for out-of-network as well?

DAVE DICKEY: So today, we do show in a grid the out-of-network benefit. If they can't find the individual named provider in the search, then they would find it in their grid. But, as you know, these national networks are very large and, virtually, all providers are included. And inside of all those providers, we then actually set a price tag for them.

STEVE BLUMENFIELD: And for mental health where you have a lot of out-of-network?

DAVE DICKEY: Yeah. So this is where our plan sponsors have been creative around that and enriching coverage for both in and out-of-network for mental health coverage. We also have some point solutions that address that on a more virtual basis. But this one is a big problem for Americans, as you know, and we want to make sure that there's coverage for this and access for folks.

STEVE BLUMENFIELD: So the takeaway on that is there's still an underlying network. There is the opportunity to at least understand what it'll be if it's out-of-network. You have to kind of look for that in the grid, but by virtue of the entire experience you're trying to deliver, you're steering people to what is covered. And if someone really wants to work hard to not find someone that's covered, then they can do it, but it's going to be a little more complicated and maybe a little more costly for them. And if that's not the same experience, well, that was never what was intended to cover.

DAVE DICKEY: Right, right. And again, it all depends on what that plan sponsor wants to cover initially. And I would say most of our plan sponsors do have an out-of-network benefit and it's double the co-pay.

REGINA IHRKE: That's helpful.

STEVE BLUMENFIELD: So let's shift gears. Bind. Bind Health. Let's just say Bind weren't a health plan. Let's say Bind were a mythological creature, god or goddess, Greek/Roman, you name it. What would Bind be?

[LAUGHTER]

DAVE DICKEY: Oh, gosh. This is awesome. I went to the place that was a little more fun for me and my family because I asked my kids who are studying Greek mythology right now, and they said, you know what, dad? We think you're like Iron Man.

[LAUGHTER]

STEVE BLUMENFIELD: Hmm. Yeah, I remember him. It was Socrates. He was talking about Iron Man, I think.

[LAUGHTER]

DAVE DICKEY: You guys are really smart. You're innovative. You're kind of quirky, kind of quirky. But at its soul, we're good at heart. So I'm sorry to disrupt--

STEVE BLUMENFIELD: That's OK. Modern-day myths are OK.

[LAUGHTER]

That's all right. I'm kind of disturbed that you think that's a myth, but OK.

[LAUGHTER]

DAVE DICKEY: Right, right.

STEVE BLUMENFIELD: All right, you are definitely the first reference that modern, Iron Man.

DAVE DICKEY: But the other great irony of Iron Man is, of course, he--

STEVE BLUMENFIELD: Oh.

DAVE DICKEY: He died in the great battle.

[LAUGHTER]

REGINA IHRKE: There you go.

STEVE BLUMENFIELD: Wow.

[LAUGHTER]

DAVE DICKEY: There you go. That's probably another question you had.

[LAUGHTER]

STEVE BLUMENFIELD: If Bind Health were an animal, what would that animal be?

DAVE DICKEY: It's the tsetse fly.

STEVE BLUMENFIELD: Explain. That requires explanation.

DAVE DICKEY: Yeah. The tsetse fly is a tiny fly that can bring down elephants.

STEVE BLUMENFIELD: Hmm. And are there certain elephants you're trying to bring down, Dave?

[LAUGHTER]

DAVE DICKEY: We'll just let that sit out there, Stevie.

[LAUGHTER]

STEVE BLUMENFIELD: OK. Stevie. Wow. My mom just joined the podcast.

DAVE DICKEY: That's right. That's right. Yeah, this is a little known fact. We saw it and we're like, oh, that's really good. And as you know, many young companies are trying to disrupt very big issues in the world, and I think metaphorically, an elephant's pretty big.

STEVE BLUMENFIELD: All right. And in actuality as well.

DAVE DICKEY: That's right. That's right.

STEVE BLUMENFIELD: All right, well, Dave Dickey, this has been remarkably educational as you got us out of the bind of not knowing about Bind Healthcare. Oh, man, that was so bad, but we got to keep it.

DAVE DICKEY: Please. Please. We got to keep it. Yeah, absolutely. Yes. Actually, Bind, the name, is an acronym.

STEVE BLUMENFIELD: Yes.

DAVE DICKEY: Because Insurance Needs Differ.

STEVE BLUMENFIELD: Because Insurance Needs Differ.

DAVE DICKEY: And you need something more personal, and that's what Bind is able to deliver for you.

STEVE BLUMENFIELD: All right. Well, Dave Dickey, thank you for the education on Bind Health, and we forgive you for the sins that you may have accidentally wrought upon the world with HDHPs. Certainly, there have been some good things as well. So Dave, thanks for being here.

DAVE DICKEY: Thank you so much, Steve. Thank you, Regina. This was awesome. And again, thanks for doing this for all entrepreneurs out there.

STEVE BLUMENFIELD: You're welcome, and Regina Ihrke, thank you so much. It's always great to see you.

REGINA IHRKE: Thanks, Steve, for having me and really helping all these employers figure out where they go next.

STEVE BLUMENFIELD: Oh, you're both so nice. And thank you most of all to our listeners of the Cure the Common Co podcast. We appreciate you being here. Please remember to listen, to rate us, to subscribe, and to tell your friends. Everyone, have a great day.

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